IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

UNITED STATES OF AMERICA *ex rel.* RIBIK and SLOUGH,	)	
Plaintiffs,	)	
v.	)	CIVIL ACTION NUMBERS:
	)	1:09cv13 (CMH/TCB) (LEAD CASE)
HCR MANORCARE, INC., MANOR CARE, INC., HCR MANOR CARE SERVICES, LLC, AND HEARTLAND EMPLOYMENT SERVICES LLC,	)	1:14cv1228 (CMH/TCB)
Defendants.	)	

UNITED STATES' MEMORANDUM IN OPPOSITION TO
DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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The United States of America, through counsel, pursuant to Federal Rule of Civil Procedure 56 and Local Civil Rule 56, respectfully submits this Memorandum in Opposition to Defendants' Motion for Summary Judgment.

PRELIMINARY STATEMENT

"I honestly felt that my license could be in jeopardy because the manager was pressuring me to treat inappropriate patients; it just felt wrong." "I was told to basically show up and shut up." "I was asked to perform unethical procedures and bullied into billing addt'l units. My job was threatened when I didn't want to sacrifice my integrity." "It's all about getting minutes, minutes, minutes." "[E]asy to leave the 'corporate' push of HCR."

These are just some of the complaints that ManorCare's corporate therapy managers received from therapists at ManorCare skilled nursing facilities ("SNFs") upon these therapists' resignations. These complaints, along with other evidence of the widespread provision of unnecessary, unreasonable, and unskilled therapy, resulted from a corporate strategy ManorCare adopted between 2006 and 2012. That strategy was simple: to game the Medicare system, by pressuring and manipulating its employees into providing thousands of hours of unnecessary and useless therapy, so that ManorCare could reap millions of dollars in improper reimbursements.

More than sufficient record evidence exists for a reasonable trier of fact to conclude that ManorCare did so. Evidence in many different forms—ManorCare's own documents showing therapists being forced to provide unnecessary therapy, testimony from former ManorCare therapists attesting to the same, testimony from ManorCare's corporate leadership showing that they took no identifiable steps to ensure that patients received only reimbursable therapy, all buttressed by reliable expert testimony—provides a firm basis from which a jury could conclude that ManorCare violated the FCA by knowingly submitting thousands of false claims for

unnecessary, unreasonable, and unskilled therapy, with measureable detriment to the public fisc and immeasurable detriment to its therapists and patients.

ManorCare has no answer for this evidence. Instead, ManorCare relies on a series of technical arguments, which are equal parts unpersuasive and self-contradictory. ManorCare contends, for example, that the Medicare rules under which it collected millions of dollars in reimbursements were simply too difficult to understand, even though its own employees testified that they understood the Medicare rules, and even though the multifarious pressure tactics it used to force unnecessary therapy from its own therapists show a widespread disregard for those rules. ManorCare contends that no claim can ever be false for FCA purposes when the claim involves a clinical opinion, even though the Fourth Circuit has concluded that statements of opinions *can* serve as false claims, and even though adoption of ManorCare's argument would offer *carte blanche* FCA immunity for medical providers subsidized with taxpayer funds. ManorCare appears to suggest that its SNFs operated independently of ManorCare's officers, even though each ManorCare officer was an officer or director of each ManorCare SNF, and even though all Medicare reimbursements flowed through a single ManorCare bank account.

ManorCare's incorrect technical arguments cannot distract from what the evidence on record easily suffices for the jury to conclude: between 2006 and 2012, ManorCare improperly obtained millions of dollars in taxpayer-funded reimbursements through knowing pressure and manipulation of its own therapists and patients. The Court should deny ManorCare's motion.

COUNTERSTATEMENT OF UNDISPUTED FACTS

Pursuant to Federal Rule of Civil Procedure 56 and Local Civil Rule 56, the United States sets forth the following material facts in opposition to ManorCare's Motion. Based on the facts set forth below, the United States objects to ManorCare's Statement of Undisputed Material Facts in Appendix A attached to this Memorandum.

I. Between 2006 and 2012, Medicare Part A's Skilled Nursing Facility ("SNF") Benefit Covered Rehabilitation Therapy Documented as Meeting Coverage Criteria

1. Medicare Part A covers up to 100 days of skilled nursing and rehabilitation care for a benefit period following a qualifying hospital stay of at least three consecutive days where: (1) the patient requires daily skilled nursing care or skilled rehabilitation services (or both); (2) the daily services must be services that, as a practical matter, can only be provided at an inpatient skilled nursing center; and (3) the services are provided to address a condition for which the patient received treatment during a qualifying hospital stay, or a condition that arose while the patient was receiving care in a SNF to address a condition for which the patient received treatment during a qualifying hospital stay. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b).

2. "Skilled" therapy is therapy that is "so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel." 42 C.F.R. § 409.32(a).

3. Medicare Part A covers services that are both "reasonable" and "necessary". 42 U.S.C. § 1395y(a)(1)(A). Reasonable and necessary services are: (1) consistent with the nature and severity of the patient's illness, injury, or particular medical needs; (2) consistent with accepted standards of medical practice; and (3) reasonable in duration and quantity. 42 U.S.C. § 1395g(a); Medicare Benefit Policy Manual, Ch. 8, § 30.

4. ManorCare's corporate managers responsible for overseeing rehabilitation therapy services understood the meaning of skilled, reasonable and necessary. Ex. 1 at 227:5-228:7 (Vice President of Rehabilitation Services and Support providing example of medical necessity and skilled service); Ex. 2 at 128:13-131:20; 140:14-16 (Corporate Rehab Consultant); Ex. 3 at 141:7-22; 165:21-166:11 (Vice President of Rehab).

5. CMS requires that providers such as ManorCare maintain sufficient documentation or information in the medical record to support that the services were payable by Medicare. 42 U.S.C. § 1395g(a).

6. ManorCare's Rehabilitation Services corporate managers also understood that CMS requires the SNF to support the services that billed. Ex. 1 at 228:5-7 ("So I have to put in the documentation why is it that it takes my skills to do it and someone who's unskilled couldn't do it."); Ex. 2 at 223:22-224:8; Ex. 3 at 46:1-47:13.

7. Under Medicare's SNF Prospective Payment System (PPS), ManorCare employees reported the therapy minutes provided to patients at roughly the 5th, 14th, 30th, 60th, and 90th days of their stays. 63 Fed. Reg. 26,252, 26,259-60 (May 12, 1998). Based in large part on the amount of therapy provided prior to the 14-, 30-, 60-, or 90-day assessment, patients were placed in a "Resource Utilization Group" ("RUG"). 63 Fed. Reg. at 26,262.

8. The PPS contained five rehabilitation RUGs: Ultra High, Very High, High, Medium, and Low. Between 2006 and 2012, the "Ultra High" (RU) RUG yielded the largest reimbursement. The "Very High" (RV) RUG yielded the next-highest reimbursement of all RUG categories. 70 Fed. Reg. 45,025, 45,038 (Aug. 4, 2005); 76 Fed. Reg. 48,486, 48,501 (Aug. 8, 2011). Ultra High was "intended to apply only to the most complex cases requiring rehabilitative therapy well above the average amount of service time." 63 Fed. Reg. at 26,258.

II. The ManorCare Defendants and the ManorCare SNFs Operated as a Single Corporate Entity Between 2006 and 2012

9. ManorCare is a single corporate entity that operates a chain of SNFs ("ManorCare SNFs"). Ex. 4 at 15:18-16:8.

10. ManorCare was operated through its corporate parents. ManorCare, Inc., was the corporate parent through December 2007, after which HCR ManorCare, Inc. ("HCR ManorCare") became the corporate parent. Ex. 5; Ex. 6.

11. ManorCare, Inc., and then HCR ManorCare, Inc., wholly owned and operated HCR ManorCare Services, LLC ("ManorCare Services") and Heartland Employment Services ("HES") (collectively "ManorCare," "ManorCare Defendants"). Ex. 5; Ex. 6. HES employed SNF employees, including staff that provided patients rehabilitation therapy. Ex. 4 at 60:6-62:7.

12. ManorCare held a single board-of-directors meeting for all ManorCare Defendants and ManorCare SNFs. *See, e.g.*, Ex. 7 at -1014; Ex. 8 at -9347.

13. The ManorCare Defendants shared a single "home office" in Toledo, Ohio. Ex. 4 at 66:3-4, 72:1-2, 71:9-11, 71:20-22.

14. ManorCare, Inc., and then later HCR ManorCare, indirectly owned and operated each of the ManorCare SNFs, which ManorCare incorporated as LLCs. *Id.* at 24:15-25:1; Ex. 6.

15. The ManorCare SNFs' directors and officers were also ManorCare Defendants' directors and officers, and they did not convene separately from convening as the ManorCare Defendants' directors and officers. *See* Ex. 8 at -9363-9364; Ex. 9 at 3.

16. ManorCare CEO Paul Ormond and CFO Steve Cavanaugh approved the ManorCare SNFs' operating budget when they approved the budgets of each of the regional divisions encompassing the SNFs. *Id.* at 49:17-51:19.

17. Medicare reimbursements for therapy provided at the ManorCare SNFs was a significant part of ManorCare's financial performance. *Id.* at 164:11-166:11.

18. The ManorCare Defendants and ManorCare SNFs mingled funds in the same corporate bank account, which received Medicare reimbursements. *Id.* at 18:2-19:8.

19. Each ManorCare SNF designated ManorCare's Toledo office as its "chain home office" for receipt of Medicare reimbursements and ManorCare Vice President of Reimbursement, Barry Lazarus, as its official authorized to make changes to the SNF's Medicare status. *Id.* at 71:12-72:22; *see, e.g.*, Ex. 10; 42 C.F.R. § 424.502.

20. The ManorCare SNFs also designated Medicare reimbursements to be made to a JPMorganChase bank account over which "HCR ManorCare, Inc., ManorCare, Inc., or one of their corporate affiliates ha[d] sole control" over. Appendix B is a compilation of the Medicare provider applications ("855As"), as well as Electronic Funds Transfer Authorization agreements ("EFTs"), filed for the 212 ManorCare SNFs from which the ManorCare Sample was drawn.[1]

21. ManorCare's corporate leadership included Ormond, Cavanaugh, COO Stephen Guillard, Director of Rehabilitations Services James Pagoaga, Divisional Rehabilitation Directors ("DRDs"), and Regional Rehabilitation Managers ("RRMs"). Ex. 11 (DRD email address with "CORPORATE" designation); Ex. 12 (RRM email address with "CORPORATE" designation). As ManorCare witness Stephen Cline testified, "DRDs, RRMs, regional rehab managers, VP. Corporate, that's our corporate employees." Ex. 13 at 56:13-18.

22. The Rehabilitation Services department, led by Pagoaga, reported directly to Guillard through 2010, after which the department reported indirectly to Guillard. Ex. 14 at 145:16-146:11, 154:14-156:7. Pagoaga worked at ManorCare's Toledo office. *Id.* at 156:8-22.

[1] The ManorCare Sample is drawn from ManorCare patients who (1) were admitted to one of the 212 ManorCare facilities that billed an average of at least 65% of patient-days at the Ultra High RUG, and (2) were billed at the Ultra High RUG level at the 30-, 60-, or 90-day assessment. *See* U.S. Mem. in Opp'n to ManorCare *Daubert* Mot. at 7, Dkt. 557. Appendix B lists the 855As and EFTs for these 212 facilities and includes the 855As and EFTs as attachments. Due to the large volume of documents in Appendices B and C, *see infra.*, the United States has provided media containing Appendices B and C to the Court.

23. For most of the relevant period, the Rehabilitation Services department was divided into six divisions: Central, Eastern, Mid-Atlantic, Midwest, Southeast, and West. Each Division was led by a DRD, each of whom had several RRMs as direct reports. Ex. 111. Directors of Rehabilitation ("DORs") at the ManorCare SNFs reported to an RRM.

24. ManorCare's operations staff—composed of general managers, regional directors of operations, and facility administrators—also reported to Guillard. Ex. 14 at 145:16-146:11.

III. Between 2006 and 2012, ManorCare's Corporate Leadership Pressured Therapists to Provide Unnecessary Services to Increase Medicare Reimbursement

25. Between 2006 and 2012, ManorCare's corporate leadership pressured and manipulated SNF therapists to provide patients unnecessary therapy sufficient to bill patients at the Ultra High RUG. This pressure took many forms, as discussed below. That pressure permeated the facilities from which the patients in the ManorCare Sample were drawn. *See infra* n.1. Appendix C is a compilation of documents showing pressure discussed below filtering from ManorCare's corporate leadership to the facilities from which the Sample Patients were drawn.

A. Medicare Power Ratings

26. Therapy managers exerted pressure through the use of "Medicare Power Ratings," an internal, proprietary accounting tool designed to highlight ManorCare SNFs' high-revenue billings. Within the Medicare Power Ratings were "Rehab Power Ratings" ("RPR"), also called "RUG Distribution Reports," which quantified the number of patient-days billed to Medicare at the RU and RV levels of rehabilitation therapy. Exs. 15-16; *see* Ex. 13 at 57:2-61:1.

27. The purpose of Medicare Power Ratings was to pressure SNF staff to provide more therapy using the "Hawthorne Effect," which is "[t]he tendency of humans to improve their performance when they are aware it is being studied." Ex. 17 at 51.

28. On a monthly basis, Power Ratings reports were sent to Guillard, DRDs and RRMs in the Rehabilitation Services department, facility-level Directors of Rehabilitation, and facility-level administrators. Ex. 13 at 49:19-56:20. DRDs and RRMs also had access to Power Ratings reports in a centralized ManorCare repository. *Id.* at 49:19-56:20.

29. DRDs and RRMs used Medicare Power Ratings to pressure facility-level therapy staff to provide patients more therapy. They did so by using each SNF's Power Ratings to measure the SNF's performance, and by pushing SNFs to compete with other ManorCare SNFs, regions, and divisions with higher Power Ratings. *See, e.g.*, Ex. 18 at -3780 (quoting facility manager blaming decrease in RU percentage on "a few rogue therapists"); Ex. 19 at -0427 ("RU grew by .5% to 75.2% (CORP RU in September @ 78.6%) 28 centers in the MW below corporate results…"); Ex. 20 at -3762 ("**GOAL: RPR % = 88%**"); Ex. 21 at -1825.

30. Cavanaugh testified that "unequivocally the board of directors wouldn't even know what a power rating is." Ex. 4 at 294:9-16 ("[N]o one in senior management…that I'm aware of, and certainly at the board level, nobody used it or cared about it.").

31. The record belies this assertion. Testifying as a fact witness, Cavanaugh stated that he was aware of Power Ratings and "knew people used" them. Ex. 22 at 183:1-3, 191:7-15 ("I mean, I knew there was a report. I knew people used it.").

32. Guillard also included Medicare Power Ratings in a presentation to the ManorCare board of directors. Ex. 23 at -3643 ("PUT IN A PARAGRAPH ON MEDICARE POWER RATINGS AND HOW THIS TOOL IS USED.").

33. Cavanaugh was involved in ManorCare internal correspondence discussing Power Ratings. Ex. 24 at -6563-6564; Ex. 25 at -6693, -6695.

34. Power Ratings were on the agenda of a November 2008 meeting that Pagoaga, Cavanaugh, and Guillard attended with ManorCare's owner, The Carlyle Group. Ex. 26 at -0711 ("Medicare Power Rating System in place to maximize revenue."); Ex. 3 at 376:19-386:11.

35. Guillard had access to power ratings and instructed operations and therapy staff to "verify that…power ratings…are being used" in ManorCare SNFs. Ex. 25 at -6695; *see* Ex. 14 at 205:21-210:4; *see also* Ex. 26 at -6128; Ex. 27.

B. Medicare Entitlement Training

36. Rehabilitation managers also exerted pressure through "Medicare Entitlement Training" ("MET"), a program used to pressure therapists to "CHALLENGE EACH OTHER" to "[p]rovide the maximum amount of therapy that the patient can tolerate." Ex. 28 at 3, 38.

37. Before ManorCare implemented MET, no data, research, or audit found that any ManorCare patients were not receiving Medicare benefits, or that ManorCare therapy personnel were not notifying patients of services that Medicare would cover. Ex. 4 at 361:22-365:14.

38. Thus, while ManorCare described MET as a training to help patients learn about services Medicare would reimburse, MET taught ManorCare therapists to find any and all ways to bill patients at Ultra High. Various Medicare Entitlement presentations instructed therapy supervisors responsible for scheduling therapy to ask, "WHY NOT U?" (i.e., RU) for every patient, Ex. 28 at 28, stated that "Medicare revenue is EXTREMELY IMPORTANT!!!" while depicting Medicare as a series of credit cards being handed to ManorCare, Ex. 29 at 3, 6, and portrayed a fictional superhero named "Super RU," Ex. 30 at 32.

39. The phrase "Medicare Entitlement" became synonymous with billing for more therapy. Guillard directed a manager whose division provided less therapy to go to a division that provided more therapy and "learn their entitlement program." Ex. 31 at 193:8-199:20.

40. Managers told subordinates to scrutinize "any patient not achieving an RU and what can be done to be sure that the patient receives full entitlement," Ex. 32 at -9551, and be "inspired by Medicare Entitlement Training [to look for] Percentage in RU—with a philosophy of why not RU??" Ex. 33 at -5302. A therapy supervisor reported that after receiving MET presentations, "incredibly[,] 6 out of 8 facilities had RU greater than 70%." Ex. 34 at -5598.

C. Goals for Ultra High RUGs

41. Rehabilitation managers also exerted pressure by setting goals for Ultra High rehabilitation billing, which were not based on the individualized needs of ManorCare patients. DRDs and RRMs set goals for the percentage of patients billed at the RU level by facility, region, and division. *See, e.g.*, Ex. 20 at -3762 ("This a 9 month trend of not reaching goal of 70% RU."); Ex. 36 at -3449 ("Key Focus Areas…Increase RUGs by 10%"); Ex. 37 (noting "Entitlement Metrics," including "Medicare A U's: @ / >: 80%") at 12; Ex. 38 (RRM Mark LeFever noting an Ultra High "goal of 40% or greater").

42. Further, goals for Ultra High billing were used in evaluating the performance of rehabilitation managers, and were discussed in both action plans and performance improvement plans for both facilities and individual managers. *See e.g.*, Ex. 39 at -8540 (noting goal to increase the facility's RU percentage to 75%); Ex. 40 at -130.

D. Group Therapy

43. Group therapy is the treatment of up to four patients at once, performing similar activities, supervised by a therapist or assistant. Through October 2011, CMS rules allowed SNFs to separately bill for each patient in group therapy, so that ManorCare could bill four hours of therapy for a single hour of group therapy provided to four patients. These rules also allowed

up to 25% percent of a patient's total therapy minutes per discipline during the 7-day look-back period to be billed for group therapy. 74 Fed. Reg. 40,288, at 40,317 (Aug. 11, 2009).

44. No different than individual therapy, the necessity, reasonableness, and skilled nature of group therapy had to be documented under Medicare rules. 42 U.S.C. § 1395g(a). ManorCare was well aware of this fact, as evidence by its internal documents. Ex. 41 ("Documentation is an essential component for reimbursement of group therapy."); Ex. 42 ("Reminder! Each time a patient participates in group therapy service, the weekly summary needs to reflect what skilled service was delivered in group.").

45. Regional therapy managers set goals for group therapy, such as requiring 25% of therapy billed for group therapy. *See, e.g.*, Ex. 43 at -4257. ManorCare used group therapy rules as an "expense control" allowing ManorCare SNFs to provide the most therapy with the fewest therapy staff members, Ex. 44 at 78:11-21, 110:18-111:22, as evidenced by one therapy manager's direction to "group the crap out of every Medicare A" when a ManorCare SNF had few Medicare patients, Ex. 45. ManorCare therapists were required to provide group therapy that was unnecessary, unreasonable, and unskilled. Ex. 46 at 53:20-54:20; Ex. 47 at 26:17-18.

46. In October 2011, CMS changed group therapy rules to require SNFs to bill group therapy collectively for all participating patients, so that ManorCare could only bill a total of one hour of therapy for one hour of group therapy provided to four patients. 76 Fed. Reg. at 48,512.

47. After this rule change, ManorCare's group therapy billing plummeted. For example, at ManorCare's Devon Manor SNF, 15% of the therapy minutes billed in June 2009 were devoted to group therapy, with roughly the same percentage of 15.3% a year later. Ex. 48; Ex. 49. One week before the rule change went into effect, that percentage had fallen to 0.23%, consistent with what Russell described as ManorCare's "transition strategy." Ex. 50 at -8757.

E. Modalities

48. Modalities are treatments such as electrical stimulation and diathermy that are used by therapists in conjunction with therapy exercises or activities to manage pain, or strengthen, relax, or heal muscles. ManorCare, which leased modalities through a company named ACP, referred to such modalities as "minutes insurance" to increase the number of reported minutes and thus, reap a larger reimbursement. Ex. 51 at -9717; *see* Ex. 52 at -7558; Ex. 53 at -0870 ("Utilize ACP CPM representative to facilitate use of advanced modalities when staff say nothing is working and want to discharge."); Ex. 54 at 17:14-18:6, 85:1-86:18, 97:1-11.

F. Length of Stay

49. ManorCare pressured SNF DORs and therapists to maximize patients' length of stay in order to increase Medicare revenue. This effort began with Guillard, who instructed divisional operations staff to "help centers focus on how they manage their length of stay" to bring it closer to Central Division's longest average length of stay. Ex. 55 at -2639.

50. After Guillard began emphasizing length of stay, DRDs and RRMs pressured facility staff to keep patients in therapy longer before discharge, and criticized facility staff for discharging too soon. *See, e.g.*, Ex. 20 at -3762 ("ALOS has declined as well…. June is at 24.1."). Some regional and divisional therapy managers required their approval before a patient could be discharged sooner than 30 or 35 days into a stay. Ex. 56 at -6389; Ex. 57 at 18.

G. Action Plans

51. ManorCare placed managers who fell short of RUG, group therapy, and other goals on "action plans" tied to those goals. *See, e.g.*, Ex. 58 at -7007-08 ("We must ensure that our patients are receiving the maximum rehabilitation services that they can tolerate… Please complete action plans for your centers and monitor your results weekly… ***Congratulations to all***

of you that have reached 70% [RU patient-days].”). Pagoaga and General Manager Alan Hash called for action plans to support their “three-pronged revenue strategy” and ranked SNFs by percentage of patients at Ultra High. Ex. 59 at -3006-3011; *see* Ex. 31 at 231:15-238:22.

52. For instance, in May 2007, ManorCare placed a therapy supervisor in New Jersey on an action plan to “meet the following operational targets . . . RU 50%+.” Ex. 60 at -3912.

53. In March 2008, ManorCare placed its therapy supervisor in Boca Raton, Florida on an action plan to “Increase group therapy from YTD 8.1% to divisional goal of 15%” and “Increase RU delivery by 20%.” Ex. 52 at -7557-7558; Ex. 31 at 213:1-214:11.

54. In June 2008, ManorCare placed several therapy supervisors in Oklahoma and Texas on action plans to “Increase each facilities [sic] RU% to greater than 55%.” Ex. 61 at -2646; Ex. 31 at 244:19-246-21. In 2009, ManorCare amended the action plan for one of these same SNFs to “Increase RU% to >70%.” Ex. 62 at -8388.

55. In January 2010, ManorCare placed a therapy supervisor in Virginia on an action plan requiring him to email his supervisor daily, listing “[a]ll non RU patients . . . for review of alternate strategies to deliver full entitlement.” *See* Ex. 63 at -3485; Ex. 64 at 277:14-278:3.

H. Employee Performance Evaluations

56. Therapy managers were evaluated based on the Power Ratings and Ultra High RUG percentage of patient-days at the facilities for which they were responsible. Ex. 65 at 104:11-105:11. DRDs used RUG levels as the top evaluation criterion. Ex. 66 at -6605.

57. For instance, in 2007, ManorCare Vice President James Pagoaga noted in his performance evaluation of DRD Delaine Rice-White, “RU + RV has increase [sic] 2.4% from prior year to 77.4%,” and set the goal to “Maximize RUG Utilization.” Ex. 67 at -7763-7764.

58. The following year, Pagoaga wrote in Rice-White's performance evaluation, "RU + RV has increase [sic] 7.3% from prior year to 84% percent," and restated the goal to "Maximize RUG utilization." Ex. 68 at -7757-7758.

59. In 2009, Pagoaga instructed Rice-White to "[b]ring West Division RUG's performance to company average in RU% and RPR." Ex. 69 at -1543. Likewise, in 2009, Russell instructed an RRM that "RU's need to increase by 13.6% & RPR by 7.5% to at least match the co average." Ex. 70 at 2; Ex. 64 at 251:7-252:8.

I. Operations Staff's Involvement in Therapy Decisions

60. ManorCare's operations staff—who were typically not therapists—influenced therapy decisions. Ex. 14 at 95:15-20. For example, an RRM in ManorCare's Midwest Division created an "Administrator Medicare 'Q' Card," which encouraged facility administrators to pressure therapy staff by asking questions such as, "Is the patient in a Rehab Ultra High (RU) RUG? If not, why not?" Ex. 35 at -7095; *see* Ex. 65 at 236:20-262:18.

61. ManorCare had no policy to prevent operations staff from influencing therapy decisions. Ex. 14 at 95:2-97:10. Nor were administrators prohibited from using Power Ratings, even though operations staff had no responsibility for providing patients therapy. *Id.* at 98:10-20, 176:18-21. Indeed, Cavanaugh testified with regard to Power Ratings that "operators may have been looking at that and dealing with that." Ex. 22 at 183:6-184:2.

62. As a result, ManorCare's operations staff used Medicare Power Ratings, as well as Ultra High RUG and length-of-stay goals to pressure therapy staff to provide patients unnecessary therapy. Ex. 71 at -2169 ("When does the new Regional Rehab [Mangers] start? I have a number of facilities running below corporate averages [in Power Ratings]."); Ex. 59 at -

3006-07 ("We are running about 17% [lower in length of stay] than the company as a division… We are running about 10 percentage points [in RU billing] below the company average.")

63. Asked whether operators pressured therapists, Pagoaga stated, "Never say never. You know, they—I don't know—I can't say that they don't. All right?" Ex. 3 at 219:16-20.

J. Failure to Prevent Unnecessary, Unreasonable, and Unskilled Therapy

64. Therapy managers were aware that the aforementioned corporate practices created the risk that pressure tactics from ManorCare's corporate leadership would cause ManorCare therapists to provide therapy that was not tailored to their patients' actual needs. For example, in a July 2008 presentation to Guillard about Medicare Power Ratings, DRD Rick Grahn raised the possibility that Power Ratings could be used "to set targets or minimum levels of performance" and "to compel inaccurate or inappropriate behavior." Ex. 27 at 22.

65. Similarly, ManorCare was aware that MET communicated that therapists should bill Medicare for RU therapy. According to the presentations, a commonly asked question was, "Our company does this training just to make more money, don't they?" Ex. 28 at 31.

66. ManorCare was also aware that therapists complained about pressure. In January 2008, Grahn notified Pagoaga of a "troublesome trend" of an increasing number of resignations of facility-level therapists. Ex. 72 at -9661-62. Exit interview data showed numerous complaints of pressure, including, but not limited to, the following complaints:

> Your "Medicare entitlement" philosophy is nothing more than institutionalized gouging.
>
> Do not force "group therapy" onto therapists. It is sometimes not appropriate. Do not push for extended stays. It's unethical to purposely extend a stay when it's appropriate and safe for someone to go home.
>
> [T]he rehab director has received questionable speech therapy orders. When the physicians were called to confirm these orders, they stated that they did not order the patients to have speech therapy.

> Question such strong focus on productivity and meeting certain RUG levels from corporate.
>
> During my employment[], I have had to compromise my ethics and morals.
>
> I honestly felt that my license could be in jeopardy because the manager was pressuring me to treat inappropriate patients; it just felt wrong.
>
> I was told to basically show up and shut up. Too many inappropriate requirements 15% groups, 30% ACP [modalities], unethical length of stay and RUG levels all for the sake of a buck.
>
> Hire management with morals. I was asked to perform unethical procedures and bullied into billing addt'l units. My job was threatened when I didn't want to sacrifice my integrity. I went to a regional mgr and received no help.
>
> This DOR also commited [sic] unethical pratices [sic] such as writing and back dating speech orders on numerous 16ccasions,[] changing treatment grids to get patients in a higher rugs level and I attempted to tell [the RRM] but she stated she had complete faith in her DOR's.
>
> Hard to leave [DOR] and our immediate rehab team—easy to leave the "corporate" push of HCR.

Id. (attached chart columns BJ and BK); *see* Ex. 112 ("It's all about getting minutes, minutes, minutes."). No evidence suggests that Pagoaga investigated these complaints.

67. Pagoaga was also aware of pressure that facility administrators placed on facility therapy staff. In July and August 2011, Pagoaga asked DRDs to provide him administrators' remarks to therapy staff reported to the DRDs. *See* Ex. 3 at 226:21-239:6. DRD Terri Russell sent an email containing the following remarks, among others: "If they have a pulse, they can get an RU." "If that region can get high RU's, why can't we." "Bring in all the staff you need, just get me the RU's." "When the caseload of only 10 Medicare, there is no reason they can't ALL be RU's." "If they are all at RV, why can't you just add the few extra minutes to get them all to RU." Ex. 73 at -4910. No evidence suggests that Pagoaga investigated these remarks.

68. Grahn sent an email containing the following remarks: "I need more Rus." "Everyone should be an RU when they come in." "You need to keep him on (caseload) for at least two more weeks." "We're the lowest in the division in Rus, what's wrong with that DOR"? "Can't they just give her 20 more minutes?" "Those therapists are playing the 'ethics card' again." Ex. 74 at -3825. No evidence suggests that Pagoaga investigated these remarks.

69. Nor did ManorCare as a whole take steps to ensure that ManorCare's aforementioned corporate practices did not result in the provision of unnecessary, unreasonable, and unskilled rehabilitation therapy. Guillard testified that ManorCare had in place "systems and processes," "various checks and balances," "audits," and "trainings" to ensure that ManorCare provided only necessary, reasonable, and skilled therapy. However, Guillard could not identify a specific system, process, check, balance, audit, or training ManorCare implemented to ensure the provision of appropriate therapy. Ex. 14 at 80:20-88:5, 177:11-194:17.

70. DRDs and RRMs could not identify steps they took to ensure that ManorCare's corporate practices did not result in the provision of unnecessary, unreasonable, and unskilled rehabilitation therapy. *See, e.g.*, Ex. 65 at 231:14-232:8 ("I don't remember what I personally did…"); Ex. 64 at 291:19-292:7 ("I don't know that I did anything unique and different than the whole company did…"); Ex. 75 at 240:10-241:4 ("I can't give you any specifics.").

71. Certain witnesses referred to "audits" that ManorCare conducted to ensure the provision of necessary, reasonable, and skilled therapy, but none of the audits ManorCare conducted were designed to ensure that therapy provided was necessary, reasonable, and skilled. Rather, all of ManorCare's audits began from the assumption that ManorCare had provided only necessary, reasonable, and skilled therapy, and sought to find documentation justifying the therapy provided to the patient. Ex. 1 at 56:14-249:1; Ex. 75 at 193:11-194:22.

IV. As a Result of These Pressure Tactics, ManorCare Therapists Were Forced to Provide Thousands of Hours of Unnecessary, Unreasonable, and Unskilled Therapy

72. Dr. Rebecca L. Clearwater conducted a review of the medical necessity of the rehabilitation therapy services ManorCare provided to patients in the ManorCare Sample. *See generally* Ex. 76. Dr. Clearwater's findings show how ManorCare's pressure tactics resulted in the widespread provision of unreasonable, unnecessary, and unskilled rehabilitation therapy.[2]

73. Dr. Clearwater and her team "consider[ed] everything in the beneficiary's medical record as a whole and [made] a determination based on the full record, as to whether therapy services were reasonable, necessary, and skilled in accordance with Medicare program requirements as outlined in" the Code of Federal Regulations, Federal Register, and Medicare manuals with SNF coverage criteria. *Id.* at 15.

74. Dr. Donald Edwards extrapolated the results of Dr. Clearwater's review back to the ManorCare Population and concluded, at the 95% confidence level that ManorCare submitted thousands of claims to Medicare for reimbursement for non-covered services, resulting in the receipt of millions of dollars in unwarranted payments. Ex. 77.

A. Corporate Pressure Forced Therapists to Provide Unnecessary, Unreasonable, and Unskilled Therapy in ManorCare's Eastern Division

75. In ManorCare's Eastern Division, DRD Terri Russell and RRM Anne Gilbertson, who reported to Pagoaga directly and indirectly, respectively, used a variety of pressure tactics discussed above, including Medicare Power Ratings and numeric goals for Ultra High RUG billing. Ex. 75 at 64:12-15. Russell described the two ManorCare custodians of Medicare Power

[2] As the Court is aware, on October 27, 2017, Magistrate Judge Buchanan excluded Dr. Clearwater's testimony under Federal Rule of Civil Procedure 37. The United States respectfully disagrees with Magistrate Judge Buchanan's ruling and will likely appeal it. Believing meritorious grounds exist for that appeal, here the United States includes Dr. Clearwater's opinions among the evidence that shows ManorCare does not merit summary judgment.

Ratings as "MY rehab $$ men," who told her "in 'formulas' what will make my [Medicare daily] rate move." Ex. 78 at -4137. Russell asserted that she could create a clinical justification for "mak[ing her] rate move": "I can translate that to clinical rationale any day." *Id.*

76. The ManorCare Sample included patients who received therapy at the Mercy Fitzgerald and Devon Manor SNFs under Gilbertson's responsibility. Ex. 75 at 8:21-11:30. N.B., a patient at Mercy Fitzgerald, had end-stage renal disease and received hemodialysis, but was nevertheless provided Ultra High therapy for 100 days. The documentation did not support the necessity, reasonableness, or skilled nature of all of this therapy. Ex. 79.

77. Devon Manor Sample Patient [redacted], a patient with hearing loss that did not adversely affect her functional ability, was provided speech therapy for eight days. [redacted] was also provided electrical stimulation ostensibly to improve her upper-body strength, even though she demonstrated adequate strength during her evaluation. The documentation did not support the necessity, reasonableness, or skilled nature of all of this therapy. Ex. 80.

78. Devon Manor Sample Patient [redacted] received group therapy for physical therapy nineteen times and for occupational therapy six times, even though her therapy orders did not include group therapy, and the therapists never documented why she was receiving group therapy, what the group therapy consisted of, and how she responded. Ex. 81.

B. Corporate Pressure Forced Therapists to Provide Unnecessary, Unreasonable, and Unskilled Therapy in ManorCare's Central and Midwest Divisions

79. Central and Midwest Division therapy managers also pressured therapists. Central and Midwest DRD Grahn created and distributed Power Ratings and presentations explaining how to use them, which recognized the risks of improper billing they created. *See supra* ¶¶ 26-28. RRM Shelley Leverso pressured her facilities to exceed company goals for

Power Ratings, Ultra High RUGs, group therapy, and length of stay. Ex. 82 at -4098; Ex. 83 -3897-3901; Ex. 84 at -0406 ("I have been more than patient regarding the development of group therapy, but I am now going to intervene directly…"); Ex. 85 -3309-3310; Ex. 86 at -1557 ("Remember the commitment we have made for the 2009 year – to increase LOS for the Division by 2 days.").

80. Robert Halkovich was a physical therapist at the Libertyville SNF, which was under Leverso's responsibility. Halkovich was forced to provide unnecessary therapy to patients based on pressure from his facility's therapy manager. Halkovich's manager specified the number of minutes he was to provide a patient each day, in order for the patient to reach the Ultra High level, even though Halkovich thought some of the therapy he was required to provide was "dangerous." Echoing MET, Halkovich was ordered to provide Ultra High therapy under the premise that patients "deserve[d] the full basket of services that Medicare can provide" because "patients have paid into Medicare their whole lives." Halkovich once discharged a patient who wanted to go home. Halkovich testified that if his manager "ever found out that I did that, I'd have been fired on the spot." Ex. 54 at 32:12-40:10, 99:22-100:13.

81. Sample Patient G.M., a woman in her 70s, had four stays in ManorCare's Libertyville SNF over a one-year period, and ManorCare billed G[redacted] at the Ultra High level for all days. The documentation did not support the necessity, reasonableness, or skilled nature of all of this therapy. Ex. 89. Therapists provided high levels of therapy despite [redacted]'s complaints of pain. On a day when she reported pain at a level "9" on a 10-point scale, ManorCare reported providing [redacted] 110 minutes of physical therapy. Exs. 90- 91.

82. ManorCare billed Medicare for 100 days at Ultra High for services allegedly provided to sample patient [redacted] at its Louisville, Kentucky, SNF. [redacted]'s daughter attended her

mother's therapy sessions and received reports of any care provided to her mother from 24-hour sitters. Ex. 87 at 251:1-17. [redacted]'s daughter testified that her mother did not receive anywhere near the amount of therapy ManorCare claimed to have provided, and did not participate in group therapy that was nonetheless billed to Medicare. *Id.* at 30:13-34:6; 37:4-11; 74:17-76:22; 82:11-106:22; 249:21-252:14; 279:23-280:7; 281:3-281:23.

83. Sample Patient [redacted] was a 93-year-old woman at ManorCare's Hinsdale, Illinois, SNF. ManorCare billed Medicare for all 61 days of her 2011 stay at RU. During one month, 47.5% of her physical therapy and 32% of her occupational therapy was provided in the form of group therapy, but therapists never documented what the group therapy consisted of or how she responded to group therapy. The documentation did not support the necessity, reasonableness, or skilled nature of all of this therapy. Ex. 114.

C. Corporate Pressure Forced Therapists to Provide Unnecessary, Unreasonable, and Unskilled Therapy in ManorCare's Southeast and West Divisions

84. Managers in the West Division also pressured therapists. Southeast and West DRD Rice-White pressured therapists with Medicare Power Ratings and RUG goals. *See infra.* ¶¶ 30, 43, 55.

85. Raymond Acacio was a physical therapist at the West Division's Walnut Creek, California, facility. Acacio testified that his DOR determined the number of therapy minutes he was required to provide patients, that his DOR rejected his recommendations for therapy provision at a level lower than Ultra High, that patients reached Ultra High at the MDS initial assessment because minutes not allowed under Medicare rules were counted toward the patients' total minutes, and that he was required to provide group therapy that did not benefit his patients. Ex. 92 at 31:7-21, 40:9-14, 52:7-15, 56:16-58:12, 60:16-62:10, 67:7-24, 70:19-24.

86. Sample Patient [redacted] received therapy at the Walnut Creek, California, SNF. [redacted] was a 98-year-old man who was being treated at ManorCare's Walnut Creek SNF following surgery to repair a broken arm. ManorCare billed for [redacted]'s care, which included group therapy, at the Ultra High RUG for his entire stay. The documentation did not support the necessity, reasonableness, or skilled nature of all of his therapy. Ex. 93. ManorCare billed for 735 minutes of therapy during one week, even though ManorCare's own therapy logs showed that [redacted] was provided 675 minutes, enough only for billing at the Very High RUG. Ex. 94 at -3325, -3327.

87. In January 2009, the therapy manager at the Boynton Beach, Florida, SNF was required to "[i]mprove Group percentage to meet company benchmark of 15%" in speech and physical therapy. Ex. 95 at 7. The next year, an RRM put the Boynton Beach therapy manager on action plans requiring an increasing in group therapy billing from 15% to 20%. Exs. 96-97.

88. Sample Patient [redacted] was an 85-year-old male admitted to the Boynton Beach SNF after leg surgery. [redacted] had Alzheimer's dementia, and he was not aware of what was going on around him. Nevertheless, ManorCare billed for all 52 days of his stay at the Ultra High RUG, generally provided group therapy four days per week. The documentation did not support the necessity, reasonableness, or skilled nature of all of this therapy. Ex. 98.

D. Corporate Pressure Forced Therapists to Provide Unnecessary, Unreasonable, and Unskilled Therapy in ManorCare's Mid-Atlantic Division

89. Mid-Atlantic Division managers also pressured therapists. Therapists from the Mid-Atlantic Division's Arlington, Virginia SNF described an environment in which they were pressured to provide therapy to fatigued and ill patients to meet regional RUG goals, to provide unnecessary minutes just to meet a RUG level targeted for the patient, and to provide more therapy to patients during their assessment period (i.e., "ramping"). Ex. 99 at 68:14-71:6, 73:9-76:22, 77:11-78:11; Ex. 46 at 106:5-107:5; Ex. 100 at 187:8-188:18, 197:14-199:4.

90. A March 2010 action plan required the Arlington therapy staff to bill 15% of therapy as group therapy, to reach Ultra High RUG levels that "m[e]t or exceed[ed] the company average on a consistent basis," and to "increase to [length of stay] goal level by end of the month." Notably, the action plan required the therapy manager to approve the discharge of any Medicare patient within the first 35 days of the patient's stay. Ex. 101 at -1301-1304.

91. Just months after the March 2010 action plan was implemented, Sample Patient [redacted] was an 87-year-old patient admitted to the Arlington facility for palliative care. Nevertheless, [redacted] was given Very High-level therapy for two weeks and Ultra High-level therapy for thirty days. [redacted] died on January 9, 2011. The documentation did not support the necessity, reasonableness, or skilled nature of all of this therapy. Ex. 102.

E. ManorCare's Provision of Unnecessary, Unreasonable, and Unskilled Therapy Is Further Evidenced by the Lack of Changes in ManorCare's Patient Profile and Lack of Improvements in Therapeutic Outcomes

92. Drs. John N. Morris and Brant E. Fries analyzed MDS data submitted by ManorCare for patients for whom ManorCare reported therapy between 2005 and 2012. Drs. Morris and Fries analyzed whether the substantial increase in therapy reported by ManorCare was consistent with (1) changes in the characteristics of patients admitted to ManorCare facilities and/or (2) changes in therapy outcomes for ManorCare patients. Ex. 103 at 12.

93. Drs. Morris and Fries found that ManorCare reported a substantial increase in the amount of therapy it provided between 2006 and 2012, including a substantial increase in the share of patients billed at the Ultra High RUG level. *Id.* at 5-11.

94. ManorCare's substantial increase in therapy reporting was not commensurate with small changes in ManorCare's patient population between 2005 and 2012. Based on two comparative analyses and regression models of ManorCare's MDS data, Drs. Morris and Fries

found that, while ManorCare's therapy billing increased substantially, the clinical characteristics of ManorCare's patients barely changed. This data discounts the possibility that ManorCare's substantial increase in therapy reporting resulted from increasing patient needs. *See id.* at 13.

95. ManorCare's substantial increase in reported therapy was not reflected in substantial improvements in patient function. To the contrary, ManorCare's data showed that over the years ManorCare's therapy reporting led to a slower increase in patient function, meaning a slower recovery of the patient's ability to operate independently. *Id.* at 42-26.

V. Neither CMS, Nor CMS's Contractors, Were Aware of ManorCare's Knowing Submission of False Claims Between 2006 and 2012, and the DOJ Diligently Investigated the Allegations of Fraud

96. As explained in the attached declaration of Michael Handrigan, a Senior Medical Officer in CMS's Center for Program Integrity, CMS considers it important only to reimburse SNF services supported by appropriately-documented medical necessity, reasonableness, and skill. Ex. 113 ¶¶ 1, 5-6. Without documentation of necessity, reasonableness and skill, CMS cannot determine whether the reimbursed services are covered under Medicare. *Id.* ¶ 6.

97. CMS employed Medicare Administrative Contractors ("MACs")—National Government Services, Novitas Solutions, and Cigna Government Services—to process Medicare Part A claims ManorCare submitted to CMS between 2006 and 2012. In addition, Maximus, a Qualified Independent Contractor, reviewed ManorCare Medicare Part A claims in the event of an administrative appeal from the MAC.

98. Consistent with Medicare rules, the contractors did not apply "rules of thumb" when determining whether ManorCare billed for reimbursable services. 42 C.F.R. § 409.32(b). Rather, the contractors looked at each patient's entire file—including evidence of the patient's condition and the services provided—to determine whether services were necessary, reasonable,

and skilled. *See* Ex. 104 at 191:12-14 ("[W]e don't adjudicate claims based on pieces of the record. We look at the entire content."); Ex. 105 at 518:7-13 ("[T]he whole description of that patient has to be considered in deciding whether or not services are medically necessary.").

99. When denying a claim, the MACs did not exhaustively list every reason that the therapy services were not necessary, reasonable, and skilled. *Id.* at 98:12-99:3.

100. The MACs were not responsible for investigating whether ManorCare knowingly submitted false claims. Rather, if, after providing education to the facility, the MAC suspected the facility had submitted claims for un-reimbursable services, the MAC would refer the facility to the appropriate Zone Program Integrity Contractor, a contractor responsible for investigating suspected fraud. Ex. 106 at 61:18-64:6; Ex. 104 at 179:14-21.

101. In January 2009, after Relator Christine Ribik filed her complaint, the United States Department of Justice (DOJ) began investigating allegations that ManorCare knowingly submitted claims for unnecessary, unreasonable, and unskilled therapy at certain Virginia ManorCare SNFs. A June 2009 report of contact between AdvanceMed personnel and DOJ attorneys Andy Mao and Jill Callahan reported that Mao "stated that they are in the very initial stages of collecting information on ManorCare." Ex. 107 at -3295.

102. As explained in the attached declaration of former DOJ Trial Attorney Jullia Callahan Bradley, DOJ continued its investigation through 2012 without determining whether factual evidence existed sufficient to plead claims of FCA and common-law violations against ManorCare. Ex. 108 ¶¶ 6-23; *see* Ex. 109; Ex. 110 (AdvanceMed stating in December 2010 that DOJ was "looking at opening a national case on HCR Manorcare").

103. During the pendency of its investigation, DOJ filed a number of requests for an Extension of Time to Consider Election to Intervene. Each of these requests accurately represented the Government's investigative efforts. Ex. 108 ¶¶ 13, 28.

104. Defendants' had notice of DOJ's investigation as early as September 8, 2009, when the first HHS-OIG subpoena was issued to a ManorCare skilled nursing facility in Fair Oaks, Virginia. Ex. 115; Ex. 108 ¶ 17. Subsequently, at least 14 additional HHS-OIG subpoenas were issued to various ManorCare facilities, including similar requests. Ex. 116. In addition, a corporate Civil Investigative Demand (CID) was served on ManorCare on January 2, 2013, which included requests for a broad range of documents related to the United States' allegations in this case, and further, included a request for medical records for the exact 180 Sample Patients at issue in this matter. Ex. 117.

105. ManorCare's production of documents in response to these investigative requests took a significant amount of time. For example, ManorCare's production of medical records in response to the CID request for the 180 Sample Patients began on February 1, 2013 and was not complete until October 2016, well after litigation in this matter began. Ex. 118.

LEGAL FRAMEWORK

Summary judgment is not appropriate unless the moving party "shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). In reviewing ManorCare's Motion, the Court should view both the facts and all reasonable inferences in favor of the non-moving party, the United States. *Lettieri v. Equant, Inc.*, 478 F.3d 640, 642-43 (4th Cir. 2007) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986)). A genuine factual dispute about an issue material to the outcome is sufficient to prohibit summary judgment. *See Anderson*, 477 U.S. at 247-48.

Based on a view of facts and reasonable inferences in the United States' favor, the Court should deny summary judgment if "a reasonable trier of fact" could find in the United States' favor. *Rosetta Stone Ltd. v. Google, Inc.*, 676 F.3d 144, 156 (4th Cir. 2012).

ARGUMENT

I. A Reasonable Trier of Fact Could Conclude That ManorCare Submitted False Claims for Unnecessary, Unreasonable, and/or Unskilled Rehabilitation Therapy

A reasonable trier of fact could conclude that ManorCare's claims to Medicare were false. A correct recitation of both applicable FCA requirements and evidence of ManorCare's false-claims submissions leads to the conclusion that a genuine issue of material fact exists with respect to the falsity of ManorCare's Medicare reimbursement claims.

A. The Appropriate Legal Standard for Deciding Whether ManorCare's Claims Were False Encompasses Expressions of Clinical Judgment

The FCA imposes civil liability where a defendant knowingly presents a "false or fraudulent claim" to the government. 31 U.S.C. § 3729(a)(1)(A); *see id.* § 3729(a)(1)(B). Congress intended the FCA to "reach all types of fraud, without qualification, that might result in financial loss to the Government." *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968). A defendant submits a false claim when a government "program required compliance with certain conditions as a prerequisite to a government benefit, payment, or program; the defendant failed to comply with those conditions, and the defendant falsely certified that it had complied with the conditions in order to induce the government benefit." *United States ex rel. Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 786 (4th Cir. 1999) ("*Westinghouse I*").

Claims for reimbursement by Medicare "may be false if they claim reimbursement for services or costs that either are not reimbursable or were not rendered as claimed." *United States ex rel. Walker v. R&F Props. Of Lake Cty., Inc.*, 433 F.3d 1349, 1356 (11th Cir. 2005). In this case, Medicare rules limit reimbursement of therapy to necessary, reasonable, and skilled

services. SUF ¶¶ 1-8. ManorCare submitted claims for unnecessary, unreasonable, and unskilled services that were not reimbursable under Medicare rules. SUF ¶¶ 72-96. Therefore, ManorCare obtained reimbursement for services not reimbursable under Medicare.

ManorCare advances the far-reaching argument that medical judgments can *never* form the basis of a false claim, arguing that "subjective clinical judgments about ambiguous terms such as 'reasonable' and 'necessary' do not and cannot establish falsity as required by the FCA." Defs.' Sum. J. Mem. at 26-27. The potential breadth of this proposition is remarkable: in essence, ManorCare argues that a medical provider's claim for reimbursement can never be false, so long as the claim involves the exercise of a clinical opinion, thereby immunizing from FCA liability any provider that submits a claim for services that involved clinical judgment. As the Court explained in rejecting this argument at the pleading stage, if a certification of medical judgment could never form the basis of a false claim,

> you could never have a false claims case. If you're going to take the position that just because you did certain treatment and your clinician thought it was appropriate and you bill for it, there can never be a false claims case. We even prosecute criminal cases based on this. I've tried several criminal cases where the allegation is that there was charges for a higher level of treatment than would be appropriate… If you delivered ten hours of unneeded clinical care and you knew it was unneeded, that would be a problem, wouldn't it?

Sept. 16, 2015 Hr'g Tr. at 7:21-8:20, Dkt. 133.

As in criminal cases, the knowing provision of unnecessary or unreasonable care can also provide the basis for FCA liability. In *Westinghouse Savannah River I*, which involved a cost estimate of performance of a subcontract, the Fourth Circuit made it clear that a claim involving the expression of judgment can be false for FCA purposes. The Fourth Circuit rejected the district court's "narrow interpretation of the phrase 'false or fraudulent claim'" that would exclude opinions. *Westinghouse I*, 176 F.3d at 786. Noting that the defendant's false statements were "estimates"—similar to the clinical judgments forming the basis of ManorCare's claims—

the Fourth Circuit concluded that an estimate could form the basis of a false claim. *Id.* at 792; *see Hooper v. Lockheed Martin Corp.*, 688 F.3d 1037, 1047-49 (9th Cir. 2012) (citing *Westinghouse I* and holding the same). Despite ManorCare's characterization of the case to the contrary, *see* Defs.' Sum. J. Mem. at 24-25, in *Westinghouse I*, the Fourth Circuit reversed a district court for adopting the very argument that ManorCare advances.

Westinghouse I rests on the proposition that an opinion can be false because it implies an assertion that the speaker believes the opinion to be true. As the Fourth Circuit explained "an opinion or estimate carries with it 'an implied assertion, not only that the speaker knows no facts which would preclude such an opinion, but that he does know facts which justify it.'" *Id.* at 792 (internal citation omitted). The Fourth Circuit's reasoning is consistent with that of the Supreme Court, which has held that an opinion can be false if the speaker does not believe it *or lacks facts to support it*. *See Omnicare, Inc. v. Laborers Dist. Council Constr. Indus. Pension Fund*, 135 S. Ct. 1318, 1330 (2015) (applying principle in a securities case and noting that it is "not unique to" securities fraud); *MHC Mut. Conversion Fund, L.P. v. Sandler O'Neill & Partners, L.P.*, 761 F.3d 1109, 1113 (10th Cir. 2014) ("In offering an opinion,… a speaker is making the factual statement that *he believes* something.").

Hence, while it is true that proof of a false claim is conditioned on proof of an "objective falsehood," *see United States ex rel. Wilson v. Kellogg Brown & Root, Inc.*, 525 F.3d 370, 377 (4th Cir. 2008), a speaker's opinion can form the basis of an objective falsehood "where the speaker knows facts which would preclude such an opinion." *United States ex rel. Loughren v. Unum Grp.*, 613 F.3d 300, 310 (1st Cir. 2010) (citing *Westinghouse I*, 176 F.3d at 792).

For this reason, federal courts have regularly accepted the falsity theory advanced by the United States in this case, namely that a medical provider may violate the FCA by knowingly

submitting a claim for Medicare reimbursement for medically unnecessary services.[3] These cases include one district court that accepted allegations that a SNF chain provided unnecessary rehabilitation therapy, exactly as the United States alleges in this case. *United States ex rel. Martin v. Life Care Ctrs. of Am., Inc.*, 1:08-cv-251, 2014 WL 11429265, at *8-9 (E.D. Tenn. Mar. 26, 2014). They include another case in this Circuit, in which, just days after ManorCare moved for summary judgment, the district court rejected the identical argument that a medical provider of laboratory tests could never be liable under the FCA because doctors could have differences of opinion about the necessity of such tests. *United States ex rel. Lutz v. Berkeley Heartlab, Inc.*, No. 9:14-cv-230, 2017 WL 4803911, at *6 (D.S.C. Oct. 23, 2017) ("[T]he relevant inquiry for FCA liability is whether the tests were medically necessary, not whether practitioners unanimously agree that [the tests] were absolutely devoid of any value."). The logic underlying these cases is simple and consistent with the FCA: Medicare only reimburses necessary, reasonable, and skilled services; so claims for non-covered services are false claims.

The two out-of-circuit cases ManorCare relies on are inconsistent with the law of this Circuit and this Court's well-supported recitation of the law.[4] *See United States ex rel. Wall v. Vista Hospice Care, Inc.*, No. 3:07-CV-00604-M, 2016 WL 3449833, at *17 (N.D. Tex. June 20, 2016); *United States v. AseraCare Inc.*, 176 F. Supp. 3d 1282, 1283 (N.D. Ala. 2016). The

[3] *United States ex rel. Riley v. St. Luke's Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004) (holding that "claims for medically unnecessary treatment are actionable under the FCA" and declining to dismiss claim where defendants allegedly "ordered…services knowing they were unnecessary"); *United States ex rel. Hayward v. SavaSeniorCare, LLC*, No. 11-821, 2016 WL 5395949, at *9-10 (M.D. Tenn. Sept. 27, 2016); *United States v. Robinson*, No. 13-cv-27, 2015 WL 1479396, at *5-6 (E.D. Ky. Mar. 31, 2015); *United States ex rel. Fontanive v. Caris Life Scis., Inc.*, No. 10-cv-2237, 2013 WL 11579021, at *3 (N.D. Tex. Oct. 23, 2013); *United States ex rel. Kneepkins v. Gambro Healthcare, Inc.*, 115 F. Supp. 2d 35, 41-42 (D. Mass. 2000).

[4] ManorCare neglects to mention that the United States has appealed the *AseraCare* decision. *See United States v. AseraCare, Inc.*, No. 16-13004 (11th Cir. May 27, 2016).

AseraCare and *Vista Hospice Care* courts did not account for the principle that an opinion can be false if the speaker does not believe it or lacks facts to support it.[5] *See, e.g.*, *Westinghouse I*, 176 F.3d at 792. The FCA's text and legislative history, judicial authorities in and out of this Circuit, and this Court's own recitation of the law militate against adoption of such a drastic position.

The law has a long-recognized tool for resolving disputes such as the necessity of medical services: the jury. "The very essence of [the jury's] function is to select from among conflicting inferences and conclusions that which it considers most reasonable." *Tennant v. Peoria & P. U. Ry. Co.*, 321 U.S. 29, 35 (1944). Faced with dueling expert testimony about the clinical necessity of therapy services, it is the jury's "duty to 'weigh the evidence and the credibility of each expert.'" *United States v. Sharp*, 400 F. App'x 741, 747 (4th Cir. 2010) (quoting *Mosser v. Fruehauf Corp.*, 940 F.2d 77, 83 (4th Cir. 1991)). While differences of opinion between parties' experts may pose difficult decisions for a jury, making such decisions lies within the jury's ken. As the *Berkeley Heartlab* court explained in rejecting the argument ManorCare advances, "to remove a plaintiff's claims from the jury simply because a difference of opinion among experts exists would abrogate the jury's responsibility to weigh the evidence and determine the credibility of witnesses." 2017 WL 4803911, at *6 (internal citation omitted)

[5] *AseraCare* and *Vista Hospice Care* also ignore the role that the FCA's scienter requirement plays in protecting providers from liability based on defensible clinical judgments. The scienter requirement protects a defendant for "honest mistakes or incorrect claims submitted through mere negligence," such as the provision of therapy in which reasonable clinical minds could differ. *United States ex rel. Drakeford v. Tuomey*, 792 F3d 364, 380 (4th Cir. 2015) (internal citation omitted). As the Supreme Court has recently advised, it is unnecessary to "adopt[] a circumscribed view of what it means for a claim to be false or fraudulent," because "concerns about fair notice and open-ended liability can be effectively addressed through strict enforcement of the Act's materiality and scienter requirements." *Univ. Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2002 (2016) (internal citation omitted). *See infra.* § II.

B. A Reasonable Trier of Fact Could Conclude ManorCare's Claims Were False Based on ManorCare's Documents, Testimony from Lay Witnesses, and Testimony from Expert Witnesses

Based on the appropriate standard, a reasonable trier of fact could infer that ManorCare submitted claims for unnecessary, unreasonable, and unskilled therapy. Between 2006 and 2012, ManorCare's corporate-wide approach in billing Medicare for non-covered therapy took on a discernable pattern. Various pressure tactics, SUF ¶¶ 25-63, sanctioned at the highest quarters of the organization, *id.* ¶¶ 30-35, 49-50, 61-68, were exerted by divisional and regional therapy managers, *id.* ¶¶ 25-63, resulting in SNF-level therapy staff providing unnecessary, unreasonable, and unskilled therapy, *id.* ¶¶ 25-63, with a substantial increase in the Ultra High billing category the rule-makers intended to be used only those patients with the most complex needs, *id.* ¶ 8, resulting in little benefit to patients, *id.* ¶¶ 93-96, detriment to ManorCare's own therapists, *id.* ¶¶ 66-68, and damages to a taxpayer-funded federal healthcare program, *id.* ¶ 74.

A prime example of how the evidence permits the fact-finder to conclude that ManorCare submitted false claims is ManorCare's abuse of CMS rules regarding group therapy. Group therapy can be clinically beneficial, which is why Medicare reimburses for the service. Contrary to ManorCare's contention that Medicare rules were too confusing to understand, *see* Defs.' Sum. J. Mem. at 28-29, ManorCare's own employees testified that they could determine whether therapy was necessary, reasonable, and skilled, as Medicare requires. *Id.* ¶ 44. ManorCare was also aware that the necessity, reasonableness, and skilled nature of services—including group therapy—had to be appropriately documented. *Id.* ¶¶ 4, 6.

Nevertheless, ManorCare used group therapy not because it was clinically beneficial, but to maximize therapy minutes and push patients into the Ultra High billing category. *Id.* ¶¶ 43-47. By "group[ing] the crap out of" Medicare patients, ManorCare billed for medically unreasonable, unnecessary, and unskilled therapy services. *Id.* ¶ 45. As one of many examples,

ManorCare's "action plans" contained specific thresholds for the percentage of minutes that a facility under an action plan should devote to group therapy. *Id.* ¶¶ 51, 88. It is unsurprising, then, that Dr. Clearwater's review of the Sample Patients found numerous minutes of group therapy that were not necessary, not skilled, and not sufficiently documented. *Id.* ¶ 89.

Much of this therapy had little-to-no clinical benefit. As Drs. Morris and Fries found, the substantial increase in therapy minutes ManorCare reported during the relevant period yielded marginal benefit to patients, based on measured outcomes across patient assessments. *Id.* ¶ 96. Therefore, ManorCare was billing thousands of therapy minutes with decreasing marginal benefit for every additional minute. Those useless minutes likely included numerous group therapy minutes, evidenced by first-hand testimony that ManorCare billed for unnecessary group therapy, and even group therapy in which patients did not participate. *Id.* ¶¶ 45, 78, 80, 82, 89.

ManorCare's own behavior confirms how it relied upon group therapy largely to generate therapy minutes and not for its clinical benefits. When CMS changed rules governing the reimbursement of group therapy to prohibit SNFs from billing up to four patients simultaneously, the percentage of therapy minutes ManorCare devoted to group therapy plunged. *Id.* ¶ 47. A reasonable juror could infer from ManorCare's dramatic reduction in group therapy after the CMS rule change, in addition to instructions to "group the crap" out of patients, that ManorCare was not providing group therapy for its clinical benefits, but rather to increase reimbursements.

C. A Reasonable Trier of Fact Could Conclude that Evidence of False Claims in the ManorCare Sample Can Be Extrapolated to the ManorCare Population

In an attempt to narrow the permissible scope of the United States' evidence, ManorCare rehashes the arguments it advanced in its *Daubert* motion on the ManorCare Sample. *See* Dkt. 481. ManorCare continues to insist that extrapolated evidence is not valid evidence. Defs.' Sum. J. Mem. at 38-39. This argument ignores that sampling evidence is consistent with the text

and purpose of the FCA, both the Supreme Court and the Fourth Circuit have recognized the admissibility of sampling evidence in a variety of contexts, and evidence from the ManorCare Sample is simply one piece of the United States' evidence of ManorCare's knowing submission of false claims. *See* U.S. Mem. in Opp'n to ManorCare *Daubert* Mot. at 12-25, Dkt. 557.

ManorCare once again suggests that the Fourth Circuit's ruling in *United States ex rel. Michaels v. Agape Senior Community, Inc.*, 848 F.3d 330 (4th Cir. 2017), was somehow an affirmation of the district court's decision excluding sampling evidence. It was not, by the clear terms of the court's holding. *Id.* at 341 (dismissing appeal as improvidently granted). ManorCare has offered no valid argument for why evidence from the ManorCare Sample is not valid evidence from which a reasonable trier of fact may conclude that ManorCare knowingly submitted false claims from the ManorCare Population.

II. A Reasonable Trier of Fact Could Conclude That ManorCare Acted with Scienter When ManorCare Submitted False Claims

As with its falsity argument, ManorCare's contention that the United States lacks scienter evidence depends on mischaracterizations about the proof the FCA requires to show that ManorCare acted with the requisite knowledge. Based on a correct understanding of the FCA's scienter requirements, the record contains evidence sufficient from which a jury could conclude that ManorCare knowingly submitted false claims for Medicare reimbursement.

A. The Appropriate Legal Standard for Deciding Whether ManorCare Permits the Inference That ManorCare Acted with Actual Knowledge, Deliberate Indifference, or Reckless Disregard

ManorCare is incorrect when it suggests that the United States must prove that ManorCare committed "fraud," *see, e.g.*, Defs.' Sum. J. Mem. at 2-3, 27, 28, because the FCA expressly disclaims fraudulent intent as proof of an FCA violation, 31 U.S.C. § 3729(b)(1)(B). Rather, ManorCare submitted false claims knowingly if it (1) actually knew of the falsity of its

Medicare claims, (2) was deliberately ignorant of the falsity of its Medicare claims, or (3) recklessly disregarded the falsity of its Medicare claims. 31 U.S.C. § 3729(b)(1)(A). A defendant acts with reckless disregard by failing to undertake a reasonable and prudent inquiry into the truth of a claim. *United States ex rel. Williams v. Renal Care Group*, 696 F.3d 518, 530 (6th Cir. 2012). A defendant acts with deliberate ignorance by failing to fulfill the obligation to become familiar with the legal requirements of the government program at issue. *See United States v. Mackby*, 261 F.3d 821, 828 (9th Cir. 2001).

To create a genuine issue of material fact with respect to ManorCare's scienter, the United States need not prove that a "single actor" within ManorCare knew of, provided, and submitted a false claim for unnecessary therapy. Rather, as ManorCare concedes, "a corporation's scienter can be proved with evidence that 'at least one' employee of the corporation had knowledge of the alleged 'wrongful conduct.'" Defs.' Sum. J. Mem. at 30 (quoting *Westinghouse II*, 352 F.3d at 918 n.9). And the ManorCare employee who possessed that knowledge may be different from the ManorCare employee who transmitted the false reimbursement request to CMS for that therapy.[6] *Westinghouse II*, 352 F.3d at 920.

ManorCare's use of Medicare Power Ratings illustrates how *Westinghouse II* applies to this case. ManorCare's corporate leadership, as far up the corporate hierarchy as Guillard and Pagoaga, were aware of ManorCare's use of Power Ratings. SUF ¶¶ 30-35. The ManorCare

[6] This standard of proof is different from the "collective knowledge" standard that the Fourth Circuit rejected. Under that standard, an FCA plaintiff could "prove scienter by piecing together scraps of 'innocent' knowledge held by various corporate officials, even if those officials never had contact with each other or knew what others were doing in connection with a claim seeking government funds." *Westinghouse II*, 352 F.3d at 918 n.9. Under the Fourth Circuit's standard, an FCA plaintiff must show that one employee possesses scienter—i.e., non-innocent knowledge—with respect to a claim, but that employee does not have to be the one that submitted the false certifications or claims. *Id.* at 920 n.12.

corporate leadership was also aware of the risk that Power Ratings could be used to manipulate therapists into billing Medicare for non-covered therapy. *Id.* ¶ 64. But the ManorCare corporate leadership—from Guillard and Pagoaga, down through the divisional and regional therapy staff—took no steps to ensure that Power Ratings were not used for that purpose. *Id.* ¶¶ 66-69. To the contrary: Pagoaga, DRDs, and RRMs actively used Power Ratings, relying on them for employee performance appraisals. *Id.* ¶¶ 51, 56-59. No wonder, then, that ManorCare billed Medicare for thousands of hours of non-covered services. A reasonable trier of fact could conclude that numerous ManorCare employees acted with scienter with respect to the risk that ManorCare's pressure tactics could lead to the submission of false claims.

For this reason, ManorCare's attempt to take refuge in the purported ambiguity of Medicare SNF billing rules is unpersuasive. *See* Defs.' Sum. J. Mem. at 31 (citing *United States ex rel. Donegan v. Anesthesia Assocs. Of Kansas City, PC*, 833 F.3d 874, 879 (8th Cir. 2016)). Obtaining the benefit of the rule that a reasonable interpretation prohibits a finding of scienter for a violation of an ambiguous regulation requires a reasonable interpretation, which ManorCare cannot supply. No reasonable interpretation of Medicare's requirement that services be necessary, reasonable, and skilled permitted ManorCare to "group the crap out of every Med A." SUF ¶ 45. No reasonable interpretation allowed ManorCare to instruct therapists, in a training seminar, to "[p]rovide the maximum amount of therapy that the patient can tolerate." *Id.* ¶ 36. A reasonable trier of fact would not likely consider any interpretation applied in these ways as reasonable. To say the least, a genuine issue of material fact exists with respect to ManorCare's interpretation of the Medicare reimbursement standard.

B. The Scienter of ManorCare Employees Is Imputed to ManorCare

ManorCare tries to distance itself from the conduct of its employees by arguing that conduct at ManorCare SNFs cannot be imputed to the ManorCare Defendants. *See* Defs.' Sum. J. Mem. at 36-37. However, the scienter of ManorCare's therapy managers, who were employed by Defendant HES, may be imputed to the Defendants. SUF ¶ 11.

The Fourth Circuit's ruling in *Westinghouse II* was based in part on the court's conclusion that "whatever knowledge [the defendant's] employees possessed relating to the facts of this case are imputed to [the defendant]." *Westinghouse II*, 352 F.3d at 920 n.11. Similarly, in another FCA case the Fourth Circuit embraced, *Grand Union Co. v. United States*, 696 F.2d 888 (11th Cir. 1983), the Eleventh Circuit rejected a "single actor" argument and instead concluded that, for purposes of FCA liability, "the knowledge of an employee is imputed to the corporation when the employee acts for the benefit of the corporation and within the scope of his employment." *Id.* at 891; *see Westinghouse II*, 352 F.3d at 920 n.12 ("Our conclusion is consistent with the Eleventh Circuit's opinion in *Grand Union*…"). Thus, under the law of this Circuit, "a corporation can be held liable under the FCA even if the certifying employee was unaware of the wrongful conduct of other employees."[7] *Westinghouse II*, 352 F.3d at 920 n.12.

Lest there be any doubt that a jury could impute conduct at the ManorCare SNFs to the ManorCare Defendants, ample evidence exists from which a reasonable trier of fact could conclude that ManorCare was a single corporate entity that included the ManorCare Defendants and the ManorCare SNFs. *Vitol, S.A. v. Primerose Shipping Co. Ltd.*, 708 F.3d 527, 544 (4th Cir. 2013) (factors such as "siphoning of funds," "failure to observe corporate formalities," and

[7] ManorCare's sole support for the contrary argument is two cases, *United States v. Southern Maryland Home Health Services*, 95 F. Supp. 2d 465 (D. Md. 2000), and *United States v. Domestic Industries, Inc.*, 32 F. Supp. 2d 855 (E.D. Va. 1999). Both cases pre-date the Fourth Circuit's decision in *Westinghouse II*.

"control by a dominant stockholder" affect whether entities are "alter egos" under federal common law). Corporate parents ManorCare and HCR ManorCare indirectly owned 100% of the interest in the ManorCare SNFs, and the directors common to all ManorCare entities only met in their capacity as directors of ManorCare as a whole. SUF ¶ 15. Most crucially, ManorCare's home office in Toledo received the ManorCare SNFs' Medicare reimbursements, which flowed into a single ManorCare bank account. SUF ¶ 18. So when ManorCare hints that the ManorCare SNFs received reimbursement assistance "in some instances with the assistance of a Central Billing Office," Defs.' Sum. J. Mem. at 36, ManorCare drastically understates the complete control that the ManorCare Defendants had over the ManorCare SNFs.

That is not all. ManorCare's Medicare revenue was crucial to the company's business, SUF ¶ 17, and so ManorCare was obligated to ensure compliance with Medicare regulations. *See Mackby*, 261 F.3d at 828. But none of the supposed compliance efforts ManorCare trumpets—including the various "audits" ManorCare conducted—addressed the most crucial issue of whether ManorCare was delivering only necessary, and skilled therapy. SUF ¶¶ 69-71.

Additionally, ManorCare's corporate leadership recklessly failed to inquire about whether ManorCare's pressure and manipulation tactics risked the submission of false claims. *See Renal Care Group*, 696 F.3d at 530. For example, not only was ManorCare's leadership aware of Medicare Power Ratings, but ManorCare executives championed Power Ratings as a revenue-enhancing tool in front of ManorCare's board of directors and the private equity firm that owned ManorCare. SUF ¶¶ 30-35. ManorCare's leadership was also aware of the risk that operations staff pressured therapy staff to increase revenue by providing more therapy. *Id.* ¶ 63 ("Q. Does the therapy side get pressure from the administrative side…of the facility? A. Never say never. You know, they—I don't know—I can't say that they don't. All right?").

The record contains no evidence that ManorCare's corporate leadership even inquired, much less ensured, that the various forms of pressure DRDs and RRMs placed on therapists did not result in the provision of unnecessary therapy and, in turn, in the submission of false claims. Even when Pagaoga was provided evidence of pressure—in the form of comments from therapists who resigned from ManorCare and from his on divisional therapy managers about pressure from operations staff, SUF ¶ 66—Pagoaga took no action. This inaction is consistent with the scienter necessary to prove ManorCare's knowing submission of false claims.

III. A Reasonable Trier of Fact Could Conclude That ManorCare's Knowing Submission of False Claims Was Material to Medicare's Reimbursement of ManorCare

A reasonable trier of fact could conclude that ManorCare's knowing submission of false claims was "material to the Government's payment decision." *Univ. Health Servs.*, 136 S.Ct. at 1996. ManorCare's false claims are material if they had "a natural tendency to influence, or [were] capable of influencing," CMS's decision to reimburse ManorCare. 31 U.S.C. § 3729(b)(4). A false claim has such a tendency or capability if (1) "a reasonable man would attach importance to it in determining his choice of action in the transaction," or (2) "the defendant knew or had reason to know that the recipient of the representation attaches importance to the specific matter in determining his choice of action." *Univ. Health Servs.*, 136 S.Ct. at 2003 (internal quotation omitted).

A SNF's entitlement to payment is based on the statutory condition that therapy services are necessary, reasonable, and skilled. SUF ¶ 3. As Dr. Handrigan explains in his declaration, the appropriate reimbursement of Medicare funds depends on a documented showing that the therapy provided meets these three criteria. SUF ¶ 97. Federal health care programs would not be expected to expend scarce taxpayer dollars on claims seeking reimbursement for services that are not reasonable or necessary. Just this week, the Fourth Circuit recognized this common-

sense proposition, affirming convictions arising from reimbursement requests for medically unnecessary drug tests. *See United States v. Palin*, --- F.3d ---, 2017 WL 4871381, at *3 (4th Cir. Oct. 30, 2017). Analyzing the materiality of the reimbursements under *Universal Health Services*, the Fourth Circuit concluded that "insurers would not have paid for the sophisticated tests had they known those tests were unnecessary." *Id.*

Neither of ManorCare's arguments to the contrary is persuasive. First, ManorCare contends that the United States' knowledge of "allegations" of ManorCare's overbilling in 2006 obligated the United States to take the momentous step of halting reimbursements to ManorCare in order to show that ManorCare's false claims—only alleged at the time—were material. Defs.' Sum. J. Mem. at 34-35. This argument falters on the truism that allegations are different than evidence. The Supreme Court has emphasized that the Government's payment of claims based on "actual knowledge" of their falsity can be evidence of materiality, but neither the Court nor any other authority suggest that allegations alone are probative of the tendency of false claims to influence the Government's payment behavior. *See Univ. Health Servs.*, 136 S. Ct. at 2003-04.

As the *Berkeley Heartlab* court recently explained in rejecting a similar argument, "[t]he Government does not enjoy the luxury of refusing to reimburse health care claims the moment is suspects there may be wrongdoing." *Berkeley HeartLab, Inc.*, 2017 WL 4803911, at *7. Hence, the Government's knowledge of allegations against ManorCare are not valid proof that ManorCare's false claims were immaterial, let alone proof sufficient as a matter of law. Nor would it serve providers, their patients, or concerns about fairness and equity if the government were to cease paying claims based on nothing more than allegations of wrongdoing.

ManorCare's second argument—that Dr. Clearwater denials are immaterial because she denied services that the MACs did not deny—is based on not one, but two straw men. The first

straw man is the assumption that the MACs identified to providers every reason for denying a claim. They did not. SUF ¶¶ 99-100. The second is the assumption that Dr. Clearwater applied "rules of thumb" in her review, denying all group-therapy and modality services. She did not. SUF ¶ 73. To the contrary, Dr. Clearwater and the MACs conducted a similar review, in which they considered all evidence of a patient's condition and the services provided to determine whether services were necessary, reasonable, and skilled.

So ManorCare fails to demonstrate a factual predicate to support a finding as a matter of law that the unnecessary, unreasonable, and unskilled services Dr. Clearwater identified were immaterial to the United States. The mere fact that a Medicare contractor could not identify an instance when it denied or downcoded a ManorCare submitted claim for precisely the same reason as Dr. Clearwater does not preclude the possibility that it may have done so for a different provider, or, that it *could have* denied or downcoded a ManorCare claim for the same reasons as Dr. Clearwater. At best, whether there was any inconsistency between the reviews performed by the Medicare contractors and Dr. Clearwater is a classic issue for the trier of fact. *In re Complaint of Jackson Creek Marine, LLC*, No. 2:16cv98, 2017 WL 3585515, at *4 (E.D. Va. Apr. 21, 2017)) ("'[The court must draw all reasonable inferences in favor of the nonmoving party, and it may not make credibility determinations or weigh the evidence.'" (quoting *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 150 (2000)).

IV. A Reasonable Trier of Fact Could Conclude That the FCA Claims and the Common Law Claims ManorCare Faces Are Not Time-Barred

The United States' claims are not time-barred. Under the express terms of the FCA, the United States' Complaint relates back to January 7, 2009, the date on which Relator Christine Ribik filed her complaint, because—as ManorCare does not dispute—the Government's claims "arise[] out of the conduct, transactions, or occurrences set forth" in Relator's complaint. 31

U.S.C. § 3731(c). Thus, that date controls the analysis of whether the United States' claims are time-barred under the FCA's six-year statute of limitations. *See* 31 U.S.C. § 3731(b)(1). ManorCare makes two arguments about why the United States' claims are not entitled to application of § 3731(c)'s relation-back provision. Neither is persuasive.

First, ManorCare's contention that relation back would "prejudice the Defendants," *see* Defs.' Sum. J. Mem. at 42, is unsupported. Even granting ManorCare's argument that § 3731(c) somehow incorporated Federal Rule of Civil Procedure 15 to make prejudice to a defendant a factor in whether to allow claims to relate back—a tenuous argument at best given that the FCA *required* Relator's complaint to remain under seal while the United States investigated, *see* 31 U.S.C. § 3730; *United States ex rel. Freedman v. Suarez-Hoyos*, 781 F.Supp.2d 1270, 1282 (M.D. Fla. 2011)—ManorCare was emphatically not ""denied notice of DOJ's claims for at least six years after Ribik filed her complaint." Defs.' Sum. J. Mem. at 42. To the contrary, ManorCare was on notice of DOJ's investigation as early as September 8, 2009 when the first HHS-OIG subpoena was issued, followed by at least 14 additional subpoenas. *See* SUF ¶ 105. Then, in January 2013, ManorCare was served with a corporate-wide CID, which included requests for documents related to the allegations in this case and, perhaps most importantly, for medical records for the Sample Patients. And while ManorCare believes it was "deprived of the opportunity to appeal" the United States' investigative findings "or change its practices," Defs.' Sum. J. Mem. at 43, that argument hardly stands up in light of ManorCare's contention, with its Motion, that it submitted no false claims and rendered no unnecessary therapy.

Second, and more importantly, DOJ committed no misconduct in its investigation of Relator's allegations. Again granting ManorCare's argument that "relation back is an equitable doctrine subject to equitable principles," Defs.' Sum. J. Mem. at 43—a proposition courts have

recognized does not apply to § 3731(c), *see United States ex. rel. Miller v. Bill Harbert Int'l Construction, Inc.*, 608 F.3d 871, 879 (D.C. Cir. 2010)—ManorCare's claim that the Department misled the Court in its extension requests is factually wrong. Here, Jullia Callahan Bradley, the attorney who led the DOJ's investigation into Relator's allegations through September 2011, has declared here that every representation made to the Court in the United States' extension requests was accurate. SUF ¶ 104. Bradley's details DOJ's investigative steps through her departure from the DOJ, and makes clear that the United States diligently investigated Relator's allegations. ManorCare attempts to gin up the impression of misconduct by citing a number of odd items—the discrete nature of investigative resources, AdvanceMed's administrative work as a CMS contractor, and even Mrs. Bradley's maternity leave—that ManorCare believes the United States should have disclosed to the Court. Defs.' Sum. J. Mem. at 13-14.

Rather, the Government's investigative efforts were always dictated by established rules of pleading. ManorCare fails to acknowledge that, under Federal Rules of Civil Procedure 9, 11, and 12, the United States could not intervene until it could reasonably plead all elements of an FCA claim. The time it took the United States to do so was partly the result of the breadth of Relator's allegations, *see* SUF ¶ 103, and partly the time ManorCare took in responding to the United States' investigative requests, *see* SUF ¶ 106. Once the United States could plead FCA claims against ManorCare sufficient under the appropriate pleading rules, it did so.

ManorCare also seems to argue that the Government's claims are time-barred because "facts material to the [Government's] right of action [were] known or reasonably should have been known" by the DOJ before Ribik filed her complaint. 31 U.S.C. § 3731(b)(2). This argument is also factually wrong. Whatever knowledge Ribik or Medicare contractors had regarding ManorCare's corporate practices in advance of January 11, 2009, filing did not trigger

the statute of limitations. Pre-filing information that Relator knew, or that Medicare contractors acting in their capacity as CMS agents knew, or that Senator Grassley knew, is irrelevant to whether the DOJ, as responsible party for investigating claims, knew of sufficient information. Determining the date that the statute was triggered requires analyzing when DOJ, as the "official of the United States charged with responsibility" to litigate intervened FCA claims, could plead an FCA claim. 31 U.S.C. § 3731(b)(2). What matters is when DOJ had information—as opposed to simply allegations—sufficient to plead an FCA claim. Defendants have no evidence that the DOJ could have pleaded an FCA claim before January 11, 2009, because none exists.

The United States' common law claims are also timely. The statute of limitations for common law claims of unjust enrichment and payment by mistake founded in fraud is six years pursuant to 28 U.S.C. § 2415(a), not three years. *See e.g., United States ex rel. Lutz v. Berkeley Heartlab, Inc.*, 225 F. Supp. 3d 487, 503 (D.S.C. 2016). Regardless of whether the three year or six year statute of limitations applies, the Government's complaint in intervention relates back to Ribik's complaint because these common law claims arise out of the same conduct alleged by Ribik. *See e.g., United States ex rel. Vavra v. Kellogg Brown and Root Inc.*, 848 F.3d 366, (5th Cir. 2017).

V. A Reasonable Trier of Fact Could Conclude That ManorCare Is Liable for Unjust Enrichment and Payment by Mistake

Finally, the United States has come forward with evidence sufficient from which a trier of fact could conclude that ManorCare is liable for unjust enrichment and payment by mistake.[8]

[8] ManorCare is wrong that the United States' common-law claims are "derivative" of its FCA claims. Defs.' Sum. J. Mem. at 37-38 (citing *United States ex rel. Lawson v. Aegis Therapies, Inc.*, No. CV 210-072, 2015 WL 1541491, at *14 (S.D. Ga. March 31, 2015)). "[I]t is readily possible to envision scenarios where the Government's claims for payment under mistake of fact and unjust enrichment may remain in play even if the FCA claims fail." *Crumb*, 2016 WL 4480690, at *17, n. 26 (rejecting "derivative" argument as "incorrect" and criticizing *Aegis Therapies*).

These claims "are independent of, alternative to, and have distinct elements of proof from," the United States' FCA claims. *United States v. Crumb*, No. 15-0655, 2016 WL 4480690, at *17 (S.D. Ala. Aug. 23, 2016). For example, neither claim requires proof of scienter.

To prove unjust enrichment, the United States must show that (1) the United States "had a reasonable expectation of payment," (2) ManorCare "should reasonably have expected to pay," and (3) "society's reasonable expectations of persons and property would be defeated by nonpayment." *Provident Life & Acc. Ins. Co. v. Waller*, 906 F.2d 985, 993-94 (4th Cir. 1990). To prove payment by mistake, the United States must show that it paid ManorCare money under an erroneous belief induced by a mistake of fact—namely, that ManorCare provided patients medically necessary, reasonable, and skilled therapy. *See Willis North Am., Inc. v. Walters*, No. 3:10-462, 2011 WL 1226032, at *3 (E.D. Va. March 30, 2011).

The particular method by which ManorCare obtained its undeserved reimbursements makes equitable relief particularly appropriate. Between 2006 and 2012, ManorCare's corporate leadership sanctioned pressure- and manipulation-filled business practices that caused deep and widespread unfairness—unfairness to ManorCare's patients, unfairness to its therapists, and unfairness to taxpayers who expect Medicare to fund medical services that patients actually need. A trial is warranted to decide whether ManorCare should be required to repay the United States for ManorCare's inappropriate reimbursements.

CONCLUSION

For the reasons stated above, the United States respectfully requests that the Court deny ManorCare's motion for summary judgment.

Dated: November 2, 2017

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on November 2, 2017, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send a notification of such filing ("NEF") to the following.

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