IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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UNITED STATES OF AMERICA,
STATE OF CALIFORNIA and
STATE OF MINNESOTA and
ESTATE OF JAY HEIDBREDER,
individually and as Relator for
UNITED STATES OF AMERICA,
STATE OF FLORIDA,
COMMONWEALTH OF MASSACHUSETTS,
STATE OF NEW HAMPSHIRE,
STATE OF NEVADA,
STATE OF RHODE ISLAND,

OPINION AND ORDER

Plaintiffs,

08-cv-578-bbc

v.

SUPERVALU, INC.,

Defendant.

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

was entitled to recover.

Jay Heidbreder filed this action under seal on October 1, 2008, bringing claims on behalf of the United States against defendant SuperValu under the federal False Claims Act, 31 U.S.C. §§ 3729-32, and the analogous state false claim acts. (Heidbreder is now deceased and has been replaced by his estate.) 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. (In this opinion, I will refer to the intervenors collectively as "the government," and individually as the United States, California or Minnesota, and will refer to Heidbreder's estate as the "relator.")

The government intervenors filed an amended complaint on May 4, 2011, contending that defendant SuperValu submitted inflated claims for prescription reimbursement to the Medicaid programs administered by the states of California, Florida, Massachusetts, Minnesota, Nevada, New Hampshire and Rhode Island. In addition, the government contends that defendant knowingly and improperly avoided an obligation to return overpayments received from the Medicaid programs. The government's claims arise under the federal False Claims Act, 31 U.S.C. § 3729, the California False Claims Act, Cal. Gov't Code § 12651, the Minnesota False Claims Act, Minn. Stat. § 15C.02, the Minnesota treble damages statute, Minn. Stat. § 256B.121, and common law. The relator filed a third amended complaint on May 23, 2011, raising claims under the Federal False Claims Act and

the false claims acts of several states.

(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, unless otherwise noted, refer to the pre-amended version of the Act.

Now before the court are defendant's motion to dismiss the government's amended complaint in intervention, dkt. #79, and the relator's third amended complaint, dkt. #85, for failure to state a claim upon which relief may be granted and for failure to plead claims of fraud with particularity. The court has jurisdiction over the False Claims Act claims under 31 U.S.C. § 3732(a), and over the state law claims under § 3732(b), which confers jurisdiction to federal courts over state law claims arising from the same transactions or occurrences as the federal claims.

After considering the allegations of the complaints, the applicable state and federal laws and the parties' arguments, I am granting defendant's motion to dismiss the

government's amended complaint in intervention in part and denying it in part. I am granting the motion to dismiss the United States' claims under the False Claims Act § 3729(a)(1) (1986), as well as California's and Minnesota's claims under their state false claims acts for the government's failure to plead defendant's alleged fraud with particularity as required by Fed. R. Civ. P. 9(b). I am also granting the motion to dismiss the United States' claims under the False Claims Act involving the states of Florida, Massachusetts and Rhode Island, for failure to plead any specific instances of false claims or overpayments occurring in these states. I am denying the motion to dismiss the United States' claims under § 3729(a)(1)(G) (2009) of the False Claims Act, as well as the motion to dismiss the United States' federal common law claim for unjust enrichment. Finally, I am denying the motion to dismiss Minnesota's claim for breach of contract.

With respect to defendant's motion to dismiss the relator's third amended complaint, I conclude that the motion must be granted in full. The relator's claims under § 3729(a)(1) (1986) are superseded by the government's intervention in this case and the remainder of the relator's claims do not satisfy the pleading requirements of Rule 9(b).

In resolving defendant's motions to dismiss, I have accepted as true all well-pleaded facts in the government's and relator's complaints and drawn all reasonable inferences in their favor. (The allegations in both complaints are substantially similar.) Additionally, I have considered the documents attached to defendant's motion to dismiss the government's

complaint. These documents include electronic pharmacy claim standards developed by the National Council for Prescription Drug Programs, state Medicaid payer sheets and manuals prepared by state agencies. (Defendant has filed a motion for judicial notice, dkt. #82, in which it asks the court to consider these documents in deciding its motion to dismiss. As discussed below, the government opposes the motion and contends that the documents should not be considered.)

Although it is not customary to consider extrinsic evidence when deciding a motion to dismiss, courts have some leeway to consider documents attached to a motion to dismiss without converting the motion into one for summary judgment under Fed. R. Civ. P. 12(d). Courts may consider documents that are undisputedly authentic and central to the plaintiff's claim. Tierney v. Vahle, 304 F.3d 734, 738 (7th Cir. 2002). Additionally, they may take judicial notice of undisputed matters within the public record. Adkins v. VIM Recycling, Inc., 644 F.3d 483, 493 (7th Cir. 2011); Pugh v. Tribune, 521 F.3d 686, 691 n.2 (7th Cir. 2008) (court may take judicial notice of documents in public record, including publicly reported stock prices, without converting motion to dismiss into motion for summary judgment); 520 South Michigan Ave. Associates, Ltd. v. Shannon, 549 F.3d 1119, 1138 n.14 (7th Cir. 2008) (court may take judicial notice of "historical documents, documents contained in the public record, and reports of administrative bodies"); Laborers' Pension Fund v. Blackmore Sewer Construction, Inc., 298 F.3d 600, 608 (7th Cir. 2002) (courts may

take judicial notice of "information readily available in the public domain"). This exception allows courts to avoid unnecessary proceedings when an undisputed fact in the public record establishes that the plaintiff cannot satisfy the 12(b)(6) standard. General Electric Capital Corp. v. Lease Resolution Corp., 128 F.3d 1074, 1081 (7th Cir. 1997); see also Tellabs, Inc. v. Makor Issues & Rights, Ltd., 551 U.S. 308, 322 (2007) ("[C]ourts must consider the complaint in its entirety, as well as other sources courts ordinarily examine when ruling on Rule 12(b)(6) motions to dismiss, in particular, documents incorporated into the complaint by reference, and matters of which a court may take judicial notice.").

In this case, the documents attached to defendant's motion to dismiss are subject to judicial notice. The National Council for Prescription Drug Programs Standard (dkt. #80, Exh. A), Implementation Guide (dkt. #80, Exh. B), Q&A (dkt. #80. Exh. D), and Payer Sheet (dkt. #97-2), are subject to judicial notice because they were created under authority delegated by Congress and are publicly available. In particular, in the Health Insurance Portability and Accountability Act of 1996, Congress directed the Department of Health and Human Services to develop a nationwide standard for the submission of electronic healthcare claims. 42 U.S.C. § 1320d-1. Congress then delegated the responsibility for electronic pharmacy claims to the National Council for Prescription Drug Programs, the designated "standard setting organization" under the Act. Id. §§ 1320d(8), 1320d-1(c). The council developed the Implementation Guide, which was adopted by the Department of Health and

Human Services, 45 C.F.R. §§ 162.1102, 162.1802, and was subsequently incorporated into the Federal Register at 45 C.F.R. § 162.920. The other documents, including the Standard, Data Dictionary, Q&A, and Payer Sheet, were incorporated into the Implementation Guide by reference. Because this information has been incorporated in the Federal Register, it is subject to judicial notice. 44 U.S.C. § 1507 ("The contents of the Federal Register shall be judicially noticed. . . ."); Mora v. Vasquez, 199 F.3d 1024, 1028, n.7 (9th Cir. 1999) (judicially noticing United States Postal Service's Domestic Mail Manual, which was incorporated by reference into Federal Register).

Additionally, the state Medicaid payer sheets and related guidance are judicially noticeable because they are government publications and publicly available online on government agency and government contractor websites. Dft.'s Rep. Br., dkt. #97, at 12-13 (listing websites on which manuals and guidelines are publically accessible). Courts regularly take judicial notice of government agency publications, including manuals and other records pertaining to Medicaid and Medicare. E.g., McGRX, Inc. v. Vermont, 2011 WL 31022, *1, n.1 (D. Vt. Jan. 5, 2011) (taking judicial notice of Centers for Medicare and Medicaid Services document regarding Vermont's state Medicaid plan); Cota v. Maxwell-Jolly, 688 F. Supp. 2d 980, 998 (N.D. Cal. 2010) (taking judicial notice of record of California Department of Health Services); Wall v. Leavitt, 2008 WL 4737164, *14, n.27 (E.D. Cal. Oct. 29. 2008) (taking judicial notice of Centers for Medicare and Medicaid Services'

Secondary Payments Manual).

The government objects to the court's consideration of these documents, arguing that in deciding whether the government has stated a claim against defendant for violation of the state Medicaid requirements, the court should examine only the allegations in the amended complaint and only those portions of state provider manuals or publications that it referred to specifically in its amended complaint. In addition, the government contends that it is disputed whether defendant complied with the state Medicaid requirements and thus, the court cannot consider the documents as evidence of defendant's compliance.

The government provides no persuasive reason why the documents at issue should not be considered. Although it argues that the documents have not been authenticated, it does not point to any inaccuracies in the documents provided by defendant and does not deny that the exhibits provided by defendant can be verified by comparing them to publicly available versions. In addition, although I agree with the government that I cannot decide at this stage whether defendant complied with state claims submission requirements, that does not mean that I cannot consider the exhibits for the purpose of determining what those requirements are. The exhibits provided by defendant constitute a significant portion of the legal framework implicated by the government's claims and allegations. As the government alleges in the amended complaint, defendant was "required to comply with federal law, as well as state law, regulations, provider manuals, and/or other guidance applicable to Medicaid

providers governing the appropriate billing of prescription claims for Dual-eligible Beneficiaries that were promulgated by individual State Medicaid Programs." Am. Cpt., dkt. #76, ¶ 23.

In deciding whether the government has stated a claim, it is necessary to take into account the entire law surrounding claims submission, not just the select statutes and regulations that the government chose to cite explicitly in its amended complaint. Therefore, I will grant defendant's motion for judicial notice and consider the exhibits attached to defendant's motion to dismiss.

ALLEGATIONS OF FACT

A. The Parties

Former relator Jay Heidbreder was a pharmacist and pharmacy manager for defendant SuperValu in Minnesota. He died on November 8, 2010, and his brother, plaintiff Todd Heidbreder, was appointed personal representative of his estate. Todd Heidbreder is a United States citizen and brings this action on behalf of the estate of Jay Heidbreder and on behalf of the United States Government as a relator.

Defendant SuperValu, Inc. is a nationwide retail pharmacy corporation headquartered in Eden Prairie, Minnesota. It operates more than 800 pharmacies in at least 25 states. Its pharmacies participate in the federal Medicaid program in the states in which their

pharmacies are located, filling prescriptions for low income individuals.

B. Claims for Medicaid Reimbursement

The Medicaid program is administered by state agencies under agreements with the United States government. Funding for federal Medicaid programs usually is shared equally between the federal government and the states, although the percentage can vary from state to state, depending on economic conditions within the state.

Under federal law, states must impose certain obligations on individuals and entities that furnish services to Medicaid recipients. The obligations of providers are set out in a body of state laws, regulations, manuals and other documents, as well as provider agreements entered into between state Medicaid agencies and providers, through which providers submit claims for reimbursement. 42 U.S.C. § 1396a(a)(27). The states implement and control the claims transmission process and calculate the reimbursement rates for each claim in reliance on their own statutes, regulations and billing procedures. As a participating provider in the Medicaid program, defendant must comply with all federal and state statutes, rules, regulations, guidance and provider manuals relating to the Medicaid program, including state rules for claims transmissions.

Pharmacies such as defendant seek 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) (requiring Secretary of Health and Human Services to "adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically"); 45 C.F.R. §§ 162.1102, 162.1802. In implementing these provisions, the Secretary adopted the "Telecommunication Standard" version 5.1 of the National Council for Prescription Drug Programs. 45 C.F.R. § 162.1102(a)(1).

Pharmacies are required to use this standard for all claims submissions to all health plans, including all state Medicaid programs. Id. The format developed by the National Council for Prescription Drug Programs provides detailed specifications for data elements, known as "fields." From this 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," which may not necessarily include all possible fields in the council's version 5.1 payer sheet. No one data field represents an invoice or request by a pharmacy to Medicaid for a specific amount of money. Rather, once the state Medicaid program receives the data, it uses the data to calculate the amount of reimbursement due to the pharmacy according to state payment schedules and limitations.

C. Dual-Eligible Patients

Some Medicaid recipients also have health insurance coverage from private third-party insurers. These patients are referred to as "dual-eligible" beneficiaries or patients. When dual-eligible patients apply for benefits from a state agency that administers Medicaid, they are required to assign to the state their right to receive payment from their health insurance plans or other liable third-parties. 42 U.S.C. § 1396k(a)(1)(A); 42 C.F.R. § 433.145. States must coordinate benefits between the Medicaid program and private insurance plans. Because Medicaid is the payer of last resort, states are required to determine the liability of third-party insurers and bill them before billing Medicaid. 42 U.S.C. § 1396a(a)(25)(A). Under federal regulation, when the Medicaid agency is billed for items or services furnished to a recipient who also has private coverage, the state must pay the claim to the provider "to the extent that payment allowed under the [state] agency's payment schedule exceeds the amount of the third party payment." 42 C.F.R. § 433.139(b)(1).

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 often purchase prescriptions at lower prices than state Medicaid agencies can. In most 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. Neither dual-eligible patients nor the state Medicaid agencies are parties to the contracts between pharmacies and private insurance companies and do not know the discounted rates that may apply to certain prescription medications.

Every state Medicaid program at issue in this case has issued regulations or other guidance 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. For example, Florida Medicaid regulations provide that the state Medicaid agency "provides medical assistance only to the extent that there remains liability to the patient under the plan, such as a copayment, after payment by the third party. Payment by Medicaid, in such cases, is not to exceed the Medicaid payment schedule." Fla. Admin. Code Ann. r. 59G-7.056(3).

Minnesota's Medicaid statutes state that "[t]he amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service." Minn. Stat.

§ 256B.0625(13e). See also Am. Cpt., dkt. #76, ¶¶ 25-86 (listing laws, regulations and guidelines limiting reimbursement for California, New Hampshire, Nevada, Rhode Island and Massachusetts).

Also, each of the states have created payer sheets based on the National Council for Prescription Drug Programs standard, as well as instructions and guidance for providers submitting these sheets. None of the state Medicaid programs involved in this case use payer sheets requiring pharmacies to submit the amount of the patient's outstanding co-pay liability or any information that would allow the state agency to determine the patient's liability. For example, California's payer sheet requires pharmacies to submit the amount paid by the primary insurer but does not request submission of the patient liability (co-pay) amount. The payer sheet states that "only those segments and fields pertinent to Medi-Cal processing will be utilized in the Medi-Cal system." Dkt. #80, Exh. F. Florida's payer sheet directs pharmacies to include the amount paid by another insurer, but does not require submission of the patient's copay amount, stating that this field is "[n]ot used by Florida." Id. Exhs. H & G. See also id. Exhs. J & L (Minn. payer sheets); L & M (NH payer sheets); O (NV payer sheet); P (RI payer sheet).

D. Defendant's Claims for Reimbursement

Since 2002, many of defendant's pharmacies have used a variety of electronic computer systems to bill Medicaid for prescription drug claims, although some pharmacies submitted paper claims during this period. Since 2006, defendant has depended primarily on a computer system called ARx, which was developed at defendant's corporate level. Defendant's employees are trained to use ARx to seek reimbursement from state Medicaid agencies for prescription claims submitted on behalf of dual-eligible patients.

Since at least October 1, 2002, defendant's billing methods have resulted in defendant's receipt of Medicaid reimbursement for dual-eligible patients in an amount greater than the dual-eligible patient's outstanding liability or co-pay obligation. A specific example of such a submission involved prescription no. 1124074778 filled on December 15, 2006 at a SuperValu pharmacy store in California. In that transaction, a private insurance company reimbursed defendant for the cost of the prescription, with the exception of a $10 co-pay owed defendant by a dual-eligible patient. Defendant submitted a claim for reimbursement to California's Medicaid program and received a reimbursement of $17.74. (Plaintiffs provide similar specific examples of defendant's submissions to the state Medicaid programs of California, Minnesota, Nevada and New Hampshire. Plaintiff has not provided specific examples of claims submissions from Florida, Rhode Island or Massachusetts.)

The ARx system does not provide the state Medicaid programs information about the actual liability of dual-eligible patients. Other pharmacies operating within Minnesota

provided such information either during or after the claims submission process. For example, certain pharmacies in Minnesota that do not provide information sufficient to determine the actual liability of dual-eligible claims during the claims submission process perform monthly reconciliations and refund any overpayments to the Minnesota Department of Human Services. These pharmacies submit claims data along with the refund that allows the department to confirm the actual liability of dual-eligible patients. Defendant has not refunded any overpayments for dual-eligible claims to the United States or the state Medicaid programs.

E. Minnesota's Investigation

Minnesota's Medicaid agency, the Department of Human Services, audits dual-eligible beneficiary claims on a periodic and random basis. When the agency discovers potentially improperly billed claims, it writes to the pharmacy, asking it to re-process the claims or it offers to re-process the claims for the pharmacy. If the pharmacy accepts the offer to have the department re-process the claims, it gives the department authority to determine the amount of overpayment, if any. If the department finds an overpayment has been made to the pharmacy, the pharmacy can choose to have the department recoup the overpayment by way of a warrant reduction or the pharmacy can issue a check to the department for the amount of the overpayment.

In 2007, the department's Surveillance and Integrity Review Section conducted a limited review of prescription reimbursement claims submitted by numerous SuperValu pharmacies in Minnesota. During this review, it requested third-party payment information from the pharmacies. Several of these pharmacies ignored the requests for information and defendant's corporate officers were unresponsive to audit efforts.

In November 2008, the department notified SuperValu pharmacy #661 that the department was taking action to recover wrongfully obtained Medicaid funds. It wrote defendant that it had "discovered that [the department] paid off your usual and customary charge instead of the patient responsibility or copay amount determined by the recipient's primary insurance." Am. Cpt., dkt. #76, ¶ 114.

OPINION

A. Motion to Dismiss Government Intervenors' Complaint

The government's complaint in intervention raises claims under two sections of the federal False Claims Act, the false claims acts of California and Minnesota, federal common law and Minnesota contract law. Defendant has moved to dismiss the complaint under Fed. R. Civ. P. 9(b) for failure to plead allegations of fraud with particularity and under Fed. R. Civ. P. 12(b)(6) for failure to state a claim upon which relief may be granted.

To survive a motion to dismiss under Rule 12(b)(6), "a complaint must contain

sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" Ashcroft v. Iqbal, 129 S. Ct. 1937, 1949 (2009) (quoting Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 570 (2007)). "When there are well-pleaded factual allegations, a court should assume their veracity and then determine whether they plausibly give rise to an entitlement to relief." Id. at 1950. Motions to dismiss require the court to accept as true all well-pleaded factual allegations and draw all reasonable inferences in favor of the plaintiff. Reger Development, LLC v. National City Bank, 592 F.3d 759, 763 (7th Cir. 2010).

Because the False Claims Act "is an antifraud statute," "claims under it are subject to the heightened pleading requirements 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. Goldman Sachs Group, Inc., 477 F.3d 502, 507 (7th Cir. 2007). In the False Claims Act context, this means that a complaint must not only provide a specific description of the allegedly fraudulent scheme, but also must allege a false claim "at an individualized transaction level." Fowler, 496 F.3d at 741-42 (affirming dismissal of FCA claim where relators described fraudulent scheme without providing any specific allegations of actual false

claim). Rule 9(b) focuses on the details about the misrepresentation itself and requires "facts such as the identity of the person making the misrepresentation, the time, place and content of the misrepresentation, and the method by which the misrepresentation was communicated." United States ex rel. Turner v. Michaelis Jackson & Associates, LLC, 2007 WL 496384, at *1 (N.D. Ill. Feb. 13, 2007) (quoting Hefferman v. Bass, 467 F.3d 596, 601 (7th Cir. 2006)).

1. United States' claims under 31 U.S.C. § 3729(a)(1)

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).

The general theory behind the United States' claims under the False Claims Act is that defendant should be reimbursed for prescriptions provided to dual-eligible patients only to the extent of the patient's liability to the pharmacy. The United States finds support for its theory in state laws imposing limitations on reimbursement for dual-eligible patients, e.g., Fla. Admin. Code Ann. r. 59G-7.056(3); Minn. Stat. § 256B.0625(13e), and in the federal assignment statute that requires dual-eligible patients receiving benefits under Medicaid to

assign their rights to receive payment from their health insurance plans to the state. 42 U.S.C. § 1396k(a)(1)(A); 42 C.F.R. § 433.145. (It is not entirely clear how the federal assignment provision applies to the billing obligations of a Medicaid provider, but defendant does not raise that issue.) The United States contends that defendant violated § 3729(a)(1) of the False Claims Act by "submitt[ing] prescription drug claims for reimbursement for Dual-eligible Beneficiaries in an amount greater than it was entitled to receive" under the state Medicaid programs and by "knowingly omitt[ing] material information from prescription drug claims" that it submitted to state Medicaid programs. Am. Cpt., dkt. #76, ¶¶ 120, 121, 129, 130, 139, 140, 149, 150, 159, 160, 169, 170, 179, 180.

Defendant contends that the United States has failed to state a claim under § 3729(a)(1) because the defendant's claims for reimbursement were not false or fraudulent under the governing state and federal law and even if they were, the governing law was so confusing and ambiguous that defendant could not have known that it was submitting false claims. Moreover, defendant contends, even if the United States' legal theory could support a claim under § 3729(a)(1), its allegations do not satisfy Rule 9(b) because it has failed to allege what information defendant provided to the Medicaid programs was factually false.

a. Failure to state a claim

Defendant contends that the United States cannot state a claim under § 3729(a)(1) for defendant's failure to disclose patient co-pay information because defendant had no obligation to disclose that information under the state guidelines and payer sheets in force during the relevant period. It is true that "[t]here can only be liability under the False Claims Act where the defendant has an obligation to disclose omitted information." United States ex rel. Berge v. Board of Trustees of the University of Alabama, 104 F.3d 1453, 1461 (4th Cir. 1997); United States ex rel. Haight v. Catholic Healthcare West, 2007 WL 2330790, *5 (D. Ariz. Aug. 14, 2007) ("The False Claims Act does not impose liability for omissions unless the defendant had an obligation to disclose the omitted information."); United States ex rel. Milam v. Regents of University of California, 912 F. Supp. 868, 883 (D. Md. 1995) (finding no false statement by way of omission under False Claims Act where defendants were not obligated to disclose information withheld from United States).

Defendant cites state statutes, regulations and sub-regulatory guidance, including provider manuals and payer sheets that were adopted pursuant to federal standards, showing that the relevant states' payer sheets did not require defendant to disclose patient copay information. E.g., dkt. #80, exh. F (California's payer sheet); exhs. H & G (Florida's payer sheet). In addition, defendant cites federal law requiring providers to comply with the National Council for Prescription Drug Programs' standards implemented by state Medicaid agencies. 42 U.S.C. § 1320d-5; 45 C.F.R. §§ 160.102, 160.402, 160.404.

Rather than address directly whether the payer sheets and billing standards on which defendant relies either imposed an obligation or exempted defendant from an obligation to submit patient co-pay information, the United States makes the same arguments it made in opposition to defendant's motion for judicial notice, contending that the court should not consider the payer sheets and related guidance at the motion to dismiss stage because they are extrinsic evidence outside the complaint. The United States contends that in light of the state statutes, regulations and guidance cited in the amended complaint, the court should accept as true its allegation that state laws require defendant to submit patient co-pay information to state Medicaid agencies when seeking reimbursement for dual-eligible patient claims.

However, whether defendant was required by law to submit particular information is a question of law, not of fact, and courts are "not bound to accept as true a legal conclusion couched as a factual allegation" when considering a motion to dismiss. Iqbal, 129 S. Ct. at 1949. Thus, I must consider the entire legal framework implicated by the United States' allegations, including all laws and state guidance related to claims submission. Unfortunately, because the United States has not addressed defendant's arguments regarding the payer sheets, I cannot determine whether the combination of the payer sheets and other state statutes and regulations imposed an obligation on defendant to submit co-pay information. After considering defendant's arguments, however, it seems unlikely that the

United States can state a claim under the False Claims Act for defendant's failure to include co-pay information on its payer sheets. At the very least, the regulations and guidance regarding what information should be submitted in the payer sheets are unclear and possibly contradictory. The Court of Appeals for the Seventh Circuit has explained that a false claim 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).

Several other courts have reached similar conclusions. See, e.g., 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 FCA 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, – F. Supp. 2d – , 2011 WL 1226267, *12 (S.D.N.Y.

Mar. 31, 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).

All that said, however, I will not dismiss the United States' § 3729(a)(1) claim for failure to state a claim upon which relief may be granted because it is not clear whether the United States' claim is even based on defendant's failure to submit co-pay information *on the payer sheets*. Rather, the United States argues that there are two reasons why defendant's claims for reimbursement were false claims regardless whether defendant had an obligation to include co-pay information on the payer sheets themselves. The United States contends, first, that defendant submitted claims that were "literally false," and second, that defendant

had an obligation to figure out some way to submit co-pay information to state Medicaid agencies other than the payer sheets so that the agencies could calculate reimbursement payments properly. As discussed below, however, the problem with both of these theories is that the United States has not pleaded sufficient facts in its amended complaint to support them.

b. Failure to plead with particularity

1) "literally false" claims

The United States contends that defendant submitted "literally false" claims by using its nationwide electronic claims submission system to submit claims to the state Medicaid programs that "misrepresented" the sums to which it was entitled to receive. The United States identifies twenty examples of allegedly false claims by location, prescription number and overpayment. For each of these examples, the United States alleges that "despite knowing that the Dual-Eligible Beneficiary was liable to [defendant] for [the co-pay amount] and that state law and/or guidance limited reimbursement to this amount, [defendant] submitted a claim for reimbursement to [the state Medicaid program] and received from [the program] a reimbursement of [a greater amount]." E.g., Am. Cpt., dkt. #76, ¶¶ 98(1)–(4). For example, in a particular example for an allegedly false claim submitted by defendant in California, the United States alleges that

> On December 15, 2006, Sav-on Pharmacy No. 1124074778 dispensed Prescription No. 267149 and submitted a claim for reimbursement for this prescription to Insurance Company D. After the reimbursement from Insurance Company D, the Dual-eligible Beneficiary was liable to [defendant] for $10.00 for the remaining prescription cost. Despite knowing that the Dual-eligible Beneficiary was only liable to [defendant] for $10.00 and that state law and/or guidance limited reimbursement to this amount, [defendant] submitted a claim for reimbursement to Medi-Cal and received from Medi-Cal a reimbursement of $17.74. Thereafter, [defendant] also wrongfully retained the funds in excess of the Dual-eligible Beneficiary's actual liability to [defendant].

Id. ¶ 98(1)a.

These allegations do not satisfy Rule 9(b) because the United States has not identified any specific false information in any claim defendant submitted to any state Medicaid program. In fact, the United States fails to articulate what it is that defendant submitted to the state Medicaid agencies, let alone what was false. "To satisfy [the] first element of an FCA claim [(a false or fraudulent claim)], the statement or conduct alleged must represent an objective false-hood." United States ex rel. Wilson v. Kellogg Brown & Root, Inc., 525 F.3d 370, 377 (4th Cir. 2008) (citing Lamers, 168 F.3d at 1018)). "An example of a false statement in an invoice . . . is the representation that a resident worked five days a week at a hospital for a given quarter when he worked only three[.]" Hindo v. University of Health Sciences/The Chicago Medical School, 65 F.3d 608, 613 (7th Cir. 1995) ("In short, [a false] claim must be a lie."); see also United States v. Caremark, Inc., 634 F.3d 808, 818 (5th Cir. 2011) (because "false is the opposite of true, statements that are factually true are not false

statements about the facts" under False Claims Act).

What is missing from the United States' complaint are allegations of *how* defendant perpetrated the alleged fraud and *what* false statements or claims defendant presented through its electronic claims transmission system. The only allegations describing the alleged false claims are conclusory, namely, that defendant "misrepresented" the amount to which it was entitled to receive payment from Medicaid. However, the United States fails to explain *how* defendant's claims misrepresented that amount. The representative examples of alleged false claims do nothing to clarify what about the claims was false or fraudulent. Through these examples, the United States merely states that defendant submitted several claims for reimbursement that resulted in defendant's receiving overpayments from Medicaid, but does not shed any light on what precise aspect of defendant's claims caused the overpayments or what information in defendant's claims was "literally false."

The government has not alleged that defendant recklessly disregarded transmission rules, knowingly entered incorrect information into its computer system or caused its system to submit incorrect or incomplete data to the state agencies. The United States never alleges that defendant billed for a specific amount from Medicaid that was higher than that to which defendant was entitled. (Presumably, this is because none of the state Medicaid program's billing procedures request or allow pharmacies to "bill for" any specific dollar amounts. Rather, pharmacies must submit information in a format prescribed by the state Medicaid

agencies, containing information fields prescribed by federal and state laws, and the agency or its processor then determines what amount to pay using that information.)

In sum, the United States has not identified which of the data or information defendant submitted was false or inaccurate as required by Rule 9(b) and thus, cannot ground its § 3729(a)(1) claims on the theory that defendant submitted "literally false" claims.

2) Defendant's failure to submit co-pay information separately from state payer sheets

The United States' second theory under § 3729(a)(1) is that defendant submitted false claims 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 contends that all of defendant's arguments about the payer sheet requirements are beside the point because defendant had an independent obligation, arising out of state laws and statutes limiting reimbursement for dual-eligibles claims, to notify state Medicaid agencies of the dual-eligible patient's outstanding liability. The United States alleges that other pharmacies were able to provide such information after the claims submission process through another medium. Thus, the United States contends, defendant violated the False Claims Act by failing to disclose patient co-pay information in a subsequent and separate manner.

This is not a contention that the United States asserted in its complaint or supported

with allegations about how defendant should have disclosed this information. The United States has provided no details about how other pharmacies provided such information or whether the other pharmacies' submissions complied with the requirements of the Health Insurance Portability and Accountability Act of 1996. Moreover, the United States does not explain how defendant's failure to disclose patient co-pay information at a later time would render its initial claim false. Other courts have held that when a plaintiff alleges fraud based on a failure to disclose facts, "a plaintiff is required to plead the 'type of facts omitted, the type of document in which they should have appeared, and the way in which their omission made the documents misleading.'" Leung v. Haines, 2007 WL 1650142, *4 (S.D. Ind. June 1, 2007) (quoting Fujisawa Pharmaceutical Co. v. Kapoor, 814 F. Supp. 720, 727 (N.D. Ill. 1993)). Because the United States has not alleged where the omitted information should have appeared, when defendant was supposed to disclose this information or how the failure to disclose resulted in a false claim, the claim does not meet the standards of Rule 9(b).

In sum, I cannot determine whether the United States can state claims against defendant for violation of the False Claims Act § 3721(a)(1) because the United States' amended complaint does not contain enough information describing defendant's alleged fraud. Additionally, the United States has not explained its theories of liability clearly. Therefore, I will dismiss these claims for failure to meet the pleading standards of Rule 9(b).

2. 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 at 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. It adds that regardless whether defendant knowingly presented false claims, the state Medicaid programs overpaid defendant and defendant has not refunded those overpayments. Because the statute defines "obligation" specifically as including "retention of any overpayment," the United States has sufficiently alleged the existence of an obligation.

However, defendant contends that the United States' claims under this provision

should be dismissed because the United States has failed to identify any action taken by defendant to "avoid" or "conceal" its obligation to repay overpayments. Moreover, defendant contends, the United States cannot show that defendant "knowingly" avoided repayment because the applicable state law was so unclear and contradictory that defendant did not know that it had been overpaid. Although defendant's argument has some merit in light of the seemingly inconsistent regulations governing submission of Medicaid claims, I conclude that the United States has pleaded sufficient facts at this stage to proceed with its claims under the reverse false claims provision.

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). The United States has cited several state statutes and regulations that limit reimbursement of Medicaid claims to the amount of the patient's liability to the provider. E.g., Fla. Admin. Code Ann. r. 59G-7.056(3); Minn. Stat. § 256B.0625(13e). Although other regulations and manuals provided inconsistent guidance regarding how pharmacies should submit claims for reimbursement in compliance with federal law, I can infer at this stage that defendant was aware of the state regulations limiting reimbursement to the patient's co-pay amount and thus, that it knew that any amount received in excess of the co-pay was an overpayment. (I note, however, that neither party addresses the question whether retention

of an overpayment from the state Medicaid agency is necessarily "retention of an overpayment" from the United States government within the meaning of the False Claims Act, particularly where federal regulations do not clearly limit reimbursement to a patient's co-pay amount.)

Additionally, even if the inconsistency in the state regulations somehow negated defendant's knowledge that it had received overpayments, both the relator's complaint in 2008 and the investigation performed by the Minnesota Department of Human Services could have provided defendant notice of the alleged overpayments. The government alleges that in 2007 and 2008, the department notified several of defendant's pharmacies and defendant's corporate officers that defendant had received possible overpayments from the state Medicaid agency. The United States alleges that defendant 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 defendant's usual and customary charge. Assuming at this stage that defendant had in fact received overpayments (a fact that is disputed), these allegations imply that defendant was on notice by 2009 (when the reverse false claims provision came into effect) that it had received overpayments but knowingly and improperly avoided repaying them. Therefore, the United States may proceed with its claims under § 3729(a)(1)(G).

3. Claims under the False Claims Act involving Florida, Massachusetts and Rhode Island

I concluded above that the United States' claims under § 3729(a)(1) (1986) must be dismissed for failure to satisfy Rule 9(b), but that the United States may proceed with its claims under § 3729(a)(1)(G) (2009) arising out of defendant's alleged failure to refund overpayments after May 20, 2009. In its motion to dismiss, defendant raises an alternative reason why the United States' claims under both sections of the False Claims Act should be dismissed with respect to the claims involving the states of Florida, Massachusetts and Rhode Island. In particular, defendant contends that the claims with respect to these states are grounded on impermissible speculation because the United States has failed to allege the particulars of a single false claim made by defendant to those states' programs or a single overpayment received by defendant from them.

I agree with defendant that the United States' claims under both § 3729(a)(1) and § 3729(a)(1)(G) involving these three states must be dismissed for failure to satisfy Rule 9(b). As the court of appeals has explained, plaintiffs asserting claims under the False Claims Act must plead at least some allegedly false claims "at an individualized transaction level." Fowler, 496 F.3d at 742. See also United States ex rel. Bledsoe v. Community Health Systems, Inc., 501 F.3d 493, 511 (6th Cir. 2007) (affirming district court's order granting FCA defendant's Rule 9(b) motion to dismiss for failure to include specific examples of claims "illustrative of the class of all claims covered by the fraudulent scheme") (internal quotation

marks omitted); United States ex rel. Joshi v. St. Luke's Hospital, Inc., 441 F.3d 552, 557 (8th Cir. 2006) (affirming district court's order granting FCA defendant's Rule 9(b) motion to dismiss complaint alleging fraudulent scheme for failure to "provide some representative examples of [] alleged fraudulent conduct, specifying the time, place, and content of [] acts and the identity of the actors") (emphasis in original).

In this case, the amended complaint does not contain a single example of an alleged false claim submitted to Florida, Massachusetts or Rhode Island or an alleged overpayment (or any payment at all) from these states' programs to defendant or from the United States to the state programs. The United States does not identify even a single prescription for a dual-eligible patient that was submitted for reimbursement by defendant to the programs in these states. Although the United States contends that the information necessary to plead such claims is in the exclusive control of defendant, it does not explain why it could not at least determine from state payment records whether defendant had submitted claims for dual-eligible patients that were paid by the state agencies.

Moreover, it is not sufficient that the United States has pleaded the existence of alleged overpayments in other states, because each state program has different payment schedules and imposes different requirements on pharmacies for submitting claims and receiving reimbursements. In this circumstance, the United States must identify at least some claims and overpayments for each state before it can proceed with its claims for those states.

Therefore, the United States' claims under the False Claims Act involving the states of Florida, Massachusetts and Rhode Island will be dismissed for failure to satisfy Rule 9(b).

4. 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. Defendant contends that the United States' unjust enrichment claims should be dismissed for two reasons.

First, the claims are predicated on fraud but fail to meet the pleading requirements of Rule 9(b). Defendant cites several cases in which the court of appeals has held that all claims based on allegations of fraud must be dismissed if they fail to meet the heightened pleading requirements of Rule 9(b). E.g., Borsellino, 477 F.3d at 507 ("Rule 9(b) applies to 'averments of fraud,' not claims of fraud, so whether the rule applies will depend on the plaintiffs' factual allegations."); Association Benefit Services, Inc. v. Caremark RX, Inc., 493 F.3d 841, 855 (7th Cir. 2007); Kennedy v. Venrock Associates, 348 F.3d 584, 593 (7th Cir. 2003).

However, the United States' federal common law claims for unjust enrichment do not depend on allegations of fraud. Hill v. Waxberg, 237 F.2d 936, 939 (9th Cir. 1956). Under the equitable theory of unjust enrichment, "a person is unjustly enriched if the retention of

[a] benefit would be unjust." Restatement of Restitution, § 1 (1937). 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).

The United States alleges that applicable state law limited to the recipient's liability the amount of reimbursement that defendant was entitled to receive for prescription claims for dual-eligible beneficiaries. Thus, the state Medicaid agencies, and ultimately the United States Treasury, should not have reimbursed defendant for quite as much as it did, and defendant obtained more money in Medicaid reimbursements than it was entitled to receive by law. Because defendant was not entitled to all of the money it received, defendant should reasonably be expected to refund it. The United States has a reasonable expectation of repayment. These allegations are sufficient to state a claim for unjust enrichment that is not predicated on fraudulent conduct and not subject to the pleading requirements of Rule 9(b).

Defendant's second argument for dismissal of the unjust enrichment claims is that it cannot be inferred from the United States' allegations that defendant was unjustly enriched

because defendant will actually lose money to which it was otherwise entitled if it has to repay the state Medicaid agencies. Defendant supports this argument by positing a hypothetical prescription and payment plan. However, whether defendant will be deprived of money unlawfully is a factual issue. Defendant's hypothetical is not appropriate for consideration on a motion to dismiss, but if it believes the argument has merit, it may raise it again at summary judgment or trial.

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

4. State law claims

a. California False Claims Act

In addition to the federal claims asserted by the United States on behalf of California under the federal False Claims Act, the state of California has pleaded claims against defendant under three provisions of the California False Claims Act, Cal. Gov't Code §§ 12651(a)(1), (a)(2), (a)(8). California alleges that defendant "knowingly . . . presented false claims for payment or approval to the officers of employees of the State of California" in violation of § 12651(a)(1); "made, used, or caused to be made or used, false records or statements to get false claims paid by the State of California" in violation of § 12651(a)(2); and "even if [defendant] did not knowingly or intentionally submit false claims, [defendant]

was a beneficiary of an inadvertent submission of a false claim to the State of California, subsequently discovered the falsity of the claim, and failed to disclose the false claim to the State of California within a reasonable time after its discovery," in violation of § 12651(a)(8). Am. Cpt., dkt. #76, ¶¶ 188-203.

California's claims are subject to the heightened pleading standards of Rule 9(b). Sullivan v. Leor Energy, LLC, 600 F.3d 542, 550-51 (5th Cir. 2010) (state law fraud claims subject to Rule 9(b) pleading standards); North American Catholic Educational Programming Foundation, Inc. v. Cardinale, 567 F.3d 8, 13 (1st Cir. 2009) (same). Defendant contends that California's claims fail to meet Rule 9(b)'s requirements for the same reason that the United State's federal False Claims Act claims under § 3729(a)(1) were insufficient.

I agree with defendant. For reasons already explained, California's claims must be dismissed because the state has not pleaded with particularity the existence of a false claim or a false record that was made to obtain payment on a false claim. The existence of a false claim or record is a prerequisite to each of the claims it asserts against defendant. Therefore, I will grant defendant's motion to dismiss the claims under California's False Claims Act.

b. Minnesota's state law claims

Minnesota brings claims against defendant for violation of the Minnesota False Claims Act, Minn. Stat. § 15C.01-02, Minnesota's treble damages statute, Minn. Stat. § 256B.121,

and for breach of contract. Am. Cpt., dkt. #76, ¶¶ 204-210. I will grant defendant's motion to dismiss Minnesota's claims under the False Claims Act and treble damages statute for failure to satisfy Rule 9(b). Claims under those statutory provisions require Minnesota to plead the existence of a specific "false or fraudulent claim," § 15C.02(a)(1), a "false record or statement," § 15C.02(a)(2), or a "false representation," § 256B.121, which Minnesota has failed to do.

As to Minnesota's breach of contract claim, the state contends 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. 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). Minnesota's breach of contract claim is not predicated on fraud and is not subject to the pleading requirements of Rule 9(b). Additionally, Minnesota was not required to plead around defendant's affirmative defense that it would have been impossible for defendant to comply both with the terms of contract and the Health Insurance Portability and Accountability Act of 1996. Without more information about the requirements of the provider agreement and the methods by which defendant could comply with them, I cannot

determine whether defendant complied with federal law or whether defendant's compliance with federal law made it impossible to comply with its contractual obligations. Defendant can raise this affirmative defense at summary judgment or trial. Accordingly, I will deny defendant's motion to dismiss Minnesota's breach of contract claim.

B. Motion to Dismiss Relator's Complaint

The False Claims Act "authorizes private citizens (called 'relators') to file civil actions on behalf of the government ('qui tam' actions) to recover money that the government paid on account of false or fraudulent claims." Glaser v. Wound Care Consultants, Inc., 570 F.3d 907, 912 (7th Cir. 2009) (citing 31 U.S.C. § 3730(b)(1)). In this case, the relator filed claims under the federal False Claims Act on behalf of the United States. Although the relator does not identify the specific provisions of the False Claims Act that it is asserting against defendant, it appears from its third amended complaint that it is raising claims under subsections (a)(1), (a)(2), and (a)(3) of § 3729 of the pre-2009 Act. Relator's 3d Am. Cpt., dkt. #78, ¶¶ 92-95.

Under 31 U.S.C. § 3729(a)(1) (effective through May 20, 2009), it is unlawful to "knowingly present[], or cause[] to be presented, a false or fraudulent claim for payment or approval." Under § 3729(a)(2), it is unlawful to "knowingly make[], use[], or cause[] to be made or used, a false record or statement to get a false or fraudulent claim paid or approved

by the Government." Section 3729(a)(3), the conspiracy provision, prohibits "conspir[ing] to defraud the Government by getting a false or fraudulent claim allowed or paid."

The relator also brings claims under the false claims acts of Florida, Massachusetts, New Hampshire, Nevada and Rhode Island, on behalf of those five states. Each of the state false claims acts at issue is substantially similar to its federal counterpart. Compare 31 U.S.C. § 3729 with Fla. Stat. § 68.082; Mass. Gen. Laws ch. 12 § 5B; Nev. Rev. Stat. § 357.040; N.H. Rev. Stat. Ann. § 167:61-a; and R.I. Gen. Laws § 9-1.1-3. Defendant has moved to dismiss all of the relator's claims under Fed. R. Civ. P. 9(b), 12(b)(1) and 12(b)(6).

1. Pleading problems

Defendant contends that all of the relator's claims must be dismissed because they are all predicated on the existence of a "false or fraudulent claim," and the relator has failed to identify any false or fraudulent claim with specificity. (Because the relator's state and federal claims arise out of allegedly fraudulent conduct, they are subject to the heightened pleading standards of Rule 9(b)). Additionally, with respect to the relator's § 3729(a)(2) claims, the relator has failed to alleged the submission of a false record or statement. Finally, the relator has failed to allege any facts supporting the existence of a conspiracy as required by § 3729(a)(3), including an agreement between conspirators or the identity of defendant's alleged co-conspirators.

I agree that the relator has not pleaded sufficient allegations to support its claims under the federal or state false claims acts. The relator's third amended complaint contains even fewer details about defendant's alleged fraud and "false claims" than does the government's complaint in intervention, which I have concluded contains insufficient allegations to meet the heightened pleading requirements of Rule 9(b). In brief, the relator has failed to allege specifically that defendant submitted a claim containing false or inaccurate information or a claim that omitted required information. Additionally, with respect to its claim under § 3729(a)(2), the relator has failed to identify what "false record or statement" defendant made or used that was material to its claims for reimbursement. Finally, the relator has not even tried to argue in its opposition brief that its third amended complaint satisfies the pleading requirements for its (a)(3) conspiracy claims. Instead, the relator abandoned those claims by failing to mention them at all in its brief.

In sum, because the relator's claims under the federal and state false claims acts fail to satisfy the pleading requirements of Rule 9(b), I will grant defendant's motion to dismiss these claims.

2. United States' intervention on § 3729(a)(1) claims

Finally, even if the relator had pleaded its claims under subsection (a)(1) with the

particularity required by Rule 9(b), these claims must be dismissed because the United States has intervened and asserts claims under the same subsection for the same states. The only states named as plaintiffs and mentioned specifically in the relator's complaint are Florida, Massachusetts, New Hampshire, Nevada and Rhode Island. The United States' complaint in intervention alleges subsection (a)(1) violations relating to claims for reimbursement submitted by defendant in those same five states, as well as California and Minnesota. The complaint in intervention also states that "This Amended Complaint also substitutes for and supersedes the Second Amended Complaint of [the Relators] . . . to the extent that it adopts or asserts the same causes of action as asserted by Relators on behalf of the United States, California, and Minnesota." Am. Cpt., dkt. #76, at 2.

When the United States exercises its option to intervene in a False Claims Act case, the United States takes "primary responsibility for prosecuting" the claim and "the action shall be conducted by the Government." 31 U.S.C. §§ 3730(b)(4)(A), (c). This means that a relator may not maintain a separate action based upon the same claims alleged by the government. United States ex rel. Magee v. Lockeed Martin Corp., 2010 WL 972214, *2-3 (S.D. Miss. Mar. 12, 2010) (dismissing relator's FCA claim as duplicative because government intervened on same allegations); United States ex rel. Becker v. Tools & Metals, Inc., 2009 WL 855651, *6 (N.D. Tex. Mar. 31, 2009) (same); In re Pharmaceutical Industries Average Wholesale Price Litigation, 2007 WL 4287572, *4 (D. Mass. Dec. 6, 2007) (same) (citing

United States ex rel. Barajas v. Northrop Corp., 147 F.3d 905, 910 (9th Cir. 1998) ("[T]here is one claim, the government's, pursuable either by the qui tam relator on behalf of the government, or by the government on its own behalf.")). Thus, although a relator can remain a party to the action and can help pursue the claims asserted by the United States against defendant, its separate claims must be dismissed.

C. Conclusion

All of the relator's claims and several of the government's claims must be dismissed for failure to satisfy the pleading rules of Rule 9(b). Because some of the deficiencies could be cured with additional allegations or clarification, I will give the government and relator one more opportunity to amend their complaints. They may have until September 29, 2011 to file an amended complaint addressing the deficiencies identified in this opinion. Defendant may have until October 12, 2011 to file any new motions to dismiss.

ORDER

IT IS ORDERED that

1. Defendant SuperValu, Inc.'s motion for judicial notice, dkt. #82, is GRANTED.

2. Defendant's motion to dismiss the complaint brought by the Estate of Jay Heidbreder as the relator for the United States, Florida, Massachusetts, New Hampshire,

Nevada and Rhode Island, dkt. #85, is GRANTED. The relator's claims under 31 U.S.C. § 3729(a)(1)(1986) and 31 U.S.C. § 3729(a)(1)(A) (2009) are DISMISSED WITH PREJUDICE because they are duplicative of claims asserted in the United States' complaint in intervention. The relator's claims under 31 U.S.C. §§ 3729(a)(2) and (a)(3) (1986) and the false claims acts of Florida, Massachusetts, New Hampshire, Nevada and Rhode Island are DISMISSED WITHOUT PREJUDICE because they do not comply with Fed. R. Civ. P. 9(b).

3. Defendant's motion to dismiss the complaint in intervention brought by the United States, California and Minnesota, dkt. #79, is GRANTED IN PART and DENIED IN PART:

a. The United States' claims under 31 U.S.C. § 3729(a)(1) (1986) and 31 U.S.C. § 3729(a)(1)(A) (2009) are DISMISSED WITHOUT PREJUDICE because they do not comply with Fed. R. Civ. P. 9(b).

b. The United States' claims under 31 U.S.C. § 3729(a)(1) (1986) and 31 U.S.C. §§ 3729(a)(1)(A) and (a)(1)(G) (2009) involving the states of Florida, Massachusetts and Rhode Island are DISMISSED WITHOUT PREJUDICE because they do not comply with Fed. R. Civ. P. 9(b).

c. The state of California's claims under California's False Claims Act, Cal. Govt. Code §§ 12651(a)(1), (2), (8), are DISMISSED WITHOUT PREJUDICE because they do not comply with Fed. R. Civ. P. 9(b).

d. The state of Minnesota's claims under Minnesota's False Claims Act, Minn. Stat. § 15C.01-02, and Minnesota's treble damages statute, Minn. Stat. § 256B.121, are DISMISSED WITHOUT PREJUDICE because they do not comply with Fed. R. Civ. P. 9(b).

e. Defendant's motion is DENIED in all other respects.

4. The United States, California, Minnesota and the relator may have until September 29, 2011 to file amended complaints addressing the deficiencies identified in this opinion. Defendant may have until October 12, 2011 to file any new motions to dismiss.

Entered this 19th day of September, 2011.

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