IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT

UNITED STATES OF AMERICA, ex rel. THOMAS JOSEPH,	)	
Plaintiff,	)	
v.	)	Civil Action Docket No. 2:13-cv-00055-wks
THE BRATTLEBORO RETREAT,	)	**ORAL ARGUMENT REQUESTED**
Defendant.	)	

OPPOSITION TO THE BRATTLEBORO RETREAT'S MOTION TO DISMISS

Introduction

Through its motion to dismiss, The Brattleboro Retreat ("Retreat") seeks to paint itself as a victim. In the Retreat's version, the Retreat is a partner of the U.S. and state governments, a benevolent provider of mental health counseling and treatment for drug and alcohol addiction. The facts, however - specific, explicit and damning - tell a very different story. The state and federal governments provided The Retreat with millions of dollars meant to pay for patients' care. In return, the Retreat exploited that arrangement by double and triple billing and pocketed millions more by pulling an accounting sleight of hand to move payments owed to the government off its books.

The Retreat now offers a slough of technical defenses in its Motion which the Retreat asserts should relieve it of being held to account for this misconduct. None has merit.

First, the Retreat contends that most of these claims are too late, past the statute of limitations under the False Claims Act. The Retreat's Motion overlooks plain law that provides that the statute begins to run when the relator learns of the false claims.

Next, the Retreat argues that the Complaint should be dismissed because it does not identify a specific claim made to the Government. In doing so, the Retreat attempts to import law from other circuits that courts here have made efforts to avoid. As is required, the Complaint shows a clear nexus between the Retreat's fraudulent statements and claims to the Government.

Third, the Retreat argues the Complaint has made insufficient claims that the Retreat has avoided paying back its overpayments to the Government (so-called "reverse payments"). To make this argument, however, the Retreat is forced to draw upon an admittedly obsolete definition and to overlook its legal obligation to repay the Government what is owed.

In short, nothing in the Retreat's motion provides it with the escape it seeks from liability for the years of misconduct detailed in the Complaint.

I. Statement of Facts

The Retreat provides mental health care and substance abuse services for patients in Vermont, Massachusetts, New Hampshire, Connecticut, Nebraska and elsewhere. (Compl. ¶ 12) In 2011, the Retreat provided inpatient and outpatient services to more than 5,500 children, adolescents and adults, including veterans. It is a "provider" or "provider of services" within the meaning of 42 U.S.C. §1395x(u) and 42 C.F.R §§ 400.202 and 405.902. (*Id.*)

In early January 2011, Relator Thomas Joseph accepted a position as a Self-Pay Collections Representative at the Retreat. (Compl. ¶ 9) In that capacity, Mr. Joseph was responsible for the collections of all patient balances that existed after insurance - Medicare, Medicaid, Champus/Champva/Tricare and private insurance - had processed and paid their

shares. (Compl. ¶ 13) Mr. Joseph had responsibility for about 1,800 patient accounts, records that included the patients' past Medicare or Medicaid payments. He also assisted with any Coordination of Benefit issues that arose, a need that often put Mr. Joseph in direct contact with patients who had unresolved issues with Medicare and Medicaid.

Mr. Joseph worked in the Retreat's Patient Financial Services Department, which is responsible for handing billing and accounting for receipts, reimbursements and refunds. Through this department, the Retreat receives from $3 million to $5 million in revenue each month from patients and insurance providers, including from the state and federal governments.

As Mr. Joseph began his work, he learned that the Retreat receives overpayments in the ordinary course of business. (Compl. ¶ 13) For example, when the Retreat sends bills to more than one insurance provider for the same services, more than one insurer may pay as the primary payor, and an overpayment results. (Compl. ¶ 48)

In November 2011, department manager Jennifer Broussard asked Mr. Joseph to assist her with the Retreat's handling of insurance credits. (Compl. ¶ 85) In doing this work, Mr. Joseph learned that many credits in patient accounts were simply never returned. (Compl. ¶ 84) When Mr. Joseph brought some of these credits to Ms. Broussard's attention, he watched as she entered allowance reversals into the Retreat's accounting system by entering an offsetting amount to the charge using code "21." (Compl. ¶ 85) Code 21 is the Retreat's posting code used to designate an "allowance reversal" in the ledger to a payer's account. (Compl. ¶ 18) By posting a code 21 against a credit that was already entered in the ledger, Ms. Broussard's action effectively eliminated the credit from any account for which the Retreat did not have a request for the refund.

When the Retreat makes a claim to Medicare or Medicaid, the claim form uses a code to indicate the services rendered to a patient and the charges on which a claim is being made. (Compl. ¶ 24) When the Centers for Medicare and Medicaid Services ("CMS") reviews the claim forms, it may deny some charges and pay others. (Compl. ¶ 100) When that happens, the Retreat will then recode and resubmit the claims. (Compl. ¶ 101)

However, when the Retreat receives a partially-paid claim from CMS, the Retreat recodes and resubmits all of the charges - including those for which the Retreat has already been fully paid. (Compl. ¶ 101) This causes Medicare or Medicaid to make duplicate payments for the same services. (*Id.*) The Retreat then conceals these duplicate payments by applying the code "21" allowance reversal to offset the credit balance to Medicare and Medicaid. (*Id.*)

Similarly, when a government health benefit program mistakenly pays for a service another payor is responsible for, the Retreat deploys this same scheme so that it can retain the overpayments due and payable to the United States, Connecticut, Massachusetts and Nebraska governments. (Compl. ¶ 98)

As a condition of payment, the Retreat is required to submit an accurate form CMS-838, which informs Medicare and Medicaid of any overpayment, so that the Government can be assured of obtaining a refund of its overpayments. (Compl. ¶ 97) Healthcare providers are instructed to provide information for this form from their own financial records. (Ex. 1) Drawing from its doctored financial records as instructed, the Retreat submits a CMS-838 form that reveals that the Retreat owes far less to the Government than it actually does. (Compl. ¶ 97)

After learning of the unlawful scheme, Mr. Joseph quickly alerted the Retreat's Controller, Lisa Dixon. (Compl. ¶ 86) By e-mail, Ms. Dixon assured Mr. Joseph she would look

into it. (*Id*.) Shortly after that, Ms. Broussard switched Mr. Joseph's work schedule to a time less accommodating to his health condition. (Compl. ¶ 87)

Over the next six months, the Retreat held a series of meetings regarding the overpayments, in which Mr. Joseph explained the finance department's stratagem to eliminate traces of overpayments from its system. (Compl. ¶ 88) On September 5, 2012, Chief Financial Officer and Senior Vice President John Blaha explained to Mr. Joseph that refunding these overpayments had to be balanced with the Retreat's "other financial obligations, including payroll." (Compl.¶ 75)

In October and December 2012, Mr. Joseph brought these allegations to the government's attention. (Compl. ¶ 13) On April 12, 2013, he filed this Complaint under seal, 13-55. Dkt. 1. On August 20, 2013, the U.S. Attorney informed this Court that it would not pursue the case on its own, and on September 12, 2013, the case was unsealed and publicly available. Dkt. 6-7. Shortly after that, on October 18, 2013, Mr. Joseph was instructed to leave the Retreat and on November 20, 2013, he learned he was terminated.

II. The Court's Standard of Review Compels Denial of the Retreat's Motion to Dismiss

To pass muster under the standards of Rules 8, 9(b) and 12(b)(6), claims under the False Claims Act ("FCA") needs to show the specifics of a fraudulent scheme and provide an adequate basis for a reasonable inference that false claims were submitted as part of that scheme. *Lemmon v. Envirocare of Utah*, 614 F.3d 1163, 1172 (10th Cir. 2010)(collecting cases). These requirements are analyzed separately below.

A. The Complaint Demonstrates a Plausible Scheme as Required by Rule 12(b)(6)

A motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) may only be granted if, accepting all well-pleaded allegations in the complaint as true and viewing them in the light

most favorable to Mr. Joseph, a court finds that Mr. Joseph has failed to set forth fair notice of what the claim is and the grounds upon which it rests. *Bell Atlantic Corp. v. Twombly*, 127 S.Ct. 1955, 1964 (2007). In other words, a complaint need merely contain sufficient factual allegations to "give the defendant fair notice of what the . . . claim is and the grounds upon which it rests." *Wendie v. Hudson Group (HG) Retail, LLC.* 11-04 (D.Vt.)(February 29, 2012) (quoting *Twombly*, 550 U.S. at 555).

Accordingly, the issue is not whether Mr. Joseph "will ultimately prevail but whether the claimant is entitled to offer evidence in support of the claims." *McDowell v. N. Shore-Long Island Jewish Health Sys., Inc*., 839 F. Supp. 2d 562, 565 (E.D.N.Y. 2012)(citing *Todd v. Exxon Corp.*, 275 F.3d 191, 198 (2d Cir.2001)). A plaintiff need not provide a factual basis for every allegation. Nor must every allegation, taken in isolation, contain all the necessary information. Rather, to avoid dismissal under Rules 9(b) and 8(a), plaintiffs need only show that, taken as a whole, a complaint entitles them to relief. *Twombly*, 550 U.S. at 554-56.

In reviewing a motion to dismiss pursuant to Rule 12(b)(6), a court is generally limited to "the facts as asserted within the four corners of the complaint, the documents attached to the complaint as exhibits, and any documents incorporated in the complaint by reference." *Seeman v. United Postal Service*, 11-206, (D.Vt. 2012)(quoting *Brass v. Am. Film Techs., Inc.*, 987 F.2d 142, 150 (2d Cir. 1993)). In addition, the Court may also consider "matters of which judicial notice may be taken" and "documents either in plaintiffs' possession or of which plaintiffs had knowledge and relied on in bringing suit." *Id*. A court may take judicial notice of public documents. *Kramer v. Time Warner, Inc.*, 937 F.2d 767, 773 (2d Cir. 1991).

B. <u>The Complaint States Ample Particularity as Required by Rule 9(b)</u>

Because the False Claims Act sounds in fraud, the circumstances surrounding fraud must be pleaded with the particularity required by Rule 9(b). *United States v. Countrywide Fin. Corp.*, 2013 WL 4437232, at *2 (S.D.N.Y. Aug. 16, 2013). Typically, this means that the complaint must (1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent. *U.S. ex rel. Taylor v. Gabelli*, 345 F. Supp. 2d 313, 326 (S.D.N.Y. 2004).

Rule 9(b) states that scienter may be pled generally. This can be done by showing motive and opportunity to commit fraud, or else circumstances indicating conscious behavior by the defendant. *Id.*

The particularity requirement also requires that a False Claims Act complaint "allege a factual nexus between the improper conduct and the resulting submission of a false claim to the government." *Johnson v. The University of Rochester Medical Ctr.*, 686 F.Supp.2d 259, 266 (W.D.N.Y. 2010).

The Complaint meets all of these requirements. For example, after detailing a train of transactions involving "Patient 3," at Paragraph 123, the Complaint shows how the Retreat manipulated entries totaling $18,668 into an Unapplied Cash ledger entry that removed it from entry as a refund. The next paragraph shows that this manipulation was performed by Rose Dietz at the Retreat and Paragraph 127 states that Ms. Dietz was under the direction of Robert Simpson, John Blaha, Lisa Dixon and Jennifer Broussard. The Complaint also shows the Retreat had both motive and opportunity to commit fraud. For example, at Paragraph 75, Relator Joseph was told the Retreat must keep overpayments to "meet other financial obligations, including payroll."

Finally, the Complaint establishes a clear nexus between the improper conduct and resulting submissions of fraudulent claims. As will be shown below, these ledger entries are the basis for the Retreat's submission of its quarterly CMS-838 reports that inform the Government about existing overpayments. Accordingly, the Retreat's manipulation of its ledger entries necessarily resulted in false claims.

1. *Rule 9(b)'s Particularity Requirement Should Be Relaxed Because the Fraud is Complex and Enduring and Certain Information is Within the Defendant's Control*

Courts typically relax Rule 9(b)'s pleading requirements in cases involving especially complex or extensive fraudulent schemes. *United States ex rel. Smith v. Yale University*, 415 F.Supp. 58, 83 (D.Conn. 2006); *citing, inter alia, Payne v. United States*, 247 F.2d 481, 486 (8th Cir. 1957), cert. denied, 355 U.S. 923, 78 S.Ct. 367, 2 L.Ed.2d 354 (1958) (noting that "it is to be borne in mind that . . . the sufficiency of a pleading must largely depend upon the nature of the case, the complexity or simplicity of the transaction or occurrence, the relationship of the parties and the determination of how much circumstantial detail is necessary to give notice to the adverse party and enable him to prepare a responsive pleading"). Where the alleged fraud involved numerous transactions that occurred over a long period of time, courts have found it impractical to require the plaintiff to plead the specifics with respect to "each and every instance of fraudulent conduct." *Id*. at 84. "To approach the issue otherwise would allow the more sophisticated to escape liability under a False Claims case due to the complexity of their scheme and their deviousness in escaping detection." *In re Cardiac Devices Qui Tam Litig*., 221 F.R.D. 318, 333 (D.Conn. 2004).

Moreover, in evaluating a motion to dismiss under Rule 9(b), "[t]he degree of particularity required should be determined in light of such circumstances of whether the plaintiff

has had an opportunity to take discovery of those who may possess knowledge of the pertinent facts." *Devaney v. Chester*, 813 F.2d 566, 569 (2d Cir. 1987).

The Complaint here alleges fraud that occurred over an extended period, is highly complex - requiring sophisticated accounting maneuvers, tens of thousands of billing records and involves information "peculiarly within the adverse parties' knowledge." *Segal v. Gordon*, 467 F.2d 602, 608 (2d Cir. 1972). It is also within Defendant's capacity to identify the fraud from the facts alleged. Furthermore, to the Relator's knowledge, the Government took no discovery, nor has the Relator had any such opportunity. Accordingly, to the degree that the Rule 9(b) particularity requirements may not be fully met, the requirement should be relaxed.

III. The Statue of Limitations Does Not Limit Any Of These Claims Because the Complaint Was Filed Within Three Years of Discovery

The Brattleboro Retreat demands that the Court dismiss all claims that date from before six years of the filing of the Complaint because, the Retreat says, the six-year statute of limitations should bar all of those claims. (MTD at 11) It is true that 31 U.SC. § 3731(b)(1) provides that a false claim may not be brought "more than six years" after the violation has been committed. However, that is not the end of the analysis.

In the Second Circuit, this limitation is similar to other fraud statutes and means that "a qui tam plaintiff must bring suit within three years after he learned of the material facts or within three years after the responsible government official learned or should have learned of the facts)." *U.S. ex rel. Thistlethwaite v. Dowdy Woodville Polymer Limited*, 6 F. Supp. 2d 263, 265 (S.D.N.Y. 1998). Indeed, if the law went as the Retreat would have it, then fraudsters could keep their lucre scot-free if they only conceal their schemes for six years.

Mr. Joseph brought his claim to the Government's attention in late 2012, in the same year that he learned of the fraud afoot. As such, all of his claims are well within the statute of limitations.

A. Statute of Limitations Regarding Government Discovery Does Not Pertain

The limitations statute has another prong that applies in cases where the Government is informed of a potential claim. *Id*. That statute, 31 USC § 3731(b)(2), provides that a false claim "more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed."

This provision simply means that "[t]he statute of limitations does not begin to run until the material facts are known by an official within the Department of Justice with the authority to act in the circumstances." *U.S. v. Incorporated Village of Island Park*, 791 F.Supp. 354, 262 (E.D.N.Y 1990) (quoting S.Rep. No. 345, 99th Cong., 2d Sess. 30 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, 5295).

For some reason, the Retreat seeks to apply this second prong to Mr. Joseph's complaint, even though the Retreat acknowledges that the Government was not informed of the claims until 2012. The first prong, as discussed above, is the one that properly applies here.

IV. The Complaint Alleges Adequate Facts for Claims Under §§ 3729(a)(1)(A), (B)

A. The Second Circuit Does Not Require that a False Claims Complaint Show an Actual False Claim Made to the Government

The Retreat tries to argue that the Complaint should be dismissed because it "fails to identify any claims submitted to the government for payment." (MTD at 12). Absent a showing

of an actual fraudulent claim form to the Government, the Retreat argues, the entire Complaint should be dismissed.

This "per se" requirement that the Retreat attempts to import into the Second Circuit is not supported by Rule 9(b) and undermines the effectiveness of the False Claims Act. It is clearly unsupported in the Second Circuit. *U.S. v. Countrywide Financial Corporation*, No. 12-1422 (S.D.N.Y. August 16, 2013)(citing cases discussing the divergence across the circuits and within the Second of agreement on such a requirement). Indeed, of seven types of actionable conduct listed in the FCA, only three even require that the misconduct involve an actual demand for payment. 31 U.S.C. §§ 3729(a)(1)-(3). In fact, even in circuits with the strictest standard, such as the one discussed in *United States ex rel. Karvelas v. Wakefield Hospital*, 360 F.3d 220 (1st Cir. 2004), the courts leave room for complaints "where, although some questions remain unanswered, the complaint as a whole is sufficiently particular to pass muster under the FCA." *United States ex rel. Rost v. Pfizer*, 507 F.3d 520, 732 (1st Cir. 2010).

This requirement has retreated even in the Sixth, Eighth, Tenth and Eleventh Circuits, where this per se rule originally applied. In the Sixth Circuit, the requirement may be relaxed when the "relator has pled facts which support a strong inference that a claim was submitted." *Chesbrough v. VPA, P.C.*, 655 F.3d 461, 471 (2011). Likewise in the Tenth Circuit an FCA complaint "need only show the specifics of a fraudulent scheme and provide an adequate basis for a reasonable inference that false claims were submitted as part of that scheme." *United States ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163, 1172 (10 Cir. 2010). Similarly both the Eighth and Eleventh Circuits have allowed False Claims cases to proceed even though the relator had not identified "specific claims for payment to the government." *In re Baycol Prods. Litig.*, 732 F.3d 869, 875-877 (8th Cir. 2013); *United States ex rel. Walker v. R&F Props. of Lake*

Cnty., Inc., 433 F.3d 1349, 1360 (11th Cir. 2005), cert. denied, 549 U.S. 1027 (2006); *United States ex rel. Clausen v. Laboratory Corp. of Am.*, 290 F.3d 1301, 1311 (11th Cir. 2002) (stating that a qui tam complaint must contain "some indicia of reliability...to support the allegation of an actual false claim for payment") (emphasis omitted), cert. denied, 537 U.S. 1105 (2003).

Here, Mr. Joseph should not be held to this standard because he had no access to this information. *See U.S. ex rel. Mooney v. Americare, Inc.*, Civ. No. 06-1806, 2013 U.S. Dist. LEXIS 49398 at *11 (E.D.N.Y. April 6, 2013)("[A relaxed standard] typically applies in cases where the plaintiff-relator never had access to billing information."). A relator in the Second Circuit need only show a "factual nexus" between the fraudulent statement and the claim to the Government. *Johnson v. The University of Rochester Medical Ctr.*, 686 F.Supp.2d 259, 266 (W.D.N.Y. 2010). As explained in the next section below, the Retreat's fraudulent statements in its ledger were unavoidably reflected in claims made to the Government.

Moreover, the central question to the Complaint is whether it provides sufficient information that the Retreat has fair notice of the claims against it, and that sufficient evidence has been presented to rule out the possibility of a strike suit in which the plaintiff is fishing for a cause of action. *O'Brien v. Nat'l Prop. Analysts Partners*, 936 F.2d 674, 676 (2d Cir. 1991). Congress wrote the FCA expansively, "meaning to reach all types of fraud, without qualification, that might result in financial loss to the Government." *Cook County, Ill. v. United States ex rel. Chandler*, 538 U.S. 119, 129 (2003) (citation omitted). In amending the FCA in 1986, Congress emphasized that the scope of "false or fraudulent claims" should be broadly construed:

> [E]ach and every claim submitted under a contract, loan guarantee, or other agreement which was originally obtained by means of false statements or other corrupt or fraudulent conduct, or in violation of any statute or applicable regulation, constitutes a false claim.

S.Rep. No. 99-345, at 9 (1986), reprinted in 1986 U.S.C.C.A.N. at 5247.

A complaint such as this one that includes particular details of a scheme to present fraudulent bills to the Government as well as allegations that make it likely bills were actually submitted, however, limits any "fishing" to a small pond that is either stocked or dead. *Grubbs v. Kannegati*, 565 F.3d 180, 192 (5th Cir. 2009).

B. The Complaint Demonstrates Specific Examples in Which the Retreat Duplicately Billed the Government

The Complaint here supplies ample specific instances in which the Retreat has fraudulently billed for services. For example, the Complaint states that when CMS denies or only partially pays a claim, the Retreat routinely recodes the charge - including those that have been denied or for which payments have been received before - and then resubmits the full claim. Complaint §§ 100-101. As a result, Medicare is caused to be duplicately or otherwise falsely billed. *Id*.

To paint the Complaint as overly vague, the Retreat's motion flourishes discrete paragraphs in isolation, but does not supply the Court with the full context of these paragraphs. For example, the Retreat states that Patient 8 "turns out to be one in which nothing improper is alleged." This is true only if one stops reading the Complaint at Paragraph 130. That paragraph was intended to show that there were times when the Retreat actually billed properly and no fraud was committed. In doing so, the Complaint shows that the Retreat's actions were knowing and intentional.

The next two paragraphs of the Complaint, however, show with jarring specificity the manner in which the Retreat duplicately billed the Government for services. After Medicare Part A refused to pay for "service 11000," the Complaint shows at Paragraphs 131 and 132 that the Retreat billed three times for that same service, the dates for that billing and the person who executed the entries.

The Retreat then argues that the false statement alleged in the Complaint to trigger liability under §§ 3729(a)(1)(A) and (B) is in the CMS-838 Credit Balance Reports that the Retreat was required to submit quarterly to the U.S. government, and these reports are not specifically cited. (MTD at 14)

The CMS-838 reports are "specifically used to monitor identification and recovery of 'credit balances' owed to Medicare." (Ex. 1, Medicare Credit Balance Report - Provider Instructions at 1) A credit balance is defined as an "improper or excess payment made to a provider as a result of patient billing or processing errors." *Id*. In preparing the report, providers are instructed to "report all credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program." (Ex. 2, Instructions for Medicare Credit Balance Reporting Activities, MM5084 (June 30, 2006) at 2)

It follows to a certainty, then, that the CMS-838 reports are a reflection of the provider's own records. The Retreat made the false statements in its ledger entries, knowing that they would be carried over into its reports to the Government, rendering those reports false. The dates for the false statements in the CMS reports would necessarily be those that cover the quarter in which the entries were made.

C. The Retreat is Liable under 31 U.S.C. § 3729(a)(1)(A) Because it Falsely Certified Compliance with the Requirement to Provide Accurate CMS-838 Reports

Defendants are liable under the False Claims Act if they "knowingly ... cause[d] to be presented, a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1)(A). Claims may be "false or fraudulent" either factually or legally. *Mikes v. Straus*, 274 F.3d 687, 697 (2d Cir.2001).

Factually false claims are claims involving "an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided." *Id*. Legally false claims are those that falsely certify compliance with applicable statutes and regulations when the government conditions payment on such compliance. *Id*. False certification can be express - where the claim is accompanied by an explicit statement of compliance - or implied, where the act of submitting the claim implies compliance. *Conner v. Salina Regional Health Center*, 543 F.3d 1211, 1217-18 (10th Cir.2008). 1217-18.

When the Retreat signs its quarterly CMS-838 Credit Balance Report, it certifies that the report is "true, accurate and correct." Ex. 1. Section 1815(a) of the Social Security Act, 42 U.S.C. § 1395g, states that "no [Medicare] payments shall be made to any provider unless it has furnished" the required CMS-838 report. Thus, by submitting reports containing false information or omitting information, the Retreat made legally false claims. As such, it is liable under § 3729(a)(1)(A).

D. The Retreat is Liable Under § 3729(a)(1)(B) Because it Caused False Statements to be Made That Were Material to the Retreat's Contractual Requirement to Submit Accurate CMS-838 Reports

Section 3729(a)(1)(B) of the FCA states that parties may be liable if they "cause to be made or used" a false statement material to a false record or claim. A plaintiff asserting this claim must prove that the defendant intended that the false record or statement be used to get the Government to pay or approve the false claim. *Alison Engine v. U.S. ex rel. Sanders*, 128 S.Ct. 2123, 2130 (2008). One way a false claim can be pled under this statute is to plead that a government contractor "withheld information about its noncompliance with material contractual requirements." *U.S. v. Science Applications Intern. Corp.*, 626 F.3d 1257, 1269 (D.C. App. 2010).

Here, the false statements pervade the Complaint with instance after instance of fraudulent entries entered in the Retreat's accounts. For example:

- For Patient 1, the Retreat billed Medicare $561 per diem for a charge recorded for March 21, 2006. (Compl. ¶ 105) The Retreat then billed Medicaid for the same service. (Compl. ¶ 106)

- For Patient 8, the Retreat submitted a claim to Vermont State Hospital, a Medicaid-funded program, for $70,829 that should have been for only $21,508. (Compl.¶ 141) Moreover, that entire claim was invalid because it was submitted even though documentation did not exist. (*Id.*)

By manipulating the ledger entries in this fashion, the Retreat was able to avoid detection of its multiple billing and invalid claims. These ledger entries were necessarily reflected in the Retreat's CMS-838 reports, rendering those reports false. In doing so, the Retreat was noncompliant with a material contractual requirement to receive Medicare funds. The Retreat is therefore liable under § 3729(a)(1)(B).

V. The Retreat is Liable for Payments Withheld from the Government

The Retreat argues that it should not be held to account for any payments it withheld from the Government before May 20, 2009, when the Fraud Enforcement and Recovery Act ("FERA") went into effect.[1] (MTD at 16) FERA amended the False Claims Act to specifically create liability for any entity that "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1)(G)). The Retreat contends that pre-FERA, the FCA did not create liability for overpayment.

The Retreat's contention holds no water. Before the FERA amendment, the "reverse claim" provision of the FCA, § 3729(a)(7), created liability for the knowing use of a "false

[1] Actually, Section 4(f)(1) of FERA states that § 3729(a)(1)(B), applies to all claims under the FCA pending on or after June 7, 2008.

record or statement to conceal, avoid, or decrease an obligation . . . to transmit money or property to the Government." In essence, this provision provided that "fraudulently reducing the amount owed to the government constitutes a false claim." 1 John T. Boese, CIVIL FALSE CLAIMS & QUI TAM ACTIONS, § 2.01[K] at 2-56 (3d ed.2010).

The Complaint alleges more than pure, passive withholding of overpayment from the Government. Instead, the Complaint documents a scheme in which the Retreat actively reported to the Government that it owed less than it actually did, misleading the Government into believing little or nothing was owed. These allegations fit right into the both the current and earlier versions of the False Claims Act. As discussed below, the Complaint states a claim under either version.

A. The Retreat Faced an Obligation to Return the Overpayments to the Government

The first prong of Section 3729(a)(1)(G) provides for FCA liability where a defendant "knowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay money to the government." The statute defines obligation as "an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of overpayment." This definition reflected the Senate Judiciary Committee's view "held since the passage of the 1986 Amendments, that an 'obligation' arises across the spectrum of possibilities from the fixed amount debt obligation where all particulars are defined to the instant where there is a relationship between the government and a person that results in a duty to pay the government money, whether or not the amount owed is yet fixed." Senate Judiciary Committee Report (March 23, 2009 at 14), cited by *United States ex rel. Yannapolous v. General Dynamics*, 636 F.Supp.2d 739, 751 (N.D.Ill. 2009).

Instead of analyzing this definition, however, the Retreat simply dismisses it altogether, arguing that it should somehow not be used to inform this Court of the meaning of the term ”obligation.” The Retreat substitutes citations to cases from other circuits that pre-date the enactment of the definition of “obligation” supplied by FERA. (MTD at 16, fn1) Those dusty cases do not help its cause, either. Back then, the meaning of “present obligation” was one

> in the nature of those that gave rise to actions of debt at common law for money or things owed. This interpretation of the term 'obligation' is supported by the legislative history of the reverse false claims provision, which refers twice to "money owed," S.Rep. No. 99-345, at 15, 18, reprinted in 1986 U.S.C.C.A.N., at 5280, 5283, as the kind of duty that the reverse claims provision is designed to address.
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> - *U.S. v. Q Intern. Courier, Inc.*, 131 F.3d 770, 773 (8th Cir. 1997)(citing *United States ex rel. S. Prawer & Co. v. Verrill & Dana*, 946 F.Supp. 87, 93-95 (D.Me.1996).

The Retreat is under just this sort of duty. Section 1870 of the Social Security Act, 42 USC §§ 1395gg, establishes that providers and suppliers to the Government through the Medicare program are liable for overpayments and 42 C.F.R. §§ 405.301-405.378 (1997) specified the method before 2009 for recouping overpayments. *(*Compl. ¶ 52) As the 11th Circuit stated in the pre-FERA case of *U.S. v. Blue Shield of Alabama*, 156 F.3d 1098, 1112 (11th Cir. 1998), this system allows the Government to recoup incorrect payments from providers, and “it can certainly bring an FCA action against the recipient of the funds if that recipient participated in the scheme.”

Under both the current or earlier definition of “obligation,” then, the Retreat clearly had a duty to return any overpayment to the Government. As the complaint shows the Retreat manipulated its financial records to avoid doing so, a False Claims Act action such as this became the appropriate means of forcing the return of the money, pre- and post-FERA.

B. The Complaint Provides Sufficient Specificity to the False Reports Submitted to the Government

The Retreat acknowledges that the Complaint alleges that the Retreat submitted quarterly and annual reports to the Government that contained false statements regarding the Retreat's obligations to the Government. (MTD at 12) However, the Retreat complains that allegations about falsities in "every report" are insufficient and that the Complaint should identify specific reports. (*Id.*)

As explained above, these reports - the CMS-838 Credit Balance Report - are regular reports to the government that are "specifically used to monitor identification and recovery of 'credit balances' owed to Medicare." (Ex. 1, Medicare Credit Balance Report - Provider Instructions at 1) A credit balance is defined as an "improper or excess payment made to a provider as a result of patient billing or processing errors." (*Id*.) In preparing the report, providers are instructed to "report all credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program." (Ex. 2, Instructions for Medicare Credit Balance Reporting Activities, MM5084 (June 30, 2006) at 2) It follows to a certainty, then, that the CMS-838 reports are a reflection of the provider's own records.

The Complaint painstakingly details how the Retreat manipulated its records so as to show much lower credit balances. As a requirement to participate in the Medicare program, the Retreat then had to use these same records in preparing the CMS-838 reports. Thus, every fraudulent manipulation detailed in the Complaint pertaining to Medicare must be reflected in each CMS-838 report corresponding to that date. Each of these CMS-838 reports must therefore contain false statements material to an obligation to pay money to the Government. (Compl. ¶97)

Accordingly, the allegations in the Complaint are reliable indicia that, pursuant to either § 3729(a)(1) or § 3729(a)(G), the Retreat is liable to the Government for reverse false claims.

C. The Complaint Provides Ample Specificity of the Cases in Which the Retreat Has Manipulated Its Own Financial Records

According to the Retreat, the Complaint provides insufficient details of the financial manipulation the Retreat performed on specific patient records. Although the Retreat demands "paragraph-by-paragraph" scrutiny of a complaint - whatever that means - it excised from its quote of *U.S. ex rel. Marlar v. BWXI*, 525 F.3d 439, 444 (6th Cir. 2008) supporting that mandate that this scrutiny should only be required where the complaint alleges "separate and unrelated conduct." Here, of course, the Complaint describes one common scheme to manipulate government payments and merely provides examples to show how the scheme works.

For example, the Retreat attempts to make the Complaint's allegations regarding Patient 3 more uncertain and in good faith than the Complaint actually depicts. The Complaint frequently shows that the Retreat properly recorded accounts on occasion. This demonstrates that the Retreat's manipulation at other times was purposeful, directed and knowing.

For Patient 3, the Complaint specifically details at Paragraph 123 that "at least three" of the code entries on February 5, 2011, totaling $18,668.05 "were not actually refunded to DMH" because instead of placing that money in an entry where it could be refunded, it was posted as an "Unapplied Cash" entry on the same date. By doing that, the Complaint shows in Paragraph 124 that the Retreat "concealed the existence of an $18,668.05 overpayment" that should have been returned. With the overpayment hidden elsewhere in its records, the Retreat would prepare its next CMS-838 report in a manner that would unavoidably be skewed in favor of the Retreat and the report to the Government would necessarily be false. Paragraph 127 shows that these manipulations were done at the direction of the Retreat's management.

Again, for Patient 1, Medicare was billed $3,330.77, when it should only have been billed $560.89. (Compl. ¶ 106) To conceal the overpayment, on April 20, 2006, the Retreat entered a posting code 10, and then zeroed it out with a simultaneous posting code of 21. (*Id*.) By doing this, the Retreat recorded that the original payment had been wrongly entered and was now being reversed. The result was that the entire balance of the overpayment was erased from the patient ledger. The allegations are clear, specific and devastating.

VI. If Any Deficiencies Should Be Found In The Complaint, The Plaintiff Should Be Allowed To Amend

Complaints dismissed under Rule 9(b) are "almost always" dismissed with leave to amend. *Luce v. Edelstein,* 802 F.2d 49, 57 (2d Cir. 1986) (quoting *2A* J. Moore & J. Lucas, MOORE'S FEDERAL PRACTICE, ¶ 9.03 at 9-34 (2d ed. 1986)). Leave is sometimes denied in cases where plaintiffs have usually already had opportunity to amend or the defective allegations were made after full discovery in a related case. *Id.*

As demonstrated above, the existing Complaint alleges facts with sufficient specificity that the Retreat's Motion should be denied. Should more facts be warranted, however, pursuant to Rule 15(a), the Plaintiff respectfully requests leave to amend the Complaint.

Conclusion

The Retreat is required to submit quarterly CMS-838 reports to the government that detail the amount of overpayment the Retreat must return. By manipulating the ledger entries that these reports are based on, the Retreat was able to escape detection of double and triple billing and avoid refunding millions in overpayment. The False Claims Act complaint brought by insider Thomas Joseph is within the statute of limitations on all claims because it was brought within a year of discovery. The Complaint states with the specificity required by Rule 9(b) the false statements made, who made them and why they were fraudulent. Because the false

statements recorded in the Retreat's ledger were necessarily reflected in the Retreat's CMS-838 reports submitted to the Government for payment from Medicare, the Complaint demonstrates the Retreat's clear liability under the False Claims Act.

WHEREFORE, the undersigned move this court to deny the Defendant's Motion to Dismiss.

DATED this 10th Day of April 2014

/s/ Timothy Cornell

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CERTIFICATE OF SERVICE

I certify that on April 10, 2014, I electronically filed with the Clerk of Court the foregoing document, Opposition to The Brattleboro Retreat's Motion To Dismiss using the ECF system. The ECF system will provide service of such filing(s) via Notice of Electronic Filing (NEF) to the following NEF parties:

United States Attorney's Office; Nikolas P. Kerest, which has consented to NEF service.

The Brattleboro Retreat, Elizabeth Wohl and Craig Miskovich, of Downs Rachlin & Martin, which has consented to NEF service.

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