CASE NO. 04-16167-B

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

UNITED STATES OF AMERICA *ex rel*. PATRICK BRUCE ATKINS, M.D.,

Appellant,

v.

CHARLES M. McINTEER, M.D., et al.,

Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT,
NORTHERN DISTRICT OF ALABAMA, SOUTHERN DIVISION

BRIEF *AMICUS CURIAE* OF TAXPAYERS AGAINST FRAUD EDUCATION FUND IN SUPPORT OF APPELLANT AND REVERSAL

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U.S. ex rel. Atkins v. Charles McInteer
Case No. 04-16167-B

CERTIFICATE OF INTERESTED PERSONS AND
DISCLOSURE STATEMENT

(1) Taxpayers Against Fraud Education Fund, the False Claims Act Legal Center (TAFEF) is a nonprofit public interest organization.

(2) TAFEF is represented by its President, James Moorman, its Associate Director, Amy Wilken, and its Staff Attorney, Joseph E. B. White.

(3) TAFEF Represents no parties in this matter and has no pecuniary interest in its outcome. However, TAFEF has an institutional interest in the effectiveness and correct interpretation of the False Claims Act.

(4) Pursuant to Eleventh Circuit Rule 26.1, the following is a list of the persons and entities that have an interest in the outcome of this matter.

Hon. William M. Acker, Jr., USDC

Patrick Bruce Atkins, M.D., Relator

J. Wilson Axon, Jr., Esquire

BEP Services (Southern) LLC

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Beverly Health and Rehabilitation Services, Inc.

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Capitol Hill Healthcare Center, Inc.

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Eastern Health System, Inc.

Thomas C. Fox, Esquire

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HealthSouth Corporation

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Alabama Medicaid, *Alabama Medicaid Provider Enrollment Application Packet, available at* http://www.medicaid.state.al.us/forms/provenroll.pdf (last visited
January 25, 2005) 10

STATEMENT OF INTEREST OF *AMICUS CURIAE*

Taxpayers Against Fraud Education Fund is a nonprofit public interest organization dedicated to combating fraud against the Federal Government through the promotion of the *qui tam* provisions of the False Claims Act. It has a profound interest in ensuring that the Act is appropriately interpreted and utilized. The issue here is the applicability of the FCA to defendants accused of defrauding Medicaid, the federal-state healthcare program for low-income Americans. The decision below gravely undermines the efficacy of the Act in policing fraud on the Federal Government, because it exempts from FCA liability fraudfeasors who submit false claims to state Medicaid agencies, the recipients of billions of dollars in reimbursement funds from the Federal Government.

STATEMENT OF THE ISSUE

Whether the district court erred in dismissing the Relator's 31 U.S.C. § 3729(a)(1) claim on the grounds that false claims submitted to a state Medicaid agency, which causes the agency to forward false claims to the Federal Government, are not actionable because the fraudfeasor does not personally present the claims to a federal employee.

SUMMARY OF THE ARGUMENT

The False Claims Act (FCA), 31 U.S.C. §§ 3729 *et seq.*, imposes civil liability on any person who "knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval." *Id.* § 3729(a)(1). The Act broadly defines "claim" to include not only those claims paid directly by the Government, but also claims in which the Federal Government "reimburse[s] [a] contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded" by the alleged fraudfeasor. 31 U.S.C. 3729(c). Indeed, the legislative history explains that FCA liability attaches to false claims "submitted to State, local, or private programs funded in part by the United States where there is significant Federal regulation and involvement." S. Rep. No. 99-345, 99th Cong., 2d Sess. (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5287.

The district court held that false claims submitted to Medicaid, a federal-state health care program, causing a state agency to present false or fraudulent reimbursement claims to the Federal Government, are nevertheless excluded from the scope of the False

Claims Act because the defendant does not personally present the claims to a federal employee. This reading of the statute is inconsistent with its plain language, irreconcilable with applicable legislative history, and at odds with the principle case relied on in support of the ruling, *United States ex rel. Totten v. Bombardier Corp.*, 380 F.3d 488 (D.C. Cir. 2004). The district court decision, by failing to recognize that claims submitted to state Medicaid agencies are necessarily forwarded to the Federal Government for approval and reimbursement, significantly restricts the reach of the False Claims Act in a manner that Congress did not intend, withdrawing False Claims Act protection with respect to the Medicaid system, leaving hundreds of billions of dollars in federal funds in jeopardy. The decision is legally unsustainable, and should be reversed.

The lower court's ruling selectively reads the language of 31 U.S.C. § 3729(a)(1), which explicitly attaches liability not only to those who "present" false claims to the Federal Government, but also to those who "cause" false claims "to be presented" to the Federal Government. *Id*. In addition, the district court decision overly restricts the plain meaning of 31 U.S.C. § 3729(c), which, by its very terms, defines "claim" to include those "made to" recipients of federal funds, which are subsequently forwarded to the Federal Government for reimbursement. *Id.* Thus, the Act imposes no "direct presentment" requirement as a prerequisite to Section 3729(a)(1) False Claims Act liability.

The district court's ruling is particularly flawed with respect to the Medicaid system, a federal-state program, which, by its very nature, depends upon state agencies forwarding claims to the Federal Government for payment and approval. By adopting a blanket rule that lifts the FCA shield protecting federal grantees, the district court jeopardizes the federal fisc, the very entity Congress sought to protect.

Additionally, the relevant legislative history shows beyond question that the result reached by the district court is contrary to the intent of Congress. In its 1986 amendments to the False Claims Act, Congress, in clarifying the existing scope of FCA liability, unequivocally stressed that the Act's protective veil shields the Government from false claims submitted to state Medicaid agencies. Indeed, Congress specifically inserted the more precise definition of "claim" reflected in 31 U.S.C. § 3729(c), so as to protect grantees who are required to forward claims to the Government for reimbursement or approval. Thus, the lower court's ruling not only ignores the plain meaning of the Act, but also disregards the applicable legislative history.

Furthermore, the district court announces, *sua sponte*, that it is adopting the D.C. Circuit's ruling in *United States ex rel. Totten v. Bombardier Corporation*, 380 F.3d 488 (D.C. Cir. 2004). However, the lower court misinterprets the *Totten* opinion, which plainly states that false claims submitted to a federal grantee are actionable *if they are resubmitted to the Government by the grant recipient*. *Id.* at 491. Thus, the lower court's ruling fails to correctly apply the D.C. Circuit opinion that it relies upon.

ARGUMENT

I. THE DISTRICT COURT ERRED IN RULING THAT FALSE CLAIMS SUBMITTED TO MEDICAID, A FEDERAL-STATE HEALTH CARE PROGRAM, CAUSING A STATE AGENCY TO PRESENT FALSE OR FRAUDULENT REIMBURSEMENT CLAIMS TO THE FEDERAL GOVERNMENT, ARE NEVERTHELESS EXCLUDED FROM THE SCOPE OF THE FALSE CLAIMS ACT BECAUSE THE DEFENDANT DOES NOT PERSONALLY PRESENT THE CLAIM TO A FEDERAL EMPLOYEE.

A. The District Court's Ruling Ignores The Plain Language Of The False Claims Act.

In 31 U.S.C. § 3729(a)(1), the False Claims Act imposes civil liability and treble damages upon any person who "knowingly presents, or *causes to be presented*, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval." *Id.* (emphasis added). The lower court held that, under this provision, a false claim submitted to a recipient of federal funds does not fall within the scope of the False Claims Act, even if the submission causes the federal funding recipient to resubmit the claim to an officer or employee of the United States. *See* R. 67 at 3.

By its terms, Section 3729(a)(1) applies not only to a defendant who "presents" a false claim to a federal official, but it also applies to the defendant who "causes" a false claim "to be presented." Indeed, every court that has addressed this issue, including the United States Supreme Court, has recognized this cause of action. *See, e.g.*, *United States v. Bornstein*, 423 U.S. 303, 309 (1976) (ruling that "[i]t is settled that the [FCA] . . . gives

the United States a cause of action against a subcontractor who causes a prime contractor to submit a false claim to the Government.").

In addition to selectively applying the language of Section 3729(a)(1) and disregarding this settled theory of FCA liability, the district court also ignores the definition of "claim" outlined in Section 3729(c). Most importantly for this case, Section 3729(c) explicitly states that an actionable false claim "includes any request or demand for money or property which is ***made to*** a contractor, grantee, or other recipient." *Id.* (emphasis added). The section further clarifies that a false claim submitted to a recipient of federal funds *is* a "claim" for purposes of the Act "if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded." *Id.* Thus, Congress, in adding this definitional section to the Act, explicitly clarified that the fraudfeasor cannot escape liability by simply arguing that the claims were submitted to a recipient of federal funds, not the Government. The lower court's cursory interpretation is therefore legally unsustainable.

B. The District Court's Ruling Disregards The Necessary Resubmission Of The Medicaid Claims To The Federal Government.

Because the district court failed to even consider whether a false claim submitted to a state Medicaid agency "cause[s]" a false claim "to be presented" to the Government,

an analysis of the Medicaid claims process is needed. Medicaid is a 40-year-old federal grant-in-aid program to states. To encourage states to participate, the Federal Government guarantees that it will share in the cost of hospital, nursing home, and other covered services furnished to eligible individuals. Depending on the state, at least half and as much as three quarters of the amounts paid out to providers are federal funds. It follows that a false or fraudulent claim presented to the state Medicaid agency by a provider or managed care plan or administrative contractor is a false or fraudulent claim against both the Federal Government and the state.

The mechanics of the Medicaid claims process are as follows. Operating within broad federal guidelines, state Medicaid agencies decide what populations they will cover, what services they will pay for, and whether they will purchase those services on a fee-for-service basis, from managed care plans, or both. If a state Medicaid agency buys a service on a fee-for-service basis, the provider submits a claim for the service, the state processes the claim, and, when appropriate, reimburses the provider. If a state Medicaid agency buys services from a managed care plan, the agency makes a fixed monthly capitation payment to the plan reflecting the cost of the services for which the plan is responsible. In either case, these payments by the state Medicaid agency qualify for federal matching funds.

Federal Medicaid matching funds flow to state Medicaid agencies in the form of quarterly grant payments. In order to receive these payments, the state Medicaid agency must file, on a quarterly basis, an accounting statement with the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services that administers the Medicaid program for the Federal Government. *See* 42 C.F.R. § 430.30(c). On this accounting statement, Form CMS-64 Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, state Medicaid agencies list in considerable detail the amounts they have paid out for covered services on behalf of eligible individuals, whether in the form of fee-for-service payments or capitation payments. *Id.* CMS then reviews these accounting statements to determine whether the expenditures set forth by the state Medicaid agency qualify for federal matching. In the case of state expenditures that CMS determines qualify for federal matching, CMS then applies the statutory matching rate for that state to the amount of the expenditures in order to calculate the amount of federal matching funds owed to the state. For example, if a state in its CMS-64 reports a total of $770 million in Medicaid fee-for-service and capitation payments that CMS determines are allowable, and if the state's matching rate is seventy percent, the amount of federal funds owed to the state would be $539 million. CMS then authorizes the transfer of this amount of federal funds to the state.

The amounts reported by the state on the CMS-64 must be thoroughly documented, as CMS guidance to states makes clear:

> The amounts reported on Form CMS-64 and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, have been compiled and is available immediately at the time the claim is filed. Form CMS-64 is a statement of expenditures for which States are entitled to Federal reimbursement under title XIX [of the Social Security Act] and which reconciles the monetary advance made on the basis of Form CMS-37 filed previously for the same quarter. Consequently, the amount claimed on the Form CMS-64 is a summary of expenditures derived from source documents such as invoices, cost reports and eligibility records. All summary statements or descriptions of each claim must identify the claim and source documentation.

See Centers for Medicare & Medicaid Services, *Guidelines to Form CMS-64*, *available at* http://www.cms.hhs.gov/medicaid/mbes/ofs-64.asp (last visited Jan. 25, 2005). The documentation that the state must make available is the same documentation on which the state relies in making its expenditure. *Id.* In the case of a fee-for-service payment, the documentation is the claim submitted by the provider to the state. In the case of a capitation payment, the documentation is the monthly enrollment statement submitted by the managed care organization under the terms of the contract with the state.

In short, the claim that a provider or managed care plan presents to a state Medicaid agency is also presented to CMS. CMS authorizes payment of federal matching funds for a state Medicaid agency's expenditure on the basis of the same documentation

that the state agency used to make its expenditure. Thus, if a provider or managed care plan submits a false or fraudulent claim to the state Medicaid agency, and the state Medicaid agency pays the claim, and CMS approves federal matching payments for the state's expenditure, then both the state Medicaid agency and the federal government have been defrauded.

Furthermore, just to ensure that the fraudfeasor is aware that he is defrauding both the federal and state governments, the claims submission form contains the following language in ALL CAPS:

> PROVIDER UNDERSTANDS THAT SUBMISSION OF AN ELECTRONIC MEDIA CLAIM IS A CLAIM FOR MEDICAL PAYMENT AND THAT ANY PERSON WHO, WITH INTENT TO DEFRAUD OR DECEIVE, MAKES, CAUSES TO BE MADE . . . ANY FALSE STATEMENT, MISREPRESENTATION OR OMISSION OF A MATERIAL FACT IN ANY CLAIM OR APPLICATION FOR ANY PAYMENT, REGARDLESS OF AMOUNT, KNOWING THE SAME TO BE FALSE, IS SUBJECT TO CIVIL AND/OR CRIMINAL SANCTIONS UNDER THE APPLICABLE STATE AND FEDERAL STATUTES.

See Alabama Medicaid, *Alabama Medicaid Provider Enrollment Application Packet,* 2, *available at* http://www.medicaid.state.al.us/forms/provenroll.pdf (last visited January

25, 2005).[1] Thus, applying the correct statutory interpretation of 31 U.S.C. § 3729(a)(1) to the Medicaid claims process, it is hard to fathom how the alleged fraudfeasor did not "knowingly present[ ], or cause[ ] to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval." *Id.*

C. The District Court's Ruling Is Inconsistent With The 1986 Legislative History.

In addition to misinterpreting and misapplying the False Claims Act, the district court's analysis directly conflicts with the applicable legislative history. Prior to the 1986 amendments to the Act, some courts applied a similar misinterpretation, ruling that false claims submitted to a recipient of federal funds were not covered by the False Claims Act, even though the payment process clearly required the federal grantee to present to the Government claims for reimbursement after it paid the fraudulent claims. *See, e.g.*, *United States v. Azzarelli Construction Co.,* 647 F.2d 757, 761 (7th Cir. 1981). Responding to such judicial misreadings, Congress amended the False Claims Act in 1986 to declare that "a false claim is actionable although the claims or false statements were made to a party other than the Government, if the payment thereon would ultimately result in a loss to the United States." S. Rep. No. 99-345, at 10. Congress further

[1] Indeed, the application lists the "Penalties for Falsifying Information on the Medicaid Health Care Provider/Supplier Enrollment Application." *Id.* at 11. Included within this list of four different federal statutory authorities is the federal False Claims Act.

stressed that the purpose of the amendments was to "clarif[y] that the statute permits the Government to sue under the False Claims Act for frauds perpetrated on Federal grantees, *including States* and other recipients of federal funds." S. Rep. 99-345, *supra*, at 21, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5286 (emphasis added).

In fact, the legislative history addresses the *exact* issue raised in this case. The Senate Judiciary Committee observed: "The question has arisen whether claims under the Medicare and Medicaid programs are claims 'upon or against the Government of the United States, or any department or officer thereof.'" S. Rep. 99-345, *supra*, at 21, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5286. The Committee clarified that these "claims have been uniformly held to be within the ambit of the False Claims Act, though the claims were actually filed with, and paid by insurance companies." *Id*. The Committee stressed that the FCA applies in the circumstances "where claims are submitted to State, local, or private programs funded in part by the United States where there is significant Federal regulation and involvement." S. Rep. 99-345, *supra*, at 22, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5287.

The addition of the Section 3729(c) definition of "claim" etched the underlying congressional intent into the False Claims Act. Congress specifically intended to overrule the *Azzarelli* reasoning that the district court mimicked in this case, clarifying: "[T]he Committee intends the new subsection [(c)] to overrule *Azzarelli* and similar cases which have limited the ability of the United States to use the act to reach fraud perpetrated on

federal grantees, contractors or other recipients of Federal funds." S. Rep. 99-345, *supra*, at 22, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5287. Indeed, Congress "endorse[d]" the Supreme Court's interpretation that the Act "'was intended to reach all types of fraud, without qualification, that might result in financial loss to the Government.'" S. Rep. 99-345, *supra*, at 19, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5284 (quoting *United States v. Neifert-White Co.,* 390 U.S. 228, 232 (1968)). The district court's ruling, on the other hand, adds a "direct presentment" qualification that appears nowhere in the statutory language, the controlling case law, or the applicable legislative history.

D. The District Court's Ruling Misapplies The D.C. Circuit's *Totten* Opinion.

The district court, reaching outside of the Eleventh Circuit, relied on the recent ruling from *United States ex rel. Totten v. Bombardier Corporation,* 380 F.3d 488 (D.C. Cir. 2004), and ruled that "[i]f the *Totten* court is correct, fraud perpetrated upon a non-federal agency cannot form the basis for an FCA claim just because the non-federal agency thereafter presents a claim for payment to a federal official." R. 67 at 3. However, the district court misapplied *Totten*. In *Totten*, the D.C. Circuit stated that false claims submitted to a federal grantee are actionable if the grant recipient resubmits the claims to the Government. *See Totten*, 380 F.3d at 491. While the district court seems to recognize the proper mechanics behind the Medicaid claims process, the resulting rule is contrary to

the *Totten* analysis upon which it attempts to rely.

The D.C. Circuit's *Totten* opinion accepts the analysis outlined in this brief.[2] In *Totten*, the relator alleged that the defendant-companies violated the False Claims Act by selling defective railcars to Amtrak and then submitting invoices to Amtrak for payment. Even though Amtrak paid these allegedly false claims from an account that included block-grant federal money, the D.C. Circuit ruled that FCA liability did not apply, for the claims were never resubmitted to the Federal Government. *See Totten*, 380 F.3d at 491. In the present case, however, "the non-federal agency thereafter present[ed] [the] claim[s] for payment to a federal official."

In fact, the *Totten* court, in reassessing the facts of the *Azzarelli* case under the amended FCA, directly addressed the fact pattern present in the case at bar, explaining that FCA liability attaches when "the payment scheme clearly require[s] the state to present to the Government claims for reimbursement after it paid the contractors' fraudulent claims." *Id.* at 495. The D.C. Circuit reached this conclusion by "squar[ing] the language of Section 3729(c) . . . with the presentment requirement in Section

[2] This brief does not, in any way, endorse the *Totten* majority's interpretation of 31 U.S.C. 3729(a)(2). In fact, it is our contention that the *Totten* minority correctly interpreted this provision. *See Totten*, 380 F.3d at 503 (Garland, J., dissenting) ("The court's interpretation of [Section 3729(a)(2)] as requiring presentment is inconsistent with its plain text . . . [and] irreconcilable with the legislative history of the 1986 Amendments to the False Claims Act.").

3729(a)(1)." *Id.* at 493. The *Totten* court outlined their interpretation: "[FCA] liability . . . attaches if the Government provides the funds to the grantee upon presentment of a claim to the Government." *Id.* The court also emphasized that "liability will attach if the Government—again, upon presentment of the claim—reimburses the grantee for funds that the grantee has already disbursed to the claimant." *Id.*

Thus, *Totten* makes clear that false claims submitted to a federal grantee **are** actionable if they are *re*-submitted to the Government by the grant recipient. If the district court had properly followed *Totten*, it the lower court would have ruled that the type of fraud alleged in this case could form the basis for an FCA claim, when the non-federal agency thereafter presents a claim for payment to a federal official. Perhaps this is why Medicaid fraud cases involving hundreds of billions of federal dollars have been successfully settled under the federal False Claims Act,[3] but not one court has reached the same conclusion as this Alabama district court. With an annual budget of over $325 billion in federal and state funds, the Medicaid system—and the U.S. taxpayer—deserve an accurate reading of the False Claims Act.

[3] *See* Andy Schneider, *The Role of the False Claims Act in Reducing Medicare and Medicaid Fraud by Drug Manufacturers: An Update*, *available at* http://www.taf.org/publications/TAFSingle.pdf (last visited January 25, 2005).

CONCLUSION

For the foregoing reasons, the judgment of the district court should be reversed.

Respectfully submitted,

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February 1, 2005

CERTIFICATE OF COMPLIANCE

In accord with Fed. R. App. P. 32(a)(7)(C), the undersigned certifies that this brief complies with the type-volume limitation set forth in the Rule. Excluding the portions exempted by Rule 32(a)(7)(B)(iii), the brief contains 3,436 words as reported by the word count function of Microsoft Word. The brief was prepared in Microsoft Word in Times New Roman font, 14-point type for both text and footnotes.

February 1, 2005

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Joseph White, Taxpayers Against Fraud

CERTIFICATE OF SERVICE

I hereby certify that copies of this Brief *Amicus Curiae* of Taxpayers Against Fraud Education Fund, The False Claims Act Legal Center, were served by first-class mail, postage prepaid, this 1 day of February, 2005, upon:

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The Brief *Amicus Curiae* of Taxpayers Against Fraud was filed with the clerk on February 1, 2005, pursuant to Fed. R. App. P. 25(a)(2)(B) by first-class United States Mail, and was electronically filed on the same date.

This 1st day of February, 2005.

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