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INSIDE...

The *False Claims Act and Qui Tam Quarterly Review* is published by the Taxpayers Against Fraud Education Fund. This publication provides an overview of major False Claims Act and *qui tam* developments including case decisions, DOJ interventions, and settlements.

The TAF Education Fund is a nonprofit charitable organization dedicated to combating fraud against the Federal Government through the promotion and use of the *qui tam* provisions of the False Claims Act (FCA). The TAF Education Fund serves to inform and educate the general public, the legal community, and other interested groups about the FCA and its *qui tam* provisions.

The TAF Education Fund is based in Washington, D.C., where it maintains a comprehensive FCA library for public use and a staff of lawyers and other professionals who are available to assist anyone interested in the False Claims Act and *qui tam.*

Taxpayers Against Fraud Education Fund
1220 19th Street, NW Suite 501 Washington, DC 20036
Phone (202) 296-4826 Fax (202) 296-4838
Internet: http://www.taf.org

FCA Liability of Government Entities

Cook County v. U.S. ex rel. Chandler,
123 S. Ct. 1239 (Mar. 10, 2003)

The Supreme Court ruled that local governments are subject to liability in *qui tam* actions under the FCA. The Court held that municipal corporations have been "persons" subject to suit under the FCA ever since it was first enacted in 1863, and that the 1986 amendments did not repeal municipal liability. The court also clarified that the treble damages provision in the current version of the FCA has a compensatory function as well as a punitive one, and is certainly not to be equated with classic punitive damages.

Dr. Janet Chandler brought this *qui tam* action in 1997 against the Hektoen Institute for Medical Research (Hektoen), Cook County, and Cook County Hospital (CCH). CCH had obtained a grant from the National Institute of Drug Abuse to study the treatment of drug-dependent pregnant women. The grant was later transferred to Hektoen, which is a CCH affiliate. The terms of the grant required the grantee to comply with federal regulations for research on human subjects. Chandler's lawsuit alleged that the defendants forged data pertaining to nonexistent "ghost" research subjects and submitted false progress reports to the Government. She also alleged that they failed to comply with the regulations governing research on human subjects, failed to obtain informed consent or thorough medical histories from participants, and failed to keep accurate records or provide proper care. Finally, she alleged that CCH unlawfully retaliated against her by firing her for speaking out about these abuses.

Cook County moved to dismiss, arguing that it is not a "person" subject to liability under the Act. The district court initially denied the county's motion, ruling that the term "person" in the Act's liability provision includes municipalities. Furthermore, the court ruled that the Act's treble damages provision is not punitive, so the traditional immunity of municipalities from punitive damages was not implicated. *See United States ex rel. Chandler v. Hektoen Institute for Medical Research*, 35 F. Supp. 2d 1078 (N.D. Ill. 1999), 16 TAF QR 3 (Apr. 1999). Subsequently, in *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765 (2000), 19 TAF QR 1 (July 2000), the Supreme Court ruled, per Justice Scalia, that states are not "persons" for purposes of FCA *qui tam* suits, and stated that the Act's treble damages provision is "essentially punitive in nature." In light of *Stevens*, Cook County moved for reconsideration of the district court's decision.

On reconsideration, the district court found nothing in *Stevens* to alter its conclusion that the county is a "person" for purposes of FCA liability. *See United States ex rel. Chandler v. Hektoen Institute for Medical Research*, 118 F. Supp. 2d 902 (N.D. Ill. 2000), 21 TAF QR 2 (Jan. 2001). However, in view of *Stevens*, the court abandoned the position that FCA damages are not punitive. Holding that the county was immune from the imposition of punitive damages, the court dismissed the case against it. On appeal, the Seventh Circuit reversed and remanded, ordering the district court to reinstate Cook County as a defendant. *See United States ex rel. Chandler v. Cook County*, 277 F.3d 969 (7th Cir. 2002), 26 TAF QR 1 (Apr. 2002). The court of appeals ruled that municipalities have been "persons" subject to FCA liability since the Act was first adopted in 1863, and that nothing in the 1986 amendments exempted municipalities from liability. The Supreme

Court granted certiorari. *See* 536 U.S. 956 (2002), 27 TAF QR 1 (July 2002).

Municipalities are "Persons" Subject to FCA Liability

The Supreme Court affirmed the judgment of the Seventh Circuit. Writing for a unanimous Court, Justice Souter observed that as early as 1826, the Court, quoting Coke's *Institutes*, expressly recognized the presumption that the statutory term "person" "extends as well to persons politic and incorporate, as to natural persons whatsoever." *United States v. Amedy*, 24 U.S. (11 Wheat.) 392, 412 (1826). The defendant Cook County conceded that private corporations were considered to be persons subject to suit when the FCA was passed in 1863, but argued that municipal corporations were not so considered until six years later, when the Court in *Cowles v. Mercer County*, 74 U.S. (7 Wall.) 118 (1869), specifically held that municipal corporations are persons subject to suit. However, the court noted that both case law and legal commentary in the nineteenth century reflected the widespread understanding that municipal corporations, like private corporations, are included in the term "person." Indeed, municipalities were the archetypal corporations of the eighteenth century, and it was not until the nineteenth century that private corporations became widespread. In light of this long history going back at least to Coke's 1628 treatise, the *Cowles* court was able to conclude automatically and without discussion that municipal corporations should be treated like natural persons for virtually all purposes of constitutional and statutory analysis.

The Court also rejected the defendant's arguments that municipal liability was inconsistent with the criminal penalties and the historical context of the 1863 Act. Although the Act's criminal penalty of imprisonment clearly could not apply to municipalities, it has never been considered anomalous to require municipalities to comply with the substantive standards of federal statutes imposing both civil and criminal sanctions upon "persons." That municipalities may not be susceptible to every statutory penalty is no reason to exempt them from remedies that sensibly apply. Moreover, although it is true that local governments were not recipients of massive amounts of federal funding in 1863, Congress drafted the FCA expansively in order to reach all types of fraud that might result in financial loss to the Government. Thus, neither the Act's text nor its history supports the exclusion of municipalities from liability.

Treble Damages Serve Remedial Purposes

The court also rejected the defendant's attempt to rely on the *Stevens* Court's statement that the current FCA treble damages are "essentially punitive in nature" to argue that even if the 1863 Act provided for municipal liability, the 1986 amendments eliminated such liability. Clarifying its statement in *Stevens*, the Court observed that "treble damages have a compensatory side, serving remedial purposes in addition to punitive objectives." Although "the tipping point between pay-back and punishment defies general formulation," several features of the FCA suggest a remedial function.

First of all, some liability beyond the amount of the fraud is unquestionably necessary to compensate the Government completely for ancillary costs, such as the costs of detection and investigation, as well as the delays and inconveniences occasioned by fraudulent claims. Moreover, the *qui tam* feature, which diverts as much as thirty percent of the recovery to a private relator, is the "most obvious indication that the treble damages ceiling has a remedial place under this statute." Once the relator's share is subtracted, the Government's recovery is roughly double damages, which the Court recognized as remedial in *United States v. Bornstein*, 423

U.S. 303, 315 & n.11 (1976). Moreover, the FCA has no separate provision for prejudgment interest, which is usually thought essential to compensation. Finally, the Act does not expressly provide for consequential damages, which are typically available in actions for fraud at common law. In fact, the Court observed, the Act's legislative history suggests that Congress adopted the treble damages provision as a substitute for consequential damages.

Thus, the Court concluded, the FCA's treble damages provision "certainly does not equate with classic punitive damages." Classic punitive damages leave the jury with open-ended discretion, raising concerns that municipal defendants, because of their taxing power, may be unfairly targeted by unduly generous juries, resulting in the imposition of liability on blameless or unknowing taxpayers. These concerns are much less acute under the FCA. If the jury finds liability in an FCA case, it is instructed to return a verdict for actual damages: the court then determines any multiplier, and sets any separate penalty. Moreover, the FCA imposes liability only on local taxpayers who have already enjoyed the indirect benefit of the fraud, to the extent that the ill-gotten federal money has already been passed along in the form of lower taxes or expanded services. The courts, by exercising their discretion, and the Government, by deploying its power to intervene and dismiss or settle, can determine whether the local taxpayer should make up for an undeserved benefit, or the federal taxpayer should be permanently out of pocket. Thus, the presumption against "punitive" damages has only limited vigor in this context.

1986 Amendments Did Not Repeal 1863 Definition of "Person" by Implication

Working against the weakened presumption regarding "punitive" damages was a different presumption, this one at full strength: the cardinal rule that repeals by implication are disfavored. As the Court observed: "Inferring repeal from legislative silence is hazardous at best, and error seems overwhelmingly likely in the notion that the 1986 amendments wordlessly redefined 'person' to exclude municipalities." In fact, in light of the objectives of the 1986 amendments, the Court concluded, it is impossible to believe that Congress intended silently to repeal municipal liability. The purpose of the amendments was to strengthen the FCA: thus Congress abolished the government knowledge defense, increased the measure of recovery, and enhanced the incentives for relators to bring suit. There is also evidence in the legislative history that Congress affirmatively endorsed municipal liability. Thus, the Court ruled, "[i]t is simply not plausible that Congress intended to repeal municipal liability *sub silentio* by the very Act it passed to strengthen the Government's hand in fighting false claims." Because the term "person" in the FCA included local governments in 1863, and nothing in the 1986 amendments redefined the term, the Court affirmed the judgment of the Seventh Circuit.

***U.S. v. Hickman County*, 2003 U.S. App. LEXIS 5397 (6th Cir. Feb. 18, 2003)**

The Sixth Circuit reversed a district court decision holding that the Government may not bring an FCA action against a county. The court of appeals remanded the case to the district court for further proceedings consistent with the recent decision of the Supreme Court that local governments are "persons" subject to liability under the FCA.

The Government brought this FCA action against Hickman County, Tennessee, alleging that the county fraudulently sought federal disaster funds to replace several bridges purportedly damaged as the result of a flood. After the Government filed suit, the Supreme Court ruled in *Vermont Agency of Natural Resources v.*

United States ex rel. Stevens, 529 U.S. 765, 787-88 (2000), that states are not "persons" subject to *qui tam* suits under the FCA. Although Hickman County is not a state, and the Government's suit against it is not a *qui tam* action, the district court ruled in an unpublished decision that under *Stevens* the county was not a person subject to *qui tam* liability and dismissed the suit. The Government appealed.

County Is Subject to FCA Liability

The Sixth Circuit, in an unpublished per curiam decision, reversed. The court observed that while the Government's appeal was pending, the Supreme Court decided another case directly on point. In *Cook County v. United States ex rel. Chandler*, 2003 U.S. LEXIS 1957 (March 10, 2003), the Supreme Court ruled that local governments are "persons" subject to liability under the FCA, and that the Act's treble damages remedy does not preclude recovery against a county. *See* above at page —-. Accordingly, the Sixth Circuit reversed the district court's decision dismissing the case against Hickman County, and remanded to the district court for further proceedings consistent with the Supreme Court's decision in *Chandler*.

U.S. ex rel. Dunleavy v. County of Delaware, 155 L. Ed. 2d 308 (Mar. 24, 2003)

The Supreme Court vacated a Third Circuit judgment ruling that local governments are not amenable to suit under the False Claims Act. The Supreme Court remanded the case for further proceedings consistent with its recent decision that local governments are "persons" subject to liability under the FCA.

Anthony Dunleavy, a former consultant to Delaware County, brought this *qui tam* suit in 1994, alleging that the county improperly used HUD program funds for general county purposes. In 2000, in light of the Supreme Court's decision in *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765, 787-88 (2000), that states are not "persons" subject to *qui tam* suits under the FCA, the district court concluded that local governments are immune from *qui tam* suits as well, because FCA damages are "essentially punitive." *See* 2000 WL 1522854 (E.D. Pa. Oct. 12, 2000), 21 TAF QR 3 (Jan. 2001).

Dunleavy appealed, but the Third Circuit affirmed the judgment of the district court. *See* 279 F.3d 219 (3d Cir. 2002), 26 TAF QR 4 (Apr. 2002). Noting that the term "person" is not defined in the FCA, the court of appeals concluded that "this lack of clarity in the text of the Act is insufficient indicia [sic] of congressional intent to abrogate local governmental immunity under the FCA." Dunleavy petitioned for a writ of certiorari in the Supreme Court.

The Third Circuit's decision ignored a decision issued a week before in the Seventh Circuit, *United States ex rel. Chandler v. Cook County*, 277 F.3d 969 (7th Cir. 2002), 26 TAF QR 1 (Apr. 2002). In *Chandler*, the Seventh Circuit held that the FCA authorizes *qui tam* suits against local governments, and pointed out that decisions in other courts to the contrary were inconsistent with established doctrinal distinctions between states, which are sovereigns, and municipalities, which are not. The Supreme Court granted certiorari in *Chandler*, and on March 10, 2003 affirmed the judgment of the Seventh Circuit. *See* above at page —-. The Supreme Court ruled that local governments have never enjoyed immunity under the FCA, and observed that the Act's treble damages certainly cannot be equated with classic punitive damages.

Third Circuit Judgment Vacated

In a summary disposition on March 24, 2003, the Supreme Court granted Dunleavy's peti-

tion for certiorari and vacated the judgment of the Third Circuit. Without discussion, the Supreme Court remanded the case to the court of appeals for further consideration in light of the recent decision in *Chandler*.

FCA Liability/Materiality

U.S. ex rel. Costner v. U.S., *317 F.3d 883 (8th Cir. Jan. 28, 2003)*

The Eighth Circuit affirmed a district court's grant of summary judgment in favor of the defendants in a *qui tam* action based on allegations that the defendants submitted false claims for the treatment and disposal of hazardous waste. Without deciding the precise contours of a materiality requirement under the FCA, the court of appeals ruled that the district court properly granted summary judgment on most of the relators' claims for failure to show that the alleged misstatements were even relevant to the Government's decision to pay. The Eighth Circuit also ruled that the district court properly held that the Government's knowledge and approval of the particulars of several of the claims at issue negated the scienter required for liability. Furthermore, the district court did not err in dismissing the remaining claims for failure to plead fraud with particularity as required by Federal Rule of Civil Procedure 9(b).

The plaintiffs in this *qui tam* action, a group of individuals and public interest groups, filed suit in 1995 alleging that the defendant corporations conspired to submit false claims for payment under a government contract for the treatment and disposal of hazardous waste at the Vertac Chemical Plant site in Jacksonville, Arkansas. The Vertac site was home to various chemical, herbicide, and pesticide production facilities from 1948 to 1987, when Vertac abandoned it, leaving approximately 28,000 corroding and leaking drums of toxic waste on the premises. The EPA subsequently contracted with the defendants to clean up the site. In their *qui tam* action, the relators alleged that the defendants concealed operational problems and numerous regulatory violations from the EPA, rendering their requests for payment false under the FCA.

The Government declined to intervene, and subsequently appeared as a movant in the action on the side of the defendants. After extended discovery, the district court granted summary judgment to the defendants on all claims except those alleging tampering with monitoring devices. The court then dismissed certain of the tampering claims, finding that they had been pleaded with insufficient particularity. After trial on the two remaining tampering claims, the district court entered judgment in favor of the defendants on all claims. The relators appealed, arguing that the district court erred (1) in holding that they had failed to produce evidence of materiality on most claims; (2) in finding that the defendants' disclosure of their operational difficulties to the EPA negated the scienter required for liability; and (3) in dismissing most of the tampering claims for failure to plead with particularity.

Relator Failed to Show Alleged Omissions Were Relevant to Government's Decision to Pay

The Eighth Circuit affirmed the judgment of the district court. The district court had rejected most of the plaintiffs' claims for failure to show materiality, noting that the EPA was informed of the operational problems from at least three sources and nevertheless continued to approve monthly payments. The Eighth Circuit observed that the existence of and appropriate standard for materiality in FCA cases is a matter of some disagreement among

the courts. Although the Eighth Circuit has not directly resolved this question, it has stated that the Act provides recovery for material misrepresentations, and has suggested that outcome materiality is the proper standard, ruling that only actions by the claimant that have the purpose and effect of causing the Government to pay money that it is not obligated to pay are actionable claims under the FCA.

However, the court did not need to decide the precise contours of the materiality requirement in this case, because it held that the plaintiffs had failed to produce evidence raising a genuine issue of material fact as to whether the allegedly withheld information was even relevant to the EPA's payment decision. Only with respect to the allegations of tampering with monitoring devices did the plaintiffs produce evidence that the EPA's decision would probably have been affected had it known of the alleged omission. Therefore, the district court did not err in granting summary judgment on all but the monitor tampering claims.

Government Knowledge and Approval of Omissions Negated Scienter Required for Liability

The court of appeals also ruled that the defendants' openness with the EPA about their problems and their close working relationship in solving those problems negated the required scienter regarding those issues. The court quoted with approval the holding of its sister circuits on this point: "If the government knows and approves of the particulars of a claim for payment before that claim is presented, the presenter cannot be said to have knowingly presented a fraudulent or false claim." *United States ex rel. Becker v. Westinghouse Savannah River Co.*, 305 F.3d 284, 289 (4th Cir. 2002), 28 TAF QR 9 (Oct. 2002) (quoting *United States ex rel. Durcholz v. FKW, Inc.*, 189 F.3d 542, 543 (7th Cir. 1999)). Although the defendants' performance under the contract was not perfect, the record showed that the Government was aware of ongoing problems as they occurred, worked with the defendants to correct them, and got what it paid for. Therefore, the district court properly granted summary judgment on these claims.

Relators Failed to State Remaining Claims With Particularity

The only claims that survived the district court's rulings on materiality and scienter were the allegations of intentional tampering with the kiln draft monitor, a measuring device on the waste incinerator. The plaintiffs alleged that the tampering occurred on two specified as well as several other unspecified occasions, but did not indicate who allegedly carried out the tampering, or how it was carried out. Without information as to who allegedly carried out the tampering and how and when it occurred, the court ruled, the defendants would be largely unable to respond with witnesses and documents to defend against these charges. Therefore, the district court did not err in dismissing the claims of tampering on unspecified occasions, and proceeding to trial only on the claims of tampering on the two specified occasions. Accordingly, the Eighth Circuit affirmed the judgment of the district court.

The Eighth Circuit issued two additional decisions in this action on the same date. The court of appeals affirmed the district court's award of costs to the defendants pursuant to Fed. R. Civ. P. 54(b). *See* 317 F.3d 889, summarized under "Attorneys' Fees, Costs, and Expenses" below at page 47. The court also affirmed the district court's denial of the plaintiffs' motion for a default judgment against one of the defendants, MRK Incineration, Inc., which had failed to defend against the suit. *See* 2003 U.S. App. LEXIS 1314, summarized in "Litigation Developments" below at page 50.

***U.S. ex rel. Bidani v. Lewis*, 2003 U.S. Dist. LEXIS 3291 (N.D. Ill. Mar. 4, 2003)**

An Illinois district court denied the defendants' motion for summary judgment in a *qui tam* action based on allegations that the defendants submitted kickback-tainted claims to Medicare. The court ruled that because the Anti-Kickback Act is a critical provision of the Medicare Statute, compliance with it is material to the Government's payment of claims for reimbursement.

Dr. Anil Bidani brought this *qui tam* action against Edmund Lewis and two companies controlled by Lewis, American Medical Supply Corporation (AMS) and Circle Medical Management Corporation. The procedural history of this case is extensive and has been the subject of numerous prior rulings by the district court. *See* 2001 WL 1609377 (Dec. 14, 2001), 25 TAF QR 20 (Jan. 2001); 2001 WL 747524 (June 29, 2001); 2001 WL 32868 (Jan. 1, 2001), 22 TAF QR 10 (April 2001); 1999 WL 163503 (March 12, 1999); 1998 WL 1820753 (Dec. 29, 1998). One count of the complaint remains, in which Bidani alleges that the defendants billed Medicare for dialysis supplies without reporting that they received discounts which were in fact illegal kickbacks under the provisions of the Anti-Kickback Act. The defendants moved for summary judgment on this remaining count, arguing that Bidani had failed to offer evidence that the alleged kickback violations were material to the Government's handling of their Medicare claims.

Court Embraces Outcome Materiality Standard

The court denied the defendants' motion. The court observed that an implied false certification claim such as Bidani's is viable only if compliance with the statute or regulation in question is required in order to receive funds from the Government. The court agreed with the defendants that Bidani needed to show that the alleged violation of the Anti-Kickback Act was material to the Government's treatment of the defendants' Medicare claims. However, the court noted a split of authority as to whether the FCA requires a showing of outcome materiality (that the misrepresentation affected the Government's decision to remit funds) or claim materiality (that the misrepresentation was material to the defendant's claim of right). The court observed that the Seventh Circuit has leaned toward an outcome materiality standard, stating that an omission must be "material to the government's buying decision." *Luckey v. Baxter Healthcare Corp.*, 183 F.3d 730, 732 (7th Cir. 1999). Thus, the court adopted the more stringent outcome materiality standard.

Violation of Anti-Kickback Act Is Material to Payment Decision

Because the defendants' alleged violation of the Anti-Kickback Act was not disclosed to the Government, the question whether the misrepresentation affected the Government's decision to remit funds was a hypothetical one. In such a case, courts must inquire whether compliance with the Anti-Kickback Act was so important or central to the Medicare reimbursement process that failure to disclose noncompliance resulted in wrongful payments. The defendants pointed to the commentary on the 1992 amendments to the Medicare program setting reimbursement caps for the supplies at issue in this case. The comments recognized that the Government often does not have access to suppliers' costs and that the real costs are often lower than the set caps. In the defendants' view, these comments showed that failure to disclose their discounts was not material since the government payment amount would have been the same regardless of the actual cost of the supplies.

The court ruled that the defendants' arguments misread Bidani's allegations. Bidani alleged

not merely that the defendants failed to report discounts that lowered their actual supply costs, but that they submitted claims for supplies for which they received illegal kickbacks.

The Government had entered a statement of interest arguing that because the Anti-Kickback Act is a critical provision of the Medicare Statute, compliance with it is material to the Government's payment decision. The court agreed. The Anti-Kickback Act criminalizes the submission of kickback-tainted claims to Medicare, and bars those convicted of violations from participating in the program. Thus, compliance with the Anti-Kickback Act is central to Medicare, and reimbursing a kickback-tainted claim would put the Government in the position of funding illegal kickbacks after the fact. Accordingly, the court ruled that the alleged kickback violations were material to the Government's payment decision, and denied the defendants' motion for summary judgment.

FCA Liability/False Certification

U.S. ex rel. Ortega v. Columbia Healthcare, Inc., 240 F. Supp. 2d 8 (D.D.C. Jan. 15, 2003)

See "Section 3730(b)(5) First-to-File Bar" below at page 26.

U.S. ex rel. Watson v. Connecticut General Life Insurance Co., 2003 U.S. Dist. LEXIS 2054 (E.D. Pa. Feb. 11, 2003)

See "FCA Liability of Medicare Carriers and Fiscal Intermediaries" below at page 17.

U.S. ex rel. Bidani v. Lewis, 2003 U.S. Dist. LEXIS 3291 (N.D. Ill. Mar. 4, 2003)

See "FCA Liability/Materiality" above at page 8.

U.S. ex rel. Diop v. Wayne County Community College District, 242 F. Supp. 2d 497 (E.D. Mich. Jan. 31, 2003)

A Michigan district court granted the defendant's motion for summary judgment in a case purporting to state, inter alia, a *qui tam* claim for "academic fraud" as well as a claim for retaliation in violation of the FCA's whistleblower protection provision. The court ruled that the plaintiff had failed to establish a claim for false certification, and rejected the retaliation claim on the grounds of Eleventh Amendment immunity, or in the alternative, on the grounds that the plaintiff did not act in furtherance of an FCA claim.

Seydou Diop is an African male employed as a part-time chemistry instructor by the Wayne County Community College District (WCCCD), which operated five campuses in the Detroit area. In 2000, WCCCD posted a job notice for a full-time chemistry faculty position, which was sent to all part-time instructors, including Diop. Diop and various others applied for the position; all applicants, including Diop, who met the minimum requirements for the job (a master's degree and relevant teaching experience) were invited for an interview. However, Diop did not make himself available for an interview. Another part-time chemistry instructor, a white female, was hired for the position.

Three months later Diop filed suit against WCCCD and various college officials, alleging gender, race, and national origin discrimination in violation of Michigan state law and the

Fourteenth Amendment, as well as substantive and procedural due process violations. He also asserted a *qui tam* claim, alleging that the defendants received federal funds by falsely certifying compliance with applicable statutory and regulatory provisions and accreditation standards. He alleged that he suffered retaliation in violation of the FCA's whistleblower protection provisions for complaining of the defendants' "academic fraud." At the close of discovery the defendants moved for summary judgment on all claims.

Plaintiff Misconstrued Nature and Extent of Defendant's Certification to the Government

The court granted the motion and dismissed the case in its entirety with prejudice. Diop's theory of *qui tam* liability was that the accreditation information in WCCCD's application for participation in the Federal Student Financial Aid program was false because the chemistry laboratories were ill-equipped. However, the court observed, although 20 U.S.C. § 1099b requires accrediting agencies to apply certain educational standards in accrediting educational institutions, it imposes no duties on the institutions themselves. WCCCD truthfully certified that it was accredited, but did not certify adherence to any particular standards, much less the particular standards regarding equipment of its chemistry laboratories that Diop sought to engraft onto its certification. Accordingly, the court granted summary judgment to the defendant on Diop's *qui tam* claim.

Defendants Enjoyed Sovereign Immunity From Liability on Retaliation Claim

The court also ruled that the defendants enjoyed immunity under the Eleventh Amendment from liability on Diop's retaliation claim. The court observed that while state colleges and universities almost always enjoy Eleventh Amendment immunity, community and technical colleges tend to present a more difficult question, because they are most often hybrids of state entities, which enjoy such immunity, and local entities, which do not. In such cases courts must examine the degree of local autonomy, and most importantly, the funding of the particular entity in question. The court found that WCCCD was created and governed by state law, and that it received a little more than a third of its revenues from the state in recent years. While the Sixth Circuit has not directly addressed the question of immunity of community colleges, the court found persuasive an Eighth Circuit opinion holding that a community college that received about 75% of its funding from the state enjoyed Eleventh Amendment immunity. Although WCCCD received a smaller percentage of its funding from the state, the court noted that any damage award would necessarily "invade the state treasury, at least in part." Therefore, given the totality of the circumstances, the court held that WCCCD enjoyed Eleventh Amendment immunity.

Plaintiff Had Not Acted in Furtherance of an FCA Claim

As an alternative basis for its ruling, the court held that even if WCCCD did not enjoy immunity, Diop had failed to raise a legally cognizable FCA retaliation claim. Diop had produced no evidence that his complaints about the inadequacies of the chemistry laboratories were made in furtherance of an FCA action. Even accepting his post-deposition affidavit, where he stated that he complained that the condition of the laboratories constituted "academic fraud," Diop had failed to show that he had engaged in activity protected under the whistleblower provisions of the FCA. Because Diop's FCA *qui tam* and retaliation claims, as well as his other claims, did not raise a genuine issue of material fact, the court granted the defendants' motion for summary judgment.

U.S. ex rel. Perales v. St. Margaret's Hospital, 243 F. Supp. 2d 843 (C.D. Ill. Feb. 7, 2003)

An Illinois district court denied the relator's motion for partial summary judgment and granted the defendant's motions for summary judgment in a *qui tam* action based on allegations of violations of the Stark and Anti-Kickback Statutes. The court ruled that the contracts and arrangements identified by the relator did not violate those statutes, and thus could not serve as the basis for an FCA violation.

Constantino Perales, a physician, had a contractual relationship with St. Margaret's Hospital in Spring Valley, Illinois from 1989 through early 1992. In 1994 a dispute arose between Perales and the hospital over payment he allegedly owed it, resulting in state court litigation. In 1998, Perales brought a *qui tam* action against the hospital in federal court, alleging that the hospital violated the Stark and Anti-Kickback Statutes both in its relationship with Perales and by purchasing the practices of several other physicians at prices that exceeded the fair market value of the practices and included kickbacks for future referrals. After discovery, Perales moved for partial summary judgment on his contention that the hospital paid remuneration for referrals. The hospital filed multiple motions for summary judgment, on the grounds that Perales had failed to raise a genuine issue of material fact as to the existence of violations of the Stark and Anti-Kickback Statutes, and that the statute of limitations barred claims arising out of Perales' own relationship with the hospital.

Relator Failed to Establish That Hospital Paid More Than Fair Market Value for Physician Practices

The court denied Perales' motion and granted the defendant's motions. Central to Perales' claim regarding the practice purchases was his allegation that the hospital paid more than fair market value. Perales sought partial summary judgment on this allegation, while the hospital sought partial summary judgment to the contrary. While Perales sought to rely on various depositions to support his motion, the court found that they did not in fact support his contention that the hospital paid more than fair market value. Perales failed to demonstrate what the fair market value for the practices in question was, much less that the amounts paid included any improper inducements. Accordingly, the court denied his motion for partial summary judgment, and granted the defendant's corresponding motion on the issue of practice purchases for more than fair market value. The court similarly granted the defendant's motion for summary judgment on Perales' unsupported assertion that it made improper payments for non-compete agreements and goodwill.

Relator's Own Relationship to Hospital Could Not Give Rise to FCA Claim

Perales alleged that his own contract with the hospital required him to make certain referrals only to the hospital and therefore violated the Stark and Anti-Kickback Statutes. However, Perales also alleged that he did not abide by this contractual restriction and never made an illegal referral to the defendant hospital. The court observed that for FCA liability to attach, the plaintiff must show not just that an inducement to make improper referrals was offered, but also that at least one timely claim for payment tainted by the improper referral relationship was submitted to the Government. Perales' tainted contract with the hospital expired in early 1992, but he did not file his *qui tam* suit until six years and nine months afterward, in late 1998. The court could find no authority indicating that the taint continues once the improper referral-inducing contract is no longer in effect, and the vast majority of the services Perales referred to in his complaint were provided and apparently

billed well outside the statute of limitations. Perales also claimed that he although he never specified that patients should be referred to St. Margaret's, a nurse in his office routinely directed all patients to the hospital, resulting in the filing of false claims. The court rejected this theory, which would impose liability without any culpable conduct, as absurd. Because Perales failed to raise a genuine issue of material fact on his allegations of FCA violations arising out of his own relationship with the hospital, the court granted summary judgment to the defendant on these claims.

Loans and Compensation Paid to Physicians Were Not Contingent on Value or Volume of Referrals

The court also rejected Perales' contention that loans that the defendant made to physicians whose practices it purchased were illegal remunerations for referrals. The court noted that the hospital charged an appropriate amount of interest and the physicians repaid the loans in full. Furthermore, the hospital's contracts with these physicians were bona fide employment agreements, and did not require unlawful referrals. The contracts required the physicians to maintain staff privileges at the hospital, but this requirement was not illegal as it was not contingent on the value or volume of referrals. Therefore, the court granted summary judgment to the defendants on the relator's contention that the loans were illegal remunerations for referrals. Similarly, an independent contractor agreement between the hospital and a physician the hospital had recruited was not contingent on the value or volume of referrals, and thus did not give rise to liability.

Lease Charges For Space and Equipment Were Commercially Reasonable

The court found that, contrary to Perales' assertions, leases for space and equipment between the hospital and various physicians were commercially reasonable and not contingent on the value or volume of referrals. Perales had failed to make any attempt to demonstrate that the rates charged exceeded fair market value. Accordingly, the court granted summary judgment to the defendants on these claims.

Relator Failed to Show Scienter

The defendants also argued, and the court agreed, that even if the relator could show that a violation of the Anti-Kickback or Stark Statute occurred, he had produced no support for his assertion that false claims were made with actual knowledge or in willful ignorance or reckless disregard of their truth or falsity, as the FCA requires. The record showed that SMH obtained independent market valuations before setting compensation and rental rates, received and considered relevant publications on compliance, established a corporate compliance committee, and routinely consulted counsel in drafting contracts and agreements. Moreover, the record did not support a finding of reckless disregard: rather, the court found, "the theories presented by Perales and therefore the process by which any conceivable violation could be demonstrated, are so convoluted and attenuated that it has taken the Court substantial amounts of time even to discern what Perales is talking about, let alone the legal merits of the allegations." Ultimately, however, the court determined that the allegations were without merit, and hence ruled that the defendant could not have "knowingly" violated the FCA as that term is defined in the Act.

Court Criticizes Implied Certification Theory

In conclusion, the court observed that the FCA, which was originally applied to such patently fraudulent activities as billing for services not provided, has recently been expanded

by plaintiffs seeking to reach indirect violations such as the implied false certification claims at issue in this case. There is a lack of consensus on the implied false certification theory, and the Seventh Circuit has not yet addressed it. The court had no need to grapple with this question, as it disposed of the case on other grounds. However, the court suggested that the proceedings in this case could be considered "vivid examples" in support of the rejection of the implied certification theory. The court chastised Perales for expanding exponentially on the few facts of which he had personal knowledge to pursue untenable theories despite repeated warnings, resulting in many years of litigation, substantial expense, and considerable waste of judicial resources.

U.S. ex rel. Barrett v. Columbia/HCA Healthcare Corp., 2003 U.S. Dist. LEXIS 25884 (D.D.C. Feb. 13, 2003)

A District of Columbia district court granted in part the defendant's motion to dismiss a *qui tam* action alleging that the defendant submitted kickback-tainted claims to Medicare. The court rejected the defendant's arguments that kickbacks cannot give rise to an FCA claim and that the implied certification theory is not viable. However, the court granted without prejudice the defendant's motion to dismiss the FCA claims for failure to plead fraud with particularity. The court denied the defendant's motion to dismiss the plaintiff's claim under § 3730(h) for unlawful retaliation.

Scott Barrett and Marie Goodwin worked for Gramercy Surgery Center, Ltd., a subsidiary of Columbia/HCA Healthcare Corporation in Houston. They filed a *qui tam* action against Gramercy, HCA, and various other entities, alleging that the defendants violated the FCA by submitting kickback-tainted claims to federal health care programs, by waiving mandatory copayments, by coding uncovered claims as covered procedures, and by concealing overpayments from Medicare by fraudulent accounting practices. In addition, they raised claims under § 3730(h) for unlawful retaliation. They also asserted a claim under Texas law for intentional infliction of emotional distress, and purported to assert federal common-law claims for unjust enrichment and conspiracy to perform illegal acts, as well as a federal statutory claim for violation of the Anti-Kickback Act. The Government declined to intervene, and the case was transferred to the District of Columbia as part of a multi-district litigation.

HCA moved to dismiss, arguing that kickbacks cannot give rise to an FCA cause of action, and that the relators' implied false certification theory of liability was not viable. They also argued that the relators had failed to plead fraud with particularity as required by Fed. R. Civ. P. 9(b). They urged that the whistleblower retaliation claims should be dismissed because the underlying *qui tam* claim was not viable. They also argued that the non-FCA claims should be dismissed. The relators opposed the motion, and the Government also filed a statement of interest arguing that kickbacks can give rise to an FCA claim, and that the implied false certification theory is viable. *See* 28 TAF QR 49 (Oct. 2002).

Kickbacks May Give Rise to FCA Liability

The court rejected HCA's argument that kickbacks cannot give rise to an FCA cause of action. The court observed that HCA's argument ran contrary to existing precedent. Courts have found that violations of the Anti-Kickback and Stark Acts affect the Government's decision to pay. For a more extensive discussion of this issue, the court referred the parties to its prior opinion in *United States ex rel. Pogue v. Diabetes Treatment Centers of America, Inc.*, 2002 U.S. Dist LEXIS

24425 (D.D.C. Dec. 18, 2002), 29 TAF QR 5 (Jan. 2003).

Implied Certification Theory is Viable

The court also rejected HCA's argument that the implied false certification theory is not viable in the D.C. Circuit. HCA relied heavily on *United States ex rel. Siewick v. Jamieson Science and Engineering, Inc.*, 214 F.3d 1372 (D.C. Cir. 2000), 19 TAF QR 5 (July 2000). However, the *Siewick* court merely held that the relator's implied certification claim in that case failed because the relator had not proved that compliance with the statute at issue there (the so-called "revolving door statute") was a condition of the contract. Thus, the D.C. Circuit in no way rejected the implied certification theory in *Siewick*, and in fact expressed willingness to endorse the theory two years later in *United States v. TDC Management Corp.*, 288 F.3d 421, 426 (D.C. Cir. 2002), 27 TAF QR 21 (July 2002).

Qui Tam Claims Failed to Satisfy Rule 9(b)

Nevertheless, the court dismissed the relators' *qui tam* claims for failure to plead fraud with particularity as required by Fed. R. Civ. P. 9(b). With regard to the claims alleging waiver of copayments, the court found that the relators had not shown that such violations affected the Government's decision to pay, and had not linked those allegations to specific claims for payment by the Government. The upcoding, miscoding, and kickback allegations were also insufficiently linked with the submission of claims to Medicare. The allegations that Gramercy retained overpayments did not refer to a false record or statement, as required under § 3729(a)(7).

HCA argued that the complaint should be dismissed with prejudice, but the court observed that that would be contrary to the principles and policies of Fed. R. Civ. P. 15, which states that leave to amend "shall be freely given when justice so requires." HCA argued that the relators' failure to submit an adequate complaint in three years constituted undue delay, but the court observed that discovery had been stayed pending decision on HCA's motion to dismiss, and thus HCA had suffered no harm or prejudice. Because the relators' complaint in this case was inartfully drafted but not obviously meritless, the court dismissed it without prejudice, and directed the relators to seek leave to file an amended complaint expeditiously.

Retaliation Claim May Be Viable Even If *Qui Tam* Claim Is Not

The court ruled that HCA was wrong to argue that the retaliatory discharge claim failed because the *qui tam* claim was deficient. Congress intended to protect employees engaged in collecting information even before they have put all the pieces together. Thus the employee need not have developed a winning *qui tam* claim to fall under the protection of the retaliation provision; all that is required is that an employee be investigating false or fraudulent claims.

In this case, the plaintiffs alleged that they spoke to supervisors and management regarding the waiver of copayments, discounting, kickbacks, and the retention of overpayments. This satisfied the first two requirements for an action under § 3730(h), namely, that the employees were engaged in protected activity and that their employer was on notice of the activity. Furthermore, the plaintiffs also alleged the third required element, that the employer discharged them because of their activity in furtherance of their *qui tam* action. Accordingly, the court ruled that they had adequately stated a claim for retaliation and denied HCA's motion to dismiss that claim.

The court also denied HCA's motion to dismiss the plaintiffs' claim for intentional infliction of

emotional distress. However, the court granted its motion to dismiss their federal non-FCA claims, which they lacked standing to assert.

U.S. ex rel. Local 342 Plumbers & Steamfitters v. Caputo Co., 321 F.3d 926 (9th Cir. Mar. 5, 2003)

The Ninth Circuit affirmed grants of summary judgment to the defendants in two separate *qui tam* actions by different locals of a plumbers' union based on allegations that the defendants failed to pay wages at the prevailing rate as required by the Davis-Bacon Act. The court ruled that the plaintiffs could not show that the defendants had failed to pay the prevailing wage, because no prevailing wage had been established.

In 1993 and 1994 federal wastewater treatment plant expansion contracts were awarded to the Dan Caputo Company and the C.W. Roen Company, respectively. The projects were governed by the Davis-Bacon Act, 40 U.S.C. § 276a, and applicable regulations, which require contractors to pay prevailing wage rates and to submit weekly certifications of compliance with this requirement to the Government.

In 1992 the Plumbers' Union and the Laborers' Union had signed a "jurisdictional agreement" resolving the classification of piping work on Northern California water treatment plant projects. The 1992 Agreement provided that Plumber-Steamfitter-Pipefitter prevailing wages were to be paid to all employees who performed piping work. In 1994, Frank Conte, the Department of Labor Wage and Hour Division District Director in San Francisco, wrote a letter to the Plumbers' Union's counsel stating that the 1992 Agreement established the prevailing practice in Northern California for classification of work done on water treatment plants. In 1996 Conte sent a second letter to the union's counsel confirming that the relevant job classifications were as set out in the 1992 Agreement. However, in 1997 John Fraser, the acting administrator of the Wage and Hour Division, notified the union's counsel that the Department of Labor had reexamined its position and concluded that it could not enforce the 1992 Agreement because there were indications that the agreement had not been followed in practice.

Meanwhile, in 1995, Local 342 of the Plumbers' Union filed a *qui tam* action against Caputo, alleging that it had violated the FCA by falsely certifying in its Davis-Bacon compliance statements that its employees performing piping work had performed work falling with in a Laborer or Millwright wage classification rather than a Plumber-Steamfitter-Pipefitter classification. The parties filed cross motions for summary judgment.

The court granted the defendant's motion for summary judgment. *See United States ex rel. Plumbers & Steamfitters Local Union No. 342 v. Dan Caputo Co.*, 2001 U.S. Dist. LEXIS 13762 (N.D. Cal. 2001), 24 TAF QR 36 (Oct. 2001). It ruled that the Conte letters were not binding classification determinations because they were not issued in accordance with the regulatory scheme adopted by the Department of Labor to resolve disputed classification issues. Therefore, the relators had presented no evidence that the defendant's Bacon-Davis certifications were false. Moreover, the 1999 letter issued by the Department of Labor constituted a valid final ruling, from which the relators did not appeal. This final ruling determined that the defendant did not misclassify the employees performing piping work on the project. Because the Department issued this ruling in the exercise of its primary jurisdiction on an issue within its regulatory authority, it was appropriate for the court to defer to it. Therefore, both because the relators had failed

to present evidence supporting an essential element of their claim and because that claim was precluded by the Department's ruling, the defendant was entitled to summary judgment.

Similarly, in 1996, Local 38 of the Plumbers' Union filed a *qui tam* action under seal against Roen. The Government declined to intervene. In 1997 the district court entered summary judgment for the defendant, but the Ninth Circuit reversed, holding that the FCA does extend to false claims regarding the payment of prevailing wages, and remanded for further proceedings to ascertain (among other things) the manner in which the Department of Labor may determine prevailing wage rates and job classifications and the effect of the Department's repudiation of earlier wage-rate determinations on the falsity of previously submitted certifications. *See* 183 F.3d 1088 (9th Cir. 1999). In 2001 the union filed a renewed motion for summary adjudication of the defendant's liability, and the defendant filed a cross motion for summary judgment.

The court granted summary judgment to the defendants. *See United States ex rel. Plumbers & Steamfitters Local Union No. 38 v. C.W. Roen Construction Co.*, 2002 U.S. Dist. LEXIS 730, 26 TAF QR 31 (Apr. 2002). The court ruled that there was a genuine issue of material fact whether Conte as District Director had the authority to issue a prevailing wage determination. This ruling foreclosed the possibility of summary adjudication in the union's favor.

The court then examined whether Conte's letters could have constituted a binding determination of prevailing wage rates (assuming he had the proper authority). The parties disagreed over the requirements governing Department of Labor determinations of prevailing wage rates and job classifications. The defendants argued that the applicable procedure is set out in 29 C.F.R. § 5.11, while the union argued that the applicable procedure is set out in § 5.13. The court noted that the facts of this case were almost identical to those in the *Caputo* case. Like the *Caputo* court, the court in this case ruled that because § 5.11 by its own terms "sets forth the procedure for resolution of disputes of fact of law concerning payment of prevailing wage rates, overtime pay, or proper classification," that section, and not § 5.13, sets forth the administrative procedure by which wage classification determinations must be made. Because the union did not dispute that the Conte letters were not issued in accordance with the § 5.11 procedures, those letters did not constitute binding agency determinations.

The union appealed both judgments. The Ninth Circuit consolidated the appeals, and affirmed the judgments of both district courts.

Plaintiffs Failed to Establish Claims Were False

The Ninth Circuit ruled that that the defendants failed to seek a determination of prevailing wage rates in accordance with the § 5.11 procedures. The 1992 agreement did not establish a prevailing wage, as the agreement was not followed. Nor was a prevailing wage established by a collective bargaining agreement, by an actual survey, or by the Conte letters. Therefore, the union did not show that the defendants failed to pay the prevailing wage, and thus they could not show that the defendant's certifications of compliance with the Davis-Bacon Act were false. Accordingly, the district courts properly granted summary judgment in each case.

FCA Liability of Medicare Carriers and Fiscal Intermediaries

U.S. ex rel. Sarasola v. Aetna Life Insurance Co., 319 F.3d 1292 (11th Cir. Jan. 28, 2003)

The Eleventh Circuit ruled that Medicare fiscal intermediaries enjoy immunity from *qui tam* liability for a provider's false claims for payment that the intermediary failed to audit properly. The court stated that if a fiscal intermediary fails to audit a provider's claims, it may be held liable only for its own claim to the Government for auditing services, but not for the provider's claims that it improperly approved.

The relators in this action, Mario Cardoso and Valentine Sarasola, worked for St. Johns Home Health Agency, Inc., a Florida corporation, in the early 1990s. During this period, Aetna Life Insurance Company served as the Medicare fiscal intermediary for the state of Florida. During 1992 and 1993, a dispute arose between Aetna and St. Johns over Medicare reimbursements. Aetna claimed that St. Johns had been overpaid nearly $2.8 million in the two preceding fiscal years, and expressed skepticism about Aetna's claims for home health visits and transcription charges. In 1993 St. Johns sued Aetna and HHS, seeking injunctive and declaratory relief. Later that year St. Johns filed for bankruptcy protection under Chapter 11 and sought a court order prohibiting CMS and Aetna from withholding reimbursement payments. The court denied the motion in 1994, and subsequently approved the sale of St. Johns' assets and its liquidation under Chapter 7.

While St. Johns' chapter 11 case was still pending, Cardoso and Sarasola reported to the FBI that under the direction of its CEO Arnold Friedman, St. Johns was defrauding the Government by seeking reimbursement from Aetna for home health care services it had not provided. Fifteen months later, in June 1995, Cardoso and Sarasola brought a *qui tam* action against St. Johns, Friedman, and Aetna. They alleged that St. Johns, at Friedman's direction, had presented claims for services to fictitious, deceased, or otherwise ineligible persons, for services that were not medically justified, and for services that were never provided. Their complaint also alleged that Aetna aided and abetted this conduct by submitting claims it knew or should have known were false. The Government filed an unopposed motion to stay the *qui tam* action while it conducted a criminal investigation. In 1998 a grand jury returned an indictment against twenty-six defendants. Sixteen pleaded guilty and the Government proceeded to trial against the rest in 1999.

The Government declined to intervene in the *qui tam* action against Aetna, and in 2000 the court dismissed the action, instructing the relators to file a new complaint if they wished to proceed. The relators filed a new complaint, which was almost verbatim the same complaint that they had filed in 1995. Aetna moved to dismiss, contending that it was immune from liability under *United States ex rel. Body v. Blue Cross & Blue Shield of Alabama, Inc.*, 156 F.3d 1098 (11th Cir. 1998), 15 TAF QR 8 (Oct. 1998). The *Body* court had ruled that 42 U.S.C. § 1395h(i)(3) immunizes fiscal intermediaries from FCA liability for payment of fraudulent claims. Conceding that the holding in *Body* applied squarely to their claim as it was currently stated in their complaint, the relators sought leave to amend, which the court granted. The relators then filed an amended complaint, which repeated the same factual allegations as their earlier complaint, but sought to premise liability not on Aetna's certification and disbursement of St. Johns' claims, but rather on Aetna's failure to audit in accordance with its obligations to CMS.

Aetna again moved to dismiss. The district court denied Aetna's motion, ruling that Aetna was not immune under § 1395h(i)(3) from the relators' reformulated claim. Aetna appealed.

Fiscal Intermediaries Are Immune From Liability for Payment of Fraudulent Claims

The Eleventh Circuit held that *Body* foreclosed the relators' claim. To allow the relators to seek recovery of treble damages based on the value of the funds St. Johns fraudulently received from Medicare, the court ruled, would render *Body* and § 1395h(i)(3) "virtual nullities." In the court's view, the relators sought recovery for the very conduct deemed immune in *Body* simply by recasting their theory of liability from "'aiding and abetting' to some sort of contractual *res ipsa loquitur*," under which the intermediary would be presumed to have failed to perform audits properly merely because fraudulent claims were paid.

In *Body* that the court had held that the absolute immunity of fiscal intermediaries was a recognition of their unique administrative function in the operation of the Medicare system and Congress' unwillingness to impose liability for the vast amounts of federal money they disburse. In the case at bar the court held that the relators could not circumvent this immunity simply by alleging a failure to audit.

However, the court reiterated the observation it made in *Body* that the statutory immunity is not so broad as to foreclose all claims against fiscal intermediaries. If a fiscal intermediary has in fact failed to fulfill its contractual obligation to audit a provider's records, than it might be liable in a *qui tam* action for submitting a claim for auditing services never rendered. However, because the court's jurisdiction in this interlocutory appeal was strictly limited under the collateral order doctrine, it had no occasion to rule on the legal or factual feasibility of such a claim.

U.S. ex rel. Watson v. Connecticut General Life Insurance Co., 2003 U.S. Dist. LEXIS 2054 (E.D. Pa. Feb. 11, 2003)

A Pennsylvania district court granted summary judgment to the defendant in a *qui tam* action against a Medicare carrier. The court ruled that the relator had failed to raise a genuine issue for trial on his allegations that the carrier manipulated its software to ignore duplicate claims and engaged in other improper conduct that could give rise to FCA liability, and had not even attempted to demonstrate that the defendant acted with the required scienter. The court also granted summary judgment to the defendant on his FCA retaliation claim, ruling that as an independent contractor rather than an employee of the defendant, the plaintiff lacked standing to bring such a claim.

Michael Watson contracted in 1994 with the Connecticut General Life Insurance Company (CGLIC), a Medicare carrier that processes durable equipment claims for the western part of the United States, to serve as an independent hearing officer in the Medicare appeals process. Under the contracts, Watson was an independent contractor who was compensated on a case-by-case basis, received no employee benefits, set his own schedule, and provided the bulk of his own supplies. CGLIC terminated Watson's contracts pursuant to their terms in 1998. Later that year, Watson filed a *qui tam* action against CGLIC, alleging that it engaged in a multitude of deceptive practices that caused its claims processing costs to rise and thereby increased the reimbursements it received from HCFA. Watson also stated a claim for retaliatory discharge in violation of § 3730(h) as well as various state law claims. In 2000 the Government declined to intervene, and in April 2002 CGLIC moved for summary judgment.

Relator Failed to Provide Evidence Supporting *Qui Tam* Claim

The district court granted summary judgment to the defendant on all counts. Watson alleged numerous forms of improper conduct as the basis for his *qui tam* claim. He averred that CGLIC encouraged Medicare suppliers to resubmit rather than seek review of their denied or incomplete claims to increase its reimbursement; that it manipulated its computer software to allow duplicate claims through its system; that it fraudulently certified compliance with the Medicare Carriers Manual; that it manipulated its Carrier Performance Evaluations in order to boost its compensation, avoid penalties, and secure renewal of its contracts; and that it failed to impose late fees on delinquent providers. None of these allegations survived summary judgment.

Policy of Encouraging Resubmissions Did Not Cause Presentation of False Claims

The court found that CGLIC's policy of encouraging resubmissions did not cause the presentation of false claims. For the most part, this policy had the effect of reducing the amount of money the Government owed to CGLIC. While on at least one occasion the policy resulted in an increase of the amount of funds budgeted to CGLIC for interim payments, CGLIC would retain those funds only if its actual claims processing costs rose, and thus this incident did not give rise to an FCA claim. The court also ruled that there was no evidence that the policy of encouraging resubmissions was wrongful, and noted that there was evidence that the Government was well aware of the policy. Finally, there was no evidence that CGLIC acted with the scienter required for FCA liability. In fact, CGLIC presented evidence that it considered resubmission to be the more efficient and cost-effective method of dealing with denied or incomplete claims.

Allegation that Defendant Manipulated Software to Ignore Duplicate Claims Was Unsupported by Evidence

The court found that Watson had failed to present sufficient evidence to support his claim that CGLIC knowingly manipulated its software to cause duplicate claims to be paid. The court found that Watson's evidence in fact demonstrated that CGLIC properly managed its computer system, educated its employees as to how to process claims correctly, and consulted with the Government and took action when problems did arise. Even assuming that Watson could present sufficient evidence to support his claim that CGLIC manipulated its software, Watson failed to demonstrate that CGLIC did so knowing that it would cause a false or fraudulent claim to be presented to the Government. There was no evidence that CGLIC's occasional failure to catch duplicate claims was caused by anything more than negligence or mistake. Because the court found that Watson presented insufficient evidence to support these allegations, the court had no need to address CGLIC's alternative argument that it could not be held liable under the FCA for duplicate payments because it enjoyed statutory immunity as a Medicare carrier under the approach of *United States ex rel. Body v. Blue Cross & Blue Shield of Alabama*, 156 F.3d 1098 (11th Cir. 1998), 15 TAF QR 8 (Oct. 1998).

Alleged False Certifications of Regulatory Compliance Did Not Influence Government's Decision to Pay

The court ruled that Watson's allegations that CGLIC falsely certified compliance with HCFA regulations and the Medicare Carriers Manual (MCM) could not give rise to FCA liability, because Watson had provided no evidence that such alleged false certifications influenced the

Government's payment decision. Following the holding in *Mikes v. Straus*, 274 F.3d 687, 697 (2d Cir. 2001), 25 TAF QR 6 (Jan. 2002), the court ruled that false certification of compliance cannot give rise to FCA liability when the alleged noncompliance would not have influenced the Government's decision to pay. CGLIC's government funding was based on its workload, not on its compliance with MCM or HCFA directives, and although a provision in its government contract authorized a reduction in funding when the services provided did not correspond to contract requirements, Watson provided no evidence that noncompliance with MCM or HCFA directives would have resulted in the imposition of this contractual penalty. Moreover, CGLIC provided evidence that such penalties were never imposed on carriers like CGLIC that operated under cost-reimbursement contracts. Accordingly, the court ruled that Watson had failed to provide evidence supporting a prima facie FCA false certification claim.

Relator Did Not Support *Qui Tam* Claim Based on Allegations That Defendant Manipulated Contractor Performance Evaluations

The court ruled that Watson failed to carry his burden of providing evidence to support his FCA claim based on allegations that CGLIC engaged in deceptive practices to obtain a favorable Contractor Performance Evaluation (CPE). According to Watson, these alleged practices enabled CGLIC (1) to obtain renewal of its HCFA contracts, (2) to receive incentive payments under the contracts, and (3) to avoid penalties for noncompliance. However, the court found no evidence that CGLIC's CPE would have been deficient had it not engaged in the alleged manipulation, or that the CPE played a decisive role in HCFA's decision to renew the contracts. Moreover, even assuming that the CPE did play a decisive role in the contract renewal decision, the court ruled that the link between the renewal and any false or fraudulent claim was too attenuated to give rise to FCA liability. Similarly, the court ruled that CGLIC's right to incentive payments was unrelated to its CPE. Finally, the court ruled that Watson's claim that the alleged manipulation enabled CGLIC to avoid penalties failed for the same reason as his contract renewal claim: there was no evidence that the CPE would have been deficient absent the alleged manipulation, or that the alleged manipulation caused the Government to pay sums that it otherwise would have withheld as penalties.

Evidence Insufficient to Support Claim Based on Failure to Impose Late Fees

The court found that Watson did not identify evidence sufficient to establish that CGLIC knowingly failed to assess late fees. Medicare carriers are obligated by statute to assess a penalty of ten percent on claims filed by suppliers more than twelve months from the date of service. To support his claim, Watson relied solely on the expert report of Stephen Brooks. However, Brooks' report was completely undermined by his deposition testimony that the late fee could have been waived for good cause or administrative error. Moreover, Watson provided no evidence that CGLIC acted knowingly, recklessly, or with deliberate ignorance in failing to assess the fees. Accordingly, the court granted summary judgment on this claim as well.

Retaliatory Discharge Claim Failed Because Plaintiff Was Not Employee of Defendant

The court granted summary judgment on Watson's FCA retaliation claim, because Watson was an independent contractor rather than an employee of CGLIC, and therefore lacked standing to bring a retaliation claim.

The court observed that the plain language of § 3730(h) limits retaliation claims to employees, and since the FCA does not define the term "employee," its meaning is prescribed by the common law agency doctrine. Watson was a skilled hearing officer who required no training when he contracted with CGLIC, provided most of his own materials and tools, was paid on a case-by-case basis rather than a set salary, and exercised complete control over the time and location of his work. The contract between Watson and CGLIC expressly stated that Watson was "an independent contractor and not an employee" of CGLIC. All these factors pointed in favor of a finding that Watson was an independent contractor. The court conceded that the four year duration of Watson's contract with CGLIC and the fact that they both were in the same business tended to point in the opposite direction, but concluded that these two factors were hardly sufficient to allow a rational jury to conclude that they outweighed the other factors. Accordingly, the court ruled that Watson was an independent contractor and as such lacked standing to bring an FCA retaliation claim against CGLIC.

The court also ruled that Watson had failed to provide evidence supporting his state law claims. Accordingly, it granted CGLIC's motion for summary judgment in its entirety. For a summary of an earlier decision in this case on an evidentiary dispute, see "Litigation Developments" below at page 51.

Government Employee Relators

***U.S. ex rel. Holmes v. Consumer Insurance Group*, 318 F.3d 1199 (10th Cir. Feb. 10, 2003) (en banc)**

The Tenth Circuit, sitting en banc, vacated a panel decision holding that a government employee investigating fraud allegations pursuant to her official duties may not bring a *qui tam* suit based on those allegations. The court rejected the rationales of both the appellate panel, which had held that such an employee is not a "person" for purposes of the FCA's *qui tam* provisions, and the district court, which had held that the Government's ongoing investigation precluded the employee's suit. The en banc majority ruled that the term "person" in the *qui tam* provisions unambiguously encompasses all natural persons. Accordingly, the court reversed the judgment of the district court and remanded for further proceedings.

In 1995 Mary Holmes, who is postmaster in Poncha Springs, Colorado, confirmed the eligibility of Consumer Insurance Group (CIG) for the per pound bulk postal mailing rate. After further investigation, however, Holmes determined that CIG was not eligible for the per pound rate because the pieces in its mailing did not satisfy minimum weight requirements. Two years later Holmes discovered that CIG was nevertheless receiving the per pound rate and reported the matter first orally to her superior and then several months later in a letter to the Office of the Inspector General. The Postal Inspection Service initiated an investigation and turned the case over to the U.S. Attorney. The Government interviewed one current and two former CIG employees, revealing its suspicions to them, although it later became clear that the interviewees were already aware of the fraud. In 1998 the Postal Service commended Holmes' efforts with a letter of appreciation and a $500 award.

In 1999 Holmes filed a *qui tam* action against CIG. The Government moved to dismiss Holmes from the action for lack of subject matter jurisdiction, arguing that its revelations of the allegations to the CIG employees constituted public disclosure, and that Holmes was not an original source. The district court

granted the motion, not on the public disclosure grounds advanced by the Government, but rather on the ground that the Government's ongoing investigation precluded Holmes' suit. Holmes appealed.

A divided panel of the Tenth Circuit affirmed the dismissal of Holmes, but not on the grounds advanced either by the Government or the district court. *See* 279 F.3d 1245 (10th Cir. 2002), 26 TAF QR 9 (April 2002). Rather, the panel majority ruled that a government employee who is part an ongoing government investigation of fraud is not a "person" who may bring a *qui tam* action based on that fraud under § 3730(b)(1). Judge Briscoe dissented, urging that the term "person" clearly encompasses all human beings, including government employees. Holmes appealed the panel's decision to the en banc court of appeals.

Ongoing Government Investigation Does Not Bar *Qui Tam* Action

Upon rehearing en banc, the Tenth Circuit vacated the panel's opinion and reversed the judgment of the district court. Judge Briscoe, who had dissented from the earlier panel decision, now wrote for the majority of the en banc court. The en banc court of appeals rejected the district court's holding that an ongoing government investigation bars subject matter jurisdiction over a *qui tam* action. Under the district court's analysis, a prospective relator would have to report her information to the Government and then immediately file suit in an attempt to act before the Government instituted an investigation into her allegations. Such an analysis runs contrary to congressional intent, because it could prevent persons with legitimate inside knowledge from pursuing a *qui tam* action. The court of appeals concluded that the district court erred in failing to apply the normal public disclosure analysis.

Disclosure to Persons With Prior Knowledge of Wrongdoing Is Not "Public Disclosure"

The court of appeals also rejected the Government's arguments that the public disclosure bar applied, calling them "perplexing, and at times disingenuous." In *United States ex rel. Ramseyer v. Century Healthcare Corp.*, 90 F.3d 1514, 1521 (10th Cir. 1996), 7 TAF QR 1 (Oct. 1996), the Tenth Circuit had held that "public disclosure occurs only when the allegations or fraudulent transactions are affirmatively provided to others not previously informed thereof." Applying this principle to the case at hand, the court concluded that a public disclosure did not occur when government investigators questioned the current and former employees of CIG. Because all three of those employees participated in the alleged fraudulent scheme and had thus been "previously informed thereof," no public disclosure took place during the government investigation.

Term "Person" in *Qui Tam* Provision Unambiguously Encompasses All Individual Human Beings

Finally, the en banc majority rejected the panel majority's conclusion that a government employee investigating fraud allegations pursuant to her official duties is not a "person" who may maintain a *qui tam* action under § 3730(b)(1) based on those allegations. The court noted that the Dictionary Act defines the word "person" to include "individuals," and a number of authoritative dictionaries define "person" as a "human being." Therefore, the court held, there can be no doubt that the word "person" unambiguously encompasses all human beings.

The court rejected the notion that § 3730(b)'s title, "Actions by private persons" might limit who may qualify as a relator under the section.

The court noted that the title of a staturory provision cannot limit the plain meaning of the text, but may only be used to shed light on an ambiguous word or phrase. The court ruled that the word "person" is not ambiguous, but stated that even if it were, consideration of the title could only lead to one of two conclusions—either that all government employees are persons, or that all government employees are not persons. However, the latter conclusion would render superfluous the specific exclusion of certain suits by members of the armed forces in § 3730(e)(1).

The court also rejected the argument that a federal employee who discovers fraud in the course of her employment and is required to report it is not a "person" under § 3730(b) because that section draws a distinction between the Government and the individual *qui tam* plaintiff. The court reasoned that although Holmes may have been acting "as the Government" (that is, in her official capacity) when she obtained the information that formed the basis of her *qui tam* complaint, she was acting as a "person" (that is, in her individual capacity) in filing and pursuing her *qui tam* complaint. The court noted that in *United States ex rel. Marcus v. Hess*, 317 U.S. 537, 546 (1943), the Supreme Court observed that the Senate sponsor of the FCA in 1863 stated that "even a district attorney, who would presumably gain all his knowledge of a fraud from his official position, might sue as the informer." The court opined that the *Marcus v. Hess* Court's view that a government official may file suit based upon information obtained in the course of his or her official duties remains valid.

The court noted the policy arguments that the Government offered against allowing federal employees to maintain *qui tam* actions based upon information obtained in the course of their employment. Government employees are prohibited from using their office for private gain, and permitting *qui tam* suits by federal employees who are already obligated to disclose fraud may create perverse incentives. Although the court conceded that these arguments "have some appeal" and "may be sound," the court held that it lacked the power to interpret the FCA in a way that would eliminate these difficulties. In the majority's view, this is Congress' prerogative, not the courts'.

Dissent Argues Government Employee Investigating Fraud Allegations Pursuant to Duties May Not Bring *Qui Tam* Action Based on Those Allegations

Three judges dissented, arguing that the FCA's grant of jurisdiction over *qui tam* actions plainly assumes a distinction between the Government and the relator, which was not present in this case. The dissent observed that federal courts are of limited jurisdiction, and any doubts must be resolved against jurisdiction. The grant of jurisdiction in § 3730(b)(1) provides that a person acting as relator may bring an action "for the person and for the United States Government." This language, the dissent insisted, assumes a distinction between the Government and the relator, and such a distinction is absent where, as in this case, the relator is a government employee whose job duties include uncovering and reporting the particular type of fraud that is the basis for the *qui tam* action and the relator is participating in an ongoing investigation of that very same fraud.

The dissent criticized the majority for interpreting the word "person" in isolation. It urged instead that the word must be interpreted in its statutory context. Because the statute extends jurisdiction only to persons in a position to bring suit on behalf of themselves and the Government, if there is no distinction between the person and the Government, then, in the

dissent's view, § 3730(b)(1) does not confer jurisdiction on the person.

The dissent noted that the Supreme Court has taught that statutory titles should be used to resolve ambiguity arising from a discrepancy between the title and the text. The title of the provision granting federal jurisdiction over *qui tam* actions refers to actions by "private persons," while the text of the provision refers only to "persons," creating ambiguity. The dissent concluded that the text's reference to "persons" should be understood to refer to the "private persons" referred to in the title, and not persons acting as the Government with regard to the fraud at issue.

The dissent also argued that consideration of the purposes of the FCA, as well as policy considerations embodied in federal conflict of interest statutes, bolstered its conclusion that jurisdiction was lacking in this case. Congress sought to encourage exposure of fraud while preventing parasitic suits. In the dissent's view, Holmes' suit was parasitic because she already had a duty as a government employee to report the alleged fraud, and the Government, by Holmes' own admission, was already engaged in active pursuit of the allegations. Moreover, federal regulations prohibit government employees from using nonpublic government information to further any private interest or to use their office for private gain. In the dissent's view, the majority's construction maximizes the inherent tension between the FCA and the conflict of interest rules. The dissent did not assert that federal employees may never act as *qui tam* relators, but it argued that they may not do so when they are acting as the Government with regard to the particular evidence of fraud that grounds their *qui tam* suits.

Section 3729(b) Knowledge Requirement

***U.S. ex rel. Costner v. U.S.*, 317 F.3d 883 (8th Cir. Jan. 28, 2003)**

See "FCA Liability/Materiality" above at page 5.

***U.S. ex rel. Watson v. Connecticut General Life Insurance Co.*, 2003 U.S. Dist. LEXIS 2054 (E.D. Pa. Feb. 11, 2003)**

See "FCA Liability of Medicare Carriers and Fiscal Intermediaries" above at page 17.

Section 3730(b)(2) Disclosure Statement

***U.S. ex rel. Bagley v. TRW Inc.*, 212 F.R.D. 554 (C.D. Cal. Feb. 5, 2003)**

A California district court granted in part and denied in part the defendant's motion to compel the Government and relator to produce several disclosure statements prepared by the relator pursuant to a *qui tam* suit. The court ruled that the statutory disclosure statement ought to include legal analysis rather than a mere recitation of facts, and both the factual narrative and legal analysis ought to be protected as opinion work product. Accordingly, the disclosure statements were protected from discovery, with the exception of a statement that was used by the relator to refresh his recollection before testifying at his deposition, and any portions of statements already revealed to the defendant, for which work product protection had been waived.

Richard Bagley, the former director of financial control at TRW's Space & Technology Group in Redondo Beach, California, brought this *qui tam* action in 1994, alleging that TRW engaged in various cost mischarging schemes. In 1998, the Government intervened in two of Bagley's claims, and added new claims of its own. *See* 13 TAF QR 26 (Apr. 1998).

The case moved into discovery, and the defendant sought to obtain several disclosure statements prepared by Bagley and his counsel and served on the Government pursuant to § 3730(b)(2). The relator asserted that these statements were protected under the work product doctrine, and the defendants moved to compel production.

Disclosure Statement Should Include Legal Theories As Well As Facts

The court granted the motion in part and denied it in part. The court observed that the FCA does not specify in detail the nature and extent of the relator's disclosure obligation under § 3730(b)(2), and few reported decisions have addressed this issue. While some decisions have suggested that a disclosure statement should contain only facts, others have recognized that the statement may contain additional information, such as legal analysis, theories, and opinion. This inconsistency in reported decisions is paralleled in the practices of relators' counsel, who invest different levels of effort in preparing disclosure statements. Of the two views, however, the court found that the one favoring inclusion of analysis is more consonant with the purpose of § 3730(b)(2). In drafting the 1986 amendments to the FCA, Congress sought to encourage a working partnership between the Government and relators' counsel, and this purpose is promoted if the disclosure statement provides a complete analysis of the factual and legal issues in the case.

However, the court noted, a relator preparing a disclosure statement today is in a bind. On the one hand, the relator should make the statement as complete as possible in order to persuade the Government to intervene and dissuade it from moving to dismiss. On the other hand, it is not in the relator's interest to provide a full and candid discussion of the strengths and weaknesses of the case in the disclosure statement if there is a risk that the statement may be turned over to the defendant. The court observed: "Forcing the relator to navigate unerringly at his or her peril the narrow passage between the Scylla of too little disclosure and the Charybdis of too much disclosure may be unfair and probably makes little sense." Thus, the statutory purpose of the disclosure requirement would be best served by a bright line rule precluding discovery of all portions of disclosure statements or drafts thereof. However, no such bright line rule currently exists: the Act does not explicitly prohibit discovery of disclosure statements, and reported decisions have uniformly concluded that the attorney-client privilege does not protect them.

Work Product Doctrine Protects Disclosure Statements

Nevertheless, the Government and the relator contended that the attorney work product doctrine protected the disclosure statements from discovery. The defendant countered that the statements were not work product, and that even if they were, the defendant had demonstrated "substantial need" justifying discovery of the information contained therein under Fed. R. Civ. P. 26(b)(3).

The court observed that most opinions addressing the issue have concluded that disclosure statements prepared pursuant to § 3730(b)(2) are work product because they are prepared in anticipation of litigation. Although the statements are also prepared to satisfy the statutory disclosure requirement that is a pre-

requisite to suit, that purpose and the litigation purpose are inseparably intertwined.

The court ruled that the relator did not waive work product protection by providing the disclosure statements to the Government. Waiver may occur when a party discloses work product in a manner that increases the likelihood that a current or potential opponent in the litigation might gain access to it. However, although the Government is not a co-party at the time the disclosure statement is filed, and may subsequently take actions adverse to the relator, the court ruled that it would be antithetical to the language and purposes of the FCA to characterize the Government as an adversary or potential adversary of the relator at the time that the disclosure occurs. The FCA seeks to ally relators with the Government to uncover and remedy fraud, and there was no evidence in the record that the Government commonly reveals disclosure statements to the defendants in *qui tam* actions. Accordingly, a number of courts have held that the "common interest" or "joint prosecution" doctrine applies to prevent the relator's disclosure of work product (including the written disclosure statement) to the Government from operating as a waiver.

However, the defendant stated that the Government or the relator had already provided it with redacted versions of the disclosure statement regarding three of their claims. To the extent that the plaintiffs had already produced any disclosure statements to the defendant, the court ruled, they had waived work product protection as to the portions already revealed.

Both Factual Narrative and Legal Analysis Are Opinion Work Product

The court examined whether the disclosure statements at issue were ordinary work product, which enjoys only qualified protection from discovery, or opinion work product, which enjoys nearly absolute protection. The disclosure statements consisted of three parts: (1) a narrative of specific facts and evidence supporting the relator's claim; (2) an analysis of the facts and evidence in light of the relevant legal standards; and (3) a set of supporting exhibits. The third component was not at issue, because all the documents attached as supporting exhibits had already been produced in discovery. The second component plainly constituted opinion work product because it consisted of the mental impressions, conclusions, opinions, or legal theories of the relator and his counsel.

The analysis of the first component (the factual narrative) was more challenging. At a minimum, the narrative was ordinary work product, but arguably it deserved the nearly absolute protection enjoyed by opinion work product. Where the selection, organization, and characterization of facts in a given material reveal the theories, opinions, or mental impressions of a party or the party's representative, that material qualifies as opinion work product. Accordingly, the court ruled that the subjective and analytical process of culling, organizing, and summarizing the factual information presented in the disclosure statement deserved the heightened protection accorded to opinion work product. The statutory requirement that the relator disclose "substantially all material evidence and information" does not call for an indiscriminate catalogue of the entire universe of known facts, but rather requires the relator and his counsel to engage in a process of selecting or winnowing from the totality of information only those facts and evidence that are material to the relator's claims. Thus, the factual narrative necessarily reveals the mental impressions, conclusions, opinions, or legal theories of the relator and his counsel, and accordingly qualifies as opinion work product. Such an approach also furthers the purposes of the FCA by encouraging relators to make their statements as complete as possible, and spares the parties and the court

the expense and burden of litigating the discoverability of disclosure statements.

Thus, the court ruled that the disclosure statements were opinion work product, and denied the defendant's motion to compel production, with two exceptions. First, as noted above, work product protection had been waived as to any portions of the disclosure statements already revealed to the defendants. Second, the relator used one of the disclosure statements to refresh his recollection before testifying at his deposition. Under Fed. R. Evid. 612, courts have the discretion to require production of written material used to refresh the memory of a witness while or before testifying, where the interests of justice so require, for example for purposes of cross-examination. Accordingly, the relator's use of the document to refresh his recollection prior to testifying amounted to a limited waiver of work product protection, and the court granted the defendant's motion to compel production of that document.

Section 3730(b)(5) First-to-File Bar

U.S. ex rel. Ortega v. Columbia Healthcare, Inc., 240 F. Supp. 2d 8 (D.D.C. Jan. 15, 2003)

A District of Columbia district court dismissed a *qui tam* action alleging that the defendant health care corporation violated the FCA by paying kickbacks to physicians for referrals and fraudulently procuring certification from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The court dismissed the kickback claims pursuant to the first-to-file bar, ruling that a later-filed *qui tam* complaint is barred unless (1) it alleges a different type of wrongdoing, based on different material facts than those alleged in the earlier suit and (2) it gives rise to a separate and distinct recovery by the Government. The court also dismissed the JCAHO certification claim, on the ground that JCAHO certification is not a prerequisite to participation in Medicare.

Sara Ortega filed this *qui tam* action in the Western District of Texas in 1995, alleging that Columbia Medical Center West, an El Paso hospital owned by HCA, fraudulently procured certification from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and that this fraud excluded it from participation in Medicare, rendering its claims for Medicare reimbursement false. In late 1997, Ortega amended her complaint, adding allegations that the defendant provided illegal kickbacks for referrals and upcoded treatments to inflate the compensation it received from Medicare. In 1998, the Government intervened in the kickback and upcoding claims, but not the JCAHO certification claim. The upcoding allegations were subsequently settled and Ortega received a relator's share.

The Government later filed a suggestion of dismissal of the kickback claims based on the first-to-file bar, on the grounds that other relators had filed claims, predating Ortega's, that alleged the same scheme. HCA moved to dismiss, asserting in addition to the first-to-file bar that the complaint did not plead fraud with particularity, and that JCAHO accreditation is not a prerequisite to participation in Medicare, and therefore the fraudulent procurement of JCAHO certification would not have affected the Government's decision to pay.

Court Adopts "Material Facts" Rather Than "Identical Facts" Test

The court dismissed the kickback claims pursuant to the first-to-file bar, and the certification claims for failure to plead with particularity and failure to state a claim. Turning first to

the kickback claims, the court observed that § 3730(b)(5) establishes an exception-free first-to-file bar. Litigants have advanced different interpretations of the provision's proscription of a "related action based on the facts underlying the pending action." Relators have argued that the test should be whether the later complaint relies on facts identical to those in the first complaint, while defendants have favored a "material facts" test.

The court ruled that the "material facts" test, rather than the "identical facts" test, is consistent with the language and policy of the FCA. The court noted that § 3730(b)(5) refers to "related" actions and "underlying" facts, language inconsistent with a rigid identical facts test. Moreover, the court observed, "permitting infinitely fine distinctions among complaints has the practical effect of dividing the bounty among more and more relators, thereby reducing the incentive to come forward with information on wrongdoing." For this reason, courts have rejected the identical facts test in favor of the material facts approach.

Later-Filed Claim Barred Unless It Alleges Different Type of Wrongdoing Based on Different Material Facts and Gives Rise to Separate Government Recovery

The court observed that while no single formulation of the material facts test has won universal approval, there is widespread agreement on the test's basic elements. Rather than adopting wholesale the formulation of others, the court combined them to obtain a test that in its view best effectuated the purpose of the first-to-file bar. The court adopted the following formulation: "A later-filed *qui tam* complaint is barred unless (1) it alleges a different type of wrongdoing, based on different material facts than those alleged in the earlier suit; and (2) it gives rise to a separate and distinct recovery by the government."

Under this approach, if the later-filed complaint alleges the same type of wrongdoing as the first, and the first alleges a broad scheme encompassing the time and location of the later complaint, then the later complaint is barred even if it could theoretically lead to a separate recovery. The court reasoned that once the Government learns of the essential facts of the fraudulent scheme, it is able to discover related frauds without outside assistance. The court observed that Rule 9(b) limits the preclusive effect of the first-filed complaint to claims that can be pleaded with particularity, obviating the danger of unsupported placeholder complaints filed for the sole purpose of preemption.

In applying this test, courts need only examine the relevant complaints, and no background evidence is necessary. Therefore, the court denied Ortega's request for an evidentiary hearing. Two other *qui tam* actions based on similar facts to Ortega's were currently before the court. James Thompson filed his original complaint in 1995, alleging that HCA provided kickbacks to physicians to induce referrals "in the Corpus Christi division of the Southern District of Texas as well as elsewhere." Gary Lee King filed his complaint in 1996, alleging that HCA and El Paso Healthcare Systems, Ltd. (EPHS) provided kickbacks to physicians. EPHS owned both Columbia Medical Center East, where King worked, and Columbia Medical Center West, where Ortega worked, although King's complaint did not specifically mention the latter facility. Ortega did not file her amended complaint containing the kickback allegations until 1997. Because these earlier-filed complaints alleged the same type of wrongdoing, based on the same material facts, as Ortega's later complaint, Ortega's later-filed kickback allegations were barred under § 3730(b)(5). The fact that the two earlier complaints did not specifically mention Columbia

Medical Center West did not save Ortega's kickback claim, because a mere variation in geographic location is not a different material fact, and in any case King's specific inclusion of EPHS, which owns Columbia Medical Center West, preempted Ortega's claim.

JCAHO Certification Is Not Required for Participation in Medicare

HCA argued that Ortega's remaining claim, that HCA fraudulently obtained JCAHO certification, was not pleaded with sufficient particularity to satisfy Rule 9(b), and that JCAHO certification is not a prerequisite for participation in Medicare. Turning first to the Rule 9(b) argument, the court ruled that Ortega's description of the fraudulent scheme was sufficiently specific, but that Ortega had failed to connect the scheme to claims for payment. Ortega had listed the names of the committees whose minutes were allegedly falsified, the names of those involved in the falsification, and described the individual instances of falsification. Presumably, her theory was that all claims submitted to Medicare while the hospital held a fraudulently obtained JCAHO certification were tainted and therefore false under the FCA, but her complaint did not explicitly make this allegation. Ordinarily she would have been granted leave to amend to cure this flaw, but because the court went on to hold that her JCAHO certification theory was insufficient to state an FCA claim, amendment would have been futile.

Although JCAHO accreditation automatically confers eligibility to participate in Medicare, the court ruled, it is not a prerequisite. Rather, applicable regulations authorize a number of entities to determine compliance and eligibility to participate in Medicare, including private national accreditation programs, states, JCAHO, and the American Osteopathic Association. The Government will pay a claim submitted by a provider that is not JCAHO-accredited, and the CMS state operations manual provides that when a provider loses its JCAHO certification, it is not automatically disqualified, but rather may be recertified by the state agency. Because JCAHO certification is not a prerequisite to receiving payment, failure to obtain certification does not give rise to FCA liability.

The court also denied Ortega's motion to file various responses under seal, and vacated the seal on all remaining proceedings in the case. Because Ortega's kickback allegations were barred by the first-to-file rule, and her JCAHO allegations did not state a claim under the FCA, the court dismissed her entire complaint with prejudice.

U.S. ex rel. Hampton v. Columbia/HCA Healthcare Corp., 318 F.3d 214 (D.C. Cir. Feb. 7, 2003)

The D.C. Circuit affirmed the dismissal of a *qui tam* action based on the first-to-file bar. In applying the bar, the court adopted the "material facts" test, rejecting the rival "identical facts" test. The court ruled that the fact that the later-filed complaint named different defendants and specified different geographical locations than the earlier-filed complaint did not save the later-filed complaint from dismissal.

Mary Hampton filed this *qui tam* action in the Middle District of Georgia in February 1999, alleging that the defendants, Columbia/HCA Healthcare Corporation, Clinical Arts Comprehensive Services, Inc. (an HCA subsidiary), and several Clinical Arts employees, improperly billed Medicare for home health services. In August 1997, Randall Boston had filed an earlier *qui tam* action in the Northern District of Texas based on similar allegations. In December 1999, the Judicial Panel on

Multidistrict Litigation transferred Hampton's case and twenty-nine others from various districts to the District of Columbia for coordinated pretrial proceedings.

In December 2000, the Government and HCA reached a partial settlement agreement covering thirteen of these cases, including Hampton's. *See* 21 TAF QR 16 (Jan. 2001). Under the agreement, HCA agreed to pay more than $731 million and the Government agreed to dismiss numerous claims against HCA, including claims about the billing practices of more than 600 HCA subsidiaries, among them Clinical Arts. Pursuant to the settlement agreement, in February 2001 the Government intervened in Hampton's case with respect to the improper billing claims against HCA and Clinical Arts, but declined to intervene with respect to the claims against the individual employees. One month later the Government moved to dismiss Hampton's complaint under the first-to-file rule, arguing that it was barred by Boston's earlier-filed action. The district court granted the motion and dismissed Hampton's complaint. Hampton appealed.

Court Adopts "Material Facts" Test

The D.C. Circuit asserted jurisdiction over the appeal and affirmed. The court observed that a split in authority exists as to whether consolidated cases retain their separate identity or become one for purposes of appellate jurisdiction. Some circuits treat consolidated cases as separate actions that may be appealed without certification under Fed. R. Civ. P. 54(b); others treat consolidated cases as a single action; still others focus on the reasons for the consolidation to determine whether the cases are one or separate. The D.C. Circuit has inclined toward the last view, and since Hampton's case and the twenty-nine others were consolidated only for purposes of pretrial proceedings, the court ruled that the order dismissing Hampton's case was a final judgment appealable without certification under Rule 54(b).

Turning to the merits of the appeal, the court adopted the "material facts" test as the proper standard for applying the FCA's first-to-file bar, and rejected the rival "identical facts" test. Under this approach, the language of § 3730(b)(5) barring a "related action based on the facts underlying the pending action" is interpreted to bar actions alleging the same material elements of fraud as the earlier suit, even if the allegations incorporate somewhat different details. The court ruled that this interpretation best serves the purposes of the 1986 amendments, which sought to encourage whistleblowing while at the same time to discourage opportunistic behavior.

Later Action Was Related to and Based on Same Underlying Facts as Earlier Action

Hampton did not dispute that the material facts test was the proper standard but argued that her action was not barred under that standard. She pointed out that while Boston sued only HCA, she sued not only HCA but also Clinical Arts and several Clinical Arts employees. Moreover, although Boston's complaint specifically alleged fraud at HCA home health care subsidiaries in six states, it did not mention Georgia, where Clinical Arts is located. The court ruled that these were not differences in the material elements of the fraud. Boston alleged a corporate-wide problem, in which HCA committed fraud in providing health care services through numerous subsidiaries. Although Boston gave specific details relating to only six states, he described these as "examples" and "samplings" of a widespread pattern of fraud at 550 home health locations in 37 states. The fraud allegations in the two complaints were very much along the same lines.

Hampton also raised an issue about the differ-

ence in the time periods covered by the two complaints. She argued that her complaint included allegations of fraud by Clinical Arts beginning in 1994, and that HCA did not acquire Clinical Arts until 1996. The court indicated that if Hampton was right about the timing of the acquisition, she might have a valid argument that her claims of fraud committed by Clinical Arts before it was acquired by HCA were not precluded by the first-to-file bar. However, the court declined to address this argument, because Hampton did not raise it in the district court, and there was no evidence in the record as to when the acquisition occurred. Ruling that Hampton's action was related to and based on the same underlying facts as Boston's, the court of appeals affirmed the judgment of the district court.

Section 3730(c)(2)(A) Dismissal by the Government

Swift v. United States, 318 F.3d 250 (D.C. Cir. Feb. 11, 2003)

The D.C. Circuit affirmed the district court's dismissal of a *qui tam* action on the motion of the Government pursuant to § 3730(c)(2)(A). The court concluded that that provision sets no substantive limits on the Government's power to dismiss a *qui tam* action, but merely provides the relator a formal opportunity to convince the Government not to end the case.

Susan Swift, a former Department of Justice employee, brought this *qui tam* action in January 1999 against one current and two former employees of DOJ's Office of Legal Counsel. Swift alleged that the employees (one of whom was subsequently dropped from the case) violated the FCA by submitting false time sheets and leave slips, defrauding the Government of $6169.20. Without purporting to intervene, the Government moved to dismiss the complaint, arguing that the amount of money involved did not justify the expense of litigation even if the allegations could be proved. Swift sought a hearing and discovery about the Government's dismissal policy, and moved to unseal the record. The district court granted a hearing, but denied Swift's request for discovery and unsealing. After the hearing the court dismissed the complaint, holding that the dismissal was rationally related to a valid governmental purpose. Swift appealed pro se, arguing that the Government cannot dismiss without first intervening, and that the dismissal was improper.

Government Need Not Intervene to Seek Dismissal

The D.C. Circuit affirmed the judgment of the district court. Section 3730(c)(2)(A) provides: "The Government may dismiss [a *qui tam*] action notwithstanding the objections of the [relator] if the [relator] has been notified by the Government of the filing of the motion and the court has provided the [relator] with an opportunity for a hearing on the motion." While this provision does not require the Government to intervene to seek dismissal, Swift argued that intervention is required under § 3730(b), which requires the Government to intervene if it wishes to "proceed with the action," and under § 3730(c)(1), which provides that once the Government intervenes, the relator may continue as a party subject to the limitations set forth in the dismissal provision, § 3730(c)(2).

The court ruled that Swift's interpretation was unwarranted. While § 3730(b) requires the Government to intervene if it wishes to "proceed with the action," ending the case is not proceeding with the action, so intervention is not required to dismiss. Moreover, although the relator's right to continue as a party after intervention is limited by the right of the Government to dismiss, it does not follow that

the Government must intervene in order to dismiss. In any case, the court ruled, the question whether the Government must intervene in order to seek dismissal is largely academic, because, as Swift conceded at oral argument, the court could construe the motion to dismiss as including a motion to intervene, which the district court granted by ordering dismissal.

Government's Decision to Dismiss is Presumptively Unreviewable

Swift also argued that the Government improperly applied the standard set forth in *United States ex rel. Sequoia Orange Co. v. Baird-Neece Packing Corp.*, 151 F.3d 1139 (9th Cir. 1998), 14 TAF QR 9 (July 1998). The *Sequoia Orange* court ruled that the Government's dismissal power under § 3730(c)(2)(A) is very broad: the Government may dismiss a *qui tam* case regardless of its merits over the relator's objections if (1) the Government shows that the dismissal is rationally related to a valid purpose, and (2) the relator fails to show that the decision to dismiss was fraudulent, illegal, or arbitrary and capricious. The Ninth Circuit reasoned that this standard imposes no greater restriction on the Government's power to dismiss than is already imposed by the Constitution, which prohibits arbitrary or irrational prosecutorial decisions.

Nevertheless, the D.C. Circuit hesitated to adopt this test, suggesting that the Government's power to dismiss is even broader than indicated by the *Sequoia Orange* court. The D.C. Circuit could not see how § 3730(c)(2)(A) could give the Judiciary oversight over the Executive's decision to dismiss, and noted that the provision's language—"the Government [i.e. the Executive] may dismiss"—suggested the absence of judicial constraint. The court added that decisions not to prosecute, which is what the Government's decision to dismiss amounted to, are presumptively unreviewable.

In the D.C. Circuit's view, the *Sequoia Orange* court's interpretation of the constitutional limits on the Government's decision not to prosecute was incorrect. The D.C. Circuit held that the Government's decision whether to bring an action on behalf of the United States is generally committed to the absolute discretion of the Executive, because the Constitution entrusts to the Executive the duty to "take Care that the Laws be faithfully executed." U.S. CONST., art. II, § 3. The court found that nothing in § 3730(c)(2)(A) purports to deprive the Executive of its historical prerogative to decide which cases should go forward in the name of the United States, and concluded that the function of a hearing when the relator requests one is simply to give the relator a formal opportunity to convince the Government not to end the case.

The court also ruled that even if *Sequoia Orange* set the proper standard, the Government easily satisfied it. The Government asserted that the dollar recovery would not justify the expense of resources necessary to monitor the case, comply with discovery requests, and so forth, and that the case would divert scarce resources from more significant cases. The goal of minimizing expenses is a legitimate governmental objective, and dismissal of the suit furthered that objective. Moreover, Swift's assertion that the Government's decision was arbitrary and capricious, illegal, or fraudulent was pretextual and unsupported.

The court ruled that the Government was not required to investigate the validity of Swift's charges, because its decision to dismiss was unrelated to the merits of the case. Moreover, she was not entitled to discovery, because her allegations of improper conduct lacked evidentiary support, and a substantial threshold showing is required for discovery of information related to prosecutorial decisions. The district court did not err in denying Swift's motion to unseal, which came at the eleventh

hour and would have further delayed the hearing, which Swift had already twice postponed. Accordingly, the court of appeals affirmed the judgment of the district court.

Section 3730(d) Relator's Share

U.S. ex rel. Johnson-Pochardt v. Rapid City Regional Hospital, 2003 U.S. Dist. LEXIS 5344 (D.S.D. Feb. 26, 2003)

A South Dakota district court awarded the relator $1.566 million or 24% of the total recovery in a Medicare fraud case that was settled late last year for $6.525 million. In light of the relator's energetic persistence, her attorneys' crucial contributions, and her personal hardships, the court determined that she was entitled to a robust share of the settlement proceeds.

Karen Johnson-Pochardt worked in the 1990s as the administrator at the Rapid City Regional Hospital (RCRH) Cancer Care Institute (CCI). In the early 1990's, Dr. Larry Ebbert and Oncology Associates (OA) entered into a lease arrangement with RCRH, under which Ebbert paid RCRH $19,000 per year to rent 400 square feet of space, while RCRH paid him a medical director fee of $20,000 per year and allowed him to use hospital resources such as staff, equipment, and supplies.

In 1997, after becoming director of CCI, Johnson-Pochardt spoke to Ebbert's practice consultant about the possible illegality of the lease arrangement. Ebbert thereupon wrote a letter to Johnson-Pochardt's supervisor asking that Johnson-Pochardt's responsibilities be confined to public education and marketing. When the supervisor refused, Johnson-Pochardt and the supervisor sustained personal insults from Ebbert and his wife.

Johnson-Pochardt then queried hospital managers whether RCRH was complying with the Stark and Anti-Kickback Statutes, because it did not appear that OA was paying RCRH fair market value for the space and services. Johnson-Pochardt undertook an analysis of the arrangement and concluded that OA was paying $19,000 annually for space and services actually worth $136,441. In 1998 and 1999 Johnson-Pochardt sought legal advice, and in 2000 she presented RCRH's CEO with a spreadsheet indicating that RCRH had subsidized OA by over one million dollars. RCRH still took no action.

Having determined that internal complaints were futile, Johnson-Pochardt filed a *qui tam* action against RCRH, Ebbert, and OA. The complaint was served on the Government in March 2001. The Government sought and obtained ten extensions of time between June 2001 and December 2002 to decide whether to intervene. In December 2002, the parties reached a written settlement, and the Government intervened. RCRH agreed to pay $6 million, and OA agreed to pay $525,000. *See* 29 TAF QR 54 (Jan. 2003). Meanwhile, Johnson-Pochardt reached a severance agreement with RCRH and resigned from her position.

Johnson-Pochardt moved for a relator's share award of 25 percent of the proceeds of the settlement. The Government opposed her motion and moved the court to grant her a share of 16 percent.

Relator's Share Varies According to Relator's Contribution

The court awarded Johnson-Pochardt a share of 24 percent. Quoting from statements made by Representative Berman, House sponsor of the 1986 amendments to the FCA, the court observed it had discretion to award between 15 and 25 percent of the total recovery to the relator in cases in which the Government intervenes, and that the greater the relator's assistance to the Government in investigating and

prosecuting the case, the greater the relator's share should be. In evaluating the relator's contribution and determining her share, the court relied heavily on the analysis in *United States ex rel. Alderson v. Quorum Health Group, Inc.*, 171 F. Supp. 2d 1323 (M.D. Fla. 2001), 25 TAF QR 11 (Jan. 2002).

Senate Factors

The court first considered the factors to be taken into account in determining the percentage of the relator's share based on the discussion in the Senate debates over the 1986 amendments. These factors are the significance of the information provided by the relator, the relator's contribution to the final outcome, and whether the Government previously knew of the information. The court found that all three of these factors indicated that a robust relator's share was appropriate in this case.

Because of her position as director of CCI, Johnson-Pochardt was able to contribute significant information to the Government. She supplied the Government with many important documents and spent a great deal of time analyzing the subsidies OA received and meeting with Government officials to help develop the case. Her assistance was critical in persuading the Government to intervene and instrumental to the success of the settlement negotiations. Moreover, there was no evidence that the Government would have learned of the violations had Johnson-Pochardt not come forward.

Department of Justice Guidelines

The court also considered the internal guidelines established by the Department of Justice for calculating the relator's share. (For the full text of these guidelines, see 11 TAF QR 17 (Oct. 1997)). The court observed that these guidelines are merely non-binding internal standards, and quoted with approval the criticism of the *Alderson* court that the guidelines are self-contradictory, and that their incoherent and "indiscriminate enumeration of fairly obvious factors" is not terribly helpful for purposes of adjudication. Nevertheless, the court stated that some of the guidelines embody common sense considerations that can be of use in determining the relator's share.

The Government argued that factors 1 and 2 in the Guidelines, which indicate that the relator should report the fraud promptly and notify a superior or the Government, militated against an increased relator's share, because Johnson-Pochardt took four years to report the matter to the Government. The court disagreed. Johnson-Pochardt was not a lawyer and needed time to determine whether the defendants were violating federal law. It took her less than a year to bring the matter to the attention of RCRH personnel, and she followed the natural chain of command in hopes that RCRH would correct the matter without resort to a lawsuit. When her efforts proved unsuccessful, and while she was still employed at RCRH, she reported the violations to the Government, thus putting herself at risk of retaliation and termination. These actions supported an increased award.

Johnson-Pochardt also satisfied factors 3, 6, 7, 8, 9, 10, and 11 in the DOJ Guidelines, all of which supported an increased relator's share. Her actions caused the fraud to stop, she provided extensive, first-hand details, the Government had no prior knowledge of the fraud, she provided substantial assistance to the Government, and was candid, honest, and helpful. Her attorneys played a significant role in the case. The Government argued that she was uncooperative because she opposed the Government's requests for long extensions of time to decide whether to intervene. The court rejected this argument, noting that the Government has sixty days by statute to make

its intervention decision, and Johnson-Pochardt's actions in opposing ten extensions over two years did not demonstrate resistance to the Government's investigation. The court observed that Johnson-Pochardt ran the risk of discovery and possible retaliation while the suit remained under seal, and that her attorneys were concerned that the defendants might destroy important documents before they received notice of the suit.

Johnson-Pochardt also suffered substantial harm as a result of her *qui tam* action, which supported an increased award under factor 14 in the DOJ Guidelines. She and her husband sold their business to ensure some financial stability, and her work environment and relationships with co-workers deteriorated drastically. She became withdrawn, her marriage came under severe strain, and she lost hair and suffered other physical ailments. Ultimately, she lost a well-paying job in a field that she loved, together with insurance and retirement benefits, and positions on numerous boards and organizations. Her chances of finding a similar position in South Dakota were greatly reduced.

Like the *Alderson* court, the court in this case rejected the DOJ's factor 13 in its list of factors suggesting an increase in relator's share, and its factor 11 in its list of factors suggesting a decrease. These two factors in the Guidelines suggest that the relator's share should be increased if the recovery is relatively small and decreased if it is relatively large. The court ruled that Congress did not establish a sliding scale to graduate the percentages inversely as the size of recovery increases, and rejected the Government's argument that the size of the total recovery is a relevant factor in determining the relator's share.

However, the court observed that one of the DOJ Guidelines did support a reduced share in this case: the case was settled rather than going to trial. This factor suggested that the relator should not receive the maximum share of 25 percent. Nevertheless, the settlement negotiations themselves were quite arduous, and all of the Senate factors as well as most of the factors in the DOJ Guidelines supported a robust award. Accordingly, the court awarded Johnson-Pochardt a share of 24 percent, one percent short of the maximum.

In an earlier decision in this case, the court denied the Government's motion to keep its requests for extensions sealed. *See* "Litigation Developments" below at page 49.

Section 3730(e) Public Disclosure Bar and Original Source Exception

***U.S. ex rel. Holmes v. Consumer Insurance Group*, 318 F.3d 1199 (10th Cir. Feb. 10, 2003) (en banc)**

See "Government Employee Relators" above at page 20.

***U.S. ex rel. Brennan v. Devereux Foundation*, 2003 U.S. Dist. LEXIS 709 (E.D. Pa. Jan. 14, 2003)**

***U.S. ex rel. Brennan v. Devereux Foundation*, 2003 U.S. Dist. LEXIS 2783 (E.D. Pa. Feb. 25, 2003)**

A Pennsylvania district court denied a defendant's motion to dismiss a *qui tam* action based on the public disclosure bar and Fed. R. Civ. P. 9(b). The court ruled that there had been no public disclosure in any of the statutorily enumerated contexts, and that the relator had pleaded his claim with adequate particularity. The court criticized the approach of

the Seventh Circuit, under which disclosure to a responsible public official is sufficient to raise the public disclosure bar.

Kevin Brennan, a former employee of the Devereux Foundation, brought this *qui tam* suit against his former employer as well as Devereux Properties, Inc., alleging that the defendants submitted false claims for payment for rehabilitation services to Medicaid and Medicare. The Government declined to intervene. The defendants moved to dismiss for lack of jurisdiction pursuant to the public disclosure bar, lack of standing to assert common law claims, and failure to plead with particularity as required by Fed. R. Civ. P. 9(b).

No Public Disclosure Occurred in Any Statutorily Enumerated Context

On January 14, 2003, the court denied the defendants' motion to dismiss Brennan's *qui tam* FCA claim, but granted their motion to dismiss his common law claims, which Brennan conceded he lacked standing to assert. In support of their public disclosure argument, the defendants argued that the Foundation publicly disclosed the transactions underlying Brennan's claim by voluntary disclosures to the intermediary payors responsible for processing their Medicare claims. The defendants relied exclusively on *United States ex rel. Mathews v. Bank of Farmington*, 166 F.3d 853, 861 (7th Cir. 1999), 16 TAF QR 5 (April 1999), which held that "public disclosure within the meaning of § 3730(e)(4)(A) [occurs] when the disclosure is made to one who has managerial responsibility for the very claims being made."

The court ruled that the defendants' argument was without merit. It noted that the Third Circuit has not endorsed the Seventh Circuit's interpretation, but instead strictly adheres to the statutory language, which refers to "the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, civil, or Government Accounting Office [sic] report, hearing, audit, or investigation, or from the news media." The Third Circuit has insisted that in order to fall within this language, the disclosure "must occur in one of the specified contexts." *United States ex rel. Mistick PBT v. Housing Authority of the City of Pittsburgh*, 186 F.3d 376, 383 (3d Cir. 1999). Therefore, the court ruled, under the Third Circuit's interpretation, the defendants' notification to the intermediary payors did not constitute public disclosure.

Rule 9(b) Was Satisfied

The court rejected the defendants' argument that the relator had failed to plead his claim with particularity as required by Rule 9(b). The court ruled that the relator had provided sufficient facts to put the defendants on notice of the claims against them. In fact, the court observed, the defendants proved this point by addressing some of the specific allegations of fraud in support of their motion to dismiss. Accordingly, the court denied the defendants' motion to dismiss the relator's *qui tam* FCA claims.

Motion to Reconsider Denied

On February 25, 2003, the court denied a motion by the defendants to reconsider its January 14 ruling. In its opinion denying its motion to reconsider, the court stated that the defendants had presented two contradictory arguments to support their claim that Brennan's suit was based upon publicly disclosed transactions. The defendants argued that the transactions in question were (1) voluntarily disclosed to a public official with managerial responsibility and (2) disclosed during an administrative investigation or audit.

The court again rejected the first argument, which was based on the Seventh Circuit's opin-

ion in *Mathews*. The court reiterated that the Third Circuit had rejected the approach of the *Mathews* court.

The court also rejected the second argument, which in its view was based on a factually inaccurate premise. Upon reviewing the documents submitted by the defendants, the court concluded that the defendants were right the first time, when they characterized the disclosure as voluntary. The court found no evidence to suggest a federal government audit or investigation prior to the filing of Brennan's *qui tam* action. Accordingly, the court ruled, the jurisdictional bar of § 3730(e)(4) was never triggered.

Seventh Circuit Approach Criticized

Even if the disclosure source were properly classified as an administrative audit or investigation, the court ruled, the defendants still failed to meet the requirement that the disclosure be public. In discussing this requirement, the court offered a detailed critique of the Seventh Circuit's approach in *Mathews*. The court observed that the Third Circuit has consistently held that disclosures are not public unless they are directly in the public's view or within the public access. Thus, in the court's view, the Seventh Circuit's approach, which considers disclosure to a responsible government official public even if the public has no access to the disclosure, is directly contradictory to the Third Circuit's approach.

Moreover, in the court held, the Seventh Circuit's approach directly contradicts the intent of Congress in drafting the public disclosure provision. In enacting this provision, Congress sought to abolish the pre-1986 government knowledge bar. Instead of barring private claims based on any information known to the Government, Congress sought to prevent claims based on information obtained from government inquiries or media accounts rather than personal knowledge. However, the disclosure at issue in *Mathews*, like those in the case at bar, were made to the Government privately, rather than being made to the public or even available to the public. In the district court's view, such a scenario is not what Congress intended to guard against, and application of the public disclosure bar in such a context is unnecessary and unduly burdensome. Furthermore, in the district court's view, the Seventh Circuit in *Mathews* appeared to confuse the disclosure statement requirements of § 3730(b)(2) with the public disclosure bar of § 3730(e)(4)(A).

The court also criticized the *Mathews* court's approach from a public policy perspective. If disclosure to a responsible government official is sufficient to trigger the public disclosure bar, the court ruled, relators will be discouraged from coming forward with important information before filing suit on their own, a result contrary to Congress' intent in enacting the 1986 amendments.

Finally, the court questioned whether the defendants would prevail even if *Mathews* established the proper standard. The *Mathews* court required the disclosure to be made to a "competent public official . . . who has managerial responsibility for the very claims being made." In the case at bar, the defendants made the disclosure not to a public official, but to private Medicaid payors hired by governmental agencies. Thus, there was no evidence that those notified had managerial responsibility for the claim.

U.S. ex rel. Coppock v. Northrop Grumman Corp., 2003 U.S. Dist. LEXIS 3329 (N.D. Tex. Mar. 5, 2003)

A Texas district court denied the defendant's motion to dismiss *qui tam* claims based on the public disclosure bar. Instead, the court directed the parties to brief the issue whether

the defendant was an original source, and indicated that it would allow discovery on the issue whether public disclosure had occurred only if it first determined that the defendant was not an original source.

Stephen Coppock, a former engineer at Northrop Grumman Corporation's Naval Weapons Industrial Reserve Plant in Dallas, a government-owned industrial production and waste treatment facility, brought a *qui tam* action against Northrop, alleging that it falsely certified compliance with contractual and legal duties while contaminating a government-owned production site as well as the local water supply. Northrop moved to dismiss pursuant to the public disclosure bar and Rule 9(b), as well as for failure to state a claim. In August 2002 the court granted that motion in part. The court ruled that it lacked jurisdiction pursuant to the public disclosure bar because Coppock's complaint failed to allege that his claims were not based on public disclosures, and alleged that he was the original source only with respect to claims based on a toxic waste spill in July 1997. The court also dismissed the latter claims for failure to plead fraud with particularity, failure to plead that the alleged false certifications were a prerequisite of payment or forbearance, and failure to plead materiality. However, the court granted Coppock leave to replead the spill component of his claim. *See* 2002 U.S. Dist. LEXIS 14510 (N.D. Tex. Aug. 1, 2002), 28 TAF QR 15 (Oct. 2002).

In September 2002 Coppock filed a second amended complaint, which not only repleaded the spill component of his claim (Count III), but also reasserted the claims that the court had dismissed pursuant to the public disclosure bar (Counts I, II, IV, and V). In the new complaint Coppock alleged that he was the original source with respect to all counts, and also alleged that the information in Counts I, II, IV, and V was not publicly disclosed. Northrop moved to strike Counts I, II, IV, and V, arguing that they reasserted dismissed claims that Coppock did not obtain leave to assert, and moved to dismiss the amended complaint under the public disclosure bar, Rule 9(b), and Rule 12(b)(6).

Motion to Strike Denied

The court denied Northrop's motion to strike and deferred ruling on its motion to dismiss. The court stated that when it directed Coppock "to replead in order to comply with Rule 9(b) with respect to the spill component of his claim" and "to file an amended complaint that cures the deficiencies identified," it meant the deficiencies "that related to the July 31, 1997 spill, but it also intended to include the other deficiencies found." Accordingly, the court ruled that Coppock would be allowed to seek to cure all deficiencies, jurisdictional or otherwise, and denied the motion to strike.

Factual Challenge to Jurisdiction Could Be Resolved Without Discovery

Turning next to Northrop's motion to dismiss pursuant to the public disclosure bar, the court observed that Northrop, relying on affidavits, deposition testimony, and other documents, contended that each of Coppock's FCA claims were based on publicly disclosed information, and that Coppock was not an original source. Because Northrop presented evidence this time to support its jurisdictional challenge, the court held that this challenge, unlike the previous one, was factual rather than facial. Accordingly, Coppock was required to defeat the challenge by a preponderance of the evidence.

In the context of a factual challenge, the court observed, it would normally make sense to grant a stay to allow Coppock to conduct discovery to establish jurisdiction. However, the court ruled, it was possible that Coppock could withstand a factual attack on the court's subject matter jurisdiction by demonstrating that

he was an original source, which he could prove without discovery by means of information in his exclusive custody and control. Therefore, the court discerned no reason to grant a stay to allow additional discovery.

Original Source Issue To Be Resolved Before Public Disclosure Issue

Instead, the court ordered briefing without discovery on the original source issue. If the court then determined that Coppock was not an original source of any of the counts in the second amended complaint, it stated that it would at that point allow discovery to determine whether a public disclosure had occurred. The court recognized that this "regimen" could potentially cause additional delay for discovery on the issue of public disclosure, but considered that preferable to allowing discovery that would not be needed if the jurisdictional question could be resolved based on the original source inquiry alone.

U.S. ex rel. Feingold v. AdminaStar Federal, Inc., 2003 U.S. App. LEXIS 5833 (7th Cir. Mar. 27, 2003)

The Seventh Circuit affirmed the dismissal of a *qui tam* action pursuant to the public disclosure bar. The court ruled that the action was based upon publicly disclosed allegations or transactions and that the relator was not an original source of the information.

Richard Feingold brought this *qui tam* action in 1998 against Associated Insurance Companies, Inc. (AIC), AdminaStar, Inc., and AdminaStar Federal, Inc., which had contracts with HCFA to approve claims submitted by health care equipment providers for reimbursement under Medicare. During the relevant time period, Medicare did not provide reimbursement for adult diapers, and Feingold suspected that the three companies he eventually named as defendants had recklessly approved claims for diapers that were disguised as claims for other, reimbursable items. Feingold believed he found confirmation of his suspicions in the following documents: (1) HCFA and HHS Fraud Alerts issued in 1994; (2) a July 1998 newspaper article reporting the criminal indictments of two individuals for billing Medicare for diapers; (3) the indictments of those two individuals; (4) HCFA statistical reports created in 1998 showing the number of improper claims approved by AIC, AdminaStar, and AdminaStar Federal; and (5) papers from prior *qui tam* litigation that Feingold had brought against other entities.

The Government declined to intervene and the defendants moved for summary judgment. The district court ruled that Feingold's action was based upon public disclosures in the five categories of documents, and that Feingold was not the original source of the information. Accordingly, the district court concluded that it lacked jurisdiction and granted the defendants' motion for summary judgment. Feingold appealed.

Suit Was Based Upon Publicly Disclosed Allegations or Transactions

The Seventh Circuit affirmed the district court's entry of summary judgment, but clarified that the suit failed under the public disclosure bar as a matter of substantive law rather than for lack of jurisdiction. Although the text of the public disclosure bar uses the term "jurisdiction," and courts often refer to it as a "jurisdictional bar," the Seventh Circuit observed that the Supreme Court has held that the FCA's public disclosure provision is actually substantive rather than jurisdictional. *See Hughes Aircraft Co. v. United States*, 520 U.S. 939, 950-51 (1997). The Seventh Circuit pointed this out merely as a technical clarification; it did not materially affect the court's analysis.

The court explained that the underlying policy behind the public disclosure bar is that when a public disclosure has brought a false claim to the attention of the relevant authority, that authority is already in a position to vindicate society's interests, and a *qui tam* action would serve no purpose. Under the Seventh Circuit's approach, a public disclosure occurs when the critical elements exposing the transaction as fraudulent are placed in the public domain. Turning to the dictionary, the court observed that "public" meant "accessible to or shared by all members of the community," while "to disclose" meant "to make known or public." The court also found that its definition of public disclosure was consistent with the context of the FCA and with Congress' intention to encourage those with inside information to come forward, and to discourage parasitic suits.

Accordingly, the court examined the five categories of documents on which Feingold relied in order to determine whether they placed the critical elements of his fraud allegations in the public domain. Feingold conceded that the documents in the first three categories, the newspaper article, the criminal indictments, and the fraud alerts, were publicly disclosed.

The fourth category, the HCFA reports, were administrative reports issued by the responsible government agency, and were therefore placed in the public domain. Feingold sought to avoid the conclusion that they were publicly disclosed by arguing that a DOJ attorney was unaware of any public disclosure. The court dismissed this argument as irrelevant. The administrative report in itself constituted public disclosure; it was of no moment whether a particular attorney was aware of the information.

The fifth and final category consisted of papers from Feingold's previous FCA litigation. Feingold conceded that documents filed in that litigation were publicly disclosed, but stated that suppliers' claims containing patient medical information were not filed in those previous lawsuits and therefore were not publicly disclosed. However, Feingold did not provide the court of appeals with any information about those papers, and did not cite to any part of the record from which the court could examine them. Thus the court was unable to evaluate whether they were even relevant to the case. Accordingly, the court held that all of the information on which Feingold's suit was based was publicly disclosed.

Relator Was Not Original Source

Feingold pointed to no evidence that would allow a factfinder to conclude that he had independent knowledge of the allegations or transactions upon which his suit was based. Instead, he merely offered the conclusory assertion that "through his own investigation, [Feingold] gathered the information necessary in order to make the allegations against" the defendants. Thus the district court did not err in concluding that Feingold was not an original source. Therefore, the court of appeals affirmed the district court's grant of summary judgment.

Section 3730(h) Retaliation Claims

***U.S. ex rel. Diop v. Wayne County Community College District*, 242 F. Supp. 2d 497 (E.D. Mich. Jan. 31, 2003)**

***U.S. ex rel. Barrett v. Columbia/HCA Healthcare Corp.*, 2003 U.S. Dist. LEXIS 3083 (D.D.C. Feb. 24, 2003)**

See "FCA Liability/False Certification" above at page 8.

U.S. ex rel. Watson v. Connecticut General Life Insurance Co., 2003 U.S. Dist. LEXIS 2054 (E.D. Pa. Feb. 11, 2003)

See "FCA Liability of Medicare Carriers and Fiscal Intermediaries" above at page 17.

U.S. ex rel. Siewick v. Jamieson Science & Engineering, Inc., 2003 U.S. App. LEXIS 5924 (D.C. Cir. Mar. 28, 2003)

The D.C. Circuit affirmed a grant of summary judgment in favor of an individual supervisor who was named as an additional defendant in a § 3730(h) action against a corporate employer. The court ruled that as a matter of law the supervisor was not the plaintiff's employer and could not be held liable for retaliation.

Dr. Joseph Siewick brought this § 3730(h) action against his former employer Jamieson Science and Engineering, Inc., as well as his immediate supervisor Dr. John Jamieson, who was the company's chairman, president, and majority shareholder, alleging that the defendants wrongfully fired him for blowing the whistle on improprieties in the company's billing for government contracts. After Jamieson's death his estate was substituted as a defendant. The estate moved for summary judgment, arguing that Jamieson was not Siewick's "employer" for purposes of § 3730(h).

In July 2001 the district court denied that motion, but on reconsideration in light of intervening D.C. Circuit precedent the court granted the motion in February 2002. *See* 191 F. Supp. 2d 17 (D.D.C. 2002), 26 TAF QR 23 (Apr. 2002). The district court noted that under *United States ex rel. Yesudian v. Howard University*, 270 F.3d 969 (D.C. Cir. 2001), 25 TAF QR 13 (Jan. 2002), the question whether an individual defendant is an "employer" for purposes of § 3730(h) is legal rather than factual, and the word "employer" as used in the retaliation provision "does not normally apply to a supervisor in his individual capacity." The court held that Jamieson's estate could not be held liable for the acts of the corporation absent circumstances warranting piercing the corporate veil. Siewick appealed.

Existence of Employment Relationship is Question of Law

The D.C. Circuit affirmed. Siewick argued that whether Jamieson was Siewick's employer was a factual issue precluding a grant of summary judgment, but the court of appeals reiterated that the existence of an employment relationship is a question of law, not fact. Because Congress did not define the term "employer" in the FCA, the court presumed that Congress intended the term to have its ordinary common law meaning. Siewick argued that the Senate Report on the 1986 amendments, which states that "the definition[] of . . . 'employer' should be all-inclusive," supported a different meaning. However, as far as the court could determine, the Report signified only that the term was meant to cover both public and private employers.

Corporation is Sole Employer of Its Employees

The court ruled that "[t]he corporation only is the employer of the corporation's employees." Thus neither Jamieson's ownership nor his control of the corporation made him Siewick's "employer" within the common law meaning of that term. A footnote in Siewick's brief asserted that the corporate veil should be pierced because the corporation allegedly engaged in fraud. But his complaint did not even allege that the corporate form was a sham in this case. The district court in this case correctly insisted on the importance of the differ-

ence between being a fraud and conducting one. Because there was no basis for piercing the corporate veil in this case, the court of appeals ruled, the district court did not err in granting summary judgment.

Section 3731(b) Statute of Limitations

U.S. ex rel. Purcell v. MWI Corp., 2003 U.S. Dist. LEXIS 4410 (D.D.C. Mar. 25, 2003)

A District of Columbia district court denied a motion to dismiss the Government's complaint in intervention in a *qui tam* action as either time-barred or precluded by principles of equity. The court ruled that the Government's complaint was timely under the relation-back doctrine, and that there were insufficient facts in the record to determine when the FCA's three-year tolling provision was triggered.

Robert Purcell filed this *qui tam* action on August 28, 1998 against his former employer MWI Corporation, a manufacturer of industrial pumps. In the early 1990s MWI arranged to sell irrigation pumps to seven Nigerian states, and in 1992 the U.S. Export-Import Bank made eight loans totaling $74.3 million to Nigeria to finance the sales. As a condition of approving and disbursing the payments, the Government required MWI to certify that it had not paid any commissions or other payments in connection with the pump sales. J. David Eller, the former president of MWI, signed most of these certifications. Purcell alleged that the certifications were false, because the company had paid $28 million in commissions to their Nigerian sales representative to obtain the sales contracts.

Purcell's suit sparked a criminal investigation, and the Government obtained multiple extensions to determine whether to intervene in the *qui tam* action. Finally, in January 2002 the Government elected to intervene, and in April 2002 it filed its own complaint in the action. *See* 27 TAF QR 46 (July 2002). In addition to joining Purcell's FCA claims against MWI, the Government added an FCA claim against Eller, as well as equitable claims for unjust enrichment and payment by mistake.

The defendants moved to dismiss the Government's complaint. They argued that all of the Government's claims were time-barred, and that its equitable claims were barred because the FCA furnished a complete and adequate remedy at law. Eller also argued that the Government could not add him as a defendant, because the statute of limitations had expired and the relation-back doctrine does not apply to new defendants absent a mistake of identification.

Relation Back Doctrine Applied to Government's FCA and Equitable Claims

The court denied the defendants' motion, ruling that the Government's complaint was timely under Fed. R. Civ. P. 15(c). That rule provides that a plaintiff may amend its complaint to add a claim or defense that "arose out of the conduct, transaction, or occurrence" set forth in the original pleading. In determining whether an amendment relates back to the original complaint, courts inquire whether the complaint gave the defendant notice of the new claim. The defendants argued that the Government's complaint represented a new action that paralleled rather than amended the relator's complaint, and noted that the Government's complaint was broader than the relator's complaint in that it added Eller as a defendant and included non-FCA claims, but also narrower in that it did not repeat the rela-

tor's allegations that MWI created deceptive equipment descriptions.

The court rejected the defendants' argument. It observed that the United States is the real party in interest in *qui tam* actions, and hence the Government's complaint in intervention is an amendment of the relator's complaint. Therefore, if the Government's claims arose out of the conduct set forth in the relator's complaint, then under Rule 15(c) the Government's complaint relates back to the date of the relator's complaint. In the case at bar, both the Government's FCA claims and its additional equitable claims arose out of the defendants' alleged concealment of its improper "commission" payments. Hence the relation-back doctrine applied to both the Government's FCA claims and its equitable claims.

Motion to Dismiss Claims Against Eller Was Premature

However, the relation-back doctrine did not apply to the Government's claims against Eller. Rule 15(c) permits relation back for newly-added defendants only if cases of mistaken identity. Therefore, the Government's claims against Eller were viable only if the Government's complaint was filed within the applicable statute of limitations. Because the last alleged violation occurred in 1994 and the Government's complaint was not filed until 2002, the six-year limitations period of § 3731(b)(1) had clearly expired. Therefore, the Government's FCA claim against Eller was viable only if it fell within the three-year tolling period of § 3731(b)(2), which provides that an FCA claim may not be brought "more than 3 years after the date when the facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstance." Similarly, the equitable claims against Eller were limited by 28 U.S.C. § 2415, which provides a three-year limitations period for tort claims, subject to a tolling provision in § 2416(c) that excludes periods when "facts material to the right of action are not known and reasonably could not be known" by the responsible federal official.

Accordingly, the viability of the Government's FCA and equitable claims against Eller turned on when the responsible federal official knew or should have known of the material facts. The defendants contended that the applicable date was August 27, 1998, when the relator's complaint was served on the Department of Justice. The relator's complaint stated that Eller was the president, CEO, and sole owner of MWI and that he signed the supplier's certificates. Applying the three-year limit, the defendants concluded that the Government's claims against Eller, which were filed on April 4, 2002, were time-barred.

However, the Government contended that the relator's complaint did not allege that Eller knowingly approved the alleged commissions, and even if it had, receipt of such allegations would not have been enough to trigger the limitations period. Instead, the Government insisted that the date on which the Government learned of Eller's alleged role was a question of fact that could only be resolved on a motion for summary judgment, not on a motion to dismiss. The court agreed, ruling that there were not enough facts in the record to permit it to determine when the responsible federal official should have known of the material facts underlying the allegations against Eller. Therefore, the court declined to dismiss the Government's claims against Eller at this point in the proceedings.

Government May Plead Alternative Theories of Liability

The court also rejected the defendants' argu-

ment that it should dismiss the Government's equitable claims because they were inconsistent with its FCA claims. The defendants observed that equitable relief is not available when the plaintiff has a complete and adequate remedy at law, and asserted that the FCA's treble damages are more than adequate because they allow the Government both to recoup its losses and punish the defendants. To bolster their argument, the defendants relied on the Supreme Court's statement in *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765, 784 (2000) that FCA damages are "essentially punitive in nature."

The court rejected this argument, observing that under Fed. R. Civ. P. 8(e)(2), a plaintiff may plead alternative theories of liability, regardless of whether such theories are consistent with one another, although a plaintiff may not recover damages on the basis of mutually inconsistent theories. Accordingly, dismissal of the equitable claims was not appropriate on a motion to dismiss.

Moreover, the court observed that recently in *Cook County v. United States ex rel. Chandler*, 123 S. Ct. 1239 (2003), *supra* page 1, the Supreme Court clarified that FCA treble damages have a compensatory side and may be necessary for full recovery. Accordingly, the court declined to determine at this stage of the proceedings whether FCA damages in this case constituted a complete and adequate remedy at law that barred equitable relief.

Rule 9(b)

U.S. ex rel. Costner v. U.S., 317 F.3d 883 (8th Cir. Jan. 28, 2003)

See "FCA Liability/Materiality" above at page 5.

U.S. ex rel. Ortega v. Columbia Healthcare, Inc., 240 F. Supp. 2d 8 (D.D.C. Jan. 15, 2003)

See "Section 3730(b)(5) First-to-File Bar" above at page 26.

U.S. ex rel. Brennan v. Devereux Foundation, 2003 U.S. Dist. LEXIS 709 (E.D. Pa. Jan. 14, 2003)

See "Section 3730(e) Public Disclosure Bar and Original Source Exception" above at page 34.

U.S. ex rel. Barrett v. Columbia/HCA Healthcare Corp., 2003 U.S. Dist. LEXIS 3083 (D.D.C. Feb. 24, 2003)

See "FCA Liability/False Certification" above at page 12.

U.S. ex rel. Cericola v. Ben Franklin Bank, 2003 U.S. Dist. LEXIS 1044 (N.D. Ill. Jan. 27, 2003)

An Illinois district court denied a motion to dismiss a *qui tam* complaint alleging that the defendants submitted false claims to HUD for Title I loan insurance. The court ruled that the relator had stated her allegations with sufficient particularity to satisfy Rule 9(b).

Karen Cericola, a senior vice president of Ben Franklin Bank, brought this *qui tam* action against the bank and its officers, alleging that they submitted false claims for federal mortgage insurance payments under the HUD Title I loan insurance program. Cericola alleged that the officers caused the bank to purchase a portfolio of 424 low-grade mortgage loan investments shortly before attempting to take the bank public in late 1990. The officers

intended to use the portfolio to inflate the bank's reported earnings by recognizing in the year of the initial public offering all of the revenue that the bank could expect to receive from servicing the loans over their expected six-year life. In fact, these loans were highly risky and improperly underwritten, and it was unreasonable to believe that they would reach their expected life without defaulting. By exposing this scheme, Cericola forced the bank to call off the IPO, and shortly thereafter the bank began experiencing a crippling number of defaults on these loans.

Faced with the potential failure of the bank, Cericola alleged, the officers tried to unload the loans onto the taxpayers through a scheme of false claims for federal mortgage insurance payments under the HUD Title I loan insurance program. Both Cericola and an outside consultant discovered numerous instances of improper underwriting on the loans, and shared their findings with the bank's officers. Nevertheless, Cericola alleged, in late 1999 the defendants began submitting claims to HUD for insurance on loans that it knew to be uninsurable. HUD refused to make payment on 50 of the 81 submitted loans, but paid $715,694 on the remaining 31 loans.

In addition to her *qui tam* claim, Cericola brought a claim under the anti-retaliation provisions of the FCA and the Financial Institution Reform, Recovery, and Enforcement Act of 1989 (FIRREA), as well as a claim for intentional infliction of emotional distress. The defendants moved to dismiss for failure to plead fraud with particularity as required by Fed. R. Civ. P. 9(b) and failure to plead materiality. They also filed various motions seeking to dismiss Cericola's FCA and FIRREA retaliation claims, as well as her claim for intentional infliction of emotional distress.

Complaint Satisfied Rule 9(b)

The court denied the defendants' motion to dismiss. The court noted that Cericola identified each of the 81 loan claims and set forth the reasons why each was false by identifying specific underwriting deficiencies. Moreover, Cericola alleged that the board of directors caused false claims to be submitted, and it was reasonable to presume that the submissions of the allegedly false claims were the collective actions of the officers of the bank. Thus, Cericola had adequately pleaded her fraud allegations with particularity, and had informed the defendants of their role in the alleged fraud, thus satisfying Rule 9(b).

The court also rejected the defendants' argument that Cericola failed to allege materiality, noting that she alleged that the defendants submitted claims that they knew were ineligible for reimbursement. The court rejected as meritless the defendants' argument that HUD regulations provided a safe harbor for their actions. It also rejected their argument that Cericola's FCA retaliation claim should be dismissed because she had not adequately pleaded her FCA *qui tam* claim. However, it granted the defendants' motion for a more definite statement of her FIRREA retaliation claim. Finally, the court denied the defendants' motion to dismiss Cericola's claim for intentional infliction of emotional distress.

***Peterson v. Comm Gen Hosp*, 2003 U.S. Dist. LEXIS 1783 (N.D. Ill. Feb. 7, 2003)**

An Illinois district court granted the defendants' motion to dismiss a *qui tam* action based on allegations of self-referrals for failure to plead with particularity as required by Fed. R. Civ. P. 9(b). The relator failed to specify which claims were fraudulent and which patients had been illegally referred to the defendants, or to provide representative examples of the alleged fraud.

Dr. David Peterson filed this improperly captioned *qui tam* action against CGH Medical Center (incorrectly named "Community General Hospital"), Sterling Rock Falls Clinic, and Katherine Shaw Bethea Hospital, alleging that the defendants violated the FCA by submitting Medicare claims tainted by self-referrals in violation of the Stark law. The defendants moved to dismiss pursuant to Fed. R. Civ. P. 9(b) and 12(b)(6).

Complaint Failed to Specify Allegedly False Claims

The court granted the motion. For present purposes the court assumed that violation of the Stark law could render otherwise proper claims false under the FCA, because the defendants did not contest that issue. Rather, the defendants argued that the relator's allegations did not meet the heightened pleading standard of Rule 9(b). Although the gravamen of the relator's complaint was that the defendants billed Medicare for services to patients referred to them in exchange for financial and other remuneration, the complaint did not identify a single Medicare patient referred to the defendants through any of the allegedly unlawful arrangements. The complaint also failed to identify a single Medicare claim submitted for services rendered pursuant to an unlawful self-referral. The court stated that it did not expect the relator to list every single patient, claim, or document involved, but it did expect him to provide at least some representative examples.

The relator argued that he was unable to provide this information because it was within the defendants' exclusive control. However, the court rejected this assertion, noting that the claims at issue were submitted to the Government. Moreover, the court ruled, even if the relator were correct, he should at least plead the particular circumstances of the fraud on information and belief, as well as the factual basis for his suspicions. Accordingly, the court granted the defendants' motion to dismiss, and gave the relator twenty-one days to file an amended complaint or face dismissal with prejudice. The court also directed the relator to supply a proper caption for the amended complaint, in which he should identify the plaintiff as "United States ex rel. Dr. David Peterson."

U.S. ex rel. McCready v. Columbia/HCA Healthcare Corp., 2003 U.S. Dist. LEXIS 3300 (D.D.C. Mar. 7, 2003)

A District of Columbia district court denied a defendant's motion to dismiss a *qui tam* action alleging that the defendant health care providers manipulated the length of patient stays to maximize reimbursement. The court held that the allegations in the complaint met the standard of pleading fraud with particularity. The court also rejected the moving defendant's argument that it could not be held liable because it did not benefit from the alleged fraud. Finally, the court clarified that the Government may participate in a declined case by submitting a statement carefully crafted to protect its interests but avoid involvement in the factual issues.

Dr. Clint McCready brought this *qui tam* action against Columbia North Monroe Hospital, its owner and operator Columbia/HCA Healthcare Corporation, Milestone Healthcare (a management company), and various others, alleging that the defendants manipulated the length of patient stays to maximize reimbursement. Medicare reimbursement of illnesses covered by certain diagnostic codes is made on a per diem basis, up to a maximum amount based on the geometric mean length of stay. McCready alleged that the defendants acted to keep patients with such diagnoses in hospital care at North Monroe until they reached the geometric mean length of stay, regardless of the

medical suitability of that course of treatment. Milestone, which manages a rehabilitation center, is reimbursed on a cost basis rather than on the basis of diagnostic codes, but the relator alleged that Milestone participated in the scheme to retain patients at North Monroe. This case is now part of the multidistrict litigation of *qui tam* suits against HCA and various related entities.

Milestone moved to dismiss, arguing that the relator's complaint failed to plead fraud with particularity as required by Fed. R. Civ. P. 9(b). It also argued that it could not be held liable for North Monroe's alleged fraud because it did not benefit from that fraud. The relator responded to Milestone's motion, and the Government also filed a statement of interest, requesting that any dismissal resulting from Milestone's motion be without prejudice to the Government, and contesting Milestone's argument that its lack of pecuniary benefit mandated dismissal. In its reply, Milestone challenged the Government's right to participate in the motions practice of a case in which it had not intervened.

Complaint Satisfied Rule 9(b)

The court denied Milestone's motion to dismiss. The relator alleged that while he was employed as the medical director of the Milestone rehabilitation unit, he was instructed not to allow the transfer of patients until the geometric mean length of stay had been reached, and named specific patients to whom this scheme had been applied. He alleged that as a result of these extended stays, cost reports and reimbursement claims submitted to Medicare contained inflated costs, and that this practice was widespread in the HCA system. The court found that the complaint identified the time period of the alleged fraud, the parties involved, the schemes employed, and the inflated claims that resulted. Thus, the complaint amply prepared the defendants to meet the allegations contained in them and accordingly satisfied Rule 9(b).

Defendant Need Not Benefit From Fraud to Incur Liability

The court also rejected Milestone's argument that it could not be held liable under the FCA because it was not reimbursed on a per diem basis and thus did not benefit from the alleged fraud. The court observed that an FCA plaintiff need only plead the facts forming the basis for the fraud, and is not required to plead his legal theory. Furthermore, a corporation is liable for the fraudulent acts of its agents even if it received no benefit from the fraud. Milestone sought to rely on a 1981 case quoting an older version of *Moore's Federal Practice* for the proposition that to satisfy Rule 9(b) a fraud complaint must state not only the time, place, and content of the false representation, but also "what was obtained or given up as a consequence of the fraud." However, the court observed that the current version of *Moore's* omits the latter phrase and substitutes the phrase "the resulting injury," thus clarifying that the older reference to "what was obtained or given up" refers to the defrauded party (the Government) rather than the perpetrator. Because the relator had adequately alleged that the Government paid more than was necessary to treat Medicare patients, he had specified what was given up by the Government, *i.e.*, the resulting injury.

Government May File Statement of Interest in Declined Case

The court ruled that the Government acted properly in filing a statement that was carefully crafted to avoid involvement in the factual issues of this declined case and designed solely to protect its own interests. While nonparties generally may not participate in litigation, the Government is in a unique position in declined

qui tam cases, because it remains the real party in interest regardless of whether it has intervened. In its statement of interest in this case, the Government expressly disclaimed taking a position on the sufficiency of the relator's complaint. Rather, it requested that any dismissal be without prejudice to it, and it discussed the purely legal aspect of Milestone's claim that pecuniary benefit to the defendant is required for liability, thus assisting the court by enlightening it on a point of FCA jurisprudence. Accordingly, the Government's participation in motions practice in this case was not improper.

Attorneys' Fees, Costs, and Expenses

U.S. ex rel. Costner v. U.S., 317 F.3d 889 (8th Cir. Jan. 28, 2003)

The Eighth Circuit affirmed the district court's award of costs to the defendants in a *qui tam* action pursuant to Fed. R. Civ. P. 54(b). The court rejected the relators' contention that § 3730(d)(4) of the FCA precludes an award of costs under Rule 54(b).

The plaintiffs in this *qui tam* action, a group of individuals and public interest groups, filed suit in 1995 alleging that the defendant corporations conspired to submit false claims for payment under a government contract for the treatment and disposal of hazardous waste at the Vertac Chemical Plant site in Jacksonville, Arkansas. The Government declined to intervene, and after extended discovery, the district court granted summary judgment to the defendants on most claims, and after trial entered judgment on the remaining claims. The Eighth Circuit affirmed.

After entry of judgment, the defendants moved for reimbursement of costs in the amount of $163,592. The district court ordered the plaintiffs to pay $26,408, reducing the amount in part because of the defendants' failure to itemize many of the submitted costs. The relators appealed on three grounds: (1) that § 3730(d)(4) of the FCA precluded an award of costs under Fed. R. Civ. P. 54; (2) that the relators were entitled to relief from the award of costs because of their limited financial resources; and (3) that the defendants' improper conduct precluded an award of costs.

Section 3730(d)(4) Does Not Preclude an Award of Costs Under Rule 54(b)

The Eighth Circuit affirmed the judgment of the district court. Rule 54(d)(1) provides: "Except when express provision therefor is made either in a statute of the United States or in these rules, costs other than attorneys' fees shall be allowed as of course to the prevailing party unless the court otherwise directs." The relators argued that § 3730(d)(4) of the FCA is an "express provision" for costs that displaces the court's authority under Rule 54 to award costs to the defendant. Section 3730(d)(4) provides that "the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for the purposes of harassment."

The court observed that the term "costs" does not appear in § 3730(d)(4). However, the relators contended that the term "expenses" in the FCA includes costs, and thus the reference to expenses in § 3730(d)(4) is an express provision regarding costs. The court rejected this contention, observing that in contrast to § 3730(d)(4), § 3730(d)(2) provides for the award to a prevailing *qui tam* plaintiff of "reasonable expenses . . . plus reasonable attorneys' fees and costs." Similarly, § 3730(g) provides for an award of costs to a prevailing defendant

when the Government intervenes by referring to 28 U.S.C. § 2412(d), which also distinguishes among fees, expenses, and costs. The court concluded that the reference to fees and expenses in one subsection, and to expenses, fees, and costs in two other subsections evinced an intent to treat the awards differently. If the term "expenses" included costs, the court reasoned, there would have been no need for an express reference to costs in the latter two subsections.

Award of Costs Was Not Abuse of Discretion

The Eighth Circuit found no abuse of discretion in the award of costs, observing that the district court substantially reduced the amount of costs requested by the defendants. The court of appeals noted that "the defendants [*Editor's Note*—The court apparently meant to say "the plaintiffs"] have produced no evidence of their inability to pay." Furthermore, the court ruled that the plaintiffs' contention that the defendants engaged in improper conduct was without merit. Accordingly, the Eighth Circuit affirmed the judgment of the district court.

The Eighth Circuit issued two additional decisions in this action on the same date. As noted above, the court of appeals affirmed the district court's grant of summary judgment. *See* 317 F.3d 883, summarized under "FCA Liability/Materiality" above at page 5. The court also affirmed the district court's denial of the plaintiffs' motion for a default judgment against one of the defendants, MRK Incineration, Inc., which had failed to defend against the suit. *See* 2003 U.S. App. LEXIS 1314, summarized in "Litigation Developments" below at page 50.

***U.S. ex rel. Health Outcome Technologies v. Pennock Hospital*, 2003 U.S. Dist. LEXIS 937 (W.D. Mich. Jan. 21, 2003)**

In January 2003, a district court denied a defendant's motion for reconsideration of an order maintaining certain court documents under seal, and ordered all but one of the defendant's affirmative defenses stricken. The matter came before the court on the defendant's motion for reconsideration as well as the Government's motion for partial judgment on the pleadings. The defendant's motion for reconsideration primarily repeated arguments that the court had previously rejected, and the court ruled that "[t]he fact that the Defendant has repeated those arguments with a full complement of adjectives to reflect its extreme displeasure is hardly a proper basis for reconsideration."

The court then turned to the eight affirmative defenses, which included: (1) statute of limitations; (2) due process; (3) excessive fines; (4) public disclosure; (5) laches; (6) failure to exhaust administrative remedies; (7) failure to state a claim; (8) inapplicability of the FCA. The Government moved to strike or dismiss all but the third for failure to state a defense as a matter of law. In response, the defendant conceded that its fifth and sixth defenses were legally deficient and should be dismissed, and failed to respond in support of its seventh and eighth defenses. Therefore, the court struck these defenses.

The court also struck the remaining defenses, with the exception of the third. The court observed that the defendant had failed to plead any factual basis for its defenses, which were therefore subject to dismissal. Accordingly, the court granted the Government's motion.

***U.S. ex rel. Johnson-Pochardt v. Rapid City Regional Hospital*, 2003 U.S. Dist. LEXIS 4758 (D.S.D. Jan. 21, 2003)**

In January 2003, a South Dakota district court denied the Government's motion to keep under seal its requests for extensions of time in a *qui tam* action. Karen Johnson-Pochardt, former director of the Cancer Care Institute (CCI) at Rapid City Regional Hospital (RCRH), brought this action against RCRH, Dr. Larry Ebbert, and Oncology Associates (OA) in 2001. The complaint alleged that RCRH entered into a prohibited financial relationship with OA, through which OA received substantial medical referrals in violation of federal law. The Government filed eleven motions between June 2001 and December 2002 for extension of time to decide whether to intervene. On December 18, 2002, the parties reached a settlement agreement, and the Government intervened the following day. The court unsealed the complaints, notice of intervention, and settlement agreement, but all other documents filed before December 19, 2002 remained under seal. The Government moved to keep those documents under seal.

The court denied the motion. The purpose of the seal provision, the court observed, is to protect the confidentiality of the Government's investigation and prevent injury to the defendant's reputation. Because the underlying action had been settled and the complaint and settlement agreement had been made public, these interests were no longer at issue. The documents that the Government sought to keep under seal contained no specific information about the internal workings of the Government's investigation. They did not discuss client agencies and contractors, reveal any details relating to the content of documents received from the defendants, or indicate the

process of the Government's decision not to intervene. Thus, maintaining the seal on the documents would not promote the public interest, comport with the requirements of the FCA, or serve any justifiable purpose. Accordingly, the court lifted the seal from the remaining documents.

In a decision in this case issued the following month, the district court granted Johnson-Pochardt a relator's share of 24 percent or $1.566 million. *See* "Section 3730(d) Relator's Share" above at page 32.

U.S. ex rel. Costner v. U.S., 2003 U.S. App. LEXIS 1314 (8th Cir. Jan. 28, 2003)

In January 2003, the Eighth Circuit affirmed a district court judgment in favor of a defendant that had failed to defend against a *qui tam* action. The relators, a group of individuals and public interest groups, filed suit in 1995 alleging that the defendant corporations conspired to submit false claims for payment under a government contract for the treatment and disposal of hazardous waste at the Vertac Chemical Plant site in Jacksonville, Arkansas. The Government declined to intervene, and after extended discovery, the district court granted summary judgment to the defendants on most claims, and after trial entered judgment on the remaining claims. The Eighth Circuit affirmed.

Among the defendants in this action was MRK Incineration, Inc. MRK and Morrison Knudsen Corp., a second defendant, had entered into a joint venture named Vertac Site Contractors, a third defendant in the action, to incinerate toxic waste at the site. While the other defendants appeared, defended the suit, and were found not liable, MRK did not answer the complaint or otherwise defend against the suit. The relators moved for a default judgment against MRK. However, after the other defendants prevailed at trial, the district court declined to enter a default judgment against MRK, relying on *Frow v. De La Vega*, 82 U.S. 552, 554 (1872), which held that the issuance of inconsistent verdicts between jointly liable defendants is "incongruous and illegal."

The relators appealed the denial of their motion for a default judgment. They sought to distinguish *Frow* on the grounds that the liability at issue there was merely joint, whereas liability under the FCA is joint and several. However, in an unpublished per curiam opinion, the Eighth Circuit rejected that distinction. The court ruled that the holding in *Frow* was that logically inconsistent verdicts should be avoided. Although joint liability is one circumstance where such inconsistency may arise, it is not the only one. The relators' action was based upon claims submitted by Vertac Site Contractors and another defendant, URS Consultants. They did not allege that MRK submitted any separate claims to the Government. Therefore, a verdict against MRK could not be reconciled with the verdict in favor of its joint venture partner Morrison Knudsen Corp. Accordingly, the Eighth Circuit affirmed the judgment of the district court.

The Eighth Circuit issued two additional decisions in this action on the same date. As noted above, the court of appeals affirmed the district court's grant of summary judgment. *See* 317 F.3d 883, summarized under "FCA Liability/Materiality" above at page 5. The court of appeals also affirmed the district court's award of costs to the defendants pursuant to Fed. R. Civ. P. 54(b). *See* 317 F.3d 889, summarized under "Attorneys' Fees, Costs, and Expenses" above at page 47.

U.S. ex rel. Watson v. Connecticut General Life Insurance Co., 2003 U.S. Dist. LEXIS 2003 (E.D. Pa. Jan. 30, 2003)

In January 2003, a Pennsylvania district court denied a *qui tam* relator's motion to exclude the declarations of a former government employee from consideration in connection with a pending motion for summary judgment. The proposed witness, John Barton, was the government contracting officer for the contract at issue in the case at bar. He retired from government service in November 2001.

The relator sought to exclude Barton's declaration pursuant to 18 U.S.C. § 207 and Fed. R. Evid. 701. However, the court observed that § 207 only prohibits former government employees from representing or acting on behalf of a party in a matter in which the former employee participated personally and substantially. In the case at bar, there was no evidence that Barton was acting on behalf of the defendant: he received no compensation from the defendant or defense counsel, but merely responded to questions based on his personal knowledge of certain contracts while employed by the Government.

The court also rejected the relator's contention that Barton's declaration was impermissible expert testimony under Fed. R. Evid. 701. Rather, most of his declaration consisted of factual statements based on his personal knowledge and perception, and to the extent he stated opinions, they were admissible as lay opinion testimony based on knowledge he obtained by virtue of his position as the former contracting officer for the defendant's contract during the years at issue. However, to the extent that any of Barton's statements might go beyond his personal knowledge and offer expert opinion testimony, the court stated that it would not rely on them in deciding the pending motions for summary judgment. Accordingly, the court denied the relator's motion.

In a subsequent decision issued the following month, the court granted summary judgment to the defendant. *See* 2003 U.S. Dist. LEXIS 2054 (February 11, 2003), summarized under "FCA Liability of Medicare Carriers and Fiscal Intermediaries" above at page 17.

White v. Apollo Group, 241 F. Supp. 2d 710 (W.D. Tex. Jan. 30, 2003)

In January 2003, a Texas district court dismissed a pro se complaint alleging, *inter alia*, violations of the federal criminal False Claims Act. Leeland White sought a student loan totaling approximately $9,200 from the Apollo Group, doing business as the University of Phoenix. The University at first awarded $500, explaining that White had failed to inform it of financial aid he had already received. After an altercation, the University cancelled White's financial aid and barred him from the campus; ultimately it expelled White for harassment. White sued, alleging various violations of the Higher Education Act, "swindle by mail," and violation of the criminal False Claims Act. The defendant moved to dismiss on the grounds that there is no private right of action for violation of any of the statutes White cited.

The court agreed. With respect to White's purported FCA claim, the court noted that White had failed to comply with any of the strict procedural requirements of the civil FCA, including the requirements that a *qui tam* action be brought in the name of the Government, and filed in camera and under seal; that the complaint and a disclosure statement be served on the Government; and that the complaint not

be served on the defendant until the court so orders. White's other claims were also fatally deficient. Accordingly, the court granted the defendant's motion to dismiss.

U.S. ex rel. Drake v. Norden Systems, Inc., 2003 U.S. Dist. LEXIS 3044 (D. Conn. Feb. 19, 2003)

In February 2003, a Connecticut district court dismissed a *qui tam* action with prejudice for failure to prosecute. Walter Drake, a former Supervisor of Facilities Accounting at Norden Systems, Inc. (NSI) filed this action in 1994 against NSI and United Technologies Corporation (UTC). The Government declined to intervene, and in 1997 Drake twice amended his complaint. In 1998, the defendants moved to dismiss the second amended complaint, and the court granted the motion in part in August 2000, ordering Drake to file a final amended complaint within sixty days of that ruling. However, Drake failed to do so for sixteen months: he did not file his third amended complaint until February 2002. That same month, the defendants moved to strike the third amended complaint and dismiss the case for failure to prosecute.

The court granted the motion, ruling that dismissal for failure to prosecute was appropriate under Fed. R. Civ. P. 41(b). The court found that the delay in filing the third amended complaint was lengthy and in no way attributable to the defendants; that the plaintiff was on notice that further delays would result in dismissal; that the defendants were prejudiced both actually and as a matter of law by the long delay; and that no lesser sanction than dismissal would suffice to recompense the defendants for the prejudice suffered. Although the court's calendar had not been adversely affected by the delay, this single countervailing factor did not outweigh the factors militating in favor of dismissal. Accordingly, the court dismissed the action with prejudice.

U.S. v. Reed, 2003 U.S. Dist. LEXIS 2659 (N.D. Ill. Feb. 25, 2003)

In February 2003, an Illinois district court entered judgment sua sponte in favor of the defendants in an FCA action. The Government brought this action against Carl and Patricia Reed and their children Carla and Sharay, alleging that they submitted false parental income information in order for Carla and Sharay to receive federal need-based financial aid. The Government sought recovery under the False Claims Act as well as under the common law doctrines of payment by mistake and unjust enrichment. The defendants, acting pro se, each denied under oath that they submitted false claims. The Government moved for summary judgment.

The court denied the Government's motion and entered judgment sua sponte in favor of the defendants. The court found that the Government had provided no admissible evidence that the documents the defendants submitted were false. The Government provided only an affidavit by a Special Agent with the Department of Education stating that based on a plea agreement and interviews with third parties, the defendants submitted financial aid applications using false income information. This evidence was hearsay and inadmissible to establish the falsity of the defendants' statements. The Government presented no W-2 forms or other evidence indicating that the tax returns that the defendants submitted in conjunction with their aid applications were false. Nor did the Government attempt to depose the defendants to obtain an admission. Thus, the Government had failed to establish a prima facie case. Although the defendants had not cross-moved, the court observed that the

Government, as movant, was on notice that it had to come forward with all of its evidence, and its failure to produce evidence was fatal. Therefore, the court entered judgment in favor of the defendants.

U.S. ex rel. Goodstein v. McLaren Regional Medical Center, No. 97-CV-72992-DT (E.D. Mich. Feb. 28, 2003)

In February 2003 a Michigan district court denied the motions of several defendants in a *qui tam* action for costs and fees pursuant to the Equal Access to Justice Act. Peter Goodstein and Charles Grossmann brought this action in 1997 against McLaren Regional Medical Center, Family Orthopedic Realty, L.L.C. (FOR), and Family Orthopedic Associates, P.L.C. (FOA). In 2000 the Government elected to intervene and filed a complaint. The Government contended that McLaren paid the FOA physicians, through FOR, remuneration in the form of a lease at above-market rates, in exchange for referrals of Medicare patients. The Government contended that this lease agreement, as well as the payment of a medical director fee, violated the Stark II statute, 42 U.S.C. § 1395nn(a)(1), and the anti-kickback statute, 42 U.S.C. § 1320a-7b. The Government later amended its complaint to substitute several individual physicians for FOA. *See* 2002 U.S. Dist. LEXIS 15700 (July 9, 2002), 28 TAF QR 41 (Oct. 2002).

In September 2001 several defendants filed a motion, which the court granted, to bifurcate the trial by first conducting a separate bench trial as to whether McLaren's lease payments were above fair market value. On February 14, 2002, the court granted judgment to the defendants, ruling that the lease rate was at fair market value and did not take into account the value of potential patient referrals.

McLaren and FOR filed applications pursuant to the Equal Access to Justice Act, 28 U.S.C. § 2412, arguing that they were entitled as prevailing parties to expenses and attorney fees because the Government's position was not substantially justified. The Government opposed the applications, maintaining that its position was substantially justified, and alternatively, that the defendants were not entitled to attorney fees exceeding the statutory limit.

The court denied the fee applications. The court observed that merely because it found the defendants' experts more credible than the Government's, it did not follow that the Government's position was not substantially justified. The lease rate did vary depending on the amount of director fees paid and the Government relied on its experts' conclusion that the lease rate exceeded fair market value. The Government offered testimony that the defendants considered referrals in choosing a location, and pointed to admissions by a McLaren representative that the lease payments were "too high" as well as alleged flaws in the appraisals of the defendants' experts. Accordingly, the court ruled that the Government's justifications for its position were reasonable.

In re Cardiac Devices Qui Tam Litigation, 2003 U.S. Dist. LEXIS 3448 (J.P.M.L. Mar. 5, 2003)

In March 2003, the Judicial Panel on Multidistrict Litigation consolidated 35 *qui tam* actions pending in 25 judicial districts by transferring them to the District of Connecticut. Kevin Cosens originally filed these actions as a single *qui tam* action in the Western District of Washington against 132 hospital defendants, accusing them of submitting false claims for payment for unapproved cardiac devices. Many of these claims have been settled, while the remaining claims were transferred to the

home districts of the hospital defendants. Meanwhile, the Government intervened in all but one of the remaining actions. The relator and the Government moved to centralize the litigation in the Western District of Washington. All defendants opposed this motion.

The panel found that the actions should be consolidated because they involved common questions of fact and law, but decided to centralize them in the District of Connecticut. Given the wide dispersal of parties and witnesses, a range of suitable transferee districts existed, but several factors, in the panel's view, pointed to the District of Connecticut as the most suitable. Most of the remaining parties were located in the eastern United States; the Connecticut district court enjoyed the resources that the complex docket was likely to require; and that court also had an available transferee judge who had presided over other litigation involving the core regulations at issue and thus possessed expertise in the underlying issues. Therefore, the panel ordered the actions to be transferred to the District of Connecticut and assigned to Judge Gerard Goettel for coordinated or consolidated pretrial proceedings.

U.S. ex rel. Johnson v. MacNeal Health Services Corp., 2003 U.S. Dist. LEXIS 4817 (N.D. Ill. Mar. 27, 2003)

In March 2003, an Illinois district court denied the defendant's motion for summary judgment and granted in part and denied in part a motion to strike certain testimony in a *qui tam* action. Sandra Johnson brought this action against her former employer Genesis Clinical Laboratory, a wholly owned subsidiary of MacNeal Health Services Corporation that performs laboratory services for MacNeal Memorial Hospital. While she was serving as Director of Operations for Genesis, Johnson alleges that she discovered that Genesis was illegally bundling profiles, forcing physicians to order laboratory tests that were not medically necessary. Johnson stated a *qui tam* claim based on these allegations as well as a claim under § 3730(h) for retaliation. The defendant moved for summary judgment on both claims, and moved to strike Johnson's testimony regarding whether the Genesis requisition form complied with standards promulgated by the Office of Inspector General.

The court denied the defendant's motion for summary judgment. Genesis argued that its requisition form complied with Medicare regulations, and asserted that the forms allocated space where physicians could write in the names of tests and thus order individual tests rather than bundled tests. However, Johnson claimed that the forms were formatted in a manner that encouraged physicians to order bundles of tests and thus include tests that were medically unnecessary. The court found that the essence of Genesis' argument was that the court should believe it rather than Johnson, and ruled that there was a genuine issue of material fact as to whether the form violated Medicare regulations, precluding summary judgment. Genesis also argued that Johnson did not point to specific false claims. However, the court held that the trier of fact could draw reasonable inferences as to whether improper diagnosis codes were being entered.

As for the retaliation claim, Johnson alleged that she repeatedly told Genesis management that Genesis was not in compliance with Medicare regulations, but Genesis denied that such conversations ever took place. Once again, the court found that Genesis was arguing that the court should believe it rather than Johnson. The court ruled that Johnson had raised a genuine issue of material fact as to whether Genesis

knew that she engaged in protected activity.

The court denied Genesis' motion to strike Johnson's testimony about the information she provided to Genesis regarding federal billing requirements and regarding the company's alleged submission of false claims. The assessment of the admissibility and credibility of these statements, the court ruled, should be left for trial. However, the court granted Genesis' motion to strike Johnson's references to an investigation at a company where Genesis' president worked before coming to Genesis. The court ruled that these references were not relevant and were prejudicial to Genesis.

NURSING HOME LIABILITY FOR FAILURE OF CARE UNDER THE FALSE CLAIMS ACT

*Kristine Blackwood and Howard F. Daniels**
Assistant United States Attorneys
Central District of California

I. INTRODUCTION

In recent years, the Department of Justice and various United States Attorney's Offices have brought cases against nursing homes under the False Claims Act, 31 U.S.C. §§ 3729-3733 (FCA), where the homes' egregious failures to provide their residents with proper care resulted in serious harm and, in some cases, death. *E.g.*, *United States v. Chester Care,* No. CV 98-139 (E.D. Pa. 1998) (resident left to scald to death in the bathtub);[1] *United States v. GMS Management-Tucker, Inc.*, No. CV 96-1271 (E.D. Pa. 1996) (grossly inadequate nutritional and wound care provided to three nursing home residents who developed several severe medical conditions including malnutrition, dehydration, gangrene, and multiple decubitus ulcers at the facility); *United States v. City of Philadelphia,* No. CV 98-4253 (E.D. Pa. 1998) (FCA counts brought in conjunction with Civil Rights of Institutionalized Persons Act claim for inadequate medical, psychiatric, and nursing care, and failure to ensure resident safety at a city-owned nursing home);

*Ms. Blackwood and Mr. Daniels are Assistant United States Attorneys (AUSAs) in the Civil Fraud Section of the United States Attorney's Office for the Central District of California, the section responsible for enforcement of actions under the False Claims Act and other federal civil statutes. The opinions expressed in this article are solely those of the authors and do not represent the official policy of the United States Department of Justice or the United States Attorney's Office for the Central District of California. This article is a revised and adapted version of earlier articles published by the BNA and the ABA. Reproduced with permission from BNA's HEALTH CARE FRAUD REPORT, Vol. 6, No. 4, pp. 158-61 (Feb. 20, 2002). A second version published by the same authors under the same title appeared in the 2003 ABA-CLE publication THE CIVIL FALSE CLAIMS ACT AND *QUI TAM* ENFORCEMENT.

1 For a description of the *Chester Care* case and the U.S. Attorney's Office for the Eastern District of Pennsylvania prosecution of failure-of-care cases under the FCA, see David R. Hoffman, *The Role of the Federal Government in Ensuring Quality of Care in Long-Term Care Facilities*, 6 ANNALS HEALTH L. 147 (1997).

United States v. NHC Health Care Corp., 163 F. Supp. 2d 1051 (W.D. Mo. 2001) (two residents died from overall lack of proper care).

The largest failure-of-care case to date involved the nursing home chain, Vencor, Inc., now called Kindred Healthcare, Inc. (Vencor). Vencor paid $20 million in the context of its Chapter 11 reorganization to settle significant systemic failure-of-care claims under the FCA. *In re Vencor, Inc.,* Nos. 99-3199 through 99-3327 (Bankr. D. Del., petition filed September 13, 1999). In addition to other claims, the United States alleged that Vencor failed to provide adequate care to patients at its long-term care hospitals by staffing these facilities with insufficient number of nursing staff or using unqualified staff members to provide services to beneficiaries of the Medicare and TRICARE[2] programs. The Government's investigation arose out of a *qui tam* lawsuit under the FCA and evidence that grossly inadequate care at certain Vencor facilities had resulted in numerous deaths.

The FCA is the Government's primary weapon against fraud on Medicare, Medicaid, and other taxpayer-funded programs. Providers defending failure-of-care cases sometimes argue that they represent a radical departure from the "normal" FCA fraud case and an attempt to "federalize" malpractice cases. The defense bar also has argued that the health care industry is unique in that the quality of services rendered turns on professional judgments that should not be second-guessed by federal courts in the context of FCA cases. The battle lines are generally drawn over whether billing the Medicare or Medicaid program for failures of care can constitute a "false" claim under the FCA.

FCA cases alleging fraudulent billing for failure of care may reflect a new focus, but these cases apply well-established and conventional legal principles for proving falsity under the FCA. The cases are actionable under several different theories of falsity, such as that the billing is for nonexistent or grossly deficient goods and services (worthless services), or is for services that violate core statutory, regulatory, or contractual requirements, or is based on false certifications, or, as often is the case in a failure-of-care matter, all of the above.[3]

2 The TRICARE program formerly was known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

3 For example, recent failure-of-care cases have relied on a combined regulatory violation and worthless services approach. *See, e.g., United States v. NHC Health Care Corp.,* 163 F. Supp. 2d 1051 (W.D. Mo. 2001); *In re Vencor*, Nos. 99-3199 through 99-3327 (Bankr. D. Del., petition filed Sept. 13, 1999); *United States v. Mercy Douglass Human Servs. Corp.*, No. CV 00-3471 (E.D. Pa. 2000).

A. Worthless Services Theory Of Falsity

The most typical FCA claim is for services not rendered or goods not provided by a Government contractor. As Congress said in adopting amendments to the FCA in 1986: "a false claim may take many forms, the most common being a claim *for goods and services not provided*." S. REP. NO. 99-345, at 25, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5274 (emphasis added). *See also United States v. McNinch*, 356 U.S. 595, 599 (1958) (FCA primarily directed against exorbitant billing or billing for nonexistent or worthless goods); *United States v. Krizek*, 111 F.3d 934 (D.C. Cir.1997) (psychiatrist's claims to Medicare for treatment sessions adding up to more than 24 hours in a day were false); *United States ex rel. Compton v. Midwest Specialties United,* 142 F.3d 296 (6th Cir. 1998) (claim for brake shoes false when defendant delivered shoddy, untested goods). In *United States v. NHC*, 115 F. Supp. 2d 1149 (W.D. Mo. 2000), the court squarely addressed the worthless services theory in the context of nursing home care. In denying the defendant's motion to dismiss, the court considered it self-evident that charging for services never provided or provided in such a manner as to be worthless establishes falsity under the FCA. *Id.* at 1152 ("While at certain times a court is required to consider policy questions, it is generally the function of the courts to interpret the law as written").

In *United States ex rel. Lee v. Smithkline Beecham, Inc.*, 245 F.3d 1048, 1050 (9th Cir. 2001), the relator alleged that an operator of regional clinical laboratories falsified laboratory control test data that fell outside the acceptable standard of error. The court held that the relator should have an opportunity to amend his complaint to allege a worthless services claim. The *Lee* court also rejected the defendant's argument that the Government had to show false certification or that it "relied" on a representation, express or implied, of value by the provider. *Id.* at 1053. The court concluded:

> In an appropriate case, knowingly billing for worthless services or recklessly doing so with deliberate ignorance may be actionable under [the FCA], regardless of any false certification conduct . . . . Neither false certification nor a showing of government reliance on false certification for payment need be proven if the fraud claim asserts fraud in the provision of goods and services.

Id.

Other courts have recognized that a claim may be false when an entity bills the Government for services that are so far beneath the standard of care as to be tantamount to no services. In *Aranda v. Community Psychiatric Centers of Oklahoma, Inc.*, 945 F. Supp. 1485 (W.D. Okla. 1996), the United States alleged that children in a psychiatric hospital suffered physical injuries and sexual abuse because the hospital failed in its obligation to maintain a reasonably safe environment, as required by Medicaid

rules and regulations. The court rejected the defendant's argument that the governing care regulations were too vague to have been knowingly violated:

> It may be easier for a maker of widgets to determine whether its product meets contract specifications than for a hospital to determine whether its services meet "professionally recognized standards for health care." In the Court's view, however, a problem of measurement should not pose a bar to pursuing an FCA claim against a provider of substandard health care services under appropriate circumstances.

945 F. Supp. at 1488.

The question whether the Government has proved worthlessness for purposes of establishing the element of falsity is a question properly decided by the jury. *NHC*, 163 F. Supp. 2d at 1056 n.4. In *NHC*, the Government was prepared to present evidence of falsity based on: (1) severe staffing shortages at NHC's Joplin, Missouri facility; (2) unsanitary conditions at the home; (3) the neglected condition of the subject residents; and (4) expert opinions that the patients' physical conditions were caused by lack of care and that the facility was not adequately staffed to meet the needs of its residents. *Id.* at 1057. The district court held that a reasonable jury reviewing this type of evidence could conclude that the facility's claims for payment were false. *Id.* at 1056-1057.

Even courts not squarely faced with the worthless services theory have acknowledged its validity. In *United States ex rel. Mikes v. Straus*, 274 F.3d 687 (2d Cir. 2001), a *qui tam* case that the United States declined to pursue, the relator attempted to turn a violation of guidelines recommended by a private organization, the American Thoracic Society, into an FCA violation. The relator alleged that defendants' failure to calibrate a spirometry machine rendered the test results so unreliable as to render their payment claims "false" under the FCA. *Id.* at 693. Although the Second Circuit rejected the relator's false certification theories, the court recognized, among other things, that a worthless services claim (raised at oral argument and in the Government's *amicus* brief on appeal) is separately actionable:

> We agree that a worthless services claim is a distinct claim under the [FCA]. It is effectively derivative of an allegation that a claim is factually false because it seeks reimbursement for a service not provided. [Citation omitted]. In a worthless services claim, the performance of the service is so deficient that for all practical purposes it is the equivalent of no performance at all.

Id. at 703. Although the *Mikes* court found no FCA violation under this theory, it did so not because the worthless services theory was unsound. Rather, the court held that the relator,

as a matter of law, could not overcome the defendants' evidence of a good faith belief in the medical value of the spirometry tests so as to survive summary judgment. *Id.* at 704.

B. False Express Certifications

It is well established that the Government can show falsity when defendants have expressly certified compliance with a Government contract or program. *See, e.g., Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 786 (4th Cir. 1999) (prime contractor for Department of Energy held liable for subcontractor's false certification of lack of conflict of interest); *United States ex rel. Fallon v. Accudyne Corp.*, 880 F. Supp. 636, 638 (W.D. Wis.1995) (false certification of compliance with environmental standards); and *United States v. Incorporated Village of Island Park*, 888 F. Supp. 419, 434-36, 440-41 (E.D.N.Y.1995) (false certifications of compliance with the nondiscrimination requirements of the Fair Housing Act and with an affirmative action plan). Many failure-of-care cases will involve one or more falsifications of an express certification. Indeed, as of September 1, 2000, the standardized forms that Medicare-certified Skilled Nursing Facilities (SNFs) must complete for each resident in order to receive payment under the new prospective payment system[4] contains a very detailed certification that reads as follows:

> I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

4 Under the new payment system, SNFs must use the MDS every time they perform a resident assessment. The MDS assigns the resident to one of 44 groups according to Version III of the Resource Utilization Group (RUG-III) system, according to the relative intensity of resource use for that resident, such as nursing hours , therapy time, or other relevant factors such as ventilators or feeding tubes. 42 C.F.R. § 413, Subpart J. Medicare's per diem payments to SNFs are based on the national average cost of treating beneficiaries in each RUG-III category, adjusted for local wage costs. The rates cover an SNF's cost of furnishing typical nursing home services to patients in the particular RUG-III category, such as room, board, nursing services, minor medical supplies; related costs such as therapies, drugs and lab services; and capital costs including land, building and equipment. Medicaid-certified nursing facilities in some states (*e.g.*, Pennsylvania) also must submit an MDS form or a similar form in order to receive reimbursement.

Minimum Data Set (MDS) – Version 2.0. The attestation makes clear that adequate care is a condition of federal payment, that the Government relies on the accuracy of MDS data to calculate payment for the patient, and that the MDS translates directly into a claim for payment.

C. Core Violations

The courts also have recognized that the Government can show falsity when an entity bills the Government for services that do not comply with a contract specification, regulation, or statute that goes to the core of the Government's agreement. *See, e.g., Miller v. United States* 550 F.2d 17 (Ct. Cl. 1997) (contractor billed for service calls and repairs not furnished)*; United States ex rel. Marcus v. Hess,* 317 U.S. 537 (1943) (collusive bidding); *United States v. Bornstein,* 423 U.S. 303 (1976) (goods failed to conform to specifications); *United States ex rel. Roby v. Boeing Co.*, 79 F. Supp. 2d 877 (S.D. Ohio 1999) (helicopters with defective gears violated Government contract); *United States v. Hangar One, Inc.,* 563 F.2d 1155 (5th Cir. 1977) (artillery shells did not conform to specification); *United States v. Aerodex, Inc.,* 469 F.2d 1003 (5th Cir. 1972) (subspecification aircraft bearings); *United States v. Mead,* 426 F.2d 118 (9th Cir. 1970) (violation of Department of Agriculture regulations); *Faulk v. United States,* 198 F.2d 169 (5th Cir. 1952) (false labels in provision of substandard milk). In cases such as these, the Government establishes falsity simply by showing that the defendant violated contract specifications or regulations governing contract performance.

In the Nursing Home Reform Act, as incorporated in the Omnibus Budget Reconciliation Act of 1987, 42 U.S.C. §§ 1395i-3, 1396r (OBRA 87), Congress sought to ensure that publicly-subsidized nursing home residents achieve and maintain the "highest practicable physical, mental, and psychosocial well-being." 42 U.S.C. §§ 1395i-3(b)(2), 1396r(b)(2). OBRA 87 has been translated into a set of highly specific requirements in the implementing regulations, found at 42 C.F.R. § 483.1-483.75, which impose specific standards on nursing homes in the areas on which the Government's failure-of-care cases tend to focus, such as inadequate staffing. The grossly deficient care and resulting harm, or death, to patients in these cases clearly involve "core" violations of OBRA 87 by any measure. *See NHC,* 115 F. Supp. 2d at 1154 (finding that allegations concerning pressure sores, weight loss, and unnecessary pain were "at the heart" of the provider agreement).

Basing falsity on statutory, regulatory, or contractual violations is hardly a novel theory. Indeed, the legislative history of the FCA amendments in 1986 could not be clearer:

> The False Claims Act is intended to reach all fraudulent attempts to cause the Government to pay out sums of money or to deliver property or services. Accordingly, a false claim may take many forms, the most

> common being a claim for goods or services not provided *or provided in violation of contract terms, specifications, statute or regulation. . . .*

S. REP. No. 99-345 (emphasis added).

Some providers have argued that the OBRA 87 regulations are "merely" conditions of participation in the Medicare or Medicaid programs and not conditions of payment. Indeed, the court accepted this theory in *Mikes*, 274 F. 3d at 699. But this is a classic distinction without a difference. If one violates the conditions of participation and cannot be in the program at all, then it necessarily follows that one is not entitled to any payments from the program. As the Supreme Court held in *Fischer v. United States*, with respect to hospital reimbursement from federal funds: "[w]hile [Medicare] payments might have similarities to payments an insurer would remit to a hospital quite without regard to the Medicare program, *the Government does not make the payment unless the hospital complies with its intricate regulatory scheme.* The payments are made not simply to reimburse for treatment of qualifying patients but to assist the hospital in making available and maintaining a certain level and quality." 529 U.S. 667, 679-680 (2000) (emphasis added). Likewise, in *Aranda,* the court relied on the Medicaid participation requirements as the applicable standards, the violation of which gave rise to a cause of action under the FCA. The court attached no significance to the fact that the regulations pertained to participation and were not express conditions precedent to payment. 945 F. Supp. at 1488. Where violations of the participation requirements result in serious or fatal harm to patients, such outcomes are hardly "tangential" to the service for which reimbursement is sought.

Nonetheless, in *Mikes v. Straus,* the court accepted the defendant's argument that permitting an FCA case based on alleged failure to meet "medical standards" to go forward would "federalize" routine malpractice actions. 274 F.3d at 700. This argument ignores the fact that the Government must prove that the statutory, regulatory, or contractual violations were *made knowingly* to establish an FCA case, whereas malpractice actions are based on mere negligence. Moreover, while a nursing home patient's clinical care may be supervised by a physician exercising professional judgments, that is not generally the focus of failure-of-care cases. In most such cases brought by the United States, the issue is not the failure to comply with a particular medical standard of practice, but rather systemic failures involving primarily day-to-day ministerial and administrative functions such as failing to turn bed-bound patients regularly to prevent them from developing pressure sores, or failing to feed or hydrate patients sufficiently to keep them alive.

D. Battle Over "Implied Certification" Theory

As discussed above, the United States has several sound and conventional theories under which it may pursue failure-of-care cases, including worthless services, express

false certifications, and core regulatory violations. The Government need not, therefore, rely on the "implied certification" theory that has attracted so much fire from the defense bar. Nonetheless, there is support in the case law for the theory. To begin with, in most substandard goods or services cases, the contractor has not expressly certified that it has complied with all of the contract terms or with the military specifications and standards embodied in Department of Defense or other agency regulations. The courts simply take it as a given that an invoice seeking payment for work performed is an implicit representation that there was such compliance.

In *United States ex rel. Pogue v. American Healthcorp., Inc.*, 914 F. Supp. 1507 (M.D. Tenn. 1996), *appeal denied*, No. 96-8518 (6th Cir. April 19, 1996), the United States alleged that Medicare claims for payment were tainted by underlying kickback violations and that the defendant had implicitly certified compliance with the anti-kickback laws in its Medicare cost report. The court held that certifications need not be express but can be implied, and found sufficient the certification that the hospital had not violated state or federal law. Likewise, in *Ab-Tech Construction, Inc. v. United States,* 31 Fed. Cl. 429 (1994), *aff'd*, 57 F.3d 1084 (Fed. Cir. 1995) (table), the court held that a request for payment constitutes a representation that the entity billing is eligible for payment. Where the entity was in fact not eligible, the bills are false under the FCA.

The implied certification theory is, in effect, the core violation theory restated. Cases rejecting the implied certification approach tend to involve technical regulatory requirements that are peripheral to the agreement between the Government and the defendant, and that seem to stretch the FCA beyond its tenable limits. In such cases, the courts avoid distinguishing between core and non-core violations based on the implied certification theory. For example, in *United States ex rel. Hopper v. Anton*, 91 F.3d 1261 (9th Cir. 1996), the relator relied on a state requirement that a classroom teacher attend certain meetings pursuant to a special education program, and claimed that this technical violation rose to the level of a false claim for federal special education funds by the school district. The *Hopper* court affirmed the trial court's grant of summary judgment, holding that, absent a false certification of compliance upon which payment is conditioned, there is no remedy under the FCA. In *Hopper*, however, there was no allegation that the services were not rendered or were rendered in a manner so as to make them of less value.[5] Similarly, in *Mikes*, the relator tried to convert violations of guidelines for ensuring reliability of spirometry tests into false claims for medically necessary services.

5 In *Lee*, the Ninth Circuit was not content merely to distinguish its prior decision in *Hopper*, but went out of its way to narrow *Hopper* to circumstances where false certifications are specifically at issue. *Lee*, 245 F.3d at 1053; *see also United States ex rel. Plumbers & Steamfitters Local Union No. 18 v. Roen Constr. Co.*, 183 F.3d 1088, 1092 (9th Cir. 1999) (noting that *Hopper* applies only to cases resting on a certification theory and not to "overcharging" cases).

II. COMPUTATION OF DAMAGES IN FAILURE-OF-CARE CASES

Before discussing the appropriate measure of damages in a failure-of-care case, it is important to note that the Government's overriding objective in most of these cases is to obtain prospective relief. Settlements reached in several failure-of-care cases have focused on injunctive relief that establishes baselines for the provision of care, sometimes enforced by a monitor. The Government will undoubtedly continue to bring failure of care cases in which the recovery of damages is a secondary consideration.

There is no reported case law on computation of damages in FCA failure-of-care cases, although there have been settlements of several matters. However, traditional measures of FCA damages lend themselves to application in failure-of-care cases.

As is well established, the measure of damages in an FCA case depends on the specific facts, and the Government has leeway in establishing its loss. The overarching rule in cases involving goods or services (as opposed to defective pricing or other accounting cases) is that the Government's damages are equal to the difference between the market value of the goods or services it received and the market value of the goods or services had they been of the quality required by the contract or applicable statutes or regulations. *Bornstein*, 423 U.S. at 316 n.13. *See also United States v. Woodbury*, 359 F.2d 370, 379 (9th Cir. 1966) ("the measure of the government's damages would be the amount that it paid out by reason of the false statements over and above what it would have paid if the claims had been truthful."); *United States v. Ben Grunstein & Sons Co.*, 137 F. Supp. 197, 205 (D.N.J. 1956); *United States v. American Packing Corp.*, 125 F. Supp. 788, 791 (D.N.J. 1954).

In failure-of-care cases, the Government is paying for services provided to a third party (the resident) and not to a government agency. However, analytically, that makes no difference in determining the proper method of computation of damages. In those failure-of-care cases in which the Government alleges and proves that the services provided were worthless, the value of what was received is obviously zero, so that under the traditional formula, the Government is entitled to recover all amounts paid to the defendant for the care of the residents who did not receive proper care, for the time period supported by the evidence at trial.

The types of evidence that could be offered to support a claim of damages in the full amount paid to the SNF are discussed in *NHC*. *See* 163 F. Supp. 2d 1051. Such evidence could include time cards and testimony that there was a staffing shortage, such that a jury could conclude that it was a physical impossibility for the defendant to have provided all of the services necessary for the proper care of the residents. It could also include evidence of lack of care at the facility in general, without direct linkage to spe-

cific patients. Such evidence could include unsanitary conditions, improper or unclean clothing, use of unlicenced personnel, failure to provide in-service training, safety hazards and the like.

A third type of evidence could consist of direct evidence of lack of care for specific residents. Some of this evidence would be documentary records of care, such as inadequate care plans, incomplete progress notes, family complaints, reports of abuse, or wound care logs. Additional documentary evidence would focus on the medical condition of the resident, such as nursing assessments, physician histories, hospital admission records or emergency care records.

This last category of evidence would dovetail with expert testimony. As the *NHC* court pointed out, expert testimony can be presented to the fact-finder in the form of medical experts' opinions that the physical conditions developed by a patient, or conditions that worsened, were the result of lack of care. *See* 163 F. Supp. 2d at 1056.

Defendants in failure-of-care cases contend that they incurred costs for and provided all services to which the government was entitled. They argue that the residents received sufficient hours of nursing care, nutrition, therapies and assistance with daily activities. The argument is in essence that the Government received services equal in market value to what it paid. This contention misses the point that the Government is contending that the *quality* of services provided was so inadequate as to be worthless. It may be that the SNF incurred costs that approximate the amounts paid by the Government, so that the market value of the care provided is close to the amount reimbursed. However, the value of those services *to the Government* was nil. An analogous situation was presented in *Faulk v. United States*, 198 F.2d 169 (5th Cir. 1952). The defendants in that case substituted reconstituted milk for the fresh milk called for by the Army's contract. The evidence showed that the reconstituted milk had the same market value as the fresh milk. However, the court refused to find that there were no damages and held instead that damages were to be measured by the amount of milk that the servicemen refused to drink.

The rule should be the same as that followed in cases involving defective products. If the product is of no use to the Government because it does not satisfy the Government's purposes, damages are the full contract amount, even if the product had some market value. For example, in *Aerodex,* the defendants delivered engine bearings that were not manufactured to contract specifications. The defendants offered evidence that the bearings were acceptable substitutes in the industry and had the same market value as the bearings sought by the Government. The court rejected this argument and held that, because the bearings had no value *to the Government*, the Government it was entitled to the full contract amount as single damages. 469 F.2d at 1011.

A somewhat different approach to the computation of damages would be to compute the cost of the services that were required but not provided. This is a more conservative methodology than treating the services as completely worthless. The Government would identify certain categories of services that were not provided, or were not provided in sufficient amount. For example, the evidence might establish that the SNF should have had two additional registered nurses and six additional certified nursing assistants, as well as added physical therapy. The Government would then introduce evidence of the market value of the services that were missing and treat that figure as single damages.

This "cost of services" method is one that the Government has frequently used in false testing cases. In such cases it may be that the product itself complies with the contract specifications but the required testing was not done or was done improperly. If the government agency that purchased the product places it into service, the Government cannot argue that it is entitled to the full contract price. However, the Government paid for testing that was not performed and that has a value. Accordingly, it is entitled to single damages in the amount of the market value of the testing.

However, this "cost of services" approach may not be appropriate in the context of a failure-of-care case. Human beings are not ball bearings. An SNF's failure to provide one particular service, such as turning the patient to avoid pressure sores, can cascade into an overall deterioration of health, resulting in serious illnesses and even the resident's death. An approximate analogy presented itself in the recent case of *Roby v. Boeing*. Boeing sold a helicopter with a defective gear to the Army, and the malfunctioning of the gear caused the helicopter to crash during a flight over the Saudi Arabian desert in Operation Desert Shield. Boeing argued that the proper measure of FCA damages was the market value of the defective gear, not the value of the entire helicopter. However, the court held that because the gear was "flight critical," the entire helicopter was defective, so that the Government was entitled to single damages in the amount of the helicopter's market value. 302 F. 3d at 646. Similarly, if an SNF fails to provide one aspect of care, the Government would be entitled to claim as damages the entire cost of care for an individual who suffered ill effects.

Finally, the Government may also seek to recover as damages the costs of additional health care services that had to be provided to a patient as a result of the facility's failure of care. Thus, if a patient receives emergency care, acute hospital care or physician services because of the failure of care on the part of the SNF, the Government could seek to recover such reimbursements.

III. CONCLUSION.

When nursing home owners bill the Government for worthless, nonexistent, or grossly inadequate care, their claims for payment are false. Congress designed the FCA as a weapon to rectify the squandering of public funds by government contractors unjustly enriching themselves at public expense. Where necessary and appropriate to protect frail, elderly, and disabled nursing home residents, the Government should and must use the FCA to ensure that nursing home residents receive the care that Congress intended them to receive, and for which taxpayers are paying. The Government should recover the full amount of its reimbursements for a failure of care, under the theory that the services provided were worthless.

ALLEGATION: UPCODING CLAIMS

***U.S. v. Tenet Healthcare Corporation*, No. CV-03-206 GAF (C.D. Cal.)**

In January 2003, DOJ announced that it had filed an FCA suit against Tenet Healthcare for submitting fraudulent claims to Medicare. The Government alleges that Tenet and its hospitals upcoded inpatient claims for pneumonia, septicemia, and other respiratory treatments. Most of the alleged upcoding took place during a time when Tenet was under a Corporate Integrity Agreement with the Department of Health and Human Services. One of the central issues in the case involves allegations that Tenet, pursuant to the integrity agreement, falsely certified that it was in compliance with Medicare regulations.

ALLEGATION: BILLING FOR EXPERIMENTAL DEVICES

U.S. ex rel. Cosens v. Johns Hopkins Hospital

U.S. ex rel. Cosens v. Methodist Hospitals

In January 2003, DOJ announced that it had intervened in two cases filed by Kevin Cosens against Johns Hopkins Hospital and Methodist Hospitals for submitting false claims to Medicare. The Government alleges that from 1987 to 1995 these hospitals falsely charged Medicare for procedures involving experimental cardiac devices that were not reimbursable. Cosens, a former medical device salesman, initially filed *qui tam* actions against 132 hospitals. 31 other hospitals have settled for a combined total of over $46 million. *See* 28 TAF QR 54 (Oct. 2002); 29 TAF QR 55 (Jan. 2003); and this issue's "Judgments and Settlements" section below at page 73. Don Warren and Phil Benson of the Warren & Benson Law Group (San Diego & Los Angeles) represent the relator.

ALLEGATION: MEDICARE FRAUD

U.S. ex rel. Stacy v. Eastridge Health Systems

In January 2003, the Government reportedly intervened in a case against Eastridge Health Systems, a West Virginia-based mental health and drug treatment provider. The Government alleges that from July 1994 to June 1999 Eastridge filed false claims under the Medicare program. Valerie Stacy, a former Eastridge billing specialist, filed this *qui tam* suit. Lauren Clingan represents the relator.

ALLEGATION: FRAUDULENT PRICING

U.S. ex rel. LaCorte v. Merck & Co., Inc., No. 99-cv-3807 (E.D. La.)

In January 2003, a *qui tam* lawsuit was unsealed alleging that Merck defrauded the Medicare and Medicaid programs in marketing its heartburn drug, Pepcid. The complaint alleges that Merck sold Pepcid to hospitals and nursing homes for about 10 cents per tablet, while charging the Government as much as $1.65 per tablet. Under federal law, drug companies are required to give the Medicare and Medicaid programs the lowest price it offers to private customers. Dr. William St. John LaCorte filed this *qui tam* suit in 1999. J. Marc Vezina (Gretna, Louisiana) represents the relator. The Government has not yet decided whether to intervene in this suit.

ALLEGATION: NONCOMPLIANCE WITH ANTIDISCRIMINATION LAWS

Old Baldy Council of Boy Scouts of America

In January 2003, a *qui tam* lawsuit was unsealed alleging that the Old Baldy Council of Boy

Scouts of America falsified information in order to receive a $15,000 federal grant. The complaint alleges that by signing a grant contract to comply with federal and state anti-discrimination laws while adhering to a national policy that bars gays and atheists, the Boy Scouts of America violated the FCA. The American Civil Liberties Union filed this *qui tam* suit in 2002. The Government has decided to not intervene in this case.

ALLEGATION: BILLING FOR UNNECESSARY EQUIPMENT

U.S. v. Paulin, No. 03-CV-0186-W (S.D. Cal.)

In January 2003, DOJ announced that it had filed an FCA suit against Renato Paulin and his company, Benison Medical Supply, for defrauding the Medicare program. The Government alleges that Paulin and his company submitted false documents to obtain reimbursement for the purchase of power wheelchairs, hospital beds, and other equipment that were either medically unnecessary or not actually supplied to patients.

ALLEGATION: BILLING FOR MEDICALLY UNNECESSARY BLOOD TESTS

U.S. v. Lahey Clinic Hospital, No. 03-10194 (D. Mass.)

U.S. v. University of Massachusetts Medical Center, No. 03-10195 (D. Mass.)

In January 2003, the Government reportedly filed FCA suits against the Lahey Clinic and the University of Massachusetts Medical Center for defrauding Medicare. The Government alleges that the two hospitals repeatedly misbilled for hematology indices—which were generated from routine complete blood count tests—even though the indices were neither medically necessary nor ordered by a physician.

ALLEGATION: BILLING NAVY FOR COMMERICIAL CUSTOMER COSTS

U.S. v. Newport News Shipbuilding, Inc., No. 1:03-CV-142 (E.D. Va.)

In February 2003, DOJ announced that it had filed an FCA suit against Newport News Shipbuilding for defrauding the U.S. Navy. The Government alleges that from 1994 to 1999 Newport News, a wholly-owned subsidiary of Northrop Grumman Corp., billed the Navy for independent research and development costs for double-hulled tankers that the company was building for its commercial customers. The Government alleges that more than $72 million of fraudulent costs were passed through as overhead on Newport News' major Navy shipbuilding contracts. DCIS, the Naval Investigative Service, and auditors from the Defense Contract Audit Agency investigated this matter.

ALLEGATION: UNDERPAYING FOR CARE OF MEDICARE BENEFICIARIES

U.S. ex rel. Drescher v. Highmark Inc., No. 00-CV-3513 (E.D. Pa.)

In February 2003, DOJ announced that it had partially intervened in case filed by Elizabeth Drescher against Highmark, Inc. The Government alleges that Highmark, a Pittsburgh-based private insurance company, knowingly underpaid the amounts due for care of certain Medicare beneficiaries under employer group health plans insured or administered by Highmark. Highmark pro-

vides health insurance under employer group health plans and also contracts with HHS to process Medicare claims. Mitchell Kreindler of Kreindler & Associates (Pennsylvania) represents the relator in this case.

ALLEGATION: FALSIFYING INVOICES FOR SECURITY SERVICES

***U.S. v. MVM Inc.* (D. Mass.)**

In March 2003, the Government reportedly filed an FCA suit against MVM Inc. for submitting false invoices for security services provided to various federal buildings in New England. The Government alleges that MVM, Inc., a security contractor based in Virginia, billed for security services it did not provide. In particular, the Government alleges that MVM billed for supervisors who had not been properly trained and failed to provide the required ratio of security guards to supervisors as required under its contract with the Government. The General Services Administration OIG investigated the matter. Assistant U.S. Attorney Jeremy Sternberg is handling the case for the Government.

ALLEGATION: FALSE CLAIMS FOR AMBULANCE TRANSPORTATION

***US v. Greybor Medical Transportation*, No. CV 03-1770 (C.D. Cal.)**

In March 2003, the Government filed an FCA action alleging that Greybor Medical Transportation, its owner, and its former chairman submitted tens of thousands of false ambulance transportation claims to the Medicare program. The Government alleges that Greybor Medical sought reimbursement for transporting patients who did not meet Medicare eligibility requirements, were never transported, or were transported with other patients in a single ambulance but billed as if transported separately. Assistant U.S. Attorney Vipal Patel is handling this case for the Government. HHS OIG investigated this matter.

Caremark Rx, Inc.

In January 2003, DOJ announced that Caremark Rx, formerly known as MedPartners, had agreed to pay **$7.5 million** to settle Medicare fraud allegations. The Government alleged that pharmacy benefit managers at AmCare, a Caremark subsidiary, submitted $5 million in fraudulent home health care services claims. Caremark officials voluntarily reported the false claims to the Government in 1999.

Cleveland Clinic Foundation

In January 2003, Cleveland Clinic Foundation reportedly agreed to pay **$4 million** to settle allegations of Medicare billing fraud. The Government alleged that from 1992 to 1996 Cleveland Clinic, which has one of the nation's largest residency teaching programs, falsely claimed that supervising physicians had rendered patient services that were actually performed by medical residents. Assistant U.S. Attorney Alex Rokakis handled this case for the Government.

U.S. ex rel. Taylor v. Maury Regional Hospital, No. 1-99-0100 (M.D. Tenn.)

In January 2003, DOJ announced that Maury Regional Hospital had agreed to pay **$2 million** to settle Medicare fraud allegations. The Government alleged that from 1994 to 1999 Maury Regional upcoded diagnosis codes in order to increase its reimbursements. Ed Taylor, a former hospital employee, filed this *qui tam* action. The relator's share is $350,000 or 17.5% of the settlement recovery. Ralph Mello of the Brentwood Law Offices (Brentwood, Tennessee) and Kenneth Nolan (Ft. Lauderdale) represented the relator. HHS OIG investigated this matter.

ARV Assisted Living, Inc.

In January 2003, ARV Assisted Living, Inc. reportedly agreed to pay **$1.6 million** to settle Medicare fraud allegations. The Government alleged that from 1992 to 1998 GeriCare, an ARV subsidiary, included unallowable costs on its Medicare cost reports. HHS OIG investigated this matter. Assistant U.S. Attorney Donna Maizel handled this case for the Government.

U.S. ex rel. Heiser v. Lockheed Martin Corp., No. C-1-97-767 (S.D. Ohio)

In January 2003, DOJ announced that Lockheed Martin Corporation had agreed to pay **$1,407,834** to settle allegations that it defrauded the Government on an Air Force contract. The Government alleged that Lockheed Martin's predecessor, Loral Corporation, inflated estimated costs it was required to disclose during contract negotiations, resulting in an inflated contract price and false claims for payment. Glen Heiser, a former Loral employee, filed this *qui tam* action. The relator's share is $274,527 or 19% of the total recovery. James Helmer, Jr. of Helmer, Martins & Morgan Co., L.P.A. (Cincinnati) represented the relator. DCIS investigated this matter.

U.S. ex rel. Wilkins v. North American Construction Corp., No. H-95-5614 (S.D. Tex.)

In January 2003, DOJ announced that North American Construction Corporation and two of its subcontractors had agreed to pay **$765,000** to settle allegations that the companies conspired to file false claims with the Army. The Government alleged that North American Construction, CH&A, Inc., and EVI Cherrington Environmental, Inc. filed a request for money with the Army Corps of

Engineers falsely claiming that the Government was responsible for the companies' increased costs for performing contract work at Tinker Air Force Base in Oklahoma City. The Government also alleged that the companies filed false claims for progress payments. Patrick Wilkins, a former officer of CH&A, filed this *qui tam* suit. The relator's share is $183,600 or 24% of the total recovery. Allan Levine of Christian, Smith & Jewel, LLP (Houston) represented the relator. DCIS investigated this matter.

U.S. v. State University of New York Health Science Center at Brooklyn

In January 2003, DOJ announced that State University of New York Health Science Center at Brooklyn had agreed to pay **$655,000** to settle Medicare fraud allegations. The Government alleged that SUNY Brooklyn failed to provide proper documentation to establish that faculty physicians, rather than medical students and interns, provided the claimed patient services. HHS OIG investigated this matter. Assistant U.S. Attorney Richard Hayes handled this case for the Government.

Integris Baptist Regional Health Center

In January 2003, Integris Baptist Regional Health Center reportedly agreed to pay **$520,000** to settle Medicare fraud allegations. The Government alleged that from 1993 to 1998, Integris upcoded pneumonia claims in order to obtain higher Medicare reimbursements. HHS OIG investigated the matter.

U.S. ex rel. Mak v. Knapp, No. 00CV1530-JM (S.D. Cal.)

In January 2003, David Knapp reportedly agreed to pay **$500,000** to settle allegations of health care fraud. The Government alleged that Knapp, a San Diego-based physician, misrepresented the person rendering services at two dermatological clinics he owned. Linda Mak, a physician employed by Knapp, filed this *qui tam* suit in 2000. The relator's share is $90,000 or 18% of the total recovery. The FBI, HHS OIG, OPM OIG, and DCIS investigated this matter.

Cooper Health System, Inc.

In January 2003, Cooper Health System reportedly agreed to pay **$400,000** to settle allegations that from 1992 to 1998 it improperly billed Medicare. The Government alleged that Cooper Health, a New Jersey-based hospital, submitted claims for inpatient hospital stays for patients who actually received outpatient services. HHS OIG investigated this matter.

U.S. v. Braun, No. 4:02CV00463 (E.D. Mo.)

In January 2003, Jeff Braun reportedly agreed to pay **$126,217** to settle allegations that he submitted false claims to Medicare from January 1995 to June 1995. The Government alleged that Braun and his co-conspirators improperly billed Medicare for medically unnecessary incontinence supplies for some 600 Chicago area nursing home residents. The Government estimated that a total of $1.5 million was improperly paid out as a result of the false billings. With this settlement, the Government's total recovery from the scheme's conspirators is approximately $3 million. *Cf. U.S. v. Sandler* (E.D. Mo.), 29 TAF QR 55 (Jan. 2003). The FBI investigated the matter. Assistant U.S. Attorneys James Crowe Jr. and Suzanne Gau represented the Government in the case.

U.S. ex rel. Schwiderski v. Northwestern University No. 02-CV-5287 (N.D. Ill.)

In February 2003, DOJ announced that Northwestern University had agreed to pay **$5.5 million** to settle allegations that it violated NIH grant requirements. The Government alleged that Northwestern knowingly failed to comply with a federal grant requirement that a specific percentage of researchers' effort be devoted to the grant project. Richard Schwiderski, a former Northwestern research administrator, filed this *qui tam* suit in 2000. The relator's share is $907,500 or approximately 17% of the total recovery. Edward Cloutman, III (Dallas) represented the relator.

U.S. ex rel. Cosens v. Methodist Hospital, No. 02-1449 (S.D. Tex.)

U.S. ex rel. Cosens v. Deaconess Medical Center, No. 02-CS-127 (E.D. Wash.)

U.S. ex rel. Cosens v. Good Samaritan Hospital and Medical Center, No. 3-02-01251-JE (D. Ore.)

In February 2003, DOJ announced that five hospitals in Texas, Washington, and Florida had agreed to pay **$4.9 million** to settle allegations of Medicare fraud. The Government alleged that The Methodist Hospital, St. Luke's Episcopal Hospital, Deaconess Medical Center, Legacy Good Samaritan Hospital and Medical Center, and Orlando Regional Medical Center falsely charged Medicare for procedures involving experimental cardiac devices that were not reimbursable. Kevin Cosens, a former medical device salesman, has filed similar suits against 132 hospitals, 31 of which have previously settled for a total of over $46 million. *See* 28 TAF QR 54 (Oct. 2002); 29 TAF QR 55 (Jan. 2003); and this issue's "Interventions and Suits Filed/Unsealed" section above at page 68. Cosens will receive approximately $1 million from the settlement announced in February, and to date has received over $9 million in total settlement shares. Don Warren and Phil Benson of the Warren & Benson Law Group (San Diego & Los Angeles) and William Keller (Seattle) represented the relator. HHS OIG investigated the matter.

U.S. ex rel. Health Outcomes Technologies v. Parkway Regional Medical Center, No. 01-3332-CIV (S.D. Fla.)

In February 2003, DOJ announced that Tenet Healthcare had agreed to pay **$4.3 million** to settle allegations that five of its Florida hospitals submitted fraudulent claims to Medicare. The Government alleged that Parkway Regional Medical Center, Coral Gables Hospital, Hollywood Medical Center, Hialeah Hospital, and Florida Medical Center upcoded pneumonia diagnosis codes in order to receive higher reimbursement rates from Medicare. Health Outcomes Technologies, a Pennsylvania-based software company, filed a *qui tam* action against three of the defendants in this suit after analyzing their diagnostic code billing patterns. The relator's share of the recovery was $309,303. Michael Holsten of Drinker, Biddle & Reath (Philadelphia) represented the relator. The HHS OIG investigated this matter.

U.S. ex rel. Health Outcomes Technologies v. Robert F. Kennedy Medical Center, No. CV 01-6840 (C.D. Cal.)

In February 2003, Robert F. Kennedy Medical Center (RFKMC) reportedly agreed to pay **$2 million** to settle Medicare fraud allegations. The Government alleged that from 1994 to 1998 RFKMC upcoded a pneumonia diagnosis code in order to receive higher reimbursement rates from Medicare. Health Outcomes Technologies, a Pennsylvania-based software

company, filed this *qui tam* action in 1998 after analyzing RFKMC's diagnostic code billing patterns. The relator's share was $280,000 or approximately 14% of the total recovery. Michael Holsten of Drinker, Biddle & Reath (Philadelphia) represented the relator. The HHS OIG investigated this matter.

Johns Hopkins University

In February 2003, Johns Hopkins University (JHU) reportedly agreed to pay **$800,000** to settle Medicare fraud allegations. The Government alleged that from January 1994 to December 1994, JHU failed to provide proper documentation to establish that faculty physicians, rather than interns and residents, provided the claimed patient services. HHS OIG investigated this matter.

U.S. ex rel. Finks v. Huda, No. 99-CV-108 (S.D. Ill.)

In February 2003, Nurul Huda reportedly agreed to pay **$525,000** to settle allegations of health care fraud. The Government alleged that Huda, an East St. Louis-based ophthalmologist, falsified records in response to an audit request from the Medicare program and submitted false claims for ophthalmology procedures. Linda Finks and William Shanks filed this *qui tam* action.

U.S. v. Durango Construction Co., No. 01-CV-9824 (C.D. Cal.)

In February 2003, Durango Construction Company, Westworld Contractors, and Jet Construction reportedly agreed to pay **$500,000** to settle FCA allegations. The Government alleged that the construction companies falsely certified that they were minority-owned businesses in order to win military contracts.

Midwestern Medical Supply Company

In February 2003, Midwestern Medical Supply Company reportedly agreed to pay **$150,000** to settle allegations of Medicare fraud. The Government alleged that Midwestern Medical, a Chicago-based company, submitted false claims for payment for unauthorized products. The Medicare program requires that medical equipment suppliers obtain authorizations from beneficiaries or their authorized representatives before billing Medicare. According to the Government, Midwestern falsely stated that it had obtained these authorizations.

U.S. ex rel. King v. San Diego Hospital Assoc., No. 00-CV-00848 (S.D. Cal.)

In March 2003, San Diego Hospital Association and one of its facilities, Sharp Memorial Hospital, reportedly agreed to pay **$6.2 million** to settle allegations that Sharp Memorial fraudulently misstated organ acquisition costs in its Medicare reports. The Government alleged that Sharp Memorial listed employee salaries, medical director fees, lab costs, and rental expenses in cost reports for its organ transplant program, when in fact the costs were unrelated to organ transplants. Judith King, a heart transplant coordinator at Sharp Memorial, filed this *qui tam* action in 2000. The relator's share is $1.2 million or approximately 19% of the total recovery. Bonnie Harbinger of Phillips & Cohen, LLP (San Francisco) represented the relator. HHS OIG investigated this matter.

U.S. ex rel. Health Outcomes Technologies v. Leesburg Regional Medical Center, No. 01-CV-1384 (M.D. Fla.)

In March 2003, DOJ announced that Leesburg Medical Center had agreed to pay **$1,476,104**

to settle Medicare fraud allegations. The Government alleged that Leesburg Medical, a Florida-based hospital, upcoded a pneumonia diagnosis code in order to receive higher reimbursements rates from Medicare. Health Outcomes Technologies, a Pennsylvania-based software company, filed this *qui tam* action in 1996 after analyzing Leesburg Medical's diagnostic code billing patterns. The relator's share of the recovery was $206,655 or approximately 14% of the settlement recovery. Michael Holsten of Drinker, Biddle & Reath (Philadelphia) represented the relator. The HHS OIG investigated this matter.

U.S. ex rel. Lytel v. NYSERNet, Inc., No. 00-CV-0039 (W.D.N.Y.)

In March 2003, NYSERNet Inc. reportedly agreed to pay **$1.4 million** to settle allegations that it violated federal grant requirements. The Government alleged that NYSERNet, a nonprofit consortium of New York universities, violated the conditions of its National Science Foundation grants by passing on grant money to AppliedTheory Communications, a related for-profit corporation. Additionally, the Government alleged that NYSERNet sold assets developed and produced with federal grant awards but failed to disclose these proceeds as required under federal law. David Lytel, a former NYSERNet president, filed this *qui tam* action in 2000. Bonny Harbinger of Phillips & Cohen LLP (Washington, D.C.) represented the relator.

U.S. ex rel. Kazimiroff v. Dentsply International Inc., No. 2:99cv04203 (E.D. Pa.)

In March 2003, Dentsply International Inc. reportedly agreed to pay **$600,000** to settle allegations that it violated the FCA. The Government alleged that Dentsply, a Pennsylvania-based dental devices manufacturer, sold defective dental devices to the U.S. Government. Julie Kazimiroff, a former Dentsply employee, filed this *qui tam* suit. The relator's share has not yet been determined.

Temple Continuing Care Center

In March 2003, two Philadelphia-based nursing homes affiliated with Temple University Health Care System reportedly agreed to pay **$500,000** to settle health care fraud allegations. The Government alleged that Temple Continuing Care Center and Jeffries Memorial Home violated the FCA by providing substandard care to its elderly residents. Specifically, the Government alleged that the nursing homes failed to provide sufficient resident assessments and evaluations, nutrition, hydration, pressure ulcer treatment, dental care, and pain management.

U.S. v. Persons, No. 02-CV-164 (E.D. Mo.)

In March 2003, Michael Persons and his company, KAJACS Contractors Inc., reportedly agreed to pay **$500,000** to settle an FCA suit. The Government alleged that Persons falsely claimed to be of Native American ancestry in order to win federal contracts under the Small Business Administration's 8(a) program, which provides assistance to small businesses owned by members of socially or economically disadvantaged groups.

James Bowen, Jr. and Bowen Family Chiropractic Center, Inc.

In March 2003, DOJ announced that James Bowen, Jr. and his company, Bowen Family Chiropractic Center, Inc., had agreed to pay **$90,000** to settle allegations of Medicare fraud. The Government alleged that Dr. Bowen billed

Medicare for treatment of conditions he claimed were new or acute exacerbations of prior conditions, when in fact he was treating chronic, ongoing conditions that were not reimbursable under Medicare regulations. The FBI and HHS OIG investigated this matter.

Michael Zahm and Central Vermont Urology of Berlin

In March 2003, Michael Zahm and his clinic, Central Vermont Urology of Berlin, reportedly agreed to pay **$75,000** to settle allegations of Medicare fraud. The Government alleged that Dr. Zahm billed Medicare for 39 samples of the drug Lupron, which he received for free from TAP Pharmaceutical Products Inc. HHS OIG investigated this matter. Assistant U.S. Attorney Scott Cameron handled this case for the Government.

TAF NEWS

FCA Conference Materials

- As part of its information clearinghouse activities, TAF has materials available for distribution at conferences and other programs. Information can be tailored to a legal or general audience. Resource material, including statistical information, is also available for those writing articles on the FCA.

Qui Tam Practitioner Guide

- The *TAF Qui Tam Practitioner Guide: Evaluating and Filing a Case* can be ordered at no charge by phone, fax, or mail. This "how to" manual includes sections on evaluating the merits and viability of a case, pre-filing and practical considerations, and preparing and filing the complaint.

TAF on the Internet

- TAF's Internet presence is designed to educate the public and legal community about the False Claims Act and *qui tam*. TAF's site is located at http://www.taf.org.

Previous Publications

- Back issues of the *Quarterly Review* are available in hard copy as well as on TAF's Internet site.

Quarterly Review Submissions

- TAF seeks submissions for future issues of the *Quarterly Review* (e.g., opinion pieces, legal analysis, practice tips). To discuss a potential article, please contact *Quarterly Review* Editor Bret Boyce.

Anniversary Reports and Video

- To mark the anniversary of the 1986 FCA Amendments, TAF has available a variety of resources including a Tenth Anniversary Report, an Assessment of Economic Impact, and an educational video highlighting the effectiveness of the Act. These materials are available at no charge.

Call for Experts and Investigators

- In response to inquiries, TAF is working to compile a list of experts and investigators across an array of substantive areas. Please contact TAF with any suggestions you may have.

Qui Tam Attorney Network

- TAF is continuing to build and facilitate an information network for *qui tam* attorneys. For an Attorney Network Application or a description of activities, please contact TAF. Be sure to ask about TAFNET, our electronic mail system for Attorney Network members.

TAF Library

- TAF's FCA library is open to the public, by appointment, during regular business hours. Submissions of case materials such as complaints, disclosure statements, briefs, and settlement agreements are appreciated.

Acknowledgments

- TAF thanks the Department of Justice and *qui tam* counsel for providing source materials.