IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

UNITED STATES OF AMERICA, ex rel. MITCHELL J. PERETZ, Plaintiff, vs. HUMANA INC., a Delaware Corporation and HUMANA PHARMACY INC. dba RIGHTSOURCE, a Delaware Corporation, Defendants.	)	No. 2:08-cv-1799-HRH

O R D E R

Motion to Dismiss

Defendants move to dismiss relator's complaint.[1] This motion is opposed.[2] Oral argument was requested and has been heard.

Facts

Mitchell Peretz is the relator in this qui tam action. Humana Inc. and Humana Pharmacy, Inc. are the defendants.

Relator alleges that defendants violated the False Claims Act (FCA), 31 U.S.C. §§ 3729-3733, and retaliated against him in violation of the FCA and state law. Relator was employed by

[1]Docket No. 29.

[2]Docket No. 35.

defendants from January 2006 through January 3, 2008 as the Pharmacy operations manager for RightSource,[3] which is a national mail-order pharmacy wholly owned by Humana Inc.

Humana created RightSource in 2006 in order to participate in Medicare Part D. The Medicare program has several parts, all of which are administered through the Centers for Medicare and Medicaid Services (CMS). Medicare Part D is a voluntary outpatient prescription drug program. Under Part D, private insurers apply with CMS to offer Part D plans to Medicare beneficiaries. These private insurers are known as Prescription Drug Plan sponsors, or PDP sponsors.

To qualify for Part D payments, a PDP sponsor must submit a bid in the year prior to the calendar year in which Part D benefits will actually be delivered. See 42 C.F.R. § 423.265. The bid contains a per member per month (PMPM) cost estimate for providing Part D benefits to an average Medicare beneficiary in a particular geographic area. From the PDP bids, CMS calculates nationwide and regional benchmarks which represent an average PMPM cost. If the PDP sponsor's bid exceeds the benchmark, the plan member must pay the difference.

During the benefit year, CMS pays PDP sponsors estimated payments on a monthly basis. In turn, PDP sponsors provide CMS with documentation of their actual costs. One way PDP sponsors provide

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[3]Complaint at 2, ¶ 7, Docket No. 1.

actual cost information is by submitting a Prescription Drug Event (PDE) record for every prescription that is filled for a plan member.

In the year following the benefit year, CMS reconciles a PDP sponsor's actual prescription drug costs as derived from its PDE records against the sponsor's bid. If a PDP sponsor's actual costs exceed the estimated costs, the sponsor may be able to recoup some of its losses through a risk-sharing arrangement with CMS. Conversely, if a PDP sponsor's estimated costs exceed its actual costs, the sponsor may have to pay back some of its estimated payments to CMS.

Relator alleges that defendants were engaged in four fraudulent practices related to the delivery of prescription drugs to Part D Medicare beneficiaries. First, relator alleges that toward the end of 2006, defendants decided to add an extra dollar, which Humana characterized as a dispensing fee,[4] to every Part D Medicare prescription for 2007.[5] Relator alleges that "at the end of 2006 William Fleming, Defendant Humana's Vice President of Pharmacy and Clinical Integration, and Jeff Kimmell, Humana's Director of Pharmacy, informed Relator and RightSource's Finance Manager, Bryan

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[4]Dispensing fees are "costs . . . incurred at the point of sale and pay for costs in excess of the ingredient cost of a covered Part D drug each time a covered Part D drug is dispensed[.]" 42 C.F.R. § 423.100.

[5]Complaint at 7, ¶¶ 27, 29, Docket No. 1.

Wyborg, that Humana would begin paying RightSource the additional dollar per Part D prescription starting on January 1, 2007."[6] Relator alleges that Rightsource's 2006 prices already included RightSource's costs, profits, and dispensing fees.[7] Relator alleges that by adding the extra $1 to every Part D prescription, RightSource and by extension, Humana, was able to generate approximately $1,890,000 in additional profit in 2007.[8]

Relator alleges that he and Wyborg "expressed concern regarding the justification for the additional dollar charge on Part D prescriptions" and that Fleming told them that "the dollar add would be removed if there was no justification for it."[9] Relator further alleges that "Wyborg and his subordinate, Joshua Katz, both attempted to find justification for the dollar add, but could not."[10] Relator alleges that by overstating its costs, Humana "falsely document[ed] to CMS a 'higher' cost of doing business."[11]

Secondly, relator alleges that in spring 2007,

> Humana through its agents including Fleming, directed its marketing department, Humana Direct Marketing Services ("DMS") through DMS

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[6] Id. at 8, ¶ 30.

[7] Id. at ¶ 32

[8] Id. at ¶ 33.

[9] Id. at 9, ¶ 35

[10] Id.

[11] Id. at ¶ 38.

> agents including Khursheed Zafar, a DMS Director, to solicit by telephone Humana Medicare Part D insured beneficiaries and solicit them to use Humana's own RightSource pharmacy for their prescription benefits.[12]

Relator alleges that Humana, as it was required to do, received approval from CMS for its telephone solicitation scripts.[13] Relator alleges that "[s]everal Humana insureds rejected Humana's solicitations via DMS but with Fleming's knowledge, Humana signed them up for prescriptions from RightSource anyway."[14] Relator alleges that RightSource then caused the physicians of these "members" to issue new prescriptions which RightSource filled and then billed the members their copays.[15] Relator alleges that under his direction, RightSource investigated complaints from numerous individuals who called to complain that they had been charged copays and sent prescriptions even though they had not enrolled in RightSource's prescription services.[16] Relator includes in his allegations the names of thirty-seven individuals whom he alleges were enrolled as RightSource Medicare Part D customers without their permission.[17]

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[12] Id. at 10, ¶ 39.

[13] Id. at ¶ 40.

[14] Id. at ¶ 41.

[15] Id. at ¶¶ 42-44.

[16] Id. at 11, ¶¶ 45-46.

[17] Id. at 11-15, ¶ 46.

Relator alleges that he "repeatedly reported the illegal nature of these mis-selling tactics to Humana and its marketing arm, DMS."[18] Relator further alleges that "Humana never corrected the problem, but instead Humana instructed Jennifer Renville, RightSource's interim Customer Service Manager, not to report the solicitation problems to Relator."[19]

Thirdly, relator alleges that Humana attempted to address complaints about the mis-selling was to offer to waive the co-pay and let the individual keep the prescription.[20] Relator alleges that this was done at the direction of Fleming, Humana's vice-president.[21] Relator alleges that "Medicare prohibits payment based on prescriptions issued where the beneficiary does not pay a copay, unless the copay is waived based on a determination of financial need for the beneficiary."[22] By waiving copays not based on financial need for mis-sold individuals, relator alleges that "Humana's cost/charge reports to CMS falsely included unallowed costs in the form of prescriptions that did not meet Medicare copay guidelines."[23]

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[18] Id. at 15, ¶ 47.

[19] Id. at ¶ 48.

[20] Id. at 16, ¶ 49(c).

[21] Id. at ¶ 49(b).

[22] Id. at ¶ 50.

[23] Id. at ¶ 52.

Fourthly, relator alleges that during 2007, "RightSource refilled 1,699 prescriptions (about 1,189 of which were under Part D) without proper pharmacist authorization[.]"[24] Relator alleges that when RightSource pharmacists identified a possible over-prescribing situation, they would contact the prescribing doctor and then "enter into RightSource's computer system the information as received by the physician including any errant excessive refill authorization."[25] Relator alleges, however, that "in practice, RightSource ignored the corrected number of refills, and the pharmacist's approval of the corrected number and instead automatically allowed for refilling the maximum amount as mis-prescribed by the physician and regardless of the pharmacist's approval of only the limited refills."[26]

Relator contends that "over prescribed medication is not an allowable cost under Medicare Part D. However, RightSource did nothing to exclude these over prescriptions from its cost/charge reports to CMS."[27] Relator alleges that defendants allowed this problem to persist until they could no longer ignore his complaints,

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[24]Id. at 17, ¶ 53.

[25]Id. at 17-18, ¶ 56.

[26]Id. at 18, ¶ 57.

[27]Id. at ¶ 59.

but that even after the problem was corrected, "CMS was never informed and the claims were never reversed[.]"[28]

Relator also alleges that Humana made the following false certifications to CMS in order to qualify as a PDP sponsor:

1. Relator alleges that Humana falsely certified to CMS that it maintained policies and procedures to prevent over-utilization of prescribed medications because it was actually "Humana's policy to allow over prescriptions by excessive refills. . . ."[29]
2. Relator alleges that Humana falsely certified that it would establish procedures for tracking and addressing member grievances and that it would train its staff about these procedures because "Humana's express procedure was to not report [the mis-selling] to the head of RightSource. . . ."[30]
3. Relator alleges that Humana falsely certified that it would maintain and provide to CMS, if requested, records on all grievances because actually "Humana had a policy and practice of deliberately ignoring records from RightSource and its DMS department that showed grievances and [Humana] expressly instructed RightSource personnel

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[28]Id. at 18-19, ¶ 60.

[29]Id. at 19, ¶ 62.

[30]Id. at ¶¶ 63-64.

not to report grievances of" mis-selling.[31] Relator alleges that "[o]n or about November 16, 2007, Tony Keller, COO of RightSource . . . expressly told Jennifer Renville, RightSource's interim manager of customer service, not to report any violations or customer complaints to Relator."[32]

4. Relator alleges that Humana falsely certified that it would comply with CMS marketing guidelines and approval procedures "because it used unapproved and non-compliant marketing materials and practices."[33]

5. Relator alleges that Humana falsely certified that it "would implement a Part D compliance plan in accordance with all Federal and State regulations and guidelines[,]" because it "did not have a mechanism in place to effectively implement compliance as evidenced by Humana's violations of the False Claims Act and state pharmaceutical laws. . . ."[34]

6. Relator alleges that Humana falsely certified that it would implement a Part D compliance plan that included internal monitoring and auditing procedures designed to

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[31] Id. at ¶¶ 65-66.

[32] Id. at 19-20, ¶¶ 64-65.

[33] Id. at 20-21, ¶¶ 67-68.

[34] Id. at 21, ¶¶ 69-70.

address any detected problems because Humana did next to nothing to correct the $1 dispensing fee problem, the improper waiving of copays, or the 1,699 prescriptions that were improperly refilled.[35] Relator alleges that it was not until he went to the Arizona Pharmacy Board on September 5, 2007, that Humana took any action to prevent these problems.[36] Relator alleges that on September 6, 2007, Fleming formed a task force headed by Scott Greenwell, Humana's Director of Professional Practice and Compliance, but that [t]he task force "routinely downplayed violations."[37]

7. Relator alleges that Humana falsely certified that it would provide accurate information concerning Part D enrollment and payments because "every Medicare PDE record Humana submitted from RightSource transactions (approximately 2.7 million per year) was provided to CMS in order to ensure *in*accurate payments in Humana's favor to CMS's detriment."[38]

8. Relator alleges that Humana falsely certified that the data it was providing in support of its monthly payment

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[35] Id. at 21-23, ¶¶ 71-72.

[36] Id. at 22, ¶ 72c.

[37] Id.

[38] Id. at 23-24, ¶¶ 74-75 (both emphases in the original).

was accurate, complete, and truthful because Humana and RightSource knowingly submitted false PDEs, documentation that members had enrolled when they really had not, false documentation of prescriptions for which the copays were waived, and false documentation of prescriptions that were refilled without pharmacist authorization.[39]

9. Relator alleges that Humana "inappropriately and deliberately overestimated" its annual bid "to manipulate CMS payments."[40]

Relator asserts thirteen claims against defendants in his complaint. Count I asserts FCA false certification claims. Counts II-V assert FCA false record claims. Counts VI-IX assert FCA reverse false claims. Count X is a FCA conspiracy claim. Count XI is a FCA retaliation claim. Counts XII and XIII assert state-law retaliation claims.

Pursuant to Rules 12(b)(6) and 9(b), Federal Rules of Civil Procedure, defendants now move to dismiss all of relator's claims.

Discussion

"A complaint may survive a [Rule 12(b)(6)] motion to dismiss if, taking all well-pleaded factual allegations as true, it contains 'enough facts to state a claim to relief that is plausible on its face.'" Coto Settlement v. Eisenberg, 593 F.3d 1031, 1034 (9th Cir.

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[39]Id. at 24, ¶¶ 76-77.

[40]Id. at 24-25, ¶¶ 78-79.

2010) (quoting Ashcroft v. Iqbal, --- U.S. ---, 129 S. Ct. 1937, 1949 (2009)). In addition to meeting the requirements of Rule 12(b)(6), "[b]ecause the FCA is an anti-fraud statute and requires fraud allegations, complaints alleging a FCA violation must fulfill the requirements of Rule 9(b)." Mendiondo v. Centinela Hosp. Medical Ctr., 521 F.3d 1097, 1103 (9th Cir. 2008). "Rule 9(b) requires a party to 'state with particularity the circumstances constituting fraud or mistake,' including 'the who, what, when, where, and how of the misconduct charged.'" Ebeid ex rel. United States v. Lungwitz, 616 F.3d 993, 998 (9th Cir. 2010) (quoting Vess v. Ciba-Geigy Corp. USA, 317 F.3d 1097, 1106 (9th Cir. 2003)). A FCA complaint must be "'"specific enough to give defendants notice of the particular misconduct which is alleged to constitute the fraud charged so that they can defend against the charge and not just deny that they have done anything wrong.'" United States ex rel. Lee v. SmithKline Beecham, Inc., 245 F.3d 1048, 1051-52 (9th Cir. 2001) (quoting Neubronner v. Milken, 6 F.3d 666, 671 (9th Cir. 1993)).

In Count I, relator alleges that defendants violated section 3729(a)(2) of the FCA by making the nine false certifications set out above and that defendants made these certifications with the intent to obtain payment from the government.[41] A false certification claim may involve an express certification or it may involve

[41] Id. at 25, ¶¶ 84-85.

an implied certification. "Express certification simply means that the entity seeking payment certifies compliance with a law, rule or regulation as part of the process through which the claim for payment is submitted." Ebeid, 616 F.3d at 998. "Implied false certification occurs when an entity has previously undertaken to expressly comply with a law, rule, or regulation, and that obligation is implicated by submitting a claim for payment even though a certification of compliance is not required in the process of submitting the claim." Id.

Relator primarily argues that his Count I should not be dismissed because he has adequately pleaded implied false certification claims. Relator contends that he has pleaded implied false certification claims as to the second, third, fourth, sixth, seventh, eighth, and ninth certifications set out above. However, relator's complaint only alleges express false certification claims. By arguing that only two of the nine certifications in Count I are express false certification claims, relator, in effect, concedes that as to the other seven certifications, he has failed to state plausible express certification claims. Relator's false certification claims as to certification numbers two, three, four, six, seven, eight and nine are thus dismissed.

The only two express false certification claims in relator's Count I involve his allegation that Humana falsely certified to CMS that it had policies and procedures to prevent over-utilization of

prescription medicine because in practice Humana ignored these policies and procedures[42] and his allegation that Humana's certification that it would implement a Part D compliance plan was false because Humana engaged in "unethical and unprofessional practices."[43] These claims cannot survive defendants' motion to dismiss because relator has not adequately alleged that they were false when made. See United States ex rel. Hendow v. Univ. of Phoenix, 461 F.3d 1166, 1171-72 (9th Cir. 2006) (one condition that must be met to prevail on a false certification claim is "a palpably false statement, known to be a lie when it is made"). Although relator does not allege exactly when Humana became a Part D sponsor,[44] a reasonable inference is that it was sometime prior to the creation of Rightsource, which is alleged to have begun operating in January 2006.[45] Humana could not have known that its certifications were false when made if the conduct which allegedly demonstrates falsity did not occur until after the certifications were made.

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[42]Id. at 17-19, ¶¶ 53-61.

[43]Id. at 21, ¶ 69-70.

[44]Defendants contend that this occurred in 2005, but the court's review here is limited to facts alleged in relator's complaint and it cannot consider facts asserted in a party's briefing. g on a motion to dismiss pursuant to Rule 12(b)(6). See Schneider v. Calif. Dep't of Corrections, 151 F.3d 1194, 1197 n. 1 (9th Cir. 1998) ("In determining the propriety of a Rule 12(b)(6) dismissal, a court may not look beyond the complaint to a plaintiff's moving papers, such as a memorandum in opposition to a defendant's motion to dismiss.").

[45]Complaint at 6, ¶ 25, Docket No. 1.

Relator's Count I is dismissed in its entirety. Relator is, however, given leave to amend to plead any implied false certification claims he believes he has. See Lopez v. Smith, 203 F.3d 1122, 1130 (9th Cir. 2000) (quoting Doe v. United States, 58 F.3d 494, 497 (9th Cir. 1995)) ("'A district court should grant leave to amend even if no request to amend the pleading was made, unless it determines that the pleading could not possibly be cured by the allegation of other facts.'").

In Counts II-V, relator alleges that defendants violated section 3729(a)(2) of the FCA, which prohibits "[a]ny person" from "knowingly mak[ing], us[ing], or caus[ing] to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government[.]" 31 U.S.C. § 3729(a)(2).[46] These are "archetypal qui tam" FCA claims in which it is alleged that "the claim for payment is itself literally false or fraudulent." Hendow, 461 F.3d at 1170. In Counts VI-IX, relator alleges that defendants violated section 3729(a)(7) of the FCA, which prohibits "[a]ny person" from "knowingly mak[ing], us[ing], or caus[ing] to be used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Govern-

[46]In 2009, Congress amended 31 U.S.C. § 3729. See Fraud Enforcement & Recovery Act of 2009, Pub. L. 111-21, § 4(f)(1), 123 Stat. 1617, 1625 (2009). Because relator's complaint was filed in 2008, the pre-2009 version of the FCA applies here. All references in this order to § 3729 are to the earlier, pre-2009 version of the FCA.

ment[.]" Id. § 3729(a)(7). There are reverse false claims, which "require[] that a defendant make or use a false record or statement in order to conceal, avoid or decrease an obligation to pay the government." United States v. Bourseau, 531 F.3d 1159, 1169 (9th Cir. 2008). In order to prevail on either a false record claim or a reverse false claim, the relator must prove, inter alia, "a false statement or fraudulent course of conduct[.]" Hendow, 461 F.3d at 1174.

"The FCA does not define false. Rather, courts decide whether a claim is false or fraudulent by determining whether a defendant's representations are accurate in light of applicable law." Bourseau, 531 F.3d at 1164. "Violations of laws, rules, or regulations alone do not create a cause of action under the FCA." United States ex rel. Hopper v. Anton, 91 F.3d 1261, 1266 (9th Cir. 1996). "It is the false certification of compliance which creates liability when certification is a prerequisite to obtaining a government benefit." Id. A claim can also be false when it complies with the applicable rule or regulation, but where false information was used to receive the benefit. See United States v. Mackby, 261 F.3d 821, 826-27 (9th Cir. 2001) (holding defendant liable for using false group name to receive otherwise correct Medicare benefits).

Defendants first argue that relator's claims in Counts II and VI, in which relator alleges that the $1 charge was inflated and unjustified, must be dismissed because relator has not alleged that

this charge was false "in light of [any] applicable law." Bourseau, 531 F.3d at 1164. Defendants insist that it is not sufficient for relator to merely allege that the $1 charge that was added in 2007 was inflated and unjustified. Defendants contend that relator must allege that they violated some statute, rule, or regulation when they added the additional $1 to the cost of Part D prescriptions.

Relator has failed to allege that the $1 charge violated any specific rule, regulation, or statute. Relator must do more than allege that the $1 charge was not legitimate or not part of a negotiated rate. Relator must allege why the $1 charge was not legitimate and why failing to include it in a negotiated rate would make defendants' cost bills false.

Defendants also argue that Counts II and VI should be dismissed because relator has failed to plead with the specificity required by Rule 9. This argument fails. Relator has adequately pleaded fraud because he alleged when defendants started charging the fee, who told RightSource to start charging it, what the fee was supposedly for, how this fee was reported to CMS (through PDEs), and that there was no justification for this fee. But, because relator has not adequately alleged falsity, Counts II and VI are dismissed.

The court must, however, consider whether relator should be given leave to amend as to Counts II and VI. In his briefing on the instant motion, relator identified three possible rules and regulations an unjustified dispensing fee might violate, and these

three bases were the focus of defendants' presentation at oral argument. The court treats these arguments as futility arguments.

First, relator contends that the $1 charge violates 42 C.F.R. § 423.514(b)(1), which provides that

> [e]ach Part D plan sponsor must report to CMS annually, . . . the following:
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> (1) A description of significant business transactions, as defined in § 423.501, between the Part D plan sponsor and a party in interest, including the following:
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> (i) Indication that the costs of the transactions listed in paragraph (c) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or
>
> (ii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

Relator's reliance on § 423.514(b) is misplaced because the definition of a "business transaction" specifically excludes transactions for health care services provided by pharmacies to Part D plan beneficiaries. "Business transaction" for purposes of § 423.514(b) includes

> [g]oods, services, or facilities furnished for a monetary consideration, including management services, but not including . . . [h]ealth services furnished to the Part D plan sponsor's enrollees by pharmacies and other providers, by Part D plan sponsor staff, medical groups, or independent practice associations, or by any combination of those entities.

42 C.F.R. § 423.501(3)(ii) (emphasis added).

Second, relator contends that the $1 charge violates Section 20.5 of the CMS Prescription Drug Benefit Manual. Section 20.5 provides that "negotiated prices must include any applicable dispensing fees. . . ."[47] Relator argues that the negotiated price for defendants' Part D prescriptions had to include all dispensing fees prior to the $1 charge being added in 2007. Defendants argue that it is possible that their dispensing fee changed from 2006 in 2007; or in other words, that it is possible that they had a $0 dispensing fee in 2006 and a $1 fee in 2007, and thus they never violated section 20.5.

While it is possible that the $1 additional charge was legitimate and did not violate Section 20.5, it is also possible that Humana had already included all of its costs in its 2006 dispensing fee and was double-billing, as relator alleges. Defendants argue that relator is confusing dispensing fees with dispensing costs and that section 20.5 provides that a Part D sponsor can decide which dispensing costs it wants to include in its dispensing fee. Defendants thus suggest that they legitimately decided to include some costs in their dispensing fee that had not been included in 2006. The court cannot decide whether defendants in fact violated section 20.5 on a motion to dismiss. The court's task here is to decide whether it is possible that relator could

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[47] Prescription Drug Benefit Manual, Chapter 5, § 20.5 (12-13-09).

amend to allege a violation of section 20.5, which the court concludes is possible.

It is also possible that the $1 charge violates Section 20.6 of the CMS Prescription Drug Benefit Manual, which provides that "[i]n the case of pharmacies owned and operated by a Part D sponsor, [a dispensing fee can only include] the equivalent of all reasonable pharmacy costs. . . ."[48] If the $1 charge were not legitimate, as relator alleges, then it was not reasonable for Humana to include it in its dispensing fee. In sum, because amendment would not futile, relator is given leave to amend Counts II and VI.

Defendants next argue that Counts III and VII, in which relator alleges that Humana call center employees mis-sold RightSource's prescription services, must be dismissed. Defendants acknowledge that relator listed several customers by name who were "mis-sold" but they argue that he only vaguely alleges that this "slamming" impacted Humana's cost/charge reports and PDE forms, which in turn inflated the payments CMS made to Humana. Defendants contend that relator has failed to provide any details about the cost reports and PDE forms, such as dates, who submitted them, or exactly how they impacted CMS payments to Humana. Defendants also argue that because relator has not alleged that this mis-selling violated any statute or regulation, he has failed to allege falsity.

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[48] Id. at § 20.6.

Relator has failed to allege that mis-selling Rightsource's prescription services violated a specific statute, rule, or regulation. Relator points out in his opposition to the instant motion that Part D regulations prohibit using marketing that is misleading, confusing, or misrepresenting. See 42 C.F.R. § 423.2268(e) ("a Part D plan may not . . . [e]ngage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the Part D sponsor or its Part D plan."). But, relator cannot add allegations to his complaint via his opposition to a motion to dismiss.

Relator's other allegations in Counts III and VII are, however, sufficient to state a plausible FCA claim. Relator alleges that Humana received CMS's approval for its solicitation scripts, that it failed to follow those scripts, and that RightSource then filled prescriptions for at least thirty-seven specific people who had not agreed to enroll in RightSource's service. But, because relator has not adequately alleged falsity as to Counts III and VII, these claims are dismissed. Relator is given leave to amend as to these claims as it is possible that he could allege that defendants' mis-selling of RightSource's prescription services violated a rule, statute, or regulation.

Defendants next argue that Counts IV and VIII, in which relator alleges that Humana waived copayments for "slammed" members who received RightSource prescriptions in violation of CMS

guidelines, must be dismissed. Defendants argue that these counts fail to satisfy Rule 9(b) requirements because relator has failed to identify any member whose copayment was waived, when it occurred, what exact regulation was violated, or what specific false record or payment occurred as a result.

Relator argues that his co-pay waiver arguments are adequate. He contends that he has alleged that this fraudulent scheme began in the spring of 2007,[49] who some of the "slammed" customers were,[50] that it was telephone solicitors from Humana's marketing arm, DMS, who were involved in this scheme;[51] and that the waivers of co-pays were not justified under the narrow exception allowing for waivers.[52] Relator also points out that he has alleged that defendants made false statements in cost/charge reports and PDEs concealing the illegal waivers[53] and he referenced audio recordings of solicitation calls that he provided to defendants which demonstrated that Humana solicitors were not using approved scripts during sales call.[54] Relator also argues that he has adequately alleged that the waiver of co-pays for mis-selling violates Medicare regulations and thus

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[49]Complaint at 10, ¶ 39, Docket No. 1.

[50]Id. at 11-15, ¶ 46.

[51]Id. at 15, ¶ 47.

[52]Id. at 16, ¶ 51.

[53]Id. at 31, ¶ 102.

[54]Id. at 15, ¶ 47.

the reports and PDEs that included statements about mis-sold prescriptions are factually false. Relator also suggests that the waiver of co-pays violates the Anti-Kickback Statute. "The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), prohibits any person or entity from offering, making or accepting payment to induce or reward any person for referring, recommending or arranging for federally funded medical services, including services provided under the Medicare and Medicaid programs[.]" United States v. Rogan, 459 F. Supp. 2d 692, 714 (N.D. Ill. 2006). "A violation of the Anti-Kickback Statute may occur where payments for the exercise of decisions to refer increase the legitimate costs of the transaction." Id.

As with his other claims, relator has not alleged in his complaint that defendants' waiving of co-pays violated any specific rule, regulation, or statute. Relator may be able to allege that the waiver of co-pays violated Medicare regulations or the AKS, but he has not done so in his complaint. More importantly, contrary to relator's contention, he has not alleged the names of any persons who had their copays waived. He only alleges the names of people who were mis-sold, not that these individuals also had their co-pays waived. Counts IV and VIII are dismissed, but relator is given leave to amend as to these counts.

Defendants next argue that Counts V and IX, in which relator alleges that RightSource overfilled prescriptions, must be

dismissed. Defendants argue that absent a specific allegation that Humana's alleged reliance on the refills originally authorized by the physician violated a Part D statute or regulation, there is no factual basis to support relator's allegation of falsity here.

Relator once again has failed to allege any specific rule, regulation, or statute that was violated by the overfilling of prescriptions. In his opposition to the instant motion, relator points out that a classic example of Medicaid fraud is "[p]rescription refill errors: A pharmacist provides the incorrect number of refills prescribed by the provider."[55] In addition, he points out that overfilling prescriptions could violate state pharmaceutical practice standards, standards that PDP Sponsors are to ensure that their pharmacies follow. See 42 C.F.R. § 423.153(c)(1). Overfilling prescriptions could also possibly violate the most fundamental Medicare requirement that all services be provided "only when, and to the extent, medically necessary[.]" 42 U.S.C. § 1320c-5(a)(1). But none of this is alleged in relator's complaint. Counts V and IX are dismissed with leave to amend.

Next, defendants argue that relator's FCA conspiracy claim in Count X should be dismissed. The elements of a FCA conspiracy claim "are: (1) that the defendant conspired with one or more persons to get a false or fraudulent claim allowed or paid by the United

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[55]Prescription Drug Benefit Manual, Chapter 9, § 70.1.3 (4-25-06).

States; (2) that one or more conspirators performed any act to effect the object of the conspiracy; and (3) that the United States suffered damages as a result of the false or fraudulent claim." Blusal Meats, Inc. v. United States, 638 F. Supp. 824, 828 (S.D.N.Y. 1986). Relator's conspiracy claim fails for two reasons. One, it is a legal impossibility for Humana to conspire with RightSource because a parent corporation cannot conspire with its wholly owned subsidiary when the parent and the subsidiary have a complete unity of interest. Copperwood Corp. v. Independence Tube Corp., 467 U.S. 752, 771 (1984). Secondly, relator has failed to allege that Humana and RightSource entered into any agreement to defraud the United States nor has he alleged any details of the agreement.

Relator's argument that Copperweld does not apply to FCA cases is not well taken. See United States ex rel. Brooks v. Lockheed Martin Corp., 423 F. Supp. 2d 522, 528 (D. Md. 2006) (citing Copperweld for the proposition that "[a] parent corporation and its wholly owned subsidiaries, however, are legally incapable of forming a conspiracy with one another"); United States ex rel. Reagon v. E. Tex. Medical Ctr. Regional Healthcare Sys., 274 F. Supp. 2d 824, 856 (S.D. Tex. 2003) (citing Cooperweld for the proposition that "it is a matter of law that a parent corporation cannot conspire with its own subsidiary"). Relator's reliance on Fobbs v. Holy Cross Health System Corporation, 29 F.3d 1439 (9th Cir. 1994), overruled on other grounds by Daviton v. Columbia/HCA Healthcare Corp., 241 F.3d 1131

(9th Cir. 2001)), is misplaced. There, without considering whether a conspiracy could exist between a parent company and its subsidiary, the court held that the plaintiff had adequately alleged a conspiracy between a parent, its subsidiary, and twenty-seven individual defendants. Id. at 1450. Here, there are no individual defendants.

Relator's reliance on In re Commonwealth Companies Inc., 913 F.2d 518 (8th Cir. 1990), and Palladino ex rel. United States v. VNA of Southern New Jersey, Inc., 68 F. Supp. 2d 455, 458 (D.N.J. 1999), is also misplaced. Commonwealth did not involve the question of whether a parent and a subsidiary could conspire with each other but rather whether "§ 362(b)(4) [of the bankruptcy code] excepts the government's proposed FCA action against the debtors from the automatic stay up to and including the entry of a money judgment." Commonwealth, 913 F.2d at 520. Palladino involved a conspiracy claim against a nursing service, its subsidiary, and various employees of the subsidiary, not a conspiracy claim against only a parent corporation and its subsidiary. Id. at 458.

Count X of relator's complaint is dismissed. Relator is not given leave to amend because under Cooperweld he would never be able to plead a plausible conspiracy claim between Humana and Rightsource.

Defendants also argue that relator's FCA retaliation claim in Count XI must be dismissed. The heightened pleading requirements

of Rule 9(b) do not apply to FCA retaliation claims. Mendiondo, 521 F.3d at 1103. "A plaintiff alleging a FCA retaliation claim must show three elements: (1) that he or she engaged in activity protected under the statute; (2) that the employer knew the plaintiff engaged in protected activity; and (3) that the employer discriminated against the plaintiff because he or she engaged in protected activity." Id. Defendants argue that relator fails to allege that Humana knew that he was engaged in protected activity. Defendants contend that all relator has alleged is that he was engaged in job-related compliance duties, which the Ninth Circuit has held is not sufficient to put the defendant on notice of protected activity. See Hopper, 91 F.3d at 1269 ("the record quite clearly shows Hopper was merely attempting to get the School District to comply with Federal and State regulations", not that she was "investigating fraud"). Defendants also point out that relator alleges that as the Pharmacy Operations Manager for RightSource, one of his responsibilities was "pharmaceutical law compliance[.]"[56]

Relator had adequately alleged a FCA retaliation claim. Paragraph 35 alleges that relator "expressed concern regarding the justification for the additional dollar charge on Part D prescriptions."[57] Paragraph 46 alleges that "[u]nder Relator's direction, RightSource investigated the customer complaints" about mis-

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[56]Complaint at 2-3, ¶ 7, Docket No. 1.

[57]Id. at 9, ¶ 35.

selling.[58] Paragraph 47 alleges that "[r]elator repeatedly reported the illegal nature of these mis-selling tactics to Humana and its marketing arm, DMS."[59] Paragraph 72 alleges that "[d]espite Relator's efforts to curb violations of the Medicare laws and report illegal conduct . . . Defendants never took any significant action . . . ."[60] These allegations are sufficient to suggest that relator was investigating fraud, not just engaging in compliance activities. If, as defendants contend, relator's concerns were actually about compliance and could not have put defendants on notice that relator was investigating Medicare fraud, then relator will not have proven his retaliation claim. But, on a motion to dismiss, the court's task is only to determine whether relator has stated a claim that is plausible on its face, not whether relator has proven his claim.

Relator has also adequately alleged that defendants retaliated against him because of his protected activity. In paragraph 48, relator alleges that "Humana instructed Jennifer Renville, RightSource's interim Customer Service Manager, not to report solicitation problems to Relator."[61] In paragraph 66, relator again alleges that Renville was instructed to not "share any information

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[58] Id. at 11, ¶ 46.

[59] Id. at 15, ¶ 47.

[60] Id. at 22, ¶ 72c.

[61] Id. at 15, ¶ 48.

with Relator regarding any violations or customer service issues."[62] In paragraph 72e, relator alleges that in response to his reporting to Humana that RightSource was violating Medicare and pharmaceutical laws, "Fleming and Keller instructed Relator that he was not to report any concerns to state Pharmacy Boards or any other agencies, including, presumably, CMS."[63] In paragraph 144, relator alleges that he "was fired from his employment in retaliation for protected activities including investigating and opposing fraudulent practices by Humana and RightSource in violation of 31 U.S.C. § 3730(h)."[64] Paragraph 145 alleges that "[i]n retaliation for reporting improper conduct, Defendants . . . placed Relator on a corrective action plan on December 27, 2007. The plan prohibited Relator from discussing Defendants' conduct with most regulatory agencies (including CMS) and required him to destroy evidence implicating Defendants."[65] Relator's Count XI is not subject to dismissal.

Finally, defendants argue that the court should decline to exercise its supplemental jurisdiction over relator's state law claims in Counts XII and XIII. This argument is premised on defendants' contention that all of relator's federal claims are

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[62] Id. at 20, ¶ 66.

[63] Id. at 22, ¶ 72e.

[64] Id. at 44, ¶ 144.

[65] Id. at 45, ¶ 145.

subject to dismissal, which is not the case. The court will exercise its supplemental jurisdiction over Counts XII and XIII.

Conclusion

Defendants' motion to dismiss[66] is denied in part and granted in part. Counts I-IX of relator's complaint are dismissed with leave to amend. Count X is dismissed without leave to amend. Counts XI-XIII are not subject to dismissal.

Relator's amended complaint, should he choose to file one, shall be filed on or before May 9, 2011.

DATED at Anchorage, Alaska, this 7th day of April, 2011.

/s/ H. Russel Holland
United States District Judge

[66]Docket No. 29.