IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

The STATES of TENNESSEE and LOUISIANA *ex rel.* GREGORY FOLSE, Plaintiffs, v. MARQUIS "MARK" NAPPER, JOSHUA KILGORE, DANIEL BIRD, CARE SERVICES MANAGEMENT LLC, MARQUIS HEALTH SYSTEMS LLC, MARQUIS MOBILE DENTAL SERVICES LLC, and SALLY B DALY DDS LLC d/b/a FLEUR DE LIS MOBILE DENTAL, Defendants.	Civil Action No. 3:17-cv-01478 JUDGE TRAUGER Jury trial requested

COMPLAINT IN INTERVENTION

1. This action, brought by the States of Tennessee and Louisiana against the defendants named above, seeks civil penalties and treble damages under the Tennessee Medicaid False Claims Act, Tenn. Code Ann. §§ 71-5-181 to -185 (TMFCA) and the Louisiana Medical Assistance Programs Integrity Law, La. Rev. Stat. §§ 46:437 et seq. (MAPIL).

2. Defendant Care Services Management LLC (CSM) is a health services management organization that provides certain services to long term care (LTC) facilities. CSM contracts with mobile healthcare providers (CSM provider affiliates) to provide dental, podiatry, and telemedicine services to the elderly who reside in the LTC facilities with which CSM does business, primarily throughout the Southeast, including in Tennessee and Louisiana. It offers to provide these services at no additional cost to the facilities, the residents, or their families.

3. This business arrangement of CSM, the LTC facilities, and the CSM provider affiliates involved two types of illegal kickbacks which caused false claims to be filed with the Medicaid programs of Tennessee and Louisiana:

a. CSM provided valuable services to the LTC facilities at no cost in return for referrals to CSM by the LTC facilities of patients for dental, podiatry, and other services, and

b. CSM referred those same patients to its provider affiliates in return for cash payments.

4. Beginning in 2008 and continuing to the present, through these illegal kickback schemes, Defendants knowingly caused, or conspired to cause, the submission of false claims to Tennessee's and Louisiana's Medicaid programs. Upon information and belief, the States of Tennessee and Louisiana allege the following:

JURISDICTION AND VENUE

5. Relator filed his complaint on behalf of the United States, Tennessee, Louisiana, Georgia, and Virginia under the federal False Claims Act, 31 U.S.C. § 3729 et seq., the TMFCA, and the other states' false claims acts. This Court has subject matter jurisdiction over the TMFCA and the Louisiana MAPIL claims in this action under 28 U.S.C. § 1367(a) and 31 U.S.C. § 3732(b).

6. Venue lies in the Middle District of Tennessee pursuant to 28 U.S.C. § 1391(b) and 31 U.S.C. § 3732(a) because a substantial part of the events and omissions giving rise to the claims alleged occurred in this District and because Defendants Napper, Bird, CSM, Marquis Health Systems LLC (MHS), and Marquis Mobile Dental Services LLC (MMDS) operate and are located here.

7. This Court may exercise personal jurisdiction over Defendants Napper, Bird, and Kilgore pursuant to 31 U.S.C. § 3732(a) because they transacted business and/or lived in this District during the relevant period.

8. This Court may exercise personal jurisdiction over Defendants CSM, MHS, MMDS, FDLMD pursuant to 31 U.S.C. § 3732(a) because some are located in and transact business in this District.

THE PARTIES

PLAINTIFFS

9. Plaintiff State of Tennessee brings this action through the Tennessee Attorney General, on behalf of its state Medicaid program, known as TennCare. The Attorney General has standing to bring this action pursuant to Tenn. Code Ann. § 71-5-183(a).

10. Plaintiff State of Louisiana brings this action through the Louisiana Department of Justice, on behalf of its Medicaid program, known as Louisiana Medicaid. Louisiana's Attorney General has standing to bring this action pursuant to LSA – R. S. 46:438.1; 439.1(F).

DEFENDANTS

11. Defendant Care Services Management LLC (CSM) is a Tennessee limited liability company with a principal place of business at 2626 Merchants Walk, Murfreesboro, Tennessee.

12. Defendant Marquis Health Systems LLC (MHS) is a Tennessee limited liability company with a principal place of business at 2626 Merchants Walk, Murfreesboro, Tennessee.

13. Defendant Marquis Mobile Dental Services LLC (MMDS) is a Tennessee limited liability company with a principal place of business at 2626 Merchants Walk, Murfreesboro, Tennessee.

14. Defendant Marquis "Mark" Napper is a Tennessee resident, who lives in Rutherford County. Mr. Napper was an owner and Chief Executive Officer of CSM and MHS, and was the Chief Executive Officer of MMDS, during the relevant time and caused the submission of the false claims at issue in this case.

15. Defendant Joshua Kilgore is an Arkansas resident. Mr. Kilgore is the managing partner of CSM and MHS during the relevant time and caused the submission of the false claims at issue in this case.

16. Defendant Daniel Bird is a Tennessee resident. Mr. Bird is the owner of MMDS, and also had an ownership interest in CSM, during the relevant time and caused the submission of false claims at issue in this case.

17. Defendant Sally B Daly DDS LLC d/b/a Fleur De Lis Mobile Dental is a Louisiana limited liability company with a principal place of business at 11822 Justice Avenue, Suite B3, Baton Rouge, Louisiana 70816.

18. Unless otherwise noted, any reference to "CSM" in this complaint includes all defendants described above.

RELATOR

19. Relator Gregory Folse, D.D.S. is a Louisiana resident. He is a practicing dentist in Louisiana.

LEGAL AND REGULATORY BACKGROUND

THE MEDICAID/TENNCARE PROGRAM

20. The Medicaid Program, enacted under title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396 et seq., provides funding for medical and health-related services for certain individuals and families with low incomes and virtually no financial resources. Those eligible for Medicaid include pregnant women, children, and persons who are blind or suffer from other disabilities and who cannot afford the cost of healthcare. 42 U.S.C. § 1396d. The Medicaid program is a joint federal–state program. 42 U.S.C. § 1396b. If a state elects to participate in the program, the costs of Medicaid are shared between the state and the federal government. 42 U.S.C. § 1396a(a)(2). In order to receive federal funding, a participating state must comply with requirements imposed by the Social Security Act and regulations promulgated thereunder.

21. The State of Tennessee participates in the Medicaid program pursuant to Tenn. Code Ann. §§ 71-5-101 to -199. The federal government, through the Centers for Medicare & Medicaid Services (CMS), provides approximately 65% of the funds used by the Tennessee Medicaid program, and approximately 63% of the funds used by the Louisiana Medicaid program, to provide medical assistance to persons enrolled in the Medicaid program.

22. In return for receipt of federal subsidies, the States of Tennessee and Louisiana are required to administer their Medicaid programs in conformity with a state plan that satisfies the requirements of the Social Security Act and accompanying regulations. 42 U.S.C. §§ 1396–1396v; Tenn. Code Ann. § 71-5-102; LSA – R. S. 36:254. In Tennessee, the Department of Finance &

Administration (F&A) administers the state Medicaid program through the Division of TennCare. Tenn. Code Ann. § 71-5-104. TennCare operates as a special demonstration project authorized by the Secretary of the Department of Health and Human Services under the waiver authority conferred by 42 U.S.C. § 1315. F&A supervises TennCare's administration of medical assistance for eligible recipients. Tenn. Code Ann. §§ 71-5-105 to -107. F&A is authorized to promulgate rules and regulations to carry out the purposes of TennCare. Tenn. Code Ann. §§ 71-5-124 to -134.

23. TennCare contracts with private managed care contractors (MCCs) through contracts known as Contractor Risk Agreements (CRAs), which must conform to the requirements of 42 U.S.C. § 1395mm, along with any related federal rules and regulations. Tenn. Code Ann. § 71-5-128. The MCCs contract directly with healthcare providers to provide services to eligible TennCare beneficiaries, including the telemedicine services CSM provider affiliates provide. Providers who have entered into such a contract with an MCC are known as Participating Providers. Tenn. Comp. R. & Regs. § 1200-13-13-.01(91). Pursuant to the CRAs, TennCare distributes the combined state and federal Medicaid funding to the MCCs, which then pay Participating Providers for treatment of TennCare beneficiaries. TennCare-eligible persons seeking medical assistance enroll with an MCC to receive healthcare services from a Participating Provider.

24. In Louisiana, the Louisiana Department of Health (LDH) administers the state's Medicaid program. The LDH is authorized to take such actions as necessary to meet federal standards as are established for the administration and use of Medicaid funds granted to the state.

25. The Louisiana Medicaid program is generally comprised of two parts: 1) the legacy Medicaid program, which is a fee for service program where providers submit claims for reimbursement directly to the government through its fiscal intermediary; and 2) a managed care pro-

gram, currently known as Bayou Health, where LDH contracts with MCCs to administer the benefits provided to Louisiana Medicaid beneficiaries. Long-term care benefits in Louisiana are provided through the legacy Medicaid program, while dental benefits services are generally provided through the dental MCC.

26. TennCare and Louisiana Medicaid do not normally cover certain healthcare services, such as adult dental and optometry. However, residents who receive Medicaid assistance for their long-term care may deduct certain of those otherwise non-covered healthcare expenses from their payments to the LTC facility. TennCare and Louisiana Medicaid then make up the difference for those otherwise non-covered expenses when they pay the LTC facility. These Medicaid-reimbursed deductions are known as incurred medical expenses (IMEs).

TennCare/Louisiana Medicaid Patient Liability for LTC Facility Residents

27. The TennCare and Louisiana Medicaid programs are required to make long-term care available to eligible beneficiaries, including care in LTC facilities. 42 U.S.C. 13966a(a)(10); 1396d(a)(4).

28. An individual's eligibility for TennCare or Louisiana Medicaid coverage for LTC facilities is based on his or her financial situation and medical need. To be eligible financially, an individual cannot have more than $2,000 in assets (minus certain exempt assets such as a personal residence) and cannot have monthly income greater than 300% of the Social Security Income (SSI) Federal Benefit Rate. For 2021, that amount is $2,382 per month.

29. There are two categories of LTC facility residents in terms of their level of TennCare and Louisiana Medicaid coverage: 1) IME-eligible residents, and 2) zero-liability residents.

IME-Eligible Residents/SSI Residents

30. Incurred Medical Expense (IME)[1] is an income-offset mechanism by which the TennCare or Louisiana Medicaid program indirectly pays for medical expenses, not otherwise covered by Medicaid, for beneficiaries who live in LTC facilities. The cost of LTC facility care for residents who have a qualifying income is shared between the respective governmental program (TennCare or Louisiana Medicaid) and the beneficiary, with the governmental program's portion defined by federal regulation. Generally, TennCare pays an amount equal to the entire cost of care, less the beneficiary's income after certain enumerated expenses are deducted. 42 C.F.R. § 435.725(a); Tenn. Code Ann. § 71-5-147; Tenn. Comp. R. & Regs. 1200-13-20; LAC 50:II.10147. For TennCare, "patient liability" is the monthly amount that TennCare beneficiaries are required to contribute to the cost of their care if their incomes are at certain levels. The beneficiary's required patient liability is calculated based on the individual's total income after the allowable deductions. For Louisiana, "patient liability" is "a post-eligibility calculation used to determine the amount the [Medicaid] applicant/enrollee must pay to the LTC facility towards their monthly care." Louisiana Medicaid Eligibility Manual H-810.3.

31. The patient liability is determined by each state's Medicaid program according to federal and state laws and regulations. In Tennessee, TennCare's Member Services makes the patient liability determination. An income assessment of the beneficiary is performed when he or she first enters care. This includes an assessment of the optional and mandatory deductions for which the beneficiary is eligible.

32. When determining the patient liability, the allowable deductions from the patient's

[1] In Tennessee, "IME" was formerly referred to as "Item D" expenses. In the supporting documents to this complaint, both "IME" and "Item D" are used. They refer to the same deduction.

total income are: garnishments, some health insurance premiums and deductibles, personal needs allowance for clothing and other personal needs while residing in the facility, certain allowances for spousal or dependent maintenance, the cost of home maintenance, and incurred medical expenses not covered by TennCare or Louisiana Medicaid and allowed under the State Plan.

33. The patient liability is based on the Medicaid beneficiary's income assessment, i.e., the amount he or she will have to contribute to the LTC facility's monthly cost for his or her care. The state's Medicaid program will pay the remainder of the costs of the LTC facility. TennCare and Louisiana Medicaid require the LTC facilities to collect each Medicaid resident's patient liability.

34. For example, if the cost of the LTC facility is $4,000 per month, and the beneficiary's social security and other income is $1,000 a month, of which $200 qualifies for deduction, then the patient liability is $800, and TennCare or Louisiana Medicaid will pay the remaining $3,200.

35. The IME reimbursement mechanism most commonly applies to funds in a Qualified Income Trust (QIT), but it could also apply to beneficiary income that is not in a QIT.

36. Many TennCare beneficiaries use a QIT to secure eligibility for LTC facility coverage. A QIT is a trust account created specifically for the purpose of becoming eligible for TennCare LTC services. A QIT is a trust consisting of the individual's income. Any type of income may be directed into the QIT, although Social Security and pension income are among the more common.

37. A QIT can only be funded with an individual's income, so no other assets can be placed in a QIT. Distributions from a QIT are limited to payments for a monthly personal needs allowance for the beneficiary; a monthly maintenance allowance for a spouse, if any; and the cost

of medical assistance. The only beneficiaries of a QIT are the individual patient and the State of Tennessee, and "the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan [. . .] 42 U.S.C. § 1396p(d)(4)(B). In practice, the QIT usually receives all of a patient's income, pays the personal needs allowance, and then the remaining funds are used to pay for medical assistance, primarily the beneficiary's "patient liability" contribution for their nursing home care, so the balance of the account is $0 each month.

38. The IME deduction is governed by federal and state law. Generally speaking, a Medicaid beneficiary's income will be paid toward the cost of care in a LTC facility (patient liability), with TennCare and Louisiana Medicaid contributing the remainder. Federal and state rules permit certain deductions from the patient liability to include "necessary medical or remedial care recognized under State law but not covered under the state's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses." Id. at § 435.725(c)(4)(ii); 42 U.S.C. § 1396(a)(1)(A). "Reasonable limits" are defined in each State's Medicaid plan and vary state by state. Louisiana has not established limits on necessary but not covered care. Tennessee has a specified fee schedule.

39. The Fee Schedule that TennCare uses for dental IME is attached as Exhibit 1.

40. If a TennCare beneficiary in a LTC facility requires specialized care such as dentistry, the LTC facility is required to assist the resident in making appointments and by arranging transportation for residents to and from a dentist's office. 42 CFR 483.55(b). For Medicaid residents, they must also provide or obtain from an outside resource, without charge, emergency dental services. The nursing home is not required to provide routine dental services under TennCare. The same is true for residents residing in a Louisiana LTC facility.

41. However, dental services may generally be paid for out of a patient's QIT or other income. When a TennCare or Louisiana Medicaid beneficiary in an LTC Facility receives routine dental services, the beneficiary is responsible for payment. However, as a condition of receiving LTC facility benefits in the TennCare or Louisiana Medicaid programs, the beneficiary's income is entirely assigned to pay for the services they are receiving in the LTC facility (with the exception of minor personal and spousal allowances). The beneficiary, or his or her facility case worker must submit a request to TennCare or Louisiana Medicaid to pay for the dental care. TennCare or Louisiana Medicaid must then review the request and recalculate the mandatory deductions to the beneficiary's income. If the Medicaid program approves payment for the dental service as an IME, that decreases the beneficiary's patient liability to the LTC facility for future months by the amount of the IME, and the Medicaid program then increases its Medicaid payment to the LTC facility correspondingly to make up the difference.

42. With a resident in a CSM client LTC facility, CSM, MHS, MMDS, or FDLMD will prepare the appropriate paperwork on behalf of the resident and facility to submit to TennCare or Louisiana Medicaid for approval of the IME deductions.

43. Thus, when a beneficiary receives medical care that qualifies for an IME deduction, and it is approved, the TennCare program's or Louisiana Medicaid's reimbursement to the LTC facility on behalf of the resident includes the amount of the care that was provided to the resident.

44. Also, as of November 28, 2016, LTC facilities must "assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an IME" under the State Medicaid plan. 42 C.F.R. § 483.55(b)(5).

45. SSI makes up the bulk of the income for most of these IME-eligible residents. These residents are therefore sometimes referred to as "SSI residents" or "SSI patients."

Zero-Liability Patients

46. Finally, a small number of residents of LTC facilities do not have any SSI or other income to offset. These are known as "zero-liability residents."

47. The zero-liability residents in LTC facilities are not able to make use of IME deductions to pay for medical expenses. In order to utilize IME deductions to pay for non-covered medical expenses, the beneficiary must have some income to offset. If a TennCare or Louisiana Medicaid beneficiary does not have any income to offset, TennCare or Louisiana Medicaid pays the full cost for the LTC facility and the beneficiary is ineligible for IME deductions.

48. The Omnibus Budget Reconciliation Act of 1987 requires that Medicaid-certified LTC facilities conform to minimum accepted standards of care, including with respect to the provision of dental services. See 42 C.F.R. § 483.55. Among other requirements, LTC facilities must provide or obtain from outside resources emergency dental services. Id. at § 483.55(b)(1). CMS guidance defines "emergency dental services" to include "services needed to treat an episode of acute pain in the teeth, gums, or palate; broke, or otherwise damaged teeth, or any other problem of the oral cavity by a dentist that required immediate attention." CMS, State Operations Manual: Appendix PP—Guidance to Surveyors for Long Term Care Facilities § F411 (2011) and § F791 (2017). Nursing facilities must provide required care "without charge" to the resident, id. at § F412 and § F791, regardless of a resident's ability to pay. No provision is made for the facility to recoup money expended on these services.

THE ANTI-KICKBACK STATUTE

49. The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), (AKS) arose out of concern that financial inducements can improperly influence healthcare decisions and result in goods and

services being more expensive, medically unnecessary, or harmful to patients. To protect the integrity of government healthcare programs, the U.S. Congress prohibited the payment of kickbacks in any form, regardless of whether the kickback actually gives rise to overutilization or unnecessary care. The AKS also reaches kickbacks concealed as legitimate transactions. See Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare and Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

50. The AKS prohibits any person or entity from making, soliciting, or accepting payments to induce or reward any person for referring, recommending, or arranging for the purchase of any item for which payment may be made under a federal healthcare program. 42 U.S.C. § 1320a-7b(b). "Federal healthcare program," for purposes of the statute, means "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government," or, "any State health care program," which includes state Medicaid programs, such as TennCare and Louisiana Medicaid. Id. at s. 1320a-7b(e)(1)-(2); § 1320a-7(h).

51. The AKS has been interpreted to cover arrangements where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals. *United States v. Borrasi,* 639 F.3d 774, 782 (7th Cir. 2011); *United States v. McClatchey,* 217 F.3d 823, 835 (10th Cir. 2000); *United States v. Davis,* 132 F.3d 1092, 1094 (5th Cir. 1998); *United States v. Kats,* 871 F.2d 105, 108 (9th Cir. 1989).

52. Compliance with the AKS is a precondition to participation as a healthcare provider and for any payment or reimbursement under the TennCare and Louisiana Medicaid programs.

53. Compliance with the AKS is material to TennCare's decision to reimburse

healthcare services. To receive payment, providers participating in the TennCare program must expressly certify, in the Provider Agreement that they have complied with the applicable laws, rules, and regulations, including specifically, the AKS.

54. Any party convicted of violating the AKS must be excluded from participating in federal healthcare programs for at least five years. 42 U.S.C. § 1320a-7(a)(1). Even without a conviction, the Secretary of the Department of Health and Human Services (HHS) may exclude providers administratively found to have violated the AKS from participating in federal healthcare programs for a discretionary period (in which event the Secretary must direct the relevant state agency to also exclude the provider). HHS also may impose administrative sanctions of $50,000 per violation. Id. at § 1320a-7(b).

55. In addition to the penalties above, "a claim that includes items or services resulting from [an illegal kickback] constitutes a false or fraudulent claim for the purposes of [the federal False Claims Act]." Id. at § 1320a-7b(g).

TENNESSEE MEDICAID FALSE CLAIMS ACT

56. The TMFCA creates a cause of action for the State of Tennessee against any person who:

> (A) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval under the medicaid program;
>
> (B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim under the medicaid program;
>
> (C) Conspires to commit a violation of subdivision (a)(1)(A), (a)(1)(B), or (a)(1)(D); or

(D) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money, or property to the state, or knowingly conceals, or knowingly and improperly, avoids, or decreases an obligation to pay or transmit money or property to the state, relative to the medicaid program.

Tenn. Code Ann. § 71-5-182(a)(1) (Supp. 2013) (prior versions of the above provisions for the relevant period are substantially similar to this current version). Any such person is liable to the State of Tennessee for both treble damages and civil penalties "of not less than five thousand dollars ($5,000) and not more than twenty-five thousand dollars ($25,000)" per violation, subject to adjustment for inflation. *Id.*

57. The TMFCA defines "knowingly" to mean that a person, with respect to information:

(1) Has actual knowledge of the information;

(2) Acts in deliberate ignorance of the truth or falsity of the information; or

(3) Acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

Tenn. Code Ann. § 71-5-182(b). Accordingly, an individual who did not have actual contemporaneous knowledge of the falsity of claims or statements may nevertheless be liable under the TMFCA if the individual acted either in deliberate ignorance of or with reckless disregard to the claims' or statements' truth or falsity.

58. In this Complaint, whenever Plaintiff alleges that a defendant "knowingly" presented or caused to be presented a false claim, Plaintiff also alleges, in the alternative, that the defendant acted with "deliberate ignorance" or "reckless disregard" as those terms are used in the TMFCA or MAPIL.

59. The TMFCA defines "claim" to mean:

> any request or demand, whether under a contract or otherwise, for money or property and whether or not the state has title to the money or property, that is presented to any employee, officer, or agent of the state, or is made to any contractor, grantee, or other recipient, if the money or property is to be spent or used on the state's behalf or to advance a state program or interest, and if the state provides or has provided any portion of the money or property requested or demanded; or if the state will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

Tenn. Code Ann. § 71-5-182(c).

LOUISIANA MEDICAL ASSISTANCE PROGRAMS INTEGRITY LAW

60. The MAPIL, at LSA-R.S. 46:438.2 creates a cause of action on behalf of the Louisiana Medical Assistance Programs against any person who solicits, receives, offers, or pays any remuneration, including but not limited to kickbacks, bribes, rebates, or bed hold payments, directly or indirectly, overtly or covertly, in cash or in kind, for the following:

> 1. In return for referring an individual to a health care provider, or for referring an individual to another person for the purpose of referring an individual to a health care provider, for the furnishing or arranging to furnish any good, supply, or service for which payment may be made, in whole or in part, under the medical assistance programs.
>
> 2. In return for purchasing, leasing, or ordering, or for arranging for or recommending purchasing, leasing, or ordering, any good, supply, or service, or facility for which payment may be made, in whole or in part, under the medical assistance programs.
>
> 3. To a recipient of goods, services, or supplies, or his representative, for which payment may be made, in whole or in part, under the medical assistance programs.

61. Additionally, at LSA-R.S. 46:438.3, MAPIL creates a cause of action on behalf of the medical assistance programs against any person who:

A. Knowingly presents or cause to be presented a false or fraudulent claims;

B. Knowing engages in misrepresentation or makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claims;

C. Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the medical assistance programs, or to knowingly conceal, avoid or decrease an obligation to pay or transmit money or property to the medical assistance programs;

D. Conspires to defraud, or attempts to defraud, the medical assistance programs through misrepresentation or by obtaining, or attempting to obtain, payment for a false or fraudulent claims.

E. Knowingly submits a claim for goods, services, or supplies which were medically unnecessary or which were of substandard quality or quantity

62. MAPIL defines "knowingly" as the person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information. Claim is defined as any request or demand, whether under a contract or otherwise, for money or property, whether or not the state or department has title to the money or property, that is drawn in whole or in part on medical assistance programs funds that are either presented to an officer, employee, or agent of the state or department or made to a contractor, grantee, or other recipient, if the money or property is to be used in any manner in any program administered by the department under the authority of federal or state law, rule or regulation, and if the state or

department provides or has provided any portion of the money or property requested or demanded or reimburses the contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

63. Any person who violates the provisions of La R.S. 46:438.2 and 438.3 is liable to the state for actual damages, defined as the difference between what the medical assistance programs paid and what it would have paid had not a violation of this part occurred plus interest. Any person who violations LSA-R.s. 46:438.2 shall also be subject to a civil fine in an amount not to exceed ten thousand dollars per violation, or an amount equal to three times the value of the illegal remuneration, whichever is greater. A person who violates LSA-R.S. 46:438.3 shall be subject to a civil fine not to exceed three times the actual damages sustained by the medical assistance programs as a result of the violation. In addition to the above, any person who violates LSA-R.S. 46:438.2 or 438.3 shall be assessed a civil monetary penalty of not less than $5,500 but not more than $11,000 for each false or fraudulent claims, misrepresentation, illegal remuneration, or other prohibited act.

FACTUAL BACKGROUND

64. Defendant Napper founded MMDS in 2008 with Defendant Bird.

65. The early days of Defendant Napper's business (2008-2012) focused on providing mobile dental services to residents in LTC facilities and reaping lucrative IME-offset payments for them. Defendant Napper operated MMDS to have four functions: 1) market to and sign up client LTC facilities to provide mobile dental services to their residents, 2) obtain consents for treatment

from and then schedule residents at particular client LTC facilities for treatment, 3) treat the residents with MMDS-contracted dentists, and 4) generate invoices to be submitted to the state agency that approves IME deductions.

66. In Tennessee, that state agency is TennCare.

67. In Louisiana, that state agency is the Louisiana Department of Health (LDH).

68. An MMDS mobile dental unit typically treated 30 residents per day, and an MMDS mobile unit's daily revenue was approximately $10,000.

69. Defendant Napper grew this mobile dental business gradually over the next five years, adding more mobile units and roughly $1 million in additional collections with each year.

70. Up to 2013, Defendants Napper and Bird had only been collecting IME reimbursements for dental services. They wanted to branch out and collect IME money for additional healthcare services such as optometry, podiatry, audiology, psychology, and dermatology.

71. In 2013, Defendants Napper and Bird began franchising their mobile dental business model to healthcare providers to provide those additional services, as well as telemedicine services. They formed CSM in 2013 to allow them to group all these different healthcare specialty services—dental, optometry, podiatry, audiology, dermatology, and telemedicine—under one management company to offer their client LTC facilities "one stop shopping" for their residents' specialty healthcare.

72. Also with the formation of CSM in 2013, Defendants expanded their reach to other states. Upon information and belief, Defendants Napper and CSM affiliated with Louisiana dental provider FDLMD to contract with and perform dental services in Louisiana LTC facilities.

73. CSM's sister entity Defendant MHS provides the CSM provider affiliates with billing and collections services.

74. Defendant CSM coordinates services provided by its provider affiliates to its network of client LTC facilities, using mobile units, such as trailers outfitted to provide the particular healthcare services.

75. Defendant CSM offers its client LTC facilities healthcare services that are not "Covered Services" under the states' Medicaid programs, such as adult dental and optometry.

76. For example, in Tennessee and Louisiana, the state Medicaid programs include dental service as a "Covered Service" for individuals under age 21 but does not include dental services as a "Covered Service" for individuals aged 21 and older. So, if a dentist were to submit a claim for payment directly to one of the TennCare MCCs for dental services provided to an individual 21 or older, the MCC would not pay for it.

77. Defendant CSM claims to have a large network of client LTC facilities across the country, primarily in the Southeast, but also in California, Colorado, Ohio, Texas, and Missouri. In Tennessee, CSM claims to have 219 LTC facilities in its network, with 5,500 active residents with signed consents. In Louisiana, CSM provider affiliate FDLMD had contracts with approximately 100 nursing facilities, almost all of which contained a kickback clause.

78. At least as of April 2013, Defendant Kilgore joined Defendants Bird and Napper in the ownership and operation of CSM.

79. Defendants' pitch to potential client LTC facilities is twofold: 1) CSM will provide an array of specialist providers (both mobile and telemedicine), and 2) at no additional cost to the LTC facility, its residents, or their families. Defendants will take care of all the associated administrative duties so that all services are free to the facilities.

80. CSM touts the benefits to the LTC facilities: 1) ambulance transportation for off-site care is reduced, 2) transportation costs are significantly reduced, and 3) loss of revenue due to bed vacancies caused by hospitalizations is reduced.

81. Additionally, the LTC facility can highlight this free specialty care to all of its potential residents and their families.

82. Once a LTC facility agrees to use CSM and its provider affiliates, usually by signing a Letter of Participation and selecting the various specialty healthcare services it wants to make available to its residents, CSM will then coordinate with the client LTC facility to schedule the days for its various provider affiliates to be on-site and will also work with the LTC facility to schedule its residents to be treated by the CSM provider affiliate. A sample Letter of Participation and agreement is attached as Exhibit 2.

83. The CSM provider affiliates generally do not participate in scheduling residents for treatment.

84. Defendants' pitch to potential provider affiliates is: the provider will get a turn-key operation, complete with 1) an already established patient pool of IME-eligible residents and other TennCare or Louisiana Medicaid beneficiaries at the client LTC facilities, 2) a trailer, outfitted with the mobile equipment ready to treat patients, or, in the case of telemedicine, the telemedicine equipment, 3) all billing and collections services, 4) a standard services agreement to enter into with the LTC facilities that the provider gets assigned to, and 5) scheduling of the residents to be treated.

85. The provider affiliates pay CSM between $300,000 to $500,000 per mobile unit franchise.

86. Thereafter, once the provider affiliate begins visiting the LTC facilities, CSM and MHS take roughly 20% of the provider's income from treating the LTC facilities' IME-eligible residents. Usually the CSM provider affiliate agrees to pay CSM 12% of what is billed for the IME-eligible residents and agrees to pay MHS 8% of the money collected.

87. At least two of CSM's provider affiliates agreed on a flat fee kickback to CSM per patient referred by CSM for services.

88. Defendant Napper expects the mobile dental units to generate $100,000 a month in collections.

89. Essentially, CSM provides a franchised turn-key operation to reap large amounts of IME money, in addition to reimbursements for telemedicine services, and the affiliate providers just need to show up where they get scheduled and treat the patients that are scheduled. Defendants CSM, MHS, MMDS, and FDLMD take care of the rest.

SCHEMES OF FRAUD

SCHEME ONE: FREE SERVICES KICKBACKS

90. Defendant MMDS, and then later, Defendant CSM, and CSM provider affiliates, induced referrals of IME-eligible patients by providing kickbacks to their client LTC facilities.

91. To gain access to the lucrative pool of IME-eligible residents in LTC facilities, Defendants offered kickbacks in the form of free services. CSM provides administrative, scheduling, and communications services on behalf of the client LTC facilities at no cost to the facilities. CSM emphasizes in its marketing materials that all services are provided at no cost to the LTC facilities.

92. Additionally, CSM, and its provider affiliates offer free healthcare services to the facilities' zero-liability residents.

93. The value of the free dental services provided to zero-liability patients varied from patient to patient. For a general examination, the value from the dental fee schedule in the IME program was about $25. For a patient receiving a full set of dentures, the value of the services could exceed $1,500. In a set of zero-liability patients identified by CSM whose dental treatment records were reviewed by Tennessee, the average value of dental services provided to each patient per dentist visit was approximately $249.

94. This is a valuable benefit to the LTC facilities, because they otherwise have to provide or obtain from outside resources emergency dental care for their zero-liability residents per federal law. CSM's marketing materials emphasizes that it will coordinate its providers to visit facilities when emergencies arise. Additionally, non-emergency, routine dental care decreases the likelihood of the need for emergency dental care.

95. The CSM client LTC facilities also have a competitive advantage over other LTC facilities who did not enter into this kickback arrangement and thus do not have the ability to offer potential zero-liability residents and their families this free dental care.

96. At some point, taking into account the volume and value of the referrals vis-à-vis the kickback of free services, MMDS, and later CSM and its provider affiliates, established a ratio whereby they would provide free services to one zero-liability patient (this is one of the kickbacks) for every six IME-eligible patients that a facility referred to them.

97. CSM memorialized this kickback arrangement in a series of contracts with the client LTC facilities.

98. One of the things included in the turn-key mobile unit franchise is a form facility contract for the CSM provider affiliate to enter with the various LTC facilities that CSM assigns to the affiliate in its particular territory.

99. The CSM provider affiliates use the form facility contract supplied by CSM to contract with the LTC facilities. Many of the CSM and CSM affiliate provider facility contracts include exclusivity clauses, barring the LTC facilities from engaging the healthcare services of any non-CSM-affiliated providers.

100. The facility contract supplied by CSM includes the following provision:

> 4(e). SSI/Zero liability residents: Provider shall provide exam, cleanings, x-rays, extractions and prothesis adjustments annually. Residents are only eligible for this program if a resident does not have resources to pay for these dental services ("zero liability residents"), **Provider will provide these services annually at no additional cost, subject to a cap of one zero liability resident to every six Item-D [IME] eligible residents per unit visit.**

Exhibit 3, Sample CSM dental provider affiliate facility contract with client LTC facility, Para. 4(e) (emphasis added).

101. CSM even required this kickback provision to be included in some of its provider affiliate contracts with its client LTC facilities:

> [CSM] shall submit all Facility Contracts to Provider for final approval and acceptance, which said approval and acceptance shall not be unreasonably withheld. Provider shall have the right to reject Facility Contracts that fail to contain terms reasonably acceptable to Provider and such rejected Facility Contracts shall not count toward the minimum requirements of Section 4(b) above so long as said rejection is not arbitrary or unreasonable. **The ratio of non-pay to pay billing shall remain at or above one (1) non-pay billing to six (6) pay billings per Facility Contract.**

Exhibit 4, Sample CSM Services Agreement with a CSM provider affiliate, Para. 4(e) (emphasis added).

102. CSM tracked the patient liability status of the residents it scheduled for treatment by its contracted affiliate providers and would remove some zero-liability residents from the schedule if there were too many zero-liability residents.

103. This promise to provide free healthcare to a limited number of the LTC facilities' zero-liability residents in exchange for the referral of the exclusive pool of IME-eligible residents violates the AKS.

104. In addition to the offer of free medical services to the LTC facilities' zero-liability residents, CSM, MHS, MMDS, and FDLMD also provide kickbacks in the form of free administrative services to the LTC facilities. Specifically, CSM secures the patient consents for treatment; CSM then schedules residents for treatment; MHS, MMDS, and FDLMD prepare all the paperwork—including invoices for IME—for submission to TennCare or Louisiana Medicaid on the residents' and facilities' behalf; and CSM, MHS, MMDS, and FDLMD will then work directly with TennCare to coordinate approval and reimbursement for the healthcare services.

105. After a CSM affiliate provider provides healthcare services to a LTC resident in one of the CSM client facilities, MHS, MMDS, or FDLMD will prepare a packet to submit to TennCare or Louisiana Medicaid. This packet includes the itemized invoice for reimbursement for the services provided. It also includes the CSM patient consent for treatment form, a verification of services form, and a treatment notes, describing the healthcare services.

106. CSM, MHS, MMDS, or FDLMD will then follow up with TennCare or Louisiana Medicaid to seek the status of the approvals of the invoices for the services.

107. An example of one of the invoices is Exhibit 5. MMDS submitted this invoice to TennCare's Member Services for IME reimbursement for providing dental services to Patient X. Patient X was a resident at Grace Healthcare of Decatur.[2] That LTC facility was a CSM client facility and used the CSM standard agreement that included the six-for-one kickback arrangement.

[2] For privacy reasons, all patient-identifying information has been redacted from this exhibit and all other exhibits and claims data that have individual patient information. Unredacted versions of the exhibits, which identify the patients by name and identification numbers, will be served on Defendants.

108. Such an arrangement to provide remuneration (in the form of free administrative services and free healthcare services to a limited number of zero-liability residents) to induce patient referrals, the healthcare services for which are reimbursed by TennCare and Louisiana Medicaid, is a violation of the AKS.

109. Defendants knew they were paying remuneration to induce referrals of patients for services to be paid under a federal healthcare program.

110. Compliance with the AKS is material to TennCare's and Louisiana Medicaid's decisions to reimburse for IME deductions.

111. Claims for reimbursement for providing services to the illegally referred patients are false and submitted in violation of the TMFCA and the Louisiana FCA.

112. Defendants knowingly caused, or conspired to cause, the submission of false claims for payment to TennCare and Louisiana Medicaid and knowingly caused to be made or used false records material to false claims under the TennCare program and Louisiana Medicaid.

SCHEME TWO: KICKBACKS FOR REFERRING PATIENTS TO ITS CONTRACTED PROVIDERS

113. CSM also acted as a referral source for its affiliate providers—the contracted mobile and telemedicine providers—and received kickbacks in exchange for the referrals.

114. Once CSM signed up the residents referred to it by the LTC facilities and secured all of the consents from the residents or their guardians, CSM then had a large and lucrative pool of IME-eligible and other residents in its network.

115. CSM schedules when and at which LTC facilities its particular provider affiliates would need to go with their mobile units.

116. CSM also schedules the specific residents to be seen at each visit by its contracted provider affiliates.

117. In exchange for these patient referrals, the provider affiliates kick back to CSM roughly 20% of the TennCare/Louisiana Medicaid and other reimbursements for each of the residents treated, for both IME services and telemedicine services.

118. Sometimes, CSM will take a flat fee in exchange for the patient referrals to its provider affiliates. For example, CSM and one of its affiliate providers, Dr. John Cauthon, D.P.M., agreed that Dr. Cauthon would pay CSM $2.50 per patient that CSM referred. Another example is the agreement between CSM and another provider affiliate, Dr. Wayne Tasker, wherein Dr. Tasker would pay CSM $10 per referred encounter.

119. Dr. Cauthon is a podiatrist who treated patients in nursing homes.[3]

120. Unlike dental services, podiatry services are "Covered Services" under the TennCare program and also under Louisiana Medicare.

121. In the arrangement between CSM and Dr. Cauthon, CSM agreed to refer all patients at certain client LTC facilities for regular podiatry services to Dr. Cauthon, and Dr. Cauthon agreed to pay CSM $2.50 for every patient he treated at these facilities.

122. When Dr. Cauthon visited the nursing homes, he submitted claims for the patients that he treated directly to the TennCare program, Medicare, and other healthcare programs.

123. The claims to the TennCare program for services that Dr. Cauthon purported to provide to patients referred by CSM were false claims because he illegally obtained the referrals through the payment of a cash kickback.

[3] In September 2017, Dr. Cauthon was convicted of healthcare fraud in the U.S. District Court for the Middle District of Tennessee for submitting claims for podiatry services at nursing facilities that he did not perform. At sentencing, the court found that Dr. Cauthon submitted claims for over $200,000 of services that he did not perform, and Dr. Cauthon was ordered to pay restitution of over $80,000 for payments that he received for services he did not perform.

124. CSM caused these false claims to be submitted by soliciting kickbacks in exchange for the referral of these patients to Dr. Cauthon, knowing he would submit claims for payment to Medicaid and other government healthcare programs.

125. An example of a claim submitted under this scheme is the treatment of Patient Y for a nail debridement and nursing facility care on January 27, 2015 at Alamo Nursing and Rehabilitation Center in Alamo, Tennessee. Exhibit 6 is the TennCare data showing its submission and payment.

126. Dr. Tasker provides behavioral health services via telemedicine to residents in LTC facilities.

127. Like podiatry services, many of the telemedicine services provided by Dr. Tasker are "Covered Services" under the TennCare program.

128. In the arrangement between CSM and Dr. Tasker, Dr. Tasker agreed to pay CSM $10 per telemedicine encounter for patients that CSM referred to him.

129. When Dr. Tasker provided telemedicine services to residents in CSM client facilities, he would submit the claims directly to a TennCare MCC for payment.

130. These claims submitted to the TennCare program are false claims because he illegally obtained the referrals through payment of a cash kickback.

131. An example of a claim submitted under this scheme is the treatment of Patient Z for psychotherapy services for bipolar disorder at the Spring City Care and Rehab facility on September 12, 2013. Exhibit 7 is the TennCare claims data showing its submission to and payment by TennCare.

132. These kickback arrangements between CSM and its contracted providers incentivized CSM to schedule as many of its IME-eligible residents for treatment by its affiliate providers

as possible, rather than the patients' course of treatment being primarily driven and guided by the providers' medical decision making.

133. Defendants knew they were soliciting remuneration in return for referring residents to their contracted providers to provide services for which payment may be made under a federal healthcare program.

134. Such arrangements are in violation of the AKS.

135. Compliance with the AKS is material to TennCare's decision to reimburse for IME, podiatry services, and telemedicine services.

136. Claims for reimbursement for providing these services to the illegally referred patients are false and submitted in violation of the TMFCA and the Louisiana FCA.

137. Defendants knowingly caused, or conspired to cause, the submission of false claims for payment to TennCare and Louisiana Medicaid.

RESULTS OF THE SCHEMES OF FRAUD

138. Under these illegal relationships, CSM induces LTC facilities to refer its lucrative IME-eligible residents to CSM. CSM then offers, in exchange for cash payments, to refer these residents to providers who they know will seek reimbursement from TennCare and Louisiana Medicaid for those services.

139. These kickback-induced referrals of IME-eligible residents were profitable for the Defendants. From 2016 through May 2019, the scheme resulted in TennCare paying Defendants and their affiliates over $5.8 million for kickback-tainted claims just for dental services.

140. From November 2014 through November 2018, the scheme resulted in Louisiana Medicaid paying defendants and their affiliate providers over $6 million for kickback-tainted claims for dental services.

141. This arrangement worked well for the Defendants, their provider affiliates, and the client LTC facilities: Defendants and their provider affiliates profited by providing healthcare services that are not normally covered by Medicaid to a steady pool of IME-eligible and other patients, and the LTC facilities saved the expense and resources of the administrative services required to prepare and submit all the paperwork for IME reimbursement, as well as the expense of emergency dental treatment and transportation costs.

142. However, under this scheme, the TennCare program and Louisiana Medicaid ended up paying millions of dollars for treatment of illegally referred patients. All such claims for payment for the treatment of the illegally referred patients are false and in violation of the TMFCA and MAPIL.

143. In 2018, MMDS billed and collected over 60% of all IME money that TennCare reimbursed for dental services.

144. Indeed, TennCare, perceiving a high rate of overutilization by MMDS, prepared to implement more oversight into the IME invoice process in early 2020.

145. However, before TennCare was able to implement the additional controls and oversight, CSM required the IME-eligible residents in its network to join a dental insurance program CSM offered in order "to ensure dental services are provided at no out-of-pocket expense." Exhibit 8. CSM then sought reimbursement from TennCare for the insurance premiums for this new dental insurance product.

146. These insurance premium reimbursement requests are also false, as the residents for whom they were requested were illegally referred under the first scheme of fraud described above.

LEGAL CLAIMS

STATE OF TENNESSEE

COUNT ONE

Defendants knowingly caused false or fraudulent claims to be presented under the TennCare program

147. The State of Tennessee re-alleges by incorporating herein by reference the allegations in ¶¶ 1-146.

148. By and through the acts described above, from 2013 through 2020, Defendants knowingly caused false or fraudulent claims to be presented for payment or approval under the TennCare program in violation of the TMFCA. Tenn. Code Ann. § 71-5-182(a)(1)(A).

149. Specifically, by submitting or causing to be submitted claims for reimbursement to the TennCare program for treating patients whose referrals were induced by illegal kickbacks, Defendants caused false claims to be submitted under the TennCare program.

150. As a result of Defendants' knowingly causing false claims for payment to be presented under the TennCare program, the State has suffered damages, in an amount to be determined at trial, and is entitled to a civil penalty of $5,000 to $25,000 for each violation plus treble damages.

COUNT TWO

Defendants conspired to cause false claims to be presented under the TennCare program

151. The State of Tennessee re-alleges by incorporating herein by reference the allegations in ¶¶ 1-146.

152. By and through the acts described above, from 2013 through 2020, Defendants Napper, Kilgore, and Bird conspired to cause false claims to be presented for payment or approval under the TennCare program in violation of the TMFCA. Tenn. Code Ann. § 71-5-182(a)(1)(C).

Specifically, by agreeing with that their companies would submit "invoices" for kickback-tainted claims for reimbursement, Defendants conspired to cause false claims to be presented for payment or approval under the TennCare program.

153. As a result of this conspiracy, the State has suffered damages, in an amount to be determined at trial, and is entitled to a civil penalty of $5,000 to $25,000 for each violation plus treble damages.

COUNT THREE

Unjust Enrichment

154. The State of Tennessee re-alleges by incorporating herein by reference the allegations in ¶¶ 1-146.

155. By and through the acts described above, from 2013 through 2020, Defendants wrongfully received and retained the benefit of government monies paid by TennCare for services that were provided after being induced by illegal kickbacks and were therefore false. Specifically, the claims for IME reimbursement were for services provided to patients referred in exchange for illegal kickbacks.

156. The monies received by Defendants from TennCare was a benefit from the State.

157. Defendants were unjustly enriched with those government monies from TennCare, which they should not in equity and good conscience be permitted to retain, and which Defendants should account for and disgorge to Tennessee, in an amount to be determined at trial.

COUNT FOUR

Payment by Mistake

158. The State of Tennessee re-alleges by incorporating herein by reference the allegations in ¶¶ 1-146.

159. By and through the acts described above, from 2013 through 2020, TennCare paid the false IME claims based upon mistaken or erroneous understandings of material fact. Specifically, Defendants' invoices were for treating patients who were referred in exchange for illegal kickbacks.

160. TennCare, without knowledge of the falsity of Defendants' IME claims, mistakenly paid Defendants certain sums of money to which they were not entitled.

STATE OF LOUISIANA

COUNT ONE

161. The State of Louisiana re-alleges by incorporating herein by reference the allegations in ¶¶ 1-146.

162. By and through the acts described above, from November, 2014, through November, 2018, the defendants violated LSA-R.S. 46:438.2 by soliciting, receiving, offering, or paying any remuneration, including but not limited to kickbacks or bribes directly or indirectly, overtly or covertly, in cash or in kind:

a. in return for referring an individual to a health care provider or for referring an individual to another person for the purpose of referring an individual to a health

care provider for the furnishing or arranging to furnish any service for which payment was made, in whole or in part, under the Louisiana medical assistance programs;

b. In return for arranging for or recommending any service or facility for which payment may be made, in whole or in part, under the medical assistance programs.

163. As a result of the above actions, the State of Louisiana has suffered damages in an amount to be proven at trial and is entitled to the greater of a civil fine of up to $10,000 dollars per violation or three times the value of the illegal remuneration and a civil monetary penalty of no less than $5,500 and no more than $11,000 for each act of illegal remuneration.

COUNT TWO

CSM, Mark Napper, and FDLMD caused false claims to be submitted to the Louisiana Medicaid Program

164. The State of Louisiana re-alleges by incorporating herein by reference the allegations in ¶¶ 1-146.

165. By and through the acts described above, from November, 2014, through November, 2018, the defendants CSM, Mark Napper and FDLMD violated LSA 46:438.3 by knowingly causing to be presented false and fraudulent claims to be paid under the Louisiana medical assistance programs.

166. Specifically, by causing the CSM provider affiliate FDLMD to submit claims for reimbursement to the Louisiana medical assistance programs for treating patients whose referrals were induced by illegal kickbacks, Mr. Napper and CSM caused false claims to be submitted under the Louisiana medical assistance programs that were induced by an illegal kickback or remuneration in violation of the federal AKS and LSA – R.S. 46:438.2

167. As a result of the above actions, the State has suffered damages, in an amount to be determined at trial, and is entitled to a civil penalty of no less than $5,500 and no more than $11,000 for each violation plus treble damages.

PRAYER FOR RELIEF

WHEREFORE, the States of Tennessee and Louisiana respectfully request this Court grant the following relief against the defendants:

a) Damages to be proved at trial, believed to exceed $12,000,000, trebled as required by Tenn. Code Ann. § 71-5-182(a) and LSA – R. S. 46:438.6;

b) Civil penalties up to the statutory amount as provided by Tenn. Code Ann. § 71-5-182(a) and LSA – R. S. 46:438.6 for each violation;

c) Pre-judgment and post-judgment interest; and

d) Any additional remedies the Court finds fair and just.

The States of Tennessee and Louisiana further respectfully request a jury trial.

Respectfully submitted,

STATE OF TENNESSEE

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