IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

- -

UNITED STATES OF AMERICA,
STATE OF CALIFORNIA and
STATE OF MINNESOTA,

OPINION AND ORDER

Plaintiffs,[1]

08-cv-578-bbc

v.

SUPERVALU, INC.,

Defendant.

- -

This civil action relates to the process through which defendant SuperValu Inc. is reimbursed for filling prescriptions for individuals who are Medicaid recipients and also have private health insurance (these individuals are classified as "dual-eligible" patients). Plaintiffs contend that defendant billed or was reimbursed for more money from state Medicaid programs than it was entitled to recover.

This case was filed initially on October 1, 2008 by Jay Heidbreder, as relator on behalf of the United States, for defendant's alleged violations of the federal False Claims Act, 31 U.S.C. §§ 3729-32, and the analogous state false claim acts. (Heidbreder is now deceased

[1] I have removed the relator, Estate of Jay Heidbreder, from the caption in this case. The relator has no claims remaining in this case and is no longer a plaintiff.

and his estate has no claims remaining in this case.) After conducting an investigation into the relator's allegations for more than two years, the United States and the states of California and Minnesota filed a complaint in intervention on February 11, 2011 and an amended complaint on May 4, 2011. (In this opinion, I will refer to the intervenors collectively as "the government," and individually as the United States, California or Minnesota.)

On September 19, 2011, I granted a motion filed by defendant to dismiss the relator's claims in full, concluding that the relator's claims under the federal False Claims Act § 3729(a)(1) were superseded by the government's intervention and the remainder of the relator's claims did not satisfy the pleading requirements of Fed. R. Civ. P. 9(b).[2] I granted defendant's motion to dismiss the government's amended complaint in part, concluding that the United States' claims under the False Claims Act § 3729(a)(1), as well as California's and Minnesota's claims under their state false claims acts did not meet the requirements of Rule 9(b). I denied the motion to dismiss with respect to the United States' claims under §

[2] In May 2009, the Fraud Enforcement and Recovery Act recodifed the False Claims Act's liability provisions from 31 U.S.C. § 3729(a)(1)-(a)(7) to 31 U.S.C. § 3729(a)(1)(A)-(G) and made some changes to the False Claims Act's language. Pub. L. No. 111-21, § 4, 123 Stat. 1617, 1621-25 (2009). The majority of the conduct at issue in this case is governed by the prior version, although the government alleges a violation of subsection (a)(1)(G) of the current version. Pub. L. No. 111-21, § 4(f), 123 Stat. at 1625 (providing that changes to § 3729(a) apply only to conduct after May 20, 2009, with one exception that does not apply here). Accordingly, all references to the False Claims Act refer to the pre-amended version of the Act unless otherwise noted.

3729(a)(1)(G) (2009) of the False Claims Act, as well as its claims for unjust enrichment under federal common law. Finally, I denied the motion to dismiss Minnesota's claim for breach of contract. I gave the government and relator until September 29, 2011 to file amended complaints addressing the deficiencies identified by the court. After receiving one extension of time, the government filed a second amended complaint in intervention. The relator did not file a new complaint.

Now before the court is defendant's motion to dismiss all claims in the government's second amended complaint under Fed. R. Civ. P. 9 and 12(b)(6). After reviewing that complaint and the parties' arguments, I conclude that the United States has pleaded enough facts to satisfy the requirements of Rules 9 and 12(b)(6) with respect to its claims under § 3729(a)(1) (1986) and § 3729(a)(1)(G) (2009) of the False Claims Act relating to the state Medicaid programs in California, Minnesota, Massachusetts, Florida and Nevada. Additionally, the United States has stated a claim for unjust enrichment under federal common law related to defendant's retention of payments from those states. Finally, the states of California and Minnesota have pleaded enough facts to state claims under their false claim laws and Minnesota has stated a claim for breach of contract under Minnesota law. Therefore, I am denying defendant's motion to dismiss these claims. However, I am granting defendant's motion to strike the government's newly asserted claim that defendant violated the False Claims Act by submitting fraudulent claims for reimbursement for patients who were eligible for both Medicaid and Medicare Part D. The government added the

allegations and claims regarding Medicare Part D without seeking or obtaining leave of the court.

In resolving defendant's motion to dismiss, I have accepted as true all well-pleaded facts in the government's second amended complaint and drawn all reasonable inferences in its favor. A detailed recitation of the allegations of fact and legal framework relevant to the government's claims is provided in the September 19, 2011 order. Dkt. #104. Instead of repeating it in this opinion, I will set out only a brief overview of the government's allegations and claims and will refer to the new allegations pleaded in the government's second amended complaint as they become relevant.

Both sides have filed motions for judicial notice of certain public documents, including electronic pharmacy claim submission standards developed by the National Council for Prescription Drug Programs, state Medicaid payer sheets, state Medicaid plans and manuals prepared by state agencies. Dkt. ##110, 120, 124. As I explained in the September 19 order, these documents are subject to judicial notice because they are government publications, they are publicly available and they form the legal framework for the government's claims. Dkt. #104 at 6-8. Thus, for the reasons explained more fully in the September 19 order, I will grant the motions for judicial notice. As discussed below, however, taking judicial notice of these documents does not mean that I am accepting any party's interpretation of the contents of the documents or their relevance to the government's claims.

BACKGROUND

Defendant SuperValu, Inc. is a nationwide retail pharmacy that operates more than 800 pharmacies in at least 25 states. Its pharmacies participate in the federal Medicaid program, which is administered by state agencies under agreements with the United States government. Defendant seeks reimbursement from state Medicaid programs through a standardized electronic claims transmission process mandated by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and regulations promulgated pursuant to that Act. 42 U.S.C. §§ 1320d-1, 1320d-2(a)(1); 45 C.F.R. §§ 162.1102, 162.1802. In implementing these provisions, the Department of Health and Human Services adopted the "Telecommunication Standard" version 5.1 of the National Council for Prescription Drug Programs for electronic exchange of prescription information. 45 C.F.R. § 162.1102(a)(1).

The format developed by the National Council for Prescription Drug Programs provides detailed specifications for data elements, known as "fields." No one data field represents an invoice or request by a pharmacy to Medicaid for a specific amount of money, but there is a set of fields known as the "pricing segment," which allows the state Medicaid programs to process a pharmacy claim submission for payment. The pricing segment contains various fields, including a "Gross Amount Due" field, an "Other Amount Claimed Submitted" field and a "Usual and Customary Charge" field. From the nationally-mandated standard, states choose which fields to require pharmacies to use in their claims

transmissions. States set forth these requirements using documents known as "payer sheets," and also in provider manuals, regulations and other guidelines.

Some Medicaid recipients have health insurance coverage from private third-party insurers. These patients are referred to as "dual-eligible" beneficiaries or patients. Generally, private health insurance companies are able to obtain discounts and purchasing benefits for their customers by entering into private contracts with pharmacies. As a result, private insurance companies may purchase prescriptions at lower prices than state Medicaid agencies can. In some cases, the private insurance company pays for medications at a discounted rate and the patient pays a deductible or co-pay amount for each prescription. In many of the contracts defendant enters into with private insurance companies, defendant agrees to accept as "payment in full" the sum of the discounted rate and the patient's co-pay. In other words, rather than bill private insurance companies for its usual and customary charge for prescription medications, defendant bills the insurance company at a discounted rate.

Every state Medicaid program at issue in this case has issued regulations or other guidelines limiting reimbursement to providers for dual-eligible claims to the patient's own liability to the provider. In other words, state regulations direct agencies to reimburse providers only for the amount of the patient's co-pay that remains after the private insurance company has paid its required amount. The government contends that despite these limitations, defendant knowingly billed the state Medicaid programs for amounts in excess of the contracted rates it had negotiated with various insurers by submitting false or

misleading data in the pricing segment fields on its payer sheets. Allegedly, defendant submitted false numbers in the fields representing "Gross Amount Due," "Other Amount Claimed Submitted" and "Usual and Customary Charge."

In the second amended complaint, the United States and California also contend that defendant improperly billed the state Medicaid Programs of Florida and California for claims in which the Medicaid beneficiary was covered by a private carrier administering a Medicare Part D plan.

OPINION

To survive a motion to dismiss under Rule 12(b)(6), the government's second amended complaint must "contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" Ashcroft v. Iqbal, 556 U.S. 662, —, 129 S. Ct. 1937, 1949 (2009) (quoting Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 570 (2007)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." Id. Because the False Claims Act "is an antifraud statute," "claims under it are subject to the heightened pleading standards of Rule 9(b)." United States ex rel. Gross v. AIDS Research Alliance-Chicago, 415 F.3d 601, 604 (7th Cir. 2005). Rule 9(b) requires "the circumstances constituting fraud [to] be stated with particularity," which includes describing "the who, what, when, where, and how" of the alleged fraud. United States ex rel. Fowler v. Caremark

RX, LLC, 496 F.3d 730, 740 (7th Cir. 2007), overruled on other grounds by Glaser v. Wound Care Consultants, Inc., 570 F.3d 907 (7th Cir. 2009); Borsellino v. Goldmen Sachs Group, Inc., 477 F.3d 502, 507 (7th Cir. 2007).

A. Claims under 31 U.S.C. § 3729(a)(1) and Analogous State Statutes

The United States asserts a claim under the False Claims Act § 3729(a)(1) and the states of California and Minnesota assert claims under analogous state statutes. Cal. Gov't Code §§ 12651(a)(1), (a)(2), (a)(7), (a)(8); Minn. Stat. § 15C.01-02; Minn. Stat. § 256B.121. (Minnesota's claims under the Minnesota False Claims Act are limited to claims for reimbursement that defendant submitted after July 1, 2010, the date the statute took effect.)

To state a cause of action under 31 U.S.C. § 3729(a)(1), the United States must allege "(1) a false or fraudulent claim; (2) which was presented, or caused to be presented, by the defendant to the United States for payment or approval; (3) with the knowledge that the claim was false." Fowler, 496 F.3d at 741; see also § 3729(a)(1) (1986) (effective through May 20, 2009); id. § 3729(a)(1)(A) (effective after May 20, 2009). Under the False Claims Act, a person acts "knowingly" if he or she "(1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b). For purposes of a motion to dismiss, "[m]alice, intent, knowledge, and other conditions of

a person's mind may be alleged generally." Fed. R. Civ. P. 9(b); DiLeo v. Ernst & Young, 901 F.2d 624, 627 (7th Cir. 1990) ("[S]tates of mind may be pleaded generally.").

In the September 19 order, I concluded that I could not determine whether the government could state a claim under § 3729(a)(1) or the analogous state laws because the allegations supporting these claims were vague and did not satisfy the pleading requirements of Rule 9(b). In particular, the government had not identified any specific information defendant had submitted to state Medicaid agencies, let alone what aspect of defendant's submissions was "false" within the meaning of the False Claims Act. Instead, the complaint consisted of conclusory statements about how defendant had "misrepresented" the amount to which it was entitled to receive payment from Medicaid. Additionally, although the United States contended that defendant violated § 3729(a)(1) by failing to disclose patient co-pay information to state Medicaid agencies through some medium that complied with state and federal law, the United States had not alleged where the omitted information should have appeared, when defendant should have disclosed this information or how the failure to disclose resulted in a false claim.

The government explains its theory of liability more clearly in its second amended complaint, alleging that defendant submitted false and misleading information on its payer sheets when requesting reimbursement for dual-eligible claims from state Medicaid agencies. First, the government cites state Medicaid regulations that prohibit reimbursement for dual-eligible claims in excess of the patient's liability to the Medicaid provider. Plts.' Sec. Am.

Cpt., dkt. #107, at ¶¶ 38, 39, 43, 44 (1998 Medi-Cal Provider Manual; 1999 Medi-Cal Billing Bulletin); ¶¶ 58-61 (Fla. Admin. Code § 59G-4.250(2); § 59G-7.056; Fla. Medical General Provider Handbook, § 1-13); ¶¶ 71-74 (Mass. Code Regs. § 450.317); ¶¶ 85-88 (Minn. Stat. § 256B.0625; Minn. Health Care Programs Provider Manual, "Third Party Liability"); ¶¶ 95-96 (Nev. Medicaid Services Manual, §§ 103-04).

Additionally, the government alleges that the state payer sheets and pharmacy claim submission guidance issued by the state Medicaid programs in California, Florida, Massachusetts, Minnesota and Nevada instructed Medicaid providers to bill the state Medicaid programs in a way that would allow the states to reimburse providers only for the dual-eligible patients' liability. Id. at ¶¶ 46-49 (California); ¶ 62 (Florida); ¶¶ 75-78 (Massachusetts); ¶¶ 87, 89-91 (Minnesota); ¶¶ 97-98 (Nevada). For example, when submitting requests for reimbursement of dual-eligible claims to Medi-Cal in California, providers are instructed to enter the contracted rate they accepted as "payment in full" from the private insurer in the "Gross Amount Due" field and the amount paid by the primary insurer in the "Other Payer Amount Paid" field. If providers follow these instructions, Medi-Cal can calculate the co-pay amount that is owed to the provider. Plts.' Sec. Am. Cpt., dkt. #107, at ¶¶ 46-49. In Florida, providers are instructed to enter the rate they agreed to under their contracts with private insurers in the "Usual and Customary Charge" field and the amount that the third party actually paid in the "Other Payer Amount" field. Florida's Medicaid system then calculates the difference that is owed to the provider. Id. at ¶ 62.

Minnesota Medical Assistance provides three separate ways that providers can submit claims that allow Minnesota to reimburse them only for the amount of the dual-eligible patient's liability. First, providers can use "Other Coverage Code 08" for billing co-pay-only claims; enter a qualifier in the "Other Amount Claimed Submitted" field; or enter the patient's liability in the "Gross Amount Due" field. Alternatively, Minnesota allows providers to submit the discounted rate they agreed to charge private insurers in the "Usual and Customary Charge" field. Finally, since at least 2004, Minnesota has allowed providers to bill for a dual-eligible patient's liability by inserting a qualifier of "99" in the "Other Amount Paid Qualifier" field and by including the patient's liability in the "Other Payer Amount Paid" field. Id. at ¶¶ 87, 89-91. See also id. at ¶ 76 (procedures in Massachusetts); ¶¶ 97-98 (procedures in Nevada).

The government alleges that defendant was aware that reimbursement for dual-eligible claims was limited to the patient co-pay amount and that defendant knew there were various options for submitting dual-eligible claims that would result in accurate compensation. In addition, in 2007 and 2008, the Minnesota's Department of Human Services notified several of defendant's pharmacies and defendant's corporate officers that defendant might have received overpayments from the state Medicaid agency. Defendant allegedly refused to cooperate with the agency during the investigation and did not respond to the agency's warning that defendant should have been compensated only for the patient's co-pay amount and not for defendant's usual and customary charge. Nonetheless, instead of heeding the

warnings of the department and following the instructions provided by the state Medicaid programs, defendant allegedly failed to acknowledge reduced contract rates in its reimbursement requests, entered inflated numbers in the "Gross Amount Due" or "Usual and Customary Charge" fields and did not disclose the patient's actual co-pay liability to the state Medicaid programs. By omitting this data, defendant allegedly received reimbursements in excess of what it was entitled to receive.

By providing these detailed allegations in its second amended complaint, the government has addressed the deficiencies raised in the September 19 order. The government has alleged that defendant knowingly submitted false and fraudulent claims to the United States for payment, via the state Medicaid agencies. Additionally, the government has satisfied the requirements of Rule 9(b) by identifying specific examples in its second amended complaint of alleged false claims submitted to California, Minnesota, Massachusetts, Florida and Nevada and explaining what aspects of those claims are false and misleading.

Defendant contends that despite these detailed allegations, the government has failed to state a claim under § 3729(a)(1) or the state laws of California and Minnesota for two primary reasons: (1) defendant's claims for reimbursement were not false or fraudulent under the governing state and federal laws; and (2) even if its claims were false, defendant lacked the requisite scienter required under the federal and state false claim acts because it relied on a reasonable interpretation of inadequate claim submission guidance. Defendant

relies on the principle that false claims cannot arise from "imprecise statements or differences in interpretation growing out of a disputed legal question . . . ." United States ex rel. Lamers v. City of Green Bay, 168 F.3d 1013, 1018 (7th Cir. 1999). See also United States ex rel. Quinn v. Omnicare Inc., 382 F.3d 432, 434, 437, 445 (3d Cir. 2004) (pharmacy's failure to credit Medicaid for value of returned medications did not violate False Claims Act because Medicaid regulations did not clearly "instruct pharmacies on how to credit or adjust a claim for medications after those medications have been returned for recycling"); Hagwood v. Sonoma County Water Agency, 81 F.3d 1465, 1477 (9th Cir. 1996) (holding that applicable "statute's imprecise and discretionary language" created disputed legal issue that could not support finding of falsity as matter of law); United States v. Medica Rents Co., 2008 WL 3876307, *3 (5th Cir. Aug. 19, 2008) (holding that use of incorrect billing code in seeking Medicare payments was not false claim because of "substantial confusion created by contradictory instructions and guidance" with respect to use of codes); United States ex rel. Colucci v. Beth Israel Medical Center, 785 F. Supp. 2d 303, 316 (S.D.N.Y. 2011) ("given the lack of clarity in the law, it cannot be said that defendants 'knew' the claims were false"); United States ex rel. Raynor v. Natural Rural Utilities Cooperative Finance Corp., 2011 WL 976482, *9 (D. Neb. Mar. 15, 2011) (dismissing claims because relator's allegations relied on nothing "more than imprecise statements or differences in interpretation of disputed or unclear legal question, neither of which are false claims"); United States v. Sodexho, Inc., 2009 WL 579380, *17 (E.D. Pa. Mar. 6, 2009) (dismissing

claims and holding that "lack of clarity regarding the proper interpretation of the regulations indicates that no basis exists for imposing FCA liability on Defendants, who merely adopted a reasonable interpretation of the regulatory requirements") (citing Lamers); United States ex rel. Englund v. L.A. County, 2006 WL 3097941, *11 (E.D. Cal. Oct. 31, 2006) ("Claims are not 'false' under the FCA when reasonable persons can disagree regarding whether the service was properly billed to the Government.") (citing Lamers).

In support of its arguments, defendant urges the court to adopt its proposed interpretation of the standards set by the National Council for Prescription Drug Programs, as well as state regulations, provider manuals and state payer sheets. Doing so would allow defendant to show that it would have been impossible for it to comply both with state requirements and national standards, which it categorizes as ambiguous, contradictory and invalid under state and federal requirements.

For example, defendant contends that the California instructions are ambiguous and unenforceable because the are contradicted by other regulations and instructions issued by Medi-Cal, they apply only to paper submissions and they amount to invalid "underground" regulations because they were not subject to proper notice and comment rulemaking required by California's Administrative Procedures Act. Similarly, defendant contends that the Florida, Minnesota, Massachusetts and Nevada instructions for claim submission cited in the government's complaint are contradicted by other state requirements and apply only to paper submissions or submissions by non-pharmacy providers. Further, defendant contends

that to the extent any of the state payer sheets allowed or instructed defendant to enter a contracted or reduced rate in the "Gross Amount Due" field or the "Usual and Customary Charge" field or instructed defendant to enter the dual-eligible patient's liability in the "Other Payer Amount Paid" field, the payer sheets conflicted with the standards set by the National Council for Prescription Drug Programs for these fields and are preempted.

Defendant also contends that all of the state regulations on which the government relies are invalid because none of the state Medicaid programs at issue sought or received permission from the Centers for Medicare and Medicaid Services to limit reimbursement to providers of dual-eligible patient claims, as required by 42 C.F.R. § 430.12(c). Under this regulation, state Medicaid programs must submit "material changes" to the operation of the state Medicaid program to the Centers for Medicare and Medicaid Services for approval.

The government responds to each of defendant's arguments, challenging defendant's interpretation of the state Medicaid provider manuals, payer sheets and the standards set by the National Council for Prescription Drug Program and providing its own interpretation of the relevant documents. After reviewing the arguments presented by both sides, I conclude that the parties' disputes regarding the validity and requirements of the various manuals, rules, charges and other documents cannot be resolved in the context of a motion to dismiss.

First, several of defendant's arguments rely on facts outside the complaint that are not subject to judicial notice, such as defendant's arguments that certain California regulations

were not subject to proper notice and comment rulemaking or that state Medicaid agencies have not sought approval from the Centers for Medicare and Medicaid Services regarding the state reimbursement limitations for dual-eligible patient claims. The government's second amended complaint contains no allegations regarding whether the state Medicaid programs have sought permission from the Centers for Medicare and Medicaid Services to limit reimbursement for dual-eligible patient claims or whether California's Medicaid provider manual was subject to the appropriate notice and comment requirements.

Additionally, both sides are relying on technical instructions, charts, criteria, bulletins, manuals, orders and regulations issued by the state Medicaid agencies and the National Council for Prescription Drug Programs as evidence to support their respective positions. However, they disagree about the meaning of these various documents and regulations and whether they applied to defendant at any particular time. Although I have taken judicial notice of the existence of these regulations, provider manuals, payer sheets and other documents, defendant's motion to dismiss asks the court to draw several inferences about the meaning and import of these documents. Unfortunately, neither side has provided the court a straightforward, clear presentation of the various documents at issue and how they interact with and affect each other. Rather, each side focuses on the portions of particular regulations, instructions and documents that support its respective position. If defendant had raised its arguments in the context of a motion for summary judgment, the parties would have been forced to propose and respond to specific proposed findings of fact regarding the

various documents at issue. Under the present circumstances, however, the parties' approaches make it impossible to determine whether the government's or defendant's interpretations of the documents are correct.

Because this case is before the court on defendant's motion to dismiss, I must draw all reasonable inferences in favor of the government. In its second amended complaint, the government alleges that defendant was not entitled to be reimbursed for more than the co-pay amount for dual-eligible patients, that there were clear methods for defendant to properly submit reimbursement claims and that these methods were consistent with the national standards. In addition, the government's allegations permit the drawing of a plausible inference that defendant knew that it was submitting false information on its reimbursement claims, or at least that defendant acted with reckless disregard to the accuracy of the information on its claims. At the pleading stage, these allegations are sufficient to state a plausible claim under 31 U.S.C. § 3729(a)(1) and the analogous statutes of California and Minnesota. Therefore, I am denying defendant's motion to dismiss these claims.

B. Claims under 31 U.S.C. § 3729(a)(1)(G)

The United States also brings claims under the "reverse false claim" provision of the statute, 31 U.S.C. § 3729(a)(1)(G), which was established by the Fraud Enforcement and Recovery Act of 2009. (The United States has explained that its claims under this provision

are limited to overpayments received by defendant on or after May 20, 2009 to the present.) Under this provision, the United States is not required to show that defendant "presented" a false claim to it. Instead, the United States can state a claim under § 3729(a)(1)(G) by pleading that defendant "knowingly conceal[ed] or knowingly and improperly avoid[ed] or decreas[ed] an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1)(G). The term "obligation" includes "an established duty, whether or not fixed, arising from . . . the retention of any overpayment." 31 U.S.C. § 3729(b)(3).

The United States contends that defendant violated this provision by knowingly concealing or knowingly and improperly avoiding its obligation to report and repay overpayments it had received from the state Medicaid programs. These state programs received funding from the United States and are required to account to the United States for money received through third-party reimbursement. Thus, the United States was allegedly harmed by defendant's allegedly unlawful withholding of money from the state Medicaid programs.

Defendant contends that the United States' claims under this provision should be dismissed for some of the same reasons defendant argued that the § 3729(a)(1) should be dismissed. In particular, defendant argues that none of the state Medicaid programs at issue sought or obtained permission from the Centers for Medicare and Medicaid Services to limit reimbursement for dual-eligible patient claims as required by 42 C.F.R. §§ 433.137-39. Additionally, defendant contends, with respect to California, the manual provision on which

the United States' theory of liability is based is invalid under the California Administrative Procedures Act because it was not adopted pursuant to notice and comment rulemaking requirements.

As discussed above, these arguments rely on facts outside the complaint and cannot be resolved at this stage. Defendant can make these arguments in the context of a motion for summary judgment. At this stage, I will deny defendant's motion to dismiss the United States' claims under § 3729(a)(1)(G).

C. Unjust Enrichment

In the alternative to its claims under the False Claims Act, the United States has raised federal common law claims for unjust enrichment, contending that defendant was unjustly enriched at the expense of the United States by wrongfully retaining overpayments made by the state Medicaid programs. The elements of federal common law unjust enrichment are that (1) the United States had a reasonable expectation of payment; and (2) the defendant should reasonably have expected to pay; or (3) "society's reasonable expectations of person and property would be defeated by nonpayment." Harris Trust & Savings Bank v. Provident Life & Accident Insurance Co., 57 F.3d 608, 615 (7th Cir. 1995); United States ex rel. Williams v. Renal Care Group, 2010 WL 1062634, *11 (M.D. Tenn. Mar. 22, 2010); United States v. Rogan, 459 F. Supp. 2d 692, 728 (N.D. Ill. 2006).

Defendant argues that the United States' unjust enrichment claims should be

dismissed because the United States had no reasonable expectation of payment and defendant had no reason to think it would have to pay the United States. Once again, defendant is relying on its own interpretation of complex claim submission instructions and documents. In order to accept its arguments, I would be required to adopt defendant's interpretation of documentary evidence and resolve ambiguities in those documents in its favor. However, if I draw all reasonable inferences in favor of the United States, as I must at this stage of the proceedings, I conclude that it has easily stated a claim for unjust enrichment. The United States alleges that state Medicaid agencies, and ultimately the United States Treasury, overpaid defendant for dual-eligible claims. Because defendant was not entitled to all of the money it received, the United States has a reasonable expectation of repayment and defendant should expect to be required to refund it.

Because the United States has stated a claim for unjust enrichment under federal common law, I am denying defendant's motion to dismiss that claim.

D. Minnesota's Claim for Breach of Contract

Minnesota has asserted a claim for breach of contract against defendant, contending that defendant breached its provider agreement by failing to submit accurate claims to Minnesota's Medicaid agency and retaining funds in excess of what it was entitled to. Sec. Am. Cpt., dkt. #107, ¶¶ 212-15. These allegations are sufficient to state a claim for breach of contract under Minnesota law, which requires a plaintiff to plead only "(1) the formation

of a contract, (2) the performance of conditions precedent by the plaintiff, and (3) the breach of the contract by the defendant." Thomas B. Olson & Assocs., P.A. v. Leffert, Jay & Polglaze, P.A., 756 N.W.2d 907, 918 (Minn. Ct. App. 2008).

However, defendant contends that Minnesota's breach of contract claim should be dismissed for failure to state a claim under Rule 12(b)(6) because complying with the provider agreement would have required defendant to violate federal law and particularly, the standards set by the National Council for Prescription Drug Programs. However, if I accept Minnesota's allegations as true, defendant had multiple options for submitting claims that would have allowed it to comply with both the provider agreement and federal standards. Moreover, as I explained in the September 19 order in which I rejected a similar argument raised by defendant, Minnesota was not required to plead around defendant's affirmative defense that it could not comply both with the agreement and federal standards. Dkt. #104 at 39. Defendant can raise this affirmative defense at summary judgment or trial. Accordingly, I am denying defendant's motion to dismiss Minnesota's breach of contract claim.

E. Medicare Part D Claims

In its second amended complaint, the government alleges that defendant violated the False Claims Act and analogous state statute by improperly billing state Medicaid programs for claims in which patients had coverage under Medicare Part D. Sec. Am. Cpt., dkt. #107,

¶ 110. The government's previous complaints contained no allegations or claims involving Medicare Part D. Defendant has moved to strike these new allegations, contending that the government did not receive permission to amend its complaint and add new claims.

The court's September 19, 2011 order permitted the government to file an amended complaint solely to "address[] the deficiencies identified in this opinion." Dkt. #104 at 46. It did not grant the government permission to add wholly-new claims that were not previously before the court and that were not addressed in the September 19 order. Before asserting any new claims, the government was required by Fed. R. Civ. P. 15(a)(2) and the court's scheduling order, dkt. #95, to seek leave of the court. The government violated these procedures by adding allegations and claims to its second amended complaint related to defendant's alleged improper billing related to Medicare Part D without requesting or obtaining leave of the court. Further, I am not persuaded by the government's argument that it has not added new "claims," but merely factual allegations supporting its original claims for violations of §§ 3729(a)(1) and (a)(1)(G) of the False Claims Act and the California False Claims Act. The government's new allegations are not grounded upon the same claims for reimbursement as the prior allegations, but arise from claims for reimbursement for different payers, different patients and allege different obligations on defendant's part.

This case has been pending for more than three years and the government intervened in this case more than one year ago. Although the case has not progressed beyond the

motion to dismiss stage, the government has had ample time to consider which allegations and claims it should assert in this case. I will not permit either side to amend their pleadings to add new claims and allegations at this stage. Accordingly, I am granting defendant's motion to strike the government's allegations regarding Medicare Part D.

ORDER

IT IS ORDERED that

1. Defendant SuperValu, Inc.'s motions for judicial notice, dkt. ##110, 124, are GRANTED.

2. The motion for judicial notice filed by intervenors the United States, California and Minnesota, dkt. #120, is GRANTED.

3. Defendant's motion to dismiss the second amended complaint in intervention, dkt. #108, is GRANTED IN PART and DENIED IN PART. Defendant's motion to dismiss the intervenor's claims and allegations related to reimbursement claims for Medicare Part D eligible patients is GRANTED. Defendant's motion to dismiss is DENIED in all other respects.

Entered this 21st day of March, 2012.

BY THE COURT:
/s/
BARBARA B. CRABB
District Judge