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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

UNITED STATES OF AMERICA, the STATE OF ARKANSAS, the STATE OF CALIFORNIA, the STATE OF FLORIDA, the STATE OF ILLINOIS, the STATE OF LOUISIANA, the STATE OF TENNESSEE, and the STATE OF TEXAS ex rel. JANAKI RAMADOSS	)	
Plaintiffs,	)	SA99CA0914HG
	)	CIVIL ACTION NO._____
v.	)	
CAREMARK INC.; CAREMARK INTERNATIONAL, INC.; CAREMARK INTERNATIONAL HOLDINGS INC.; And MEDPARTNERS INC., Defendants.	)	**FILED IN CAMERA AND UNDER SEAL**

ORIGINAL COMPLAINT FOR DAMAGES AND OTHER RELIEF UNDER THE FALSE CLAIMS ACT

This is an action to recover damages, civil penalties and other equitable relief on behalf of 1) Plaintiff, the United States of America, arising from the submission of reverse false claims by Defendants and their employees, agents, and/or their contractors to avoid, conceal, or decrease Defendants' and/or Defendants' Clients' obligation to pay or transmit

money to the Government of the United States of America under various federal health insurance programs including the Medicaid Program, the Indian Health Services of the Bureau of Indian Affairs, and the Veterans Affairs Program (collectively "the Federal Health Insurance Programs") in violation of 31 USC Sections 3729 (a) (7). This action arises under the provisions of Title 31 U.S.C. Section 3729, et seq. popularly known as the False Claims Act (the "Act") which provides that the United States District Courts shall have exclusive jurisdiction of actions brought under that Act; and

2) Plaintiff States (herein listed in alphabetical order with the applicable law cited) arising from the submission of reverse false claims by Defendants and their employees, agents, and/or their contractors to avoid, conceal, or decrease their obligation to pay or transmit Medicaid monies to these State governments under the State Medicaid Programs (for ease of reference, to be considered included collectively as part of the "Federal Health Insurance Programs") :

a) **Arkansas**, in violation of the Arkansas Medicaid Fraud False Claims Act, Ark. Code Ann. Section 20-97-9 *et seq.*, and in particular section 20-7902 (1) and (3);

b) **California**, in violation of the California False Claims Act, Cal. Govt. Code section 12650 *et seq.*, and in particular sections 12651 (a)(7) and (8);

c) **Florida**, in violation of the Florida False Claims Act, Fla. Stat. Ann. section 68.081 *et seq.*, and in particular section 68.082(2)(g);

d) **Illinois**, in violation of the Illinois Whistleblower Reward and Protection Act, Ill. Ann. Stat. Ch. 740 para. 175, and in particular 740 ILCS 175, section 3(a)(7);

e) **Louisiana**, in violation of the Louisiana Medical Assistance Integrity Law, La. Rev. Stat. Ann. Section 437.2a;

f) **Tennessee**, in violation of the Tennessee Medicaid False Claims Act, Tenn.Code Ann.

71-5-182 *et seq.*, and in particular section 71-5-182(a)(1)(D); and

g) **Texas**, in violation of the Texas Medicaid Fraud Prevention Law, Tex.Hum.Res.Code Ann. Section 37.001 et seq., and in particular sections 36.002(1)(A) and (4)(B); and

3) Relator, Janaki Ramadoss, arising from Defendants discharging, threatening, harassing, or otherwise discriminating against Relator in response to Relator's discovery and reporting of the aforesaid false statements and reverse false claims.

Relator, by the undersigned counsel and acting on behalf of and in the name of the United States for Counts I- III , , and acting on behalf of the States of Arkansas, California, Florida, Illinois, Louisiana, Texas, and Tennessee for Counts IV-X, and acting on her own for Count XI brings this civil action under the *qui tam* provisions, and alleges as follows:

JURISDICTION AND VENUE

1. This Court has jurisdiction over the subject matter of this Complaint pursuant to the False Claims Act, 31 U.S.C 3729 et seq., 28 U.S.C. § 1345 and 31 U.S.C. §§ 3732(a) and 3730(h). The Court has personal jurisdiction over the Defendants because the Defendants reside and/or transact business in San Antonio, Bexar County, Texas. Plaintiff Relator also invokes this Court's ancillary jurisdiction over pendent state claims arising out of the same operant facts.

2. Venue in this District is proper pursuant to 28 U.S.C. § 1345 and 31 U.S.C. § 3732 (a). Section 3732(a) of the Act provides that "[a]ny action under section 3730 may be

brought in any judicial district in which the Defendant or, in the case of multiple Defendants, any one Defendant can be found, resides, transacts business, or in which any act proscribed by section judicial district". The acts and violations complained of herein occurred in Bexar County , Texas where Defendants resided and/or transacted business.

3. The Act allows any person having information regarding a false or fraudulent claim against the Government to bring an action for himself (the "Relator") and for the Government and to share in any recovery. Under the Act, this complaint is said to be filed *in camera* and remain under seal for a period of at least sixty (60) days and shall not be served on the Defendants until the Court so orders. The government may elect to intervene and proceed with the action within sixty (60) days after it receives both the complaint and the material evidence and information.

4. As required under False Claims Act, 31 U.S.C. Section 3730 (b)(2), Relator shall provide to the Attorney General of the United States and to the United States Attorney for the Western District of Texas, San Antonio Division shortly after the filing of this complaint, a statement of all material evidence and information related to the complaint. This disclosure statement supports the existence of reverse false claims by the

Defendants. Relator shall also serve the appropriate parties in each of the Plaintiff States with the Complaint and the Disclosure Statement as indicated by their respective statutes.

5. This action is not based upon any public disclosure of information within the meaning of 31 U.S.C. § 3730 (e)(4)(A). The Relator has direct and independent knowledge, within the meaning of 31 U.S.C. § 3730(e)(4)(B) of the information on which the allegations set forth in this Complaint are based. Relator has voluntarily provided this information to the government prior filing this Complaint to the extent any of these allegations may have been publicly disclosed within the meaning of 31 U.S.C. § 3730.

6. Based on those provisions, plaintiff/Relator seeks to recover damages and civil penalties arising from Defendants' presentation of false records, claims, and statements to the United States Government and its agents in connection with Defendants' efforts to conceal Defendants' and Defendants' Clients' obligations to the Federal Health Insurance Programs and the failure to reimburse these programs for prescription drugs paid for. Under federal law, the Federal Health Insurance Programs are the payers of last resort. If a patient has private insurance coverage, such as a prescription drug benefit program, as in this case, that private carrier is the payer of

first resort and required to pay for the prescription drugs as per the terms of the plan. Defendants did not. Furthermore, Defendants, parties to one certain Corporate Integrity Agreement entered into with the Department of Health and Human Services in June, 1995, are in violation of the terms of this agreement by way of their fraudulent acts.

PARTIES

7. Qui Tam Plaintiff and Relator, Janaki Ramadoss, is a U.S. citizen and resident of San Antonio, Texas. She is employed as a Quality Assurance Representative with Caremark, Inc. and has personal knowledge of reverse false claims, false records, statements and/or claims presented to the Government by and for the Defendants named herein and of Defendants' fraudulent reimbursement practices.

8. Defendant Caremark, Inc. ("Caremark, inc") is a corporation authorized to do business in the State of Illinois and headquartered in Northbrook, Illinois. Caremark Inc. is also authorized to do business in the State of Texas. Caremark, Inc., a subsidiary of parent, Medpartners, Inc., has a pharmaceutical division that is in the business of providing prescription benefit management (PBM) services to over 1,200 self-insured drug plan Clients in the United Sates with more than 15 million participants. Caremark Inc.'s

Clients include managed care organizations, insurance companies, corporate health plans, unions, government agencies and other funded benefit plans. Caremark operates a national retail pharmacy network with over 53,000 participating pharmacies and three state-of-the-art mail service pharmacies. Caremark processes more than 44 million prescriptions a year and had 1998 net revenues of $2.6 billion.

9. Defendants Caremark International Inc., and Caremark International Holdings Inc., authorized to do business in the State of Illinois and headquartered in Northbrook, Illinois are affiliates of Caremark (the "Caremark Entities"). Caremark, Inc. and the Caremark Entities shall collectively be referred to as "Caremark" heretofore.

10. The respective Officers and the Boards of Directors of Caremark have fiduciary duties that include the responsibility to identify and deal with known, suspected or reported instances of misconduct by employees with efficient and decisive measures especially as they relate to the underpayment or overcharging of the United States for services and goods provided. The Officers and Directors have a duty to see that corporate information and reporting systems are in place to ensure compliance with the law, typically with a compliance programs.

11. Medpartners, Inc., the parent of Caremark, is publicly traded on the New York Stock Exchange and is authorized to do business in Alabama. It has its headquarters in Birmingham. Medpartners has publicized its intent to make Caremark's pharmaceutical division its core industry.

12. The Officers and the Boards of Directors of Medpartners, Inc. have fiduciary duties that include the responsibility to identify and deal with known, suspected or reported instances of misconduct by employees with efficient and decisive measures especially as they relate to the underpayment or overcharging of the United States for services and goods provided. The Officers and Directors have a duty to see that corporate information and reporting systems are in place to ensure compliance with the law, typically by way of an established compliance programs.

13. The Medicaid program is funded by both the federal and state governments based on a Federal Matching Percentage (FMP) which is calculated on a yearly basis for each state. When the Defendants denied reimbursements to Medicaid resulting in reverse false claims to the federal government, it also resulted in the concealment and reduction of an obligation owed to the state. The non-payment of an obligation owed to the listed states for their share of the FMP resulted in damages to these states which

in some cases give rise to claims under the respective states' False Claims Acts and other laws.

BACKGROUND INFORMATION AND GENERAL ALLEGATIONS

14. Relator is the Quality Assurance Representative for Caremark in the department that handles the processing of all paper claims for reimbursement and/or payment for prescription drugs. She has been employed at Caremark from 1993 to the present in various capacities. Her duties include performing daily audits of claims for data entry error, performing quality checks on claims and identifying system problems that impede the correct processing of claims for payment. Relator maintains daily, monthly and yearly logs of all error incidents and presents them to management. She audits approximately 6% of all paper claims processed.

15. Defendants are all providers of health care goods, drugs and/or services and all have direct and fixed obligations to the Federal Health Insurance Programs including Medicaid (42 USC §§ 1396 et. seq.) ("Medicaid"), Indian Health Services ("IHS")(Indian Health Care Amendments, PL 100-713-1988) and the Veterans Affairs Program

("VA")(38 USC §§ 1701 et. seq.). Relator believes that Defendants may also have obligations to other Federal Health Insurance Programs including those under the Railroad Retirement Trust Fund (43 USC §§ 1395 et. seq.)., Civilian Health and Medical Program/ Champus/Tricare (10 USC §§ 1071 et. seq.), the Federal Employees Health Benefits Program (5 CFR Chapter 59), Medicare and other programs under the Department of Defense ("DOD").

CAREMARK: PROVIDER OF PHARMACY BENEFIT MANAGEMENT ("PBM") SERVICES

16. Caremark has 1,200 Clients for which it provides PBM services. A plan is designed by each Client which details what benefits , deductibles and co-pays will be offered to that plan's participating employees ("participants") . Generally, the Clients agree to provide certain prescription drug benefits to their participants and self-insure for the related costs of the plan. Caremark is the pharmaceutical agent for these Clients and assumes all the duties and responsibilities of the Clients to its participants. For most Clients Caremark has a "fee for service" agreement. The Client sets up a Fund from which Caremark is authorized to write checks and pay for prescriptions after processing. For some Clients, Caremark has a "capitation" agreement by which the Client pays a fixed amount per life to Caremark and Caremark must provide all services within that amount. In the "fee for service" agreements, Caremark administers the program for the Client and in compensation may receive a premium to cover its

services and administrative fees to process claims. Caremark may receive a fixed price per prescription from the Client and is charged a fixed amount per prescription by the pharmacy. Caremark operates a pharmacy network of its "List of 53". These are 53,000 pharmacies that have agreed with Caremark to only charge a fixed amount for a given prescription in return for being on the preferred "List of 53" used by Clients and their participants, thus ensuring a volume of business. For some participants, Caremark receives the participants' prescriptions through the mail, fills them through the mail service pharmacy and has them delivered via mail. For other participants, the participants pay a co-payment, pick up their their drugs at one of 53,000+ pharmacies in Caremark's network and the pharmacy's claim for payment is received electronically and paid by Caremark electronically. For still others, the participants purchase their drugs and submit a paper claim for reimbursement from Caremark. The paper claims department is located in San Antonio, Texas where all paper claims are processed. Each Client has a Caremark Client Representative assigned who monitors the service received by the Client and troubleshoots problems. The contract between the Client and Caremark guarantees a turnaround time of no more than four (4) days for payment of any claims.

DUAL COVERAGE: CAREMARK AND THE FEDERAL HEALTH INSURANCE PROGRAMS

17. Clients generally provide benefits to their employees and employee's dependents (the "participants") . A significant number of the participants have dual coverage of benefits- from their Client and under one of the Federal Health Insurance Programs. Some of the participants are retired military or have military spouses with corresponding medical benefits from Champus/Tricare or the Veterans Program. Some of the participants are working poor and have coverage under Medicaid. Some of the participants are dependent children or elderly parents who are Medicaid-eligible and can access benefits. Some of the participants are employees of the Client but also have coverage under the Indian Health Services Program. When purchasing prescription drugs, these participants will purchase them at federal locations or with federal drug cards entitling them to free or reduced prescriptions at the point of sale pharmacy. The Federal Health Insurance Programs pay for the drugs and are assigned by each participant whatever benefits each participant may be entitled to receive from Caremark in its capacity as the Third Party pharmaceutical agent for its Clients. The purchase and payment for a prescription in this manner gives rise to a fixed and determinate obligation to the federal and state governments on the part of Caremark..

18. The Federal Health Insurance Programs are the payers of last resort, that is, where there is other third party insurance coverage available to pay for the prescription drugs of a recipient, those private resources must first be exhausted before there is federal liability to pay prescription charges with government moneys. Since the Federal Health Insurance Programs have already paid for goods and services for which there is coverage under other health insurance, they are entitled to reimbursement of 1) the lower of the actual amount expended or 2) the amount covered under the private plan. The statutory provisions which entitle the Medicaid Program to such reimbursement are 42 USCA 1396 (a) (25) (A) and 42 CFR 433.135. The Federal Health Insurance Programs are entitled to reimbursement of all disbursements for pharmaceuticals that are covered under the Client's plan design. Caremark, as the agent and/or third party administrator and/or underwriter for the Client is obligated to pay reimbursement to the Federal Health Insurance Programs on the same terms as other claims submitted under the respective Client's plan design.

19. In every case, the Federal Health Insurance Programs have paid the pharmacy for the prescriptions of its covered parties before filing a claim for reimbursement from Caremark. The obligation to the federal and state governments is a fixed dollar amount and exists at the time reimbursement is requested.

20. Relator will show that Caremark has not been reimbursing the Federal Health Insurance Programs for those moneys that are owed. In fact, Caremark has been denying reimbursement of Medicaid, the VA and the IHS Claims for up to three years despite the repeated requests in writing from the various federal agencies. Relator has identified these reimbursement problems to Caremark's management over the last two years and no corrective action has been forthcoming. The PBM industry is price driven and cutthroat. Caremark's survival is dependent on volume from Client retention and the generation of new Clients. If Caremark does a good job of administering a PBM plan for a Client, it will be reflected by low payouts on the PBM benefits from the Client's Fund. If Caremark does not control payouts, the Fund will be depleted and possibly have to be replenished by the Client. Poor performance has resulted in the loss of Clients for Caremark. By refusing to reimburse the Federal Health Insurance Programs for legitimate claims, Caremark is able to retain more money in a Client's Fund , thereby keeping the Client happy and retaining and growing its Client base. This is done at a cost to the U.S. Treasury and those of the Plaintiff States.

DUMMY CODE 9999991:
DENIAL OF FEDERAL CLAIMS FOR REIMBURSEMENT

21. Relator would show that Caremark's *Quantum* computer system has been knowingly and intentionally programmed with certain codes so as to reject the reimbursement of

Medicaid and VA claims that are submitted. The *Quantum* computer system was implemented in 1994, and Relator would show that it is not being properly tested even today. Code 9999991 is a dummy code that was created by Caremark to be used exclusively for the processing of all Medicaid claims, and Relator will show that, for at least 34 Clients, it results in the outright denial of all Medicaid claims submitted for reimbursement without any analysis.

INDIAN HEALTH SERVICES: MANUAL REJECTION FOR COORDINATION OF BENEFITS ("COB")

22. Relator will further show that the IHS claims are automatically rejected manually by the claims processors and returned to the agencies unpaid , as per the direct instructions of Caremark Management. Manual rejection means that the records are never entered into the computer system, and, consequently, no audit trail exists. These claims are being rejected for "*Coordination of Benefits*", which means that since the participant has other coverage, in this case under the IHS, Caremark is rejecting the claim. Normally, reputable insurance companies have guidelines in place to coordinate the payment of benefits when there is coverage under more than one private insurance company (i.e. a child is covered by both Mom and Dad's separate health policies). Many times, policy dictates that the coverage first obtained will be primary, and the secondary coverage will pay for what the primary did not cover., never exceeding the costs

actually incurred and paid by the participant. There are many acceptable and equitable variations of such procedures for Coordination of Benefits ("COB"). In the case of the Indian claims from IHS, Caremark is rejecting all claims from IHS for reimbursement in their entirety. In essence, Caremark's system makes IHS the payer of first resort and, worse yet, the only payer. No effort is made to analyze the claim because the claims processors have been instructed to summarily reject them.

"TERMED" CLIENTS

23. Relator will further show that Defendants have been denying payment to the Federal Health Insurance Programs citing *"PB is not active"* (Plan Benefit is not active). This message means that the Client, or the employer, is no longer a Client of Caremark, and that they have terminated their contract for services. Caremark rejects reimbursement on these claims, implying that there are no longer any benefits to be reimbursed under the given Plan because it has expired, when in fact, participants are entitled to reimbursement for all prescriptions purchased before the "*termination date"* of the plan. Clients who have changed plans or are no longer Caremark Clients are considered "*termed clients'.* Once a Client has been "termed" , there is a *"termination date"* and a *"run out date"*. If the participants of a plan have incurred prescription charges before the "*termination date*, they only have until the "*run out date*" to submit

a claim for reimbursement. If the participants are beneficiaries of the Federal Health Insurance Programs, any reimbursement due to them is assigned to the Government. Caremark is denying reimbursement to the Federal Health Insurance Programs citing 1) there is no coverage in force and/or 2) the claim is stale and past the *run out date.* These reasons are being falsely cited even when the prescription charges were timely incurred and paid for by the Federal Health Insurance Programs during the effective life of the Client/employer's plan and prior to termination. Federal law dictates that the Federal Health Insurance Programs are generally not bound by *stale date/run out date* restrictions of short duration, and that reimbursement must be made. To date, Caremark continues to provide the federal and state governments with false statements and letters that deny Caremark's liability on these existing obligations to them.

BILLED/SUBMITTED CHARGE REQUIRED FOR MEDICAID

24. Relator will also show that many reimbursement claims from the Federal Health Insurance Programs are being denied because information is missing, specifically "*Billed/Submitted Charge Required for Medicaid".* Caremark is refusing reimbursement because it wants a line item indicating what the pharmacy "billed/submitted" to the Federal Health Insurance Program. The preprinted claims forms of many state Medicaid programs, such as for example, Texas and California, reiterate that the

"billed/submitted" amounts are always identical to the amounts listed as "paid" on the reimbursement request. These states further reiterate that denial of payment for failure to separately state these two amounts on the claim is not justified and illegal. Caremark continues to reject hundreds of thousands of dollars in claims from the Federal Health Insurance Programs on the basis of a typographical disparity.

34 CLIENTS: DENIED REIMBURSEMENT FOR MEDICAID AND VA

25. Relator would further show that she has been informing management of these reimbursement violations for over two years, sometimes on a daily basis. Relator has identified over 34 Clients or Caremark Clients for which the computer system has been denying any and all reimbursement of claims to the Federal Health Insurance Programs. The most prevalent reasons given are *"denied for out of network"* and *"denied for stale date"*, both reasons that specifically do not apply to the Federal Health Insurance Programs regardless of the Client's plan design. To date, the Caremark computer system continues to reject reimbursement of these federal claims. Earlier this year, Relator formally requested by way of an internal "ticket" that the Systems Department test dummy code #9999991 for the affected Clients. Relator later received a response that the ticket was being closed, despite the fact that no action had been taken to test the system and resolve the denial of claims.

OUT OF NETWORK: REDUCED REIMBURSEMENT FOR MEDICAID AND VA

26. Relator would further show that, for the Medicaid claims submitted for reimbursement under the plans of still other Caremark Clients or Clients that she has identified, Caremark is denying portions of reimbursement of claims to the Federal Health Insurance Programs citing reasons that have no merit and that are in direct violation of state and federal law. Caremark is paying on these claims, but is reducing reimbursement citing that the "pharmacy" (Medicaid is not a pharmacy) is not a member of the List of 53 and, therefore, considered "out of network". Under some of the Client PBM Plans, the participants are entitled to some if not full reimbursement for drugs purchased at out-of-net-work pharmacies. Federal and state law is clear, and many States state on their *claims " Do Not Deny Because the Pharmacy is Not a Plan Participant"*. Caremark is discriminating against the Federal Health Insurance Programs in these cases by not even reimbursing the Government's claims on the same basis as it reimburses the similar claims of other private insured participants. The computer system has been programmed to automatically deny all reimbursement to the Federal Health Insurance Programs. No effort is made to treat the state and federal programs on equal terms with private companies. Caremark is aware that most Medicaid programs have limited investigatory resources. Upon receiving some form of partial reimbursement from Caremark with an accompanying false Explanation of

Benefits (EOB) , most, if not all Medicaid programs, assume payment is correct. They will not follow-up with a request to Caremark for the Client's Plan Design so that they may be sure that the payment disbursed is the maximum allowable under the plan. Since the subject of the claim is for a relatively low dollar amount, it is not cost effective for the states and federal programs to routinely investigate each claim. Under these circumstances, Caremark has been able to retain the monies of Clients in their respective Funds with few challenges from the federal or state assignee of benefits when it involves a "fee for service" plan. Caremark is motivated to keep the balances in the Clients' Funds high because that performance measure is the most important factor in retaining and generating new clients. For Clients that have a "capitation" plan with Caremark, it means that those extra funds are retained by Caremark directly.

CORPORATE INTEGRITY AGREEMENT AND RELATOR'S REPORTS OF WRONGDOING

27. Relator's immediate supervisor, Marsha Lancaster, is the Quality Assurance Manager for Caremark's Paper Claims Department and CarePatterns. She also serves as the local Caremark Continuous Quality Improvement representative, and further reports to the Compliance Committee at a national level. The Caremark Compliance Committee was formed as part of Caremark's Corporate Integrity Agreement with the Department of Health and Human Services. In her capacity as the Caremark Continuous Quality Improvement Representative, Ms. Lancaster conducts the yearly Ethics and Integrity

meetings for all local employees in San Antonio, and orients all new employees in the Claims Department on the importance of compliance with federal laws and regulations. Marsha Lancaster advises employees that they should contact their supervisors with information of any wrongdoing or improprieties. Even so, Marsha Lancaster and other supervisors have repeatedly ignored Relator's reports of wrongdoing and reverse false claims.

28. In June, 1995, Caremark settled an action by the federal government under the False Claims Act for improper physician payments and kickbacks. As part of that settlement, Caremark repaid the Federal Health Insurance Programs $161 million dollars and entered into a Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services (HHS). The CIA is very clear on Caremark's responsibilities and mandates extensive notification to all employees on *the "Government Program legal requirements"* as well as a certification procedure to ensure that every employee understands their duty to report any wrongdoing or integrity issues. Additionally, the CIA requires that Caremark "*shall review the billing, billing policies, procedures and practices of all Caremark businesses, and other health care providers for whom Caremark provides any billing-related services, aimed at ensuring that Government Program payers are billed appropriately for services which are rendered as claimed.*"

29. In response to Relator's repeated reports of problems in the system and the reimbursement procedures, Relator has been called a "troublemaker" and accused of "opening up a can of worms" by Ms. Lancaster and other supervisors, most often in open Department meetings. Relator has been advised by her supervisors that Julie Fogarty, Vice President of Legal Services at Caremark's headquarters offices in Chicago, has approved the procedures by which Medicaid and VA claims for reimbursement are denied. At other times, Relator has been promised by Marsha Lancaster and Doris Mitchell, the Director of Claims Department, that the system problems Relator reported would be resolved, but nothing has been done to date to reprogram and correct the system. Relator has designed a system procedure to correct the various problems even though that is not her job duty. Her suggestions have repeatedly been rebuffed as being too costly. The claims for reimbursement by the Federal Health Insurance Programs are being summarily denied for payment. It is clear, as Relator will show, that Defendants are benefiting from their denial of government claims for reimbursement . Under capitation plans, Caremark is directly enriched. Under fee-for-service plans, Caremark retains Clients and market share. Caremark is the top PBM firm in the U.S. (of those that are not owned by a drug

manufacturer). From all indications, Defendants appear to have elected to cut costs in the regulatory compliance area so as to channel compliance dollars to beef up expenditures in Y2K and to generate new clients.

30. Additionally, the Relator has reported to her supervisors that the system is denying reimbursement requests from the Federal Health Insurance Programs, particularly Medicare, for drugs and supplies for participants in nursing homes. Relator became concerned with the arbitrary and premature rejection of these requests without analysis. Relator was particularly concerned since, to her personal knowledge, Caremark had been paying these nursing home claims for the prior five years and just recently determined that they would no longer be covered. Relator has attempted to explain to her supervisors, that under federal law and the plan designs of each of these participants, the Federal Health Insurance Programs, as the assignee of benefits for the participants, is entitled to reimbursement of some portion of its expenditures made. Many of these nursing homes are ordering and purchasing a Client's normal drugs as a courtesy during their stay and billing for reimbursement through the nursing home bill to Medicare. This money should be reimbursed to Medicare.

31. The CIA requires that Caremark report to HHS "*any evidence of misconduct by Caremark...supported by credible evidence... and brought to Caremark's attention ...that Caremark..has reasonable grounds to believe...may constitute a material violation of the civil law or the rules and regulations governing Government Programs*". Relator's constant reports of problems have not been reported to HHS nor have the problems been resolved. As such, the Government has not received moneys it is owed. Relator's warnings, findings and admonishments have been reported to upper management including the Legal Department of Caremark.

FALSE STATEMENTS AND RECORDS: EOBs, REJECTION LETTERS, DENIAL LETTERS, FALSE CERTIFICATIONS

32. Caremark has received written requests for reimbursement from the Federal Government together with accompanying detailed policies of applicable regulations, procedures, and instructions that must be followed in calculating and paying reimbursement claims. Parties participating in or dealing with Federal Health Insurance Programs are required to familiarize themselves with all applicable regulations, procedures, and instructions. The parties denying reimbursement to the Federal Health Insurance Programs are required to certify in the EOB or other statements provided that the reasons given for the denial or rejection of reimbursement claims are true,

correct, complete and prepared in accordance with applicable law, except as explicitly noted otherwise. These parties further certify that the underlying supporting documentation and records are true and correct. Relator would show how Caremark has violated these precepts.

33. If an obligor to the Federal Health Insurance Programs disagrees with the Government's interpretations of the proper application of federal reimbursement requirements to the particular facts of a case, a protest process is available. It is not lawful to deny reimbursement for illegal reasons nor to ignore directives from the Government agencies. Caremark routinely rejects claims from the Federal Health Insurance Programs and dismisses protests from the same. Marsha Lancaster maintains files of sample letters from the various federal and state agencies, but no action is taken.

34. Relator would show that, once Caremark was put on notice from Relator with respect to reimbursement improprieties, Caremark had knowledge of material errors and omissions in the certification process and of the improper denial of claims submitted for reimbursement by Medicaid, the VA and the IHS. Caremark was not free to silently to accept windfalls and indirect benefits from such denials of payment , much less to

knowingly make, use or cause to make or use a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government. The false records and statements used by Caremark include, but are not limited to, denial letters, rejection letters, and false EOBs.

DAMAGES

35. Relator would further show that treble damages for the reverse false claims amount to tens of millions of dollars and that in excess of 150,000 claims were denied and falsely certified and presented as not being an obligation to the United States. These claims remain unpaid. Relator further estimates that total damages to the U.S. Government in damages and penalties are in the hundreds of million dollars. Caremark is a "fiduciary" under the Employees Retirement Income Security Act of 1974 ("ERISA") and, as such, " any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations or duties imposed upon fiduciaries.... shall be held liable to make good to such plan resulting from such breach". In all cases, the Federal Health Insurance Programs are the assignees of the participants. In all cases, the Federal Health Insurance Programs have paid for the benefits received by the participants before seeking reimbursement from third party payers. Furthermore, based upon the maximum statutory civil penalty of Ten Thousand Dollars ($10,000) for each false claim or statement submitted and treble

damages applied to the underpayments, Relator estimates the total amount to be recovered from the Defendants to be in excess of Five Hundred Million Dollars ($500,000,000.00).

CONTINUING CONSPIRACY TO DEFRAUD THE FEDERAL GOVERNMENT AND THE PLAINTIFF STATES

36. Aware of the limited capacity of the federal and state governments and their respective agencies to delve deeply into these denied and rejected reimbursement claims, Defendants have systematically defrauded the United States for at least the last three, and possibly six, years. Caremark has to failed implement procedures that would ensure that the reimbursement claims from the Federal Health Insurance Programs for the participants of at least 34 of its Clients would be handled in a transparent manner in conformity with federal and state law. Relator will show that Caremark and its officers and directors did not attempt to correct the problem confident that the Government would not audit Caremark. With an HHS-approved CIA in place, there is a presumption that Caremark has "learned its lesson" and is, therefore, a remote candidate for further fraud and false acts. Relator would show that Caremark is responsible for millions of dollars in reverse false claims resulting in losses to the federal government and that these were presented after the implementation of the CIA.

37. As per the terms of the CIA, Defendants failed to disclose to the Government information about known computer system errors which have been permitting Defendants to, either directly or on behalf of their Clients, retain millions of dollars that should rightfully have been reimbursed to the Federal Health Insurance Programs by Caremark, the payer of first resort for all of the referenced claims.

38. Defendants have systematically ignored their obligation to amend procedures that result in the wrongful denial of legitimate Government claims for reimbursement nor have they followed the procedures set forth in the CIA. By their acts, Defendants have condoned and promoted improper and illegal conduct to all their employees, including the claims processors and other compliance staff. These acts are the more egregious because they were performed with knowledge by middle and senior staff while under the terms of a five-year CIA scheduled to terminate in 2000.

COUNT I

39. Realtor adopts and reiterates all the facts alleged in paragraphs 1 through 38, as fully and completely as if they were incorporated herein verbatim. Relator would show the following:

a) That an obligation existed for the Defendants to pay money to the United States

because the Federal Health Insurance Programs are payers of last resort;

b) That the Defendants, through the acts of their officers, agents, and/or employees made statements to the United States regarding Caremark's refusal to reimburse the government;

c) That the Defendants' statements regarding the reason for not paying the government was false because Defendants' duty to pay had not been discharged;

d) That the Defendants knew that such statements were false, and that the Relator made the Defendants aware of the falsity and illegality;

e) That such statements were intended to, and did conceal, avoid, or decrease the obligation to pay or transmit money to the Government; and

f) That such nonpayment caused direct financial impact or damage to the Treasury of the United States for drugs and goods paid for under the provisions of the Medicaid, VA, IHS , and other Federal Health Insurance Programs which were entitled to reimbursement from available private health insurance coverage.

COUNT II

40. Relator adopts and reiterates all the facts alleged in paragraphs 1 through 38 as fully and completely as if they were incorporated herein verbatim.

41. Relator would show that in performing the foregoing acts, Defendants, through the acts

of their officers, agents, and/or employees, knowingly or in deliberate ignorance of the truth or the falsity of the information, conspired to defraud the Government through the non-payment of obligations owed, that is, a process of reverse false claims to the damage of the Treasury of the United States.

COUNT III

42. Relator adopts and reiterates all of the facts alleged in paragraphs 1 through 38, as fully and completely as if they were incorporated herein verbatim.

43. In addition, Relator charges that in performing the acts hereinbefore set out, Defendants, through the acts of their officers, agents, and/or employees, knowingly or in deliberate ignorance of the truth or the falsity of the information permitted themselves to be unjustly enriched, either directly or indirectly, by their false actions and reverse false claims, to the damage of the Treasury of the United States.

COUNT IV

44. Relator adopts and reiterates all of the foregoing facts alleged in paragraphs 1 through 38 as fully and completely as if they were incorporated herein verbatim.

45. Relator would show that in performing the foregoing acts, Defendants violated the

Texas Medicaid Fraud Prevention Law, Tex. Hum. Res. Code Ann. Section 37.001 et seq., and in particular sections 36.002(1)(A) and (4)(B). The **State of Texas** contributes approximately 37% of all Medicaid payments in Texas. These acts by Defendants have resulted in reverse false claims and have caused damage to the Treasury of the State of Texas;

COUNT V

46. Relator adopts and reiterates all of the foregoing facts alleged in paragraphs 1 through 38 as fully and completely as if they were incorporated herein verbatim.

47. Relator would show that in performing the foregoing acts, Defendants violated the Arkansas Medicaid Fraud False Claims Act, Ark. Code Ann. Section 20-97-9 *et seq.*, and in particular section 20-7902 (1) and (3). The **State of Arkansas** contributes approximately 27% of all Medicaid payments in Arkansas. These acts by Defendants have resulted in reverse false claims and have caused damage to the Treasury of the State of Arkansas;

COUNT VI

48. Relator adopts and reiterates all of the foregoing facts alleged in paragraphs 1 through 38 as fully and completely as if they were incorporated herein verbatim.

49. Relator would show that in performing the foregoing acts, Defendants violated the California False Claims Act, Cal. Govt. Code section 12650 *et seq.*, and in particular

sections 12651 (a)(7) and (8). The **State of California** contributes approximately 50% of all Medicaid payments in California. These acts by Defendants have resulted in reverse false claims and Defendants have caused damage to the Treasury of the State of California;

COUNT VII

50. Relator adopts and reiterates all of the foregoing facts alleged in paragraphs 1 through 38 as fully and completely as if they were incorporated herein verbatim.

51. Relator would show that in performing the foregoing acts, Defendants violated the Florida False Claims Act, Fla. Stat. Ann. section 68.081 *et seq.*, and in particular section 68.082(2)(g). The **State of Florida** contributes approximately 44% of all Medicaid payments in Florida. These acts by Defendants have resulted in reverse false claims and Defendants have caused damage to the Treasury of the State of Florida;

COUNT VIII

52. Relator adopts and reiterates all of the foregoing facts alleged in paragraphs 1 through 38 as fully and completely as if they were incorporated herein verbatim.

53. Relator would show that in performing the foregoing acts, Defendants violated the Illinois Whistleblower Reward and Protection Act, Ill. Ann. Stat. Ch. 740 para. 175, and in particular 740 ILCS 175, section 3(a)(7). The **State of Illinois** contributes

approximately 50% of all Medicaid payments in Illinois. These acts by Defendants have resulted in reverse false claims and Defendants have caused damage to the Treasury of the State of Illinois;

COUNT IX

54. Relator adopts and reiterates all of the foregoing facts alleged in paragraphs 1 through 38 as fully and completely as if they were incorporated herein verbatim.

55. Relator would show that in performing the foregoing acts, Defendants violated the Louisiana Medical Assistance Integrity Law, La. Rev. Stat. Ann. Section 437.2a. The **State of Louisiana** contributes approximately 29% of all Medicaid payments in Louisiana. These acts by Defendants have resulted in reverse false claims and Defendants have caused damage to the Treasury of the State of Louisiana;

COUNT X

56. Relator adopts and reiterates all of the foregoing facts alleged in paragraphs 1 through 38 as fully and completely as if they were incorporated herein verbatim.

57. Relator would show that in performing the foregoing acts, Defendants violated the Tennessee Medicaid False Claims Act, Tenn.Code Ann. 71-5-182 *et seq.*, and in particular section 71-5-182(a)(1)(D). The **State of Tennessee** contributes approximately 35% of all Medicaid payments in Tennessee. These acts by Defendants have resulted in reverse false claims and Defendants have caused damage to the

Treasury of the State of Tennessee ;

COUNT XI

58. Relator Janaki Ramadoss acting on behalf of herself against Defendants under the "whistleblower protection" provision of the False Claims Act, 31 U.S.C. § 3730(h), adopts and reiterates all of the foregoing facts alleged in paragraphs 1 through 38 as fully and completely as if they were incorporated herein verbatim. This Court has jurisdiction over this claim pursuant to 31 U.S.C. § 3730(h) and 3732(a), as well as through pendent claim jurisdiction.

59. Relator would show that Defendants in their acts and/or practices, subjected her to harassment, retaliation, discrimination and public humiliation resulting in loss of promotions and wages and which actions continue to date. During her employment with Caremark, Relator learned of the fraud perpetrated upon the Government by Defendants as herein set out. On several occasions, she requested officers and agents for Defendants to investigate, stop and report the fraud to the government. Defendants not only failed and refused, but also set about to obstruct Relator's further efforts to gather information regarding all fraudulent activities. Defendants harassed and discriminated against Relator, and undermined her credibility and personal and professional integrity and competence.

60. RELATOR requests this Court to grant her such relief as is appropriate under the provisions of § 3730(h). She also requests an injunction to issue, restraining and enjoining the Defendants, and each of them from harassing, discharging or otherwise discriminating against her.

PRAYER FOR RELIEF

WHEREFORE, RELATOR Janaki Ramadoss, acting on behalf of and in the name of the United States, demands and prays that judgment be entered in favor of the United States against Defendants as follows:

1. For treble the amount of the United States' damages, plus civil penalties of $10,000 for each false claim;

2. For all costs of this civil action, including attorneys' fees and court costs;

3. For such other and further relief as the Court deems equitable and just.

MOREOVER, RELATOR Janaki Ramadoss, acting on behalf and in the name of Plaintiff States Arkansas, California, Florida, Illinois, Louisiana, Tennessee, and Texas, demands and prays that an award be entered in favor of the Plaintiff States as follows:

1. For an appropriate and just multiple of the amount of the respective Plaintiff States' damages plus civil penalties for each false claim as permitted by the respective applicable law of Plaintiff States;

2. For all costs of this civil action, including attorneys' fees and court costs;

3. For such other and further relief as the Court deems equitable and just.

MOREOVER, RELATOR Janaki Ramadoss, acting on her own behalf, demands and prays that an award be entered in her favor as follows:

1. That Relator, as *qui tam* plaintiff, be awarded the maximum amount allowed pursuant to § 3730(d) of the False Claims Act (25% of the proceeds collected by the U.S. if the U.S. intervenes and conducts this action, or for 30% of the proceeds if the U.S. does not intervene) and/ or any other applicable provision of law; for an amount for reasonable expenses incurred by the Relator in the prosecution of this action; and for all reasonable attorney's fees and costs incurred by the Relator;

2. That on the Count XI, for twice the amount of pay she has lost as a result of Defendants' actions in violation of 31 U.S.C. 3730(h); for interest on lost pay; for special damages suffered as a result of the misconduct; for litigation costs; and for reasonable attorneys' fees;

3. That Relator on Counts IV-X, , as *qui tam* plaintiff in the actions on behalf of Plaintiff States be awarded the maximum amount allowed for Relator pursuant to the respective laws of the Plaintiff States with respect to Medicaid Fraud and False Claims as herein cited in Paragraph 2 and/ or any other applicable provision of law; for an amount for reasonable expenses incurred by the Relator in the prosecution of this action; and for all reasonable attorney's fees and costs incurred by the Relator;

4. Such and further relief to which the Relator may show herself justly entitled.

DEMAND FOR JURY TRIAL

Plaintiff Janaki Ramadoss demands that this case be tried before a jury.

Respectfully submitted,

Marlene M. Martin

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ATTORNEY FOR RELATOR

Dated: August ____, 1999

CERTIFICATE OF SERVICE

The undersigned certifies that on this 25 day of August, 1999, a copy of the foregoing Original Complaint was placed in the United States Mail, first class mail, postage prepaid, and addressed to:

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