ORIGINAL

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FILED
2012 AUG 17 AM 11:42
CLERK U.S. DISTRICT COURT
CENTRAL DIST. OF CALIF.
LOS ANGELES
BY

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

| | |
|---|---|
| UNITED STATES OF AMERICA and STATE OF CALIFORNIA, ex rel. [UNDER SEAL];<br><br>Plaintiffs,<br><br>v.<br><br>[UNDER SEAL],<br><br>Defendants. | NO. CV 09-5013 JFW (JEMx)<br><br>NOTICE OF LODGING [SEALED]<br><br>[LODGED UNDER SEAL pursuant to the False Claims Act, 31 U.S.C. § 3730(b)(2) and (3)]<br><br>[FILED OR LODGED CONCURRENTLY HEREWITH: JOINT NOTICE [SEALED]; [PROPOSED] ORDER REGARDING [SEALED]<br><br>[LODGED CONCURRENTLY HEREWITH, BUT DEEMED BY THE PARTIES TO BE LODGED AFTER THIS DOCUMENT: NOTICE OF [SEALED]] |

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WESTERN DIVISION

UNITED STATES OF AMERICA and STATE OF CALIFORNIA, _ex rel._ [UNDER SEAL];

Plaintiffs,

v.

[UNDER SEAL],

Defendants.

NO. CV 09-5013 JFW (JEMx)

**NOTICE OF LODGING [SEALED]**

**[LODGED UNDER SEAL pursuant to the False Claims Act, 31 U.S.C. § 3730(b)(2) and (3)]**

**[FILED OR LODGED CONCURRENTLY HEREWITH: JOINT NOTICE [SEALED]; [PROPOSED] ORDER REGARDING [SEALED]**

**[LODGED CONCURRENTLY HEREWITH, BUT DEEMED BY THE PARTIES TO BE LODGED AFTER THIS DOCUMENT: NOTICE OF [SEALED]]**

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12 UNITED STATES DISTRICT COURT

13 FOR THE CENTRAL DISTRICT OF CALIFORNIA

14 WESTERN DIVISION

15

| | |
|---|---|
| 16 UNITED STATES OF AMERICA and STATE OF CALIFORNIA, ex rel. 17 JAMES M. SWOBEN, | NO. CV 09-5013 JFW (JEMx) |
| 18 Plaintiffs, | **NOTICE OF LODGING REDACTED RELATOR'S THIRD AMENDED COMPLAINT** |
| 19 v. | **[LODGED UNDER SEAL pursuant to the False Claims Act, 31 U.S.C. § 3730(b)(2) and (3)]** |
| 20 SCAN HEALTH PLAN, a California corporation, fka SENIOR CARE 21 ACTION NETWORK; SENIOR CARE ACTION NETWORK, a business 22 entity, form unknown; SCAN GROUP, a California corporation; 23 **[NAMES OF REMAINING DEFENDANTS SEALED]**, | **[FILED OR LODGED CONCURRENTLY HEREWITH: JOINT NOTICE BY THE UNITED STATES OF AMERICA AND THE STATE OF CALIFORNIA OF ELECTION TO INTERVENE IN PART; [PROPOSED] ORDER REGARDING PARTIAL INTERVENTION AND PARTIAL UNSEALING]** |
| 24 25 Defendants. | **[LODGED CONCURRENTLY HEREWITH, BUT DEEMED BY THE PARTIES TO BE LODGED AFTER THIS DOCUMENT: NOTICE OF DISMISSAL OF ALL CLAIMS AGAINST DEFENDANTS SCAN HEALTH PLAN, SENIOR CARE ACTION** |

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NETWORK, AND SCAN GROUP PURSUANT TO SETTLEMENT AGREEMENT; CONSENTS OF THE UNITED STATES AND STATE OF CALIFORNIA ATTORNEYS GENERAL THERETO; AND [PROPOSED] ORDER THEREON]

TO THE COURT, ALL PARTIES, AND THEIR RESPECTIVE ATTORNEYS OF RECORD HEREIN, PLEASE TAKE NOTICE THAT:

The United States of America hereby lodges, as Exhibit 1 hereto, a redacted copy of the relator's Third Amended Complaint in the above-captioned action.

Respectfully submitted,

DATED: August 15, 2012

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Exhibit 1

FILED
CLERK, U.S. DISTRICT COURT
NOV 23 2011
CENTRAL DISTRICT OF CALIFORNIA
BY DEPUTY

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Attorneys for Plaintiff and Qui Tam Relator

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

| | |
|---|---|
| UNITED STATES OF AMERICA [UNDER SEAL],<br><br>Plaintiffs,<br><br>vs.<br><br>[UNDER SEAL],<br><br>Defendants. | CASE NO.: CV09-5013 JFW(JEMx)<br><br>THIRD AMENDED COMPLAINT FOR VIOLATIONS OF FEDERAL FALSE CLAIMS ACT AND [UNDER SEAL]<br><br>[**UNDER SEAL** PER 31 U.S.C. § 3730(b)(2)] |

[UNDER SEAL]

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Attorneys for Plaintiff and Qui Tam Relator,
James M. Swoben

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA and STATE OF CALIFORNIA, *ex rel* JAMES M. SWOBEN,

Plaintiffs,

vs.

SCAN HEALTH PLAN, a California corporation, fka SENIOR CARE ACTION NETWORK; SENIOR CARE ACTION NETWORK, a business entity, form unknown; SCAN GROUP, a California corporation;

CASE NO.: CV09-5013 JFW(JEMx)

THIRD AMENDED COMPLAINT FOR VIOLATIONS OF FEDERAL FALSE CLAIMS ACT AND CALIFORNIA FALSE CLAIMS ACT; REQUEST FOR JURY TRIAL

[**UNDER SEAL** PER 31 U.S.C. § 3730(b)(2)]

**Exhibit 1 - Page 5**

Defendants.

COMES NOW, Plaintiff and Qui Tam Relator James M. Swoben, individually and on behalf of the United States of America and the State of California, and alleges as follows:

## JURISDICTION AND VENUE

1. Plaintiff and Qui Tam Relator James M. Swoben (Swoben) files this action on behalf and in the name of the United States Government ("Government") seeking damages and civil penalties against the defendants for violations of 31 U.S.C. § 3729(a). Swoben also files this action on behalf and in the name of the State of California ("California") seeking damages and civil penalties against the defendants for violations of California Government Code § 12651(a).

2. This Court's jurisdiction over the claims for violations of 31 U.S.C. § 3729(a) is based upon 31 U.S.C. § 3732(a). This Court's jurisdiction over the claims for violations of California Government Code § 12651(a) is based upon 31 U.S.C. § 3732(b).

3. Venue is vested in this Court under 31 U.S.C. § 3732(a) because at least one of the defendants transacts business in the Central District of California and many acts constituting violations of 31 U.S.C. § 3729(a) occurred in the Central District of California.

## THE PARTIES

4. Swoben is a resident and citizen of the United States, the State of California, and of this District. Swoben brings this action of behalf of the Government under 31 U.S.C. § 3730(b) and on behalf of California under California Government Code § 12652(c).

1 5. At all times relevant, the Government funded the Medicare program which
2 provides payment of healthcare services for, among others, those 65 years or older. The
3 Government provided a Medicare option known as Medicare+Choice, now known as
4 Medicare Advantage, in which eligible Medicare beneficiaries could enroll with a managed
5 care organization (MCO) contracted with the Government for a capitated rate paid by the
6 Government that would provide at least those services provided to standard Medicare
7 beneficiaries.

8 6. At all time relevant, California administered and partially funded the Medi-Cal
9 program (the Medicaid program in California) in which eligible Medi-Cal beneficiaries could
10 enroll with a MCO contracted with California for a capitated rate paid by Medi-Cal that would
11 provide at least those services provided to standard Medi-Cal beneficiaries. The Government
12 also partially funded the Medi-Cal program as part of the Government's Medicaid program.

13 7. Defendant SCAN Health Plan and SCAN Group are and were corporations
14 formed under the laws of the State of California, and transacted business in, among other
15 places, the Central District of California. SCAN Health Plan was formerly known and doing
16 business as Senior Care Action Network. Defendant Senior Care Action Network is a business
17 entity, form unknown, that transacted business in, among other places, the Central District of
18 California. All defendants referenced in this paragraph are collectively referred in this
19 Complaint as "SCAN."

20 8. At all times relevant, SCAN was and is a health maintenance organization
21 (HMO) that provides health care services in Southern California to the elderly covered under
22 Medicare. Between March 2004 and September 2006, Swoben was employed with SCAN.

23 9.

24

25

26

27 **Exhibit 1 - Page 7**

28

COMMON ALLEGATIONS

12. During or after about 1984, SCAN was awarded a contract by the Government to operate as a Social HMO Demonstration Project ("Social HMO contract"). The purpose of the Social HMO Demonstration Project was to explore the viability of preventing or delaying older-adult institutionalization in skilled-nursing facilities by providing such eligible individuals with a combination of healthcare and personal care services, including homemaker services, personal-care services, adult day care, respite care, and medical transportation. SCAN served, among other places, the California counties of Los Angeles, Riverside and San Bernardino. Under the terms of the Social HMO contract, SCAN agreed to provide such services to Medicare+Choice, now Medicare Advantage, beneficiaries for a monthly capitated payment paid by the Government. Plaintiff is informed and believes that during and after

1 2001, the Government paid SCAN an additional monthly capitated rate of approximately $800
2 per nursing home certifiable (NHC) beneficiary. Plaintiff is informed and believes that the
3 Social HMO contract ended on or about December 31, 2007.

4 13. During or about 2001, California awarded a contract to SCAN (the "Medi-Cal
5 contract") to provide home and community-based long-term care to Medi-Cal beneficiaries
6 that were 65 years of age or older and eligible for Medicare Parts A and B. The purpose of
7 this contract was to keep senior citizens out of long-term placement in skilled-nursing
8 facilities. The Medi-Cal contract was extended or renewed until about December 31, 2007.
9 Plaintiff is informed and believes that SCAN received a monthly capitated rate of
10 approximately $3,300 per Medi-Cal beneficiary from Medi-Cal.

11 14. The services SCAN was to provide under its Medi-Cal contract were included
12 in the services SCAN undertook and provided under its Social HMO contract with the
13 Government.

14 15. SCAN provided services to numerous patients that were beneficiaries under both
15 the Medicare Social HMO contract and the Medi-Cal contract ("dual eligible beneficiaries").
16 During or about 2006, Swoben discovered that although SCAN undertook and provided such
17 dual eligible beneficiaries the care and services that were covered and paid for by the
18 Government under the Medicare Social HMO contract, SCAN continued to bill for and receive
19 capitated monthly payments of approximately $3,300 per beneficiary from Medi-Cal without
20 reduction in payment for the care and services SCAN undertook and provided under the
21 Medicare Social HMO contract.

22 16. Under applicable law, Medicare is primary and Medi-Cal secondary in
23 connection with the care and services undertook and rendered by SCAN to the dual eligible
24 beneficiaries. Plaintiff is informed and believes that by law, or the terms of SCAN's contracts
25 with the Government or California, SCAN was required to not bill, and/or not retain payments
26 from, Medi-Cal for undertaking the services rendered to the dual eligible beneficiaries to the
27 extent such services were covered and paid for under the Medicare Social HMO contract.
28 Plaintiff is informed and believes that Medi-Cal's overpayments for dual eligible NHC

beneficiaries amount to at least $800 per NHC beneficiary between 2001 and 2007 amounting to more than $200 million.

17. SCAN was required to periodically provide Medicare and Medi-Cal cost reports and other financial reports and information reflecting SCAN's true cost to furnish the services to be provided under the Medicare Social HMO contract and Medi-Cal contract, respectively. The purpose of such requirement was, among other things, so that Medicare and Medi-Cal could determine if the capitated rate paid to SCAN under the Medicare Social HMO contract or Medi-Cal contract, respectively, was excessive in light of SCAN's costs to furnish services under such contract. If SCAN's costs of furnishing such services under the Medicare Social HMO contract or Medi-Cal contract were significantly lower than the capitated rate paid to SCAN by Medicare or Medi-Cal, respectively, the capitated rate would be lowered accordingly.

18. SCAN's fraudulent billing practices included failing to submit cost reports and other financial reports and information to Medi-Cal that disclosed SCAN's true cost (in light of SCAN's receipt of monies from the Medicare Social HMO contract) of the services to be provided under the Medi-Cal contract, or alternatively, submitting cost reports and other financial reports and information to Medi-Cal that failed to disclose, among other things, SCAN's receipts of monies from the Medicare Social HMO contract. SCAN's utilization of such fraudulent practices and concealments caused Medi-Cal to overpay SCAN for services it already undertook by virtue of, among other things, the Medicare Social HMO contract, and concealed such overpayments. At all times relevant, SCAN was aware that such overpayments by Medi-Cal were due and owing to Medi-Cal, but SCAN continued to conceal said overpayments.

19. SCAN knew that its cost reports, loss ratio reports, and other financial reports submitted to Medi-Cal were fraudulent as evidenced by the fact that its outside actuaries refused to sign and approve such submissions. Further SCAN knew or should have known that it had the ability to provide Medi-Cal the true costs of the services to be provided under the Medi-Cal contract, but failed to do so because SCAN knew that its capitated rates would

be reduced if such information was provided to Medi-Cal.

FIRST CLAIM FOR RELIEF

(Violation of 31 U.S.C. § 3729(a) against SCAN)

20. Plaintiff realleges and incorporates by reference paragraphs 1 through 19, inclusive, of this complaint as though fully set forth at length.

21. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. § 3729(a)(1) by knowingly presenting and/or causing to present to agents, contractors or employees of the Government false and fraudulent billings for payment and approval.

22. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. § 3729(a)(2) by knowingly making, using, and/or causing to make or use false records and statements to get false and excessive billings paid or approved by Medicare and Medi-Cal.

23. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. § 3729(a)(4) by improperly retaining and concealing the excessive capitated payments SCAN received.

24. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. § 3729(a)(7) by knowingly making, using and/or causing to make or use false records and statements to conceal, avoid, or decrease its obligation to return to the Medi-Cal program the excessive capitated payments SCAN received.

25. Swoben is informed and believes, and upon such information and belief alleges, that as a result of SCAN's concealments and use of false records and statements, Medi-Cal paid in excess of $200 million more than it would have if SCAN had properly and truthfully billed and reported, and revealed the excessive payments received.

26. As a result of SCAN's conduct, SCAN is liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent billing, reporting and concealment practices alleged above.

27. As a result of SCAN's conduct, 31 U.S.C. § 3729(a) provides that SCAN is liable to the Government for civil penalties between $5,000 and $10,000 for each such false

and fraudulent billing, reporting and concealment.

28. Swoben is also entitled to recover his attorneys fees, costs and expenses from the SCAN pursuant to 31 U.S.C. § 3730(d).

SECOND CLAIM FOR RELIEF

(Violation of California Government Code § 12651(a) against SCAN)

29. Plaintiff realleges and incorporates by reference paragraphs 1 through 28, inclusive, of this complaint as though fully set forth at length.

30. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(1) by knowingly presenting and/or causing to present to California employees, agents and/or contractors false and fraudulent billings for payment and approval.

31. At all times mentioned, defendants routinely and repeatedly violated California Government Code § 12651(a)(2) by knowingly making, using, and/or causing to make or use false records and statements to get false and excessive billings paid or approved by Medi-Cal.

32. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(4) by improperly retaining and concealing the excessive capitated payments SCAN received.

33. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(7) by knowingly making, using and/or causing to make or use false records and statements to conceal, avoid, or decrease its obligation to return to the Medi-Cal program the excessive capitated payments SCAN received.

34. Swoben is informed and believes, and upon such information and belief alleges, that as a result of SCAN's concealments and use of false records and statements, Medi-Cal paid in excess of $200 million more than it would have if SCAN had properly and truthfully billed and reported, and revealed the excessive payments received.

35. As a result of SCAN's conduct, SCAN is liable to California for up to three times the amount of damages sustained by California as a result of the false and fraudulent

1 billing, reporting and concealment practices alleged above.

2 36. As a result of SCAN's conduct, California Government Code §12651(a)
3 provides that defendants are liable to California for civil penalties of up to $10,000 for each
4 such false and fraudulent billing, reporting and concealment.

5 37. Swoben is also entitled to recover his attorneys fees, costs and expenses from
6 SCAN pursuant to California Government Code § 12652(g)(8).

7

8 THIRD CLAIM FOR RELIEF

9 (Violation of 31 U.S.C. § 3729(a) against SCAN and )

10 [Up-Coding]

11 38. Plaintiff realleges and incorporates by reference paragraphs 1 through 19,
12 inclusive, of this complaint as though fully set forth at length.

13 39.

14 At all times
15 relevant, SCAN submitted diagnoses codes of
16 patients to the Government and California. The diagnosis codes were used
17 to develop risk scores that were used to adjust the capitated payment rates paid by the
18 Government and California. The risk scores compensated with a population of
19 patients with more severe illnesses than normal through higher capitation rates. Likewise,
20 with a population of patients with less severe illnesses than normal would see a
21 downward adjustment of its capitation rates because it was servicing a healthier than normal
22 population of patients. SCAN and were allowed an 18 month period in
23 which to make retrospective corrections to their data submissions of the Government and
24 California.

25 40. Under applicable Medicare and Medi-Cal regulations, defendants can only
26 submit diagnosis codes to the Government and California, respectively, that are supported by
27 properly documented chart notes.

28 41.

42. Beginning in or about 2005 and continuing thereafter, SCAN retained coding companies to perform a retrospective review of the medical charts of approximately 10,000 of its patients with severe illnesses. Although SCAN provided such coding companies with the lists of patients whose charts were to be reviewed, SCAN concealed from the coding companies what diagnosis codes had been previously submitted to the Government and California.

43. The coding companies conducted their review of the medical charts of tens of thousands of SCAN and patients, determined the diagnosis codes that were supported by proper documentation of the reviewed medical charts, and provided their results to SCAN and respectively. The coding companies' review resulted in (a) diagnosis codes that were supported by proper documentation of the reviewed medical charts that had been previously submitted to the Government and California, and (b) new diagnosis codes that were supported by proper documentation of the reviewed medical charts that had not been previously submitted to the Government and California. Because SCAN and concealed from the coding companies what diagnosis codes had been previously submitted to the Government and California, the results of the coding companies' review did not identify the diagnosis codes unsupported by proper documentation of the reviewed medical charts that had been previously submitted to the Government and California.

44. SCAN and made no effort to advise the Government and California of the diagnosis codes for the reviewed medical charts that were not supported, and made no effort to withdraw from the Government and California the previously submitted diagnosis codes that were not supported by proper documentation of the reviewed medical charts.

45. Further, the defendants had a duty to have compliance programs in place to monitor and detect attempts to artificially increase risk scores and capitated payments.

46. SCAN and improperly conceived, planned and conducted the coding companies' reviews by not causing the previously submitted diagnosis codes that were unsupported by the coding companies' reviews to be corrected and withdrawn from the Government and California. Rather, the procedures and methods developed and used by SCAN and were biased in favor of "up coding" the patients' diagnoses because the previously submitted diagnoses that were not unsupported by the coding companies' reviews were not corrected and withdrawn from the Government and California. SCAN and did so with the knowledge and intent that the coding companies' review would only increase, and not decrease, the number of diagnoses, and thus their respective risk scores in order to increase capitated payments paid by the Government and California.

47. During or about 2005 or 2006, SCAN and submitted to the Government and California the diagnosis codes determined by the coding companies' review, knowing that the effect of such submissions would only increase the number of diagnoses, and thus artificially inflate their respective risk scores.

48. As a result of the acts and concealments of SCAN and their respective capitated payments paid by the Government and California became inflated due to the artificially high risk scores.

49. At all times mentioned, SCAN and routinely and repeatedly violated 31 U.S.C. § 3729(a)(1) by knowingly presenting and/or causing to present to agents, contractors or employees of the Government false and fraudulent billings for payment and approval during and after 2004.

50. At all times mentioned, SCAN and routinely and repeatedly violated 31 U.S.C. § 3729(a)(2) by knowingly making, using, and/or causing to make or use false records and statements to get false and excessive billings paid or approved under the Medicare and Medi-Cal contracts during and after 2004.

51. At all times mentioned, SCAN and routinely and repeatedly violated 31 U.S.C. § 3729(a)(4) by improperly retaining and concealing the unsupported diagnosis codes and inflated risk scores that inflated the capitated payments they received under the Medicare and Medi-Cal contracts during and after 2004.

52. At all times mentioned, SCAN and routinely and repeatedly violated 31 U.S.C. § 3729(a)(7) by knowingly making, using and/or causing to make or use false records and statements to conceal, avoid, or decrease its obligation to return to the Medicare and Medi-Cal programs the inflated capitated payments they received during and after 2004.

53. Swoben is informed and believes, and upon such information and belief alleges, that as a result of the concealments and use of false records and statements, Medicare and Medi-Cal paid more than they would have if SCAN and had properly and truthfully billed and reported, and revealed and withdrawn the diagnosis codes that were not supported by their medical charts.

54. As a result of their conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent billing, reporting and concealment practices alleged above.

55. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties between $5,000 and $10,000 for each such false and fraudulent billing, reporting and concealment.

56. Swoben is also entitled to recover his attorneys fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

## FOURTH CLAIM FOR RELIEF

(Violation of California Government Code § 12651(a) against SCAN and )

[Up-Coding]

57. Plaintiff realleges and incorporates by reference paragraphs 1 through 19, inclusive, and 39 through 56, inclusive, of this complaint as though fully set forth at length.

1 58. At all times mentioned, SCAN and routinely and repeatedly
2 violated California Government Code § 12651(a)(1) by knowingly presenting and/or causing
3 to present to California employees, agents and/or contractors false and fraudulent billings for
4 payment and approval during and after 2004.
5 59. At all times mentioned, SCAN and routinely and repeatedly
6 violated California Government Code § 12651(a)(2) by knowingly making, using, and/or
7 causing to make or use false records and statements to get false and excessive billings paid or
8 approved under the Medi-Cal contract during and after 2004.
9 60. At all times mentioned, SCAN and routinely and repeatedly
10 violated California Government Code § 12651(a)(4) by improperly retaining and concealing
11 the unsupported diagnosis codes and inflated risk scores that inflated the capitated payments
12 they received under the Medi-Cal contract during and after 2004.
13 61. At all times mentioned, SCAN and routinely and repeatedly
14 violated California Government Code § 12651(a)(7) by knowingly making, using and/or
15 causing to make or use false records and statements to conceal, avoid, or decrease their
16 obligation to return to the Medi-Cal program the inflated the capitated payments they received
17 under the Medicare and Medi-Cal contracts during and after 2004.
18 62. Swoben is informed and believes, and upon such information and belief alleges,
19 that as a result of SCAN's and concealments and use of false records and
20 statements, Medi-Cal paid more than it would have if defendants had properly and truthfully
21 billed and reported, and revealed and withdrawn the diagnosis codes that were not supported
22 by their medical charts.
23 63. As a result of their conduct, defendants are liable to California for three times
24 the amount of damages sustained by California as a result of the false and fraudulent billing,
25 reporting and concealment practices alleged above.
26 64. As a result of their conduct, California Government Code § 12651(a) provides
27 that defendants are liable to California for civil penalties of up to $10,000 for each such false
28 and fraudulent billing, reporting and concealment.

1 65. Swoben is also entitled to recover his attorneys fees, costs and expenses from
2 defendants pursuant to California Government Code § 12652(g)(8).
3
4 FIFTH CLAIM FOR RELIEF
5 (Violation of 31 U.S.C. § 3729(a) against SCAN)
6 [PACE]
7 66. Plaintiff realleges and incorporates by reference paragraphs 1 through 19,
8 inclusive, of this complaint as though fully set forth at length.
9 67. SCAN's Medi-Cal contract was initially for the period of July 1, 2001 through
10 June 30, 2004, and was extended or renewed a number of times until about December 31,
11 2007.
12 68. California Welfare & Institutions Code §14598(c) provides that the SCAN
13 Medi-Cal contract could not be renewed after June 30, 2004. Further, SCAN was ineligible
14 to receive funds after June 30, 2004 under the Medi-Cal contract because SCAN was not a
15 PACE[1] organization as defined under 42 C.F.R. 460.6 because SCAN did not have an
16 agreement with the Government's Centers of Medicare and Medicaid Services (CMS) and
17 California for participation in the PACE program. Accordingly, SCAN's requests for
18 capitation payments from Medi-Cal for the period July 1, 2004 through December 1, 2007
19 were fraudulent because SCAN was not a PACE organization.
20 69. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. §
21 3729(a)(1) by knowingly presenting and/or causing to present to agents, contractors or
22 employees of the Government false and fraudulent billings for payment and approval for the
23 period July 1, 2004 through December 1, 2007.
24 70. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. §
25 3729(a)(2) by knowingly making, using, and/or causing to make or use false records and
26 statements to get false and excessive billings paid or approved under the Medi-Cal contract
27 for the period July 1, 2004 through December 1, 2007.
28

[1]PACE means "Programs of All-Inclusive Care for the Elderly." (*See,* 42 C.F.R. 460.6.)

71. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. § 3729(a)(4) by improperly retaining and concealing the unauthorized capitated payments SCAN received under the Medi-Cal contract for the period July 1, 2004 through December 1, 2007.

72. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. § 3729(a)(7) by knowingly making, using and/or causing to make or use false records and statements to conceal, avoid, or decrease its obligation to return to the Medi-Cal program the unauthorized capitated payments SCAN received under the Medi-Cal contract for the period July 1, 2004 through December 1, 2007.

73. Swoben is informed and believes, and upon such information and belief alleges, that as a result of SCAN's concealments and use of false records and statements, Medi-Cal paid more than it would have if SCAN had properly and truthfully billed and reported, and revealed that it was ineligible to receive payments under the Medi-Cal contract because SCAN was not a PACE organization.

74. As a result of SCAN's conduct, SCAN is liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent billing, reporting and concealment practices alleged above.

75. As a result of SCAN's conduct, 31 U.S.C. § 3729(a) provides that SCAN is liable to the Government for civil penalties between $5,000 and $10,000 for each such false and fraudulent billing, reporting and concealment.

76. Swoben is also entitled to recover his attorneys fees, costs and expenses from the SCAN pursuant to 31 U.S.C. § 3730(d).

## SIXTH CLAIM FOR RELIEF

(Violation of California Government Code § 12651(a) against SCAN)

[PACE]

77. Plaintiff realleges and incorporates by reference paragraphs 1 through 19, inclusive, of this complaint as though fully set forth at length.

78. SCAN's Medi-Cal contract was initially for the period of July 1, 2001 through

June 30, 2004, and was extended or renewed a number of times until about December 31, 2007.

79. California Welfare & Institutions Code §14598(c) provides that the SCAN Medi-Cal contract could not be renewed after June 30, 2004. Further, SCAN was ineligible to receive funds after June 30, 2004 under the Medi-Cal contract because SCAN was not a PACE[2] organization as defined under 42 C.F.R. 460.6 because SCAN did not have an agreement with the Government's Centers of Medicare and Medicaid Services (CMS) and California for participation in the PACE program. Accordingly, SCAN's requests for capitation payments from Medi-Cal for the period July 1, 2004 through December 1, 2007 were fraudulent because SCAN misrepresented that it had complied with all applicable laws and regulations in connection with such payments, even though SCAN was not a PACE organization.

80. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(1) by knowingly presenting and/or causing to present to California employees, agents and/or contractors false and fraudulent billings for payment and approval for the period July 1, 2004 through December 1, 2007.

81. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(2) by knowingly making, using, and/or causing to make or use false records and statements to get false and excessive billings paid or approved under the Medi-Cal contract for the period July 1, 2004 through December 1, 2007.

82. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(4) by improperly retaining and concealing the unauthorized capitated payments SCAN received under the Medi-Cal contract for the period July 1, 2004 through December 1, 2007.

83. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(7) by knowingly making, using and/or causing to make or use false records and statements to conceal, avoid, or decrease its obligation to return to the Medi-

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[2]PACE means "Programs of All-Inclusive Care for the Elderly." (*See,* 42 C.F.R. 460.6.)

1 Cal program the unauthorized capitated payments SCAN received under the Medi-Cal contract
2 for the period July 1, 2004 through December 1, 2007.
3 84. Swoben is informed and believes, and upon such information and belief alleges,
4 that as a result of SCAN's concealments and use of false records and statements, Medi-Cal
5 paid more than it would have if SCAN had properly and truthfully billed and reported, and
6 revealed that it was ineligible to receive payments under the Medi-Cal contract because SCAN
7 was not a PACE organization.
8 85. As a result of SCAN's conduct, SCAN is liable to California for three times the
9 amount of damages sustained by California as a result of the false and fraudulent billing,
10 reporting and concealment practices alleged above.
11 86. As a result of SCAN's conduct, California Government Code § 12651(a)
12 provides that SCAN is liable to California for civil penalties of up to $10,000 for each such
13 false and fraudulent billing, reporting and concealment.
14 87. Swoben is also entitled to recover his attorneys fees, costs and expenses from
15 the SCAN pursuant to California Government Code § 12652(g)(8).
16
17 SEVENTH CLAIM FOR RELIEF
18 (Violation of 31 U.S.C. § 3729(a) against SCAN)
19 [False Diagnosis Reporting]
20 88. Plaintiff realleges and incorporates by reference paragraphs 1 through 19,
21 inclusive, of this complaint as though fully set forth at length.
22 89. At all times relevant, SCAN was and/or operated a health maintenance
23 organization that had HMO contracts with Medicare and Medi-Cal. At all times relevant,
24 SCAN, as did other HMOs, submitted diagnoses codes of its HMO patients to the Government
25 and California. The diagnosis codes were used to develop risk scores that were used to adjust
26 the capitated payment rates paid by the Government and California. The risk scores
27 compensated an HMO with a population of patients with more severe illnesses than normal
28 through higher capitation rates. Likewise, an HMO with a population of patients with less

severe illnesses than normal would see a downward adjustment of its capitation rates because it was servicing a healthier than normal population of patients.

90. Under applicable Medicare and Medi-Cal regulations, HMOs can only submit diagnosis codes to the Government and California, respectively, that are supported by properly documented chart notes.

91. During or about 2005, Medicare conducted a review of about 200 of SCAN's 2003 medical charts of its Medicare patients, and determined that about 40% (more than twice the norm in the industry) of the reviewed chart notes did not support the 2003 diagnosis codes previously supplied to Medicare. As a result, Medicare disallowed the diagnosis codes of the 200 reviewed charts that were not supported by properly documented chart notes. During 2003, SCAN had more than 90,000 Medicare patients.

92. The procedures utilized by SCAN to document chart notes and diagnoses, and submit diagnosis codes to the Government and California remained the same between and including 2003 and 2006. SCAN did not take any corrective action to reduce its error rate (the percentage of submitted diagnosis codes unsupported by properly documented chart notes) during that time.

93. Based upon the results of Medicare 2005 review, Plaintiff is informed and believes, and upon such information and belief alleges, that 40% of the 2004 and 2005 diagnosis codes SCAN submitted to the Government and California were not supported by properly documented chart notes as SCAN utilized the same procedures to document chart notes and submit diagnosis codes to the Government and California. In spite of the excessively high error rate, SCAN took no action to review the 2004 and 2005 diagnosis codes submitted to the Government and California, <u>and</u> failed to either (a) ensure that the diagnosis codes were supported by properly documented chart notes, or (b) withdraw the 2004 and 2005 diagnosis codes that were not supported by properly documented chart notes.

94. Plaintiff is informed and believes, and upon such information and belief alleges, that 40% of the diagnosis codes SCAN submitted to the Government and California for 2006 and beyond were not supported by properly documented chart notes as SCAN utilized the

1 same procedures to document chart notes and submit diagnosis codes to the Government and
2 California that were in place during 2003.

3 95. As a result of SCAN's submission of diagnosis codes to the Government and
4 California since 2004, 40% of which are invalid because they were not supported by properly
5 documented chart notes, failure to ensure that the diagnosis codes were supported by properly
6 documented chart notes, and failure to withdraw the 2004 and 2005 diagnosis codes that were
7 not supported by properly documented chart notes, the Government and California were
8 induced to and did pay capitation rates to SCAN that were excessively high.

9 96. During each year in question, SCAN's authorized officer or representative
10 submitted to the Government and California an attestation that SCAN had truthfully submitted
11 all required information to the Government and California, respectively, and had complied
12 with all applicable laws and Medicare and Medi-Cal regulations.

13 97. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. §
14 3729(a)(1) by knowingly presenting and/or causing to present to agents, contractors or
15 employees of the Government false and fraudulent billings for payment and approval by
16 Medicare and Medi-Cal for the period 2004 through and including 2007.

17 98. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. §
18 3729(a)(2) by knowingly making, using, and/or causing to make or use false records and
19 statements to get false and excessive billings paid or approved by Medicare and Medi-Cal for
20 the period 2004 through and including 2007.

21 99. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. §
22 3729(a)(4) by improperly retaining and concealing the excessive capitated payments SCAN
23 received from Medicare and Medi-Cal for the period 2004 through and including 2007.

24 100. At all times mentioned, SCAN routinely and repeatedly violated 31 U.S.C. §
25 3729(a)(7) by knowingly making, using and/or causing to make or use false records and
26 statements to conceal, avoid, or decrease its obligation to return to the Medicare and Medi-Cal
27 programs the excessive capitated payments SCAN received from the Government and
28 California for the period 2004 through and including 2007.

1 101. As a result of SCAN's conduct, SCAN is liable to the Government for three
2 times the amount of damages sustained by the Government as a result of the false and
3 fraudulent billing, reporting and concealment practices alleged above.
4 102. As a result of SCAN's conduct, 31 U.S.C. § 3729(a) provides that SCAN is
5 liable to the Government for civil penalties between $5,000 and $10,000 for each such false
6 and fraudulent billing, reporting and concealment.
7 103. Swoben is also entitled to recover his attorneys fees, costs and expenses from
8 the SCAN pursuant to 31 U.S.C. § 3730(d).
9
10 EIGHTH CLAIM FOR RELIEF
11 (Violation of California Government Code § 12651(a) against SCAN)
12 [False Diagnosis Reporting]
13 104. Plaintiff realleges and incorporates by reference paragraphs 1 through 19,
14 inclusive, of this complaint as though fully set forth at length.
15 105. At all times relevant, SCAN was and/or operated a health maintenance
16 organization that had HMO contracts with Medicare and Medi-Cal. At all times relevant,
17 SCAN, as did other HMOs, submitted diagnoses codes of its HMO patients to the Government
18 and California. The diagnosis codes were used to develop risk scores that were used to adjust
19 the capitated payment rates paid by the Government and California. The risk scores
20 compensated an HMO with a population of patients with more severe illnesses than normal
21 through higher capitation rates. Likewise, an HMO with a population of patients with less
22 severe illnesses than normal would see a downward adjustment of its capitation rates because
23 it was servicing a healthier than normal population of patients.
24 106. Under applicable Medicare and Medi-Cal regulations, HMOs can only submit
25 diagnosis codes to the Government and California, respectively, that are supported by properly
26 documented chart notes.
27 107. During or about 2005, Medicare conducted a review of about 200 of SCAN's
28 2003 medical charts of its Medicare patients, and determined that about 40% (more than twice

1 the norm in the industry) of the reviewed chart notes did not support the 2003 diagnosis codes
2 previously supplied to Medicare. As a result, Medicare disallowed the diagnosis codes of the
3 200 reviewed charts that were not supported by properly documented chart notes. During
4 2003, SCAN had more than 19,000 Medi-Cal patients.

5 108. The procedures utilized by SCAN to document chart notes and diagnoses, and
6 submit diagnosis codes to the Government and California, remained the same between and
7 including 2003 and 2006. SCAN did not take any corrective action to reduce its error rate (the
8 percentage of submitted diagnosis codes unsupported by properly documented chart notes)
9 during that time.

10 109. Based upon the results of Medicare 2005 review, Plaintiff is informed and
11 believes, and upon such information and belief alleges, that 40% of the 2004 and 2005
12 diagnosis codes SCAN submitted to California were not supported by properly documented
13 chart notes as SCAN utilized the same procedures to document chart notes and submit
14 diagnosis codes to the Government and California. In spite of the excessively high error rate,
15 SCAN took no action to review the 2004 and 2005 diagnosis codes submitted to California,
16 and failed to either (a) ensure that the diagnosis codes were supported by properly documented
17 chart notes, or (b) withdraw the 2004 and 2005 diagnosis codes that were not supported by
18 properly documented chart notes.

19 110. Plaintiff is informed and believes, and upon such information and belief alleges,
20 that 40% of the diagnosis codes SCAN submitted to California for 2006 and beyond were not
21 supported by properly documented chart notes as SCAN utilized the same procedures to
22 document chart notes and submit diagnosis codes to the Government and California that were
23 in place during 2003.

24 111. As a result of SCAN's submission of diagnosis codes to the Government and
25 California since 2004, 40% of which are invalid because they were not supported by properly
26 documented chart notes, failure to ensure that the diagnosis codes were supported by properly
27 documented chart notes, and failure to withdraw the 2004 and 2005 diagnosis codes that were
28 not supported by properly documented chart notes, California was induced to and did pay

capitation rates to SCAN that were excessively high.

112. During each year in question, SCAN's authorized officer or representative submitted to the Government and California an attestation that SCAN had truthfully submitted all required information to the Government and California, respectively, and had complied with all applicable laws and Medicare and Medi-Cal regulations.

113. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(2) by knowingly making, using, and/or causing to make or use false records and statements to get false and excessive billings paid or approved by Medi-Cal for the 2004 through and including 2007.

114. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(4) by improperly retaining and concealing the excessive capitated payments SCAN received from Medi-Cal for the period 2004 through and including 2007.

115. At all times mentioned, SCAN routinely and repeatedly violated California Government Code § 12651(a)(7) by knowingly making, using and/or causing to make or use false records and statements to conceal, avoid, or decrease its obligation to return to the Medi-Cal program the excessive capitated payments SCAN received from Medi-Cal for the period 2004 through and including 2007.

116. Swoben is informed and believes, and upon such information and belief alleges, that as a result of SCAN's concealments and use of false records and statements, Medi-Cal paid more than it would have if SCAN had properly and truthfully disclosed the diagnoses supported by properly documented chart notes.

117. As a result of SCAN's conduct, SCAN is liable to California for three times the amount of damages sustained by California as a result of the false and fraudulent billing, reporting and concealment practices alleged above.

118. As a result of SCAN's conduct, California Government Code § 12651(a) provides that SCAN is liable to California for civil penalties of up to $10,000 for each such false and fraudulent billing, reporting and concealment.

1 119. Swoben is also entitled to recover his attorneys fees, costs and expenses from
2 the SCAN pursuant to California Government Code § 12652(g)(8).
3
4 NINTH CLAIM FOR RELIEF
5 (Violation of 31 U.S.C. § 3729(a) against all defendants)
6 [Up-Coding]
7 120. Plaintiff realleges and incorporates by reference paragraphs 1 through 19,
8 inclusive, of this complaint as though fully set forth at length.
9 121. At all times relevant, submitted diagnoses
10 codes of patients to the Government and California. The diagnosis
11 codes were used to develop risk scores that were used to adjust the capitated payment rates
12 paid by the Government and California. The risk scores compensated with a
13 population of patients with more severe illnesses than normal through higher capitation rates.
14 Likewise, with a population of patients with less severe illnesses than normal would
15 see a downward adjustment of its capitation rates because it was servicing a healthier than
16 normal population of patients. Defendants were allowed an 18 month period in which to make
17 retrospective corrections to their data submissions of the Government and California.
18 122. Under applicable Medicare and Medi-Cal regulations, defendants can only
19 submit diagnosis codes to the Government and California, respectively, that are supported by
20 properly documented chart notes.
21 123.
22
23 utilized the diagnosis codes of its various contracted healthcare providers, such as and
24 including to develop risk scores that were used to adjust the capitated
25 payment rates paid by the Government and California to
26 124. During or after June 2008, utilized software
27 to evaluate claims data and reviewed the medical charts of more than 125,000 of
28 patients with severe illnesses. used the data for prospective care,

1 as well as retrospective review of its Medicare and Medi-Cal patients' medical charts for
2 previous years' submissions.

3 125. conducted its review of the medical charts of thousands of
4 its patients, determined the diagnosis codes that were supported by proper documentation of
5 the reviewed medical charts, and provided their results to the
6 review resulted in (a) diagnosis codes that were supported by proper documentation
7 of the reviewed medical charts that had been previously submitted to the Government and
8 California, and (b) new diagnosis codes that were supported by proper documentation of the
9 reviewed medical charts that had not been previously submitted to the Government and
10 California. The results of review did not identify the diagnosis codes
11 unsupported by proper documentation of the reviewed medical charts that had been previously
12 submitted to the Government and California.

13 126. made no effort to advise the
14 Government and California of the diagnosis codes for the reviewed medical charts that were
15 unsupported by proper documentation, and made no effort to withdraw from the Government
16 and California the previously submitted diagnosis codes that were unsupported by proper
17 documentation of the reviewed medical charts.

18 127. improperly conceived, planned and
19 conducted the coding company's reviews by not causing the previously submitted diagnosis
20 codes that were unsupported by reviews to be corrected and withdrawn
21 from the Government and California. Rather, the procedures and methods developed and used
22 were biased in favor of "up coding" the patients' diagnoses because the previously submitted
23 diagnoses that were not unsupported by reviews were not corrected and
24 withdrawn from the Government and California.
25 did so with the knowledge and intent that reviews would only increase,
26 and not decrease, the number of diagnoses, and thus their respective risk scores in order to
27 increase capitated payments paid by the Government and California.

28 128. During or about 2008-2011,

1 submitted to the Government and California the diagnosis codes determined by
2 reviews, knowing that the effect of such submissions would only increase the number
3 of diagnoses, and thus artificially inflate their respective risk scores and capitated payments.
4 129. As a result of the acts and concealments of
5 their respective capitated payments paid by the Government and California became
6 inflated due to the artificially high risk scores.
7 130. Further, the had a duty to have compliance programs in place
8 to monitor and detect attempts to artificially increase risk scores and capitated payments.
9 131. At all times mentioned, routinely and
10 repeatedly violated 31 U.S.C. § 3729(a)(2) by knowingly making, using, and/or causing to
11 make or use false records and statements to get false and excessive billings paid or approved
12 under the Medicare and Medi-Cal contracts during and after 2008.
13 132. At all times mentioned, routinely and
14 repeatedly violated 31 U.S.C. § 3729(a)(4) by improperly retaining and concealing the
15 unsupported diagnosis codes and inflated risk scores that inflated the capitated payments they
16 received under the Medicare and Medi-Cal contracts during and after 2008.
17 133. At all times mentioned, routinely and
18 repeatedly violated 31 U.S.C. § 3729(a)(7) by knowingly making, using and/or causing to
19 make or use false records and statements to conceal, avoid, or decrease its obligation to return
20 to the Medicare and Medi-Cal programs the inflated capitated payments they received during
21 and after 2008.
22 134. Swoben is informed and believes, and upon such information and belief alleges,
23 that as a result of the concealments and use of false records and statements, Medicare and
24 Medi-Cal paid more than they would have if had
25 properly and truthfully billed and reported, and revealed and withdrawn the diagnosis codes
26 that were not supported by their medical charts.
27 135. As a result of their conduct, defendants are liable to the Government for three
28 times the amount of damages sustained by the Government as a result of the false and

1 fraudulent billing, reporting and concealment practices alleged above.

2 136. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants
3 are liable to the Government for civil penalties between $5,000 and $10,000 for each such
4 false and fraudulent billing, reporting and concealment.

5 137. Swoben is also entitled to recover his attorneys fees, costs and expenses from
6 defendants pursuant to 31 U.S.C. § 3730(d).

7

8 TENTH CLAIM FOR RELIEF

9 (Violation of California Government Code § 12651(a) against all defendants)

10 [Up-Coding]

11 138. Plaintiff realleges and incorporates by reference paragraphs 1 through 19,
12 inclusive, and 121 through 137, inclusive, of this complaint as though fully set forth at length.

13 139. At all times mentioned, routinely and
14 repeatedly violated California Government Code § 12651(a)(1) by knowingly presenting
15 and/or causing to present to California employees, agents and/or contractors false and
16 fraudulent billings for payment and approval during and after 2008.

17 140. At all times mentioned, routinely and
18 repeatedly violated California Government Code § 12651(a)(2) by knowingly making, using,
19 and/or causing to make or use false records and statements to get false and excessive billings
20 paid or approved under the Medi-Cal contract during and after 2008.

21 141. At all times mentioned, routinely and
22 repeatedly violated California Government Code § 12651(a)(4) by improperly retaining and
23 concealing the unsupported diagnosis codes and inflated risk scores that inflated the capitated
24 payments they received under the Medi-Cal contract during and after 2008.

25 142. At all times mentioned, routinely and
26 repeatedly violated California Government Code § 12651(a)(7) by knowingly making, using
27 and/or causing to make or use false records and statements to conceal, avoid, or decrease their
28 obligation to return to the Medi-Cal program the inflated the capitated payments they received

under the Medicare and Medi-Cal contracts during and after 2008.

143. Swoben is informed and believes, and upon such information and belief alleges, that as a result of concealments and use of false records and statements, Medi-Cal paid more than it would have if defendants had properly and truthfully billed and reported, and revealed and withdrawn the diagnosis codes that were not supported by their medical charts.

144. As a result of their conduct, defendants are liable to California for three times the amount of damages sustained by California as a result of the false and fraudulent billing, reporting and concealment practices alleged above.

145. As a result of their conduct, California Government Code § 12651(a) provides that defendants are liable to California for civil penalties of up to $10,000 for each such false and fraudulent billing, reporting and concealment.

146. Swoben is also entitled to recover his attorneys fees, costs and expenses from defendants pursuant to California Government Code § 12652(g)(8).

## PRAYER FOR RELIEF

WHEREFORE, Plaintiff and Qui Tam Relator James M. Swoben prays for relief as follows:

### FOR THE FIRST CLAIM FOR RELIEF

1. Treble the Government's damages according to proof;
2. Civil penalties according to proof;
3. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

### FOR THE SECOND CLAIM FOR RELIEF

4. Treble the State of California's damages according to proof;
5. Civil penalties according to proof;
6. A relator's award of up to 50% of the amounts recovered by or on behalf of the State of California;

FOR THE THIRD CLAIM FOR RELIEF

7. Treble the Government's damages according to proof;

8. Civil penalties according to proof;

9. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE FOURTH CLAIM FOR RELIEF

10. Treble the State of California's damages according to proof;

11. Civil penalties according to proof;

12. A relator's award of up to 50% of the amounts recovered by or on behalf of the State of California;

FOR THE FIFTH CLAIM FOR RELIEF

13. Treble the Government's damages according to proof;

14. Civil penalties according to proof;

15. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE SIXTH CLAIM FOR RELIEF

16. Treble the State of California's damages according to proof;

17. Civil penalties according to proof;

18. A relator's award of up to 50% of the amounts recovered by or on behalf of the State of California;

FOR THE SEVENTH CLAIM FOR RELIEF

19. Treble the Government's damages according to proof;

20. Civil penalties according to proof;

21. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE EIGHTH CLAIM FOR RELIEF

22. Treble the State of California's damages according to proof;

23. Civil penalties according to proof;

24. A relator's award of up to 50% of the amounts recovered by or on behalf of the State of California;

FOR THE NINTH CLAIM FOR RELIEF

25. Treble the Government's damages according to proof;

26. Civil penalties according to proof;

27. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE TENTH CLAIM FOR RELIEF

28. Treble the State of California's damages according to proof;

29. Civil penalties according to proof;

30. A relator's award of up to 50% of the amounts recovered by or on behalf of the State of California;

FOR ALL CLAIMS FOR RELIEF

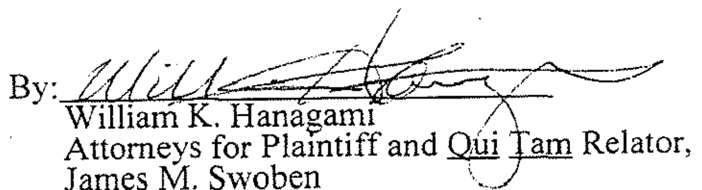
31. Attorneys fees, expenses, and costs; and

32. Such other and further relief as the Court deems just and proper.

ABRAM J. ZINBERG, ESQ.

THE HANAGAMI LAW FIRM
A Professional Corporation

Dated: November 23, 2011

By: 
William K. Hanagami
Attorneys for Plaintiff and Qui Tam Relator, James M. Swoben

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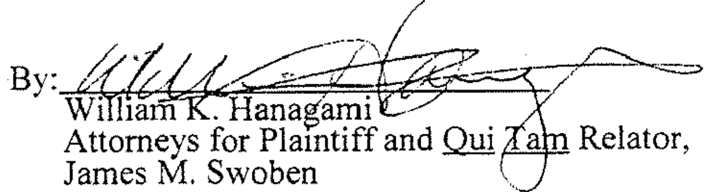
REQUEST FOR JURY TRIAL

Plaintiff and Qui Tam Relator James M. Swoben hereby requests a trial by jury.

ABRAM J. ZINBERG, ESQ.

THE HANAGAMI LAW FIRM
A Professional Corporation

Dated: November 23, 2011

By: 
William K. Hanagami
Attorneys for Plaintiff and Qui Tam Relator,
James M. Swoben

Complaint.P05.wpd

1 PROOF OF SERVICE BY MAIL

2 I am over the age of 18 and not a party to the within action.
3 I am employed by the Office of United States Attorney, Central
4 District of California. My business address is 300 North Los
5 Angeles Street, Suite 7516, Los Angeles, California 90012.

6 On August 17, 2012, I served the following documents:

7 **JOINT NOTICE BY THE UNITED STATES OF AMERICA AND THE STATE**
8 **OF CALIFORNIA OF ELECTION TO INTERVENE IN PART;**
9 **ORDER REGARDING PARTIAL INTERVENTION AND PARTIAL**
10 **UNSEALING;**
11 **NOTICE OF LODGING REDACTED RELATOR'S THIRD AMENDED**
12 **COMPLAINT;**
13 **NOTICE OF DISMISSAL OF ALL CLAIMS AGAINST DEFENDANTS SCAN**
14 **HEALTH PLAN, SENIOR CARE ACTION NETWORK, AND SCAN GROUP**
15 **PURSUANT TO SETTLEMENT AGREEMENT; CONSENTS OF THE UNITED**
16 **STATES AND STATE OF CALIFORNIA ATTORNEYS GENERAL THERETO;**
17 **AND [PROPOSED] ORDER THEREON**

18 upon each person or entity named below by enclosing a copy in an
19 envelope addressed as shown below and placing the envelope for
20 collection and mailing on the date and at the place shown below
21 following our ordinary office practices. I am readily familiar with
22 the practice of this office for collection and processing
23 correspondence for mailing. On the same day that correspondence is
24 placed for collection and mailing, it is deposited in the ordinary
25 course of business with the United States Postal Service in a sealed
26 envelope with postage fully prepaid.
27
28

Date of mailing: August 17, 2012.

Place of mailing: Los Angeles, California.

Person(s) and/or Entity(ies) to whom mailed:

See attached service list.

I declare that I am employed in the office of a member of the bar of this Court at whose direction the service was made.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct and that this declaration was executed on August 17, 2012 at Los Angeles, California.

ANGELA M. FIORE

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William K. Hanagami,
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San Diego, CA 92108