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RICHARD W. NAGEL
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U.S. DISTRICT COURT
SOUTHERN DIST. OHIO
EAST. DIV. COLUMBUS

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION (COLUMBUS)

UNITED STATES OF AMERICA, and the STATE of OHIO,	:	Case No. 2:15CV2628
Plaintiffs,	:	Judge Judge Watson
	:	MAGISTRATE JUDGE KING
ex rel.	:	**COMPLAINT**
RUEBEN MILLER,	:	
Relator,	:	**Filed Under Seal Pursuant to 31 U.S.C. § 3730(b)(2)**
v.	:	
ACADEMY HEALTH SERVICES, INC.	:	**Jury Trial Demanded**
Defendant.	:	

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I. INTRODUCTION

1. *Qui tam* Relator Rueben Miller brings this action in the name of the United States Government under the False Claims Act for false claims involving Academy Health Services, Inc. ("Defendant" or "Academy"). As a licensed practical nurse ("LPN"), Relator Miller witnessed Defendant's illegal Medicaid billing practices regarding his home health care patients and other patients receiving care from Defendant, almost all of whom were developmentally disabled individuals.

2. Relator Rueben Miller became aware of his former employer's False Claims Act violations and other illegal practices described in this Complaint from his own direct observations of Defendant's practices while working for Defendant as an LPN. Mr. Miller worked five days a week, providing services twice daily to his Academy patients. Most of Mr. Miller's nursing and home health services were provided in a group setting, where two or more developmentally disabled patients typically resided. A few additional patients resided in locations where there were no other Academy patients.

3. Defendant maintains a policy of over-billing Medicaid for home nursing services provided to developmentally disabled and other patients. Academy bills Medicaid for home health patients who are seen by Academy home health workers in a group setting as if those patients were seen individually and not at the same location as other patients. Academy charged Medicaid a higher rate applicable to services rendered in an individual setting, rather than the lower amount applicable to services provided in a group setting.

4. Defendant's practices violate Medicaid regulations and the applicable Ohio Medicaid billing provisions. In order to be eligible for Medicaid reimbursement in Ohio, Defendant is required to discount its billing for home health care services when services are

provided to patients in a group setting. By failing to apply the group setting discount for home health care services, Defendant has and continues to fraudulently overcharge Medicaid.

5. By failing to apply the required group setting discount, Defendant submitted or caused to be submitted to the United States Government and the State of Ohio fraudulent Medicaid billings for individual setting services not provided and "upcoded" or falsely stated the services provided from group setting service to individual setting service.

6. Defendant also violated the federal Anti-Kickback Statute by paying patients' "spend-down" amounts—the medical expenses necessary to render the patients Medicaid-eligible. These improper payments permitted Defendant to artificially increase the number of Medicaid-eligible clients and overbill Medicaid for its services.

7. This case is brought pursuant to the Federal False Claims Act *qui tam* provisions, 31 U.S.C. § 3729 *et seq.*, to recover treble damages and civil penalties on behalf of the United States of America arising from false or fraudulent claims for reimbursement for medical treatment that were submitted or caused to be submitted by Defendant to the Federal and Ohio Governments in violation of the False Claims Act. The False Claims Act specifically proscribes Defendant's conduct involving fraudulent billing and, thus, the submission of false or non-reimbursable claims to Medicaid and other Government-funded health programs

8. Relator Rueben Miller became aware of the False Claims Act violations and other illegal practices described in this Complaint from his own direct observations of Defendant's practices when he worked for Defendant as an LPN.

9. Relator brings this action on behalf of himself and the United States of America for violations of the United States False Claims Act.

10. Defendant's False Claims Act violations and its various fraudulent billing schemes unlawfully increased costs to the United States for medical services. Defendant knew or should have known that its unlawful activities constituted filing false claims for reimbursement from the Federal Government in violation of the False Claims Act and involved violations of Medicaid regulations and similar State laws.

11. Defendant's scheme illegally charged Government health programs and insurance plans for medical treatment that was not provided and overcharged Government health programs and plans for covered treatment. The Federal and Ohio Governments consequently paid claims that they would have rejected had they been aware of Defendant's illegal actions. Moreover, as a result of Defendant's illegal billing practices, reimbursement costs to the Federal Government increased.

II. JURISDICTION AND VENUE

12. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confer jurisdiction on this Court over actions brought pursuant to 31 U.S.C. §§ 3729 and 3730.

13. This Court has personal jurisdiction over the Defendant pursuant to 31 U.S.C. § 3732(a) because acts prohibited by 31 U.S.C. § 3729 occurred in this State and this judicial district, particularly in Knox County, Ohio, where Mr. Miller formerly was employed by Defendant Academy. Venue is proper in this district pursuant to 31 U.S.C. § 3732(a) because one or more acts proscribed by 31 U.S.C. § 3729 occurred in this district, including, but not limited to, fraudulent billing for Medicaid-funded home health care services rendered in group settings.

14. In accordance with 31 U.S.C. § 3730(b)(2), this Complaint is filed under seal and will remain under seal for a period of at least 60 days from its filing date or such other date as is required by law or the Court so orders, and shall not be served upon Defendant unless the Court so orders.

15. This suit is not based upon prior public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, lawsuit or investigation, in a Government Accountability Office or Auditor General's report, hearing, audit, or investigation, from the news media, or in any other location as the term "publicly disclosed" is defined in 31 U.S.C. § 3730(e)(4)(A), amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1313(j)(2), 124 Stat. 901-902 (2010).

16. To the extent that there has been a public disclosure of the information upon which the allegations of this Complaint are based that is unknown to Relator, Relator is an original source of this information as defined in 31 U.S.C. § 3730(e)(4)(B), amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1313(j)(2), 124 Stat. 901-902 (2010). Relator possesses direct and independent knowledge of the information as a result of his employment with Defendant and investigations made into Defendant's billing practices after his employment with Defendant ended. Relator voluntarily and affirmatively disclosed the allegations herein to the Department of Justice prior to filing this Complaint. *See* 31 U.S.C. § 3730(e)(4).

III. PARTIES

A. Relator Rueben Miller

17. Relator Rueben Miller is a Licensed Practical Nurse and resides in Ohio. Relator has worked as an LPN for 4 years. Relator Miller worked for Defendant performing skilled nursing home health care services for approximately two years, between January 2012 and March 2014. Almost all of Relator Miller's patients were developmentally disabled and eligible for Medicaid. Relator Miller's home health patient assignments were issued from Defendant's Mt. Vernon, Knox County, Ohio office. Relator Miller has additional experience working as an LPN for another home health agency and has also worked at a long term care facility and a VA clinic in Columbus, Ohio.

18. During his employment at Academy, Relator Miller routinely visited patients in their residences to perform nursing services. Among other nursing duties, Relator Miller administered medications and coordinated care with physicians.

19. Relator Miller typically visited his patients twice per day. For each visit, Relator Miller prepared time sheets for the patient to sign.

20. The vast majority of Relator Miller's patients lived in residences housing more than one patient. Although some of these residences were private residences, several were small group homes managed by private companies. These companies contracted with Defendant for the provision of home nursing services to their residents.

21. Defendant paid Relator Miller and other LPNs a portion of the amount Defendant charged its clients for in-home nursing visits.

22. Defendant paid Relator Miller the same amount for every patient for whom he provided care, whether they lived in an individual setting or a group setting.

23. Defendant based Relator Miller's pay on the amounts it charged Medicaid, which is the individual service rate without applying the group setting rate reduction.

B. Defendant Academy Health Services, Inc.

24. Defendant Academy Health Services, Inc. is an Ohio corporation engaged in the business of providing home nursing and other health care services. Defendant operates in Ohio, Illinois, and Indiana.

IV. REGULATORY FRAMEWORK

A. Federal Government Health Programs

25. The Federal and State Governments, through Government health programs including Medicaid, are among the principal payors for medical services rendered by medical providers affiliated with Defendant. The allegations in this Complaint apply to claims reimbursed by Medicaid.

26. Medicaid is a public assistance program that provides payment of medical expenses for low-income patients. Congress created Medicaid in 1965 when it adopted Title XIX of the Social Security Act. Funding for Medicaid is shared between the Federal Government and those State Governments choosing to participate in the program, including Ohio. The Federal Government separately matches certain state expenses incurred in administering the Medicaid program.

27. Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS), a federal agency which sets standards and regulations for participation in the programs. The Ohio Department of Medicaid administers Ohio's Medicaid program.

28. The Medicaid programs work by reimbursing health care providers for the cost of services and ancillary items. Medicaid is supposed to reimburse health care providers, such as Defendant, only for those services that were actually performed. The Medicaid administrators rely on direct and implied representations by providers, reimbursable in whole or in part, that the services billed by the providers are actually performed as billed and are compensable by law.

29. CMS utilizes a standardized coding system known as the Healthcare Common Procedure Coding System ("HCPCS"). The HCPCS and other similar coding systems establish uniform national definitions of services, codes to represent services, and payment modifiers to the codes. The HCPCS identifies with particularity the nature of the service performed.

30. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II. Level I of the HCPCS is comprised of Current Procedural Terminology ("CPT") codes, a numeric coding system for medical services maintained by the American Medical Association (AMA). Each CPT code consists of five numeric digits. Level II, which is maintained and distributed by CMS, identifies products, supplies, and services not included in the CPT codes. Each Level II code consists of a single alphabetical letter followed by 4 numeric digits.

31. Level II codes beginning with the letter "G" are temporary codes used to identify professional health care procedures and services that would otherwise be coded in the CPT but for which there are no CPT codes. CMS identifies direct skilled nursing and other services offered in the home health or hospice setting by several G-series Level II HCPCS codes. Ohio uses G-Series codes for home health services provided under the Ohio Medicaid Adult State Plan.

32. Level II codes beginning with the letter "T" are temporary codes designated for use by Medicaid state agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need. In addition to G-series codes for home health services, Ohio uses codes in the T-series for nursing and personal care aide services specifically provided under the Ohio Home Care Waiver Program, a State Medicaid program permitting financially eligible individuals aged 59 or younger who require hospital or nursing home care to receive nursing and other services at home. As part of the HCPCS, CMS also established two-digit payment modifiers. These modifiers are used when the information provided by a HCPCS code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service. The modifier "HQ" applies to services performed in a "group setting."

33. Under Medicaid, states set the compensation rates for HCPCS Level II codes and modifiers by assigning provider reimbursement payment amounts. Ohio regulations require that providers add a modifier "HQ" to the G-Series or T-Series payment code when home nursing or personal care aide services are performed in a group setting. When the HQ modifier applies, a provider of those services may charge at most seventy-five percent of the Medicaid maximum rate for those services. *See* Ohio Admin. Code 5160-12-04(D); 5160-12-05(D); 5160-46-06(D)(1). Ohio defines "group setting" as a situation where a nursing and/or personal care aide furnishes the same type of services to two or three individuals at the same address. *See* Ohio Admin. Code 5160-46-06(A)(4).

34. Medicaid requires that the home health services had to be physically performed and billed accurately and according to CMS policies and procedure codes. CMS requires healthcare providers' certifications that they complied with all laws and regulations governing

the provision of health care services. This includes Ohio regulations requiring the application of the HQ modifier for services performed in a group setting. These certifications are an absolute condition precedent to retaining the Medicaid funds conditionally advanced by the United States and the State of Ohio, and a prerequisite to continued future participation in Medicaid. Without such certification, Defendant is required to repay all payments previously received. But for Defendant's certifications of compliance with these coding requirements, impliedly or otherwise, the United States and the State of Ohio would not reimburse Defendant for claimed services. *See* 42 U.S.C. § 1395bbb; 42 C.F.R. § 484.12; Ohio Admin. Code 5160-1-17.2; Form 1500 OMB-0938-1197.

B. The False Claims Act

35. Originally enacted in 1863, the False Claims Act was substantially amended in 1986. The 1986 Amendments enhanced the Government's ability to recover losses sustained as a result of fraud against the United States. The Act was again amended in 2009 and 2010, further strengthening the law.

36. The False Claims Act provides that any person who knowingly presents or causes another to present 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, plus three times the amount of the damages sustained by the Government. 31 U.S.C. § 3729(a)(1), (2). The False Claims Act empowers private persons who have information regarding a false or fraudulent claim against the Government to bring an action on behalf of the Government and to share in any recovery. The complaint must be filed under seal without service on any defendant. The complaint remains under seal while the Government conducts an investigation of the allegations in the complaint and determines whether to join the action.

37. Knowingly billing a Government health care program for services that were not provided as stated violates the False Claims Act.

C. The Anti-Kickback Statute

38. The federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b) ("AKS"), prohibits knowingly and willfully offering, paying, soliciting or receiving any remuneration to induce a person (a) to refer an individual to a person for the furnishing of any item or service covered under a federal health care program; or (b) to purchase, lease, order, arrange for or recommend any good, facility, service or item covered under a federal health care program. 42 U.S.C. § 1320a-7b(b)(1) and (2). A violation of the AKS constitutes a felony punishable by fines of up to $25,000 and imprisonment for up to five years.

39. Unlawful remuneration is broadly interpreted to include any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind, for referrals, subject to specific exclusions. 42 U.S.C. § 1395nn(h)(1)(B); 42 C.F.R. § 411.351. Further, the AKS is violated if even one purpose of remuneration is to induce referrals, even if other, legitimate purposes are also present. U.S. v. Greber, 760 F.2d 68, 69 (3d Cir. 1985), *cert. denied*, 474 U.S. 988 (1985).

40. Compliance with the AKS is expressly and impliedly required for reimbursement of federal program claims, and claims made in violation of the law are actionable civilly under the False Claims Act. *See* 42 U.S.C. § 1320a-7b(g) (2010) (a "claim that includes items or services resulting from a violation of . . . [the AKS] constitutes a false or fraudulent claim for purposes of [the False Claims Act]. . . ."). Further, the United States has deemed violations of the AKS to be material to its decision to pay health care claims, demonstrated in part through the

requirement that providers and suppliers certify compliance with the AKS as a condition of payment under federal health care programs. *See* Form 1500 OMB-0938-1197.

41. The Medicare and Medicaid Patient Program Protection Act of 1987 authorizes the exclusion of any individual or entity from participation in the Medicare and Medicaid programs if it is determined that the party violated the AKS. In addition, the Balanced Budget Act of 1997 amended the AKS to include administrative penalties of $50,000 for each act violating the Anti-Kickback Statute, as well as an assessment of not more than three times the amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of that amount was offered, paid, solicited, or received for an unlawful purpose.

D. The Medicaid Spend-Down Program

42. Under Title XIX of the Social Security Act, individuals over age 65 and disabled individuals whose incomes exceed the Medicaid maximum income limit may nonetheless be eligible for Medicaid reimbursement if they incur medical bills that are equal to or greater than the amount of their income in excess of the Medicaid limit. 42 C.F.R. § 435.831(d).

43. The Medicaid spend-down program allows eligible individuals to deduct medical expenses from their incomes in order to meet Medicaid guidelines. The spend-down amount is the amount of medical expenses the patient must pay to receive Medicaid reimbursement. For example, in Ohio, patients must pay the spend-down amount to the county Departments of Job and Family Services.

44. Third parties, such as medical providers, are not permitted to pay the spend-down amount to the states. Federal regulations require that the medical expenses must be incurred by the "individual or family or financially responsible relatives that are not subject to payment by a third party." 42 C.F.R. § 435.831(d). If the individual, family, or financially responsible

relative does not incur the expense, CMS views the Medicaid applicant's income as remaining above the maximum limit. Consequently, the applicant will not be eligible for Medicaid reimbursement.

45. A medical provider may not pay the spend-down amount and then seek to pass on those costs by seeking reimbursement from Medicaid. 42 C.F.R. § 435.831(h)(5).

V. SPECIFIC ALLEGATIONS OF DEFENDANT'S VIOLATIONS OF LAW

A. Defendant Failed to Apply Discount for Services Performed in a Group Setting

46. Defendant provides home health care services, including skilled nursing care, to Medicaid patients in Ohio.

47. Defendant regularly provides home nursing and other health care services to patients who reside with other Medicaid patients. Defendant provides skilled nursing and other services to an estimated 200-300 patients in such group homes. Typically, a nurse or other health care provider employed by Defendant visits each patient twice each day. Thus, Academy home health workers provide services resulting in 400-600 group home charges to Medicaid daily and 2800-4200 group home charges to Medicaid weekly.

48. For at least the past five years, Defendant has maintained a policy of refusing to apply the HQ modifier for home health services performed in a group setting, in contravention of Ohio law. Specifically, Defendant's policy is to charge Medicaid the same rate for home health services performed in an individual setting as it does for services performed in a group setting. As a result, Defendant fails to apply the 25 percent discount for home health services performed in a group setting as mandated under Ohio law.

B. Defendant Overcharged Medicaid by Failing to Apply the Required Discount

49. According to the Ohio Department of Medicaid Fee Schedule and Rates, Ohio uses the HCPCS Level II code G0154 for a 15 minute unit of Home Health Nursing services. This code covers home nursing services provided under the Ohio Medicaid Adult State Plan. From October 1, 2011 until at least July 1, 2015, the base reimbursement rate for the first four 15 minute units of service provided under code G0154 was $52.20. Thereafter, Ohio paid a unit rate of $5.69 for each additional 15 minute unit.

50. According to Ohio Administrative Code 5160-46-06, Ohio uses the HCPCS Level II code T1003 for a 15 minute unit of Waiver nursing services provided by an agency LPN under the Ohio Home Care Waiver program. From October 1, 2011 until July 1, 2015, the base reimbursement rate for the first four 15 minute units of service provided under code T1003 was $52.20. Thereafter, Ohio paid a unit rate of $5.69 for each additional 15 minute unit. Effective July 1, 2015, the base reimbursement rate for the first four 15 minute units of service provided under code T1003 was reduced to $37.90, but Ohio pays an increased unit rate of $6.82 for each additional 15 minute unit.

51. In November 2014, Defendant submitted claims to the Ohio Medicaid Adult State Plan for at least two patients residing at the same address in Mt. Vernon, Ohio. For each patient, Defendant billed $52.20 per visit using the G0154 code. Defendant typically billed the full $52.20 twice per day for each patient.

52. In November 2014, Defendant submitted claims to the Ohio Medicaid Adult State Plan for at least three patients residing at the same address in Tallmadge, Ohio. For each patient, Defendant billed $52.20 per visit using the G0154 code. Records indicate that Defendant typically billed the full $52.20 twice per day for each patient.

53. In November 2014, Defendant submitted claims to the Ohio Medicaid Adult State Plan for at least two patients residing at the same address in Fairborn, Ohio. For each patient, Defendant billed $52.20 per visit using the G0154 code. Records indicate that Defendant typically billed the full $52.20 twice per day for each patient.

54. By failing to apply the 25 percent discount for nursing services performed in group homes, Defendant overcharged Medicaid $52.20 x 0.25, or $13.05 per visit. As Defendant billed $52.20 for two patient visits each day for at least 200 patients, that results in an overcharge of at least $ 5,220.00 per day. Consequently, from at least October 1, 2011 until July 1, 2015, Defendant falsely and fraudulently overcharged Medicaid at least $1,905,000 per year for nursing services alone. This estimate does not include possible overcharges for non-nursing services, including personal aide care and therapy.

C. Defendant Violated Anti-Kickback Statute by Paying Patient Spend-Downs

55. Defendant regularly pays the spend-down amount for patients who do not reside in group homes managed by private companies.

56. Defendant pays the spend-down amount to maximize its number of Medicaid-eligible clients and, accordingly, the amount of Medicaid reimbursement it receives.

57. For example, one patient, a highly functioning but developmentally disabled individual, resides alone and relies on Defendant for various services. The patient informed Relator that, over the course of at least two years, Defendant routinely paid his spend-down amount to the Department of Job and Family Services. The patient informed Relator that one of Defendant's managers specifically told the patient that he would lose these spend-down payments if he ever left Defendant for another home health care agency.

58. As another example, Defendant paid over $1,000 in outstanding spend-down expenses to the Department of Job and Family Services for another client who suffered from drug addiction.

59. The Anti-Kickback Statute prohibits offering or paying anything of value to induce or reward referrals or to generate Federal health care program business, including Medicaid business. Defendant violated the Anti-Kickback Statute by knowingly and willfully paying patient spend-down amounts to artificially increase the number of Medicaid-eligible clients and therefore illegally inflate its Medicaid business.

V. CLAIMS FOR RELIEF

COUNT I
False Claims Act - Presentation of False Claims
31 U.S.C. § 3729(a)(1), 31 U.S.C. § 3729(a)(1)(A) as amended in 2009

60. The allegations of the preceding paragraphs are re-alleged as if fully set forth below.

61. Through the acts described above, Defendant and its agents and employees knowingly presented and caused to be presented to an officer or employee of the United States Government a false and/or fraudulent claim for payment or approval in violation of 31 U.S.C. § 3729(a)(1), and, as amended 31 U.S.C. § 3729(a)(1)(A).

COUNT II
False Claims Act - Making or Using False
Record or Statement to Cause Claim to Be Paid
31 U.S.C. § 3729(a)(2), 31 U.S.C. § 3729(a)(1)(B) as amended in 2009

62. The allegations of the preceding paragraphs are re-alleged as if fully set forth below.

63. Through the acts described above and otherwise, Defendant and its agents and employees knowingly made, used, and/or caused to be made or used false records and statements in violation of 31 U.S.C. § 3729(a)(2), and, as amended 31 U.S.C. § 3729(a)(1)(B) in order to get such false and fraudulent claims paid and approved by the United States Government.

COUNT III
False Claims Act - Making or Using False Record or Statement
to Conceal, Avoid and/or Decrease Obligation to Repay
31 U.S.C. § 3729(a)(7), 31 U.S.C. § 3729(a)(1)(G) as amended in 2009

64. The allegations of the preceding paragraphs are re-alleged as if fully set forth below.

65. Through the acts described above, in violation of 31 U.S.C. § 3729(a)(7) and as amended, 31 U.S.C. § 3729(a)(1)(G), Defendant and its agents and employees knowingly made, used, and caused to be made or used false records and statements to conceal, avoid, and/or decrease Defendant's obligation to repay money to the United States Government that Defendant illegally and fraudulently received. Defendant also failed to disclose material facts that would have resulted in substantial repayments to the United States.

PRAYER FOR RELIEF

WHEREFORE, Relator Miller requests that judgment be entered against the Defendant, ordering that:

1. Defendant cease and desist from violating the False Claims Act, 31 U.S.C. § 3729,
et seq.;

2. Defendant pay not less than $5,500 and not more than $11,000 for each violation of 31 U.S.C. § 3729, plus three times the amount of damages the United States has sustained because of the Defendant's actions;

3. Relator be awarded the maximum "relator's share" allowed pursuant to 31 U.S.C. § 3730(d);

4. Relator be awarded all costs of this action, including attorneys' fees and costs pursuant to 31 U.S.C. § 3730(d);

5. Relator be awarded all litigation costs, expert fees, and reasonable attorneys' fees incurred as provided pursuant to 31 U.S.C. § 3730(h);

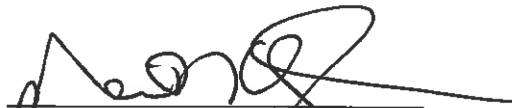
6. Defendant be enjoined from concealing, removing, encumbering, or disposing of assets which may be required to pay the civil monetary penalties imposed by the Court;

7. Defendant disgorge all sums by which they have been enriched unjustly by their wrongful conduct;

8. Relator be awarded all other damages to which he is entitled, including compensatory and punitive damages; and

9. The United States, the State of Ohio, and Relator recover such other relief as the Court deems just and proper.

Respectfully submitted,



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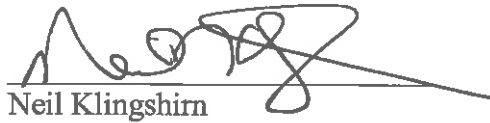
Counsel for Relator Rueben Miller

RELATOR HEREBY DEMANDS A TRIAL BY JURY



Neil Klingshirn

CERTIFICATE OF SERVICE

I hereby certify that on this 20th day of July 2015, a copy of the foregoing Complaint was filed *in camera* and *under seal* pursuant to the False Claims Act and was served upon the following individuals as indicated below. A copy of the Complaint also has been provided to Andrew Malek, Assistant U.S. Attorney, S.D. Ohio, via email. The Relator has completed, prior to filing, the requirements of Local Rule 3.2, including service of the False Claims Act disclosure.

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U.S. Department of Justice - via Certified Mail, Return Receipt, with a copy of Relator's disclosure:

Loretta E. Lynch
Attorney General of the United States
Office of the Attorney General, Civil Division
Attn: Michael Granston, Director, Civil Fraud Section
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U.S. Department of Justice - via Hand Delivery, with a copy of Relator's disclosure:

Carter M. Stewart
United States Attorney
Attn: Andrew Malek, Asst. U.S. Attorney
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Columbus, OH 43215

Counsel for the State of Ohio - via Hand Delivery, with a copy of Relator's disclosure:

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