IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
GREENVILLE DIVISION

UNITED STATES ex rel. SIBLEY	**PLAINTIFF**
VS.	**NO.: 4:17-cv-53-GHD-RP**
DELTA REGIONAL MEDICAL CENTER	**DEFENDANT**

DELTA REGIONAL MEDICAL CENTER'S
MEMORANDUM IN SUPPORT OF ITS MOTION TO DISMISS

Delta Regional Medical Center's ("DRMC") former employee Candi Sibley brings this False Claims Act ("FCA") suit, the majority of which is premised on alleged regulatory violations having no relation to claims for payment from the federal government. This is not a proper use of the FCA: "The [FCA] is not an all-purpose antifraud statute or a vehicle for punishing garden variety . . . regulatory violations." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2003 (2016) (quotation marks and citation omitted). Understandably, the government has declined to intervene in Sibley's case.

Sibley's ill-conceived FCA claims are based on alleged violations of the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. §1395dd, as well as of state regulations related to the Mississippi Trauma Systems Fund ("State Trauma Fund"). Under this unprecedented theory of FCA liability, the alleged EMTALA violations would transform each and every claim for government-payor reimbursement filed by DRMC into a false claim under the FCA.

Sibley fundamentally misunderstands the FCA, and as a consequence, she has failed to state claims under either the express or implied false certification theory of liability. EMTALA violations are not a valid, recognized basis for FCA claims. They do not taint legitimate claims for payment with false or misleading representations and they are not material to the government's

payment decision. In addition, the Department of Health and Human Services ("DHHS"), which has authority to enforce EMTALA, has established a detailed administrative scheme to address, sanction, and correct alleged EMTALA violations; however, none of these potential sanctions involve withholding payment of claims. Sibley wholly ignores this framework in trying to levy financially ruinous damages and penalties on DRMC, a county-owned, charitable hospital.

Similarly, Sibley cannot state a reverse FCA claim because DRMC has no established duty obligating it to pay fines or penalties to the government. Sibley's conclusory claim for "worthless services" suffers the same fate because it entirely lacks any supporting factual allegations. Finally, the Complaint's allegations regarding the alleged fraudulent billing scheme allegedly conducted by Dr. Robert Corkern completely fail to identify any false claims actually submitted to the Medicaid program and fail to comply with the particularity requirements of Federal Rule of Civil Procedure 9(b). For all these reasons, the Court should dismiss Sibley's Complaint in its entirety.

BACKGROUND

I. The FCA.

The FCA imposes liability on anyone who "knowingly presents, or causes to be presented, to . . . the United States Government . . . a false or fraudulent claim for payment or approval" or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(A) and (B). "FCA claims can be either legally false or factually false." *United States ex rel. Ruscher v. Omnicare, Inc.*, 663 F. App'x 368, 373 (5th Cir. 2016) (citation omitted). "A claim is factually false when the information provided to the government for reimbursement is inaccurate." *Id.* "A claim is legally false when a claimant . . . falsely certifies compliance with a statute or regulation." *Id.* (internal marks omitted).

Legally false claims may be advanced through one of two theories: express or implied. The express false certification theory is predicated on a false statement and "applies when a

government payee 'falsely certifies compliance with a particular statute, regulation or contractual term, where compliance is a prerequisite to payment.'" *U.S. ex rel. Conner v. Salina Reg'l Health Ctr., Inc.*, 543 F.3d 1211, 1217 (10th Cir. 2008) (citation omitted). An implied false certification theory is predicated on grounds that when a government payee "submits a claim, it impliedly certifies compliance with all conditions of payment[, b]ut if that claim fails to disclose the [payee's] violation of a material statutory, regulatory, or contractual requirement, . . . the [payee] has made a misrepresentation that renders the claim 'false or fraudulent' . . . ." *Escobar*, 136 S. Ct. at 1995.

The FCA also imposes liability on those who fail to "pay or transmit" money to the government through fraudulent means. *See* 31 U.S.C. § 3729(a)(1)(G). This is known as a "reverse" false claim, and "[i]n a reverse false claims suit, the defendant's action does not result in improper payment by the government to the defendant, but instead results in no payment to the government when a payment is obligated." *Ruscher*, 663 F. App'x at 376.

To enforce its provisions, "[t]he FCA authorizes both civil actions by the Attorney General and private *qui tam* actions" brought by private citizens who are referred to as "relators." *Schindler Elevator Corp. v. U.S. ex rel. Kirk*, 563 U.S. 401, 405 (2011). The government may elect to intervene and prosecute the action or allow the relator to do so. 31 U.S.C. §§ 3730(b)(2), (c)(3). Here, Sibley prosecutes a *qui tam* action on her own, and as with all civil actions brought under the FCA, her claims "must comply with [Rule] 9(b), which requires pleading with particularity in cases alleging fraud." *U.S. ex rel. Doe v. Dow Chem. Co.*, 343 F.3d 325, 328 (5th Cir. 2003).

II. The Emergency Medical Treatment and Labor Act.

EMTALA, often called the "anti-dumping statute [of uninsured]," was originally enacted by Congress in 1986 as a response to an increasing number of reports that hospital emergency rooms were refusing to treat uninsured individuals. 68 *Federal Register* 53222, 53223 (Sept. 9,

2003). EMTALA and its implementing regulations generally mandate that Medicare participating hospitals must "conduct appropriate screening examinations for any individual who presents to its emergency department" and, "if an emergency condition is found to exist, the hospital must either provide sufficient treatment to stabilize the patient" or arrange for an appropriate transfer. *Miller v. Medical Ctr. Of Sw. La.*, 22 F.3d 626, 628 (5th Cir. 1994); 42 U.S.C. §§ 1395dd(a), (b)(1)(A)-(B); 42 C.F.R. § 489.24(a). Compliance with EMTALA is a condition of participation in the Medicare program. 42 C.F.R. § 489.20(l). A hospital is also required to report to CMS any time it believes it has received a transfer in violation of EMTALA. 42 C.F.R. § 489.20(m).

DHHS has authority to monitor and enforce compliance with EMTALA, including investigating alleged violations, determining whether violations have occurred, and deciding what—if any—penalties are to be imposed. In turn, DHHS has delegated enforcement authority to two agencies of DHHS: The Centers for Medicare and Medicaid Services ("CMS") and the Office of Inspector General ("OIG"). EMTALA is enforced pursuant to a detailed administrative scheme to address and remedy alleged violations, including a specifically prescribed investigatory process which includes a process for hospitals to correct any cited deficiencies.

CMS is primarily responsible for investigating alleged EMTALA violations and has issued detailed guidance regarding the EMTALA investigation and enforcement process in the CMS State Operations Manual. "The enforcement of EMTALA is a complaint driven process." CMS, State Operations Manual ("SOM") Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Part I.[1] This investigative process is described in detail in the SOM.[2] As part of this investigative process, if the surveyor confirms the allegations

[1] The CMS SOM and its appendices may be accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html.

[2] *Id.* at Part II.

of the complaint, the investigation will continue with an emphasis on the hospital's compliance within the last six (6) months. *Id.* Within ten (10) days of completion of the on-site survey, any violations are to be documented on Form CMS-2567 Statement of Deficiencies and Plan of Correction. *Id.* The hospital is provided an opportunity to present evidence, with the CMS Regional Office retaining authority to make the final enforcement decision. *Id.*

If CMS concludes EMTALA violations have occurred, CMS follows set administrative procedures and affords hospitals an opportunity to correct any cited deficiencies and return to compliance prior to termination of the Medicare provider agreement. CMS's procedures for termination of a hospital's provider agreement are set forth in the CMS State Operations Manual, Ch. 5, § 5470 (Termination Procedures for EMTALA Violations) & Ch. 3, §§3010-3011. If it is determined that a violation of EMTALA has occurred, CMS may place the provider on a "termination track" of either twenty-three (23) days (if the violation is determined to constitute an "immediate jeopardy" to a patient) or ninety (90) days (for non-immediate jeopardy violations). CMS SOM, Ch. 3 §§ 3010-3012; CMS, SOM Ch. 5, §5470. However, hospitals are provided an opportunity to correct the cited violations during this time period and "[**t**]**he hospital may avoid the termination action** . . . **by either providing acceptable** [**Plans of Correction**] for the deficiencies or by successfully showing that the deficiencies did not exist" prior to the projected termination date. *Id.* at Ch. 5, § 5470.1 (immediate jeopardy); *Id*. at Ch. 3, § 3012 (non-immediate jeopardy); *see also* 42 C.F.R. § 489.53(d)(2); 42 U.S.C. § 1395cc(b)(2)(A) (stating that CMS *may* terminate provider agreement after finding a lack of substantial compliance).

EMTALA violations may also be punished by the assessment of civil monetary penalties ("CMPs"). 42 U.S.C. § 1395dd(d)(1)(A) (CMPs may be assessed for EMTALA violations pursuant to "[t]he provisions of section 1320a-7a"); *id*. §1320a-7a(c)(1) ("The Secretary *may* initiate a proceeding to determine whether to impose a [CMP], assessment, or exclusion . . . .")

(emphasis added). CMS refers EMTALA violations to the OIG, which has been delegated the authority to impose CMPs. *Id.* at Ch. 5, § 5470.1; *see also* 42 C.F.R. § 1003, Subpart E (CMPs and Exclusions for EMTALA Violations); 42 C.F.R. § 1003.150. CMPs may only be assessed after the provider has had an opportunity for a hearing before an Administrative Law Judge, which is also subject to judicial review in federal court. 42 U.S.C. §§ 1320a-7a(c)(2)-(3) & 1320a-7a(e); *see also* 42 C.F.R. Part 1005 (Appeals of CMPs and Assessments). The OIG is to consider numerous factors in determining the amount of any CMPs imposed. 42 U.S.C. § 1320a-7a(d); 42 C.F.R. § 1003.140.

Alleged EMTALA violations are not a basis for FCA liability. EMTALA compliance is one of many conditions of participation for hospitals to participate in the Medicare program. CMS does not condition the payment of individual Medicare or Medicaid claims on EMTALA compliance. In fact, even if a hospital is placed on a termination track, CMS continues to pay the hospital's Medicare claims during this time period. DRMC is aware of no law or regulation that conditions Medicare payment on EMTALA compliance, or that would cause Medicare not to pay a claim or to recoup claims already paid due to an EMTALA violation.

III. The Mississippi State Trauma Fund.

Mississippi law requires every licensed hospital to participate in a statewide trauma system. Miss. Code. § 41-59-5. Facilities are designated as Level I – IV trauma centers based on specific criteria, including the services each facility offers. *Report to the Mississippi Legislature* (January 3, 2013) (cited in [16] Compl. ¶38). The State Trauma Fund has been established to administer and implement the state trauma care plan. *Id.* In pertinent part, the fund receives revenues from penalties assessed against hospitals that choose not to participate in the state's trauma care system. *Id.* The State Trauma Fund receives no federal funding. Miss. Code. § 41-59-75.

IV. Relevant Allegations and Claims.

DRMC operates in Greenville, Mississippi. [16] Compl. ¶¶1, 16. DRMC is designated as a Level III trauma hospital for purposes of the State Trauma Fund. *Id.* at ¶ 41. The Complaint states that the alleged violations of the FCA involve DRMC's claims for reimbursement from Medicare and Medicaid presented to the government from at least 2012 through the present, although Sibley never alleges when she was employed at DRMC. *Id.* at ¶2. Sibley alleges she identified and reported violations of the Trauma System Regulations to DRMC administrative staff. *Id.* at ¶46. Sibley never alleges that she reported any concerns regarding alleged EMTALA violations to either DRMC or any regulatory agency. Nor does Sibley allege that any receiving hospital ever filed a complaint against DRMC for alleged improper patient transfers, even though they are required to do so by law if they suspect a non-compliant transfer.

However, Sibley alleges that she has identified fifty-two (52) instances spanning from January 8, 2014 through March 11, 2016 where DRMC failed to comply with EMTALA by either providing inappropriate treatment or inappropriately transferring patients. *Id.* at ¶58-243.[3] Sibley also alleges that DRMC violated the Mississippi Trauma System Regulations and received improper payments from the Trauma System. *Id.* at ¶38-47. Finally, Sibley alleges that Dr. Robert Corkern, DRMC's Emergency Department Medical Director, engaged in a fraudulent scheme to submit improper Medicaid claims. *Id.* at ¶52-56, ¶268-271.

As per the FCA, Sibley filed the original Complaint under seal on April 27, 2017 to allow the government to review the allegations and consider intervening. *See* 31 U.S.C. § 3730(b)(4).

[3] Curiously, while compiling patient information to use in this case, Sibley never thought these alleged violations merited notification to CMS, despite the fact EMTALA enforcement is a "complaint driven" process. Secondly, with respect to transferred patients, the receiving hospital is required, under the same threat of possible termination or penalty for failure to do so, to report an EMTALA violation to CMS. 42 C.F.R. § 489.20(m). Sibley has not alleged that ever happened with respect to any of the alleged instances of inappropriate transfers alleged in the Complaint.

On April 24, 2018, the government declined to intervene. [13] Notice of Election. On May 21, 2018, the Court unsealed the original Complaint, and Sibley filed both her [15] Amended Complaint and the operative [16] Second Amended Complaint on May 22, 2018.

LEGAL STANDARD

When considering a motion to dismiss under Rule 12(b)(6), all well-pleaded facts must be viewed in the light most favorable to the plaintiff. *Fin. Acquisition Partners LP v. Blackwell*, 440 F.3d 278, 286 (5th Cir. 2006). Yet, courts "do not accept as true '[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements.'" *City of Clinton, Ark. v. Pilgrim's Pride Corp.*, 632 F.3d 148, 153 (5th Cir. 2010) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). A plaintiff must plead "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do . . . ." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (citations omitted). Rather, a plaintiff must set forth specific facts, not conclusory allegations. *Blackwell*, 440 F.3d at 286. A complaint must contain sufficient factual matter to state a claim that is plausible on its face, going beyond pleading facts that show "a sheer possibility that a defendant has acted unlawfully." *Iqbal*, 556 U.S. at 678 (citation and internal marks omitted).

FCA claims must also comply with the particularity requirements of Rule 9(b). *Escobar*, 136 S. Ct. at 2004 n.6. "In alleging fraud . . . , a party must state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). A plaintiff must "set forth the 'who, what, when, where, and how' of the alleged fraud." *U.S. ex rel. Spicer v. Westbrook*, 751 F.3d 354, 365 (5th Cir. 2014) (citation omitted); *see also U.S. ex rel. Doe v. Dow Chem. Co.*, 343 F.3d 325, 329 (5th Cir. 2003) (observing that a complaint must state the "contents of the false representations" to sufficiently allege a FCA violation and "satisfy Rule 9(b)") (citation omitted). "Rule 9(b) serves to give defendants adequate notice to allow them to defend against the charge

and to deter the filing of complaints as a pretext for the discovery of unknown wrongs . . . and to prohibit plaintiffs from unilaterally imposing upon the court, the parties and society enormous social and economic costs absent some factual basis." *In re Stac Elecs. Sec. Litig.*, 89 F.3d 1399, 1405 (9th Cir. 1996) (citations and internal marks omitted).

ARGUMENT

I. Sibley Fails to State a Claim for Either Express or Implied False Certification (Counts One and Three).

Sibley does not allege that DRMC's claims submitted to Medicare or Medicaid were factually false. Rather, she contends that claims for Medicare and/or Medicaid reimbursement included either an "express" or an "implied" certification that DRMC was in compliance with EMTALA or the requirements of the State Trauma Fund. Compl. ¶244-250, 256-264. Sibley, however, fails to state a claim under either theory. Moreover, EMTALA violations are not material to the government's payment decision as required to state a FCA claim, and based on DRMC's research, no court has permitted a FCA claim based on alleged EMTALA violations.

A. Sibley has not sufficiently plead any specific express certification of compliance with EMTALA.

Sibley cannot state a claim for express false certification because she has no alleged facts showing that DRMC ever certified compliance with EMTALA when submitting a claim for payment. Sibley appears to allege at least two (2) types of certifications made by DRMC, although she loosely refers to a potential third certification. None of these purported certifications can serve as the basis for a claim of express false certification.

Sibley's first alleged certification is based on the following language: "payment and satisfaction of this claim will be made from Federal and State funds, and false claims, statements, documents, or concealment of any material fact, may be prosecuted under applicable Federal or State laws." Compl. ¶30 (quoting Form UB-04). This is not a certification, but rather an

acknowledgement that certain actions related to seeking reimbursement from the government may be prosecuted. As such, this statement cannot serve as the basis for a FCA claim. *See U.S. ex rel. Hobbs v. MedQuest Assocs., Inc.*, 711 F.3d 707, 714 (6th Cir. 2013) (noting there could be no FCA violation where statements at issue "d[id]not constitute certifications that would support an FCA action").

The second certification Sibley cites is the "Physician Certification" which is executed when transferring a patient from one hospital to another. [16] Compl. ¶48. This certification is part of a transferring patient's medical record and forwarded with their medical record to the receiving hospital. 42 C.F.R. § 489.24(e)(2)(iii). Sibley neither alleges that the "Physician Certification" is actually submitted to the government at any point nor alleges any basis to believe that this form is ever provided to the government. A purported false certification which is never provided to the government cannot plausibly serve as the basis for an express certification FCA claim. *See, e.g., U.S. ex rel. Steury v. Cardinal Health, Inc.*, 625 F.3d 262, 269 (5th Cir. 2010) (noting "even if a contractor falsely certifies compliance (implicitly or explicitly) with some statute, regulation, or contract provision, the underlying claim for payment is not "false" within the meaning of the FCA if the contractor is not required to certify compliance in order to receive payment"); *United States ex rel. Doe v. Jan-Care Ambulance Serv.*, 187 F. Supp. 3d 786, 793 (E.D. Ky. 2016) (finding that a relator "must provide 'concrete facts' about the [allegedly false] claims, such as when any actual improper claims were submitted to the government").

Sibley also suggests a third certification of unspecified origin: the "Government . . . [relied] upon . . . the certification that [DRMC] had and was providing healthcare services under circumstances satisfying all of Medicare and Medicaid's conditions of payment, including EMTALA." [16] Compl. ¶32. Sibley does not allege who made such a supposed certification, nor say when or where it was made. She thus fails to comply with the particularity required by

Rule 9(b). *See Dow Chem.*, 343 F.3d at 329 (noting that, to satisfy Rule 9(b), a FCA claimant must specifically allege the time of the alleged misrepresentation and the person making it).

Moreover, "[t]he FCA is not a general 'enforcement device' for federal statutes, regulations, and contracts." *U.S. ex rel. Steury v. Cardinal Health, Inc.*, 625 F.3d 262, 268 (5th Cir. 2010) (citation omitted). Even if Sibley's allegation satisfied Rule 9(b)'s requirements, it amounts to nothing more than a general promise to comply with the law, which is insufficient to support a FCA claim. *See U.S. ex rel. Stephenson v. Archer W. Contractors, L.L.C.*, 548 F. App'x 135, 137-38 (5th Cir. 2013) (finding alleged express certifications that contractors "were in compliance with all 'Federal, State, and municipal laws, codes and regulations applicable to the performance of their work[,]'" merely amounted to a promise "to follow the law" which, if permitted to serve as the basis for a FCA claim, would transform the "FCA [into] a general enforcement device"). Sibley has failed to state a claim for express false certification.

B. Sibley fails to state a FCA claim under the implied false certification theory because she fails to allege that DRMC submitted any claim for payment that made specific, misleading representations about the services provided.

Sibley next theorizes that the act of submitting claims for payment impliedly certifies compliance with EMTALA, such that *every* claim DRMC submitted to the federal government for Medicare or Medicaid reimbursement following the alleged EMTALA violations was a false claim under the FCA. An "implied false certification" theory under the FCA requires two conditions: (1) "the claim does not merely request payment, but also makes specific representations about the goods or services provided" and (2) "the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths." *Escobar*, 136 S Ct. at 2001. Here, however, Sibley neither identifies any claims submitted to the government which made specific representations about the goods or services

provided nor explains how a failure to disclose the alleged EMTALA violations made those representations misleading. *See id*. The facts underlying *Escobar* are instructive.

Escobar was a *qui tam* action involving a claim for implied false certification arising from the death of a teenage Medicaid beneficiary after she had an adverse reaction to medication prescribed to her by unlicensed and unqualified personnel at a mental health facility. *Id.* at 1997. The complaint alleged that the facility submitted Medicaid claims which contained specific representations regarding the types of services provided (such as "individual therapy" or "family therapy') and contained national provider identifier ("NPI") numbers associated with specific job titles (such as "Social Worker, Clinical") which were obtained by staff members who had misrepresented their qualifications and licensing status to the federal government. *Id* at 1997-1998. In these circumstances, the Court found that "by submitting claims for payment using payment codes that corresponded to specific counseling services . . . [and] by using [NPI] numbers corresponding to specific job titles," the representations were clearly misleading in context. *Id. at* 2000-2001.

As compared to the allegations in *Escobar*, Sibley's allegations look more like "pretext for the discovery of unknown wrongs" than a well-pleaded claim for implied false certification. *In re Stac*, 89 F.3d at 1405. Beyond the façade of identifying fifty-two (52) alleged EMTALA violations, Sibley's allegations offer nothing of the sort seen in *Escobar*. Sibley fails to identify which of those fifty-two (52) patients, if any, were Medicare or Medicaid beneficiaries. Sibley fails to allege that a single Medicare or Medicaid reimbursement claim submitted by DRMC included any "specific representations about the goods or services provided" or that any specific representation was rendered misleading due to DRMC's failure to disclose alleged EMTALA violations. In fact, Sibley fails to allege any facts detailing the contents of DRMC's reimbursement requests.

At bottom, Sibley has done nothing more than identify alleged EMTALA violations and claims that DRMC submits requests for reimbursement, all while providing no factual allegations tying the two together. The failure to allege any "specific representation about the goods or services provided" and how this representation was rendered misleading is fatal to Sibley's implied certification claim, and it must be dismissed. *See, e.g., United States ex rel. Kelly v. Serco, Inc.*, 846 F.3d 325, 332 (9th Cir. 2017) (citing *Escobar*, 136 S. Ct. at 2001) (observing that even if the defendant's compliance with particular industry standard "was a condition of payment for its work[,]" the plaintiff's "implied false certification claim . . . fails as a matter of law [because] there is no evidence that [the defendant's claims] made any specific representations about [its] performance"); *United States v. Beauty Basics Inc*, No. 2:13-CV-1989-VEH, 2016 WL 3519365, at *3 (N.D. Ala. June 28, 2016) ("To plead a false certification, the plaintiff must allege that 'the claim does not merely request payment, but also makes specific representations about the goods or services provided'" and that "'those representations [are made] misleading half-truths[]'" by a failure to disclose noncompliance with a material statutory, regulatory, or contractual requirement.) (quoting *Escobar*, 136 S. Ct. at 2001).

C. Under either theory, EMTALA violations do not impact the Government's decision to pay Medicare or Medicaid claims and therefore do not satisfy the FCA's demanding and rigorous materiality standard.

The FCA's materiality standard is both "rigorous" and "demanding," and creates a hurdle which Sibley cannot clear. *Escobar*, 136 S. Ct. at 1996, 2003. To be actionable under the FCA, "a misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government's payment decision . . . ." *Id*. at 1996. "A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment." *Id*. at 2003 (citations omitted). "*Nor is it sufficient for a finding of materiality that the Government would*

have the option to decline to pay if it knew of the defendant's noncompliance." *Id*. at 2003 (citations omitted) (emphasis added).

Here, the government, through CMS, does not condition payment of individual Medicare or Medicaid claims on EMTALA compliance. There is no connection between claims routinely submitted for patient care and services on the one hand, and the proper transfer or admission of emergency room patients, uninsured or otherwise, on the other hand. Sibley has not alleged, and DRMC has not found, any law, regulation, or practice that suspends or refuses payment of Medicare or Medicaid claims due to an EMTALA violation. Rather, DHHS has a detailed administrative process to investigate and enforce EMTALA compliance, and even where violations are found, the permitted sanctions do not include denying reimbursement of pending or future claims or seeking repayment of claims already paid. *Compare Escobar*, 136 S. Ct. at 2003 (observing the fact that the government "consistently refuses to pay claims in the mine run of cases based on the noncompliance with the particular statutory, regulatory, or contractual requirement" demonstrates materiality). Instead, where CMS finds an EMTALA violation, a hospital may be placed on one of two Medicare provider agreement termination tracks, but CMS continues to pay the hospital's Medicare claims during the resulting time period and allows the hospital to cure the violation.[4] And, where CMS refers an EMTALA violation to the OIG, the violation is punishable by CMPs only after the hospital is afforded a hearing before an Administrative Law Judge, subject to federal court review. 42 U.S.C. §§ 1320a-7a(c)(2)-(3) & 1320a-7a(e); *see also* 42 C.F.R. Part 1005. The absence of either withholding or reclaiming payments of claims from the range of administrative remedies available to the government is significant indicia that the government does not condition its decision to pay Medicare or Medicaid claims on EMTALA compliance.

[4] *See* CMS SOM, Ch. 3 §§ 3010-3012; CMS SOM Ch.5, § 5470, 5470.1.

In sum, Sibley has not and cannot plead facts supporting the materiality of EMTALA compliance to any payment decision by the government.[5] Even in instances where EMTALA violations are found, the government continues paying claims and offers the provider an opportunity to correct any deficiencies and return to compliance.[6] Because Sibley has failed to sufficiently plead facts indicating the materiality of EMTALA compliance, her claims of express and implied false certification must be dismissed. *See United States ex rel. Kietzman v. Bethany Circle of King's Daughters of Madison, Indiana, Inc.*, --- F. Supp. 3d ---, 2018 WL 1566814, at *7 (S.D. Ind. Mar. 30, 2018) (finding "the complaint does not contain a single nonconclusory allegation of materiality" reasoning that "[n]o facts are alleged as to what types of claims the government usually did or did not pay, nor as to what the government's compliance priorities were, nor as to the degree of severity of the hospital's alleged breaches of regulation"); *United States ex rel. Ruckh v. Salus Rehabilitation, LLC,* 304 F. Supp. 3d 1258, --- (M.D. Fl. 2018) ("relator's burden was to show . . . government would have refused to pay [and] . . . likely would need to exclude the government's choosing to resort to a more moderate, more proportional . . . remedy").

II. Sibley fails to state a FCA claim based on the State Trauma Fund because it does not include federal dollars nor is compliance "material" to any government payment decision.

The FCA does not apply to allegedly false claims where only state funds are involved. The FCA requires a "claim" to be "presented to an officer, employee, or agent of the United States" or to a party, such as a contractor, where the federal government "provides any portion" of the funds. 31 U.S.C. §3729(b)(2). Where federal funds are not an issue, there can be no FCA liability. *See,*

[5] Sibley's conclusory assertion in ¶33 that EMTALA compliance is a "material . . . condition for payment under [] Medicare and Medicaid" falls well short of pleading requirements. *Blackwell*, 440 F.3d at 286.

[6] Some Courts have declined to find FCA liability for regulatory non-compliance where, as here, the government already has a detailed administrative mechanism for managing compliance. *Conner*, 543 F.3d at 1221. The *Conner* Court noted that otherwise "[a]n individual private litigant, ostensibly acting on behalf of the United States, could prevent the government from proceeding deliberately through the carefully crafted remedial process and could demand damages far in excess of the entire value of Medicare services performed by a hospital." *Id.*

e.g., United States ex rel Shupe v. Cisco Sys., Inc., 759 F.3d 379, 383 (5th Cir. 2014) (discussing programs that "do not trigger FCA protection because they do not receive federal funds").

Sibley's Complaint discusses the State Trauma Fund and related state law obligations. *E.g.*, Comp. ¶8-10, 38-47, 57, 259. The State Trauma Fund receives no funding from the federal government. *See* Miss. Code. § 41-59-75. Rather, according to the report cited in the Complaint, the State Trauma Fund receives revenues from state-level sources. *See Report to the Mississippi Legislature* (January 3, 2013) (cited in Compl. ¶38). Sibley does not allege that the State Trauma Fund involves any federal money, and therefore she cannot premise FCA liability on purported fraud involving only state funds, and as noted in Section I.C above, Sibley does not and cannot allege that compliance with State Trauma Fund regulations is material to any payment decision by the government. Thus, Sibley's claims related to the State Trauma Fund should be dismissed.

III. As a matter of law, Sibley has not stated a Reverse False Claim (Count Two).

In Count Two, Sibley alleges DRMC violated the "reverse false claim" provision of 31 U.S.C. § 3729(a)(1)(G) by concealing and/or failing to disclose material facts "that would have resulted in substantial repayment of fines and penalties." [16] Compl. ¶252. Sibley set out two (2) sources of fines and penalties, the first of which is based on Sibley's allegation that DRMC "is subject to fines and penalties for negligent violation of EMTALA, 1395dd(d)(1)(A)." [16] Compl. ¶37, ¶252(b). Sibley also alleges reverse false claims arise from the fines and penalties as set out in 28 C.F.R. § 85.3(a)(9), "for each bill and/or request for payment fraudulently submitted under the False Claim Act . . . ." [16] Compl. ¶252(a).

A reverse false claim "creates liability for wrongfully avoiding payments that should be made to the government. But, critically, . . . reverse false claim [liability] requires existence of an 'obligation'—defined as 'an established duty'—to pay money to the government." *U.S. ex rel Barrick v. Parker – Migliorini Int'l, LLC*, 878 F.3d 1224, 1226 (10th Cir. 2017).

To prevail on a reverse false claim, a relator must prove that the defendant had an established duty to pay or repay money to the government. *U.S. ex rel Simoneaux v. E.I. DuPont DeNemours & Co.*, 843 F.3d 1033, 1039 (5th Cir. 2016). A contingent or potential liability for a statutory penalty is not an "established duty to pay." *Barrick*, 878 F. 3d at 1227 ("[A]n established duty is one owed at the time the improper conduct occurred, not a duty dependent on a future discretionary act . . . ."). Sibley has not alleged a fine or penalty has already been assessed or levied against DRMC or that CMS has initiated any EMTALA proceeding to assess a penalty. "Where . . . a regulatory penalty has not been assessed and the government has initiated no proceeding to assess it, there is no established duty to pay." *Simoneaux*, 843 F.3d at 1039.[7]

In *Simoneaux*, the relator contended DuPont was liable for reverse false claim because it concealed an obligation to pay a penalty arising from the leaking of toxic pollutants in violation of the Toxic Substance Control Act ("TSCA"). *Id*. at 1034. The relator argued that since TSCA required DuPont to report the leak to the EPA, this "unpaid civil penalty" was an obligation within the reverse false claim provision. *Id*. at 1036. As *amicus curiae* in support of DuPont, the government argued that "[a] statute enforceable through an unassessed monetary penalty creates an obligation to obey the law, not an obligation to pay money." *Id*. at 1037. The Fifth Circuit rejected the relator's argument that the penalty for the unreported TSCA violation was an "obligation." *Id*. at 1039. Echoing the government's *amicus* position, the court noted, "most

[7] The Fifth Circuit's view is consistent with jurisdictions throughout the United States. *See, e.g., Barrick*, 878 F.3d at 1231 (observing "there is no liability under reverse false claim for obligations to pay that are merely potential or contingent"); *United States ex rel Petras v. Simparel*, 857 F.3d 497, 505 (3rd Cir. 2017) ("[T]he term [established duty] does not include a duty that is dependent on a future discretionary act."); *U.S. ex rel Schneider v. JP Morgan Chase*, 878 F.3d 309, 314-15 (2nd Cir. 2017) (reaffirming that contingent exposure to penalties which may or may not ultimately materialize does not qualify as an "obligation"); *see also Olson v. Fairview Health Services of Minnesota*, 831 F.3d 1063, 1074 (8th Cir. 2016) (no reverse false claim liability where "at most (defendant) merely had a potential liability"); *U.S. ex rel Landis v. Tailivind Sports Corp.*, 160 F. Supp. 3d 253, 267-270 (D.D.C. Feb. 12, 2016), *reconsideration denied*, 167 F. Supp. 3d 80 (D.D.C. March 7, 2016) (one does not incur reverse-false-claim liability by violating, and affirmatively concealing one's violation of a statute, regulation or contract, that merely authorizes the government to levy certain fines and penalties.").

regulatory statutes . . . impose a duty to obey the law, and the duty to pay regulatory penalties is not 'established' until the penalties are assessed." *Id*. at 1040.

Here, Sibley's reverse claim rests upon DRMC's purported failure to report alleged EMTALA violations to CMS. EMTALA provides an administrative process to assess a penalty, but leaves the initiation of the process to the government's discretion. *Simoneaux* instructs that a failure to report a violation of a statutory requirement that may or may not have resulted in an assessment of a penalty does not establish a reverse false claim obligation. *Id*. at 1039-40.

EMTALA's CMP procedure (42 U.S.C. § 1395dd(d)(1)) incorporates by reference the administrative procedure set out in 42 U.S.C. § 1320a-7a; *see also* 42 C.F.R. Part 1003 (regulations implementing CMP process). Section 1320a-7a(c) begins with, "The Secretary may initiate a proceeding …." *See also* 42 C.F.R. § 1003.500 (OIG "may" impose a penalty). "[T]he word 'may' clearly connotes discretion." *Halo Electronics, Inc. v. Pulse Electronics,* 136 S. Ct. 1923, 1931 (2016). Under this statutory and regulatory procedure, a provider must be given notice of the potential for assessment of penalties and be provided an administrative hearing with the right to discovery, to present evidence, and to cross-examine witnesses. Only at the conclusion of the hearing would assessment of penalties be considered. Even then, Section 1320a-7a(d) lists discretionary factors to be considered in setting the amount and scope of a penalty, if any. Accordingly, assessment of penalties for alleged EMTALA violations is not certain, mandatory, or automatic. Rather, potential liability for EMTALA penalties is contingent upon the exercise of the government's considerable discretion. Sibley's contention that the government would actually impose CMPs on DRMC is pure speculation. Thus, this potential liability for EMTALA violations cannot meet the established duty to pay requirement for a reverse false claim.

Secondly, that DRMC would be subject to penalties in this proceeding should there be an adverse determination of liability by definition is a contingent liability, which cannot constitute a reverse false claim obligation. *See, e.g.*, *Simoneaux*, 843 F.3d at 1039-40.

IV. Sibley Fails to State a Claim for Worthless Services (Count Four).

Sibley alleges "upon information and belief" that DRMC is liable for "providing and charging for inadequate medical screening through its emergency department for tests and procedures that had to be repeated after patients were inappropriately transferred to UMMC." [16] Compl. ¶ 266. Pleading on information and belief does not otherwise relieve a *qui tam* plaintiff from the requirements of Rule 9(b) and "generalized allegations do not come close to satisfying Rule 9(b)." *United States ex rel. Hebert v. Dizney*, 295 F. App'x 717, 723 (5th Cir. 2008). Sibley's bare-bones allegation completely fails to comply with Rule 9(b)'s particularity requirement and fails to provide the "who, what, when, where or how" of any purportedly worthless services. *See United States ex rel. Steury v. Cardinal Health, Inc.*, 735 F.3d 202, 207-08 (5th Cir. 2013) (dismissing relator's claims based on "worthless goods theory" because "[t]here is no who, what, when, where, or how on this claim to comply with Rule 9(b)").

Moreover, Sibley's "worthless services" theory is wholly inapplicable to the facts here. Although the Fifth Circuit has not adopted a "worthless goods" theory of FCA liability, *see Steury*, 735 F.3d at 207, other circuits have held that "the performance of the service [must be] so deficient that for all practical purposes it is the equivalent of no performance at all." *United States ex rel. Absher v. Momence Meadows Nursing Center, Inc.*, 764 F.3d 699, 709-710 (7th Cir. 2014) (citations omitted). Worthless services claims are "effectively derivative of an allegation that a claim is factually false because it seeks reimbursement for a service not provided." *Mikes v. Straus*, 274 F.3d 687-703 (2nd Cir. 2001), *abrogated on other grounds by Escobar*, 136 S. Ct. 1989 (2016). Sibley's Complaint contains no allegations whatsoever that DRMC provided tests

or procedures that were of such poor quality that they were the equivalent of never being performed at all. Sibley thus has failed to state a claim under this theory and such claims should be dismissed.

V. Sibley Fails to State a Claim Related to Allegedly Fraudulent Billing by DRMC and Dr. Corkern (Count Five).

Sibley next alleges that DRMC and Dr. Robert Corkern engaged in a fraudulent scheme to improperly bill Medicaid for services provided by Dr. Corkern. [16] Compl. ¶52-56, 268-271. "[T]o plead a false claim successfully . . . a plaintiff must state the factual basis for the fraudulent claim with particularity . . . [and] 'the time, place and contents of the false representations, as well as the identity of the person making the misrepresentation and what that person obtained thereby' in order to satisfy Rule 9(b)." *United States ex rel. Rafizadeh v. Cont'l Commons, Inc.*, 553 F.3d 869 (5th Cir. 2008). Sibley's Complaint here completely fails to plead with particularity any false claim associated with the allegations referenced in Count Five.

However, the Fifth Circuit has acknowledged that "to plead with particularity the circumstances constituting fraud . . . a relator's complaint, if it cannot allege the details of an actually submitted false claim, may nevertheless survive by alleging particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *United States ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009). Such reliable indicia may include "dates and descriptions of services recorded, but unprovided, and a description of the billing system that the records were likely entered into." *Id.* at 190-91. The *Grubbs* standard "reaffirms the importance of Rule 9(b) in FCA claims" and "does not absolve [Relators] of the burden of otherwise pleading the time, place, or identity details of the traditional standard, in order to effectuate Rule 9(b)'s function of fair notice and protection from frivolous suits." *United States ex rel. Nunnally v. West Calcasieu Cameron Hosp.*, 519 F. App'x 890, 893, 895 (5th Cir. 2013) (per curiam). The factual background in *Grubbs* is crucial for an

understanding of the court's holding and illustrates the comparative paucity of details contained in Sibley's Complaint.

In *Grubbs*, the relator, a psychiatrist, alleged that shortly after he was hired to work at a hospital, two other physicians invited him to a dinner over which they solicited him to participate in a fraudulent scheme to improperly bill Medicare for face-to-face patient visits without ever actually seeing the patient. *Grubbs*, 565 F.3d at 184-185. Following the dinner, hospital nursing staff attempted to assist the relator in carrying out the scheme. *Id.* The relator's Complaint contained a detailed description of the scheme and at least one example of false billing for each physician similar to the following paragraph:

> Dr. Desai billed Medicaid for psychotherapy services on January 8, 2004, CPT Code #90805, which constituted a false claim in that the medical records indicate that no psychotherapy was provided by Desai on that date.

Id.

The district court nonetheless dismissed the relator's complaint for failure to meet the pleading requirements of Rule 9(b) because the relator could not describe with specificity an actual claim (or bill) that was submitted to the government. *Id.* On appeal, the Fifth Circuit reversed, and applying the standard enunciated above, found that:

> The complaint sets out the particular workings of a scheme that was communicated directly to the relator by those perpetrating the fraud**. Grubbs describes, in detail, including the date, place, and participants, the dinner meeting at which two doctors in his section attempted to bring him into the fold** of their on-going fraudulent plot. He alleges his first-hand experience of the scheme unfolding as it related to him, describing how the weekend on-call nursing staff attempted to assist him in recording face-to-face physician visits that had no occurred. **Also alleged are specific dates that each doctor falsely claimed to have provided services to patients and often the type of medical service or its Current Procedural Terminology Code that would have been used in the bill**.

Id. at 191-192 (emphasis added). Therefore, although the relator could not describe a particular claim (or bill) with particularity, the Fifth Circuit found that relator had met his burden to allege sufficient factual details to satisfy Rule 9(b). *Id.*

In contrast to the detailed factual allegations found in *Grubbs*, Sibley's Complaint not only fails to identify with particularity any specific false claim presented in connection with the alleged scheme, it also wholly fails to provide both "particular details of a scheme" to submit false claims and "reliable indicia that lead to a strong inference that claims were actually submitted." For these reasons, Sibley's allegations related to the alleged fraudulent Medicaid billing scheme referenced in Count Five must be dismissed for lack of particularity pursuant to Rule 9(b).

The only allegations in the Complaint supporting Count Five are located in ¶¶52-56 and ¶¶268-271. Sibley generally alleges that Dr. Corkern is prohibited from billing Medicaid for services provided to Medicaid patients. [16] Compl. ¶53. Sibley then attempts to set forth an alleged fraudulent billing scheme, which is quoted in full below:

> 55. Corkern has routinely seen/treated Medicaid patients and billed those patients "through" other providers, including but not limited to Physician Assistant (PA) Kyle Campbell, using their User IDs in the electronic health record. Certain nurse practitioners have been instructed that if they consult Corkern on a patient, they are required to falsify medical records by affirmatively "documenting" that they consulted the Physician Assistant instead. Such procedure creates billing records for Medicaid patients which are fraudulent and which represent charges illegally created by Corkern. Additionally, nurse practitioners have been instructed by DRMC's supervisory personnel that certain Medicaid admissions must be "turned over" to a PA (a lateral move), where Corkern then writes admissions orders under the PA's name.

Sibley further alleges that "Cockern [sic], in the scope and course of his employment agency with DRMC, has knowingly submitted, or caused to be submitted, fraudulent charges to the Medicaid program." [16] Compl. ¶ 269. These vague allegations completely fail to satisfy the "who, what, when, where, and how" requirements of Rule 9(b). These allegations neither describe

with particularity the submission of any particular false claim, nor provide the requisite "particular details of a scheme to submit false claims" and "reliable indicia that lead to a strong inference that claims were actually submitted." *Grubbs*, 565 F.3d at 190.

First, with respect to the "when," Sibley fails to state any dates regarding when these Medicaid patients were allegedly treated by Dr. Corkern, when he allegedly "billed" these services through other providers, or when the other allegations in ¶55 occurred. The failure to provide any particular dates of when the allegedly fraudulent services were provided alone is fatal to this claim. *United States ex rel. Williams v. McKesson Corp*., 2014 WL 3353247, at *7 (N.D. Tex. July 9, 2014) ("[a]t one point [the Complaint] alleges that Dr. Larson 'routinely' signed records falsely, but it never provides a single date as Rule 9(b) requires") (internal quotations omitted).

Next, with respect to the "what," Sibley again fails to include any description of the services which Dr. Corkern allegedly provided or fraudulently billed to Medicaid. Sibley also fails to provide any description of the billing system that the records were entered into or how such services were allegedly illegally billed to Medicaid. *Compare Grubbs*, 565 F.3d at 189, 190-91.

Other than Dr. Corkern and purported Physician Assistant Kyle Campbell,[8] the Complaint otherwise fails to state with particularity "who" is involved, instead making only vague references to "other providers," "certain nurse practitioners," "patients," "[DRMC] supervisory staff," and

[8] DRMC has never employed or utilized a Physician Assistant named "Kyle Campbell." Moreover, the publicly available records of the Mississippi Board of Medical Licensure ("MBLM"), which is responsible for licensing both physicians and physician assistants, available at https://www.ms.gov/medical_licensure/renewal/verificationSearch.jsp, reveal that there is no physician assistant licensed in the State of Mississippi named "Kyle Campbell." DRMC asks the Court to take judicial notice of the fact that no physician assistant named "Kyle Campbell" is licensed to practice in the State of Mississippi. *See* Fed. R. Evid. 201(b). This further illustrates the lack of indicia indicating reliability in Plaintiff's Complaint and completely undermines the plausibility of Sibley's allegations. Finally, to the extent that Sibley's Complaint misleadingly implies that Dr. Corkern is not licensed to practice medicine, DRMC asks the Court to take judicial notice, again pursuant to Fed. R. Evid. 201(b), that Dr. Corkern's license to practice medicine was reinstated on May 15, 2014, s*ee* In the Matter of the Physician's License of Robert Stephen Corkern, M.D., MBML (May 15, 2014), *available at* https://dsitspe01.its.ms.gov/msbml/MLB.nsf/ByLicenseNo/12101 (follow "Display Public Records" link), and he remains licensed and in good standing with the MBML as reflected in the MBML database.

"certain Medicaid admissions." The failure to state with particularity the identity of these individuals further demonstrates the lack of particular details and indicia of reliability accompanying Sibley's allegations.

Finally, although linked with the other deficiencies discussed above, the Complaint contains no specific details regarding "how" false claims were submitted, who submitted them (or on whose behalf they were submitted), or what was submitted. None of the allegations related to Count Five contain a single specific date or description of any services allegedly improperly billed to Medicaid. Moreover, the relevant sections of the Complaint do not contain a single citation to a statute or regulation which was allegedly violated, or an allegation of any false certification submitted in relation to this scheme. The Complaint contains only a conclusory allegation that "[s]uch procedure creates billing records for Medicaid patients which are fraudulent and which represent charges illegally created by Corkern" yet provides no information about DRMC's billing system or other facts to suggest that Sibley has knowledge about how DRMC or Dr. Corkern submitted bills to Medicaid. This does not come close to satisfying Sibley's burden to describe the alleged fraud with particularity as required by Rule 9(b). *See United States ex rel. Colquitt v. Abbot Lab.*, 858 F.3d 365, 370-372 (5th Cir. 2017) ("single, vague paragraph" describing alleged kickback scheme failed to allege details of the scheme with sufficient particularity); *United States ex rel. Doe v. Lincare Holdings*, Inc., 2017 WL 752288 at *5-6 (S.D. Miss. Feb. 27, 2017) (dismissing relator's claims for alleged scheme to generate false oxygen readings where relator failed to provide indicia of a specific scheme to submit false claims); *Williams*, 2014 3353247 at *6-7 (finding relator's Complaint failed to satisfy Rule 9(b) as to alleged scheme to submit "out-of-scope" services claims submitted to Medicare/Medicaid).

In sum, Sibley has completely failed in her burden to plead the "time, place, or identity details of the traditional standard . . . to effectuate Rule 9(b)'s function of fair notice and protection

from frivolous suits." *Nunnally*, 519 F. App'x at 895. Sibley has not alleged with particularity any specific false claim submitted to Medicaid, nor has she alleged "particular details of a scheme to submit false claims" paired with "reliable indicia that lead to a strong inference that claims were actually submitted" such as dates, descriptions of services provided, or a description of DRMC's billing system. *Grubbs*, 565 F.3d at 190-191. Sibley's allegations regarding the alleged scheme involving Dr. Corkern fall well short of alleging the particular details required by Rule 9(b) for purposes of establishing a false or fraudulent claim under the FCA and must be dismissed.

CONCLUSION

For the foregoing reasons, Delta Regional Medical Center respectfully requests that the Court dismiss Sibley's Second Amended Complaint in its entirety.

Dated: July 10, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, Frank Trapp, hereby certify that I have electronically filed this Memorandum with the Clerk of the Court using the CM/ECF system, which sent notification to all counsel of record who have entered an appearance in this case as of the date below.

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