UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
Columbia Division

UNITED STATES OF AMERICA ex rel. CARA GARCIA, *Plaintiff,* v. INTEGRATED HEALTH SYSTEMS, INC. and MAGNOLIA MANOR OF MONCKS CORNER, INC. *Defendants.*	)	*Civil Action No.* 3-02-3796-19

UNITED STATES' AMICUS BRIEF FILED IN RESPONSE
TO DEFENDANTS' MOTION TO DISMISS DATED MAY 27, 2003

INTRODUCTION

The United States of America ("United States") respectfully submits this amicus brief in response to Defendants' Motion To Dismiss For Failure To Plead Fraud With Sufficient Particularity And Failure To State A Claim Upon Which Relief Can Be Granted dated May 27, 2003 ("motion to dismiss"). The United States takes no position on the sufficiency of Relator's factual allegations in the context of Defendants' Fed. R. Civ. P. 9(b) claim. The United States, however, does take issue with Defendants' suggestion that Relator's complaint should be dismissed for failure to state a claim under Fed. R. Civ. P. 12(b)(6) because it did not allege that Defendants' failure to provide care was "total," "striking or pervasive," a standard that is without any support in the statute or case law. To the extent Relator has pled facts sufficient to support a claim that Defendants knowingly billed for services that were not rendered or were worthless, Relator has stated a claim that survives Defendants' motion to dismiss pursuant to Fed. R. Civ. P.

12(b)(6).

FACTUAL BACKGROUND

This *qui tam* action against Integrated Health Systems, Inc. ("IHS"), a nursing home chain, and Magnolia Manor of Moncks Corner, Inc. ("Magnolia"), one of the facilities owned by IHS, (collectively "Defendants"), was initiated by Cara Garcia ("Relator"), a former employee of Magnolia, pursuant to the False Claims Act, 31 U.S.C. §§ 3729 - 3733. In her complaint, Relator alleges that in June 2002, Defendants presented false claims to the United States under the federal Medicare program by knowingly billing Medicare for services, equipment and supplies that were not provided to patients at Magnolia. (Compl. ¶¶ 36-27, 46-50.) Specifically, Relator alleges that Defendants provided inadequate staffing of nurses and certified nursing assistants to meet even the most basic needs of the residents, such as adequate nutrition and the prevention and treatment of pressure ulcers (bed sores), and that Defendants failed to provide the residents the requisite medications and supplies. (Compl. ¶¶ 36-27, 46-50.) Relator alleges that as a result of the insufficient staff, poor care, and lack of supplies and medications, patients at Magnolia suffered physical harm. (Compl. ¶¶ 26-41.)

Defendants have moved to dismiss Relator's complaint on three legal grounds:

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

2. Relator's allegations with respect to some IHS facilities (other than Magnolia) were previously, publically disclosed and therefore cannot be pursued under 31 U.S.C. § 3730(e)(4); and

3. Relator has failed to state a claim on which relief can be granted (Fed. R. Civ. P. 12(b)(6)).

(Def.'s Mem. Supp. Mot. Dismiss at 1-2.)

The United States addresses only Defendants' Fed. R. Civ. P. 12(b)(6) argument. That

argument relates to Relator's allegations that Defendants provided their patients, and nevertheless knowingly billed the government, for non-existent and worthless goods and services. Defendants argue that Relator's allegations, viewed in the most favorable light, are insufficient to state a claim under the False Claims Act. The United States, while not taking a position on the sufficiency of the facts alleged by the Relator in the context of Defendants' Fed. R. Civ. P. 9(b) claim, files this amicus brief to clarify the correct legal standard.

THE INTEREST OF THE UNITED STATES

The United States has a significant interest in False Claims Act case law, even when generated in a declined *qui tam* case such as this one. False Claim Act case law also impacts 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). After conducting an investigation of Relator's allegations, the United States, pursuant to 31 U.S.C. § 3730(b)(4)(B), declined to intervene and take over the litigation of this action. Consequently, the Relator has pursued this case pursuant to 31 U.S.C. § 3730(c)(3). In the event the 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). Moreover, the United States may seek to intervene and take over the litigation of this matter at any time for good cause. 31 U.S.C. § 3730(c)(3).

The United States has a substantial interest in the developing case law in the "worthless services" area to assure that the False Claims Act is correctly interpreted. Worthless services cases, where a defendant bills the government for grossly substandard products or services, present a prototypical False Claims Act claim — billing for items that have no value to the United States. Over the past several years, the United States increasingly has pursued worthless

services cases in a nursing home setting, when health care providers knowingly bill a federal health care program for worthless services. Such cases involve not only false claims and losses to the government, but also usually devastating consequences for the vulnerable elderly and disabled patients who were the intended beneficiaries of the goods and services that were billed for but effectively not provided. The United States files this amicus brief to correct and clarify the legal standard proffered by the defendants for a worthless services case.

ARGUMENT

I. The Allegation that a Defendant Knowingly Billed for Non-Existent or Worthless Services States a Viable 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). A worthless services claim 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 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. 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."). There is no question that a health care provider that knowingly makes claims for payment for substandard or worthless goods or services may be liable to the United States under the False Claims Act.

The determination of what constitutes worthless services is highly fact specific and must be made on a case-by-case basis. In assessing whether the government 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 the providers of skilled nursing services. The Medicare program pays such providers 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 skilled care. These ancillary services include room, board, and routine care such as feeding, hydration, and turning and repositioning (which is necessary to prevent bed sores and contractures).

Although skilled nursing care is at the heart of the bargain between Medicare and the providers of nursing services, Medicare pays a bundled per diem rate that includes the provision of other ancillary services based on its recognition that such services are integral to the provision of skilled nursing care. For example, to take an extreme but all too frequent occurrence, if a resident who needs help with eating is not being fed, skilled nursing care will be of little value to this patient, who may ultimately get sick or die due to weight loss or malnutrition. 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 worthless services claim may properly be alleged even where a provider has adequately performed some portion of the bundled services. If a portion of the bundled services are not provided, or are performed in a grossly deficient manner, it may render worthless any services that are performed. The key question is whether the government received value for the bundle of services for which it paid. If the patient's condition is the same as, or worse than, it would have been had the provider not performed any services, then the answer clearly is no. 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.

II. Defendants' Contention that a Worthless Services Case Arises Only When The Deficiencies Were "Total" Or "Striking and Pervasive" Is Without Legal Support

Defendants claim that Relator's allegations are insufficient to state a cause of action under Fed. R. Civ. P. 12(b)(6) because they fail to allege that Defendant's failure to provide care was "striking or pervasive," and assert that "in the few cases that have allowed claims regarding quality of care to proceed, Plaintiffs alleged a total failure of care." (Def.'s Mem. Supp. Mot. Dismiss at 10-11.) Defendants' brief, however, does not explain or provide any support for these assertions. The question is not whether the failure was "total," "striking or pervasive," but whether Defendants' failure to provide critical services rendered the services they did provide medically worthless.[1] See United States ex rel. Lee v. Smithkline Beecham, Inc., 245 F.3d 1048, 1053 (9th Cir. 2001). This Court should not dismiss Relator's complaint for failing to comply with a standard that has never heretofore been articulated under the False Claims Act, and that is not

[1] In addition to a worthless services claim, the United States may have a false certification claim even when the deficiencies in those services do not rise to the level of being worthless. As six Courts of Appeal have recognized, the false certification may be express or implied. See 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 False Claims Act); United States ex rel. Shaw v. AAA Eng'g & Drafting, Inc., 213 F.3d 519, 531-33 (10th Cir. 2000) (expressly endorsing theory); Skolnick v. United States, 331 F.2d 598, 599 (1st Cir. 1964) (imposing False Claims Act 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). The key inquiry in such a case is whether the defendant certified compliance with a condition of payment. See Siewick, 214 F.3d at 1376. We take no position on whether the relator in this case has properly alleged that Defendant has falsely certified compliance with a condition of payment.

supported by statute or case law.

In focusing on whether or not any services were provided, Defendants' analysis eliminates the inquiry as to whether or not the billed-for services were valuable. See Lee, 245 F.3d at 1053; United States ex rel. Mikes v. Strauss, 274 F.3d 687, 703 (2d Cir. 2001). Worthless services, by definition, imply that the provider has provided some of the services for which it billed. The question under a worthless services analysis is not whether the services were provided, but whether the services were so deficient or otherwise of so little value as to be medically worthless. See Lee, 245 F.3d at 1053; Mikes, 274 F.3d at 703.

The cases cited by Defendants do not support Defendants' arguments and recognize that liability may be found even when services were provided. See United States v. NHC Healthcare Corp., 115 F. Supp. 2d 1149 (W.D. Mo. 2000)(opinion denying the defendant's motion to dismiss); 163 F. Supp. 2d 1051 (W.D. Mo. 2001)(opinion denying the defendant's motion for summary judgment), and United States ex rel. Aranda v. Comm. Psych. Ctrs. of Okla., Inc., 945 F. Supp. 1485 (W.D. Okla. 1996). In Aranda, the United States alleged that Defendants, operators of a psychiatric in-patient facility for adolescents, billed the government for care of children who were subject to unreasonable risks of physical and mental harm, including sexual assaults. Despite the fact that it was undisputed that Defendants provided *some* services, the court denied Defendant's motion to dismiss for failure to state a claim, stating:

> FCA cases cited by the government involving contractors who furnished inferior goods are inapposite, but they provide a useful analogy. It may be easier for a maker of widgets to determine whether its product meets contract specifications than for a hospital to determine whether its services meet "professionally recognized standards for health care." In the court's view, however, a problem of measurement should not pose a bar to pursuing an FCA claim against a provider of substandard health care services under appropriate circumstances.

Aranda, 945 F. Supp. at 1488.

In NHC Healthcare, the United States alleged that patients were given grossly inadequate care and developed pressure sores, incurred unusual weight loss, and suffered unnecessary pain because Defendant knowingly maintained inadequate staffing and supplies at its facility to provide the requisite care, but knowingly billed for care nonetheless; allegations similar to those raised by Relators in this case. See United States v. NHC Healthcare Corp., 163 F. Supp. 2d at 1055-56. The NHC Healthcare court denied both Defendant's motion to dismiss for failure to state a claim, and its motion for summary judgment. In denying Defendant's motion for summary judgment, the NHC Healthcare court noted:

> NHC agreed to provide 'the quality of care which promotes the maintenance and the enhancement of the quality of life.' At some 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.

Id. Thus, both Aranda and NHC Healthcare recognize that there is a point where services, although provided at least in part, are so inadequate that they become actionable under the False Claims Act.

III. Relators Have Alleged A Viable Cause of Action Under The False Claims Act

Defendants argue that Relator's complaint should be dismissed under Fed. R. Civ. P. 12(b)(6) because the failure to comply with broad standards of care will not render claims for healthcare services false. (Def's Mem. Supp. Mot. Dismiss at 10.) Read in the most favorable light, Relator's complaint alleges far more than failures to comply with broad standards of care. For example, Relator alleges that Magnolia was inadequately staffed and that "[r]esidents with pressure sores were not turned as required to decrease further pressure and infection" and that "[m]any of these residents had open pressure sores without any dressings, and those who did have

dressings were not changed in a timely fashion." (Compl. ¶ 31.) Relator further alleges that she witnessed "strong, offensive odors of urine throughout the facility due to the lack of any sanitation procedures" and that "[r]esidents throughout the facility were left for days in urine-stained bed linens and clothing due to lack of staffing and lack of supplies." (Compl. ¶ 33.) Finally, Relator alleges that Magnolia continued to bill Medicare despite being aware of the inadequate staffing and that facility records "incorrectly indicated more personnel than were actually on duty." (Compl. ¶ 29.)

Taking Relator's allegations to be true, Defendants' care was so deficient that patients who were supposed to be receiving therapeutic and rehabilitative care in fact were being neglected to the point of becoming much sicker and suffering from uncontrolled or untreated infection and pain. The conduct alleged by Relator meets no standard of care applicable in a skilled nursing facility. Accordingly, if Relator's claims are true, Defendants have done more than violate the standards of care: they have failed to provide critical services that rendered any services they did provide medically worthless.

To the extent Relator alleges breaches in the standards of care, Defendants incorrectly state that the only appellate court to address the issue of whether deficient care that does not comply with a standard of care may render a claim for healthcare services false is United States ex rel. Mikes v. Strauss, 274 F.3d 687, 702 (2d Cir. 2001). (Def.'s Mem. Supp. Mot. Dismiss at 10.) In fact, Mikes reaffirms the viability of worthless services claims under the False Claims Act. Id. at 703 ("[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"). Moreover, Defendants' analysis ignores United States ex rel. Lee v. Smithkline Beecham, Inc., 245 F.3d 1048 (9th Cir. 2001). In Lee, (also a declined *qui tam* case) the Ninth Circuit held that a Relator's

allegation that Defendant's billing for test services that did not meet the relevant standard of care could state a viable cause of action under the False Claims Act if the omission in question rendered the test result "medically worthless." Lee, 245 F.3d at 1053.

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). Thus, the NHC Healthcare court suggested the use of the statutory and regulatory standards of care as a "measuring stick," to help the finder of fact determine whether the defendants' services provided sufficient value to support a bill for payment. See NHC Healthcare 115 F. Supp. 2d 1051, 1155 (W.D. Mo. 2000). Similarly, Relator appears to be arguing that Defendant's gross violations of the standards of care provide evidence that it billed for non-rendered or worthless services. Relator does not appear to be arguing that a violation of the standard of care creates a per se violation of the False Claims Act. Furthermore, while violations of the regulatory standard of care may well form the basis for a regulatory claim, the existence of such a claim (whether pursued or not) would not extinguish or obviate any potential False Claims Act action arising from the same or similar facts.

Finally, Defendants' assertion that "the essence of Relator's complaint involves the quality of care provided by Defendants, not billing for services that were simply never performed," (Def. Mem. Supp. Mot. Dismiss at 10.), is erroneous and overlooks Relator's allegations that question, in the words of the NHC Healthcare court, "not how the Defendant turned, bathed, administered drugs to, and fed the two residents in question, but whether the Defendant did these things at all." See NHC Healthcare 115 F. Supp. 2d at 1155. Such a complaint is cognizable under the False

Claims Act, and accordingly, Defendants' request that this Court dismiss the complaint for failure to state a claim on which relief can be granted should be denied.

CONCLUSION

To the extent this Court reaches this issue, the United States respectfully requests this Court to deny Defendant's Fed. R. Civ. P. 12(b)(6) motion for failure to state a claim on which relief can be granted.

Respectfully submitted,

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Dated: July 16, 2003

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing UNITED STATES' AMICUS BRIEF FILED IN RESPONSE TO DEFENDANTS' MOTION TO DISMISS DATED MAY 27, 2003 was mailed, postage prepaid to the parties named below on this the 16th day of July, 2003.

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