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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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## State Entities as FCA Defendants

*U.S. ex rel. Long v. SCS Business & Technical Institute, Inc. et al., 1999 WL 178713 (D.C. Cir. Apr. 2, 1999)*

Holding that states are not "persons" who may be liable under the False Claims Act, the D.C. Circuit dismissed a *qui tam* action against New York alleging federal tuition assistance fraud. The D.C. Circuit found that holding states liable under the Act would alter the usual constitutional balance between federal and state powers, and that Congress failed to make its intention to alter this balance unmistakeably clear in the language of the statute. The court also expressed its "profound doubts" that Congress intended to abrogate states' 11th Amendment sovereign immunity in the FCA, as Congress failed to put enforcement of the statute "at the instance and under the control of responsible federal officers."

Ronald Long, a former Coordinator of Investigations and Audit for the Bureau of Proprietary School Supervision (BPSS) of the New York State Department of Education, brought a *qui tam* action against the State of New York and his supervisor at BPSS, as well as SCS Business & Technical Institute, the operator of five New York proprietary schools. His suit alleged that SCS made false claims to the Government in return for federal tuition assistance for its students. Long further alleged that BPSS, whose funding depended in large part on tuition assessments and fines paid by SCS, had an incentive to conceal the fraud in order to secure further federal funding for SCS, and conspired with SCS to do so.

The Government intervened as to the SCS defendants, but declined to intervene against the state defendants. The district court denied the state's motion to dismiss on sovereign immunity grounds, holding that states are defendant persons under the Act and that the 11th Amendment does not bar the suit.

### Term "Person" Does Not Include States Absent Affirmative Contrary Showing

The D.C. Circuit first addressed whether a state can be a defendant "person" within the meaning of the FCA's liability provision. The circuit court held that relator Long and the Government failed to meet the burden of persuasion established by what the court called the "Will-Wilson default rule" — that states are excluded from the term person absent an affirmative contrary showing.

In establishing the default rule, the court relied on Will v. Michigan Dep't of State Police, 491 U.S. 58 (1989), in which the Supreme Court stated that "in common usage, the term 'person' does not include the sovereign, and statutes employing the word are ordinarily construed to exclude it," and Wilson v. Omaha Indian Tribe, 442 U.S. 653 (1979), in which the Court stated that this "often-expressed understanding" is not a "hard and fast rule of exclusion." The Wilson Court included context, legislative history, and executive interpretation as factors to be considered in defining person. The D.C. Circuit therefore established the default rule in order to reconcile the Will and Wilson holdings.

### Congressional Intent to Reach States Not Clear in FCA

The D.C. Circuit noted that neither the FCA as currently written nor as originally passed in 1863 defines the term person. Moreover, the court rejected Long's argument that the purposes and legislative history of the statute affirmatively demonstrate that Congress intended

to reach fraud committed by states. The court stated, "Even if one assumes that states commit a good deal of fraud against the federal government, it cannot seriously be argued that the very purpose of the Act would be thwarted if states were not liable under the Act."

The court also rejected Long's reliance on the definition of the term person in § 3733, the FCA's Civil Investigative Demand section. That section defines person to include "any State or political subdivision of a State." Long questioned why Congress would create such a discovery tool to be used to gain information from states if Congress did not intend to subject states to the Act. According to the court, this is solely so that states may provide useful evidence to establish that private contractors and others made false claims.

In addition, Long argued that Congress must have left out states from the group of defendants subject to administrative penalties under the Program Fraud Civil Remedies Act because it intended to subject them to liability under the FCA. The court reasoned, however, that "it would have been quite bizarre for Congress to exempt states from administrative liability if it had thought that states already were subject to the more onerous" damages and penalties under the FCA.

## Treble Damages Provision Inconsistent With State Liability

The appellate court also found the statute's treble damages provision to be incompatible with the concept of state liability. The court rejected out of hand Long's reliance on the Supreme Court's holding in U.S. v. Bornstein, 423 U.S. 303 (1976), that the FCA is remedial in nature, because the FCA only provided for double damages when the Bornstein Court ruled in 1976.

Finally, the circuit court rejected Long's argument that, pursuant to the statutory canon of consistent meaning, if states can be relators they must also be potential defendants. According to the court, whether states can act as relators is not a statutory given. The court interpreted § 3732(b) of the statute (giving federal district courts jurisdiction over state law actions to recover state funds lost during the same events giving rise to a federal false claims action) as simply giving states permissive intervention rights, not establishing them as relators.

## 11th Amendment Bars *Qui Tam* Suits Against States

Because the Supreme Court had never explained just how much of a showing suffices to overcome the presumption in the Will-Wilson default rule, the appellate court decided to bolster its holding by reaching the 11th Amendment issue. The court then immediately rejected the rulings of three of its sister circuits, however, that since a *qui tam* suit is essentially a suit by and for the United States, and since the United States is not subject to the 11th Amendment bar, that the 11th Amendment does not preclude a *qui tam* suit in federal court.

In rejecting these rulings, the court relied on Blatchford v. Native Village of Noatak, 501 U.S. 775 (1991), in which the Supreme Court held that a statute giving federal district courts jurisdiction over suits brought by Indian tribes was not a delegation to the tribes of the United States' ability to sue states on the tribes' behalf. Although Blatchford dealt with a statute in which Congress intended no delegation to private citizens, the D.C. Circuit interpreted the Blatchford Court as being "dubious that such a delegation would have been constitutionally permissible." According to the circuit court, therefore, permitting a *qui tam* relator to sue a state in federal court based on the Government's exemption from the 11th Amendment bar involves just the kind of delegation that the Blatchford Court questioned.

The court stated: "To assume that the United States possesses plenary power to do what it will with its Eleventh Amendment exemption is to acknowledge that Congress can make an end-run around the limits that that Amendment imposes on its legislative choices." The circuit court reasoned that Congress could get around the constitutional bar to private causes of action against states in federal court by using the *qui tam* device. The court admitted that Congress can impose liability on the states if it chooses to put enforcement of the statute "at the instance and under the control of responsible federal officers," but concluded that Congress failed to do so in the FCA.

The fact that the Government is a real party in interest in a *qui tam* suit is not enough to overcome these impediments because, according to the court, the relator is also a real party in interest in a *qui tam* suit. This is demonstrated by the relator's rights which must be protected under the statute. Moreover, the court did not find that the Government's control over a *qui tam* suit alters this result. Since the 11th Amendment must be satisfied as to every party in the suit, the Government's presence does not remove the 11th Amendment bar.

The court concluded that the Government's decision only to intervene as to the private defendants in this case "suggests that the government does not lightly take on the task of probing into the internal operations of the sovereign states, and may well think it better to leave such politically unpalatable tasks for the *qui tam* relators of the world." The court also went on to state:

> [T]he government wishes the option to sit back while the relator brings an action against a state, thus removing itself from direct accountability and from the subtle political pressures that might have precluded the lawsuit in the first place had the United States been more actively involved from the start.

## Usual Constitutional Balance Between Federal and State Powers Altered

Having reached its holding as to the 11th Amendment bar, the court then reiterated that, in order to construe the statute in such a way as to avoid serious constitutional questions, its holding really must rest on interpreting "person" not to include states. The court stated that its 11th Amendment holding only reflects its "profound doubts that the Eleventh Amendment permits this lawsuit against New York even if Congress implicitly authorized relators to bring suits against the states."

The court stated that in statutory construction, Congress must not only avoid serious constitutional questions but must also be specific if intending to alter the usual constitutional balance between the states and the Federal Government: Congress must "make its intention to do so unmistakably clear in the language of the statute." The court noted that such an alteration occurs, among other ways, when Congress attempts to interfere with an essential state governmental function.

The court rejected Long's argument that, because fraudulent conduct cannot be seen as an essential state function, treating states as persons would not alter the constitutional balance of powers. The circuit court focused on the state functions affected by the operation of the FCA, and not exclusively on the conduct proscribed by Congress.

The court also extended this clear statement rule to congressional abrogation of 11th Amendment immunity. Thus, the court found it "highly artificial" to conclude that Congress must use the utmost textual specificity in abrogating states' 11th Amendment rights, but that liability against the states — potentially implicating the 11th Amendment — can be imposed using as imprecise a term as person.

*U.S. ex rel. Garibaldi and Samuel v. Orleans Parish School Board, 1999 WL 250159 (E.D.La. Apr. 27, 1999)*

A Louisiana district court ruled that the FCA does not violate the 10th Amendment, as states can avoid federal government regulations by declining to accept federal funds. The court also ruled that a Louisiana school board is a municipal corporation not entitled to 11th Amendment sovereign immunity. However, in response to the school board's request, the court reduced a jury-imposed penalty amount, calling it "excessive." Finally, the court increased the award of attorneys' fees to relators' counsel because of the challenging and novel issues presented in this case.

A federal jury awarded William Garibaldi and Carlos Samuel (the relators) more than $30 million in a *qui tam* suit alleging that the Orleans Parish School Board (the School Board) in Louisiana violated the False Claims Act. In its post-trial Motion for Judgment as a Matter of Law, among other requests, the School Board asked the court to find that the Act violates the 10th Amendment, that the School Board is entitled to 11th Amendment sovereign immunity, and to reduce the jury's $7.85 million penalty award to the Government. The relators asked the district court to review a magistrate judge's findings with regard to attorneys' fees.

## Act Does Not Violate 10th Amendment Because States May Choose Not to Accept Federal Funds

The 10th Amendment provides that: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." In analyzing the 10th Amendment's application to the FCA, the district court relied upon Prinz v. United States, 521 U.S. 98 (1997), in which the Supreme Court declined to hold unconstitutional federal regulations which require states to participate in specific activities once they have voluntarily participated in a general federal scheme. In accordance with Prinz, the district court concluded that states subject themselves to regulation by the Federal Government when they accept federal funds. Thus, the court ruled that the Act does not violate the 10th Amendment, as states can avoid any Federal Government requirements by declining to apply for and accept federal funds. Furthermore, according to the court, there is no coercion of states on the part of the Federal Government when the United States subjects states to the same conditions for federal funding as other grant recipients.

## School Board Not Entitled to 11th Amendment Protection

The court also rejected the School Board's assertion that it is entitled to 11th Amendment sovereign immunity. Applying a six-factor test developed by the 5th Circuit in Minton v. St. Bernard Parish School District, 803 F.2d 129 (5th Cir. 1986), the court determined that the School Board is not an "arm of the state" entitled to 11th Amendment protections. According to the court, the School Board is more akin to a political subdivision or municipal corporation.

The court's conclusion was not changed by the fact that the School Board receives 60 percent of its funding from state sources, a factor not considered in the Minton test. In addition, the court found relevant the School Board's classification as a corporate entity, with the power to sue and be sued, to make contracts, and to purchase and sell property. Moreover, the fact that state law might curtail certain activities of the School Board members was not enough to make the School Board "become the state" for 11th Amendment purposes.

## Penalty Award "Excessive"

Although the False Claims Act's penalty provision was amended in 1986, the court applied

pre-1986 caselaw in reducing the jury's penalty award of $7.85 million. In Peterson v. Weinberger, 598 F.2d 45 (5th Cir. 1975), the 5th Circuit held that a court may exercise its discretion to ensure that penalties assessed "reflect a fair ratio to damages" and that damages should not be "excessive and out of proportion." Although Peterson was pre-1986, it was never overturned by the 5th Circuit. Therefore the district court, considering Petersen still to be good law, used the discretion granted in Peterson to lower the award. The court stated:

> The judgment, against a public school district responsible for educating children, many of them poor, is for over four times the losses actually incurred by the federal government. The court finds that this judgment, especially in light of [the] importance of protecting the real victims of the School Board's actions — the public school children of New Orleans — is excessive.

The court therefore reduced the penalty amount from $7.85 million to $100,000.

### Novel and Challenging Case Merits Increase in Lodestar Amount

The relators asked the district court to review a magistrate judge's award of attorneys' fees pursuant to § 3730(d)(1) of the Act. On review, the court found this case to be one of those "rare and exceptional" cases in which the lodestar should be increased.

The magistrate judge utilized the lodestar method — the usual method in fee-shifting cases — in awarding attorneys' fees. The lodestar is the number of hours worked multiplied by an hourly fee. In making its decision, the magistrate judge determined that the legal questions involved in prosecuting the action were neither novel nor difficult enough to warrant any special increase in fees. The district court disagreed, finding the legal questions to have been novel and challenging enough to warrant a 1.5 factor increase in the lodestar amount.

In addition to the complex legal issues, the district court took into account the paucity of 5th Circuit precedent on many issues in the case, which therefore demanded of the attorneys that they craft arguments which would invite the district court, and the 5th Circuit, to make new law. According to the court, the relators' counsel should be compensated for accepting this challenge.

## FCA Liability/False Certification Claims

*U.S. ex rel. Harrison v. Westinghouse Savannah River Co., 176 F.3d 776 (4th Cir. May 17, 1999)*

The 4th Circuit reversed a lower court's dismissal for failure to state a claim in a *qui tam* action which alleged that a contractor fraudulently induced the Government to award a subcontract. According to the court, where a contractor falsely certifies compliance with laws and regulations in order to receive a government benefit, or where the Government is induced to award a contract through false statements, all claims for payment made under the contract are false claims.

Westinghouse Savannah River Company (WSRC) serves as the management and operations contractor for the United States Department of Energy (DOE) at the Savannah River Site, a nuclear facility in South Carolina. Edwin Harrison was employed as a vice president by one of WSRC's subcontractors, the General Physics Corporation (GPC). Harrison

filed a *qui tam* suit against WSRC alleging that the company misrepresented the cost and duration of a proposed subcontract in order to get DOE approval, and that WSRC falsely certified to the DOE that there was no conflict of interest with the subcontractor.

The district court granted WSRC's Fed. R. Civ. P. 12(b)(6) motion to dismiss for failure to state a claim on the grounds that Harrison's complaint amounted only to allegations of waste and inefficiency and that, even if Harrison proved false statements or fraud, they were not made in connection with the presentation of a "claim."

The district court rejected the possibility that FCA liability could stem from false statements submitted to the Government to gain approval for a subcontract. According to the district court, a false claim arises only when the demand for payment itself is false or fraudulent. The 4th Circuit affirmed in part and reversed in part the district court's decision, finding that the district court had erroneously interpreted the phrase "false or fraudulent claim."

## Phrase "False or Fraudulent Claim" Must Be Interpreted Broadly

The 4th Circuit noted that the district court approach contradicts many court decisions, as well as the Act's legislative history, which demand that the phrase "false or fraudulent claims" be interpreted broadly. The court noted those cases which have held that the FCA is intended to reach all types of fraud which cause financial loss to the Government, including going beyond "claims" which might be legally enforced to all fraudulent attempts to cause the Government to pay out sums of money. The court stated that "any time a false statement is made in a transaction involving a call on the U.S. fisc, False Claims Act liability may attach."

The appellate court included "false certification" and "fraud in the inducement" cases as types of transactions making a call on the U.S. fisc. According to the court, where a contractor falsely certifies compliance with certain conditions or regulations in order to obtain payment of a government benefit, the contractor creates an actionable false certification case. Likewise, in reversing the district court's holding, the appellate court held that where the contract or extension of government benefit was induced originally through false statements or fraudulent conduct, FCA liability attaches to each claim submitted to the Government under the contract.

From a variety of sources, the court then developed the following four-part test to determine FCA liability: (1) whether there was a false statement or fraudulent course of conduct; (2) made or carried out with the requisite scienter; (3) that was material; and (4) that caused the government to pay out money or to forfeit moneys due (i.e. that involved a 'claim'). Using this four-part test, the court performed a fact-specific analysis of each of Harrison's claims, and ruled that most of them had been properly dismissed. However, the court also determined that three of Harrison's claims fell into either the false certification or fraud in the inducement categories and reinstated these claims.

## Relator Properly Stated a Claim for Fraud in the Inducement

In two of these three claims, the court ruled that Harrison had properly alleged a "classic" fraud in the inducement — that WSRC obtained a fraudulent approval for a subcontract from the DOE and therefore that all demands for payment made under the subcontract were false claims. More specifically, the court determined that Harrison had properly stated a claim by alleging that WSRC misrepresented the need for and costs of subcontracting in order to convince the DOE to approve the subcontract, thereby causing the Government

to pay out more than if WSRC had not made the false statements.

Applying the materiality requirement of its four-part test, the court rejected WSRC's assertion that because the project performed by the subcontractor was necessary, and because the DOE was bound by the contract to pay all costs necessarily incurred by WSRC, the statements could not be material to the DOE's decision to pay. According to the court, the key issue was that the false statements could have been material to the Government's decision to pay a higher amount for a subcontractor than it would have otherwise.

WSRC also argued that this case should be distinguished from other fraud in the inducement cases because the subcontractor, and not it, was the recipient of the benefit. Pointing to other cases on this issue, the court rejected this argument, stating:

> In none of those cases did the courts indicate that False Claims Act liability was contingent upon the defendant's status as recipient and beneficiary of the contract. More importantly, the language of the False Claims Act statute does not anywhere state that False Claims Act liability depends upon a defendant's status as a recipient or beneficiary of the fraudulently induced contract. All that is required is the submission of a false claim.

### Court Reinstates False Certification Claim

The third claim reinstated by the circuit court fell into the false certification category. Here, Harrison alleged that WSRC falsely certified that there were no conflicts of interest between WSRC and GPC in order to induce the DOE to give GPC the subcontract. Complicating the matter was the fact that the false certification was made by the subcontractor to WSRC, and not by WSRC to the Government. However, the court stated: "In this situation, where the prime contractor allegedly knows that a material certification by a subcontractor was false, we find as a matter of law that the prime contractor has adopted the subcontractor's certification by submitting it to the government."

Applying the materiality prong to this claim, the circuit court determined that there is a heightened pleading requirement in false certification cases: the Government must have conditioned payment of the claim upon the certification of compliance with the statute or regulation at issue. The court found that WSRC could have made such a certification.

Finally, combining the false certification and fraud in the inducement theories, the court found that this false certification was a prerequisite, and thus a fraudulent inducement, to approval of the subcontract. Therefore, WSRC could face false claims liability for each claim for payment under the GPC subcontract.

## Public Disclosure Bar and Original Source Exception

*U.S. ex rel. Burns v. A.D. Roe Company, Inc. et al., 1999 WL 427383 (6th Cir. June 28, 1999)*

The 6th Circuit reversed a district court's dismissal of a relator on public disclosure grounds, ruling that the district court had failed to ascertain whether the public disclosures at issue were of the "allegations or transactions" making up the fraud. Also, in a matter of first impression in the 6th Circuit, the court ruled that FOIA materials must be received by a relator prior to filing suit to count as a public disclosure under the bar.

On June 23, 1994, Fred Burns filed a *qui tam* complaint alleging that A.D. Roe Company, Inc., a general contractor for a naval facility modernization project, submitted false claims for payment under its contract with the Department of the Navy. In the lawsuit, Burns alleged that A.D. Roe billed the Government for workmanship and testing that did not meet contract specifications. The Government intervened in the action.

Burns, a government employee, served as the construction representative on the project. His job duties included oversight of the contractors on the job, quality control inspections, and the preparation of noncompliance notices for the Government when necessary. According to Burns, it was part of his job duties to report to his superiors any violation or deviation from the requirements of the contract specifications. Based on Burns' recommendations, the Navy could withhold payments from the contractors.

The Government urged the 6th Circuit to rule that, as a matter of law, government employees cannot be relators, and more specifically, that they cannot be original sources as that is defined in § 3730(e)(4)(B) of the statute. The 6th Circuit refused to make such a sweeping ruling regarding government employees generally, and instead focused on the meaning of the statutory prongs of the § 3730(e)(4) public disclosure bar and original source exception.

## Theoretically Available FOIA Documents Not Publicly Disclosed

In a matter of first impression in the 6th Circuit, the appellate court addressed the issue of whether information received under the Freedom of Information Act (FOIA) constitutes public disclosures pursuant to the FCA. Relying on other circuits which have ruled on the issue, particularly U.S. ex rel. Schumer v. Hughes Aircraft, 63 F.3d 1512 (9th Cir. 1995), 10 TAF QR 1 (July 1997), the court held that only when a party is in actual receipt of the information requested under FOIA has a public disclosure occurred. Information on which someone might theoretically make a FOIA request is not publicly disclosed.

The district court had found that Burns received his FOIA documents prior to filing his *qui tam* suit. Therefore, after finding that a public disclosure had occurred and that Burns was not an original source, the district court dismissed the suit. The appellate court, however, relied upon information provided by the Government which indicated that Burns had not received his FOIA information until after he had filed the *qui tam* action.

## Public Disclosures Must Be of "Allegations or Transactions"

In addition, the appellate court ruled that the district court had erroneously focused only on the public disclosure element of the jurisdictional test, and had failed to recognize that the public disclosure must be of "allegations or transactions." The 6th Circuit remanded the case to the district court for factual findings on whether the "allegations or transactions" of the fraud had been publicly disclosed.

As guidance to the district court, the circuit court reiterated its previous reliance on the "X + Y = Z" analysis of U.S. ex rel. Springfield Terminal Ry. Co. v. Quinn, 14 F.3d 645 (D.C.Cir. 1994), in which the D.C. Circuit reasoned that if either "X (the alleged state of facts) plus Y (the true state of facts)" or "Z" (the allegation of fraud) were in the public domain, then there had been a public disclosure of the "allegations or transactions" making up the fraud. The circuit court required that "the public disclosure at issue be of something more than simple information from which no one could deduce that fraud had occurred."

*U.S. ex rel. McAllan v. City of New York et al., 1999 WL 280416 (S.D.N.Y. May 5, 1999)*

A New York district court dismissed a *qui tam* suit alleging fraud by the New York City ambulance service on public disclosure grounds. The court held that the relator's fraud allegations had been publicly disclosed in his prior state lawsuit and that the relator did not qualify as an original source because he could have learned of the fraud from sources outside of his job as a paramedic.

In 1996, New York City Health and Hospitals Corporation (HHC) conveyed the state certificate authorizing ambulance service to the City's fire department in an effort to improve response time to medical emergencies. At the same time, the appropriate state agency also gave permission to HHC to continue to receive Medicare reimbursement for such ambulance services, and then in turn reimburse the fire department. Richard J. McAllan, a senior paramedic employed by HHC, filed a lawsuit in state court challenging the validity of the transfer, which was dismissed.

On May 5, 1998, McAllan filed a *qui tam* suit against the City of New York and New York City Health and Hospitals Corporation alleging that the defendants filed false Medicare claims for emergency ambulance services after the services were transferred to the fire department. The DOJ declined to intervene in the action.

In his *qui tam* suit, McAllan alleged that after the ambulance service had been transferred from HHC to the fire department, HHC defrauded the Government by (1) submitting Medicare claims without obtaining the proper licenses for the post-transfer ambulance service; (2) improperly receiving Medicare reimbursement after the transfer; and (3) improperly maintaining ownership of the service in an effort to boost such reimbursements. Defendants moved to dismiss the suit for lack of subject matter jurisdiction on § 3730(e)(4) public disclosure grounds.

## Allegations Publicly Disclosed in Prior State Action

The court first addressed the issue of whether, pursuant to § 3730(e)(4)(A) of the statute, the "allegations or transactions" making up the fraud had been publicly disclosed in McAllan's prior lawsuit. McAllan argued that his *qui tam* allegations could not have been disclosed in his previous lawsuit because they arose after the transfer of the ambulance service, whereas the focus of his earlier suit was the transfer itself. Nevertheless, the court ruled that McAllan's allegation that HHC improperly maintained ownership of the ambulance service was publicly disclosed not only in the state complaint, but also through other statutorily "enumerated means," including public hearings regarding the transfer of service, various board and agency meetings, numerous official reports, and news media coverage. In addition, the court dismissed McAllan's other two *qui tam* claims because it found that he had not properly stated a claim for fraud against the Government and because they were also disclosed in the prior state action. Finally, the court concluded that all three of McAllan's claims "essentially cloak the [state court action] in a new dress."

## Relator Lacks "Direct and Independent" Knowledge

The court then moved immediately to determining whether McAllan qualified as an "original source" pursuant to § 3730(e)(4)(B) of the FCA. The court noted the 2nd Circuit's extra-textual requirement, not written in the statute, that to be an original source the relator must have been the source to the entity that makes the public disclosure. However, the court never reached its analysis of this extra requirement, as it determined that McAllan did not have the "direct" and "independent" knowledge required

by the statute. The court stated: "While plaintiff may have learned about the billing practices of EMS subsequent to the transfer as a direct result of his position, such practices could easily have been uncovered from other sources."

## Section 3729(a)(7) Reverse False Claims

*U.S. v. Raymond & Whitcomb Co., 1999 WL 430552 (S.D.N.Y. June 19, 1999)*

The Government proved the falsity and obligation elements of its § 3729(a)(7) "reverse" false claim action, but failed to prove that the defendant acted knowingly, ruled a New York district court. The court found that the defendant, a for-profit entity, may have reasonably relied upon the advice of its nonprofit clients when it illegally used the lower nonprofit mailing rate.

The United States filed this § 3729(a)(7) "reverse" false claims action against Raymond & Whitcomb Co. (R & W), a commercial travel agency specializing in cruises and tours for institutional clients, for illegally using the lower nonprofit mail rate for ineligible mailings. U.S. Postal Service regulations prohibit the use of the nonprofit rate when the mailings are for a cooperative venture between nonprofit and for-profit entities. Although R & W works with nonprofit institutions which qualify for the lower mailing rate, R & W itself, a for-profit commercial entity, does not.

According to the United States, the disputed mailings included 6.1 million pieces of mail in 753 separate submissions to the U.S. Postal Service during the period included in the complaint, causing the Government losses in the range of $400,000. In addition to alleging false claims, the United States sued R & W under the Federal Debt Collection Procedure Act and for unjust enrichment.

### Company's Participation in Joint Venture Sufficient to Impose FCA Liability

Section 3729(a)(7) of the FCA states that: "[Any person who] knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government" is liable under the Act. While ruling that the Government had demonstrated the falsity element of its case, as well as the requisite obligation to the Government necessary to have a reverse false claim, the district court held that there existed an issue of material fact as to whether R & W acted "knowingly," thereby precluding summary judgment.

R & W had hired St. John Associates, Inc. (St. John), a mailing agent, to submit the mailings of the nonprofit institutions to the U.S. Postal Service. It was St. John, therefore, which submitted statements to the Postal Service certifying compliance with regulations regarding use of the nonprofit rate. R & W argued that the mailing statements were the work of St. John, on behalf of the institutions, and that the decision to use the nonprofit rate was that of the institutions.

According to the court however, R & W's participation in the venture was sufficient to impose liability, despite the fact that it was St. John that actually completed and submitted the mailing statements. The court found that R & W had instructed St. John to claim the nonprofit rate by listing only the nonprofit institutions on the mailers. The court stated:

> False Claims Act liability attaches not only to the actual maker of the false statement, but also to any person who knowingly assisted in causing the government to pay claims which were grounded in fraud, without regard to whether that person had direct con-

tractual relations with the government or only had contact with the government through an intermediary.

The court held, therefore, that whether St. John was acting as an agent of R & W, or as a separate entity following R & W's instructions, R & W sufficiently participated in the making of the false statements to be a cause of the falsity.

### Government Established Requisite Obligation

The court further held that there existed the requisite obligation to the United States necessary for there to be a reverse false claim. The court contrasted the facts of this case with that of United States v. Q Int'l Courier, Inc., 131 F.3d 770 (8th Cir. 1997), 12 TAF QR 8 (Jan. 1998), where the 8th Circuit had declined to find a reverse false claim because the international mailing rate at issue in that case did not impose an obligation to pay to the United States a particular postage rate. Here, in contrast, the Postal Service mailing statement signed by St. John explicitly stated that the signature of the mailer certified responsibility for use of the correct, required rate.

### Government Fails to Prove Knowledge Element

Despite finding the requisite falsity and obligation, however, the court held that there remained an issue of material fact as to whether R & W acted "knowingly." R & W argued that it relied upon the institutions' expertise in nonprofit rate eligibility and St. John's expertise in postal submissions. In particular, R & W asserted that it reasonably followed the view of the institutions, which hold the requisite nonprofit rate permit, that the disputed mailings qualified for the lower rate. The court rejected this argument on the one hand, holding that a person who signs a mailing statement certification has a duty to investigate whether that certification is correct. Thus, such failure to conduct a proper investigation before making a false statement may constitute sufficient "reckless disregard" to yield FCA liability. On the other hand, the court found that a reasonable fact-finder might conclude that R & W was justified in relying upon the expertise of its esteemed clients, which included such well-established and well-respected nonprofits as the Smithsonian and the New York Metropolitan Museum of Art. According to this view, while R & W's actions might have been "unjustifiable" or "negligent," they did not rise to the level of fraud.

## FCA Liability/Corporate Knowledge Doctrine

*U.S. v. United Technologies Corp., Sikorsky Aircraft Division, 1999 WL 396417 (D.Conn. June 7, 1999)*

Refusing to apply the Corporate Knowledge Doctrine, a Connecticut district court dismissed a False Claims Act suit alleging that a defense contractor failed to provide accurate and complete pricing data during contract negotiations. The court accepted the contractor's contention that accurate pricing information had not been forwarded to the contract negotiators due to an honest mistake, and held that the overcharges at issue did not rise to the level of fraud.

The United States filed suit against United Technologies Corporation, Sikorsky Aircraft Division (Sikorsky) alleging that the defense contractor violated the FCA and the Truth in Negotiations Act (TINA) by submitting false cost data to the U.S. Navy during negotiations for certain helicopter parts in 1984 and 1985. The Government prevailed on its TINA claim because Sikorsky conceded that it had over-

charged the Government for "modification kits," and was awarded over $300,000.

The district court ruled, however, that the Government failed on its FCA claim because it did not prove that Sikorsky had "knowingly" defrauded the Government as required by the Act. The court rejected the Government's request that it apply the "collective knowledge doctrine," also known as the "corporate knowledge doctrine" — that is, that only one employee of Sikorsky need have had actual knowledge that the final price agreed upon with the Navy was not the most accurate, current and complete cost or pricing data — to impute that knowledge to the entire corporate entity.

In a lengthy recital of the facts, the court explained that Sikorsky and the Government contracted for certain helicopter parts without naming a final price. Sikorsky and the Navy then negotiated a bottom-line price without itemizing costs. The Defense Contract Audit Agency (DCAA) audited the contract and Sikorsky turned over a compilation of documents that had not existed at the time the pricing agreement with the Navy had been reached. These documents included item-by-item costs for the assembly of the helicopter parts. The Government based its FCA allegations on this compilation.

### Court Refuses to Impute Employee Knowledge to Corporate Entity

The Government asserted that the documents contained in the compilation sent to DCAA had existed at the time of pricing negotiations and had come from various Sikorsky employees. For this reason, the Government urged the court to apply the corporate knowledge doctrine in order to impute the employees' knowledge to Sikorsky as a corporate entity. However, the court found that the case law used for support by the Government did not compel the court to apply the doctrine in this case. The court also found "irrelevant" to its application of the doctrine language contained in the footnote of the certification form signed by a Sikorsky employee which stated: "The responsibility of the contractor is not limited by the personal knowledge of the contractor's negotiator if the contractor had information reasonably available at the time of the agreement, showing that the negotiated price is not based on accurate, complete, and current data." According to the court, the existence of such language in the certification was not in any way dispositive of Sikorsky's FCA liability.

### Overcharges Did Not Rise to the Level of Fraud

Finally, the court dismissed the Government's contention that Sikorsky's overcharges for the modification kits, for which it was found liable under TINA, rose to the level of fraud. The court examined correspondence between Sikorsky and the manufacturer of the kits which discussed reducing the price of the kits, but which was never forwarded to Sikorsky's government contract negotiator or to the Navy. The court concluded that the information had never been forwarded because of an "honest mistake and not some scheme or process on the part of Sikorsky to mislead the government."

## Attorneys' Fees

*U.S. ex rel. Doe et al. v. Pennsylvania Blue Shield, 1999 WL 412324 (M.D.Pa. June 16, 1999)*

A Pennsylvania district court refused to reduce an award of attorneys' fees pursuant to § 3730(d)(1) of the statute where the defendant could not provide specific reasons why the amount billed was unreasonable. In granting the fee request, the court acknowledged

the substantial efforts of the relators' attorneys in handling the complex case.

In August 1998, Xact Medicare Service, Inc., d/b/a Pennsylvania Blue Shield, settled four related *qui tam* suits for $38.5 million. The relators petitioned for attorneys' fees pursuant to § 3730(d)(1) of the Act. Xact opposed the petition.

The relevant portion of § 3730(d)(1) provides that a prevailing relator "shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs." The district court and the parties agreed that the proper method for determining the amount of attorneys' fees is the "lodestar method"— the usual method in fee-shifting cases — which is the number of hours worked multiplied by an hourly fee. Once the fee applicant has met the initial burden of providing evidence of its lodestar amount, the burden then switches to the party opposing the request to challenge its reasonableness.

Following 3rd Circuit caselaw, the district court stated that hours are unreasonable and may be excluded if they are undocumented, excessive, redundant, if they relate to distinct claims on which the applicant did not succeeed, or are otherwise unnecessary. Relying on Supreme Court caselaw, the court noted that an hourly rate is reasonable if it is consistent with the prevailing market rates in the relevant community. Under federal law regarding fee-shifting statutes, time expended by attorneys seeking an award of fees justifiably may be included in the application and the award.

## Complicated Nature of Action Supports Reasonableness of Relators' Request

The district court summarily rejected several of Xact's objections to the relators' petition, finding them to be completely contrary to 3rd Circuit caselaw on the lodestar method. The court refused to reduce the lodestar based on the defendant's general "it's too much" objections, and held Xact responsible for providing specific reasons why the amount of time spent or rate billed was unreasonable.

Xact contested the time relators' counsel spent drafting the complaint and disclosure statement. In response, the court stated, "Given the complicated nature of the actions and the heightened pleading requirements for complaints alleging fraud, as well as the necessity of preparing the requisite disclosure statements, we cannot say that the hours billed were unreasonable." Likewise, in rejecting Xact's argument that the relators billed for duplicate efforts, such as billing for more than one attorney to attend the same meetings, the court stated that "[w]e see no reason to exclude these hours from the lodestar: the complicated nature of the case makes employment of multiple attorneys proper for such a task."

The court refused to reduce the fee award because the relators' attorneys had used a method called "block billing," in which they summarized activities rather than detailing every task performed. According to the court, only if there were a substantial number of vague block entries would the court reduce the fees. Moreover, without specific evidence as to where the relators' attorneys might have duplicated the Government's efforts, the court refused to reduce the award because the Government had already performed an intensive investigation into the relators' allegations of fraud.

Finally, the court rejected outright the defendant's argument that the relators could only bill for time spent advancing the government interest, and that hours spent working against the Government or other relators should be excluded from the lodestar. The court stated,

"Nothing in § 3730(d)(1) so limits an award of attorney's fees. In fact, this argument is inconsistent with the nature of legal representation: counsel represents relators, not the government."

### Relators' Contributions Not Basis for Lowering Lodestar Amount

After performing a fact-specific analysis of each of and largely granting the relators' requests for attorneys' fees, the court addressed Xact's argument that since the other relators involved in the settlement had incurred significantly fewer attorneys' fees, the fee petition before the court must be unreasonable. Xact heavily relied upon statements made by the U.S. Attorney's Office during relator's share negotiations which labeled the relators' contributions as the "same." However, the court refused to apply this information to the attorneys' fee issue, finding that it only pertained to the awarding of the relator's share. In addition, the court found the statements relied upon to be too conclusory to provide a basis for lowering the lodestar amount.

## Attorneys' Fees/Penalties

*U.S. ex rel. Garibaldi and Samuel v. Orleans Parish School Board, 1999 WL 250159 (E.D.La. Apr. 27, 1999)*

*See* "State Entities as FCA Defendants" above at page 4.

## Section 3730(h) Retaliation Claims

*Mann v. Olsten Certified Healthcare Corp. et al., 1999 WL 320865 (M.D. Ala. May 18, 1999)*

Despite ruling that the plaintiff had engaged in "protected activity" under the Act, an Alabama district court dismissed her § 3730(h) retaliatory discharge action because she failed to prove a causal connection between her protected activity and her firing. According to the court, the plaintiff could not overcome the "overwhelming" evidence provided by her employer that she was fired for reasons unrelated to her fraud fighting activities.

Debra Mann worked at Olsten Certified Healthcare as a registered nurse and director of clinical management. In March 1997, Mann reported fraudulent documentation of care that resulted in the termination of an Olsten caregiver, but Mann's supervisor Debbie Northcutt allegedly refused to investigate the allegations. Three months later, Mann and Northcutt disagreed about what services were allowable under Medicare. Mann requested further information from Olsten's designated Medicare regulations support person, and asked that explanations of the pertinent regulations be sent to Northcutt. Northcutt fired Mann slightly less than one year later. In 1998, Mann filed a § 3730(h) retaliation claim, arguing that she was fired in retaliation for engaging in "protected activity" under the FCA.

### Employer Put on Notice that Litigation is "Distinct Possibility"

The district court ruled that Mann had indeed engaged in protected activity by reporting the fraudulent behavior of the fired caregiver and by seeking advice on the billing regulations she disputed with Northcutt. The court found that, based on Mann's actions, the defendants reasonably could have feared a "distinct possibility" that Mann would report fraud to the Government or file a whistleblower action. The fact that Mann neither knew of the FCA nor filed a *qui tam* action did not preclude her from having engaged in protected activity for purposes of the FCA.

## Plaintiff Fails to Prove Causal Connection Between Protected Activity and Firing

The court next considered whether there was the necessary causal connection between Mann's protected activity and her termination. The court determined that Mann had presented a prima facie case of retaliation by engaging in protected activity and subsequently being terminated. Nevertheless, the defendants asserted a nonretaliatory explanation for firing Mann: she was laid off, along with many other similarly situated employees, in an effort to combat declining revenues.

According to the court, Mann then failed to present sufficient evidence against Olsten and Northcutt's proffered justification for firing her, thereby raising no genuine issue of material fact which would preclude summary judgment. In finding that the defendants had provided "overwhelming" evidence that Mann's termination was for valid reasons, the court emphasized that almost a year had passed between her protected activity and her firing. The court also noted that Mann had not proven that she was prevented from performing her job duties, which included pointing out billing errors and investigating complaints from clients. Therefore, having held that Mann failed to establish a causal connection between her protected activity and her termination, the court granted summary judgment for the defendants.

*U.S. ex rel. Olloh-Okeke v. Home Care Services Inc. et al. (ND TX No. CIV A 3:97-CV-2738-H)*

In April 1999, a Texas district court denied the defendants' motion to dismiss Clara Olloh-Okeke's *qui tam* suit on constitutional and Rule 9(b) grounds. The court, explicitly rejecting the Texas court's ruling in U.S. ex rel. Riley v. St. Luke's Episcopal Hospital, 982 F.Supp. 1261 (S.D.Tex. 1997), 12 TAF QR 1 (Jan. 1998), and instead relying on the opinion by Judge Harmon in U.S. ex rel. Thompson v. Columbia/HCA, 20 F.Supp.2d 1017, 1044-46 (S.D.Tex. 1998), 15 TAF QR 10 (Oct. 1998), stated that "[t]his court joins Judge Harmon and every other federal appellate court that has considered the issue in disagreeing with Riley because it goes against 134 years of case law specifically concluding or assuming that the *qui tam* provisions are constitutional." In addition, harmonizing the heightened pleading requirement of Rule 9(b) with Rule 8, which requires only that a complaint give the defendant fair notice of the plaintiff's claim and the grounds upon which it rests, the court found that Olloh-Okeke had satisfied the Rule 9(b) particularity requirement.

*Hoefer v. Fluor Daniel Inc. et al. (CD CA No. SA CV 98-447-GLT(KY))*

In May 1999, a California district court granted the defendants' motion to dismiss Patrick Hoefer's state retaliatory discharge claims, which he alleged arose from actions he took in furtherance of the federal FCA. On two issues of first impression within the 9th Circuit, the district court held that California's state False Claims Act does not protect federal whistleblowers from retaliation, and that the federal FCA preempts state wrongful discharge actions that are brought by federal whistleblowers. The court reasoned that the comprehensive nature of the federal FCA was designed both to protect whistleblowers and to prevent frivolous lawsuits, thus creating a dominant federal interest such that the federal FCA preempts a state FCA. Hoefer, a former Fluor Director of Government Finance Compliance, alleged that he was fired in retaliation for filing two *qui tam* suits against Fluor for overbilling the Federal Government. The defendants did not challenge the federal *qui tam* suits in this motion.

*Pentagen Technologies Int'l Ltd. v. United States (SD NY No. 98 CIV 4831(AGS))*

In June 1999, a New York district court denied Pentagen Technology's Freedom of Information Act request to obtain government documents evidencing the government's communications with the defendant after it declined to intervene in Pentagen's prior *qui tam* suit. Pentagen's current suit alleges that after declining to intervene, the Government and defendant secretly colluded to handicap Pentagen's *qui tam* case. The court ruled as it did in U.S. ex rel. Pentagen Technologies Int'l Ltd. v. CACI Int'l et al., 953 F.Supp. 74 (S.D.N.Y. 1995) ("Pentagen I"), 3 TAF QR 17 (Oct. 1995), when it addressed this same issue. In Pentagen I, the court held that there is no basis for enjoining communications between the government and the defendants where the government has not intervened, and in fact such communications are commonplace. Moreover, the court noted that even where the Government has not intervened, it does not become the relator's client. Here, since the documents at issue were protected as government attorney work-product, and since the Government/defendant contact evidenced by the documents was not illegal, the court declined to order the Government to provide the documents to Pentagen.

*State of Vermont Agency of Natural Resources v. U.S. ex rel. Stevens (S.Ct. No. 98-1828), review granted 6/24/99*

In June 1999, the Supreme Court granted the state of Vermont's Petition for Certiorari on the issue of whether *qui tam* relators may sue states under the False Claims Act. On appeal are the issues of whether states are "persons" subject to liability under the Act, and whether states are immune from suit under the Act pursuant to the 11th Amendment. Vermont appealed from a decision by the 2nd Circuit both holding that the definition of "person" includes states and that the 11th Amendment does not protect states from suit, even where the Federal Government has not intervened, because the United States is always the real party in interest in a *qui tam* suit. The 2nd Circuit joined the 1st, 4th, 8th, and 9th circuits in holding that states are subject to FCA liability. The 5th and D.C. circuits have recently held that states are immune from suit under the Act. The lawsuit was originally filed in 1995 by Jonathan Stevens, a lawyer for the Vermont Agency of Natural Resources. Stevens alleged that the Agency submitted false time records to the Federal Government in connection with federal grant programs. The case is scheduled to be heard during the Supreme Court's fall 1999 term.

# PRESCRIPTION DRUG PLANS, FRAUD SCHEMES, AND THE FALSE CLAIMS ACT

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The activities of pharmaceutical manufacturers and pharmacy benefit management firms (PBM's) until recently have seldom been the subjects of investigative interest under the federal False Claims Act. Although pharmaceutical costs to the public for filling over 3 billion prescriptions now exceed $100 billion per year, health care fraud enforcement has emphasized cases involving hospitals, physicians, laboratories, medical equipment suppliers and home health agencies. Pharmaceutical fraud cases which have been prosecuted tend to involve frauds at the retail level: substitution of generic for brand name drugs, resale of expired and sample drugs, "recycling" of drugs "purchased" by Medicaid beneficiaries, or billing for prescriptions never picked up by beneficiaries.

This lack of investigative interest arose from a number of factors. The Medicare program so far provides limited direct coverage for prescription drugs. In addition, most payments for prescription drugs for Medicare beneficiaries are made by organizations under contract with the Medicare program — such as hospitals, health maintenance organizations (HMO's), dialysis centers and, under some circumstances, skilled nursing facilities — who receive payment for bundled services. As a result, the Health Care Financing Administration has lacked data about the nature and extent of prescription drug activity in the system.

The Medicaid program has had far more extensive involvement with prescription drugs, which are directly covered by most state plans. Again, however, claims are submitted primarily by retailers or more recently through HMO's.

Historically, federal agencies have not made pharmaceutical purchases a primary procurement focus either. The Office of Personnel Management (OPM), for example,

[1] The opinions expressed herein do not represent the position of the United States Department of Justice and are solely those of the author.

which manages health insurance plan services for civilian federal employees, does most of its direct contracting with health plans, through which the OPM gets its information about the operation of drug benefits. Other federal agencies make payments to contractors and to health plans on behalf of defined groups of employees (e.g. Amtrak workers, defense contract employees) which generally have not pursued these payments after they left federal programs.

However, it is likely that the next five years will see a substantial increase in investigations and prosecutions involving pharmaceutical manufacturers and PBM's, as it becomes clear that some of their activities may implicate the False Claims Act, the Anti-Kickback Act, and other anti-fraud statutes. This article is intended to outline the likely nature of the fraud schemes involving these entities, the laws governing their provision of goods or services to government agencies or beneficiaries, and theories of liability and defenses under the False Claims Act as well as other laws.

## THE BUSINESS OF DEVELOPING AND MARKETING PRESCRIPTION DRUGS

The business of developing and marketing brand name drugs has much in common with the film, recording, or publishing industries. Huge amounts are spent in the development of the product, prior to release, with limited ability to predict the success of the product — or even whether it will be released at all. Manufacturing costs for additional units of successful product are minimal; apparently independent experts can make or break your product. Federal and state regulatory agencies have the ability to delay or kill a product upon which the future of the company may rest. Patent protection for new drugs expires relatively quickly; as the expiration approaches, generic manufacturers gear up to provide the product to the customer at substantially lower cost.

Additional problems arise from the fact that all prescription drugs require a prescriber — a physician authorized by law to make decisions for his/her patients. The physicians often lack sophistication in pharmaceutical issues. In some situations, physicians are active solicitors for, or passive recipients of, gifts and payments from drug retailers to induce them to select particular drugs. *See, The Economic Wisdom of Regulating Pharmaceutical Freebies* by Susan Heilbronner Fisher, 1991 Duke L.J. 206. These gifts and payments are subject to specific statutory restrictions under the Prescription Drug Marketing Act, as well as the ethical restrictions of licensing boards and the American Medical Association's Council on Ethical and Judicial Affairs Code of Medical Ethics Paragraph 8,061 (Gifts to physicians from industry).

In the early 1990's, PBM's began to emerge to manage pharmacy benefits promised by employers and health plans. The theory was that PBM's would be large enough to obtain substantial price concessions from manufacturers, and sophisticated enough to be able to identify and press for therapeutic equivalency (drugs with different chemical compositions which are given to treat the same disease condition). Marketing to the

PBM, which was in a position to advise or direct the ordering physician, was potentially more effective than marketing to thousands of individual physicians. The PBM's ability to control initial selection and continuation of brand name drugs offered an opportunity to commit patients to long-term drug regimens using a particular product - even if the patient subsequently left a particular health plan.

## PHARMACY BENEFIT MANAGEMENT FIRMS

PBM's are in essence pharmaceutical agents for health plans. They are paid a fixed rate per prescription by the health plan, and a fixed amount per prescription by the dispensing pharmacy. In most cases, they do not acquire ownership of the prescription drugs, and they take no risk with respect to price or volume of drugs provided to beneficiaries.

PBMs offer significant advantages to health plans, health plan beneficiaries, and to pharmaceutical manufacturers. Because of their size and market power, they can obtain substantial discounts on the retail price of prescription drugs and the cost of dispensing those drugs to plan members. They can also obtain discounts and rebates from drug manufacturers in addition to retailer concessions. Because of their extensive data systems, they can develop disease management programs for plan members with chronic diseases like asthma, diabetes, and high blood pressure. These programs can include communication with patients and physicians, provision of information to patients and pharmacists on alternative therapies, and tracking of drug prescriptions and refills, including drug utilization reviews to avoid adverse drug interactions. Finally, in the interest of cost and quality of care, PBM's can identify physician prescribing patterns and suggest which physicians could benefit from modification of those patterns.

The two most significant activities performed by PBM's, however, are: (1) the development and management of a formulary through a pharmacy and therapeutics (P & T) committee and (2) therapeutic intervention.

The P & T committee is the entity charged with responsibility for developing a formulary for the health plan or for the PBM. Many health plans describe their formularies as "open formularies." This means that if a doctor expresses personal concern in writing, any drug which the doctor believes is appropriate for the patient can be obtained. However, the P & T committee process is designed to direct pharmacists, patients, and physicians toward certain preferred drugs. Most PBM's describe their drug formulary as a list developed by "distinguished health care professionals" and claim that it helps to maintain the quality of patient care while containing costs. The formulary usually includes preferred alternative drugs, which are sometimes generics, or sometimes drugs designed with similar therapeutic objectives but different chemical compounds. The formulary choices are communicated to physicians and pharmacists and reinforced by the PBM's software programs which make it difficult and time-consuming to select or receive the non-preferred alternatives.

Therapeutic intervention refers to the variety of ways PBM's intervene with patients, physicians, and pharmacists to move market share in the direction of a preferred drug. The PBM's may accomplish this intervention through telephone contact, direct mail or faxes to physicians, or direct payments to pharmacists or pharmacies to switch patients from one drug to another.

The position of a drug on the formulary and the efforts which will be undertaken by the PBM to move market share in the direction of that drug are based in part on legitimate considerations of efficacy, cost, and side effects. However, government investigations also suggest that in certain circumstances the focus of the PBM has not been on saving money for the health plan or beneficiaries nor on assuring the best drug for the patients, but on obtaining payments from the manufacturers which the PBM keeps for itself to the detriment of the patient, the plan, and often, the physician.

## VIOLATIONS OF LAW

The law governing the effect of a kickback on the falsity or fraudulent nature of a claim made to a federally funded health care program has been discussed in detail elsewhere and will not be repeated here. The legal theory is that switching prescription drugs in return for payments from the manufacturer may be the basis of a false claim under certain circumstances. *See generally*, *Applying Medicare and Medicaid Anti-Kickback Laws to Disease Management Programs*, 69 Temp. L. Rev. 245 (Spring 1996) This legal theory is most easily applied:

1) in the Medicaid context where the Medicaid program pays directly for each prescription;
2) where a Medicare HMO has made specific representations concerning prescription drug benefits to the Medicare program as part of its qualification process and those representations do not accurately reflect the benefit provided;
3) where the Federal Employee Health Benefits Plan makes representations about the nature of that program and how decisions are made; and,
4) where federal agencies pay for certain health benefits in the context of a cost-plus contract.

The are two other contexts in which PBM conduct may result in False Claims Act exposure. The first is under the Medicaid rebate program. This program requires that manufacturers report to the Medicaid program their average wholesale price for a given drug and their best price for a given drug. The Government has determined that certain payments for benefits provided to PBMs by the pharmaceutical manufacturers are not reported to the Medicaid program as discounts on the price of the drug as required. These benefits have included disease management programs, risk sharing programs, and marketing programs. Failure to disclose these programs has resulted in an overstatement of the price actually offered to the PBM. As a result, the pharamaceutical

manufacturer makes a false statement to reduce its rebate liability, in violation of the rebate statute. See, 42 U.S.C. § 1396r-8.

Similar liabilities are imposed under the Veterans Assistance Act of 1992, 38 U.S.C. § 8126. This provision requires that a manufacturer shall "provide a discount in an amount equal to" in essence, the best price provided other buyers. This statute also requires that the company report quarterly on the "non-federal average manufacturer price for the drug."

## DRUG SWITCHING AND FRAUD

As our investigations continue, we will be required to refine our analysis of the nature of the false and fraudulent claim based upon specific documents submitted by a particular company (PBM, HMO, or manufacturer) to federal contractors or programs. However, it is clear from the public record that the process of selection of drugs is subject to corruption influences.

In 1995, for example, a complaint was filed in New York by Pfizer, Inc. alleging that it paid PCS Health Systems over $10 million to assure that PCS "shall use its best efforts to cause each health plan to which PCS provides formulary management services ... to add all the Pfizer products to the Plan's formulary, and to maintain them on the Plan's formulary at all times during the term of this agreement," and to use its best efforts to cause each health plan to treat Pfizer product in a favorable manner. Pfizer states that "promptly upon commencement of the ... Agreement, PCS included all of the Pfizer products in the formularies it recommended for the Plans that it managed."

According to the Pfizer complaint, "PCS informed Pfizer that it intended to create new formularies. PCS has announced that these new formularies will not include any Pfizer products unless Pfizer agrees to make substantial additional payments."

Pfizer claimed breach of contract in specific instances where PCS recommended competing products, and pointed to the power of pharmacy benefit managers to control prescriptions: "PBM's contact physicians asking that they change their prescriptions." In essence, Pfizer was asking for the benefit of its bargain. Since PCS had accepted $10 million to favor Pfizer products over others in its formulary design and its recommendations to physicians, it should stay bought. Pfizer asked the court to enter an injunction enjoining PCS from "encouraging physicians not to prescribe Pfizer products and instead to prescribe products of Pfizer's competitors." It is hard to imagine an arrangement less likely to result in physicians receiving "objective information about drugs," much less in PBM's making objective judgments on a valid analytical basis as to the cost, efficacy, and appropriateness of therapeutic agents.

Health plans and other plan sponsors have begun to notice the potential impact of drug

switching. In a 1997 study, OEI-01-95-00110 (April 1997), the Health and Human Services Office of Inspector General states that HMO's expressed significant concern "that PBMs may bias their programs to favor their industry partners; and in so doing, compromise the quality of the HMO's drug use practices and the patient care they provide. Particularly vulnerable areas include formularies, drug-use review programs, educational interventions, and cost-effectiveness research."

In a 1994 Special Fraud Alert, the Inspector General condemns drug switching programs as a violation of the Anti-Kickback Act. *OIG Special Fraud Alert: Prescription Drug Marketing Schemes*, 59 FR 65376 (12/19/94):

If one purpose of any of these marketing schemes (product conversion programs, frequent flier programs, and research grant programs described in the fraud alert) is to induce the provision of a prescription reimbursable by Medicaid, then the criminal anti-kickback statute is implicated. Such a marketing program ... may interfere with a physician's judgment in determining the most appropriate treatment for the patient.

## PRESCRIPTION DRUG FRAUD AND CONSPIRACY TO SUBMIT FALSE CLAIMS UNDER 31 U.S.C. § 3729(a)(2) OR (3)

In the traditional procurement context, the Government defines with substantial precision the product to be supplied, the testing to be performed, and the specific criteria which the product must meet. The product is then supplied to the Government for its own use.

In a health care context, the product that the Government is buying is something very different. The beneficiary of the health care product or service has the opportunity to select the provider and, in consultation with the provider, to select the service or goods for which the Government has agreed, in whole or in part, to pay. Implicit in that selection by the beneficiary is the idea that the providers will conduct themselves in accordance with their professional standards and responsibilities to provide objective and accurate information about the product or service, and that they will not be influenced by inappropriate outside persuasion. *See generally*, American Medical Association Code of Medical Ethics § 8. Where patients or their physicians are induced to switch medications to the patient's detriment, based on false, misleading, or intentionally incomplete statements by PBM's or by pharmacists receiving inducement from PBM's, it seems reasonable to argue that there is a violation of 31 U.S.C. § 3729 (a)(2), in that the defendant "uses, or causes to be used a false record or statement to get a false or fraudulent claim paid by the Government."

Such claims may be those submitted by the HMO or other government contractor to the United States, or the direct claim for payment for the prescription drug submitted to the health plan contractors, since the United States Government provides "any portion of the money or property which is requested" of the Plan. 31 U.S.C. § 3729(c).

In this type of situation, the False Claim's Act liability provision should be broadly construed: "[e]ach and every claim submitted under a contract, loan guarantee, or other agreements which was originally obtained by means of false statements or other corrupt or fraudulent conduct, or in violation of any statute or applicable regulation constitutes a false claim." S. Rep. No. 99-.45, at 9 reprinted in 1986 U.S.C.A. 7 at 5274, cited in *U.S. ex rel. Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776 (4th Cir. 1999).

## CONCLUSION

Of course, as these cases progress, the Government will have to further clarify the nature of the claims submitted and the Government's contribution. However, the activities of PBM's in causing switches in prescription drugs is clearly an area worthy of further investigation for potential False Claims Act liability.

*The Congressional Record is available in its entirety on the Government Printing Office website, located online at www.access.gpo.gov.*

## Rep. Howard Berman and Sen. Charles Grassley Write Letter to Attorney General Expressing Concerns About Courts' Interpretation of FCA's Public Disclosure Bar

145 Cong. Rec. E1540 (daily ed. July 14, 1999) (statement of Rep. Berman)
145 Cong. Rec. E1546 (daily ed. July 14, 1999) (letter to Attorney General)

On June 14, 1999, Representative Howard Berman (D-CA), co-sponsor with Senator Charles Grassley (R-IA) of the 1986 Amendments to the False Claims Act which strengthened the Act's *qui tam* provisions, made a special statement in the House expressing his and Sen. Grassley's satisfaction with the Act's success. However, Rep. Berman also expressed the grave concerns that he and Sen. Grassley have about judicial decisions involving the Act's § 3730(e)(4) public disclosure bar. As a result of these concerns, Rep. Berman and Sen. Grassley wrote a letter to Attorney General Reno discussing the proper interpretation of the bar. The congressmen chose to publicize the letter in the *Congressional Record* in order to "make it available to federal courts for guidance and perspective."

The lengthy and detailed letter contains strong language concerning the effect of the courts' misinterpretation of the bar. The letter makes clear that these misinterpretations are contrary to Congress' expressed intent and may make the Act a much less effective fraud fighting tool. In addition, the letter charges the Department of Justice with a critical role in the administration of the Act, and states that the DOJ's silence on public disclosure issues not only may be a failure in its obligation to shape the courts' interpretation of the FCA, but may also contravene Congressional intent. The letter exhorts the DOJ to be vigilant in helping courts correctly implement the Congressional policy that underlies the public disclosure bar.

The letter focuses on a number of circuit court cases which Rep. Berman and Sen. Grassley believe exemplify these misinterpretations. The described cases cover many aspects of the public disclosure bar and original source analysis. In particular, the letter describes how certain judicial decisions may be thwarting the efforts of relators who file meritorious *qui tam* suits.

The letter reminds the DOJ that one of the principal goals of the 1986 Amendments to the FCA was to ameliorate the lack of resources on the part of federal enforcement agencies. The letter asserts that where meritorious *qui tam* cases are not allowed to proceed because of spurious interpretations of the public disclosure bar, the courts are depriving the Government of these additional resources.

# INTERVENTIONS AND SUITS FILED/UNSEALED

## ALLEGATION: OVERCHARGING FOR LABOR COSTS

*U.S. ex rel. Carbaugh v. Westinghouse Hanford Co. et al. (ED WA No. SC-96-0171-WFN)*

In April 1999, a *qui tam* suit was unsealed alleging that Westinghouse Hanford Company and Fluor Daniel Hanford Inc. overbilled the Government for labor costs in the environmental clean-up of the Hanford Nuclear Reservation in Richland, Washington and kept two sets of books to cover the overcharges. According to the lawsuit, the contractors used a complex computerized accounting scheme to obtain more than $85 million in fictitious costs from the U.S. Department of Energy (DOE). The suit was filed on March 19, 1996 by David Carbaugh, a former accountant for both companies. Under their contract with the DOE, the companies were permitted to bill the Government an extra 14 percent for each regular hour worked to cover vacation, sick days and holiday pay. The complaint alleges that the defendants fraudulently charged this extra amount to overtime hours as well, inflating labor costs and masking over-budget projects. Fluor allegedly adopted the same procedure upon succeeding Westinghouse in 1996 as the primary contractor at the Hanford site. Westinghouse Hanford Co., a subsidiary of the CBS Corporation, was formerly known as Westinghouse Electric Corporation. DOJ has declined to intervene. The relator is represented by Steve Berman, Jeffrey Sprung, and Karl Barth of Hagens Berman (Seattle, WA), Cyrus Mehri, Michael Kanovitz and Reuben Robertson of Mehri, Malkin & Ross (Washington, D.C.), and Thomas Carpenter and Jack Sheridan of the Government Accountability Project (Seattle, WA).

## ALLEGATION: FEDERAL RESEARCH GRANT FRAUD

*U.S. ex rel. Kozhukh v. Constellation Technology Corporation (MD FL No. 98-521-CIV-T-17E)*

In April 1999, a *qui tam* suit was unsealed alleging that Constellation Technology Corporation (CTC), through the use of misleading and obsolete data, fraudulently induced the Air Force to fund research used for the company's commercial profit. The Air Force contracted with Florida-based CTC to develop radiation detectors to monitor international compliance with nuclear proliferation treaties and implement counter-terrorism programs. According to the lawsuit filed March 10, 1998 by Mikhail Kozhukh, a nuclear physicist and former senior research scientist at CTC, CTC led the Air Force to believe that mercuric iodide was a promising material for such military uses, when in fact it was not. CTC then allegedly utilized the federal grant money to develop and manufacture nonmilitary radiation detectors to sell for a profit in the commercial marketplace. DOJ declined to intervene. Representing the relator are Andrew Grosso (Washington, D.C.) and Joan Vecchiole and Amber Williams of Johnson, Blakely, Pope, Ruppel and Burns (Clearwater, FL).

## ALLEGATION: INFLATED MANAGEMENT FEES

*U.S. ex rel. Parslow v. Columbia/HCA Health Care Corp. and Curative Health Services Inc. (MD FL No. 98-1260-CIV-T-23F)*

In April 1999, DOJ intervened in a *qui tam* suit alleging that Columbia/HCA — the target of a widespread federal fraud investigation — and its business partner, Curative Health Services

Inc., defrauded Medicare by cost shifting and including excessive management fees in Medicare cost reports. According to the lawsuit, filed by Joseph Parslow, Chief Financial Officer of a Columbia/HCA hospital in Florida, the major hospital chain contracted with Curative to manage medical centers set up to treat chronic, non-healing wounds with the exclusive use of a Curative product. The complaint alleges that shortly after Medicare decided not to reimburse for this product in 1993, the defendants amended their agreement to compensate for the resulting loss of income by billing Medicare for increased management fees — purportedly inflated by 400 percent — for the same goods and services. The complaint also alleges that the higher management fees were used for advertising costs, which are not reimbursable by Medicare, and included kickbacks that Columbia/HCA paid to Curative for patient referrals. Representing the relator are Henry Lee Paul and Betsy Singer of Paul & Singer, P.A. (Tampa, FL). The Government is being represented by Assistant U.S. Attorney Jay Trezevant and Joyce Branda and Marie O'Connell of the DOJ Civil Division.

## ALLEGATION: FRAUDULENT DEFAULT INSURANCE CLAIMS

*United States v. Corus Bankshares Inc. and Corus Bank Inc. (ND IL No. 99C-2300)*

In April 1999, DOJ announced that it filed a False Claims Act suit against Corus Bankshares Inc. and wholly-owned subsidiary Corus Bank Inc. alleging that the bank defrauded the Government by failing to exercise due diligence in the collection of federally insured student loans. The United States Department of Education insures certain student loans and reimburses lenders for defaulted loans through guaranty agencies, but only if the lender exercises due diligence in collecting the debt and adequately documents its collection efforts. Corus allegedly submitted thousands of default insurance claims with falsified collection histories, resulting in unwarranted reimbursement amounting to millions of dollars. The complaint also alleges that Corus aggressively expanded its student loan business without adding the commensurate staff and resources necessary to pursue delinquent accounts, causing a disproportionately high number of defaults. Handling the case are Assistant U.S. Attorney Joseph Ferguson and Stephen Altman of the DOJ Civil Division.

## ALLEGATION: MEDICALLY UNNECESSARY TESTS/BILLING FOR TESTS NEVER PERFORMED

*United States v. Heaston et al. (ED CA No. 99-00669)*

In April 1999, DOJ filed a False Claims Act suit against Premier Diagnostic Laboratories and its owners, President John Heaston and CEO Corey Underwood, alleging that they filed false Medicare claims for medically unnecessary tests or tests that were never performed. Premier, an independent clinical laboratory located in Riverside, California, tests blood oxygen levels of Medicare beneficiaries to determine eligibility for home oxygen therapy. According to the lawsuit, the laboratory tacked on claims for unallowable tests or tests never performed to its bills for allowable blood oxygen tests. Premier allegedly lied to the Government about the purpose of these additional tests. Handling the case for the Government is Assistant U.S. Attorney Andrea Gross.

## ALLEGATION: FRAUDULENT INCREASE OF HOSPITAL COST-TO-CHARGES RATIO

*U.S. ex rel. Lanford et al. v. Vencor Inc. (MD FL No. 97-2845-CIV-T-23B)*

In May 1999, DOJ intervened in a *qui tam* suit against Vencor Inc. alleging that the hospital chain improperly billed nursing home services as hospital costs in order to increase reimbursement amounts. Vencor subsidiary Vencare Health Services contracted with nursing homes to provide respiratory, pharmaceutical, and rehabilitation services. According to the complaint, Vencor added the costs of operating its nursing home services to its hospital cost reports in violation of Medicare regulations, thereby increasing the hospitals' "cost-to-charges" ratio. The higher the costs are compared to charges in the cost-to-charges ratio, the higher the Medicare reimbursement. The lawsuit was originally filed in 1997 by Virginia Lee Lanford, the former quality review manager at Vencor's Central Tampa Hospital in Tampa, Florida, and Gwendolyn Cavanaugh, former assistant Administrator of Finance at the same facility. The relators are represented by Kenneth Nolan (Hollywood, FL). Representing the Government are Assistant U.S. Attorney Jay Trezevant and Polly Dammann and Rosemary Filou of the DOJ Civil Division.

## ALLEGATION: MEDICARE COST SHIFTING/KICKBACKS

*U.S. ex rel. Ortega v. Columbia/HCA Healthcare Corp. et al. (WD TX No. EP-95-CA-259H)*

In May 1999, DOJ intervened in a *qui tam* suit against a hospital owned by the Columbia/HCA Healthcare Corporation and three other health care companies, alleging cost shifting, upcoding, and kickbacks. According to the complaint, Columbia Medical Center West in El Paso, Texas improperly charged costs from its rehabilitation center to its back care center to raise the base for Medicare funding at the back care center. Columbia/HCA also allegedly gave kickbacks to physicians in return for patient referrals, including hospital ownership interests, medical directorships, and other benefits. The *qui tam* suit was filed in June 1995 by Sara Ortega, a former employee of Columbia/HCA in El Paso. DOJ declined to intervene in additional allegations made by Ortega that the hospital fabricated meeting minutes and other documents in order to achieve accreditation for Medicare eligibility. Columbia/HCA is currently the focus of a far-reaching federal fraud investigation. Representing the relator are Thomas Spieczny and David Curl (El Paso, TX).

## ALLEGATION: FALSE CLAIMS FOR ELECTRICAL GENERATORS

*U.S. ex rel. Sanders et al. v. General Tool Co. et al. (SD OH No. 6-1-95-970)*

In May 1999, a *qui tam* suit was unsealed alleging that General Tool Company (GTC) and six other contractors defrauded the Government by submitting false claims for the construction and testing of electrical generating sets. The Navy contracted with the companies for the development and manufacture of the generators, known as "Gen-Sets," for use on 26 Navy destroyers. GTC was the primary construction and assembly subcontractor. According to the complaint, the companies failed to perform required tests, falsified inspection reports, and used parts that failed to meet contract specifications. The lawsuit was filed in November

1995 by two former GTC employees, Roger Sanders and Roger Thacker. DOJ declined to intervene. The relators are represented by James Helmer and Paul Martins of Helmer, Martins and Morgan (Cincinnati, OH).

## ALLEGATION: SUBMISSON OF FALSE COST REPORTS

*U.S. ex rel. Schilling v. KPMG Peat Marwick LLP (MD FL No. 98-901-CIV-T-17F)*

In May 1999, a *qui tam* suit was unsealed alleging that accounting firm KPMG Peat Marwick violated the False Claims Act by helping clients Basic American Medical, Inc. and Columbia/HCA to submit false cost reports to Medicare and other federally funded health care programs. According to the complaint, KPMG also knew that its hospital clients were maintaining two sets of books — called "reserve cost reports" — for the purpose of manipulating Medicare reimbursements. The lawsuit was filed by John Schilling, a former Columbia/HCA executive, who is also the *qui tam* relator in *U.S. ex rel. Schilling v. Columbia/HCA Healthcare Corp. (MD FL No. 96-12640-CIV-T-23B)*, unsealed in December 1998. Defendant KPMG is one of the largest public accounting firms in the nation. DOJ has been granted an extension of time to intervene. The relator is represented by W. Christian Hoyer of James, Hoyer, Newcomer, Forizs & Smiljanich (Tampa, FL), and Stephen Meagher and Peter Chatfield of Phillips & Cohen (San Francisco, CA and Washington, D.C.).

## ALLEGATION: FRAUDULENT USE OF POSTAGE METERS

*United States v. Bodine (ED PA No. ____ )*

In May 1999, DOJ announced that it filed a False Claims Act suit against Edward P. Bodine, alleging that he fraudulently obtained hundreds of thousands of dollars of free postage from the U.S. Postal Service. Bodine was the functional chief operating officer of Kenward Mailing, Inc., a direct mailing service. The complaint alleges that Bodine tampered with the company's postage meters to get them to stamp mail without recording the application and directed Kenward Mailing employees to do the same. According to the lawsuit, Bodine submitted false claims by failing to register each use of the meter before returning it to the Postal Service for additional postage. The case was investigated by the U.S. Postal Inspection Service. Representing the Government is Assistant U.S. Attorney Patricia Gugin.

## ALLEGATION: BILLING FOR SERVICES NOT PROVIDED OR PROVIDED BY UNLICENSED PERSONNEL

*United States v. Truman Medical Center et al. (WD MO No. 99-0498-CV-W-ECF)*

In May 1999, DOJ announced that it filed a False Claims Act suit against Truman Medical Center (TMC) and Hospital Hill Health Services Corporation (HHH) for fraudulently billing Medicare for substandard services provided to indigent pregnant woman. The complaint alleges that TMC and HHH billed Medicare for prenatal services that were never provided and for physician deliveries of newborns that were actually performed by medical students or nurses. The case was investigated

by the FBI and the Medicaid Fraud and Control Unit of the Missouri Attorney General's office. Assistant U.S. Attorney Andrew Lay is handling the matter for the Government.

## ALLEGATION: FALSE CLAIMS FOR AMBULANCE SERVICES

*U.S. ex rel. Goeggel v. Abbott Ambulance Inc. et al. (ED MO No. 4:99CV00985JCH)*

In June 1999, DOJ intervened in a *qui tam* suit alleging that nonprofit Abbott Ambulance and its president, Terrence Dougherty, falsified billing codes and submitted false claims to Medicare for medically unnecessary ambulance services. The suit was filed in November 1996 by Robert Goeggel, the owner of competitor Gateway Ambulance. According to the complaint, Dougherty created a computer default system for the handling of Medicare claims to ensure fewer Medicare rejections, including automatically reporting all ambulance transportation of Medicare patients as medically necessary. The complaint also alleges that Dougherty claimed unreimbursable ambulance transport to doctors' office as reimbursable transport to hospitals. In addition, Dougherty allegedly directed Abbott to train ambulance crews to manipulate the billing codes of the actual injuries sustained by patients in order to fit them into reimbursable categories. Goeggel's suit also names Abbott owners Barnes-Jewish Hospital and St. Louis University as defendants, but DOJ did not intervene as to those parties. The relator is represented by Jeffrey Sprung of Hagens Berman (Seattle, WA). Handling the case for the Government is Assistant U.S. Attorney Claire Schenk.

## ALLEGATION: OVERBILLING FOR RESPIRATORY THERAPY SERVICES

*U.S. ex rel. Norris et al. v. Extended Care Services (D CO No. 96-M-2383)*

In June 1999, DOJ intervened in a *qui tam* suit alleging that Extended Care Services Inc., d/b/a Hospital Therapy Services, overbilled for respiratory therapy services provided to Medicare beneficiaries. The suit also names Glen and Judy Conley, co-owners and officers of HTS, as well as Yolanda Acosta, director of the Pulmonary Extended Care Program at HTS. According to the lawsuit, HTS contracted with a hospital owned by Portercare Adventist Health System to recruit, train, and supervise repiratory therapists who would be sent by the hospital to work in long-term skilled nursing facilities. The complaint alleges that over a three year period HTS directed the therapists to bill Medicare for more and longer respiratory therapy sessions than actually provided and for medically unnecessary respiratory therapy services. The complaint further alleges that HTS instructed the therapists to falsify clinical data and billing records used to substantiate payment for these services. The *qui tam* suit was filed on October 10, 1996 by Gary Norris, Julie Christiansen, Lea Desmond, Shawn McGurran, Kelly Gruber, and Christie Leborne. In 1996, after receiving complaints about alleged Medicare violations, Portercare management initiated an internal audit of its respiratory therapy program. The relators are being represented by John Parisi of Shamberg, Johnson, and Bergman (Overland Park, KS). Assistant U.S. Attorney Michael Theis and Polly Dammann and Elizabeth Rinaldo of the DOJ Civil Division are representing the Government.

*U.S. ex rel. Figurski v. Forest Hospital System (ND IL No. 96C4763)*

In April 1999, Forest Health System, Inc. of Illinois and Forest Hospital agreed to pay the Government $4 million to settle a *qui tam* suit alleging that the hospital billed Medicare for medically unnecessary services provided to Alzheimer patients. Forest allegedly targeted for its partial hospitalization program patients who were suffering from dementia and other symptoms of Alzheimer's disease, even though such patients do not benefit from that type of treatment. The suit further alleged that the elderly patients, some of whom spoke no English, were bused from nursing homes and assisted living centers to a facility where they received little or no psychiatric care. The lawsuit was filed in July 1996 by registered psychiatric nurse Carol Figurski and certified nursing assistant Suzanne Rospappa. As part of the settlement agreement, Forest entered into a Corporate Integrity Agreement with HHS OIG. The relators' share was 19 percent or $760,000. Representing the relators was Robin Potter of Potter & Schaffner (Chicago, IL). The Government was represented by Assistant U.S. Attorney Christopher Tracy.

*U.S. ex rel. Boerrigter v. Beth Israel Deaconess Medical Center (D MA No. 97-11858)*

In April 1999, Beth Israel Deaconess Medical Center agreed to pay the Government $920,000 to settle a *qui tam* suit alleging that it knowingly accepted federal research funds in violation of the terms of the grant. The lawsuit was filed August 14, 1997 by former Beth Israel employee Michael Boerrigter. According to the suit, Beth Israel not only accepted a National Institute of Health (NIH) grant earmarked for a former employee who did not devote the requisite amount of time to the research being funded, but also diverted the award money to other projects. According to DOJ, Beth Israel is one of the most frequent recipients of NIH grants in the Boston area. As part of the settlement, Beth Israel has agreed to maintain a compliance program tailored to prevent fraud. The case was investigated by the HHS OIG and the FBI. The relator's share was 17 percent or $156,000. Representing the relator was Evan Slavitt of Gadsby & Hannah (Boston, MA). Assistant U.S. Attorney George Henderson represented the Government.

*U.S. ex rel. Stone v. Rockwell International Corp. (D CO No. 89-M-1154)*

In April 1999, a federal jury awarded $1.4 million to the Government in a *qui tam* suit alleging that Rockwell International Corp. misrepresented to the Department of Energy its progress under its contract to clean up the Rocky Flats Nuclear Weapons Plant near Denver, Colorado. The damages award will be trebled to $4.2 million pursuant to the False Claims Act. Relator James Stone filed his *qui tam* suit in 1989, alleging that Rockwell lied to the DOE about its handling of environmental waste at Rocky Flats in order to collect payments and win a new contract to operate the plant. The plant was previously used to manufacture plutonium triggers for nuclear weapons, which contaminated the site with radioactive waste. Rockwell represented to the Government that it would clean up the waste by mixing the radioactive sludge into cement blocks, but the blocks fell apart, leaking waste into the ground. Rockwell continued to submit claims for payment under its contract with the DOE. The jury ruled that Rockwell made false claims about its performance and expenses three times during the period of April 1987 to September 1988. However, it also determined that Rockwell did not breach its contract with DOE. In 1989, the FBI raided Rocky Flats,

charging Rockwell with environmental violations. In 1992, Rockwell pleaded guilty and paid an $18.5 million fine. The relator was represented by Hartley David Alley (Denver, CO) and Maria Vullo, Jeannie Kang, and Matthew Chavez of Paul, Weiss, Rifkind, Wharton & Garrison (New York, NY).

*U.S. ex rel. Lissack v. Lazard Freres & Co. (SD NY No. 95 CIV 1363 (BSJ))*

In April 1999, Lazard Freres & Co. agreed to pay the Government $7.5 million to settle a *qui tam* suit alleging that it engaged in "yield burning" in the municipal bond market. Yield burning refers to the practice in which investment banks divert the proceeds from bond transactions made on behalf of municipalities that should have gone to the Federal Government. The lawsuit was filed by Michael Lissack, a former managing director of competitor Smith Barney Inc. The case was investigated by the SEC and the IRS. The relator was represented by John Phillips and Erika Kelton of Phillips & Cohen (Washington, D.C.). Assistant U.S. Attorney Neil Corwin represented the Government.

*Anne Arundel Medical Center*

In April 1999, DOJ announced that the Anne Arundel Medical Center agreed to pay the Government $2.1 million to resolve allegations that the hospital improperly billed Medicare and TRICARE for infusion, or intravenous, therapy. DOJ alleged that Anne Arundel Medical Center billed for self-administered home infusion therapy as outpatient hospital services in order to be reimbursed by Medicare. Self-administered home infusion is not covered by Medicare or any other federally funded health care program. According to the settlement agreement, Medicare paid Anne Arundel Medical Center for over 350 improper claims. The medical center has also entered into a Corporate Integrity Agreement. The matter was investigated by the HHS OIG, the FBI, and the Defense Criminal Investigative Service. The Government's investigation originated from a referral by the Fraud and Abuse Unit of the Maryland Medicare Part A carrier, CareFirst Blue Cross/Blue Shield. Assistant U.S. Attorneys Kathleen McDermott and Roann Nichols handled the case for the Government.

*Southcoast Hospitals Group Inc.*

In April 1999, Southcoast Hospitals Group, Inc. and its subsidiary Charlton Memorial Hospital agreed to pay the Government $395,000 to resolve allegations that the hospital submitted false claims to Medicare for reimbursement of oncology services. According to DOJ, Charlton voluntarily disclosed that over a five year period it had inaccurately billed certain evaluation and management services for oncology patients as "consultations," which are reimbursed at a higher rate. As part of the settlement, the hospital must also comply with an expanded Corporate Integrity Agreement. The hospital is located in Fall River, Massachusetts. HHS OIG investigated the matter. Representing the Government was Assistant U.S. Attorney Susan Winkler.

*U.S. ex rel. Pijut v. Morgan (ED PA No. 98-3365)*

In April 1999, Richard J. Morgan, M.D. & Associates, P.C. and its sole owner physician Richard John Morgan agreed to pay the Government $225,000 to settle a *qui tam* suit alleging that the doctor bilked Medicare by upcoding physician services and falsely billing for assistants at surgery. DOJ intervened only as to the upcoding claims. Morgan also entered into a three year integrity agreement as part of the settlement. The relator was represented by Howard Klein. Representing the Government were Assistant U.S. Attorneys James Sheehan and Susan Shinkman.

*U.S. ex rel. West v. Biotrax International Inc. (ED PA No. 95-CV-3223)*

*U.S. ex rel. Strelow v. National Medical Care Inc. (ED PA No. 96-CV-7423)*

*U.S. ex rel. Piacentile v. NMC Diagnostic Services Inc. (ED PA No. 97-CV-4071)*

In May 1999, German-owned Fresenius Medical Care Holdings Inc. agreed to pay the Government $16.5 million to settle a string of *qui tam* suits alleging that two Fresenius subsidiaries submitted false claims to Medicare, unbundled tests, and gave kickbacks to physicians. Biotrax and National Medical Care (NMC) primarily provide dialysis services to severely debilitated patients with end stage renal disease and provide noninvasive testing services to Medicare patients at kidney dialysis facilities. According to the lawsuits, in order to induce physicians to order the tests, the companies provided the doctors with test interpretations but advised the doctors to bill Medicare as if they had interpreted the tests themselves. Medicare regulations prohibit claims for services not actually provided by the doctor, and the financial inducement to the physicians constituted kickbacks which are prohibited both by Medicare regulations and the Anti-Kickback Act. Company salesmen also allegedly provided doctors with false codes under which they could bill for certain tests not reimbursed by Medicare. In addition, the suits alleged that Biotrax and NMC automatically billed the Government for electrocardiograms (EKG's) every time they billed for echocardiograms in violation of Medicare regulations.

Biotrax was purchased in 1994 by NMC, which later became a subsidiary of Fresenius. The North American branch of Fresenius is located in Lexington, Massachusettts. In the suit against Biotrax, relators Franklin W. West, a registered nurse and registered vascular and cardiovascular technologist, and Robert T. Kane, a medical administrative consultant, received a relator's share of $3.2 million. Elizabeth Strelow, a medical technician, will receive $25,500 as a relator's share in the suit against National Medical Care Inc. Christopher Piacentile, the relator in the NMC Diagnostic Services Inc. suit, will receive over $20,000. HHS OIG and the FBI assisted in the investigation. Relators Kane and West were represented by Marc Raspanti and David Laigaie of Miller, Alfano & Raspanti (Philadelphia, PA). Relator Strelow was represented by Brian Denney of Elliot, Reihner, Siedzikowski & Egan (Blue Bell, PA). Relator Piacentile was represented by Mitchell Kreindler of Phebus & Winklemann (West Chester, PA). Assistant U.S. Attorney David Resnicoff handled the case for the Government.

*Georgetown University d/b/a Georgetown University Faculty Practice Group*

In May 1999, the Georgetown University Faculty Practice Group agreed to pay the Government $5.3 million to settle claims that the teaching hospital billed at the higher physician rate for services provided by residents and interns. The settlement resulted from an ongoing national health care fraud initiative known as Physicians at Teaching Hospitals, or PATH, through which the Government focuses on how doctors at teaching hospitals bill Medicare. Under Medicare regulations, staff physicians must be present to supervise and adequately document these efforts to properly bill for them. The Georgetown investigation was conducted by the HHS OIG. Representing the Government were Assistant U.S. Attorneys Mark Nagle and Dara Corrigan.

*U.S. ex rel. Health Outcomes Technology v. Doctors Hospital of Hyde Park et al. (ED PA No. 96-1552)*

In May 1999, DOJ announced that Doctors Hospital of Hyde Park, in Chicago, Illinois and Palm Springs General Hospital of Hialeah, Florida agreed to pay the Government $4.5 million and $2.4 million respectively to settle a *qui tam* lawsuit alleging that the hospitals upcoded Medicare bills for pneumonia treatment. The lawsuit was originally filed in 1996 by Health Outcomes Technologies, a Doyleston, Pennsylvania software firm that analyzes billing practices of medical facilities across the country to pinpoint abuses. According to DOJ, Doctors Hospital and Palm Springs Hospital are two of five medical facilities named in the lawsuit to settle. Claims against the remaining facilities are still under seal. Doctors Hospital entered into a Corporate Integrity Agreement and agreed to undertake a self-audit of the billing records of certain hospital personnel. The relator's share is $519,391. The case was investigated by HHS OIG and the FBI. The relator was represented by Michael Holston of Drinker, Biddle & Reath (Philadelphia, PA). Assistant U.S. Attorney Daniel May and Joyce Branda and Jamie Ann Yavelberg of the DOJ Civil Division represented the Government.

*United States v. Integrated Health Services at Penn Inc. d/b/a Integrated Health Services of Bryn Mawr at the Chateau*

In May 1999, Integrated Health Services at Penn Inc., d/b/a Integrated Health Services of Bryn Mawr at the Chateau agreed to pay the Government $195,000 to settle claims that it falsely certified compliance with federal law regarding nursing home standards of care in order to continue participating in the Medicare program. IHS is a for-profit Pennsylvania company which operates long-term care facilities. According to DOJ, the Chateau did not provide proper nutritional, wound, and incontinence care to nursing home residents and failed to properly train its staff. As part of the settlement agreement, IHS agreed to retain a quality of care consultant and increase staff training. This case marks the fourth nursing home quality of care case involving False Claims Act allegations to be resolved by the U.S. Attorney's Office for the Eastern District of Pennsylvania. The case was investigated by HCFA and HHS OIG. Assistant U.S. Attorney David Hoffman handled the case for the Government.

*Suprenant Cable Corporation*

In May 1999, Suprenant Cable Corporation agreed to pay the Government $120,000 to settle allegations that it falsely certified that electrical cable it sold to the U.S. Navy met federal specifications. According to the settlement agreement, Suprenant falsely certified that eleven orders of its electrical cable met the Navy's watertightness requirements and used quality assurance forms prestamped with the signature of a former employee. Suprenant, owned by the Chicago-based Marmon Group's Rockbestos Company of East Granby, Connecticut, is now known as IGA Leasing Company. The case was investigated by the DOD OIG. Assistant U.S. Attorney David Mackey represented the Government.

*Kansas Healthcare Investors Rehab Works Inc.*

In May 1999, DOJ announced that Kansas Healthcare Investors (KHI) and Rehab Works Inc. agreed to pay the Government a total of $863,996 to resolve allegations that the companies falsely billed Medicare and Medicaid for services provided in the same Kansas nursing homes. According to DOJ, Georgia-based KHI falsely certified compliance with federal regulations regarding nursing home standards of care in order to receive Medicare reimbursement. The substandard care alleged included inadequate nutrition and unsanitary living conditions. Maryland-based Rehab Works allegedly

falsely billed Medicare for physical, occupational, and speech pathology therapy services that were not medically necessary, and charged Medicare for unreimbursable costs such as staff education. DOJ reports that KHI paid $175,000 and Rehab paid $688, 996 to settle the allegations. The Government was represented by Assistant U.S. Attorney Richard Schodorf.

*PacifiCare of Oklahoma Inc.*

In May 1999, PacifiCare of Oklahoma Inc. agreed to pay the Government $9 million to settle claims that the health maintenance organization overcharged the Federal Employees Health Benefits Program (FEHBP) from 1990 to 1995. PacifiCare allegedly gave discounts and better prices on its package of health benefits to commercial entities and certain municipalities than it gave to federal agencies, while falsely guaranteeing on its certificates of community rating and market pricing that FEHBP was receiving the same pricing. PacifiCare is a health maintenance organization based in Oklahoma City and Tulsa. Assistant U.S. Attorney Anthony Alexis handled the case for the Government.

*U.S. ex rel. Caplan v. National Consulting Group Inc. (SD FL No. 96-6482-CIV-GR)*

In May 1999, the National Consulting Group, a/k/a National Recovery Institutes Group, Inc. (NRIG), agreed to pay the Government over $7.7 million to settle a *qui tam* suit alleging that NRIG defrauded Medicare, Medicaid and TRICARE by billing recreational outings as group therapy. The lawsuit, filed by former NRIG therapist Joelee Caplan in May 1996, alleged that the fraudulent billings included overlapping counseling sessions and grocery shopping trips, bowling outings and beach excursions. Ft. Lauderdale-based NRIG was an alcohol and drug rehabilitation provider that declared bankruptcy shortly after DOJ intervened in Caplan's *qui tam* suit. As part of the settlement, the Government preserves its right to $142,000 in payments it had suspended prior to NRIG's declaration of bankruptcy. The relator's share was 20 percent of these suspended payments, or about $28,400, as well as 20 percent of the final recovery, which will be a pro rata share of the bankruptcy estate. The case was investigated by HHS OIG and the Defense Criminal Investigative Service. Representing the relator was Ken Nolan (Hollywood, FL). Assistant U.S. Attorney Laurie Rucoba and Daniel Anderson of DOJ Civil Division handled the case for the Government.

*United States v. Finkel (D MA No. 97-12806 RCL )*

In June 1999, DOJ announced that a default judgment for over $2 million was entered against physician Richard F. Finkel for failing to answer the Government's amended complaint alleging that Finkel defrauded Medicare. According to DOJ, Finkel falsely billed Medicare for dermatology services — ostensibly removing cancerous skin lesions with liquid nitrogen — that were needlessly performed on weight loss patients in order to increase Medicare reimbursements. Finkel sprayed the patients with the liquid nitrogen without their consent and from such a distance as to be ineffective. Finkel was sentenced in 1995 to over two years of incarceration and ordered to pay a criminal fine for the same type of fraud. The civil case was handled by Assistant U.S. Attorney Thomas Kanwit.

*United States ex rel. Pobre v. Pobre (ED IL No. 97-C-7442)*

In June 1999, Silvestra Sally Pobre agreed to pay the Government $500,000 pursuant to a consent judgment to settle a *qui tam* suit alleging that she filed fraudulent Medicare cost reports. According to the lawsuit filed by Fe Pobre, the ex-wife of the defendant's husband, over several years the defendant charged jewelry, cars, furniture, and personal loans as Medicare related expenses and later failed to file the required cost reports at all. The

defendant, who was arrested while attempting to flee the country with hundreds of thousands of dollars in cash and jewelry, is permanently excluded from all federal health programs pursuant to the settlement agreement and is currently serving a two year prison sentence stemming from the related criminal matter. The relator's share is 20 percent, or $100,000. The relator was represented by Mark Allen Kleiman (Santa Monica, CA). The Government was represented by Assistant U.S. Attorney Young Kim.

*United States v. A.W. Stevens and Sons Waste Disposal Systems Inc. et al. (D MD No. ___ )*

In June 1999, DOJ announced that A.W. Stevens and Sons Waste Disposal Systems Inc. and St. Mary's Disposal Systems, Inc. agreed by consent decree to pay the Government $2 million to resolve False Claims Act liability under waste disposal contracts with the Navy. The suit also names Albert Stevens, Michael Stevens, Susan Goolsby Stevens, and Patrick Stevens. According to the DOJ, the defendants illegally operated unlicensed solid waste transfer stations, which are the facilities where solid waste materials are transferred from one transportation unit to another for transport to other solid waste acceptance facilities. Maryland law requires transfer stations to be licensed by the Maryland Department of the Environment. The suit alleged that the defendants submitted substituted or falsified dump tickets to the Navy to cover up the absence of legitimate local disposal receipts. The companies held contracts with Navy facilities at the Patuxent River-Naval Air Station, Indian Head-Naval Ordinance Station, and the U.S. Naval Academy in Annapolis. The defendants entered into a plea agreement on related criminal fraud and environmental charges, bringing the payment to the Government up to $3.5 million and possibly resulting in prison terms for the individual defendants. The case was investigated by the Naval Criminal Investigative Service, the Prince George's County, Maryland Department of Public Health, the U.S. Environmental Protection Agency, the FBI, the Maryland Attorney General's Office Environmental Crimes Unit, and the Prince George's County Environmental Crimes Task Force. Assistant U.S. Attorney James Howard represented the Government.

*Sun-Maid Growers of California*

In June 1999, Sun-Maid Growers of California, the nation's largest raisin cooperative, agreed to pay the Government $887,000 to resolve allegations that it caused the payment of federal catastrophic crop insurance for raisins it later sold. According to DOJ, many of Sun-Maid's cooperative growers filed for crop insurance because Sun-Maid falsely claimed that rain-damaged 1994 crops were too damaged to be sold, and instead would be distilled to make alcohol. This allowed Sun-Maid to purchase the raisins from the growers at a much lower than usual price. Sun-Maid later reconditioned the purportedly less valuable fruit and sold it at market value. Sun-Maid, based in Kingsburg, California, represents 1,200 California raisin growers. The case was investigated by the U.S. Department of Agriculture. The Government was represented by Assistant U.S. Attorney E. Robert Wright.

*Greenbelt Nursing & Rehabilitation Center*

In June 1999, Greenbelt Nursing & Rehabilitation Center reportedly agreed to pay the Government $100,000 to settle claims that the nursing home falsely certified compliance with federal law regarding nursing home standards of care in order to continue participating in state and federally funded health care programs. A Health Care Financing Administration investigation found continuing, systemic substandard care in the course of several administrative investigations of the Maryland nursing home. Among other deficiencies, the substandard care alleged includ-

ed failure to timely notify physicians of medical issues, failure to administer and monitor medications properly, failure to assess nutritional needs of residents, and failure to provide appropriate wound care. The nursing home closed in 1998 after losing its funding.

*U.S. ex rel. Young v. Puyallup Tribe et al. (WD WA No. ___ )*

In June 1999, the Puyallup Tribe of Indians reportedly agreed to pay the Government $4.5 million to settle a *qui tam* suit alleging that the tribe falsified school bus mileage records to obtain increased federal funding from the Bureau of Indian Affairs. The lawsuit against the Tribe, Chief Leschi school, and former school superintendent Linda Rudolph, was filed in January 1998 by former school employees Roberta and Dennis Young. The suit alleged that the school kept two sets of mileage books and ordered drivers to drive empty buses to inflate mileage. The relators were represented by Linda Severin. The Government was represented by Assistant U.S. Attorney Harold Malkin.

*U.S. ex rel. Walsh v. Daughters of Charity National Health System (D MA No. ___ )*

In June 1999, Daughters of Charity National Health System reportedly agreed to pay $146,500 to settle a *qui tam* suit alleging that the hospital failed to pass through discounts obtained from suppliers to the Medicare program. The hospital reportedly failed to include the discounts on cost reports submitted to Medicare. The settlement stems from a suit filed by Timothy Walsh, who will receive $31,572 as a relator's share. The matter was investigated by HHS OIG and the FBI. Assistant U.S. Attorney Susan Winkler handled the case for the Government.

*Allied Signal Technical Services Corp.*

In June 1999, DOJ announced that Allied Signal Technical Services Corp. agreed to pay the Government $200,000 to settle claims that it misallocated labor charges on a contract to install electronic security systems at the Cape Canaveral Air Force Station in 1993 and 1994. ATSC, a Columbia, Maryland-based subsidiary of AlliedSignal, Inc., voluntarily disclosed to DOD that it incorrectly charged work done under one contract to another contract in order to avoid exceeding contract ceilings.

*U.S. ex rel. Costa and Thornburg v. Baker & Taylor, Inc. (ND CA No. ___ )*

In June 1999, DOJ announced that Baker & Taylor, Inc., a nationwide book distributor headquartered in Charlotte, North Carolina, agreed to pay the Government $3 million to settle allegations that the Government was overcharged for book purchases. The allegations stemmed from a *qui tam* suit brought by Robert Costa, head librarian for the city of Richmond, Virginia, and Ronald Thornburg, a former Baker & Taylor sales representative. According to DOJ, Baker & Taylor provided 40 percent discounts to its retail customers on trade books, but then misclassified the trade books as nontrade titles in sales to the Government so that it could charge the Government full price. The settlement covers overcharges by Baker & Taylor after it was sold by its former parent company, W.R. Grace & Co., in March 1992. W.R. Grace did not participate in the settlement and remains a defendant in the pending lawsuit for sales before March 1992. The state of California is a co-plaintiff in the suit and several other states are trying to intervene to recover claimed losses on behalf of their own schools and libraries. The relators were represented by Peter Chatfield and Eric Havian of Phillips & Cohen (Washington, D.C.). The Government was represented by Assistant U.S. Attorney Mary Beth Uitti and Diane Younts and Dee Lord of the DOJ Civil Division.

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, designed to educate the public and legal community about the False Claims Act and *qui tam*, has expanded to highlight the growing health care trend and recent legislative developments. 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). We thank James Sheehan for his contribution in this issue. 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.