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Quarterly Review

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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*.

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FROM THE EDITOR

"The IRS needs to do everything possible to strengthen the whistleblower program and build on the progress already made in implementing the law. I am committed to expanding the program's reach and improving communications with existing and potential whistleblowers."
–IRS Commissioner John A. Koskinen, September 15, 2014

Commissioner Koskinen spoke those words as part of the keynote address he delivered during Taxpayers Against Fraud Education Fund's 2014 IRS, SEC and CFTC Whistleblower "Boot Camp"—an event held in conjunction with TAFEF's annual False Claims Act conference that featured the Directors of the agencies' respective whistleblower offices and other high-ranking staff. This announcement reflects a shift in the IRS's approach to whistleblowers, which to this point has consistently been a one-way street in which whistleblowers submit information to the Service . . . and then wait. Unfortunately, thus far the IRS has not made use of whistleblowers' knowledge and expertise by executing confidentiality agreements and allowing whistleblowers to ease some of the government's investigative burdens and thereby speed up the process for recovering unpaid taxes. It seems that the Commissioner recognizes the unparalleled success of the False Claims Act, which according to a recent Department of Justice report, recovered nearly $6 billion this year—the first year to surpass the $5 billion mark. Of course, whistleblowers were integral to these recoveries, and Joyce Branda, Acting Assistant Attorney General, speaking on behalf of DOJ, specifically "acknowledge[d] the men and women who have come forward to blow the whistle on those who would commit fraud on our government programs."

Similarly, the FCA concept is being exported to the SEC and CFTC whistleblower programs. A week after the boot camp event, the SEC whistleblower office announced a $30 million award to a whistleblower, and issued a statement soliciting more whistleblower submissions: "[w]e hope that awards like this one will incentivize company and industry insiders, or others who may have knowledge of possible federal securities law violations, both in the U.S. and abroad, to come forward and report their information promptly to the Commission." This award follows multiple whistleblower payments in August, July and June. The CFTC whistleblower office recently released its annual report to Congress, which noted that the office issued its first whistleblower award earlier this year and that whistleblower submission are up 65% from last year. Regarding the award payment, Christopher Ehrman, Director of the CFTC Whistleblower Office, declared: "Our Whistleblower Program is a necessary enforcement tool for the agency, and my hope is that this award will send the strong message that the CFTC will pay for information that helps us do our jobs." Clearly the idea of "incentivized integrity" is taking hold—and paying dividends.

Enjoy the October 2014 issue!

All the best,
Cleveland Lawrence III

Recent False Claims Act & *Qui Tam* Decisions

JULY 1, 2014–SEPTEMBER 30, 2014

FALSE CLAIMS ACT LIABILITY

A. Violations of the Anti-Kickback Statute and/or Stark Law

U.S. ex rel. Kester v. Novartis Pharms. Corp., 2014 WL 4370597; 2014 WL 44001275 (S.D.N.Y. Sept. 3, 2014)

The relator—a former sales employee for the defendant Novartis, a pharmaceutical company that develops, manufactures, and markets prescription drugs—brought a *qui tam* action against Novartis. The United States government, as well as ten states (the Intervening States) elected to intervene in the *qui tam* claims against Novartis. The plaintiffs alleged that Novartis violated the False Claims Act by participating in illegal kickback schemes involving prescription drugs covered by government healthcare programs, because the kickbacks caused various pharmacies to submit false claims for reimbursement for Novartis' drugs to government healthcare programs—claims that falsely certified the pharmacies' compliance with the Anti-Kickback Statute, which is a precondition to payment under those programs. The Intervening States alleged violations of their respective state FCAs, based on alleged kickback schemes specifically related to Novartis' drug, Exjade, and the pharmacy, Bioscrip.

The relator also named as defendants several specialty pharmacies that were alleged to have participated in the kickback scheme, including Caremark, Accredo, and Curascript (the Pharmacy Defendants). The relator detailed schemes involving volume and quantity-based rebates paid to the Pharmacy Defendants in exchange for the promotion of five different Novartis drugs to patients. The government entities declined to intervene in the relator's claims against the Pharmacy Defendants.

Each of the defendants moved to dismiss all the plaintiffs' claims, arguing that the claims failed to state a claim as required by Rule 12(b)(6), and that the fraud allegations were not pled with particularity as required by Rule 9(b). In addition, the Pharmacy Defendants moved to dismiss the *qui tam* claims on public disclosure grounds, and Novartis moved to dismiss for lack of standing.

Holding: The U.S. District Court for the Southern District of New York denied Caremark's motion to dismiss on public disclosure grounds in part and granted it in part, finding that some of the allegations in the relator's complaint had been previously publicly disclosed. The court dismissed Novartis' motion to dismiss the relator's complaint for lack of standing, though, holding that the government's intervention in the case had not deprived the relator of standing to pursue his claims, and that only if the government settled its claims would the relator not be permitted continue to litigate those claims on his own. The court denied the Pharmacy Defendants' motion to dismiss for failure to state a fraud claim with respect

to most of the relator's claims against them. The court denied Novartis's motion to dismiss for failure to plead fraud with particularity.

Public Disclosure Bar

The court first decided that, even after the Patient Protection and Affordable Care Act (PPACA) amended the public disclosure bar in 2010, the bar remains jurisdictional. The court then addressed the Pharmacy Defendants' arguments that the public disclosure bar applied in this case because the relator's allegations were "substantially similar" to public disclosures made prior to the filing of his complaint. Specifically, Defendant Caremark argued that the relator's allegations regarding its kickback scheme with Novartis were "substantially similar" to accusations made in a series of lawsuits filed and settled in 2008 by 28 states for violations of those states' consumer protection acts. Those cases involved allegations of, among other things, *quid pro quo* agreements between Caremark and drug manufacturers to promote certain drugs to doctors and patients in exchange for rebates. The allegations and nationwide settlement—in which Caremark did not admit any wrongdoing, but did promise to disclose the receipt of any rebates in the future—were widely reported in the news media. The court agreed with Caremark and held that while the relator provided additional detail and information about the alleged kickback schemes, the "crux" of the schemes had been publicly disclosed in the previous cases and in the settlement. The court explained that the previous allegations were "more than enough to 'alert [] law enforcement authorities to the likelihood of wrongdoing,'" and that all of the essential elements of the alleged fraud had been exposed.

However, the court then addressed the "novel" argument made by the relator, that though the allegations of Caremark's wrongdoing up to the settlement may have been publicly disclosed, there was no evidence of public disclosure from 2008 forward. The relator alleged that Caremark continued to participate in the kickback scheme after the settlement and failed to disclose any rebates to the government—in violation of its settlement agreement—and that this information was not publicly disclosed. The court agreed with the relator and explained that while there was sufficient information to alert the government to the likelihood of wrongdoing prior to 2008, no public disclosure ever revealed Caremark's intention not to comply with its obligations under the settlement; and as time passed, the public disclosure "ceased to be contemporaneous," and was "less and less suggestive of active, ongoing fraud." The court held that information that was disclosed about a fraud in 2007 and a settlement in 2008 could not constitute a public disclosure of "facts on the ground several years later." To hold otherwise, the court explained, would immunize certain fraudulent conduct by a defendant in perpetuity. In order to set a "cutoff" date when publicly disclosed information was too old to trigger the public disclosure bar, the court used the effective date of PPACA, when the public disclosure bar was amended so that state court filings ceased to qualify as sources of public disclosures. Thus, the court concluded that the relator's allegations concerning Caremark's conduct between 2007 and March 2010

were "substantially similar" to the allegations in the 2008 cases and settlement, but the allegations of conduct after March 2010 were not and thus were not subject to the public disclosure bar.

The court also explained that while the relator alleged that he had firsthand knowledge of the kickback schemes dating back to 2006, he only alleged firsthand knowledge involving Caremark starting in 2009. Therefore, the court held that the relator could only be considered an "original source" for allegations from 2009 onward. Because the relator was not an original source for the information underlying the allegations that the court found "substantially similar" to allegations regarding Caremark's conduct between 2007 and March 2009, those claims against Caremark were dismissed.

The court held that there was no prior public disclosure involving the allegations against Novartis, Accredo, or Curascript. The court rejected those defendants' arguments that several news reports made general reference to medication "adherence" plans, or relationships between drug manufacturers and pharmacies involving discounts or rebates. The court explained that there were no allegations of wrongdoing or *quid pro quo* relationships mentioned in the articles cited in connection with any of the particular defendants.

Failure to State a Claim/Failure to Plead Fraud with Particularity

Caremark moved to dismiss the relator's complaint for failure to state a claim under Rule 12(b)(6), arguing that it was "implausible" that Novartis would pay kickbacks to pharmacies because doctors, not pharmacies, write prescriptions. The court rejected this argument as "logically flawed," citing the relator's allegations that Novartis made a decision to leverage the pharmacies influence and his claims about the success of the alleged kickback scheme.

Novartis moved to dismiss the Intervening States' complaint relating specifically to the scheme involving Exjade for failure to plead fraud with particularity as required by Rule 9(b). The court denied this motion, explaining that although the Intervening States alleged that all of BioScrip's claims submitted during the five-year period indicated in the complaint were rendered false by the alleged kickback scheme, the States' allegations were sufficient to satisfy Rule 9(b) because they pled the specific pharmacy at issue, the name of the drug, the total number of claims submitted, the total reimbursement amount, the government program at issue, and the precise time period during which the claims were submitted.

The defendants also argued that the plaintiffs had not adequately pled that the claims at issue were "false" within the meaning of the FCA. The plaintiffs countered, and the court agreed, that the claims submitted were rendered "legally false" by the pharmacies' express and implied certifications of compliance with the AKS. The AKS was amended by the PPACA to codify compliance with the AKS as a precondition to payment of claims by the government. The court held however, that under either the pre or post-amendment version of the statute, compliance with the AKS was a pre-

condition of payment. The court rejected the defendants' argument that compliance with the AKS was not a precondition of payment prior to the 2010 and the PPACA amendment, explaining that though the PPACA codified it, "the overwhelming weight of authority…is that compliance with the statute was such a precondition, even before the 2010 amendment." The court further explained that the Medicare claim reimbursement forms stated as far back as 2001 that "payment of a claim by Medicare or other federal health care programs is *conditioned on* the claim and the underlying transactions complying with such laws, regulations, and program instructions (including the *antikickback statute* and Stark [L]aw)." In addition, the relator alleged that the Medicare reimbursement forms that the Pharmacy Defendants submitted for Novartis drugs expressly certified compliance with federal laws and the AKS. Moreover, the court found that the relator sufficiently alleged that the Medicaid enrollment forms for four of the states referenced in the *qui tam* complaint also required express certifications; but the court found that the relator offered only conclusory observations about the additional states' forms—the relator was granted ten days leave to amend his allegations regarding the defendants' purported false certifications of compliance to the other states. Since the plaintiffs adequately pled that the pharmacies violated the AKS, the court held that their allegations that the pharmacies' express certifications of compliance with the AKS—and their corresponding claims for reimbursement—were false for FCA purposes.

The court, though reached a different holding with respect to the plaintiffs' allegations that the pharmacies also made implied false certifications of compliance with the AKS, rendering their reimbursement claims to the government false. The court held that because the PPACA amended the AKS to make explicit that compliance with the AKS is a precondition of payment, the Intervening States properly pled that when the pharmacies submitted claims to state Medicaid programs after March 2010, they "impliedly" certified compliance with the AKS. Therefore, the alleged existence of the kickback scheme rendered all of the pharmacies post-PPACA claims both expressly and impliedly false. However, the plaintiffs' allegations of implied certification prior to 2010 failed, as compliance with the AKS was not an express precondition of payment at that time. The court held that only two of the intervening states adequately pled false claims prior to the PPACA amendment, as those states pled that their Medicaid programs require providers to specifically certify compliance with the AKS as a precondition of payment. The court determined that most of the remaining states failed to cite specific Medicaid regulations that expressly conditioned payment under their respective programs on AKS compliance. The states attempted to provide the court with the necessary information in their opposition to Novartis' motion to dismiss, but the court refused to allow the states to amend their allegations in this way. Instead, the court granted the states ten days leave to amend their claims to include the necessary information.

U.S. ex rel. Bartlett v. Ashcroft, 2014 WL 4179862 (W.D. Pa. Aug. 21, 2014)

The two relators alleged that a group of defendants violated the False Claims Act by participating in a patient referral scheme in violation of the Anti-Kickback Statute and the Stark Law. The relators asserted that defendants violated the FCA by submitting claims for reimbursement from Medicare and Medicaid while falsely certifying that they were in compliance with the underlying relevant laws and regulations. The relators were former employees of one defendant, Tyrone Hospital, which provided in-patient and ancillary hospital services. The Hospital allegedly entered into an arrangement with another defendant, Tri-County Imaging Associates, to provide CT scanning services to the Hospital. The relators also sued five physicians, all of whom were stockholders in Tri-County.

The relators alleged that the physician improperly defendants referred more than 8,000 patients to Tyrone Hospital, in exchange for illegal payments -- for instance, Tyrone Hospital allegedly paid one of the Physician Defendants, Dr. DiGiacobbe (now deceased) $410 for each CT scan performed. These payments were allegedly placed in a Tri-County operating account and distributed to the shareholders, including the physician defendants, and DiGiacobbe collected a 15% fee. Both sides moved for summary judgment on the relators' claims.

Holding: The U.S. District Court for the Western District of Pennsylvania held that an improper financial relationship existed between the physician defendants and Tyrone Hospital for the purposes of the Stark Law; the defendants' financial relationship did not fit within a Stark Law exception. Further, the court held that the hospital submitted claims for payment to Medicare pursuant to referrals from physician defendants and received payments from such claims. However, the court held that the relators did not cite any evidence of the defendants' subjective knowledge of false claims submitted by the hospital. The court explained that the relators' arguments that the physician defendants violated the Stark Act and benefited from the financial relationship was not sufficient to show that those defendants had knowledge of or were responsible for the submission of claims to the government for reimbursement. The court granted the relators' motion for summary judgment in part and denied the defendants' motion for summary judgment.

U.S. ex rel. McDonough v. Symphony Diagnostic Servs., Inc.,2014 WL 3906461 (S.D. Ohio Aug. 12, 2014)

A relator brought an action under the False Claims Act,, against two related defendants—both of which provided mobile, on-site x-ray and diagnostic services to hospitals, prisons, long-term care facilities, and skilled nursing facilities ("SNFs"). The relator alleged that the defendants impermissibly priced their services below

"costs" in order to take advantage of the differences in reimbursement rates between Medicare Part A and Part B. According to the relator, the defendants' pricing violated the Anti-Kickback Statute, and any claims submitted to Medicare resulting from those violations were false under the FCA. The U.S. District Court for the Southern District of Ohio held that the definition of "costs" relied on by the relator "is not the only permissible measure of costs under the AKS," and that "because Relator cannot support the legal conclusion that his method of determining costs is demanded by the AKS, his entire chain of logic unravels," requiring dismissal of his fraud claim. The court granted summary judgment in favor of the defendants.

U.S. ex rel. Corporate Compliance Assoc. v. N.Y. Soc'y for the Relief of the Ruptured and Crippled, Maintaining the Hosp. for Special Surgery, 2014 WL 3905742 (S.D.N.Y. Aug. 7, 2014)

The relator filed a *qui tam* action against the defendants—a hospital; Reynolds, the hospital's former CFO and CEO; and Kemp, the owner of an outside billing company for the hospital—alleging the defendants violated the False Claims Act. According to the relator, the defendants' practices gave rise to FCA liability because they submitted claims to the government in which they knowingly falsely certified compliance with the Anti-Kickback Statute and the Stark Law. Specifically, the hospital was alleged to have generated "derivative revenue" from billing patients for physicians' use of the hospital for office visits, surgeries, and diagnostic and rehabilitation services. The relator alleged the hospital paid kickbacks to physicians in the form of a percentage of the derivative revenue that the physicians generated, an additional $80,000 payment for work purportedly related to ancillary hospital duties (so-called "CARA payments"), and administrative titles and increased salary for physicians that drove additional derivative revenue. In addition, the hospital allegedly received kickback payments from the outside billing company owned by Kemp through monthly payments to Reynolds' consulting company in exchange for the hospital's billing business. The hospital also allegedly billed the government for services performed at unlicensed off-site facilities. Finally, the relator alleged that in the claim forms submitted to the government for reimbursement, the hospital used the billing code reserved for services performed in physicians' offices, which are reimbursed at a high rate, instead of the code for services performed in the hospital, though the services at issue were actually performed in the hospital. The defendants moved to dismiss, claiming that the relator failed to plead the alleged fraud with particularity, as required by Rule 9(b).

Holding: The U.S. District Court for the Southern District of New York granted the defendants' motion.

Failure to Plead Fraud with Particularity

The court held that the relator failed to satisfy the requirements of Rule 9(b), stating that in order to plead fraud with particularity under Rule 9(b), an FCA claim "must allege the particulars of the false claims themselves" rather than allegations regarding an overall fraudulent scheme. The court explained that when alleging a long-running scheme, like the one at issue here, relators do not have to detail each false claim, but may come forward with examples of false claims within the scheme in order to put the defendant on notice as to the claims against them. In this case, the relator alleged a large fraud scheme, but did not provide sufficiently detailed examples of the allegedly false claims. For instance, the relator alleged that the hospital "filed approximately 355,000 CMS 1500 Forms that falsely stated such medical services were performed in private office settings—and not in hospital-based settings—and thereby intentionally caused Medicare to over-reimburse [the hospital] by approximately $8,500,000." However, the court explained, the relator did not detail the actual contents or filings of any of the forms, nor were there any examples of an identified physician providing a service to a patient in a hospital-based setting and then falsely coding the forms. In addition, the court held that the Complaint failed because it did not distinguish between individual defendants, improperly contained allegations that conduct was "consistent with fraud," and "failed to distinguish between express and implied theories of false certification." The court also held that the relator failed to link the allegedly bolstered base salaries of physicians receiving kickbacks to the derivative revenue to which they contributed, because it only alleged that the salaries were "consistent with" liability and the allegations were "purely conclusory," as the Complaint failed to provide any detail tying the alleged overcompensation to derivative revenue. The relator also failed to allege that any particular physician received a CARA payment in exchange for referrals to the hospitals, or that the executive titles were given out in exchange for referrals. The court also held that the relator made only conclusory assertions that the hospital was negligent in not discovering the alleged kickback scheme between Reynolds and Kemp; the relator did not allege that Reynolds had apparent authority to solicit kickbacks on behalf of the hospital or that the hospital benefited, nor did they allege how the purportedly illegal payments rendered the hospital's claims for reimbursement false. The relator also failed to properly plead conspiracy under the FCA, conflating the defendants and failing to allege with particularity the role of any specific defendant nor any participation in any conspiracy by any of the hospital's physicians.

False Certification of Compliance

The court held that the relator failed to state a FCA claims because it did not distinguish between the defendants' alleged "express" false certifications to the government and their alleged "implied" false certifications; in fact, the court held that the relator failed to allege that defendants actually submitted either type of certification. As to express certification, the relator failed to identify any express false statements of com-

pliance. The court also held that the relator failed to properly plead implied certification, because the relator did not identify any underlying statute or regulation which expressly stated that the provider must comply in order to receive payment. The court held that although the relator alleged that: 1) the hospital submitted cost reports to Medicare in which it was required to certify knowledge of the laws and regulations regarding the provision of health care services and that the services identified in the reports were provided in compliance with those laws and regulations; 2) the forms required the hospital officials to certify that they understood that payment would come from government funds and that any false claims or statements may be prosecuted under Federal and State laws; and 3) forms submitted in order to receive reimbursement from state Medicaid included an acknowledgement that providing false statements or claims may lead to prosecution; these "generalized certifications of legal compliance [did] not satisfy the standard for alleging implied false legal certification."

See *U.S. ex rel. Hallman v. Millennium Radiology, Inc.*, 2014 WL 4908275 (S.D. Ohio Sept. 30, 2014), at page 69.

See *U.S. ex rel. Bilotta v. Novartis Pharms. Corp.*, 2014 WL 4922291 (S.D.N.Y. Sept. 30, 2014), at page 70.

See *U.S. ex rel. Silver v. Omnicare, Inc.*, 2014 WL 4827410 (D.N.J. Sept. 29, 2014), at page 46.

See *U.S. ex rel. Dowell v. Penn*, 2014 WL 4778531 (E.D. La. Sept 23, 2014), at page 50.

See *Randazzo v. CH2M Hill, Inc.*, 2014 WL 4697131 (D. Colo. Sept. 22, 2014), at page 23.

See *U.S. ex rel. Bates v. Dentsply Int'l, Inc.*, 2014 WL 4384503 (E.D. Pa. Sept. 4, 2014), at page 81.

See *U.S. ex rel. Barker v. Columbus Reg'l Healthcare Sys., Inc.*, 2014 WL 4287744 (M.D. Ga. Aug. 29, 2014), at page 32.

JURISDICTIONAL ISSUES

A. Section 3730(B)(5) First-to-File Bar

See *U.S. ex rel. Parikh v. Citizens Med. Ctr.*, 2014 WL 4364875 (S.D. Tex. Sept. 3, 2014), at page 82.

B. Section 3730(e)(3) Proceedings in which the Government is Already a Party

Taul v. Nagle Enter., Inc., 2014 WL 4681584 (N.D. Ala. Sept. 17, 2014)

The relator was a former employee of the defendants, corporate and individual owners and operators of a mortuary and crematory. The relator alleged that the defendants violated the False Claims Act by engaging in a kickback scheme with the Alabama Organ Center, a local organ donor center. The relator alleged that he overheard the defendants discussing the scheme, that one of the owners told him that "it takes a little grease on some palms sometimes to make money," and that the owner even admitted the fraudulent scheme to him. The defendants moved to dismiss the *qui tam* claims on public disclosure grounds, citing a civil forfeiture complaint against the defendants based on the same allegations. The relator oppose the defendants' motion, however, claiming that he informed the Federal Bureau of Investigation about the alleged scheme before any public disclosure took place.

Holding: The U.S. District Court for the Northern District of Alabama denied the defendants' motion to dismiss, characterizing the defendants' challenge as a factual one, and explaining that the facts alleged by the relator corroborated that he had qualified as an "original source" under the FCA, as he demonstrated direct and independent knowledge of the information on which his fraud allegations were based, and that he provided that information to the government before he filed his *qui tam* complaint.

C. Section 3730(e)(4) Public Disclosure Bar and Original Source Exception

U.S. ex rel. Buckley v. Hill & Cox Corp., 2014 WL 4425800 (W.D. Ark. Sept. 9, 2014)

The relator, a former contractor for the defendant, filed an action under the False Claims Act, alleging that the defendant failed to pay him the prevailing wage as required by the Davis-Bacon Act for work on four different government contracts over a six month period. This case was before the U.S. District Court for the Western District of Arkansas for its consideration of the Report and Recommendation from the Magistrate Judge recommending that the defendant's motion to dismiss for lack of jurisdiction and failure to state a claim be granted.

During his employment, the plaintiff became aware that he was not being paid the prevailing wage for his work, as required by the Davis-Bacon Act. He notified the Department of Labor (DOL) about the defendant's failure to pay the prevailing wage on the four contracts. DOL investigated the matter and found that the defendant failed to pay nineteen employees, including the plaintiff, the prevailing wage, and ordered the defendant to pay back wages to these employees. However, the DOL report only referenced one of the four contracts that the relator worked on, even though he reported payment deficiencies in all four of the contracts to DOL. The defendant moved to dismiss for lack of subject matter jurisdiction, arguing that the FCA's rule prohibiting *qui tam* suits "based upon allegations or transactions which are the subject of a civil suit or an administrative money penalty proceeding in which the Government is already a party." The relator countered that while his complaint was not barred because the DOL administrative proceeding only dealt with one of the contracts at issue, while his *qui tam* suit dealt with all four.

Holding: The court adopted the Report and Recommendation *in toto* and granted the defendant's motion to dismiss. The court explained that the fact that the DOL report did not specifically name all four contracts did not mean that all four were not investigated. The court noted that the relator requested that DOL review all of the contracts and handed over all four for review. The DOL report also addressed the specific time period covering all four contracts. Therefore, the court held that the administrative proceeding and the FCA suit addressed the same allegations or transactions and consequently, the *qui tam* suit was dismissed for lack of subject matter jurisdiction.

U.S. ex rel. Customs Fraud Investigations, LLC v. Victaulic Co., 2014 WL 4375638 (E.D. Pa. Sept. 4, 2014)

The relator, a company that conducts research related to customs fraud, brought an action against the defendant, a producer of pipe fittings manufactured in the U.S., China, Poland, and Mexico. The relator alleged that the defendant violated the False Claims Act by failing to mark or by mismarking its foreign-made pipe fittings, in violation of the U.S. Tariff Act, and by falsifying customs documents to avoid paying "marking duties" on mismarked or unmarked foreign products.

In gathering support for its claims, the relator consulted a paid subscriber internet database, Zepol, which collects and makes available shipping manifests and import information collected by U.S. Customs and Border Patrol (CBP). From this database the relator gleaned that the defendant had imported approximately 83 million pounds of pipe fittings from China and Poland. The relator performed calculations based on the market and other unidentified sources to determine that "upon information and belief" these imports accounted for the significant majority of the defendant's annual U.S. sales. The relator then tracked advertisements for the secondary sale of the defendant's pipe fittings on the internet auction site, eBay. Based on its examination of a sample of 221 listings, the relator determined that at least 75% of the defendant's fittings on eBay were unmarked, only three were marked as being made in China, and only one of those complied with Tariff Act requirements. From this analysis, the relator concluded that "almost all" of the defendant's pipe fittings for sale in the U.S. were unmarked or mismarked, and that the defendant knowingly failed to mark or knowingly mismarked those fittings.

The relator also alleged that because the CBP only inspected a small fraction of the imports arriving in the U.S., it was likely that the defendant was falsifying entry documents on its imports by indicating that no marking duties were owed when duties actually were owed, in light of the large quantity of unmarked foreign fittings discovered by the relator. Specifically, the relator argued that the customs entry form required importers to report the specifically enumerated fees listed on the form, and any additional fees—including the marking fees that would apply to improperly marked products. Though instructions for listing this fee were not included on the form, the relator argued that the marking fee duty is included in phrases such as "estimated duty" and "any other fees or charges," and that the defendant falsified its entry documents by not including the marking fees on its customs entry forms.

The U.S. declined to intervene, and the defendant moved to dismiss on public disclosure grounds and for failure to state a claim.

Holding: The U.S. District Court for the Eastern District of Pennsylvania denied the defendant's motion to dismiss on public disclosure grounds but granted its motion to dismiss for failure to state a claim.

Public Disclosure Bar

As an initial matter, the court held that although the public disclosure bar still remains a threshold question for dismissal, it is no longer jurisdictional in nature, after the 2010 amendments to the FCA. Ultimately, the court held that it would apply the pre-2010 version of the statute to the claims based on conduct that occurred before the amendments became effective; however, the court's analysis would have been the same under either version of the statute.

The defendant argued that facts from the websites that the relator relied on to obtain the information used in forming its claims constituted public disclosures in the news media or in Federal or administrative reports, and the relator's claims were thus barred. The court held that a "publicly available website may qualify as 'news media' where the information provided is to some extent curated…and where the information bears at least some of the 'indicia of reliability or substantiation' common to more traditional news media sources." The court went on to agree with the defendant that the shipping manifest data relied on by the relator was publicly disclosed through the Zepol website, because that site collects, organizes, and disseminates the manifests that the CBP collected for distribution to the public, along with providing data, analysis, and articles worldwide. However, the court found that the information obtained through the eBay website was not publicly disclosed. The court explained that an online auction site does not fit into any category of public disclosure listed in the statute. The court explained that unlike Zepol, the eBay website is simply an online marketplace, and does not contain analysis, articles, or editorializing, nor does it disseminate government reports such as those from the CBP. The court further explained that, "if the products listed for sale on-line on eBay were instead available in a brick-and-mortar storefront, the information obtained from observing the products would not be publicly disclosed within the meaning of [the FCA]." Because the court found that the information from the eBay website was not publicly disclosed, and that information was necessary to the relator's claims, the action was not barred.

Reverse False Claims Act

The defendant argued that the failure to properly mark goods or pay marking duties under the Tariff Act does not give rise to FCA liability. While the relator argued that the marking duties are due at the time of importation, the defendant asserted that the duties are fines that it might owe if it imported unmarked or mismarked goods and failed to subsequently mark, export, or destroy them. The defendant argued that its purported obligation to pay marking duties was only "contingent" and did not fall within the scope of the FCA's definition of "obligation to pay," as used in the "reverse" false claims provision. The court noted that the Tariff Act does not define at what point an importer is obligated to pay the duties. The court held that because of this ambiguity, the relator could not plausibly allege at what point the defendant knowingly concealed an obligation to pay marking duties, or made a false statement or omis-

sion, and dismissed this claim. Thus, the relator could not maintain a claim based on "reverse" false claim liability.

Failure to State a Claim/Plead Fraud with Particularity

The court held that the relator's claims also fell far short of the level of specificity required by Rule 9(b). The court explained that the relator provided no factual support for its assertions that imported pipe fittings constituted the majority of the defendant's U.S. sales, or that only a fraction of those products had proper foreign markings. The only support the relator provided was its own conclusory calculations and interpretation of data. Additionally, the relator did not provide any factual basis for its allegations that the defendant falsified customs documents. The court further explained that the relator did not provide any facts to show that the unmarked pipe fittings that it viewed on eBay were not actually U.S.-made, or present any facts to show that the defendant did not pay marking duties on any unmarked pipe fittings it may have imported.

U.S. ex rel. Oliver v. Philip Morris USA Inc., 2014 WL 4197803 (D.C. Cir. Aug. 26, 2014)

The relator, a competitor of the defendant Philip Morris, brought a *qui tam* action alleging that the defendant violated the False Claims Act by failing to provide the government with "Most Favored Customer" pricing for cigarettes as required by its contracts, but certifying to the government that it was providing said pricing. The relator alleged that the defendant provided lower pricing to affiliates operating in the same markets as government purchasers. Philip Morris argued that an internal memorandum which disclosed a Philip Morris affiliates' practice of selling cigarettes on the duty-free market at prices lower than it charged to the government, as well as the government's objections to the price differences, constituted a public disclosure of the relator's fraud allegations for the purposes of the FCA's public disclosure bar. The U.S. District Court for the District of Columbia acknowledged that the memorandum did not explain that the price differential was contrary to the Most Favored Customer provisions of the contracts, however, the court nevertheless held that the public disclosure bar applied because the transactions upon which the relator's suit was based had been publicly disclosed; the relator's complaint was dismissed for lack of subject matter jurisdiction. The relator appealed the district court's ruling the U.S. Court of Appeals for the District of Columbia.

Holding: The D.C. Circuit vacated the district court's ruling that the court lacked subject matter jurisdiction due to the public disclosure bar. The circuit court held that neither the contract terms obligating the defendant to provide the government with Most Favored Customer pricing, nor the defendant's allegedly false certifica-

tions that it complied with that pricing had been publicly disclosed. The circuit court explained that where only one element of the fraudulent transaction is in the public domain, the relator may supply other elements of the fraud in order to make a case. The circuit court also explained that the government's knowledge of the Most Favored Customer requirements did not amount to a public disclosure, as a "public" disclosure must be made to the public outside of the government.

U.S. ex rel. Paulos v. Stryker Corp., 2014 WL 3866043 (8th Cir. Aug. 7, 2014)

The relator filed a *qui tam* action in U.S. District Court for the Western District of Missouri, alleging that a group of defendants—manufacturers of pain pump medical devices—violated the False Claims Act ("FCA") by marketing their devices for placement into patient's joints after orthopedic procedures, but failing to disclose information regarding the dangers of the pumps to the Food and Drug Administration, mislabeling promotional materials related to the pumps, and then seeking reimbursement from Medicare. The district court dismissed the relator's claims, finding that the public disclosure bar applied and the relator was not an original source of the allegations contained in his complaint. The relator appealed to the U.S. Court of Appeals for the Eighth Circuit.

Holding: The 8th Circuit affirmed the district court's decision.

The appellate court held that the information contained in the relator's complaint had previously been the subject of numerous media reports, FDA reports, and federal regulatory disclosures. The relator did not deny this; however, he argued that he alleged additional specific allegations that were not yet disclosed, and that he was an "original source" for the information that had been made public. The circuit court rejected the relator's argument that his allegations had not been specifically disclosed, holding that those exact allegations had been laid out in public documents. The court also rejected the relator's attempt to distinguish his claims from the public disclosures because the public disclosures did not provide evidence of the defendants' scienter, holding that there was also evidence in the publicly disclosed documents that showed the defendants' knowledge of the complications. Finally, the district court rejected the relator's argument that his allegations that the defendants actually submitted claims to the government for reimbursement were not publicly disclosed, explaining that the additional facts "merely 'add[ed] some color'" and supplied further detail but did not distinguish it from the public disclosures.

The relator argued that he was the "original source" of the public disclosures, because he was among the first to suspect and investigate the complications arising from the pain pumps. However, the circuit court held that a relator is not an original source of fraud allegations, simply because he discovered them first. The rela-

tor also argued that he added independent knowledge of the defendants scienter, because he warned the defendants about the connection between the pumps and the complications. The court rejected this claim, holding that the information that the relator reported to his supervisors was not directly related to the complications at issue here.

U.S. ex rel. Lockey v. City of Dallas, 2014 WL 3809754 (5th Cir. Aug. 4, 2014)

Two relators filed a *qui tam* action in the U.S. District Court for the Northern District of Texas, claiming that a U.S. city and its housing authority violated the False Claims Act by falsely certifying to the U.S. Department of Housing and Urban Development their compliance with civil rights and fair housing laws and that they were affirmatively furthering fair housing. The defendants received federal funding from HUD for the purpose of providing housing and expanding economic opportunity for low-income persons. The defendants were required to submit reports and certifications to HUD stating that they would "affirmatively further fair housing." The relators sought to redevelop an office building in downtown Dallas into a housing complex. They alleged that although the defendants initially approved the project, they soon began to disavow the project because of the high level of low-income housing included in the project. Because of the defendants' alleged active discouragement of the project, the relators claimed that funding for the project lapsed. The relators alleged that the defendants made false certifications to HUD that they were in compliance with their obligation to provide low-income housing and received illegal subsidies as a result. The U.S. District Court for the Northern District of Texas granted summary judgment in favor of the defendants, citing the FCA's public disclosure bar. The relators appealed that ruling to the U.S. Court of Appeals for the Fifth Circuit.

Holding: The Fifth Circuit affirmed the district court's summary judgment decision.

The defendants argued, and the circuit court agreed, that the public disclosure bar applied, because the majority of the information that the relators used to form the allegations in their brief was publicly available via news articles, on-going litigation filed before the relators' complaint, and a review by the Texas Affordable Housing Project. The court rejected the relators' argument that they had personal knowledge of the alleged fraud because of their personal experience with the defendants. Instead, the court explained that the relators' personal experience formed the basis for only one paragraph in a 40-page complaint, and that the bulk of the complaint was simply a regurgitation of publicly available information, regulations, and HUD guidelines. The relators argued that they should be considered "original sources" of that information, because they began their own investigation of the defendants' practices and were put "on the trail" of the alleged fraud. However, the

court held that because the relators' investigation failed to "translate into some additional compelling fact, or…demonstrate a new and undisclosed relationship between disclosed facts…," they could not claim original source status.

U.S. ex rel. Heath v. Wisconsin Bell, Inc., 2014 WL 3704023 (7th Cir. July 28, 2014)

The relator filed a *qui tam* action alleging that the defendant violated the False Claims Act by overcharging school districts for telecommunications services that it provided under the Education Rate Program ("E-Rate Program"), which is a federal subsidy program. The U.S. District Court for the Eastern District of Wisconsin held that the relator's complaint was based on a prior public disclosure, and dismissed the suit. The relator appealed the district court's ruling to the U.S. Court of Appeals for the Seventh Circuit.

In order to participate in the E-Rate program, providers such as the defendant had to offer schools the "lowest corresponding price" ("LCP") for their services -- the "lowest price that a service provider charges to non-residential customers who are similarly situated to a particular school, library, or library consortium for similar services." The relator was retained by school districts to perform audits of their telecommunications bills and identify improper charges. He alleged that in reviewing the defendant's bills, he discovered that certain schools paid much higher rates than others for the same services. As a result, those school districts were not receiving the benefit of the LCP, yet the government was paying the subsidies to the defendant under the program. As the relator continued to investigate, he discovered the existence of a contract between the Wisconsin Department of Administration (DOA) and the defendant for similar services to those being provided to the school districts. The rates in the agreement with the DOA were significantly less than those being provided to the school districts. The relator brought the discrepancies to the attention of the defendant, but it refused to provide the lower rates to the school districts. The relator then found additional information regarding the DOA pricing, including the actual contract for services with the defendant, on the DOA website. The relator continued to request the lower DOA pricing for the school districts, and the defendant relented and lowered the rates for a few of the districts, but not all of them.

The relator filed a *qui tam* in 2008 and the government declined to intervene. The district court held that the public disclosure bar applied and that the relator could not rely on the original source exception based on his reliance on the contract from the DOA website in preparing portions of his complaint.

Holding: The Seventh Circuit reversed the district court's ruling that the public disclosure bar applied in this case. The circuit court held that while the relator's allegations may have partially relied on the agreement found on the DOA website,

the allegations in his complaint "required independent investigation and analysis to reveal any fraudulent behavior." The agreement with the DOA was not evidence on its own of any fraud. The relator's knowledge of the pricing received by the schools was required in order to establish fraud.

U.S. ex rel. Hoggett et al. v. Univ. of Phoenix, 2014 WL 3689764 (E.D. Cal. July 24, 2014)

The relators were former admissions counselors for the defendants and alleged that the defendants violated the False Claims Act by submitting false claims for financial aid funding. The U.S. District Court for the Eastern District of California originally denied the defendants' motion to dismiss and allowed discovery. After discovery was completed, the defendants renewed their motion to dismiss, arguing that the public disclosure bar applied and the relators' claims were not saved by the original source exception. The court granted the motion.

The defendants' tuition revenue came mainly from federally-guaranteed loans, which were made subject to various conditions, including the requirement that recruiters not be compensated based solely on the number of students they enroll. In 2009, the defendants settled a *qui tam* suit alleging that recruiter compensation was based on enrollment count alone. The relators filed the present suit approximately nine months later, alleging that the defendants continued to compensate recruiters based solely on the number of students they enrolled. In order to receive the federal funds, the defendants submitted participation agreements to the government stating that they had not "paid to any persons or entities any commission, bonus, or other incentive payment based directly or indirectly on the success in securing enrollments…." The relators alleged that the defendants disguised the compensation practices "with a 'matrix' that lists non-enrollment criteria for performance evaluation," however, in reality; compensation was based solely on enrollment numbers.

Public Disclosure Bar

The defendants argued that the public disclosure bar applied. The court noted that despite the relators' arguments to the contrary, the current public disclosure law provides that the court "shall" dismiss an action if substantially the same claims were publicly disclosed and the relator does not qualify as an original source. The court also mentioned that various courts have interpreted "the public disclosure bar as remaining jurisdictional in nature even after the 2010 amendment." In any event, the court held that the relators' claims dated back to before the amendment's effective date, giving the court jurisdiction under the 2006 version of the statute.

The court explained that the publicly disclosed facts need not be identical to the relators' allegations, as long as the "material elements" of the "underlying 'transaction'"

were disclosed publicly. The defendants argued that in the months after the 2009 settlement, several news reports and television programs discussed the alleged unauthorized incentive program in the present suit. In addition, several government investigations and reports were published containing details regarding the compensation programs. The court held that these reports and investigations constituted public disclosures, and that the relators could not avail themselves to the original source exception, as they did not play any part in the public disclosures—a requirement adopted by the Ninth Circuit. The court further held that the relators failed to establish that they had independent knowledge of the allegations in their Complaint; even if they had established this knowledge, the court held that because their knowledge did not "materially add" to the publicly disclosed allegations, they could not qualify as original sources. Indeed, during the relators' depositions, they admitted that enrollment was not the sole basis for their own compensation. The court also noted that there was no evidence that the relators participated in the development or implementation of the fraudulent practices, or that they played a role or "had any real understanding of" the practices. The relators admitted that they were never part of any conversations regarding the compensation policy and had no direct knowledge or role in the creation or distribution of that policy. As such, the court held that the relators could not qualify as original sources, and granted the defendants' motion to dismiss.

U.S. ex rel. Gage v. S.R. Aviation, 2014 WL 3007201 (W.D. Tex. July 2, 2014)

A relator filed a *qui tam* suit alleging that a group of defendants purchased a crashed aircraft, salvaged its parts, and then sold the parts to military contractors for use in U.S. military aircraft in Afghanistan. According to the relator, the defendants violated the False Claims Act because they falsely represented to the government that the salvaged parts were airworthy. The relator was an expert witness in a separate, non-FCA lawsuit related to the same crashed aircraft and involving many of the defendants in the *qui tam* lawsuit. The relator's second amended complaint was dismissed without prejudice, as the U.S. District Court for the Western District of Texas found its allegations were "'nigh unintelligible,' full of irrelevant, inflammatory, and inappropriate statements, and missing any facts tending to show the existence of any plausible Federal Claims Act claim." The relator filed a third amended complaint and the defendants moved to dismiss, arguing that the FCA's public disclosure bar provision precluded the claims and that the alleged fraud was not pled with the requisite particularity.

Holding: The Western District of Texas granted the defendants' motions with prejudice.

Public Disclosure Bar

The court noted that the FCA's public disclosure bar provision was amended in 2010, but held that the prior version of the law applied, since the fraud allegations at issue concerned events that took place prior to the amendment. Under the previous public disclosure bar, the relevant questions are: (1) whether there has been a public disclosure of the allegations or transactions; (2) whether the *qui tam* action is "based upon" such public disclosures; and (3) if so, whether the relator is an "original source" of the allegations. The court addressed each question in turn.

First, the court found that there had been a previous public disclosure—namely, the related action in which the relator was an expert witness. The public filings from that case laid out the same basic fraudulent scheme as the relator's *qui tam* complaint, and at a minimum, the overlap was enough "to allow the Government to draw the same inference of fraud it could draw from the pleadings in this case." With respect to the second element, that court stated that "[t]here is no disputing this *qui tam* case is also 'based upon' those publicly disclosed allegations." Even though the allegations in the *qui tam* case were broader, the court determined that they were at least "partly based upon" the allegations in the previous case. Finally, the court found that the relator was not an original source of the information on which his fraud allegations were based, because he acquired that information while serving as an expert in the related litigation and did not possess any direct or independent information. Consequently, the relator's claims were dismissed pursuant to the public disclosure bar.

Failure to Plead Fraud with Particularity

The court held that dismissal was also warranted because the *qui tam* complaint failed to plead fraud with particularity. The court noted that the complaint failed to identify any specific false claims. In addition, the relator's allegations were "as generic as possible with respect to each Defendant," and therefore, he failed adequately to plead "who" made the allegedly false statements to the government. He did not adequately plead the "what" of the fraud, either as he failed to specify any relevant provision of the sales contract the defendant violated; in reaching that conclusion, the court rejected the relator's argument that he should be excused from citing the relevant provision because the contract was classified and inaccessible, finding instead that the relator's position only proved that he was speculating at the defendant's potential violations.

See *U.S. ex rel. D'Agostino v. EV3, Inc.*, 2014 WL 4926369 (D. Mass. Sept. 30, 2014), at page 44.

See *U.S. ex rel. Willis v. Southerncare, Inc.*, 2014 WL 4829279 (S.D. Ga. Sept. 29, 2014), at page 47.

See *U.S. ex rel. Kester v. Novartis Pharms. Corp.,* 2014 WL 4370597; 2014 WL 44001275 (S.D.N.Y. Sept. 3, 2014), at page 3.

See *U.S. ex rel. Absher v. Momence Meadows Nursing Ctr., Inc.,* 2014 WL 4092258 (7th Cir. Aug. 20, 2014), at page 114.

See *U.S. ex rel. Academy of Health Ctr., Inc. v. Hyperion Found., Inc.,* 2014 WL 3385189 (S.D. Miss. July 9, 2014), at page 97.

See *U.S. ex rel. Awad v. Chrysler Grp., LLC*, 2014 WL 2978191 (6th Cir. July 2, 2014), at page 34.

FALSE CLAIMS ACT RETALIATION CLAIMS

Randazzo v. CH2M Hill, Inc., 2014 WL 4697131 (D. Colo. Sept. 22, 2014)

The plaintiff was a former paralegal for the defendants—two companies hired by the U.S. Department of Energy (DOE) to perform professional services, as well as the individual who served as her direct supervisor during her employment. She claimed that the defendants violated the False Claims Act's anti-retaliation provision, and brought various common law claims as well. This case was before the U.S. District Court for the District of Colorado for its consideration of a magistrate judge's report and recommendation regarding the defendant's motion to dismiss.

According to the plaintiff, the U.S. Department of Justice (DOJ) launched an investigation into the defendant's billing practices, amid concerns that the DOE was being overbilled. The DOJ filed a lawsuit against the defendants under the Anti-Kickback Statute, and issued subpoenas requesting information related to other possible misconduct. The plaintiff's supervisor was responsible for responding to the subpoenas and enlisted the plaintiff's assistance. The plaintiff alleged that the defendants purposefully omitted and concealed relevant documents in their responses to the subpoenas—she claimed that the supervisor directed her to omit certain facts and documents from the responses. She alleged that she informed her supervisor several times that she believed the missing documents might reveal that the defendants committed fraud, but that she was chastised for raising her concerns and was eventually removed from the project. After reporting her concerns to several others in management, the plaintiff was terminated from her job. She then brought the present FCA action, alleging that she was fired for her whistleblowing activities. The defendants moved to dismiss the FCA retaliation claim for failure to state a claim under Rule 12(b)(6).

Holding: The U.S. District Court for the District of Colorado adopted the magistrate judge's report and recommendation and granted the defendants' motion to dismiss. The court held that the relator was not engaged in "protected activity" because although she alleged that she voiced her concerns about missing items in the subpoena responses, she did not allege that she informed the defendants "that she was assisting in or pursuing an FCA claim herself." Instead, the court concluded, "she has merely pled allegations that consistent with acting in accordance with her employment obligations as opposed to making clear her alleged intention of bringing or assisting in an FCA action." Furthermore, the court held that to the extent that the plaintiff's retaliation claim was based on her reports that the defendants' subpoena responses were fraudulent, those allegations were not sufficient to establish protected activity under the FCA, because the defen-

dant's subpoena responses could not have reasonably led to an FCA claim. The court explained that producing documents in response to a subpoena request is not a "'making a 'claim' on the Government, and failing to adequately respond to a subpoena does not involve a 'request or demand…for money or property from the Government.'" The retaliation claim was dismissed with prejudice.

Lombardi v. George Washington Univ., 2014 WL 4470789 (D.D.C. Sept. 11, 2014)

The plaintiff was the former principal investigator on a subcontract from the U.S. State Department for the defendant, George Washington University. He was tasked with securing grants and other external funding for the defendant's research centers and institutes within its Office of Homeland Security, and he secured a subcontract for the defendant for work on a Science Applications International Corporation (SAIC) contract with the State Department. As principal investigator, the plaintiff was in charge of regulatory compliance on the subcontract with SAIC, and that arrangement was represented to the government and included in the subcontract. The plaintiff alleged that despite his work securing the SAIC contract with the State Department, as well as his work bidding on an upcoming SAIC subcontract for the Federal Emergency Management Administration (FEMA), the defendant reduced the plaintiff's salary and responsibilities on the contracts and bidding process, and eventually eliminated his position and terminated him. The termination letter purportedly stated that the defendant was terminating the plaintiff because of lack of funding, however, the plaintiff alleged that there would have been "millions of dollars in sponsored projects for…staff, including [the plaintiff], to manage over the next several years…which would have easily covered [his] salar[y]." Instead, the plaintiff alleged that he was terminated because during the management of the SAIC State Department subcontract, the defendant attempted to replace him on the contract without notifying SAIC, and the plaintiff reported this potential impropriety to his superiors as well as the defendant's general counsel. He brought a retaliation claim under the False Claims Act and the defendant moved to dismiss for failure to state a claim.

Holding: The U.S. District Court for the District of Columbia granted the defendant's motion to dismiss. The court explained that because the plaintiff's theory of liability was based on mere speculation that the defendant would have submitted false certifications to SAIC to support future claims for payment—if the defendant had replaced him on the government contract—he failed to allege that he was engaged in protected activity under the FCA. The court held that the plaintiff failed to "establish an objectively reasonable basis for his belief that [the defendant] would have submitted false claims."

The court further explained that the contract did not require performance or create a right to collect payment, but was based on task orders to create continuing rights and obligations; and that the defendant's identification of the plaintiff as principal investigator did not necessarily guarantee his continued performance. While the court recognized that the plaintiff was not required to sufficiently allege a violation of the FCA's anti-fraud provisions, it explained that in order to establish protected activity in support of an FCA retaliation claim, the plaintiff must have been investigating claims that reasonably could lead to a viable FCA action.

Bracken v. DASCO Home Med. Equip., Inc., 2014 WL 4388261 (S.D. Ohio, Sept. 5, 2014)

The plaintiff was the former Director of Operations for the defendant, a home medical device provider. Throughout his tenure with the defendant, the plaintiff had a multitude of personal and professional problems that impacted his performance at the company, culminating with his termination. He brought an action for retaliation under the False Claims Act, as well as discrimination under the Americans with Disabilities Act. The defendant moved for summary judgment on both claims.

During the plaintiff's employment by the defendant, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) audited the defendant for the purpose of accrediting the defendant's new joint venture facility in Dover, Ohio. The plaintiff alleged that prior to receiving accreditation, enrolling in Medicare reimbursement plans, or obtaining the requisite supplier or billing number for the Dover facility, the defendant was improperly billing Medicare from the Dover facility under the billing number for a different location in Alliance, Ohio. The plaintiff alleged that the branch manager for the Dover facility informed him that she had been instructed by the defendant's Director of Risk and Reimbursement to mislead JCAHO during the audit by falsely representing to JCAHO that the Dover facility was using the Alliance facility's billing number because the Alliance facility was overseeing the Dover facility. The plaintiff reported this discrepancy to the inspector during the audit and informed JCAHO that the Dover facility was billing under an incorrect billing number. The defendant subsequently refunded Medicare for the Dover facility's claims and obtained a billing number for the Dover facility. The plaintiff alleged that his supervisor told him that he "said too much" to the investigator, after which the plaintiff consulted a Medicare attorney privately.

Over a year later, the plaintiff was terminated from his job. In addition to personality and culture problems, the plaintiff's discharge form referenced his "warning" regarding his communication with JCAHO. The defendant moved for summary judgment on the plaintiff's claims.

Holding: The U.S. District Court for the Southern District of Ohio denied the defendant's summary judgment motion as to both the plaintiff's FCA and ADA claims. With respect to the FCA claim, the court held that there was sufficient evidence for a jury to conclude that the plaintiff was engaged in protected activity under the FCA. The court explained that the plaintiff's report of the defendant's use of an improper billing number to JCAHO and his consultation of a Medicare attorney constituted protected activity under the FCA, even though the defendant paid Medicare back to resolve the issue and no FCA claim was ever filed. The court also held that there was sufficient factual support to show that the defendant had knowledge of this protected activity. Though the court acknowledged that the defendant did not know that the plaintiff had consulted an attorney, the defendant was required to make payments to Medicare as a result of the plaintiff's actions, and the plaintiff's supervisor indicated in notes that she did not want the plaintiff talking to JCAHO inspectors. Finally, the court held that while there was no temporal proximity between the protected activity and the plaintiff's termination, his discharge notice referred to his interaction with JCAHO. Therefore, there was sufficient evidence to establish causation between the plaintiff's protected activity and his termination.

Stein v. Tri-City Healthcare District, 2014 WL 4277213 (S.D. Cal. Aug. 27, 2014)

The plaintiff brought a retaliation claim under the False Claims Act against the hospital where he was formally employed, as well as the hospital's chief executive officer alleging that the defendants terminated him for his whistleblowing activities. The plaintiff also brought a host of additional civil suits surrounding his termination. The defendants argued that, as a compliance officer, the plaintiff could not establish that he went beyond his normal job duties to show that they knew that he was engaged in protected activities, under the FCA. The defendants argued that any legal advice given within the normal course of the plaintiff's duties was not sufficient to put them on notice of protected conduct, even if the plaintiff warned that certain of the defendants' actions violated the False Claims Act. The plaintiff asserted that he did act outside of his normal job duties, as he reported his knowledge of several transactions that he believed would violate the FCA not only up the chain of command, but to board members and others within management. In addition, the plaintiff sought meetings with management and members of the board outside his day-to-day duties several times and was denied those requests.

The defendants further argued that the plaintiff could not prove his claims because the alleged basis for his termination was his legal advice, which was subject to the attorney-client privilege. The defendants moved for summary judgment on the plaintiff's FCA retaliation claim.

Holding: The U.S. District Court for the District of Southern California denied summary judgment for both defendants. The court held that a reasonable jury could find that the plaintiff's multiple reports outside the chain of command went beyond his day-to-day duties and put the defendants on notice that he was engaged in protected activities under the FCA. The court also held that the plaintiff would likely be able to prove his case without disclosing the contents of communications that were subject to the attorney-client privilege, but if he did seek to admit privileged information into evidence, then the court had "a variety of tools to prevent public disclosure of that information."

The court also denied summary judgment as to the CEO defendant, who was sued in his personal capacity. The court explained that there was sufficient evidence to show that the plaintiff had a cognizable property interest in his continued employment at the hospital due to his employment contract's due process clause. The court determined that the CEO personally directed or set in motion the plaintiff's termination without due process, in violation of his agreement and rights that were clearly established under the contract. The court further held that there was sufficient evidence that the CEO knew that the plaintiff was acting outside of his normal job duties in an attempt to prevent violations of the FCA.

Boone v. MountinMade Found., 2014 WL 4096477 (D.D.C. Aug. 20, 2014)

The four plaintiffs brought an action alleging that they were terminated by the defendant in violation of the anti-retaliation provisions of the False Claims Act. The defendant is a nonprofit organization, funded through government grants from the Small Business Administration ("SBA"). The plaintiffs alleged that they were demoted and terminated after they raised concerns to the defendant's board of directors that its executive director was using the organization's debit card for personal expenditures. The defendant moved for summary judgment on the plaintiffs' claims, arguing that the plaintiffs had not demonstrated that they were engaged in protected activity under the FCA. In addition, the defendant argued that none of the plaintiffs could demonstrate that they were demoted or terminated in retaliation for their reports to the board, and that the plaintiffs who were not terminated outright could not show that they were constructively terminated.

Holding: The U.S. District Court for the District of Columbia held that the plaintiffs were engaged in protected activity under the FCA. The court explained that the plaintiffs were not required to know that their investigation could result in an FCA suit, and therefore, were not required to alert the defendant to the prospect of one. The court explained that the acts simply must have been done in furtherance of an FCA action. Here, the plaintiffs each investigated and discovered violations involving the defendant's executive director's use of the organization's debit

card and vehicle for personal use, misrepresentation of hours worked, and other issues regarding management which they collectively brought to the attention of the board. The defendant argued that the plaintiffs presented no evidence that it made false statements to the government or had the specific intent to submit a false claim to the government. However, the plaintiffs asserted, and the court agreed, that because the majority of the defendant's funding comes from SBA grants, the defendant's actions could reasonably have led to an FCA violation. While the defendant argued that the plaintiffs' claims failed because they did not prove that they could have raised a viable *qui tam* claim, the court explained that such a standard of proof was not required in a whistleblower retaliation claim.

The court noted that following the plaintiffs' report to the board regarding the executive director's alleged improprieties, the defendant hired a management consultant to "evaluate management practices and restructure the organization." Plaintiffs Boone, Barker, and Smith were demoted as a result of the consultant's suggestions. The defendant argued that these plaintiffs were not "demoted" because they received the same salary and benefits before and after the reorganization. The plaintiffs, though, contended that the changes to their titles and responsibilities constituted a demotion. The court agreed, holding that each plaintiff was given a less prestigious title, less decision-making authority, and had their job responsibilities changed adversely, constituting a demotion. The court rejected the defendant's contention that the demotions were motivated by legitimate management concerns, given the temporal proximity of the changes to the report to the board, among other discriminatory conduct directed at the plaintiffs. The court further observed that Plaintiff Boone also alleged that she was constructively terminated by the defendant. However, the court held that Boone failed to demonstrate that she was in an intolerable work environment and limited Boone's retaliation claim to her allegation of being demoted. Similarly, the court held that neither Plaintiff Barker nor Smith presented sufficient evidence that they were terminated as a result of their protected activities. The court then granted summary judgment in favor of the defendant with respect to Plaintiff Harris' demotion claim, holding that she did not present evidence that she suffered any sort of adverse job change, but the court held that Harris had pled sufficient facts to demonstrate that she had been constructively terminated. The court explained that because Harris was told when she was hired that the defendant would accommodate her school schedule, but she was told after she reported the alleged misconduct to the board that the defendant would not accommodate her scheduling needs, she had been constructively terminated.

Fed. Nat'l Mortgage Assoc. v. K.O. Realty, Inc., 2014 WL 3900619 (N.D. Tex. Aug. 8, 2014)

Fannie Mae brought this action against the defendant, seeking a declaratory judgment relating to the parties' rights and obligations under a 2011 "Master Listing Agreement" ("MLA"), specifically that the plaintiff properly terminated its contract with the defendant to market and sell properties the government acquired through foreclosures and deed-in-lieu of foreclosure. The defendant brought counterclaims against the plaintiff, alleging violations of the False Claims Act among other civil law claims. According to the defendant, Fannie Mae's system for assigning properties to brokers—which limited the number of property assignments that each broker could receive—impermissibly awarded a larger number of properties to a competing broker who had listed two office addresses in their contract with the plaintiff. The defendant alleged that one of the offices was fake, and that because the competing broker did not actually use two offices, it should not be allowed to receive additional listings. The defendant further alleged that after he brought the discrepancy to Fannie Mae's attention, its MLA was terminated, in violation of the FCA's anti-retaliation clause.

Holding: The U.S. District Court for the Northern District of Texas held that the defendant's FCA counterclaim failed because, as the defendant acknowledged, it only complained to the plaintiff regarding the actions of third parties (i.e. the competing broker), and not about any alleged fraud the plaintiff—a government entity itself—committed against the United States. Consequently, the court held that the defendant was not engaged in a protected activity under the FCA, because their complaints and investigation could not have led to a viable claim under the FCA. Since the defendant was not engaged in protected activity, the FCA retaliation claim was dismissed.

See *U.S. ex rel. Besancon v. UChicago Argonne, LLC*, 2014 WL 4783056 (N.D. Ill. Sept 24, 2014), at page 49.

See *U.S. ex rel. Ligai v. ETS-Lindgren Inc.*, 2014 WL 4649885 (S.D. Tex. Sept. 16, 2014), at page 75.

See *U.S. ex rel. Todd v. Fidelity Nat'l Fin., Inc.*, 2014 WL 4636394 (D. Colo. Sept. 16, 2014), at page 79.

See *U.S. ex rel. Notorfransesco v. Surgical Monitoring Assoc., Inc.*, 2014 WL 4375654 (E.D. Pa. Sept. 3, 2014), at page 54.

See *U.S. ex rel. Helfer v. Assoc. Anesthesiologists of Springfield, Ltd.,* 2014 WL 4198199 (C.D. Ill. Aug. 25, 2014), at page 90.

See *U.S. ex rel. Absher v. Momence Meadows Nursing Ctr., Inc.,* 2014 WL 4092258 (7th Cir. Aug. 20, 2014), at page 114.

See *U.S. ex rel. Goulden v. BAE Sys. Info. and Elec. Sys. Integration, Inc.,* 2014 WL 3897645 (D. Mass. Aug 7, 2014), at page 119.

See *U.S. ex rel. Donegan v. Anesthesia Assoc. of Kansas City, PC,* 2014 WL 3729641 (W.D. Mo. July 28, 2014), at page 59.

See *U.S. ex rel. Dolan v. Long Grove Manor, Inc., et al.,* 2014 WL 3583980 (N.D. Ill. July 18, 2014), at page 60.

See *U.S. ex rel. Tran v. Computer Sciences Corp.*, 2014 WL 2989948 (D. D. C. July 3, 2014), at page 65.

See *U.S. ex rel McGinnis v. OSF Healthcare Sys.*, 2014 WL 2960344 (C.D. Ill. July 1, 2014), at page 102.

COMMON DEFENSES TO FCA ALLEGATIONS

A. Breach of Contract/Fiduciary Duty

Walsh v. Amerisource Bergen Corp., 2014 WL 2738215 (E.D. Pa. June 17, 2014)

A *qui tam* relator alleged that his employer—a pharmaceutical services company—and two of the company's wholly-owned subsidiaries violated the federal False Claims Act and multiple state FCA statutes. The represented governmental plaintiffs declined to intervene in the *qui tam* suit. The defendants filed a counterclaim against the relator, alleging breach of contract, breach of fiduciary duty, implied contract, and promissory estoppel. The defendants argued that as a condition of his employment, the relator signed a confidentiality agreement, and that he violated that agreement by taking and removing the defendants' confidential, proprietary, and privileged information and sharing it with his attorney—and to some extent—with the public at large, once the *qui tam* complaint was unsealed. The relator moved to dismiss the counterclaim, arguing that the defendants failed to establish that any of the information he removed was entitled to protection from disclosure; that the defendants did not show that they were harmed in any way by his removal of the information; and that the counterclaim violated public policy considerations that encourage *qui tam* lawsuits.

See *U.S. ex rel. Willis v. Southerncare, Inc.*, 2014 WL 4829279 (S.D. Ga. Sept. 29, 2014), at page 47.

B. Not Knowingly False

U.S. ex rel. Barker v. Columbus Reg'l Healthcare Sys., Inc., 2014 WL 4287744 (M.D. Ga. Aug. 29, 2014)

The relator alleged that defendant Columbus Regional Hospital purchased defendant Tidwell Cancer Center for more than fair market value in order to induce Tidwell to refer patients to Columbus Regional. According to the relator, the purchase violated the Stark Law and Anti-Kickback Statute and consequently, these defendants violated the False Claims Act when they submitted claims to federal healthcare programs for reimbursement. In addition, the relator alleged that Columbus Regional had illegal remuneration relationships with defendant Radiation Oncology that were designed to induce referrals to Columbus Regional, and thereby also violated the FCA. Finally, the relator alleged that employees of defendant John B. Amos Cancer Center engaged in improper billing practices in violation of the FCA. Columbus Regional claimed that it did not know that it was violating the law, but asserted that it was not offering an "advice of counsel" defense or rely on communication with its attorneys in its defense. The relator, however, contended that by taking the position that it believed its conduct was lawful, Columbus Regional waived the attorney-client privilege. The relator moved to compel Columbus Regional to disclose its attorney-client communications regarding the alleged Stark and Anti-Kickback violations.

The U.S. District Court for the Middle District of Georgia granted the relator's motion. The court rejected Columbus Regional's arguments that because it was not asserting an advice of counsel defense, and was simply denying the plaintiff's allegations that its conduct was unlawful, it had not waived the attorney-client privilege. The court also rejected Columbus Regional's argument for a "healthcare industry exception," finding no legal justification for such an exception. The court explained that Columbus Regional intended to affirmatively assert that it had a good faith belief that it complied with the relevant laws, and thus "injected its belief as to the lawfulness of its conduct into the case and waived its attorney-client privilege as to communications relating to the legality of the transactions that form the basis of Plaintiff's claims."

U.S. ex rel. Gonzalez v. Planned Parenthood of L.A., 2014 WL 3583514 (9th Cir. July 22, 2014)

The relator, former Chief Financial Officer for a Planned Parenthood affiliate, filed a *qui tam* action under the False Claims Act alleging that multiple Planned Parenthood affiliates as well as several individuals knowingly overbilled the government for contraceptives supplied to low-income individuals. The defendants participated in the Family Planning, Access, Care, and Treatment program ("Family PACT"), which reimburses Planned Parenthood for contraceptives provided to low-income individuals. Family PACT is jointly funded by the federal and state government. Through their agreements with contraceptive manufacturers, the defendants received discounted rates on the contraceptives they bought, but when billing the government for reimbursement, they allegedly quoted the government their "usual and customary rates," *i.e.*, what they would charge an average patient. In 1997, the defendants and the California Department of Healthcare Services ("CDHS") exchanged letters discussing the billing discrepancy, but the exchange did not result in CDHS ordering the defendants to change their claims policy. In 2004, CDHS conducted an audit of the defendants and discovered that the billing practices did not comply with Family PACT requirements. The audit uncovered over five million dollars in overcharges. However, CDHS informed the defendants that even though they were required to bill the Government "at cost," because that term was not defined in the billing manual, there were conflicting and ambiguous representations made to providers, and CDHS would not seek reimbursement for the overcharges. The U.S. District Court for the Central District of California dismissed the relator's *qui tam* claims for failure to plead fraud with particularity. The relator appealed the district court's decision to the U.S. Court of Appeals for the Ninth Circuit.

Holding: The Ninth Circuit affirmed the district court's dismissal on the alternate ground that the complaint did not state a plausible claim for relief. The court held that even if the relator sufficiently alleged falsity, the complaint did not plead that the defendants acted with the requisite scienter to violate the FCA. The circuit court noted that the FCA imposes a standard of knowing falsity, not negligent misrepresentation. The appeals court further stated that the relator undermined his own allegations by pointing to the letters between CDHS and the defendants, wherein the defendants explained their billing practices without rebuke, and after being audited, received an acknowledgement from CDHS that there was no specific definition of "at cost." Indeed, the State did not pursue reimbursement for the overcharges. Given the explicit statements from the government, the court held that the relator's allegations that the defendant acted knowingly must fail.

C. Relator Released Defendant from FCA Claims

See *U.S. ex rel. Academy of Health Ctr., Inc. v. Hyperion Found., Inc.*, 2014 WL 3385189 (S.D. Miss. July 9, 2014) , at page 97.

D. *Res Judicata* and Collateral Estoppel

U.S. ex rel. Awad v. Chrysler Grp., LLC, 2014 WL 2978191 (6th Cir. July 2, 2014)

A relator filed a *qui tam* suit against his former employer—an auto manufacturer—for whom he had worked as a regional controller for Latin America. In 2009, in the midst of the automotive industry crisis, the defendant was formed as a limited liability company using federal funds. The company's operating agreement with the United States required it to keep complete and accurate books and records. Yet the relator claimed that the defendant instructed him to manipulate its books to underreport the fair market value of its Columbia division. The relator alleged that he voiced objections to upper management and was subsequently transferred to the Venezuela division, and was eventually terminated. After being fired, the relator sued the defendant for wrongful termination in a Michigan state court action. Eight days later, he filed a memorandum with the U.S. Department of Justice, disclosing his allegations of the defendant's financial wrongdoings. And five days later, he filed a *qui tam* action in the U.S. District Court for the Eastern District of Michigan, alleging that the defendant violated the False Claims Act by falsely misrepresenting the fair market value of its Columbia division, in violation of its operating agreement with the United States.

The relator's state court case was eventually settled and dismissed with prejudice. The defendant then moved to dismiss the federal FCA claims, arguing that they were barred by *res judicata* principles. The district court agreed and dismissed the relator's False Claims Act case. The relator appealed the district court's ruling to the U.S. Court of Appeals for the Sixth Circuit.

Holding: The Sixth Circuit affirmed the district court's ruling.

Public Disclosure Bar

The defendant first argued that the relator's state court complaint constituted a public disclosure under the FCA, and consequently deprived the district court of subject-matter jurisdiction over the *qui tam* suit. But the Sixth Circuit determined that the state court complaint was not a public disclosure, because it only addressed factual allegations regarding the relator's termination. Since the state court case made no mention of any fraud related to the federal Government, the circuit court held that it was

insufficient to put the Government on notice of the alleged FCA violations, and thus could not be considered a public disclosure.

Res Judicata

The circuit court recognized that "Michigan takes a transactional approach to res judicata, barring all subsequent claims arising out of the same factual transaction." Because the relator's wrongful termination and False Claims Act claims all related to his time working for the defendant, and related to the defendant's alleged motivations for terminating him, the court held that the relator could have raised his False Claims Act allegations in the state action. Consequently, the circuit court affirmed the district court's ruling that the *qui tam* claims were barred by *res judicata* once the state court action was decided on the merits.

See *U.S. ex rel. Willis v. Southerncare, Inc.*, 2014 WL 4829279 (S.D. Ga. Sept. 29, 2014), at page 47.

E. Sovereign Immunity

U.S. ex rel. Bachmann v. Minn. Transitions Charter Schools, 2014 WL 4829081 (D. Minn. Sept. 29, 2014)

The relators were former employees of the defendants, Minnesota Transitions Charter Schools and Minnesota Virtual High School. The relators alleged that the defendants violated the False Claims Act by submitting fraudulent attendance and enrollment information and special education instruction reports to the State of Minnesota and to the federal government in order to receive unwarranted government funds. Specifically, the relators claimed that the defendants aggressively enrolled students who should not have been enrolled in order to boost enrollment numbers prior to the yearly submission of attendance data to the government. The government then funded the schools based on those numbers, though many of the students had subsequently left school. In addition, the relators alleged that the defendants inflated the amount of time special education providers spent with special education students in order to receive additional funding. Both relators claimed that they complained about these and other issues to their supervisors but were ignored, and eventually terminated. The defendants moved to dismiss, arguing that as state entities, they were not the proper defendants under the FCA but instead enjoyed immunity from *qui tam* suits under the Eleventh Amendment. The defendants argued that the relators failed to state a claim against them.

Holding: The U.S. District Court for the District of Minnesota granted the defendants' motion to dismiss, but without prejudice. The court explained that the defendants were not automatically entitled to immunity under the Eleventh Amendment because the *qui tam* suit could be "fairly considered to have been brought by the United States." The court further explained that the defendants were "persons" for the purpose of the FCA, because they did not clearly derive all of their funds from the state's treasury and were not so controlled by the state to deem them arms of the state. The court therefore held that the schools were proper defendants under the FCA. However, the court held that because the relators had not adequately alleged how the relevant funding mechanisms operated or how the falsified documents and other reports related to these funding mechanisms, the FCA claims were dismissed with leave to amend.

U.S. ex rel. Parikh v. Brown, 2014 WL 3906268 (5th Cir. Aug. 11, 2014)

The three relators were former cardiologists at Citizens Medical Center ("CMC"), where Appellant Brown was the hospital administrator and Appellant Campbell was a cardiologist. The relators alleged that the appellants violated the False Claims Act ("FCA") by paying bonuses to emergency room physicians in exchange for referrals of Medicare and Medicaid patients. They alleged that Brown de-

signed and was responsible for implementing the bonus system, that Brown paid Campbell an excessive salary and discounted his office space rental in exchange for referrals, and that Brown implemented a system in which gastroenterologists who participated in CMC's colonoscopy screening program received bonuses for referring patients. The U.S. District Court for the Southern District of Texas denied appellants' motion to dismiss the complaint based on qualified immunity. The defendants appealed to the U.S. Court of Appeals for the Fifth Circuit.

Holding: The Fifth Circuit affirmed the district court's ruling.

The appeals court held that in order to show that the appellants were not entitled to qualified immunity, the relators had to sufficiently plead that these individual defendants violated a statute and that their actions were objectively unreasonable. As to the first of the requirements, the circuit court held that the relators sufficiently pled that the appellants violated the FCA by submitting claims for reimbursement from Medicare and Medicaid while falsely certifying that they were in compliance with the Anti-Kickback Statute and the Stark Law. Regarding the second step, the appellants argued that their alleged violations of the AKS and Stark Law had not been clearly established at the time of the offenses; however, the court explained that the *qui tam* complaint was not filed under those laws, but under the FCA. Focusing instead on the FCA, the court held that the "contours of the FCA were sufficiently clear at the time such that every reasonable official would have understood that…presenting claims for payment, while knowingly falsely certifying compliance with the AKS and Stark Law, violated the FCA." Thus, the appellate court affirmed the district court's decision and held that the appellants were not entitled to qualified immunity.

O'Shell v. Cline et al., 2014 WL 3537824 (7th Cir. July, 17, 2014)

The plaintiff brought a suit against her former employers at the Indiana Department of Transportation, alleging that she was terminated for reporting that the Department had wrongly dispersed federal funds.

The plaintiff worked as a lawyer for the Department of Transportation from 2001-08. During an audit in 2008, the plaintiff alleged that she discovered discrepancies related to the disbursement of highway funds, and that when she reported the discrepancies to her supervisors, she was asked to change her report to omit them. The plaintiff complained to her supervisors that her audit had uncovered violations of the False Claims Act and that it would be illegal to cover them up. The plaintiff was terminated soon after, and she brought this suit, alleging violations of the FCA's anti-retaliation provision. The U.S. District Court for the Southern District of Indiana dismissed the plaintiff's claim, finding that she could not maintain the claim against the defendants in their official capacities, due to sovereign immunity.

The plaintiff appealed the district court's ruling to the U.S. Court of Appeals for the Seventh Circuit, arguing that she could pursue her official-capacity False Claims Act claims because Congress has abrogated Indiana's sovereign immunity. The plaintiff asserted that because the False Claims Act prohibits discriminating against whistleblowers, 42 U.S.C. § 20000d-7—a provision of Title IV of the Civil Rights Act which abrogates state sovereign immunity for suits involving any "Federal Statute prohibiting discrimination by recipients of Federal financial assistance"—applied.

Holding: The Seventh Circuit rejected the plaintiff's argument and affirmed the district court's dismissal of her claims. The court explained that first, according to the Supreme Court; the FCA does not permit suits against states or their agencies. Second, the circuit court observed that Congress "may validly abrogate a state's sovereign immunity only by using the enforcement powers granted to it by the Civil War amendments," including the Fourteenth Amendment. Ultimately, the Seventh Circuit noted that the FCA was passed before the Civil War amendments were ratified. As a result the appeals court reasoned that Congress "could not possibly have used powers that it did not yet have," and therefore, held that the Fourteen Amendment does not abrogate states' sovereign immunity for FCA purposes.

F. Statute of Limitations

See *U.S. ex rel. Silver v. Omnicare, Inc.,* 2014 WL 4827410 (D.N.J. Sept. 29, 2014), at page 46.

See *U.S. ex rel. Grupp v. DHL Express, Inc.,* 2014 WL 4542465 (W.D.N.Y. Sept. 11, 2014), at page 80.

See *U.S. ex rel. Tahlor v. AHS Hosp. Corp.,* 2014 WL 4238148 (D.N.J. Aug. 26, 2014), at page 88.

See *U.S. ex rel. Helfer v. Assoc. Anesthesiologists of Springfield, Ltd.,* 2014 WL 4198199 (C.D. Ill. Aug. 25, 2014), at page 90.

See *U.S. ex rel. Joseph v. Brattleboro Retreat,* 2014 WL 3908432 (D. Vt. Aug. 10, 2014), at page 57.

See *U.S. ex rel. Sansbury v. LB & B Assocs., Inc.,* 2014 WL 3509789 (D.D.C. July 16, 2014), at page 62.

See *Baklid-Kunz v. Halifax Hosp. Med. Ctr.*, 2014 WL 2968251 (M.D. Fla. July 1, 2014), at page 109.

FEDERAL RULES OF CIVIL PROCEDURE

A. Rule 9(b) and Pleading Fraud with Particularity

U.S. ex rel. McCarthy v. Marathon Tech., Inc., 2014 WL 4924445 (N.D. Ill. Sept. 30, 2014)

The relator was a former Purchasing Manager for the defendant, Marathon Technologies. He brought a *qui tam* action against Marathon and its owner, Jerry Kozlowski, as well as a separate corporation, Sigmatek, which was also owned by Kozlowski. The defendants were manufacturers of military grade weapons and equipment. The relator alleged that the defendants violated the False Claims Act by knowingly submitting false claims for payment under two contracts with the U.S. government. In 2004, Marathon won a contract with the U.S. Army to manufacture machine gun mounting systems for a total of $21.7 million. In 2008, Sigmatek won an approximately $9 million contract to produce tripod mounts for the U.S. Army. The 2008 contract was designated as a "HUBZone" set-aside contract, which gave preference to small businesses. In 2007, Sigmatek applied for HUBZone certification, but did not receive its certification until after solicitation for the contract closed. While Sigmatek was initially told it would not be considered for the bid because it was not certified in time, it was ultimately awarded the contract. The relator alleged that the defendants manipulated employment records and falsely represented Sigmatek's place of business in order to satisfy the HUBZone requirements.

Both contracts included a certificate of conformance to be signed with each delivery. The certificates expressly represented compliance with the contract terms and requirements, and stated that the document was "made for the purpose of inducing payment and with the knowledge that the information and certification may be used as a basis for payment." Kozlowski signed these certificates with each delivery. The relator alleged that as to both contracts, the defendants failed to comply with the contract terms by failing to properly test equipment or to use the specified materials in the production of the goods. The defendants moved to dismiss the relator's fraud claims under Rule 12(b)(6) and Rule 9(b).

Holding: The U.S. District Court for the Northern District of Illinois denied the defendants' motion to dismiss.

Failure to Plead Fraud with Particularity

The court held that the relator properly pled his FCA claims based on allegations that the defendants made false certifications of conformance, noting that the relator alleged that the forms the defendants were required to submit with the deliveries expressly stated that they complied with the contract provisions in order to deliver the manufactured goods and demand payment from the government, and that this certification was a condition of payment of the defendants' claims. The court further explained that the relator properly alleged the "who" involved in the fraud: Marathon and Sigmatek through Kozlowski who authorized the certificates of conformance. The court rejected the defendants argument that relator failed to allege the "who" because he did not allege that anyone else was involved in submitting the claims, explaining that information—which was in the sole possession of the defendants—was not required at the pleading stage. The court also explained that the relator alleged the "what," as the compliance documents themselves. The court rejected the defendants' argument that the relator failed to produce copies of the compliance forms, stating that this information was also in the sole possession of the defendants. The court went on to explain that the relator alleged the "when," as ongoing between 2006 and 2011, and that he gave approximate dates that he was instructed to purchase hardware that did not comply with the contract specifications. The court also found that the relator properly alleged the "how" by asserting that the defendants failed to perform contractually-required inspections and testing; used parts from unapproved vendors; purchased and used non-military specification hardware; and then knowingly certified that they had met the contract specifications on the certificates of conformance. Because the relator properly alleged a claim under the FCA and pled his false certification of compliance theory with the requisite particularity, the court denied the defendants' motion to dismiss.

Fraudulent Inducement

The court also held that the relator sufficiently pled his allegations that the defendants falsely induced the government to grant Sigmatek the 2008 contract because they did properly obtain HUBZone certification. The court rejected the defendants' arguments that because the government already knew that the company was not HUBZone-certified, there could be no FCA violation; the defendants argued that the HUBZone certification was not material to the government's decision to award Sigmatek the contract. The court explained that materiality was not relevant "in FCA claims in the context of misrepresentations," and allowed the relator's fraudulent inducement claim to proceed.

United States v. Kellogg, Brown & Root Serv., Inc., 2014 WL 4948136 (C.D. Ill. Sept. 30, 2014)

The United States brought an action alleging that a group of military contractors violated the False Claims Act by inflating the costs of providing living quarters for troops in Iraq under a government contract to provide a multitude of services. The defendants included Kellogg Brown & Root (KBR), a large provider of military support services under an expansive general contract with the government; KBR's subsidiary, Overseas Administrative Services (OAS); and its subcontractor, First Kuwaiti Trading Company. In 2001, in support of the war efforts in Iraq, the government awarded the Logistics Civil Augmentation Program III (LOGCAP III) contract to KBR. The government alleged that OAS employed most of the administrators working on the LOGCAP III contract and that most of the work was preformed through subcontractors, including work subcontracted to First Kuwaiti to provide, setup, and maintain living trailers at Camp Anaconda in Iraq. Throughout First Kuwaiti's performance on the contract, it submitted several requests for equitable adjustment (REA) of the subcontract price, based on unexpected costs and delays that First Kuwaiti attributed to the government. These REAs included payments of $24 million and $25 million in 2004, which KBR paid to First Kuwaiti and then billed to the government. The government alleged that these costs were severely inflated, and that after an investigation and hearing by the Administrative Contracting Officer, it discovered that it only should have paid $3.7 million of the $49 million billed by KBR. First Kuwaiti and OAS moved to dismiss the government's claims for lack of personal jurisdiction and failure to plead fraud with particularity as required by Rule 9(b).

Holding: The U.S. District Court for the Central District of Illinois granted First Kuwaiti's motion to dismiss, but denied OAS's motion.

The court held that the government could not establish the court's personal jurisdiction over First Kuwaiti, a foreign company with no U.S. employees, property or offices and no other ties to the United States. The court rejected the government's argument that First Kuwaiti's "intimate involvement" in the preparation and submission of the claims for payment at issue gave the court jurisdiction. The court explained that the government did not allege that First Kuwaiti was involved with KBR's bid for LOGCAP III or that it was organized for the purpose of bidding on U.S. contracts. There was no indication, the court found, that First Kuwaiti should have "reasonably anticipated being haled into [a U.S.] court." All claims against First Kuwaiti were dismissed for lack of personal jurisdiction.

However, the court held that all allegations against KBR included OAS, because the government specifically alleged that OAS was a foreign, wholly owned subsidiary of KBR; that OAS employed the KBR administrators working on the LOG-

CAP III contract; and that OAS employees were trained using the same policy and procedure manuals, and received the same benefits and resources, as KBR employees. While recognizing that "lumping together" entities normally does not satisfy the particularity standard required by Rule 9(b), the court held that the government's allegations of closely-related corporate entities in a position to easily determine their respective roles in the alleged fraud were sufficient. The court explained that the pleading standard with respect to the relationship between KBR and OAS would be relaxed because only the defendants had access to the necessary information to determine who was working for whom and the roles each company played. Therefore, the court denied OAS's motion to dismiss.

U.S. ex rel. D'Agostino v. EV3, Inc., 2014 WL 4926369 (D. Mass. Sept. 30, 2014)

The relator, a former sales manager for medical device manufacturer, EV3, brought a *qui tam* action alleging that EV3, Micro Therapeutics, Inc.—another medical device manufacturer that merged with Ev3—and two of the companies' employees violated the False Claims Act by making misrepresentations to the Food and Drug Administration in order to induce the agency to grant approval for two medical devices, Onyx and Axium.

With respect to Onyx, the relator alleged that the defendants misrepresented the safety of the device and gave false assurances that they would train surgeons in the proper use of the device. Moreover, according to the relator, the defendants promoted Onyx for off-label uses, even though they knew that doing so was dangerous, and notwithstanding the FDA's denial of their request to expand the scope of the uses for which the device was approved. The relator alleged that all claims for payment to the government for off-label uses of Onyx were false, because all off-label uses of the device were hazardous.

Regarding Axium, the relator alleged that the defendants were hurried in the development of the device and therefore, it was not adequately designed or manufactured, and was not safe for use. The relator alleged that the defendants withheld this safety information from the FDA to receive approval of Axium, and that the device was not manufactured in accordance with FDA standards. As such, the relator alleged that the device was misbranded, and could not have been deemed "reasonable and necessary" for Medicare reimbursement purposes. The relator further alleged that the defendants performed improper investigations into adverse events that occurred as a result of Axium's use, and failed to adequately file Medical Device Reports with the FDA related to these events. The relator asserted that the FDA would have recalled or restricted Axium if it had known of the negative results. The relator claimed that the defendants induced hospitals to make false statements certifying that the Axium devices complied with applicable statutes and regulations, even though the defendants knew they were faulty.

The defendants moved to dismiss for failure to state a claim under Rule 12(b)(6) and failure to plead fraud with particularity under Rule 9(b). They also asserted that the relator's claims were precluded by the public disclosure bar.

Holding: The U.S. District Court for the District of Massachusetts granted the defendants' motion to dismiss. The court found that some of the claims were barred by the public disclosure bar, but that all of the claims failed to state a claim and failed to plead fraud with particularity.

Public Disclosure Bar

The court held that the claims that the defendants omitted safety information during the FDA approval process and that they misrepresented the training program they put in place had been publicly disclosed before the relator filed the *qui tam* action. The court observed that information the relator used in his complaint came from publicly-available FDA documents. The court further held that the relator was not an original source of that information because he did not provide the information to the FDA. Those claims were dismissed. However, the court held that the relator's allegation that the defendants knowingly made misrepresentations when marketing the devices for off-label purposes had not been publicly disclosed, explaining that while the statements themselves were in the public domain, "the facts from which the existence of a fraud might be inferred were drawn from [the relator's] experience as an employee of EV3."

Failure to Plead Fraud with Particularity/Failure to State a Claim

The court held that the relator failed to provide the necessary detail to meet the requirements of Rule 9(b) with regard to his allegations surrounding Onyx. While the relator provided two specific examples of adverse incidents attributed to Onyx, the court determined that those examples lacked particularity, as they did not identify the surgeons or facilities involved, did not describe a monetary loss by the government, and did not allege that any false claims were actually presented to the government. The court held that the additional allegations that "hundreds" of similar incidents must have occurred, and thus, the government must have lost some money, were "illustrative of the kind of opportunistic pleading that Rule 9(b) was designed to prevent."

Similarly, the court found the relator's allegations regarding Axium lacking in detail. While the relator attempted to plead the "who," "what," when," "where" and "how" of the fraud scheme, the court held that his allegations within those categories were too vague and conclusory to meet the 9(b) requirements.

Finally, the court held that the relator's allegations failed to state a claim, finding that he was in effect, asking the court "to usurp the FDA and assume the function" of determining whether the defendants' devices should be on the market. The court explained that there is a proper regulatory venue for challenges to a device's safety and marketability. Consequently, the court granted the defendants' motion to dismiss.

U.S. ex rel. Silver v. Omnicare, Inc., 2014 WL 4827410 (D.N.J. Sept. 29, 2014)

The relator brought a *qui tam* action against multiple defendants, including prescription drug distributor PharMerica and its subsidiaries, Kindred and Chem Rx. The relator alleged that the defendants violated the False Claims Act by engaging in a kickback scheme with skilled nursing facilities (SNFs), in which the defendants offered the SNFs below-market pricing for drugs for patients insured by Medicare Part A in exchange for referrals of prescriptions for patients insured by Medicare Part D or Medicaid—which reimbursed at a higher rate. The relator also alleged that the defendants violated the FCA's conspiracy provision, by conspiraing with the SNFs to defraud the government. PharMerica moved to dismiss for failure to plead fraud with particularity under Rule 9(b), and for failure to state a claim for conspiracy under Rule 12(b)(6). PharMerica also moved to dismiss on statute of limitations grounds.

Holding: The U.S. District Court for the District of New Jersey denied PharMerica's motion to dismiss on 9(b) and 12(b)(6) grounds, but granted the motion in part on statute of limitations grounds.

The court explained that the relator pled sufficient details of the fraud scheme "paired with reliable indicia that leads to a strong inference that claims were actually submitted." The court further explained that the relator was not required at the pleading stage to specify dates, the content of the claims, particular amounts of money, the particular goods or services for which the government was billed, or the individuals involved. The court further held that the relator adequately pled his conspiracy claim by alleging the kickbacks scheme and that PharMerica conspired with the SNFs with the intent to defraud the government. Thus, the court denied PhaMerica's motion to dismiss the fraud and conspiracy claims for failure to state a claim.

The court agreed with PharMerica, however, that the FCA's six-year statute of limitations provision applied, and not the statute's ten-year limitations period relied on by the relator. The court explained that because the government did not intervene in the relator's suit, only the six-year limitations period was applicable. The court also rejected the relator's argument that the Wartime Suspension of Limitations Act applied to extend the statute of limitations, explaining that the limitations period is only tolled under the WSLA when the government intervenes. The court granted PharMerica's motion to dismiss all claims that were based on alleged fraud that occurred more than six years before the *qui tam* complaint was filed.

U.S. ex rel. Willis v. Southerncare, Inc., 2014 WL 4829279 (S.D. Ga. Sept. 29, 2014)

The relator, a former employee of the defendant—a large provider of hospice care services—brought a *qui tam* action alleging that the defendant violated the False Claims Act by providing hospice care to patients who were ineligible for such care, and submitting false claims to Medicare for payment for these patients. The relator identified 27 patients who were receiving care despite ineligibility, including thirteen patients who were admitted despite lack of necessary referrals and documentation, seven patients who continued to receive care for over one year, six patients whose documentation was altered by the defendant, and one patient who the defendant improperly drugged to cause a decline in health to support eligibility for hospice care. Prior to the relator's *qui tam* suit, two other employees of the defendant filed *qui tam* suits alleging the same misconduct. The government intervened in both of the prior cases and settled with the defendant. The settlement released the defendant from any claims the government had for this conduct from January 2000 through September 2008, and required the defendant to institute a compliance program to prevent the submission of future false claims.

Citing the prior settlement agreement, the defendant moved to dismiss the present *qui tam* action. The defendant argued that the relator's complaint failed to state a claim and failed to plead fraud with particularity, and was barred by *res judicata*, collateral estoppel, and/or the FCA's public disclosure bar. The defendant also brought a counterclaim for breach of duty of loyalty, alleging that prior to ending his employment with the defendant, the relator referred potential customers away to a competitor.

Holding: The U.S. District Court for the Southern District of Georgia held that the relator's claims were not precluded by the public disclosure, *res judicata* or collateral estoppel. The court also held that the relator's claims were pled with the requisite particularity under Rule 9(b). However, the court ultimately dismissed the relator's complaint, finding that he did not allege sufficient facts to state a claim; the court dismissed the fraud claims without prejudice and granted the relator leave to amend. The court also dismissed the defendant's counterclaim for breach of duty of loyalty.

Public Disclosure Bar

The defendant argued that a press release announcing the two prior lawsuits, as well as the filings from those cases, publicly disclosed the conduct at issue and barred the relator's claims. The relator asserted that the claims his case stemmed only from the defendant's misconduct after the settlement date, and thus, had not been publicly disclosed. The court noted that the relator's allegations included patients admitted before the settlement date and who continued to receive treatment even though they were

ineligible, as well as patients admitted after the settlement date. Thus, the court determined that the relator's fraud allegations were publicly disclosed in part; the claims related to patients admitted prior to the settlement date were subject to dismissal on public disclosure grounds. The court, though, held that the relator qualified as an original source, as he alleged that he had direct, personal knowledge of the facts in his complaint; additionally, since nine of the allegedly improper patient admissions occurred after the passage of the Patient Protection and Affordable Care Act (PPACA), the court evaluated those claims under the amended, more relaxed public disclosure bar and original source exception.

Res Judicata/Collateral Estoppel

The court agreed with the relator that because his allegations only related to the defendant's conduct after the 2008 settlement agreement, his *qui tam* claims were never litigated, not covered by the settlement agreement, and thus not barred by *res judicata* or collateral estoppel.

Failure to Plead Fraud with Particularity

The court rejected the defendant's argument that the relator's complaint was insufficient because it failed to include the names of principals or employees involved in the alleged fraud scheme; failed to describe document titles, authors, or dates; and failed to allege specific dates and people involved in allegedly incriminating statements made by the defendant's employees. The court held that the relator provided the necessary indicia of reliability and sufficient detail regarding the conduct to meet Rule 9(b)'s requirements. The court explained that the relator alleged: 1) the "who"—the defendant and its employees; 2) the "what"—improper admissions and recertifications of ineligible patients; 3) the "when"—after the effective date of the settlement in 2008; 4) the "where"—within the Southern District of Georgia; and 5) the how—various details of the alleged misconduct. The court held that the complaint was sufficient to put the defendant on notice of the relator's allegations.

However, the court held that the relator failed to provide the necessary link between the defendant's alleged conduct and the submission of claims to the government. The court explained that the relator never alleged facts tying the defendant's conduct to actual submissions, but only alleged the defendant's general process for preparing and submitting claims to the government. The court granted the defendant's motion to dismiss, but gave the relator leave to amend his complaint, based on his assertions that he could provide the missing details to remedy the deficiencies.

Breach of Duty of Loyalty

The court dismissed the defendant's counterclaim for breach of duty of loyalty, holding that the defendant pled no facts to show that the relator improperly aided the defendant's competitor while he still employed by the defendant. The court explained

that the defendant merely alleged that it experienced a drop in admissions, and due to the timing, assumed the relator was to blame. The court did not address whether the relator actually owed any duty to the defendant.

U.S. ex rel. Besancon v. UChicago Argonne, LLC, 2014 WL 4783056 (N.D. Ill. Sept 24, 2014)

The relator was the former chief financial officer for the defendant, which managed and operated the Argonne National Laboratory for the U.S. Department of Energy. The research conducted at the laboratory was performed under federally-funded contracts for various federal agencies. The relator brought a *qui tam* action alleging fraud and retaliation claims under the False Claims Act. According to the relator, the defendant violated the FCA by submitting false certifications, cost statements, and overhead rate sheets with its invoices to the DOE, resulting in overpayments. The relator asserted that when he brought his concerns to the attention of the defendant's president and CEO, he was directed to continue with the practices that he believed resulted in fraudulent claims. He was eventually terminated after continuing to object to, and refusing to continue with, those practices. The relator alleged violations of the FCA's fraud provisions—including the "reverse" false claims provision—as well as the FCA's retaliation provision. The defendant moved to dismiss the relator's claims for failure to state a claim under Rule 12(b)(6) and failure to plead fraud with particularity under Rule 9(b).

Holding: The U.S. District Court for the Northern District of Illinois denied the defendant's motion to dismiss the retaliation claim, and denied the motion to dismiss the fraud claims in part—the court granted the defendant's motion to dismiss the "reverse" false claims allegation.

The court held that the relator set out in detail a "complicated scheme to defraud the government by overcharging for certain costs." The court explained that the relator alleged the particulars of how the overcharges were accomplished and who was involved, and found it sufficient that the relator alleged that every invoice for payment submitted over a five year period contained false claims. The court also held that the relator's allegations regarding his termination were sufficient to allege that he had been retaliated against in response to his "protected activity."

But the court rejected the relator's reverse false claim argument, based on his assertion that "every cost-reimbursement contract inherently contains an obligation to return any overpayment." The court observed that if that were the case, then the "reverse" false claims provisions would be rendered redundant. Thus, the court dismissed that claim.

U.S. ex rel. Dowell v. Penn, 2014 WL 4778531 (E.D. La. Sept 23, 2014)

The relator brought a *qui tam* action alleging that the defendants, Metro Disposal—a waste removal company—Metro's employee, Anthony Penn, and Kenneth Johnson—the owner of another waste removal company—were involved in a scheme to violate the False Claims Act. Metro Disposal had entered into a subcontract with a prime contractor on a contract with the U.S. Army Corps of Engineers' for the removal of storm debris in New Orleans caused by Hurricane Katrina. Metro then entered into a sub-tier contract with Johnson for his company to provide the work on the government contract. The contracts all contained language certifying compliance with the Anti-Kickback Statute. In a related criminal proceeding, Penn admitted that Johnson made kickback payments to Penn from the money that Johnson's company received from the contract. The relator alleged that the defendants had no intention of complying with the AKS language in the contracts, and that Penn was liable for fraudulent inducement under the FCA. The defendants moved to dismiss for failure to state a claim under Rule 12(b)(6) and for failure to plead fraud with particularity under Rule 9(b).

Holding: The U.S. District Court for the Eastern District of Louisiana denied the defendants' motion to dismiss, holding that the relator had pled his claims for fraudulent inducement with particularity, and that the disputed issues of knowledge and intent were not required to be pled with particularity at this stage. Although the court allowed the relator's claims to proceed, the court ordered him to file an amended complaint clarifying the total amount of kickback payments alleged.

U.S. ex rel. John v. Hastert, 2014 WL 4652662 (N.D. Ill. Sept. 18, 2014)

The relator was an acquaintance and business partner of the defendant, Dennis Hastert, former Speaker of the U.S. House of Representatives. Upon retirement from the government in 2007, Hastert—who was now employed as a lobbyist and consultant—continued to maintain an office with staff and received a federal allowance for his office expenses pursuant to a law allowing former Speakers of the House to wind down matters pertaining to his/her former position.

The relator alleged that he met with the defendant to discuss business ventures three times at that office in 2008 and 2009. He asserted that the defendant used the office, staff, equipment, and supplies for his personal business dealings. The relator brought a *qui tam* action alleging that the defendant violated the False Claims Act by submitting and verifying employee wage contracts and hourly claims for time that was not spent on government work, and by accepting payments from the government for the allegedly false claims. The defendant moved to dismiss for failure to plead fraud with particularity under Rule 9(b).

Holding: The U.S. District Court for the Northern District of Illinois granted the defendant's motion to dismiss. The court explained that the relator failed to identify "a single false or fraudulent invoice, statement, wage contract or claim that was actually submitted to the government." Instead, the relator only alleged generally that based on invoices and claims submitted to the government, the defendant was paid almost $2 million dollars. The relator did not allege any particulars related to when claims were submitted, who in the government the claims were presented to, or the contents of the claims; nor did he allege details with regard to the meetings he had at the defendant's office. Consequently, the court held that the relator did not satisfy Rule 9(b)'s particularity standard, and granted the defendant's motion to dismiss.

U.S. ex rel. Deane v. Dynasplint Sys., Inc., 2014 WL 4403182 (E.D. La. Sept. 5, 2014)

In this intervened action, the State of Washington brought allegations against the defendants, a provider of durable medical equipment (DME) and its president, claiming that the defendants violated the False Claims Act by submitting false bills to Medicaid stating that DMEs were provided to patients in their homes, when the DMEs were actually provided to patients at skilled nursing facilities (SNF)—which is prohibited under Medicaid. In addition, the State alleged that the defendants misidentified over 400 of its billings under a billing code for a covered service, when in fact, the service provided was not covered. The State also alleged breach of contract claims with regard to the Medicaid provider agreements. The defendants moved to dismiss for failure to plead fraud with particularity under Rule 9(b).

Holding: The U.S. District Court for the Eastern District of Louisiana granted the defendants' motion to dismiss, holding that the State did not put forth facts sufficient to meet the pleading standards of Rule 9(b).

The court explained that with regard to the State's allegation regarding the submission of false claims related to DMEs, while the State offered evidence that the Department of Justice investigated the matter and concluded that 100% of the claims reviewed by the DOJ were submitted with false codes indicating the place of service as home when the claims were actually submitted for patients in SNFs, the State did not "indicate which of [the defendants'] submitted bills or claims are at issue in this case, or specify the total number of claims it believe[d] to be fraudulent." The court further explained that the State not only failed to identify a specific claim that was fraudulently submitted, it also failed to offer evidence as to who submitted the claim knowing it was false, or to provide details as to the why, when, where, or how the claims were submitted. The court held that the State was not entitled to the relaxed pleading standard afforded to plaintiffs when the facts

are "particularly within the defendant's knowledge," because the DOJ investigated the matter, and thus the State was privy to "some, if not all, of the information needed . . . to comply with Rule 9(b)."

The court held that the State's second allegation—that the defendants submitted over 400 miscoded bills for services that were not provided under Medicaid—failed for the same reasons. While the State alleged an estimate of the total claims, the court explained that it failed to provide the "who, what, when, where, and how," of the alleged fraud.

U.S. ex rel. Krahling v. Merck & Co., Inc., 2014 WL 44007969 (E.D. Pa. Sept. 5, 2014)

The relators were former virologists in the defendant's lab. The defendant, Merck, was the sole manufacturer licensed by the Food and Drug Administration to sell the mumps vaccine. The relators alleged that Merck violated the FCA by billing the government for the mumps vaccine when the defendant knew of the vaccine's diminished efficacy. Because the vaccine's efficacy was diminished, the relators explained, the vaccine was mislabeled and was not the product for which the government paid through the federal healthcare programs. In addition, the relators alleged that the defendant falsified, concealed, and manipulated testing data that should have been shared with the government in order to induce the government to purchase the vaccine, and knowingly incorporated falsified records into its claims for payment. This case also involved antitrust class action and breach of contract claims.

According to the relators, the defendant fraudulently misled the government regarding material information related to the efficacy of its mumps vaccine. Specifically, the relators claimed that rather than using the "gold standard" approach to testing the vaccine, the defendant used less accurate and outdated testing methods and manipulated test outcomes in order to obtain the effectiveness rates required by the FDA. The relators reported their allegations to the FDA, leading to an FDA visit, after which the relators were barred from participating in the defendant's mumps vaccine testing. The relators asserted that the defendant continued to make false representations of the vaccine's effectiveness rate after this visit while deliberately covering up the results of the negative tests.

Holding: The U.S. District Court for the Eastern District of Pennsylvania denied the defendant's motion to dismiss the FCA claims.

Failure to State a Claim/Failure to Plead Fraud with Particularity

First, the court rejected the defendant's argument that the relators' claim regarding the mislabeling of the vaccine was strictly within the purview of the FDA and could not be remedied under the FCA. Instead, the court agreed with the relators and the U.S. Government (which filed a statement of interest) that holding that only the government can pursue claims arising out of allegations of fraud on the FDA "would be inconsistent with the purposes of the False Claims Act." The court further explained that it was not simply the mislabeling, but the allegations that the defendant deliberately withheld information from the government, that formed the basis for FCA liability.

The court then held that realtors sufficiently alleged that the defendant submitted claims for payment to the government for the purchase of the vaccine on many occasions following the allegedly fraudulent testing and reporting of false test results. The court held that under Third Circuit jurisprudence, even though the relators did not point to a specific instance of a false claim, their allegations met the heighted pleading requirement under Rule 9(b), stating that the "Relators plainly allege[d] that Defendant submitted claims for payment to the government for the government's purchase of the vaccine on many occasions between 1999 and the present, following the allegedly fraudulent testing." The court also held that the relators sufficiently pled that the defendant withheld information about the diminished efficacy of the vaccine from the government and that those omissions were material to the government's decision to purchase the vaccines. The court explained that the relators alleged that the defendant's duty to disclose accurate information regarding the efficacy of the vaccine was a "condition for the [d]efendant's ability to sell the vaccine at all," and that this duty was codified throughout the regulations with which the defendant expressly and impliedly agreed to comply. The court also held that the relators sufficiently alleged that the defendant knew that its claims were false, as the realtors witnessed firsthand managers and supervisors instructing staff to withhold information from the government. The defendant's motion to dismiss the relators' claims based on allegations that the defendant submitted false claims was denied.

Similarly, the court denied the defendant's motion to dismiss the relators' claims alleging that the defendant knowingly made false statements that were material to its false claims. The court held that the relators sufficiently pled that claim as well, noting that the relators described multiple instances of material false statements to the government, including in package inserts, false representations made to receive approvals for expanded distribution of the vaccine, and various other false representations made by the defendant, that deliberately misled the government.

U.S. ex rel. Notorfransesco v. Surgical Monitoring Assoc., Inc., 2014 WL 4375654 (E.D. Pa. Sept. 3, 2014)

The relator was the former billing manager for the defendant, Surgical Monitoring Associates, Inc. (SMA), a healthcare provider specializing in intraoperative neuromonitoring (IONM), which identifies injuries to the brain, spinal cord, and other neural structures during surgery. SMA was acquired by Defendant SpecialtyCare in October 2011. The relator brought a *qui tam* action against both companies, alleging SMA violated the False Claims Act by improperly billing for IONM, making false representations regarding IONM, and knowingly employing a physician whose license was revoked. The relator also brought an FCA retaliation claim against SMA. Though IONM occurred only during surgery, the relator asserted that SMA improperly billed the government for IONM during periods before and after surgeries, as well as for remote observation for IONM at hospitals that had no remote connection. The relator also claimed that she was instructed to falsify physician names and information on billing forms, including substituting physicians who were covered under government healthcare plans for those who were not. She claimed that she warned her supervisors about the fraudulently billing and was fired from her job soon after. As a result, she brought a claim against the defendants under the FCA's anti-retaliation provision. The defendants moved to dismiss the fraud and retaliation claims for failure to state a claim under 12(b)(6); the defendants also moved to dismiss the fraud claims on the alternative bases of failure to plead fraud with particularity under Rule 9(b), and on public disclosure grounds.

Holding: The U.S. District Court for the Eastern District of Pennsylvania granted SpecialtyCare's motion to dismiss, but denied SMA's motion.

With respect to SpecialtyCare, the court observed that the fraudulent conduct that the relator alleged took place prior to the sale of SMA, and noted that the relator made no specific allegations against SpecialtyCare.

However, the court held that the claims against SMA were valid.

Failure to Plead Fraud with Particularity

The court held that the relator pled her allegations against SMA with the particularity required by Rule 9(b). The court found that the relator sufficiently pled that on multiple occasions, the charge sheets used for IONM reported longer surgery times than the accompanying comment summary reports which are completed during surgeries. The relator also reported specific times that she was instructed to falsify names on billing forms. While the relator did not present evidence that false claims were actually submitted, the court held that she "need not make such a showing to survive a motion to dismiss." The court also rejected SMA's argument that the relator's allegation that SMA knowingly employed a doctor who was not licensed was unsupported, explaining that "Rule 9(b)…explicitly allows general allegations as to a person's knowledge."

Retaliation

The relator alleged that she warned her supervisors about SMA's fraudulent billing practices. In August 2008, she participated in an audit that revealed the fraudulent activity, and she was terminated two months later. The court held that it could be reasonably inferred that the relator was engaged in protected activity under the FCA by participating in internal reporting and auditing, and that she was fired in retaliation for that protected activity, given the fact that she was terminated two months after assisting with the audit.

Public Disclosure Bar

SMA argued that the relator publicly disclosed the allegations of fraud at issue here in her administrative proceedings before the Pennsylvania Unemployment Compensation Board of Review after her termination. However, the court held that because the relator qualified as an original source of that information, her *qui tam* claims were not barred.

U.S. ex rel. Thayer v. Planned Parenthood of the Heartland, 2014 WL 4251603 (8th Cir. Aug. 29, 2014)

The relator brought a *qui tam* action against the defendant, Planned Parenthood, alleging that the defendant violated the False Claims Act by: 1) submitting claims to Medicare for prescriptions and services that were not reimbursable; 2) instructing patients to give false information to medical professionals at other hospitals in order to induce those professionals to unknowingly file claims for services connected to abortions performed by the defendant; 3) filing claims for the full amount of services that had already been paid; and 4) engaging in "upcoding" when billing Medicare. The U.S. District Court for Southern District of Iowa dismissed the relator's complaint for failure to plead fraud with the particularity, as required by Rule 9(b). The relator appealed the district court's dismissal to the U.S Court of Appeals for the Eighth Circuit.

Holding: The Eighth Circuit affirmed the district court's ruling in part, and reversed it in part, allowing some of the relator's claims to proceed. The court held that a relator can satisfy Rule 9(b) by "alleging particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted," in lieu of representative examples of false claims. The relator must provide sufficient details "to enable the defendant to respond specifically and quickly to potentially damaging allegations." Here, because the relator had first-hand knowledge of the defendant's billing practices, she sufficiently pled facts to support her claims that the defendant violated the False Claims Act by filing claims for unnecessary quantities of birth control pills, dispensing birth control without examination, filing claims for unnecessary abortion-related services, and filing claims for the full amount of services that had already been paid.

Failure to Plead Fraud with Particularity

The Eighth Circuit held that because the relator was the center manager for two Planned Parenthood clinics and directly oversaw the billing and claims systems, she was able to plead personal, first-hand knowledge of the submission of false claims. Therefore, the circuit court held that the relator had sufficiently pled particularized facts to support her allegations that the defendant had submitted claims for services that were not reimbursable and had filed claims for services that had already been paid. The relator alleged details such as names of individuals, clinics involved, and methods by which the schemes were carried out.

However, the circuit court held that the allegations that the defendant violated the False Claims Act by causing other hospitals to unknowingly submit claims for abortion-related services were not sufficiently pled under Rule 9(b). The relator did not allege that she had access to the billing systems of the unidentified hospitals which purportedly submitted claims for these abortion-related services, nor did the relator allege that she had knowledge of the hospitals' billing practices. The circuit court also held that the relator's "upcoding" allegations were not properly pled. The relator alleged that the defendant billed visits as "problem visits" even when patients had no medical problems and a physicians did not spend any time with patients (i.e., patients were only seeking family planning services). The circuit court held that while the relator was not required to allege representative examples, she was still required to plead particularized details such as how often the alleged upcoding occurred, how many physicians were involved, or what types of services were involved.

The circuit court noted that on remand, the district court should consider whether the relator's remaining allegations survived the defendant's Rule 12(b)(6) challenges, which the circuit court did not address.

Ellis v. City of Minneapolis, 2014 WL 3928525 (D. Minn. Aug. 12, 2014)

Two relators alleged that two U.S. cities violated the False Claims Act ("FCA") by defrauding the U.S. Department of Housing and Urban Development ("HUD"). The relators claimed that the defendants affirmed to HUD that they were taking steps to further fair housing when they were not doing so, resulting in a windfall of HUD funds to the defendants of approximately $250 million. The government declined to intervene.

Holding: The U.S. District Court for the District of Minnesota dismissed the relators' claims, citing the FCA's public disclosure bar provision, and based on its finding that the relators' claims failed to plead fraud with particularity under Rule 9(b). The court explained that the allegations the relators raised had already been publicly disclosed in two prior complaints. The court also held that the relators failed to allege with particularity that the defendants made any actual false state-

ments to the government, explaining that the relators' allegations were vague and did not describe any particular instances of improper action by the defendants.

U.S. ex rel. Joseph v. Brattleboro Retreat, 2014 WL 3908432 (D. Vt. Aug. 10, 2014)

The relator brought an action under the False Claims Act alleging that the defendant—a mental health and substance abuse facility—improperly retained overpayments from the government's health care benefit programs and falsified records to conceal the overpayments. The relator identified 32 patient accounts from 2005-12 that he alleged were representative cases of the defendant retaining payments illegally. The relator alleged that, in addition to illegally retaining the overpayments, the defendant fraudulently double-billed for services and falsified reports to cover up the retention of the overpayments.

As an initial matter, the U.S. District Court for the District of Vermont held that any allegations prior to 2007 were time barred, citing the FCA's six-year statute of limitations provision.

As to the remaining allegations, the court held that, even in the examples listed, the relator did not adequately plead the alleged fraud with particularity. Notably, the court held that the relator failed to describe how the defendants were actually overpaid—while he provided numerous examples of what he alleged were overpayments, the court found that he never described what the actual patient bill should have been or how the codes that the defendant used in their computer system actually concealed the overages. In addition to alleging that the defendant eliminated overpayments from its system, the relator alleged that the defendant shifted the credits between patients in order to conceal them. The court held that the relator did not provide sufficient detail relating to this credit shifting, as the relator provided only total estimates of overpayment amounts, rather than describing actual instances of overpayment. The court also dismissed the relator's claims that, in some instances, the defendant repaid the overages, but did not do so in a timely manner, holding that the mere delay did not constitute an FCA violation. The court further held that the relator's allegation that the defendant recoded and resubmitted partially paid claims from the government as full claims was not adequately pled, as the relator did not actually indicate whether any payments were made on these claims. The court also held that the relator's allegations regarding the use of codes to cover up the overpayments failed, because he did not cite any specific inaccuracies in the reports. Finally, the court held that even if the relator had pled facts sufficient to show that the defendants improperly retained payments, he provided no evidence to indicate that the defendant knowingly did so. While the relator asserted that he notified his superiors of the allegedly improper billing practices, those discussions involved commercial insurance overpayments, which do not implicate the FCA.

Hendricks v. Bronson Methodist Hosp., Inc., 2014 WL 3752917 (W.D. Mich. July 30, 2014)

The relator filed a *qui tam* action alleging that the defendants—a hospital and a healthcare group—violated the False Claims Act by billing the U.S. government and the State of Michigan for sonograms from ultrasound examinations that were certified, despite the certifying physicians lacking the expertise to review the sonogram, or failing to review the sonogram at all. The relator was employed by the defendants from March 2003-11, and the relator entered into a three-year employment contract with the defendants in 2010. Shortly after signing the employment contract, the relator alleged that she learned of the defendant's policy of improperly certifying sonograms. After a dangerous incident involving a missed hernia in a sonogram, the defendants asked the relator to investigate and provide her opinion. During her investigation, the relator found that the three OBGYN's that certified the sonogram had done so without viewing it.

The relator brought her concerns about the improper certifications to the defendants' attention and communicated to them that she believed the certification policy was illegal. The relator asserted that she would need to report the policy if she were not allowed to complete grand rounds to remedy the deficiencies that she noted. She was allowed to do so until her termination in 2011.

The defendants moved to dismiss the relator's fraud allegations, arguing that the relator failed to state a claim and failed to plead fraud with particularity under Rule 9(b). The court declined to apply a relaxed pleading standard in this case, because this was not a case where the relator had personal knowledge of the submitted claims and had "pled facts which support a strong inference that a claim was submitted." The court dismissed the relator's claims under the FCA, holding that the relator's allegations that the defendants submitted false claims to the government, without pleading any particular presentation of a false claim, failed to satisfy 9(b). The relator alleged generally that the government may have paid claims that it otherwise would not have paid, but did not supply the requisite detail to put the defendants on notice.

The court addressed the "false certification" theory of liability under the FCA, and explained that "[w]hen a claim expressly states that it complies with a particular statute, regulation, or contractual term that is a prerequisite for payment, failure to actually comply would render the claim fraudulent." Also, under the "implied certification" theory of liability, "noncompliance constitutes actionable fraud only when compliance is a prerequisite of obtaining payment." The relator did not allege with particularity either theory of false certification liability here. The court also discussed the "worthless services" theory of liability, wherein "[a] test known to be of 'no medical value,' that is billed to the government would constitute a claim for 'worthless services,' because the test is 'so deficient that for all practical pur-

poses it is the equivalent of no performance at all.'" The relator also failed to plead the "worthless services" claim with the particularity required under 9(b), as she still failed to specify even one actual submission for payment.

U.S. ex rel. Donegan v. Anesthesia Assoc. of Kansas City, PC, 2014 WL 3729641 (W.D. Mo. July 28, 2014)

The relator filed a *qui tam* suit claiming that the defendant violated the False Claims Act by submitting fraudulent claims relating to anesthesia administration to Medicare and other Government healthcare programs. He also brought an FCA retaliation claim in connection with his termination. The government declined to intervene. The relator was a Certified Registered Nurse Anesthetist ("CRNA") at the defendant's medical center from 2006-12. He alleged that his superiors and co-workers told him that it was the defendant's policy always to check the "medical direction" box on Medicare Part B billing forms, regardless of whether anesthesia services being billed for were at the direction of a physician anesthesiologist. The relator claimed that he witnessed eleven physician anesthesiologists—whom he identified—improperly check the "medical direction" box even though they did not prescribe the anesthetic and were not present during administration. He also detailed five representative examples of instances where he checked the "medical direction" box even though the anesthesiologist did not prescribe the anesthetic or monitor the course of administration.

The relator alleged that when he learned that this billing practice was illegal, he told the physician anesthesiologist that he was working with and the defendant's COO that he would no longer mark the "medical direction" box improperly; he did not explain why. The defendant informed the relator that he would be terminated if he did not continue to check the box, and eventually, he was fired.

The U.S. District Court for the Western District of Missouri granted the defendant's motion in part and denied it in part. The court dismissed the FCA retaliation claim, but allowed the fraud claims to go forward.

Failure to Plead Fraud with Particularity

The defendant argued that the relator failed to identify the "who, what, where, when, and how of the fraud." The court held that the relator provided sufficient information to survive a motion to dismiss. Specifically, the relator had personal knowledge and supplied detail relating to the "who" (eleven named anesthesiologists); "what" (submission of false "medical direction" claims); "where" ("hospitals staffed by the defendant in the Kansas City area and the defendant's billing office); "when" (from 2006 to present with each individual example providing a narrower time frame); and "how" (by instructing CRNA's to always check the "medical direction" box on the billing form and the submitting the billing form to a government healthcare program). As the rela-

tor's fraud allegations satisfied Rule 9(b)'s pleading requirements, the court denied the defendant's motion to dismiss those claims.

Retaliation

The court also considered the relator's retaliation claim. The defendant argued that the relator's complaint failed to properly allege that the defendant terminated the relator in retaliation for protected activity under the FCA (defined as an activity "in furtherance of an FCA action or 'reasonably could lead [] to a viable FCA action'"), specifically, that the relator failed to allege that the defendant knew the relator was engaged in protected activity because he did not report any fraud to his supervisors or specify why he would not check the "medical direction" box. The court agreed with the defendant and ruled that the relator's act of simply failing to do something his employer instructed him to do, without more, did not put the defendant on notice that the relator was engaged in protected activity. The retaliation claim was dismissed without prejudice.

***U.S. ex rel. Dolan v. Long Grove Manor, Inc., et al.*, 2014 WL 3583980 (N.D. Ill. July 18, 2014)**

The relator filed a *qui tam* suit alleging the defendants (three physicians and thirteen entities, including a wound care service provider and various skilled nursing facilities) violated the False Claims Act by engaging in Medicare and Medicaid fraud and by retaliation against him after he engaged in protected whistleblowing activity. The relator also alleged a variety of other federal and state statutory and common law claims against the defendants. The relator was employed by the defendants as a Corporate Nurse from 2003-07, and that in that capacity, he alleged that he was exposed to far-reaching fraud. The relator alleged that physician defendants were illegally compensated for referrals; they were paid a flat monthly fee to serve as medical directors, on the basis that they continued to refer patients to the defendants' facilities. The relator also alleged that illegal bonuses were paid to the defendants' directors, as they were tied to increasing the Medicare patient population.

The relator alleged that the defendants admitted patients to acute care facilities and then re-admitted them to skilled nursing facilities ("SNFs"), thereby manipulating the records to satisfy the government's payment criteria. This included falsifying medical information, ordering unnecessary tests, and ordering unnecessary physical or occupational therapy. The relator also alleged that the defendant physicians provided services that "exceeded the lawful scope of their licensure," including podiatrists performing wound care outside of their specialty and billing the government for these and other unnecessary services, as well as billing services under the names of other physicians.

The relator also alleged a variety of other ways the defendants provided improper

care and incorrectly accounted for the services they provided in order to receive payments from the government. The defendants allegedly colluded with SNFs to provide unnecessary services, used unlicensed staff, backdated certifications, and fabricated patient records in order to justify the care provided to meet the government criteria. In addition, the relator alleged that the defendants "upcoded" their services. The relator provided examples of four specific patients as evidence of these allegations.

The defendants also allegedly submitted false Cost Reports and Certificates of Compliance to Medicare and Medicaid. The relator alleged that the defendants knew that they had violated various laws, but proceeded to submit the false reports and compliance certificates, which were relied upon by the government to pay the claims. The defendants moved to dismiss the fraud and retaliation claims pursuant to Rule 9(b) and 12(b)(6).

The court granted the defendants' motion to dismiss, holding that the relator failed to describe the alleged fraud with the detail required under Rule 9(b), and also dismissed the relator's retaliation claims.

Failure to Plead Fraud with Particularity

The defendants moved to dismiss the relator's fraud claims pursuant to Rule 9(b), arguing that the relator did not identify any specific false claims that were submitted to the government, that the complaint improperly conflated the defendants by failing to specify which defendant allegedly committed which wrongful act, and that the relator failed to identify which counts were asserted against which defendants. In addition, the defendants argued that with regard to the allegation related to self-referrals and bonuses, the relator failed to identify any particular patients referred in violation of the law, or any other specifics about the bonuses. With regard to the allegations related to improper or out-of-scope treatment, "upcoded" or double-billed services, and manipulated records, the defendants argued that the relator failed to identify any claims actually presented related to these practices, including in the examples of four patients that the relator provided. The court agreed, holding that the description provided by the relator was far too vague to sufficiently allege that any of the defendants had the requisite knowledge required by the FCA. Nor did the relator sufficiently allege that any Cost Report or Certification was actually submitted. The court declined to apply the relaxed pleading standard that would allow the claims to proceed where evidence of the specific false claims were outside of the relator's reach at the pleading stage, noting that "relator is not entitled to embark on a fishing expedition against thirteen entities (not to mention individuals) based on the fraud he claims to have witnessed as an employee of one of them." In addition, the court stated that the "sparse details" provided in the patient representative examples did not even meet the relaxed standards for pleading at this stage. Allegations were also made "under information and belief," a standard that the court held was not sufficient under 9(b) unless the relator "pro-

vides the grounds for his suspicions." The court held that the Complaint was absent of details as to what the false records contained and what they would have contained had the records been properly made. The fraud allegations were dismissed without prejudice, with the court noting that "these are not flaws that have no hope of a cure."

Retaliation

The relator alleged that he was terminated as a result of his actions leading to this suit. The defendants argued, and the court agreed, that the relator did not adequately plead that he engaged in "protected activity," or that the defendants knew that he did. While the relator did allegedly notify the defendants of his concerns regarding the perceived improper conduct, the court held that simply complaining internally was not sufficient to put the defendants on notice of any conduct taken in furtherance of a *qui tam* claim. The FCA retaliation claim was dismissed without prejudice.

U.S. ex rel. Sansbury v. LB & B Assocs., Inc., 2014 WL 3509789 (D.D.C. July 16, 2014)

The relators alleged the defendants' participation in the Small Business Association's ("SBA") Section 8(a) program and 8(a) Mentor Protégé program violated the False Claims Act. The SBA's Section 8(a) program gives preferential treatment in the form of "set aside" contracts and other assistance to small businesses that are owned by individuals who are deemed socially and economically disadvantaged. In order to be considered "disadvantaged" for the purposes of the program, at least 51 percent of the business must be owned and controlled by socially and economically "disadvantaged individuals," i.e., those who have been subjected to racial, ethnic, or cultural bias; or those whose ability to compete in free enterprise has been hampered due to lack of capital or credit as compared to others in the same line of business. If selected to participate in the program, the business must certify eligibility each year for a maximum of nine years. The Mentor Protégé program allows a non-Section 8(a) company to form a joint venture with a Section 8(a) eligible company in order to encourage the mentor company to provide managerial, financial, and technical assistance in bidding on government contracts. The joint venture plan must be approved by the SBA, with the Section 8(a) participant in the role of the "managing venturer" and an 8(a) concern designated as a project manager for contract performance.

The President of defendant LB & B, Mrs. Lily Brandon, was an Asian Pacific American and a woman who was considered socially disadvantaged for the purposes of the program. Both relators were employed by LB & B. The relators alleged that Mr. F. Edward Brandon, Mrs. Brandon's husband, as well as another director at LB & B, had extensive experience in business and government contracting, and though Mrs. Brandon was the President of the company, her title and

holding in the company were superficial. The relators alleged that Mrs. Brandon had "no meaningful substantive role in the daily operations of the company," and it was actually Mr. Brandon who controlled the business. The relators claimed that LB & B thereby failed to satisfy the statutory requirements of the Section 8(a) program. The SBA certified LB & B as a Section 8(a) concern from 1995-2004, during which the defendants bid on and won many "set aside" contracts based on this certification.

The relators also alleged that the defendants violated the FCA under the SBA Mentor Protégé program. Prior to LB & B's "graduation" from the 8(a) program in early 2004, it began looking for a protégé company to enter into a joint venture with, and allegedly, continue illegally to benefit from the advantages of program participation. Approximately four months after exiting the program, LB & B entered into an SBA-approved joint venture with Bering Straits Aki, LLC ("BSA"), an Alaskan, Inuit company owned by defendant Gail Schuber. The joint venture was able to secure several "set aside" government contracts pursuant to the Mentor Protégé program. The relators alleged that the project managers for these contracts were LB & B employees until 2005 when they were instructed to change their employer to BSA.

The relators filed the present *qui tam* action the U.S. District Court for the District of Columbia in 2011. The Government intervened in the part of the action relating to the Section 8(a) program, but declined to intervene in the claims relating to the Mentor Protégé program. The relators had previously filed a similar action in United States District Court for the District of Maryland in 2004. The Government elected not to intervene in that suit, which was unsealed after the Government intervened in the present suit.

The defendants moved to dismiss, arguing that the relators lacked standing to pursue their claims after the Government intervened, that some of the Government's claims were time-barred, and that the plaintiffs failed to plead fraud with particularity. The court denied the defendants' motion.

Standing

The defendants argued that because the Government intervened in the Section 8(a) program claims, the *qui tam* claims were rendered duplicative and the relators lacked standing to continue pursuing them. The court held that the FCA gives relators the explicit right to continue as a party in *qui tam* actions in which the government intervenes. The court held that the Government's complaint-in-intervention becomes the operative complaint for the claims for which the Government intervened, however, the relators' initial complaint continues to be operative for all non-intervened claims; the relators remain a party to the Government's claims with rights to participate in, and receive recovery pursuant to, those claims.

Statute of Limitations

While the defendants agreed that the Government's compliant "relates back" to the date of the filing of the relators' complaint and that the FCA includes a general six-year statute of limitations that can be extended up to ten years, the defendants argued that because the Government did not file its complaint-in-intervention within three years of when the relators filed their initial complaint in Maryland in 2004, the Government's claims are not subject to the FCA's extended ten year statute of limitations, but instead are limited to the statute's six year limitations period. The Government argued that, for statute of limitations purposes, "the Government stands in the shoes of the relator," and since the relators filed the present, D.C. *qui tam* complaint within three years of when the Government first became aware of the alleged fraud (through the relators' prior, Maryland complaint) , the Government's complaint-in-intervention in the present suit can allege fraud going back ten years from the date of the present *qui tam* complaint, pursuant to the FCA's relation back provision.

The court looked to the text of the statute's ten-year extended limitations provision and found that while it is silent as to whether it applies to relators, it does state that it applies to "civil actions under section 3730," which the court reasoned includes both actions filed by relators as well as actions filed by the government. The court held that because the relators are allowed to take advantage of the FCA's tolling provision, and since they filed the present *qui tam* complaint within three years of the Government being put on notice of the alleged fraud, the Government's claims dating back ten years were timely as well.

Failure to State a Claim/Plead Fraud with Particularity

The defendants argued that the plaintiffs failed to plead the Section 8(a) claims with particularity as required by Rule 9(b). The defendants argued that the Government failed to identify a "single specific false claim or invoice for payment or date(s) or cost(s) of any such claims." Specifically, the defendants argue that the claims fail because they "(a) do not specify particular claims or payments made in relation to the alleged fraudulent activity; (b) do not allege any fraudulent activity on the part of Mrs. Brandon or Mr. Brandon (c) make allegations 'upon information and belief;' [and] (d) make general allegations against all the defendants in their Complaint." The Government contended that it pled its claims with particularity, noting that it identified the "who" (LB &B); the "what" (representations regarding Mrs. Brandon's role in LB & B and its eligibility for the 8(a) program; the "when" (on or after 1997 in yearly certifications to the SBA and government contracts, until LB & B's exit from the program; the "where/with whom" (the SBA and government agencies that awarded the contracts to LB & B); the "how" (claims for payment submitted pursuant to those contracts, statements in annual certifications, and contract materials submitted to the SBA and contracting government agencies); and "damages" (contracts awarded under Section 8(a) and extensions, and payments and invoices made pursuant to those contracts).

The court held that Rule 9(b) must be read with "simplicity and flexibility," and that the defendants' reading of the rule would require that claimants provide detailed proof of their allegations in the early stages of litigation. The court held that the plaintiffs' claims clearly met the pleading requirements under Rule 9(b), as they alleged detailed circumstances of the fraud related to both programs and identified the defendants involved. The plaintiffs are not required to plead "specific dates, invoices, or payment amounts pursuant to a Section 8(a) scheme that spanned many years."

The court also considered the relators' claims related to the Mentor Protégé program, in which the Government did not intervene. The relators alleged that because the defendants made several false representations to the Government regarding the management and employees of the joint venture, which caused the joint venture to be approved for the program, they violated the FCA. In support of their Mentor Protégé program claims, the relators named specific instances where the defendants misrepresented the employment status of employees and managers, where employees switched employers in violation of program requirements, and where employees performed work in violation of regulations. The defendants, though, argued that the relators failed to state a claim under the FCA related to this program and that these claims should be dismissed. The court disagreed and held that the relators provided "more than the 'short and plain statement of the claim showing that [they are] entitled to relief.'" The court determined that the defendants were on notice of the claims against them and held that the relators would be allowed to gain additional information through the discovery process.

Conspiracy

Courts have held that general conspiracy principles apply to FCA conspiracy claims. As such, the court held that the Government's conspiracy claims fail to state a claim, as a corporation cannot conspire with its employees, or its employees among themselves. However, the relators alleged a conspiracy between LB & B, BSA, and Chilkat (a third joint venture company that was not served in this litigation), claiming that LB & B conspired with BSA and Chilkat to form the non-compliant joint ventures, misrepresent the managerial and employment status within these joint ventures, and switch employees within the companies in order to secure government contracts. The court held that the relators' conspiracy claims survive the motion to dismiss.

U.S. ex rel. Tran v. Computer Sciences Corp., 2014 WL 2989948 (D. D. C. July 3, 2014)

A relator filed a *qui tam* action against a prime contractor, a direct subcontractor, and a second-tier subcontractor, alleging that the defendants committed fraud in connection with a contract for information technology work to be performed for the United States Citizenship and Immigration Service. The prime contractor, Computer Sciences Corporation ("CSC") included in its bid for the govern-

ment contract a "Small Business Subcontracting Plan," in which the company represented that, if awarded the contract, a minimum of 40% of the money paid to subcontractors for personnel supplied to perform the work would go to qualified "small business concerns." The relator alleged that if CSC had not included the Small Business Subcontracting Plan in its bid, it would not have been awarded the $200 million task order. The relator further alleged that, rather than comply with its obligation to award certain work to small business, CSC set up a scheme under which it subcontracted work to small businesses such as defendant Sagent Partners ("Sagent"), and as a condition of the subcontract, those small businesses agreed to further subcontract the work to large businesses that CSC trusted, such as defendant Modis, Inc. ("Modis"), in exchange for a small fee. This scheme was called a "pass-through" scheme. The relator alleged that CSC approached his company—a small business subcontractor hired to work on the project—with an offer to participate in the pass-through scheme, but that he refused to allow Modis' employees to replace his own. He claimed that Modis responded by suing his company for breach of a no-compete agreement; in addition, CSC refused to grant the relator's company further work.

The relator alleged FCA fraud claims against all of the defendants, and FCA retaliation claims against CSC and Modis. Each of the defendants separately moved to dismiss the relator's claims.

Holding: The U.S. District Court for the District of Columbia granted Sagent's motion to dismiss in full, and denied in part and granted in part CSC's and Modis' motions to dismiss.

Failure to Plead Fraud with Particularity

First, the court addressed the relator's fraud claims based on allegations that the defendants submitted false claims/made false statements or caused such false claims or statements to be made. As a threshold matter, the court rejected the defendants' argument that the pass-through scheme was legal, based on the language and purpose of the Small Business Act. With respect to the prime contractor, CSC, the court held that the relator adequately alleged a presentment claim based on an implied false certification theory. The court further held that the claim survived Rule 9(b) even though the complaint did not specify the dates on which CSC submitted its invoices to the government; the court held that it was sufficient that the relator alleged the fraud scheme in "substantial detail," including identifying employees involved and describing the mechanics of the scheme. The court applied the same analysis to reject CSC's motion to dismiss the claim alleging that the company made material false statements. The court further concluded that the relator adequately pled a fraudulent inducement claim against CSC.

As to the claims against subcontractors Modis and Sagent, the court noted that those claims were based on the theory that those two defendants caused CSC to sub-

mit false claims to the government. The court explained that to plead this type of claim, the relator must allege that the defendant's conduct was "at least a substantial factor in causing, if not the but-for cause of, submission of false claims," and added that, "in examining whether a non-submitting party has 'caused' the submission of a false claim or statement, a court must look at the degree to which that party was involved in the scheme that results in the actual submission." The court held that the relator stated a claim as to Modis because he alleged that the defendant was "fully aware of, and an active participant in" the scheme. The relator did not, however, state a claim as to Sagent; he alleged far less about this defendant, and nothing concerning Sagent's knowledge of CSC's small business obligations, or the link between those obligations and the pass-through dynamic.

Conspiracy

The court concluded that the relator sufficiently pled a claim for conspiracy to present false claims by CSC and Modis based on the complaint's description of the relationship between those two defendants, including, among other things, allegations of the parties' agreement to develop and maintain the pass-through scheme and allegations of actions taken by both parties in furtherance of that agreement. The court rejected the defendants' argument that the relator failed to allege sufficiently that there was an "actual agreement," stating that "a plaintiff need not allege that an express or formal agreement was entered into in order to establish that the parties were in agreement for purposes of the conspiracy claim."

Retaliation

Finally, the court rejected the relator's retaliation claim, finding that his alleged refusal to participate in the fraud scheme was not "protected activity" under the FCA—and that even if it was, the complaint did not allege facts establishing the requisite causal connection between protected activity and the alleged retaliation he suffered.

U.S. ex rel. Richards v. R&T Invs., LLC, 2014 WL 3055407 (W.D. Pa. July 3, 2014)

A relator filed a *qui tam* action against her former residential landlord, alleging that the defendant submitted false claims to the federal government for rental subsidy payments under the Section 8 Low-Income Housing Choice Voucher Program. The relator claimed that the landlord inappropriately charged her more for rent than was approved by the Government, and charged her for water and sewage services that it was required to pay itself. The Government declined to intervene in the case. The defendant moved to dismiss the relator's first amended complaint, arguing that it failed to state a claim under the False Claims Act and failed to allege fraud with particularity.

Holding: The U.S. District Court for the Western District of Pennsylvania denied the defendant's motion to dismiss.

Failure to State a Claim/Plead Fraud with Particularity

In response to the defendant's Rule 9(b) argument, the court recognized the Third Circuit's recent decision in *U.S. ex rel. Foglia v. Renal Ventures Mgmt*, in which the circuit court held that "a 'more nuanced reading of the heightened pleading requirements of 9(b)' was appropriate, such that 'it is sufficient for a plaintiff to allege particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted.'" Based on that standard, the court held that the relator was not obligated to identify documents actually submitted to the Government; instead, she could proceed under a "false certification theory" of FCA liability—she alleged that each of the defendant's claims for Section 8 funds with respect to her housing was "factually" false because they included the defendant's false representation that it was not receiving additional payments for its rental property and that the relator's lease complied with program requirements; and each claim was "legally" false because compliance with provisions in the housing assistance payment contracts between the defendant and the Government created a "condition of payment" with which the defendants failed to satisfy. The court also rejected the defendant's argument that the relator insufficiently pled scienter, noting that "Federal Rule of Civil Procedure 9(b) provides that scienter may be pled 'generally.'"

Finally, the court rejected the relator's argument that in addition to recovering the government's damages from the defendant, she could recover "actual damages" that she alone suffered—the overpayments she made to the defendant and for water and sewer services. Although the court denied the defendant's motion to dismiss on those grounds, the denial was "without prejudice to further litigation of that issue by the parties based upon their citation to relevant statutory and caselaw in support of their respective positions."

See *U.S. ex rel. Corporate Compliance Assoc. v. N.Y. Soc'y for the Relief of the Ruptured and Crippled, Maintaining the Hosp. for Special Surgery*, 2014 WL 3905742 (S.D.N.Y. Aug. 7, 2014), at page 8.

See *U.S. ex rel. Gage v. S.R. Aviation*, 2014 WL 3007201 (W.D. Tex. July 2, 2014), at page 20.

B. Rule 12(b)(6) Failure to State a Claim upon which Relief can be Granted

U.S. ex rel. Hallman v. Millennium Radiology, Inc., 2014 WL 4908275 (S.D. Ohio Sept. 30, 2014)

The relator was a former employee of defendant Millennium Radiology, Inc. (MRI), the exclusive provider of radiology services to patients at defendant Mercy Hospitals' facilities. The relator alleged that the defendants violated the False Claims Act by entering into an illegal kickback agreement in violation of the Anti-Kickback Statute (AKS) in which MRI provided Mercy with marketing services and a medical director free of charge, in exchange for patient referrals from Mercy. The relator alleged that the defendants falsely certified their compliance with the AKS in their reimbursement claims to the government healthcare programs, rendering those claims false under the False Claims Act. The relator also alleged conspiracy to defraud claim under the FCA. The defendants moved to dismiss the relator's claims for failure to state a claim and failure to plead fraud with particularity.

Holding: The U.S. District Court for the Southern District of Ohio denied the defendants' motion to dismiss.

The court held that because the relator alleged a "far-reaching fraudulent scheme," he was not required to plead each of the defendants' allegedly false submissions to the government or to allege that he had personal knowledge that false claims were submitted. The court explained that reports submitted by MRI supported the relator's allegations, as they included amounts and times that MRI submitted claims to the government. The court rejected Mercy's argument that the relator could not rely on reports submitted by MRI to infer that Mercy also submitted false claims, explaining the 98% of MRI's overall revenue was allegedly received from Mercy. In addition, the relator identified a sample of 19 specific examples of patients whose procedures were performed at Mercy's facilities by MRI physicians, and which were allegedly billed to Medicare by Mercy. The court held that the relator sufficiently pled that the defendants submitted false claims to the government. The court also held that the relator properly pled his false certification theory of FCA liability, because he alleged that under the terms of their provider agreements, the defendants certified that they would comply with all laws and regulations governing Medicare, and he argued that each time the defendants submitted a claim to the government for payment, they falsely certifying compliance with the AKS. In addition, the relator alleged that the cost reports and payment reconciliations the defendants later submitted to the government constituted false claims for FCA purposes. Finally, the court held that the relator sufficiently pled his conspiracy claim, as he described actions taken in furtherance of the conspiracy as well as when the conspiracy occurred. The defendants' motion to dismiss was denied.

U.S. ex rel. Bilotta v. Novartis Pharms. Corp., 2014 WL 4922291 (S.D.N.Y. Sept. 30, 2014)

The relator, a former sales representative for drug manufacturer, Novartis, brought a *qui tam* action alleging that Novartis violated the False Claims Act by submitting Medicaid reimbursement claims for prescriptions that were written in exchange for illegal kickbacks, in violation of the Anti-Kickback statute. Specifically, the relator alleged that the defendant used "sham" educational speaker events—which were actually merely upscale social outings and meals designed—to induce doctors to write more Novartis prescriptions. Doctors who wrote a large amount of Novartis prescriptions were asked to be "speakers" at these events and were paid from $750-$3000 per event. The relator alleged that Novartis's internal analysis showed that these events had a high return on investment, as doctors who attended the events and received additional incentives prescribed additional Novartis prescriptions. The relator asserted that the defendant encouraged its sales representatives to host these events, and compensated the representatives based on the number of prescriptions doctors wrote for Novartis drugs. The relator alleged that by using illegal kickbacks to induce doctors to write prescriptions for its drugs—prescriptions that were filled by pharmacies who then submitted claims for payment to the federal and state healthcare programs—Novartis caused thousands of false claims to be submitted to the government.

The relator also alleged that the defendant violated the FCA by promoting one of its drugs, Valturna, for off-label uses. According to the relator, the defendant trained sales representatives in off-label sales and marketing practices, and used promotional materials that suggested an off-label, non-approved use. The relator claimed that Novartis' off-label promotion caused the doctors to prescribe Valturna for non-approved—and thus, not "medically necessary" and not reimbursable—uses, and caused doctors who prescribed the drug for off-label uses to falsely certify to the government that they were only billing for medically necessary services. The relator again noted that this certification was required as a precondition of payment under the healthcare programs.

The defendant had been accused of engaging in this scheme in the past, and entered into a settlement agreement with the government to resolve associated fraud claims. The settlement agreement required the defendant to create a compliance plan to address the sales representative compensation issue. However, the relator alleged that the defendant continued its unlawful practices, which led to the submission of additional false healthcare claims that were not included in the settlement agreement. The United States and the State of New York intervened in the relator's *qui tam* suit with respect to the kickback claims. The defendant moved to dismiss those claims for failure to state a claim under Rule 12(b)(6) and for failure to plead fraud with particularity as required by Rule 9(b). The defendant also

moved to dismiss the relator's kickback claims, arguing that since the government intervened in those claims, the relator no longer had standing to pursue them. Finally, the defendant moved to dismiss the relator's non-intervened claims that the defendant's off-label marketing practices caused providers to falsely certify their compliance with applicable regulations.

Holding: The U.S. District Court for the District of New York denied the defendant's motion to dismiss the fraud claims stemming from the kickback scheme, but granted the motion to dismiss the off-label claims.

Failure to State a Claim/Plead Fraud with Particularity

As an initial matter, the court held that because the relator's kickback claims under the FCA had already been superseded by the government's intervention, there is "nothing to dismiss." The court denied the defendant's motion to dismiss those claims as moot. The court then held that the plaintiffs sufficiently pled their kickback allegations, explaining that they alleged the "sham" speaker event scheme in detail and provided specific examples of events, as well as specific doctors who were repeat speakers or attendees. The court explained that because the plaintiffs alleged a "complex and far-reaching scheme" they were not required to plead the details of all of the events, employees, or doctors involved, but only representative samples. The court also held that the plaintiffs sufficiently plead the defendant's scienter related to the AKS violations, noting that the defendant's internal ethics and compliance policies, as well as industry-wide standards, prohibited kickbacks and outlined requirements for interactions with doctors; the relator claimed that despite this knowledge the defendant did not enforce the proper standards and actually encouraged its sales staff to disregard them.

The court rejected the defendant's argument that the plaintiffs did not sufficiently link the alleged false claims to AKS violations. Instead, the court explained that the plaintiffs presented hundreds of pages of records listing particular alleged false claims. These records contained the name of the prescribing doctor, the name of the drug and National Drug Code, the government program to which the claim was submitted, the date the prescription was filled, the name and identification number of the pharmacy that filled it, the cost of the prescription, and the date the claim was processed and paid by the government. The plaintiffs specifically alleged that each of these claims was false because it was the result of a prescription induced by remuneration through the sham events. The plaintiffs also detailed the process by which the doctors wrote the prescriptions and how they were submitted to pharmacies, how the prescriptions were filled, and how the claims were submitted and reimbursed. The court explained that it was not necessary at the pleading stage for the plaintiffs to "demonstrate with precision that every prescription written by every doctor was written in exchange for a kickback." The court rejected the defendant's argument that it was impossible for it to determine which claims and doctors were at issue based on the plaintiffs' pleadings, explaining that the specific false claims the plaintiffs pled, combined with the detailed allegations

concerning the sham events were sufficient to put the defendant on notice of the allegations against them. The court also held that the examples of false claims that plaintiffs furnished to the court were sufficiently representative of the large fraud scheme.

The court also rejected the defendant's argument that the plaintiffs' claims failed because they did not sufficiently link the alleged false claims with the announced topic of a sham speaker event, since they did not establish a correlation between the drug discussed at a particular event and an uptick in prescriptions for that drug. The court explained that the plaintiffs alleged that the topic of the event was "largely irrelevant," as there was very little substantive discussion about the drugs at these sham events; rather, the purpose of the events, the plaintiffs alleged, was to induce the doctors in attendance to write more Novartis prescriptions generally. The court also held that for the same reasons given in connection with the underlying AKS violations, the plaintiffs adequately pled that the defendant had actual knowledge or acted with reckless disregard that its kickbacks caused false claims to be submitted to the government.

The defendant argued for the dismissal of all the plaintiffs' kickback claims based on fraud allegations that preceded the passage of the Patient Protection and Affordable Care Act (PPACA), which amended the AKS. According to the defendant, prior to the PPACA amendments to the AKS, a violation of the AKS was not a *per se* violation of the FCA, and thus, could not serve as the basis for FCA liability. The court held that with respect to this subset of claims, the plaintiffs sufficiently pled falsity based on an implied certification theory of liability. The court determined that the statutes, rules, and regulations governing Medicaid indicated that compliance with the AKS was a condition of payment of claims. The court further explained that the plaintiffs sufficiently alleged that the claims at issue stemmed from prescriptions written by doctors in exchange for illegal kickbacks, and that the defendant knew that the claims would subsequently be submitted to the government. In addition, the court held that the plaintiffs' allegations that the doctors falsely certified that they were in compliance with the contractual provisions of their Medicaid enrollment obligations—which were undoubtedly conditions of payment—were properly pled. Consequently, the court denied the defendant's motion to dismiss the fraud claims based on the defendant's alleged kickback scheme.

The court then turned to the relator's claims based on the defendant's alleged off-label marketing. The court explained that, consistent with other courts in the Second Circuit, it had rejected the reasoning put forth by some circuits that a relaxed pleading standard should apply when the information required to plead actual false claims with particularity resides solely with the defendant. Instead, the court held that in order to satisfy Rule 9(b), plaintiffs must plead the particulars of the false claims themselves and cannot merely allege details of an underlying fraud scheme. The court held that the relator failed to identify any particular false claims submitted, and granted the defendant's motion to dismiss these claims.

U.S. ex rel. Powell v. Am. Intercontinental Univ., Inc., 2014 WL 4829206 (N.D. Ga. Sept. 29, 2014)

The relators, former employees of American Intercontinental University (AIU), brought a *qui tam* action against the defendants, AIU and its parent company, Career Education Corp. (CEC). The relators alleged that the defendants violated the False Claims Act by falsely certifying to the government that AIU was properly accredited and in compliance with accreditation standards, enabling the defendants to improperly receive federal funds through student financial aid programs. The relators alleged that the accrediting association that evaluated AIU, the Southern Association of Colleges and Schools (SACS), investigated AIU and found that recruiters and admissions personnel were compensated and promoted based on enrollment numbers, in violation of SACS' standards and "Principles of Integrity." The relators further alleged that the defendants falsely represented to SACS that they changed their compensation plans and recruitment procedures several times in order to comply with SACS' principles. Specifically, the relators alleged that the defendants represented to SACS that, as a way to move away from a sales-driven enrollment strategy, they were implementing a questionnaire (the IDM tool) to gauge prospective students' interest, desire, and motivation in attending AIU. However, the relators claimed that the defendants quickly abandoned the use of the IDM tool in favor of their prior practices. In addition, the relators alleged that AIU did not maintain the required number of faculty with terminal degrees in their fields—25%—necessary to satisfy SACS guidelines. According to the relators, although the defendants knew that AIU was not in compliance, they submitted documentation to the Department of Education (DOE) representing that the university was in compliance with all DOE and SACS requirements, so that AIU would remain eligible to receive federal funds. The defendants moved for summary judgment on the relators' fraud claims.

Holding: The U.S. District Court for the Northern District of Georgia granted the defendants' motion for summary judgment.

The court held that the relators' allegations related to the defendants' improper enrollment strategies, their discontinued use of the IDM tool, and their misrepresentations to SACS regarding their enrollment practices, were insufficient, finding that the relators failed to show that SACS would have revoked AIU's accreditation based on any of the alleged false statements. The court explained that the relators presented no evidence that the alleged misrepresentations were material to SACS's accreditation decisions. The court rejected as conclusory both of the relators' expert opinions stating that the fraud related to the IDM was material. The court further explained that the relators failed to present evidence to prove their claims regarding the requirement that AIU maintain a sufficient number of terminally-degreed faculty. The relators' only evidence that the university did not

meet the 25% guideline were various assertions regarding the school "renting" terminally-degreed faculty during SACS visits. The court explained that the relators gave no basis for calculating whether the alleged practice resulted in AIU meeting the 25% standard, nor did they present any evidence that the defendants made misrepresentations to SACS about the alleged deficiencies. Further, the relators did not present any evidence that this percentage was material to AIU's accreditation decision. The motion for summary judgment was granted.

U.S. ex rel. Martin v. Life Care Ctrs. Of Am., Inc., Case Nos. 1:08-cv-251; 1:12-cv-64 (E.D. Tenn. Sept. 29, 2014)

The relators, former employees of a healthcare company, brought separate *qui tam* actions against their former employer, alleging that the defendant violated the False Claims Act by overbilling the government for services rendered at its skilled nursing facilities. The government intervened in the relators' cases and consolidated them. The plaintiffs alleged that the defendant billed Medicare for unnecessary and medically unreasonable treatment, specifically, that it provided improper treatment to patients to increase the amount it billed the government for, and that it billed the government for patients that should have been discharged. The plaintiffs alleged that the defendant engaged in a large-scale fraud scheme in which it knowingly billed for unnecessary, unreasonable, and unskilled services in order to increase its reimbursements from government healthcare programs. The defendant moved for partial summary judgment with respect to the plaintiffs' use of statistical sampling as a means of extrapolating the total number of false claims they alleged were submitted to the government, and as a way of calculating the total amount of overpayments the defendant received from the government.

Holding: The U.S. District Court for the Eastern District of Tennessee denied the defendant's motion for partial summary judgment.

The defendant argued that the plaintiffs could not meet their burden of proof with evidence based on statistical sampling, as they could not show individualized proof of specific claims for payment. The court rejected this argument, explaining that it was possible for the plaintiffs to specify in detail each specific claim, but that doing so would require an impracticable amount of time and resources for all of the parties involved, including the court.

In addition the court rejected the defendant's argument that the plaintiffs could not prove the falsity of its claims through statistical sampling, because the determination of whether a treatment is medically necessary requires an "individual assessment of the patient's clinical condition." The court held that this did not preclude the use of statistical sampling, which has been "used in litigation for decades," and that given the large number of claims at issue, the statistical sample was a valid representative of the universe of claims. The court also rejected the

defendant's argument that the plaintiffs could not satisfy the knowledge requirement of the FCA because the statute requires the plaintiffs to show a particular employee acted with the requisite scienter, and a statistical sample only shows "collective knowledge." The court explained that the plaintiffs would rely on other evidence to establish the defendant's scienter.

The court then turned to the question of whether the plaintiffs could prove the materiality element of a FCA claim through statistical sampling, stating that the focus should be on the potential effect of the false statement when it was made, not the actual effect. Ultimately, the court held that the question of whether the alleged false statements at issue were material to the government would be an issue left to the fact-finder. The court further held that the use of statistical sampling did not violate the defendant's due process rights, as the defendant would still have the opportunity to challenge the plaintiffs' expert and evidence at trial.

Finally, the court held that statistical sampling was appropriate in this case because a claim-by-claim review was impractical. The court noted that if Congress had intended to preclude statistical sampling in FCA cases, then it would have done so in the several recent amendments to the FCA, as statistical sampling has been disputed in FCA cases since 1993. The court further noted that—particularly in the current environment of large scale health care fraud—if statistical sampling were precluded and a claim-by-claim review were required in every FCA action, then perpetrators of fraud would be emboldened to submit more and more false claims, as doing so would decrease the threat of prosecution.

The defendant's partial summary judgment motion challenging the plaintiffs' use of statistical sampling was denied.

U.S. ex rel. Ligai v. ETS-Lindgren Inc., 2014 WL 4649885 (S.D. Tex. Sept. 16, 2014)

Relators, Slav and Tatiana Ligai, brought a *qui tam* action against their former employer, ETS-Lindgren, and its parent company, alleging the defendants violated the False Claims Act by submitting claims for payment for improperly conducted calibration tests and equipment adjustments under contracts with the federal government. ETS was a technology company specializing in electromagnetic energy systems and the relators worked for ETS in various laboratories. The relators alleged that ETS falsely certified compliance with industry standards and specifications related to several types of equipment sold to the government, and falsely certified compliance with certain accreditation standards required by the government under ETS's contract; the relators asserted that ETS certified that it had properly calibrated and tested equipment that it sold to the government when it had not done so. The relators also alleged that each of the payments the defendants received from the government was an overpayment, and that the failure to return

the money to the U.S. resulted in liability under the "reverse" false claims theory.

The relators also alleged that they were terminated as a result of Slav Ligai's whistleblowing activities. They claimed that Slav often informed his supervisors about calibration problems and errors, but was ignored. He also reported his concerns to the Federal Bureau of Investigation, a U.S. Attorney General, and the American Association for Laboratory Accreditation, which audited ETS and reportedly found violations, but did not revoke ETS's accreditation. Tatiana was fired over a year and a half after the audit, and Slav was fired almost another year later, both allegedly in retaliation for Slav's whistleblowing activities. The U.S. did not intervene, and the defendants each moved to dismiss the claims on Rule 9(b) and Rule 12(b)(6) grounds.

Holding: The U.S. District Court for the Southern District of Texas granted ETS's motion to dismiss; the fraud claims against that defendant were dismissed with prejudice but the retaliation claim was dismissed without prejudice and with leave to amend. All claims against ETS's parent company were dismissed with prejudice, as the court held that the parent-subsidiary relationship was insufficient to maintain claims against that defendant, and the relators did not present any evidence on which to pierce the corporate veil.

False Certification of Compliance

The court held that the relators' false certification claims failed because the relators did not allege that payment was conditioned on certifying compliance with the calibration standards cited, nor did they cite any statute or contract provision requiring such a certification as a precondition of payment. The court also rejected the relators' argument that ETS's adherence to the accreditation standards required by the government contracts was a condition of payment, and that ETS's failure to meet those standards made the payment claims fraudulent under the FCA. The court held that the accreditation was simply a condition of participation in the government contract, not a condition of payment, and therefore was insufficient to create FCA liability. Thus, the relators' claims based on a false certification theory of FCA liability were dismissed.

"Reverse" False Claims

The court also rejected the relators' argument that the defendants received payments from the government through fraud and then knowingly retained those payments, in violations of the FCA's "reverse" false claims provision. The relators asserted that the defendants knew of the calibration errors but did not notify the government and continued to deliver faulty equipment under the contracts. The court held that the relators failed to allege that any false record was made for the purpose of concealing an obligation to pay money and that they did not demonstrate that the defendants knowingly concealed overpayments. The evidence that the relators provided relating

to inquiries by the government about the accuracy of the calibrations, and a technical bulletin showing improvements made to calibration instruments in response to those inquiries, may support a claim for breach of contract, the court explained, but not for "reverse" false claims. In granting the defendants' motion to dismiss, the court concluded that the relators "merely recast[ ]" their false statement claim as a "reverse" false claims allegation.

Failure to Plead Fraud with Particularity

The court explained that the relators failed to point to any contract provision or other document or statute requiring certification of accurate calibration as a condition of payment, even though they provided many documents to the court, including service orders, purchase orders, and invoices. The court rejected the relators' argument that they were entitled to a relaxed pleading standard under Rule 9(b), because they did not have the necessary documents—including ETS government contracts—to plead with sufficient particularity, as that information was held solely by the defendants. The court explained that because the U.S. government was also in possession of the information needed to plead the relators' claims, the relaxed pleading requirement was inappropriate.

Retaliation

The court held that the relators did not adequately allege that they were engaged in "protected activity" under the FCA or that the defendants were put on notice of any such conduct by the relators. While the court acknowledged Slav Ligai's allegation that he complained about the calibration errors to management and to the government, it held that the assertions were insufficient to state an FCA retaliation claim because he never complained about fraudulent claims or possible FCA liability, but only to "standard violations and technical issues." The court further noted that the relators did not allege that the defendants knew about Slav's contact with the FBI or the accreditation agency. In their opposition to the defendants' motions to dismiss, the relators attached a 2011 email conversation between Slav and his supervisor and a team of employees at ETS, which the relators alleged supported their allegation that Slav complained about "fraud." In the emails, Slav complained about the calibration errors and discussed a "technical fraud" and reporting the issues to upper management. In response, a senior vice president chastised Slav for his method of communication and his "inflammatory" assertions of fraud. The court, however, would not allow the relators to supplement their complaint with this additional information, and thus dismissed their retaliation claims without prejudice and with leave to amend. However, the court cautioned the relators that the temporal gap between the email in 2011 and the relators' respective termination dates—Tatiana's in 2012, and Slav's in 2013—might be too long to establish causation for FCA retaliation purposes.

U.S. ex rel. Cannon v. Rescare, Inc., 2014 WL 4638715 (E.D. Pa. Sept. 16, 2014)

The relator brought a *qui tam* action against defendant, Rescare, Inc. and its subsidiary—which formerly employed the relator, alleging violations of the False Claims Act. The defendants contracted with the Philadelphia Workforce Development Cooperation to provide employment placement and training for individuals who received government assistance under the federal Temporary Assistance to Needy Families (TANF) program and the Supplemental Nutrition Assistance Program (SNAP). The TANF and state funds the defendants received were based on the number of people they placed in a job and trained. The relator alleged that the defendants inflated and falsified their employment and participation rates and improperly placed unqualified and unemployable people in jobs and job readiness classes in order to receive additional funds. The relator alleged that he complained to his supervisors and threatened to inform the government of the allegedly fraudulent activity, and was terminated from his job soon after. He claimed that his termination was in retaliation for his whistleblowing activity, and violated the FCA's anti-retaliation provision. The defendants moved to dismiss the relator's fraud and retaliation claims for failure to state and claim.

After two failed attempts to sufficiently plead his case, the relator filed a second amended complaint that alleged his causes of action under the FCA's amended, post-FERA fraud and retaliation provisions.

Holding: The U.S. District Court for the Eastern District of Pennsylvania dismissed the relator's claims with prejudice. The court acknowledged that as a result of the FERA amendments, the relator was no longer required to establish the defendant's intent to defraud the government, and denied the defendants' motion to dismiss on that basis. The court also rejected the defendants' argument that the *ex post facto* principle should bar the retroactive application of the FERA amendments to the FCA, because the FCA was a civil law that was not punitive—but rather, remedial—in nature. Ultimately, though, the court granted the defendants' motion to dismiss, agreeing that the relator failed to state a claim. The court determined that the relator only alleged that Pennsylvania state government officials submitted the defendants' fraudulent financial information to the U.S. government, but not that the defendants themselves presented false claims or caused false claims to be submitted to the government. Thus, the court held, the relator did not adequately plead the "presentment" element of FCA liability. The court explained that the relator's allegations were dismissed with prejudice, as the relator was unable to plead properly in three attempts.

U.S. ex rel. Todd v. Fidelity Nat'l Fin., Inc., 2014 WL 4636394 (D. Colo. Sept. 16, 2014)

The relator was a former employee of two of the defendants, First American and Service Link—companies that provided title insurance and other services to Freddie Mac. The relator alleged that these two companies, as well as three other defendants, violated the False Claims Act by omitting required title information from title commitments and then submitting fraudulent claims for payments to Freddie Mac. According to the relator, he reported the issues to his supervisors but no action was taken, and he was subsequently demoted and eventually terminated as a result of his whistleblowing activities. As a result, the relator brought claims under both the FCA's fraud and retaliation provisions. The defendants moved to dismiss the relator's claims for failure to state a claim. The U.S. District Court for the District of Colorado referred the matter to a magistrate judge, who issued a report and recommendation that the defendants' motion to dismiss the fraud claim be granted, but that the motion be denied with respect to the retaliation claim.

Holding: The Colorado district court accepted the magistrate's recommendation and dismissed the relator's fraud claims, holding that since Freddie Mac was not a government entity or agent, the fraud allegations did not give rise to FCA liability. The court also accepted the magistrate's recommendation that the retaliation claim proceed.

The court held that although Freddie Mac was created by Congress in an attempt to stabilize the market for residential mortgages, and although the entity received the bulk of its funding from the government, Freddie Mac remained a private corporation over which the government did not exercise control. The court explained that the relator had not alleged the "requisite nexus between Freddie Mac's payments to the defendants and an economic loss or possibility of an economic loss suffered by the federal government." As to the merits of the relator's fraud allegations, the court rejected the relator's argument that the defendants' failure to conduct a search that would identify all possible defects resulted in substandard insurance policies, and thus, the defendants' requests for payment for these policies constituted false claims. The court explained that there was no requirement in any contract or under the law that the defendants perform more than a "reasonably detailed" title search. The relator's claims failed, the court explained, because he did not demonstrate any objectively reasonable standard by which to determine how detailed the searches were required to be. The court also rejected the relator's "worthless services" argument, explaining that Freddie Mac received the policies that it contracted for; moreover, by contract Freddie Mac assumed the risk of any defects the title searches failed to detect. Thus, the court granted the defendants' motion to dismiss the relator's fraud claims.

The court denied the defendants' motion to dismiss the retaliation claims however, finding that the relator had properly alleged that he was engaged in "protected activity" under the FCA and was terminated in response. The realtor alleged that he brought his concerns regarding the insufficient title searches to the attention of his superiors several times without response, before finally informing his chief compliance officer that he would take his concerns to the chairman of the board if they were not addressed. This prompted a meeting at headquarters in which the relator explained that he believed the company was defrauding the government. Over the next few months, the relator was ostracized, demoted, had his pay reduced, and eventually had his salary eliminated altogether. The court held that these allegations showed that the relator was engaged in protected activity, that the defendants know of the activity, and that the relator was retaliated against in response. Since all of the elements of an FCA retaliation claim had been properly pled, the court denied the defendants' motion to dismiss that claim.

U.S. ex rel. Grupp v. DHL Express, Inc., 2014 WL 4542465 (W.D.N.Y. Sept. 11, 2014)

The two relators were the owners of a trucking company that the defendants, shipping company DHL, as well as one of its affiliates, hired to transport packages, some of which were shipped on behalf of the government. In a non-intervened *qui tam* action, the relators alleged that the defendants violated the False Claims Act by knowingly falsely representing to the government that next day and 2nd day shipments were transported by air when they actually traveled by ground transportation; the defendants were also accused of improperly imposing jet fuel surcharges on those shipments, as well as applying unnecessary diesel fuel surcharges on ground delivery shipments. The U.S. District Court for the Western District of New York initially granted the defendants' motion to dismiss based on their argument that the relators' allegations failed to satisfy a statutory notice requirement that mandated that bills be contested within 180 days of receipt. The relators appealed to the Second Circuit, which held that the statutory rule did not apply to *qui tam* actions under the FCA. The circuit court remanded the matter to the district court, with instructions to address the defendants' motion to dismiss for failure to state a claim under the FCA, as well as their argument that the FCA's statute of limitations barred some of the relators' claims.

Holding: The district court granted the defendants' motion to dismiss for failure to state a claim under Rule 12(b)(6) and Rule 9(b), but denied the motion as to the statute of limitations.

First, the court explained that the defendants' representative waybills that the relators proffered as proof of the alleged improper billing actually showed that the defendants "expressly advise[d]" customers that they reserved the right to trans-

port next day and 2nd day shipments by any means of transportation. In addition, the defendants' rate guide stated that a jet fuel surcharge was imposed on all "Air Express" shipments, which while not explicitly defined, the court explained could be reasonably read to include next day and 2nd day shipments. The court held that while the relators interpreted the term "Air Express" to refer to a mode of transportation rather than a category of service, the relators' allegations based on alternate interpretations of the documents did not meet Rule 9(b)'s pleading requirements. The court explained that the relators' "allegation of contract ambiguity, without more" was not sufficient to allege a claim under the FCA. The relators' claims were dismissed with prejudice.

With respect to the defendants' statute of limitations argument, the court held that, the relators' amended complaint related back to the date of their original *qui tam* complaint—which was filed under seal within the limitations period. Thus, the court denied the defendants' motion to dismiss on statute of limitations grounds.

U.S. ex rel. Bates v. Dentsply Int'l, Inc., 2014 WL 4384503 (E.D. Pa. Sept. 4, 2014)

The relators were former and current employees for the defendant, the largest developer and manufacturer of professional dental products in the world. The relators alleged that the defendant violated the False Claims Act under an implied certification theory. According to the relators, the defendant violated the Anti-Kickback Statute by creating an array of kickback schemes to induce healthcare providers to buy and use its products. As a result, of the kickback scheme, the relators contended, the providers' healthcare claims to the government contained false certifications of compliance with the AKS, and therefore, were false under the FCA. The relators alleged detailed accounts of cash payments, free travel, free equipment, and other benefits given to dentists in exchange for the purchase of the defendant's products. The relators also alleged claims under the FCA for conspiracy and retaliation. The defendant moved to dismiss all of the relators' claims for failure to state a claim.

Holding: The U.S. District Court for the Eastern District of Pennsylvania denied the defendant's motion to dismiss the fraud claims, but granted the defendant's motion to dismiss the conspiracy and retaliation claims.

The court rejected the defendant's argument that the relators' use of the words "upon information and belief" in the complaint rendered it insufficient to assert that false claims were actually submitted to the government, because the relators provided in-depth allegations setting forth particular details of the schemes and supported their allegations with evidence that would allow the court to draw strong inferences that the claims were actually submitted. In addition, the court

held that the relators were able to avail themselves of the more relaxed pleading standard under Rule 9(b) for information that is "peculiarly within the defendant's control." The court also held that while the dental providers are ultimately responsible for filing claims for reimbursement with the government, the relators properly pled that the defendant was subject to FCA liability for "causing" false claims to be submitted to the government. The court further held that the relators adequately pled that the falsity of the claims was material to the government's decision to reimburse the healthcare providers, explaining that certifying compliance with a federal statute would have the potential to influence the government's decision. The court held that because the relators alleged that the defendant knew that the healthcare providers participated in government healthcare programs, by offering incentives to them, the defendants knew that they were causing the providers to falsely certify compliance with the AKS. The defendant's motion to dismiss the relators' fraud claims was denied.

The court granted the defendant's motion to dismiss the conspiracy claims, however, explaining that the relators failed to identify any co-conspirators. In addition, the court granted the defendant's motion to dismiss the relators' retaliation claims. The court explained that while the relators reported their concerns to management, they never used the terms "illegal," "unlawful," or "*qui tam* action," and never informed anyone that they intended to contact the government. Thus, they did not put the defendant on notice of any protected activity under the FCA.

U.S. ex rel. Parikh v. Citizens Med. Ctr., 2014 WL 4364875 (S.D. Tex. Sept. 3, 2014)

The relators were former cardiologists at the defendant, Citizens Medical Center (CMC). The U.S. Court for the Southern District of Texas previously ruled on multiple challenges to the sufficiency of the relators' allegations that the defendant violated the False Claims Act by paying bonuses to emergency room physicians in exchange for referrals of Medicare and Medicaid patients. The court dismissed some claims but allowed most to proceed past the pleading stage. This dispute was before the court to determine the sufficiency of affirmative defenses that CMC asserted. The court determined that it was appropriate to use the traditional pleading standard under Rule 12(f) for affirmative defenses rather than the heightened standard under Rule(b)(6). The Rule 12(f) standard merely required that the defendant's affirmative defenses contain "enough specificity or factual particularity to give the plaintiff 'fair notice' of the defense that is being advanced."

The court declined to strike the defendant's statute of limitations defense. The court found that the defendant provided sufficient notice of this defense, and the court declined to rule on the relators' argument that the Wartime Suspension of Limitations Act tolled the limitations period, noting that the Supreme Court would be deciding the applicability of that statute in its upcoming term. In ad-

ditional the court declined to strike the defendant's argument that the relators' claims for damages were barred because the government did not suffer any actual damages. The court explained that this defense was simply the defendant's method of stating that if the relators do not prove that any false claims were submitted, then their case fails. The defendant also pled that any award of damages above the amount of actual damages would be unconstitutional. The court recognized that this was an attempt to preserve a constitutional challenge in the event that the outcome of the case warranted the argument later, and therefore, declined to strike the defense. The court also declined to strike the defendant's public disclosure bar defense, in the event that the "jurisdictional pre-2010 public disclosure bar applies." The court held that even if the bar is no longer jurisdictional, the defendant provided fair notice of the defense being asserted. The court also declined to strike the defendant's first-to-file defense. While the court found it "unlikely" that a prior related suit existed that had not yet been identified, it reasoned that the defense should not be struck because the defendant gave sufficient notice of the defense. In addition, the court declined to strike the defendant's argument that the relators' claims were barred by the doctrine of primary jurisdiction and should have been litigated under Medicare regulations in an administrative proceeding. The court explained that while this doctrine is rarely applicable to FCA cases, it is "possible" that it could apply. Finally, the court declined to strike the defendant's safe harbor affirmative defenses under the fair notice standard.

The court did strike the defendant ratification, waiver, and consent affirmative defenses, however, holding that those defenses were improper because "estoppel against the government is impermissible" under Fifth Circuit precedent.

U.S. ex rel. Buth v. Pharmerica Corp., 2014 WL 4355342 (E.D. Wis. Sept. 3, 2014)

The relator, a former employee for the defendant—a long-term care pharmacy that dispenses drugs to residents of nursing homes and other facilities—brought a *qui tam* action alleging that the defendant submitted false claims to Medicare. The United States intervened. Because the defendant was a subcontractor provider for Medicare Part D plan sponsors, it was required to comply with all applicable laws, regulations, Medicare instructions, and regulations defining the requirements of a valid prescription. In addition, the defendant was required to certify the accuracy and completeness of all data related to claims for payment. When the defendant dispensed drugs as a Part D sponsor, it was required to notify the Centers for Medicare and Medicaid Services (CMS) that a drug had been purchased and dispensed through a document called a Prescription Drug Event (PDE) record. According to the plaintiffs, payment to the defendant was conditioned on the accuracy of the data contained in the PDEs.

The plaintiffs alleged that the defendant violated the False Claims Act by submitting claims to Medicare for controlled narcotic substances that were not eligible for reimbursement because they were dispensed without valid prescriptions. Specifically, the plaintiffs alleged that the defendant would dispense drugs to long-term care facilities upon the request of the facilities' staff rather than the treating physicians, thereby exercising their own judgment as to the quantity of drugs to dispense. The plaintiffs alleged that over a period of eight months the defendant dispensed controlled substances without a valid prescription at least 4285 times. The plaintiffs alleged that the defendant made or caused to be made false and inaccurate PDEs with respect to those controlled substances. The plaintiffs alleged that the defendant caused Part D sponsors to submit false claims that were material to the payment of claims to be submitted at least 250 times, and that it was on notice that its practice for dispensing narcotics failed to comply with the law because it had been audited by government agents. The defendant moved to dismiss for failure to state a claim and failure to plead fraud with particularity.

Holding: The U.S. District Court for the Eastern District of Wisconsin denied the defendant's motion to dismiss. The court held that the plaintiffs properly pled that the defendant's claims were factually false because they contained inaccurate descriptions what was provided. The court also held that the plaintiffs sufficiently pled a false certification theory of liability, because the PDEs required an express certification regarding their accuracy, and all contracts between Part D sponsors and subcontractors contained assurances that the parties would comply with federal laws, regulations, and CMS instructions.

The court explained that the plaintiffs sufficiently pled that the defendant knowingly caused false claims to be submitted, as the defendant was put on notice several times that it was not in compliance with the law, including several investigations and audits by government agents who advised them of such. The court rejected the defendant's argument that there was no loss to the government, relying on the plaintiffs' allegations of a reconciliation methodology employed by the government based on actual costs submitted by the plan sponsors. The court held that by pleading this reliance on actual costs, the plaintiffs satisfied the requirement that the false statement be material to the claim being paid. The court also held that the plaintiffs pled their claims with the requisite particularity under Rule 9(b). The plaintiffs alleged a specific number of times drugs were dispensed by the defendant without a proper prescription. The plaintiffs also offered three occasions involving a specific patient, for whom the defendant allegedly dispensed a drug without a written prescription and received a payment; the plan sponsor submitted the false PDE to CMS; and CMS paid the claim. The plaintiffs also detailed the process for payment under the Part D plan at length. Consequently, the court held the plaintiffs identified the "who, what, where, what, and how," of the alleged fraud and denied the defendant's motion to dismiss on that basis.

U.S. ex rel. Folliard v. Gov't Acquisitions, Inc., 2014 WL 4251150 (D.C. Cir. Aug. 29, 2014)

The appellant/relator brought a *qui tam* suit under the False Claims Act alleging that the products that the appellee sold to the federal government did not originate from a "designated country" as required by the Trade Agreements Act (TAA), despite the appellee's certification that the products complied with the TAA. Therefore, the appellee made false statements and presented false claims to the government for payment when it certified that the products complied with the TAA. The appellee was a provider of IT support to the public sector and a recipient of a General Services Administration schedule contract ("GSA contract"). All products sold pursuant to a GSA contract were required to comply with the TAA. The appellee contended that it relied on express certifications from its third party distributor regarding the country of origin. The appellant claimed that the appellee acted in reckless disregard of the truth, because its purported reliance on the third party's certification was not reasonable. The appellant sought additional discovery under Rule 56(d) in order to support his allegations. The U.S. District Court for the District of Columbia denied the majority of the appellant's discovery requests, holding that appellant failed to specify what additional information he expected to garner from the additional discovery, and noting that the requests were "inappropriately vague." However, the district court granted one Rule 56(d) request related to discovery focused on the appellee's reliance on the certification by the third party provider.

After that discovery was allowed to take place, the district court considered and rejected the appellant's arguments that the appellee's reliance on the third party's certification met a "gross negligence-plus" standard of reckless disregard. The district court granted summary judgment on the merits to the appellee, holding that the appellee's reliance on the third party's certification was not negligent, and denied the appellant's additional discovery requests. The relator appealed the district court's rulings to the U.S. Court of Appeals for the District of Columbia Circuit.

Holding: The D.C. Circuit affirmed the district court's decision, concluding that the appellee reasonably relied on its third party supplier's certification of compliance with the TAA.

On appeal, the D.C. Circuit rejected the appellant's contention that he was entitled to discovery related to sales by the appellee that were not specifically identified in his complaint, because the sales identified in his complaint were "representative" of other "yet-discovered" transactions. The circuit court explained that the appellant failed to allege this in his complaint. The circuit court also affirmed the district court's ruling as to the lack of foundation for the additional discovery requests. Finally, the circuit court also affirmed the district court's grant of summary judgment, holding that the appellee's reliance on the third party was reasonable.

U.S. v. Americus Mortgage Corp., 2014 WL 4274279; 2014 WL 4273884 (S.D. Tex. Aug. 29, 2014)

The Government alleged that the defendants, Americus Mortgage Corporation (formerly known as "Allied Capital"), Allquest Home Mortgage Corporation (formerly known as "Allied Corp"), Jim Hodge (founder, President, and CEO of Allied Capital and Allied Corp), and Jeanne Stell (Executive Vice President and Director of Compliance for Allied Capital and Allied Corp), violated the False Claims Act by making false statements in loan applications and related documents to procure home mortgage insurance from the U.S. Department of Housing and Urban Development ("HUD"). HUD insured lenders such as the defendants against losses on loans made to homebuyers through the Federal Housing Administration ("FHA"). In order to obtain approval to originate loans, a lender had to submit a form containing basic information and certifying that it met HUD requirements and regulations. Thereafter, the loan correspondent received a "HUD ID" to operate a particular branch office. Lenders were required to make annual certifications as to their compliance with HUD and FHA regulations and to implement a quality-control program to monitor loans.

First, the Government alleged that the defendants made misrepresentations in their loan application packages to secure insurance on individual loans by routinely entering the HUD ID numbers of approved branches into the loan documentation for loans originating from branches that were not disclosed to HUD (so-called "shadow branches"). HUD relied on these false statements and endorsed the loans. Second, the Government alleged that the defendants required each branch manager to assume the operating costs for the branch in violation of HUD policy and despite certifying to HUD that the defendants assumed the costs for each new branch office. Third, the Government alleged that the defendants misrepresented in their annual certifications that the defendants were not subject to state sanctions, did not employ felons, and maintained the requisite quality-control program. Finally, the Government alleged that the defendants failed to implement a quality-control program as required, and falsified quality-control reports that were then submitted to HUD. The defendants moved to dismiss the Government's FCA claims for failure to state a claim under Rule 12(b)(6) and failure to plead fraud with particularity under Rule 9(b).

Holding: The U.S. District Court for the Southern District of Texas held that the Government sufficiently pled allegations of FCA liability under the false certification and fraudulent inducement theories, and in accordance with both Rule 12(b)(6) and Rule 9(b).

False Certifications of Compliance

The court held that the Government satisfied the pleading requirements, because it specifically identified instances in which the defendants "falsely certified, on a loan-by-loan basis, that [they] complied with HUD rules and requirements, and that the mortgages [they] endorsed were eligible for FHA insurance under HUD rules," causing HUD to insure loans that were not eligible for FHA insurance. The Government also alleged that these false submissions were made knowingly.

Fraudulent Inducement

The court also held that the government properly pled that false statements made by the defendants caused the Government to provide FHA insurance, and thereby obligated the Government to pay insurance claims on defaulted mortgages that it would not have otherwise paid.

Scienter

The court held that the Government pled facts sufficient to establish the defendants' scienter. The Government alleged that the defendants submitted the certifications "knowingly or…with deliberate ignorance and/or with reckless disregard for the truth." The Government additionally alleged that the "motive" behind the defendants' disregarding the quality-control requirements was "to maximize…profit at the expense of ensuring the quality of the loans being insured by the HUD/FHA program." The Government included details, including instances of employees directed to disregard quality-control measures and employees being instructed to "make it appear" as if the defendants had complied with quality-control measures. The court rejected the defendants' argument that the Government's allegations failed because HUD had knowledge of the defendants' violations. The court held that while HUD became aware of a limited number of "shadow branches" using duplicative HUD ID numbers, HUD believed that was a localized incident.

Materiality and Causation

The court held that the Government sufficiently pled that the defendants' alleged false statements were material, in that they had the potential to influence the Government's decision to endorse the defendants' loans—absent the loan-level and annual certifications, the FHA would not have insured the loans and HUD would not have paid the claims on them. The court also held that the Government properly alleged that the defendants' actions caused the Government to pay "hundreds of millions of dollars" it would not otherwise have paid. In particular, the Government provided six examples of mortgages that were recklessly underwritten by the defendants and ultimately resulted in an FHA insurance claim. The court rejected the defendants' argument that the Government failed to allege any facts showing presentment of a claim, explaining

that the Government alleged that the defendants originated approximately 18,000 loans, 1,850 of which had gone into claim status. The Government estimated that HUD had paid $230 million in FHA insurance claims on these loans.

In additional to the False Claims Act allegations, the court held that the Government properly pled allegations under the Financial Institutions Reform, Recovery, and Enforcement Act; but not its' claim for indemnification.

U.S. ex rel. Tahlor v. AHS Hosp. Corp., 2014 WL 4238148 (D.N.J. Aug. 26, 2014)

The two relators, former employees at a hospital called OMC, alleged that several physicians and physician practice groups violated the False Claims Act by submitting false claims to Medicare. Hospital services at OMC were provided by defendant AHS Hospital Corporation, along with providing services to two other hospitals, MMC and Mountainside. The relators alleged that the defendants violated the False Claims Act by: 1) billing Medicare for inpatient services for patients who did not meet the criteria for inpatient admission, and 2) by improperly keeping patients on inpatient service for three days so that Medicare would pay for those patients to be admitted to skilled nursing facilities. The defendants moved under Rule 12(b)(6) and Rule 9(b) to dismiss the claims based on the alleged first scheme, to the extent those claims were based on conduct at MMC and Mountainside; the defendants moved to dismiss the claims based on the alleged second scheme at all three of the facilities. In the alternative, the defendants move to dismiss all of the claims prior to November 2006 on statute of limitations grounds.

Holding: The U.S. District Court for the District of New Jersey held that, with respect to the alleged first scheme, because the relators had properly pled that the defendants admitted patients for unnecessary inpatient care; that the defendants had stated that "they could admit patients as they pleased;" and that the defendants refused to use the "observation" level of care in order to submit higher bills to Medicare at OMC, the court could infer the same behavior at MMC and Mountainside. The court denied the motion to dismiss the claims alleging improper billing at MMC and Mountainside for patients ineligible for inpatient services.

The court characterized the second scheme as a "special case" of the first scheme, because both alleged improper uses of inpatient care. The court held that although the complaint was not specific as to the named defendants, dismissal was not proper; and because the first scheme was moving into discovery, the second scheme should move ahead as well. Therefore, the court denied the motion to dismiss with regard to this scheme for all of the hospitals as well.

With respect to the defendants' statute of limitations argument, the court observed that an administrative order put in place less than a month after the origi-

nal complaint was filed in this case stated that if the case were reopened (after being stayed), then the relators' rights would be "fully preserved as they exist[ed] at the time of the entry of this Order." Thus, the court held that the administrative order tolled the FCA's statute of limitations and denied the defendants' motion to dismiss on that basis.

Skinner v. Armet Armored Vehicles, Inc., 2014 WL 4243670 (W.D. Va. Aug. 26, 2014)

The relator brought a *qui tam* action against an armored vehicle manufacturer, Armet, and its owner and Chief Executive Officer, William Whyte. The relator was the former President of Armet. The government awarded Armet a contract to build armored vehicles for personal security forces in Iraq. In the defendants' bid to the government to receive the contract, the defendants asserted that the vehicles would meet certain ballistic standards that were eventually adopted into the contract. Under the terms of the contract, Armet was required to deliver four trucks within 45 days of the contract signing, and an additional 20 trucks within approximately three months. Shortly after the award of the initial contract, Armet was awarded an additional contract for eight armored gun trucks to be delivered to Iraq within 90 days of the contract award. Armet failed to ship a single truck by the deadline. It shipped two armored trucks several months after the initial deadline, and two more several months later. The defendants submitted a "Material Inspection and Receiving Report" with each truck they delivered, certifying that the trucks met ballistics standards, and the government paid approximately $199,000 for each.

Several months after the award of the contracts, the defendants requested a cash advance for a "progress payment," despite failing to deliver even a small portion of the promised trucks; the government granted the request, in the amount of $824,531. The defendants delivered only three additional armored gun trucks after receiving this payment. The government accepted and paid for two of these trucks, but declined the third. The government issued a "Show Cause Notice" notifying the defendants that they were in breach of contract. Of the 32 vehicles that the government contracted for, they received only six. The defendants billed the government a total of $1,194,923.36 and yet received $2,019,454.36 in federal funds. None of the trucks met the ballistic standards required by the contracts.

In his *qui tam* suit, the relator alleged that the defendants committed fraud in the inducement by entering into the contract with the government knowing that they would not be able to meet the ballistic standards, in violation of the FCA. In addition, the relator alleged that the defendants falsely certified that the vehicles complied with the contract specifications each time they invoiced the government for a truck. Finally, the relator alleged that the defendants falsely claimed that they

would use the progress payment to manufacture vehicles, but instead used the money for other business and personal expenses. Whyte moved to dismiss for lack of personal jurisdiction and Armet moved to dismiss for failure to state a claim pursuant to Rule 12(b)(6).

Holding: The U.S. District Court for the Western District of Virginia granted defendant Whyte's motion to dismiss, finding that while the relator referenced Whyte several times in his complaint, he did so only in Whyte's capacity as owner and CEO of Armet. The court determined that the relator did not indicate what, if any actions Whyte took in his individual capacity, and therefore held that the relator could not establish jurisdiction over Whyte in his personal capacity.

The court denied Armet's motion to dismiss the count relating to the progress payment, but granted Armet's motion to dismiss, without prejudice, the relator's other counts. The court found that the relator did not properly plead a fraud in the inducement claim against Armet. Specifically, the relator did not allege that the defendants knew at the time they entered into the contracts with the government that they would not be able to manufacture the trucks to the required specifications. In addition, the court held that the relator's false certification claims failed, because the relator did not allege which statements, if any, regarding the quality of the trucks contained in the invoices were false. The court explained that even under an "implied certification" theory, the relator did not allege facts sufficient to show that under its agreement with the government, Armet's invoices were understood to imply compliance with the contract or that the invoices omitted information that they should have contained.

However, the court held that the relator properly pled an FCA violation with regard to Armet's misuse of the progress payment. The court held that the relator alleged an intentional "lie for the sole purpose of inducing the government to pay out money, and the government complied."

U.S. ex rel. Helfer v. Assoc. Anesthesiologists of Springfield, Ltd., 2014 WL 4198199 (C.D. Ill. Aug. 25, 2014)

The relator was an anesthesiologist, shareholder, and member of the Board of Directors of the defendant, Associated Anesthesiologists of Springfield—which was the provider of anesthesia services for defendant Memorial Medical Center. Throughout relator's tenure at Associated, Associated's medical billing was contracted to Anesthesia Business Consultants ("ABC"). The relator brought a *qui tam* action, as well as a retaliation claim, against Associated under the False Claims Act when he was terminated from his employment and board membership after he voiced his concerns about what were, in his opinion, Associated's improper billing practices for obstetrics patients.

The relator alleged that during a 2009 board meeting, a representative from ABC explained that they would begin indicating that anesthesiologists were continuously performing epidural anesthesia from the time epidurals were administered until the time children were delivered. In practice, the anesthesiologists were administering the epidurals and then leaving the area to monitor other patients. The ABC representative suggested capping the billing for these services at 90% of the maximum charged by other anesthesia groups to avoid being flagged by Medicare. The relator reviewed the Medicare regulations after this meeting and became concerned that this practice ran contrary to the regulations, specifically, that the defendants were coding concurrent services as "medically directed" rather than "medically supervised" and also that the defendants were improperly billing continuous time with obstetrics patients.

The relator also alleged that the defendants engaged in a kickback scheme in which Memorial paid for Associated's supplies, equipment, and Certified Registered Nurse Anesthetists ("CRNAs") costs, in exchange for referrals. In addition, the relator alleged that Associated submitted claims for compensation for the CRNAs to Medicare, despite Memorial actually paying their salaries and benefits.

The defendants moved to dismiss the relator's fraud claims for failure to state a claim under Rule 12(b)(6) and failure to plead fraud with particularity under Rule 9(b). Defendant Associated moved to dismiss the relator's FCA retaliation claim, on Rule 12(b)(6) and state of limitations grounds.

Holding: The U.S. District Court for the Central District of Illinois held that the relator sufficiently pled his claims for retaliation under the False Claims Act. However, the court dismissed the relator's fraud claims.

Retaliation

The court explained that although the relator could not actually prove an FCA violation, he established his good faith belief that the defendant was committing fraud against the government, and that he was engaged in a protected activity under the FCA. Notably, the relator claimed that he contacted several doctors within the hospital and representatives from ABC regarding his concerns, and, on several occasions, was told that he was "just trying to cause trouble." The relator also asserted that he asked his former employer to call the Medicare help-line to obtain clarification on the regulations, but they refused and told the relator to call himself, which he did. The relator received an email via the Medicare help-line confirming his concerns, and he informed Associated that he had received the email confirmation and that the billing practices were improper. In a subsequent email exchange between Associated, ABC, and the relator, the relator was told that the ABC representative was going to send Medicare another email "re-wording" the relator's email, "so the practice would not be flagged by Medicare for review." He was subsequently terminated, after allegedly being told that he "should not have talked to Medicare."

The court held that the relator's actions were sufficient to put Associated on notice about his investigation and concerns about the legality of the defendant's conduct. The court also held that the speed in which the events occurred, in addition to the alleged comments made by the relator's colleagues, showed that his termination was motivated by his investigation into the billing practices.

Failure to State a Claim

After reviewing the applicable regulations, the court held that, contrary to the relator's understanding and the interpretation he received from the Medicare help-line, the defendant was properly "medically directing" patients, even when monitoring up to four patients at a time under the Medicare guidelines. The allegations contained in the relator's claims regarding billing counts contradicted his contention that the anesthesiologists were over billing, either by billing for more patients than they could be "medically directing," or by billing for more patients than they could be "continuously monitoring." Therefore, the court dismissed these claims.

Failure to Plead Fraud with Particularity

Because the court dismissed the "billing counts" claims, it only applied Rule 9(b) to the relator's CRNA and Cost Report counts. The court held that although the relator alleged that the defendants were required to certify that they complied with the applicable regulations and laws as a condition of payment when submitting claims, the allegations were void of any detail about the underlying scheme. The relator did not identify any instance in which he or anyone else was pressured to refer a patient to Memorial, or even any secondhand information about a referral scheme. The court dismissed the CRNA and counts for failure to plead fraud with particularity.

Statute of Limitations

The court found that the relator timely filed his complaint within the FCA's statute of limitations, and he could pursue claims back ten years from the date of the filing of his complaint.

U.S. ex rel. Guardiola v. Renown Health, 2014 WL 4162201 (D. Nev. Aug. 20, 2014)

The relator brought a *qui tam* action alleging that two affiliated medical centers knowingly submitted short-stay inpatient claims that should have been billed as outpatient claims. The relator was the former Director of Clinical Documentation for one of the defendants, and claimed that the defendants' allegedly improperly billed claims were caused by inadequate clinical documentation, antiquated computer systems, internal processes designed to improperly classify patients, and a lack of review to ensure the appropriate status was assigned. The defendants

moved to dismiss the relator's *qui tam* claims pursuant to Rule 12(b)(6) for failure to state a claim and Rule 9(b) for failure to plead fraud with particularity.

Holding: The U.S. District Court for the District of Nevada held that the relator properly alleged that the defendants knowingly submitted claims to Medicare for reimbursement for patients who were improperly characterized as inpatient and denied the defendants' motion to dismiss.

Failure to State a Claim/Failure to Plead with Particularity

The court held that the relator properly pled her claims under the FCA; specifically the relator alleged 579 inpatient claims for zero day stays in which the patient was admitted to and discharged from the hospital on the same day, in addition to 68 one day stays in which patients were discharged within 24 hours. The relator alleged that these claims were for elective outpatient procedures, but that the defendants improperly billed the government for inpatient stays. The court held that the relator sufficiently alleged that the defendants had actual knowledge of the fraud, or acted in deliberate ignorance or reckless disregard of the falsity of inpatient claims. The court explained that the relator informed her then-supervisor of her concerns regarding the improper billing practices; however, while the defendants acknowledged the billing problems, they failed to take any corrective measures. The relator also alleged that the defendants were aware of the Medicare rules regarding inpatient/outpatient criteria, but continued their billing practices.

The court further held that the relator met 9(b)'s heighted pleading standard by setting forth details of the scheme, as well as the manner in which the allegedly false claims were submitted.

U.S. ex rel. Cook v. Providence Health & Services, 2014 WL 4094116 (W.D. Wash. Aug. 18, 2014)

The relator was a former employee of the defendant Health Services Asset Management ("HSAM"). HSAM was responsible for billing for the health care providers under the defendant Providence Health Care System. The relator alleged the HSAM violated the False Claims Act by failing to credit patient accounts when it received payments from government healthcare, private insurance, or patients. In addition, the realtor alleged that Providence failed to properly identify patients who were eligible for government healthcare or private insurance, failed to properly describe the services they provided, and failed to use proper billing codes, leading to Medicare and Medicaid denying claims they otherwise would have paid. As an initial matter, the court explained that the FCA addresses false claims to the federal government and not to private parties such as Providence's patients and private insurance. However, the relator alleged that the defendants submitted false claims by falsely certifying, as part of the process of participating in Medicare

and Medicaid, it had complied with all applicable Medicare or Medicaid statutes and regulations. The defendants moved to dismiss for failure to state a claim under Rule 12(b)(6) and failure to plead fraud with particularity under Rule 9(b).

Holding: The U.S. District Court for the Western District of Washington granted the defendants' motion to dismiss.

Failure to State a Claim/Plead Fraud with Particularity

The relator alleged that the provider agreements that participants such as the defendants must submit in order to participate in Medicare and Medicaid contain certifications requiring the participant to comply with the relevant laws and regulations including the Stark Law and Anti-Kickback laws. The court held that unlike the Medicare provider agreements, the Medicaid provider agreements that the relator pointed to as a basis for her claims did not require an express certification of compliance with the law as a condition of payment. Therefore, the court held that the Medicare provider agreements provided a basis for the relator's false certification claims, but the Medicaid agreements did not.

The court rejected the relator's proffered example of a false certification in the form of a case study involving a Medicaid beneficiary for whom she was responsible for collecting payment, even though the relator alleged that Medicaid had paid the account in full. The court held that even if Providence certified when it requested government reimbursement for services it provided to that patient that it was in compliance with all applicable laws, there was no indication that the certification was false. The court explained that at the time of the certification, there was no allegation that the defendants had done anything improper with respect to that patient. The court further explained that if the defendants did make any false certification with respect to that patient, it was because they had violated the law or regulations with respect to other patients. The court further explained that the relator made no allegations about what Providence knew or should have known regarding HSAM's collection activity, and no allegations giving rise to a plausible inference that Providence was deliberately ignoring or recklessly disregarding information about HSAM's allegedly unlawful collection activity. Therefore, the court held that the relator failed to plausibly allege scienter.

The court also held that the alleged false certifications were not material under the FCA, noting that rather than refuse the defendants' reimbursement requests had the improper billing been disclosed to the government, Medicare and Medicaid would have simply instructed the defendants to remedy the billing errors. "It is not plausible to conclude that Medicaid would have refused Providence's reimbursement request." Moreover, the court rejected the relator's fraud claims that were not based on the false certification theory of liability, holding that: 1) there was no violation of the FCA for failing to identify eligible Medicare and Medicaid patients; 2) the relator did not adequately plead scienter with respect to improperly coded services; 3) the relator did not adequately plead that the defendants withheld subrogation payments with scienter; and 4) relator failed to adequately plead conspiracy between HSAM and Providence.

Weiss v. AER Servs., Inc., 2014 WL 3850059 (E.D. Wis. Aug. 5, 2014)

The plaintiff brought an action against the defendant for retaliation under the False Claims Act after he was terminated for disclosing that the defendant allegedly employed Israeli citizens who entered the U.S. on fraudulently obtained R-1 visas. The defendant was a provider of kosher meat for the brand Hebrew National, and employed the relator as a "Shochet," a person who engages in the ritual slaughter of animals for meat in the Jewish religion. The relator claimed that a friend showed the relator a copy of his R-1 visa application with the petitioner listed as Ravenswood Budlong Congregation, describing the congregation as a highly regarded Jewish congregation in the Chicago area. The visa application also stated that kosher food providers were integral to the community. The relator grew up in the area where the congregation was located, and believed that the Jewish community had moved from that location. He drove to the location to investigate and found that the building where the congregation was supposed to be located had been torn down several years earlier. Based on these facts, the relator alleged that the defendant was using the congregation to fraudulently petition the government for R-1 visas for workers in its kosher meat plant, though the visas are only supposed to be granted to foreign nationals employed by a religious non-profit to work in a religious vocation. The relator maintained that he reported the potential violations to Homeland Security and U.S. Immigration and Customs Enforcement beginning in 2008-09. He claimed that as a result of his whistleblowing, the State Department stopped granting the R-1 visas to the congregation.

Under the relator's employment contract, he was subject to a change of location at the direction of the defendant. The relator alleged the defendants "set him up to be fired" by requiring him to transfer unreasonably, and that when he did not accept the transfer, he was subsequently terminated. The defendants argued that the relator's claims were based on a false premise; the congregation existed and was flourishing in another part of Chicago—it had simply changed location. In addition, the defendant asserted that it only employed American citizens, and that the R-1 visas were for the employees of the congregation only. The defendant claimed that it did not own any part of the congregation and vice versa, and that the relator was terminated for refusing the transfer, rather than any whistleblowing activities.

Holding: The U.S. District Court for the Eastern District of Wisconsin granted the defendant's motion. The court held that the relator provided no evidence of an underlying fraud. The visa application that the relator used as support for his claims did not "hint of fraud." Moreover, his allegations regarding the existence of the congregation were merely speculative. For instance, the relator asserted that he visited the congregation's purported new location congregation multiple times, but was unable to verify the occupant because the door was locked. The court found this insufficient to support the relator's allegations.

U.S. ex rel. Williams v. McKesson Corp., 2014 WL 3353247 (N.D. Tex. July 9, 2014)

A relator brought a *qui tam* action alleging that her former employer—an entity that provided billing-related services to the health care industry—and a dentist violated the False Claims Act and the Texas Medicaid Fraud Prevention Act ("TMFPA"). According to the relator, the billing company submitted false Medicare/Medicaid claims; the claims were false because they involved general anesthesia services either provided by or approved by the dentist, who was acting outside the scope of his licensure. The relator claimed that when she discovered the fraudulent billing, she notified her direct supervisor at the entity. However, nearly two years later, she noticed that the entity was still processing "out of scope" billing statements for the dentist. She again notified her supervisor and instructed one of her subordinate managers to check the dentist's credentials and to follow up on the investigation into these concerns. The next day, the entity terminated the relator's employment, ostensibly as part of a reduction in force; but within a week of the termination, the entity posted an advertisement for someone to fill the relator's former position. The relator also alleged a claim under the TMFPA's anti-retaliation provision. Neither the United States nor the State of Texas chose to intervene in the *qui tam* action. The defendants each moved to dismiss the complaint pursuant to Federal Rules of Civil Procedure 12(b)(6) and 9(b).

Holding: The U.S. District Court for the Northern District of Texas granted the defendants' motions and the relator's claims were dismissed without prejudice.

Failure to State a Claim/Plead Fraud with Particularity

The court first noted that while the language of the federal False Claims Act and the TMPFA differed, since the relator's claims depended on the same operative facts and legal requirements, the court could analyze the fraud claims under each statute together. In addition, while the relator did not specify the provisions of the False Claims Act and the TMPFA that were at issue, the court determined that the complaint was sufficient to allow the defendants to discern that it could only be based on the acts' respective "presentment" provisions.

Ultimately, the court agreed with the defendants that the plaintiff had not alleged an essential element of her FCA and TMPFA claims—namely, the existence of a false or fraudulent claim submitted to the government for payment. In reaching that conclusion, the court recognized that claims may be "factually" false or "legally" false: claims are factually false when the prospective payee has submitted an inaccurate description of services provided, or requested payment for services never provided; and claims are legally false when a prospective payee falsely certifies compliance with a statute or regulation as a condition to government payment. Since the relator never alleged that the defendants submitted inaccurate claims or claims for services that were never provided, the court held that complaint did not involve allegations of factually false

claims. Instead, the relator alleged that the defendants submitted legally false claims, by seeking reimbursement for services that the dentist provided in violation of statutes and regulations that limited the scope of his service to his licensure. But the relator failed to identify the statutes and regulations at issue, nor did she plausibly allege that the government expressly conditioned payment on compliance with those provisions. Consequently, she could not allege that the defendants knowingly and falsely certified any such compliance. The court further noted that the relator failed to describe when any allegedly false claims were presented to the government—only that the fraud occurred between 1977 and 2010—and did not discuss how the claims were prepared or their content. As a result of these findings, the court granted the defendants' motions to dismiss on Rule 9(b) and 12(b)(6) grounds. However, the court stated that dismissal with prejudice should be used sparingly and therefore granted the relator leave to submit an amended complaint.

The court dismissed the pendant state retaliation claim in light of the dismissal of the federal claims, and, therefore, did not address the merits of that claim.

U.S. ex rel. Academy of Health Ctr., Inc. v. Hyperion Found., Inc., 2014 WL 3385189 (S.D. Miss. July 9, 2014)

Relator Academy Health Center, Inc. ("AHC"), a healthcare provider that owned and leased skilled nursing facilities to other healthcare companies to manage, brought a *qui tam* action alleging Medicare and Medicaid fraud. According to the relator, one of its lessees, Hyperion, violated its lease agreement by failing to pay rent. As a result, the relator investigated Hyperion, found that it could not provide the requisite level of care for residents, and began legal proceedings to evict Hyperion and terminate the lease relationship. Hyperion filed for bankruptcy, though, which halted the eviction proceeding. While the bankruptcy case proceeded, the relator filed a *qui tam* action under seal, alleging that Hyperion and other defendants—including a related company and the man who controlled it (Douglas Mittleider)—submitted false Medicare/Medicaid claims to the government (or caused false claims to be submitted) and conspired to submit false claims. Specifically, the relator claimed that the defendants engaged in a scheme whereby Hyperion provided worthless services and engaged in resident abuse by willfully and negligently inflicting pain on the residents of its centers; financially abandoned the center by intentionally diverting funds meant for the residents to other entities controlled by Mittleider; and kept the center short-staffed and re-used materials to the extent of causing infection. Many of the health and safety transgressions alleged by the relator were verified in evaluations and surveys conducted by both ACH and the State. Among those allegations were a pest control problem that led to snakes in the facilities—even into one resident's bed—repeated failures to provide staff on a 24-hour basis, and lack of food for residents. At one point, the State determined that the facility was in "Immediate Jeopardy" of causing serious harm or death to a resident; after several attempts, Hyperion was able to remove itself

from this status. Still, State and AHC investigations found continued, repeated failures by Hyperion. The complaint further alleged that the defendants violated various rules Hyperion was required to follow in order to receive Medicare and Medicaid payments, which rendered the company's healthcare claims false. Hyperion was eventually dismissed from the bankruptcy proceeding for its failure to comply with court requirements, resulting in a settlement agreement with AHC on the lease issues.

With respect to the *qui tam* suit, the government filed a complaint-in-intervention, joining the relator's claims discussed above. The *qui tam* complaint also named other companies related to Hyperion, as well as Mittleider's wife, and a doctor who was appointed to run Hyperion as additional defendants, and alleged a nationwide pattern of misconduct by the defendants; but the government did not join the claims against any other defendants and limited its intervention to the fraud that was alleged to have occurred at the facility the relator owned and leased to Hyperion.

The defendants argued that AHC's *qui tam* complaint should be dismissed for lack of subject matter jurisdiction. First, they claimed that AHC executed releases in settlement agreements between Hyperion and AHC. In addition, they asserted that the FCA's public disclosure bar precluded the relator's claims. Furthermore, the defendants argued that both the *qui tam* complaint and the complaint-in-intervention should be dismissed for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) and for failure to plead fraud with particularity under Rule 9(b).

Holding: The U.S. District Court for the Southern District of Mississippi denied the defendants' motion to dismiss the United States' complaint-in-intervention. The court granted in part and denied in part the motion to dismiss the *qui tam* complaint.

Release of *Qui Tam* Claims

The court found that AHC and Hyperion had engaged in disputed and somewhat disjointed settlement negotiations on several occasions, but concluded that the parties never reached a settlement that contained a release encompassing the *qui tam* claims. True, the parties reached a settlement in the bankruptcy case that released "all claims between the parties" and stated that "[a]ll litigation goes away." But the court held that parties' negotiations only encompassed previously-filed claims and that the release was "narrow and limited to the bankruptcy disputes enumerated" within it. Since the *qui tam* suit was filed after those settlement negotiations began, the court held that the bankruptcy release did not apply. Next, the defendants argued that the parties' agreement resolving the eviction proceeding included a release that barred the *qui tam* complaint. Again, the court held that the release did not apply, as it expressly excluded

claims involving Medicare and Medicaid. The court denied the defendants' motion to dismiss the *qui* tam claims on the grounds that those claims were precluded by prior releases signed by the relator.

Public Disclosure Bar

The defendants also argued that the court lacked subject matter jurisdiction over AHC's *qui tam* complaint because of the FCA's public disclosure bar provision. The defendants claimed that AHC's worthless services allegations related to the facility it leased to Hyperion had been previously publicly disclosed in court filings in personal injury and bankruptcy lawsuits, in Mississippi State Department of Health Surveys, and in newspaper articles. Similarly, the defendants contended that AHC's allegations of a nationwide fraud scheme were based on news stories that AHC even attached to its *qui tam* complaint.

As an initial matter, the court recognized that the public disclosure bar provision was amended in 2010, and that the *qui tam* complaint was filed in 2009 but after amendments, alleged fraud from 2005 to 2012. Since the *qui tam* suit was filed before the public disclosure bar provision was amended—and since the amendment did not apply retroactively—the court applied the pre-amendment version of the provision, which treated state (as opposed to federal solely) reports and investigations as public disclosures.

The court then explained that the public disclosure bar will be triggered if the *qui tam* action is "even partly based upon publicly disclosed allegations," and that under Fifth Circuit law, "based upon" encompasses allegations that are substantially similar to or are merely supported by the publicly disclosed allegations. The court then determined that the relator's fraud allegations had been previously publicly disclosed, rejecting the relator's argument that none of the public materials, separately or taken together, contained information that would expose the alleged fraud scheme. Instead, the court stated, that "each component of the alleged fraudulent conduct need not be publicly disclosed to trigger the statutory bar," and that it was sufficient that the relator's fraud allegations were "substantially similar to public disclosures."

The court further found that AHC was not an original source of the information on which his fraud allegations were based. Although the relator's allegations were based on its own investigations of the facility it owned, its investigations commenced after some of the public disclosures had already occurred, and did not add anything new to what had already been publicly disclosed. Consequently, the relator's *qui tam* allegations were dismissed. The court clarified that the dismissal was without prejudice to the United States, which had intervened in many of the relator's claims. The government's allegations would be evaluated under Federal Rules of Civil Procedure 9(b) and 12(b)(6).

Failure to State a Claim/Plead Fraud with Particularity

The court first determined that the complaint-in-intervention provided more than enough details to satisfy Rule 9(b). The government alleged facts regarding seven residents at the facility, and noted that these were "only examples" of the worthless services provided at the defendants' facility; the court held that there was no need for the government to plead every specific instance of a complex fraudulent scheme over a substantial time period—otherwise, more sophisticated and intricate fraudulent schemes would evade liability under the FCA due to the pleading challenges they would present.

The non-Hyperion defendants then argued that they should be dismissed from the government's suit because the allegations were insufficient to prove that they were alter egos of Hyperion. However, the court agreed with the government that this was a "garden-variety" FCA claim in the government did not need to allege that the non-Hyperion defendants were alter egos of the company—only that they knowingly caused Hyperion to submit false Medicare and Medicaid claims. The motion to dismiss on that basis was denied.

Next, the defendants argued that AHC and the government only alleged that they violated conditions of participation in the Medicare and Medicaid programs—which cannot form the basis for an FCA claim—rather than conditions of payment. The court, though, found that the statutes and regulations the government alleged the defendants violated created conditions of payment, and therefore subjected the defendants to FCA liability. The motion to dismiss on the basis of the conditions of participation argument was denied.

The court also rejected the defendants' argument that the government's complaint must be dismissed because it did not allege that the entire bundle of services billed on a *per diem* basis had no value to the government. The court explained, "courts have recognized that worthless services claims under the FCA are not, as a legal matter, limited to instances where no services at all are provided. A service can be worthless because of its deficient nature even if the service was provided." While worthless services can be hard to prove when they are billed on a *per diem* basis, services become worthless when they fall short of the minimum needed to promote a patient's quality of life. Here, the court held that the government's complaint alleged that residents died or became repeatedly ill and/or hospitalized after living in defendants' care, which satisfied the standard for pleading a worthless services claim. The court agreed with the government that "taken to its extreme, defendants' argument is that a nursing home is entitled to payment for doing nothing more than housing an elderly person and providing her with just enough bread and water for short-term survival, even in conditions of filth, mold and insect infestation; and even if it consistently provides her too little medication, or too much, or the wrong medication, contrary to her physician's orders; and even if it allows her to develop horrific pressure ulcers infected by feces and urine to the point that amputations are required; and even if it permits her to suffer falls and fractures; and even it allows her to asphyxiate on her own fluids due to

inadequate resources to properly attend to her worsening condition. This cannot be the case and it is not the law." Rather, the court found that the government's allegations of "heinous examples of grossly deficient care" suffered by residents at the facility were sufficient to could support a finding that the defendants "had actual knowledge, recklessly disregarded and/or remained in deliberate ignorance, of the truth or falsity of the claims and statements made to Medicaid and Medicare, and thus 'knowingly' made or caused to be made to Medicaid and Medicare false or fraudulent claims and statements, within the meaning of the FCA," for services that were worthless.

Finally, the court rejected the defendant's argument to dismiss the FCA conspiracy claim. The court stated that conspiracy claims need not plead details of actually submitted claims, but may allege the details of a fraud scheme along with reliable indicia that lead to a strong inference that claims were submitted. The court found that the complaint provided specific details about the agreement as well as participation by the defendants in carrying out the fraud scheme. Therefore, the court denied the motion to dismiss the conspiracy claim.

U.S. ex rel. Shupe v. Cisco Sys., Inc., 2014 WL 3057093 (5th Cir. July 7, 2014)

A relator brought a *qui tam* action against several telecommunications companies, alleging that the defendants violated the False Claims Act while bidding for, and being awarded, contracts to install and operate communications networks for school districts and libraries throughout South Texas. Partial funding for the installation and operation of these networks came from the Education Rate ("E-Rate") Program, which was administered by the Universal Service Administrative Company ("USAC") with funds from the Universal Service Fund ("USF"). USAC and USF were created as part of the 1996 Telecommunications Act and the Federal Communications Commission ("FCC") rulemaking that followed.

USAC is an independent, not-for-profit corporation designated by the FCC as administrator of the USF. USAC operates by collecting mandatory contributions from telecommunications carriers and distributing those funds through the E-Rate program. To obtain E-Rate funds, an applicant must develop and submit a technology plan to the state, the USAC or an independent entity approved by FCC or certified by USAC to provide approval. The applicant must then file a request for proposals with USAC to begin a bidding process. Once bidding is complete, the applicant certifies to USAC that it has complied with the requirements of the E-Rate program and requests discounts for the services provided.

The relator alleged that the defendants violated the False Claims Act by presenting materially false or fraudulent claims for payment to USAC. The defendants moved to dismiss for failure to state a claim, arguing that because USAC was not a government body or funded with government dollars, certifications to USAC

could not form the basis of a False Claims Act claim. The U.S. District Court for the Southern District of Texas rejected the defendants' contention that False Claims Act liability could only be triggered if the funds at issue were deposited in the U.S. Treasury or distributed by a federal government body. The district court held that because USAC collected funds based on a government mandate and distributed those funds in accordance with FCC regulations, the government effectively provided the money for the E-Rate Program, and therefore false certifications to USAC to receive E-Rate benefits gave rise to FCA liability. The defendants filed an interlocutory appeal of the district court's ruling to the U.S. Court of Appeals for the Fifth Circuit.

Holding: The Fifth Circuit reversed the district court's ruling, and held that the FCA requires plaintiffs to show that U.S. Treasury funds flowed to the defrauding entity or that a false claim was submitted to a government entity.

Failure to State a Claim

The circuit court determined that False Claims Act liability is not triggered when the government merely makes money available by directing its collection and disbursement. Rather, the court stated, the funds requested or provided for the false claim must come from the U.S. Treasury. Thus, the Fifth Circuit held that it was irrelevant that USAC was created by actions of Congress and the FCC, that by overseeing USAC, the FCC held substantial power over USF indirectly, or that the government may have had a regulatory interest in the E-Rate program. Instead, the court focused on the fact that the government did not provide funds to the USF and the FCC had no authority to control USF through direct seizure of discretionary spending, and did not have a financial stake in the program's losses. The circuit court acknowledged that an entity that does not receive government funds may nevertheless be covered by the False Claims Act—if the entity is considered an agency or instrumentality of the government, as provided by statute. In this case, the Fifth Circuit determined that—like Amtrak, and unlike the Postal Service and the Commodity Credit Corporation—USAC's services are not provided by the government; USAC "is explicitly a private corporation owned by an industry trade group." The appeals court held that "[i]f Congress had wanted the FCA to apply to the USAC and the USF, it could have made it clear in [the FCA] or administered these funds through a governmental entity."

The Fifth Circuit reversed the district court's ruling and remanded the matter for further proceedings.

U.S. ex rel McGinnis v. OSF Healthcare Sys., 2014 WL 2960344 (C.D. Ill. July 1, 2014)

A *qui tam* relator alleged that his former employers, two affiliated healthcare services companies, violated the federal False Claims Act and the Illinois False

Claims Act. The relator claimed that the defendants provided services through multiple facilities under four main divisions: hospice, home health services, durable medical equipment, and pharmacy infusion. Only some of these facilities, however, were eligible for Medicare and Medicaid reimbursement payments. The relator alleged that prior to and during his tenure as the defendants' Director of Reimbursement, the defendants submitted several thousand durable medical equipment claims that had an error rate of 75%, due to a variety of factors. He claimed that he told the companies' CFO that submitting these claims constituted fraud, but was he intimidated by the defendants after making his report. Later, the relator heard the CFO tell claims processors to submit home health services claims for reimbursement to Medicare and Medicaid with false information regarding the facility where the care was administered; these claims had been previously submitted and rejected, and were altered to appear to be from facilities that were eligible for Medicare/Medicaid reimbursement. The relator was eventually terminated/forced to resign.

The relator alleged violations of the anti-fraud and anti-retaliation provisions of the federal False Claims Act and the Illinois False Claims Act. The defendants moved to dismiss all the claims, arguing that: (1) the relator failed to plead *prima facie* elements of a False Claims Act action; (2) the relator failed to allege a conspiracy under the False Claims Act; (3) the retaliation-based claims failed because the relator failed sufficiently to allege that he took lawful acts in furtherance of preventing a conspiracy to violate the False Claims Act; and (4) certain state and federal False Claims Act were not pled with sufficient particularity.

Holding: The motion to dismiss was granted and the relator's claims were dismissed with prejudice.

Home Health Services Claims

The court first considered the relator's claims based on allegations that the defendants falsified information on Medicare/Medicaid reimbursement claims with respect to the location where home health services were administered, finding that those claims were not clearly pled and vacillated between allegations regarding home health services and allegations regarding hospice services. Ultimately, the court held that the home health services claims were insufficient to put he defendants on notice of what was being alleged. As a result, the claims were dismissed.

Durable Medical Equipment Claims

The court then dismissed the relator's claims based on allegations that the defendants submitted untimely, year-old reimbursement claims to Medicare/Medicaid, finding that such grounds, standing alone, were not sufficient to give rise to False Claims Act liability. Rather, the court held, for liability to be imposed, there must be some allega-

tion demonstrating falsity or deceit (*e.g.*, masking the untimeliness of the claim)—which was lacking in this case. In addition, the court rejected the relator's argument that the defendants' claims included false certifications; instead, the court determined that the defendants were not required to provide any certifications to the government in connection with the Medicare/Medicaid claims at issue.

Conspiracy Claims

Next, the court addressed the relator's conspiracy claims, and determined that no one outside the defendants' corporate entities was alleged to have been involved in the conspiracy. Consequently, the court held that the intracorporate conspiracy doctrine applied, and the conspiracy claims were dismissed.

Retaliation Claims

Finally, the court found that because the relator could not plead a fraud claim under the FCA statutes, he could not have been acting in furtherance of a False Claims Act enforcement action and thus, was not protected under the FCAs' anti-retaliation provisions. The court further held that even if the relator had sufficiently pled a fraud claim, his retaliation claim would still fail because he did not allege that he was retaliated against for acting in furtherance of the False Claims Act claim.

See *U.S. ex rel. Customs Fraud Investigations, LLC v. Victaulic Co.*, 2014 WL 4375638 (E.D. Pa. Sept. 4, 2014), at page 13.

See *U.S. ex rel. Kester v. Novartis Pharms. Corp.*, 2014 WL 4370597; 2014 WL 44001275 (S.D.N.Y. Sept. 3, 2014), at page 3.

See *U.S. ex rel. Fox Rx, Inc. v. Omnicare, Inc.*, 2014 WL 3928780 (S.D.N.Y. Aug. 12, 2014), at page 117.

See *McLain v. KBR, Inc.*, 2014 WL 3101818 (E.D. Va. July 7, 2014), at page 121.

A. Bankruptcy Proceedings

U.S. ex rel. Saidiani v. Nextcare, Inc., 2014 WL 4672417 (W.D.N.C. Sept. 18, 2014)

The relator brought a *qui tam* action against the defendants, a group of urgent care clinics. During the pendency of his case, relator declared bankruptcy, but failed to disclose his FCA case and potential reward to the bankruptcy court or to his creditors. Before the FCA case was resolved, the bankruptcy case was closed, and the bankrupt relator received a full and final discharge. The next year, the government intervened and partially settled the relator's case, but allowed the relator to pursue his remaining individual claims independently. The FCA defendants then moved to dismiss the relator's *qui tam* case, arguing that he had no standing to proceed with the case following the bankruptcy—only the trustee had standing—and that the relator was judicially estopped from proceeding, after he concealed the *qui tam* case as an asset from the bankruptcy court.

Holding: The U.S. District Court for the Western District of North Carolina granted the defendants' motion to dismiss. The court held that debtors must disclose FCA cases in which they have an interest to the bankruptcy court. In reaching its holding, the district court rejected the relator's argument that he could not lose standing because the U.S. is the real party in interest in all FCA cases; instead, the court explained that according to the bankruptcy laws of that circuit, because the cause of action was part of the estate, only the bankruptcy trustee could have standing to pursue the relator's FCA claim.

The district court also held that the relator was judicially estopped from asserting his FCA claims because he failed to disclose the case as part of his assets to the bankruptcy court. Because the relator had sworn in his bankruptcy proceedings that he had no assets to prevent a discharge, he could not simultaneously represent to the government that his FCA claims were worth millions of dollars. The court rejected the relator's argument that judicial estoppel should not apply because he failed to disclose his still sealed case to the bankruptcy court in good faith. The court explained that he was required to list all assets without exception, and that there were a number of ways that he could have satisfied his obligations in the bankruptcy proceedings while preventing a public disclosure of the *qui tam* action.

B. Calculating Damages and Civil Penalties

U.S. ex rel. Wall v. Circle C Constr., LLC, 2014 WL 4199097 (M.D. Tenn. Aug. 22, 2014)

This case was before the U.S. District Court for the Middle District of Tennessee on remand from the Sixth Circuit, for a determination of damages. The relator alleged that the defendant—a construction company—violated the False Claims Act by knowingly submitting false payroll certifications to the Army. The relator was an employee of the defendant's subcontractor, Phase Tech, which the defendant used for the majority of the work on its contract with the Army to complete the electrical work on buildings at the Fort Campbell military base. The contract included determinations of minimum hourly wages in accordance with Davis-Bacon labor requirements. The defendant had been performing on government contracts for approximately twenty years, had attended a training session at Fort Campbell on the prevailing wage requirement for government contracts, and acknowledged in the contracts that the defendant was familiar with the wage requirements. Rather than perform the work itself, the defendant subcontracted the work to Phase Tech. The defendant was required to submit complete and accurate payroll certifications for all employees on the project, certifying that they complied with Davis-Bacon. The relator claimed that defendant submitted its payroll certifications, but did not list Phase Tech employees—according to the relator, the defendant did not even discuss the Davis-Bacon requirements with Phase Tech, and did not verify whether Phase Tech submitted certifications to Fort Campbell. As a result, the relator argued, the defendant violated the FCA.

The defendant's paystubs and payroll certifications were reviewed by the Department of Labor pursuant to this action being filed, and 62 instances of workers being paid less than the required wage were found, as well as multiple instances of inconsistencies in the defendant's payroll certifications, wherein employees from Phase Tech were not listed or were listed in the inappropriate role. The district and circuit courts found that the defendant violated Davis-Bacon in paying the Phase Tech employees less that the minimum hourly wage, and that it falsely certified to the government that it was, in fact, paying the required wage, causing the government to erroneously pay the defendant in accordance with the minimum hourly wage required by Davis-Bacon. The circuit court, though, held that the district court did not sufficiently detail its damages determination and remanded the case.

Holding: The U.S. District Court for the Middle District of Tennessee awarded the plaintiffs $762,894.54.

Damages

On remand, the district court held that the government may recover as actual damages "the difference between what it paid and what it should have paid for the goods." The

court explained compliance with the Davis-Bacon Act's certification requirement is a precondition of payment, and that contractors who fail to comply with that requirement undermine the Act's purposes. "In short, contractors like [the defendant] who knowingly make false certifications of their compliance with the Davis-Bacon Act that are material to the government's payment decision subvert Congress's policy goals," the court declared.

The record in this case showed several measures of damages based on testimony from experts and witnesses familiar with the electrical work that Phase Tech performed. The court considered these measures and determined that the total amount the government paid for electrical work that was attributable to Phase Tech was $259,298.18. The plaintiffs argued and the court agreed that when the government conditions payment on certain requirements, "its damages may amount to all payments tainted by a contractor's failure to comply with those requirements, with no reduction for the value the government received." Therefore, the court awarded the plaintiffs the total amount the government paid, trebled, in accordance with FCA.

Veridyne Corp. v. U.S., 2014 WL 3408567 (Fed. Cir. July 15, 2014)

The plaintiff brought an action under the Contracts Disputes Act (CDA) related to a contract awarded pursuant to the Small Business Association's (SBA) set-aside program for disadvantaged businesses. The Government argued the plaintiff's contract was forfeited under the Special Plea in Fraud Statute, and asserted counterclaims under the False Claims Act and the antifraud provisions of the CDA. The Court of Special Claims held that the plaintiff's contract claim was forfeited under the Forfeiture of Fraudulent Claim Act, but awarded the plaintiff partial recovery under a quantum meruit theory and awarded penalties to the government under the FCA and CDA.

The plaintiff was certified by the SBA for participation in the Section 8(a) set-aside program for a nine-year term set to expire in 1998. In 1995, the Maritime Administration (MARAD) awarded an indefinite delivery and quantity contract for its logistics program to the SBA, who subcontracted that work to the plaintiff for one base year and up to four option years. The plaintiff was paid over twenty million dollars during the initial contract period. In an effort to extend the contract prior to its "graduation" from the 8(a) program, the plaintiff contacted MARAD and entered into discussions regarding an extension of the current contract. If the new contract award price exceeded three million dollars, MARAD would have to open up the new contract to competition amongst all of the qualified 8(a) qualified businesses, delaying the award of the contract until after the plaintiff's exit from the program. As a result, the new contract proposal submitted to MARAD specified that all the contract terms and scope would remain the same for the contract period of five years, at a cost specified in the proposal of $2,999,949.00. The plaintiff knew that the costs of the services provided would greatly exceed

this amount, and admitted that "the costs established in [the proposal] were never intended to reflect MARAD's actual needs, but were developed to meet SBA's $3 million limit." MARAD officials also acknowledged that the proposal was written to stay within this limit. The SBA, relying on statements from MARAD, executed the contract with the plaintiff.

The Department of Transportation Office of Inspector General began investigating the contract in 2003 and concluded that it had been obtained through fraud. MARAD was ordered not to make any additional payments under the contract, and subsequently issued a stop order to the plaintiff suspending contract performance (not before the plaintiff performed on the contract for several additional months). The Court of Special Claims held that the plaintiff was owed $1,068,636.22 in quantum meruit based on the work it performed prior to the stop order. The court also held that the plaintiff's proposal for the extension violated the FCA, and treated each invoice that the plaintiff submitted as a separate false claim, imposing the maximum penalty for each claim for an award of $1,397,000 to the Government. The court also awarded the Government $568,802.09 in damages under the CDA. Both parties appealed the damages awards to the U.S. Court of Appeals for the Federal Circuit.

Holding: The Federal Circuit held that the plaintiff should not have been awarded quantum meruit recovery because the contract was awarded as a result of fraud. Further, the court affirmed damages awarded to the government under the FCA and CDA. The circuit court rejected the plaintiff's argument that the proposal did not contain false statements because it was never intended to reflect MARAD's actual needs, and instead noted that the proposal for the contract extension indicated that it would have the same scope as the original contract covering all of MARAD's logistics needs. The appellate court also rejected the plaintiff's argument that the plaintiff did not have the requisite intent to defraud MARAD, because MARAD knew that the statements were false. The court noted that the contract was with the SBA, not MARAD, and that there was no evidence to suggest that the SBA knew of the fraud. The circuit court also rejected the plaintiff's argument that even if the extension was procured by fraud, the invoices submitted pursuant to the contract did not contain any false statements and could not, therefore, result in FCA penalties. The court explained that claims submitted pursuant to a fraudulently obtained contract are automatically deemed FCA violations. Finally, the court rejected the plaintiff's argument that because the invoices were submitted to MARAD and not to the SBA, they did not present the claims to the contracting government party; instead, the court noted that it is not necessary for the claims to be presented to the contracting party directly when they are being paid with federal funds.

Baklid-Kunz v. Halifax Hosp. Med. Ctr., 2014 WL 2968251 (M.D. Fla. July 1, 2014)

A relator alleged that a hospital regularly admitted Medicare patients whose admissions were not medically necessary and then submitted inflated reimbursement claims to the government, in violation of the False Claims Act. The defendant moved for summary judgment on the issue of whether the relator presented sufficient evidence regarding damages. The defendant also filed two motions in limine: (1) seeking a ruling that a failure to abide by certain Medicare "conditions of participation" cannot render Medicare claims "false" for FCA purposes; and (2) seeking a ruling that evidence relating to claims which would be time-barred cannot be presented.

Holding: The U.S. District Court for the Middle District of Florida granted the defendant's summary judgment motion, granted the motion in limine relating to the defendant's condition of participation argument, and denied the motion in limine to bar evidence from claims prior to as far back as the statute of limitations goes.

Calculating Damages

The relator argued the government's damages amounted to the total of each inflated claim, which was then subject to trebling under the Federal Claims Act. The defendant countered that the proper measure of damages should be only the amount that the claims were allegedly inflated—the amount above what the claims would have been had the services been performed on an inpatient basis. The court sided with the defendant noting that the relator only alleged that the defendant billed the government too much for its services, not that the services rendered were medically unnecessary. Thus, the court reasoned, the government at least would have paid the inpatient rates for those services. Since the relator failed to produce evidence—as was her burden, according to the court—from which a jury could determine the measure of damages, the defendant was entitled to summary judgment on that issue.

Conditions of Participation

The relator also argued that all claims for patient admissions that were submitted without a corresponding physician's order constituted false claims. The defendant argued that the rule requiring a physician's order merely created a condition of participation—not a condition of payment. Accordingly, the court agreed with the defendant that the failure to obtain a physician's order could not form the basis of a False Claims Act violation, finding that the government would not be damaged by paying an otherwise valid claim in the absence of such an order. As a result, the court held that the relator could not maintain fraud claims based on the lack of an admission order.

Statute of Limitations

On the eve of trial, the defendant argued that the relator could not present evidence of false claims dating back to 2002 because the statute of limitations would bar claims submitted prior to June of 2003. The court, however, refused to bar the evidence, finding that the defendant was sufficiently put on notice that the relator intended to use such evidence, based on the allegations of the original *qui tam* complaint, and the defendant waited too long to raise this argument.

See *U.S. ex rel. Absher v. Momence Meadows Nursing Ctr., Inc.*, 2014 WL 4092258 (7th Cir. Aug. 20, 2014), at page 114.

C. Costs and Attorneys' Fees

Ulysses Inc. v. U.S., 2014 WL 3883329 (Fed. Cl. Aug. 7, 2014)

A plaintiff filed an application for attorney's fees pursuant to the Equal Access to Justice Act ("EAJA"), which allows parties who successfully defend against claims brought by the Government—including claims under the False Claims Act—to recover their attorneys' fees and expenses, unless the Government's position was substantially justified.

The plaintiff was a manufacturer of electrical equipment with 60% of its sales going to the Government. The plaintiff was an "approved source" of certain parts it manufactured for the Government. When the Government issued a Request for Quotation ("RFQ") for a component part (the 112 Part) of a larger part (the 110 Part) that the plaintiff had already manufactured for the Government and for which they were an "approved source," the plaintiff believed that it was an "approved source" for the 112 Part as well, and submitted bids in response to the RFQ. The Government issued two purchase orders to the plaintiff to supply the 112 Part. The first purchase order contained a clause requiring that plaintiff provide "an exact product" manufactured by or under the direction of Raytheon. The second purchase order included a requirement that the 112 Part be manufactured by Frequency Selective Networks, Inc., "a requirement that 'came out of nowhere,'" according to the plaintiff.

While the plaintiff was in the process of manufacturing the parts, the Government learned that the plaintiff intended to deliver 112 Parts that it manufactured itself, rather than by or under the direction of Raytheon or Frequency. The Government cancelled both purchase orders after the plaintiff could not provide documentation stating that it was an "approved source" for the 112 Part. The plaintiff filed a complaint alleging that the cancellation of the purchase orders was improper, and that it was entitled to reinstatement of the purchase orders or payment for full performance. The Government asserted counterclaims alleging that the plaintiff had violated the FCA by knowingly submitting a false RFQ to secure the purchase orders, and presenting a claim for payment based upon that illegally obtained purchase order.

In order to determine whether the Government's position in bringing the FCA claims was "substantially justified," the court examined whether "the Government's position prior to and throughout litigation had a 'reasonable basis in both law and fact.'" The court held that the plaintiff's interpretation of the less-than-clear RFQ and purchase order language, while mistaken, was reasonable, and that the plaintiff did not intentionally falsify its quote. The court also held that the Government failed to show that the plaintiff knew it was not an approved source, and therefore misrepresented itself in submitting its claims for payment. The court explained

that the plaintiff asserted that it was an "approved source" and that it intended to manufacture the parts itself in correspondence with the Government. Therefore, the court held that the Government's position was "wholly unreasonable," and awarded the plaintiff a total of $26,684.75 in fees.

D. False Certifications of Compliance

U.S. ex rel. Fortenberry v. Holloway Group, Inc., 2014 WL 4375047 (W.D. Okla. Sept. 2, 2014)

The relator was a former provider of mental health services in clinics owned by the defendants, Holloway Group Inc. (HGI) and Southern Oklahoma Treatment Centers (SOTS). Defendant Willis Holloway was the CEO of HGI and defendant Janet Scott was an HGI employee. The relator alleged that the defendants violated the False Claims Act by falsely certifying compliance with applicable statutes and by improperly submitting claims to the Oklahoma Health Care Authority (OHCA) for reimbursement. Each party moved for summary judgment.

Holding: The U.S. District Court for the Western District of Oklahoma court denied the relator's motion for summary judgment on his express certification theory of liability, and granted summary judgment to SOTS on that issue. The court denied summary judgment to both the relator and SOTS with respect to the relator's implied certification theory of liability. The court granted summary judgment with respect to HGI, Holloway, and Scott on all the claims asserted against them.

The court explained that in order to participate in Medicaid and Medicare in Oklahoma, providers had to certify compliance with state and federal regulations, as well as have a Provider Agreement on file with OHCA. This agreement certified that all information included on claims submitted was accurate and that providers were issued a provider number based on their registration with OHCA. The relator asserted that while he was employed by HGI, the defendants devised a scheme in which the relator would see a patient at HGI and then, unbeknownst to him, his clinical records would be used at SOTS to bill Medicaid, because SOTS had an OHCA provider number but HGI did not. The money was then distributed between HGI and SOTS, and the relator was paid from those funds.

Express False Certification

The court explained that the relator's express false certification theory of liability failed because, first, with regard to defendants HGI, Holloway, and Scott, there was no evidence that they ever submitted claims to OCHA for reimbursement. In addition, the relator failed to supply any examples of actual claims submitted by SOTS. Specifically, the court held that because it could not analyze a claim to determine whether any false certification was made to OHCA in tandem with the submission of the claim for reimbursement, the relator's express false certification allegations failed against all the defendants. The court held that the "general, sweeping," language in the OCHA Provider Agreements was too broad to support these allegations.

Implied False Certification

Again, the court explained that the relator's theory of liability failed because there was no evidence that HGI, Holloway, or Scott ever submitted claims to OCHA for reimbursement. The implied false certification claims against those defendants were dismissed. However, the court held that a violation of the site specific requirement for provider numbers under the Oklahoma rules regulating government healthcare services was a condition of payment, and determined that the government might not have paid the claims submitted by SOTS, if it had known that SOTS was violating this requirement. As a result, the court held that the relator properly alleged that SOTS knowingly violated the site specific requirement. However, the court explained, there remained questions of material fact. Therefore, the court did not grant summary judgment to either the relator or to SOTS on this issue.

U.S. ex rel. Absher v. Momence Meadows Nursing Ctr., Inc., 2014 WL 4092258 (7th Cir. Aug. 20, 2014)

The relators, former nurses at the defendant long-term care facility, brought a *qui tam* action under the False Claims Act alleging the defendant submitted "thousands of false claims" to Medicare and Medicaid. The defendant was reimbursed by the government on a "per patient day" basis, meaning it was paid for each resident, not based on the services it provided. In order to receive reimbursements, the defendant periodically submitted a Minimum Data Sheet ("MDS") form, which was both a billing document and a care assessment certification for Medicare and Medicaid. Each form contained a section stating that it accurately reflected the assessment for that patient, that the defendant conformed with Medicare and Medicaid requirements, that the defendant understood the information formed the basis for payment, and that inaccuracy could lead to criminal or civil penalties. The relators also brought claims alleging that the defendant violated the FCA's anti-retaliation provision.

At trial, the relators presented evidence of multiple instances of non-compliant care at the defendant's facility, including infections, pest control problems, scabies, sore management, medication issues, food and water temperature problems, accidents, cleanliness, issues with patient trust accounts, among other problems. In addition, the relators presented evidence that the defendant actively concealed its non-compliance by not charting symptoms or problems and by staffing up in response to visits by government regulators. The jury concluded that the defendant submitted 1,729 false claims, and imposed the highest statutory penalty under the FCA—$11,000 per claim ($19,019,000); the jury awarded compensatory damages in the amount of $3,030,409. The jury also awarded the nurses $150,000 and $262,320 respectively, on their retaliation claims. The U.S. District Court for the Central District of Illinois trebled the compensatory damages, awarding damages

in the amount of $9,091,227, and entered judgment in the relators' favor on their retaliation claims, but vacated the jury's award of statutory penalties as violative of the Eighth Amendment. Both parties appealed the district court's rulings to the U.S. Court of Appeals for the Seventh Circuit, with the defendant contending that the court lacked subject-matter jurisdiction over the relators' fraud claims due to the FCA's public disclosure bar provision, and that the retaliation claims failed as a matter of law. The relators cross-appealed the district court's decision to vacate the statutory penalties awarded by the jury.

Holding: The Seventh Circuit held that the relators' fraud claims were not barred by the public disclosure bar. However, the circuit court vacated the jury verdict in favor of the relators, rejecting the relators' "worthless services" theory of FCA liability, as well as the relators' false certification theories. Moreover, the circuit court dismissed the relators' cross-appeal regarding the set-aside of the statutory penalties. The circuit court further held that the relators' retaliation claims failed as a matter of law.

Public Disclosure Bar

On appeal, the defendant argued that the relators' *qui tam* claims were based on incidents that were documented in government survey reports that gave rise to administrative penalty proceedings prior to the relators' filing their complaint. The court held that the FCA's public disclosure bar was triggered, explaining that facts included in administrative government reports and proceedings are considered publicly disclosed for the purposes to of the FCA. The circuit court held that while one aspect of the alleged fraud—that the defendant provided non-compliant care to residents—was disclosed in these administrative actions, the relators provided additional information that was not publicly disclosed. Specifically the relators provided the other aspect of the alleged fraud scheme—that the defendant was not charting the instances of non-compliant care and was misrepresenting the standard of care in submitting the claim forms to the government for payment.

Worthless Services

The circuit court held that the district court's "worthless services" jury instruction was incorrect. The relators had argued that because the residents at the defendant's facility received woefully inadequate care, the care amounted to "worthless services" under the FCA, and therefore claims made to the government for reimbursement were false. The district court gave the following example: "if Uncle Sam paid [the defendant] 200 bucks and they only got $120 worth of value, [then the defendant] defrauded them of $80 worth of services." The circuit court held that this interpretation was incorrect, and that the performance of a service "must be so deficient that for all practical purposes it is the equivalent of no performance at all." The circuit court held that despite the evidence of fairly deplorable conditions and non-compliance at the defendant's facility,

"[s]ervices that are 'worth less' are not 'worthless,'" under the FCA. Consequently, the Seventh Circuit vacated the jury's award to the plaintiffs on that basis.

False Certifications of Compliance

The relators had argued that the defendant violated the FCA by certifying that the MDS forms accurately reflected the condition, status, and treatment of the patients, when in actuality, the forms did not reflect the symptoms, diagnosis, or treatment of a multitude of problems and illnesses stemming from the conditions at the facility. The circuit court held that a reasonable jury could find that these forms were a condition of payment because they specifically affirmed that reimbursement is "conditioned on the accuracy and truthfulness of [the] information." However, the circuit court held that the relators failed to allege how many MDS forms contained false certifications. The jury found that the defendant made 1,729 false certifications. The circuit court, though, held that this figure was based on speculation. While the relators presented evidence that the defendant created approximately 2,070 MDS forms per patient per year, the court held that any actual number the relators or jury arrived upon was not based on any actual evidence presented and could not support the relators' fraud claims.

Retaliation

Relator Mitchell alleged that she reported her concern about patient neglect, scabies, and other patient care issues to her supervisors and to the Illinois Department of Public Health several times. Mitchell alleged that she was told she would be terminated if she contacted IDPH again. Thereafter, she called IDPH to report her concerns about the death of a resident. Mitchell alleged that she was threatened again and ordered to alter the resident's chart, which she did not do. She was terminated thereafter. The circuit court held that Mitchell failed to offer evidence that she was engaged in a protected activity under the FCA. The circuit court explained that Mitchell did not present evidence that showed that she was conducting an investigation of or suspected fraud against the government by the defendant.

Relator Absher alleged that she was constructively discharged by the defendant, as she could not "bear to continue working at the facility in light of the poor care being provided." Absher offered evidence that she complained to her superiors often about the allegedly poor conditions at the facility and that they reacted with hostility towards her. She alleged that the death of the resident was "the last straw," and she resigned. The circuit court held that Absher did not offer any evidence that the defendant made her employment unbearable such that she was constructively terminated, and that she offered no evidence that she was engaged in a protected activity under the FCA. The Seventh Circuit dismissed the relators' retaliation claims.

U.S. ex rel. Fox Rx, Inc. v. Omnicare, Inc., 2014 WL 3928780 (S.D.N.Y. Aug. 12, 2014)

A corporate relator that was contracted by Medicare to administer prescription drug plans from 2006—2010 filed a *qui tam* action alleging that a group of defendants defrauded Medicare and Medicaid by failing to substitute generic drugs for brand-name drugs in violation of state law, and by dispensing drugs after the termination date of a national drug code. Two defendants, Omnicare and PharMerica (the "Pharmacy Defendants") provided pharmacy services to long term care facilities ("LTCFs"). The third defendant, MHA Long Term Care Network ("MHA") contracted with independent long term care pharmacies to negotiate rates of reimbursement and manage Medicare Part D claims on the pharmacies' behalf. Pursuant to its contracts with the pharmacies, MHA agreed to comply with all laws and regulations applicable to pharmacists.

The relator was one of the sponsors that Medicare contracted with to administer prescription drug plans from 2006-10. The sponsors received monthly payments based on the number of enrollees in their program. Medicare required that contracts between sponsors and pharmacies contain language requiring that the pharmacy comply with federal law.

When sponsors submitted claims to Medicare for reimbursement, they were required to fill in data fields in their submission; including the "Dispense as Written/Product Selection Code ("DAW Code")," where the prescriber indicated whether to substitute generic drugs for brand-name drugs. A selection of "0" for the DAW Code indicated that no production selection was designated, or production selection was not an issue. The relator alleged that the Pharmacy Defendants used a "0" DAW Code when they chose not to substitute an available generic drug for a brand-name drug, in violation of state laws and their contracts with sponsors.

In addition, each drug has a unique National Drug Code ("NDC") to identify certain product information. According to the relator, Medicare set the termination date for the NDC as the "self-life [sic] expiration date of the last batch of a discontinued drug" or when the drug was withdrawn from the market. The relator alleged that any claims submitted to Medicare or Medicaid for drugs dispensed after the NDC termination date were invalid. The defendants moved to dismiss the relator's claims, arguing that the relator failed to state a claim under the False Claims Act and failed to plead its fraud claims with particularity.

Holding: The U.S. District Court for the Southern District of New York granted the defendants' motion to dismiss, holding that the relator failed to identify any law or regulation that conditions reimbursement on the substituting generic drugs, on dispensing drugs only prior to their NDC termination date, or on complying with state pharmacy laws.

False Certification of Compliance

The relator relied on an implied certification theory, alleging that the Pharmacy Defendants falsely represented compliance with regulations that expressly stated that the provider must comply with the law in order to be reimbursed. First, the relator cited a regulation that required sponsors to have quality assurance measures in place, including the representation that providers are required to "comply with minimum standards for pharmacy practice…." The court held that this regulation was too vague to create a condition of payment, and that the relator failed to provide a link between the regulation and Medicare's payment of a claim. Next, the relator relied on a regulation related to contract provisions, which described the contracts between the sponsor and Medicare and listed the provisions that were required in those contracts. This regulation stated that the sponsors agreed to comply with federal laws and regulations preventing fraud including the False Claims Act. The court held that this regulation was too general to support a claim and "[did] not describe a condition for payment of Part D claims." The relator also cited a regulation relating to the relationship between the sponsors and the downstream entities which stated that their contracts had to specify that all entities comply with federal law and Medicare regulations. The court held that this regulation was simply a "component of the regulatory framework," not a condition of payment, and that the relator failed to allege that the Pharmacy Defendants were the downstream entities at which the regulation was aimed. Finally, the relator relied on a regulation regarding the certification of claims by sponsors and their contractors. This regulation stated that the claims data must be certified as accurate, and the designated individual must acknowledge that the claims data would be used for the purposes of reimbursement. While the court held that this regulation contained a condition of payment, and therefore could serve as a basis for an FCA claim, the relator failed to plead fraud relating to any claims that the Pharmacy Defendants made.

Failure to State a Claim/Plead Fraud with Particularity

The relator alleged that the Pharmacy Defendants violated the FCA when they used the DAW Code "0" on their submission to sponsors when they knew that a generic drug was available. The Pharmacy Defendants argued that the relator failed to plead that they actually submitted any false claims, as the claims submitted listed the actual brand name drug that was dispensed, public information was accessible as to the availability of generic drugs which any sponsor "could examine if it were material to its decision-making," and that there is no federal regulation requiring the substitution of generic drugs. The court held that the relator had not adequately pled falsity, because it had not shown that the use of a "0" code was inaccurate or false, considering the definition of the code was "No production selection indicated," and thus rather than specifying that there was not a generic available, simply gives no indication either way.

The relator also alleged that the Pharmacy Defendants dispensed drugs after their NDC termination date, in violation of state laws prohibiting the dispensing of ex-

pired drugs, which the relator characterized as a "worthless service" under the FCA. The court held that the relator had not adequately pled that the NDC termination date should be equated with the expiration date on drugs, and dismissed the relator's claims.

Finally, the relator also alleged that MHA violated the FCA by failing to oversee its network of pharmacies and ensure that the pharmacies complied with the law, as required by their contracts. The court held that the contracts actually imposed duties on the pharmacies and not MHA, and dismissed these claims as well.

U.S. ex rel. Goulden v. BAE Sys. Info. and Elec. Sys. Integration, Inc., 2014 WL 3897645 (D. Mass. Aug 7, 2014)

The relator, a former employee of the defendant—a defense contractor that, among other things, manufactured "thermal weapon sights" for the U.S. Army—alleged that the defendant violated the False Claims Act by falsely certifying that it had performed testing on its thermal weapon sights using "military standard or military-spec" machine guns as purportedly required by the contracts it entered into with the Army. The relator also alleged that he was terminated as a result of his investigation into this matter. In support of his claims, the relator asserted that while the contracts did not actually specify the requirement for military-grade weapons, the weapons listed in the contract were designated with an "M," which the relator claimed was "well known" in the industry as military standard. In addition, the relator provided several external documents in which he alleged parties to the contracts discussed the use of military-spec weapons. The realtor also alleged that the defendant purchased weapons illegally for this testing, because under the Bureau of Alcohol, Tobacco, Firearms, and Explosives ("ATF") rules, weapons manufacturers were only entitled to transfer military grade weapons as "sales samples," and not for testing purposes. In addition, the relator alleged that the defendant fraudulently obtained a license to manufacture these weapons because the defendant was not "in the business of manufacturing" firearms. Instead of actually manufacturing the weapons, the relator alleged that the defendant transferred the "restricted" parts that they acquired to a third-party weapons manufacturer to build the weapons for them, and when the guns broke apart in the field, the defendant would repair them with replacement parts. According to the relator, this resulted in weapons that were "cobbled together" with "mismatched parts of unknown quality," though the defendant certified to the government in its claims for payment that it had properly tested its thermal weapon sights using the Army specifications set forth in its contract. The government, the relator claimed, relied on these certifications in issuing payments to the defendant. The relator also claimed that he was terminated in retaliation for reporting his concerns to his employer and other employees for the defendant. He alleged that he came under investigation for unrelated issues involving missing company property after

he reported his concerns about the weapons testing standards, and that he was terminated soon after the investigation began.

The relator filed an initial complaint and the government declined to intervene. Subsequently, the relator filed his First Amended Complaint alleging that the defendant violated the FCA and terminated the relator in retaliation for his investigation. The defendant moved to dismiss and the relator opposed the defendant's motion and sought leave to file a Second Amended Complaint omitting the retaliation claims.

The defendant moved to dismiss the fraud claims, arguing that the relator did not plead with particularity that any claim or invoice was submitted under the contracts.

Holding: The U.S. District Court for the District of Massachusetts granted the defendant's motion. While the court held that the relator identified the contracts at issue and the approximate value of the contracts, and although the court acknowledged that he was not required to identify the particular invoices or employees who submitted the claims, ultimately, the court held that the relator could not show that the defendant actually submitted any false claims.

False Certification of Compliance

Relying on a "false certification" theory, the relator alleged that compliance with contractual terms related to testing and compliance with certain laws and regulations were "material precondition[s] for payment by the Army," and that in submitting claims for payment, the defendant "impliedly certified" that it had complied with those contract terms and laws. The court interpreted the prior First Circuit decision in *U.S. ex rel. Hutcheson v. Blackstone Medical* to create a two part test for false certification. First, the court must determine "whether the claims at issue…misrepresented compliance with a precondition of payment so as to be false or fraudulent." Second the court must decide whether the misrepresentation was "material."

The court held that the relator's allegations that the defendant violated federal law by fraudulently obtaining a license to manufacture military grade weapons and illegally outsourcing the manufacture of those weapons to a third party did not implicate the FCA because there was no allegation that there was a false claim or certification with regard to these actions. The court also held that the relator failed to provide the proper factual support for its assertion that the defendant was required by contract to certify that it tested the thermal weapon sights on military standard weapons. The court explained that it is not enough to allege that records or statements were made in violation of federal law, "a relator must allege that the statements were actually false." The relator, the court held, did not allege that the defendant was required to conduct the testing as he claimed, because he did not prove that his interpretation of the contract was the correct one.

Conspiracy to Violate the FCA

The court also rejected the relator's allegations that the defendant and its outside weapons manufacturer conspired to violate the FCA. The court explained that the relator did not allege any facts that suggested that the manufacturer knew the terms of the contracts between the defendant and the government or knew that its involvement would be material to whether the defendant's claims were paid.

Retaliation

The court rejected the relator's retaliation claim, explaining that while he alleged that he brought the potential illegality of the manufacturing agreement to the attention of his supervisors, he never mentioned to his employer the alleged non-compliance with the contracts or false claims submitted pursuant to those contracts in the context of FCA violations. The court held that while the relator's retaliation claims failed under the FCA, they were properly pled under the state laws, and allowed those claims to proceed.

McLain v. KBR, Inc., 2014 WL 3101818 (E.D. Va. July 7, 2014)

A relator filed a *qui tam* action against a defense contractor alleging fraud in connection with the defendant's contract to provide logistical support to U.S. troops in Iraq. According to the relator, who served as an electrician for the defendant, the company received a Corrective Action Request from the Defense Contract Management Agency regarding its failure to perform certain safety testing. The relator alleged that, after receiving the request, the defendant began creating false logs and inspection reports for electrical tests that were inadequately performed or not performed at all,. The defendant then submitted false certifications of compliance with contractual testing requirements, and subsequently submitted invoices to the Government for electrical services. The defendant filed a motion to dismiss the relator's fraud allegations pursuant to Federal Rule of Civil Procedure 12(b)(6).

Holding: The U.S. District Court for the Eastern District of Virginia granted the defendant's motion to dismiss with prejudice.

The court held that the relator failed to adequately plead his claims because: (1) the relator did not "allege[] a causal nexus between the false records and the Government's decision to pay," and therefore did not establish the materiality element of FCA liability; (2) the relator failed to plead a claim because he did not plead any facts to suggest that the Government made certifications of contractual compliance a "prerequisite to payment;" and (3) the relator's complaint failed to satisfy Rule 9(b) because although he identified seven specific invoices submitted to the Government, he did not allege the "who, what, when, where, and how" of those invoices—he did not state whether six of the invoices were for electrical services;

and although the seventh invoice (which consisted of 269 pages) did specify electrical services, the relator did not identify the specific services for which the government was billed.

Finally, the court denied the relator leave to amend because he "had two full opportunities to state his claims," and "had ample notice of the defects that befell his Original Complaint," but was unable to correct those defects.

See *U.S. ex rel. Ligai v. ETS-Lindgren Inc.,* 2014 WL 4649885 (S.D. Tex. Sept. 16, 2014), at page 75.

See *U.S. v. Americus Mortgage Corp.,* 2014 WL 4274279; 2014 WL 4273884 (S.D. Tex. Aug. 29, 2014), at page 86.

See *U.S. ex rel. Corporate Compliance Assoc. v. N.Y. Soc'y for the Relief of the Ruptured and Crippled, Maintaining the Hosp. for Special Surgery,* 2014 WL 3905742 (S.D.N.Y. Aug. 7, 2014), at page 8.

See *Baklid-Kunz v. Halifax Hosp. Med. Ctr.*, 2014 WL 2968251 (M.D. Fla. July 1, 2014), at page 109.

E. FCA Seal/Service Issues

U.S. ex rel. Brooks v. Stevens-Henager Coll., Inc., 2014 WL 3101817 (D. Idaho July 7, 2014)

Two relators, former college admissions consultants, filed a *qui tam* complaint alleging that the defendant violated the False Claims Act by paying admissions personnel enrollment incentives that violated the incentive-compensation ban of the Higher Education Act (HEA). According to the relator, the defendant falsely certified its compliance with the HEA and thereby fraudulently induced the U.S. Department of Education to make it eligible for certain federal funds. After the *qui tam* complaint was filed, the government successfully requested five extensions of the suit's initial 60-day seal period, resulting in about a 15-month government investigation of the relator's allegations. Eventually, the relator's complaint was unsealed and the government filed its own complaint-in-intervention. Subsequently, the relators sought to file an amended complaint; they redacted some of their new allegations and asked the court to seal the unredacted version for 60-days, to allow the government time to commence a new investigation. Around the same time, the government moved to seal the exhibits to its complaint-in-intervention.

Holding: The U.S. District Court for the District of Idaho denied the government's motion to seal without prejudice, and granted the relators' motion to seal their amended complaint.

Government's Motion to Seal Exhibits

The government sought to seal various exhibits to its complaint-in-intervention, including program participation agreements, employment manuals, and internal directives to employees. But the court observed that the government supported this request with only three sentences, including an assertion that the materials "may contain proprietary information." The court denied the government's request, recognizing the strong presumption that judicial records should be open to the public, and finding that the government did not attempt to articulate a compelling reason in favor of sealing, particularly since these were not records that are "traditionally kept secret." Thus, the court denied the government's motion to seal without prejudice.

Relators' Motion to Seal Their Amended Complaint

In response to the relators' motion, the court first explained that the False Claims Act's seal provision only references original *qui tam* complaints and "does not definitively require amended complaints to be filed under seal." It further explained that some courts have held that as to amended complaints, only new claims and/or substantially different allegations of fraud should be filed under seal. Ultimately, the court concluded that some of the relators' new claims contained substantial and different allegations of fraud, and the relators were allowed to file the unredacted version of the amended

complaint under seal for 60-days. The court further informed the government that it had no intention of granting any extensions to the 60-day seal, and that within the 60-day period it must investigate the new allegations, decide whether to intervene in the new allegations, and make any necessary filings related to an intervention.

Judgments & Settlements

JULY 1, 2014–SEPTEMBER 30, 2014

Caremark LLC (W.D. Tex. Sept. 26, 2014)

Caremark LLC has agreed to pay $6 million to settle allegations that it violated the False Claims Act by failing to reimburse Medicaid for prescription drug costs paid on behalf of Medicaid beneficiaries who also were eligible for drug benefits under Caremark-administered private health plans. The *qui tam* suit was filed by Donald Well, a former employee of Caremark. Well will receive a reward of $1.02 million plus interest as part of the settlement. He was represented by TAFEF member Glenn Grossenbacher of the Law Office of Glenn Grossenbacher.

Shire Pharmaceuticals (E.D. Penn., N.D. Ill. Sept. 24, 2014)

Shire Pharmaceuticals has agreed to pay $56.5 million to settle allegations that it violated the False Claims Act by marketing Adderall XR, Vyvanse and Daytrana for unapproved purposes. From January 2004 through December 2007, the corporation allegedly exaggerated the efficiency of the three ADHD medications, stating that the drugs were so clinically superior to other ADHD drugs that they could render people with the disorder indistinguishable from those without it. Shire allegedly marketed the drugs as cure-alls for poor academic performance, loss of employment, criminal behavior, traffic accidents, and sexually transmitted diseases—without FDA approval. The settlement resolves two *qui tam* suits: a suit filed by Dr. Gerardo Torres, a former Shire executive; as well as a suit filed by former Shire sales representatives, Anita Hsieh, Kara Harris, and Ian Clark. Torres was represented by Stephen Sheller of the Sheller Law Firm, and Joseph Trautwein of Joseph Trautwein & Associates. Hsieh, Harris, and Clark were represented by David Chizewer, Matt Organ, and Colin Wexler of Goldberg Kohn, and Robin Potter of Robin Potter & Associates. All of the attorneys are TAFEF members.

Banks-Jackson-Commerce Hospital and Nursing Home Authority (M.D. Ga. Sept. 22, 2014)

Banks-Jackson-Commerce Hospital and Nursing Home Authority d/b/a Banks Jackson Commerce Medical Center (BJC) and cardiologist Narasimhulu Neelagaru have agreed to pay $500,000 to settle allegations that they violated the False Claims Act and the Anti-Kickback Statute. A *qui tam* suit filed by Ralph D. Williams alleged that from 2000-2009, BJC paid Dr. Neelagaru for professional services and medical director services above fair market value. To resolves those allegations, BJC will pay the government $329,000 and Dr. Neelagaru will pay $200,000. As a condition of the settlement, BJC has entered into a Corporate Integrity Agreement with the Department of Health and Human Services which stipulates that the company must submit an independent review of its financial arrangements with medical providers who refer patients to BJC.

A Plus Home Health Care Inc., Tracy Nemerofsky, and Stephen Nemerofsky (S.D. Fla. Sept. 18, 2014)

A Plus Home Health Care Inc. and its owners, Tracy and Stephen Nemerofsky, have agreed to pay $1.65 million to the United States to settle allegations that they violated the False Claims Act and the Anti-Kickback Statute. William Guthrie, a former director of development at A Plus, filed a *qui tam* suit alleging that the Fort Lauderdale, FL-based company paid spouses of referring physicians for fraudulent marketing positions in order to increase Medicare referrals -- A Plus allegedly hired seven physicians' spouses and one physician's boyfriend to perform marketing duties with salaries that served as a reward for referrals of Medicare patients to the facility.

M.K. Battery, Inc. and East Penn Manufacturing Co. (D. Minn. Sept. 16, 2014)

M.K. Battery, Inc., East Penn Manufacturing Co., and affiliated corporations have agreed to pay $5.5 million to resolve *qui tam* allegations that that violated the False Claims Act. The corporations involved are manufacturers of machinery used in combat vehicles in Iraq. The lawsuit alleged that the companies substituted a battery used in Humvee gun turrets that was not as efficient as the batteries the Army believed it had purchased. The *qui tam* suit was filed by David McIntosh, a former employee of M.K. Battery. He was represented by Clayton Halunen and TAFEF member Susan Coler of Halunen & Associates.

Episcopal Ministries to the Aging Inc. (D. Mass. Sept. 15, 2014)

Episcopal Ministries to the Aging Inc. (EMA) has agreed to pay $1.3 million to settle allegations that it violated the False Claims Act by submitting false claims to federal health programs. The Maryland-based nonprofit, which operates skilled nursing facilities, allegedly billed Medicare for unreasonable or medically unnecessary rehabilitation therapy provided by RehabCare Group Inc. At the EMA-owned William Hill Manor, the company allegedly allowed RehabCare to ignore individual evaluations to: determine the level of care most suitable for each patient's clinical needs; place patients in the highest reimbursement level unless it was shown that the patients could not tolerate that amount of therapy; provide the minimum number of minutes of therapy required to bill at the highest reimbursement level while discouraging the provision of therapy in amounts beyond that minimum threshold, despite the Medicare requirement that the amount of care provided be determined by patients' clinical needs; arbitrarily change the number of minutes of planned therapy between therapy disciplines to ensure targeted reimbursement levels were achieved; and report estimated or rounded minutes instead of reporting the actual minutes of therapy provided.

Meridian Surgical Partners (M.D. Tenn. Sept. 10, 2014)

Meridian Surgical Partners has agreed to pay $5.12 million to settle allegations that it violated the False Claims Act and the Anti-Kickback Statute by paying certain physicians above fair market value in exchange for promises of referrals of Medicare patients. The allegations were made in a *qui tam* suit filed by Thomas Reed Simmons, a former manager of a surgery center affiliated with Meridian. Simmons was represented by TAFEF member Jonathan Kroner of the Jonathan Kroner Law Office.

Dr. Hubert Zachary, Dr. George Restea, and Sleep Medicine Center (M.D. Fla. Sept. 10, 2014)

Dr. Hubert Zachary and Dr. George Restea of the Florida-based Sleep Medicine Center have agreed to pay $300,000 to settle *qui tam* allegations that the clinic and its physicians submitted false claims to the government. Between January 1, 2010 to November 13, 2013 patients treated at the Sleep Medicine Center were allegedly subjected to medically unnecessary tests performed by individuals who were not licensed to do so. In addition to submitting claims to Medicare and TRICARE for these tests, the clinic also allegedly billed federal healthcare programs for tests that were never performed. The Sleep Medicine Center will be excluded from Medicare and TRICARE for the next eight years. The *qui tam* suit was filed by Donna Nichols, a former employee of the medical center. Nichols will receive approximately $60,000 as part of the settlement. She was represented by TAFEF members David Scher and R. Scott Oswald of the Employment Law Group.

Life Care Services LLC and CoreCare V LLP (D. Mass. Sept. 5, 2014)

Skilled nursing facilities manager Life Care Services LLC and CoreCare V LLP, a skilled nursing facility operating as ParkVista, have agreed to pay $3.75 million to settle allegations of submitting inflated bills to Medicare for unreasonable or unnecessary rehabilitation services provided by RehabCare Group East, Inc. RehabCare Group's alleged methods of improperly increasing Medicare reimbursement included, but were not limited to: ignoring individual evaluations to determine the level of care most suitable for each patient's clinical needs; presumptively placing patients in the highest reimbursement level unless it was shown that the patients could not tolerate that amount of therapy; providing the minimum number of minutes of therapy required to bill at the highest reimbursement level while discouraging the provision of therapy in amounts beyond that minimum threshold, despite the Medicare requirement that the amount of care provided be determined by patients' clinical needs; arbitrarily shifting the number of minutes of planned therapy between therapy disciplines to ensure targeted reimbursement levels were achieved; and reporting estimated or rounded minutes instead of reporting the actual minutes of therapy provided.

Smith & Nephew (W.D. Tenn. Sept. 2, 2014)

U.K.-based medical device manufacturer Smith & Nephew has agreed to pay $8 million to settle allegations that it violated the False Claims Act and the Trade Agreements Act (TAA) by disregarding the provisions of the TAA and selling products manufactured in Malaysia—a nation that does not hold a trade agreement with the United States. The corporation allegedly falsified the "country of origin" labels on products sold to U.S. Government agencies. These allegations were included in a *qui tam* lawsuit filed by Sam Cox, a former information technology manager at Smith and Nephew. Cox, who represented by TAFEF member H. Vincent McKnight of Sanford, Heisler, Kempel, LLC, will receive a $2.3 million reward. This settlement is believed to be the first to involve false country of origin claims involving medical devices.

Dr. Jamie Gottlieb and Omni Surgical L.P. (N.D. Ind. Aug. 29, 2014)

Elkhart, Indiana spinal surgeon Dr. Jamie Gottlieb and Texas-based medical device maker Omni Surgical L.P. have agreed to pay $2.6 million to settle allegations that from 2007 to 2009 they violated the False Claims Act and the Anti-Kickback Statute when Dr. Gottlieb accepted payments from Omni Surgical L.P., doing business as Spine 360, in exchange for agreeing to use the company's products.

Circle C Construction (M.D. Tenn. Aug. 26, 2014)

Tennessee-based construction company Circle C Construction has agreed to pay $762,0894.54 to settle allegations that it falsified payroll documents to misrepresent that its workers were receiving the required prevailing wages as required by the Davis-Bacon Act. The *qui tam* suit was filed by a former Circle C employee, and the government intervened. The district court found that Circle C had underpaid employees of its electrical subcontractor, Phase Tech by more than $250,000. That figure was tripled, resulting in the final settlement amount.

Topline Appliance Center and Michael Moretti (S.D.N.Y. Aug. 22, 2014)

New Jersey Appliance retailer, Topline Appliance Center, and its owner, Michael Moretti, have agreed to pay $1.56 million to settle *qui tam* allegations that Moretti knowingly failed to collect and pay sales taxes and corporate franchise taxes to New York over the course of 10 years, as out-of-state companies that do business in New York are required, to ensure that they will not have an advantage over New York businesses. The *qui tam* suit was filed by a whistleblower represented by TAFEF member Raphael Katz of Sadowski Fischer, PLLC.

Ralex Services, Inc. and Glen Island Center for Nursing and Rehabilitation (E.D.N.Y. Aug. 21, 2014)

Ralex Services Inc. has agreed to pay $2.2 million to settle allegations that its Glen Island Center for Nursing and Rehabilitation submitted false claims to the New York State Medicaid Program. The government alleged that the nursing home submitted more than 62,000 false claims to the New York Department of Health between April 2002 and November 2006 and exaggerated the degree of care required by many of its residents and falsified medical records in order to receive greater Medicaid reimbursements. In accordance with the terms of the settlement, Ralex and Glen Island owner Leah Friedman must return $2.2 million to Medicaid. Since Medicaid is a program jointly funded by federal and state governments, New York will receive $1,320,000 of the total restitution.

Bank of America August 21, 2014

Bank of America agreed to pay $16.65 billion to settle allegations that it knowingly sold toxic mortgages prior to the 2008 financial crisis. This represents the largest settlement ever reached between the U.S. government and a single company. Prior to January 1, 2009, Bank of America allegedly provided credit to borrowers who could not afford the loans and then sold the low-quality mortgages to investors. The borrowers quickly defaulted on the loans, subsequently leaving the investors with large losses. The government concluded that Bank of America evaded underwriting standards by falsifying loan applicants' financial qualifications and the origination of faulty loans had widespread ramifications. Under the settlement, the government reserved the right to file criminal charges against Bank of America in addition to the civil penalties.

Washington Area Metropolitan Transit Authority (D.D.C. Aug. 20, 2014)

The Washington Area Metropolitan Transit Authority (WMATA) paid $4.2 million to settle allegations that it violated the False Claims Act and Federal Transit Administration guidelines. The government alleged that WMATA improperly used federal funds to award a contract for a financial management information technology project. In August 2009, Virginia-based business Metaformers, Inc. received a contract from WMATA to integrate its financial and business systems. WMATA funded the $14 million project with $9 million of grant funds from the Federal Transit Administration. In order to use the grant funds, however, WMATA was required to comply with FTA regulations mandating full and open competition and in a manner that did not create a conflict of interest. WMATA allegedly violated both requirements. The *qui tam* suit was filed by Shahiq Khwaja, a former WMATA employee. Khwaja was represented by TAFEF member David Colapinto of Kohn, Kohn, & Colapinto, LLP, as

well as Geoffrey H. Simpson of Webster & Fredrickson, PLLC. He will receive approximately $996,480 as his share of the government's recovery. He will also receive $390,000 to resolve a wrongful termination claim against the company.

Samsung (D. Md. Aug. 19, 2014)

The American division of Samsung has agreed to pay $2.3 million to settle charges that it violated the False Claims Act by misleading the United States government regarding where its products were manufactured. A *qui tam* suit alleged that from January 2005 through August 2013, Samsung caused the submission of false claims for products sold on General Service Administration (GSA) Multiple Award Schedule (MAS) contracts, in violation of the Trade Agreements Act of 1979 (TAA). Government contracting regulations stipulate that federal agencies must purchase products manufactured in the United States or in a country with which it holds a trade agreement. Federal agencies purchased products from Samsung resellers under the belief that the products were produced in South Korea or Mexico when they were allegedly manufactured in China, a country that was not involved in the trade agreement with the United States. The *qui tam* suit was filed by Robert Simmons, a former Samsung employee. Simmons was represented by TAFEF member Nathan M. Peak of Ashcraft & Gerel LLP.

Carondelet Health Network (D. Ariz. Aug. 18, 2014)

The Carondelet Health Network has agreed to pay $35 million to settle accusations that it submitted false claims to Medicare and other federal health programs. From April 2004 and December 2011, Carondelet St. Mary's and Carondelet St. Joseph's hospitals in Tucson allegedly submitted false bills to Medicare, the Federal Employees Health Benefit Program, and the Arizona Health Care Cost Containment System—the state's Medicaid program. The allegations were made in a *qui tam* suit filed in 2011 by Jacqueline Bloink, a former employee of Carondelet. Bloink will receive $6 million as part of the settlement. She was represented by TAFEF members David Williams and David J. Caputo of Kline & Specter of Philadelphia, PA, and TAFEF member Joseph Trautwein of Joseph Trautwein and Associates.

New York Heart Center (N.D.N.Y. Aug. 14, 2014)

New York Heart Center has agreed to pay $1.3 million to settle allegations that it violated the Stark Law and False Claims Act by improperly taking into account the volume or value of doctors' referrals for nuclear scans and CT scans when determining physician compensation.

Optim Healthcare (S.D. Ga. Aug. 14, 2014)

Savannah-based Optim Healthcare and an affiliate hospital in Tattnall County have agreed to pay $4 million to settle *qui tam* allegations that they violated the False Claims Act. The suit alleged that Optim Healthcare, through its physician-owned hospital in Tattnall County and through its ambulatory surgical center in Savannah, submitted inflated claims for surgical and other medical procedures to Medicare, made false representations to generate higher reimbursements rates, and committed constituted Stark Law violations. The suit was filed by multiple patients who underwent medical procedures at the Tattnall location.

McKesson (M.D. Tenn. Aug. 8, 2014)

San Francisco-based pharmaceutical distributor, McKesson, has agreed to pay $18 million to settle allegations that it violated the False Claims Act by disregarding the terms of its distribution contract with the Centers for Disease Control and Prevention (CDC). Terrell Fox, a former finance director at McKesson Specialty Distribution LLC, file a *qui tam* suit that alleged that from April 2007 to November 2007 McKesson failed to comply with the shipping and handling requirements of its vaccine distribution contract—which stipulated that during shipping, the vaccines were to be kept at proper temperatures with electronic temperature monitors—and then knowingly submitted false claims to the CDC.

City of New York (N.D.N.Y. Aug. 4, 2014)

The City of New York has agreed to pay the United States $1.05 million to settle allegations in a *qui tam* suit that the New York City Human Resources Administration (HRA) violated the False Claims Act. The suit alleged that the city allowed managed care organizations (MCOs) to provide health care coverage to individuals that HRA knew, or should have known, were ineligible to receive Medicaid benefits through New York State's Medicaid program. According to the suit, although MCOs on several occasions notified HRA in writing that certain beneficiaries may have moved out of State, HRA failed to appropriately follow up on that information and work with DOH to ensure that MCOs stopped receiving monthly payments. The *qui tam* suit was filed by an unidentified whistleblower who will receive a $175,000 reward as part of the settlement.

Community Health Systems Inc. (M.D. Tenn. Aug. 4, 2014)

Tennessee-based Community Health Systems Inc. (CHS), the nation's largest operator of acute care hospitals, has agreed to pay $98.15 million to settle allegations that it fraudulently billed government health care programs for inpatient services that should have been billed as outpatient or observation services. The settlement also addresses allegations that CHS affiliate, Laredo Medical Center, improperly billed Medicare for inpatient procedures and services for patients referred in violation of the Stark Law. Several relators filed a *qui tam* suit that alleged that from 2005 through 2010, CHS developed an illegal scheme to increase inpatient admissions of Medicare, Medicaid and TRICARE program beneficiaries over the age of 65 who originally presented to the emergency departments at 119 CHS hospitals. According to the complaint, inpatient admission of these beneficiaries was not medically necessary, and the care given to the beneficiaries should have been provided in a less costly outpatient or observation setting. As part of the settlement, CHS entered into a Corporate Integrity Agreement with the U.S. Department of Health and Human Services Office of Inspector General, requiring the health system to retain independent review organizations to review the accuracy of its claims for inpatient services furnished to federal health care program beneficiaries. The *qui tam* suit was filed by several whistleblowers, all of whom are former employees of CHS: Kathleen Bryant, Rachel Bryant, Bryan Carnithan, Amy Cook-Reska, James Doghramji, Thomas Mason, Scott Plantz, and Nancy Reuille. The relators' share has yet to be determined. The relators were represented by Mitch Kreindler and Sharon Gurak of Kreindler & Associates; Jan Soifer and Patrick J. O'Connell of O'Connell & Soifer LLP; and David J. Chizewer and Matthew K. Organ of Goldberg Kohn Ltd.—all of whom are TAFEF members.

Brooklyn Plaza Medical Center (E.D.N.Y. Aug. 1, 2014)

Brooklyn Plaza Medical Center (BPMC) has agreed to pay $600,000 to settle *qui tam* allegations that it ran a satellite facility, the Whitman Ingersoll Farragut Health Center, without an operating certificate issued by the New York State Department of Health; the satellite facility could not bill Medicaid at the rate that had been negotiated between BPMC and the State unless it had an operating certificate. The settlement also addresses allegations that BPMC altered Whitman's Medicaid billings to make them appear as if services were rendered at the BPMC, not a satellite center.

Hewlett-Packard Aug. 1, 2014

Hewlett-Packard (HP) has agreed to pay $32.5 million to settle allegations that, between October 2001 and December 2010, it violated the False Claims Act by overcharging the U.S. Postal Service for products. The government alleged that under a contract between HP and the USPS, HP overcharged USPS by failing to comply with pricing terms of the contract. The government also claimed that HP violated a stipulation of the contract that required the company to charge to the government prices no more than those offered to other HP customers under similar contracts. The corporation allegedly misrepresented its intentions during contract negotiations when it ensured that it would provide the government with appropriate pricing.

Vascular Solutions, Inc. (W.D. Tex. July 28, 2014)

Vascular Solutions, Inc. (VSI) has agreed to pay $520,000 to resolve allegations that it marketed its Vari-Lase Short Kit medical devices—which were designed for treatment of varicose veins—for unapproved uses. The corporation also allegedly paid illegal kickbacks to physicians to promote the product and led healthcare providers to make submit false claims to Medicare and TRICARE, which had not approved the Vari-Lase treatment. The *qui tam* suit was filed by Desalle Bui, a former VSI employee, in 2010. Bui was represented by TAFEF members David Stone and Robert Magnanini of Stone & Magnanini LLP.

Matson Navigation Co. Inc. (C.D. Cal. July 28, 2014)

Matson Navigation Co. Inc. has agreed to pay $9.95 million to settle allegations that it violated the False Claims Act by over-billing the U.S. Department of Defense. The *qui tam* suit, filed by Illinois freight consultant Mario Rizzo, alleged that Matson, along with cargo container shipping company Horizon Lines, improperly billed the U.S Department of Defense for ocean transport fuel charges in cases when rail was used, resulting in $2 million a year in damages for the Department of Defense. Rizzo will receive $950,000 for court costs and attorney's fees, as well as $2.5 million reward.

BNP Paribas (S.D.N.Y. July 25, 2014)

French bank BNP Paribas has agreed to pay $80 million for defrauding a program run by the U.S. Department of Agriculture. The program's purpose was to encourage American exports by covering losses for American commodities exporters in the event that their import partners failed to make payments. From 1998 to 2005, BNP Paribas violated the program requirements by guaranteeing credit for companies controlling both importation and exportation of a trade, but in some instances never making a payment or shipment. The $80 million is part of a greater $8.9 billion settlement with U.S. authorities for violating economic sanctions.

American International Biotechnology (W.D. Pa. July 23, 2014)

Virginia-based medical research firm American International Biotechnology has agreed to pay $343,000 to settle allegations that it violated the False Claims Act by using illegal referrals for genetic tests and billing them to Medicare. Jason Hoover, a contract sales agent employed by the firm, has also been accused of offering kickbacks of $50 per patient to a nurse employed by Lions Medical Center in Rices Landings, PA, a healthcare center run by Greentree Medical Center—the hospital from which the allegations stemmed. The aforementioned nurse, Matt Burkett, stated that Hoover asked him to swab each patient and submit an order form for each patient's signature so the DNA tests could be ordered. When Burkett declined the $50 kickback, Hoover gave him the impression the testing was free and proceeded to complete the genetic testing order forms with the patients' insurers and listed Burkett as the referring physician. In some cases Medicare was billed as much as $4,000 per patient.

Infirmary Health System Inc. (S.D. Ala. July 21, 2014)

Infirmary Health System Inc. (IHS) and its affiliated clinics: IMC-Diagnostic and Medical Clinic, IMC-Northside Clinic, and the Diagnostic Physicians Group P.C. (DPG), have agreed to pay $24.5 million to settle allegations that they violated the False Claims Act, Stark Law, and the Anti-Kickback Statute. A *qui tam* suit filed by Dr. Christian Heesch, a former DPG physician, alleged that IHS and its affiliates made financial arrangements that compensated physicians for referrals—IMC-Diagnostic and Medical Clinic and IMC-Northside Clinic agreed to pay DPG a percentage of Medicare payments for medical procedures referred by DPG physicians. As a condition of the settlement, IHS, its two affiliated clinics, and DPG have agreed to enter into a Corporate Integrity Agreement with the US Department of Health and Human Services Office of the Inspector General, which stipulates that the defendants must submit their federal healthcare program claims to independent review for the next five years. Dr. Heesch will receive a $4.41 million reward.

Halifax Health (M.D. Fla. July 14, 2014)

Florida-based Halifax Health has agreed to pay $1 million to settle allegations that it submitted false claims to Medicaid. Elin Baklid-Kunz, the hospital's former compliance director, alleged in a *qui tam* suit that from 2002 to 2013, the hospital collected $73 million in undeserved Medicaid reimbursements. Baklid-Kunz also stated that Halifax misrepresented inexpensive outpatient care as more costly inpatient procedures and ignored evidence of blatant overbilling.

Citigroup Inc. July 14, 2014

Citigroup Inc. has agreed to pay $7 billion to settle allegations that it knowingly sold residential mortgage-backed securities (RMBS) with underlying defective mortgage loans to investors prior to January 1, 2009. Upon being notified of the loans' subpar quality by a third-party due-diligence firms, Citigroup continued to conceal this fact and marketed and sold the RMBS to investors. The settlement includes a $4 billion civil penalty—the largest of its kind recovered under the Financial Institutions Reform, Recovery and Enforcement Act. It also includes $500 million to be paid to the Federal Deposit Insurance Corporation and $2.5 billion in consumer relief.

Carthage Area Hospital (N.D.N.Y. July 10, 2014)

Carthage Area Hospital, an upstate New York medical center, has agreed to pay $750,000 to settle allegations that it submitted 1,900 false claims to Medicare. From September 1, 2006- June 30, 2010, Carthage Hospital allegedly double-billed Medicare for operating room services and ambulatory surgeries. Due to the hospital's cooperation throughout the investigation, the government did not seek double or triple damages plus fines and penalties under the False Claims Act.

Advanced Power & Lighting (N.D. Ga. July 10, 2014)

Chattanooga, TN-based construction services provider Advanced Power & Lighting (APL), has agreed to pay $780,000 to settle *qui tam* allegations that it underpaid employees completing federally-funded projects in Georgia and subsequently submitted false payroll records. In 2010, APL received a Broadband Technologies Opportunities Program subcontract to develop broadband projects in North Georgia. The contract required the company to comply with the project's Davis-Bacon Act requirements, which stipulated that contractors and subcontractors must pay their workers equal wages and fringe benefits for corresponding work on similar projects in the area. APL allegedly underpaid its workers by $10 over the course of the project's completion.

RE/MAX Allegiance Relocation Services (E.D. Va. July 8, 2014)

Woodbridge, VA-based RE/MAX has agreed to pay the government $509,807 to settle allegations that it violated the False Claims Act by overbilling for transportation services. Michael Angel, a former RE/MAX employee, filed a *qui tam* suit that alleged that the move management company charged for services it failed to provide and overbilled agencies by charging inapplicable tariff rates. Angel will receive a reward of $86,667.

U.S. Bank (N.D. Ohio; E.D. Mich. July 1, 2014)

Financial services provider, U.S. Bank, has agreed to pay $200 million to settle allegations that it knowingly underwrote Federal Housing Administration loans that did not meet quality assurance program requirements. From 2006-2011, U.S. Bank is alleged to have submitted falsely certified loans for FHA insurance, resulting in foreclosures and loss of government funds.

Medtronic (N.D. Tex. July 1, 2014)

Medtronic has agreed to pay $2.8million to resolve allegations that it submitted false claims to Medicaid programs and violated federal anti-solicitation rules. The Minnesota-based medical device manufacturer allegedly submitted claims for replacement insulin infusion pumps that were initiated through improper solicitation of Medicaid recipients. The settlement resolves a *qui tam* suit filed in 2011 by former Medtronic employees. The National Association of Medicaid Fraud Control Units negotiated the settlement on behalf of the 36 states involved.

HSBC Holdings PLC (S.D.N.Y. July 1, 2014)

HSBC Holdings has agreed to pay $10 million in response to allegations that it submitted false claims to the United States government in the form of inflated bills to process residential foreclosures. From 2009 to 2010, the multinational banking corporation allegedly submitted inflated fees to the FHA and Fannie Mae for reimbursement. HSBC also allegedly failed to properly regulate foreclosure related fees charged by lawyers and other mortgage suppliers, resulting in millions of dollars in losses for the FHA and Fannie Mae.