UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
CENTRAL DIVISION at FRANKFORT

CIVIL ACTION NO. 11-43-DCR **ELECTRONICALLY FILED**

UNITED STATES OF AMERICA PLAINTIFF

v.

VILLASPRING HEALTH CARE CENTER, INC., d/b/a VILLASPRING OF ERLANGER HEALTH CENTER AND REHABILITATION; CARESPRING HEALTH CARE MANAGEMENT, LLC; and BARRY N. BORTZ DEFENDANTS

UNITED STATES'S RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

The Defendants' Motion to Dismiss the Complaint should be denied. The Defendants caused egregious harm to numerous people entrusted to their care. The Defendants then billed Medicare and Medicaid for this "care" despite knowing these services were so deficient or inadequate as to be worthless. Having failed their residents, their residents' families, and the government that paid for these services, the Defendants nonetheless seek to keep money they did not earn.

The United States is pursuing theories of liability under both the False Claims Act, 31 U.S.C. § 3729, *et. seq*, ("FCA") and federal common law that are well-established by the case law. The Complaint is properly pled, as the United States has set forth in great factual detail examples of the Defendants' failure of care, the resulting submission of false claims to both Medicare and Medicaid, the fraudulent amount paid, and the role of each Defendant. Dismissal

is not appropriate.

I. THE COMPLAINT SATISFIES RULE 12(B)(6)

A. The Complaint pleads allegations that, if proven, entitle the Government to Relief

In ruling on Defendants' motion to dismiss for failure to state a claim, the Court must construe the complaint in the light most favorable to the United States, accept all factual allegations as true, and draw all reasonable inferences in the United States's favor in order to determine whether the complaint contains enough facts to state a facially plausible claim. *United States ex rel. Chesbrough v. VPA, P.C.*, — F.3d. —, 2011 WL 3667648, at *3 (6th Cir. Aug. 23, 2011) (citing *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007)); *Bassett v. Nat'l Coll. Ath. Ass'n*, 528 F.3d 426, 430 (6th Cir. 2008). Accordingly, for purposes of this motion, the Court must accept as true the following allegations:

- Villaspring did not maintain sufficient nursing staff to provide the necessary level of care to its residents. Complaint, ¶¶ 52-60.
- Villaspring failed to provide residents with necessary medication. *Id*. at ¶ 62.
- Villaspring's lack of care caused residents to develop preventable pressure ulcers. *Id*. at ¶ 63.
- Villaspring failed to treat residents' pressure ulcers and wounds. *Id*.
- All allegations regarding Resident # 1, including but not limited to Villaspring's use of adult diapers on a continent patient, failure to follow physician orders, failure to bathe, the development of preventable pressure ulcers, and his death. *Id*. at ¶ 68-79.
- All allegations regarding Resident # 2, including but not limited to Villaspring's use of adult diapers on a continent patient, failure to maintain necessary nutritional intake for a

diabetic, the use of a laxative for a patient experiencing diarrhea, the development of preventable pressure ulcers, and her death. *Id*. at ¶ 80-93.

- All allegations regarding Resident # 3 , including but not limited to Villaspring's failure to monitor and control blood glucose levels, failure to notify the physician about Resident # 4's drastic glucose fluctuations despite clear orders to do so, failure to timely send Resident # 4 to the emergency room when he displayed signs of hypoglycemia, and his death. *Id*. at ¶ 94-106.
- All allegations regarding Resident # 4, including but not limited to Villaspring's failure to monitor and control blood glucose levels, development of preventable pressure ulcers, and failure to provide basic hygiene, such as baths. *Id*. at ¶ 107-119.
- All allegations regarding Resident # 5, including but not limited to Villaspring's failure monitor and treat pressure ulcers and failure to document any nursing care for 95 days.
- All allegations regarding Resident # 6, including but not limited to Villaspring's failure to monitor and treat pressure ulcers, failure to refer Resident # 6 to the hospital despite running a temperature in excess of 101 degrees for three days, failure to document nursing care, and her death. *Id*. at ¶ 134-139.
- All allegations regarding poor care to other residents, including at least twenty-five additional patients with substantiated cases of abuse and neglect. *Id*. at ¶ 140-143.
- Defendants knew that these services were either not rendered or were so deficient that they were essentially worthless. *Id*. at ¶ 9.
- Despite this knowledge, Defendants submitted or caused to be submitted claims for payment to Medicare and/or Medicaid for these non-existent or worthless services. *Id*. at ¶ 155.

- As a result of Defendants' submission of these bills for worthless services, the government paid Defendants and thereby suffered financial injury. *Id*.

The Defendants were required to care for these elderly and vulnerable people. The Government paid the Defendants for complete care of these patients. Assuming the above facts are true, the Defendants did not care for these patients and billed the Government for worthless services. The case law is well-established that submitting claims for services not rendered or rendered in such an inadequate manner violates the FCA. This is precisely what the United States has alleged in this case.

The Defendants' motion to dismiss repeatedly ignores the standards governing such a motion. Rather than assume the above allegations are true, the Defendants instead opt for angry rhetoric challenging the facts as pled and questioning the Government's motivation for bringing suit. While the Defendants can raise fact-based arguments in a motion for summary judgment or at the trial of this matter, the pending motion to dismiss is the wrong vehicle by which to dispute facts. The Defendants' motion to dismiss must therefore be denied.

B. The Complaint states claims for "worthless services" under the FCA

The FCA "covers all fraudulent attempts to cause the government to pay out sums of money." *United States ex rel. Loughren v. Unum Group*, 613 F.3d 300, 305-06 (1st Cir. 2010). Liability attaches under the FCA when "(1) a person presents, or causes to be presented, a claim for payment or approval; (2) the claim is false or fraudulent; and (3) the person's acts are undertaken 'knowingly,' i.e., with actual knowledge of the information, or with deliberate ignorance or reckless disregard for the truth or falsity of the claim." 31 U.S.C. § 3729(a)(1)

(1986);[1] *United States ex rel. Bledsoe v. Community Health Sys., Inc.*, 501 F.3d 493, 503 (6th Cir. 2008).

A "worthless services" claim made pursuant to the False Claims Act stands for the unexceptional proposition that an entity may not bill the Government for products or services that are so deficient that they have no value to the United States. *See, e.g., United States v. Cathedral Rock Corp.*, No. 03-1090, 2007 WL 4270784 (E.D. Mo. Nov. 30, 2007) ("In a worthless services claim, the performance of the service is so deficient that for all practical purposes it is the equivalent of no performance at all."); *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."); *United States ex rel. Lee v. Smithkline Beecham, Inc.*, 245 F.3d 1048, 1053 (9th Cir. 2001) ("In an appropriate case, knowingly billing for worthless services or recklessly doing so with deliberate ignorance may be actionable under § 3729, regardless of any false certification conduct.");; *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996) (FCA actions "have also been sustained under theories of supplying substandard products or services"). It is axiomatic that billing the government for a product or service of no value, if done with the requisite knowledge, violates the FCA. *See United States v. Bornstein*, 423 U.S. 303 (1976). Thus, "[k]nowingly submitting claims against the United States for Medicare and Medicaid services not actually performed clearly violates the FCA." *United States v. NHC*

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[1] The False Claims Act was amended by Congress as part of the Fraud Enforcement and Recovery Act of 2009, Pub.L. 111-21 (May 20, 2009), and again as part of the Patient Protection and Affordable Care Act, Pub.L. 111-148 (March 23, 2010). The amendments made to section 3729(a)(1) (now numbered 3729(a)(1)(A)) are not retroactive, and therefore the 1986 version of the False Claims Act applies to the claims at issue in this case.

Healthcare Corp., 115 F. Supp. 2d 1149, 1155-56 (W.D. Mo. 2000).

In *Unites States v. NHC Healthcare*, the complaint alleged that nursing home patients were given grossly inadequate care and developed pressure sores, incurred weight loss, and suffered unnecessary pain because the defendant knowingly maintained inadequate staffing but nonetheless billed for care. The court denied both the defendant's motion to dismiss and subsequent motion for summary judgment, stating:

> NHC agreed to provide "the quality of care which promotes the maintenance and enhancement of the quality of life." At some very blurry point, 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.

163 F. Supp. 2d 1051, 1055-56 (W.D. Mo. 2001). *See also United States v. Momence Meadows Nursing Center*, No. 04-2289, 2007 WL 685693 (C.D. Ill. March 2, 2007); *Fisher v. United States*, 529 U.S. 667, 679 (2000) (Medicare payments are made "not simply to reimburse for treatment" but to "maintain a certain level of quality medical care . . . .").

In another health care fraud context, the Sixth Circuit has affirmed the viability of the worthless services theory under the FCA. *See Chesbrough*, — F.3d —, 2011 WL 3667648, at *5 (stating that billing government for deficient radiology studies that had no medical value would constitute claim for worthless services under the FCA). Most of the district courts that have considered the worthless services theory in the context of a failure of care case such as this one have held it represents a viable cause of action. *United States v. Cathedral Rock, supra*; *United States v. Health Care Mgmt. Partners*, No. 04-2340 (D. Colo. Oct. 31, 2005); *United States ex rel. Garcia v. Integrated Health Systems, Inc.*, No. 02-3796-24 (D. S.C. Sept. 25, 2005); *United States v. NHC Health Care Corp.*, 163 F. Supp. 2d at 1055-57. *See also United States v. Houser*,

2011 WL 2118847, at *10 (N.D. Ga. May 23, 2011) (stating, in criminal health care fraud case against nursing home owners, that "the overall conditions at the Facilities were so poor and the residents neglected to such a degree that any services provided were worthless. . . . Even where services are provided per diem, reasonable persons would know that supplying limited, or no, basic services would fail to comport with the very essence of the provider and benefit agreements, and that seeking reimbursement for such deficient services would constitute fraud."). In this case, the United States has pled that the care Defendants' provided to residents at Villaspring was grossly inadequate and so egregiously deficient that it had no medical value. Complaint, ¶ 157. The Complaint provides specific examples of such care, and explains in detail why it is worthless. Complaint, ¶¶ 68-139. The United States has pled that the Defendants knew that the care was worthless, and yet proceeded to submit or cause to be submitted claims for payment to the Medicare and Medicaid programs. Complaint, ¶ 155. These allegations state a claim under 31 U.S.C. § 3729(a)(1).

The Defendants' argument that no FCA liability exists simply because it may have provided *some* care or *some* portion of the bundle of services paid by Medicare and Medicaid is without merit, for at least two reasons. First, it ignores the nature of the agreement Defendants entered into with the Medicare and Medicaid programs. Skilled nursing care is at the heart of bargain between the parties. *See* 42 U.S.C. § 1395x(h); *United States v. NHC Healthcare Corp.*, 115 F. Supp. 2d 1149, 1155 (W.D. Mo. 2000). The Defendants were paid a *per diem* amount for a bundle of services that includes room, board, and routine care such as feeding, hydration, and turning and repositioning (necessary to prevent pressure sores). This money was given to Defendants so that they could provide a level of care to elderly and medically fragile patients

that would "promote maintenance or enhancement of [their] quality of life." 42 U.S.C. § 1396r(b)(1)(A). Where, as here, a provider abjectly fails to provide that level of care, and bills the government for it anyway, an actionable fraud has been committed. As stated in *NHC Healthcare*, "[a]t the heart of the agreement in the present case is the overall promotion and maintenance of the quality of life of these two residents. . . . [W]hen caring for the infirmed it is not the end product result that is crucial, it is the dignity and quality of life provided through the care process. The Government has alleged that this essential agreement was grossly violated and the Court finds that for purposes of a motion to dismiss, this allegation satisfies the requirements under the FCA." *NHC Healthcare Corp.*, 115 F. Supp. 2d at 1155. Taken to its logical extreme, Defendants' argument would mean that FCA liability could be avoided so long as patients were given a bed to lay in and otherwise ignored, because one part of the bundle of services for which they are paid has been provided. The FCA's reach is not so limited.

Second, Defendants' argument regarding the medical value of the bundle of services provided is inherently fact-based, and is therefore not properly advanced at the motion to dismiss stage. Their contention that "on any given day, the average resident literally receives 100 or more different items of service" is a factual allegation that is (a) completely unsupported and (b) outside the four corners of the Complaint, which is the focus of the Court's inquiry at this point in the litigation. Def. Mem. at 8-9. The Complaint alleges that the "care" Defendants provided to certain Villaspring residents during the relevant time period was so deficient that the bundle of services had no medical value, and it sets forth detailed factual allegations in support. Those facts are true for purposes of this motion to dismiss, and, taken as true, they set forth a claim under the FCA. Complaint, ¶¶ 68-139.

Defendants' gratuitous hypothetical regarding medication administrations highlights the fact-intensive nature of a worthless services case, and illustrates why their motion should be denied. Def. Mem. at 17-18. If this hypothetical patient received 43 of 44 medication administrations, as well as all other necessary services, the United States agrees there may be regulatory non-compliance but no fraud, because the services provided on that day had medical value as a whole. However, if this hypothetical patient received only 1 of 44 medication administrations, resulting in severe injury or death to the patient, then the service provided on that day may be worthless even if the patient was also bathed, or offered food. There is a point at which a facility's skilled nursing services fall so far below the standard of care that they have no value. The United States has alleged that Defendants' consistent failures of care were so egregious that the bundle of services provided to Villaspring's residents was worthless, and that despite knowing this, Defendants proceeded to bill the government for those services. Defendants are entitled to dispute the value of the bundle of services provided, but that is inherently a factual question, not a legal one that may be decided on a motion to dismiss. *See Cathedral Rock*, 2007 WL 4270784 at *7 ("Plaintiffs allege that the services provided were so deficient as to be worthless and thus constitute a false claim. The Complaint includes substantial descriptions of these allegedly deficient services. At the pleading stage of this litigation, it cannot be said that Plaintiff can prove no set of facts consistent with these allegations which would entitle Plaintiff to relief. As such, the motion to dismiss on this ground is denied.").

For this reason, almost all of the cases that Defendants cite as "requir[ing] dismissal of the Complaint" [Def. Mem. at11] are actually motion for summary judgment cases, where the parties conducted discovery and made fact-based arguments regarding the care provided, the

value of that care, and the defendants' knowledge. *See United States ex rel. Mikes v. Straus*, 274 F.3d 687, 704 (2d Cir. 2001) (affirming summary judgment in light of "ample evidence" of tests' medical value); *United States ex rel. Lamers v. City of Green Bay*, 168 F.3d 1013 (7th Cir. 1999) (affirming grant of summary judgment after review of evidence); *United States ex rel. Hopper v. Anton*, 91 F.3d 1261 (9th Cir. 1996); *United States ex rel. Landers v. Baptist Mem. Health Care Corp.*, 525 F. Supp. 2d 972, 979-80 (W.D. Tenn. 2007) (granting summary judgment on worthless services claim because plaintiff "failed to present sufficient evidence" of deficiencies); *United States ex rel. Phillips v. Permian Residential Care Center*, 386 F. Supp. 2d 879, 884-85 (W.D. Tex. 2005) (holding, on motion for summary judgment, that "record does not show the Defendant's services were so deficient as to be worthless" and not crediting affidavit submitted on plaintiff's behalf); *United States ex rel. Swan v. Covenant Care, Inc.*, 279 F. Supp. 2d 1212 (E.D. Cal. 2002).

Defendants cite a single case where, in a nursing home context, the court granted a motion to dismiss the relator's worthless services FCA claim. *See United States ex rel. Sweeney v. ManorCare Health Serv., Inc.*, 2005 WL 4030950 (W.D. Wash. 2005). Defendants omit mention of the fact that the court permitted the relator to file an amended complaint, and in a subsequent order stated "the Court takes no position on the viability of 'quality of care' or 'worthless services' as theories of recovery under the FCA in a nursing home setting under different facts. Clearly, each case should be decided on a case to case basis." *United States ex rel. Sweeney v. ManorCare Health Serv., Inc.*, No. C03-5320 (W.D. Wash. Feb. 27, 2006 Order, p.9) (attached as Exhibit 1).

These cases are distinguishable from this one by their facts as well as their procedural

posture. In *United States ex rel. Sweeney v. ManorCare Health Services, Inc.*, No. 03-5320, 2005 WL 4030950 (W.D. Wash. March 4, 2005), the United States declined to intervene in a *qui tam* where the relator alleged violations of the FCA because the defendant nursing facility was not administering certain dietary supplements and snacks. *Id* at *1. Failing to administer snacks is much different than the failures of care alleged in the instant Complaint.

Likewise, *United States ex rel. Swan v. Covenant Care, Inc.*, 279 F. Supp. 2d 1212 (E.D. Ca. 2002) is inapplicable. In *Swan*, like in *Sweeney*, the United States declined to intervene in the suit, and the relators pursued the matter on their own. The court stated the relator "has introduced no evidence to demonstrate that Covenant Care certified compliance with the applicable Medicare regulations as prerequisite to receiving federal payment." *Id*. at 1221. The *Swan* court was apparently unaware of the Medicare provider of benefits agreements, in which providers acknowledge that a pre-requisite to receiving payment is compliance with Medicare regulations. With regard to the worthless services theory, the court acknowledged its viability but found the allegations of neglect were not severe enough to support an FCA claim. *Id*.

Finally, the Defendants' reliance on *United States ex rel. Landers v. Baptist Memorial Health Care Corp.*, 525 F. Supp. 2d 972 (W.D. Tenn. 2007) is also misplaced. In *Landers*, yet another *qui tam* wherein the United States declined to intervene, the relator alleged the hospital was liable for failing to satisfy certain standards of sterilization and cleanliness. *Id*. at 975. The relators pursued a false certification theory, alleging FCA liability attached for failing to follow a regulatory condition of payment. *Id*. at 978. The court rejected this theory, finding the regulations in question covered conditions of participation, not conditions of payment. *Id*. Because Medicare did not premise payment on the sterilization regulations, the court dismissed

the relator's false certification theory. *Id*. As an afterthought, the relator claimed her false certification theory also stated a cause of action as a worthless services claim. *Id*. at 979. The court, addressing the claim in two sentences, stated the mere failure to follow Medicare's conditions of participation, by itself, did not create a worthless services claim. *Id*. at 980.

Here, the United States is not arguing the Defendants' merely failed to follow certain regulations. This is not a regulatory compliance case, nor is it a "malpractice case in disguise." Def. Mem. at 1. This is a fraud case where the services provided to Villaspring's residents fell so far below accepted standards of care that they were essentially worthless, causing very real harm to both the patients and to the government when Defendants billed it for those services.[2] The United States has clearly pled and alleged facts that, assumed to be true, demonstrate the Defendants committed a fraud. *Landers* therefore has no applicability to the instant case.

In sum, Defendants' argument that, as a matter of law, their provision of some unidentified nursing services insulates them from FCA liability fails. The Complaint alleges that the Defendants either failed to provide a critical portion of the bundled services or performed these services in a grossly deficient manner.[3] Based upon the facts alleged, the government did not receive fair value for the services for which it paid. Under these circumstances, the

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[2]The United States agrees with Defendants that simple violations of the standard of care do not give rise to FCA liability. The FCA is not a malpractice statute. However, the regulations detailed in the Complaint provide guidance on the level of care the government bargained for and expected from skilled nursing facility providers, and serve as a measuring stick when determining just how egregious Defendants' care was.

[3]In several instances there are no documents indicating the Defendants' provided *any* care. *See* Complaint at ¶¶ 77, 101, 117, 130, 139. In at least one instance, the Government was billed for services allegedly rendered by Villaspring while the patient was in a hospital. *See* Complaint at ¶ 115. The Defendants seemingly concede, as they must, that billing for services that were never rendered at all violates the FCA.

Defendants' claims for payments are no less fraudulent, and no less actionable under the FCA, than if they had failed to provide any services at all. *See United States v. NHC Healthcare Corp.*, 163 F. Supp. 2d 1051, 1056 (W.D. Mo. 2001). The Defendants' argument that no FCA liability exists because some service was provided, such as a bed or a roof over the patient's head, is the equivalent of finding the Union Army was not harmed when a contractor provided a box of bullets filled with sawdust.[4] In both situations the Government was provided *something*; in neither instance did it get what was paid for.

Defendants' other arguments fare no better. Their gripe that the Complaint leaves out which specific services were not provided over the entirety of the relevant time period is improper at this stage of the litigation. As the Sixth Circuit recognized in *Bledsoe*, "[T]here are, however, valid reasons for not requiring a relator to plead every specific instance of fraud where the relator's allegations encompass many allegedly false claims over a substantial period of time." *Bledsoe*, 501 F.3d at 50. *Accord NHC Healthcare Corp.*, 115 F. Supp. 2d at 1151 ("this type of more specific information is likely not in the possession of the Plaintiff at this time and is more properly brought to light in discovery.") *See also United States ex rel. Mikes v. Strauss*, 853 F. Supp. 115, 119 (S.D.N.Y. 1994) (holding that the plaintiff is not required to provide information at the complaint stage that is not available to him). "Rule 9 was meant to require detailed pleadings in cases of fraud so as to aid a defendant in supporting its case. It was never

[4] For a history of the False Claims Act, *see United States ex rel. Newham v. Lockheed Missiles and Space Co., Inc.*, 722 F. Supp. 607, 609 (N.D. Cal. 1989); *see also* Cong. Globe, 37th Cong., 3rd Session, 952, 955 (1863) (Congress enacted the FCA "to assist in ferreting out unscrupulous defense contractors who committed fraud against the Union Army by delivering bullets loaded with sawdust.")

meant to require a plaintiff to set forth every factual detail supporting its claim, nor was it meant to fuse the stages of pretrial investigation and discovery." *NHC Healthcare Corp*., 115 F. Supp. 2d at 1151.

Defendants next argue the United States has failed to establish that "all the care provided to all the residents over a multi-year period were 'worthless.'" Def. Mem. at 11. The purpose of this argument is unclear. The United States does not have to "establish" (whatever that means at this stage of the litigation) that "all care" to "all residents" during the relevant time period was worthless in order to set forth a FCA violation. If the United States establishes that Defendants provided a mere three weeks of worthless services to thirty patients, or five patients, or even one patient, and knowingly billed the government for that care, then it is entitled to recover whatever damages resulted from those particular false claims. *See United States v. NHC Health Care Corp.*, 163 F. Supp. 2d 1051 (W.D. Mo. 2001) (alleging FCA violations for worthless services provided to two nursing home residents during summer and fall of 1998). At this pre-discovery stage, the United States does not know exactly how many residents and how many false claims will be at issue. However, because its Complaint sets forth specific examples of the fraud, *see* Complaint at ¶¶ 68-139, it is entitled to proceed to discovery on the entire fraudulent scheme. *See Bledsoe*, 501 F.3d 493, 510.

C. The Complaint Also Establishes FCA Liability Under the "Implied Certification Theory."

Defendants suggest, again incorrectly, that the United States has not pled its case under a false certification theory of FCA liability. Def. Mem. at 12, n.5. The Complaint sets forth viable claims under this theory as well as the "worthless services" theory.

The "false certification" theory of FCA liability applies to situations where a claimant's

failure to comply with regulations renders its claims for payment to the government fraudulent within the meaning of the FCA. *See Chesbrough*, — F.3d —, 2011 WL 3667648, at *3 (outlining theory). In some instances, a claimant will, on the face of the claim, expressly certify that the claim complies with applicable laws and regulations. If the claim does not comply with those regulations, then the certification is false and FCA liability may attach, assuming other elements such as knowledge are met. *Id.* The certification does not have to be on the face of the claim, however. The Sixth Circuit has adopted the "implied certification theory," wherein liability attaches "if the claimant violates its continuing duty to comply with the regulations on which payment is conditioned." *United States ex rel. Augustine v. Century Health Servs., Inc.*, 289 F.3d 409, 415 (6th Cir. 2002). Thus, a claim is false or fraudulent under the FCA if it does not meet a material pre-condition of payment. Pre-conditions of payment do not have to be expressly stated in a statute or regulation, but may be found in contracts as well. *United States ex rel. Hutcheson v. Blackstone Medical, Inc.*, 647 F.3d 377, 386-88 (1st Cir. 2011); *United States ex rel. Connor v. Saline Reg'l Health Ctr.*, 543 F.3d 1211, 1218 (10th Cir. 2008) (the implied false certification analysis "focuses on the underlying contracts, statutes, or regulations themselves to determine whether they make compliance a prerequisite to the government's payment.").

In this case, the agreements that Villaspring entered into with the government in order to participate in the Medicare program explicitly condition payment on Villaspring's compliance with applicable laws and regulations, include those set forth at paragraphs 22 through 37 of the Complaint. For example, Villaspring's Medicare provider agreement certifies that "I understand that payment of a claim by Medicare or other federal health care programs is conditioned on the

claim and the underlying transaction complying with such laws, regulations and program instructions . . ., and on a provider/supplier being in compliance with any applicable conditions of participation in any federal health care program." Complaint, ¶ 40; Complaint, Exhibit 1. Defendant Bortz made that certification. *Id*. at ¶ 39. Similarly, the Health Insurance Benefit Agreement, Form CMS-1561, which Villaspring is believed to have signed, conditions payment on the provider's conformity to skilled nursing facility regulations. *Id*. at ¶¶ 48, 49.

Villaspring's specific claims for payment identified in the Complaint do not expressly certify that the service for which payment is claimed complied with all applicable regulations. However, in providing the services described in the Complaint, Villaspring violated its duty to comply with the regulations on which Medicare conditioned payment, such that Villaspring's claims for payment for those services were false. *See Hutcheson*, 647 F.3d at 392-95 (holding that language of Medicare provider agreement made clear that compliance with applicable health care laws was pre-condition of payment, and that claims submitted for payment implicitly represented compliance with those laws). Accordingly, drawing all inferences in favor of the United States, the Complaint's FCA claims are viable under an implied false certification theory as well as a worthless services theory.

D. The Defendants had knowledge of their false claims

The Defendants improperly seek to make factual allegations regarding their lack of knowledge of submitting false claims.[5] At this stage, all factual allegations in the Complaint are deemed true and all reasonable inferences are drawn in favor of the non-moving party. *See*

[5]See, for example, Defendants' unsupported averments regarding "long-standing CMS practices." Def. Mem. at 21-22.

Bledsoe, 501 F.3d 493, 502. Here, the United States has adequately pled facts that would prove the Defendants' knowledge. *See* Complaint at ¶¶ 55-59, 64, 76, 89, 105, 114, 129, 138, 141, 144-153.

Under the False Claims Act, a person "knowingly" submits a false claim for payment when he acts with "actual knowledge of the information, or with deliberate ignorance or reckless disregard for the truth or falsity of the claim." 31 U.S.C. § 3729(a)(1); *see also United States ex rel. Bledsoe v. Community Health Systems*, 501 F.3d 493, 503 (6th Cir. 2008). Here, the Defendants knew they were submitting claims for worthless services. The Defendants had actual knowledge based upon the findings of state surveyors, civil monetary penalties imposed by the Center for Medicare and Medicaid Services, and lawsuits brought by victims' families.[6] In addition, the Defendants were fully aware of the patients' hospitalizations and deaths that resulted from their failure of care.

The Defendants' complaint the Government has not specifically identified the person responsible for submitting the false claim is also meritless. "The identity of the natural person within the corporate defendant who submitted false claims is not an essential element of a FCA violation." *Bledsoe*, 501 F.3d at 506. For purposes of FCA liability, "'person' includes not merely natural persons, but also private corporations." *Id*. The Sixth Circuit concluded "it is the identity of the corporation, not the identity of the natural person" that must be pled with

[6]The Defendants assert that "[n]othing in the complaint suggests that any court found against Villaspring in these suits on any issue." Def. Mem. at 14. The Defendants notably fail to advise the Court that these suits were settled prior to trial. To suggest the lawsuits had no merit is misleading. Regardless, the issue is whether the Defendants had notice of potential fraudulent claims. A lawsuit alleging wrongful death based upon substandard care provides the Defendants direct knowledge of potential false claims. The Defendants' decision to settle such a suit seemingly confirms, at minimum, knowledge of the claims.

particularity. *Id*.

The Defendants next argue the Government's own knowledge precludes any FCA claim. Def. Mem. at 20 - 22. The cases they cite in support of this proposition are clearly distinguishable. In these cases, each a minimum of thirty-eight years old, the defendants' criminal convictions were overturned due to assurances of government agents that certain conduct was legal. *Id*. No such assurance occurred here.

CMS's decision to continue to pay the Defendants despite survey violations and sanctions in no way provides immunity from a FCA claim. Indeed, the Sixth Circuit has rejected the argument that government knowledge precludes FCA liability. "[W]e conclude [the defendant's] argument that liability is precluded by the Government's knowledge is unpersuasive." *United States ex rel. A+ Homecare, Inc. v. Medshares Management Group, Inc.*, 400 F.3d 428, 454 (6th Cir. 2005) (affirming FCA liability for a home health agency that submitted fraudulent cost reports). *See also United States ex rel. Kreindler & Kriendler v. United Techs. Corp.*, 985 F.2d 1148, 1156 (2nd Cir. 1993) ("the statutory basis for an FCA claim is the defendant's knowledge of the falsity of its claim, which is not automatically exonerated by any overlapping knowledge [of] government officials.")

In addition to finding no support in the case law, the Defendants' argument has no logical basis. Their argument, at its core, is that the government cannot recover fraud when later discovered because it (a) regulated the field and (b) did not catch the fraud prior to payment. Given the numerous diverse areas the government either regulates and/or spends money, it is difficult to see how such reasoning would not preclude virtually all civil and criminal claims of program fraud against any government agency. Defendants' suggestion that a provider may

continue to submit false or fraudulent claims so long as it has not been terminated from the Medicare program or denied payment for regulatory non-compliance is illogical. Def. Mem. at 19-20.

E. The United States has standing to bring this suit

The Defendants submitted false claims to the Government. Having paid these fraudulent claims, the Government has standing to demand its money back. The Defendants' argument to the contrary has no basis in law.

Courts have routinely held that Medicaid fraud claims are actionable under § 3729(a)(1). *See, e.g., United States v. NHC Healthcare Corp.*, 115 F. Supp. 2d 1149, 1156 (W.D. Mo. 2000) ("Knowingly submitting claims against the United States for Medicare and Medicaid services not actually performed clearly violates the FCA."); *United States v. Rogan*, 459 F. Supp. 2d 692, 717 (N.D. Ill. 2006); *United States ex rel. Ven-a-Care v. Actavis Mid Atlantic, LLC*, 659 F. Supp. 2d 262, 269 (D. Mass. 2009); *Cathedral Rock*, 2007 WL 4270784 at * 3. Medicaid providers, such as the Defendants, submit claims to state Medicaid agencies for reimbursement. 42 U.S.C. § 1396a(a)(23), (a)(32). The federal government reimburses states for a substantial portions of the funds allotted. 42 U.S.C. § 1396. "For this reason, claims submitted to state Medicaid agencies are considered claims presented to the federal government and may give rise to liability under the FCA." *Rogan*, 459 F. Supp. 2d at 717.

Moreover, the Defendants completely ignore the Medicare claims, which are paid directly by the federal government. 42 U.S.C. § 1320c-5(A)(2). The United States clearly set forth in the complaint the Medicare and Medicaid legal and regulatory framework, *see* Complaint, ¶¶ 21 - 37; the provider agreements the Defendants signed with Medicare and

Medicaid, *Id*. at ¶¶ 38 - 51; and the claim for relief. The Government is seeking only damages resulting from its payment for the worthless services, as well as statutory or common law penalties. The Government makes no claim for the personal injuries suffered by the Defendants' patients. The Defendants' allegation the "residents and their families have appropriate remedies available to address any deficiency of care," while true, is of no legal significance. These families may recover money for the pain and suffering inflicted upon their loved ones. The United States is seeking recovery for the money it paid the Defendants to care for these and other individuals. Because the United States has standing to recover money it was fraudulently induced to pay, the motion to dismiss should be denied.

F. The False Claims Act is appropriately used in health care settings

The Defendants spend significant time complaining the United States should not use the FCA to regulate nursing homes. *See* Brief at 13, 15-20. The Defendants allege the Government is attempting to engage in "administrative or judicial expansion of federal regulation of health care" and even insinuate the Government is attempting to fund health care reform through use of the False Claims Act. *Id*. at 13.

The Defendants are wrong. The Government brought this claim because the level of "care" they provided their patients is simply unacceptable, and because billing the government for that unacceptable care constitutes fraud. Among other things, the Defendants failed to prevent pressure ulcers, failed to monitor diabetics' blood glucose level, failed to help people eat who could not feed themselves, and failed to help patients use the restroom. Frequently family members would have to clean their loved ones because the Defendants failed to do so. Notably, the Defendants never failed to accept the Government's money for the "care" provided these

patients.

As one district noted in responding to similar claims regarding the propriety of using the FCA in the health care setting, "In this case there may be broad negative implications for the health care industry by the continued prosecution of providers under the FCA. But it is not the place of this Court to exempt an entire industry from FCA liability simply because it may be hurt by such suits." *NHC Healthcare Corp., Inc.*, 115 F. Supp. 2d at 1152. Similarly, the Defendants' desire to escape responsibility for their actions is irrelevant. The United States has properly pled a FCA complaint under well-established law. The Complaint should not be dismissed.

II. THE COMPLAINT SATISFIES RULE 9(b)

The Government has stated its claims with particularity. This is all that is required at this stage in the litigation. Rule 9(b) provides that "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally." Rule 9(b) is not to be read in isolation, but is to be interpreted in conjunction with Federal Rule of Civil Procedure 8. *See Bledso*e, 501 F.3d at 503. "The two rules must be read in harmony." *Id.* (citing *Michaels Bld. Co. v. Ameritrust Co., N.A.*, 848 F.2d 674, 679 (6th Cir. 1988). Rule 8 requires only "a short and plain statement of the claim" made by "simple, concise, and direct allegations." *Id.* Rule 8 is commonly understood to embody "notice pleading" where technical pleading requirements are rejected in favor of an approach designed to reach the merits of an action. *Id.* In complying with Rule 9(b), a plaintiff, at a minimum, must "allege the time, place, and content of the alleged misrepresentation on which he or she relied; the fraudulent scheme;

the fraudulent intent of the defendants; and the injury resulting from the fraud." *Id*. at 504. As with Rule 12, motions to dismiss pursuant to Rule 9(b) require the court to construe "the complaint in the light most favorable to the plaintiff and accepting all factual allegations as true . . . ." *Chesbrough*, 2011 WL 3667648 at *3.

The Complaint readily satisfies the requirements of Fed.R.Civ.P. 9(b). The Complaint sets forth in particular detail the basis upon which the United States claims the Defendants violated the FCA and how they are responsible under common law. The United States identifies:

- Who: the named Defendants in each count and throughout the Complaint.
- What: the false claims identified by resident, and exactly why these claims, and others, were worthless.
- Where: at Villaspring of Erlanger Health Care Center.
- When: the dates during which the worthless service was provided and billed.
- How: through the submission of claims for reimbursement to Medicare and Medicaid.

The Defendants' arguments to the contrary collapse when examined in the context of the particular allegations set forth in the Complaint. Moreover, the Defendants' allegations are belied by the fact-specific arguments they raise in their Motion to Strike. [Record No. 13]. While the Defendants argue they do not have adequate knowledge of the Government's claims, they refute this argument themselves with the specificity of their motion to strike. The purpose of Rule 9(b) is "not to reintroduce formalities to pleading, but is instead to provide defendants with a more specific form of notice as to the particulars of their alleged misconduct." *Bledso*e, 501 F.3d at 503. In light of the detailed allegations of the Complaint and Defendants' litany of

fact-based refutations in their motion to strike, there can be little doubt that Defendants are on notice as to the particulars of the government's claims against them.

III. THE COMMON LAW CLAIMS SHOULD NOT BE DISMISSED

The Defendants summarily claim the Government's common law claims must be dismissed for the same reasons they seek dismissal for the FCA claim. As explained above, dismissal on these grounds is inappropriate. Dismissal of the common law claims is therefore similarly inappropriate.

The United States's common law claims have a sound legal basis. To state a common law fraud claim under Kentucky law, a plaintiff must prove the defendant (1) made a material misrepresentation; (2) which is false; (3) which defendant knew to be false; (4) which was made in order to induce plaintiff to act in a certain manner; (5) that plaintiff so acted in reliance on the misrepresentation; and (6) the plaintiff was injured as a result. *See Broughton v. Adams Pontiac Buick GMC Truck, Inc.*, 272 F. App'x 491, 497 (6th cir. 2008) (citing *Denzik v. Denzik*, 197 S.W. 3d 108, 110 (Ky. 2006)). "Fraud may be established by evidence which is wholly circumstantial." *Id*.

Here, the United States has pled allegations which, if proven, would lead to recovery under common law fraud. The Defendants made a material misrepresentation in that they agreed to care for elderly and vulnerable patients, yet failed to do so; they submitted claims based upon this misrepresentation; they knew their claim was false; they submitted the claim to obtain payment from Medicare or Medicaid; the Government paid the Defendants as a result of these claims; and the Government was injured by paying claims for services that had no value.

Likewise, the Complaint properly sets forth a claim for unjust enrichment. To prevail

under a claim of unjust enrichment, a party must prove three elements: (1) a benefit was conferred upon the defendant at plaintiff's expense; (2) a resulting appreciation of the benefit by the defendant; and (3) inequitable retention of the benefit without payment for its value. *See Ham Broadcasting Co., Inc. v. Cumulus Media, Inc.*, No. 10-cv-185, 2011 WL 1838911 at * 5 (W.D. Ky. May 13, 2011). "In other words, unjust enrichment is applicable as a basis of restitution to prevent one person from keeping money or benefits belonging to another." *Id.*

Here, the Government paid the Defendants for services that were worthless. The Defendants accepted the money and have not reimbursed the United States. It would be inequitable to allow the Defendants to retain payments for the care described in this Complaint.

The Defendants' argument the unjust enrichment claim must be dismissed because an explicit contract has been performed is misplaced. *See* Def. Mem. at 27. The Government did not plead a common law breach of contract claim. Regardless, as evidenced by the Complaint, the United States does not believe the Defendants adequately performed their obligations, contractual or otherwise. The unjust enrichment claim should therefore not be dismissed.

IV. DEFENDANT BORTZ'S SEPARATE MOTION TO DISMISS SHOULD ALSO BE DENIED

Defendant Barry N. Bortz's separate motion to dismiss the claims against him individually should likewise be denied, because the Complaint clearly and adequately pleads that Bortz caused the submission of false claims to the government. Bortz's arguments to the contrary, including those regarding vicarious liability and piercing of the corporate veil, are red herrings intended to distract the Court from this conclusion. The United States is not alleging that Bortz is vicariously liable. The United States is not alleging that the corporate veil should be pierced. The United States is not seeking to penalize Bortz for the actions of another person

or entity. Instead, the United States is alleging that Barry Bortz personally and knowingly caused the submission of false claims to the government, and the Complaint seeks to hold him responsible for his own unlawful conduct.

A. The Complaint States a Claim Against Bortz Upon Which Relief May Be Granted.

The United States' Complaint makes the following allegations regarding Bortz:

- Bortz is an owner and CEO of both Villaspring and Carespring. Complaint, ¶ 7;
- Bortz exercised direct control over Villaspring at all relevant times, and managed Villaspring. *Id*. at ¶¶ 7, 26;
- On behalf of Villaspring, and in order to facilitate Villaspring's receipt of payments from the Medicare program, Bortz certified his understanding that Medicare payments would be conditioned on Villaspring's compliance with applicable federal health care laws and regulations. *Id*. at ¶¶ 39, 40;
- On behalf of Villaspring, Bortz signed annual cost reports that represented to the government that all of the skilled nursing services identified in the reports had been provided in compliance with applicable federal health care laws and regulations. *Id*. at ¶¶ 46, 47;
- Bortz failed to provide adequate care to the elderly and vulnerable residents of Villaspring. *Id*. at ¶ 61;
- Bortz caused the submission to Medicare and/or Medicaid of the specific false claims arising out of the worthless care provided to the patients described at paragraphs 68 through 139 of the Complaint. The Complaint details the time, place, and nature of the worthless services provided to those patients, as well as the amounts paid out by

Medicare and/or Medicaid as a result of the bills Bortz caused to be submitted for those services. *Id*. at ¶¶ 65, 67, 68-139;

- Bortz caused the submission to Medicare or Medicaid of additional and presently unidentified false claims during the relevant period that likewise arise out of the non-existent or worthless care provided to patients in Bortz's Villaspring facility. *Id*. at ¶¶ 66, 67; and
- Bortz knew, within the meaning of the False Claims Act, that the services billed to Medicare and Medicaid were not provided, or were so deficient as to be worthless. *Id*. at ¶ 144.

Given these factual allegations, the United States has pled that Bortz violated 31 U.S.C. § 3729(a)(1) by causing the presentment or submission of a false claim for payment. This is undoubtedly a viable claim.

On a motion to dismiss, the court reviews the complaint in the light most favorable to the plaintiff, accepts its factual allegations as true, and draws all reasonable inferences in the plaintiff's favor. *Bassett v. Nat'l Coll. Ath. Ass'n*, 528 F.3d 426, 430 (6th Cir. 2008) (internal citations omitted). Thus, the factual allegations outlined above must be accepted as true for purposes of Bortz's motion to dismiss. Further, all reasonable inferences must be drawn in favor of the United States. By way of example only, it is reasonable to infer that because Bortz managed Villaspring and exercised control over Villaspring, he was aware of the non-existent or worthless care at or near the time it was provided to Residents #1 through 6. *See, e.g., United States ex rel. Absher v. Momence Meadows Nursing Center, Inc.*, 2007 WL 685693, at *4 (C.D. Ill. Mar. 2, 2007) ("Relators allege that Graff . . . was at all relevant times responsible for the

day-to-day management and long-term operations of the facility. The allegation that Graff managed the day-to-day operations of MMNC are [sic] sufficient to tie him to the allegations of fraud.").

The Complaint adequately sets forth a claim against Bortz under the False Claims Act, which imposes liability when "(1) a person presents, or causes to be presented, a claim for payment or approval; (2) the claim is false or fraudulent; and (3) the person's acts are undertaken 'knowingly,' i.e., with actual knowledge of the information, or with deliberate ignorance or reckless disregard for the truth or falsity of the claim." 31 U.S.C. § 3729(a)(1) (1986); *United States ex rel. Bledsoe v. Community Health Sys., Inc.*, 501 F.3d 493, 503 (6th Cir. 2008). As explained above, courts across the country have recognized the fraud inherent in submitting a bill to the government for nursing home services that were so grossly inadequate that they essentially had no value. *See supra* at 6-7. Per the facts pled in the Complaint, that is precisely what Bortz caused to occur, and the claims against Bortz satisfy Rule 12(b)(6).[7]

B. The Claims Against Bortz Are Pled With Specificity.

Bortz's argument that the Complaint is not pled with sufficient particularity also fails. For allegations of fraud or mistake, Rule 9(b) requires that the complaint "state with particularity

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[7] Bortz argues that "the government has not alleged that Villaspring filed claims for services it did not provide, or that Villaspring altered its claims to receive a higher payment rate. Indeed, the government does not allege this necessary and fundamental element of its claim." Bortz Brief at 6. A cursory review of the Complaint and the relevant case law reveals the factual and legal inaccuracy of Bortz's argument. The Complaint does allege that Villaspring filed claims for services it did not provide, and that Bortz caused the submission of such claims. *See, e.g.*, Complaint, ¶ 67. Furthermore, that allegation is not a "necessary and fundamental element" of the government's claim, as the False Claims Act imposes liability for the submission of claims for worthless services in addition to non-existent or upcoded services. *See Cathedral Rock*, 2007 WL 4270784 at * 6.

the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). However, knowledge or other conditions of a person's mind may be pled generally. *Id.* The Sixth Circuit has explained that in the context of a False Claims Act action, a complaint satisfies Rule 9(b) if it alleges "the time, place, and content of the alleged misrepresentation on which he or she relied; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud, and enables defendants to prepare an informed pleading responsive to the specific allegations of fraud." *Bledsoe*, 501 F.3d at 509.

Courts have cautioned that Rule 9(b) is not to be read in isolation, but rather should be interpreted in light of Rule 8, which requires a "short and plain statement of the claim" with "simple, concise, and direct allegations." Fed. R. Civ. P. 8(a)(2), (d)(1). "When read against the backdrop of Rule 8, it is clear that the purpose of Rule 9 is not to reintroduce formalities to pleading, but is instead to provide defendants with a more specific form of notice as to the particulars of their alleged misconduct." *Id*. at 503.

As set forth above, the Complaint makes factual allegations that tie Bortz to the submission of specific false claims, namely those submitted for worthless services provided to Residents #1 through #6. It details, in more than seventy (70) paragraphs of pleading, the time periods and location of those services, the nature of the poor care delivered, the horrific results of that care, and the financial injury suffered by the Medicare and Medicaid programs following Villaspring's submission of bills for that care. *See* Complaint ¶¶ 65, 68-139. This pleading is more than sufficient to notify Bortz of the particulars of his alleged misconduct. Notably, Bortz does not argue that he is unaware of the specifics of the claims against him, or that the Complaint leaves him unable to prepare an informed responsive pleading.

Bortz's contention that the Complaint must be dismissed because it "lumps him in with the other defendants" is an argument in favor of hyper-technical formality in pleading. In the instances where Defendants are identified collectively in the Complaint, the United States intends its allegations to be against each Defendant, including Bortz. The purpose of Rule 9(b) is to provide a specific form of notice; it does not demand unnecessarily duplicative or formalistic pleading in a complaint alleging fraud. *Bledsoe*, 501 F.3d at 503. Bortz has ample notice of the violations he is alleged to have committed.

For these reasons as well as those set forth in the United States's response to Defendants' collective motion to dismiss, Barry Bortz's motion should be denied.

C. If the Court Finds That Rule 9(b) Is Not Satisfied, The United States Seeks Leave to Amend the Complaint.

If this Court determines that the Complaint is lacking in some aspect of the particularity required by Rule 9(b), as to any Defendant, the United States respectfully seeks leave to amend. Leave to amend should be freely given, particularly in the context of a complaint's compliance with Rule 9(b). Fed. R. Civ. P. 15; *United States ex. rel Bledsoe v. Community Health Sys., Inc.*, 342 F.3d 634, 644 (6th Cir. 2003) (reversing district court's dismissal of FCA complaint with prejudice without leave to amend, and stating that "where a more carefully drafted complaint might state a claim, a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice.") (internal citations omitted). In this case, since the filing of its Complaint, the United States has been made aware of additional facts and evidence that support its False Claims Act claims against Defendants, and would incorporate those facts into any Amended Complaint.

V. CONCLUSION

For the foregoing reasons, the Defendants' motions to dismiss should be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 27th day of September 2011, I electronically filed the foregoing with the clerk of the court by using the CM/ECF system, which will send notice to the following ECF participants:

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