THOMAS JOSEPH

P.O. BOX 2111
BRATTLEBORO, VERMONT 05303

November 30, 2015

Attorney Betsy Garber
Investigations Disciplinary Counsel
Board of Professional Responsibility
10 Cadillac Drive, Suite 220
Brentwood, TN 37027

RE: File No: 37705-5-KB
Respondent: Matthew Michael Curley, #18613
Supplemental Filing to TN BPR submission dated 11/15/15

Counsel for Defendant, The Brattleboro Retreat in the matter of
United States ex. rel. Thomas Joseph v. The Brattleboro Retreat
United States District Court, District of Vermont, Case No: 2:13-cv-55wks

Dear Attorney Garber:

As you are aware, I represent myself in the above captioned matter. I am submitting additional and new information which, I respectfully request be considered together with the already extensive analysis I have provided the TN BPR in my four (4) prior submissions dated 02/16/15, 08/02/15, 09/17/15 and 11/15/15.

For those new to any aspect of the many examples I have provided the TN BPR, my submissions often provide examples that I have identified which evidence material misrepresentations of the factual allegations and follow directly with aspects of the federal Complaint that demonstrate defense counsel's often patently false assertions that when contrasted with the written word of the federal Complaint evidence their falsity. In many of these now numerous examples, defense counsel is caught red-handed asserting flat out lies to the Court. As the original Complaint to the TN BPR noted, Attorney Curley and co-counsel's misconduct wasn't the result of human or other error, but was deliberate and purposeful. By doing so, they have manipulated the use of "persuasive force" to advance assertions in there pleadings that were more often false, erroneous, and materially misrepresentative of the factual allegations contained in the federal Complaint and therefore, evidence sanction-able misconduct for their collective fraud before the Court.

In many respects, despite defense counsel's own concession that *"the legal standards applicable to this analysis involved a review of the facts as set forth in Mr. Joseph's own complaint, with the assumption for purposes of the Motion to Dismiss that such facts are true"* they ignore this legal standard to advance materially misleading assertions that when contrasted with the written word of the federal Complaint evidence their falsity.

TN BPR: MTD Page 2: Last Paragragh of Preliminary Statement:

Defense counsel state as follows:

> "Finally, Mr. Joseph has failed to plead his claim under § 3729(a)(1)(G) with the particularity required by Rule 9(b). While Mr. Joseph makes general allegations that the Retreat improperly retained overpayments in violation of § 3729(a)(1)(G), he failed to plead sufficient facts with respect to any particular overpayment to state a claim as a matter of law. His Complaint includes nothing more than convoluted allegations regarding supposed application of internal accounting codes from which Mr. Joseph extrapolates fraud and fails to assert specific factual allegations required to state a claim under § 3729(a)(1)(G), or its predecessor § 3729(a)(7)."

The above paragraph by Attorney Matthew M. Curley and his co-conspirator Attorney Elizabeth R. Wohl found at the conclusion of the Preliminary Statement captures the essence of defense counsel's entire Motion to Dismiss: It was knowingly and intentionally materially misleading and included asserting new facts which are nowhere to be found in the federal Complaint and whose pleadings often contained assertions that were not representative of the factual allegations found in the federal Complaint as they simply refused to acknowledge them by this assessment that the body of evidence contained "nothing more" than "supposed application of internal accounting codes." Defense counsel have also mislead the Court by its failure to accurately cite or restate where necessary, the factual allegations contained in the Complaint, and as a result, have materially mislead the tribunal and by doing so have actively carried out a fraud before the Court which has ultimately derailed the administration of justice.

In two areas of the federal Complaint identified previously, defense counsel assert at least twice and similarly that the Complaint includes "nothing more" than "convoluted allegations" regarding "supposed application of internal accounting codes" from which Mr. Joseph "extrapolates fraud." By suggesting that the entire body of evidence memorialized in the federal Complaint referred to "nothing more" than "supposed application of internal accounting codes" is terribly misrepresentative of what the federal Complaint actually states. Defense counsel conceded the legal analysis that they were to have used in their MTD analysis, then proceeded to jettison any sense of obligation to follow through as they decided to ignore vast sections of the Complaint and pretend that the accompanying factual allegations didn't exist.

Indeed, we see the same misrepresentative and erroneous theme surfacing again on Motion to Dismiss at Page 7 (Last paragraph of MTD III. The Complaint) where defense counsel state similarly:

> "Rather, the "entirety" of the Complaint is based on inferences drawn from the use of accounting entries and codes on particular patient accounts and his review of patient ledgers."

This exercise and example also demonstrates that rather than treat the Complaint factual allegations as true or not, defense counsel decided to ignore the majority of factual allegations referred in the Complaint and by doing so have materially misrepresented the totality of the factual allegations by asserting that the "entirety" of the Complaint relates to just simply "convoluted allegations regarding supposed application of internal accounting codes" as part of their purposeful and devious scheme to mislead the Court with numerous material misrepresentations of the factual allegations to carry forward their historic client's fraud to deceive a federal Court.

As to defense counsel's assertion that the "entirety" of the Complaint related to the "extrapolation of accounting codes", how does defense counsel explain the following highlighted section of various federal Complaint paragraphs that overwhelming demonstrate that defense counsel only acknowledged one small observation that my interpretation of the Retreat's accounting codes and entries formed the "entirety" of the federal Complaint. This is just not true and underscores the extent to which defense counsel went to mislead the Court as the following federal Complaint paragraphs demonstrate:

➔ **TN BPR**: Complaint ¶ 13: "Relator states that all allegations in this Complaint are based on evidence (TN BPR Note: "Evidence" not an "extrapolation of supposed internal accounting codes") obtained directly by Relator independently and through his own labor and efforts. The information and evidence he has obtained or of which he has personal knowledge, and on which these allegations of violations of the False Claims Act are based, consist of documents, computer data, conversations with authorized agents and employees of the Retreat, and his own direct observations of manipulations of computer accounting data or other actions taken by such authorized agents and employees of the Retreat."

➔ **TN BPR**: Complaint ¶ 75: In response to Relator Thomas Joseph's queries regarding when, if ever, self-payment and commercial insurance overpayments would be refunded to the proper parties or sent, as required by law, to the State of Vermont's Unclaimed Property division, Chief Financial Officer and Senior Vice President John Blaha informed Relator Thomas Joseph on September 5, 2012 that refunding of such overpayments had to be balanced with the Retreat's "other financial obligations, including payroll."

➔ **TN BPR**: Complaint ¶79: When an overpayment exists to the credit of a commercial insurance payer, but no refund request respecting that overpayment is on file, Jennifer Broussard routinely uses an "allowance reversal," or posting code "21," to eliminate the credit from the patient ledger, thereby eliminating the possibility of the insurance company overpayment remaining on the client ledger or the Retreat pursuing a refund due to the fact that the individual client ledger for that patient no longer reflect the existence of the overpayment. In so doing, "her hand-written notes on patient ledgers sometimes reflect that an "allowance reversal" was done because no refund request was on file."

➔ **TN BPR**: Complaint ¶80: States "there is a handwritten notation which states: "Claim paid twice, No request for refund. Allowance reversal done 11/15/11," followed by Jennifer Broussard's signature. (See Exhibit A)

In Complaint ¶75 above you see the Senior Vice President and Chief Financial Officer admitting that he was using unrefunded credits, essentially stolen money, as a line of credit to which Mr. Blaha indicated whose refund and voluntary return had to be balanced with the Retreat's "other financial obligations, including payroll" but that is not at all reflective of what defense counsel erroneously project when they advance that the "entirety" of the federal Complaint relates to simply "the extrapolation of fraud from supposed accounting codes" when Complaint ¶75 verifies that defense counsel flat out lied to the Court.

Defense counsel accomplished this by their refusal to acknowledge the existence of the vast factual allegations in the Complaint. Indeed, they never had to worrying about their conceded knowledge of "*the legal standards applicable to this analysis involved a review of the facts as set forth in Mr. Joseph's own complaint, with the assumption for purposes of the Motion to Dismiss that such facts are true"* because they just chose to ignore nearly all factual allegations to falsely misrepresent that the body of evidence memorialized in the 59 page federal that the "entirety" of the Complaint amounted to "nothing more" than "convoluted allegations" regarding "supposed application of internal accounting codes" from which Mr. Joseph "extrapolates fraud."

➔ **TN BPR**: Complaint ¶127: Finally, the printed RA appearing in the Retreat's hardcopy records conclusively shows that such an illegitimate juggling of overpayments is in fact what happened: it contains a handwritten annotation in Rose Dietz' handwriting showing that the recoupment of overpayments made with respect to Patients 4 through 7's claims was "paid for" by the Retreat using an overpayment amount transferred from Patient 3's ledger, stating unequivocally that the amount of $6932.84 had been "took [sic] from o/p [Patient 2]," This annotation also establishes that these operations were all performed by cash poster Rose Dietz acting at the direction of Robert Simpson, John Blaha, Lisa Dixon, and/or Jennifer Broussard's instructions. (See Exhibit B)

Note to TN BPR: Exhibit B attached represents the actual Vermont Medicaid Remittance document with the actual handwritten notes from Rose Dietz, the Retreat's Cash Poster with some identifiers redacted that are referred to in Complaint ¶127. As shown previously, the paragraphs of the federal Complaint often and did provide a written narrative and description of the physical evidence in many cases. When you have handwritten admissions by the person who posts all cash receipts for the hospital, there wasn't any "extrapolation" necessary to understand the fraud afoot and memorialized for this patient example and supported by the evidence found in **Exhibit B**.

Question to TN BPR: As defense counsel have made it very clear that it's their belief the "entirety" of the Complaint amounted to "nothing more" than "convoluted allegations" regarding "supposed application of internal accounting codes" from which Mr. Joseph "extrapolates fraud" how do defense counsel explain Complaint ¶127 supported by Exhibit B which represents the actual physical evidence and handwritten admissions contained in Complaint ¶127? There

should be no doubt to anyone that defense counsel were asserting material misrepresentation of the factual allegations in furtherance of their collective fraud before the tribunal.

To further support the material misrepresentations of the factual allegations, I refer you to Complaint ¶137, 138, 139, 140, 141 and 142 found below all of which relate to **Exhibit C** which provide the TN BPR with the physical evidence for exactly what the federal Complaint states in written form but which defense counsel ignored and mislead the tribunal by their false and erroneous assertion that "nothing more" than "convoluted allegations" regarding "supposed application of internal accounting codes" from which Mr. Joseph "extrapolates fraud". Contrary to defense counsel's assertions, in the following example there is no need to "extrapolate" anything as the physical evidence as memorialized in Complaint ¶137-142 clearly articulates the fraud and the exhibits only provide the physical evidence that demonstrated that what was asserted was factually correct despite defense counsel's material misrepresentation of the factual allegations contained in the Complaint.

➔ **TN BPR**: Complaint ¶137: The anomaly of a Medicaid program paying more for the same services than Medicare Part A throughout the ledger is partially resolved by looking to the RA for the Medicare Part A payment made to the Retreat for Patient 8's entire episode 8 as well as the Payment/Adjustment Report for June 7, 2012. The RA reveals that CMS imposed a downward adjustment of $148,410.17 from the Retreat's nominal charges of $219,945.96 for the 94 per diem days that made up Patient 8's episode 8, leaving $71,535.79 that CMS believed represented the full reasonable value of the service at the per diem rate. (**See Exhibit C**).

➔ **TN BPR**: Complaint ¶138: The RA also shows that CMS determined that the Medicare Part A payment would be further reduced by $21,508.00 to account for the required patient responsibility portion of the remaining charges, for a net payment of $50,027.81. Turning to the Payment/Adjustment Report for June 7, 2012, the mystery of why Medicaid would pay more for a service than Medicare Part A does is fully resolved: on June 7, 2011, three postings related to this particular RA were posted to Patient 8's ledger for episode 8. (**See Exhibit C**).

➔ **TN BPR**: Complaint ¶139: The first of these was posted using code 10 and was in the amount actually paid by Medicare A for the claim, or $50,027.81. The second of these was posted using code 20, and shows a discount or allowance credit in favor of Medicare Part A in the amount of $91,970.20, or a full $56,439.97 less than the amount that the RA indicated should have been written as an amount or allowance credit in favor of Medicare Part A. (**See Exhibit C**).

➔ **TN BPR**: Complaint ¶140: The third posting was posted using code 61, which designates the amount that is supposed to be the patient's responsibility, and was in the amount of $70,829.81. Here again the Retreat's records diverge from the RA, as the RA indicated that only $21,508.00 was to be designated as patient responsibility. The patient responsibility amount listed in the Retreat records exceeds the amount CMS designation on its RA as patient responsibility by $49,321.80. (**See Exhibit C**).

➔ **TN BPR**: Complaint ¶141: Not withstanding its legal obligation to submit only claims for which documentation exists, the Retreat submitted claims to VSH, a Medicaid-funded program, purportedly for this dual-eligible patient's patient responsibility amount as designated by Medicare Part A, but in the amount of $70,829.81 rather than in the amount of $21,508 as the patient responsibility for these DOS was determined by CMS. This resulted in an overpayment from VSH in the amount of $49,321.89. (**See Exhibit C**).

Note to TN BPR: Page 2 of Exhibit C provides a clear description for all three line items associated with this patient on the Payment/Adjustment Report found on Page 2 of **Exhibit C** where it was confirmed the amount of "Deductible/Copay" was $70,829.81 when the actual Medicare RA on Page 1 of Exhibit C indicate the total patient responsibility and billable to any secondary payer was only $21,508.00 evidencing fraud without any need for "extrapolation" or worry about "supposed application of internal accounting codes" when the fraud was clear to anyone with a cursory understanding of Medicare's Secondary Payer Guidelines which were discussed in the Complaint but also discussed in my prior submissions to the TN BPR.

➔ **TN BPR**: Complaint ¶142: The Retreat's record of submission of this claim to VSH, contained in the cash reconciliation report documents for June 2, 2012. Because 100% of the reasonable value of the services paid for by Medicare Part A was determined to be $71,535.79, but the Retreat actually received a total of $120,857.62, the total overpayment the Retreat received for this one patient's eight episode alone amounts to $49,321.83. The cash reconciliation report documents for June 2, 2012 show that Rose Dietz performed the transactions described in this paragraph acting pursuant to Robert Simpson, John Blaha, Lisa Dixon, and/or Jennifer Broussard's instructions.

Question for TN BPR: Given defense counsel's clear and unambiguous false assertion that the "entirety" of the Complaint related to "nothing more" than "supposed application of internal accounting codes", how does the TN BPR explain away defense counsel's materially false assertions contained in the federal Complaint evidenced above that show everyone that defense counsel flat out lied to the Court repeatedly?

DEFENSE COUNSEL ASSERT "NEW" FACTS IN MOTION TO DISMISS LIKELY EVIDENCING ADDITIONAL VIOLATIONS OR MISCONDUCT OF THE FEDERAL RULES OF CIVIL PROCEDURE AND/OR THE RULES OF PROFESSIONAL CONDUCT ("RPC") IN THE STATE OF TENNESSEE AND THE STATE OF VERMONT

As defense counsel had asserted in their legal pleadings, not surprisingly, the suggestion that I may not have *ever* seen a claim form, I refer you to page 3 of Exhibit 3 where you find the actual claim form or UB-04/CMS-1450 which relates to the patient example discussed in Complaint ¶137-142. In this example, we see additional unsupported and misleading assertions (in this case), suggesting I may not have ever *seen* a claim form) of "new" facts by defense counsel which were nowhere to be found in the federal Complaint but inserted solely to deceive and mislead the tribunal.

In addition, in my Cover Letter to the TN BPR dated 11/15/15, I also referred to defense counsel's propensity to insert "new" facts into their Motion to Dismiss, which my formal attorneys had indicated to me was a big "no-no" but did not elaborate. Because some of the patient examples involved reimbursement by Medicare of amounts that exceeded in some instances the gross charge of some admissions is why defense counsel's failure to provide all of the multiple reimbursement methodologies for the entire ten year period represented a further material misrepresentation of the facts. Indeed, defense counsel use "new" facts found nowhere in the federal Complaint to falsely paint the picture to the Court that it was somehow perfectly normal or "OK" for a provider like the Retreat to keep any excess overpayment it may have receive from Medicare when the providers obligation to return any amount it is not entitled is absolute.

In order to understand why the above statements are misleading aside from the fact that this entire discussion is nowhere to be found in the federal Complaint, it is necessary to walk you through the complex reimbursement scheme used by CMS or Medicare which changed multiple times over the entire ten years at issue in the federal Complaint. I apologize in advance to have to provide the extensive and complex explanation but it is necessary given the unfortunate and likely further misconduct by defense counsel asserting "new" facts while providing conclusory and broad statements supposedly explaining how the Retreat was reimbursed by Medicare but where they never provided the Court with the varying methodologies or calculations that were needed and which varied for the years 2003 to 2012. By failing to explain or provide the Court with the requisite information some of which is highlighted below demonstrates defense counsel's lack of candor to the tribunal as they make representations that are patently misrepresentative of the reimbursement criteria needed to compute a reimbursement methodology for any of the ten years in the Complaint as well as mislead the Court by their suggestion that it was perfectly normal for hospitals to receive and keep overpayments.

MEDICARE AND MEDICAID REIMBURSEMENT ANALYSIS PREPARED BY MY FORMER ATTORNEYS AT THORNTON & NAUMES LLP (PORTIONS OF WHICH WERE GIVEN THE GOVERNMENT AS POST FILING SUPPLEMENTAL ANALYSIS)

Defense counsels assertions above are more suspect given the recent Fraud Enforcement Recovery Act of 2009 ("FERA") and the Patient Protection and Affordable Care Act of 2010 ("PPACA"), as discussed herein. The relevant portions of these acts, stand in stark contrast to the notion that the Retreat's actions were permissible. To the contrary, The False Claims Act is clear that "an established duty" exists 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 an overpayment. 31 U.S.C. § 3729(b)(3)(2010). The Retreat, notwithstanding the explicit duty to return funds to which it is not entitled, used improper accounting practices to retain those government funds and prevent the government from discovering the overpayments.

As the federal Complaint makes clear the Retreat's actions with respect to overpayments have always been *knowing* and *intentional*. The Retreat's consistent practice of entering "code

21" allowance reversals when it encounters or receives overpayments, including those from federal health benefit programs, or receives sums to which it is not entitled, demonstrates unequivocally that it takes *knowing* and *intentional* actions to avoid repayment of government funds. The Retreat's established duty to return any amounts to which it is not entitled demonstrated active and ongoing FCA liability under FERA for the periods at issue. The facility's treatment of commercial insurance credits (combined with "needing to make payroll") are evidence that it has little or no concern about *any* overpayments it receives, regardless of the source.

Medicare rules related to the status of government as payer are straightforward. Coupled with the improper retention of overpayments, the Retreat's actions serve as the basis of multiple FCA violations. Further, as all of these predicate actions affect the Retreat's compensation, the government suffered additional harm in the form of paying falsely inflated compensation to the Retreat for the period at issue in the federal Complaint.

In reference to Diagnosis Related Group ("DRG") and their relation to the factual allegations, however, I am providing background information necessary to understand both DRGs pertinent to the types of services at issue in the Complaint whose calculation changed multiple times over the ten year period at issue in the federal Complaint. This is followed with a discussion on the impact of FERA and PPACA on the factual allegations.

1. AN OVERVIEW OF DRG AND MEDICARE REIMBURSEMENT FOR PSYCHIATRIC SERVICES

A. Beginning in 2004, inpatient psychiatric facilities were transitioned from a reasonable cost basis to a prospective payment system with respect to their reimbursement for treating Medicare beneficiaries.

The federal Complaint alleges that the Retreat has impermissibly hidden and retained overpayments that are in fact due and payable to the federal government – all with the intent to avoid or reduce the Retreat's obligations to the federal government. This raises the issue of whether the funds at issue do, in fact, constitute overpayments to which the Retreat is not entitled and which the federal government was not in fact obligated to pay. In order to understand why this is not an issue in the present case, it is necessary to provide a brief explanation of the reimbursement scheme mandated by Congress and implemented by CMS regulations. Such a discussion will be incomplete if it were limited solely to the prospective payment system ("PPS") for inpatient psychiatric facilities ("IPF"s); accordingly, the following begins with a brief discussion of the origin and purpose of PPSs in federal health care law, followed by a detailed examination of the PPS specifically applicable to IPFs such as the Retreat.

i. Background and purpose of PPS in Federal law

Congress first mandated transition to the use of a PPS for Medicare reimbursement in 1983, and initially limited the scope of its mandate to acute care hospitals and certain other

facilities; inpatient psychiatric facilities were excluded from PPS requirements and instead continued on the previous retrospective reasonable cost of care model (also known as TEFRA[1] reimbursement), where reimbursement was based on the retrospectively reported cost of providing care to the individual provider in question. *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 141-42 (D.C. Cir. 1986) ("The Social Security Amendments of 1983 instituted "a major change in the method of payment under Medicare for inpatient hospital services." Certain types of hospitals, such as psychiatric hospitals and children's hospitals, and certain types of costs, such as medical education, continue to be reimbursed on a [retrospective] reasonable cost basis. For most hospitals, however, Medicare now pays for inpatient services on the basis of prospectively determined rates.") (brackets added) (citing S. Rep. No. 23, 98th Cong., 1st Sess. 47, *reprinted in* 1983 U.S. Code Cong. & Ad. News 143, 187 and 42 U.S.C. §§ 1395ww(a)(4), 1395ww(d)(1)(B) (Supp. II 1984)). In enacting PPS, Congress intended to reduce the cost of care by creating incentives for providers to conduct themselves in the most economically efficient manner available to them. *Id.* at 142 (stating that "Congress instituted the Prospective Payment System ("PPS") in order 'to reform the financial incentives hospitals face, promoting efficiency in the provision of services by rewarding cost/effective hospital practices.'") (quoting H.R. Rep. No. 25, 98th Cong., 1st Sess. 132, *reprinted in* 1983 U.S. Code Cong. & Ad. News 219, 351). This intention was most clearly brought to fruition in the provisions allowing providers to keep the difference, if any, between the PPS reimbursement amount and the provider's actual cost of care while simultaneously capping for most purposes the allowable reimbursement at the PPS-determined rate, placing the risk of cost overruns more squarely on the providers' shoulders. *Id.* ("By informing hospitals in advance of the payments they will receive per patient for various types of treatment, Congress hoped to induce the hospitals to lower their costs to levels below the amount of the payments.").

Under PPS, providers are reimbursed not based on their actual cost history, but rather on national average costs of care for clinically related conditions, adjusted for various region-, locality-, and patient-specific factors that Congress adjudged to be out of the provider's control; these averages were initially calculated for 470 categories, known as Diagnosis Related Groups ("DRGs"). *Id.* (stating that under PPS, "hospitals will be paid according to a standard national rate calculated for each of approximately 470 treatment categories or "Diagnosis Related Groups" ("DRGs").") (citing 42 U.S.C. § 1395ww(d) (Supp. II 1984) and 49 Fed.Reg. 34,728, 34,780–90 (1984)). As noted above, the purpose of PPS was to encourage efficient care delivery by allowing providers to pocket the difference between their DRG-based standard reimbursement rate and their actual costs incurred in providing care.

ii. PPS currently in place for IPFs

With respect to IPFs, Congress did not require reimbursement of such facilities under a

1 TEFRA is an acronym for the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 1982 U.S. Code Cong. & Ad. News (96 Stat.) 324.

PPS until it enacted Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. No. 106-113. This section required the Secretary of the Department of Health and Human Services to: (1) develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units; (2) include in the PPS an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and psychiatric units; (3) maintain budget neutrality; (4) permit the Secretary to require psychiatric hospitals and psychiatric units to submit information necessary for the development of the PPS; and (5) submit a report to the Congress describing the development of the PPS. *Id.* at § 124(a). In addition, HHS was required to submit a report regarding its efforts to implement such a system by October 1, 2001, and to implement it for cost reporting periods beginning on or after October 1, 2002. *Id.* At §§ 124(b) and 124(c). Even with those requirements, the PPS system was not implemented with respect to IPFs until several years after the statutory deadline, due to difficulties in assembling and analyzing the data necessary to construct reasonably accurate base per diem rates. *See generally* Tommy G. Thompson, Secretary of Health and Human Services, "Report to Congress: Prospective Payment System for Inpatient Services in Psychiatric Hospitals and Exempt Units" (2002) (see URL at end of paragraph). Accordingly, the following will begin with a brief overview of the retrospective reasonable cost system of reimbursement operative for rate years 2003 and 2004, with a description of the current PPS system to follow. http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/InpatientPsychFacilPPS/Downloads/rptcongress.pdf

For the years 2003 and 2004, IPFs were reimbursed according to the old retrospective reasonable cost method of reimbursement, under which providers were reimbursed for their actual cost incurred in providing reasonably necessary services. *See, e.g.*, *Washington Hosp. Ctr.*, 795 F.2d at 141. Further, [u]nder the "reasonable cost" system, which continues to apply to a limited class of providers, fiscal intermediaries such as Blue Cross make estimated interim payments to providers during the year and later retroactively adjust them to bring the amount paid into conformity with the actual, reasonable costs incurred by the hospital. At the end of a cost reporting year the hospital submits a cost report to the intermediary, which audits the report to determine which costs are reimbursable. The intermediary's conclusion as to the total amount of reimbursement due the provider is contained in a Notice of Program Reimbursement ("NPR").

Id. (internal citations omitted). Beginning on January 1, 2005, however, IPFs were transitioned to the PPS system mandated by section 124 of the BBRA. *See* 42 C.F.R. § 412.400(b).[2] The transition period involved a graduated reduction in the portion of the total reimbursement calculated using the retrospective reasonable cost method coupled with a simultaneous graduated increase in the proportion of the total reimbursement calculated using the PPS method; the transition was complete as of January 1, 2008. *See* 42 C.F.R. § 412.426(a).[3] The regulations governing the PPS

2 Unless otherwise specified, this and all subsequent citations to the Code of Federal Regulations is to the version in effect as of June 13, 2013.

3 The proportions were as follows: 75% retrospective (or "facility-specific" in the terms used in the regulation), 25% PPS for cost reporting periods beginning on or after January 1, 2005; 50% retrospective, 50% PPS for cost-reporting

for IPFs are located at 42 C.F.R. 412 subpart N, and what follows is an overview of the method by which IPFs are now reimbursed under the PPS.

The rate-setting methodology begins with deriving the national average cost of treatment in IPFs as of the base year, designated by regulation to be fiscal year 2002, which is the total of average inpatient operating, ancillary, and capital-related costs for all IPFs, calculated on a per-patient, per-diem basis. 42 C.F.R. § 412.424(b). This amount is used as the baseline for calculation of the Federal per diem base rate, which is then to be adjusted according to various facility- and patient-specific factors. 42 C.F.R. § 412.422. This base amount is adjusted each year by "the most recent estimate of increases in the prices of an appropriate market basket of goods and services provided by inpatient psychiatric facilities." 42 C.F.R. § 412.424(c)(6)(ii). This resulting amount is then split into labor-related costs and non-labor-related costs for purposes of applying the facility- and patient-specific adjustment factors. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicare Claims Processing Manual*, CMS Pub. 100-4, Ch. 3, § 190.4 (2008) (hereinafter CMS Manual).

Following the calculation of this base rate, the final Federal per diem payment is derived in a somewhat complicated fashion. First, the portion of the Federal per diem base rate representing labor-related costs is adjusted "to account for geographic differences in the area wage levels using an appropriate wage index[;] . . . application of the wage index is made on the basis of the location of the inpatient psychiatric facility in an urban or rural area as defined in [42 C.F.R.] § 412.402." 42 C.F.R. § 412.424(d)(1)(i). Next, the adjusted labor-related portion is added to the non-labor-related portion, and adjusted upward to account for: rural versus urban location and indirect teaching costs, 42 C.F.R. § 412.424(d)(1)(ii) and (iii); patient-specific factors, including age, length of stay, co-morbidities (physical ailments commonly coinciding with mental illness), and DRG. 42 C.F.R. § 412.424(d)(2). If applicable, the result may also be adjusted upward to account having a qualified emergency department. 42 C.F.R. § 412.424(d)(1)(v). The resulting amount is the Federal per diem payment rate to be paid for any given day of treatment for any given patient at a particular facility. During the 18-month period from January 1, 2005 to July 1, 2006, reduction factors were applied to the end result of the above formula to determine the Federal per diem payment rate, namely: the estimated amount of outlier payments[4] to be made during that period; and the estimated amount of the patient- and facility-specific adjustment factors mentioned above. 42 C.F.R. § 412.424(c)(4)-(5). This Federal per diem payment rate will ultimately be supplemented after the cost report is filed by the actual outlier payments as well as additional payments for electroconvulsive therapy (ECT) treatments. 42 C.F.R. § 412.424(d)(3)(i) and (v). Finally, for the transition period spanning January 1, 2005 to July 1,

periods beginning on or after January 1, 2006; 25% retrospective, 75% PPS for cost-reporting periods beginning on or after January 1, 2007; and 100% PPS for cost-reporting periods beginning on or after January 1, 2008, and for all cost-reporting periods thereafter. 42 C.F.R. § 412.426(a)(1)-(4).

4 Outlier payments are additional payments granted where a facility incurs extraordinary costs in treating a patient such that they exceed a certain proportion of the ordinary per diem payment rate, and they diminish as the excess grows larger. 42 C.F.R. § 412.424(d)(3)(i)(A)-(C).

2006, "stop-loss" payments were given in the event that the total reimbursement for a given day of treatment of a given patient under the PPS system was less than 70% of the estimated reimbursement amount under the previous retrospective reasonable cost reimbursement system. 42 C.F.R. § 412.424(d)(3)(ii). It should also be noted here that the Federal per diem payment rate, as adjusted, was not to exceed in any event the estimated amount of payment that would have been made under the retrospective reasonable cost reimbursement system during the first five years of the implementation of the PPS system for IPFs (e.g., until 2010), but could rise thereafter. 42 C.F.R. § 412.424(c)(i)-(ii).

I. The Fact That Inpatient Psychiatric Facilities May Permissibly Keep The Positive Difference, If Any, Between Their Actual Cost Of Providing Care And The Properly Calculated Medicare Reimbursement Under The Prevailing Prospective Payment System Is Irrelevant To Relator's Theory Of The Case.

It is crucial in the context of the present case to note that the final adjusted payment amount, together with any outlier payments, payments for ECT treatments, and any applicable co-payments and deductibles (or payments for bad debt arising from those co-payments and deductibles, see 42 C.F.R. §§ 412.115(a) and 412.2(f)(4)), is intended to be the payment in full for that particular patient on that particular day under Medicare Part A. 42 C.F.R. § 412.2(b)(1)-(2). This means that any amounts the Retreat received in excess of the total amount described above represent funds to which the Retreat was not entitled, and which the government was not obligated to pay. Such amounts are overpayments, and to the extent that the Retreat knowingly sought to hide their existence from their fiscal intermediary and/or the government by means of false records, statements, or accounting maneuvers, the Retreat violated the False Claims Act. 31 U.S.C. § 3729(a)(1)(G). In addition, as noted above,[5] the Retreat's reimbursement formula for inpatient psychiatric services provided to Medicare beneficiaries has changed several times over the time period relevant to this action.

And to the extent that any overpayment was generated, in whole or part, through the knowing or willful submission of duplicate or otherwise false claims, the Retreat's obligation to return those specific sums to the government is absolute.

A. Retrospective Reasonable Cost Reimbursement and the Retreat's Balance-Forward Credits

Until January 1, 2005, the Retreat and all other IPFs were reimbursed under the pre-1983 system whereby Medicare providers reported their actual cost of providing care and were reimbursed for the reasonable amounts of those costs, up to a statutorily imposed cap, on a periodic interim basis throughout the year, with retroactive adjustments made annually based on the provider's actual reported costs for the year.[6] Thus, for the years 2003 and 2004, the

5 *See* Section I.A.ii.

6 *See* Section I.A.i above; *see generally* 42 C.F.R. § 413.40.

Retreat's reimbursement was essentially based on its self-reported costs of care, including any Medicare copayments and deductibles written off by the Retreat as bad debt, which were reportable components of its actual and reasonable cost of care. 42 C.F.R. § 413.89(d).

B. **Mixed Reimbursement During the Transition to PPS**

Beginning on January 1, 2005, the Retreat and all other Medicare-reimbursed IPFs began transitioning from the TEFRA retrospective reimbursement system to the current IPF PPS reimbursement system.[7] This TEFRA portion of the mixture was computed as before, then reduced to 75% the first year, decreasing by 25% each year thereafter until the transition was complete as of January 1, 2008, when 100% of the Retreat's reimbursement from Medicare was calculated using the IPF PPS system.[8] During this time, retroactive cost reports continued to directly affect the Retreat's reimbursement amounts for each patient, but in a decreasingly important fashion. In no event, however, could it be said that payment of amounts totaling more than 200% of the Retreat's stated charge for a per diem inpatient stay reasonably reflect additional unanticipated costs of care; it strains credulity to believe that such payments are anything other than overpayments.

C. **IPF PPS Reimbursement From January 1, 2008 to the Present**

Beginning on January 1, 2008, the Retreat's reimbursement from Medicare for inpatient psychiatric care was entirely calculated based on the IPF PPS formula specified in 42 C.F.R. Part 412 subpart N. 42 C.F.R. § 412.426(a)(4). Thus, the argument that what appear to be overpayments to the Retreat are in fact the difference between its actual cost of care and the PPS reimbursement amount set by subpart N's formula ought to appear strongest from 2008 forward.

III. FERA and PPACA strengthen Relator's claims, and subject the Retreat to potential liability for every overpayment is has *ever* received from the federal government of which it has knowledge, yet has failed to repay.

The federal Complaint contains allegations that the Retreat retained overpayments, knowingly withheld repayment of these overpayments, and certified to CMS that no overpayments existed, or that the amount of said overpayments was less than it really was. 31 U.S.C. § 3729(a)(7) (2003). On May 20, 2009, Congress enacted the Fraud Enforcement Recovery Act of 2009 (“FERA”), which significantly relaxed the showing required of FCA plaintiffs with respect to improperly retained overpayments by eliminating the requirement that a false statement or record be presented to the government; it also increased the measure of damages from twice to three times the amount of the overpayments wrongfully retained. 31 U.S.C. § 3729(a)(1)(G) (2009); *see also* FERA, Pub. L. No. 111-21, § 4, 124 Stat. 1617, 1621 (May 20, 2009).

7 *See* note 3 *supra*.

8 *Id.*

Further, on March 23, 2010, provisions of the Patient Protection and Affordable Care Act of 2010 ("PPACA") went into effect that further clarified the time period within which a knowing recipient of an overpayment from the federal government must return the overpaid funds, or face FCA liability. The significance of these developments will be discussed separately and in turn.

A. **Under the FERA, knowing retention of overpaid funds from the federal government, whether by use of a false statement or record, or by mere silent retention, subjects the overpaid recipient to treble damages and attorney's fees and costs.**

The FERA made a number of changes to the False Claims Act, most important of which for present purposes is the creation of a new theory of liability for improper retention of overpayments. Under prior law, it was already considered a false claim to knowingly make a false claim, statement, or record to the federal government in an attempt to obscure or avoid an overpayment or other obligation due and payable to the federal government; silent retention of overpayments, in contrast, was not obviously covered by the FCA. *See* 31 U.S.C. § 3729(a)(7) (2003). Under FERA, the requirement that there be a false statement or record of some kind that is presented to the federal government in order to obscure, avoid, or decrease an overpayment was eliminated; anyone who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government" is now liable for treble damages and attorney's fees and costs under the newly designated 31 U.S.C. § 3729(a)(1)(G). FERA of 2009, Pub. L. No. 111-21, § 4(a), 123 Stat. 1617, 1622 (May 20, 2009).

This means that from May 22, 2009, the effective date of FERA, it was no longer necessary to show that the Retreat presented CMS with a false statement or record in an attempt to avoid repaying overpayments; the simple fact that it knowingly, albeit silently, retained the overpayments is enough to generate liability under the FCA. What the FERA did not do, however, was specify how much time could pass between a defendant's discovery of the existence of an overpayment and repayment to the federal government before liability would attach. *See* S. Rep. No. 111–10, at 15 (2009) (stating that FERA is intended to mean that "violation of the FCA for receiving an overpayment may occur once an overpayment is knowingly and improperly retained, without notice to the Government about the overpayment[,]" but failing to specify any time period for repayment after discovery of an overpayment). PPACA addressed this deficiency.

B. **Under PPACA, the improper retention theory of FCA liability provided for by the FERA was clarified by stating that overpayments must be returned within 60 days of the date the recipient acquires knowledge of their existence.**

While PPACA was a large bill altering or creating a vast array of new federal statutes, its amendments to the FCA are short, and are the only part of PPACA of interest to this case; they added a provision to Title 42 of the United States Code that clarified that overpayments must be returned to the government within 60 days of their discovery, or the date on which the relevant cost report is due, whichever is later. 42 U.S.C. § 1320a-7k(d)(2)(A)-(B) (2010); *see also* PPACA of 201, Pub. L. No. 111-148, Title VI, § 6402(a), 124 Stat. 119, 755 (May 22, 2010). Accordingly,

liability can be argued to attach at the earliest within 60 days of a recipient of federal funds' discovery of an overpayment, whenever it was generated, provided that it has not yet repaid the funds to which it was not entitled within that time period.

IV. The Retreat Intentionally And Knowingly Manipulates Cost Information In Order To Obtain Greater Medicare Reimbursement

Finally, even if at least some of the amounts in the federal Complaint are overpayments improperly kept by the Retreat are due not to duplicate or erroneous billing, but rather to unusually high costs, and thus reimbursable under the pre-IPF PPS system of payment based on retroactive cost reporting, the Retreat's cost reports appear to have been falsely inflated throughout the relevant time period due to its same code 21 and write off practices.

Indeed, defense counsel are caught failing to advance their own "specificity" to support their false and misleading assertions by their failure to clarify what the various Medicare reimbursement calculation was or more importantly, the time period which would allow you to make an informed conclusion if they hadn't neglected to share all of the necessary information. By these purposeful omissions, they mislead the tribunal with materially misleading and insufficient information from which the Court or anyone could make an informed decision or conclusion because defense counsel failed to provide the Court with anything resembling all of the requisite particulars to calculate the correct reimbursement and have therefore, mislead the Court with further material misleading statements and conclusions in their pleadings that do not provide sufficient or accurate representative information to support their misleading statements which are identified below:

1. ⏩ TN BPR: MTD Page 1: Preliminary Statement: 2nd Identified misrepresentation in addition to the one identified in my submission to the TN BPR on 11/15/15. Defense counsel state as follows:

"Founded in 1834 and based in Brattleboro, Vermont, the Retreat is a nonprofit, regional specialty mental health and addiction treatment center. With respect to government payers, the Retreat is reimbursed at a predetermined per diem rate by reference to the patient's Diagnosis Related Group ("DRG") classification, among other things, rather than cost-based reimbursement or fee-for-service reimbursement based on a set fee schedule for the services provided."

NOTE TO TN BPR: Defense counsel's statements above are materially misleading for they don't provide the necessary detail to identify how to calculate the proper reimbursement rate or for what year as the calculation/formula changed multiple times depending on the corresponding year. Indeed, defense counsel offer up their own brand of "generalities" that lack the "specificity" to support their materially misleading Medicare reimbursement assertions that provide insufficient information to give the Court any semblance of how Medicare reimbursement was calculated given the numerous times over the ten year period at issue where the Medicare reimbursement calculation/formula changed with specific considerations on at least fourteen (14) different occasions but nowhere in defense counsel's discussion of Medicare reimbursement

do you find any of the detail necessary to understand fourteen (14) considerations that were necessary to consider depending on what year in the Complaint you are referring. Please note the multiple ways Medicare reimbursement changed over the ten years at issue:

1. For the years 2003 and 2004, IPFs were reimbursed according to the old retrospective reasonable cost method of reimbursement, under which providers were reimbursed for their actual cost incurred in providing reasonably necessary services.

2. On January 1, 2005 and thereafter, however, IPFs were transitioned to the PPS system mandated by section 124 of the BBRA. *See* 42 C.F.R. § 412.400(b).[9] The transition period involved a graduated reduction in the portion of the total reimbursement calculated using the retrospective reasonable cost method coupled with a simultaneous graduated increase in the proportion of the total reimbursement calculated using the PPS method; the transition was complete as of January 1, 2008.

3. Spanning from January 1, 2005 to July 1, 2006, a transition period existed where "stop-loss" payments were given in the event that the total reimbursement for a given day of treatment of a given patient under the PPS system was less than 70% of the estimated reimbursement amount under the previous retrospective reasonable cost reimbursement system. 42 C.F.R. § 412.424(d)(3)(ii).

4. On January 1, 2008 and thereafter the Retreat's reimbursement from Medicare for inpatient psychiatric care was entirely calculated based on the IPF PPS formula specified in 42 C.F.R. Part 412 subpart N. 42 C.F.R. § 412.426(a)(4). Thus, the argument that what appear to be overpayments to the Retreat are in fact the difference between its actual cost of care and the PPS reimbursement amount set by subpart N's formula ought to appear strongest from 2008 forward;

5. On May 20, 2009, Congress enacted the Fraud Enforcement Recovery Act of 2009 ("FERA"), which significantly relaxed the showing required of FCA plaintiffs with respect to improperly retained overpayments by eliminating the requirement that a false statement or record be presented to the government;

6. May 22, 2009 represented the effective date of FERA, it was no longer necessary to show that the Retreat presented CMS with a false statement or record in an attempt to avoid repaying overpayments; the simple fact that it knowingly, albeit silently, retained the overpayments is enough to generate liability under the FCA;

7. March 23, 2010, provisions of the Patient Protection and Affordable Care Act of 2010

9 Unless otherwise specified, this and all subsequent citations to the Code of Federal Regulations is to the version in effect as of June 13, 2013.

("PPACA") went into effect that further clarified the time period within which a knowing recipient of an overpayment from the federal government must return the overpaid funds, or face FCA liability.

8. For the years 2003 and 2004, IPFs were reimbursed according to the old retrospective reasonable cost method of reimbursement, under which providers were reimbursed for their actual cost incurred in providing reasonably necessary services.

9. On January 1, 2005 and thereafter, however, IPFs were transitioned to the PPS system mandated by section 124 of the BBRA. *See* 42 C.F.R. § 412.400(b).[10] The transition period involved a graduated reduction in the portion of the total reimbursement calculated using the retrospective reasonable cost method coupled with a simultaneous graduated increase in the proportion of the total reimbursement calculated using the PPS method; the transition was complete as of January 1, 2008.

10. Spanning from January 1, 2005 to July 1, 2006, a transition period existed where "stop-loss" payments were given in the event that the total reimbursement for a given day of treatment of a given patient under the PPS system was less than 70% of the estimated reimbursement amount under the previous retrospective reasonable cost reimbursement system. 42 C.F.R. § 412.424(d)(3)(ii).

11. On January 1, 2008 and thereafter the Retreat's reimbursement from Medicare for inpatient psychiatric care was entirely calculated based on the IPF PPS formula specified in 42 C.F.R. Part 412 subpart N. 42 C.F.R. § 412.426(a)(4). Thus, the argument that what appear to be overpayments to the Retreat are in fact the difference between its actual cost of care and the PPS reimbursement amount set by subpart N's formula ought to appear strongest from 2008 forward;

12. On May 20, 2009, Congress enacted the Fraud Enforcement Recovery Act of 2009 ("FERA"), which significantly relaxed the showing required of FCA plaintiffs with respect to improperly retained overpayments by eliminating the requirement that a false statement or record be presented to the government;

13. May 22, 2009 represented the effective date of FERA, it was no longer necessary to show that the Retreat presented CMS with a false statement or record in an attempt to avoid repaying overpayments; the simple fact that it knowingly, albeit silently, retained the overpayments is enough to generate liability under the FCA;

14. March 23, 2010, provisions of the Patient Protection and Affordable Care Act of 2010

10 Unless otherwise specified, this and all subsequent citations to the Code of Federal Regulations is to the version in effect as of June 13, 2013.

("PPACA") went into effect that further clarified the time period within which a knowing recipient of an overpayment from the federal government must return the overpaid funds, or face FCA liability.

2. ⏩ TN BPR: MTD Page 4-5 Section A: Medicare Reimbursement for Inpatient Psychiatric Facilities:

"Because hospital charges are typically billed at a set rate per service or per day, while Medicare's payment to providers such as the Retreat for patients decrease over the length of a patient's stay, often Medicare's payment to providers such as the Retreat for patients with stays of shorter duration will show a payment in excess of the Retreat's charges for that stay. While CMS typically pays providers reimbursed on a fee-for-service basis the lesser of the provider's charges or the fee schedule amount, this principle is not applicable to a DRG-based system." (Taken from MTD Page 5).

Above defense counsel assert, incorrectly, a basis for the Retreat to be reimbursed in excess for the hospital's gross charge. Given the extensive discussion provided earlier of the overview of DRG and Medicare Reimbursement for Psychiatric Services should sufficiently evidence there is no rationale for the Retreat to pocket the cash received from any excess amount received beyond its gross charges from Medicare.

Additionally, setting aside the FCA for a moment or any other recent statute, the United States already has within its authority to recover government losses regardless of any FCA violation or other statute. "A statute is not required to authorize the government to recover funds which its agents have wrongfully, erroneously or illegally paid". (*United States v. Wurts*, 303 U.S. 341 (1938); see *Collins v. Donovan*, 661 F.2nd 705, 708 (8th Cir. 1981).

NOTE TO TN BPR: In *United States v. Wurts*, 303 U.S. 341 (1938); and *Collins v. Donovan*, 661 F.2nd 705, 708 (8th Cir. 1981) we see another United States Supreme Court case that would certainly provide for additional "pertinent" legal authority that would provide for controlling case law that defense counsel likely had knowledge of, but failed to assert, likely in further violation of their professional obligations to promote justice, similarly, as they did by their conceded knowledge of the Wartime Suspension of Limitations Act (WSLA) which was a pertinent legal authority at all relevant times at issue and represented both controlling and persuasive case law here in the Second Circuit despite defense counsel's failure to make the Court aware of their conceded knowledge of it.

CONCLUSION

In the last year, I have provided the TN BPR with an increasing body of evidence from which to consider. In totality, my submissions to the TN BPR show everyone how Attorney Matthew M. Curley practices law and the lengths he will go for his clients to obtain the result he seeks. Unfortunately, Attorney Matthew M. Curley forgot that there are fundamentals of our justice system including his professional obligations as an Officer of the Court to promote justice in his practice of law at all times. Therefore, it should be clear given the totality of evidence I have

provided the TN BPR that Attorney Curley's commitment to these core principles are compromised. In fact, given his performance in this matter, it's safe to say as a defense attorney he goes out of his way to derail justice instead of promoting it.

Nowhere in his legal pleadings given the numerous identified misrepresentations of material fact should anyone have any comfort that Attorney Curley understands the gravity of his misconduct or that he somehow will either correct or modify his behavior in the future without and unless the TN BPR summons the courage to hold him accountable.

Attorney Matthew M. Curley has demonstrated overwhelmingly that his continued practice of law endangers the public welfare and should never again have the opportunity to pollute our justice system or be allowed to be a participant in litigation where he could cause such huge financial harm to the American people as overwhelmingly evidenced in this matter.

For the above reasons, I respectfully ask that the Board of Professional Responsibility of the Supreme Court of Tennessee apply the necessary discipline so that Attorney Curley doesn't have another opportunity to participate in a future miscarriage of justice at the expense of our country and the American people.

Respectfully,

Thomas Joseph