UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
SHERMAN DIVISION

UNITED STATES OF AMERICA *ex rel.* STEPHEN DEAN,	§	
Plaintiffs,	§	
v.	§	
PARAMEDICS PLUS, LLC, EAST TEXAS MEDICAL CENTER REGIONAL HEALTHCARE SYSTEM, INC., EAST TEXAS MEDICAL CENTER REGIONAL HEALTH SERVICES, INC., EMERGENCY MEDICAL SERVICES AUTHORITY, and HERBERT STEPHEN WILLIAMSON,	§	CIVIL ACTION NO. 4:14-CV-203
	§	JUDGE MAZZANT
	§	ORAL HEARING REQUESTED
Defendants.	§	

PARAMEDICS PLUS, LLC'S MOTION TO DISMISS

Defendant Paramedics Plus, LLC ("Paramedics Plus" or "PMP") files this Motion to Dismiss pursuant to Rule 12(b)(6) and Rule 9(b) of the Federal Rules of Civil Procedure and respectfully requests that the Court dismiss The Complaint of the United States in Partial Intervention ("Complaint").

INTRODUCTION AND SUMMARY

Emergency Medical Services Authority ("EMSA") is an Oklahoma public utility that provides ambulance services to residents in Oklahoma City and Tulsa. Between 1998 and 2013, EMSA contracted with Paramedics Plus for paramedic and other services. The federal government (the "Government") has intervened in this case to challenge a "profit-cap" agreement between EMSA and Paramedics Plus, the purpose (and the actual effect) of which was to reduce EMSA's operating costs and to save taxpayers in Oklahoma money.

The Government is suing not only EMSA and Paramedics Plus, but also Paramedics Plus's parent company, ETMC Regional Healthcare System.[1] In its zeal to make headlines and to tout big-dollar recoveries, the Government seeks *hundreds of millions of dollars* in damages in this case, and, in doing so, threatens to destroy an entire system of hospitals upon which thousands of East Texans depend for medical care.

Despite alleging these exorbitant figures, the Government does not claim that Medicare or Medicaid lost even ***one penny*** as a result of the Defendants' profit cap. For instance, the Government does not complain that EMSA inflated its charges or otherwise billed the Government for more than its services were actually worth. Nor does the Government complain that an Oklahoma patient received care that was unnecessary or substandard. In fact, the Government does not allege that it sustained *any actual* damages in this case.

Nonetheless, the Government contends that EMSA violated the False Claims Act ("FCA") by submitting allegedly "fraudulent" claims to Medicare and Medicaid. According to the Government, these claims were fraudulent because EMSA's profit-cap agreement with Paramedics Plus violated the federal Anti-Kickback Statute ("AKS").

Instead of recognizing the obvious value and utility of EMSA's profit cap agreement, the Government has concocted a sensational theory that the profit cap was an illegal "kickback scheme" that spanned the entire fifteen years of EMSA's business relationship with Paramedics Plus. The profit-cap agreement was no such thing. The profit cap was merely a cost-savings agreement that limited the total amount of money that EMSA owed to Paramedics Plus based upon Paramedics Plus's revenue and profit. The money transferred by Paramedics Plus under

[1] Paramedics Plus is a wholly-owned subsidiary of East Texas Medical Center Regional Health Services, Inc. ("Services"), which is a wholly-owned subsidiary of East Texas Medical Center Regional Healthcare System, Inc. (the "System"). Services and the System are defendants in this case and are filing a separate motion to dismiss.

the profit cap was not illegal "remuneration" exchanged for referrals of Medicare or Medicaid business, as the Government contends. Rather, the money transferred by Paramedics Plus *belonged to EMSA* and was owed to EMSA under the profit-cap agreement.

In fact, the profit-cap agreement had nothing to do with, and had no discernible impact on, Medicare or Medicaid. As a public utility required to respond to all 911 calls, EMSA had no control over the number of requests for emergency transports, who requested those transports, and what type of transport services were required. Consequently, EMSA would have provided the *same* transports to the *same* people (and submitted the same number and type of Medicare and Medicaid claims) regardless of whether or not it utilized a profit cap to control its costs. Moreover, Paramedics Plus had no involvement in EMSA's attempts to collect money from Medicare and Medicaid. Its role was limited to providing and managing the paramedics and emergency medical technicians who provided pre-hospital care to EMSA's patients. Paramedics Plus looked to EMSA alone for payment, and EMSA was required to pay Paramedics Plus whether or not it received reimbursements from third parties, such as Medicare or Medicaid.

While the Government's Complaint makes exaggerated allegations about payments made by Paramedics Plus under the profit-cap and various political contributions and gifts, the Complaint fails to show that any of these alleged payments, contributions or gifts were actually "kickbacks" or "bribes" intended to induce EMSA to refer patients, work, or contracts to Paramedics Plus. The Government has therefore failed to allege a violation of the AKS, which is the only basis for its FCA claims.

The Government has also failed to plead the elements of its FCA and common-law causes of action. The Complaint includes only vague and conclusory allegations regarding materiality and scienter, even though the Supreme Court recently held that these requirements

are "rigorous" at the pleading stage.[2] In fact, the Government does not describe one instance in which it actually refused to pay Medicare or Medicaid claims because of a profit cap or similar cost-savings measure. The Complaint fails to allege that Paramedics Plus knowingly caused EMSA to submit false claims for Medicare and Medicaid reimbursement, and it also fails to show a plausible connection between Paramedics Plus's alleged payments under the profit cap and EMSA's Medicare and Medicaid claims.

Put simply, this case does not involve fraud on the federal government. The Government's Complaint should therefore be dismissed under Rule 12(b)(6) and Rule 9(b).

STATEMENT OF ISSUE TO BE DECIDED

Should the claims against Paramedics Plus be dismissed for failure of the Complaint to adequately plead or otherwise state plausible claims for relief under Rule 8(a) and Rule 9(b)?

STANDARDS FOR DISMISSAL

The Federal Rules of Civil Procedure require that each claim in a complaint include a short and plain statement showing that the pleader is entitled to relief. FED. R. CIV. P. 8(a)(2); *U.S. ex rel. Jackson v. Univ. of N. Texas*, 2015 U.S. Dist. LEXIS 175706, *11-12 (E.D. Tex. Nov. 18, 2015), *adopted*, 2016 U.S. Dist. LEXIS 11304 (E.D. Tex. Feb. 1, 2016) (Mazzant, J.). "The claims must include enough factual allegations 'to raise a right to relief above the speculative level.'" *Jackson*, *supra*, at *12 (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). Under the *Twombly* standard, a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face. *Id.* (quoting *Gonzalez v. Kay*, 577 F. 3d 600, 603 (5th Cir. 2009) and *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). "'A claim has facial plausibility when the [government] pleads factual content that allows the court to

[2] *Universal Health Services v. U.S. ex rel. Escobar*, __ U.S. __, 136 S. Ct. 1989, 2002 (2016) (hereinafter, "*Escobar*").

draw the reasonable inference that the defendant is liable for the misconduct alleged.'" *Id.* (quoting *Gonzalez, supra*, at 603).

"A complaint…under the FCA must [also] meet the heightened pleading standard of…[Rule 9(b)], which states '[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake.'" *Jackson, supra*, at * 10 (quoting FED. R. CIV. P. 9(b) and citing *U.S. ex rel. Grubbs v. Kanneganti*, 565 F. 3d 180, 185 (5th Cir. 2009)). "Pleading fraud with particularity in the Fifth Circuit 'requires '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.'" *Id.* "Rule 9(b) also 'requires a plaintiff to…explain why the statements were fraudulent.'" *Id.* at * 10-11. "Relators must 'set forth *specific facts* supporting an inference of fraud,' and 'simple allegations that a defendant possesses fraudulent intent will not satisfy Rule 9(b).'" *Id.* at * 11 (quotations omitted).

In deciding Rule 12(b)(6) motions, courts accept a complaint's well-pleaded allegations as true, but may not accept as true "'conclusory allegations, unwarranted deductions, or legal conclusions.'" *Hall v. Phenix Investigations, Inc.*, 642 Fed. Appx. 402, 404 (5th Cir. 2016) (citation omitted). In this regard, courts takes a two-step approach, first identifying and disregarding the complaint's conclusory allegations, and then determining whether the well-pleaded allegations plausibly suggest an entitlement to relief. *Jackson, supra*, at * 13 (quoting *Iqbal, supra*, at 681). "This evaluation will 'be a context-specific task that requires the…[Court] court to draw on its judicial experience and common sense.'" *Id.* (quoting *Iqbal, supra*, at 679).

ARGUMENT

I. THE GOVERNMENT HAS FAILED TO PLEAD ACTUAL DAMAGES.

While the Government's Complaint seeks hundreds of millions of dollars in purported

damages, it fails to allege any *actual damages*. This deficiency is fatal to the Government's fraud claim and significantly limits the Government's potential recovery under the FCA.

A. The Government must allege "actual damages" to state a claim for fraud and to recover damages under the FCA.

The Government must plead actual damages to state a claim for common-law fraud. *See Dura Pharm., Inc. v. Broudo*, 544 U.S. 336, 343-44 (2005) (noting that common-law fraud requires "that a plaintiff show actual damages"). Thus, to plead common-law fraud, a plaintiff must allege that the defendant's fraudulent acts or omissions caused the plaintiff some type of "economic loss." *See id.* ("And the common law [pertaining to fraud] has long insisted that a plaintiff in such a case show . . . that he suffered actual economic loss.").

The term "damages" is not defined in the FCA, but the Supreme Court in *United States v. Bornstein* adopted the common-law "benefit-of-the-bargain" measure of damages for FCA claims. 423 U.S. 303, 316 n.13 (1976) ("The Government's actual damages are equal to the difference between the market value of the tubes it received and retained and the market value that the tubes would have had if they had been of the specified quality."). The Fifth Circuit and courts in this District also apply the "benefit-of-the-bargain" measure of damages in FCA cases and have rejected other types of damages. *See, e.g., United States v. Aerodex, Inc.*, 469 F.2d 1003, 1010-11 (5th Cir. 1972) (discussing benefit-of-the-bargain damages with approval and holding that consequential damages are not recoverable under the FCA); *see also U.S. ex rel. Harman v. Trinity Indus.*, 166 F. Supp. 3d 737, 753 (E.D. Tex. 2015) ("Damages under the FCA are calculated under the 'benefit of the bargain theory' . . . ."). Thus, to plead a claim for damages under the FCA, the Government must allege facts showing that it sustained "actual damages" (and, specifically, benefit-of-the-bargain damages).

B. The Government has not alleged actual damages.

The Government's Complaint fails to allege an economic loss resulting from a purported "false claim." For instance, the Government has not alleged that Paramedics Plus or EMSA billed, or that the Government paid, more than any of EMSA's (or Paramedics Plus's) services were worth (through deliberate coding misstatements or otherwise). Nor has it alleged that either EMSA or Paramedics Plus billed, or that the Government paid for, services not actually performed. The Government also has not alleged that any services were unnecessary or were performed by individuals who were not qualified to perform them.

Nor does the Government allege any actual damages related to Paramedics Plus's profit-cap agreement with EMSA (or any transaction under that agreement). This is not surprising, because EMSA had a statutory "Duty to Act" and was required to respond to all 911 calls. *See* OAC 310:641-3-120(b). Neither EMSA nor Paramedics Plus had any control over whether an Oklahoma resident called 911, how often a person called 911, or the type of services required. Similarly, EMSA and Paramedics Plus had no control over whether any given caller needed care. And, of particular importance here, EMSA and Paramedics Plus had absolutely no control over whether the caller was a Medicare or Medicaid recipient. An ambulance would have been dispatched and pre-hospital care would have been provided regardless of the caller's ability to pay. *See id.* ("…[A]ll licensed ambulance services shall respond when called, regardless of the patient's ability to pay or of the geographical funding district or boundaries."). Since EMSA's services were dictated by unsolicited requests for care, EMSA's profit-cap agreement with Paramedics Plus could not have had any impact on the number of persons treated by EMSA, the type of services EMSA rendered, or EMSA's submission of Medicare or Medicaid claims.

Since the Government does not complain about the quality of EMSA's transport services

or the amount EMSA billed for those services, and since EMSA's business relationship with Paramedics Plus had no impact on EMSA's Medicare or Medicaid claims, the Government has not alleged (and cannot allege) that it sustained any economic loss.

C. The Government's "tainted reimbursement" theory does not hold water.

Rather than pleading any real financial harm, the Government contends—generally—that Paramedics Plus owes the government for *all* of the Government's payments to EMSA from 1998 to 2013 (which would then be trebled under the FCA). Complaint at ¶¶ 154, 163, 164, and 165. Under the Government's theory, "reimbursements [to EMSA] were tainted by kickbacks" and were therefore not "payable." *Id.* at ¶ 165.

This "tainted reimbursement" theory is dubious (at best) in light of the Supreme Court's decisions in *Escobar* and *Bornstein*. The Court in *Escobar* reiterated that the FCA incorporates the principles of common-law fraud and the common-law meanings of undefined terms. *Escobar*, 136 S. Ct. at 1999 ("It is a settled principle of [statutory] interpretation that, absent other indication, Congress intends to incorporate the well-settled meaning of the common-law terms it uses.") (quotations omitted). Thus, the term "damages" – which is not defined in the FCA – incorporates the common-law meaning of that term, which, according to the Court in *Bornstein*, refers to benefit-of-the-bargain damages. *Bornstein*, 423 U.S. at 316 n.13.

In fact, the Sixth Circuit recently rejected the Government's "tainted reimbursement" theory, calling it a "fairyland" measure of damages. In *U.S. ex rel. Wall v. Circle C Const., LLC*, the Government contended that it was entitled to a full refund (trebled under the FCA) for all electrical work performed by a subcontractor on a construction project, because the subcontractor failed to pay sufficient wages under the Davis-Bacon Act. 813 F.3d 616, 616–17 (6th Cir. 2016). The Government argued that the work was "valueless because all of that work –

the wiring, circuits, switches, everything in every building—[was] ***tainted***" by the subcontractor's underpayment to its electricians." *Id.* at 617 (emphasis added). As in this case, the Government argued that it would have suspended its payments on the project had it known the subcontractor was underpaying its workers. *Id.* at 618. The Sixth Circuit rejected the Government's theory of recovery, reasoning that, "in determining actual damages . . . the relevant question is not whether in some hypothetical scenario the government would have withheld payment, but rather, more prosaically, whether the government in fact got less value than it bargained for." *Id.* Allowing any more, according to the court, would amount to recognizing "fairyland rather than actual" damages. *Id.* at 616 - 617.

The Sixth Circuit's reasoning applies here. The Fifth Circuit acknowledges that the Government receives "value" for medical services rendered to Medicare and Medicaid beneficiaries, even when claims for those services might otherwise violate the FCA. *See United States v. Mahmood*, 820 F.3d 177, 195 (5th Cir. 2016) (". . . Medicare, as an insurance organization, receives 'value' when its beneficiaries receive legitimate health care services for which Medicare is obligated to pay but for a fraud."). Thus, in FCA cases where Medicare and Medicaid recipients receive healthcare services, benefit-of-the-bargain damages are appropriate.

In fact, in a recent opinion from this District, the court applied the benefit-of-the-bargain measure of damages in an FCA case involving Medicare/Medicaid fraud. *United States v. Mahmood*, 2016 U.S. Dist. LEXIS 131158, *1-*2 (E.D. Tex. Sept. 26, 2016). The defendant in that case manipulated billing codes to increase reimbursements. In determining the Government's actual damages, the court acknowledged that "Medicare . . . received value from those services provided to its beneficiaries." *Id.* at *12. The court then applied the benefit-of-the-bargain measure of damages and deducted the value of the services actually rendered to

determine the Government's actual loss. *Id.* (quoting *Bornstein*).

Here, the Government does not allege that the emergency-transport services rendered by EMSA and Paramedics Plus had no value, nor does the Government allege that it paid more than the services themselves were actually worth. Thus, the Government received the benefit of its bargain. Consequently, the Government has not alleged any "actual damages," and without a showing of actual damages, the Government's claim for common-law fraud and its claim for damages under the FCA should be dismissed pursuant to Rule 12(b)(6).

D. FCA penalties compensate for any purported non-economic harm.

To the extent the Government contends that it suffered some non-economic or other intangible harm (which Paramedics Plus denies), the FCA provides a separate remedy – penalties. 31 U.S.C. § 3729(a)(1) (a person who violates the FCA "is liable to the [Government] for a civil penalty . . . ."); *see also U.S. ex rel. Main v. Oakland City Univ.*, 426 F.3d 914, 917 (7th Cir. 2005) ("The [FCA] provides for penalties even if (indeed, *especially* if) actual loss is hard to quantify . . . ."). However, as shown below, the Government's Complaint fails to plead a claim for *any* relief under the FCA.

II. THE GOVERNMENT DOES NOT ALLEGE A PLAUSIBLE VIOLATION OF THE AKS AS TO PARAMEDICS PLUS.

The Government's FCA claims are based upon alleged violations of the AKS, which must be pleaded with particularity under Rule 9(b). 42 U.S.C. § 1320a-7b(b)(2)(B); s*ee also U.S. ex rel. Nunnally v. West Calcasieu Cameron Hospital*, 519 Fed. App'x 890, 894 (5th Cir. 2013). Because the Complaint does not allege a plausible AKS violation or plead a violation with particularity, the Government's FCA claims should be dismissed

A. The Government's alleged "kickback scheme" is implausible.

The Government alleges that, in 1998, Paramedics Plus entered into a "secret" "kickback

scheme" with EMSA. Complaint at ¶¶ 64-68. However, the Government does not cite a single instance in which a payment was actually made under the alleged "scheme" until ***2006*** (roughly eight years after the "scheme" allegedly began). According to the Complaint, the alleged scheme involved an agreement whereby Paramedics Plus would "pay back" to EMSA profits exceeding 12% of Paramedics Plus's gross revenue (*i.e.*, a "profit cap" agreement). Complaint at ¶ 64.

The Government contends that this profit-cap agreement was a "secret" kickback scheme, because it was not mentioned in the minutes of certain meetings of the EMSA Board of Trustees and was allegedly not part of EMSA's written contract with Paramedics Plus. *Id*. at ¶¶ 64-68. Paramedics Plus disputes that its profit-cap agreement with EMSA was a "secret," but, regardless, the AKS does not criminalize "secrecy."[3] Rather, the AKS prohibits the knowing and willful payment (or offers of payment) of "remuneration" intended to induce a person to refer patients or to purchase goods or services to be paid for by Medicare or Medicaid. 42 U.S.C. § 1320a-7(b)(2); *see also U.S. ex rel. Ruscher v Omnicare*, 663 Fed. App'x 368, 374 (5th Cir. 2016). The AKS does not forbid all payments to a medical provider; rather, to be unlawful under the AKS, the "remuneration" must be "designed to induce" patient referrals or the purchase of goods or services (among other requirements). *Omnicare*, 663 Fed. App'x at 374.

Money transferred under a profit-cap agreement is not unlawful "remuneration," because it returns to a healthcare provider (in this case, EMSA) its *own money.* Essentially, a profit cap is an accounting mechanism where the parties "true up" what is owed to the contractor (in this

[3] The Department of Health and Human Services ("HHS") has adopted various AKS "safe harbors," many of which require the disclosure of payments and written contracts. However, "failure to comply with a safe harbor does not mean that an arrangement is illegal." *See* Federal Register, Vol. 68 FR 14245, No. 56, March 24, 2003, at 14252. "Rather, arrangements that do not fit in a safe harbor must be analyzed under the [AKS] on a case-by-case basis to determine if there is a violation." *Id.* The AKS itself does not have any disclosure requirements. Thus, whether an agreement is secret or well-known, or written or unwritten, makes no difference in determining whether a violation of the AKS has occurred. 42 U.S.C. § 1320a-7(b)(2) ("Whoever knowingly and willfully offers or pays any remuneration . . . directly or indirectly, *overtly or covertly* . . . ") (emphasis added).

case, Paramedics Plus) as information about the contractor's gross revenue and profits become available. In other words, amounts initially paid by a provider under a profit cap are conditional and subject to correction. Thus, under a profit cap, money transferred by a contractor to (or on behalf of) a provider is money that belongs to the provider. Refunding a provider's own money to the provider (or transferring it to a third party at the provider's instructions) cannot be "remuneration" designed to induce referrals under the AKS.

Notwithstanding its allegations in this case, the Government appears to agree with this conclusion. For instance, according to Relator's First Amended Complaint in this case, AMR (Paremedics Plus's competitor) offered an almost identical profit-cap arrangement to EMSA, which EMSA accepted. *See* Relator's First Amended Complaint [Dkt. 6] at ¶¶ 71-76 (AMR is required to pay "an amount each year equal to its profits from the contract . . . exceeding 10%"). Notably, the Government did not intervene in this suit against AMR, although AMR's profit cap agreement with EMSA would clearly violate the AKS *if profit-cap agreements were unlawful*. 42 U.S.C. § 1320a-7b(b)(1) and (2). Thus, the Government's own conduct confirms that profit caps – like the agreement described in the Complaint – do not violate the AKS.

The Government does not explain why the profit-cap agreement between EMSA and Paramedics Plus constitutes a violation of the AKS. Instead, the Government offers only pejorative labels and derogatory terms to describe the profit cap. But simply labeling the profit cap as a "kickback scheme" or "bribe" does not make it so. *Iqbal*, 556 U.S. at 678 ("A pleading that offers labels and conclusions . . . will not do.") (quotations omitted).

Moreover, the Government's description of the profit-cap agreement as some unlawful "kickback scheme" is completely implausible. The Government cannot cite a single payment made by Paramedics Plus under the alleged "kickback scheme" within ***eight years*** after

Paramedics Plus and EMSA allegedly agreed to the "scheme" in 1998. In fact, the Government does not point to even one alleged "kickback" during the entire first term of EMSA's contract with Paramedics Plus. Even after payments were made under the profit-cap agreement beginning in 2006, the Complaint concedes that the total amount of payments generally tracked the amount of revenue received by Paramedics Plus, which is perfectly consistent with a legitimate profit-cap agreement. Complaint at ¶¶ 104-104. Thus, the Government's allegation of some secretive "kickback scheme" is not plausible. To the contrary, it is far more plausible – based on the Government's own allegations and conduct – that the profit-cap agreement was a legitimate cost-control mechanism that had nothing to do with the inducement of any particular contracts or referrals. Accordingly, the Government has failed to allege a plausible violation of the AKS based upon the existence of a profit-cap agreement.

B. The Government does not allege a plausible AKS violation as to any payment, gift or political contribution.

Since the Government has not shown that the parties' profit-cap agreement violated the AKS, the Government must plead specific violations of the AKS to avoid dismissal. The Government's Complaint describes various payments, gifts, and political contributions,[4] but the Complaint fails to show that any of these alleged payments, gifts or contributions were designed to induce referrals or were otherwise tied to the referral of a service or patient. *See Nunnally*, 519 Fed. App'x at 894 (". . . Nunnally must provide reliable indicia that there was a kickback provided in turn for the referral of patients."); *see also U.S. ex rel. Wall v. Vista Hospice Care,*

[4] These payments can be explained by the profit-cap agreement. For example, the Complaint describes two payments made by Paramedics Plus to cover Williamson's travel expenses, but acknowledges that one payment was purportedly "booked . . . against the rebate." Complaint at ¶ 78. Similarly, the Complaint alleges that Paramedics Plus paid for "spa visits" for EMSA personnel but quotes a Paramedics Plus employee as stating that the payments "would go against the final rebate." *Id.* at ¶ 84. In describing a political contribution allegedly requested by Williamson, the Complaint acknowledges that documents confirm that the contribution would "go against the rebate." *Id.* at ¶ 90.

Inc., 2016 U.S. Dist. LEXIS 80160, *83 (N.D. Tex. June 20, 2016) (Lynn, J.) ("[T]he Fifth Circuit has indicated that an FCA violation based on an AKS violation must involve some connection between kickbacks, referrals, and claims.").

Significantly, the Government does not allege that Paramedics Plus paid any money or gave any gifts to induce referrals of particular patients or specific jobs. As described in the Complaint, Paramedics Plus was EMSA's only contract-transporter from 1998 until 2013. During its successive contract terms, Paramedics Plus provided transport services to *all* of EMSA's patients. Thus, Paramedics Plus had no reason to pay kickbacks to EMSA to induce referrals of specific patients, nor does the Government allege that the various payments, gifts or political contributions were provided for that purpose.

Instead, the Government's theory is that Paramedics Plus made various payments, contributed to politicians, and gave people "steaks" to induce EMSA to award Paramedics Plus new contracts. EMSA's Board of Trustees contracted with Paramedics Plus for successive five-year terms in 1998, 2003 and 2008. Complaint at ¶¶ 66-67, 116. However, the Government does not allege that Paramedics Plus made any payments, political contributions or gifts ***before 2006***. In addition, ***all*** of the political contributions and gifts described in the Complaint were purportedly given ***after*** the 2008 contract renewal, and Paramedics Plus was not awarded the EMSA contract in 2013.[5]

That leaves the 2008 contract. The Government alleges that, at some point in 2007, Paramedics Plus "secretly" offered a more favorable profit cap percentage to Williamson. Complaint at ¶ 109. Then, on November 28, 2007, Williamson recommended to the EMSA

[5] Even if Paramedics Plus had been awarded the 2013 contract, the Government's Complaint does not tie any of the political contributions or gifts to that contract. Virtually all of the purported contributions and gifts (and the bulk of the profit-cap payments to EMSA) occurred from 2008 through 2011, almost two years before EMSA issued its RFP for the 2013 contract. Complaint at ¶¶ 104, 146. Thus, the Complaint fails to show any plausible connection between these gifts and payments and the 2013 contract.

Board of Trustees that the Board retain Paramedics Plus as EMSA's contract-transporter, and the Board approved the contract extension without receiving other bids. Complaint at ¶ 113. However, according to the Complaint, the Board did not consider Paramedics Plus's offer of a more favorable profit-cap in reaching its decision. *Id*. When stripped of hyperbole, the Government's theory makes no sense. Essentially, the Government contends that Paramedics Plus induced EMSA to award Paramedics Plus the 2008 contract based upon its promise of a more favorable profit cap, even though EMSA's Board – the actual decision-maker – had no knowledge of the promise. This theory is not plausible.

Moreover, the Complaint fails to allege any specific offer of "remuneration" in exchange for the 2008 contract. As explained above, payments under profit-cap agreements are not "remuneration" within the meaning of the AKS. Thus, PMP's offer "to lower the 'profit cap' percentage from 12% to 10.5% . . . ." (Complaint at ¶ 109) was not an unlawful offer of future "kickbacks" as the Government contends.[6] The Complaint does not allege that Paramedics Plus promised Williamson (or EMSA) any specific future payments, "kickbacks" or "bribes" in exchange for the 2008 contract, and Paramedics Plus did not violate the AKS by merely offering better contract terms to EMSA. *See, e.g., U.S. ex rel. Jamison v. McKesson Corp.*, 900 F. Supp. 2d 683, 699 (N.D. Miss. 2012) ("[I]n order to violate the AKS, it is not enough to covet the business of another, there must actually be some bad intent to violate the law."). Thus, the Complaint fails to show that Paramedics Plus offered specific "kickbacks" or "bribes" to Williamson with the intent to induce EMSA to award Paramedics Plus's the 2008 contract.[7]

[6] According to Relator's Complaint, AMR offered a 10% profit cap to EMSA in 2013, and EMSA awarded AMR the 2013 contract. Relator's Complaint at ¶ 73. The Government does not complain about AMR's offer in this case and has agreed to drop AMR as a defendant.

[7] The Government alleges that Paramedics Plus "secretly" met with Williams to "stop [EMSA's RFP] from being issued." Complaint at ¶ 109. This allegation lacks any factual support, and, regardless, EMSA's decision not to issue an RFP does not imply that Paramedics Plus offered kickbacks, nor is it a

In fact, according to the Complaint, the only payments related to the 2008 contract occurred *after* the Board approved the contract extension. Complaint at ¶¶ 113-116. Moreover, the Government concedes that these payments were based upon the commencement of "the lower 10.5%" profit cap. Complaint at ¶ 114. While the Complaint emphasizes that Paramedics Plus made certain payments to EMSA on the same day that Williamson executed the 2008 contract, the Complaint does not allege that the act of signing the contract had any particular significance after the Board approved the contract extension, nor does the Complaint allege that the payments induced EMSA to agree to more favorable terms. Complaint at ¶ 116. In other words, the Complaint does not allege that these payments were "designed to induce" EMSA to do anything. *See, e.g., U.S. v. Miles*, 360 F.3d 472, 480 (5th Cir. 2004) (finding that referral payments to a marketing company did not cause doctors to refer patients because the payments were made *after* the doctors made their referral decisions).

In sum, while the Complaint describes numerous payments, contributions and gifts, it fails to show a plausible connection between any of these payments or gifts and EMSA's decision to grant Paramedics Plus new contracts in 1998, 2003 and 2008. At best, the Complaint shows that a few profit-cap payments were made at or near the time when EMSA *signed* the 2008 contract, but the Complaint fails to show how these payments were designed to induce (or actually induced) EMSA to sign the contract that the Board had already approved. The timing of these payments, without more, does not support a reasonable inference that the payments were "designed to induce," or actually induced, EMSA to enter into a contract with Paramedics Plus. *See Iqbal*, 556 U.S. at 678 ("Where a complaint pleads facts that are merely consistent with a

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basis for liability under the FCA. *See, e.g., Wall*, 2016 U.S. Dist. LEXIS 80160, *69-*70 ("Even mismanagement of programs that receive federal dollars is not enough to create FCA liability.") (quoting *U.S. ex rel. Farmer v. City of Houston*, 523 F.3d 333, 339 (5th Cir. 2008)).

defendant's liability, it stops short of the line between possibility and plausibility of entitlement to relief.") (quotations omitted). Accordingly, the Government has failed to plead a violation of the AKS, and its FCA claims should therefore be dismissed.

III. THE GOVERNMENT HAS FAILED TO PLEAD ITS FCA CLAIMS WITH PARTICULATIRY.

The Government has also failed to plead the elements of its FCA claims with particularity. The FCA (as relevant herein) forbids three practices: (i) knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval by Medicare or Medicaid, (ii) knowingly making, using, or causing to be made or used, false records or statements material to a false or fraudulent claim, and (iii) conspiring to commit those acts. *See* 31 U.S.C. § 3729(a)(1)(A)-(C). The Government alleges violations of all three provisions.

A. The Government fails to allege a claim under 31 U.S.C. § 3731(a)(1)(A).

To state a claim under § 3731(a)(1)(A), the Government must allege (i) a false statement or fraudulent course of conduct, (ii) made or carried out with the requisite scienter, (iii) that was material, and (iv) that is presented to the Government. *U.S. ex rel. Steury v. Cardinal Health, Inc.*, 625 F.3d 262, 267 (5th Cir. 2010). More succinctly, "[a] claim under the FCA requires presentation of a knowingly false claim to the government for payment; *i.e.*, the requirements are a knowing conduct, falsity, and materiality." *U.S. ex rel. Steury v. Cardinal Health, Inc.*, 735 F. 3d 202, 205 (5th Cir. 2013) ("*Steury II*").

1. The Government has failed to plead "materiality" with particularity.

"Materiality" is a key component of both the FCA and common-law fraud, and it is a critical safeguard against the Government's over-zealous use of the FCA (as is the case here). *See Escobar*, 136 S. Ct. at 2002 ("[C]oncerns about fair notice and open-ended liability can be effectively addressed through strict enforcement of the [FCA's] materiality and scienter

requirements.") (quotations omitted). According to the Supreme Court in *Escobar*, the materiality requirement is "demanding," and allegations of materiality must meet the plausibility and particularity requirements of Rules 8(a) and 9(b). *Id.* at 2003, 2004 n.6. That requirement is not satisfied by rote incantations that the Government would not have paid EMSA's claims had it known of the challenged conduct. Yet that is the gist of the Government's allegations. Specifically, the Government alleges that if it had known of defendants' purported conduct, it "would have ceased making payment." Complaint at ¶ 152. That statement is conclusory and wholly insufficient to plead materiality. *Escobar*, 136 S. Ct. at 2003.

The Government also contends that Defendants knew that AKS compliance was a condition of payment and that the Government regularly files lawsuits for AKS noncompliance. Complaint at ¶¶ 150-151. But allegations about the general importance of AKS compliance do not satisfy the "rigorous" and "demanding" pleading standards for materiality under *Escobar*. *Escobar*, 136 S. Ct. at 2002-03 ("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."). Rather, the Government must plead specific facts supporting its materiality allegation, such as specific instances in which it ceased making payments after learning of the challenged conduct. *See id*. at 2003-04. The challenged conduct at issue here involves various payments under the Defendants' profit cap agreement, which, according to the Government, violated the AKS. However, the Government does not cite any other instance in which it sued a public utility (or any other entity) for entering into or making payments under a profit cap or similar agreement, nor has the Government cited any instance when it refused to pay claims because of a profit cap.

The Government's failure to cite similar instances when it refused to pay claims is

significant. In fact, as noted above, Relators' Complaint (which the Government's Complaint incorporates) describes how AMR offered a nearly identical profit-cap to EMSA in 2013, which EMSA accepted. Relator's Complaint at ¶¶ 71-76. Nonetheless, the Government chose not to intervene in this case against AMR, and the Complaint does not allege that the Government stopped paying EMSA after learning of its profit-cap agreement with AMR. The Complaint mentions public entities in California, Florida and Indiana that use profit caps, but the Government does not allege that it stopped paying those entities either. Complaint at ¶ 11. Thus, the Government has not shown that profit-cap arrangements are "material" to the its decisions regarding payment of Medicare and Medicaid claims. *See D'Agostino v. ev3, Inc.*, 845 F.3d 1, 7 (1st Cir. 2016) (citing *Escobar* and confirming that "the FCA requires that the fraudulent representation be material to the government's payment decision itself").

2. The Government has failed to plead "scienter" as to Paramedics Plus.

The FCA's "scienter" requirement is also "rigorous." *Escobar*, 136 S. Ct. at 2002. According to the Fifth Circuit, FCA scienter requires "guilty knowledge of a purpose on the part of the defendant to cheat the Government." *United States ex rel. Taylor- Vick v. Smith*, 513 F.3d 228, 231 (5th Cir. 2008). Merely alleging that a defendant "knowingly did this or recklessly did that" will not suffice. *Melder v. Morris*, 27 F.3d 1097, 1103 (5th Cir. 1994).[8]

Again, the Government's Complaint falls short. Like its allegations regarding materiality, the Government's scienter allegations are vague and generic. The Government generally alleges that the Defendants should have known that payments under the profit cap did not comply with the AKS based on *EMSA's* internal policies and general industry guidelines,

[8] For purposes of the FCA, "knowing," means that a person, with respect to the information, "(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1)(A).

none of which addressed profit caps specifically. Complaint at ¶¶ 125-134.[9]

As to the Paramedics Plus's knowledge of allegedly "false claims," the Complaint merely states that "Defendants were aware that EMSA billed Medicare and Oklahoma Medicaid for the services provided by Paramedics Plus pursuant to an illegal kickback scheme." Complaint at ¶ 157. This flimsy allegation does not satisfy the "rigorous" scienter requirement of the FCA, nor does the Government's allegation that Paramedics Plus was "aware" that EMSA billed Medicare and Medicaid support a reasonable inference that Paramedics Plus *knowingly or recklessly caused* EMSA to submit false or fraudulent claims.

As to the purported "illegal kickback scheme" (assuming, for the sake of argument only, that such a scheme actually existed), the Government does not allege that the purpose (or even *a* purpose) of the alleged scheme was to submit false claims or otherwise to "cheat the Government." *Taylor- Vick*, 513 F.3d at 231-32; *see also U.S. ex rel. Complin v. N.C. Baptist Hosp.*, 2016 U.S. Dist. LEXIS 179130, *49 (M.D.N.C. Dec. 28, 2016) (recommending dismissal of relator's complaint and finding, in part, that, "[g]iven MedCost's legitimate functions vis-à-vis the Hospitals' employee benefit plans, [plaintiff's] allegations fail to plausibly establish that the Hospitals engineered their employee benefit plans merely to defraud the United States").

The Government alleges that EMSA received payments from Medicare and Medicaid, and that it could not have billed Medicare and Medicaid for ambulance services "without the services provided by…[Paramedics Plus] personnel." Complaint at ¶ 155. True enough, but it does not follow that Paramedics Plus intended to submit (or caused EMSA to submit) false claims. Under its contract, Paramedics Plus was entitled to be paid for services rendered to

[9] In fact, the HHS-OIG guidelines referenced in the Complaint make no mention of profit caps, despite discussing at length numerous potential kickback issues in the ambulance-service industry. Some statements in these guidelines suggest that profit caps would *not* violate the AKS. *See* Federal Register, Vol. 68 FR 14245, No. 56, March 24, 2003.

EMSA whether or not EMSA was reimbursed by third parties. Thus, Paramedics Plus did not look to Medicare – or anyone other than EMSA – as a source of payment. Under these circumstances, there is no reasonable basis for inferring that Paramedics Plus knowingly or recklessly caused EMSA to defraud Medicare or Medicaid.

3. The Government has failed to show that Paramedics Plus caused EMSA to submit false claims.

As the Supreme Court recently noted, the focus of the FCA "remains on those who present or directly induce the submission of false or fraudulent claims." *Escobar*, 136 S. Ct. at 1996. Courts assess FCA "causation" under the "proximate cause" standard. *See United States ex rel. Colquitt v. Abbot Labs.*, 2016 U.S. Dist. LEXIS 1556, * 23 (N.D. Tex. Jan. 7, 2016) (Lynn, J.) (borrowing from common law and finding that "proximate causation" is the proper standard in FCA cases); *see also U.S. ex rel. Sikkenga v. Regence Bluecross Blueshield of Utah*, 472 F.3d 702, 714-15 (10th Cir. 2006) (adopting proximate causation); *see also Escobar*, 136 S. Ct. at 1999 (holding that common-law principles apply in the FCA context).

To plead proximate causation under Rule 9(b), the Government must plead specific facts showing that Paramedics Plus's conduct was "(1) a substantial factor in inducing [EMSA] to submit claims for reimbursement, and (2) . . . the submission of claims for reimbursement was reasonably foreseeable or anticipated as a natural consequence of [Paramedics Plus's] conduct." *Colquitt*, 2016 U.S. Dist. LEXIS 1556 at * 23. The law requires "more than mere passive acquiescence" in the presentation of the claims. *Id.* at *27. While Paramedics Plus need not have participated in the claims-submission process, there must be "some sort of affirmative act that causes or assists the presentation of a false claim." *Id.*

The Complaint does not describe any affirmative act by Paramedics Plus to assist in EMSA's presentation of false claims. For instance, the Government does not allege that

Paramedics Plus reviewed, approved, or had any influence over, EMSA's claims for Medicare or Medicaid reimbursement. Again, while the Complaint alleges that Paramedics Plus was "aware that EMSA billed [the Government]," mere knowledge that EMSA was submitting claims is not sufficient. *Sikkenga*, 472 F.3d at 714.

The Government also fails to allege that any payment made by Paramedics Plus was a "substantial factor in inducing [EMSA] to submit claims for reimbursement." *Colquitt*, 2016 U.S. Dist. LEXIS 1556 at * 23. Indeed, the Government *cannot* reasonably allege that payments made by Paramedics Plus were a "substantial factor in inducing" EMSA to submit Medicare or Medicaid claims, because neither EMSA nor Paramedics had any control over how many people requested ambulance services, the type of services required, whether patients were Medicare or Medicaid recipients, or any other factor that might impact EMSA's claims for reimbursement. EMSA would have submitted the *same* claims for the *same* services whether or not Paramedics Plus agreed to the profit cap.[10] Consequently, the Government has not alleged a "sufficient nexus between the [PMP's] conduct and the ultimate presentation of the allegedly false claim[s]." *Colquitt*, 2016 U.S. Dist. LEXIS 1556 at * 23 (quoting *Sikkenga*, 472 F.3d at 715).

4. The Complaint fails to allege that any claims were "false."

To plead a claim under the FCA, the Government must allege facts showing that the claims-at-issue were "false." 31 U.S.C. § 3729(a)(1)(A). Courts have recognized two categories

[10] The Government does not allege the type of "kickback scheme" where incentives are given to medical providers based upon the number of products or services purchased, such that providing the incentives could arguably induce medical providers to submit claims for Medicare or Medicaid reimbursement. *See, e.g., U.S. ex rel. Schmidt v. Zimmer, Inc.*, 386 F.3d 235, 237 (3rd Cir. 2004) (describing alleged kickback scheme where medical providers were given bonuses for buying a certain number of implants each year and additional discounts for exceeding the prior year's purchases). Here, there is no plausible connection between Paramedics Plus's profit-cap payments and EMSA's submission of Medicare and Medicaid claims. *See, e.g., Polansky*, 2016 U.S. Dist. LEXIS 102113 at *96 ("In contrast to the defendants in *Schmidt* . . ., who supposedly carried out fraudulent schemes by directly inducing medical providers to submit false claims through kickbacks, [defendants'] marketing efforts are too far removed.").

of false claims under the FCA: (i) "factually" false claims, and (ii) "legally" false claims. *See Omnicare*, 663 Fed. App'x 368; 2016 U.S. App. LEXIS 19516, * 9 (5th Cir. Oct. 28, 2016). "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.* (quoting *U.S. ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F. 2d 899, 902 (5th Cir. 1997)). This case involves alleged "legally" false claims.

"Legally" false claims can theoretically take two forms. The first is when the defendant expressly certifies compliance with a statute or regulation, and the second is when the defendant is alleged to have "impliedly" certified compliance. *Escobar*, *supra*, at 1995. The Government appears to rely upon the "express" false certification theory in this case.[11]

a. The Complaint fails to allege "express" false certification.

To be "false" under the FCA, a representation must be "known to be false." *U.S. ex rel. Riley v. St. Luke's Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004) ("[A] lie is actionable but not an error."). According to the Seventh Circuit, a certification of compliance must also be "objectively false." *U.S. ex rel. Yannacopoulos v. Gen. Dynamics*, 652 F.3d 818, 836 (7th Cir. 2011) ("A statement may be deemed "false" for purposes of the [FCA] only if the statement represents 'an objective falsehood'") (citations omitted).

The Government's Complaint fails to allege that any of EMSA's certifications of AKS compliance were false (objectively or otherwise). First, the Government has failed to allege a

[11] The Complaint alleges that EMSA submitted paper claim forms to Medicare that certified compliance with the AKS from 1998 through 2005. Complaint at ¶¶ 48-49. Significantly, however, the Government does not specifically allege any express certifications of AKS compliance to Medicare *after* 2005, and, as explained above, all of the alleged payments, political contributions and gifts described in the Complaint occurred after 2005. While the Complaint generally alleges that, "[o]n various occasions, EMSA expressly certified AKS compliance in Medicare Enrollment Applications (Complaint at ¶ 46), it does not allege when these enrollment forms were submitted. Thus, the Complaint does not allege express certification for purposes of Rule 9(b), nor does it purport to rely upon "implied certification" as a basis for liability for claims submitted after 2005.

violation of the AKS in the first place. Second, the Complaint cites no statute, regulation, guideline, or policy stating that profit-cap agreements violate the AKS, such that EMSA knew or should have known it was falsely certifying AKS compliance. Third, the Government's own conduct shows that the legality of profit-cap agreements is at least an open question, since the Government chose not to intervene in this case against AMR for offering a nearly identical profit cap (but with even lower percentages) to EMSA in 2013. Relator's Complaint at ¶ 73. The Government cannot reasonably and plausibly allege that EMSA actually knew that its profit-cap agreement with Paramedics Plus violated the AKS, when the Government is not even suing EMSA for accepting an even more favorable profit-cap offer from AMR. Accordingly, EMSA's claims for reimbursement were not "false" under an express certification theory.[12]

b. The 2010 amendments to the AKS are not retroactive.

In 2010, Congress passed the Patient Protection and Affordable Care Act ("ACA"), which amended the AKS to state: "a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of [the FCA]." 42 U.S.C. § 1320a-7b(g). Some courts have found that the amendment incorporates "implied false certification" as a basis for FCA liability based upon AKS violations, such that a defendant can be liability under the FCA regardless of whether the defendant expressly certifies AKS

[12] The Complaint also fails to allege "implied certification" for claims submitted by EMSA before 2010. In *Escobar*, the Supreme Court recognized the implied certification theory when (i) a claim for payment makes *specific* representations about goods or services provided, (ii) the defendant has knowingly failed to disclose noncompliance with a material statutory, regulatory, or contractual requirement, and (iii) that omission renders the specific representations misleading. *See Escobar*, *supra*, at 1995, 2001. The Complaint alleges that EMSA's claims contained "the beneficiary's identifying information, including name and date of birth," as well as "a procedure code, . . . procedure modifier to identify origination and destination of transport, diagnostic code, place of service, and amount billed" (Complaint at ¶ 157), but the Complaint fails to explain how EMSA's failure to disclose alleged noncompliance with the AKS rendered those representations "misleading half-truths." The Complaint therefore fails to allege "implied certification" under *Escobar*. Since the Fifth Circuit has not recognized the implied certification theory, *Escobar* provides the only basis for alleging implied certification in this Circuit for claims submitted before 2010. *See U.S. ex rel. King v. Solvay S.A.*, 823 F. Supp. 2d 472, 505-07 (S.D. Tex. 2011).

compliance.[13] The Fifth Circuit has not addressed the scope of the 2010 amendment.

Although the impact of the 2010 amendment is unclear, one issue appears to be settled – the amendment does not apply retroactively. *See Graham County Soil & Water Conservation Dist. v. U.S. ex rel. Wilson*, 559 U.S. 280, 283 n.1 (2010) (finding that the ACA does not apply retroactively). Thus, for all claims submitted by EMSA prior to the 2010 amendment, the Government must show that EMSA misrepresented AKS compliance to the Government. Since neither EMSA nor Paramedics Plus violated the AKS, and since EMSA did not knowingly submit false certifications, the Government has not alleged that EMSA submitted "false" clams before the 2010 amendment.

c. Regardless, the Government has not alleged that EMSA's claims "resulted from" an AKS violation.

If anything, the 2010 amendment confirmed the necessity of a causal link between a kickback violation and a claim for reimbursement: "a claim . . . ***resulting from*** a violation . . . constitutes a false or fraudulent claim . . . ." 42 U.S.C. § 1320a-7b(g) (emphasis added); *see also Nunnally*, 519 Fed. App'x at 894-95; *Wall*, 2016 U.S. Dist. LEXIS 80160 at *83.

The Complaint does not show a causal nexus between any alleged payment, contribution or gift and a Medicare or Medicaid claim submitted by EMSA. While the Complaint states, in the introduction, that EMSA's Medicare and Medicaid claims "resulted from" alleged kickbacks, the Complaint includes no facts to substantiate this bare-bones allegation. Complaint at ¶ 15.

[13] Several federal district courts have determined that the amendment clarified, but did not change, earlier case law (but not Fifth Circuit case law) holding that AKS compliance is a "condition" of payment under an "implied certification" theory. *See, e.g., U.S. ex rel. Brown v. Celgene Corp.*, 2014 U.S. Dist. LEXIS 99815, *26 (C.D. Cal. July 10, 2014) (holding that AKS compliance was a condition of payment before the amendment and that "[t]he amendment merely clarified existing law; it did not change it"). However, at least one court has construed the amendment as applying only to the specific fact situation addressed in the amendment's legislative history. *See, e.g., U.S. ex rel. Kester v. Novartis Pharms. Corp.*, 41 F. Supp. 3d 323, 335 (S.D.N.Y. 2014) (finding that the amendment only applies in situations where AKS noncompliance causes an innocent party to submit a claim).

The Government must do more than recite the elements of its claim. *Iqbal*, 556 U.S. at 678-79.

In any event, the claims for Medicare and Medicaid reimbursement could not have "resulted from" an alleged kickback, because, as explained above, EMSA's services were dictated by unsolicited requests for care, and EMSA had a "Duty to Act" with respect to any person who called 911. OAC 310:641-3-120(b). Consequently, EMSA's claims for reimbursement could not have "resulted from" any alleged kickback. The Government has therefore failed to plead that EMSA submitted "false" claims under the 2010 amendment or under any other theory. Accordingly, the Government's FCA claim against Paramedics Plus under 31 U.S.C. § 3731(a)(1)(A) should be dismissed.

C. The Government fails to allege a claim under 31 U.S.C. § 3731(a)(1)(B).

The Government also fails to allege that Paramedics Plus "used or caused to be made or used false records or statements that were material" to EMSA's claims. Complaint at ¶ 172 (citing 31 U.S.C. § 3729(a)(1)(B)). The Government's Complaint fails to identify a specific "false statement or record" made or used by Paramedics Plus, let alone any specifics regarding who made such a statement or when it was made. The Complaint alleges – generally – that Paramedics Plus submitted Medicare Enrollment Forms (Complaint at ¶ 47), but the Complaint does not allege (or even suggest) that such forms were material to the Government's decision to pay EMSA's Medicare claims, nor does the Complaint identify who submitted the forms, when they were submitted, or any other information about the forms.

The Complaint also states that "ETMC and Paramedics Plus submitted false claims to EMSA under the ambulance services contract." Complaint at ¶ 156. Again, however, the Complaint does not identify any "false claims," nor does it describe when such claims were

submitted, who submitted them, or how they were submitted. The Complaint also does not show how such claims were allegedly "false." These vague allegations do not satisfy Rule 9(b).

The Complaint also fails to allege that Paramedics Plus knowingly caused EMSA to submit "false records or statements." 31 U.S.C. § 3729(a)(1)(B). The Complaint generally alleges that EMSA submitted "certification statements" regarding AKS compliance from 1998 through 2005 and that EMSA signed various Medicaid-related contracts in which it agreed to comply with federal statutes. *See* Complaint at ¶¶ 46-58. However, the Complaint does not allege that anyone at Paramedics Plus reviewed, approved, or in any way influenced EMSA's alleged certifications or its Medicaid contracts. *See, e.g., U.S. ex rel. Bennett v. Medtronic, Inc.*, 747 F. Supp. 2d 745, 781 (S.D. Tex. 2010) ("Because the relators have not alleged that Medtronic caused any hospital or physician to certify compliance with the anti-kickback statute, these allegations are dismissed."). Accordingly, the Government has failed to plead a claim against Paramedics Plus with particularity under 31 U.S.C. § 3729(a)(1)(B).

D. The Government has failed to allege a claim under 31 U.S.C. § 3729(a)(1)(C).

The Government has also failed to adequately plead a conspiracy under § 3729(a)(1)(C) of the FCA. To plead a conspiracy, the Government must allege (1) the existence of an unlawful agreement between defendants to violate the FCA and (2) at least one act performed in furtherance of that agreement. *See U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 193 (5th Cir. 2009). The Government must also demonstrate "that the defendants shared a specific intent to defraud the government," and the Government must plead these elements with particularity under Rule 9(b). *U.S. ex rel. Ramsey-Ledesma v. Censeo Health, L.L.C.*, 2016 U.S. Dist. LEXIS 135392, *41 (N.D. Tex. Sept. 30, 2016) (quoting *U.S. ex rel. Farmer v. City of Houston*, 523 F.3d 333, 343 (5th Cir. 2008)).

The Government's Complaint fails to plead any facts showing an unlawful agreement to submit false Medicare/Medicaid claims to the Government. The Complaint does not describe any agreement among the Defendants to defraud the Government, nor does the Complaint allege any specific acts in furtherance of such an agreement. Accordingly, the Government's conspiracy claim should also be dismissed. *See U.S. ex rel. DeKort v. Integrated Coast Guard Sys.*, 705 F. Supp. 2d 519, 548 (N.D. Tex. 2010) ("[T]he Court finds no allegations regarding an unlawful agreement among alleged coconspirators, nor allegations of any overt acts taken in furtherance of a conspiracy.")

V. THE GOVERNMENT'S COMMON LAW CLAIMS SHOULD ALSO BE DISMISSED.

In addition to its FCA claims against Paramedics Plus, the Government alleges common-law claims for fraud, unjust enrichment and mistake. *See* Complaint at ¶¶ 178-186. The Government also fails to plead sufficient facts supporting these claims.

A. The Government has failed to plead common-law fraud with particularity.

The elements of fraud are (1) a misrepresentation or omission; (2) of material fact; (3) made with the intent to defraud; (4) on which the plaintiff relied; and (5) which proximately caused the plaintiff's injury. *Williams v. WMX Techs.*, 112 F.3d 175, 177 (5th Cir. 1997). The Government's Complaint does nothing more than recite the elements of fraud as to Paramedics Plus. *See* Complaint at ¶¶ 19-181. The Complaint does not allege any actual damages resulting from fraud, which, as explained above, is fatal to the Government's fraud allegation. The Complaint also does not identify any misrepresentation made by Paramedics Plus, let alone the time, place and content of any such misrepresentation or the person who made it. Nor does the Complaint explain how any alleged misrepresentation was material to the Government's decision to pay Medicare or Medicaid claims, or how the Government purportedly relied on such

misrepresentations. Likewise, the Complaint does not allege any facts showing that Paramedics Plus intended to defraud the Government. Accordingly, the Government's common-law fraud claims should be dismissed. *See, e.g., Iqbal*, 56 U.S. at 678 ("Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice.").

B. The Government has failed to plead claims for mistake and unjust enrichment.

"Under the common-law theory of payment by mistake, the government may recover money it mistakenly, erroneously, or illegally paid from a party that received the funds without right." *U.S. v. Medica Rents Co.*, 2008 U.S. App. LEXIS 17946, *11-*12 (5th Cir. Aug. 19, 2008). Similarly, "[r]ecovery under unjust enrichment is justified when [the government] obtains a benefit from another by fraud, duress, or the taking of an undue advantage." *Id.*

The Government's mistake and unjust enrichment claims are premised upon Defendants' alleged violations of the AKS and FCA. Complaint at ¶¶ 184, 186. Since the Government has failed to allege violations of either statute, its common-law claims should also be dismissed.

Further, to plead a claim for mistake, the Government must show that it paid EMSA under "an erroneous belief that was material to [its] decision to pay." *U.S. ex rel. Heesch v. Diagnostic Physicians Group, P.C.*, 2014 U.S. Dist. LEXIS 71170, *32 (S.D. Ala. April 11, 2014) (quoting *U.S. v. Mead*, 426 F.2d 118, 124 (9th Cir. 1970)). As explained above, the Complaint does not sufficiently plead that use of a profit cap is material to the Government's decision to pay Medicare and Medicaid claims. Accordingly, Paramedics Plus respectfully requests that the Court dismiss the Government's mistake and unjust enrichment claims.[14]

[14] A plaintiff in an FCA action may plead alternative common law theories. FED. R. CIV. P. 8(d)(3). The Government's common law claims, however, are not alleged in the alternative as contemplated by Rule 8(d)(3), and should therefore be dismissed as insufficiently pleaded. Regardless, the Government cannot recover on both its FCA and common law claims and ultimately may receive only one recovery upon election of its remedy. *See Heesch*, *infra*, at *31 n.2.

REQUEST FOR ORAL HEARING

Pursuant to Local Rule CV-7(g) Defendant requests an oral hearing on this motion.

PRAYER

For the foregoing reasons, Paramedics Plus, LLC respectfully requests that the Court dismiss the Government's Complaint as to all claims against it with prejudice and also requests such other and further relief, at law or in equity, to which they may be entitled.

Date: March 27, 2016

Respectfully submitted,

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CERTIFICATE OF SERVICE

By my signature below, I do hereby certify that on March 27 2017, a true and correct copy of the foregoing Motion was filed using the Court's electronic filing system, which will provide notice to all parties of record, specifically:

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By: */s/ Otis W. Carroll*
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