No. 17-

IN THE

Supreme Court of the United States

UNITED STATES EX REL. NANCY CHASE,

Petitioner,

v.

CHAPTERS HEALTH SYSTEM, INC., *et al.*,

Respondents.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a relator filing a *qui tam* suit under the False Claims Act, 31 U.S.C. § 3729 *et seq.*, may satisfy Rule 9(b) of the Federal Rules of Civil Procedure without identifying a specific false or fraudulent claim submitted to the government in her complaint, but instead may do so by alleging the details of a false or fraudulent scheme and facts sufficient to create a basis for an inference that false or fraudulent claims were submitted to the government.

PARTIES TO THE PROCEEDING

Petitioner Nancy Chase was the plaintiff/relator in the district court and the appellant in the court of appeals.

The Respondents are as follows, all of whom/which were defendants in the district court and appellees in the court of appeals:

Chapters Health System, Inc.

Chapters Health, Inc.

LifePath Hospice, Inc.

Good Shepherd Hospice, Inc.

Ronald Schonwetter, M.D.

Sayyed Hussain, M.D.

Diana Yates

Richard M. Wacksman, M.D.

Mobile Physician Services, P.A.

JSA Healthcare Corporation

Sunrise Senior Living Services, Inc.

Superior Residences, Inc.

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Nancy Chase respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (App., *infra*, 1a-17a) is unreported. The district court's opinion (App., *infra*, 18a-45a) is also unreported.

JURISDICTION

The Court of Appeals entered judgment on January 24, 2018. (App., *infra*, 1a-17a.) This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS AND FEDERAL RULES INVOLVED

The provisions of the False Claims Act and Federal Rules of Civil Procedure involved are, in relevant part, as follows:

False Claims Act Provisions

31 U.S.C. § 3729(a)(1)

[A]ny 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; ....

is liable to the United States Government for a civil penalty … plus 3 times the amount of damages which the Government sustains because of the act of that person.

Federal Rules of Civil Procedure

Fed. R. Civ. P. 8(a)

Claim for Relief. A pleading that states a claim for relief must contain: … (2) a short and plain statement of the claim showing that the pleader is entitled to relief ….

Fed. R. Civ. P. 9(b)

Fraud or Mistake; Conditions of Mind. In 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.

STATEMENT

This case presents an issue that continues to divide the courts of appeal: the proper standard for determining whether a complaint brought under the False Claims Act ("FCA"), 31 U.S.C. § 3729, *et seq.*, sufficiently "state[s] with particularity the circumstances constituting fraud" as required by Rule 9(b) of the Federal Rules of Civil Procedure. The Fourth, Sixth, Eighth, and Eleventh Circuits have applied Rule 9(b) so as to require that a

relator allege with particularity that specific false or fraudulent claims were presented to the government for payment while the First, Third, Fifth, Seventh, Tenth, Ninth, and District of Columbia Circuits have instead held that it is sufficient merely to allege with particularity the scheme to submit false claims together with sufficient indicia that false claims ultimately were submitted. The Solicitor General previously has noted this division of authority to this Court and emphasized the importance of the Court addressing the issue. This is an appropriate case for the Court to do so.

I. Statutory and Regulatory Background

A. False Claims Act

The FCA prohibits anyone from knowingly presenting, or causing to be presented, to the government a false or fraudulent claim for payment or approval or knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim. A defendant who violates the FCA is liable for a civil penalty for each violation, as well as treble damages. 31 U.S.C. § 3729(a)(1).

The FCA allows private individuals, referred to as relators, to bring suit on behalf of the government. Should the government elect not to intervene in the case, the relator may proceed to conduct the action. *Vt. Agency of Natural Res. v. U.S. ex rel. Stevens*, 529 U.S. 765, 769-770 (2000); 31 U.S.C. § 3730(d)(1)-(2).

B. Medicare and Medicaid Fraud in the Area of Hospice Care

The instant case alleges a scheme by which hospice providers, medical providers, nursing homes and assisted living facilities enrolled, or caused to be enrolled, patients in hospice care who did not meet the Medicare and Medicaid statutory and regulatory requirements for eligibility for hospice care, or the level of such care in which they were enrolled. Petitioner alleges that the defendants enrolled ineligible patients, enrolled patients for heightened levels of care for which they were not eligible, retained patients in hospice care after the point they were no longer eligible, and created documentation designed to conceal patients' lack of eligibility.

Hospice care refers to a comprehensive set of services for the physical, psychological, spiritual, and emotional needs of terminally-ill patients and their families. Hospice facilities provide palliative care rather than curative care so that individuals in hospice and their families receive pain relief, comfort, and emotional and spiritual support as opposed to treatments to cure the disease or condition.

Hospice is covered under Medicare and Florida Medicaid subject to certain conditions. First, it must be certified that the patient is "terminally ill," that is he or she has a medical prognosis that his or her life expectancy is six (6) months or less. 42 U.S.C. § 1395x(dd)(3)(A); 42 C.F.R. § 418.3. Such an initial certification is valid for a period of up to 90 days. If, after 90 days, the patient survives and the attending physician and medical director recertify that the patient remains terminally ill, the patient may be enrolled in hospice care for a second 90-day

period. Thereafter, the attending physician and medical director must recertify the patient's terminal condition every 60 days for him or her to remain eligible for hospice care. 42 U.S.C. § 1395f(a)(7)(A)(i)-(ii); 42 C.F.R. § 418.22.

In addition, for hospice care to be reimbursable, there must be a valid and timely election statement, in which a terminally ill patient elects to give up Part A Medicare benefits for any curative treatment of the terminal illness and, instead, opts for palliative care. 42 U.S.C. § 1395d; 42 C.F.R. §§ 418.24(a) & 418.200. There also must be "clinical information and other documentation that support the medical prognosis. 42 C.F.R. § 418.22(b). Finally, the hospice provider must establish an individualized, written Plan of Care *before* care is provided and the care must be consistent with that Plan of Care. 42 U.S.C. § 1395f(a)(7)(B)&(C); 42 C.F.R. §§ 418.200 & 418.56.

The Centers for Medicare and Medicaid Services establishes fixed payment rates for four categories of covered hospice care. One such category is "continuous home care," where staff is placed in the patient's home around the clock. *See* 42 U.S.C. § 1395f(i); 42 C.F.R. § 418.302(b) & (c). Continuous Care is only supposed to be provided when a patient has a symptom that is not being managed effectively. Hospice care "may be provided on a 24-hour, continuous basis only during periods of crisis … and only as necessary to maintain the terminally ill individual at home." 42 U.S.C. § 1395x(dd)(1). Continuous Care placements provide much higher reimbursements to hospices; for instance, the 2009 Routine Home Care Federal reimbursement rate for the Tampa area was $139.97 per day, and Inpatient Respite Care was $144.79

per day. By contrast, the 2009 Continuous Care rate for the Tampa area was $816.94 per day.

II. Proceedings Below

A. Relator's Complaint

Petitioner worked for Respondent LifePath Hospice, Inc. from 1992 until December 2012 as a Social Services Specialist, Patient and Family Counselor, and Psychosocial Consultant. App., *infra*, 51a (¶ 11). Petitioner additionally served on LifePath's Ethics Committee and on an IDG Committee that developed policies and procedures for the entire Chapters Health group of companies. *Id.* at 51a-52a (¶ 12).

Petitioner's Fourth Amended Complaint alleges that Respondent Chapters Health System, Inc. and its subsidiaries (Respondents Chapters Health, Inc., LifePath Hospice, Inc., and Good Shepherd Hospice, Inc.) and certain of their employees (Respondents Schonwetter, Hussain, Yates and Wacksman) knowingly enrolled ineligible patients in hospice care, kept patients in hospice care after they were no longer eligible, and enrolled patients at heightened levels of care for which they were not eligible. Specifically, the Complaint alleges that Respondents instructed admissions staff "to admit referrals and other potential patients as a matter of course without first verifying eligibility and obtaining all documentation" (App., *infra*. at 63a (¶ 49)); directed staff there was no reason patients should not be admitted for at least 30 days (*id.* at 64a (¶ 50)); required that referrals from certain sources always be admitted irrespective of eligibility (*id.* at 64a (¶ 54)); instructed admissions to

approach every patient from the perspective of finding a way or reason to enroll the patient and to approach re-certifications from the same perspective (*id.* at 63a, 64a, 66a (¶¶ 49, 51, 62)); required that negative responses to requests for physician certifications be redirected to a specific doctor, Respondent Wacksman (*id.* at, 64a (¶ 52)); imposed admissions and Continuous Care quotas on staff, including nurses and social workers (*id.* at 65a,71a-72a (¶¶ 55-58, 79-84)); paid compensation and incentives to employees based on the number of referrals or admissions generated (*id.* at 84a-85a (¶¶ 135-141)); up-coded patients to Continuous Care irrespective of their eligibility (*id.* at 72a-73a (¶¶ 85-88)); prohibited recertification for any patient before 90 days had elapsed (*id.* at 66a (¶¶ 60-61)); and delayed discharges by prolonging the process of evaluating continued eligibility and requiring a visit by a Chapters Health physicians before a patient could be discharged (*id.* at 66a (¶¶ 53, 59)).

Petitioner's Complaint further alleges that Respondents admitted patients to hospice without valid and timely-executed election statements, and on occasion obtained invalid and/or back-dated election statements. App., *infra*, 68a (¶¶ 67, 69-72). Respondents further trained staff to "document to decline," or prepare charts and patient records documenting only information that showed a decline in the patient's condition while ignoring any improvements (*id.* at 73a-75a (¶¶ 92-98)); instructed and trained staff that "frequent visits blind the decline" – or that staff should minimize patient visits to make it easier to show a decline (*id.* at 75a (¶ 99)); removed from patient files notes and information that did not support the appropriateness of patients for hospice care (*id.* at 75a-76a (¶¶ 101-102)); and instructed nurses and counselors to alter

Plans of Care after-the-fact to conceal failure or inability to provide the services required by the Plans of Care (*id.* at 77a-78a (¶¶ 107-111)).

Petitioner details these directives and practices, which resulted in the enrollment of patients ineligible for hospice under Medicare rules, in the Complaint. For instance, Petitioner identifies two examples of specific patients who were admitted and retained despite their known and acknowledged inappropriateness for hospice care (*id.* at 67a-68a (¶¶ 64-66)); cites another example of a patient for whom LifePath billed Medicaid when the patient was not in the United States or even receiving services from LifePath (*id.* at 79a (¶ 116)); alleges that nurses and counselors openly admitted to failing to adhere to Plans of Care and altering the same to conceal that fact (*id.* at 77a-78a (¶ 110)); and alleges that admissions nurses skewed Medicare requirements and admitted patients who were not appropriate or qualified for hospice (*id.* at 85a (¶ 140)).

The Complaint further alleges that Respondents violated the Anti-Kickback Statute and the Stark Act by offering and paying bonuses and prizes to employees for generating referrals (App., *infra*, 84a-85a (¶¶ 135-141)); agreeing to provide Respondent Superior Residences, Inc. with supplies in exchange for hospice patient referrals (*id.* at 86a-87a (¶¶ 147-150)); paying certain expenses of Respondent JSA Medical Group in exchange for referrals and agreeing to keep JSA patients in hospice care irrespective of eligibility so as to produce cost-savings for JSA (*id.* at 88a-89a (¶¶ 157-160)); agreeing with Respondent Sunrise Senior Living Services, Inc. to certify all of its patients for Continuous Care irrespective

of eligibility or medical necessity (*id.* at 85a-86a (¶¶ 142-146)); and referring patients to and receiving patient referrals from Respondent Mobile Physician Services, P.A. despite Dr. Wacksman's financial relationship with both Mobile Physician Services and the Chapters Health entities (*id.* at 87a-88a (¶¶ 151-156)).

Petitioner alleges that all of the foregoing actions and practices resulted in the submission of false claims to Medicare and Florida's Medicaid program. Petitioner specifically alleges that approximately 80 percent of Chapters patients were Medicare or Medicaid beneficiaries. *Id.* at 89a (¶ 161). She further alleges that periodic internal chart reviews or audits revealed that, at any given time, anywhere from 20 to 40 percent of the approximately 2,000 patients did not meet the Medicare eligibility requirements for hospice care. *Id.* at 90a (¶ 162). Petitioner also alleges that, in 2008, the Chapters entities' Medicare fiscal intermediary requested substantiation of the eligibility of patients for whose care Medicare had paid. App., *infra*, 62a, 75a-76a (¶¶ 44-45, 101-102). Despite obstructive efforts to excise from patient records all information affirmatively indicating patients' inappropriateness for hospice, Chapters ultimately could not document the eligibility of a third of their Medicare patients resulting in the loss of roughly 600 patients from the patient census following this review. *Id.* at 62a (¶¶ 44-45).

Petitioner's Complaint, however, does not allege the specific date, amount, patient, and services billed to Medicare or Florida Medicaid for a specifically-identified patient. The Complaint does, however, reference conversations regarding one specific patient whom Dr.

Wacksman admitted at a meeting, was not, and never had been, eligible for hospice and the fact that a claim was submitted for a patient who was not even in the country. App., *infra*, 67a-68a (¶ 66).

B. Decision of the District Court

On September 22, 2016, the district court dismissed Petitioner's Complaint with prejudice. The district court held that Petitioner did not satisfy "the requirements of Rule 9 and the standard described in" *United States ex rel. Clausen v. Lab. Corp. of Am.*, 290 F.3d 1301 (11th Cir. 2002), because, although she had "provided the 'who,' 'what,' 'where,' 'how,' and 'when' of" the defendants' "hospice-admission policies and perhaps even some of its medical practices," "[s]he has not done the same for fraudulent claims submitted to the government for those practices" but "has instead provided only conclusory claims of their existence supported by inference." App., *infra*, 35a, 38a. The district court held that Petitioner could only rely on an inference that false or fraudulent claims were submitted to the government if the inference was "supported by first-hand knowledge of billing practices." *Id.* at 38a. The district court thus concluded that while Petitioner had "describe[d] a private scheme in detail, to include facts as to some disturbing medical practices," she had not alleged the time, place and substance of "a fraudulent claim." *Id.* at 35a.

C. Decision of the Court of Appeals

The court of appeals affirmed. The court of appeals agreed with the standard applied by the district court and, quoting and/or citing its previous opinions in *United States ex rel. Clausen v. Lab. Corp. of Am.*, 290 F.3d 1301

(11th Cir. 2002) and *Corsello v. Lincare, Inc.*, 428 F.3d 1008 (11th Cir. 2005), the court of appeals held as follows:

> The submission of a false claim is the sine qua non of a False Claims Act violation. Because it is the submission of a fraudulent claim that gives rise to liability under the False Claims Act, that submission must be pleaded with particularity and not inferred from the circumstances. Therefore, unless a relator alleges with particularity that false claims were actually submitted to the government, our precedent holds that dismissal is proper.

App., *infra*, 9a (internal quotations and citations omitted).

REASONS FOR GRANTING THE PETITION

This case raises an issue that has continued to divide the courts of appeals: the proper application of Rule 9(b) to complaints brought under the FCA. The decision below held that a relator (or the government) must allege the actual submission of a false claim by a defendant with particularity and such submission *cannot* be inferred from the circumstances. This decision firmly places the Eleventh Circuit in line with decisions by the Fourth, Sixth and Eighth Circuits holding that Rule 9(b) requires the identification of "an actual false claim with particularity" at the pleading stage. *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 504 (6th Cir. 2007). By contrast, the First, Third, Fifth, Seventh, Ninth, Tenth and District of Columbia Circuits have all held that a complaint under the FCA must only allege particular details of a scheme to submit false claims accompanied by

allegations providing an adequate basis for a reasonable inference that false claims ultimately were submitted as a result of the scheme. The United States previously has acknowledged this very conflict and urged the Court to review it. *See* Brief for the United States as *Amicus Curiae* at 10-11, *United States ex rel. Nathan v. Takeda Pharm. N. Am., Inc.*, No. 12-1249 (U.S. Feb. 2014) (hereinafter "U.S. *Nathan* Br."); Brief for the United States as *Amicus Curiae* at 17, *Ortho Biotech Prods., L.P. v. United States ex rel. Duxbury*, No. 09-654 (U.S. May 2010) (hereinafter "U.S. *Duxbury* Br.").

The growing division among the courts of appeal on this issue warrants review by this Court. The question of the proper pleading standard arises in nearly every FCA case, and the issue of the required degree of specificity as to the false claims submitted implicates every health care fraud case under the FCA. Health care fraud represents a substantial burden on the government's resources. The government relies on whistleblowers to bring to its attention fraudulent schemes to bill Medicare and Medicaid for health care services that are improper, unnecessary, or not in compliance with federal rules and standards. The restrictive pleading standard applied by the district court and the court of appeals in this case would prevent relators from filing *qui tam* actions unless they were privy to both the conduct by which inappropriate or non-reimbursable services were provided and the ministerial submission of the claim to the government for payment for those services. As the Solicitor General has previously noted, this undermines the purpose of the FCA. The facts of this case and the rulings by the district court and the court of appeals below provide an ideal opportunity for this Court to review the issue.

I. The Eleventh Circuit's Decision Highlights the Circuit Split Over the Application of Rule 9(b) in False Claims Act Cases

The Eleventh Circuit's ruling that to state a claim for relief under the FCA, a relator must allege sufficient facts to show the time, place, and substance of the specific false claims submitted to the government is at odds with holdings in at least seven other circuits.

The First, Third, Fifth, Seventh, Ninth, Tenth and District of Columbia Circuits all have recognized that, while Rule 9(b) requires that a complaint plead fraud with particularity, "the rule is context specific and flexible and must remain so to achieve the remedial purpose of the False Claims Act." *United States ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009). As the Fifth Circuit has put it, "[s]tating 'with particularity the circumstances constituting fraud' does not necessarily and always mean stating the contents of a bill." *Id.* The "time, place, contents, and identity standard is not a straitjacket for Rule 9(b) …." *Id.*; *see also United States ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 125 (D.C. Cir. 2015) ("Rule 9(b) does not inflexibly dictate adherence to a preordained checklist of 'must have' allegations.").

While *qui tam* relators are often employees of the defendant who know the details of their employer's scheme to defraud the government, they often lack access to the particular false claims submitted to the government prior to filing the complaint (unless they work in the billing department). *United States ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 854-855 (7th Cir. 2009); U.S. *Duxbury* Br. 17. Consequently, these circuits have recognized that

it is sufficient to allege the fraudulent scheme together with sufficient indicia to support the inference that claims were submitted:

> [T]o plead with particularity the circumstances constituting fraud for a False Claims Act claim, a relator's complaint, if it cannot 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.*

Grubbs, 565 F.3d at 190 (5th Cir.) (emphasis added); *see also United States ex rel. Presser v. Acacia Mental Health Clinic, LLC*, 836 F.3d 770, 777 (7th Cir. 2016) ("Our case law establishes that a plaintiff does not need to present, or even include allegations about, a specific document or bill that the defendants submitted to the Government."); *Heath*, 791 F.3d at 126 (D.C. Cir.) ("the precise details of individual claims are not, as a categorical rule, an indispensable requirement of a viable False Claims Act complaint"); *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153, 155-57 (3d Cir. 2014); *United States ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163, 1172 (10th Cir. 2010) ("claims under the FCA need only show the specifics of a fraudulent scheme and provide an adequate basis for a reasonable inference that false claims were submitted as part of that scheme"); *United States ex rel. Duxbury v. Ortho Biotech Prods., L.P.,* 579 F.3d 13, 29 (1st Cir. 2009), *cert. denied*, 130 S. Ct. 3454 (2010); *Lusby,* 570 F.3d at 854-855 (7th Cir.); *Ebeid ex rel. United States v. Lungwitz,* 616 F.3d 993, 998-999 (9th Cir.), *cert. denied*, 131 S. Ct. 801 (2010).

Under this approach, it is not "essential for a relator to produce" in the complaint the "specific request for payment." *Lusby,* 570 F.3d at 854. Rather, the plaintiff may survive a motion to dismiss "by providing factual or statistical evidence to strengthen the inference of fraud beyond [mere] possibility without necessarily providing details as to each false claim." *Duxbury,* 579 F.3d at 29 (quotation marks omitted).

By contrast, the Fourth, Sixth, Eighth and Eleventh Circuits have taken a rigid view of the Rule 9(b) particularity requirement, holding that a plaintiff must allege or show "representative samples" of the alleged false claims, specifying the time, place, and content of the claims and the identity of those submitting them to the government. *See United States ex rel. Noah Nathan v. Takeda Pharm. N. Am., Inc.*, 707 F.3d 451, 455-56 (4th Cir. 2013), *cert. denied*, 134 S. Ct. 1759 (2014); *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 510 (6th Cir. 2007); *United States ex rel. Joshi v. St. Luke's Hosp., Inc.*, 441 F.3d 552, 557 (8th Cir. 2006), *cert. denied*, 549 U.S. 881 (2006).

Accordingly, whether a particular FCA case can survive a motion to dismiss presently depends significantly on the circuit in which the case is filed. The application of a federal statute and rule of civil procedure—and the government's ability to recover for fraud committed against it—should not depend on the geographic location of the defendant or the defendant's conduct.

II. The Conflict Concerns an Important and Recurring Question of Federal Law

The split of authority amongst the circuits as to the correct federal pleading standard for FCA claims is sufficiently important to warrant this Court's review. At least seven circuits have applied a pleading standard that is consistent with the FCA's purposes whereas four circuits, including the Eleventh Circuit in this case, have applied a more rigid reading that hampers the government's ability to rely on private plaintiffs to detect and prosecute fraud against the United States.

In a brief for the United States as *amicus curiae*, filed in relation to the petition for a writ of certiorari in *Nathan*, the Solicitor General indicated the government's view that "pleading the details of a specific false claim presented to the government is not an indispensable requirement of a viable FCA complaint" and that the heightened or "rigid" pleading standard is "unsupported by Rule 9(b) and undermines the FCA's effectiveness as a tool to combat fraud against the United States." U.S. *Nathan* Br. 10-11.

FCA *qui tam* complaints, unlike common law or securities fraud claims, do not require the plaintiff to prove either that a party relied on a specific representation or that there has been a monetary injury. *Grubbs*, 565 F.3d at 189. A person that presented fraudulent claims that were never actually paid remains civilly liable. *Id.* Accordingly, providing identifying details about specific payments is less important to put the defendant on notice.

Nor would such details serve the purposes of the FCA. As the Solicitor General noted in the *Nathan* amicus,

"a rigid rule that [FCA complaints that do not contain detailed allegations false claims were submitted to the government] are inadequate would hinder the ability of *qui tam* relators to perform the role that Congress intended them to play in the detection and remediation of fraud against the United States." U.S. *Nathan* Br. 14-15. The Solicitor General further explained in the *Duxbury* amicus brief that the government looks to defendants' employees and former employees to provide detailed information about their employers' actual practices, but that under such a pleading standard "relators would be disabled from filing suit under the FCA unless they were also familiar with the minutiae of their employers' billing practices." *See* U.S. *Duxbury* Br. 17. Because a prospective relator is unlikely to be privy to such details unless she "works in the defendant's accounting department," a rule demanding the details of specific false claims would "take [ ] a big bite out of *qui tam* litigation." *Lusby*, 570 F.3d at 854.

Further, "[s]ubjecting *qui tam* relators to a per se rule requiring the identification of specific false claims is especially unwarranted because it attaches dispositive significance to the relator's awareness of details that in most instances are already known to the government." U.S. *Nathan* Br. 16. The federal government already has records of those payments. Instead, "relators who make valuable contributions to the government's enforcement efforts typically do so by bringing to light information, outside the four corners of the claims for payment, that shows those claims to be false." U.S. *Duxbury* Br. 17.

Moreover, requiring billing detail for specific false claims would impose a substantial procedural obstacle to a relator proceeding in a case where the government elects not to intervene. The government's resources are not unlimited, and they cannot intervene in every meritorious case. The provisions of the FCA permitting relators to prosecute cases in the government's name provide an important mechanism to ensure that fraud committed against the government is pursued. Insisting—as the district court and court of appeals did in this case—that a relator allege in her initial pleading specific details of claims actually submitted just to be able to proceed with the lawsuit eviscerates that component of the statutory scheme adopted by Congress and effectively leaves the government as the only party who can present a complaint that can withstand a motion to dismiss.

The standard applied by the court of appeals in this case thus will unnecessarily limit the pool of potential *qui tam* relators to a very small, potentially non-existent group of individuals who happen to be employed both in the field or on the floor where the fraudulent conduct occurs and in the corporate billing department, where they would have first-hand knowledge of the submission of false claims. This overly rigid standard will undermine the FCA's core objectives of identifying and pursuing fraud, will discourage relators from reporting false claims to the government, and will establish an insurmountable pleading obstacle for cases in which the government elects not to intervene.

III. The Decision Below Provides an Appropriate Vehicle for Review

In this case, the district court held that Petitioner sufficiently pled a private scheme—*i.e.*, "the 'who,' 'what,' 'where,' 'how,' and 'when' of" the Respondents' "hospice-admission policies and perhaps even some of its medical practices[.]" App., *infra*, 38a. The court of appeals did not disturb that finding, but instead agreed that Petitioner's Complaint nonetheless should be dismissed because "[s]he has not done the same for fraudulent claims submitted to the government for those practices" but "has instead provided only conclusory claims of their existence supported by inference." *Id.* at 35a, 38a.

However, Petitioner's allegations met the pleading standards as applied in other circuits. By comparison, in *Presser*, the Seventh Circuit held that a nurse practitioner adequately alleged that her employer billed Medicare for services that were provided pursuant to questionable practices and procedures. 836 F.3d at 777-78. In *Presser*, the relator alleged only that the owner of the clinic for which she worked had told her "that almost all of [its] patients were 'on Title 19'" and that they dealt with Medicare. *Id.* at 778. The Seventh Circuit held this was enough, reasoning that "[c]onsidering Ms. Presser's position as a nurse practitioner, a position that does not appear to include regular access to medical bills, we do not see how she would have been able to plead more facts pertaining to the billing process." *Id.*

The same is true of Petitioner here. Her position did not include regular access to medical bills, but she alleged with particularity the details of the fraudulent

scheme with respect to the admission and retention of hospice patients and the creation and maintenance of false and misleading documentation with respect to hospice services. In addition, Petitioner alleges that approximately 80 percent of the hospice patients were Medicare or Medicaid patients, and that the policies and practices employed in the fraudulent scheme were directed at avoiding Medicare requirements or obscuring the lack of compliance therewith.

In the specific context of hospice-related FCA claims, courts in jurisdictions that do not follow the rigid pleading standard have found sufficient allegations similar to those made by Petitioner in her Complaint. For example, in *United States ex rel. Fowler v. Evercare Hospice, Inc.*, Nos. 11-00642, 14-01647, 2015 WL 5568614 (D. Colo. Sept. 21, 2015), the court held the complaint's allegations were sufficient to state a claim that a hospice provider had presented or caused to be presented false claims for hospice care where the complaint alleged the defendant's "management placed intense pressure on employees to admit patients into hospice care," the defendant set "target census numbers" for hospice patients and pressured "site leaders" to meet those targets, the defendant incentivized employees to admit hospice patients by providing bonuses, the defendant threatened termination or discipline if enrollment expectations were not met, and employees made "multiple complaints" that "management pressured and instructed [them] to admit and retain inappropriate patients." *Id.* at *7-8.

Likewise, in *United States ex rel. Landis v. Hospice Care of Kansas, LLC*, No. 06-2455, 2010 WL 5067614 (D. Kan. Dec. 7, 2010), the court held the complaint's

allegations were sufficient to state a claim where it alleged the defendants "followed business practices that caused the 'admission, retention, and submission of claims to Medicare for patients that were ineligible for the hospice benefit.'" *Id.* at *2 (quoting complaint). Specifically:

> Those business practices included: setting aggressive census targets for each [ ] branch office; staff incentives and monetary bonuses for meeting the aggressive census targets; threatening staff with terminations or reductions in hours if the census fell below targets; instructing staff to inaccurately document the condition of patients to make them appear appropriate for hospice and to avoid detection if medical files were reviewed by [the Government's fiscal intermediary]; implementing procedures that delayed the discharge or made it difficult to discharge ineligible patients; challenging or ignoring staff and physician recommendations to discharge patients; and disregarding or ignoring compliance concerns raised by an outside consultant.
>
> ….
>
> The Complaint also alleges that defendants had ineffective training and compliance programs that made it likely they would submit false claims for patients ineligible for the hospice benefit.

Id. at *2-3.

Petitioner's Complaint makes similar and, in many instances, more detailed allegations than those described in the foregoing cases, both of which were held sufficient to state a claim under the FCA. If the truth of the Complaint's allegations are assumed (which it must be on a motion to dismiss), it necessarily follows that fraudulent bills were submitted to the government.

Further, the fraudulent schemes alleged in the Complaint are all premised upon and directed at the conditions and criteria for reimbursement by Medicare. The policies and practices detailed in the Complaint are all directed at physician certifications, election statements, admissions records, patient records, and Plans of Care—all of which are or implicate express requirements for reimbursement under Medicare rules. Indeed, there would be no point to all of the policies and procedures (all geared to address, get around, or obscure non-compliance with Medicare requirements) if the hospice entities did not serve Medicare patients or were going to, at the last minute, just not submit a claim to the government.[1]

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1. In other instructive cases from the Seventh Circuit, the court held alleged facts to necessarily lead one to the conclusion the defendant presented false claims to the government. In *Lusby*, 570 F.3d 849, an engineer alleged his employer knowingly certified engine parts that did not meet government specifications. *Id.* at 853–54. The engineer's complaint described the parts that were shipped, noted that a contract *required* his employer to certify the parts in order to receive payment, and stated that payment was received. *See id.* at 853. However, the engineer did not provide an invoice showing a specific request for payment. *See id.* at 854. The court nonetheless held it was reasonably understood from the complaint that the employer had submitted a certificate containing false statements in asking for payment. *See id.* (noting that it was "possible that military procurement officers accepted and

In another case, the court was presented with allegations simply stating that the defendant was a Medicare and Medicaid provider and provided hospice services, describing how certain hospice services are reimbursable under Medicare statutes and regulations, alleging admission and certification of patients falling short of the criteria and identifying shortcomings in defendants' recordkeeping. *See Druding v. Care Alternatives, Inc.*, 164 F. Supp. 3d 621, 631 (D.N.J. 2016). The court found these allegations sufficient, reasoning that "[i]t is no great leap for the Court to infer that a Medicare provider would submit claims for reimbursement for any of these patients which had been certified as terminally ill, and that these purportedly legally false medical records could have formed the basis of such a claim for reimbursement." *Id.*

The lower court rulings in this case thus rest upon the premise that the hospice providers never submitted claims to Medicare or Medicaid, a fiction assumed entirely from the lack of an allegation as to particular dates, amounts, services or patients for whom such claims were submitted. Neither the hospice entities nor any other defendant has ever suggested claims were not submitted to the government. They obviously were.

Accordingly, the lower court rulings in this case present an ideal opportunity to review the question

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paid for the turbine blades without this certificate" but that the possibility was "remote"). In *Leveski v. ITT Educ. Servs., Inc.*, 719 F.3d 818 (7th Cir. 2013), the court held an employee of an educational training institution adequately pled fraud by alleging the institution failed to comply with federal law, received funding, and "could only have received federal funding by certifying compliance" with federal law. *Id.* at 839.

whether the submission of a false claim to the government must be pled with particularity or can be supported by inference.

CONCLUSION

For the foregoing reasons, this Court should grant the petition for a writ of certiorari. The Court may wish to consider the possibility of summary reversal of the decision of the Court of Appeals for the Eleventh Circuit; in the alternative, the Court should set the case for briefing and oral argument.

Respectfully submitted,

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Dated: April 24, 2018

APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT, FILED JANUARY 24, 2018

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 16-16670

UNITED STATES OF AMERICA, *et al.*,

Plaintiff,

NANCY CHASE, *ex rel.*,

Plaintiff-Appellant,

versus

HPC HEALTHCARE, INC.,
A FLORIDA CORPORATION,

Defendant,

LIFEPATH HOSPICE, INC., A FLORIDA CORPORATION, GOOD SHEPHERD HOSPICE, INC., A FLORIDA CORPORATION, MOBILE PHYSICIAN SERVICES, P.A., A FLORIDA PROFESSIONAL ASSOCIATION, CHAPTERS HEALTH, INC., A FLORIDA CORPORATION, RONALD SCHONWETTER, M.D., CHAPTER HEALTH SYSTEMS, INC., *et al.*,

Defendants-Appellees.

Appendix A

Appeal from the United States District Court
for the Middle District of Florida.

January 24, 2018, Decided

Before TJOFLAT and MARTIN, Circuit Judges, and MURPHY,* District Judge.

MARTIN, Circuit Judge:

In this *qui tam* action, relator Nancy Chase appeals from the District Court's dismissal of her complaint alleging that several health care providers violated the federal and Florida False Claims Acts. The District Court dismissed the complaint for failure to satisfy the heightened pleading requirements of Federal Rule of Civil Procedure 9(b) for claims alleging fraud. It also ruled that the complaint failed to state a claim with respect to Ms. Chase's conspiracy and retaliation claims. Ms. Chase now appeals both the dismissal of her complaint and the denial of her request to file an amended complaint. After careful review, we affirm.

I. BACKGROUND

A. THE PARTIES

The admission and billing practices of Defendant Chapters Health System, Inc., ("Chapters") and its

* Honorable Stephen J. Murphy, III, United States District Judge for the Eastern District of Michigan, sitting by designation.

subsidiaries are at issue in this case. Chapters is a Florida non-profit that provides hospice services. It has three subsidiaries: Chapters Health, Inc., LifePath Hospice, Inc., and Good Shepherd Hospice, Inc. Chapters Health manages and coordinates the activities of Chapters Health System and its entities. LifePath and Good Shepherd provide hospice and palliative care services. Collectively, these defendants are the "Chapters Defendants."[1] Approximately 80 percent of the Chapters Defendants' patients are Medicare or Medicaid beneficiaries.

JSA Healthcare Corporation, Sunrise Senior Living Services, Inc., and Superior Residences, Inc., are for-profit health care and assisted living providers. Mobile Physician Services, P.A., is a for-profit provider of at-home health care. These providers referred patients to Chapters for hospice services. Collectively, these defendants are the "Referral Defendants."

Ms. Chase, the relator, is a licensed social worker. From 1992 to 2012, she was employed by LifePath. During her employment with LifePath, she worked as a social services specialist, patient/family counselor, and psychosocial consultant. As a psychosocial consultant from 1994 to 2009, Ms. Chase's primary responsibilities included "training counselors, providing clinical supervision towards licensure, providing consultation to entire teams regarding counselor functions, dealing with any difficult or challenging cases, and providing leadership input

1. The complaint also names as defendants several people who worked for Chapters and its subsidiaries.

in the psychosocial capacity." Ms. Chase also served on LifePath's ethics committee and a committee that developed corporate policies. In 2012, she was fired.

B. THE ALLEGATIONS

In her complaint, Ms. Chase alleges that the Chapters Defendants fraudulently billed Medicare and Medicaid by admitting and recertifying patients who were not eligible for hospice care. Specifically, she alleges that the Chapters Defendants engaged in six schemes that resulted in false claims being made to the government. Ms. Chase identifies the schemes as (1) providing hospice care to ineligible patients; (2) providing hospice care to patients without properly executed documentation; (3) providing patients higher levels of care than medically necessary; (4) falsifying documents and patient records to conceal patient ineligibility for hospice services; (5) submitting claims for services that were not provided; and (6) providing services that were not in keeping with patient care plans. In addition, Ms. Chase alleges that Chapters unlawfully gave incentives to the Referral Defendants in exchange for their referral of patients for hospice care. Finally, Ms. Chase says that her former employer LifePath retaliated against her for pointing out the alleged fraud.

C. PROCEDURAL HISTORY

Ms. Chase filed this lawsuit under seal in 2010. She amended her complaint three times to add allegations and parties in September 2010, May 2012, and August

2012. In 2015, the United States and the State of Florida declined to intervene on Ms. Chase's behalf. Then in March 2016, Ms. Chase filed a fourth amended complaint, which was served on the defendants and is the operative complaint in this case. The complaint made five claims: (1) the submission of false claims in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1)(A), and the analogous Florida False Claims Act, Fla. Stat. § 68.082(2)(a); (2) making or using false statements or records material to false claims in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1)(B) and the Florida False Claims Act, Fla. Stat. § 68.082(2)(b); (3) conspiracy to commit violations of the False Claims Act and Florida False Claims Act; (4) retaliation by LifePath, in violation of 31 U.S.C. § 3730(h); and (5) discrimination by LifePath, in violation of Fla. Stat. § 68.088.[2]

The defendants moved to dismiss all counts. Then on September 22, 2016, the District Court dismissed the complaint with prejudice. It found the complaint failed to meet the heightened pleading requirement for claims alleging fraud under Federal Rule of Civil Procedure 9(b) and dismissed the counts alleging substantive violations of the federal and Florida False Claims Acts. It also found that the complaint failed to state a claim for the remaining counts of conspiracy, retaliation, and discrimination. The

2. The District Court determined that the Florida False Claims Act mirrored the federal False Claims Act, so there was no need to address them separately. Ms. Chase does not challenge this as error on appeal or otherwise argue that her state law claims should be analyzed differently from her federal law claims. We therefore address only her federal claims.

court dismissed the complaint with prejudice because it found that Ms. Chase had repeatedly failed to cure deficiencies in her complaint and further amendment would be futile. This appeal followed.

II. STANDARD OF REVIEW

We review *de novo* a district court's grant of a motion to dismiss for failure to state a claim. *Starship Enters. of Atlanta, Inc. v. Coweta Cty.*, 708 F.3d 1243, 1252 (11th Cir. 2013). We accept the facts alleged in the complaint as true and construe all inferences in the light most favorable to the plaintiff. *Id.* We review a district court's denial of leave to amend for an abuse of discretion. *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1012 (11th Cir. 2005) (per curiam). However, we review *de novo* the underlying legal conclusion of whether a particular amendment to the complaint would be futile. *Id.*

III. DISCUSSION

A. FALSE CLAIMS

Any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" or who "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim" is liable under the False Claims Act. 31 U.S.C. § 3729(a)(1)(A)—(B).[3] A "claim"

3. In 2009, Congress amended and renumbered the False Claims Act via the Fraud Enforcement and Recovery Act ("FERA"),

includes direct requests for government payment as well as reimbursement requests made under a federal benefits program. *Universal Health Servs., Inc. v. United States*, 136 S. Ct. 1989, 1996, 195 L. Ed. 2d 348 (2016); *see* 31 U.S.C. § 3729(b)(2)(A). "Liability under the False Claims Act arises from the submission of a fraudulent claim to the government, not the disregard of government regulations or failure to maintain proper internal policies." *Corsello*, 428 F.3d at 1012. In the healthcare context, a False Claims Act violation typically involves billing for services not provided or not medically necessary. *E.g., U.S. ex rel. Sanchez v. Lymphatx, Inc.*, 596 F.3d 1300, 1302 (11th Cir. 2010) (per curiam); *U.S. ex rel. Clausen v. Lab. Corp. of Am.*, 290 F.3d 1301, 1303 (11th Cir. 2002). But a provider may also be liable under the False Claims Act if it falsely certifies that it is in compliance with federal health care laws that are a condition of payment. *See McNutt ex rel. U.S. v. Haleyville Med. Supplies, Inc.*, 423 F.3d 1256, 1259-60 (11th Cir. 2005); *see also Universal Health Servs.*, 136 S. Ct. at 1996 ("A misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government's payment decision in order to be actionable under the False Claims Act."). Ms. Chase alleges that the defendants submitted false claims by fraudulently billing for certain hospice services and by falsely certifying compliance with federal health care laws.

Pub. L. No. 111-21, § 4, 123 Stat. 1617, 1621 (2009). The complaint alleges conduct that falls on either side of FERA's effective date. But because Ms. Chase's complaint and briefing cite only to the amended version of the statute, we analyze her claims under the current version.

At the pleading stage, a complaint alleging violations of the False Claims Act must satisfy two requirements. First, the complaint must include "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). To avoid dismissal, a complaint must contain enough specific factual matter to "state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S. Ct. 1937, 1949, 173 L. Ed. 2d 868 (2009) (quotation omitted). Second, the complaint must satisfy Rule 9(b)'s heightened pleading requirement for claims alleging fraud. That is, it must "state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b); *see Clausen*, 290 F.3d at 1308-09 (holding Rule 9(b) applies to False Claims Act claims). Under Rule 9(b), the plaintiff must plead "facts as to time, place, and substance of the defendant's alleged fraud," including "the details of the defendants' allegedly fraudulent acts, when they occurred, and who engaged in them." *Clausen*, 290 F.3d at 1310 (quotation omitted).

The District Court concluded that Ms. Chase's complaint failed to meet Rule 9(b)'s heightened pleading standard for claims alleging fraud. The court acknowledged that Ms. Chase had "describe[d] a private scheme in detail" regarding "disturbing medical practices," but it ruled that she had failed to satisfy Rule 9(b) with her conclusory allegations that false claims were submitted as a result of that scheme. We conclude that the District Court properly dismissed these claims.

The submission of a false claim is "the *sine qua non* of a False Claims Act violation." *Clausen*, 290 F.3d at 1311. "Because it is the submission of a fraudulent claim that gives rise to liability under the False Claims Act, that submission must be pleaded with particularity and not inferred from the circumstances." *Corsello*, 428 F.3d at 1013. Therefore, unless a relator alleges with particularity that false claims were actually submitted to the government, our precedent holds that dismissal is proper. *See Clausen*, 290 F.3d at 1311 (explaining that a plaintiff cannot "merely [] describe a private scheme in detail but then [] allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government").

The key inquiry is whether the complaint includes "some indicia of reliability" to support the allegation that an actual false claim was submitted. *Id.* One way to satisfy this requirement is by alleging the details of false claims by providing specific billing information—such as dates, times, and amounts of actual false claims or copies of bills. *See Hopper v. Solvay Pharms., Inc.*, 588 F.3d 1318, 1326 (11th Cir. 2009); *United States ex rel. Atkins v. McInteer*, 470 F.3d 1350, 1358 (11th Cir. 2006). In other circumstances, this Court has deemed indicia of reliability sufficient where the relator alleged direct knowledge of the defendants' submission of false claims based on her own experiences and on information she learned in the course of her employment. *See U.S. ex rel. Walker v. R&F Props. of Lake Cty., Inc.*, 433 F.3d 1349, 1360 (11th Cir. 2005) (holding that Rule 9(b) was satisfied where the

relator was a nurse practitioner in the defendant's employ who was required to bill under a doctor's provider number and whose conversations about the defendant's billing practices with the office manager formed the basis for the relator's belief that fraudulent claims were actually submitted to the government). However, the basis of this direct knowledge must be pled with particularity. *See Sanchez*, 596 F.3d at 1302-03 & n.4.

Ms. Chase's complaint lacked the "indicia of reliability" required by this Court's precedent because it did not include the underlying factual bases for her assertions. The complaint alleges that Chapters admitted ineligible patients for hospice care, delayed discharges when patients were no longer eligible for care, billed for improperly elevated levels of care or care not provided, falsified certain documents and patient records to conceal these practices, and made false claims as a result of this conduct. But the complaint does not give examples of specific patients who were ineligible for care, details about why they were ineligible, who at Chapters made particular falsifications, when the falsifications occurred, or when the fraudulent bills were submitted to Medicare. *See Clausen*, 290 F.3d at 1310 (explaining that to satisfy Rule 9(b), "a plaintiff must plead facts as to time, place, and substance of the defendant[s'] alleged fraud, specifically the details of the defendants' allegedly fraudulent acts, when they occurred, and who engaged in them") (quotation omitted). This Court has explained that a relator may not simply "portray[] the scheme and then summarily conclude[] that the defendants submitted false claims to the government for reimbursement." *Atkins*, 470 F.3d at 1359.

Although Ms. Chase details a scheme, her complaint does not include specific examples of the conduct she describes or allege the submission of any specific fraudulent claim. Neither does Ms. Chase allege the basis of her knowledge of the defendants' fraudulent billing practices—a process she was far removed from as a social worker. *See id.* (affirming dismissal of complaint despite inclusion of specific examples of patients, dates, and services because relator lacked direct knowledge of defendants' submissions of false claims); *cf. Walker*, 433 F.3d at 1360. In light of all these deficiencies, we conclude that Ms. Chase failed to provide the required "indicia of reliability" to support her allegations of false claims for hospice services.

We also conclude that Ms. Chase did not adequately plead a False Claims Act violation predicated on illegal kickbacks under a false certification theory. The complaint alleged that the defendants falsely certified that they were in compliance with the Anti-Kickback statute and the Stark law. The Anti-Kickback statute prohibits a healthcare provider from financially inducing a person to refer a Medicare patient, and it likewise prohibits that person from receiving any remuneration in exchange for the referral. 42 U.S.C. § 1320a-7b(b)(1), (b)(2). The Stark law prohibits "a physician" from referring Medicare patients to a healthcare provider if the doctor has a "financial relationship" with that provider. 42 U.S.C. § 1395nn(a)(1)(A).

Ms. Chase alleged that the Referral Defendants engaged in separate kickback schemes with the Chapters

Defendants, whereby Chapters conferred certain benefits on the Referral Defendants in exchange for patient referrals in violation of federal law. But her allegations fall far short of satisfying Rule 9(b). For example, she fails to identify a single individual from Sunrise, JSA, or Superior who made a referral to Chapters in exchange for a benefit, a single patient that was improperly referred, who at Chapters provided the bribes, or when those exchanges took place. *See Clausen*, 290 F.3d at 1310. Ms. Chase also alleged that Chapters and Mobile Physicians Services (owned by LifePath's medical director) improperly referred ineligible patients to each other. But she again fails to allege any specific facts supporting this conclusory allegation. Without details to support her conclusory allegations of wrongdoing, Ms. Chase's complaint lacks the necessary "indicia of reliability" under Rule 9(b). We therefore affirm the dismissal of the substantive False Claims Act counts.

B. CONSPIRACY

Ms. Chase also alleged that the defendants violated the False Claims Act's conspiracy provision. Section 3729(a)(1)(C) imposes liability on any person who conspires to commit a violation of the Act. 31 U.S.C. § 3729(a)(1)(C). To state a claim of conspiracy to violate the False Claims Act, the plaintiff must allege (1) an unlawful agreement between defendants to commit a violation of § 3729(a)(1); (2) an act performed in furtherance of the conspiracy; and (3) that the United States suffered damages as a result. *See Corsello*, 428 F.3d at 1014 (interpreting the pre-amendment version of the statute); 31 U.S.C.

§ 3729(a)(1)(C).[4] Rule 9(b)'s heightened pleading standard applies to claims brought under the conspiracy provision. *Corsello*, 428 F.3d at 1014.

The District Court dismissed the conspiracy claim saying that the complaint failed to allege an agreement to defraud the government. We agree. Ms. Chase's complaint alleged merely that "Defendants knowingly conspired with each other" to violate §§ 3729(a)(1)(A) and 3729(a)(1)(B) of the False Claims Act. On appeal, Ms. Chase argues that she sufficiently alleged an agreement between the Chapters Defendants and each of the Referral Defendants. But the complaint fails to identify the people from any of the Referral Defendants involved in the agreement or any specific facts that show an agreement to violate the False Claims Act. We therefore conclude that she falls far short of stating a conspiracy claim. *Compare Corsello*, 428 F.3d at 1014 (dismissing conspiracy claim where the "bare legal conclusion" that defendants "conspired to defraud the Government" was not supported by specific factual allegations that they had entered an agreement), *with U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 193-94 (5th Cir. 2009) (relying on "specific language" between two named coconspirators made during a particular meeting where the relator was present to conclude that the plaintiff had sufficiently alleged an unlawful agreement).

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4. It is not clear whether damages remain a required element under the new conspiracy provision following the 2009 amendments. *See* John T. Boese, *Civil False Claims and Qui Tam Actions*, § 2.01(F) (4th ed. 2011). We need not answer that question here, though, because we conclude that Ms. Chase failed to sufficiently allege an agreement between the defendants.

C. RETALIATION

In order to show retaliation under the False Claims Act, the plaintiff must show that she was "discriminated against in the terms and conditions of [her] employment" for engaging in protected activity.[5] 31 U.S.C. § 3730(h)(1). Unlawful discrimination includes discharge, demotion, suspension, threats, and harassment. *Id.* The False Claims Act defines protected activity as "lawful acts done by the employee . . . in furtherance of an action under [the False Claims Act] or other efforts to stop 1 or more violations of [the False Claims Act]." *Id.* To show retaliation, the plaintiff must establish a causal connection between the retaliation and the protected activity; that is, she must show that the retaliation was "because of" the protected activity. *Id.* This requires the plaintiff to show that the employer was at least aware of the protected activity. *Sanchez*, 596 F.3d at 1304.

In the section of her complaint asserting her retaliation claim, Ms. Chase alleged that she was demoted in 2009 "because she raised ethical issues concerning violations of the Acts." She also alleged that she was removed from two committees and later fired after she raised ethical

5. The District Court treated the requirement for showing retaliation under the federal False Claims Act as identical to the requirement for showing discrimination under the Florida False Claims Act. *See* Fla. Stat. § 68.088 (prohibiting discrimination by an employer against an employee "because of" the employee's protected activity). Ms. Chase does not challenge this as error on appeal. We therefore assume, without deciding, that the District Court was correct to treat these claims the same.

concerns about the failure to honor patients' advance medical directives. Ms. Chase alleged that her demotion, her removal from committees, and her termination all constituted unlawful retaliation.

The District Court correctly found that Ms. Chase's raising of ethical concerns about adherence to advance medical directives was not protected activity because this conduct is not related to a False Claims Act violation. We also agree that Ms. Chase's allegation that she was demoted "because she raised ethical issues concerning violations of the [False Claims] Acts" is a legal conclusion that fails to satisfy federal pleading requirements. *See Iqbal*, 556 U.S. at 678, 129 S. Ct. at 1949 ("A pleading that offers labels and conclusions or a formulaic recitation of the elements of a cause of action will not do.") (quotation omitted). Finally, we reject Ms. Chase's argument that she sufficiently pled her retaliation claim by alleging—in a different section of her complaint unrelated to the retaliation claim—that she "objected to the default enrollment" of certain patients and noted specific Medicare and Medicaid requirements. Even assuming that this objection constituted protected activity, Ms. Chase failed to plead a causal link between that objection and any of the actions she alleged constituted retaliation (i.e., her demotion, her removal from committees, or her termination). And the complaint is devoid of any allegations that the decision-makers at LifePath were aware of this objection. *See Sanchez*, 596 F.3d at 1304; *U.S. ex rel. Yesudian v. Howard Univ.*, 153 F.3d 731, 736, 332 U.S. App. D.C. 56 (D.C. Cir. 1998) (stating that "because of" language in § 3730(h)(1) requires the employee to

show that the employer had knowledge of the protected activity and was motivated to retaliate, at least in part, by the protected activity). We therefore conclude that the District Court properly dismissed the retaliation and discrimination claims.

D. DENIAL OF LEAVE TO AMEND THE COMPLAINT

Under Federal Rule of Civil Procedure 15(a), a court "should freely give leave [to amend] when justice so requires." Fed. R. Civ. P. 15(a)(2). But a district court need not allow an amendment if (1) there has been undue delay, bad faith, dilatory motive, or repeated failure to cure deficiencies in previous amendments; (2) allowing amendment would cause undue prejudice to the defendant; or (3) amendment would be futile. *Corsello*, 428 F.3d at 1014. The District Court denied Ms. Chase leave to amend because it determined she had "repeated chances to cure the deficiencies in her complaint" but had failed to do so. It also found that any further amendments would be futile.

Ms. Chase argues she should be allowed at least one opportunity to address the deficiencies identified by the District Court because this was the first time her complaint was subjected to adversarial testing. In certain circumstances, it may be appropriate for a relator to be allowed to amend the complaint after it is first subjected to adversarial testing, but Ms. Chase's failure to properly ask for leave to amend forecloses her argument that the District Court abused its discretion. *See Long v. Satz*, 181 F.3d 1275, 1279-80 (11th Cir. 1999) (per curiam). To

properly request leave to amend, a plaintiff must (1) file a motion for leave to amend, and (2) "either set forth the substance of the proposed amendment or attach a copy of the proposed amendment." *Id.* at 1279. This Court has assumed that a request to amend included in a response to a motion to dismiss (what Ms. Chase did here) is "the functional equivalent of a motion" for leave to amend. *Atkins*, 470 F.3d at 1362. But Ms. Chase made no attempt to satisfy the second requirement. In her response to the motion to dismiss, she did not identify any new allegations that would make amendment worthwhile. Neither has she provided further details about the substance of her proposed amendments on appeal. Because Ms. Chase did not address "how the complaint could be amended to save the meritless claim," *id.* (quotation omitted), we conclude that the District Court did not abuse its discretion in dismissing the complaint with prejudice.

AFFIRMED.

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION, FILED SEPTEMBER 22, 2016

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

Case No: 8:10-cv-1061-T-30TGW

UNITED STATES OF AMERICA, STATE OF FLORIDA AND NANCY CHASE,

Plaintiffs,

v.

LIFEPATH HOSPICE, INC., GOOD SHEPHERD HOSPICE, INC., MOBILE PHYSICIAN SERVICES, P.A., CHAPTERS HEALTH, INC., CHAPTERS HEALTH SYSTEM, INC., RONALD SCHONWETTER, SAYED HUSSAIN, DIANA YATES, RICHARD M. WACKSMAN, JSA HEALTHCARE CORPORATION, SUNRISE SENIOR LIVING SERVICES, INC. AND SUPERIOR RESIDENCES, INC.,

Defendants.

ORDER

In this *qui tam* action, Plaintiff-Relator Nancy Chase alleges that Defendants conspired to engage in a fraudulent scheme involving Medicare claims for the provision of

hospice care, violations of the federal and Florida False Claims Acts. Chase also alleges that Defendant LifePath Hospice, Chase's former employer, retaliated against her for shedding light on this alleged fraud. Defendants move to dismiss Relator's fourth amended complaint on a several grounds, among them failure to state a claim under the applicable rules of civil procedure (Dkts. 145, 147, 151, 152, 154, 157, 174, and 205). Chase has responded to the motions (Dkts. 167, 168, 169, 170, 171, 181, 191, 195), and several Defendants have replied. The Court has carefully reviewed these filings and the record and the applicable law. As discussed more thoroughly below, the Court concludes that Chase has failed to meet the heightened pleading requirement for claims alleging fraud and that this conclusion alone warrants dismissal of Chase's counts alleging False Claim Act violations. The Court also concludes that Chase has failed to adequately state a cause of action for her remaining counts of conspiracy and retaliation. And finally, the Court concludes that any further amendments would be futile and that the fourth amended complaint should therefore be dismissed with prejudice.

FACTUAL BACKGROUND

Plaintiff-Relator Nancy Chase is a Licensed Clinical Social Worker who worked for Defendant LifePath Hospice from 1992 till late 2012. (Fourth Amended Complaint, Dkt. 79, ¶ 11). LifePath, along with Defendant Good Shepherd Hospice, Inc., is a Florida non-profit organization that provides hospice care to the terminally ill. (*Id.* ¶¶ 15-16). Defendant Chapters Health, Inc. is also a Florida

non-profit organization, and it employs and manages professional medical staffs, to include doctors and nurses who serve LifePath and Good Shepherd's patients. All three are subsidiaries of Defendant Chapters Health System, Inc., a hospice care provider. (*Id.* at ¶¶ 13-17).

In her fourth amended complaint, Chase alleges that these defendants and several people within their leadership—collectively, the "Chapters Defendants"—conspired with other assisted-living and medical providers—the "Referral Defendants"—to defraud the government by submitting Medicare claims for hospice care they did not provide or for hospice care they provided to patients who were ineligible for that care.

Hospice care is covered under Medicare for those patients who qualify as "terminally ill," meaning they are expected live no longer than six months absent a medical miracle. For a patient to qualify, federal law requires that the patient's attending physician and the medical director of the hospice program certify in writing that the patient is in fact terminally ill. (*Id.* at ¶ 32). Initial certifications may last up to 90 days, after which, if the patient is still alive, the attending physician and the medical director may re-certify the patient. The physician and the hospice director must also create a "plan of care" for the patient. (*Id.* at ¶ 35). All care that is provided during any period of certification must be consistent with the plan and medically necessary for the palliative purposes of hospice care. (*Id.*).

Once certified, Medicare pays the hospice provider a per-diem rate, based on the type of care being provided

(e.g., routine home care, continuous home care, or general inpatient care). The hospice provider is paid for each day during which the patient is concurrently eligible for and under hospice care. According to Chase, it is this pay-per-day formula, specifically, that Defendants conspired to exploit. In her 41-page fourth amended complaint, which contains 172 factual allegations, Chase outlines how they allegedly did it.

The Alleged Hospice Care Conspiracy

1. The Chapters Defendants

According to Chase's allegations, from June 2000 to the present, the Chapters Defendants enrolled patients in hospice care despite their knowledge that many of those patients were ineligible. And once in hospice care, the Chapters Defendants engaged in fraudulent practices to keep patients in hospice care longer than authorized by law and to provide patients with more intensive care—and thus more expensive care—than medically necessary. As stated in the complaint, the Chapters Defendants did this by directing "employees to follow practices designed to maximize the number of patients enrolled and to keep them enrolled as long as possible irrespective of their eligibility status, to create documents and records that conceal or obscure the facts and circumstances showing patients' lack of eligibility, and ultimately to maximize Medicare and Medicaid billings." (*Id.* at ¶ 43).

One way in which the Chapters Defendants maximized Medicare revenue was through a process of "filling the

beds." Admissions nurses for the Chapters Defendants were instructed to "find a reason to admit" patients to hospice care. (*Id.* at ¶ 50). And if they could not find a reason, a more senior Patient Care Manager or Team Leader would. (*Id.* at ¶ 51).

Finding a reason often meant finding an attending physician to certify that the patient was terminally ill. Defendant Dr. Schonwetter, Chief Medical Officer for the Chapters Defendants, supplied these fraudulent certifications with the help of two of his alleged co-conspirators, Defendants Dr. Wacksman and Dr. Hussain. (*Id.* at ¶ 52). This practice of referral-despite-ineligibility became so pervasive and commonplace among the Chapters Defendants, Chase alleges, that the Chapters Defendants, through their leadership, went so far as to place quotas—three per week—on patient referrals to hospice care. (*Id.* at ¶ 57).

Once patients were in hospice care, Dr. Schonwetter and the Chapters Defendants engaged in a process called "up-coding," inflating their patients' needs so the patients would receive more intensive care than what was medically necessary. (*Id.* at ¶ 42, 81). More intensive care, like continuous home care, meant larger Medicare reimbursements. (*Id.* at ¶ 78). The Chapters Defendants again told Patient Care Managers to "find a reason" to get patients into continuous home care. (*Id.* at ¶ 81). They did this by lying on medical records, a process the Chapters Defendants called "documenting the decline." (*Id.* at ¶ 91-98). In the one specific example Chase provides, a LifePath counselor asked Defendant Diana Yates,

LifePath's Director of Clinical Services, whether she should document that her patient was riding a bike in her neighborhood; Yates responded by communicating, through a facial expression, that the counselor should not. (*Id.* at ¶ 98). In some instances in which they could not document the decline, the Chapters Defendants simply submitted claims for services they did not provide. (*Id.* at ¶ 122).

The Chapters Defendants further exploited the pay-per-day system by intentionally erecting barriers to the process of "non-recertification," the process by which a patient is found to no longer be in need of hospice care. (*Id.* at 60). Specifically, Dr. Schonwetter instructed staff that no patient should be considered for non-recertification before being on hospice care for 90 days, regardless of the patient's medical condition. And this attitude trickled down the organization: when re-certification time arose, Patient Care Managers and Team Leaders from the Chapters Defendants would ask their staffs, "What can you give me?" and "How can we keep them?" (*Id.* at ¶ 52).

For those patients who were non-recertified, the Chapters Defendants created a program known as "Transitions," and its purpose was to closely monitor these patients with the intention of soon readmitting them and exploiting Medicare's pay-per-day revenue source. (*Id.* at ¶ 64).

Chase provides two examples of this effort to keep and readmit patients. In one, a unnamed nurse spoke up during a 2009 LifePath meeting and insisted that an

unnamed patient had improved since admission and was no longer appropriate for hospice care; Team Medical Director Dr. Hussain allegedly instructed the nurse to make it appear in documentation that the patient was still qualified for hospice care, because, as he said, "The administration . . . is putting pressure on the physicians to keep patients even if they are not appropriate!" (*Id.* at ¶ 64). In the second, an unnamed LifePath patient was admitted in November 2007, discharged in May 2008, readmitted six days later, discharged in September 2010, readmitted a week later, non-recertified in May 2011, and readmitted less than a year later; Dr. Wacksman allegedly said that this patient "'should have never been admitted to hospice in the first place.'" (*Id.* at ¶ 66). In some instances, the Chapters Defendants submitted claims for patients who were not even in their care. (*Id.* at ¶¶ 116-117).

Chase further alleges that the Chapters Defendants used deceptive practices in the hospice-enrollment process in an effort to increase enrollment or continued care and thus Medicare profits. More specifically, staff backdated hospice-election forms, declined to use the word "hospice" around patients and families wary of the term, and lied to patients about their affiliation with hospice. (*Id.* at ¶¶ 69-71). And these deceptions deprived patients of their ability to provide informed consent—which federal regulations require—before electing hospice care. (*Id.* at ¶ 73).

Chase alleges ultimately that, because of all these fraudulent practices and others, the claims the Chapters Defendants submitted to Medicare for the provision of hospice care were likewise fraudulent and in violation of the False Claims Act.

But the success of a hospice-care fraud like the one Chase alleges depends heavily on patient referrals to hospice care. The Chapters Defendants gave incentives to their employees—bonuses and better performance evaluations—to find referral sources. (*Id.* at ¶¶ 136-141). According to the complaint, they succeeded.

2. The Referral Defendants

The Referral Defendants are other medical and hospice care-providers,[1] and according to Chase's allegations, these referral defendants assisted the fraud "by referring patients to the Chapters [] Defendants in exchange for kickbacks, including the provision of services the Referral [] Defendants otherwise would have to provide, payment for or provision of necessary materials and supplies, and corresponding referral of patients back in the event the patient was not re-certified for further hospice care." (*Id.* at ¶ 4).

More specifically, the Referral Defendants referred patients to the Chapters Defendants with the expectation

1. All told, the defendants in this case are the following:

- The Chapters Defendants: (1) Chapters Health System, Inc.; (2) Chapters Health, Inc.; (3) LifePath Hospice, Inc.; (4) Good Shepherd Hospice, Inc.; (5) Ronald Schonwetter; (6) Sayed Hussain; (7) Diana Yates; (8) Richard Wacksman;

- The Referral Defendants: (9) Mobile Physician Services, P.A.; (10) JSA HealthCare Corporation; (11) Sunrise Senior Living Services, Inc.; and (12) Superior Residences, Inc.

that those patients would be enrolled in the more intensive continuous care service, and in return the Referral Defendants obtained the marketing advantage of being able to claim that their patients receive better treatment. One Referral Defendant, in exchange for referrals, received diapers for all its patients, even those who were not eligible hospice patients. And for other Referral Defendants, the Chapters Defendants "picked up many of the costs for the care of the[] patients" in exchange for referrals. (*Id.* at ¶ 158).

By knowingly accepting these benefits, Chase alleges that the Referral Defendants violated the Anti-Kickback Statute, 42 U.S.C. §§ 1320a—7b(b)(2), rendering the subsequent Medicare claims fraudulent and subjecting the Referral Defendants to liability under the False Claims Act.

The Fraudulent Claims

Chase does not identify any specific claim submitted to either the federal or Florida government for the provision of hospice care. Instead, she conclusively alleges their existence. For example, the complaint alleges the following: "When patients left the Chapters [] Defendants' service area and were not receiving any care from [the Chapters Defendants] or any of [their] subsidiaries, the Chapters [] Defendants kept the patients on their roster and continued to bill Medicare and Medicaid the per diem rate" (*Id.* at ¶ 115); and "The Chapters [] Defendants also routinely submitted false claims to Medicaid and Medicare for reimbursement for services that they did not provide . . . ."

(*Id.* at ¶ 117). Chase supports these conclusions inferentially. For instance, she alleges that "[r]oughly 80 percent of [the Chapters Defendants'] patients were Medicare or Medicaid beneficiaries." (*Id.* at ¶ 161). And "[i]f just 20 percent of the Chapters [] Defendants' Medicare/Medicaid-eligible patients were not hospice appropriate, then the Chapters [] Defendants submitted at least $20 million in false or fraudulent claims to the Government each year." (*Id.* at ¶ 164).

Retaliation

Chase alleges that after rising to the supervisory position of Psychosocial Consultant at LifePath, she was demoted in 2009 after she raised ethical concerns about LifePath's admission and treatment of hospice patients. (*Id.* at ¶ 169). In 2010, she raised additional ethical concerns about the Chapters Defendants' failure to honor a patient's advance medical directives. (*Id.* at ¶ 170). LifePath later terminated Chase, in December 2012, after she brought her concerns about adherence to advance medical directives to LifePath's Ethics Committee. (*Id.* at ¶ 171). Chase alleges that she was informed that her firing was for having gone "above the chain of command." (*Id.*).

PROCEDURAL HISTORY

Chase first filed this lawsuit under seal in 2010. After investigating her allegations and requesting several extensions of time for further investigation, the United States and the State of Florida declined to intervene on Chase's behalf (Dkts. 56 and 74). The operative complaint

is now the fourth amended complaint, which Chase filed in March 2016, after the United States and Florida filed notices of non-intervention. In it, Chase raises four claims: Count I alleges that Defendants violated Section 3729 (a)(1)(A) of the False Claims Act and Florida's parallel statute, Fla. Stat. § 68.082(2)(a), which prohibit knowingly presenting or causing to be presented a fraudulent claim for payment to the government; Count II, also against all Defendants, alleges violations of Section 3729 (a)(1)(B) of the Act and Florida's parallel provision, Fla. Stat. § 68.082(2)(b), which prohibit knowingly making or using a false record material to a fraudulent claim; Count III alleges that Defendants conspired to violate the federal and Florida statutes; Count IV alleges retaliation against Chase›s former employer, LifePath, under the federal statute, 31 U.S.C. § 3730(h); and Count V alleges employment discriminated against LifePath under the state statute, Fla. Stat. § 68.088. Defendants move to dismiss all counts.

DISCUSSION

The False Claims Act permits private individuals to file a civil action on behalf of the United States—it is referred to as a *qui tam* action—against anyone (1) who knowingly presents, or causes to be presented, a false or fraudulent claim for payment to the United States government; (2) who knowingly makes, uses, or causes to be made or used, a false record or statement material to a false claim; or (3) who conspires to commit such a violation of the Act. 31 U.S.C. § 3729(a)(1)(A)—(C).[2]

2. Florida's parallel statute, Fla. Stat. § 68.082(2) uses nearly identical language.

Appendix B

The Act was first enacted in 1863, and its purpose, "then and now, is to encourage private individuals who are aware of fraud being perpetrated against the government to bring such information forward." *United States ex rel. Clausen v. Laboratory Corp. of America, Inc.*, 290 F.3d 1301, 1307 (11th Cir. 2002) (citing *Ragsdale v. Rubbermaid, Inc.*, 193 F.3d 1235, 1237 n.1 (11th Cir. 1999)). To this end, the Act provides that the government may elect to take over the lawsuit and that the private plaintiffs who initially filed it, known as relators, will share in the government's recovery should there be any. 31 U.S.C. § 3730(d)(1). If the government elects not to intervene, as has happened here, relators may continue to pursue the claim individually and recover between 25 and 30 percent of the proceeds from any judgment or settlement. 31 U.S.C. § 3730(d)(2).

The Anti-Kickback Statute, meanwhile, makes it a felony to offer, solicit, pay, or receive any remuneration—or "kickback"—"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." 42 U.S.C. §1320a-7b(b)(1). To incur liability, a defendant's conduct must meet the Statute's four elements: (1) knowingly and willfully; (2) paying something of value, directly or indirectly; (3) to induce the referral of individuals to the defendant for the furnishing of services; (4) paid for by a Federal health care program. *United States v. Vernon*, 723 F.3d 1234, 1252 (11th Cir. 2013). Because reimbursement from Medicare requires, as a precondition, compliance with the Statute and other health care laws, a relator's False Claims Act lawsuit may be predicated

on an underlying violation of the Statute. *McNutt ex rel. United States v. Haleyville Medical Supplies, Inc.*, 423 F.3d 1256, 1259 (11th Cir. 2005).[3] In order to prevail on such a claim, however, the relator must prove the violation of the Statute and the False Claims Act. As the Eleventh Circuit recently stated, this is because "[m]erely alleging a violation of the [Statute] does not sufficiently state a claim under the FCA. It is the *submission* and *payment* of a *false* Medicare *claim* and false certification of compliance with the law that creates FCA liability." *United States ex rel. Mastej v. Health Mgmt. Assocs., Inc.*, 591 F. App'x. 693, 706 (11th Cir. 2014) (emphasis in original).

All twelve defendants in this action move to dismiss the fourth amended complaint, and they offer various legal theories as grounds for dismissal. For example, LifePath, Chase's former employer, argues that Chase's retaliation claim is time-barred. Other defendants argue that the fourth amended complaint is an impermissible shotgun pleading. The Court, however, will not evaluate these arguments. *See McElmurray v. Consolidated Gov't of Augusta-Richmond Cnty.*, 464 F. Supp. 2d 1327, 1346-47 (N.D. Ga. 2006) (dismissing *qui tam* action and addressing only one of five grounds raised by defendant), *aff'd*, 501 F.3d 1244. Instead, the Court will dismiss the fourth amended complaint on a more fundamental basis:

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3. Another such healthcare law is the Stark Act, 42 U.S.C. § 1395nn(a)(1)(A)—(2), which generally prohibits doctors from referring Medicare patients to hospitals with which the doctors have a financial relationship, and which Chase also alleges was violated by virtue of the relationship between the Chapters Defendants and the Referral Defendants.

that Chase has failed to state a claim for which relief can be granted. Whether subject to the lenient standard contained in Rule 8 of the Federal Rules of Civil Procedure or the heightened standard for claims alleging fraud, Chase falls short of pleading sufficient factual content to survive a motion to dismiss.

Motion to Dismiss Standard

1. Rule 8

Complaints must contain "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8. When reviewing a motion to dismiss filed under Rule 12(b)(6), in most cases courts must limit their consideration to the well-pleaded allegations and accept all factual allegations contained in the complaint as true. *See Erickson v. Pardus*, 551 U.S. 89, 93-94, 127 S. Ct. 2197, 167 L. Ed. 2d 1081 (2007). Under this fairly lenient standard, to survive a motion to dismiss, a complaint need only contain sufficient factual matter to "state a claim to relief that is plausible on its face." *Iqbal*, 556 U.S. at 678 (internal quotation marks and citations omitted). This plausibility standard is met if the complaint's factual allegations permit the court "to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* (internal citations omitted). And if the standard is met, the court must allow the case to proceed to discovery. *See id.*

2. Rule 9 and Pleading Fraud with Particularity

In complaints alleging fraud, however, "the circumstances constituting the fraud or mistake shall be

stated with particularity." Fed. R. Civ. P. 9(b). In fact, in the Eleventh Circuit, the complaint must particularize the fraud in several important respects:

> Rule 9(b) is satisfied if the complaint sets forth (1) precisely what statements were made in what documents or oral presentations or what omissions were made, and (2) the time and place of each such statement and the person responsible for making (or in the case of omissions, not making) same, and (3) the content of such statements and the manner in which they misled the plaintiff, and (4) what the defendants obtained as a consequence of the fraud.

Ziemba v. Cascade Intern., Inc., 256 F.3d 1194, 1202 (11th Cir. 2001) (quoting *Brooks v. Blue Cross Blue Shield of Florida, Inc.*, 116 F.3d 1364, 1371 (11th Cir. 1997)). Complaints alleging violations of the False Claims Act are subject to this heightened pleading requirement. *Clausen*, 290 F.3d at 1308-09. So are FCA claims predicated on violations of the Anti-Kickback Statute. *See Mastej*, 591 F. App'x. at 705-06 (citing *Hopper v. Solvay Pharms., Inc.*, 588 F.3d 1318, 1324 (11th Cir. 2009)). In this context, the Eleventh Circuit has stated the Rule 9 pleading requirement more succinctly: to state a claim under the FCA, "a plaintiff must plead 'facts as to time, place, and substance of the defendant's alleged fraud,' specifically 'the details of the defendants' allegedly fraudulent acts, when they occurred, and who engaged in them.'" *Clausen*, 290 F.3d at 1310 (quoting *United States ex rel.*

Cooper v. Blue Cross & Blue Shield of Fla., 19 F.3d 562, 567-68 (11th Cir. 1994)). Moreover, because liability under the FCA attaches not to underlying fraudulent activity, but to the submission to the government of a *claim for payment*, the claims submitted to the government or the statements supporting those claims must be pled with particularity. *Id.* at 1312 (citing concurring sister circuits) (emphasis in original); *see United States ex rel. Matheny v. Medco Health Solutions Inc.*, 671 F.3d 1217, 1225 (11th Cir. 2012). As the Eleventh Circuit has repeatedly stated, the submission of a claim is "the *sine qua non* of a False Claims Act violation." *Clausen*, 290 F.3d at 1312; *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1012 (11th Cir. 2005); *Mastej*, 591 F. App'x. at 703.

In *Clausen*, for example, the relator was one of the defendant's competitors in the area of medical testing for long-term care facilities, and he alleged that the defendant had engaged in a nearly two-decades-long fraudulent scheme of performing unnecessary medical testing on patients with government-funded health-insurance plans and then knowingly charging the government for those unnecessary tests. 290 F.3d at 1303. The relator's complaint contained patient lists, a blank health-insurance claim form known as a Form 1500, medical test codes, and allegations that improper testing would be listed on the Form 1500s and then submitted to the government for payment within a few days after the medical service had been provided. *Id.* At 1306.

Still, the Eleventh Circuit affirmed the district court's dismissal for failing to plead the fraud with particularity

under Rule 9. *Id.* at 1315. The court first noted: "[N]o copies of a single actual bill or claim or payment were provided. No amounts of any charges by [the defendant] were identified. No actual dates of claims were alleged. Not a single completed Form 1500 was provided. No policies about billing or even second-hand information about billing practices were described . . . ." *Id.* at 1306. Drawing on its own precedent and that of other circuit courts, the court found that "Rule 9(b)[] . . . does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government." Clausen, the court held, had done just that, and this "failure to allege with any specificity if—or when—any actual improper claims were submitted to the Government" was fatal to his case under Rule 9. *Id.* at 1311.

Importantly, the court in *Clausen* noted the difficulty of meeting Rule 9's heightened pleading requirement, especially for a corporate outsider, like Clausen, who does not have ready access to actual claims or first-hand knowledge of billing practices. *Id.* at 1314. Yet the court still affirmed the dismissal with prejudice, finding that neither the FCA nor the Federal Rules provide a pleading leniency for those without personal knowledge. *Id.* And despite the preclusive effect of this finding, *Clausen* has been cited repeatedly in the Eleventh Circuit as providing the benchmark for pleading False Claims Act violations. *See Hopper*, 588 F.3d at 1324; *Corsello*, 428 F.3d at 1012.

Appendix B

Chase's Allegations in the Fourth Amended Complaint

1. Allegations of Fraud — Counts I and II

Chase falls well short of meeting the requirements of Rule 9 and the standard described in *Clausen*. Chase does not identify a single claim submitted to the government, let alone a false one. She does not identify anyone who submitted the alleged false claims she cannot specifically identify. She does not specify when any false claims were submitted. What Chase has done is describe a private scheme in detail, to include facts as to some disturbing medical practices. She has not alleged "'facts as to time, place, and substance of the defendant's alleged fraud'"—that is, a fraudulent claim. *Clausen*, 290 F.3d at 1310 (quoting *Cooper*, 19 F.3d at 567-68); *see Matheny*, 671 F.3d at 1225. As it was in *Clausen*, this failure is fatal to Chase's claim.

The court in *Clausen* also stated that, "if Rule 9(b) is to be adhered to, some indicia of reliability must be given in the complaint to support the allegation of an *actual false claim* for payment being made to the government." *Clausen*, 290 F.3d at 1311 (citation omitted) (emphasis in original). Citing more recent Eleventh Circuit precedent, primarily the 2014 unpublished opinion in *United States ex rel. Mastej v. Health Management Associates, Inc.*, 591 F. App'x. 693, Chase argues that her fourth amended complaint should survive Defendants' motions to dismiss because the complaint's factual allegations contain strong indicia of reliability. This argument misconstrues the precedent it cites. In fact, *Mastej* is a case in point.

There, the circuit reversed the district court's dismissal under Rule 9 even though the complaint left out critical details about the actual submission of false claims to the government—details such as dates, amounts sought in the claims, and the names of patients to which those claims referred. *Id.* at 706. The court first noted that a "relator can also provide the required indicia of reliability by showing that he personally was in a position to know that actual false claims were submitted to the government and had a factual basis for his alleged personal knowledge." *Id.* at 707 (citing *Hopper*, 588 F.3d at 1326).

In reversing the district court, the Eleventh Circuit relied exclusively on the relator's role as a corporate insider and the information to which his role gave him access. Specifically, the Court highlighted the following allegations in the complaint: (1) that, for six years, the relator was one of the defendant's Vice President of Acquisitions and Development, a period during which he "often attended weekly case management meetings in which Medicare and Medicaid patients and billing were discussed"; (2) that, during these meetings, "every patient was reviewed, including how the services were being billed to each patient"; (3) that, as a result of this role within the organization, the relator became "intimately familiar with the payor mix at the hospitals"; and (4) that, after leaving his role as Vice President, the relator served as CEO for one of the defendant hospitals, during which he was once asked by the CEO of another defendant hospital to split the cost of an unlawful kickback. *Id.* at 695-96, 707. These allegations taken cumulatively, the court held, supplied a sufficient factual basis to support the relator's

otherwise unparticular conclusion that the defendants "*actually submitted*" claims to the government. *Id.* at 708 (emphasis added).

Mastej thus never softened the focus on the *sine qua non*, the essential act, of a complaint alleging violations of the False Claims Act—the actual submission of a false claim. Instead, *Mastej* simply permits a complaint to survive Rule 9's particularity requirement if the complaint contains strong indicia of reliability *vis-à-vis* the fraudulent claim. Reliability concerning the fraudulent scheme is not enough. *See, e.g.*, 591 F. App'x. at 704 ("a plaintiff-relator without first-hand knowledge of the defendants' billing practices is unlikely to have a sufficient basis for such an allegation"). Another unpublished opinion from the Eleventh Circuit provides a good illustration. In *Hill v. Morehouse Medical Associates*, the relator was a former employee in the defendant's billing department and had "firsthand information" about the defendant's billing practices. Given this access to the "very department where she alleged the fraudulent billing schemes occurred," the court concluded that relator's otherwise general allegations that fraudulent claims were submitted daily bore the requisite indicia of reliability. 82 F. App'x. 213 (11th Cir. 2003).

By contrast, the relator in *Clausen*, as an industry competitor, could not provide enough indicia of reliability about the submission of a false claim even though he could detail more than a decade's worth of improper practices. *See Clausen*, 290 F.3d 1312. Neither could the relator in *Corsello*, a salesman for two of the defendants. 428 F.3d

at 1013-14. And neither could the relators in *Hopper*, also sales representatives for the defendants in that case.

This case is less like *Mastej* and more like *Clausen, Corsello*, and *Hopper*. As a social worker employed by LifePath, Chase had first-hand knowledge of at least one of the Referral Defendants' hospice-admission policies and perhaps even some of its medical practices. Chase has provided the "who," "what," "where," "how," and "when" of those practices. *Cf. Corsello*, 428 F.3d at 1014. She has not done the same for fraudulent claims submitted to the government for those practices. *See id.* She has instead provided only conclusory claims of their existence supported by inference. But that inference is not supported by first-hand knowledge of billing practices. *Compare Hopper*, 588 F.3d at 1328, *with Mastej*, 591 F. App'x. at 707-08. It is not supported by the required "indicia of reliability that a false claim was actually submitted." *Mastej*, 591 F. App'x. at 704. Without this kind of support, the complaint does not survive the heightened pleading requirement of Rule 9. *See Hopper*, 588 F.3d at 1328; *see also Corsello*, 428 F.3d at 1013 ("[S]ubmission [of a false claim] must be pleaded with particularity and not inferred from the circumstances"). Chase's allegations of violations of the False Claims Act, contained in Counts I and II of the fourth amended complaint, will be dismissed.

As for Chase's allegations of fraud under Florida's False Claims Act, at least one court in this circuit has concluded that the Florida law requires the same heightened pleading standard as the federal law. *See United States ex. rel. Heater v. Holy Cross Hosp., Inc.*,

510 F. Supp. 2d 1027, 1036 (S.D. Fla. 2007). And for good reason: the statutes govern the same conduct, impose the same liability, grant relators the same stake in any potential recovery, and use nearly identical language in setting forth the elements of a violation. *Compare* 31 U.S.C. § 3729(a)(1)(A), *with* Fla. Stat. § 68.082(2)(a). For these reasons, this Court agrees with the District Court for the Southern District of Florida that "the standards under both the Florida Act and the Federal Act are the same." *Heater*, 510 F. Supp. 2d at 1036. Chase's claims under Florida's False Claims Act will be dismissed as well.

2. Allegations of Conspiracy — Count III

Complaints alleging a conspiracy to violate the False Claims Act are also subject to Rule 9's heightened pleading standard. *Corsello*, 428 F.3d at 1014 ("The district court correctly dismissed [the relator's] [conspiracy count] for failure to comply with Rule 9(b)."). A defendant is liable for conspiracy if the relator can prove two elements: (1) that the defendant conspired with at least one person to get a false or fraudulent claim paid by the government; and (2) that at least one of the conspirators performed an overt act to get a false or fraudulent claim paid. *United States ex rel. Bane v. Breathe Easy Pulmonary Services, Inc.*, 597 F. Supp. 2d 1280, 1289 (M.D. Fla. 2009) (internal citations omitted). "Conspire" in this context requires a meeting of the minds "to defraud the government." *Id.* (citing *Allison Engine Co., Inc. v. United States ex rel. Sanders*, 553 U.S. 662, 672, 128 S. Ct. 2123, 170 L. Ed. 2d 1030 (2008)).

And though the Eleventh Circuit has not spoken definitively on the issue, district courts in the Eleventh Circuit—and at least one other circuit court—have held that a failure to adequately allege the existence of a false claim is fatal to a conspiracy claim. *See, e.g., United States ex rel. Marsteller v. Tilton*, No. 5:13-cv-830-AKK, 2016 U.S. Dist. LEXIS 44020, 2016 WL 1270586, *7 (N.D. Ala. Mar. 21, 2016); *United States ex rel. Potra v. Jacobson Companies, Inc.*, No. 1:12-cv-1600-WSD, 2014 U.S. Dist. LEXIS 40692, 2014 WL 1275501, *4 (N.D. Ga. Mar. 27, 2014); *accord United States ex rel. Vigil v. Nelnet, Inc.* 639 F.3d 791, 801 (8th Cir. 2011) ("Because the Complaint fails to state claims under sections 3729(a)(1) and (2), it likewise fails to state an actionable conspiracy claim under § 3729(a)(3).").

This Court agrees with those courts. Because the existence of a false claim—whether ultimately paid by the government or not—is an element of a cause of action for conspiracy to violate the False Claims Act, *see Bane*, 597 F. Supp. 2d at 1289, the failure of a relator to sufficiently plead that claim's existence necessarily means that, as a matter of law, the relator cannot prevail. *See* Fed. R. Civ. P. 12(b)(6); *see also Marshall Cnty. Bd. of Educ. v. Marshall Cnty. Gas Dist.*, 992 F.2d 1171, 1174 (11th Cir. 1993) (approving of dismissal on a dispositive question of law). As discussed above, Chase failed to plead the existence of a false claim. For this reason alone, she has failed to state a claim for conspiracy to violate the False Claims Act.

Additionally, Chase fails to allege a meeting of the minds to defraud the government. *See Allison Engine*,

553 U.S. at 672. In the fourth amended complaint, Chase alleges that the Referral Defendants received certain benefits in exchange for their having referred patients to hospice care. But nowhere does the complaint allege a specific agreement for this benefits exchange. And more important, nowhere does the complaint allege a specific agreement to engage in this exchange for the purpose of defrauding the government. Chase's only allegation of an agreement is a conclusory assertion that "Defendants knowingly conspired" to present fraudulent claims to the government for payment. (Dkt. 79, ¶ 182). This is a bare legal conclusion that may very well fail to state a claim under Rule 8. *See Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007). It certainly fails under Rule 9. *See Corsello*, 428 F.3d at 1014. Chase's Count III alleging conspiracy will be dismissed.

3. Allegations of Retaliation and Discrimination — Counts IV and V

In Counts IV and V, Chase claims that LifePath violated the retaliation provisions of the federal and Florida False Claims Acts, 31 U.S.C. § 3730(h) and Fla. Stat. § 68.088. Chase pleads factual content supporting the counts in two of the complaint's 172 paragraphs. In one of them, Chase alleges that LifePath demoted her after she raised ethical concerns about LifePath's failure to honor a patient's living will. (Dkt. 79, ¶ 170). In the other, Chase alleges that she was later fired after she raised similar objections to LifePath's Ethics Committee. (*Id.* at ¶ 171).

These allegations fail to state a claim for retaliation under Rule 8 of the Federal Rules of Civil Procedure. The

claim fails because, accepted as true, the allegations fail to allege a necessary element of the claim—namely, that Chase engaged in protected activity, which is defined as "acts done by the employee . . . in furtherance of an [FCA action] or other efforts to stop 1 or more violations of [the FCA]." 31 U.S.C. § 3730(h). In short, Chase alleges that she objected to unethical medical practices, but, critically, she does not allege that she objected to *fraudulent* medical practices. *Compare Farnsworth v. HCA, Inc.*, No. 8:15-cv-65-T-24-MAP, 2015 U.S. Dist. LEXIS 69690, 2015 WL 3453621, *7 (M.D. Fla. May 29, 2015) ("[the relator] does not connect her opposition to the resulting improper billing or the submission of a false claim to the government"), *with United States v. Wellcare Health Plans, Inc.*, No. 8:12-cv-2032-T-30EAJ, 2016 U.S. Dist. LEXIS 35404, 2016 WL 1077359, *4 (M.D. Fla. March 18, 2016) ("[the relator] alleges facts related to her efforts to stop what she believed to be fraud upon the government").

Though Congress amended the FCA in 2009 to broaden the scope of "protected activity" under the FCA retaliation provision, the activity must still be aimed at stopping an FCA violation. *See Wellcare Health Plans*, 2016 U.S. Dist. LEXIS 35404, 2016 WL 1077359, at *4. And however disappointing they may be, unethical medical practices are not frauds committed upon the government in violation of the FCA. *See Hopper*, 588 F.3d at 1328 ("Improper practices standing alone are insufficient to state a claim under [the False Claim Act] . . . ."). Internal complaints shedding light on those unethical practices, without more, do not qualify as protected activity. *See Farnsworth*, 2015 U.S. Dist. LEXIS 69690, 2015 WL 3453621, at *7.

The only allegation in the fourth amended complaint connecting Chase's internal complaints to fraud against the government is a single allegation stating that Chase was demoted "because she raised ethical issues concerning violations of the [False Claims] Acts." (Dkt. 79, ¶ 169). This is a legal conclusion couched as a factual allegation, and the Court need not accept it as true. *See Twombly*, 550 U.S. at 555. And because it is not supported by the other well-pleaded allegations of retaliation, the Court will not. Chase's well-pleaded allegations fail to establish that she engaged in protected activity. For this reason, her retaliation claim under the FCA will be dismissed. Chase's discrimination claim under Florida's False Claims Act will be dismissed on the same grounds. *See Heater*, 510 F. Supp. 2d at 1036.[4]

Throughout her complaint, Chase alleges the existence of widespread medical abuses committed by hospice-care and other medical providers. She fails, however, to allege the connection between those abuses and the existence of false claims submitted to the government for payment. Later in her complaint, Chase alleges that she objected to the medical abuses she became aware of. She fails, however, to allege the connection between the practices she objected to and the commission of fraud against the government. Chase's fourth amended complaint, Counts I through V, will be dismissed.

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4. Chase's Florida discrimination claim suffers from another flaw, albeit not in itself a fatal one. Chase's Count V states a cause of action under the retaliation provision of the Florida False Claims Act, Fla. Stat. § 68.088. That provision, however, does not provide a basis for a cause of action. *McShea v. School Bd. of Collier Cnty.*, 58 F. Supp. 3d 1325, 1345 (M.D. Fla. 2014). Rather, it permits a cause of action under Florida's Whistleblower Statute, Fla. Stat. § 112.3187.

Appendix B

Leave to Amend

Rule 15(a) of the Federal Rules of Civil Procedure governs the determination of whether plaintiffs who fail to state a cause of action, like Chase has here, should be given leave to amend their complaint. The rule states that courts "should freely give leave when justice so requires." Fed. R. Civ. P. 15(a). And ordinarily, courts should give plaintiffs at least one opportunity to amend before the court dismisses the complaint with prejudice. *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1014 (11th Cir. 2005) (citing *Bryant v. Dupree*, 252 F.3d 1161, 1163 (11th Cir. 2001)). Leave should not be given, however, in a few circumstances: "(1) [when] there has been undue delay, bad faith, dilatory motive, or repeated failure to cure deficiencies by amendments previously allowed; (2) [when] allowing amendment would cause undue prejudice to the opposing party; or (3) [when] amendment would be futile." *Id.* (internal quotations marks and citations omitted). A district court's denial of leave to amend is reviewed for an abuse of discretion. *See id.*

Chase first filed this lawsuit in 2010 and has filed, in total, five complaints. The Court has already granted leave to amend twice. (Dkt. 25; Dkt. 73). While the Court is mindful that these grants of leave were not predicated on a previous failure-to-state-a-claim dismissal, the Court is also mindful that the law on the subject has not changed since Chase first filed her complaint. The precedent compelling dismissal today is the same precedent that could have served as a model for Chase's first, second, third, fourth, and now fifth complaint in this case. Chase has had, in other words, repeated chances

to cure the deficiencies in her complaint. She has failed to do so, and this finding alone is reason enough to deny leave to amend her fourth amended complaint. *See id.* ("repeated failure to cure deficiencies by previous amendments is an explicitly permitted reason" for denying leave to amend) (brackets and internal quotation marks omitted). Moreover, given this long procedural history and the fact that Chase still falls short of alleging the particularity required to survive a motion to dismiss, the Court is convinced that any future amendment would be futile. *See id.* at 1011 ("Because . . . a third amendment of the complaint more than five years after the commencement of this action would have been futile, we affirm."). The fourth amended complaint will be dismissed with prejudice.

For the reasons discussed above, it is ORDERED AND ADJUDGED that:

1. Defendants' Motions to Dismiss (Dkts. 145, 147, 151, 152, 154, 157, 174, and 205) are GRANTED.

2. The case is DISMISSED WITH PREJUDICE.

3. The Clerk is directed to close this file and terminate any pending motions as moot.

DONE and **ORDERED** in Tampa, Florida, this 22nd day of September, 2016.

/s/_____
JAMES S. MOODY, JR.
UNITED STATES DISTRICT JUDGE

APPENDIX C — COMPLAINT IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION, FILED MARCH 24, 2016

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

Case No.: 8:10-cv-01061-JSM-TGW

UNITED STATES OF AMERICA AND STATE OF FLORIDA *ex rel.* NANCY CHASE,

Plaintiffs,

v.

CHAPTERS HEALTH SYSTEM, INC., A FLORIDA CORPORATION; CHAPTERS HEALTH, INC., A FLORIDA CORPORATION; LIFEPATH HOSPICE, INC., A FLORIDA CORPORATION; GOOD SHEPHERD HOSPICE, INC., A FLORIDA CORPORATION; RONALD SCHONWETTER, M.D.; SAYED HUSSAIN, M.D.; DIANA YATES; RICHARD M. WACKSMAN, M.D.; MOBILE PHYSICIAN SERVICES, P.A., A FLORIDA PROFESSIONAL ASSOCIATION; JSA HEALTHCARE CORPORATION, A DELAWARE CORPORATION; SUNRISE SENIOR LIVING SERVICES, INC., A DELAWARE CORPORATION; AND SUPERIOR RESIDENCES, INC., A FLORIDA CORPORATION;

Defendants.

Appendix C

Judge James S. Moody, Jr.
Magistrate Judge Thomas G. Wilson

FOURTH AMENDED FALSE CLAIMS ACT COMPLAINT AND DEMAND FOR JURY TRIAL

INTRODUCTION

1. Relator, Nancy Chase ("Relator"), brings this action to recover treble damages, restitution, and civil penalties on behalf of the State of Florida and the United States of America arising from false or fraudulent Medicare and Medicaid claims made, or caused to be made, and false records or statements material to such false or fraudulent claims made, used, or caused to be made or used, by Defendants to the United States, the State of Florida, and their agents and intermediaries in connection with hospice services and in violation of the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* and the Florida False Claims Act, Florida Statutes §§ 68.081 *et seq.* (the "Acts").

2. Defendants Chapters Health System, Inc., Chapters Health, Inc., LifePath Hospice, Inc., Good Shepherd Hospice, Inc., Ronald Schonwetter, M.D., Sayed Hussain, M.D., Diana Yates, and Richard M. Wacksman, M.D. (collectively "the Chapters Health Defendants") violated the Acts by submitting, or causing to be submitted, claims for payment that were false and fraudulent because:

a. the patients, for whose care the Chapters Health Defendants sought payment, were not eligible for hospice services because they were not terminally

ill, they had not been properly certified as terminally ill, they had not provided informed consent electing hospice care, and/or appropriate and accurate documentation had not been obtained;

b. the care or the level thereof for which the Chapters Health Defendants sought payment was greater than was medically necessary and/or for which the patient was eligible;

c. the care for which the Chapters Health Defendants sought payment had not been provided in accordance with the patient's written Plan of Care;

d. the services for which payment was sought otherwise had not been performed or provided; and

e. the patients, for whose care the Chapters Health Defendants sought payment, were out of the relevant service area at the time they supposedly were under hospice care.

3. Further, the Chapters Health Defendants identified and obtained referrals of patients for hospice services by promises and payment of incentives and kickbacks to employees, primary care providers, nursing homes, and assisted living facilities in violation of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), and the Stark Act, 42 U.S.C. § 1395nn(a)(1)(A), and contrary to the Chapters Health Defendants' false certifications of compliance therewith.

4. Defendants Richard M. Wacksman, M.D., Mobile Physician Services, P.A., JSA HealthCare Corporation, Sunrise Senior Living Services, Inc., and Superior Residences, Inc. (collectively "the Referral Source Defendants") knowingly assisted in the Chapters Health Defendants' presentation of false or fraudulent claims to the government, and conspired with the Chapters Health Defendants to accomplish the same, by referring patients to the Chapters Health Defendants in exchange for kickbacks, including the provision of services the Referral Source Defendants otherwise would have to provide, payment for or provision of necessary materials and supplies, and corresponding referrals of patients back in the event the patient was not re-certified for further hospice care.

5. Due to the systematic and continuing fraudulent schemes detailed herein, the Chapters Health Defendants were able to obtain hundreds of millions of dollars in payments from Medicare and Medicaid for providing hospice services to patients who were not eligible for such care or were not eligible for the level of care billed, for hospice services that were not medically necessary and for hospice services that were not, in fact, provided at all.

6. The Chapters Health Defendants' conduct resulted in annual patient service revenues for Chapters Health System, Inc. and its subsidiaries in excess of $120 million, approximately 80 percent of which came from Medicare and Medicaid. At any given time, however, as much as one-third of enrolled hospice patients were not eligible for hospice care under Medicare regulations and a significant

portion of those patients were identified and obtained as a result of unlawful incentive and kickback schemes

7. The Chapters Health Defendants' actions not only defrauded taxpayers, but they also compromised patient health by causing non-terminal patients to forego vital curative treatment.

8. As required by the Acts, Relator has previously provided to the Attorney General of the United States, the United States Attorney for the Middle District of Florida and the Attorney General of the State of Florida a Sworn Disclosure Statement containing all material evidence and information relating to the conduct which is the subject of these claims. The Sworn Disclosure Statement is supported by material evidence known to the Relator establishing the existence of Defendants' violations of the Acts. Because the Sworn Disclosure Statement includes attorney-client communications and work product of Relator's attorneys, and is submitted to the Attorney Generals and to the United States Attorney in their capacity as potential co-counsel in the litigation, the Relator understands this disclosure to be confidential.

JURISDICTION AND VENUE

9. This action arises under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* and the Florida False Claims Act, Florida Statutes §§ 68.081 *et seq.* This Court has jurisdiction over this case pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1345, and 31 U.S.C. § 3732(a). The Court has supplemental jurisdiction over the claims under Florida statutes pursuant to 28 U.S.C. § 1367.

10. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) because the acts proscribed by 31 U.S.C. §§ 3729 *et seq.*, Florida Statutes §§ 68.081 *et seq.*, and complained of herein took place at health care facilities, nursing homes, assisted living facilities, hospice houses and patient/family homes located in the Middle District of Florida. Venue is also proper pursuant to 28 U.S.C. § 1391(b) and (c) because, at all relevant times, Defendants transacted business in the Middle District of Florida and throughout the nation.

PARTIES

Relator

11. Relator, Nancy Chase, has a Master's Degree in Social Work ("MSW") and is a Licensed Clinical Social Worker ("LCSW"). Ms. Chase was employed by Defendant LifePath Hospice, Inc., a subsidiary of Defendant Chapters Health System, Inc., from 1992 until December 2012. She served as a Social Services Specialist, Patient/Family Counselor and Psychosocial Consultant (or equivalent) at LifePath's Tampa offices and in home settings, nursing homes, assisted living facilities and hospitals for those 20 years.

12. Relator gained direct and independent knowledge of the conduct giving rise to this action by working as a Psychosocial Consultant, Patient/Family Counselor and Social Service Specialist for LifePath as well as serving on LifePath's Ethics Committee and a corporate IDG Committee, which developed policies and procedures

for the entire Chapters Health group of companies. Her knowledge was gained by actual experience in CHS and LifePath and by talking with other similarly-situated employees employed at Good Shepherd.

The Chapters Health Defendants

13. Defendant Chapters Health System, Inc. (hereinafter "CHS"), is a not-for-profit corporation formed under Florida law to provide hospice and palliative care services. Its principal place of business is located at 12470 Telecom Drive, Suite #300 West, Temple Terrace, Florida 33637. Originally formed in 1982, CHS previously operated under the name HPC Healthcare, Inc. The company changed its name to Chapters Health System, Inc. in June 2011. CHS is the parent company of Defendants Chapters Health, Inc., LifePath Hospice, Inc. and Good Shepherd Hospice, Inc.

14. Defendant Chapters Health, Inc. (hereinafter "CHI"), is a not-for-profit corporation formed under Florida law for the purpose of owning, managing, coordinating and supporting the activities of CHS and its related entities. Its principal place of business is located at 12470 Telecom Drive, Suite #300 West, Temple Terrace, Florida 33637. CHI is a subsidiary of CHS. CHI generally serves as the employer of professional staff such as doctors and Advanced Registered Nurse Practitioners ("ARNPs") who serve patients across all CHS facilities and subsidiaries.

15. Defendant LifePath Hospice, Inc. (hereinafter "LifePath"), is a not-for-profit corporation formed under Florida law to provide hospice and palliative care services. It is located in Hillsborough County and has three offices: two offices in Tampa and one office in Sun City Center, Florida. LifePath is a subsidiary of CHS.

16. Defendant Good Shepherd Hospice, Inc. (hereinafter "Good Shepherd"), is a not-for-profit corporation formed under Florida law to provide hospice and palliative care services. It is located in Polk, Hardee and Highlands Counties and has six (6) offices. Good Shepherd is a subsidiary of CHS.

17. Defendant Ronald Schonwetter, M.D. is a citizen and resident of the State of Florida. He is the Chief Medical Officer of CHS, LifePath, and Good Shepherd.

18. Defendant Sayed Hussain, M.D. is a citizen and resident of the State of Florida. He is a Team Medical Director for LifePath.

19. Defendant Diana Yates is a citizen and resident of the State of Florida. She is the Director of Clinical Services for LifePath.

20. Defendant Richard M. Wacksman, M.D., is a citizen and resident of the State of Florida. He is a Team Medical Director for LifePath, and also the owner and P.D. of Defendant Mobile Physician Services, P.A.

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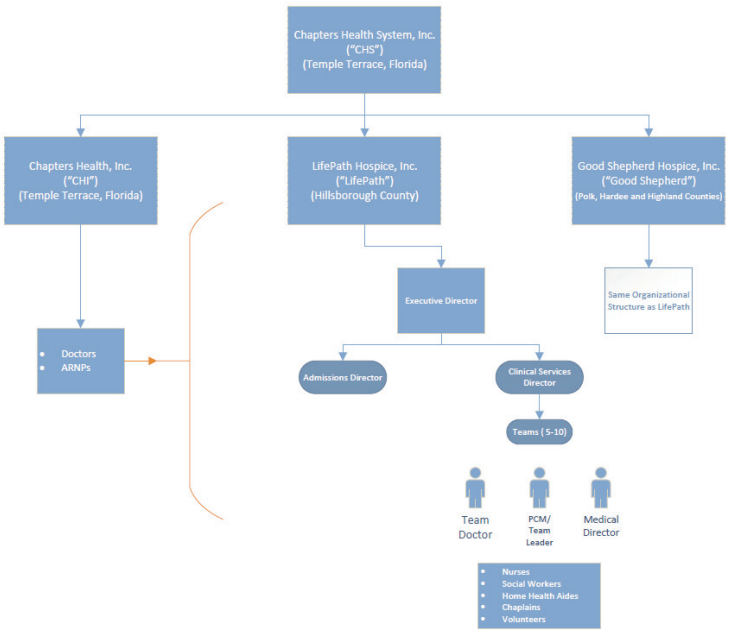
21. The below diagram summarizes the relationship and organization of the various Chapters Health Defendants and their respective staffs:



22. As detailed above, each of LifePath and Good Shepherd are operated by an Executive Director, under whom work an Admissions Director and a Clinical Services Director. Patient care is provided by teams. At LifePath, the teams were identified by reference to a color (*e.g.*, Red Team, Gold Team, *etc.*). Each team consisted of five to 10 individuals. Each team was led by Patient Care Manager ("PCM"), also referred to as a "Team Leader," and had an assigned Team Doctor and Medical Director.

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The Referral Source Defendants

23. Defendant Mobile Physician Services, P.A., is a for-profit professional association formed under Florida law to provide at-home health care. Its principal place of business is located at 6804 Cecelia Drive, New Port Richey, Florida 34653. Mobile Physician Services is owned by Dr. Wacksman.

24. Defendant JSA HealthCare Corporation is a for-profit corporation formed under Delaware law and doing business under the name "JSA Medical Group." Its principal place of business is located at 10051 5th Street, N., Suite 200, St. Petersburg, Florida 33702. JSA Medical Group is central and south Florida's largest provider of primary health care services to the Medicare population.

25. Defendant Sunrise Senior Living Services, Inc. is a for-profit corporation formed under Delaware law. Its principal place of business is located at 7902 Westpark Drive, McLean, Virginia 22102. Sunrise Senior Living operates nursing homes and assisted living centers around the country, including Brighton Gardens of Tampa.

26. Defendant Superior Residences, Inc. is a for-profit corporation formed under Florida law. Its principal place of business is 13630 Linden Drive, Spring Hill, Florida 34609. Superior Residences operates assisted living and memory care facilities in Florida, including Superior Residences of Brandon in Brandon, Florida.

Appendix C

MEDICARE, MEDICAID, AND HOSPICE CARE

27. Plaintiff the United States of America, acting through the Department of Health and Human Services, administers Grants to States for Medical Assistance Programs pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* ("Medicaid"), and the Health Insurance for the Aged and Disabled Program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.* ("Medicare").

28. Medicare is a federal government health program primarily benefiting the elderly that Congress created in 1965 when it adopted Title XVIII of the Social Security Act. Medicare is administered by the Centers for Medicare and Medicaid Services ("CMS").

29. Congress created Medicaid at the same time it created Medicare in 1965 when Title XIX was added to the Social Security Act. Medicaid is a public assistance program providing payment of medical expenses for low-income patients. Funding for Medicaid is shared between the federal and state governments. The federal government also separately matches certain state expenses incurred in administering the Medicaid program. While specific Medicaid coverage guidelines vary from state to state, Medicaid's coverage is generally modeled after Medicare's coverage.

30. Hospice care refers to a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual

and emotional needs of a terminally-ill patient and his or her family members. *See* 42 U.S.C. § 1395x(dd)(1); 42 C.F.R. § 418.3. These services include nursing care; physical or occupational therapy, or speech-language pathology services; medical social services; home health aide services; medical supplies (including drugs and biologics) and the use of medical appliances; physicians' services; counseling; and short-term inpatient respite care and procedures for pain control and symptom management. 42 U.S.C. § 1395x(dd)(1).

31. Hospice care may be elected by a patient who is nearing the end of his or her life. Hospice is focused on palliative care rather than curative care, meaning it is designed to provide pain-relief, comfort, and emotional and spiritual support to patients with a terminal diagnosis rather than designed to cure the patient's disease or condition. In electing hospice care, a patient must agree to forego Medicare coverage for curative treatment. *See* 42 U.S.C. § 1395d.

32. Hospice care is covered under Medicare subject to certain conditions. The first such requirement is that the patient's attending physician *and* the medical director of the hospice program must both certify in writing that the individual is terminally ill. 42 U.S.C. § 1395f(a)(7)(A)(i); 42 C.F.R. § 418.20(b).

33. "Terminally ill" means that a patient has a medical prognosis that his or her life expectancy is six (6) months or less if the illness runs its normal course. 42 U.S.C. § 1395x(dd)(3)(A); 42 C.F.R. § 418.3.

34. The initial certifications by the attending physician and medical director can apply for a period of up to 90 days. If the patient survives and the attending physician and medical director recertify that the individual remains terminally ill, hospice care may be covered for a second 90-day period. Thereafter, the attending physician and medical director must recertify the patient's terminal condition every 60 days. 42 U.S.C. § 1395f(a)(7)(A)(i) & (ii); 42 C.F.R. § 418.22.

35. In addition, an individualized written plan (called a "Plan of Care" or "POC") for providing hospice care must be established and periodically reviewed by the attending physician and the medical director. All hospice care must be provided in accordance with that plan. 42 U.S.C. § 1395f(a)(7)(B) & (C); 42 C.F.R. § 418.200.

36. Further, all hospice services "must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions." 42 C.F.R. § 418.200.

37. Medicare pays for hospice care on a per diem basis—that is, according to a set daily rate of payment per day. *See* 42 U.S.C. § 1395f(i). CMS establishes fixed payment rates for four categories of covered hospice care: routine home care days, continuous home care days, inpatient respite care days, and general inpatient care days. *See* 42 C.F.R. § 418.302(b) & (c). Payment is made to the hospice provider for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day. 42 C.F.R. § 418.302(e)(1).

38. Florida Medicaid also covers hospice services for terminally ill patients. Florida's Agency for Health Care Administration ("AHCA") conditions coverage of hospice services upon compliance with the Medicare requirements for coverage, specifically 42 C.F.R. §§ 418.22 and 418.24. ACHA also provides coverage for a first 90-day period, a second 90-day period, and subsequent 60-day periods—with physician certification required for each such period. *See* Florida Medicaid, *Hospice Services Coverage and Limitations Handbook.*

DEFENDANTS' VIOLATIONS OF THE ACTS

39. The False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, and the Florida False Claims Act, Florida Statutes §§ 68.081 *et seq.*, prohibit anyone from knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval, or knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim. The Acts make persons who violate these prohibitions liable for a civil penalty of not less than $5,500 and not more than $11,000 for each such violation and for three times (or treble) the amount of damages the government sustains as a result of the violation or violations.

40. As detailed below in Section I, from at least June 2000 through the present, the Chapters Health Defendants presented, or caused to be presented, to Medicare and Medicaid false or fraudulent claims for payment for hospice services:

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(a) With respect to patients whom the Chapters Health Defendants admitted and retained in hospice care knowing they did not qualify for hospice care or in deliberate ignorance or reckless disregard as to their eligibility (*see* Section I.A);

(b) With respect to patients whom the Chapters Health Defendants deceived and misled to elect hospice benefits without informed consent or who had not properly executed the required documentation (*see* Section I.B);

(c) With respect to patients whom the Chapters Health Defendants enrolled in elevated levels of hospice care such as Continuous Care and Hospice House knowing those patients were not eligible for such heightened care or in deliberate ignorance or reckless disregard as to their eligibility (*see* Section I.C);

(d) With respect to patients regarding whom the Chapters Health Defendants falsified documents and patient records so as to create a paper trial indicating patients were eligible for or had, in fact, elected hospice benefits or concealing the fact that they were not eligible for hospice care (*see* Section I.D);

(e) With respect to services that were not provided by the Chapters Health Defendants or at all (*see* Section I.E); and

(f) With respect to patients to whom the Chapters Health Defendants had not provided the services required by their Plans of Care and whose Plans the Chapters Health Defendants had altered or otherwise modified to avoid the cost of staffing to appropriate levels (*see* Section I.F).

41. As detailed below in Section II, the Chapters Health Defendants further offered and paid remuneration to employees and primary care providers, nursing homes, and assisted living facilities—including the Referral Source Defendants—in violation of the Anti-Kickback Act and Stark Act. The Referral Source Defendants knowingly assisted the Chapters Health Defendants in their violations of the Acts, and conspired with them to do so, by knowingly providing and receiving—and even *insisting upon*—incentives or kickbacks to make referrals of patients for hospice care.

I. THE CHAPTERS HEALTH DEFENDANTS OVERCHARGE MEDICARE AND MEDICAID FOR HOSPICE SERVICES

42. CHS and its subsidiaries—LifePath, Good Shepherd, and CHI—have been from at least June 2000 to the present, presenting false or fraudulent claims for payment or approval by the Medicare and Medicaid programs. The Chapters Health Defendants do this by enrolling patients in hospice care and keeping them in hospice care despite their lack of eligibility for hospice or, at the very least, in deliberate ignorance or reckless disregard of whether the patients are eligible or not, all

the while billing Medicare and Medicaid for such care. The Chapters Health Defendants also "up-code" hospice patients for more lucrative Continuous Care and Hospice House care levels irrespective of the patients' eligibility.

43. To advance these schemes, the Chapters Health Defendants direct employees to follow practices designed to maximize the number of patients enrolled and to keep them enrolled as long as possible irrespective of their eligibility status, to create documents and records that conceal or obscure the facts and circumstances showing patients' lack of eligibility, and ultimately to maximize Medicare and Medicaid billings.

44. In 2008, CHS and its subsidiaries had a combined Average Daily Census ("ADC") of approximately 2,000 patients, which means there were 2,000 patients receiving hospice care by CHS and its subsidiaries on any given day.

45. Periodic chart reviews showed that anywhere from 20 percent to as much as 40 percent of the patient census was not actually appropriate for hospice. Following an audit by CHS' Medicare fiscal intermediary in 2008, CHS' ADC dropped to less than 1,400 patients, a reduction of approximately one-third, as ineligible and inappropriate patients were removed. It was not long, however, until the Chapters Health Defendants were able to restore enrollment to previous levels and continue its unlawful practices.

Appendix C

A. Admitting and Retaining Patients Who Do Not Qualify for Hospice Care

46. CHS, through and with the aid of its subsidiary companies CHI, LifePath and Good Shepherd, consistently admits patients to hospice care who are not eligible for admission under Medicaid and Medicare criteria.

47. CHS management instructed staff on policies that facilitated, encouraged and, in some instances, *ensured* that ineligible individuals would be enrolled in hospice care.

48. The Chapters Health Defendants instructed and encouraged staff to enroll patients for hospice care without proper physician authorization and to obtain physician certifications that were not supported by clinical information and other documentation providing a basis for the certification, including numerous instances where the charts and other documentation were left incomplete, did not reflect the patient as having a terminal illness, or falsely or misleadingly described the patient's condition and prognosis.

49. Specifically, former LifePath Admissions Manager and Executive Director Cheryl Hamilton instructed and encouraged admissions staff to admit referrals and other potential patients as a matter of course without first verifying eligibility and obtaining all documentation. CHS, LifePath, and Good Shepherd directed Admissions Nurses to review the patient's record and meet with his or her family and "find a reason to admit" the patient.

50. Another Admissions Manager, Peter Shute, directed staff that there was no reason a patient should not be admitted for at least 30 days so that LifePath could review the patient's illness and condition.

51. If the Admissions Nurses could not identify a reason to admit the patient, the Chapters Health Defendants required them to work with their Patient Care Manager or Team Leader ("PCM/Team Leader") to find a way to enroll the patient.

52. If admissions staff encountered any difficulty getting a physician's certification that a patient was terminally ill from any of the team doctors, the Chapters Health Defendants, Dr. Schonwetter (the Chief Medical Officer for CHS, LifePath and Good Shepherd) in particular, directed them to other physicians who would readily provide the required certification, including Dr. Wacksman and Dr. Hussain. In any case where admissions staff received a "no" response to a request for a physician's certification, the Chapters Health Defendants instructed them to run the patient by Dr. Wacksman.

53. At one point, the Chapters Health Defendants did not permit patients to be discharged without first being visited by a Chapters Health physician, which regularly took weeks to schedule.

54. The Chapters Health Defendants instructed staff to ensure that *all* patients referred from certain health care facilities, including Brighton Gardens of Tampa operated by Defendant Sunrise Senior Living, were admitted to hospice irrespective of their eligibility.

55. The Chapters Health Defendants provided incentives to, and imposed quotas on, employees to obtain referrals and admissions, with emphasis on more lucrative admissions for Continuous Care.

56. The Chapters Health Defendants, generally through the Executive Directors and PCMs/Team Leaders at LifePath and Good Shepherd, instructed staff to look for any nursing home or assisted living facility residents who could benefit from hospice services. Staff who visited such facilities were given a quota of three to four new patient referrals per week from the buildings to which they were assigned.

57. The Chapters Health Defendants, through the Executive Directors at LifePath and Good Shepherd, instructed PCMs/Team Leaders that they were required to initiate at least three Continuous Care cases per week and place at least three patients in Hospice House.

58. Employees' performance with respect to these quotas was tracked and displayed for all to see on charts, indicating with gold stars whether individual staff had met their quota.

59. The Chapters Health Defendants also inappropriately delayed patient discharges even though they were not eligible, or were no longer eligible, in order to continue billing Medicaid and Medicare. They did so by intentionally prolonging the process of determining whether a patient no longer required hospice care—a process called "non-recertification".

60. Dr. Schonwetter instructed staff that no patient was to be considered for nonrecertification before ninety (90) days had elapsed, even when it was obvious on the very first day that the patient did not meet the Medicaid and Medicare requirements for hospice care. Sometimes the patient was not appropriate on the first day, and sometimes the staff determined the patient was no longer appropriate within a month or two. However, the Chapters Health Defendants mandated they not be discharged prior to the 90-day recertification period in order for CHS, LifePath, or Good Shepherd to benefit from the full billing cycle.

61. The Chapters Health Defendants tracked how many patients were discharged after fewer than 90 days, discussed such instances in corporate committee meetings, and investigated when such instances occurred.

62. In weekly team meetings, one of the topics for discussion was whether to recertify patients whose certification period may be coming to an end. PCMs/ Team Leaders, at the instruction of CHS management, approached such discussions from the perspective of how can we justify recertifying this patient as opposed to whether the patient should be recertified. PCMs/Team Leaders directed to staff questions like "What can you give me?" and "How can we keep them?"

63. If and when a patient was finally non-recertified, he or she was often *readmitted* within weeks or months, once again to stay in the program for the 90-day recertification period. In fact, the Chapters Health Defendants created a program called "Transitions" to track patients after they

had been non-recertified. The purpose of the Transitions program was to readmit non-recertified patients as soon as possible in order to continue to exploit them as a Medicaid and Medicare reimbursement revenue source.

64. For example, in 2009, a primary nurse stated during a LifePath team meeting that a particular patient was not appropriate for hospice, had no symptoms and had improved since his admission. The Team Medical Director, Dr. Hussain, directed the nurse not to mention in the patient's record that the patient was not appropriate for hospice because they could just leave out the facts that showed a patient was not appropriate and simply document only the elements that would make it appear as if the patient was appropriate. Dr. Hussain explained that "The administration of [CHS] is putting pressure on the physicians to keep patients even if they are not appropriate!"

65. Another example involves a patient who was initially admitted to LifePath on November 14, 2007 and then discharged on May 16, 2008. Six days later, the patient was readmitted to LifePath on May 22, 2008 until being discharged September 17, 2010. The patient then was readmitted again on September 24, 2010 and non-recertified on May 27, 2011, admitted again on May 19, 2012 and remained so at least through August 2012.

66. In discussing this patient's eligibility for continued hospice care at a team meeting in September 2009, LifePath Medical Director Dr. Wacksman admitted that this patient, who had been admitted and re-admitted

multiple times over a period of nearly five years, "should never have been admitted to hospice in the first place" and was not eligible for continued care. However, LifePath continued to bill Medicaid and Medicare for this patient's care on a per diem basis during the full time this patient was admitted.

B. Deception and Misleading of Patients

67. The Chapters Health Defendants also induced or deceived patients into enrolling in hospice care, whether they wanted to or not and irrespective of whether they were terminally ill or otherwise eligible for hospice benefits.

68. Medicare regulations require that a patient "must elect hospice care in accordance with [42 C.F.R.] § 418.24." 42 C.F.R. § 418.200. To be covered by Medicare, an individual meeting the eligibility requirements for hospice must file an "election statement" with the hospice, 42 C.F.R. § 418.24(a)(1), and the hospice must in turn file a Notice of Election with its Medicare contractor within five calendar days of the effective date of the election statement. *Id.* § 418.24(a)(2).

69. The Chapters Health Defendants instructed staff to "back-date" election statements.

70. The Chapters Health Defendants intentionally misled some patients by not informing them that they were even being admitted into hospice. Supervisors instructed staff not to use the word "hospice" around

certain potential patients, to hide their name tags from these patients, and to openly misrepresent themselves and CHS by claiming that they were from a home health agency, not a hospice.

71. The Chapters Health Defendants engaged in this deception because patients, or family members acting on behalf of patients, often will decline admission into hospice believing it to be premature, and the Chapters Health Defendants did not want to risk losing potential patients and the Medicaid and Medicare revenue they produce.

72. In many instances a person who lacked appropriate authority signed a patient's admission paperwork, thereby denying the patient his or her rights under Medicaid and Medicare to informed consent, as required to be eligible for coverage.

73. Claims to Medicaid and Medicare for the services provided to these patients were false or fraudulent because the patients were enrolled in hospice without informed patient consent and without the requisite election by the patient, in violation of Medicare regulations. 42 C.F.R. §§ 418.24, 418.200.

C. Up-Coding to Inflate Reimbursement

74. The Chapters Health Defendants also billed Medicaid and Medicare for higher levels of care than was reasonable and necessary for the palliation and management of the terminal illness, if any, of the hospice patient and related conditions. They did this by enrolling

patients in, and billing Medicare and Medicaid for, Continuous Care and Hospice House, specific elevated (and higher-paying) levels of hospice care knowing patients were not eligible for such heightened care or in deliberate ignorance or reckless disregard of their eligibility.

75. As referenced previously, CMS establishes fixed payment rates for four categories of covered hospice care: routine home care days, continuous home care days, inpatient respite care days, and general inpatient care days. *See* 42 U.S.C. § 1395f(i); 42 C.F.R. § 418.302(b) & (c).

76. Continuous Care provides staff in the patient's home around the clock, but is only supposed to be provided when a patient has a symptom that is not being managed effectively. Hospice care "may be provided on a 24-hour, continuous basis only during periods of crisis … and only as necessary to maintain the terminally ill individual at home." 42 U.S.C. § 1395x(dd)(1).

77. Inpatient hospice facilities, or Hospice Houses, are buildings where patients can go in order to relieve a symptom that cannot be managed effectively at home.

78. Both Continuous Care and Hospice House placements provide much higher reimbursements to hospices. For example, the 2009 Routine Home Care Federal reimbursement rate for the Tampa area was $139.97 per day and Inpatient Respite Care was $144.79 per day. By contrast, the 2009 Continuous Care rate for the Tampa area was $816.94 per day and the Hospice House (otherwise known as General Inpatient Care) rate was $622.66 per day.

79. The Chapters Health Defendants instructed and encouraged (and often pressured) clinical managers, nurses and staff to enroll patients in the higher-reimbursement Continuous Care Department and the Hospice Houses regardless of whether the patients qualified for that level of expensive care.

80. The Chapters Health Defendants directed PCMs/Team Leaders to monitor the number of Continuous Care patients on their teams and make sure that at least 10 percent of patients at each site were enrolled in Continuous Care.

81. Management called PCMs/Team Leaders daily and required them to report the number of Continuous Care patients on their teams. If the reported numbers fell short of the targets, the Chapters Health Defendants directed the PCMs/Team Leaders to call each nurse on their teams, review their caseloads, and find a reason to get enough patients into Continuous Care.

82. Irene Cohen, one of LifePath's Clinical Managers, actually called in all of her teams' nurses into a room and no one was allowed to leave until the teams' Continuous Care goal was met.

83. The Chapters Health Defendants established weekly quotas that a certain number of referrals be made to the Continuous Care Department and the Hospice Houses.

84. The Chapters Health Defendants, through the Executive Directors at LifePath and Good Shepherd, instructed PCMs/Team Leaders that they were required to initiate at least three Continuous Care cases per week and place at least three patients in Hospice House.

85. The Chapters Health Defendants, through the Executive Directors at LifePath and Good Shepherd, instructed PCMs/Team Leaders that they were to initiate Continuous Care on *all* discharges from Hospice House, *all* new admissions, and any discharges from hospitals that they could not directly place in Hospice House first.

86. The Chapters Health Defendants pressured supervisory employees to coerce, threaten and badger PCMs/Team Leaders and staff to provide fraudulent referrals for Continuous Care, going so far as to dismiss at least one Regional Director who refused to engage in such conduct.

87. The Chapters Health Defendants similarly pressured clinical managers, nurses, and other staff, including Relator, to place patients in Continuous Care and Hospice Houses upon discharge from a hospital, regardless of whether the patient qualified or required such a high level of care. Some patients even expressed that they felt kidnapped because they were not allowed to go home and instead were made to go to the Hospice House.

88. For example, on January 1, 2010, Dr. Hussain, a LifePath Team Medical Director, told a team of LifePath

staff to "Make patients go to the Hospice houses *whether they want to or not* to fill the beds because we are losing money!"

89. High-level management personnel of the Chapters Health Defendants communicated and enforced these directives, including Vice President of Compliance, Peggy Madill; Vice President of Clinical Services and Education, B.J. Dudney; and LifePath Executive Director, Cheryl Hamilton.

90. The Chapters Health Defendants rewarded staff and managers who went along with the fraud with better performance appraisals which led to promotions and increased salaries.

D. False or Fraudulent Documents and Records

91. The Chapters Health Defendants also falsified documents and patient records so as to create a paper trail falsely indicating patients were eligible for or had, in fact, elected hospice benefits and to conceal the fact that many patients were not eligible for the type or level of hospice care in which they were enrolled, or for hospice care at all.

92. Specifically, the Chapters Health Defendants instructed and encouraged staff to falsely record or communicate patient information to physicians in connection with certification decisions and to emphasize and highlight information suggesting a decline in the patients' condition while omitting from the documentation any indication that the patients' conditions were stabilizing or improving.

93. The Chapters Health Defendants required mandatory training for all staff in order to teach them how to "document to decline." This meant instructing staff that they were only to document a patient's *declining* health condition and to not document any *improvements* that they observed.

94. The Chapters Health Defendants also trained staff on specific verbal phrasing and techniques to use to identify and play-up anything that would appear to reflect a decline in the patient's condition.

95. In particular, the Chapters Health Defendants specifically trained staff never to use the phrases "patient is stable," "patient doing better," "no longer terminally ill" or "non-recert" in patient records.

96. In some instances, supervisors gave staff back their notes and told them to rewrite them.

97. These instructions to avoid any suggestion of improvement were mandatory for staff through CHS' Education Department.

98. These instructions were reinforced through regular interaction of staff with management and supervisors. For instance, in 2009 a counselor asked Diana Yates, LifePath's Director of Clinical Services, whether she should document that her patient was riding a bike around the neighborhood. Ms. Yates refused to respond with a "Yes" (in front of the 30-person staff), but instead communicated to the group through her silence and facial

expression that this information should *not* be recorded in the patient's file.

99. The Chapters Health Defendants also instructed staff, through education seminars, that "frequent visits blind the decline." The insight here was that if staff visited a patient often, it would be more difficult to document declining conditions. However, with infrequent visits spread apart further in time, it would be easier to draw stark contrasts in the patient's records. Accordingly, the Chapters Health Defendants encouraged staff to visit patients as infrequently as possible, because infrequent visits not only saved costs (*i.e.*, the costs of hiring the staff), but with minimal contact the patient's health was more likely to decline and present opportunities to note in the records specific things that were deteriorating.

100. The Chapters Health Defendants also regularly instructed staff to "back-date" Medicaid and Medicare forms that were not signed in a timely manner. If a staff person refused to comply, the manager simply asked another staff member to "back-date" the form. The forms that were back-dated included Election Statements, Revocations, and other similar forms. These forms are material to payment by Medicaid and Medicare for hospice services.

101. The Chapters Health Defendants also intentionally produced false and misleading documentation to its Medicare fiscal intermediary, Palmetto GBA.

102. In 2008, Palmetto GBA audited a selection of patients from both LifePath and Good Shepherd. In connection with that audit, Palmetto GBA requested documentation and records for certain patients. Before providing the requested information, the Chapters Health Defendants directed each clinical team leader to go to the office and review patient charts for the period under review. The leaders were instructed *not* to include in the materials to be provided to Palmetto GBA any notes or information that did not support the appropriateness of the patient for hospice care.

103. Despite these efforts, the Chapters Health Defendants were unable to justify the enrollment in hospice care of more than a third of their total patient census.

E. Failure to Provide Services Consistent with the Plan of Care

104. The Chapters Health Defendants also consistently provided inadequate staffing to meet the needs of patients and their families. As a result, patients and families were not provided the nursing, counseling, home health aide, physical therapy and chaplain visits required under their Plans of Care, yet the Chapters Health Defendants fraudulently billed Medicaid and Medicare for such services that they have not provided, and were incapable of providing, due to inadequate staffing levels.

105. Medicare regulations require that all hospice care and services must follow an individualized written Plan of

Care ("POC"). 42 C.F.R. §§ 418.56, 418.200. In order for there to be coverage, there must be a POC, the POC "must be established *before* hospice care is provided," and "[t]he services provided must be consistent with the [POC]." 42 C.F.R.. § 418.200 (emphasis added).

106. Among other things, the POC must contain a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs," *e.g.*, a certain level of nursing visits per week or month, counseling visits per month, *etc.* 42 C.F.R. § 418.56(c)(2).

107. The Chapters Health Defendants knowingly billed Medicaid and Medicare for services that were not in compliance with patients' POCs and they changed POCs so as to match inadequate staffing levels, rather than patient needs.

108. The Chapters Health Defendants also instructed staff, including Relator, to make patient "visits" by telephone and to encourage patients to decline a visit in order to falsely certify that patients were being serviced in compliance with the POC.

109. Patients, their families, and staff—including Relator—complained to Administrators and Compliance Officers about the inadequate staffing issue, yet the Chapters Health Defendants failed to correct the problem.

110. Relater attended meetings where overwhelmed nurses and counselors who, due to understaffing, simply did not have the time to visit with all the patients under

their care openly admitted to altering patients' POCs by decreasing the number of visits required so that they would no longer be non-compliant.

111. PCMs/Team Leaders were always present at these meetings and yet did nothing to discourage this practice because Diana Yates, LifePath's Director of Clinical Services, and Cheryl Hamilton, LifePath's Executive Director, among other senior administrators, openly instructed them to engage in and follow this wrongful practice. Ms. Yates specifically stated to PCMs/Team Leaders that, in order to be in compliance, changing POCs was an acceptable practice.

112. The National Hospice and Palliative Care Organization reports that the national average for a hospice social worker's caseload ranged from 23 to 26 patients from 2007 through 2015. CHS counselors averaged 50. By 2012, each counselor at CHS carried 75 to 100 patients—*three to four times* the national average.

113. The Chapters Health Defendants, however, knowingly submitted false claims to Medicaid and Medicare for reimbursement for hospice services that were not consistent with patient POCs and which were provided under improperly-modified POCs created due to intentional understaffing.

F. False Billing for Services Not Provided by the Chapters Health Defendants

114. The Chapters Health Defendants also submitted claims to Medicaid and Medicare for services that were not actually provided by the Chapters Health Defendants.

115. When patients left the Chapters Health Defendants' service area and were not receiving any care from CHS or any of its subsidiaries, the Chapters Health Defendants kept the patients on their roster and continued to bill Medicare and Medicaid the per diem rate.

116. In one specific instance, a patient travelled out of the country for three weeks but was never discharged from LifePath. LifePath then billed Medicaid for care provided to this patient even during his three-week absence from the service area.

117. The Chapters Health Defendants also routinely submitted false claims to Medicaid and Medicare for reimbursement for services that they did not provide, even when the patient was present in the area.

118. The fixed per diem payment by Medicare and Medicaid covers the cost of staff (including nursing, counseling, home health aide and chaplain services), equipment, medications (such as pain and anti-depressant medicines), and medical supplies (such as diapers and chux). Hospice is responsible for paying for these items whether a patient is at home, in a nursing home, or in an assisted living facility since it is reimbursed on a per

diem, per patient basis regardless of the actual services required by the patient.

119. The Chapters Health Defendants, however, knowingly allowed nursing homes and assisted living facilities to provide the counseling services and anti-depressant medication and bill Medicaid and Medicare for it separately, even though CHS or its subsidiary was obligated to provide that service to their patients since it was already being reimbursed by Medicaid and Medicare for those services.

120. The nursing homes and assisted living facilities who participated in this conduct included Sunrise Senior Living Services and Superior Residences.

121. The Chapters Health Defendants, therefore, allowed nursing homes and assisted living facilities to wrongly bill Medicaid and Medicare because in doing so, CHS and its subsidaries would lower their costs and increase their profit margins.

122. Defendants knowingly defrauded Medicaid and Medicare by billing for these services which they did not provide and for which Defendants knew nursing homes and assisted living facilities were also billing Medicaid and Medicare. Through this double-billing Defendants saved thousands of dollars a month by not providing these services to their patients in nursing homes and assisted living facilities. Medicaid and Medicare, however, paid twice for the same services and supplies.

123. Diana Yates, LifePath's Director of Clinical Services, and other senior level directors at CHS, LifePath and Good Shepherd instructed Relator, nurses, clinical managers and other staff to proceed in this fashion. When Relator objected to the practice in 2009, Ms. Yates told her it was "none of her business."

II. DEFENDANTS' UNLAWFUL INCENTIVE AND KICKBACK SCHEME

124. As detailed in this section, the Chapters Health Defendants have provided incentives to employees and patient referral sources in exchange for the identification, referral and enrollment of hospice patients.

125. The federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), arose out of congressional concern that remuneration given 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 Medicare and Medicaid programs from these harms, Congress enacted a prohibition against the payment of kickbacks in any form. First enacted in 1972, Congress strengthened the statute in 1977 and 1987 to ensure that kickbacks masquerading as legitimate transactions did not evade its reach. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare-Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

126. The Anti-Kickback Statute prohibits any person or entity from knowingly and willfully offering, making, soliciting, or accepting remuneration, in cash or in kind, directly or indirectly, to induce or reward any person for purchasing, ordering, or recommending or arranging for the purchasing or ordering of federally-reimbursable medical goods or services:

> [W]hoever 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)(2).

127. The term "remuneration" is defined to include "transfers of items or services for free or for other than fair market value". 42 U.S.C. § 1320a-7a(i)(6).

128. Because compliance with the Anti-Kickback Statute is a condition of payment, claims submitted for services rendered in violation of these statutes may be "false or fraudulent" for purposes of the FCA.

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

130. The Patient Protection and Affordable Care Act, Public Law No. 111-148, Sec. 6402(f), amended the Anti-Kickback Statute to specifically provide that claims which include items or services resulting from a violation of the Anti-Kickback Statute constitute a false or fraudulent claim for purposes of the False Claims Act. 42 U.S.C. § 1320a-7b(g).

131. The Patient Protection and Affordable Care Act further amended the Anti-Kickback Statute so as to make clear that "a person need not have actual knowledge of [the Statute] or specific intent to commit a violation" in order to violate the Anti-Kickback Statute. 42 U.S.C. § 1320a-7b(f).

132. The Stark Act 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 whom the entities had a financial relationship. *See* 42 U.S.C. § 1395nn(a)(1).

133. Prior to and after 2010, CHS, LifePath, and Good Shepherd all certified to the government that they were in compliance with the Anti-Kickback Statute and the Stark Act, including such certifications in their CMS provider agreements and their Medicare enrollment application forms.

134. As detailed below, these certifications were false

A. Employee Referral Incentives

135. The Chapters Health Defendants offered and paid kickbacks to employees in the form of bonuses, prizes, better performance evaluations, free meals, and other valuable items given to staff who generate the most referrals from their assigned nursing homes or assisted living facilities.

136. CHS and its subsidiaries paid staff bonuses based on meeting specific quotas for admissions to CHS. This practice encouraged and rewarded the unlawful admission of patients who did not qualify for hospice care according to Medicaid and Medicare criteria.

137. If nurses and clinical managers met or exceeded their quotas of Continuous Care and Hospice House referrals, the Chapters Health Defendants would not only praise, but also reward, these nurses by giving them better performance appraisals.

138. The Chapters Health Defendants also staged contests to further incentivize production of referrals and admissions. In one example, LifePath awarded a Gold Team nurse a camera for winning a contest for nurses to see who could produce the most referrals from his assigned nursing home.

139. The Chapters Health Defendants rewarded staff and managers who went along with the fraud with better performance appraisals which led to promotions and increased salaries.

140. Because of the incentives provided, nurses often skewed the admission requirements, admitting patients who were not appropriate or qualified for admission to the hospice.

141. LifePath and Good Shepherd nurses solicited referrals from nursing home staff and were permitted to review nursing home patients' medical charts in search of potential referral targets in violation of the Health Insurance Portability and Accountability Act ("HIPAA").

B. Kickbacks to Sunrise Senior Living Services, Inc.

142. The Chapters Health Defendants targeted nursing homes and assisted living facilities to gain access to records for patients whom they would sign up or enroll to elect hospice benefits. One such facility was Brighton Gardens of Tampa, operated by Sunrise Senior Living.

143. Brighton Gardens was one of, if not the, largest nursing home and assisted living facility in the Tampa area.

144. Beginning prior to 2009, the administrator of Brighton Gardens referred all of its dying patients to CHS with the expectation that CHS would enroll and certify all patients referred from Brighton Gardens for Continuous Care service irrespective of their eligibility for such heightened care. CHS assured Brighton Gardens that it would meet this expectation regardless of medical necessity.

145. Brighton Gardens used its ability to refer patients for heightened levels of hospice care as a marketing point in enrolling its own patients.

146. Relator objected to the default enrollment of Brighton Gardens patients for Continuous Care and noted the specific requirements Medicare and Medicaid imposed for Continuous Care. Irene Cohen, LifePath's Clinical Manager, and Diana Yates, LifePath's Director of Clinical Services, quickly reprimanded Relator for pointing out the issue and risking any disruption to the stream of referrals from Brighton Gardens.

C. Kickbacks to Superior Residences, Inc.

147. Another large referral source for the Chapters Health Defendants was an assisted living facility operated by Defendant Superior Residences, Inc. in Brandon, Florida.

148. Since prior to 2009, CHS provided Superior with all of the diapers and chux for the entire facility's patients even though the hospice patients were only a portion of the population. In exchange, Superior provided hospice patient referrals.

149. At one point in 2009, the administrator of the Superior facility threatened LifePath employees with stopping referrals to LifePath if it did not provide supplies for all of Superior's patients.

150. LifePath management instructed staff to provide the materials requested by Superior.

D. Kickbacks to Dr. Wacksman and Mobile Physician Services, P.A.

151. The Chapters Health Defendants also tapped companies owned by CHS management as a source of patient referrals. LifePath Medical Director, Dr. Wacksman, owned another company called Mobile Physician Services, P.A., and Dr. Wacksman often referred patients to hospice who were not terminally ill.

152. As referenced *supra*, Dr. Wacksman often would not allow patients to be non-recertified for hospice and he would find ways to recertify a patient for additional periods of hospice care. One of the only exceptions was if the patient at issue would be discharged and referred to his company, Mobile Physician Services.

153. Since at least 2006, the Chapters Health Defendants and Mobile Physician Services referred each other patients. Through Mobile Physician Services, Dr. Wacksman provided in-home primary medical care to patients either himself or (more typically) through ARNPs employed by him.

154. Dr. Wacksman and Mobile Physician Services utilized this as an opportunity to bill Medicare and Medicaid for home visits made by ARNPs under his own, physician provider identification number as "Incident to Physician Billing."

155. Such billing of non-physician services at the physician rate is only appropriate where, among other requirements, the physician is on-site and available to supervise the non-physician practitioner. *See* Medicare Benefit Policy Manual, Chapter 15, Section 60.

156. Accordingly, Dr. Wacksman used patients referred back to Mobile Physician Services to support his own scheme to present, or cause to be presented, false or fraudulent claims to Medicare.

E. Kickbacks to JSA Medical Group

157. Another kickback scheme occurred between the Chapters Health Defendants and JSA Medical Group, the largest provider of primary care services to Medicare beneficiaries in central and south Florida.

158. Since at least 2004, JSA Medical Group has made referrals to CHS and its subsidiaries, often of patients not appropriate for hospice care. In exchange, CHS picked up many of the costs for the care of these patients, who remained under JSA Medical Group for primary care purposes.

159. By virtue of the referrals to CHS, JSA Medical Group was able to keep billing Medicare the same capitated rate for the patients while reducing its costs of caring for the patients.

160. The Chapters Health Defendants, in particular Dr. Wacksman, specifically instructed that JSA Medical Group patients were not to be non-recertified. By keeping JSA Medical Group patients enrolled in hospice irrespective of eligibility the Chapters Health Defendants were able to pick up some of the costs JSA Medical Group otherwise would have incurred while both JSA Medical Group and the Chapters Health Defendants could bill Medicare or Medicaid their respective daily or capitated rates. Dr. Wacksman explained simply this is "how it goes."

III. IMPACT OF DEFENDANTS' FALSE CLAIMS ACT VIOLATIONS

161. As referenced *supra*, the Chapters Health Defendants maintained a total census of approximately 2,000 patients. Roughly 80 percent of those patients were Medicare or Medicaid beneficiaries.

162. Periodic chart reviews showed that anywhere from 20 percent to as much as 40 percent of the patient census was not actually appropriate for hospice. Following an audit by CHS' Medicare fiscal intermediary in 2008, CHS' ADC dropped to less than 1,400 patients, a reduction of approximately one-third, as ineligible and inappropriate patients were removed.

163. Though it varied from year to year, the combined annual patient service revenues for LifePath and Good Shepherd generally exceeded $120 million.

164. If just 20 percent of the Chapters Health Defendants' Medicare/Medicaid-eligible patients were not hospice appropriate, then the Chapters Health Defendants submitted at least $20 million in false or fraudulent claims to the Government each year.

165. Further, with the Chapters Health Defendants' kickback violations dating back at least to 2004, *all* of the Chapters Health Defendants' claims to Medicare or Medicaid during that period of time (approximately $100 million per year) were false or fraudulent under the False Claims Act.

IV. LIFEPATH'S UNLAWFUL RETALIATION AGAINST RELATOR

166. As detailed previously, LifePath employed Ms. Chase from 1992 until December 2012. She served in both direct counseling and supervisory positions. Between 1994 and 2009, Ms. Chase was employed primarily in the supervisory position of Psychosocial Consultant (or

its equivalent). This position included responsibility for multiple or, at certain times, all teams within the LifePath structure.

167. In the position of Psychosocial Consultant, Ms. Chase's responsibilities included training counselors, providing clinical supervision towards licensure, providing consultation to entire teams regarding counselor functions, dealing with any difficult or challenging cases, and providing leadership input in the psychosocial capacity.

168. Ms. Chase also served on various committees during her 20 years of employment by LifePath, both specific to LifePath and on corporate committees for the entire CHS group of affiliates. Among others, she served on LifePaths' Ethics Committee and the corporate IDG Committee, a committee that developed policies and procedures for the entire group of companies.

169. In 2009, however, LifePath demoted Ms. Chase to the position of Social Services Specialist, a line counselor position, because she raised ethical issues concerning violations of the Acts. This occurred even though Dr. Schonwetter previously had given her an outstanding recommendation.

170. In February 2010, LifePath discharged Ms. Chase from the Ethics Committee and the IDG Committee after she raised ethical violations by CHS, specifically for not honoring a patient's living will by utilizing a feeding tube to artificially keep the patient alive when the patient had expressly requested that he not be kept alive by artificial means.

171. LifePath terminated Ms. Chase's employment in December 2012 based upon her actions raising objection to the Ethics Committee's handling, or lack thereof, of the issue of the disregard of patient advance directives. Specifically, after Ms. Chase reported the issues to the Ethics Committee and sought action, Dr. Schonwetter directed Chad Everett to "shut down" the matter. Ms. Chase then spoke to a member of the Board of Directors, Hana Osman, who told her what Dr. Schonwetter had done was "unacceptable" but warned Ms. Chase to be "careful." LifePath terminated Ms. Chase the next day, telling her that it was doing so because she "went above the chain of command."

172. Ms. Chase's demotion, her removal from the Ethics Committee and her termination were retaliatory actions by an employer in violation of 31 U.S.C. § 3730(h) and discriminatory actions in violation of Florida Statutes § 68.088.

COUNT I

PRESENTING AND CAUSING TO BE PRESENTED FALSE OR FRAUDULENT CLAIMS IN VIOLATION OF 31 U.S.C. § 3729(A)(1)(A) AND FLORIDA STATUTES § 68.082(2)(A)

173. Relator realleges and incorporates by reference the foregoing paragraphs as if set forth fully herein.

174. By means of the acts described above and from at least June 2000 through the present, Defendants knowingly presented or caused to be presented false and fraudulent Medicaid and Medicare claims for payment or approval in violation of the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* and Florida Statutes §§ 68.081 *et seq.*

175. Defendants violated the Acts by submitting, or causing to be submitted, claims for payment that were false and fraudulent because:

a. the patients, for whose care Defendants sought payment, were not eligible for hospice services because they were not terminally ill, they had not been properly certified as terminally ill, they had not provided informed consent electing hospice care, and/or appropriate and accurate documentation had not been obtained;

b. the care or the level thereof for which Defendants sought payment was greater than was medically necessary and/or for which the patient was eligible;

c. the care for which Defendants sought payment had not been provided in accordance with the patient's written Plan of Care;

d. the services for which payment was sought otherwise had not been performed or provided;

e. the patients, for whose care Defendants sought payment, were out of the relevant service area at the time they supposedly were under Defendants' care; and

f. the Chapters Health Defendants had violated the Anti-Kickback Statute and the Stark Act in connection with their solicitation and obtainment of patient referrals.

176. Accordingly, Defendants knowingly presented or caused to be presented false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(A) and Florida Statutes § 68.082(2)(a).

177. By virtue of the false or fraudulent claims Defendants presented or caused to be presented, the United States and the State of Florida have suffered actual damages and are entitled to recover treble damages plus a civil monetary penalty for each false claim.

COUNT II

CAUSING AND MAKING FALSE OR FRAUDULENT CLAIMS, RECORDS AND STATEMENTS TO BE PRESENTED IN VIOLATION OF 31 U.S.C. § 3729(A)(1)(B) AND FLORIDA STATUTES § 68.082(2)(B)

178. Relator realleges and incorporates by reference the foregoing paragraphs as if set forth fully herein.

179. By means of the acts described above and from at least June 2000 through the present, Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims paid or approved by the United States and the State of Florida.

180. By virtue of the false records or statements Defendants caused to be made or used, the United States and the State of Florida have suffered actual damages and are entitled to recover treble damages plus a civil monetary penalty for each false claim.

COUNT III

CONSPIRACYTO COMMIT VIOLATIONS OF THE ACTS IN VIOLATION OF 31 U.S.C. § 3729(A)(1)(C) AND FLORIDA STATUTES § 68.082(2)(C)

181. Relator realleges and incorporates by reference the foregoing paragraphs as if set forth fully herein.

182. By means of the acts described above, Defendants knowingly conspired with each other to knowingly present or cause to be presented false or fraudulent claims for payment or approval and to knowingly make, use, or cause to be made or used, false records or statements material to false or fraudulent claims paid or approved by the United States and the State of Florida.

183. By virtue of the false or fraudulent claims Defendants presented or caused to be presented and the false records or statements Defendants caused to be made or used, the United States and the State of Florida have suffered actual damages and are entitled to recover treble damages plus a civil monetary penalty for each false claim.

Appendix C

COUNT IV

RETALATION CLAIM OF RELATOR, NANCY CHASE, AGAINST DEFENDANT LIFEPATH HOSPICE, INC. PURSUANT TO 31 U.S.C. § 3730(H)

184. Relator realleges and incorporates by reference the foregoing paragraphs as if set forth fully herein.

185. By virtue of the activities described above, Relator has engaged in conduct protected under the False Claims Act, specifically the reporting of violations of the Act and efforts to stop those violations.

186. Defendant LifePath Hospice, Inc. was aware of Relator's actions.

187. Defendant LifePath Hospice, Inc. retaliated against Relator, through a demotion and reduction in pay and status and, ultimately, by terminating her employment for her aforesaid conduct protected under the False Claims Act.

188. By virtue of this conduct, Relator has suffered damages.

Appendix C

COUNT V

DISCRIMINATION CLAIM OF RELATOR, NANCY CHASE, AGAINST DEFENDANT LIFEPATH HOSPICE, INC. PURSUANT TO FLORIDA STATUTES § 68.088

189. Relator realleges and incorporates by reference the foregoing paragraphs as if set forth fully herein.

190. By virtue of the activities described above, Relator has engaged in conduct protected under the Florida False Claims Act, specifically the reporting of violations of the Act and efforts to stop those violations.

191. Defendant LifePath Hospice, Inc. was aware of Relator's actions.

192. Defendant LifePath Hospice, Inc. discriminated against Relator, through a demotion and reduction in pay and status and, ultimately, by terminating her employment for her aforesaid conduct protected under the Florida False Claims Act.

193. By virtue of this conduct, Relator has suffered damages.

DEMAND FOR RELIEF

WHEREFORE, Relater respectfully requests this Court enter judgment against the Defendants, jointly and severally, as follows:

1. That the United States be awarded damages in the amount of three times the damages sustained by the United States because of the false and fraudulent claims alleged within this Complaint, as the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* and Florida Statutes §§ 68.081 *et seq.* provides;

2. That civil penalties be imposed for each and every false and fraudulent claim that Defendants presented to the State of Florida and the United States Government;

3. That pre- and post-judgment interest be awarded, along with reasonable attorneys' fees, costs and expenses which the Relator incurred in bringing and pursuing this action;

4. That the Court grant permanent injunctive relief to prevent any recurrence of the False Claims Act violations for which redress is sought in this Complaint;

5. That the Relator be awarded the maximum percentage of the amount recovered by the State of Florida and the United States Government as a result of this action pursuant to 31 U.S.C. §§ 3729 *et seq.* and Florida Statutes §§ 68.081 *et seq.*;

6. That the Relator be awarded compensation for the retaliatory discrimination in violation of 31 U.S.C. §§ 3729 *et seq.* and Florida Statutes §§ 68.081 *et seq.* in the following amounts:

(a) lost compensation based on the same seniority status as she would have had but for the discrimination;

(b) two times the amount of back pay;

(c) interest on the back pay; and

(d) compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

7. That this Court award such other and further relief as it deems proper.

DEMAND FOR JURY TRIAL

Relator, on behalf of herself, the State of Florida and the United States, demands a jury trial on all issues so triable.

Appendix C

DATED: March 18, 2016

Respectfully submitted,

/s/_____
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