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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN DIEGO, CENTRAL DIVISION

THE PEOPLE OF THE STATE OF CALIFORNIA,

Plaintiff,

v.

ALLION HEALTHCARE, INC., a Delaware Corporation; **MOMS PHARMACY, INC.**, a California Corporation; **MEDICINE MADE EASY INC.**, a California Corporation, *d/b/a* **MOMS PHARMACY**, *d/b/a* **PRIORITY PHARMACY**, *d/b/a* **WHITTIER GOODRICH PHARMACY**; and DOES 1 through 100, inclusive,

Defendants.

Case No. **37-2012-00103218-CU-BT-CTL**

AG Matter No. SD2009307480

COMPLAINT

Unlawful/Unfair Business Practices (Bus. & Prof. Code §17200)

Plaintiff, the People of the State of California, by and through California Attorney General Kamala D. Harris, allege as follows:

INTRODUCTION

1. This is an action arising from an unlawful and unfair business practice by Defendants that violated Business & Professions Code §17200.

PARTIES

2. Attorney General Kamala D. Harris is the Chief Law Officer of the State of California. She brings this action in the name of the People of the State of California as Plaintiff and real party in interest (hereinafter "the People").

3. Defendant **MOMS PHARMACY INC.** (hereinafter "**MOMS**") is a corporation organized under the laws of California, with its principal place of business located in Gardena, California. **MOMS** was, at all relevant times material to this action, a wholly-owned subsidiary of Defendant **ALLION HEALTHCARE, INC.**

4. Defendant **MEDICINE MADE EASY INC.** ***d/b/a*** **MOMS PHARMACY,** ***d/b/a*** **PRIORITY PHARMACY,** ***d/b/a*** **WHITTIER GOODRICH PHARMACY** (collectively referred to as "**MMEI**") is a corporation organized under the laws of California, with its principal place of business located in Gardena, California. **MMEI** was, at all relevant times material to this action, a wholly-owned subsidiary of Defendant **ALLION HEALTHCARE, INC.**

5. Defendant **ALLION HEALTHCARE, INC.** (hereinafter "**ALLION**") is a corporation organized under the laws of Delaware, with its principal place of business located in Melville, New York. At all relevant times material to this action, **ALLION** was the parent organization for a group of companies, including **MOMS** and **MMEI,** that provided, and still provides, pharmacy and related services to patients with HIV/AIDS. At all relevant times material to this action, **ALLION** transacted business in the State of California by and through its wholly owned subsidiaries, such as **MOMS** and **MMEI,** including but not limited to selling and distributing medications and support services to people living with HIV/AIDS. **MOMS, MMEI** and **ALLION** are hereinafter collectively referred to as "**MOMS California**".

6. The People are presently unaware of the true names and capacities, whether corporate, associate, individual, partnership or otherwise sued as fictitious defendants DOES 1 through 100, inclusive, and therefore sues such DOE Defendants pursuant to Code of Civil Procedure §474. The People are informed and believe, and thereon allege, that each of the fictitiously named defendants was responsible for the acts and/or omissions alleged herein, and are therefore responsible for and/or subject to any relief requested herein. The People will seek leave to amend

this Complaint to allege the true names and capacities of such fictitiously named defendants when their true identities become known. **MOMS California** and DOE Defendants are hereinafter collectively referred to as "Defendants".

7. All of the acts and/or omissions described in this Complaint by any defendant were duly performed by, and attributable to, all Defendants, including DOE Defendants, each acting as agent, as employee, alter ego and/or under the direction and control of the others, and such acts and/or omissions were within the scope of such agency, employment, alter ego, direction and/or control. Any reference in this Complaint to any acts of Defendants shall be deemed to be the acts of each Defendant acting individually, jointly or severally.

8. Whenever in this Complaint reference is made to any act of any individual defendant, such allegation shall be deemed to mean that said defendant is and was acting: (a) as a principal, (b) under express or implied agency, and/or (c) with actual or ostensible authority to perform the acts so alleged.

9. The People are informed and believe, and thereon allege, that, at all relevant times material to this action, each of the Defendants, including DOE Defendants, was and is the agent, employee, employer, joint venturer, representative, alter ego, subsidiary, and/or officer, director and/or partner of one or more of the other defendants and was, in performing the acts complained of herein, acting within the scope of such agency, employment, joint venture, officer, director or partnership authority, and/or is in some other way responsible for the acts of one or more of the other defendants.

10. The Department of Health Care Services' ("DHCS") is an agency of the State of California. DHCS finances and delivers individual health care service delivery programs to Californians, including the California Medical Assistance Program ("Medi-Cal"). At all relevant times material to this action, DHCS provided Medi-Cal benefits to qualified recipients, which included payments of claims to Defendants for filling prescription medications. These claims were paid based upon Defendants' certification that claims were made in accordance with, and pursuant to, applicable Medi-Cal regulations.

JURISDICTION AND VENUE

11. Venue is proper in this Court because **MOMS** and **MMEI** maintain a pharmacy in San Diego County, and because **MOMS California** engaged in conduct directed at the State of California and residents of the State of California.

12. Furthermore, much of **MOMS California's** misconduct took place in this county, and the acts complained of, including the unlawful/unfair business practice and the submission of false statements and records, occurred in and were directed at residents, pharmacies and government offices and officials located within this county.

FACTUAL ALLEGATIONS

A. Medi-Cal Reimbursements

13. Medicaid was created in 1965 when Title XIX was added to the Social Security Act. Medicaid is a public assistance program to provide payment of certain medical expenses for eligible patients. Funding for Medicaid is shared between the federal government and those state governments that choose to participate in the program.

14. In California, the Medicaid program is called Medi-Cal, which became effective in March 1966. Medi-Cal is funded with federal and state funds. The Medi-Cal program is administered by DHCS, which has statutory responsibility to formulate policy that conforms to Federal and State requirements.

15. The objective of the Medi-Cal program is to provide essential medical care and services to preserve health, alleviate sickness, and mitigate handicapping conditions for individuals or families on public assistance, or whose income is not sufficient to meet their individual needs. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity or impairment. These services are comprehensive and provide care in the major disciplines of health care.

16. One of the Medi-Cal benefits offered to eligible beneficiaries is the pharmacy benefit. Funding for Medi-Cal's pharmacy benefit is determined, in part, through Medi-Cal payment rates. These payment rates are based upon a formula including, among other things, the estimated acquisition cost and the fee paid to pharmacists to dispense the drug.

17. Qualified Medi-Care Providers, such as Defendants, submit claims for reimbursement for filling prescription medications of Medi-Cal patients.

18. The People are informed and believe, and thereon allege, that at all relevant times material to this action, AIDS/HIV prescription medications had high Medi-Cal reimbursement rates.

19. The People are informed and believe, and thereon allege, that at all relevant times material to this action, due to the participation of government AIDS/HIV management programs, the majority of patients who utilized these medications were receiving assistance under the Medi-Cal program, and that medications were ultimately billed to Medi-Cal for reimbursement.

20. The People are informed and believe, and thereon allege, that at all relevant times material to this action, the high reimbursement rates made AIDS/HIV prescription medications particularly susceptible to fraud and/or kickbacks since a pharmacy was able to maximize its monetary gains using a smaller number of claims, as opposed to other reimbursable Medi-Cal prescription medications that carried a smaller profit margin.

21. The People are informed and believe, and thereon allege, that at all relevant times material to this action, pharmacies inclined to take advantage of the higher reimbursement rates for AIDS/HIV prescription medications would often offer enticements of "free" items to Medi-Cal recipients, such as bus passes, gym memberships, and even cell phones and cell phone minutes ("airtime"), in exchange for transferring the patients' AIDS/HIV prescriptions from another competing pharmacy to their pharmacy.

22. The People are informed and believe, and thereon allege, that at all relevant times material to this action, pharmacies that offered these free enticements were then able to benefit from the profitable Medi-Cal reimbursement rates in exchange for the relatively minor expenditures incurred from supplying the enticements.

B. <u>Medi-Cal Provider Agreement</u>

23. The People are informed and believe, and thereon allege, that, at all relevant times material to this action, Defendants were parties to a California Medical Assistance Program (Medi-Cal) Provider Agreement ("Provider Agreement").

24. The Provider Agreement contains the following language:

> EXECUTION OF THIS PROVIDER AGREEMENT IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).
>
> AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, APPLICANT OR PROVIDER AGREES WITH THE DEPARTMENT OF HEALTH SERVICES (HEREINAFTER "DHS") TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:
>
> ***
>
> 18. **Prohibition of Rebate, Refund, or Discount**. Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it

will not take any other action or receive any other benefit prohibited by state or federal law.

***

PROVIDER AGREES THAT COMPLIANCE WITH THE PROVISIONS OF THIS AGREEMENT IS A CONDITION PRECEDENT TO PAYMENT TO PROVIDER.

(See Provider Agreement Attached hereto as Exhibit "A".)

25. The Provider Agreement was executed under penalty of perjury by a duly authorized representative of Defendants on June 16, 2003. (See Exhibit "A".)

C. The Free Cell Phone and Airtime Program

26. The People are informed and believe, and thereon allege, that at all relevant times material to this action, Defendants engaged in the practice of offering inducements for transferring AIDS/HIV prescription medications from other competing pharmacies. Specifically, the People are informed and believe, and thereon allege, that at all relevant times material to this action, Defendants supplied free cell phones and subsequent free airtime minutes to patients who transferred AIDS/HIV prescriptions from other competing pharmacies to Defendants (hereinafter referred to as the Cell Phone Program").

27. The People are informed and believe, and thereon allege, that at all relevant times material to this action, transferring patients received an economic benefit of the free phone as well as the free airtime minutes. These benefits were earned after prescriptions were transferred from the competing pharmacies.

28. The People are informed and believe, and thereon allege, that Defendants' Cell Phone Program violated state and federal laws, as well as the Medi-Cal Provider Agreement.

29. The People are informed and believe, and thereon allege, that each time Defendants provided a free cell phone to a transferring patient, and each time Defendants subsequently re-

filled the prescription and added free airtime minutes, a separate and distinct violation of state and federal laws occurred, as well as a violation of the Medi-Cal Provider Agreement.

FIRST CAUSE OF ACTION

(Violations of Business & Professions Code §17200, *et seq.*)

30. The People reallege and incorporate by reference, as though set forth fully herein, the allegations in Paragraphs 1 through 29, inclusive, of this Complaint.

31. Beginning on an exact date unknown to the People, but within four (4) years preceding the filing of this Complaint, Defendants, and each of them, engaged in unlawful acts and/or practices of unfair competition as defined by Business and Professions Code §17200 in the City and County of San Diego and elsewhere in the State of California.

32. Such unfair competition includes, but is not limited to, the following acts and/or practices:

a. Defendants, and each of them, violated Welfare and Institutions Code ("W&I") §14107.2, which criminalizes the receipt or payment of remuneration including, but not restricted to, any kickback, bribe, or rebate, by the acts and practices set forth in paragraphs 1 through 29 of this Complaint, which are incorporated herein by reference;

b. Defendants, and each of them, violated Civil Code §1770(a)(17), which provides a list of certain unfair methods of competition and unfair or deceptive acts or practices including, but not limited to, representing that the consumer will receive a rebate, discount or other economic benefit, if the earning of the benefit is contingent on an event to occur subsequent to the consummation of the transaction, by the acts and practices set forth in paragraphs 1 through 29 of this Complaint, which are incorporated herein by reference;

c. Defendants, and each of them, by the acts and practices set forth in paragraphs 1 through 29, threatened an incipient violation of an antitrust law, and/or violated the policy or spirit of one of those laws because its effects were comparable to or the same as a violation of the law, or otherwise significantly threatened or harmed competition. Such harm to Defendants' competitors that complied with the law outweighed any benefits to Defendants.

d. Defendants, and each of them, by the acts and practices set forth in paragraphs 1 through 29, systematically breached the Medi-Cal Provider Agreement, which prohibited gratuitous consideration in connection with the rendering of health care services to any Medi-Cal beneficiary. Moreover, Defendants systematically violated **ALLION's** very own Corporate Compliance Plan - Code of Conduct, which also expressly prohibited, among other things, the payment of gifts or other favors which may tend to influence or compromise independent judgment.

33. The People are informed and believe and thereon allege that Defendants and their agents and employees, at all relevant times material to this Complaint, were not in full compliance with the underlying laws, nor were Defendants and their agents and employees in compliance with an express provision of any state or law allowing the business act and/or practice fully described above in paragraphs 1 through 29 and incorporated herein.

34. As a direct and proximate result of Defendants' unlawful and unfair business act and practices, Defendants obtained and wrongfully retained monies that rightfully belonged to the law abiding pharmacies and the State in an amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, the People pray for judgment in its favor and against each Defendant as follows:

As to the First Cause of Action for Unfair Business Practices:

1. That Defendants be ordered to make full restitution, pursuant to Business & Professions Code §17203, of any money that may have been acquired and/or wrongfully retained by means of their violation of Business & Professions Code §17200 in an amount to be determined by the Court;

2. Civil penalties in the amount of $2,500, for *each* act by Defendants in violation of Business & Professions Code §17200, *et seq.*, pursuant to Business & Professions Code §17206;

3. For permanent injunction pursuant to Business & Professions Code §17203 restraining and enjoining Defendants, and each of them, and all those acting under, by, through or

on behalf of them, from engaging in or performing directly or indirectly, any or all of the acts of unfair competition in the State of California;

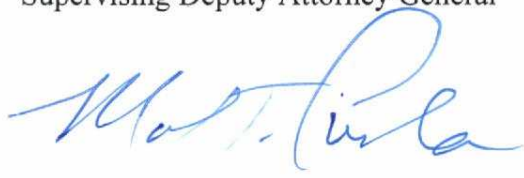
4. Costs of suit; and

5. For such further and additional relief as the Court deems just and proper.

Dated: August 31, 2012

Respectfully Submitted,

KAMALA D. HARRIS
Attorney General of California
SUE MELTON-BARTHOLOMEW
Supervising Deputy Attorney General



MARK T. CUMBA
Deputy Attorney General
Attorneys for the People of the State of California

EXHIBIT A

State of California—Health and Human Services Agency

Department of Health Services

CALIFORNIA MEDICAL ASSISTANCE PROGRAM (MEDI-CAL) PROVIDER AGREEMENT

(To Accompany Applications for Enrollment or Continued Enrollment)*

FOR STATE USE ONLY

Legal name of applicant or provider (last)	(first)	(middle)
Priority Pharmacy		

Medi-Cal provider number** (new applicants should leave blank)	Medicare billing number	Business telephone number
PHA368260		(619) 688-2290

Business address (number, street)	City	State	Nine-digit ZIP code
3935 First Ave	San Diego	CA	92103-3015
Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
3935 First Ave	San Diego	CA	92103-3015
Pay to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
3935 First Ave	San Diego	CA	92103-3015

Taxpayer identification number**
95-3208453

Proof of Liability Insurance—Applicant must attach a copy of their certificate of insurance to this application.

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)

Insurance agent's name—(first)	(middle)	(last)	(Jr., Sr., etc.)

Telephone number	Fax number	E-mail address
( )	( )	

Proof of Professional Liability Insurance—Applicant must attach a copy of their certificate of insurance to this application.

Name of insurance company
Acord Corporation.

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)
35810083	4/21/03	4/21/04

Insurance agent's name—(first)	(middle)	(last)	(Jr., Sr., etc.)
Gary S.		Levine	

Telephone number	Fax number	E-mail address
(858.) 481-8692	( )	

EXECUTION OF THIS PROVIDER AGREEMENT IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, APPLICANT OR PROVIDER AGREES WITH THE DEPARTMENT OF HEALTH SERVICES (HEREINAFTER "DHS") TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHS

* Every applicant and provider must execute this Provider Agreement, except physicians, who must execute the "Medi-Cal Physician Application/Agreement," DHS 6210.

** The taxpayer identification number may be an Individual Taxpayer Identification Number (ITIN), social security number (for sole proprietors), or a Federal Employer Identification Number (FEIN).

with 30 days advance written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program unless and until such time as Provider is re-enrolled by DHS in the Medi-Cal program. DHS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 23(a), below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program.

2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, or any applicable regulations promulgated by DHS pursuant to that Chapter. Provider further agrees that it may be subject to all sanctions or other remedies available to DHS if it violates any of the provisions of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, or any of the regulations promulgated by DHS pursuant to that Chapter. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

3. **Forbidden Conduct.** Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare and safety of any Medi-Cal beneficiary, or the fiscal integrity of the Medi-Cal program.

4. **Nondiscrimination.** Provider agrees that it shall not exclude or deny aid, care, service or other benefits available under Medi-Cal or in any other way discriminate against a person because of that person's race, color, ancestry, marital status, national origin, gender, age, economic status, physical or mental disability, political or religious affiliation or beliefs in accordance with California and federal laws. Provider further agrees that it shall provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public.

5. **Scope of Health and Medical Care.** Provider agrees that the health care services it provides may include diagnostic, preventive, corrective, and curative services, goods, supplies, and merchandise essential thereto, provided by qualified personnel for conditions that cause suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity, including employment, or for conditions which may develop into some significant handicap or disability. Provider further agrees that medical care may include, but is not limited to, other remedial care, not necessarily medical. Other remedial care may include, without being limited to, treatment by prayer or healing by spiritual means in the practice of any church or religious denomination. Provider further agrees such health care services may be subject to prior authorization to determine medical necessity.

6. **Licensing.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, valid and unexpired license(s), certificate(s), or other approval(s) to provide health care services, which is appropriate to the services, goods, supplies, and merchandise being provided, if required by the state or locality in which Provider is located, or by the Federal Government. Provider further agrees that DHS shall automatically suspend Provider as a provider in the Medi-Cal program pursuant to Welfare and Institutions Code, Section 14043.6, if Provider has license(s), certificate(s), or other approval(s) to provide health care services, which are revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that/those license(s), certificate(s), or approval(s) was pending. Such suspension shall be effective on the date that Provider's license, certificate, or approval was revoked, suspended, lost, or surrendered. Provider further agrees to notify DHS within ten business days of learning that any restriction has been placed on, or of a suspension of Provider's license, certificate, or other approval to provide health care. Provider further agrees to provide DHS complete information related to any restriction to, or revocation or loss of, Provider's license, certificate, or other approval to provide health care services.

7. **Insurance.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, liability and, if a licensed practitioner, professional liability insurance coverage from an authorized insurer pursuant to Section 700 of the Insurance Code.

8. **Record Keeping and Retention.** Provider agrees to make, keep and maintain in a systematic and orderly manner, and have readily retrievable, such records as are necessary to fully disclose the type and extent of all services, goods, supplies, and merchandise provided to Medi-Cal beneficiaries, including, but not limited to, the records described in Section 51476 of Title 22, California Code of Regulations, and the records described in Section 431.107 of Title 42 of the Code of Federal Regulations. Provider further agrees that such records shall be made at or near the time at which the services, goods, supplies, and merchandise are delivered or rendered, and that such records shall be retained by

Provider in the form in which they are regularly kept for a period of three years from the date the goods, supplies, or merchandise were delivered or the services rendered.

9. **DHS Access to Records; Copies of Records.** Provider agrees to make available, during regular business hours, all pertinent financial books and all records concerning the provision of health care services to Medi-Cal beneficiaries, and all records required to be retained pursuant to Paragraph 7, above, to any duly authorized representative of DHS including, but not limited to, employees of the California Attorney General's Medi-Cal Fraud Unit, and to the Secretary of the United States Health Care Financing Administration. Provider further agrees to provide, if requested by DHS, copies of the records and documentation. Provider will be reimbursed for reasonable photocopying-related expenses as determined by DHS. Provider further agrees that failure to comply with DHS' request to examine or receive copies of such records shall be grounds for immediate suspension of Provider pursuant to Welfare and Institutions Code, Section 14124.2.

10. **Confidentiality of Beneficiary Information.** Provider agrees that all medical records of beneficiaries made or acquired by Provider shall be confidential and shall not be released without the written consent of the beneficiary or his/her personal representative, or as otherwise authorized by law.

11. **Disclosure of Information to DHS.** Provider agrees to disclose all information as required in federal Medicaid regulations and any other information required by DHS, and to respond to all requests from DHS for information. Provider further agrees that the failure of Provider to disclose the required information, or the disclosure of false information shall, prior to any hearing, result in the denial of the application for enrollment or shall make the Provider subject to temporary suspension, which shall include temporary deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program. Provider further agrees that all bills or claims for payment to DHS by Provider shall not be due and owing to Provider for any period(s) for which information was not reported or was reported falsely to DHS. Provider further agrees to reimburse those Medi-Cal funds received during any period for which information was not reported, or reported falsely, to DHS.

12. **Background Check.** Provider agrees that DHS may conduct a background check on Provider for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud or abuse. The background check may include, but not be limited to, the following: (1) on-site inspection prior to enrollment; (2) review of business records; and, (3) data searches.

13. **Unannounced Visits By DHS.** Provider agrees that DHS may make unannounced visits to Provider, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. Provider agrees to be in compliance with the requirements of Welfare and Institutions Code, Section 14043.7. This paragraph does not apply to clinics licensed under Section 1204 of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, and natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, unless DHS has reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program.

14. **Provider Fraud and Abuse.** Provider agrees that it shall not engage in or commit fraud or abuse. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. "Abuse" means either: (1) practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state; (2) practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

15. **Investigations of Provider for Fraud or Abuse.** Provider agrees that, at the time this Agreement was signed, it was not under investigation for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations. Provider further agrees to notify DHS within ten business days of learning that it is under investigation for fraud or abuse. Provider further agrees that it shall be subject to temporary suspension pursuant to Welfare and Institutions Code, Section 14043.36(a), which shall include temporary deactivation of all

provider numbers used by Provider to obtain reimbursement from the Medi-Cal program, if it is discovered by DHS that Provider is under investigation for fraud or abuse. Provider further agrees to cooperate with and assist DHS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse.

16. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider agrees that it and its officers, directors, employees, and agents, has not: (1) been convicted of any felony or misdemeanor involving fraud or abuse in any government program, within the last five years; or (2) been convicted of any felony or misdemeanor involving the abuse of any patient; or (3) been convicted of any felony or misdemeanor substantially related to the qualifications, functions, or duties of a provider; or (4) entered into a settlement in lieu of conviction for fraud or abuse, within the last five years; or, (5) been found liable for fraud or abuse in any civil proceeding, within the last five years. Provider further agrees that DHS shall not enroll Provider if, within the last five years, Provider has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, has entered into a settlement in lieu of conviction for fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding.

17. **Changes to Provider Information.** Provider agrees to keep its application for enrollment in the Medi-Cal program current by informing DHS, Provider Enrollment Branch, in writing on a form or forms to be specified by DHS within 35 days, of any changes to the information contained in its application for enrollment, its disclosure statement, this Agreement, and any attachments to these documents.

18. **Prohibition of Rebate, Refund, or Discount.** Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it will not take any other action or receive any other benefit prohibited by state or federal law.

19. **Payment From Other Health Coverage Prerequisite to Claim Submission.** Provider agrees that it shall first seek to obtain payment for services provided to Medi-Cal beneficiaries from any private or public health insurance coverage to which the beneficiary is entitled, where Provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to DHS for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 90 days of billing by Provider, Provider may submit a claim to DHS.

20. **Beneficiary Billing.** Provider agrees that it shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to: (1) collect payments due under a contractual or legal entitlement pursuant to Welfare and Institutions Code, Section 14000(b); (2) bill a long-term care patient for the amount of his/her liability; and, (3) collect a co-payment pursuant to Welfare and Institutions Code, Sections 14134 and 14134.1. Provider further agrees that, in the event that a beneficiary willfully refuses to provide current other health care coverage billing information as described in Section 50763(a)(5) of Title 22, California Code of Regulations, Provider may, upon giving the beneficiary written notice of intent, bill the beneficiary as a private pay patient.

21. **Payment From Medi-Cal Program Shall Constitute Full Payment.** Provider agrees that payment received from DHS in accordance with Medi-Cal fee structures shall constitute payment in full, except that Provider, after making a full refund to DHS of any Medi-Cal payments received for services, goods, supplies, or merchandise, may recover all of Provider's fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the services, goods, supplies, or merchandise provided to the beneficiary.

22. **Return of Payment for Services Otherwise Covered by the Medi-Cal Program.** Provider agrees that any beneficiary who has paid Provider for health care services, goods, supplies, or merchandise otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a prompt return from Provider of any part of the payment which meets any of the following: (1) was rendered during any period prior to the receipt of the beneficiary's Medi-Cal card, for which the card authorizes payment under Welfare and Institutions Code, Sections 14018 or 14019; (2) was reimbursed to Provider by the Medi-Cal program, following audits and appeals to which Provider is entitled;

(3) is not payable by a third party under contractual or other legal entitlement; (4) was not used by the beneficiary to satisfy his/her paid or obligated liability for health care services, goods, supplies, or merchandise, or to establish eligibility.

23. **Compliance With Billing and Claims Requirements.** Provider agrees that it shall comply with all of the billing and claims requirements set forth in the Welfare and Institutions Code.

24. **Provider Suspensions; Appeal Rights; Reinstatement.** Provider agrees that it is to be subject to the following suspension actions. Provider further agrees that the suspension by DHS of Provider shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the Medi-Cal program for any services or supplies Provider has provided to the program, except for services or supplies provided prior to the suspension.

    a. **Automatic Suspensions/Mandatory Exclusions.** DHS shall automatically suspend Provider under the following circumstances:

        (1) Upon notice from the Secretary of the United States Department of Health and Human Services that Provider has been suspended from participation in the Medicare or Medicaid programs. (Applies to individual providers only.) No administrative appeal of a suspension on this ground shall be available to Provider. (Welfare and Institutions Code, Section 14123(b),(c).)

        (2) If Provider has license(s), certificate(s), or other approval (s) to provide health care services, revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that license, certificate, or approval was pending. No administrative appeal of a suspension on this ground shall be available to Provider. (Welfare and Institutions Code, Section 14043.6.)

        (3) If Provider is convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. No administrative appeal of a suspension on this ground shall be available to Provider (Welfare and Institutions Code, Section 14123(a),(c)).

    b. **Permissive Suspensions/Permissive Exclusions.** DHS may suspend Provider under the following circumstances:

        (1) Provider violates any of the provisions of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code (except for Article 1.3), or any of the regulations promulgated by DHS pursuant to those provisions. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(a),(c).)

        (2) Provider fails to comply with DHS' request to examine or receive copies of the books and records pertaining to services rendered to Medi-Cal beneficiaries. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14124.2.)

        (3) Provider participating in the Medi-Cal dental program provides services, goods, supplies, or merchandise that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. (Welfare and Institutions Code, Section 14123(f).)

    c. **Temporary Suspensions.** DHS shall temporarily suspend Provider under the following circumstances:

        (1) Provider fails to disclose all information as required in federal Medicaid regulations or any other information required by DHS, or discloses false information. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.2(a).)

        (2) If it is discovered that Provider is under investigation for fraud or abuse. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.36(a).)

(3) Provider fails to remediate discrepancies that are discovered as a result of an unannounced visit to Provider. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.7(c).)

(4) When necessary to protect the public welfare or the interests of the Medi-Cal program. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(c).)

25. **Liability of Group Providers.** Provider agrees that, if it is a provider group, the group, and each member of the group, are jointly and severally liable for any breach of this Agreement, and that action by DHS against any of the providers in the provider group may result in action against all of the members of the provider group.

26. **Legislative and Congressional Changes.** Provider agrees that this Agreement is subject to any future additional restrictions, limitations, or conditions enacted by the California Legislature or the United States Congress which may affect the provisions, terms, conditions, or funding of this Agreement in any manner.

27. **Provider Capacity.** Provider agrees that Provider, and the officers, directors, employees, and agents of Provider, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State of California.

28. **Indemnification.** Provider agrees to indemnify, defend, and save harmless the State of California, its officers, agents, and employees, from any and all claims and losses accruing or resulting to any and all persons, firms, or corporations furnishing or supplying services, materials, or supplies in connection with Provider's performance of this Agreement, and from any and all claims and losses accruing or resulting to any Medi-Cal beneficiary, or to any other person, firm, or corporation who may be injured or damaged by Provider in the performance of this Agreement.

29. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

30. **Venue.** Venue for all actions, including federal actions, concerning this Agreement, lies in Sacramento County, California, or in any other county in which the California Department of Justice maintains an office.

31. **Titles.** The titles of the provisions of this Agreement are for convenience and reference only and are not to be considered in interpreting this Agreement.

32. **Severability.** If one or more of the provisions of this Agreement shall be invalid, illegal, void, or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired. Either party having knowledge of such a provision shall promptly inform the other of the presumed nonapplicability of such provision. Should the nonapplicable provision go to the heart of this Agreement, the Agreement shall be terminated in a manner commensurate with the interests of both parties.

33. **Assignability.** Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number, or any rights and obligations it has under this Agreement.

34. **Waiver.** Any action or inaction by DHS or any failure of DHS on any occasion, to enforce any right or provision of this Agreement, shall not be interpreted to be a waiver by DHS of its rights hereunder and shall not prevent DHS from enforcing such provision or right on any future occasion. The rights and remedies of DHS herein are cumulative and are in addition to any other rights or remedies that DHS may have at law or in equity.

35. **Complete Integration.** This Agreement, including any attachments or documents incorporated herein by express reference, is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matter of this Agreement.

36. **Amendment.** No alteration or variation of the terms or provisions of this Agreement shall be valid unless made in writing and signed by the parties to this Agreement, and no oral understanding or agreement not set forth in this Agreement, shall be binding on the parties to this Agreement.

37. **Provider Attestation.** Provider agrees that all information it submits on the application form for enrollment, this Agreement, and all attachments or changes to either, is true, accurate, and complete to the best of Provider's knowledge and belief. Provider further agrees to sign the application form for enrollment, this Agreement, and all attachments or changes to either, under penalty of perjury under the laws of the State of California.

PROVIDER AGREES THAT COMPLIANCE WITH THE PROVISIONS OF THIS AGREEMENT IS A CONDITION PRECEDENT TO PAYMENT TO PROVIDER.

THE PARTIES AGREE THAT THIS AGREEMENT IS A LEGAL AND BINDING DOCUMENT AND IS FULLY ENFORCEABLE IN A COURT OF COMPETENT JURISDICTION. THE PROVIDER SIGNING THIS AGREEMENT WARRANTS THAT HE/SHE HAS READ THIS AGREEMENT AND UNDERSTANDS IT.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Printed name of provider	Signature of provider	Date
DAVID C ZEIGER		05/16/03

Notary Public (see instructions on the application form for who must notarize)

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, 714 P Street, Room 950, Sacramento, CA, 95814, (916) 323-1945.

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California
County of San Diego } ss.

On June 16, 2003 (Date) before me, Brian Patrick Cox (Name and Title of Officer [e.g., "Jane Doe, Notary Public"),
personally appeared David C. Beiser (Name(s) of Signer(s)),

☒ personally known to me
☐ proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/~~she/they~~ executed the same in his/~~her/their~~ authorized capacity(~~ies~~), and that by his/~~her/their~~ signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature of Notary Public

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document

Title or Type of Document: Medi-Cal Medical Assistance Program

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer

Signer's Name: _____

☐ Individual
☐ Corporate Officer — Title(s): _____
☐ Partner — ☐ Limited ☐ General
☐ Attorney-in-Fact
☐ Trustee
☐ Guardian or Conservator
☐ Other: _____

Signer Is Representing: _____

RIGHT THUMBPRINT OF SIGNER
Top of thumb here