IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE
AT KNOXVILLE

UNITED STATES OF AMERICA, *ex rel.* LEANN MARSHALL, and LEANN MARSHALL, INDIVIDUALLY, *Plaintiffs/Relators*, v. UNIVERSITY OF TN MEDICAL CENTER HOME CARE SERVICES, LLC, and LHC GROUP, INC., *Defendants*.	)))))))))))))	No. 3:17-CV-96 Judge Collier

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UNITED STATES OF AMERICA *ex rel.* VIB PARTNERS, *Plaintiff/Relator*, v. LHC GROUP, INC., *Defendant*.	))))))))))	No. 3:19-CV-84 Judge Collier

M E M O R A N D U M

Before the Court is a motion by Defendants, University of TN Medical Center Home Care Services, LLC ("UTMC"), and LHC Group, Inc. ("LHC"), to dismiss the claims of Relators, LeAnn Marshall and VIB Partners, pursuant to Rules 12(b)(1) and 12(b)(6) of the Federal Rules of Civil Procedure. (Doc. 46 in Case No. 3:17-CV-96 ("*Marshall*".[1]) Relators have responded in

[1] Unless otherwise noted, subsequent citations refer to *Marshall*, Case No. 3:17-CV-96.

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opposition to the motion to dismiss (Doc. 49), and Defendants have replied (Doc. 51). For the reasons set out below, the Court will **GRANT IN PART** and **DENY IN PART** Defendants' motion to dismiss (Doc. 46).

I. BACKGROUND

The Court first summarizes the relevant law regarding the False Claims Act and Medicare and then turns to the facts of this case.

A. The False Claims Act

The False Claims Act (the "FCA"), 31 U.S.C. §§ 3729, *et seq.*, imposes civil liability on persons and companies who defraud government programs.[2] For example, the FCA imposes civil liability for knowingly presenting or causing to be presented false or fraudulent claims to the United States Government for payment or approval. 31 U.S.C. § 3729(a)(1)(A). In addition, it is against the law for a person to knowingly make, use, or cause to be made or used, a false record or false statement that is material to a false or fraudulent claim. 31 U.S.C. § 3729(a)(1)(B). The FCA also imposes liability for knowingly employing a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government, commonly referred to as a "reverse" false claim. 31 U.S.C. § 3729(a)(1)(G). Those who violate the FCA are liable for civil penalties up to $10,000 and treble damages. 31 U.S.C. § 3729(a)(1).

To promote enforcement of the FCA, private individuals or organizations, called relators, can bring *qui tam* actions on behalf of the United States. 31 U.S.C. § 3730(b)(2). After the relator

[2] Tennessee has similar provisions under the Tennessee Medicaid False Claims Act. *See* Tenn. Code Ann. §§ 71-5-181, *et seq.*; Tenn. Code. §§ 4-18-101, *et seq.* Relator Marshall's original complaint asserted several claims under the Tennessee Medicaid False Claims Act (Doc. 2 ¶¶ 185–98), but these claims were not included in Relators' Consolidated Amended Complaint (*see* Doc. 40 ¶¶ 263–85). Accordingly, the State of Tennessee will be **DISMISSED** from this lawsuit, and the Clerk of the Court will be instructed to update the case caption accordingly.

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files a complaint, the United States has the option of intervening and conducting the litigation itself. 31 U.S.C. § 3730(b)(4)(B). If the United States opts not to intervene, the relator may proceed individually. 31 U.S.C. § 3730(c)(3). Successful relators are awarded a portion of the award ranging from ten to thirty percent depending on the relator's role in the case and whether the government chose to intervene. 31 U.S.C. § 3730(d). To protect whistleblowers, the FCA also includes an anti-retaliation provision to protect individuals who make efforts in furtherance of an action under the statute or to stop a violation of the FCA. 31 U.S.C. § 3730(h).

B. Medicare

The FCA applies to claims healthcare providers submit to Medicare, a government healthcare program for people over sixty-five years old. Medicare, as relevant here, includes three parts. Medicare Part A authorizes the payment of federal funds for hospitalization and post-hospitalization care, which includes home healthcare. 42 U.S.C. § 1395c–i-2. Medicare Part B authorizes the payment of federal funds for medical and other health services, including home healthcare and medical supplies. 42 U.S.C. § 1395(k), (i), (s). Medicare Part C authorizes the payment of federal funds to private "Medicare Advantage" organizations to manage the care of Medicare beneficiaries, including organizations that provide home healthcare services. 42 U.S.C. §§ 1395w-21, *et seq.*

Medicare beneficiaries who are homebound can receive certain medically necessary services at home. *See* 42 U.S.C. §§ 1395(f)(a)(2)(C), 1395n(a)(2)(A). The patients of home health agencies are referred for home health services by their physicians who are required to certify that the respective patients are under their care, that the physicians have established and will periodically review sixty-day plans of care, that the patients are homebound, and that the patients

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require one of the types of home health services that qualifies for Medicare. 42 C.F.R. § 484.205(a).

After receiving a patient referral, a home health agency is required to provide its own patient-specific, comprehensive assessment, called an Outcome and Assessment Information Set ("OASIS"). 42 C.F.R. § 484.55. During this initial assessment, the home health agency must determine the immediate care and support needs of the patient and, for Medicare patients, determine eligibility for home health benefits, which involves an assessment of their homebound status. *Id.* "The encoded OASIS data must accurately reflect the patient's status at the time of assessment." 42 C.F.R. § 484.20(b).

A sixty-day plan of care is called an "episode," and after each episode, a patient must be recertified to continue receiving funds from Medicare. To be recertified, the patient's physician must review and sign the patient's plan of care, making any necessary changes, and the home health agency must complete a new OASIS assessment and determine whether the patient is still eligible to receive home health services.

Home health agencies are not paid per service rendered; instead, Medicare pays them under a prospective payment system that provides a predetermined amount for the entire sixty-day episode. *See* 42 U.S.C. § 1395fff(a); 42 C.F.R. § 484.205(a). Adjustments are made to a standard national episode rate to account for the type of care the patient requires as well as the geographic location. *See* 42 U.S.C. § 1395fff(b)(4)(B), (C). These adjustments are made based on the OASIS forms, which are submitted to the government through a Medicare administrative contractor or fiscal intermediary for payment.

Medicare conditions payment on the physician's certification that the beneficiary is homebound and in need of skilled services. 42 C.F.R. § 409.41(b). Medicare also conditions

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payment on the beneficiary actually being homebound and actually needing skilled services. 42 C.F.R. § 409.41(c). Additionally, Congress has statutorily prohibited the payment of any Medicare claim for services that are not medically reasonable and necessary. 42 U.S.C. § 1395y(a)(1)(A).

Certain additional adjustments are made to the reimbursement rate, including Low Utilization Payment Adjustment ("LUPA"), a Therapy Threshold, and case mix. The reimbursement rate is subject to a LUPA when the home health agency visits the patient four or fewer times during a sixty-day episode. 42 C.F.R. §§ 484.205(a)(1), 484.230. In such a situation, Medicare will calculate its payment using a per-visit amount. *Id.* A Therapy Threshold is the opposite of a LUPA—when a home health agency reaches a certain number of visits during a given sixty-day episode, Medicare will increase the reimbursement paid on the patient's behalf. A case mix accounts for the health condition and resource use of each beneficiary, based on OASIS assessments, and a home health service receives a higher rate of reimbursement when its Medicare patients are sicker.

Since July 2015, the Centers for Medicare and Medicaid Services, an agency within the United States Department of Health and Human Services, has published quality ratings for home health agencies. The ratings are derived from OASIS assessments and claims data. Specifically, the patient-care rating considers OASIS data regarding patients' improvement since start of care or recertification. A higher star rating is likely when more patients score as having improved based on their OASIS assessments, and a higher rating generally results in more referrals to and patient interest in certain home health agencies.

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