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UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

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MIDDLE DISTRICT OF FLORIDA
TAMPA, FLORIDA

UNITED STATES OF AMERICA, STATE OF
FLORIDA, STATE OF ILLINOIS, STATE OF
INDIANA, STATE OF LOUISIANA, STATE
OF NEW YORK, STATE OF GEORGIA and
STATE OF HAWAII ex rel. SEAN J. HELLEIN,

Plaintiffs,

CASE NO.8:06-CV-01079-T-30TGW

v.

WELLCARE HEALTH PLANS, INC.,
WELLCARE OF FLORIDA, INC.,
HARMONY BEHAVIORAL HEALTH,
INC., HEALTHEASE HEALTH PLANS
OF FLORIDA, INC., HEALTHEASE OF
FLORIDA, INC., AMERIGROUP
CORPORATION, AMERIGROUP
FLORIDA, INC., HUMANA MEDICAL
PLAN, INC., d/b/a HUMANA FAMILY,
VALUE OPTIONS, INC., FLORIDA HEALTH
PARTNERS, INC., FLORIDA BEHAVIORAL
HEALTH, INC., UNITED HEALTHCARE
OF FLORIDA, INC., UNITED HEALTH
GROUP, INC., UNITED HEALTHCARE
SERVICES, INC., d/b/a AMERICHOICE and
VISTA HEALTHPLAN, INC., d/b/a BUENA
VISTA, TODD FARHA, PAUL BEHRENS and
THADDEUS BEREDAY,

**FILED UNDER SEAL
PURSUANT TO 31 U.S.C
§3730(b)(2) DO NOT PLACE IN
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SYSTEM**

Defendants.

**SEVENTH AMENDED FALSE CLAIMS ACT COMPLAINT
AND DEMAND FOR JURY TRIAL**

1. SEAN J. HELLEIN (hereinafter "Relator" or "HELLEIN") brings this
action on behalf of the United States of America, the State of Florida, the State of Illinois,
the State of Indiana, the State of Louisiana, the State of New York, the State of Georgia,

and the State of Hawaii, against WELLCARE HEALTH PLANS, INC., (hereinafter "WELLCARE"), WELLCARE OF FLORIDA INC., formerly known as WellCare HMO, Inc., (hereinafter "WELLCARE OF FLORIDA"), HEALTHEASE OF FLORIDA, INC., (hereinafter "HEALTHEASE"), HARMONY BEHAVIORAL HEALTH, INC., (hereinafter "HARMONY"), HEALTHEASE HEALTH PLANS OF FLORIDA, INC., AMERIGROUP CORPORATION and AMERIGROUP FLORIDA, INC., (collectively "AMERIGROUP"), VALUEOPTIONS, INC. and FLORIDA HEALTH PARTNERS, INC, and FLORIDA BEHAVIORAL HEALTH, INC., (collectively "VALUEOPTIONS"), HUMANA MEDICAL PLAN, INC., d/b/a HUMANA FAMILY (hereinafter "HUMANA"), UNITED HEALTH GROUP, INC., and UNITED HEALTHCARE SERVICES, INC., d/b/a AMERICHOICE ("collectively "UNITED HEALTHCARE") and VISTA HEALTHPLAN, INC. d/b/a BUENA VISTA (hereinafter "VISTA") for treble damages and civil penalties for the Defendants' violations of the False Claims Act, 31 U.S.C. § 3729 et seq; the Florida False Claims Act, Florida Statutes 68.081 et seq; the Illinois Whistleblower Reward and Protection Act, Illinois Compiled Statutes Chapter 740, Act 175 et seq.; the Indiana False Claims and Whistleblower Protection Act; Indiana Code 5-11-5.5, et seq; the Louisiana Medical Assistance Programs Integrity Statute, Louisiana Revised Statutes § 437.13 et seq; the New York False Claims Act, New York State Finance Law § 187 et. seq; the Georgia False Medicaid Claims Act, Code of Georgia § 49-4-168; and the Hawaii False Claims Act, 36 Hawaii Revised Statutes 661-21 et seq.

2. The False Claims Act, 31 U.S.C. §. 3729, et seq., provides that any person who knowingly submits or causes to be submitted a false or fraudulent claim to the

Government for payment or approval is liable for a civil penalty of up to \$11,000 for each such claim submitted or paid, plus three times the amount of damages sustained by the Government. Liability attaches both when a defendant knowingly seeks payment that is unwarranted from the Government; and when false records or statements are knowingly created or caused to be used to conceal, avoid or decrease an obligation to pay or transmit money to the Government. The Act allows any person having information regarding a false or fraudulent claim against the Government to bring an action for himself (the "Relator") and for the Government and to share in any recovery by the Government. The Complaint is filed under seal for 60 days (without service on the defendants during that period) to enable the Government: (a) to conduct its own investigation without the defendants' knowledge; and (b) to determine whether to join the action.

3. As required by the False Claims Act, 31 U.S.C. § 3730(b)(2), the Relator has provided to the Attorney General of the United States, to the United States Attorney for the Middle District of Florida, and to the Attorney Generals of Florida, Illinois, Indiana, Louisiana, New York, Georgia, and Hawaii, a statement of all material evidence and information related to the Complaint. This disclosure statement is supported by material evidence known to the Relator establishing the existence of Defendants' false claims. Because the disclosure statement includes attorney-client communication and work product of Relator's attorneys, and is submitted to the Attorney General, to the United States Attorney, and to the various state attorneys general in their capacity as potential co-counsel in the litigation, the Relator understands this disclosure to be confidential.

Jurisdiction and Venue

4. This action arises under the False Claims Act, 31 U.S.C. § 3729 et seq. This Court has jurisdiction over this case pursuant to 28 U.S.C. § 1345, 28 U.S.C. § 1331, 31 U.S.C. § 3732 (a) and § 3730(b), and 28 U.S.C. § 1367.

5. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a), because the acts proscribed by 31 U.S.C. § 3729 et seq. and complained of herein took place in Hillsborough County within this District, and is also proper pursuant to 28 U.S.C. §§1391(b) and (c) because at all relevant times Defendants transacted business in this District.

Parties

6. Relator SEAN J. HELLEIN worked for Defendant WELLCARE as a Senior Financial Analyst. He was employed by WELLCARE from November 2002 through October 2007. Relator HELLEIN brings this action upon his direct, independent, and personal knowledge.

7. Defendant WELLCARE is a Delaware corporation licensed to operate as a health maintenance organization with its principal place of business in Tampa, Florida. In addition to Florida, WELLCARE conducts business in New York, Connecticut, Illinois, Indiana, Louisiana, Georgia and Hawaii. Medicaid programs administered by those states pay WELLCARE and the other named Defendants, who are related entities, monthly premium or capitation for managing the cost of providing medical services to Defendants' members, who are Medicaid beneficiaries. Virtually one hundred (100) percent of WELLCARE's revenues are derived from the Government, and the above named states through Medicaid and Medicare contracts.

8. Defendant HARMONY was the behavioral health department of Defendant WELLCARE until its incorporation in 2005.

9. Defendants HEALTHEASE OF FLORIDA, INC., and HEALTHEASE HEALTH PLANS OF FLORIDA, INC., are wholly owned and operated by WELLCARE and provide similar health management services in Florida under Medicaid contracts.

10. Defendant WELLCARE OF FLORIDA is wholly owned and operated by WELLCARE and was formerly known as WellCare HMO, Inc.

11. Defendant AMERIGROUP is a Delaware corporation with its principal place of business in Virginia Beach, Virginia. AMERIGROUP operates a health maintenance organization in Florida as Defendant AMERIGROUP FLORIDA, INC. Like WELLCARE, defendant AMERIGROUP derives substantially all of its revenues from the government and from state governments, through state programs for poor people. In Florida, it is paid fixed premiums by Florida Medicaid and other, similar programs in exchange for managing the costs of medical services provided to poor persons.

12. Defendant VALUEOPTIONS is a national managed care company based in Norfolk, Virginia that specializes in management of mental health and chemical dependency diagnoses. VALUEOPTIONS delivers behavioral health services to Medicaid recipients in Florida through FLORIDA HEALTH PARTNERS, INC., which is owned by VALUEOPTIONS and FLORIDA BEHAVIORAL HEALTH INC., a group of local mental health and substance abuse providers.

13. Some of the same persons have held senior executive positions in both defendant WELLCARE and defendants AMERIGROUP and VALUEOPTIONS. For

example, M.T. Sattaur, formerly WELLCARE's President of Florida Operations, was formerly CEO of defendant AMERIGROUP.

14. Although defendants WELLCARE, AMERIGROUP and VALUEOPTIONS compete for business in Florida and elsewhere, they also cooperate with each other by consciously making the same false claims against Florida Medicaid in order to reduce the likelihood that such false claims are detected because of discrepancies with respect to costs of the same services as reported to Medicaid by each company.

15. Defendants HUMANA MEDICAL PLAN, INC., d/b/a HUMANA FAMILY, UNITED HEALTHCARE OF FLORIDA, INC., and its related entities UNITED HEALTHGROUP INC. and UNITED HEALTHCARE SERVICES., d/b/a AMERICHOICE, and VISTA HEALTHPLAN, INC., d/b/a BUENA VISTA operate HMOs for Florida Medicaid recipients.

16. Defendant TODD FARHA was the Chief Executive Officer (CEO) of WELLCARE HEALTH PLANS, Inc. during all relevant times.

17. Defendant PAUL BEHRENS was the Chief Financial Officer (CFO) of WELLCARE HEALTH PLANS, Inc. during all relevant times.

18. Defendant THADDEUS BEREDAY was the Senior Vice President, Secretary and General Counsel of WELLCARE HEALTH PLANS, Inc. during all relevant times.

General Allegations

19. Medicaid is a cooperative federal-state welfare program that pays for providing medical assistance to needy people. Although Medicaid is managed by participating states, in Florida more than fifty-five (55) percent of the cost of the Florida

Medicaid program is currently paid by the United States Government and approximately forty-five (45) percent is funded by the State of Florida. Medicaid programs in New York, Indiana, Illinois, Connecticut, Louisiana, Georgia and Hawaii are funded through similar cost sharing arrangements, although proportions of federal-state funding vary from state to state.

20. Title 42 U.S.C. § 1320a-7b(a)(3) makes it a federal crime for anyone who has “knowledge of the occurrence of any event affecting . . . his initial or continued right” to any benefit or payment under a federal health care program to “conceal or fail to disclose such event with an intent fraudulently to secure such benefit or payment in a greater amount or quantity than is due. . . .”

21. The False Claims Act, 31 U.S.C. § 3729(a)(7), prohibits knowingly making, using, or causing to be made or used, “a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Government.”

22. Health management or health maintenance organizations (HMOs) that contract with the Medicaid and Medicare programs and who discover material errors or omissions in claims or supporting documents that result in overpayments, or that erroneously decrease or avoid their obligation to pay or transmit money to the Government or to a state, are required to timely disclose those errors or omissions to Medicaid or Medicare. Contractors are not free silently to accept windfalls from such errors, much less to exploit them by continuing knowingly to avoid repayment obligations, and by taking steps to conceal errors or omissions.

23. The Florida False Claims Act, Florida Statute § 68.082(2)(g), prohibits knowingly making, using, or causing to be made or used, “a false record or statement to

conceal, avoid or decrease an obligation to pay or transmit money or property to an agency.”

24. The Illinois Whistleblower Reward and Protection Act, Illinois Compiled Statutes, Chapter 740, Act 175/3, § 3(a)(7), prohibits knowingly making, using, or causing to be made or used, “a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the State.”

25. The Louisiana Medical Assistance Programs Integrity Law, Louisiana Revised Statutes § 438.3(C), provides that “[n]o person shall conspire to defraud, or attempt to defraud the medical assistance programs through misrepresentation. . .”

26. The Indiana False Claims and Whistleblower Protection Act, Indiana Code 5-11-5.5(B)(6) prohibits knowingly or intentionally making or using “a false record or statement to avoid an obligation to pay or transmit property to the State.”

27. The New York State False Claims Act, Finance Law § 189(1)(g), prohibits knowingly making, using, or causing to be made or used, “a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the State or a local government.”

28. The Georgia False Medicaid Claims Act § 49-4.168.1(a)(7), prohibits knowingly making, using, or causing to be made or used, “a false record or statement to conceal, avoid, or decrease an obligation to pay, repay or transmit money or property to the State of Georgia.”

29. The Hawaii False Claims Act, 36 Hawaii Revised Statutes 661-21(f), prohibits knowingly making, using, or causing to be made or used, “a false record or

statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State.”

COUNT I:

**Reverse False Claims In Violation of 31 U.S.C. § 3729(a)(7),
Florida Statute § 68.082(2)(g), and Illinois Compiled Statutes,
Chapter 740, Act 175/3, § 3(a)(7)**

30. Relator realleges and incorporates by reference paragraphs 1 through 29.

31. Defendant WELLCARE contracts with the Florida Medicaid program to manage the costs of providing outpatient behavioral health services, including Targeted Case Management and Community Mental Health, to Medicaid beneficiaries.

32. Paragraph 60.3.6 of WELLCARE’s contract with Florida Medicaid relating to Targeted Case Management and Community Mental Health services provides that “80 percent of the capitation paid to the plan shall be expended for the provision of behavioral health care services. In the event the plan expends less than 80 percent of the capitation the difference shall be returned to the agency no later than May 1 of each year.” The foregoing provision mirrors language in Florida Statutes, § 409.912(3)(b). WELLCARE’s contract with the Illinois Medicaid program contained a similar refund obligation and/or an off-setting deduction from future premium payment.

33. Prior to entering into the contract described above, Defendant WELLCARE and Florida Medicaid had entered into a comprehensive cost management agreement covering a range of in-patient, out-patient, emergency room, and pharmacy services, and specifically also including behavioral health services rendered for patients in hospitals, nursing homes, and similar in-patient settings.

34. Defendant WELLCARE’s pre-existing contract differed significantly from the contract for Targeted Case Management and Community Mental Health services in

that the pre-existing contract did not contain an obligation to repay Medicaid in the event capitation expended for services was lower than a targeted percentage.

35. Although Paragraph 60.3.6, above, refers to “behavioral health care services,” the parties well understood that its coverage was necessarily limited to Targeted Case Management and Community Mental Health services because in-patient, out-patient, emergency room, and pharmacy services were already covered under WELLCARE’s pre-existing comprehensive Medicaid contract.

36. As early as 2002, and continuing thereafter at least until the date of this Amended Complaint, Defendant WELLCARE knowingly and intentionally shifted and misallocated costs pertaining to the pre-existing Medicaid contract, by fraudulently and wrongfully categorizing expenses covered under the pre-existing contract as expenses covered under the Targeted Case Management and Community Mental Health services contract in order to reduce and avoid its premium repayment obligations.

37. In or about June 2004, WellCare repaid Florida Medicaid approximately \$6 million in Targeted Case Management and Community Mental Health services premium pertaining to years 2002 - 2003. Financial Analyst Greg West told Relator that “Todd [Farha] was frustrated that the Health Services team lacked the foresight to offset the 2002-2003 payback.” CEO TODD FARHA then directed Dr. Bill Kale, then head of WellCare’s behavioral health department, to come up with a plan under which WellCare could significantly reduce or avoid future Medicaid repayment obligations for Targeted Case Management and Community Mental Health services.

38. Pursuant to CEO TODD FARHA’s directive, Dr. Kale instructed Mr. West to include specified non-related services as costs to be associated with the

behavioral health program. Although these costs were unrelated to WellCare's Targeted Case Management and Community Mental Health services, by falsely reporting them as program expenses, WellCare was able to retain significantly more Medicaid premium than its legitimate 20% profit. TODD FARHA reviewed and approved Dr. Kale's and Mr. West's false cost add-ons. As a result of these fraudulently allocated costs, WellCare reduced its payback to the Florida Medicaid program for the years 2003 thru 2005 and caused losses to the Florida Medicaid program of approximately \$23 million.

39. As shown in **Exhibit 1** in 2005, WellCare received a total premium of \$30 million from Florida Medicaid in order to provide Targeted Case Management and Community Mental Health services. According to its contract with Medicaid, "in the event that WellCare expends less than 80% of the premium [\$24 million] the difference shall be returned" to Medicaid. WellCare's actual total medical costs as illustrated in **Exhibit 1** were \$15 million. Therefore, WellCare owed Florida Medicaid between \$9-12 million. Yet according to **Exhibit 1**, WellCare was presently considering the option of making an improper refund of only approximately \$700,000.

40. **Exhibit 2** is an e-mail from Greg West to Dr. Bill Kale and Director of Medical Economics Benjamin Orris, dated March 28, 2006. It describes a "rough draft of the AHCA payback for CY 2005; outpatient behavioral health for Medicaid." In this e-mail, Mr. West offered three possible payback options for 2005. Under Option 1, WellCare would pay back "\$0" to Medicaid, assuming WellCare employed the capitation scheme involving Harmony Behavioral Health, Inc. described below. Option 2 resulted in a payback of \$11.9 million. West said this amount assumed WellCare would not wrongfully include the \$4.91 per member/per month inpatient charges "we did last year."

(Inpatient expense is not a legitimate Targeted Case Management and Community Mental Health expense.) West's payback Option 3 offered a \$9.2 million improper compromise based on a wrongful calculation utilizing non-related expenses for 2005.

41. In April 2006, Defendant WELLCARE was erroneously informed by AHCA that Florida Medicaid had paid WELLCARE a total premium of \$24,878,587 for outpatient behavioral health services. WELLCARE, however, knew that the true premium amount paid by AHCA was \$30,310,183.

42. Although WELLCARE knew of this \$5.4 million overpayment, WELLCARE knowingly made and used false records to conceal, avoid and decrease WELLCARE's obligation to pay or transmit money to the Florida Medicaid Program.

43. In June 2006, Vice President of Medical Economics Peter Clay told Financial Analyst Greg West that WELLCARE needed to maintain the same reporting method used to hide \$10 million in the prior year.

44. Around June 16, 2006, CEO TODD FARHA decided to refund \$1.4 million of the over \$10 million due to AHCA.

45. Around April 6, 2007, WellCare fraudulently sent a payback check to the State of Florida for approximately \$1.1 million. Financial Analyst Greg West had previously calculated that the correct payback should have been approximately \$14.4 million for 2006. Greg West had provided that analysis to CFO PAUL BEHRENS and Actuarial Director Jian Yu. After receiving Greg West's analysis, Jian Yu came up with a fraudulent payback calculation methodology that reduced WellCare's 2006 payback obligation to approximately \$1.1 million.

46. Documents found by Relator in the MedEcon/Actuarial network printer in June 2006 show that WellCare had calculated its payback “exposure” under its Florida Healthy Kids contract at \$3,793,429 for the October 2004 – September 2005 period.

47. Defendant WELLCARE also knowingly and intentionally shifted and misallocated costs against its Illinois Medicaid contract in a similar manner.

48. On October 31, 2006, Director of Corporate Development Dave Firdaus asked “Why do we have so many different efforts going on to inflate costs in Illinois, why don’t we just create a shell company like we do in New York and the other states to avoid paying back the State?”

49. Documents found by Relator in the MedEcon/Actuarial network provider in June 2006 show that WELLCARE calculated its payback “exposure” under its Illinois Medicaid Contract for the April 2005-March 2006 period as \$2,704,486.

50. By misallocating costs pertaining to the pre-existing Medicaid contract, and capitalizing on AHCA’s error concerning actual premium amounts paid, WELLCARE, TODD FARHA and PAUL BEHRENS concealed, decreased and avoided its contractual and statutory obligation to repay and transmit money to the Government, and to the States of Florida and Illinois, through the Florida Medicaid Program and the Illinois Medicaid Program.

51. Due to the actions of Defendants WELLCARE, FARHA and BEHRENS, the United States, the State of Florida and the State of Illinois suffered damages and therefore are entitled to multiple damages under the Federal False Claims Act, the Florida False Claims Act, and the Illinois Whistleblower Reward and Protection Act, to be determined at trial, plus a civil penalty of \$5,500 to \$11,000 for each violation.

52. Based on the conduct of WELLCARE, FARHA and BEHRENS in Florida and Illinois, Relator believes that WELLCARE shifted and misallocated costs, entered improper capitation arrangements and concealed premium overpayments on a company-wide basis to avoid or minimize payback of refund obligations in other states.

COUNT II:

Reverse False Claims and False Claims Conspiracy in Violation of 31 U.S.C. § 3729(a)(3) and (a)(7) and Florida Statute § 68.082(2)(c) and (2)(g)

53. Relator realleges and incorporates by reference paragraphs 1 through 29.

54. Florida Medicaid funds the Florida Healthy Kids Corporation (“Healthy Kids” or “FHKC”) which has been empowered by the Florida Legislature pursuant to § 624.91(4)(b)(12), Florida Statutes, to enter into contracts with health maintenance organizations to provide comprehensive health insurance coverage, principally to poor children who do not qualify under other state Medicaid programs.

55. On or about October 1, 2003, Healthy Kids entered into a medical services contract with Defendant WELLCARE and its wholly owned subsidiaries, HEALTHEASE and WELLCARE OF FLORIDA. This contract provided for Healthy Kids to utilize HEALTHEASE’s provider network to deliver comprehensive health care services to all eligible children in Citrus, Duval, Escambia, Highlands, Martin, Putnam and Wakulla Counties; the provider network of Defendant WELLCARE OF FLORIDA was to be utilized for Broward, Miami-Dade, Hernando, Hillsborough, Lee, Orange, Osceola, Palm Beach, Pinellas and Seminole Counties. This medical services contract has been renewed and remained in effect as of the original filing date of this Complaint.

56. Paragraph III of the October 2003 Medical Services Contract, attached as **Exhibit 3**, provides as follows: