UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS
URBANA DIVISION

UNITED STATES OF AMERICA and the STATE OF ILLINOIS, *ex rel* VANESSA ABSHER and LYNDA MITCHELL,	)	
Plaintiffs,	)	
v.	)	No. 2-04 C 2289
MOMENCE MEADOWS NURSING CENTER, INC., and JACOB GRAFF, individually,	)	Hon. Harold A. Baker United States District Judge
Defendants.	)	

UNITED STATES' STATEMENT OF INTEREST PURSUANT TO 28 U.S.C. § 517 AND/OR AMICUS BRIEF IN RESPONSE TO DEFENDANTS' MOTION TO DISMISS

The United States of America ("United States") respectfully submits this statement of interest, pursuant to 28 U.S.C. § 517, in response to Defendants' Motion to Dismiss, filed August 4, 2006.

The United States has a significant interest in False Claims Act ("FCA") case law, even when generated in a declined qui tam case such as this one. The United States brings most of the successful cases under the Act, and False Claim Act case law, whether generated in a declined case or not, has an impact on matters initiated by the United States and qui tam cases in which the United States intervenes. Moreover, even in cases it declines, the United States remains a real party in interest. See United States ex rel. Hyatt v. Northrop Corp., 91 F.3d 1211, 1214 (9th Cir. 1996). In the event Relator prevails in this case, the United States is entitled to receive up to 75% of the judgment against the Defendants. 31 U.S.C. § 3730(d)(2).

BACKGROUND

This qui tam action against Momence Meadows Nursing Center, Inc., and Jacob Graff (collectively, "Momence Meadows"), was initiated by Vanessa Absher and Lynda Mitchell ("Relators"), former employees at Momence Meadows, pursuant to section 3730 of the False Claims Act. On May 10, 2006, the United States and the State of Illinois declined to intervene in this case[1] and on May 22, 2006, this Court lifted the seal upon the Complaint and directed Relators to serve their Complaint upon Defendants. In their Second Amended Complaint, Relators allege that Momence Meadows failed to provide patients with necessary medical care, (Second Am. Compl. ¶¶ 2, 18), billed the government for worthless services (Second Am. Compl. ¶¶ 4, 17, 19), and billed for services that did not meet the statutory and regulatory standards that are a condition of payment (Second Am. Compl. ¶¶ 17, 63).

Defendants have moved to dismiss Relators' Complaint on four grounds:

1. Relators have failed to plead fraud with particularity under Fed. R. Civ. P. 9(b);

2. Relators have failed to state a claim on which relief can be granted under Fed. R. Civ. P. 12(b)(6);

3. Relators have failed to make any claims or assertions against individual Defendant Jacob Graff, and;

4. Relators have failed to allege the facts necessary to state a claim for retaliation under the FCA or the Illinois Whistleblower Reward and Protection Act.

(Def.'s Mem. Supp. Mot. Dismiss 2.)

The United States addresses only Defendants' Fed. R. Civ. P. 12(b)(6) argument. That argument goes to Relators' allegations that Defendants knowingly billed for worthless goods and

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[1] A decision to decline intervention should not be construed as a statement about the merits of the case. Indeed, the Government retains the right to intervene at a later date upon a showing of good cause. 31 U.S.C. § 3730(c)(3).

services and/or services that did not comply with the statutes and regulations that are conditions of government payment.[2] Defendants argue that Relators' allegations, viewed in the most favorable light, are insufficient to state a claim under the False Claims Act.

ARGUMENT

The United States takes no position on the question whether Relators have satisfied the particularity requirements of Fed. R. Civ. P. 9(b). If the Court resolves the Defendants' Motion on Fed. R. Civ. P. 9(b) grounds, there would be no need for it to reach the issues addressed below.

Unfortunately, both Relators and Defendants have muddled and conflated the two applicable theories of liability under the FCA. Worthless services cases stand for the unexceptional proposition that a government contractor may not knowingly bill the government for goods and services that have no value. False certification cases likewise stand for the unremarkable proposition that a provider may not knowingly demand payment, and in so doing certify compliance with the government's conditions of payment, when in fact they have not so complied. By citing to authorities and case law on worthless services to support their false certification arguments and visa versa, the parties treat the two theories as though the two theories are interchangeable. They are not. The worthless services theory and false certification theories are two distinct theories of liability under the FCA. Moreover, both theories are viable in the nursing home setting. Although this Court need not reach the issue if it resolves Defendants' Motion on Fed. R. Civ. P. 9(b) grounds, the United States submits this statement of

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[2] This theory is often called false certification because the provider certifies compliance with the government's requirements for payment when it submits its demand for payment.

interest to clarify the legal standards applicable when a relator has alleged such theories.

A. Relators Have Properly Stated A Worthless Services Claim

In the overview section of their Memorandum of Law In Support Of Motion To Dismiss, Defendants incorrectly argue that the existence of a regulatory scheme giving the Department of Health and Human Services ("HHS") various remedies against non-compliant nursing homes essentially should preclude a relator or the Department of Justice from pursuing an FCA case.

Although Defendants' central argument is wrong, several statements they make building to that conclusion are accurate, confusing the matter. Defendants correctly state that the FCA does not create a cause of action sounding in malpractice. They also correctly note that "nursing homes such as Momence are subject to regulations promulgated under the Social Security Act...." and go on to describe a variety of the administrative actions available to HHS. (Def.'s Mem. Supp. Mot. Dismiss 3.) Defendants also are correct in saying that "the essence of an FCA claim is that the claim for reimbursement is premised on a lie by the defendant." It also is true that "in a case where the services are not provided, the Court's inquiry is a simple one, i.e., did the facility knowingly bill for services it did not provide...?" Id. 4.

But Defendants *incorrectly* state that "a claim based on inadequate care may be malpractice; it is not fraud." In fact, depending on the facts, it may be both. It may be neither. Or it may be one or the other. Whether the inadequate care constitutes malpractice is irrelevant to the FCA analysis. If the "inadequate care" in question constitutes critical services the patient needs that are not provided, but for which the defendant knowingly bills the United States, then such "inadequate care" may be actionable. "Inadequate care" is not a legal term. It describes a broad range of facts that may give rise to different types of legal remedies. For example, patients

who are not given the food they need and therefore starve, or who are not given the medication they need, and therefore come to harm, or who lie in their own filth for days on end with inadequate reposititioning, resulting in terrible and often lethal pressure sores have received "inadequate care." If a provider bills for care to patients that was not provided, or provided in a worthless fashion, they are liable under the False Claims Act. And Relators *do* allege that Defendants failed to provide services, and that Defendants provided worthless services, both actionable claims under the FCA.

Defendants also incorrectly imply that it would be improper for this Court to rule on such a claim, because it would put the Court in a position of "second guess[ing] the outcome of years of state and federal surveys which, parenthetically, are dispositive on the quality and adequacy of issues." (Def.'s Mem. Supp. Mot. Dismiss 4.)

State surveyors inspect nursing home approximately once every 15 months, and may, in addition, address complaints in "complaint surveys." 488 C.F.R. § 308. In addition, federal surveyors do "look behind" surveys in approximately five percent of cases. <u>See</u> 488 C.F.R. § 330.

But again, Defendants misinterpret the meaning of the administrative process. The fact that surveyors may inspect a nursing home once in 15 months is far from "dispositive" about the quality of that facility. This is especially true where, as in this case, there are allegations that Momence Meadows lied to and presented false records to the surveyors. The survey report provides a snap shot of what the surveyors saw in the limited time they were in the facility. If they identify problems (called "deficiencies"), there is a detailed administrative process to address those problems, depending on their scope and severity, including that the nursing home

is required to set forth a "plan of correction." 488 C.F.R. § 402.

In a False Claims Act context, however, the survey is simply another piece of factual evidence. It describes the snapshot of time seen by the surveyors and how the provider responded. And it is examined along with the medical records, interviews, and various other types of evidence, from many sources, providing a detailed picture not limited to the period when the surveyors were in the facility.

Defendants' arguments that a False Claims Act case is precluded by the existence of (1) a regulatory scheme, (2) the survey process, (3) potential administrative actions or (4) potential malpractice actions, fails. The existence of those other processes is irrelevant to and should not confuse the False Claims Act analysis, and certainly does not obviate any False Claims Act claim.

1. *Knowingly Billing for Worthless Services Constitutes a Prototypical Claim Under the False Claims Act*

It is well-settled that billing the United States for a product or service that is of no value, if done with the requisite *scienter*, violates the False Claims Act. See United States v. Bornstein, 423 U.S. 303 (1976); United States ex rel. Lee v. Smithkline Beecham, Inc., 245 F.3d 1048, 1053 (9th Cir. 2001). Contractors who provided substandard and worthless products to the United States prompted Congress to enact the False Claims Act: "For sugar, it often got sand; for coffee, rye; for leather, something no better than brown paper; for sound horses and mules, spavined beasts and dying donkeys; and for serviceable muskets and pistols, the experimental failures of sanguine inventors or the refuse of shops and foreign armories." United States ex rel. Newsham v. Lockheed Missiles and Space Co., Inc., 722 F. Supp. 607, 609 (N.D. Cal. 1989)

(quoting 1 F. Shannon, The Organization and Administration of the Union Army, 1861-1865, at 5456 (1965) (quoting Tomes, Fortunes of War, 29 Harper's Monthly Mag. 228 (1864))).

Courts consistently have upheld False Claims Act liability for billing for deficient products and services in many contexts. See United States v. McNinch, 356 U.S. 595, 599 (1958); United States ex rel. Hopper v. Anton, 91 F.3d 1261, 1266 (9th Cir. 1996) (False Claims Act "actions have also been sustained under theories of supplying substandard products or services"). Similarly, services that are rendered but in an amount or manner that makes them the equivalent of no services, are deemed to be worthless and actionable under the False Claims Act. See Lee, 245 F.3d at 1053 ("In an appropriate case, knowingly billing for worthless services or recklessly doing so with deliberate ignorance may be actionable under § 3729. . . ."); United States ex rel. Mikes v. Strauss, 274 F.3d 687, 703 (2d Cir. 2001) ("[a] worthless services claim asserts that the knowing request of federal reimbursement for a procedure with no medical value violates the Act irrespective of any certification."). Consistent with the opinions of the Ninth and Second Circuits, both of which considered the issue in the context of health care cases, there is no question that health care providers, including nursing homes, that knowingly make claims for payment for worthless goods or services may be liable to the United States under the False Claims Act. See United States and State of Colorado v. Health Care Mgmt. Partners, No. 04-cv-2340-REB-BNB, Order Denying Defendant Robert Salazar's Motion to Dismiss (D. Colo. Oct. 31, 2005) ("Billing the government for worthless medical services, if done with the requisite scienter, violates the FCA." Id. *9); United States ex rel. Garcia v. Integrated Health Systems, Inc., No. 3:02-3796-24 (D. S.C. Sept. 25, 2005); c.f, United States v. NHC Healthcare Corp., 163 F. Supp. 2d 1051 (W.D. Mo. 2001).

The determination of what constitutes worthless services often is highly fact specific and must be made on a case-by-case basis. In assessing whether the government, and the nursing home residents who are the beneficiaries of the government programs, received any value for the service, among other factors, a court may need to examine the purpose of the service, how the service was performed, and how it was billed (whether as a stand alone service or part of a larger bundle of services). The latter factor is particularly important in assessing the services billed by skilled nursing facilities.

2. *A Properly Stated Worthless Services Claim Alleges That The Bundle of Services For Which the Government Pays Is Worthless*

Skilled nursing care *is at the heart of the bargain* between Medicare and the providers of nursing services. See 42 U.S.C. § 1395x(h). The Medicare program pays skilled nursing facilities a *per diem* amount for a bundle of services. This bundle of services consists of "skilled nursing care" as well as services ancillary or incidental to the provision of that skilled care. These ancillary services include room, board, and routine care such as feeding, hydration, and turning and repositioning (which is necessary to maintain mobility, prevent bed sores, infections, contractures, and other serious illness or injury). To ensure that both skilled care and all necessary ancillary services are provided to residents, Medicare pays the providers of nursing facilities *a bundled rate* designed to ensure that these services are provided in tandem.

Where, as here, Medicare pays for a bundle of services, a viable worthless services claim may exist even where a provider has adequately performed some portion of the bundled services. The failure to provide the government one of the bundle's services may not render the entire bundle worthless. On the other hand, if a critical portion of the bundled services are not provided, or are performed in a grossly deficient manner, that failure may render worthless the

other services that are performed. The key question is whether the government received value for the bundle of services for which it paid. If the services that were provided are meaningless, or worse, harmful to the patient, then neither the patient nor the government received value. Under these circumstances, any services performed by the provider are properly considered worthless, and the provider's claim for payment is no less fraudulent, and no less actionable under the False Claims Act, than if it had simply failed to provide any services at all. See also United States v. NHC Healthcare Corp., 163 F. Supp. 2d 1051, 1056 (W.D. Mo. 2001)(denying defendant's motion for summary judgment: "...a provider of care can cease to maintain this standard by failing to perform the minimum necessary care activities required to promote the patient's quality of life. When the provider reaches that point, and still presents claims for reimbursement to Medicare, the provider has simply committed fraud against the United States.")

3. *Relators Have Stated A Viable Worthless Services Claim Even Though Some Services Have Been Provided*

Defendants argue that Relator would have to state that Momence Meadows provided no services at all in order to successfully plead a claim under the False Claims Act.[3] (Def.'s Mem.

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[3] Defendants appear to argue that neglecting a resident to death is not equivalent to failing to provide services. They state that "nursing home patients are vulnerable members of society; they do die; accidents do occur." (Def.'s Mem. Supp. Mot. Dismiss 12.) Such deaths, Defendants continue, do not suggest that services were not provided; only that they were provided, at worst, negligently. Id. But Defendants erroneously confuse negligence and neglect. Negligence is irrelevant to an FCA analysis. Neglect, on the other hand, is defined under the regulations as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 U.S.C. § 488.301. Examples of neglect include patients who do not get food or water and therefore die from dehydration and malnutrition, or who do not receive the medication they need and therefore come to harm, or who lie in their own filth for days on end with inadequate repositioning, resulting in terrible and often lethal pressure sores. One can neglect a nursing home patient and then be liable under the FCA for knowingly billing

Supp. Mot. Dismiss 2, 3, 11, 14). This argument is incorrect as a matter of logic and law. See United States ex rel. Lee v. Smithkline Beecham, Inc., 245 F.3d 1048, 1053 (9th Cir. 2001); United States ex rel. Mikes v. Strauss, 274 F. 3d 687, 703 (2d Cir. 2001). A worthless service, by definition, *is the provision of some service*.

Defendants appear to base their argument on United States ex rel. Swan v. Covenant Care, 279 F. Supp. 2d 1212 (E.D. Cal. 2002), a declined qui tam in which the court granted the defendant's motion for summary judgment. In Swan, relator alleged the defendant billed for worthless services and violated applicable regulations.[4] See Swan 279 F. Supp. 2d at 1215. The court held that it lacked subject matter jurisdiction because the allegations had been publically disclosed and relator was not the original source. See id. at 1220. The court then further stated, in dicta, that the relator had failed to state a claim under Fed. R. Civ. P. 12(b)(6) because she did not allege that the defendant's neglect of the patient was the equivalent of providing no services at all. See id. at 1221. To the extent the Swan court's opinion or Defendants' argument states that there can never be a worthless service case so long as a nursing home provides some incidental service, such as a roof over the patient's head, such an interpretation is over broad and should be rejected.

The government pays providers only for skilled nursing services or therapy, and, because these services must be provided on an in-patient basis, it also pays for the other charges incidental to their provision, including room and board. See 42 U.S.C. § 1395x(h). The notion

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the government.

[4] Swan did not allege any nexus at all between the statutes and regulations violated by the defendants and government payment. See Swan, 279 F. Supp. 2d at 1215.

that there cannot be a worthless services case as long as a nursing home provides some services, because the *per diem* rate includes the provision of routine services for each patient, turns the very purpose of the Medicare program on its head. When measuring[5] the value of the services provided in the Medicare program, the determining factor must be whether there is value in the heart of the bundle: the skilled nursing services. Of course, if certain services are not provided, the skilled nursing services may be worthless. For example, to take an extreme but all too frequent occurrence, if a patient who needs help with eating is not fed, skilled nursing care will be of little value to this patient, who may ultimately get sick or die due to weight loss, malnutrition, or starvation.

Giving a pass to a skilled nursing facility that provided worthless services merely because the patient had a bed and a roof over his head is the equivalent of finding that the United States is not harmed when a contractor provides a box of bullets filled with sawdust, because there was some value in the crate in which it was provided. See Cong. Globe, 37th Cong., 3rd Session., 952, 955 (1863) (Congress enacted the False Claims Act "to assist in ferreting out unscrupulous defense contractors who committed fraud against the Union Army by delivering bullets loaded with sawdust."). This conclusion flies in the face of law, policy and reason.

Defendants claim that Relators fail to make a worthless services argument because Relators' only claim is that Momence Meadows provided services badly. In fact, Relators do articulate a worthless services claim. Relators state: "[t]he worthless or substantially diminished

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[5] See United States v.NHC Healthcare, 115 F. Supp. 1051, 155 (W.D. Mo. 2000) for the suggested use of the statutory and regulatory standards of care as a "measuring stick," to help the finder of fact determine whether the defendant's services provided sufficient value to support a bill for payment.

services provided by Defendants to the elderly and disabled residents of the Momence Meadows facility resulted in the submission of thousands of false claims to the federal and state-funded Medicare and Medicaid programs. Defendants knew . . . that such claims were worthless..." (Second Am. Compl. ¶ 4). Relators have therefore alleged a viable worthless services claim under the False Claims Act.[6]

B. Relators Have Failed To Allege A False Certification Claim

It is well established that violations of statutes and regulations that are prerequisites to payment do state a viable claim under the FCA. See United States ex rel. Gross v. AIDS Research Alliance-Chicago, 415 F.3d 601, 604 (7th Cir. 2005).[7] An allegation of a regulatory violation, without more, however, is insufficient to set forth a claim under the FCA. See United States ex rel. Hopper v. Anton, 91 F.3d 1261, 1266 (9th Cir. 1996). To state a claim under the FCA, relators must sufficiently allege a statutory, regulatory, or contractual violation *and* explain

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[6] We again take no position on whether Relators' worthless services claim has sufficient detail to satisfy Fed. R. Civ. P. 9(b).

[7] See, e.g., United States ex rel. Shaw v. AAA Eng'g & Drafting, Inc., 213 F.3d 519, 531-33 (10th Cir. 2000) (expressly endorsing theory); United States ex rel. Quinn v. Omnicare Inc., 382 F.3d 432, 442 (3d Cir. 2004); United States ex rel. Augustine v. Century Health, 289 F.3d 409, 414-15 (6th Cir. 2002) (implicit false certification of continuing compliance with Medicare requirements actionable under the FCA); Skolnick v. United States, 331 F.2d 598, 599 (1st Cir. 1964) (imposing FCA liability based upon mere cashing of check to which payee was not entitled, without any representation to obtain check); United States ex rel. Mikes v. Strauss, 274 F. 3d 687, 697 (2d Cir. 2001) (liability may be premised on an implied false certification when the underlying statute or regulation expressly states the provider must comply in order to be paid); United States ex rel. Siewick v. Jamieson Science & Eng'g, 214 F.3d 1372, 1376 (D.C. Cir. 2000) ("Courts have been ready to infer certification from silence, but only where certification was a prerequisite to the government action sought"); Ab-Tech Construction, Inc. v. United States, 57 F.3d 1084 (Fed. Cir. 1995) (affirming without opinion claims court's decision expressly endorsing theory); cf. Harrison v. Westinghouse Savannah River Co., 176 F.3d 776 (4th Cir. 1999) (questioning, but not addressing, the viability of an implied certification claim in the Fourth Circuit).

whether and how compliance with that statute, regulation or contract provision is a condition of payment. This theory is often referred to as false certification theory, because the provider certifies compliance with the government's requirements for payment when it submits its claim for payment.[8]

Relators claim Momence Meadows violated the Nursing Home Reform Act ("NHRA"), 42 U.S.C. § 1395 et seq. and the regulations at 42 C.F.R. § 483 et seq.[9] Relators then broadly assert, without citation or explanation, that compliance with the NHRA and 42 C.F.R. § 483 et seq. are conditions of payment. The NHRA and 42 C.F.R. § 483 et seq. are comprehensive statutory and regulatory schemes specifying the requirements relating to the provision of services

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[8] The certification may be express, on the face of the claim form itself, or implied by the act of submitting the claim. See United States ex rel. Augustine v. Century Health, 289 F.3d 409, 414-15 (6th Cir. 2002); United States ex rel. Shaw v. AAA Eng'g & Drafting, Inc., 213 F.3d 519, 531-33 (10th Cir. 2000); United States ex rel. Quinn v. Omnicare Inc., 382 F.3d 432, 442 (3d Cir. 2004); United States ex rel. Mikes v. Strauss, 274 F. 3d 687, 697; United States ex rel. Siewick v. Jamieson Science & Eng'g, 214 F.3d 1372, 1376 (D.C. Cir. 2000); Ab-Tech Construction, Inc. v. United States, 57 F.3d 1084 (Fed. Cir. 1995).

[9] 42 C.F.R. § 483.1 et seq. are also referred to as "conditions of participation" for the Medicare and Medicaid program. The fact that these regulations are labelled "conditions of participation" is not a bar to relators' claims. Conditions of participation for a nursing home can in appropriate circumstances also be considered conditions of payment and can therefore properly support an FCA claim. See United States ex rel. Quinn v. Omnicare, Inc., 382 F.3d 432, 442-43 (3d. Cir. 2004). The government frequently has the right to deny payment when a provider violates a condition of participation. Implied in a statute or regulation that authorizes the government to exclude a provider for prohibited or fraudulent acts can be the right to recoup any past payments made for that prohibited conduct. When the government acts to deny the defendant participation in the program, its goal is often to stop paying claims that the defendant falsely certified it was entitled to receive. In many circumstances, therefore, it makes no sense to hold that the government can remove the provider from the Medicaid or Medicare program for providing defective services, but must continue paying the provider for those services. The question of whether a particular condition of participation may support an FCA violation depends on the specific condition of participation, and whether it can properly be viewed as being a condition of payment.

in nursing homes. The broad statutory and regulatory schemes also govern, in part, the obligations of the state agencies charged with nursing home oversight, and the operations of CMS. It is the responsibility of Relators to allege which section or subsection of these particular statutes or regulations were violated and which were conditions of payment, thereby triggering liability under the FCA. This is particularly true where, as here, the statutes or regulations allegedly violated are lengthy and detailed, with hundreds of sub-parts, some of which may effect payment and some of which may not. Although Relator's claim that these statutes and regulations are conditions of payment makes this case unlike the situation in United States ex rel. Hopper v. Anton, 91 F.3d 1261, 1266 (9th Cir. 1996) in which relator failed to allege any nexus between the regulations violated and payment, it is still insufficient to state a claim under the FCA. See United States ex rel. Gross v. AIDS Research Alliance-Chicago, 415 F.3d 601, 604 (7th Cir. 2005). Like the district court in Gross it is not incumbent upon this Court to search for, find, and piece together the regulatory framework and payment rules or to "become an expert in all of the regulations governing" nursing homes. See Gross, 415 F.3d at 605.

Relators' failure to properly allege the elements of a false certification claim does not mean, however, as Defendants argue, that these particular statutes and regulations may never form the basis for such a claim. Certain parts of the statute may properly be viewed as conditions of payment and therefore provide a basis of liability under FCA. For instance, if a

facility has not complied with the requirements of 42 U.S.C. § 1395i-3(b),[10] (c),[11] and (d)[12] within three months after having been found to be out of compliance, 42 U.S.C. § 1395i-3(h)(2)(D) states that CMS shall deny payment for new patients. See 42 U.S.C. § 1395i-3(h)(2)(D). This section, therefore, is a condition of payment and therefore may, under the appropriate facts and when properly alleged, support an FCA claim. Courts in similar cases have recognized that subsections of the NHRA and 42 C.F.R. § 483 et seq. may be conditions of payment sufficient to support an FCA claim. See United States and State of Colorado v. Health Care Mgmt. Partners, No. 04-cv-2340-REB-BNB, Order Denying Defendant Robert Salazar's Motion to Dismiss (D. Colo. Oct. 31, 2005). See also United States ex rel. Aranda v. Comm. Psych. Ctrs. of Okla., Inc., 945 F. Supp. 1485, 1488 (W.D. Okla. 1996).

Defendants' argument that compliance with the patient care statutes and regulations is irrelevant to the government's reimbursement decisions and that a statutory or regulatory violation may never state a claim is overly broad and nonsensical. It is precisely patient care for which the provider bills the government and the government pays the provider. While the standard for payment under Medicare is not perfect compliance, and the False Claims Act is not intended to be a vehicle to coerce general regulatory compliance, as the NHC Healthcare court noted, "the standard of care is indeed at the heart of the agreement between the parties." United States v. NHC Healthcare Corp., 163 F. Supp. 2d 1051, 1055 (W.D. Mo. 2001). Although

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[10] 42 U.S.C. § 1395i-3(b) governs the provision of medical, nursing and phychosocial services that relate to a patient's quality of life.

[11] 42 U.S.C. § 1395i-3(c) provides the requirements relating to residents' rights.

[12] 42 U.S.C. § 1395i-3(d) governs the requirements relating to the administration of the facility.

Relators' complaint fails to properly articulate the elements of a false certification claim, certain parts of the statutes and regulations governing nursing homes *do* contain provisions that are conditions of payment and can therefore support FCA liability. But this Court need not reach the issue of identifying those conditions of payment. Unlike on the worthless services claim, Relators have not met their burden to properly plead their false certification case. Moreover, this Court need not reach these issues at all should it resolve Defendant's Motion on Fed. R. Civ. P. 9(b) grounds.

CONCLUSION

The United States takes no position on the question whether Relators have satisfied the particularity requirements of Fed. R. Civ. P. 9(b). For the foregoing reasons, the United States respectfully requests that the Court deny in part and grant in part the Defendants' Motion to Dismiss.

Respectfully submitted,

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Dated: September 1, 2006

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Local Rule 7.1 (B)(4) because this brief contains 6,120 words.

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CERTIFICATE OF SERVICE

I certify that the foregoing UNITED STATES' STATEMENT OF INTEREST PURSUANT TO 28 U.S.C. § 517 AND/OR AMICUS BRIEF IN RESPONSE TO DEFENDANTS' MOTION TO DISMISS has been served upon counsel, at the following addresses, by prepaid United States mail on September 1, 2006:

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