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False Claims Act and *Qui Tam* Quarterly Review

INSIDE...

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

TAF is a nonprofit public interest 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). TAF's mission is both activist and educational. Established in 1986, TAF serves to: (1) collect and evaluate evidence of fraud against the Federal Government and facilitate the filing of meritorious FCA *qui tam* suits; (2) work in partnership with *qui tam* plaintiffs, private attorneys, and the Government to effectively prosecute *qui tam* suits; (3) inform and educate the general public, the legal community, and other interested groups about the FCA and its *qui tam* provisions; and (4) advance public, legislative, and government support for *qui tam.*

TAF 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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FCA Liability/ Local Government Entities

U.S. ex rel. Garibaldi v. Orleans Parish School Board, 244 F.3d 486 (5th Cir. Mar. 28, 2001)

The 5th Circuit held that local government entities are not "persons" under the False Claims Act, and thus are immune from suit. The court ruled that the damages provisions of the FCA are punitive, and that imposing punitive damages on local governments is ordinarily contrary to public policy. Furthermore, the court held that the FCA does not authorize it to impose liability on the local government entity while vacating the portion of the award deemed punitive.

In 1996, William Garibaldi and Carlos Samuel filed a *qui tam* suit against the Orleans Parish School Board, alleging that the school board had submitted numerous false claims to the United States as a result of accounting improprieties in its allocation of premiums for unemployment compensation and workers' compensation insurance. The relators were employees of the school board's audit department. The United States declined to intervene in the *qui tam* action.

After trial the jury returned a verdict for the United States, finding actual damages in the amount of $7.6 million. In addition, the jury found that the relators had suffered damages as a result of illegal retaliation. The district court entered a judgment of $30.65 million against the school board. However, this judgment was later reduced to just under $22 million. The school board appealed, claiming that as a local government entity, it is not a "person" under the FCA, and thus is immune from suit. The United States intervened for purposes of the appeal.

Treble Damages Provision Precludes Local Government Liability

The United States Supreme Court held that states are immune from *qui tam* suits under the FCA in Vermont Agency of Natural Resources v. United States ex rel. Stevens, based in part on sovereign immunity concerns. 529 U.S. 765 (2000), 19 TAF QR 1 (July 2000). Since localities generally do not enjoy the same sovereign immunity as states, the 5th Circuit found that most of the opinion in Stevens was inapplicable to this case. However, the court did find the Supreme Court's statement that the treble damages provision was "essentially punitive in nature" to be an important factor in determining whether localities enjoy immunity from suit. According to the court, imposing punitive damages on localities is ordinarily against public policy since the punishment, in the form of higher taxes or reduced services, is borne by the general public, which is generally blameless.

The relators and the Government argued that 1 U.S.C. § 1 (the so-called Dictionary Act), which supplies definitions of certain terms when undefined in statutes, controlled, and that the definition of "person" in that section includes local governments. The court ruled that the Dictionary Act is inapplicable when the context of the statute indicates Congress intended another meaning. Thus, the court found that the treble damages provision indicated that Congress did not intend to impose liability upon local government entities.

Civil Rights and Antitrust Statutes Distinguished

The relators and the Government also argued that Supreme Court decisions upholding treble damage awards against local governments under the civil rights provisions of 42 U.S.C. § 1983, and under the antitrust laws, suggest

that treble damages should be available against local governments under the FCA as well. The court rejected these analogies. The court noted that Congress intended 42 U.S.C. § 1983 to provide broad remedies for civil rights violations perpetrated by persons acting under color of state law, and there was significant legislative history indicating that 42 U.S.C. § 1983 was intended to have a very broad scope. The court found no similar indications in the legislative history of the FCA, and noted that the FCA was not specifically targeted at those acting under color of state law. Similarly, the antitrust laws were designed to reach all the nation's commercial activity, while the FCA, in the court's view, was not intended to have such a broad scope.

The court declined to consider legislative history from the 1986 amendments indicating that Congress considered local governments to be "persons" under the FCA. The court observed that the term "person" had been in the statute since 1863, and thus concluded that the 1986 materials were "utterly irrelevant" in determining its meaning.

No Reduction of Damages for Local Governments

Finally, the court rejected the Government's argument that the court could vacate the portion of the award deemed punitive, but still subject the school board to liability under the Act. The court reasoned that since the FCA provides for a reduction in damages from treble to double in certain instances where the defendant voluntarily provides information, Congress had already considered exceptions to the damages provisions. To add another exception, the court stated, "would require us to rewrite the statute, something we will not do."

***U.S. ex rel. Rosales v. San Francisco Housing Authority*, 2000 WL 370176 (N.D. Cal. Mar. 26, 2001)**

A California district court ruled that the False Claims Act does authorize private suits against local governmental entities. Unlike states, local governments and government agencies are not sovereigns and thus were generally regarded as persons subject to suit at the time the FCA was enacted in 1863. Moreover, the court held, the 1986 amendments providing for treble damages did not affect local government liability. The main purpose of the enhanced damages provisions is to compensate the United States and relators, and Congress did not intend thereby to alter the preexisting understanding that municipalities are persons subject to suit.

In 1995, Carmen Rosales and Michael Meadows filed this *qui tam* action, and in 1997 the United States declined to intervene. The defendants moved for summary judgment, arguing that the FCA claims were precluded by the public disclosure bar and that municipal entities could not be sued under Vermont Agency of Natural Resources v. United States ex rel. Stevens, 529 U.S. 765 (2000), 19 TAF QR 1 (July 2000). The court found that the public disclosure bar did preclude some of the plaintiffs' claims, but did not preclude their claim that employees of the San Francisco Housing Authority (SFHA) sold Section 8 subsidized housing certificates from HUD for their own personal profit to ineligible individuals.

Effect of Stevens on Municipal Liability

In an extensive discussion, the court explored the effect of Stevens on municipal liability under the FCA. The defendants argued that Stevens barred all private suits against governmental entities. They seized upon Justice Scalia's statement in Stevens that the FCA

"imposes damages that are essentially punitive in nature, which would be inconsistent with state *qui tam* liability in light of the presumption against imposition of punitive damages on governmental entities." However, the court noted that while Stevens barred private FCA suits against states, it did not decide the question of suits against local entities. Thus Justice Scalia's statement was dictum, and should not be viewed in isolation from the analytical framework of Stevens. Stevens involved a suit against a state agency and was premised on the presumption against interpreting the word "person" in the FCA to include a sovereign. But local governments and agencies have not been accorded the status of sovereigns. Therefore, the presumption at work in Stevens does not apply in a case involving a local government agency.

Municipalities Are "Persons" Under the FCA

In fact, the court ruled, the opposite presumption applies to local entities: they are presumptively "persons" subject to suit under the FCA. The court noted that when Congress passed the Act in 1863, municipalities were treated as natural persons for virtually all purposes of constitutional and statutory analysis. As the Supreme Court has repeatedly demonstrated in cases construing the 1871 Civil Rights Act, during the second half of the nineteenth century municipal corporations were routinely sued in federal court and this fact was well known to members of Congress.

The court noted that in the absence of the constitutional concerns present in Stevens, the Supreme Court has emphasized that the Act should be read broadly to achieve its purpose of protecting the Federal Treasury. The presumption regarding public corporations under Supreme Court jurisprudence is the opposite of the one applying to states: public corporations are presumptively subject to private lawsuit.

Enhanced Damages Provisions Do Not Preclude Municipal Liability

The court rejected the approach of U.S. ex rel. Dunleavy v. County of Delaware, 2000 WL 1522854 (E.D. Pa. Oct 12, 2000), 21 TAF QR 3 (Jan. 2001), which held that municipalities are immune to suit because the damages mandated by the FCA are "punitive in nature." The court concluded that Dunleavy put too much weight on Justice Scalia's brief dictum in Stevens, improperly isolating it from the analytical framework of which it was a part.

Liability and damages, the court held, are separate issues. In 1863 municipalities were regarded as persons subject to private suit under the FCA. Moreover, the Supreme Court has consistently recognized that damages under the 1863 Act were essentially compensatory. Even if the 1986 amendments, which raised the remedy available from double to treble damages, arguably reflected a congressional intention to enhance the punitive aspects of the FCA, this should not be confused with the antecedent question of whether the 1863 Congress intended localities to be "persons" under the act. The court found it "hard to believe that Congress in 1986 would express its intent to exempt localities from FCA liability by so subtle a means as increasing the penalties available under the statute."

Municipalities Are Not Immune From Treble Damages

The defendant SFHA also argued that even if it were a "person" subject to FCA liability, it could not be subjected to treble damages. The SFHA asserted that the damages available under the FCA were "punitive damages" as that term is used in City of Newport v. Fact Concerts, Inc., 453 U.S. 247 (1981), and that Newport flatly prohibits punitive damages against municipal entities. The court rejected both these assertions.

The court could find no binding Supreme Court or 9th Circuit authority holding that treble damages, civil penalties, or a combination of the two must constitute "punitive damages" as that term is used in Newport. Instead, the Supreme Court in Newport defined "punitive damages" in terms of their intended purpose: compensatory damages are intended to compensate, while punitive damages are intended to punish.

FCA Damages Are Primarily Compensatory, Not Punitive

After reviewing the legislative history of the 1986 amendments to the FCA, the court concluded that Congress's aim in providing for treble damages was a complex mix of compensation, punishment, and deterrence, but that (as before the amendments) compensation of the Government and whistleblowers remained the primary goal. "The harm suffered by the government," the court ruled, "cannot be viewed narrowly as the monetary loss occasioned solely by a detected false claim." Large amounts of fraud go undetected, and fraud erodes public confidence in the Government. The Government also bears the cost of detecting, investigating, monitoring and prosecuting fraud. The legislative history of the 1986 amendments suggests that Congress intended the enhanced revenue available under the triple damages provision to offset increases in litigation costs. Moreover, Congress also intended to encourage whistleblowers to come forward with information and to compensate them for their risks and sacrifices.

FCA Statutory Damages Distinguished From Common Law Punitive Damages

Newport did not flatly prohibit the imposition upon municipalities of any damages that could be characterized as "punitive in nature." Rather, the Newport Court was concerned that allowing common law punitive damages against municipalities could overcompensate prevailing plaintiffs at the expense of local taxpayers and give rise to excessive jury awards. These concerns, the court observed, were absent in the present case.

Because multiple damages are necessary in FCA cases to compensate the Government and the relator fully for their costs and inconveniences, they do not provide a windfall for the *qui tam* plaintiff. Moreover, the court noted, the SFHA is an independent public agency with its own assets and revenues, so that any judgment would not come out of the city's budget. Local citizens would be benefited, not burdened, if federal housing aid went to its rightful recipients. Finally, the court noted, the Newport Court's concern about the unfettered discretion of juries to make unpredictably large awards is simply not an issue in false claims cases. The FCA mandates penalties with fixed ranges and multipliers keyed to actual harm. The only discretion rests in the hands of the judge who fixes the civil penalties within the prescribed statutory range. Therefore, the court concluded, application of the FCA to a local public corporation such as the SFHA did not implicate any of the policy concerns articulated in Newport.

Economic Damages

***Bly-Magee v. California*, 236 F.3d 1014 (9th Cir. Jan. 2, 2001)**

The 9th Circuit held that no actual monetary injury to the U.S. Treasury need be alleged to state a valid claim under the FCA. Furthermore, the court ruled that state officials may be sued in their individual capacities for activity unrelated to their official job duties.

Charlotte Bly-Magee, a former employee of Southern California Rehabilitation Services, Inc., filed a *qui tam* lawsuit in 1992 against the State of California, the California Department

of Rehabilitation (CDR), and seven individuals. The suit sought recovery of federal funds made available to California for vocational rehabilitation services. The Government declined intervention, and the district court granted summary judgment for the defendants, ruling that Bly-Magee failed to establish that the Government had been injured.

In 1997, Bly-Magee filed a complaint seeking to reinstate her 1992 action, adding as defendants the California Office of the Attorney General (OAG), former California Attorney General Daniel Lungren, and 100 John Does. The new complaint alleged that the original defendants committed fraud on the court during the litigation of the previous lawsuit, and that the new defendants conspired with CDR to conceal this fraud. The Government did not intervene. The district court dismissed the case pursuant to Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim. The court ruled that since the Government would be obligated under the Rehabilitation Act to forward any money recovered to the states, the relator had not alleged an actual injury to the Federal Treasury.

Relator Need Not Allege Monetary Harm to the U.S. Treasury

On appeal, the 9th Circuit held that a *qui tam* plaintiff does not need to prove actual monetary harm to state a claim under the FCA. However, the court further ruled that Bly-Magee's claims against the State of California, the state agencies, and the state officials in their official capacities were barred by the Supreme Court's ruling in Vermont Agency of Natural Resouces v. United States ex rel. Stevens, 529 U.S. 1858 (2000), 19 TAF QR 1 (July 2000). The court stated that "Bly-Magee may not assert claims against Lungren or any OAG attorneys sued as Doe defendants for conduct related to litigation duties including the defense of Bly-Magee's prior lawsuit and the defense of this lawsuit. If sued in an official capacity, Lungren and any OAG attorneys sued as Doe defendants have absolute official immunity." Therefore, the 9th Circuit affirmed the district court's dismissal with prejudice of all claims against California, state agencies, or state employees in their official capacity.

State Officials May Be Sued in Their Individual Capacities

The court ruled that state officials could be sued in their individual capacities for actions wholly unrelated to or outside their official duties. Nevertheless, the court found that Bly-Magee had failed to properly plead her claims against the defendants in their individual capacities with sufficient particularity to comply with Federal Rule of Civil Procedure 9(b). The court held that Bly-Magee could cure her complaint with additional allegations of activity beyond the scope of certain defendants' official duties, and therefore should have been granted leave to amend.

Vicarious Liability of Employer/ False Certification

U.S. ex rel. Bryant v. Williams Building Corp., 2001 WL 333055 (D.S.D. Jan. 29, 2001)

A South Dakota district court held that an employer may be held liable under the FCA for the actions of an employee acting within the scope of his employment, notwithstanding the "punitive nature" of the FCA's treble damages provision. Furthermore, either express or implied false certifications of compliance with contract specifications may form the basis for liability under the Act.

Relator Jay Bryant was employed by defendant Williams Building Corporation (WBC), begin-

ning in March 1998. WBC had a contract with the Air Force to remodel bathrooms at Ellsworth Air Force Base in South Dakota. The contract contained a clause instructing WBC immediately to inform the contracting officer of any asbestos found during the remodeling, and mandating that WBC not disturb any asbestos.

Asbestos was eventually discovered on the job site, but work on the project continued, and the Air Force was not notified. Rather than comply with the terms of the contract, project superintendent William Tilton allegedly changed certain procedures to avoid cutting through asbestos. During the project, Tilton submitted daily reports to the corporate offices of WBC and the Government. Although the reports were not required by the contract, each contained an express certification of compliance with contract plans and specifications. Moreover, Tilton orally requested that the Government inspect each unit as it was completed. Tilton admitted that by making this request he was essentially stating that the bathroom was completed according to contract specifications. In addition, WBC submitted Contract Progress Reports throughout the term of the project. Each Contract Progress Report certified that the relevant portions of the contract were completed in accordance with specifications. WBC also presented invoices to the Government during the project.

In February 1999, Bryant filed a *qui tam* action against WBC, alleging that WBC's submission of invoices, daily reports, Contract Progress Reports, and Tilton's verbal inspection requests were false claims in violation of the FCA. WBC moved for summary judgment.

Punitive Damages May be Imposed Vicariously on an Employer

WBC argued that Tilton's actions could not be imputed to WBC because damages under the FCA are punitive and may not be vicariously imposed on employers. This argument was based on two U.S. Supreme Court cases, Vermont Agency of Natural Resources v. U.S. ex rel. Stevens, 529 U.S. 765 (2000), 19 TAF QR 1 (July 2000), and Kolstad v. American Dental Ass'n, 527 U.S. 526 (2000). In Stevens, the Court stated in dictum that the FCA's treble damages provision is "essentially punitive in nature." In Kolstad, the Supreme Court limited an employer's liability for punitive damages under Title VII for the acts of an employee, holding that the employer must be culpable to some degree in order to have the employee's knowledge and acts imputed to it. WBC argued that since there was no evidence that its executives knew that asbestos had been found and disturbed, WBC did not have the type of culpable conduct required by Kolstad. However, the court ruled that the holding in Kolstad was compelled by circumstances unique to Title VII, and thus was inapplicable in this case. In the FCA context, the court held, a principal is liable for punitive damages whenever its agent is acting in the course and scope of employment or with apparent authority. Since Tilton was acting in the course and scope of his employment in dealing with the asbestos, the court ruled that as a matter of law, his actions could be imputed to WBC.

False Certifications of Compliance with Contract May Give Rise to FCA Liability

The court found that the relator had presented sufficient evidence for a reasonable jury to conclude that WBC submitted false claims to the Government. Noting that each of the daily reports and progress reports contained an express certification of compliance with contract specifications, and that WBC was not in compliance with the asbestos provision of the contract, the court ruled that the certifications could be found patently false. Moreover, even if they were not expressly false, a jury could impose liability under the theory of implied false certification. Following U.S. ex rel. Shaw v. AAA Engineering

& Drafting, Inc., 213 F.3d 519 (10th Cir. 2000), 19 TAF QR 4 (July 2000), the court ruled that even absent an express false statement, FCA liability may arise where submission of documents represents an implied certification by a contractor of its continuing adherence to all material portions of the contract. The court ruled that the invoices and oral requests for inspection could also be considered false claims, as they represented an implied certification by WBC of its continuing adherence to all material terms of the contract. Applying the theory of implied false certification was especially appropriate in this case, where the discovery and disturbance of asbestos would not be readily apparent to the Government. The defendant's motion for summary judgment was denied.

Section 3729(a)(1) "Causes to Be Presented"/ Government Consent to Dismissal

U.S. ex rel. Shaver v. Lucas Western Corp., 237 F.3d 932 (8th Cir. Feb. 6, 2001)

The 8th Circuit ruled that a company's failure to pay medical bills as required by a state Workers' Compensation Board did not "cause" the submission of a false claim, even where the defendant knew the unpaid bills would be submitted to the Government. The court further held that the Attorney General's consent is not necessary for dismissal by the court, but only for voluntary dismissal by the relator.

In 1999, John Shaver filed a *qui tam* action against his former employer, Lucas Western Corporation (Lucas). The complaint alleged that Lucas' failure to pay Shaver's medical bills caused Shaver to submit those bills to Medicare and the Social Security Administration, and had therefore violated § 3729(a)(1) of the FCA which imposes liability on one who "knowingly presents or causes to be presented" to the Government a false or fraudulent claim for payment or approval.

The relator was disabled with a work-related injury, and the California Workers' Compensation Board ordered Lucas to pay Shaver's medical bills. Lucas refused to pay the bills, and Shaver submitted them to Medicare and the Social Security Administration. Shaver filed his *qui tam* action, and an employee of Lucas mistakenly forwarded the complaint to the independent claims-manager provider, thinking it was related to ongoing workers' compensation litigation between the two parties. Lucas failed to answer the *qui tam* complaint in time, and the clerk entered default. However, the court set aside this entry of default pursuant to a motion from Lucas, and dismissed the case for failure to state a claim. Shaver appealed, claiming that the district court erred in setting aside the clerk's entry of default, that his complaint did state a claim under the FCA, and that the district court exceeded its authority by dismissing the case without consent from the Attorney General.

Failure to State a Claim Under § 3729(a)(1)

The court ruled that since Lucas had not intentionally delayed in responding, had a meritorious defense, and the relator would not be prejudiced, the district court did not err in setting aside the default. The court then affirmed the district court's dismissal of Shaver's complaint for failure to state a claim under the FCA. Shaver did not allege that Lucas instructed him to submit the bills to the Government. According to the court, even if Lucas knew that Shaver would submit the unpaid bills to the Government, it had not "caused" the submission.

Government Consent Not Required for Dismissal by Court

The court rejected Shaver's contention that the consent of the Attorney General is needed to dismiss a *qui tam* suit. Although § 3730(b)(1)

of the Act states that such an action "may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting," the court held that the provision only applied to a voluntary dismissal sought by the relator, not a situation where the district court grants a motion to dismiss.

Sections 3729(a)(2) and (7)/ Section 3730(h) Retaliation Claims

U.S. ex rel. Mock v. Lockheed Martin Idaho Technologies Co., Civ. No. 96-0061-E-BLW (D. Idaho Jan. 5, 2001)

An Idaho district court ruled that the defendants' failure to list environmental violations as "weaknesses" on self-assessment forms was not a false statement under § 3729(a)(2) of the FCA. The court also ruled that a claim under § 3729(a)(7) of the FCA requires the submission of a claim to the Government, not just the preparation of fraudulent documents.

In 1996, Neil Mock and Scott Lebow filed a *qui tam* suit against Lockheed Martin Idaho Technologies Company, Coleman Research, and other companies, alleging that the defendants covered up their noncompliance with environmental laws at a nuclear research facility. All of the defendants were either prime contractors or subcontractors at the facility. The relators were employed as environmental auditors at the site. Their complaint alleged violations of subsections § 3729(a)(1), (2), and (7) of the Act, violations of the Act's retaliation provision, and various common law claims. The court granted a motion to dismiss pursuant to Federal Rule of Civil Procedure 9(b) on the ground that the complaint failed to allege the FCA claims with the requisite particularity. The relators filed an amended complaint, and the defendants again moved to dismiss pursuant to Rules 9(b) and 12(b)(6).

The FCA Does Not Impose a General Duty to Report Noncompliance

The court first examined the motion under Rule 12(b)(6) to dismiss the relators' "award fee" allegations under § 3729(a)(2) of the Act. The relators alleged that the defendants made false statements to obtain payment of award fees that the Department of Energy (DOE) grants on a semi-annual basis. The relators claimed that the defendants failed to include environmental violations as "weaknesses" in the self-assessment forms submitted by the defendants to the DOE. The court noted that in order to state a claim under § 3729(a)(2), the relator must allege that the defendants made a false claim to the Government, and not merely that the defendants received money from the Government to which they were not entitled. As the self-assessment forms were used by DOE as a factor in determining the award fees, the forms were "claims" under the FCA. However, the court held that the defendants had no general duty to disclose all noncompliance issues on the self-assessment forms: "the FCA does not require a party to reveal non-compliance with certain laws if the Government never asks." Since the Government did not require the contractor to certify compliance with environmental regulations, the defendants had not made false statements by failing to list the violations on the self-assessment forms.

Reverse False Claim Requires Actual Submission to the Government

The court dismissed the relators' § 3729 reverse false claims allegations because they had failed to allege that the defendants submitted any of the false records to the Government. The relators had argued that § 3729(a)(7) requires only the preparation, but not the submission, of the false record. The court disagreed, pointing to the legislative history of the FCA, which

implied that the Government must be made aware of the false statement.

Whistleblower Protections Broadly Construed

Defendants Coleman and Lockheed sought to dismiss the relators' § 3730(h) retaliation claims. Coleman argued that the relators alleged only that they were fired for investigating noncompliance with environmental regulations, not for investigating fraud. The court rejected Coleman's narrow reading of the relators' complaint, noting the incorporation by reference of certain paragraphs, in which the relators alleged that they were retaliated against for investigating both the noncompliance and the fraudulent coverup of the noncompliance. The court held that a claim for retaliation need only allege that the defendant knew that the relator was engaged "in activity that reasonably could lead to an FCA case." However, the court granted Lockheed's motion to dismiss the relators' retaliation claims because Coleman, not Lockheed, employed them.

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

U.S. ex rel. Lujan v. Hughes Aircraft Co., 243 F.3d 1181 (9th Cir. Mar. 22, 2001)

The 9th Circuit affirmed a lower court's dismissal of the relator's complaint based on the Act's § 3730(b)(5) first-to-file jurisdictional bar. The court adopted a "material facts" test to determine whether, under the bar, the allegations contained in the complaint were based on the facts underlying an earlier filed claim.

In 1992, Linda Lujan filed a *qui tam* lawsuit against her former employer Hughes Aircraft Company, alleging fraudulent cost shifting from fixed-price to cost-plus contracts. The Government declined intervention. Initially, the district court dismissed the case for violation of the FCA's statutory seal provision, § 3730(b)(2), because the Los Angeles Times had published two articles about the case while it was under seal. The 9th Circuit reversed and remanded, holding that dismissal was not necessarily the appropriate remedy for violation of the seal provisions, and that the district court needed to determine whether it had jurisdiction under the Act's § 3730(e)(4)(A) public disclosure bar. On remand, the district court held that it did not have jurisdiction as the allegations contained in the complaint were "substantially similar to" and therefore "based upon" the allegations in an earlier suit, U.S. ex rel. Schumer v. Hughes Aircraft Company, 63 F.3d 1512 (9th Cir. 1995), 3 TAF QR 4 (Oct. 1995).

On appeal, the 9th Circuit dismissed all of Lujan's pre-1986 claims based on the public disclosure bar, but found that Lujan was a § 3730(e)(4)(B) original source for the post-1986 claims. On remand, Hughes moved to dismiss the suit pursuant to 31 U.S.C. § 3730(b)(5), the first-to-file jurisdictional bar. The district court granted the motion, holding that Lujan's claims were "based on" the same essential facts and raised the same issues as Schumer's claims, even though the claims contained somewhat different details. Lujan appealed, arguing that the district court improperly considered and applied the first-to-file bar.

Section 3730(b)(5) provides:

When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

Lujan argued that the bar should not apply to her case because: (1) her action could benefit the Federal Treasury; (2) she was an original source; (3) she had personal knowledge of specific mischarging; and, (4) she informed the

Government of her allegations before the Schumer action was filed. The court rejected these arguments, holding that the FCA unambiguously prohibits successive plaintiffs from bringing related actions based on the same underlying facts. The bar conforms with the dual purposes of the 1986 Amendments: to promote incentives for whistleblowers and to prevent opportunistic plaintiffs from filing parasitic suits.

In determining whether Lujan's suit was "based upon the allegations underlying" Schumer's suit, the court followed the "material facts" test adopted in U.S. ex rel. LaCorte v. SmithKline Beecham Clinical Lab., Inc., 149 F.3d 227 (3rd Cir. 1998), 15 TAF QR 7 (Oct. 1998) and rejected the rival "identical facts" test. The court reasoned that to bar only identical actions would be contrary to both the plain language of the statute and its legislative history. A narrow jurisdictional bar would decrease incentives for relators to bring *qui tam* lawsuits promptly, allowing multiple relators to recover for the same conduct, reducing each relator's individual share and incentive to bring suit, and encouraging piggyback claims that would not benefit the government. Applying the "material facts" test, the court found that Lujan's claims were substantially similar to, and encompassed the same material facts as Schumer's claims. Thus, the court affirmed the dismissal of Lujan's claims based on the first-to-file bar.

Dimissed Suit Remains Pending Action for Purposes of § 3730(b)(5)

Lujan then argued that since Schumer's complaint had been dismissed, it was not a pending action under § 3730(b)(5). The court ruled that although Schumer's complaint was dismissed in 1997, it was active when Lujan brought her *qui tam* suit, and the first-to-file bar would apply.

Public Disclosure Bar and Original Source Exception

U.S. ex rel. Bidani v. Lewis, 2001 WL 32868 (N.D. Ill. Jan. 12, 2001)

An Illinois district court ruled that to qualify as an original source under § 3730(e)(4)(B), a relator need only have direct and independent knowledge of one essential element of his fraud claim. However, the court granted summary judgment on the ground that the defendants lacked actual knowledge of the truth or falsity of their claims because they relied on the advice of their attorneys.

In 1997, Dr. Anil Bidani filed a *qui tam* action against Edmund Lewis and two companies controlled by Lewis, American Medical Supply Corporation (AMS) and Circle Medical Management Corporation (CMM). The lawsuit alleged that Lewis, in violation of Medicare regulations, used related corporate entities to obtain excessive Medicare reimbursements for kidney dialysis supplies. Following the district court's rulings on the defendants' motion to dismiss, two claims remained. The first remaining claim was that Lewis received illegal kickbacks by referring dialysis patients to a company he owned, AMS, for dialysis supplies. The second remaining claim was that because of Lewis's common ownership of AMS and CMM, AMS could not qualify as a dialysis supplier. The relator and the defendants filed cross-motions for summary judgment.

Relator Must Be an Original Source of One Essential Element

The court had previously ruled that the allegations in the complaint were publicly disclosed, and that the relator was an original source of one essential element of the complaint, Lewis's ownership of AMS. Although they did not dis-

pute the court's previous finding on this issue, the defendants argued that the intervening precedent of United States v. Bank of Farmington, 166 F.3d 853 (7th Cir. 1999), 16 TAF QR 5 (Apr. 1999) required the relator to have direct and independent knowledge of all essential elements of the complaint to qualify as an original source. In fact, the court ruled, Bank of Farmington suggested nearly the opposite: a relator may be an "original source" even though she was not the original source of all essential publicly disclosed information. Thus the court ruled that a relator only needs to have direct and independent knowledge of one essential element of a complaint to qualify as an original source. The court also rejected the the defendants' argument that the relator failed to inform the Government of the allegations prior to filing suit. In September 1995, the relator had sent letters to the General Counsel of HHS, the Assistant Director of GAO, the HHS Regional Inspector General for Investigations in Chicago, and the U.S. Attorney in Peoria. These letters satisfied the § 3730(e)(4)(B) notice requirement.

Court Upholds Advice of Counsel Defense

The defendants asserted that they lacked knowledge of the false nature of their reimbursement claims because counsel advised them that they were in compliance with the applicable laws and regulations. As set forth in United States v. Cheek, 3 F.3d 1057, 1061 (7th Cir. 1993), to raise an advice of counsel defense, the defendant must show that "(1) before taking action, (2) he in good faith sought the advice of an attorney whom he considered competent, (3) for the purpose of securing advice on the lawfulness of his possible future conduct, (4) and made a full and accurate report to his attorney of all material facts which the defendant knew, (5) and acted strictly in accordance with the advice of his attorney who had been given a full report."

After reviewing the evidence, the court found that Lewis had sought the advice of his attorneys regarding the operations of AMS as a dialysis supplier. The attorneys were aware of the relationship between the two entities and Lewis, and the functions of both AMS and CMM. The attorneys advised Lewis that his behavior was lawful, and when they advised that the law had changed, Lewis ceased operating AMS. Thus, Lewis lacked actual knowledge that common ownership prohibited him from referring patients to AMS, and that AMS failed to qualify as a dialysis supplier. The court declined to infer that Lewis acted knowingly or in reckless disregard of the truth, and granted defendants' motion for summary judgment.

U.S. ex rel. Grant v. Rush-Presbyterian/St. Luke's Medical Center, 2001 WL 40807 (N.D. Ill. Jan. 16, 2001)

An Illinois district court ruled that disclosure of false claims to government investigators was a "public disclosure" under § 3730(e)(4)(A). Because the relator's allegations were based upon this disclosure and the relator was not an original source, the court dismissed the case for lack of jurisdiction.

In January 2001, an Illinois district court dismissed two counts of an FCA claim for lack of jurisdiction pursuant to the Act's public disclosure bar. In May and June of 1999, representatives of the Rush-Presbyterian/St. Luke's Medical Center ("Rush") had met with officials from the U.S. Attorney's office, the FBI, and the Health Care Financing Administration to disclose improprieties in Rush's billing practices and discuss settlement possibilities. Rush agreed to make its employees available for questioning, and held a meeting in June at which it told nurses about its improper billing practices and the resulting investigation. In September of 1999 one of these nurses, Cherry Grant, filed a

qui tam false claims complaint under seal alleging Medicare and Medicaid fraud in violation of the FCA, and later amended her complaint to include a retaliation claim pursuant to 31 U.S.C. § 3730(h). In December 1999 the complaint was partially unsealed to permit settlement talks between Rush and the Government. The Government deferred its decision whether or not to intervene in the case but moved to dismiss Grant's claims regarding improper billing practices for lack of subject matter jurisdiction pursuant to the public disclosure bar.

Disclosure to Competent Public Official Is "Public Disclosure"

The court held that the public disclosure bar applied, and that the relator did not fall within the § 3730(e)(4)(B) original source exception. The court noted that 7th Circuit had held in United States v. Bank of Farmington, 166 F.3d 853, 861 (7th Cir. 1999), 16 TAF QR 5, that disclosure of false claims to a "competent public official" who has "managerial responsibility for the very claims made" satisfies the "public disclosure" requirement. The meetings in May and June of 1999 between Rush officials and government investigators thus amounted to "public disclosure . . . in a[n] . . . administrative . . . investigation" within the meaning of § 3730(e)(4)(A). Moreover, the relator's allegations of billing irregularities were "based upon" the public disclosure, as the relator's original and amended complaints both made reference to Rush's prior disclosures to the Government. Finally, the relator could not qualify as an original source under § 3730(e)(4)(B) because she had not provided the information to the Government before filing suit. Although the relator alleged that Rush engaged in billing fraud for at least six years while she worked there — from 1993 through 1998 — she did not file her *qui tam* complaint until September 1999, months after Rush had already disclosed the violations to the Government and notified staff that an investigation was underway.

Therefore, the court granted the Government's motion to dismiss the relator's claims of billing fraud. It let stand the relator's claims regarding inpatient procedures as well as her retaliation claim, which were outside of the scope of the Government's motion.

U.S. ex rel. O'Keeffe v. Sverdup Corp., 131 F. Supp. 2d 87 (D. Mass. Jan. 31, 2001)

A Massachusetts district court held that allegations in a *qui tam* lawsuit are "based upon" publicly disclosed allegations if they are similar to or the same as the publicly disclosed allegations. Finding that the relator's information was secondhand, as it was obtained from interviews, the court ruled that the relator did not satisfy the "direct" knowledge prong to be an original source. According to the court, the relator's expertise on the subject matter of the lawsuit, and thus his ability to interpret the publicly disclosed information, did not suffice to make him an original source.

Kevin O'Keeffe was the co-founder and president of Technical Resources for Environmental Quality, Inc., a nonprofit charitable organization. In 1998, O'Keeffe filed a *qui tam* suit against Sverdup Corporation, Cambridge Systematics, Inc, and the Massachusetts Bay Transportation Authority (MBTA), alleging that the defendants made misrepresentations to the Urban Mass Transportation Administration, the predecessor to the Federal Transportation Administration (FTA), regarding the environmental impact of a proposed commuter rail system from Boston to southeastern Massachusetts. O'Keeffe claimed that the defendants made several false statements in the Final Environmental Impact Statements/Report (FEIS/R) and supporting documents concerning the environmental benefits of the project and the results of a study conducted by the defendants. The FEIS/R was approved by the MBTA and the FTA and included a document that summarized com-

ments submitted by the public for the Draft Environmental Impact Statements/Report (DEIS/R). Subsequently, the FTA approved approximately $384 million in grants for the project. The Government declined to intervene in the *qui tam* suit and the defendants moved to dismiss, claiming the court lacked subject matter jurisdiction under the Act's public disclosure bar.

"Based Upon" Means "Supported By"

The court ruled that comments or statements contained in the FEIS/R were public disclosures. The court found that the FEIS/R could be considered either an "administrative hearing" or an "administrative . . . report" under § 3730(e)(4)(A). The court then addressed the "based upon" prong of the public disclosure analysis. Although the First Circuit had not interpreted this provision, and two Massachusetts district courts had embraced the minority position that "based upon" means "derived from," the court adopted the majority position, ruling that "where the allegation of fraud or the facts that constitute the essential components of the fraud are publicly disclosed, any *qui tam* action encompassing the supporting allegations is barred unless the relator is the original source."

Secondhand Knowledge is Not Direct

The court examined each of the relator's claims, and determined that the allegations in counts one through six were publicly disclosed. In order to qualify as an original source and escape the bar, § 3730(e)(4)(B) requires the relator to demonstrate both "direct" and "independent" knowledge of the fraudulent activity. The court ruled that O'Keeffe was not an original source because, although his knowledge might have been independent, it was not direct. O'Keeffe would not have been able to discover the alleged fraud without the information obtained in interviews with various individuals, and thus his information was at best secondhand. The court rejected O'Keeffe's argument that his expertise allowed him to understand the significance of the publicly disclosed information, ruling that such expertise did not make his knowledge direct. The court granted summary judgment for the defendants counts one through six, and dismissed count seven on liability grounds.

Damages/Excessive Fines Clause

U.S. v. Mackby, 243 F.3d 1159 (9th Cir. Mar. 21, 2001)

Finding that the FCA's damages and penalties are at least partly "punitive in nature," the 9th Circuit held that they are subject to an 8th Amendment Excessive Fines Clause analysis. The case was remanded to the district court for a determination of whether the damages imposed were grossly disproportionate to the gravity of the offense.

In June 1988, Peter Mackby purchased a physical therapy clinic. Peter Mackby instructed the clinic's billing service to substitute the physician identification number (PIN) of his father, Dr. Mackby, for that of the treating physician on Medicare claim forms. Dr. Mackby was unaware his PIN was being used, and did not perform any physical therapy services. The United States filed suit under the FCA in March 1998. Following a bench trial, the district court entered a judgment of $729,454.92 for the United States, based on a $5,000 penalty for each of the 111 claims submitted and treble damages in the amount of $174,454.92. Mackby appealed, challenging both his liability and the money judgment pursuant to the U.S. Constitution's 8th Amendment Excessive Fines Clause.

Claim May Be False Even If Services Billed For Were Provided

The 9th Circuit ruled that the claims Peter Mackby submitted to Medicare were false, because the PIN indicated that Dr. Mackby had

provided the services when in fact he had not. The court rejected Peter Mackby's argument that since the claim forms accurately described the services rendered, any violation was a result of a "technical interpretation of the instructions for the claims." If the purported provider did not actually provide the service, the court held, then the claim is false, regardless of whether the services billed for were provided. The court ruled that Peter Mackby acted in reckless disregard of the truth or falsity of the claim by failing to properly familiarize himself with the legal requirements for payment.

FCA Damages and Penalties Subject to Excessive Fines Clause Analysis

The court next addressed the applicability of the Excessive Fines Clause of the 8th Amendment to the civil penalty of $555,000. Under United States v. Bajakajian, 524 U.S. 321, 327-28 (1998), a fine is unconstitutionally excessive if (1) the payment to the government constitutes punishment for an offense, and (2) the payment is grossly disproportionate to the gravity of the defendant's offense.

Applying the first prong, the court held that the FCA's civil penalties have a punitive purpose. Since no damages need to be shown for the Government to recover under the FCA, and since treble damages are recoverable in addition to the civil fines, the court ruled that the purpose of the civil penalties was not solely to provide a form of damages, but also at least in part to punish. In addition, the court noted that the legislative history of the act indicated that the penalties were partly intended to punish and deter fraud against the Government. The court also ruled that the treble damage award was subject to an Excessive Fines Clause analysis. The 9th Circuit noted that the Supreme Court had characterized FCA damages as "essentially punitive in nature" in Vermont Agency of Natural Resources v. U.S. ex rel. Stevens, 529 U.S. 765, 784-85 (2000), 19 TAF QR 1 (2000), and that treble damages provisions in antitrust statutes have also been found to be partly punitive.

On the second prong, proportionality of the fines, the record was insufficiently developed. Therefore, the 9th Circuit remanded the case to the district court to determine whether the damages and penalties imposed were unconstitutionally excessive.

Calculation of Damages

U.S. ex rel. Giles v. Sardie, No. CV-96-20002 LGB (RCx)(C.D. Cal. Jan. 26, 2001)

A California district court ruled that the appropriate measure of damages in an FCA case was not the entire contract amount, but rather each overcharge or improper charge submitted pursuant to the contract. The court refused to impose civil penalties for each false claim, ruling that false claims submitted in relation to the same project only brought liability for one civil penalty.

In 1996, relator Diane Giles brought a *qui tam* suit against the City of Los Angeles and a number of its contractors for making false claims and fraudulent statements relating to federal funds disbursed for debris removal after the 1994 Northridge, California earthquake. After the earthquake, the United States authorized the disbursement of disaster relief funds by the Federal Emergency Management Agency. The City of Los Angeles administered these funds through the Earthquake Recovery Division (ERD), a city program established for the purpose of conducting the relief effort. ERD entered into numerous contracts with the defendants to provide disaster relief. Giles alleged that the city and the ERD contractors made false statements, predominantly on contract invoices, to defraud the Government. The

United States declined to intervene.

The clerk entered a default for non-appearance against several defendants. The relator then moved for a default judgment against all of the defendants named by the clerk, and sought: (1) treble damages based on the full amount of each defendant's contract; (2) a civil penalty of up to $10,000 against each defendant; (3) costs; and, (4) attorneys' fees. The court entered default judgment against most of the defendants. Noting, however, that the relator's complaint characterized the relief sought as overcharges and improper charges, the court denied the relator's request for damages based on the full contract amount. The court granted attorneys' fees, costs, and a civil penalty in the amount of $10,000 against each defendant subject to default. The relator moved for reconsideration, asking the court to impose damages based on the full value of the defendants' contracts and to amend the civil penalties to total $10,000 per false claim, rather than per defendant.

Full Contract Price Is Not Proper Measure of Damages for Overcharges

The court ruled that the the full contract amount is an improper measure of damages for overcharges. The court noted that the Supreme Court had ruled in United States v. Bornstein, 423 U.S. 303, 311 (1976), that it is the claims, not the contracts, that give rise to the liability. Awarding damages based on the entire contract amount would "make the government more than whole" and create a windfall.

Court Imposes Penalties Per Defendant, Not Per Claim

The court rejected the relator's request to amend the grant of civil penalties from $10,000 per defendant to $10,000 per false claim. In rejecting this argument, the court held that "each false claim is not an independent trigger of the Act's penalty provision." The court relied on United States ex rel. Marcus v. Hess, 317 U.S. 537, 552 (1943), which held that defendants should be penalized "for each separate project." According to the court, since the invoices represented the same project, the $10,000 penalty against each defendant was appropriate.

U.S. ex rel Oliver v. Gyro House, 2001 WL 312378 (9th Cir. Mar. 29, 2001)

The 9th Circuit affirmed a lower court's calculation of damages based on the contract price where the defendant had supplied the Government with worthless items. Moreover, it was no defense to claim that the items were "equivalent" to those specified in the contract if they were not what the contract called for.

In 1997, relator Lorryn Oliver filed a *qui tam* lawsuit against The Gyro House alleging falsification of records in connection with a contract to recondition navigational gyroscopes for the Government. The district court granted summary judgment for the Government and entered an award of damages and attorneys' fees. The defendants appealed, arguing, among other things, that the district court miscalculated damages.

The defendants argued that FCA damages should be calculated based on the sum The Gyro House received, not the contract price. The court rejected this argument, noting that damages under the FCA are liberally calculated. The undisputed facts showed that the Government had paid the full contract price for gyroscopes that had no market value and were not in compliance with contract requirements, and had returned them unused. Furthermore, the court noted that it was no defense under the FCA to argue that the gyroscopes provided were equivalent or better than specified if they were not what the contract required.

Rule 9(b)

U.S. ex rel. Garst v. Lockheed Integrated Solutions Co., 2001 WL 315178 (N.D. Ill. Mar. 29, 2001)

An Illinois district court dismissed without prejudice a relator's complaint for failure to plead fraud with particularity as required by Federal Rule of Civil Procedure 9(b). Moreover, finding that it was the federal agency's negligence, and not knowing fraud on the part of the contractor, which caused certain contracting practices to occur, the court dismissed the complaint for failure to state a claim under the Act's § 3729(a)(7) "reverse false claims" and § 3729(a)(3) conspiracy provisions.

In 1998, John Garst, a former employee of the United States Department of Veteran Affairs (VA), filed a *qui tam* lawsuit against Lockheed Integrated Solutions Company (Lockheed). The complaint alleged that Lockheed made fraudulent representations in order to obtain a Veterans Administration contract, and then failed to deliver on its promises under the contract. The Government elected not to intervene, and Lockheed moved to dismiss on the grounds that the relator failed to allege fraud with sufficient particularity as required by Rule 9(b) and failed to state a claim.

Plaintiff Must Identify False Claims With Specificity

Lockheed argued that the complaint lacked sufficient information to allow it to defend itself, failed to specify any claims that were false or fraudulent, did not identify any individuals who committed fraud, failed to provide specific dates, and did not state where the alleged fraud occurred. The relator argued that the requirements of Rule 9(b) should be relaxed in this case because of the contract's ten-year duration, and because the required information was within Lockheed's control. The court ruled that in a case where the relator does not allege that all invoices submitted over a period are false, it is appropriate to require that the relator describe the claims or records specifically and allege wherein they are false. Since the alleged fraud took place over a ten-year period, the court found that it would be very difficult for the defendant to respond to such a general allegation without knowing the time the claims were submitted, and what the false claims actually were. The court noted that in addition to failing to describe specific invoices, the relator failed to allege any facts that would support an inference that the conduct was fraudulent, rather than negligent.

Reverse False Claims and Conspiracy Allegations Dismissed

The relator had also alleged that Lockheed violated § 3729(a)(7) of the FCA, the "reverse" false claims provision, by failing to pay liquidated damages for late deliveries of hardware and software as agreed under the contract. However, the court found that no allegation in the complaint indicated that Lockheed avoided paying damages by lying to the VA. Rather, according to the relator, the VA simply never charged Lockheed for the late shipments. In addition, the court found that the relator's count alleging conspiracy under § 3729(a)(3) was insufficient as the relator failed to identify any co-conspirator or any agreement to defraud, preventing Lockheed from drafting a response. The relator argued that the laundry list of instances in which Lockheed was allowed to go far beyond casual contracting practices led to the common sense conclusion that Lockheed entered into an agreement with one or more parties to defraud the VA in the contract. The court rejected the relator's argument, ruling that the allegations were as consistent with simple negligence on the part of VA administrators as they were with fraud. General complaints about the behavior of

unidentified persons were insufficient to add up to conspiracy, since the relator did not allege an agreement or parties to the agreement. The court dismissed the complaint without prejudice.

Arbitrability of FCA Claims

U.S. v. Bankers Insurance Co., 245 F.3d 315 (4th Cir. Mar. 27, 2001)

The 4th Circuit held that an arbitration clause in a government contract is enforceable where the Government brings an FCA claim against a defendant for violations arising under the contract. Where the Government has previously agreed to an arbitration process, the court ruled, it may not later argue that the FCA prevents it from honoring that agreement.

Bankers Insurance Company (Bankers) is a private insurance company that sells and administers flood insurance. Bankers entered into a contract with the Government regarding the administration of federal flood insurance, which contained an arbitration provision. In 1999, the Government filed suit against Bankers for FCA violations and various common law claims. All of the claims were based on Bankers' alleged failure to turn over interest as required by the contract and provide the Federal Insurance Administration with true and accurate information. Defendants requested a stay of the proceedings pending arbitration, which the district court denied. Bankers filed an interlocutory appeal, arguing that the arbitration provision was mandatory, and that the presence of an FCA claim does not negate the arbitration requirement.

Sovereign Immunity Is a Shield, Not a Sword

The Government contended that the doctrine of sovereign immunity prohibits a court from requiring it to engage in arbitration. The court ruled that this argument bordered on frivolity. Sovereign immunity is a shield, not a sword, and is only relevant when the Government is being sued, not when it files a civil complaint against a defendant. It does not permit the Government to sue on a contract and then pick and choose the contractual provisions that it wishes to enforce.

Permissive Language in Contract Imposes Mandatory Non-Binding Arbitration

Although the contract language was permissive, stating that any dispute "may be submitted to arbitration," the court held that it imposed mandatory arbitration if one party to the contract elected to seek it. A contrary interpretation, the court noted, would render the clause meaningless, since parties can always voluntarily submit to arbitration.

The Government argued that the National Flood Insurance Act specifically precludes arbitration that is binding upon the Government, and that the arbitration clause should not be enforced because it would not resolve the dispute. The court noted the difference between mandatory and binding arbitration, ruling that mandatory but non-binding arbitration could be imposed on the Government because even non-binding arbitration is not futile.

FCA Claims Are Subject to Arbitration

According to the Government, since the Attorney General has an exclusive statutory duty to enforce the FCA and was not a party to the agreement that contained the arbitration clause, it should not be bound by its terms. The Government also argued that the arbitration agreement was not applicable to the FCA claim. Following general contract law principles, the court rejected this argument, holding that the

Attorney General's exclusive right to enforce the FCA does not give the Government the right to enforce certain parts of its contractual agreements and ignore others. As the arbitration would be non-binding, the arbitration process would not dilute the Attorney General's authority. The court observed that the Government comes to court "in the exact same position as any other plaintiff," except that the FCA claim is premised on a unique statutory right. In general, statutory claims are subject to arbitration, and so, the court ruled, is the FCA.

***U.S. ex rel. Watson v. Wagner Maritime, Inc.* (ED VA No. 2:00cv24)**

In February 2001, a Virginia district court denied the defendant's motion to permanently seal a *qui tam* case. Becky Watson, a former employee in the government contracts billing department at Wagner Maritime, filed the *qui tam* suit in January 2000. The suit alleged that Wagner Maritime charged the Government for labor and materials under delivery orders for certain government contracts when the labor and materials were attributable to different contracts. After the court granted the Government several extensions to the seal period, the case was settled, and the Government and the relator filed a notice of dismissal. The defendant then moved to maintain a permanent seal on the case.

In deciding that a permanent seal was not appropriate in this case, the court observed that the FCA does not provide for the permanent sealing of *qui tam* complaints. The court noted that the § 3730(b)(2) seal provision is designed to allow the Government a full opportunity to investigate the merits of the complaint and determine whether or not to intervene. Once the Government decides whether to intervene, the complaint is unsealed. Thus the FCA contemplates that records in *qui tam* cases should be made public. In fact, the court noted, such cases are generally publicly litigated in circumstances more sensitive than those in the case at bar. Moreover, the public's strong right of access was not effectively rebutted by the defendant's interest in keeping the matter sealed. In the 4th Circuit, a party seeking to restrict access must demonstrate a "significant interest" that "heavily outweighs the public interest in access." The defendant had not met this burden merely by asserting that unsealing the complaint would cause it embarrassment. In addition, because the case involved the recoupment of public funds, the public's interest in access was especially strong.

***U.S. v. Sriram* (ND IL No. 00 C 4988)**

In February 2001, a U.S. magistrate judge in Illinois granted a preliminary injunction pursuant to 18 U.S.C. § 1345 to freeze assets in the defendant's possession that were traceable to Medicare fraud. However, the court made clear that the injunction was issued pursuant to a showing of likelihood that the Government would prevail on the concurrent criminal Medicare fraud charges, and that a civil action under the FCA standing alone could not give rise to an injunction under § 1345. Thus, only those assets traceable to criminal fraud could be frozen, and the amount could not be increased to secure the collectibility of treble damages.

The Government filed its FCA suit against Dr. K Sriram in August 2000. Later that year the Government filed a criminal complaint against Dr. Sriram and a grand jury returned an indictment for violations of the criminal health care fraud statute, 18 U.S.C. § 1347. The court held that, in order to obtain a preliminary injunction under § 1345, the Government need only prove a likelihood of success on the merits. In this case, the court's findings of fact amply confirmed the Government's assertion that it was likely to succeed on both the criminal and civil fraud claims. However, the court based its injunction solely on the likelihood of proving criminal fraud. The statute providing for injunctive relief, 18 U.S.C. § 1345, specifies the types of statutory violations that may provide a basis for an injunction. These include violations of a number of specific criminal health care fraud and criminal banking law provisions, as well as a "[f]ederal health care

offense." The court construed the term "offense" to refer only to a criminal offense, noting that all of the specifically enumerated violations in the same context were criminal and that the legislative history of § 1345 referred only to criminal offenses. Thus, in the absence of a purported criminal violation, an FCA claim could not form a basis for injunctive relief under § 1345.

***U.S. ex rel. Oliver v. Parsons Co.** (CD CA CV 95-5423-WMB)*

In March 2001, a California district court denied the defendants' second motion for summary judgment in a government contracting fraud case. The relator, Janet Oliver, filed an FCA action in 1995 alleging that The Parsons Company and its subsidiaries developed a scheme to defraud the Government by shifting its non-federal labor costs from its subsidiary, Parsons ES, to a second, sham subsidiary, I & M, in order to inflate the rate at which the Federal Government compensated Parsons ES for overhead. I & M was in essence merely a payroll with no overhead. Because the rate at which the Government compensated Parsons ES for overhead was determined by the ratio between its overhead and its labor costs, Parsons ES was able to increase the rate it charged the Government by shifting its labor costs to I & M.

After the Government declined to intervene, the complaint was unsealed and the parties filed cross-motions for summary judgment. The district court granted summary judgment to the defendants, holding that their interpretation of the controlling accounting regulations was reasonable, and thus could not be "false or fraudulent" under the FCA. On appeal, the 9th Circuit reversed, ruling that while reasonable interpretation of the regulations might be relevant to whether the defendants "knowingly" submitted false claims, it was not relevant to the question of falsity.

On remand, the defendants again moved for summary judgment. The defendants argued that because I & M worked exclusively on non-federal contracts, it was not covered by federal accounting regulations. The court rejected this argument as irrelevant. The basis of the plaintiff's claim was the defendants' allegedly fraudulent omission of I & M from the government-required list of companies with which they had inter-organizational transfers. The court also rejected the defendants' contention that they were entitled to summary judgment because their disclosure was merely incomplete but not literally false. The regulations required contractors to certify not merely that their submission was true, but also that it was "complete and accurate." Moreover, even under a literal falsity standard, the plaintiff would survive summary judgment because the defendants had certified that transfers between Parsons Company subsidiaries were made at cost while in reality a multiplier was used for transfers between Parsons ES and I & M.

***U.S. ex rel. Wiser v. Geriatric Psychological Services, Inc.** (D MD No. Civ. Y-96-2219)*

In March 2001, a Maryland district court ruling on a relator's petition for award of attorneys' fees and costs in a *qui tam* action rejected the relator's claim of privilege for her attorney's billing records but upheld the imposition of joint and several liability for fees and costs on the defendants. Because the underlying litigation had concluded, the court held that it was a matter of public record that the relator's counsel had researched such issues as "false claim suits," "*qui tam* procedures," and "venue,"

and that it had drafted and reviewed a complaint, communicated with government attorneys, and reviewed settlement issues. No privilege protected brief references to these matters in the billing records, and the defendants had a due process right to examine the hours claimed on particular issues to challenge the reasonableness of the fee request if they so chose.

However, the court rejected the argument of two individual defendants that they should not be liable for the attorneys' fees because the relator's contribution to the litigation was not directed toward them. The relator had initially sued only the corporate defendant, Geriatric Psychological Services, Inc., and the individual defendants were added only after the United States intervened in the case. Nevertheless, the court found no authority for the proposition that attorney fee awards should be apportioned among defendants when all other recovery need not be. The court noted that joint and several liability always poses a risk of unfair or uneven treatment of defendants, and that "defendants have no right of indemnification or contribution under the False Claims Act despite the potential unfairness that they may suffer without such rights."

***U.S. v. Medco Physicians Unlimited** (ND IL No. 98 C 1622)*

In March 2001, an Illinois district court granted in part and denied in part the Government's motion for partial summary judgment against defendant Anwar Yamini in a Medicare fraud case. In 2000, the court had granted partial summary judgment against the corporate defendants, and the Government now moved for judgment against Yamini in his individual capacity. The Government alleged that Yamini presented false claims in three ways: (1) failing to maintain required financial records; (2) submitting meals and transportation costs for reimbursement in violation of Medicare regulations; and, (3) falsely stating that Medco did not transact business with related parties. The court denied summary judgment on the first ground but granted it on the second two grounds.

Yamini contended that once he realized he was unable to satisfy the Medicare reporting requirements, he hired an independent consultant to reconstruct Medco's general ledger and complete the required cost reports. The court held that Yamini had raised a genuine issue of material fact as to whether he "knowingly" failed to maintain financial records.

However, the court ruled against Yamini on the remaining grounds. In its earlier opinion, the court had already granted summary judgment against Medco for seeking Medicare reimbursement for meals and transportation, and the issue now was Yamini's personal liability for submitting those claims. Yamini sought to rely on an addendum he had attached to the final cost report indicating that he believed that the cost report form did not comply with regulations, and that although transportation and meals were categorized on the form as non-reimbursable, he had included them in order to preserve his right to claim them on appeal as "reimbursable overhead expenses." Noting that Yamini had failed to cite any regulations indicating that such costs were in fact reimbursable, the court held that "Yamini's reliance on this self-serving document" was insufficient to raise a genuine issue of material fact as to his knowledge of the falsity of his claims. Finally, the court found that Yamini had provided false answers to clear-cut questions regarding transactions with related parties, and was therefore personally liable on this ground as well.

U.S. ex rel. Matthews v. HealthSouth Corp., 2001 WL 431690 (WD LA No. CIV 99-0604)

In March 2001, a Louisiana district court dismissed *qui tam* claims involving allegations of Medicare fraud for failure to state a claim upon which relief can be granted. Paul Matthews, a former executive of the defendant HealthSouth, filed his initial complaint in April 1999 and in February 2000 the Government declined to intervene. The relator twice amended his complaint, and in October 2000 the court dismissed for failure to satisfy Fed. R. Civ. P. 9(b). In November 2000 the relator timely filed a third amended complaint and HealthSouth again moved to dismiss.

The newly amended complaint asserted that HealthSouth: (1) fraudulently certified that 75 percent of the patient population at its hospital was being treated for certain specified disorders (the 75 percent rule) and (2) fraudulently certified compliance with Medicare rules despite failing to provide three hours of therapy each day to patients (the three-hour rule). The relator alleged that these certifications enabled the hospital to be reimbursed as a prospective payment system (PPS)-exempt hospital, rather than on a PPS basis. Medicare reimburses PPS-exempt facilities at a higher rate than PPS facilities.

The court dismissed the claim regarding the 75 percent rule for failure to allege falsity or a fraudulent course of conduct. Although the complaint alleged that the defendant certified compliance with the 75 percent rule in deliberate ignorance of the true state of affairs, it failed to allege that the defendant actually violated the rule. Thus, while the relator alleged the requisite scienter, he failed to allege a false statement or a fraudulent course of conduct. This was insufficient to support an FCA claim.

The court also dismissed the three-hour rule claim, finding that no such rule was mandated by law. As the relator conceded, there was no statute or regulation imposing the three-hour requirement. According to the court, mere "standards" or "guidelines" that Medicare might set in this area do not have the force of law. Furthermore, any such guidelines might conflict with the Social Security Act, which prohibits federal interference with "the manner in which medical services are provided."

Wide-Ranging Fraud Allegations Changed the Culture at Columbia/HCA

by Dylan Trache
TAF Staff Attorney

Wide-ranging allegations of fraud against health care giant Columbia/HCA have already resulted in a combined $840 million civil False Claims Act and criminal fraud settlement, the largest in the nation's history.[1] Much of this recovery can be directly attributed to the *qui tam* provisions of the FCA. In March 2001, the United States intervened in eight of the remaining *qui tam* cases of the thirty originally filed against the company.

This article examines how a corporate culture of aggressive growth and relentless pursuit of federal health care dollars triggered a large-scale government investigation and dozens of whistleblower lawsuits. The article provides an overview of the events culminating in the fraud settlement and the issues still being litigated in the remaining lawsuits. The author concludes that *qui tam* litigation played a critical role in reforming the business practices and corporate culture of the nation's largest for-profit hospital chain.

A. THE CULTURE AT COLUMBIA EMPHASIZED PROFITS AND EXPANSION

In February 1997, Columbia/HCA was enjoying a soaring stock price and high profits. Its vast expansion had made it the nation's largest for-profit hospital company. The corporate culture at Columbia/HCA emphasized not only maximization of profits, but also an effort to create a national identity for its hospitals, known as "name branding." As part of the name branding effort, local hospitals were required to carry the name "Columbia."[2] Moreover, Columbia/HCA was taking over many not-for-profit providers, and offering physicians and management lucrative incentives to admit more patients and maximize reimbursement from federally funded health care programs.

The driving force behind this rapid national expansion was Columbia CEO and co-founder Richard L. Scott.[3] With then Chief Operating Officer David Vandewater, Scott promulgated the company policy of taking over not-for-profit hospitals, increasing profits, and creating a national identity for Columbia. According to former Columbia officials, the company pressured executives to achieve financial goals by offering bonus-

es of up to 50 percent of their salaries.[4] In addition, the company set up partnerships with doctors, giving them an economic interest in Columbia's hospitals.[5] According to Washington Post reporter David Hilzenrath, assigned to covered Columbia/HCA and the health care industry at the time, this approach to the healthcare business "inspired dread among competitors and changed the landscape of American health care."[6] Perhaps the best example of Columbia's attitude comes from a 1994 pep talk given by Vandewater to employees at a newly acquired hospital. In reference to a rival not-for-profit hospital, Vandewater stated: "the enemy is St. Mary's, they've got your patients."[7] In fact, Columbia management refused to refer to their primary competition as "not-for-profit." Rather, these hospitals were to be known as "tax-exempt" hospitals.[8]

B. COLUMBIA USED HOME HEALTH CARE TO MAXIMIZE PROFITS

One of the biggest reasons for Columbia's success was its home health care division.[9] Columbia Homecare had become the nation's largest home health care provider. Although according to Medicare regulations, home health care is designed to be a non-profit enterprise, with federal health programs reimbursing only costs and salaries, Columbia/HCA saw an opportunity to increase profits.[10] Medicare rules allow hospitals to shift some administrative costs to home health care cost reports for reimbursement.[11] The costs a company is allowed to shift depend on the number of home visits a hospital performs. If Columbia Homecare performed more home visits, the hospital could shift more costs to home health care for reimbursement, thereby increasing profits.

Internally, Columbia was particularly blunt about its profit goals, despite the Medicare regulatory ban on home-care profits. In order to increase home visits, Columbia Homecare set an internal target aimed at bringing 85 percent of all patients discharged from its hospitals and entering home health care into its home health care program.[12] Internal corporate documents reveal that Columbia saw profit potential of between six and fifteen dollars for each homecare visit, and that Columbia set targets for Columbia Homecare of 17.6 million annual visits.[13] Columbia Homecare hosted a convention in Dallas featuring presentations on how to make money from home health care.[14]

Although the Government did not at the time have access to documents evidencing these internal targets, it began to notice increased home-care visits and increased reimbursement requested per visit at home health care agencies that Columbia purchased.[15] For example, after Columbia purchased Fawcett Memorial Hospital in Port Charlotte, Florida in 1992, home-care visits increased exponentially.[16] As a result, home-care revenue skyrocketed, and profits for the hospital quadrupled between 1993 and 1996.[17] Columbia achieved this massive rise through various means. Although Columbia doctors were allowed to refer patients to outside home-care providers, the company set up a system of incentives to ensure that its targets were met. Home-care nurses and admin-

istrators were paid bonuses for hitting certain revenue and visit targets. In addition, Columbia named some of its physicians as medical directors of its home-care program, a position that paid over $8,000 a year. Columbia Fawcett also purchased two local home-care agencies.[18]

C. FRAUD ALLEGATIONS AGAINST COLUMBIA SURFACE

Scott's strategy seemed to be working. Columbia's stock price climbed rapidly, from a low of 7.416 in August 1991, to a high of 44.875 in February 1997, an increase of over 500%.[19] However, everything began to change on March 19, 1997, when the company's El Paso, Texas operations were served with federal search warrants demanding various corporate documents. This search was part of a criminal investigation into Columbia/HCA's billing practices. At the time, Columbia/HCA issued a public statement claiming that the investigation was limited to the El Paso facilities.[20] In fact, investigation was not limited to El Paso, and was only the beginning of events that would radically change the environment at Columbia/HCA.

In addition to the criminal investigation, and perhaps unbeknownst to the company, were 30 lawsuits filed under seal in courts across the country alleging a myriad of False Claims Act violations. Current or former Columbia employees who had become concerned with their employer's practices filed many of these *qui tam* suits well before the raids on the El Paso facilities. The suits alleged almost every type of Medicare fraud imaginable, including but not limited to: billing for services provided to ineligible patients, upcoding, improperly billing for certain lab tests, billing for home health services that were never provided or medically unnecessary, improper physician referral relationships, and cost report fraud. The *qui tam* suits and the willingness of insiders to cooperate with the Government allowed Federal officials to obtain an inside look into the company's operations before even disclosing the existence of an inquiry to Columbia.[21]

Soon the federal investigation expanded. In July 1997, officers from the FBI, HHS, the Defense Criminal Investigative Service, and other agencies searched 35 Columbia/HCA facilities in six states as part of the expanding criminal probe.[22] Much of the investigation centered on Columbia Homecare and Columbia/HCA's hospital-laboratory billing.[23] Later that month, three executives from Columbia's Florida facilities were charged with criminal Medicare fraud. Although the indictments dealt only with activity at one Florida hospital, all three executives oversaw reimbursement for several Columbia hospitals in Florida.[24] Eventually five more executives would face criminal indictments, signaling the extensive nature of the fraud at Columbia/HCA. Two of these indictments would lead to convictions. In December 1999, Jay A. Jarrell, the former CEO of Columbia's Southwest Florida Division, and Robert W. Whiteside, the former head of the company's Single Markets Division were sentenced to 33 months and 2 years respectively for various criminal Medicare fraud counts.[25] Moreover, in August

1997, the first of the 30 *qui tam* lawsuits was unsealed. By that time, it was clear that a company-wide problem was at hand, and that serious changes were necessary.

D. COLUMBIA ATTEMPTS TO REBUILD ITS IMAGE

The wide-ranging fraud allegations prompted Scott to resign. This resignation was the first of many at the top echelon of Columbia/HCA's management.[26] Scott's replacement, Dr. Thomas F. Frist Jr., quickly embarked on a mission to change the overall culture at Columbia/HCA. Almost immediately, Columbia/HCA eliminated its name branding strategy, allowing local hospitals to drop "Columbia" from their name.[27] Frist's overall strategy appeared to mirror his approach as the former head of the Hospital Corporation of America (HCA), which he co-founded. The two companies had merged in 1994, and Dr. Frist had served as chairman and vice-chairman of the new company from 1995-1996. Nevertheless, before his resignation, Scott had charted the course for the company without much regard to the advice of Dr. Frist or other former HCA executives.[28] Although the executive committee of which Dr. Frist was a member had the power to review certain areas of Columbia's operations, the committee did not meet in 1995 or 1996. Dr. Frist himself viewed the culture at Columbia/HCA as characterized by "an overly aggressive management style that antagonized regulators, too-rapid growth and a weak board."[29]

Before the merger, the management at HCA had been more people-oriented, less aggressive, and more concerned with compliance. Many HCA managers had become uncomfortable with Columbia's management style when Columbia purchased HCA. Frist announced a plan to change Columbia's business approach that included the end of the performance-tied bonuses, the sale of Columbia Homecare, the adoption of a comprehensive compliance program, and the elimination of partnerships that gave doctors an equity interest in hospitals.[30]

As part of a restructuring plan, Columbia began to sell off some of its operations. Not only was Columbia Homecare sold to various buyers, but Columbia/HCA sold 34 ambulatory surgery centers to HealthSouth. In total, the plan called for 32 percent of Columbia's hospitals to be spun off. Frist had implemented a similar strategy at HCA where he sold off a number of rural hospitals in 1987. At the start of 2000, Columbia owned 207 hospitals, down from almost 350 in 1997.[31] When Columbia's downsizing is completed, the for-profit health care industry will likely return to the way it looked before Richard Scott began buying hospitals in 1988, with multiple, competitive companies.[32]

As part of the effort to change corporate culture and to institute a comprehensive compliance program, Columbia/HCA created the new position of senior vice president of ethics, compliance and corporate responsibility.[33] Attorney Alan Yuspeh was named to this post.[34] Mr. Yuspeh had successfully coordinated the defense industry's efforts to

increase compliance with federal regulations and improve its public image in response to allegations of $9000 wrenches and other improprieties on the part of contractors. As head of the Defense Industry Initiative, Yuspeh instituted a system that allowed military contractors to police themselves and voluntarily disclose violations in return for gentler treatment from regulators.[35] Yuspeh hoped to institute a similar system at Columbia.

Upon assuming the job, Yuspeh stated that his priority at Columbia/HCA was to create "the finest compliance program in the country."[36] Over the next few years, Yuspeh would implement this compliance program by emphasizing five elements: organizational support/structure, setting standards, creating awareness, establishing a mechanism for reporting exceptions, and monitoring and auditing.[37] Yuspeh implemented a new Code of Conduct for Columbia/HCA employees. The code was designed to guide employees through ethical and compliance issues in their daily work. In addition, Yuspeh appointed an Ethics and Compliance Officer for each facility to implement the code on a local level. One of the final steps in the makeover of Columbia/HCA was to formally drop the name "Columbia." On May 30, 2000, Columbia/HCA changed its name to HCA – The Healthcare Company. In a press release, the company stated that the new name "reflects a return to the values that are the foundation of the current company."[38]

E. THE LARGEST FCA SETTLEMENT EVER

Despite the apparent cultural makeover and name change, both the criminal fraud investigation and the *qui tam* whistleblower lawsuits remained pending against the company. For the convenience of the parties, and to facilitate settlement, the whistleblower suits were consolidated in Washington, D.C. for pre-trial proceedings.

In December 2000, HCA settled at least 11 of the 30 *qui tam* suits, agreeing to pay the Government $745 million to resolve some of the alleged FCA violations. The settlement resolved allegations of billing for services provided to ineligible patients, upcoding, improperly billing for certain lab tests, and billing for home health services that were never provided or medically unnecessary. In addition to the civil settlement, HCA subsidiaries agreed to a $95 million fine and to plead guilty to criminal charges relating to the same fraudulent activity. The subsidiaries that pled guilty are ineligible to participate in government health care programs.

The civil agreement required HCA to pay over $95 million to resolve allegations of fraudulent laboratory billing practices; more than $403 million to resolve allegations of upcoding; $50 million to resolve allegations that the company claimed nonreimbursable marketing and advertising costs disguised as community education; $90 million to resolve allegations of improper charges to Medicare in the purchase of home health agencies; and $106 million to resolve allegations of billing for home health visits for nonqualified patients. To date, it is the largest fraud settlement ever reached by the Justice

Department. In addition to the monetary payments, HCA agreed to an eight-year corporate integrity agreement, which according to then HHS Inspector General June Gibbs Brown is unprecedented in scope and level of detail.[39] The Government is in the process of determining the relators' shares for the *qui tam* suits covered by the settlement.

F. PENDING LAWSUITS

At least seventeen *qui tam* suits were not covered by the settlement. In March 2001, the Government filed complaints and intervened at least in part in eight of the remaining cases. In addition, the Government moved to dismiss two cases as covered by the December settlement. The remaining suits in which the Government has intervened can be divided into three primary categories of allegations: payment of kickbacks to physicians to increase the numbers of government-insured patients, inflation of hospital cost reports by including unallowable charges, and payment of kickbacks and unallowable expenses on cost reports for wound care services.

Relator James M. Thompson filed the first suit against Columbia containing allegations of improper physician referral arrangements. The Government also intervened in *qui tam* cases brought by relators Gary King and Ana Mroz, which contain similar allegations. Two other relators, Craig Adams and Lawrence Baker, also filed complaints alleging improper referrals. However, the Government has declined intervention in those cases, and is seeking dismissal of the relators pursuant to the Act's § 3730(b)(5) first-to-file and § 3730(e)(4) public disclosure bars.

Relators James F. Alderson and John W. Schilling alleged that Columbia and its subsidiaries knowingly included unallowable charges in cost reports, unlawfully shifting costs from hospital departments paid at flat rates to departments reimbursed at cost. Columbia allegedly kept a secret set of reserve reports detailing the costs that should have been reported. Alderson and Schilling filed complaints containing similar allegations, but named different hospitals as defendants. The Government has consented to a motion to consolidate these cases. Another cost report case, filed by Michael Marine, involves improper cost-shifting between Cedars Medical Center and HCA's other Miami area hospitals, and the Government has intervened in part in that case. Specifically, the complaint alleges that Cedars Medical Center had exceeded its cost limit for home health costs, so the defendants allocated costs incurred by Cedars to other hospitals. According to one relator, a substantial settlement is currently on the table to resolve the cost report cases.

Joseph Parslow and Francesco Lanni alleged that HCA hospitals throughout the country included unallowable wound care expenses on Medicare cost reports. Specifically, Parslow's suit involves allegations that HCA included advertising and marketing expenses on the cost reports and paid kickbacks to Curative, a management firm that

also manufactures wound salve, for arranging for patients to receive wound care services at HCA hospitals. The kickbacks were allegedly disguised as management fees charged to Medicare on cost reports. According to the complaint filed by Lanni, HCA wound care centers knowingly included the cost of Procuren, a proprietary wound salve, in cost reports when HCA knew that the cost was non-reimbursable. According to the Status Report filed by the United States on March 15, 2001, settlement negotiations as to the wound care cases are stalled.

Two other suits were filed at least in part as a result of HCA's fraud. First, a *qui tam* lawsuit was filed against KPMG Peat Marwick, HCA's accounting firm, alleging that KPMG committed FCA violations by preparing the reserve cost reports for HCA. In December 2000, DOJ intervened in this action, marking the first official Government involvement in a *qui tam* case against an accounting firm for its role in advising another FCA defendant. HCA shareholders filed the second action, alleging that Columbia/HCA directors and officers breached their fiduciary duty of care. Both suits are currently pending.

CONCLUSION

It appears that the culture at HCA has in fact changed for the better, but time will tell whether other large providers have been deterred from similar activities. When every FCA case is concluded, HCA could end up repaying close to $2 billion to the Government. Wall Street seems to think HCA's troubles are in the past. Recently, HCA reported higher profits and increased revenues, causing another rapid increase in HCA's stock value. Although HCA is still the nation's largest for-profit health care provider, it is not the 2000 pound gorilla it was when it owned 350 hospitals. The reforms brought about by HCA's new management have helped once again make the for-profit health care industry competitive, especially the home health care business. However, *qui tam* suits against health care providers are still being filed, and many companies are currently being investigated for fraud against government health care programs. Thus, it is unclear whether the industry as a whole learned any lessons from Columbia's troubles.

ENDNOTES

[1] *See* Spotlight, 21 TAF QR 16 (January 2001).

[2] *See* Kurt Eichenwald, *Columbia/HCA Is Abandoning National Focus and Tough Image*, N.Y. Times, August 25, 1997, at D1.

[3] *See id.* Columbia purchased the Hospital Corporation of America in 1994, and became known as Columbia/HCA.

[4] *See* David S. Hilzenrath, *Probe of Columbia/HCA Takes Toll on Hospital Firm*, Wash. Post, Sept. 29, 1997, at A1.

[5] *See id.*

[6] *Id.*

[7] David Hilzenrath, *Massive Fraud Investigation Centers on Columbia/HCA*, Wash. Post, July 18, 1997, at G1.

[8] *See* Eichenwald, *supra* note 2.

[9] *See* Greg Jaffe & Anita Sharpe, *Inside Booming Columbia Home-Care Business*, Wall St. J., Oct. 9, 1997, at B1.

[10] *See* Anita Sharpe & Greg Jaffe, *U.S. Studying Profit Targets at Columbia*, Wall St. J., Aug. 28, 1997, at A3.

[11] *See id.*

[12] *See* Anita Sharpe et al., *U.S. Searches Sites in Probe of Columbia*, Wall St. J., July 17, 1997, at A3.

[13] *See id.*

[14] *See id.*

[15] *See id.*

[16] *See* Jaffe & Sharpe, *supra* note 9.

[17] *See id.*

[18] *See id.*

[19] Stock data provided by quote.cnbc.com.

[20] *See* Press Release, Columbia/HCA, Columbia/HCA Corporation Issues Statement (March 19, 1997).

[21] *See* Kurt Eichenwald, *Whistle-Blower Lawsuits Aim at Big Provider of Health Care*, N.Y. Times, Aug. 19, 1997 at D1.

[22] *See Investigators Search 35 Columbia/HCA Facilities*, Wash. Post, July 17, 1997 at A20.

[23] *See* Sharpe et al., *supra* note 12.

[24] *See* Kurt Eichenwald, *3 Executives of Hospital Chain Charged with Medicare Fraud*, N.Y. Times, July 31, 1997, at A1.

[25] *See Government Won't Indict Executives of Columbia/HCA, Olsten*, Federal Contracts Report (BNA) Vol. 73 No. 2, at 60 (Jan. 11, 2000).

[26] *See* Eichenwald, *supra* note 2.

[27] *See id.*

[28] *See* Lucette Lagnado, et al., *How 'Out of the Loop' Was Dr. Frist During Columbia's Expansion?*, Wall St. J., Sept. 4, 1997 at A1.

[29] *Id.*

[30] *See* Press Release, Columbia/HCA, Columbia/HCA CEO Announces Planned Changes in Business Approach (Aug. 7, 1997).

[31] *See INFACT 2000 People's Annual Report*, *at* http://www.infact.org/hcareprt.html.

[32] *See* Kurt Eichenwald, *Columbia Plan Would Recast Health Care*, N.Y. Times, Nov. 18, 1997, at D2.

[33] *See* Lucette Lagnado, *Columbia Taps Lawyer for Ethics Post; Yuspeh Led Defense Initiative of 1980's*, Wall St. J., October 14, 1997, at B6.

[34] *See id.*

[35] Andy Pasztor and Lucette Lagnado, *Ethics Czar Aims to Heal Columbia*, Wall St. J., Nov. 26, 1997, at B1

[36] *See* Lagnado, *supra* note 33.

[37] *See* Alan Yuspeh et al., *Above Reproach: Developing a Comprehensive Ethics and Compliance Program*, Frontiers of Health Services Management, Winter 1999, at 3.

[38] *See* Press Release, HCA – The Healthcare Company, HCA – The Healthcare Company New Name Unveiled (May 25, 2000).

[39] *See* Press Release, U.S. Department of Justice, HCA-The Health Care Company & Subsidiaries to Pay $840 Million in Criminal Fines and Civil Damages and Penalties (Dec. 14, 2000).

ALLEGATION: FILING FALSE COST REPORTS

U.S. ex rel. Kimball v. Mercy Healthcare Sacramento et al. *(ED CA No. CIV-S-99-292 LKK-JFM)*

In February 2001, DOJ announced that it intervened in new portions of a *qui tam* suit alleging that four hospitals and their parent corporations, Catholic Healthcare West and Mercy Healthcare Sacramento, defrauded Medicare by filing false cost reports. The suit alleges that the hospitals knowingly double- and triple-charged Medicare for the same capital costs on multiple occasions. Previously, the Government intervened in a portion of the original *qui tam* suit alleging that three of the hospitals submitted false cost reports to the Medicare program in order to obtain millions of dollars for costs which were inflated or not allowable. Joseph Kimball, a former reimbursement analyst for Mercy Healthcare Sacramento, filed the *qui tam* suit. The relator is being represented by Paul Scott (San Fransisco, CA). Assistant U.S. Attorney Adisa Abudu-Davis and Lani Anne Remick of the DOJ Civil Division are handling the case for the Government.

ALLEGATION: KICKBACKS AND IMPROPER SELF-REFERRALS

U.S. ex rel. Barbera v. Tenet Healthcare Corp. *(SD FL No. 97-6590)*

In February 2001, DOJ intervened in a *qui tam* suit alleging that a hospital owned by Tenet Healthcare Corp. compensated certain physicians above fair market value to induce referrals. According to the lawsuit, beginning in 1993, the North Ridge Medical Center in Ft. Lauderdale violated both the False Claims Act and the Stark physician self-referral statute. The Stark statute prohibits physicians from referring Medicare patients for certain services to an entity in which the doctor has a financial interest. A physician employed by a hospital, however, is exempt from the statute as long as the doctor's compensation is at fair market value. The Government also intends to pursue allegations against Tenet involving false cost report claims at North Ridge. The DOJ declined, however, to intervene in the complaint's allegations that physicians employed by North Ridge upcoded claims for reimbursement. Sal Barbera, a former employee of Tenet, filed the *qui tam* suit.

ALLEGATION: ALTERING EXPORT CERTIFICATES

U.S. ex rel. Bahrani v. Conagra, Inc. *(D CO No. 00-WM-1077)*

In February 2001, a *qui tam* suit was unsealed alleging that Conagra and its subsidiary Monfort fraudulently altered USDA Export Certificates. The suit was filed by Ali Bahrani, a former document coordinator for the international export of cowhides at Conagra. According to the complaint, Monfort engaged in the practice of shipping its hides bound for export without a firm commitment from a buyer. As a result, because of subsequent changes in the identity or location of the buyer, the required export certificates often contained the wrong information. Rather than applying for new export certificates as required by applicable law, Monfort allegedly altered the information on the old certificates and deprived the Government of the $21 cost per new certificate. The DOJ declined to intervene. The relator is being represented by George H. Parker (Fort Collins, Colorado).

ALLEGATION: FILING FALSE COST REPORTS AND KICKBACKS FOR REFERRALS

U.S. ex rel. Alderson et al. v. Columbia/HCA Healthcare et al. *(D DC No. 01-MS-50)*

In March 2001, DOJ announced that it had intervened in eight of the remaining *qui tam* lawsuits against HCA (formerly Columbia/HCA), the nation's largest for-profit hospital chain. In December 2000, HCA agreed to pay the Government $840 million to settle, at least in part, 11 of the 30 consolidated *qui tam* lawsuits being litigated in the District of Columbia. The remaining cases primarily allege two types of FCA violations: cost report fraud and improper referral relationships. The Government intervened in the cases filed by the following relators: Alderson, Schilling, Marine, Thompson, Mroz, King, Parslow, and Lanni. Assistant U.S. Attorneys Mark Nagle and Doris Huff, and DOJ Civil Division attorneys Michael Hertz, Joyce Branda, Jonathan Biesenhaus, and Jamie Yavelberg represent the Government in this matter. *See* Spotlight, page 23.

***U.S. ex rel. Johnson v. Shell Oil Co. et al.* (ED TX Civ. No. 9:96 CV66)**

This quarter DOJ announced settlements with five more defendants in a *qui tam* suit alleging that a number of oil companies systematically underpaid royalties due for oil produced on federal and Indian lands. In January, Exxon Mobil Corporation agreed to pay **$7 million** and Shell Oil Company agreed to pay **$110 million**. In February, Burlington Resources, Inc. agreed to pay **$8.5 million**, Marathon Oil Company agreed to pay **$7.7 million**, and Phillips Petroleum agreed to pay **$8 million**. J. Benjamin Johnson and John Martinek, former employees of Atlantic Richfield Co. filed the suit in 1997. The complaint alleged that the companies engaged in systematic underreporting of millions of barrels of oil. According to DOJ, the companies were required to submit reports reflecting the amount and value of oil the companies produced pursuant to leases administered by the Department of the Interior. Over a ten-year period, the companies allegedly undervalued the oil in order to pay fewer royalties than they owed. The relator's shares from these settlements were not announced.

The total recovery in this action now exceeds $415 million. DOJ had previously reached settlement agreements with other defendant oil companies, including a $95 million settlement with Chevron Corporation, a $45 million settlement with Mobil Oil, a $43 million settlement with Texaco, a $32 million settlement with BP Amoco, a $26 million settlement with Conoco, a $13 million settlement with Kerr-McGee Corporation, an $11.9 million settlement with Devon Energy Production Company (formerly Pennzoil) a $7.3 million settlement with Oxy USA, and a $7 million settlement with Exxon Mobil. Michael Havard and Reuben Guttman of Provost & Umphrey Law Firm (Beaumont, TX) represented the relators. Representing the Government was U.S. Attorney Mike Bradford.

***U.S. ex rel. Hill v. Contech Construction Products, Inc.* (MD LA No. 99-400-B-M2)**

***U.S. ex rel. Wingfield v. Contech Construction Products, Inc.* (MD LA No. 99-400-B-M2)**

In January 2001, Ispat-Inland and Contech Construction agreed to pay **$30 million** to the Federal Government and the State of Louisiana to settle two *qui tam* suits alleging that that the construction companies falsely certified compliance with contract specifications. According to the DOJ, from 1992 through 1997 the companies utilized unapproved polymer-coated steel pipe when building drainage culverts for highway and road construction projects. Both the Federal Highway Administration and the Louisiana Department of Transportation and Development (LADOTD) required that Ispat-Inland and Contech use only approved materials from sources that had passed LADOTD testing. According to the Government, the companies used steel that had been laminated by an unapproved source and pipe that had been specifically rejected after testing by LADOTD. To conceal these violations, false information was reportedly stenciled on the exterior of the coated steel to indicate that the materials used to produce the pipe were acceptable. The Department of Transportation OIG and the FBI investigated the matter. Kyle Keegan of Roy, Kiesel & Tucker (Baton Rouge, LA) represented relator James Hill. Mr. Hill's share of the settlement is 16.8 percent or $5,033,730. Edward Gonzales of Shows, Cali & Berthelot (Baton Rouge, LA) and Gary Corum of Wilson Engstrom Corum & Coulter (Little Rock, AR) represented relator Keith Wingfield. Mr. Wingfield's share of the settlement is 3.2 percent or $966,000. Assistant U.S.

Attorneys Randall Miller and Lyman Thornton represented the Government.

Quest Diagnostics, Inc.

In January 2001, DOJ announced that Quest Diagnostics agreed to pay **$13.1 million** to settle allegations of overbilling practices at Nichols Institute, a laboratory acquired by Quest in 1994. According to the Government, from 1989 until shortly after Quest purchased Nichols in 1995, the laboratory routinely billed Medicare, Medicaid and TRICARE for medically unnecessary tests. The Government investigated Nichols as part of Operation LABSCAM, which targeted lab unbundling practices. Unbundling occurs when groups of lab tests performed together are billed separately in order to get a higher reimbursement. To date, the United States has recovered more than $850 million as a result of LABSCAM and related investigations. HHS OIG, the FBI, DCIS, and the Oregon State Attorney General's Office investigated the matter. Attorneys from the DOJ Civil Division and the U.S. Attorneys' Offices in Portland, Houston, and San Francisco handled the matter for the Government.

U.S. ex rel. Ven-A-Care of the Florida Keys v. Bayer Corporation et al. *(SD FL No. 95-1354-Civ.)*

In January 2001, Bayer Corporation agreed to pay **$14 million** to the Federal Government and 45 states to settle a *qui tam* suit alleging that the company engaged in wholesale price manipulation practices that caused physicians and other health care providers to submit inflated reimbursement claims to Medicaid. The Federal Government will receive $7,828,000 with the remaining proceeds disbursed among the 45 states. According to the Government, Bayer falsely inflated reported drug prices, known as the Average Wholesale Price (AWP), used by state governments to set reimbursement rates for the Medicaid program. Bayer then sold to doctors at a dramatic discount, inducing physicians to purchase its products by enabling the doctors to profit from the reimbursement paid to them by the Government. The relator, Ven-A-Care, will receive 20 percent of the Federal Government's share of the recovery, or $1,565,000. The relator was represented by Atlee Wampler and James Breen of Wampler, Buchanan & Breen (Miami, FL).

U.S. ex rel. Placido v. Manor Care, Inc. et al. *(ED PA No. 98-3094)*

In January 2001, Manor Care agreed to pay **$90,000** to settle a *qui tam* suit alleging that it provided inadequate care to Medicare and Medicaid beneficiaries. According to the lawsuit, Manor Care failed to provide adequate nursing care to residents with pressure ulcers, failed to keep adequate staffing levels and otherwise failed to provide basic care to patients. Furthermore, the Government alleged that the company failed to provide the required documentation for many of its claims. In addition to the monetary settlement, the company agreed to implement quality of care standards, institute a corporate compliance program, and to hire a consultant to oversee compliance with the agreement. The settlement was in the form of a consent judgment. Charles Cooper (Bala Cynwyd, PA) represented the relator. Assistant U.S. Attorney Patricia Gugin represented the Government.

The Genesee Hospital

Kenmore Mercy Hospital

In January 2001, DOJ announced that the Genesee Hospital and Kenmore Mercy Hospital of Western New York agreed to pay a total of

$**1,943,600** to settle allegations that the hospitals improperly billed Medicare for laboratory tests known as "additional indices." According to the Government, from 1992 through 1996 the hospitals routinely billed for the tests, even though a physician did not order them and they were medically unnecessary. The Genesee investigation was part of a nationwide review of laboratory claims by the United States referred to as Operation Bad Bundle. Settlements resulting from Operation Bad Bundle currently exceed $3 million. Assistant U.S. Attorney Robert Trusiak handled the matter for the Government.

Maryland Alarm Data Corporation, Inc.

In January 2001, Maryland Alarm Data Corporation agreed to pay **$200,000** to resolve allegations that it falsely billed the Air Force under a contract according to which Alarm Data was to install, maintain, and repair fire alarm systems at Andrews Air Force Base. According to the DOJ, from September 1998 to September 1999 Alarm Data falsely billed the Air Force for unqualified workers, for phantom work hours, and for inflated prices on parts and supplies. The Air Force Office of Special Investigations investigated the matter. Assistant U.S. Attorneys David Copperthite and Charles Peters represented the Government.

Rush Presbyterian-St. Luke's Medical Center

In January 2001, Rush Presbyterian-St. Luke's Medical Center agreed to pay **$800,000** to resolve government claims that from 1993 to 1999 it billed for physician outpatient services when the attending physicians were not physically present and that it upcoded those services. The Government's recovery was the result of a voluntary disclosure by Rush. Following Rush's disclosure, Cherry Grant, a registered nurse clinician at the Rush clinic, filed a *qui tam* suit alleging the identical outpatient fraud as well as alleging fraudulent inpatient procedures. The district court dismissed the outpatient clinic and upcoding claims for lack of subject matter jurisdiction, and the Government declined to intervene in the relator's inpatient procedure claims. *See* False Claims Act and Qui Tam Decisions, page . Assistant U.S. Attorney Linda Wawzenski handled the case for the Government.

South County Hospital

In January 2001, South County Hospital of Rhode Island agreed to pay **$750,000** to settle allegations that it overstated the number of laboratory tests performed for Medicare and Medicaid patients. Of those laboratory bills at issue between 1986 and 1996, the Government maintains that the hospital billed for between two and nineteen times more procedures than had actually been performed. HHS OIG, the FBI, and the Rhode Island Medicaid Fraud Control Unit investigated the matter. Assistant U.S. Attorney Lisa Dinerman handled the case for the Government.

U.S. ex rel. Goeggel v. Barnes-Jewish Hospital et al. (ED MO No. 4:99CV00985 JCH)

In January 2001, Terrence Dougherty, former president of Abbott Ambulance, Inc. of St. Louis, Missouri, agreed to pay **$325,000** to resolve a *qui tam* suit alleging that he devised and executed a "ticket managing" scheme designed to defraud Medicare. According to the Government, Dougherty falsified Missouri Ambulance Reporting forms and Medicare claim forms to optimize reimbursement. Beginning in 1984, Dougherty allegedly began instructing Abbott Ambulance employees to program improper automatic defaults into the billing system to reduce the number of claims rejected by Medicare. Abbott Ambulance had previously settled for $5.4 million. *See* 20 TAF

QR 40 (Oct. 2000). John Carey of Carey & Danis (St. Louis, MO) represented the relator. Assistant U.S. Attorney Claire Schenk represented the Government.

***U.S. ex rel. May v. Rush Health Systems** (SD MS No. ___)*

In January 2001, it was reported that Rush Health Systems of Meridian, Mississippi and three of its affiliates agreed to pay over **$1.5 million** to settle a *qui tam* suit alleging that Rush submitted Medicare claims using the provider numbers of physicians who did not actually provide the billable services. In some instances, Rush reportedly used physicians' numbers to bill for the services of nurse practitioners who receive less payment under Medicare than do physicians. The *qui tam* suit was filed by Donna May, a former employee of Rush. The relator's share is 14.7 percent or $220,500. Assistant U.S. Attorney Cliff Johnson represented the Government.

***U.S. ex rel. Krahel et al. v. Regents of the University of California** (ND CA No. C96-1703 WHO)*

In February 2001, the University of California's five medical schools agreed to pay **$22.5 million** to settle a *qui tam* suit alleging that the schools billed Medicare, TRICARE, and MediCal for services purportedly performed by faculty physicians when in fact those services were performed by residents alone with little or no supervision. Assistant U.S. Attorneys Joann Swanson and Patricia Kenney represented the Government.

Texas Tech University Health Sciences Center

In February 2001, DOJ announced that Texas Tech University Health Sciences Center (TTUHSC) agreed to pay **$2.3 million** to settle allegations that it overbilled Medicare, Medicaid, and TRICARE. According to the DOJ, from September 1994 through December 1995 TTUHSC submitted claims for services performed by physician faculty members when in fact the faculty physicians were not documented as present. The Government also alleged that TTUHSC submitted claims for evaluation and management services that did not accurately reflect the level of services provided. A 1995 *qui tam* action brought by relator Carol Foulds commenced the investigation into TTUHSC's billing methods. Foulds' lawsuit was dismissed after the U.S. Supreme Court ruled in Vermont Agency of Natural Resources v. U.S. ex rel. Stevens, 19 TAF QR 1 (July 2000), that relators cannot sue states under the FCA. The FBI and DCIS investigated the matter. Assistant U.S. Attorney Pete Winn and Dan Spiro of the DOJ Civil Division represented the Government.

***U.S. ex rel. Sutton v. Pan American Products, Inc. et al.** (WD WA No. 99-CV-1760)*

In February 2001, six freight-moving firms agreed to pay **$2 million** to settle a *qui tam* suit alleging that the firms knowingly misrepresented to the DOD that they were not under common financial and/or administrative control in order to be approved for contract work by the Military Traffic Management Command (MTMC). The MTMC manages the transport of household goods belonging to military personnel. Common financial and administrative control of multiple carriers is prohibited in order to prevent possible price manipulation and to prevent affiliated carriers from gaining an unfair competitive advantage over independent carriers. The *qui tam* suit was filed in 1999 by Paula Sutton, the former comptroller of Pan American Products. DCIS, DCAA, Army

Criminal Investigations Command, and MTMC investigated the matter. The relator's share is 18 percent or $360,000. Angelo Calfo of Yarmuth Wilsdon & Calfo (Seattle, WA) represented the relator. Assistant U.S. Attorney Brian Kipnes handled the matter for the Government.

U.S. and State of California ex rel. Pieszak v. Glendale Medical Center et al. *(CD CA No. CV98-6501-ABC)*

In February 2001, Perinatal Medical Group (PMG) and Dr. Hugo Riffel agreed to pay **$250,000** to settle a *qui tam* case alleging that PMG and Riffel billed for obstetric services at attending physician rates when in fact the services were performed by medical residents. The portion of the lawsuit relating to the hospital, Glendale Medical Center, is still pending. The *qui tam* action was brought by Dr. Caroline Pieszak, a resident in the OB/GYN program at Glendale from 1995 through 1996. Assistant U.S. Attorney Faith Devine handled the matter for the Government.

U.S. ex rel. Castenada et al. v. GMR Healthcare Inc. et al. *(WD TX No. SA-96-CA-1305)*

In February 2001, GMR Healthcare and five San Antonio area residents agreed to pay **$1.2 million** to settle a *qui tam* suit alleging that they presented false claims for reimbursement under the Medicare program related to the provision of medical psychotherapy and occupational therapy services. The complaint alleged that the defendant's fraudulent billing scheme included: billing for patients admitted without a physicians certification and treated without a treatment plan; billing for services not provided; upcoding; billing for patients who did not attend sessions; billing for services conducted by unqualified providers; billing for sessions that were unnecessary; billing for services rendered to ineligible patients; seeking reimbursement for undocumented claims; and self-referral. The relators' share is approximately 16.7 percent or $200,000. Assistant U.S. Attorney Harold Brown represented the Government. The relator was represented by John Clark and Rand Riklin of Goode Casseb Jones Riklin Choate & Watson (San Antonio, TX) and Glenn Grossenbacher (San Antonio, TX).

U.S. ex rel. Sieg v. Moore Medical, Inc. *(D CT No. 3: 98 CV 954)*

In February 2001, DOJ announced that Moore Medical agreed to pay **$5.2 million** to settle a *qui tam* suit alleging that it overcharged the Department of Veterans Affairs from the early to mid-1990s. According to the DOJ, the New Britain, Connecticut company failed to comply with contractual requirements that it offer the Veterans Administration the same or better prices as those given to other customers. The Government maintained that Moore failed to submit current, accurate and complete pricing information to the agency. The Veterans Administration OIG investigated the matter. Assistant U.S. Attorney James Filan represented the Government.

U.S. ex rel. Feins v. Genesee Valley Cardiothoracic Group *(WD NY No. ___)*

In February 2001, DOJ announced that Genesee Valley Cardiothoracic Group (GVC) agreed to pay **$2 million** to settle a *qui tam* suit alleging that it submitted false claims to Medicare for the services of assistant attending surgeons in heart bypass and other cardiothoracic surgeries. According to the lawsuit, GVC billed Medicare for an assistant despite the presence of a qualified cardiothoracic resident to assist the primary attending surgeon. Medicare regulations generally prohibit an "assistant at surgery" claim

in a teaching hospital in which a qualified resident assists the primary surgeon because Medicare already directly pays teaching hospitals for the cost of providing qualified residents. The *qui tam* suit was filed by Dr. Richard Feins, a thoracic surgeon. The relator's share is 20 percent or $400,000. The matter was investigated by the FBI, HHS OIG, and the Defense Contract Investigative Service. Mary Louise Cohen of Phillips & Cohen (Washington, D.C.) represented the relator. Assistant U.S. Attorneys Robert Trusiak and Frank Sherman represented the Government.

***U.S. v. Creative Tutorial LLC* (ED MO No. 4:01-CR-42-CAS)**

In February 2001, Patricia Greenberg, the owner of Creative Tutorial LLC, a St. Louis-based children's psychological counseling company, agreed to pay **$130,000** to settle a False Claims Act suit alleging Medicaid fraud. According to the Government, from 1998 through 1999 the company submitted claims to Medicaid for individual counseling even though the company only provided group counseling. Additionally, an investigation revealed that the company billed for days when the school was not in session, and for children who were not Medicaid eligible. The company also pled guilty to three felony counts of Medicaid fraud. Assistant U.S. Attorney Claire Schenk handled the FCA case for the Government.

***U.S. ex rel. Watson v. Wagner Maritime, Inc.* (ED VA No. 2:99cv24)**

In February 2001, it was reported that Wagner Maritime agreed to pay **$400,000** to settle a *qui tam* case alleging that the Virginia shipyard fraudulently billed the Navy for repair and maintenance work. According to the lawsuit, when government jobs ran over budget, Wagner added charges to other government work to compensate for the deficiency. The suit also alleged that Wagner charged the Government for labor hours spent working on civilian vessels. Becky Watson, a former accountant at Wagner, filed the *qui tam* action. Jack Drescher of Breit, Drescher & Breit (Norfolk, VA) represented the relator. The relator's share was 20 percent or $80,000. Assistant U.S. Attorney Craig Whitman represented the Government.

Vencor, Inc.

In March 2001, DOJ announced that Vencor, a nursing home chain, and Ventas, a related real estate investment trust, agreed to pay **$104.5 million** and implement a comprehensive Corporate Integrity Agreement to settle allegations, some of which stemmed from nine separate *qui tam* suits, that Vencor knowingly submitted false claims to Medicare, Medicaid, and TRICARE. Vencor filed for bankruptcy in September 1999. According to the DOJ, failure of care claims, including inadequate staffing, improper care of decubitus ulcers, and failure to meet dietary needs, accounted for more than $20 million of the $104.5 million settlement, marking the largest failure of care settlement to date. The remaining portions of the settlement include more than $54 million for including improper claims on hospital Medicare reports and more than $24 million for over-billing for respiratory care services and supplies. The relators will receive more than $15 million under Vencor's bankruptcy reorganization plan.

***U.S. v. Heart Trace of Nashua, Inc. et al.* (D NH No. Civ. 99-155-M)**

In March 2001, a New Hampshire district court entered a judgment of more than **$6.8 million** against Heart Trace of Nashua, Inc., its

owners John W. Conway and Norman P. Lehrman, and Samaritan Health Systems, Inc. for submitting false claims to Medicare. The judgment followed a ruling by the court that estopped the defendants from denying FCA liability for allegations fully litigated at a previous criminal trial, where the defendants were convicted of 25 counts of conspiracy to defraud the United States by knowingly making false statements with the intent to defraud Medicare. Assistant U.S. Attorney Patrick Walsh represented the Government.

U.S. ex rel. Kneepkins v. Gambro Healthcare Inc. et al. ***(D MA No. 97-10400-GAO)***

In March 2001, it was reported that Transitional Hospitals Corp. (THC) agreed to pay **$1.56 million** to settle a *qui tam* suit alleging that it billed Medicare for medically unnecessary tests on terminally ill dialysis patients. According to the Government, THC, through its predecessor corporation, Community Psychiatric Centers Inc., entered into a joint venture with Damon Clinical Laboratories. The Government alleged that from the late 1980's to early 1990's, the companies regularly and unnecessarily drew blood from patients. Reportedly, the companies deliberately misled doctors and laboratory employees into participating in the additional blood tests. Vencor, Inc., the nursing home chain that acquired THC, will pay the settlement. Litigation is still pending against Gambro Healthcare. The *qui tam* suit was filed by Gerald Kneepkins, a former general manager of Damon's Georgia laboratory. The relator's share is 15 percent or $234,000. William Hardy of Karalekas & Noone (Washington, D.C.) represented the relator. Assistant U.S Attorney Susan Winkler represented the Government.

U.S. ex rel. [redacted] v. Suen et al. ***(D HA No. CV00-00341)***

In March 2001, Sze Ming Suen agreed to pay the Government **$2.1 million** to resolve a *qui tam* suit alleging that he submitted false claims to Medicaid. From 1988 to July 1995, Dr. Suen operated a pharmacy in his clinic. According to the Government, Dr. Suen billed Medicaid for dispensing expensive brand name drugs when in fact his clinic provided cheaper generic substitutes. Additionally, the Government alleged that Dr. Suen billed for drugs not dispensed and billed for medications that were expired or were drug samples. A former employee initiated the *qui tam* action against Dr. Suen. Dr. Suen also agreed to plead guilty to criminal charges stemming from the same fraudulent conduct. The relator's share is 22 percent for $464,167. Thomas Grande of Davis Levin Livingston & Grande (Honolulu, HI) represented the relator. Assistant U.S. Attorney Mark Recktenwald handled the civil case for the Government.

Gerald Kin

In March 2001, two Philadelphia-area laboratories and their owner, Gerald Kin, agreed to pay **$267,065** to settle allegations that they billed Medicare for pulmonary stress tests when in fact they were performing the simpler and less expensive pulse oximetry test. Both tests measure the level of oxygen saturation in the blood, which Medicare requires before determining whether it will pay for home oxygen therapy. Assistant U.S. Attorney Susan Shinkman represented the Government.

Atlantic City Medical Center

In March 2001, Atlantic City Medical Center agreed to pay over **$1.9 million** to settle allega-

tions that from 1992 to 1997 it overcharged Medicare by billing for inpatient stays for patients who actually received outpatient procedures. According to the Government, the patients in question did not meet the Medicare definition of inpatients. HHS OIG investigated the matter. Assistant U.S. Attorney Michael Chagares represented the Government.

U.S. ex rel. Veder v. West Virginia University Medical Corp.

In March 2001, it was reported that West Virginia University Medical Corp. (WVU) agreed to pay **$307,950** to settle a *qui tam* suit alleging that it filed false claims to Medicaid, Medicare, and TRICARE for anesthesia and pain management services. Reportedly, between 1995 and 1997, WVU submitted claims for services performed by physicians when in fact residents performed the procedures and the physicians were not present. The *qui tam* action was filed by Dr. Alexander Veder (formerly Alex Vedernikov), a former resident in the anesthesiology department of WVU School of Medicine. The relator's reported share is 16.7 percent or $51,500. Assistant U.S. Attorney Rita Valdrini represented the Government.

Hall-Brooke Foundation

In March 2001, DOJ announced that Hall-Brooke Foundation of Westport, Connecticut agreed to pay **$260,000** to settle allegations that it submitted fraudulent claims to Medicare and Medicaid in 1998 and 1999. According to the DOJ, a Program Coordinator for Hall-Brooke's group psychotherapy sessions falsified the attendance rosters of certain outpatient psychiatric group meetings. The falsified rosters were then used by Hall-Brooke to generate bills to Medicare and Medicaid. Hall-Brooke disclosed the Program Coordinator's fraudulent conduct pursuant to the Provider Self-Disclosure Protocol issued by HHS-OIG. Assistant U.S. Attorneys Richard Molot and Jessica Bowman handled the case for the Government.

Correction: The law firm of Phillips & Cohen did not represent William Menke as reported in the last issue of the *Quarterly Review*, 21 TAF QR 22 (Jan. 2001).

TAF News

FCA Conference Materials

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

Qui Tam Practitioner Guide

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

TAF on the Internet

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

Previous Publications

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

Quarterly Review Submissions

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

Anniversary Reports and Video

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

Call for Experts and Investigators

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

Qui Tam Attorney Network

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

TAF Library

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

Acknowledgments

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