IN THE UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

UNITED STATES OF AMERICA *ex rel.* THOMAS JOSEPH, Plaintiff-Relator, v. THE BRATTLEBORO RETREAT, Defendant.	)	Civil Action No. 2:13-CV-00055 Judge William K. Sessions III

DEFENDANT THE BRATTLEBORO RETREAT'S
MEMORANDUM IN SUPPORT OF MOTION TO DISMISS

DOWNS RACHLIN MARTIN PLLC
Elizabeth R. Wohl
28 Vernon Street, Suite 501
P.O. Box 9
Brattleboro, VT 05302-0009
Telephone: (802) 258-3070
Facsimile: (802) 258-4875
ewohl@drm.com

BASS, BERRY & SIMS PLC
Matthew M. Curley
(*pro hac vice motion pending*)
150 Third Avenue South, Suite 2800
Nashville, TN 37201-3001
Telephone: (615) 742-6200
Facsimile: (615) 742-2868
mcurley@bassberry.com

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

OTHER AUTHORITIES

PRELIMINARY STATEMENT

Qui tam relator Thomas Joseph ("Mr. Joseph" or "Relator") filed this action under the False Claims Act ("FCA"), asserting that The Brattleboro Retreat (the "Retreat") improperly and fraudulently retained overpayments by government payers for healthcare services provided by the Retreat, thereby violating the FCA. After conducting its statutorily-required investigation, the United States declined to intervene in this action and, notwithstanding the United States' declination, Mr. Joseph decided to continue his pursuit of his allegations against the Retreat.

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 for the inpatient services it provides to patients largely through the Inpatient Psychiatric Facility Prospective Payment System ("IPF-PPS"), which reimburses providers such as the Retreat 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.

Mr. Joseph formerly worked at the Retreat as a Self-Pay Collections Representative. In other words, Mr. Joseph focused on collecting amounts owed by individual patients (described by Mr. Joseph as "patient responsibility") and not amounts owed by commercial or government payers. Nonetheless, Mr. Joseph contends that the Retreat violated 31 U.S.C. §§ 3729(a)(1)(A), 3729(a)(1)(B) and 3729(a)(1)(G) of the FCA by systematically using certain internal accounting codes to mask overpayments that otherwise should have been refunded to government payers.

There are numerous legal deficiencies that require dismissal of the Complaint. The FCA's six-year statute of limitations bars Mr. Joseph's allegations concerning claims and conduct pre-dating April 12, 2007. Those allegations – involving patients identified as Patients 1, 2, 10, 11-14,

17-29 and 31-32 and involving claims from 2005 and 2006 (or failing to specify any date whatsoever) – may not form the basis of an FCA claim and must be dismissed as a matter of law.

Mr. Joseph's claims under §§ 3729(a)(1)(A) and 3729(a)(1)(B) (Counts I and II) likewise fail as a matter of law. Those provisions of the FCA contemplate liability based upon the submission of actual false claims or the use of false statements or records to obtain payment from the government. The Complaint, however, makes clear that its theory of liability is premised on the alleged improper retention of overpayments, not the submission of false claims or the use of false statements or records to obtain payment. The very few generalized allegations concerning the Retreat's submission of claims to payers fall well short of the particularity required by Rule 9(b) of the Federal Rules of Civil Procedure, which applies to actions arising under the FCA.

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 has 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).

BACKGROUND

I. The Parties

For nearly two centuries, the Retreat has been a leading regional provider of inpatient mental health and addiction treatment services. The Retreat was the first facility established for the care of the mentally ill in Vermont, and one of the first ten private psychiatric hospitals in the United States. As of 2011, the Retreat employed more than 670 full- and part-time employees and served more than 5,500 children, adolescents, and adults through its inpatient, ambulatory, outpatient, and

school programs during that calendar year. As a nonprofit healthcare provider, the Retreat obtains funding for operations through private donations and grants, and receives reimbursement for its services from self-pay patients, commercial insurance, managed care, and government payers.[1]

In January 2011, Mr. Joseph was hired by the Retreat as a Self-Pay Collections Representative within the Retreat's Financial Services Department. (Compl. ¶ 82.) In that position, Mr. Joseph was responsible for following up with patients on unpaid amounts owed to the Retreat stemming from services provided to those patients and other claims-related issues. (*Id*.) Mr. Joseph was employed at the Retreat at the time he initiated this action.

II. Inpatient Treatment Centers and the Medicare and Medicaid Programs

Like most healthcare providers, the Retreat is compensated for the care it provides through several different payment systems. Some patients choose to pay for their own care, out-of-pocket. As a result of the Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-353 §§ 511-12, codified at 29 U.S.C. § 1185a and elsewhere, however, many patients' care is now covered by private insurance. Still other patients receive coverage through Medicare, Medicaid, or other government payment programs. Each payer reimburses the Retreat for its services in a slightly different way, and each has its own particular requirements regarding how bills are submitted and how charges for services are reimbursed. All payers, however, share at least one common thread – no matter the payer, the Retreat submits a bill that lists its customary charges for

[1] This foregoing information is set forth in the Retreat's Annual Reports, which are publicly available at http://www.brattlebororetreat.org/donate/annual-report. In August 2011, when Tropical Storm Irene flooded the Vermont State Hospital ("VSH"), the Retreat also undertook to provide care to a significant number of former VSH patients. The Retreat is one of four hospitals in Vermont currently filling the void left by the VSH's destruction, and cares for more of those patients than any of the other hospitals. *See generally* Abby Goodenough, "Storm Has Vermont Scrambling to Find Beds for Mentally Ill," *N.Y. Times*, Nov. 5, 2011, at A9; Andrew Stein, "After Irene: ER Wait Times for Psychiatric Patients Longer Than Ever," *Vermont Digger*, Aug. 28, 2013 (available at http://vtdigger.org/2013/08/28/after-irene-er-wait-times-for-psychiatric-patients-longer-than-ever/) (last visited Mar. 10, 2014).

the services it provides. Upon receipt, a payer reviews the services provided against its payer agreement with the Retreat, and pays the predetermined, contracted-for amount for those services.

A. Medicare Reimbursement for Inpatient Psychiatric Facilities

Beginning in 2005, Medicare began paying inpatient psychiatric facilities according to the IPF-PPS, *see* 42 C.F.R. Parts 412 and 413, which uses the patient's DRG to calculate daily per diem rates for the patient's stay.[2] To calculate the per diem rate, the IPF-PPS starts with a base rate "derived from the national average daily routine operating, ancillary, and capital costs in IPFs in FY 2002." 77 Fed. Reg. 47226. This base rate is then modified based on certain facility-specific and patient-specific adjustments. *Id*.; *see also* 42 C.F.R. § 412.424.[3] As a particular patient's stay continues, CMS reimburses providers at a decreasing percentage of the base rate. This provides an incentive for providers to treat patients as efficiently as possible, while still recognizing that some patients require more extended care.[4]

---

[2] CMS previously determined that other types of inpatient providers would be compensated on a "prospective payment system" that paid a global amount for each type of illness – categorized by a diagnosis related group or "DRG." 69 Fed. Reg. 66934 (explaining why a pure DRG methodology does not adequately capture the variations in per diem cost for inpatient psychiatric care better than the system adopted). For example, under a pure DRG system, a hospital is paid a fixed amount for a knee replacement, regardless of how many days it takes to provide that service to the patient. The fixed amount is calculated using the DRG as a base rate and then adjusting for factors such as geographic location, the wage index for that location and the hospital's historical costs. *See* 42 C.F.R. §§ 412.60-412.64. Although CMS sought to implement a strictly DRG-based prospective payment system for inpatient psychiatric care, it was impossible to do so, as lengths of stay vary greatly even within one DRG. *See* 69 Fed. Reg. 66934.

[3] "The patient-level adjustments include age, DRG assignment, comorbidities, and variable per diem adjustments to reflect higher per diem costs in the early days of an IPF stay. Facility-level adjustments include adjustments for the IPF's wage index, rural location, teaching status, a cost of living adjustment for IPFs located in Alaska and Hawaii, and presence of a qualifying emergency department (ED)." 77 Fed. Reg. 47226.

[4] For example, the base rate for fiscal year 2012-2013 was $724.43 per day. *See* 77 Fed. Reg. 47229. This amount is then adjusted up or down based on the hospital-level and patient-level adjustments described above. Once the patient-specific base rate is determined, the amount is adjusted for length of stay. On day 1 of a patient's stay, that rate is multiplied by 1.19 to determine the amount due. Each day that the patient stays in the hospital, the multiplier decreases so that by day 22, CMS will pay only 0.92, of the base rate. *See* 69 Fed. Reg. 66949 (Table 7 – Variable Per Diem Adjustment).

Providers such as the Retreat do not submit a claim requesting the calculated IPF-PPS payment amount. Rather, providers submit their charges to CMS on a CMS Form 1450, which lists the services provided and the hospital's customary "charge" for those services – that is, the full rate that the hospital charges to all patients for each day. Medicare then calculates the payment due under the IPF-PPS, and provides a remittance advice that describes the amount paid, and the amount that should be treated as a discount from the hospital's charge based on the predetermined reimbursement amount. Because hospital charges are typically billed at a set rate per service or per day, while Medicare IPF-PPS payments 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. *See* 42 C.F.R. § 414.21 (describing "lesser of" payment under physician fee schedule).

B. Medicaid Reimbursement for Inpatient Psychiatric Facilities

Medicaid is a joint federal-state program that provides assistance to low-income individuals. *See* 42 U.S.C. § 1396. Under Medicaid, each state establishes its own plan for the provision of services to eligible individuals and is responsible for administering that plan. *See* 42 U.S.C. § 1396(a); 42 C.F.R. § 430.0 *et seq.* The state directly reimburses healthcare providers such as the Retreat for the services rendered under their plans. *See* 42 U.S.C. § 1396(a). The federal government does not make payments to healthcare providers, but rather makes quarterly grants to states to reimburse them for a certain percentage of Medicaid expenditures. *See* 42 C.F.R. § 430.30.

With respect to reimbursement of inpatient providers such as the Retreat, the Vermont Medicaid program operates in much the same way as Medicare. Upon a patient's discharge, and based upon the discharge diagnosis determined by the provider, the Vermont Medicaid utilization

reviewer enters a payment authorization into the Vermont's Medicaid Management Information System.[5] At the same time, providers submit a CMS Form 1450 to Medicaid's Fiscal Intermediary. As with Medicare, the Retreat does not calculate and bill for the amount due, but rather sends a claim for its standard charges for the services provided. Based on the patient's discharge diagnosis, Vermont Medicaid pays a certain amount, which it calculates.[6]

III. The Complaint

Mr. Joseph's Complaint is based on his belief that the Retreat fraudulently retained overpayments from government payers and maintained deliberately falsified records concealing the Retreat's obligation to return those overpayments. (Compl. ¶ 3.) This belief is based on alleged observations by Mr. Joseph during his employment as a Self-Pay Collections Representative at the Retreat, which began in January 2011. (*Id.* ¶ 82.) At bottom, the Complaint asserts that individuals within the Retreat's Patient Financial Services Department manipulated accounting data by using certain internal billing codes to eliminate credit balances from patient accounts. (*Id.* ¶¶ 3, 13.)

The Complaint alleges that the Retreat receives overpayments in the ordinary course of its business in providing medical services to patients. (*Id.* ¶ 70.) The Complaint does not allege any wrongdoing on the part of the Retreat in merely receiving an overpayment from a payer. (*Id.* ¶¶ 70-71.) Beyond the mere receipt of overpayments, the Complaint alleges, upon information and belief, that the Retreat established a policy of fraudulently retaining those alleged overpayments through the use of posting code "21" in connection with its AVATAR computer billing system. (*Id.* ¶¶ 68, 78-79.) The Retreat's use of Code 21 allegedly allowed the Retreat to eliminate credits from particular patient ledgers and avoid returning overpayments to commercial or government payers.

---

[5] *See* Standard Operating Procedures Manual for Vermont Medicaid Inpatient Psychiatric and Detoxification Authorizations, at 8, 12, 14, 16, 18 (available at http://dvha.vermont.gov/for-providers/psychatric-inpatient-authorization-manual-3-12-13-revision.pdf).

[6] As referenced in the Complaint, the Retreat also contracts with other states to provide specialized psychiatric services to patients insured through those states' Medicaid programs. Each of those contracts has particular terms, and the Retreat bills those states according to those contracts.

(*Id.* ¶ 79.) The Complaint alleges that Mr. Joseph brought the issue of the Retreat's retention of overpayments to his supervisors, but that nothing was done to correct the alleged misuse of Code 21 or to refund the alleged overpayments received by the Retreat. (*Id.* ¶ 85.)

The Complaint includes general allegations that the Retreat over-bills government payers, which results in a credit balance owed to those payers. (*Id.* ¶¶ 100-101.) The Complaint then asserts that a "posting code 21 allowance reversal" is used "in an amount calculated to offset the credit balance owed to Medicare or Medicaid due to the overpayments." (*Id.* 102.) According to the Complaint, "[t]his operation results in the patient ledger erroneously showing a zero balance when in reality, a credit remains due and payable to the government health care benefit program, and thus represents knowingly fraudulent avoidance or concealment of an obligation due and payable to the government." (*Id.*)

The Complaint includes allegations regarding 32 separate patient accounts, spanning roughly seven years, with respect to which it asserts that the Retreat used Code 21 to eliminate credits owed to federal and state government payers. (*Id.* ¶¶ 104-173.) The Complaint does not identify any actual bills submitted to government payers by the Retreat or any reimbursement received by the Retreat from those payers. 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. He also asserts without specificity that, since 2003, each and every Form CMS-838 Credit Balance Report submitted to CMS, which enrolled providers must submit to CMS each quarter and which sets forth credit balances, was fraudulent as a result of the use of Code 21 to eliminate refunds due to government payers.

IV. Procedural Background

Mr. Joseph filed this FCA action on April 12, 2013. As required by the FCA, the Complaint was filed under seal and *ex parte*, and the U.S. Department of Justice ("DOJ") and the Office of

Inspector General for the U.S. Department of Health and Human Services ("HHS/OIG") had an opportunity to investigate the allegations asserted in the Complaint. On August 20, 2013, the United States declined to intervene. (Not. of Elec. to Decline Interv. (Dkt. No. 6).) This Court ordered that the complaint be unsealed. (Order at 1 (Dkt. No. 7).)

Mr. Joseph took no action to serve the Retreat with the Summons and Complaint until 120 days after the Court's order unsealing this matter. On January 8, 2014, Mr. Joseph filed a notice indicating an intent to appear *pro se*, which was opposed by the United States. (Notice at 1 (Dkt. No. 8); U.S. Stmt. of Interest at 1 (Dkt. No. 9).) Mr. Joseph also filed a motion to extend time to serve his Complaint that same day. (Mot. For Extension at 1 (Dkt. No. 11).) Mr. Joseph obtained new counsel and on January 23, 2014, notice of the Retreat's agreement to waive service of the summons and Complaint was filed. (Waiver of Serv. (Dkt. No. 14).)

STANDARD OF REVIEW

I. Federal Rule of Civil Procedure 9(b)

FCA claims must be pleaded in accordance with Rule 9(b). *See Wood ex rel. U.S. v. Applied Research Assocs., Inc.*, 328 F. App'x 744, 747 (2d Cir. 2009). Rule 9(b) requires that the conduct, misrepresentation, or scheme that renders the particular claim at issue false must be pleaded with particularity. In nearly all instances, this requires a relator to plead specific facts that show: (1) the time, place and content of any alleged misrepresentation; (2) the fraudulent scheme; and (3) the manner in which the false statements or scheme induced the government to pay a claim to the defendant. *See id.* (citing *Shields v. Citytrust Bancorp, Inc.*, 25 F.3d 1124, 1128 (2d Cir. 1994)).

To be fraudulent, a false statement must have been made with the requisite scienter. *See id*. As such, a relator must "'plead the factual basis which gives rise to a strong inference of fraudulent intent.'" *Id.* (quoting *O'Brien v. Nat'l Prop. Analysts Partners*, 936 F.2d 674, 676 (2d Cir. 1991)). A relator's claims may not be based on speculation and conclusory allegations or upon information

and belief. Rather, "'[a]n ample factual basis must be supplied to support the charges.'" *Id.* (quoting *O'Brien*, 936 F.2d at 676).

The stringent pleading standards imposed by Rule 9(b) are "'designed to provide a defendant with fair notice of a plaintiff's claim, to safeguard a defendant's reputation from improvident charges of wrongdoing, and to protect a defendant against the institution of a strike suit.'" *Id.* (quoting *O'Brien*, 936 F.2d at 676). These concerns are especially salient "in cases involving the [FCA], which provides a windfall for the first person to file and permits recovery on behalf of the real victim, the Government." *U.S. ex rel. Clausen v. Lab. Corp. of Amer.*, 290 F.3d 1301, 1313 n.24 (11th Cir. 2002). To this end, distinguishing between properly and improperly pleaded claims at the motion-to-dismiss stage allows a defendant to "limit discovery and subsequent litigation to matters relevant to these [properly pleaded] allegations." *U.S. ex rel. SNAPP, Inc. v. Ford Motor Co.*, 532 F.3d 496, 504 (6th Cir. 2008).

II. Federal Rules of Civil Procedure 8(a) and 12(b)

An FCA complaint must be dismissed under Rule 12(b) when it fails to state a claim upon which relief can be granted. *See DeJesus v. HF Mgmt. Servs., Inc.*, 726 F.3d 85, 87-88 (2d Cir. 2013). Rules 8(a) and 12(b)(6) require that a complaint articulate a plausible claim for relief. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). The plausibility standard is only satisfied "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007)).

In determining whether a complaint has been adequately pleaded, courts must rely on "judicial experience and common sense" in weighing competing inferences of lawful and unlawful conduct. *Id.* at 679. A relator's "obligation to provide the grounds of his entitlement to relief requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of

action will not do." *Twombly*, 550 U.S. at 555 (internal quotation marks and citations omitted). Courts are not bound to accept as true legal conclusions couched as factual allegations. *Id.*

ARGUMENT

I. Relator's FCA claims based on reimbursement for claims paid or conduct outside the FCA's six-year statute of limitations are time-barred and must be dismissed.

The FCA contains a six-year statute of limitations, which precludes FCA claims filed "'more than 6 years after the date on which the violation of [the FCA] is committed.'" *United States v. Baylor Univ. Med. Ctr.*, 469 F.3d 263, 267 (2d Cir. 2006) (quoting 31 U.S.C. § 3730(b)(1)); *U.S. ex rel. Taylor v. Gabelli*, 345 F. Supp. 2d 313, 327 n.75 (S.D.N.Y. 2004). The FCA's six-year statute of limitations "begins to run on the date the claim is made, or, if the claim is paid, on the date of payment." *U.S. ex rel. Kreindler & Kreindler v. United Techs. Corp.*, 985 F.2d 1148, 1157 (2d Cir. 1993). The limitations period applies to claims under § 3729 regardless of whether the relator's theory of liability is based on the actual submission of a false claim under §§ 3729 (a)(1)(A) and (a)(1)(B) or under the FCA's reverse false claims provision set forth in § 3729(a)(1)(G).[7] *See* 31 U.S.C. § 3730; *see also U.S. ex rel. Foster v. Bristol-Myers Squibb Co.*, 587 F. Supp. 2d 805 (E.D. Tex. 2008) (dismissing reverse false claims allegations under the FCA's six-year statute of limitations).

The Complaint identifies alleged overpayments with respect to 32 separate patient accounts. Twenty-two of these patient accounts involved allegations of wrongdoing and/or alleged overpayments that were paid to the Retreat more than six-years prior to the date Mr. Joseph filed his Complaint, on April 12, 2013, or involve unspecified dates. These accounts include:

---

[7] On May 20, 2009, Congress passed the Fraud Enforcement and Recovery Act ("FERA"), Pub. L. No. 111-21, 123 Stat. 1617, which amended and renumbered the FCA sections pursuant to which Mr. Joseph asserts claims in this action. With the exception of FERA's amendments now reflected in § 3729(a)(1)(B), FERA's amendments to the FCA are effective as of the date of FERA's enactment (May 20, 2009) and apply to conduct on or after the date of that enactment. *See* FERA, Pub. L. No. 111-21, 123 Stat. 1625.

Patient Account Number	Date of Alleged Overpayment(s) Received	Compl. ¶
Patient 1	April 20, 2006 April 27, 2006	¶ 106 ¶ 107
Patient 2	Nov. 10, 2005 Oct. 26, 2005	¶ 109 ¶ 110
Patient 10	July 13, 2005	¶ 153
Patients 11-14	July 13, 2005	¶ 154
Patients 17-29	No dates specified	¶ 166
Patient 31	Feb. 16, 2007	¶ 170
Patient 32	July 31, 2005	¶ 172

Because the conduct at issue with respect to Patient Nos. 1, 2, 10, 11-14 & 31-32 falls outside the FCA's six-year statute of limitations, this conduct cannot form the basis of Mr. Joseph's FCA claims under §§ 3729(a)(1)(A), (a)(1)(B) or (a)(1)(G).[8] Likewise, Mr. Joseph has failed to plead any facts whatsoever sufficient to show that the submission or payment of claims or any alleged misconduct with respect to such claims for Patients Nos. 17-29 occurred within the FCA's six-year statute of limitations. Absent the pleading of such facts, Mr. Joseph has failed to state a claim under the FCA as a matter of law and his claims concerning Patients Nos. 17-29 also should be dismissed. *See U.S. ex rel. Robinson-Hill v. Nurses' Registry & Home Health Corp.*, 2012 U.S. Dist. LEXIS 142224, at *6 (E.D. Ky. Oct. 2, 2012) (explaining that "a motion to dismiss may appropriately be grounded upon a plaintiff's failure to plead tolling, relation back, or other facts showing the claims are not barred by the statute of limitations" when it is apparent from the face of the complaint that the time limit for bringing the claims has passed).

[8] With respect to Patient 31 and 32, the Complaint arguably includes allegations regarding conduct that allegedly occurred within the FCA's six-year statute of limitations. For purposes of this argument, Mr. Joseph's claims regarding Patient 31 and 32 are time-barred with respect to his claims under § 3729(a)(1)(A) and § 3729(a)(1)(B) (prior to FERA, §§ 3729(a)(1) and (2)). His claims under § 3729(a)(1)(G) concerning Patients 31 and 32 are deficient as a matter of law for other reasons set forth below.

II. Relator's Complaint fails to plead claims under § 3729(a)(1)(A) and (a)(1)(B).

The first two counts of Mr. Joseph's Complaint assert claims for alleged violations of § 3729(a)(1)(A), which prohibits the presentment of false claims, and § 3729(a)(1)(B), which prohibits the use of false statements or records to obtain payment. Both FCA provisions contain certain fundamental pleading requirements: (1) there must have been a "*claim*" submitted for payment by the defendant within the meaning of the FCA; (2) either the claim itself or the record or statement material to the claim must have been false or fraudulent; and (3) the defendant must have known that the claim or statement was false or fraudulent. *See U.S. ex rel. Pervez v. Beth Israel Med. Ctr.*, 736 F. Supp. 2d 804, 811 (S.D.N.Y. 2010). And, as set forth above, the facts supporting each of these pleading requirements must be pleaded in accordance with the particularity required by Rule 9(b). The Complaint, however, is devoid of the sort of particularized allegations that would meet this heightened pleading standard.

A. The Complaint fails to identify any claims submitted to the government for payment.

In the specific context of the FCA, "[p]leading an actual false claim" submitted to a government payer typically is viewed as "an indispensable element of a complaint that alleges an FCA violation in compliance with Rule 9(b)." *U.S. ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 504 (6th Cir. 2007). This is because the FCA "attaches liability, not to the underlying fraudulent activity or to the government's wrongful payment, but to the claim for payment." *U.S. ex rel Karvelas v. Melrose-Wakefield Hosp.*, 360 F.3d 220, 225 (1st Cir. 2004) (internal quotation marks and citation omitted). Consequently, "'an actual false claim is the *sine qua non* of a False Claims Act violation.'" *Id.* (quoting *Clausen*, 290 F.3d at 1311).

The Complaint includes virtually no allegations about the submission of actual claims by the Retreat. It relies largely on references to entries in the Retreat's accounting system and presupposes that claims were submitted for each entry in the system, but fails to identify any actual claim. No

bills or claim forms are attached to the Complaint; no details are provided regarding any supposed claims; no dates are given for claims submitted; and no details are provided about who completed or submitted the claim forms. Nor does Mr. Joseph even describe having *seen* an actual claim form. The absence of the foregoing reflects a fundamental pleading defect, which requires dismissal of the claims under §§ 3729(a)(1)(A) and 3729(a)(1)(B). *See Wood*, 328 F. App'x at 750 (affirming dismissal under Rule 9(b) where the complaint did "not cite to a single identifiable record or billing submission [the relators] claim to be false, or give a single example of when a purportedly false claim was presented for payment by a particular defendant at a specific time" (internal quotation marks omitted)); *see also U.S. ex rel. Ge v. Takeda Pharm. Co.*, 737 F.3d 116, 124 (1st Cir. 2013); *Karvelas*, 360 F.3d at 232; *U.S. ex rel. Nathan v. Takeda Pharm. N. Am., Inc.*, 707 F.3d 451, 457-58 (4th Cir. 2013); *Chesbrough v. VPA, P.C.*, 655 F.3d 461, 470-72 (6th Cir. 2011).

The Complaint discusses only three circumstances with respect to which Mr. Joseph suggests that false claims were allegedly submitted to government payers. His allegations, however, fall well short of the particularity required by Rule 9(b). In paragraph 101, the Complaint refers to the Retreat recoding charges and resubmitting claims after receiving partially paid claims from CMS. According to the Complaint, such resubmitted claims caused "Medicare *or* Medicaid to make duplicate payments for the same services." (Compl. ¶ 101 (emphasis supplied).) The Complaint, however, fails to include any specific examples or dates of such resubmission of claims, does not allege with any certainty that any claim was submitted to a particular government payer for reimbursement, and does not allege fraudulent intent.

Later, in paragraph 129, the Complaint alleges that "the Retreat has also presented straightforward false claims in an effort to get paid by Medicaid sums to which it was not entitled." (*Id.* ¶ 129.) The Complaint then supposedly provides an example of such a "straightforward false claim[]" – but that example turns out to be one in which nothing improper is even alleged. Rather,

the Complaint asserts that there is an entry for service 11000; that the Retreat's nominal charge for that service was $2,140; that there is an entry under code 10 for a payment of $806.93; and that there is a second entry "in the amount of $1,333.07, [which] *was properly posted* using code 20." (*Id.* ¶ 130 (emphasis supplied).)

In paragraph 141, it is alleged that "the Retreat submitted claims to VSH, a Medicaid-funded program, purportedly for [a] 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 $21,508.00 as the patient responsibility for these DOS was determined to be by CMS." (*Id.* ¶ 141.) The Complaint does not allege when these claims were submitted, or by whom. In addition, the Complaint acknowledges that Mr. Joseph does not know what the appropriate reimbursement rate for this service was, and therefore, he cannot plead with particularity whether the claim submitted was, in fact, false or fraudulent. Moreover, he has provided no basis for his assertion that the claim should be considered false simply because the amount billed to VSH allegedly differed from the guidance given in a Payment/Adjustment Report prepared by CMS. Additionally, there are no facts alleged supporting a strong inference that the claims in question were knowingly false when submitted.

Finally, the Complaint asserts that the Retreat's submission of each and every quarterly or annual report to CMS constituted a false or fraudulent claim, within the meaning of § 3729(a)(1)(A), or was a false record or statement material to a claim, within the meaning of § 3729(a)(1)(B). (Compl. ¶¶ 174, 185, 188.) The Complaint, however, fails to attach, or even describe, any specific report or to tie any report to any allegedly false claims. It includes no allegations regarding who prepared any particular reports, who filed them, or when or how they were filed. There are no facts pleaded that would identify any particular statement in any report that is actually false. These shortcomings further highlight the Complaint's failure to plead actual claims in accordance with Rule 9(b). *See Wood*, 328 F. App'x at 749-50 (listing a general

allegation that "[t]he various cost reports . . . all contained false claims for reimbursement and made false statements" as an example of "allegations [that] are plainly insufficient under Rule 9(b)").[9]

B. The Compliant fails to plead facts establishing the falsity of any supposed claims.

In addition to failing to identify actual claims, the Complaint includes no factual allegations as to why any purported claim would have been false when made. To the contrary, the Complaint makes clear in several instances that the Retreat billed government payers the Retreat's customary charges for services provided to patients. (*See, e.g.*, Compl. ¶¶ 105, 108, 116.) There are no allegations that the Retreat billed payers for services that were not provided or that the Retreat "up-coded" or otherwise falsified its charges for services provided to patients. Rather, the Complaint's entire focus is on payments to the Retreat that exceeded the pre-determined amounts that Mr. Joseph presumes, without knowledge, government payers would have paid for such services. As discussed above, the IPF-PPS contemplates that the contractually agreed upon reimbursement received by providers such as the Retreat from government payers may be more or less than the provider's customary charges on any one day, because daily payments vary over the length of the stay. Simply alleging that the Retreat was reimbursed in this manner is not an indicium of fraud.

The Complaint fails to plead the sort of particularized facts demanded by Rule 9(b) regarding the knowing submission of any false claims for payment to the federal government or the knowing use of false records material to the payment of any claim to the federal government. Accordingly, Count I and Count II must be dismissed.

---

[9] *See also Karvelas*, 360 F.3d at 233-34 (finding complaint to be inadequate under Rule 9(b) where relator "did not set forth the specifics of any one single cost report, or bill, or piece of paper that was sent to the Government to obtain funding" (internal quotation marks and ellipsis omitted)); *Bledsoe*, 501 F.3d at 512-13 ("Absent any information as to when the [cost] reports were filed, or for how much they were inflated, Relator has failed to set forth a specific FCA violation."); *U.S. ex rel. Hebert v. Dizney*, 295 F. App'x 717, 722 (5th Cir. 2008) (generalized allegations that all cost reports were false were insufficient to satisfy Rule 9(b)).

III. The Complaint fails to state a claim for reverse False Claims Act liability.

In Count Three, the Complaint asserts a claim under § 3729(a)(1)(G), the so-called "reverse false claims" provision of the FCA, which "creates FCA liability for false statements designed to conceal, reduce, or avoid an obligation to pay money or property to the Government." *U.S. ex rel. Lissack v. Sakura Global Capital Mkts., Inc.*, 377 F.3d 145, 152 (2d Cir. 2004) (discussing 31 U.S.C. § 3729(a)(7)); *see also U.S. ex rel. Drake v. Norden Sys., Inc.*, 2000 U.S. Dist. LEXIS 13371, *32 (D. Conn. Aug. 24, 2000), *aff'd in part and rev'd in part on other grounds*, 375 F.3d 248 (2d Cir. 2004). Because the Complaint fails to allege particularized facts sufficient to state a claim under § 3729(a)(1)(G), this claim must be dismissed.

A. The Complaint fails to state a claim with respect to retention of overpayments pre-dating FERA's amendment of the FCA.

Section 3729(a)(1)(G) did not exist prior to FERA's amendment of the FCA. As set forth above, with the exception of FERA's amendments now reflected in § 3729(a)(1)(B), FERA's amendments to the FCA are effective as of the date of FERA's enactment (May 20, 2009) and apply to conduct on or after the date of that enactment. *See* FERA, Pub. L. No. 111-21, 123 Stat. 1625. In other words, § 3729(a)(1)(G) is not retroactive and applies only to conduct alleged to have occurred following May 20, 2009. Accordingly, the Complaint's attempt to assert a claim under § 3729(a)(1)(G) regarding overpayments pre-dating May 20, 2009, which include Patients 1, 2, 10-15, 31, and 32 (and potentially 17-29 since no dates are alleged), fails as a matter of law.

Even if the Complaint purported to assert a claim under § 3729(a)(1)(G)'s predecessor – § 3729(a)(7) – for overpayments pre-dating May 20, 2009, such a claim likewise would fail as a matter of law. Prior to FERA's enactment, "retention of [an] overpayment did not create an obligation under the former provisions of the FCA." *U.S. ex rel. Yannacopoulos v. Gen. Dynamics*, 636 F. Supp. 2d 739, 752 (N.D. Ill. 2009), *aff'd*, 652 F.3d 818 (7th Cir. 2011); *see also U.S. ex rel. Stone v. OmniCare, Inc.*, 2011 U.S. Dist. LEXIS 73123, at *8 (N.D. Ill. July 7, 2011) ("The parties

agree that there was no liability for 'retention of an overpayment' prior to FERA's amendments to the FCA."). As such, where the retention of a purported overpayment is alleged to have occurred prior to FERA's effective date of May 20, 2009, "the liability for retention of an overpayment [under the FCA] cannot attach." *Stone*, 2011 U.S. Dist. LEXIS 73123, at *12.

B. The Complaint fails to state a claim under § 3729(a)(1)(G).

For overpayments allegedly retained by the Retreat after FERA's enactment, the Complaint fails to include specific factual allegations sufficient to state a claim under § 3729(a)(1)(G) in accordance with Rule 9(b)'s heightened pleading standard. Section 3729(a)(1)(G) provides for FCA liability where a defendant either: (1) 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; or (2) knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay money to the Government. *See* 31 U.S.C. § 3729(a)(1)(G); *see also United States v. Huron Consulting Grp., Inc.*, 2010 U.S. Dist. LEXIS 97423, at *6-7 (S.D.N.Y. Aug. 25, 2010). The Complaint fails to state a claim under either prong of § 3729(a)(1)(G).

1. The Complaint fails to plead facts with the requisite particularity that the Retreat knowingly made or used a false record or statement to avoid an obligation to pay money to the government.

The Complaint fails to state a claim under the first prong of § 3729(a)(1)(G), because it fails to identify with the requisite particularity a single specific false record or statement knowingly made or used by the Retreat that would have been material to a particular obligation to pay money to the government. "A reverse false claim action cannot proceed without proof that the defendant made a false record or statement at a time that the defendant owed to the government an obligation sufficiently certain to give rise to an action of debt at common law." *See Am. Textile Mfrs. Inst.*,

Inc. v. Limited, Inc., 190 F.3d 729, 736 (6th Cir. 1999).[10] The "obligation" necessary to plead a reverse false claim cause of action is limited to the present, existing duty to pay the government and does not cover "potential" or "future" obligations. *See U.S. ex rel. S. Prawer & Co. v. Verrill & Dana*, 946 F. Supp. 87, 94-95 (D. Me. 1996).[11]

The Complaint is premised on the assumption that the purportedly incorrect use of a code in the Retreat's internal accounting ledgers is itself a false record or statement, or represents the concealment or avoidance of an obligation. The Complaint, however, fails to include any allegations explaining how the use of an internal accounting code would constitute a false record or statement material to any particular obligation, or how the use of such codes concealed or avoided any particular obligation the Retreat presently owed to the government.[12] Absent such facts, the Complaint falls well short. *See Yannacopoulos*, 636 F. Supp. 2d at 748-49 ("Of course, how [the defendant] internally accounted for funds it had received is immaterial to Relator's FCA claim.").

The Complaint also alleges that the Retreat submitted quarterly and annual reports that falsely stated the Retreat's obligations. But, as noted above, it fails to identify any actual report with particularity, much less any specific inaccuracy contained therein. The Complaint's generalized allegations about *every* cost report being false in some unspecified way does not suffice for purposes of Rule 9(b). *See Wood*, 328 F. App'x at 749-50; *Karvelas*, 360 F.3d at 233-34; *Bledsoe*, 501 F.3d at 512-13; *Hebert*, 295 F. App'x at 722.

---

[10] For purposes of analyzing a reverse false claim allegation under the first prong of the § 3729(a)(1)(G), pre-FERA case law remains instructive on the issue of what is required to plead a cause of action, as that prong was not amended in a manner that affects the analysis set forth herein. *Compare* 31 U.S.C. § 3729(a)(7) *with* 31 U.S.C. § 3729(a)(1)(G).

[11] For purposes of the FCA, FERA 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 any overpayment." 31 U.S.C. § 3729(b)(3).

[12] To the contrary, the Complaint acknowledges occasions when an allegedly inaccurate accounting code was used, but the overpayment in question was repaid in full. (*See, e.g.*, Compl. ¶¶ 93, 162.)

In addition, the Complaint also fails to plead the existence of "an obligation" within the meaning of the FCA, because it does not adequately allege that any purported overpayment was actually retained by the Retreat. As the Complaint makes clear, Mr. Joseph has no knowledge of what payments were *actually* received, which of those payments, if any, constituted *actual* overpayments, or which of those overpayments, if any, were *actually* retained.[13] Instead, he relies entirely on conclusions he has drawn from his review of the internal accounting ledgers. Such allegations are insufficient to state a claim with the particularity required by Rule 9(b).

2. The Complaint fails to plead facts with the requisite particularity that the Retreat knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay money to the government.

The Complaint also fails to plead facts sufficient to show that the Retreat knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay money to the government, as prohibited by the second prong of § 3729(a)(1)(G). Rule 9(b) demands a paragraph-by-paragraph scrutiny of a relator's allegations to determine whether FCA claims have been pleaded with the requisite particularity. *See U.S. ex rel. Marlar v. BWXT Y-12, L.L.C.*, 525 F.3d 439, 444 (6th Cir. 2008). Scrutiny of the allegations regarding each of the patient accounts identified in the Complaint reveals Mr. Joseph's formulaic recitation of conclusory allegations couple with a failure

[13] The Complaint aptly demonstrates Mr. Joseph's lack of knowledge regarding the alleged scheme. (*See, e.g.*, Compl. ¶ 91 (noting instances in which code 55 was used to reflect repayment of commercial insurance credits, but acknowledging that he does not know whether those repayments actually occurred); *id.* ¶ 118 (speculating that ledger entries under code 10 and code 11 "*are likely* there solely for accounting purposes"); *id.* ¶ 119 (noting instances in which code 11—"ostensibly signifying recoupment by DMH"—was used, and stating that recoupment did not occur "for *at least some* of these code 11 postings"); *id.* ¶ 128 (acknowledging ignorance of actual amount of purported overpayment credit, and stating that the overpayment credit reflected in the ledger "is *at least* $25,600.86 less than the true amount"); *id.* ¶ 133 (acknowledging ignorance of applicable reimbursement rate); ¶¶ 143-50 (acknowledging ignorance of applicable reimbursement rate but speculating that "*it is doubtful* that the VA meant to pay" certain rates); ¶ 151 (noting instance involving "a commercial insurance carrier that should have been and *apparently* was eventually billed as the primary payer") (emphasis added throughout).)

to plead facts with the particularity demanded by Rule 9(b) to support his conclusion that the Retreat improperly retained overpayments.[14]

Patient 3 (Compl. ¶¶ 116-28). The Complaint's allegations concerning Patient 3 begin by describing an episode for which the Retreat properly billed and accounted. (Compl. ¶ 116.) The paragraphs that follow, however, contain a confusing array of conclusory and unsupported allegations, which purportedly related to an episode that lasted from July 2, 2010, to November 9, 2010. According to the Complaint, the Retreat was originally paid $284.13, and then used a Code 20 entry to reflect an allowance of $673.90 – reflecting a shortfall of $116.97 below the Retreat's nominal per diem rate. (*Id.* ¶ 117.) Did the VDMH *underpay* the Retreat by $116.97? The Complaint does not say, and indeed, makes no allegations whatsoever about what the proper per diem rate should have been. The Complaint then describes two later ledger entries in the amount of $116.97, and two others in the amount of ($116.97). That Mr. Joseph does not know what these actually signify is reflected by his speculation that "[t]he code 10 and 11 entries exactly offset each other and *are likely there* solely for accounting purposes." (*Id.* ¶118.)

The Complaint next alleges that there are three Code 10 entries totaling $80,493.35. The Complaint makes no allegations about any claims submitted in connection with these entries, nor does the Complaint identify the payer. The Complaint labels this an overpayment, yet fails to specify what the proper payment should have been. This is entirely insufficient under Rule 9(b).[15]

The Complaint then alleges that there are a series of Code 11 entries "ostensibly signifying recoupment by DMH." (Compl. ¶ 119.) It then asserts that "[t]his is not what actually occurred for

---

[14] As noted above, the claims under § 3729(a)(1)(G) or § 3729(a)(7) concerning Patients 1, 2, 10-14, and 17-29 are all time-barred. It is also readily evident that the allegations regarding these patients are woefully insufficient.

[15] The Complaint suggests that the entire $80,493.35 was an overpayment. This, however, is not plausible on its face. The Complaint alleges that the episode in question lasted for roughly 130 days, with a nominal per diem rate of $1,075. Yet, it seems to suggest that the $284.13 that the Retreat received on July 22 – months before the episode was over – should be treated as payment in full.

at least some of these code 11 postings." (Compl. ¶ 119.) The Complaint provides no basis for the allegation that "[t]his is not what actually occurred," and its use of the phrase "for *at least some*" only serves to highlight Mr. Joseph's lack of actual knowledge. This deficiency is reiterated a few paragraphs later, when he first notes that the overpayment credit entered for VDMH was "*at least* $25,600.86 less than the true amount," and then speculates that "*it would appear* that the Retreat . . . has used Patient 3's account as a 'slush fund.'" (Comp. ¶ 128 (emphasis added).)

Finally, the Complaint includes no allegations that would support a strong inference of fraudulent intent. Rather, it concedes that the Retreat repaid VDMH for at least some of what Mr. Joseph claims to have been an overpayment for this episode. Did the Retreat discuss the appropriate reimbursement amount with VDMH? Did VDMH consider itself to have been fully reimbursed? If any overpayment was retained, was it intentional? Who at the Retreat was aware of it, or involved in the purported decision not to repay it? The Complaint does not contain a single fact that would support Mr. Joseph's conclusory allegations.

Patients 4-7 (Compl. ¶¶ 126-27). Although Patients 4-7 are referenced in the Complaint, the Complaint does not allege that any false claims were submitted or any overpayments retained for any of these patients. The Complaint merely alleges that money was improperly classified under their accounts. As such, these allegations do not implicate the FCA.

Patient 8 (Comp. ¶¶ 130-42). For Patient 8, the Complaint again starts by describing an episode that it concedes was billed and accounted for "properly." (Compl. ¶130.) The following paragraphs are full of puzzling and inconsistent allegations about Patient 8, and episode 8, which allegedly lasted from August 29, 2011, through September 25, 2011. For example, the Complaint alleges that the first payment received by the Retreat for this episode "was posted using code 11" – which, according to the Complaint's allegations, reflects a payment *by* the Retreat, not a payment *to* the Retreat. (*Compare* Compl. ¶ 18(d) *with* ¶ 131.) It then alleges that the next two entries "were

posted on June 7, 2011" – or two and a half months *before* the episode allegedly began. (*Compare* Compl. ¶132 (describing an episode beginning in late August 2011) *with* ¶¶ 134-36, 138 (describing payments received in April or June 2011).)

The Complaint then describes various payments made by VSH. (Compl. ¶ 131.) Although it asserts that some of these payments represented overpayments, the Complaint again fails to allege what the appropriate payment rate actually was, stating only that the rate VSH paid was an "anomaly," because it is unusual for Medicaid to reimburse at a rate higher than Medicare. (Compl. ¶¶ 133 & n.6, 137.)

The Complaint does not allege whether there was a contract between VSH and the Retreat, nor what its terms actually contained. Ultimately, it alleges that the amount purportedly received by the Retreat must have been an overpayment by VSH because it differed from the remittance advice and "the Payment/Adjustment Report" prepared by an unspecified person at CMS regarding the appropriate payment under Medicare Part A. But, the Complaint provides no support for the assumption that this remittance advice and Payment/Adjustment report demonstrate the appropriate reimbursement rate for the Retreat for this patient. As such, the Complaint has not adequately alleged the existence or amount of an overpayment for this episode, let alone any facts supporting a strong inference of scienter.

Patient 9 (Compl. ¶¶ 143-50). The Complaint's allegations about Patient 9 begin with a confusing allegation, asserting simultaneously that the Retreat and "the White Mountain Veterans Administration Medical Center (VA)" had no "pre-existing contract for services," and that the Retreat and the VA had "agreed to a flat rate of $1,000 per diem for room and board." (Compl. ¶ 143.) If there was no contract, as the Complaint alleges, then how was there an agreement on the appropriate rate? Where was that agreement memorialized? The Complaint does not say.

The Complaint then goes on to reveal that Mr. Joseph does not know what price would be appropriate for the VA to pay for services other than room and board, noting only that "*it is doubtful* that the VA meant to pay 74% of the Retreat's nominal charge," and speculating that "the overpayment for Patient 9, episode 2 should be adjusted upward by at least $569.77." (Compl. ¶148 (emphasis added).) In short, Mr. Joseph concedes that he does not know what the purported overpayment amount actually was and, accordingly, he has failed to adequately allege an overpayment or any retention thereof.

Patient 15 (Compl. ¶¶ 159-65). The Complaint's allegations about Patient 15 also suffer from puzzling inconsistencies. The Complaint describes an episode in which the Massachusetts Behavioral Health Partnership allegedly overpaid by $105,000 *and was later repaid in full.* The thrust of the Complaint's allegations is that the Retreat should be liable for failing to repay this money sooner. Although it makes no allegations about when the Retreat actually had knowledge of the overpayment, the Complaint asserts that it "could not have been any later than June 20, 2008." (Compl. ¶ 162.) Yet, in the preceding paragraph, the Complaint alleges that the overpayment of $103,125 was posted "on October 6, 2009." (Compl. ¶161.) How the Retreat could have been aware of an overpayment 16 months before receiving it, the Complaint does not say. Nor does it make any allegations to support the conclusion that the period between the Retreat's receipt of the payment and its reimbursement of the payer was marked by improper retention. To the contrary, the Complaint alleges that the accounting ledger reflects numerous instances in which the Retreat tendered a refund to the payer. (Compl. ¶163.) Accordingly, the Complaint fails to allege improper retention of any overpayment, or facts supporting a strong inference of scienter.

Patient 16 (Compl. ¶¶ 79-80). The Complaint discusses an episode involving Patient 16 as an "example" of an overpayment made by "a *commercial* insurance payer." (Compl. ¶ 79-80 (emphasis supplied).) As such, the allegations about Patient 16 do not implicate the FCA.

Patients 17-29 (Compl. ¶¶ 165-66). In paragraph 166, the Complaint lists 13 patients as purported examples of concealed overpayments. It alleges nothing whatsoever about who these patients were, what services they received, when they were at the Retreat, when claims were submitted for them, how much the claims were for, how much money the Retreat received, or whether any repayments took place. Such allegations fall woefully short of what Rule 9(b) demands. *See Wood*, F. App'x at 747.

Patient 30 (Compl. ¶¶ 167-69). For this incident, the Complaint alleges that the Retreat's nominal charge was $2,140, and that Medicaid of Nebraska first paid $401.10 for this service, with the Retreat posting an allowance or discount for the remaining $1,738.90. (Compl. ¶ 167.) It then alleges that Medicaid of Nebraska later paid an additional $833.47, with a corresponding entry for an allowance-reversal in the same amount. (Compl. ¶ 168.) The Complaint assumes that the original $401.10 payment was correct and that the subsequent $833.47 was an overpayment – but provides no factual support for any such assumption. Why was the total amount of $1,234.57 (against a nominal charge of $2,140) not the correct amount? The Complaint does not say. Rather, it asserts, in a conclusory manner, that "Nebraska Medicaid did not contemplate paying more than $476.10 per diem." (Compl. ¶ 169.) The Complaint bases this assertion on "the attached contract for services and remittance advice," but fails to provide any actual contract or details about applicable payment rates. As such, the Complaint fails to adequately allege the existence or amount of an overpayment or the improper retention thereof, much less a strong inference of scienter.

Patient 31 (Compl. ¶¶ 170-71). For Patient 31, the Complaint alleges that the Retreat provided a service with a nominal charge of $1,537.53, and originally posted three entries, on February 16, 2007: two in the amount of $333.72, using code 10, and one in the amount of $1,203.81, using code 20. It then alleges that, nine and a half months later, the Retreat posted another entry in the amount of $333.72, using code 21. The Complaint assumes that this represents

an overpayment of $333.72, but makes no allegations about what the proper reimbursement rate for this service should have been, and therefore, fails to adequately allege an overpayment. The Complaint likewise fails to allege that any such overpayment was retained and provides no facts supporting a strong inference of scienter.

Patient 32 (Compl. ¶¶ 172-73). For Patient 32, the Complaint again simply alleges that the Retreat first posted entries under Codes 10 and 21 that together equaled the nominal charge for one day's service, and then posted a later entry using Code 10 for an additional $7,374.96. The Complaint does not say what the appropriate payment rate was, and therefore, has not alleged an overpayment or any retention thereof.

In sum, the Complaint's allegations regarding each particular patient fall well short of the particularity required by Rule 9(b) to state a claim for a violation of the § 3729(a)(1)(G) of the FCA or even the sort of pleading required by Rule 8(a), as contemplated by *Twombly* and *Iqbal.* For this reason, Mr. Joseph's claim under § 3729(a)(1)(G) must be dismissed.

CONCLUSION

For the reasons set forth herein, the Complaint fails to state a claim as a matter of law. Accordingly, given the reputational risks to a provider such as the Retreat as a result of unfounded FCA allegations and the patent legal insufficiency of the allegations in the Complaint, the Retreat respectfully requests that its Motion to Dismiss be granted and that the Complaint be dismissed.

Respectfully submitted:

DOWNS RACHLIN MARTIN PLLC

/s/ Elizabeth R. Wohl

Elizabeth R. Wohl
28 Vernon Street, Suite 501
P.O. Box 9
Brattleboro, VT 05302-0009
Telephone: (802) 258-3070
Facsimile: (802) 258-4875
ewohl@drm.com

BASS, BERRY & SIMS PLC
Matthew M. Curley
(*pro hac vice motion pending*)
150 Third Avenue South, Suite 2800
Nashville, TN 37201-3001
Telephone: (615) 742-6200
Facsimile: (615) 742-2868
mcurley@bassberry.com

Attorneys for Defendant The Brattleboro Retreat

CERTIFICATE OF SERVICE

This is to certify that I have caused a copy of the foregoing to be filed electronically on this 11th day of March 2014. Notice of this filing will be sent by operation of the Court's electronic filing system to all parties indicated on the electronic filing receipt and below. All other parties will be served by regular U.S. Mail. Parties may access this filing through the Court's electronic filing system.

Nikolas P. Kerest
Assistant United States Attorney
UNITED STATES ATTORNEY'S OFFICE
FOR THE DISTRICT OF VERMONT
P.O. Box 570
Burlington, VT 05402-0570

Richard T. Cassidy
HOFF CURTIS
100 Main Street
Burlington, VT 05401

Timothy Cornell
GARDNER & CORNELL, P.C.
33 Mount Vernon Street
Boston, MA 03750

/s/ Elizabeth R. Wohl