Session 202 | How to Whet Uncle Sam’s Whistle: A Guide to Litigating Cases under the False Claims Act

Session Description:
This program will cover issues that commonly arise in litigating cases brought under the False Claims Act where the government declines to intervene, with a particular focus on healthcare cases. The panelists will offer discussion from the points of view of counsel for Relators, Government, and Defendants. The panelists will discuss issues that often arise in (i) motion to dismiss briefing, including the original source exception, the public disclosure bar, filing under seal, first to file, materiality, scienter, Rule 9(b), and causation; (ii) discovery, including the handling information subject to HIPAA, Touhy requests to government agencies, and managing costs; and (iii) settlement. This program will also include an explanation of the key provisions of the FCA, recent key cases involving the healthcare industry, and recent policy developments and enforcement trends under the Biden Administration.

Moderator:
Kandis L. Kovalsky, Member, Kang Haggerty

Speakers:
Edward T. Kang, Managing Member, Kang Haggerty
Erika Hiramatsu, Supervising Deputy, Office of the Attorney General of the State of California
Steve Koh, Partner, Perkins Coie
Grace Park, Assistant United States Attorney, United States Attorney’s Office
Kolin C. Tang, Partner, Miller Shah LLP

Written Materials Provided by Kang Haggerty LLC
NAAG: National Association of Medicaid Fraud Control Units

This article is included because the presentation discusses how Medicaid Fraud Control Units recover money paid by Medicaid under fraudulent claims. This article provides background information on Medicaid Fraud Control Units in addition to what is covered in the presentation.


This article is included because the presentation discusses amendments to the federal False Claims Act. This article explains how the states’ false claims acts are impacted by the changes.


This settlement agreement is included because the settlement in U.S. v. Cardinal Health, Inc. is discussed in the presentation as an example of False Claims Act enforcement in the healthcare field in 2022.

Settlement Agreement: U.S. ex rel. Bomar v. Bayfront HMA Medical Center LLC

This settlement agreement is included because the settlement in U.S. ex rel. Bomar v. Bayfront HMA Medical Center LLC is discussed in the presentation as an example of False Claims Act enforcement in the healthcare field in 2022.


This opinion is included because the presentation discusses the split among the circuit courts regarding the Rule 9(b) pleading standard, with some courts imposing a “strict” application and some courts using a more lenient application. This case is an example of the second circuit’s “more lenient” approach.

Opinion: Universal Health Services, Inc. v. U.S. ex rel. Escobar

This Supreme Court opinion is a significant and influential False Claims Act decision. It changed the way that False Claims Act allegations are pleaded and investigated. Escobar’s impact on pleading requirements is discussed in detail in the presentation.
Article: Where FCA Litigation Stands 5 Years After Escobar
This article is included because the Escobar decision changed the way the False Claims Act cases are investigated by the government and litigated by parties to FCA lawsuits. This article discusses the trends and changes in the years following the Escobar decision.

Article: Analyzing FCA Materiality Defense Outcomes under Escobar
This article discusses how Escobar impacted the “continued payment” defense to False Claims Act claims. This expands on the discussion of how False Claims Act allegations are pleaded after Escobar and includes a defense perspective.

Article: Three Ways Escobar Leveled the Playing Field in FCA Cases
This article discusses the way Escobar has impacted the resolution of False Claims Act cases. Since Escobar, more qui tam cases are dismissed due to failures to meet the pleading requirement and the discovery burden on government agencies.

This opinion is discussed in the presentation and is included as a recent example of how courts analyze the False Claims Act’s materiality pleading requirement.

Opinion: U.S. ex rel. Sheldon v. Allergan Sales, LLC
This opinion is discussed in the presentation and is included as a recent example of how courts analyze the False Claims Act’s scienter pleading requirement.

Opinion: U.S. ex rel. Cairns v. D.S. Medical LLC
This opinion is discussed in the presentation and is included as a recent example of how courts analyze the False Claims Act’s causation pleading requirement.

Sample Order Denying Defendant’s Motion to Dismiss
This Order is a court’s decision to deny a motion to dismiss a relator’s False Claims Act complaint. It is included as an example of a court’s analysis of a relator’s pleadings and helps illustrate the litigation of a False Claims Act case from a relator’s perspective.
Sample *Touhy* Request

The presentation discusses *Touhy* requests in False Claims Act cases. This serves as an example of a *Touhy* request with all required information.

Sample Protective Order

The presentation discusses that protective orders should be utilized when seeking sensitive discovery from government agencies, including the Center for Medicare & Medicaid Services. This serves as an example of a protective order.

Article: Nonparty Witness Invoking the Fifth Amendment Privilege in a Civil Case

The presentation discusses the issue of the Fifth Amendment during discovery in a False Claims Case. This is an article written by presenter Edward Kang about the invocation of the Fifth Amendment in a False Claims Case.

Opinion: *Minnesota ex rel. Knudsen v. AT&T*

This case is discussed in the presentation as an example of a case that was dismissed on public disclosure and particularity grounds.

Sample Order Granting Defendant’s Motion to Dismiss

This Order is a court’s decision to grant a motion to dismiss a relator’s False Claims Act complaint. It is included as an example of a court’s analysis of a relator’s pleadings and helps illustrate the litigation of False Claims Act cases from a defense perspective.

Sample Notice of Entry of Order Granting Defendant’s Motion to Dismiss

This is a Notice of Entry of Order granting a defendant’s motion to dismiss a relator’s complaint and helps illustrate the litigation of False Claims Act cases from a defense perspective.

Sample Final Ruling on Demurrers

This is a court’s ruling on a defendant’s demurrers to a relator’s complaint and helps illustrate the litigation of False Claims Act cases from a defense perspective.
Article: Individual Liability in Opioid Epidemic

The presentation discusses the issue of settling cases that involve opioids. This is an article written by presenters Edward Kang and Kandis Kovalsky about the challenges presented in opioid cases.
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Panelist Biographies

Edward T. Kang

Edward T. Kang is the managing member of Kang Haggerty LLC, and has spent his career protecting his clients’ rights against some of the largest companies in the United States. As a seasoned litigator, Edward is an expert at rooting out deceit and fraud and ensuring his clients obtain maximum results in every action.

Edward has a special interest in protecting whistleblowers and assisting them to obtain the relief they are entitled to for bringing illegal conduct to light. In so doing, Edward has led efforts to pursue wrongdoers engaged in the illegal distribution of fentanyl opioid medications, paying kickbacks to healthcare providers, and various other schemes to defraud Medicare/Medicaid and other government healthcare programs. From investigating allegations to collecting a reward, Edward assists his clients through every phase of the whistleblowing process, ensuring that their rights are protected while also maximizing the value of their claims.

In addition to representing whistleblowers within the healthcare industry, Edward has substantial experience pursuing federal antitrust and civil RICO actions.

Edward is a certified Panel Member of the American Arbitration Association for Commercial Litigation and rated AV Preeminent of Martindale-Hubbell.

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Kandis L. Kovalsky

Kandis’ whistleblower practice focuses on healthcare fraud. Kandis represents relators in high stakes qui tam actions filed under the federal and state False Claims Acts relating to fraud on government healthcare payors such as Medicare, Medicaid, Department of Defense TRICARE, State Children’s Health Insurance Program, Veterans Health Administration, and the Indian Health Service program.

Kandis has a particular passion for litigating false claims cases relating to the opioid crisis, including claims for illegal activity committed by drug companies, providers, and pharmacies. Kandis does not just pursue claims against companies, but against the executives and individuals responsible for the fraudulent schemes. Kandis also has a particular interest in holding healthcare-focused private equity firms responsible for the fraudulent acts of their portfolio companies.

Kandis litigates and manages complex qui tam cases in which the government declines to intervene. While many whistleblower lawyers often do not have the experience or resources to litigate complex declined cases, Kandis utilizes her extensive experience and background as a commercial litigator to successfully prosecute declined cases.

Kandis is a member of Taxpayers Against Fraud, a public interest non-profit in the United States dedicated to advancing the interests of whistleblowers and fighting fraud against the government. She is also a member of the YLD division within Taxpayers Against Fraud.


Before she attended law school, Kandis was a competitive figure skater for fifteen years. While at the University of Delaware, Kandis was an eight-time Intercollegiate National medalist.


You can reach her at kkovalsky@kanghaggerty.com.
Erika Hiramatsu
Erika Hiramatsu is a Supervising Deputy Attorney General in the State of California Department of Justice (DOJ), Division of Medi-Cal Fraud and Elder Abuse (DMFEA), where she litigates civil qui tam False Claims Act cases involving the Medicaid program. Ms. Hiramatsu has been with the California DOJ for 20 years: 13 at DMFEA and seven in the Criminal Division. Prior to working for DOJ, she was a public defender at the San Diego County Office of the Alternate Public Defender.

Ms. Hiramatsu has served two separate terms as president of Pan Asian Lawyers of San Diego, a Southern California affiliate of NAPABA. In 2009, she was named among NAPABA’s Best Lawyers Under 40. She also served on the California State Bar Judicial Nominees Evaluation Commission and as Chair of the State Bar Committee of Bar Examiners.
Steve Koh
Steve Koh is a partner in Perkins Coie’s Seattle office. He previously served on the firm’s Executive Committee and was firmwide Hiring Partner. He leads the firm’s relationships with The Boeing Company and Tyson Foods. He has served as President of the Federal Bar Association for the Western District of Washington, a Lawyer Representative to the Ninth Circuit Judicial Conference, and as President, Board of Trustees for Childhaven.

Steve graduated from the University of Washington and Yale Law School. He clerked for the Honorable Patricia M. Wald of the U.S. Court of Appeals for the District of Columbia Circuit, and then served as Trial Attorney in the Department of Justice Honors Program. At DOJ, he worked exclusively on False Claims Act matters, and has continued to work on such cases in private practice on behalf of clients including Boeing, T-Mobile, OfficeMax, Honeywell and Niles Paint.

Steve has been named "Washington Super Lawyer" by Washington Law & Politics and listed in The Best Lawyers in America for several years. He was previously honored as one of the "Best Lawyers Under 40" by the National Asian-Pacific American Bar Association.
Grace Park
Grace is an Assistant United States Attorney. She has been with the Central District of California since September 2018 and joined the Civil Fraud section in November 2019.
Kolin C. Tang
Kolin C. Tang is a partner at Miller Shah, LLP, an international plaintiffs-oriented law firm specializing in complex litigation with active antitrust, consumer fraud, employment, ERISA, qui tam/False Claims Act, and securities fraud practices.


Kolin received his undergraduate degree in Economics and History with honors from the University of California at Berkeley and earned his law degree from The George Washington University Law School in 2011, where he was a member of The George Washington International Law Review and interned at the Federal Trade Commission. Kolin resides in Orange County, California and works out of his firm’s office in Irvine, California.
National Association of Medicaid Fraud Control Units

About the National Association of Medicaid Fraud Control Units

Founded in 1978, the National Association of Medicaid Fraud Control Units (NAMFCU) represents Medicaid Fraud Control Units (MFCUs) across the country. All 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands have Medicaid Fraud Control Units. All but five are located in the state’s Office of the Attorney General.

NAMFCU has enabled MFCUs to deter some of the largest and most insidious health care provider frauds, recover program dollars, punish corrupt practitioners, and prosecute those who abuse or neglect nursing home residents. Learn more about NAMFCU's history.

Leadership

NAMFCU’s Executive Committee oversees the Association and consists of:

- Three officers
- Six regional representatives
- The director of the New York MFCU
- All past presidents of the Association

NAMFCU officers are elected annually by Unit directors (each Unit is led by one director). Regional representatives are elected annually by members of their region.
NAMFCU Mission

The mission of the National Association of Medicaid Fraud Control Units (NAMFCU) is to serve and promote the success of its member Units in meeting their statutory obligations both in combating Medicaid provider fraud and protecting our nation’s care facility residents, through training, communication, and information sharing.

NAMFCU serves to:

- Provide a forum for the mutual exchange of views and experiences on subjects of importance to the state Medicaid Fraud Control Units.
- Foster interstate cooperation on legal and law enforcement issues affecting the Units.
- Improve the quality of Medicaid fraud and resident abuse investigations and prosecutions by conducting training programs and providing technical assistance for Association members.
- Facilitate communication among the state Medicaid Fraud Control Units that are Association members.
- Provide the public with information about the Medicaid Fraud Control Units.

NAMFCU is housed at the National Association of Attorneys General in Washington, D.C.

Other Relevant Websites

- Office of Inspector General (OIG)
- Centers for Medicare & Medicaid Services (CMS)
- National Health Care Anti-Fraud Association (NHCAA)
- National Association of Medicaid Program Integrity (NAMPI)
- State Long Term Care Ombudsman
- Taxpayers Against Fraud (TAF)

Trainings

NAMFCU’s training programs bring together MFCU staff to learn about emerging legal issues and effective investigative techniques.
State False Claims Act Reviews

The Office of Inspector General (OIG), in consultation with the Attorney General, determines whether States have false claims acts that qualify for an incentive under section 1909 of the Social Security Act. Those States deemed to have qualifying laws receive a 10-percentage-point increase in their share of any amounts recovered under such laws.

To qualify for the financial incentive, a State's false claims act must:

- establish liability to the State for false or fraudulent claims, as described in the Federal False Claims Act (FCA), with respect to Medicaid spending;
- contain provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in the FCA;
- contain a requirement for filing an action under seal for 60 days with review by the State Attorney General; and
- contain a civil penalty that is not less than the amount of the civil penalty authorized under the FCA.

Since the effective date of section 1909 of the Social Security Act, the FCA has been amended by the Fraud Enforcement and Recovery Act of 2009 (FERA), the Patient Protection and Affordable Care Act (ACA), and the Dodd-Frank Wall Street Reform and Consumer Protection Act (the Dodd-Frank Act). These three acts, among other things, amended bases for liability in the FCA and expanded certain rights of qui tam relators. In addition, effective August 1, 2016, the civil penalties authorized under the FCA increased pursuant to the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. Going forward, the civil penalties authorized under the FCA will incrementally increase on an annual basis. As such, the civil penalties authorized under a State’s false claims act must also increase at the same rate and time as those authorized under the FCA in order for the State to continue to receive the financial incentive.

To request a review of a false claims act, States should submit a complete copy of the law and any other relevant information to: officeofcounsel@oig.hhs.gov

OIG also strongly encourages States with draft legislation to submit their drafts for informal review and discussion before the draft legislation is passed.
MEDICAID LINGO

AAC: Average Actual Cost. An estimate of retail pharmacy acquisition costs for drugs, based on a review of pharmacy invoices.

ADLs: Activities of Daily Living. Six basic skills needed to properly care for oneself: eating, dressing, bathing, toileting, continence, and mobility. ADLs are used to assess a person’s functional status.

Administrative Subpoena: An investigative tool for the state AG to examine material relevant to a fraud investigation, served on a person or entity with possession, custody, or control of that material. (See also, CID.)

AMP: Average Manufacturer Price. (Pronounced “amp.”) The price, as defined by federal law, that a drug manufacturer charges for direct sales to wholesalers or pharmacies, after discounts.

ASP: Average Sales Price. The price, as defined by federal law, that is calculated as: the weighted average of a drug manufacturer's sales price for all purchasers, including price adjustments.

AWP: Average Wholesale Price.

CIA: Corporate Integrity Agreement. A document by the OIG specifying obligations to which a corporate provider must comply as part of a civil settlement.

CID: Civil Investigative Demand. Defined by 31 U.S.C. § 3733. Prior to a civil or criminal proceeding, a request by the U.S. Attorney General to a person or entity for examination of material in their possession, custody, or control, relevant to a fraud investigation. In state FCA practice, akin to an administrative subpoena.

CMS: Centers for Medicare and Medicaid Services. This federal government office is responsible for the administration of the Medicare program and the federal requirements of the Medicaid program.

COB: Close of Business. Used to indicate when a response or other task is due.


DOP: Distribution of Proceeds. The manner in which settlement monies are allocated between states.

Dispensing fee: The amount a government healthcare program will reimburse to a pharmacy for the cost of professional services and overhead.

DRA “bump”: The Deficit Reduction Act of 2006 provided for states to recover fraudulent payments after 2007. It includes an extra 10% share of Medicaid fraud recovery for states with a federally-compliant False Claims Act. This extra 10% is referred to as the DRA “bump.”

EAC: Estimated Acquisition Cost. An estimate, calculated as defined by each state Medicaid agency, of the drug price generally paid by providers.

Fiscal Intermediary: A third party contracted by the Single State Agency to process claims submitted by Medicaid providers.
FMAP: Federal Medical Assistance Percentage. (Pronounced “EFF-map.”) The federal government guarantees matching funds to states for qualifying Medicaid expenditures; states are guaranteed at least $1 in federal funds for every $1 in state spending on the program. This open-ended financing structure allows federal funds to flow to states based on actual costs and needs as economic circumstances change. In FCA cases, this would be the “Federal” share of a Medicaid settlement, with the remainder being a “State-only” share (see SMAP).

FUL: Federal Upper Limit. (Pronounced “full.”) The maximum the federal healthcare programs will pay to reimburse pharmacies for certain medications dispensed to program beneficiaries. (See also, MAC.)

HCPCS: Healthcare Common Procedure Coding System. Standardized codes, representing medical procedures, supplies, products, and services, used to facilitate the processing of health insurance claims by government healthcare programs and other insurers. HCPCS is divided into three levels. Level I consists of Current Procedural Terminology (CPT) codes, which are comprised of a five-digit number. HCPT codes are based on the American Medical Association’s CPT code set. Level II codes identify non-physician services and products, such as ambulance services and prosthetic devices, and consist of a letter and a four-digit number. Level III codes, also called “local codes,” are used by state Medicaid agencies, Medicare contractors, and private insurers, for specific programs in specific jurisdictions.


MAC: Maximum Allowable Cost. (Pronounced “mack.”) Also known as MAIC. The maximum a state healthcare program will pay to reimburse pharmacies for certain medications dispensed to program beneficiaries. (See also, FUL.)

MAIC: Maximum Allowable Ingredient Cost. (See MAC.)

MDRP: Medicaid Drug Rebate Program. Authorized by Section 1927 of the Social Security Act (42 U.S.C. § 1396r-8), a participating drug manufacturer (currently about 600) enters into a national rebate agreement with the U.S. Secretary of the Department of Health and Human Services (HHS) in exchange for state Medicaid coverage of most of the manufacturer’s drugs. As explained by Medicaid.gov: “When a manufacturer markets a new covered outpatient drug, it must also submit product and pricing data concerning the drug to CMS via the Drug Data Reporting for Medicaid (DDR) system. This ensures that states are aware of the newly marketed drug. In addition, Section II(g) of the Rebate Agreement explains that manufacturers are responsible for notifying states of a new drug’s coverage. Manufacturers are required to report all covered outpatient drugs under their labeler code to the MDRP. Manufacturers may not be selective in reporting their National Drug Code’s (NDC) to the program. Manufacturers are then responsible for paying a rebate on those drugs for which payment was made under the state plan. These rebates are paid by drug manufacturers on a quarterly basis to states and are shared between the states and the Federal government to offset the overall cost of prescription drugs under the Medicaid Program.”

Medi-Cal: California’s Medicaid program.
MCO: Managed Care Organization. Organization that contracts with the Single-State Agency to provide comprehensive medical services to a defined population for (mostly) fixed capitated rates. Frequently contract with other entities to provide some or all of those services.

MFCU: Medicaid Fraud Control Unit. (Pronounced “ma-FOO-coo.”) The state entity responsible for litigating fraud on the state’s Medicaid program.

NAMFCU: National Association of Medicaid Fraud Control Units. (Pronounced “nam-FOO-coo.”) The umbrella organization of Medicaid-participating states’ MFCUs, headquartered in New York. NAMFCU coordinates the investigation, litigation, and settlement of multi-state Medicaid litigation.

NDC: National Drug Code. The 11-digit number used by government healthcare programs to identify a drug, based on manufacturer, strength, and package size.

NPI: National Provider Identifier. A HIPAA Administrative Simplification Standard used to identify health care providers.


PBM: Pharmacy Benefit Manager. A company that administers prescription drug programs for health plans by among other things, developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims. According to Wikipedia, “[a]s of 2016, PBMs managed pharmacy benefits for 266 million Americans. In 2017, the largest PBMs had higher revenue than the largest pharmaceutical manufacturers....In 2016...three major PBMs comprise 78% of the market and cover 180 million enrollees.”

RCFE: Residential Care Facility for the Elderly. A facility that provides assistance with activities of daily living (ADLs), but not nursing or other skilled medical care. Commonly referred to as an “assisted living facility.”

SIU: Special Investigation Unit. Unit of a managed care organization responsible for investigating and reporting fraud against the MCO.

Single-State Agency: A state’s governmental agency responsible for administration of that state’s Medicaid program.

SNF: Skilled Nursing Facility. (Pronounced “sniff.”) A licensed healthcare residence with 24-hour medical attention by skilled nursing staff consisting of RNs, LPNs, and CNAs. While commonly referred to as a “nursing home,” a SNF is usually for short-term rehabilitative stays. Medicare does not cover long-term or permanent nursing home care, but Medicaid covers both short-term and extended stays for seniors with limited assets and low income who have a medical need for this level of care. Coverage and eligibility requirements vary by state.

Spread: The difference between the provider’s cost and the Medicaid reimbursement rate. Used to denote the retail profit.

U&C: Usual and Customary price. A pharmacy’s retail cash price for an uninsured customer to pay for a prescription drug. Note: there is current litigation over whether pharmacy “club” prices should be considered U&C.
**UPIC:** Unified Program Integrity Contractor. A UPIC can review medical records for MFCUs and provide expert opinion testimony. Requires a Request for Assistance (RFA) to the UPIC.

**WAC:** Wholesale Acquisition Cost. (Pronounced “wack.”) As defined by federal statute, “...the manufacturer's list price for [a] drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price...” Some state Medicaid programs use WAC as a basis for drug reimbursement.
settlement agreement

This Settlement Agreement ("Agreement") is entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General ("OIG-HHS") of the Department of Health and Human Services ("HHS") (collectively, the "United States"), Cardinal Health, Inc. ("Cardinal Health"), and Omni Healthcare, Inc., John Crowley, Jeffrey Lovesy, and Michael Mullen (collectively, the "Relators") (hereafter collectively referred to as "the Parties"), through their authorized representatives.

recitals

A. Cardinal Health is a corporation based in Ohio and headquartered at 7000 Cardinal Place, Dublin, Ohio. Cardinal Health, among other things, is a wholesaler of pharmaceutical products. Through its Specialty Pharmaceutical Distribution subsidiary, Cardinal Health 108, LLC, Cardinal Health distributes specialty pharmaceuticals to, as relevant here, hospitals and physician practices.


C. On December 10, 2019, John Crowley, Jeffrey Lovesy, and Michael Mullen filed a qui tam action in the United States District Court for the District of Massachusetts captioned United States ex rel. Jeffrey Lovesy, Michael Mullen, and John Crowley v. Cardinal Health, Inc., No. 19-cv-12488, pursuant to the qui tam provisions of the False Claims Act, 31 U.S.C. § 3730(b) (the "Lovesy Civil Action") (together with the Omni Civil Action, the "Civil Actions").
D. The Relators allege, among other things, that Cardinal Health induced physician practices to purchase specialty pharmaceutical products from Cardinal Health rather than from competing pharmaceutical distributors by paying its physician practice customers remuneration in advance of the practice making any drug purchases, and not yet in connection with specific purchases, in violation of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b) (the “AKS”).

E. The United States contends that Cardinal Health caused to be submitted claims for payment to the Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395III ("Medicare"), and the Medicaid Program, 42 U.S.C. §§ 1396-1396w-5 ("Medicaid"). Physician practices seek reimbursement from Medicare Part B and from state Medicaid programs for specialty pharmaceutical drugs, like those purchased from Cardinal Health, that their physicians administer to patients.

F. The United States contends that it has certain civil claims against Cardinal Health arising from Cardinal Health’s upfront payments, often characterized as upfront discounts, upfront rebates, or transition rebates, including payments to various Physician Practices, as defined in the attached Exhibit A, during the period from February 1, 2013, through January 15, 2022. Specifically, the United States contends that Cardinal Health paid the Physician Practices in advance of the Physician Practices’ purchase of pharmaceuticals from Cardinal Health, and that these payments either were not attributable to identifiable sales of pharmaceutical products or were purported rebates that the customers had not actually earned. The United States contends that the purpose of these upfront payments was to induce the Physician Practices to purchase pharmaceuticals paid for by federal health care programs from Cardinal Health, instead of from Cardinal Health’s competitors, in violation of the AKS. The foregoing conduct is hereinafter referred to as the "Covered Conduct."
As a result of the foregoing conduct, the United States contends that Cardinal Health caused false claims to be submitted to Medicare.

G. Relators claim entitlement under 31 U.S.C. § 3730(d) to a share of the proceeds of this Settlement Agreement and to Relators' reasonable expenses, attorneys' fees and costs.

H. Cardinal Health has entered into separate settlement agreements described in Paragraph 1.b below (the "Medicaid State Settlement Agreements"), with the states (the "Medicaid Participating States") in settlement of the conduct released in those separate Medicaid State Settlement Agreements.

I. Cardinal Health acknowledges the facts underlying the Covered Conduct and agrees not to make any public statement denying or contesting those facts. Nothing in this paragraph, however, affects Cardinal Health's: (i) testimonial obligations; or (ii) right to take legal or factual positions, or make arguments, in litigation or other legal proceedings in which the United States is not a party—including positions and arguments contrary to those of the United States in this matter.

In consideration of the mutual promises and obligations of this Settlement Agreement, the Parties agree and covenant as follows:

**TERMS AND CONDITIONS**

1. Cardinal Health shall pay to the United States and the Medicaid Participating States collectively a total of Thirteen Million One Hundred Twenty-Five Thousand Dollars ($13,125,000) and interest accruing at an annual rate of 0.875% from December 22, 2020, and continuing until and including the day of payment (collectively, the “Settlement Amount”), of which $8,750,000 is restitution. No later than thirty (30) days after the Effective Date of this Agreement, Cardinal Health shall pay the Settlement Amount as follows:
a. The sum of Twelve Million Three Hundred Thirty-Seven Five Hundred Dollars ($12,337,500) plus accrued interest as set forth above (the “Federal Settlement Amount”) to the United States by electronic funds transfer pursuant to written instructions to be provided by the United States Attorney’s Office for the District of Massachusetts; and

b. The sum of Seven Hundred Eighty-Seven Thousand Five Hundred Dollars ($787,500, plus accrued interest as set forth above (the “Medicaid State Settlement Amount”) to the Medicaid Participating States pursuant to the terms of the Medicaid State Settlement Agreements that Cardinal Health has entered into with the Medicaid Participating States.

2. Conditioned upon the United States receiving the Federal Settlement Amount, and as soon as feasible after receipt, the United States shall pay $2,467,500 to Omni by electronic funds transfer, plus 20 percent of any interest paid by Cardinal Health as part of the Federal Settlement Amount pursuant to written instructions to be provided by counsel for Omni. Omni will then pay the Relators in the Lovesy Civil Action their share of the Federal Settlement Amount pursuant to written instructions to be provided by counsel for the relators in the Lovesy Civil Action (the “Lovesy Relators”).

3. Cardinal Health agrees to pay:

   a. $625,000 of Omni’s attorney’s fees and costs incurred in connection with the Omni Civil Action to Omni’s counsel by electronic funds transfer pursuant to written instructions agreed to by Cardinal Health and Omni’s counsel. Cardinal Health agrees to make the electronic funds transfer no later than January 31, 2022. No additional attorney’s fees or costs shall be paid by Cardinal Health for claims by Omni as part of the Medicaid State Settlement Agreements.
b. $306,257.03 of the Lovesy Relators’ attorney’s fees and costs incurred in connection with the Lovesy Civil Action to the Lovesy Relators’ counsel by electronic funds transfer pursuant to written instructions agreed to by Cardinal Health and the Lovesy Relators’ counsel. Cardinal Health agrees to make the electronic funds transfer no later than January 31, 2022. No additional attorney’s fees or costs shall be paid by Cardinal Health for claims by the Lovesy Relators as part of the Medicaid State Settlement Agreements.

4. Subject to the exceptions in Paragraph 7 (concerning reserved claims) below, and upon the United States’ receipt of the Federal Settlement Amount, the United States fully and finally releases Cardinal Health, its predecessors, its current and former parents, divisions, subsidiaries, successors, and assigns from any and all civil or administrative monetary claims the United States has for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-33, the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a, the Program Fraud Civil Remedies Act, 31 U.S.C. § 3801-12, or the common law theories of payment by mistake, unjust enrichment, and fraud.

5. Upon the United States’ receipt of the Settlement Amount, Relators, for themselves and for their heirs, successors, attorneys, agents, and assigns, fully and finally release Cardinal Health, its predecessors, its current and former affiliates, parents, divisions, subsidiaries, successors, assigns, directors, officers, and employees from any and all claims and potential claims, including but not limited to all claims included in the qui tam complaints filed in the Civil Actions, any other claims Relators have on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3733, any employment claims, and any common law claims, with the express exception of any potential claims concerning conduct that post-dates the Effective Date of this Agreement.
6. In consideration of the obligations of Cardinal Health in this Agreement and the Corporate Integrity Agreement (CIA), entered into between OIG-HHS and Cardinal Health 108, LLC, and upon the United States’ receipt of full payment of the Settlement Amount, plus interest due under Paragraph 1, the OIG-HHS shall release and refrain from instituting, directing, or maintaining any administrative action seeking exclusion from Medicare, Medicaid, and other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) against Cardinal Health 108, LLC under 42 U.S.C. § 1320a-7a (Civil Monetary Penalties Law) or 42 U.S.C. § 1320a-7(b)(7) (permissive exclusion for fraud, kickbacks, and other prohibited activities) for the Covered Conduct, except as reserved in this paragraph and in Paragraph 7 (concerning reserved claims), below. The OIG-HHS expressly reserves all rights to comply with any statutory obligations to exclude Cardinal Health 108, LLC or Cardinal Health from Medicare, Medicaid, and other Federal health care programs under 42 U.S.C. § 1320a-7(a) (mandatory exclusion) based upon the Covered Conduct. Nothing in this paragraph precludes the OIG-HHS from taking action against entities or persons, or for conduct and practices, for which claims have been reserved in Paragraph 7, below.

7. Notwithstanding the releases given in Paragraphs 4 and 6 of this Agreement, or any other term of this Agreement, the following claims and rights of the United States are specifically reserved and are not released with respect to Cardinal Health:

   a. Any liability arising under Title 26, U.S. Code (Internal Revenue Code);
   b. Any criminal liability;
   c. Except as explicitly stated in this Agreement, any administrative liability or enforcement right, including mandatory or permissive exclusion from federal health care programs;
   d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;
e. Any liability based upon obligations created by this Agreement;

f. Any liability of individuals;

g. Any liability for express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services;

h. Any liability for failure to deliver goods or services due; and

i. Any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct.

8. Relators and their heirs, successors, attorneys, agents, and assigns shall not object to this Agreement but agree and confirm that this Agreement is fair, adequate, and reasonable under all the circumstances, pursuant to 31 U.S.C. § 3730(c)(2)(B). Conditioned upon Omni's receipt of the payment described in Paragraph 2, Relators and their heirs, successors, attorneys, agents, and assigns fully and finally release, waive, and forever discharge the United States, its agencies, officers, agents, employees, and servants, from any claims arising from the filing of the Civil Actions against Cardinal Health or under 31 U.S.C. § 3730, and from any claims to a share of the proceeds of this Agreement and/or the Civil Actions against Cardinal Health.

9. Relators, for themselves, and for their heirs, successors, attorneys, agents, and assigns, fully and finally release Cardinal Health, its predecessors, its current and former affiliates, parents, divisions, subsidiaries, successors, assigns, directors, officers, and employees from any liability to Relators arising from the filing of the Civil Actions, including but not limited to liability for attorneys' fees, costs, and expenses of any kind and however denominated, with the express exception of the fees and costs agreed to in Paragraph 3. Omni, for itself, and for its heirs, successors, attorneys, agents, and assigns, also fully and finally releases Cardinal Health, its predecessors, its current and former affiliates, parents, divisions, subsidiaries, successors, assigns,
directors, officers, and employees from any liability relating to Cardinal Health's forgiveness of all but $25,000 of the outstanding invoice amounts Cardinal Health claims Omni owes as of the Effective Date of this Agreement.

10. Cardinal Health fully and finally releases the Relators from any claims (including for attorneys' fees, costs, and expenses of every kind and however denominated) that Cardinal Health has asserted, could have asserted, or may assert in the future against the Relators, related to the Civil Actions and the Relators' investigation and prosecution thereof. Cardinal Health also fully and finally releases Omni from any claims relating to all but $25,000 of the outstanding invoice amounts Cardinal Health claims Omni owes as of the Effective Date of this Agreement.

11. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicare contractor (e.g., Medicare Administrative Contractor, fiscal intermediary, carrier) or any state payer, related to the Covered Conduct; and Cardinal Health agrees not to resubmit to any Medicare contractor or any state payer any previously denied claims related to the Covered Conduct, agrees not to appeal any such denials of claims, and agrees to withdraw any such pending appeals.

12. Cardinal Health agrees to the following:

a. Unallowable Costs Defined: All costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395lIII and 1396-1396w-5; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of Cardinal Health, its present or former officers, directors, employees, shareholders, and agents in connection with:

   (1) the matters covered by this Agreement;
   
   (2) the United States' audit(s) and civil investigation(s) of the matters covered by this Agreement;
(3) Cardinal Health's investigation, defense, and corrective actions undertaken in response to the United States' audit(s) and civil investigation(s) in connection with the matters covered by this Agreement (including attorneys' fees);

(4) the negotiation and performance of this Agreement;

(5) the payment Cardinal Health makes to the United States pursuant to this Agreement and any payments that Cardinal Health may make to Relator, including costs and attorney's fees; and

(6) the negotiation of, and obligations undertaken pursuant to the CIA to: (i) retain an independent review organization to perform annual reviews as described in Section III of the CIA; and (ii) prepare and submit reports to the OIG-HHS,

are unallowable costs for government contracting purposes and under the Medicare Program, Medicaid Program, TRICARE Program, and Federal Employees Health Benefits Program (FEHBP) (hereinafter referred to as Unallowable Costs). However, nothing in paragraph 12.a.(6) that may apply to the obligations undertaken pursuant to the CIA affects the status of costs that are not allowable based on any other authority applicable to Cardinal Health.

b. **Future Treatment of Unallowable Costs:** Unallowable Costs shall be separately determined and accounted for by Cardinal Health, and Cardinal Health shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost statement, information statement, or payment request submitted by Cardinal Health or any of its subsidiaries or affiliates to the Medicare, Medicaid, TRICARE, or FEHBP Programs.
c. **Treatment of Unallowable Costs Previously Submitted for Payment:**

Cardinal Health further agrees that within 90 days of the Effective Date of this Agreement it shall identify to applicable Medicare and TRICARE fiscal intermediaries, carriers, and/or contractors, and Medicaid and FEHBP fiscal agents, any Unallowable Costs (as defined in this paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by Cardinal Health or any of its subsidiaries or affiliates, and shall request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the Unallowable Costs. Cardinal Health agrees that the United States, at a minimum, shall be entitled to recoup from Cardinal Health any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by Cardinal Health or any of its subsidiaries or affiliates on the effect of inclusion of Unallowable Costs (as defined in this paragraph) on Cardinal Health or any of its subsidiaries or affiliates’ cost reports, cost statements, or information reports.

d. **Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine Cardinal Health’s books and records to determine that no Unallowable Costs have been claimed in accordance with the provisions of this Paragraph.**

13. **Cardinal Health agrees to cooperate fully and truthfully with the United States’ investigation of entities not released in this Agreement and not affiliated with Cardinal Health.**
Upon reasonable notice, Cardinal Health shall encourage, and agrees not to impair, the cooperation of its directors, officers, and employees, and shall use its best efforts to make available, and encourage, the cooperation of former directors, officers, and employees for interviews and testimony, consistent with the rights and privileges of such individuals.

14. This Agreement is intended to be for the benefit of the Parties only. The Parties do not release any claims against any other person or entity, except to the extent provided for in Paragraph 15 (waiver for beneficiaries paragraph), below.

15. Cardinal Health agrees that it waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct.

16. Upon receipt of the payment described in Paragraph 1, above, the Parties shall promptly sign and file in the Civil Actions a Joint Stipulation of Dismissal of the Civil Actions against Cardinal Health pursuant to Rule 41(a)(1) dismissing with prejudice the claims as to Cardinal Health in the Civil Actions released in this Settlement Agreement; and without prejudice to the United States as to any other claims against Cardinal Health in the Civil Actions.

17. Except as otherwise provided in this Agreement, each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

18. Each Party and signatory to this Agreement represents that it freely and voluntarily enters into this Agreement without any degree of duress or compulsion.

19. This Agreement is governed by the laws of the United States. The exclusive jurisdiction and venue for any dispute relating to this Agreement is the United States District Court for the District of Massachusetts. For purposes of construing this Agreement, this Agreement shall
be deemed to have been drafted by all Parties to this Agreement and shall not, therefore, be
construed against any Party for that reason in any subsequent dispute.

20. This Agreement constitutes the complete agreement between the Parties. This
Agreement may not be amended except by written consent of the Parties.

21. The undersigned counsel represent and warrant that they are fully authorized to
execute this Agreement on behalf of the persons and entities indicated below.

22. This Agreement may be executed in counterparts, each of which constitutes an
original and all of which constitute one and the same Agreement.

23. This Agreement is binding on Cardinal Health’s successors, transferees, heirs, and
assigns.

24. This Agreement is binding on Relators’ successors, transferees, heirs, and assigns.

25. All Parties consent to the United States’ disclosure of this Agreement, and
information about this Agreement, to the public.

26. This Agreement is effective on the date of signature of the last signatory to the
Agreement (Effective Date of this Agreement). Facsimiles and electronic transmissions of
signatures shall constitute acceptable, binding signatures for purposes of this Agreement.
THE UNITED STATES OF AMERICA

DATED: ________ BY: __________

EVAN PANICH
LINDSEY ROSS
Assistant United States Attorneys
United States Attorney’s Office
District of Massachusetts

DATED: 1/21/2022 BY: __________

LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services
CARDINAL HEALTH, INC.

DATED: 01-18-22

BY: JESSICA L. MAYER
Chief Legal and Compliance Officer
Cardinal Health, Inc.

DATED: 1-18-22

BY: STEPHEN G. SOZIO
RYAN M. DISANTIS
Counsel for Cardinal Health, Inc.
OMNI HEALTHCARE, INC. - RELATOR

DATED: 4/1/02

BY: [Signature]

MARK BOBANGO
Chief Financial Officer
Omni Healthcare, Inc.

DATED: 1/18/22

BY: [Signature]

DAVID A. KOENIGSBERG
TRACY N. LEROY
Counsel for Omni Healthcare, Inc.
CROWLEY, LOVESY, MULLEN - RELATORS

DATED: 1/18/22

BY: JOHN CROWLEY

DATED: __________

BY: __________________________

JEFFREY LOVESY

DATED: __________

BY: __________________________

MICHAEL MULLEN

DATED: __________

BY: __________________________

DAVID W.S. LIEBERMAN

SUZANNE E. DURRELL

ROBERT THOMAS

Counsel for John Crowley, Jeffrey Lovesy, and Michael Mullen
CROWLEY, LOVESY, MULLEN - RELATORS

DATED: ________  BY: __________________________

JOHN CROWLEY

DATED: 1-18-22  BY: __________________________

JEFFREY LOVESY

DATED: ________  BY: __________________________

MICHAEL MULLEN

DATED: ________  BY: __________________________

DAVID W.S. LIEBERMAN
SUZANNE E. DURRELL
ROBERT THOMAS
Counsel for John Crowley, Jeffrey Lovesy, and Michael Mullen
CROWLEY, LOVESY, MULLEN - RELATORS

DATED: __________  BY: __________
   JOHN CROWLEY

DATED: __________  BY: __________
   JEFFREY LOVESY

DATED: 11/18/22  BY: __________
   MICHAEL MULLEN

DATED: __________  BY: __________
   DAVID W.S. LIEBERMAN
   SUZANNE E. DURRELL
   ROBERT THOMAS
   Counsel for John Crowley, Jeffrey Lovesy, and Michael Mullen
CROWLEY, LOVESY, MULLEN - RELATORS

DATED: _______  BY: ____________________________
JOHN CROWLEY

DATED: _______  BY: ____________________________
JEFFREY LOVESY

DATED: _______  BY: ____________________________
MICHAEL MULLEN

DATED: 1/18/2022  BY: ____________________________
DAVID W.S. LIEBERMAN
SUZANNE E. DURRELL
ROBERT THOMAS
Counsel for John Crowley, Jeffrey Lovesy, and
Michael Mullen
EXHIBIT A

“Physician Practices”, as used in the Settlement Agreement, means:

1. Birmingham Hematology & Oncology Associates, Mountain Brook, Alabama
2. California Cancer Associates for Research & Excellence, Fresno, California
3. Cancer and Blood Specialists of Nevada, Henderson, Nevada
4. Cancer Care Northwest Centers, P.S., Spokane Valley, Washington
5. Cancer Center Associates of Carolina, Aiken, South Carolina
6. Cancer Health Treatment Centers, P.C., Crown Point, Indiana
7. Clearview Cancer Institute, P.A., Huntsville, Alabama
8. Dayton Physicians, LLC, Dayton, Ohio
9. Dean Retail Services, Inc., Madison, Wisconsin
11. Franciscan Alliance, Inc., Mishawaka, Indiana
12. Green Bay Oncology Ltd., Green Bay, Wisconsin
13. Hawaii Oncology, Inc., Honolulu, Hawaii
14. Health First Medical Group, Melbourne, Florida
15. Healthcare Partners of Nevada, Las Vegas, Nevada
16. Hematology and Oncology Associates of Rhode Island, Inc., Cranston, Rhode Island
17. Hematology and Oncology Care, Davenport, Iowa
18. Hematology Oncology Clinic, Baton Rouge, Louisiana
19. Hematology Oncology Center, Inc., Elyria, Ohio
20. Illinois CancerCare, Peoria, Illinois
21. Iowa Cancer Specialists, P.C., Davenport, Iowa
22. Michigan Healthcare Professionals, O.C., Royal Oak, Michigan
23. Mid-Ohio Oncology and Hematology, Inc., Columbus, Ohio
24. New Mexico Oncology Hematology Consultants, Ltd., Albuquerque, New Mexico
25. Northwest Medical Specialties, Tacoma, Washington
26. Northwest Oncology, P.C., Munster, Indiana
27. Omni Healthcare, Inc., Melbourne, Florida
28. Park Slope Medicine, P.C., Brooklyn, New York
29. Premier Healthcare, LLC, Bloomington, Indiana
31. Pronger Smith Medical Care, LLP, Tinley Park, Illinois
32. Providence Cancer Center, Seattle, Washington
33. Rockwood Clinic, P.S., Spokane, Washington
34. South Carolina Oncology Associates, P.A., Columbia, South Carolina
35. Southeast Florida Hematology-Oncology Group, P.A., Fort Lauderdale, Florida
36. Tennessee Cancer Specialists, PLLC, Knoxville, Tennessee
37. Tennessee Oncology, Nashville, Tennessee
38. University Cancer Institute, LLC, Boynton Beach, Florida
SETTLEMENT AGREEMENT

This Settlement Agreement (“Agreement”) is entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General (“OIG-HHS”) of the Department of Health and Human Services (“HHS”) (collectively, the “United States”); BayCare Health System Inc., Morton Plant Hospital Association, Inc., Trustees of Mease Hospital, Inc., and St. Anthony’s Hospital, Inc. (collectively, “BayCare”); and Larry Bomar (“Relator”) (hereafter collectively referred to as “the Parties”), through their authorized representatives.

RECITALS

A. BayCare Health System, Inc. is a not-for-profit health system headquartered in Clearwater, Florida, with 15 hospitals in the Tampa Bay region, including the hospitals identified in this paragraph. Morton Plant Hospital Association, Inc. is a Florida not-for-profit corporation that operates Morton Plant Hospital in Clearwater, Florida. Trustees of Mease Hospital, Inc. is a Florida not-for-profit corporation that operates Mease Countryside Hospital in Safety Harbor, Florida and Mease Dunedin Hospital in Dunedin, Florida. St. Anthony’s Hospital, Inc. is a Florida not-for-profit corporation that operates a hospital known as St. Anthony’s Hospital in St. Petersburg, Florida. Morton Plant Hospital, Mease Countryside Hospital, Mease Dunedin Hospital, and St. Anthony’s Hospital are hereafter collectively referred to as “BayCare Hospitals.”

B. On December 2, 2016, the Relator filed a qui tam action in the United States District Court for the Middle District of Florida captioned United States ex rel. Bomar v. Bayfront HMA Medical Center LLC, et al., Civil Action No. 8:16-cv-03310-MSS-JSS (M.D Fla.), pursuant to the qui tam provisions of the False Claims Act, 31 U.S.C. § 3730(b) (the “Civil Action”). Relator alleges that various hospitals, including Morton Plant Hospital, Mease
Countryside Hospital, and Mease Dunedin Hospital, made impermissible cash donations to the Juvenile Welfare Board of Pinellas County ("JWB") in order to recoup the amount of those donations plus matching federal funding under the Medicaid Program, 42 U.S.C. §§ 1396-1396w-5 ("Medicaid Program").

C. The United States contends that BayCare submitted or caused to be submitted claims for payment to the Medicaid Program, 42 U.S.C. §§ 1396-1396w-5 ("Medicaid").

D. The United States contends that it has certain civil claims against BayCare for knowingly causing false claims for federal matching funds to be submitted to the United States during the period from October 1, 2013 to September 30, 2015 by making non-bona fide donations, as defined at 42 U.S.C. § 1396b(w)(2)(B), to JWB. Specifically, the United States contends that during this time, BayCare made cash donations to JWB, a portion of which JWB used to transfer to the State of Florida’s Agency for Health Care Administration for Florida’s Medicaid Program on behalf of the BayCare Hospitals. The United States contends that these amounts were “matched” by the federal government before being returned to the BayCare Hospitals as Medicaid payments, and BayCare was thus able to recoup its original donation to JWB and also receive federal matching funds, in violation of the federal prohibition on non-bona fide donations. The United States contends that BayCare’s donations were non-bona fide donations and ultimately caused the BayCare Hospitals to receive federal Medicaid funding to which they were not entitled. This conduct is referred to below as the “Covered Conduct.”

E. This Settlement Agreement is neither an admission of liability by BayCare nor a concession by the United States that its claims are not well founded. BayCare denies the allegations contained in Paragraph D.

F. Relator claims entitlement under 31 U.S.C. § 3730(d) to a share of the proceeds of this Settlement Agreement and to Relator’s reasonable expenses, attorneys’ fees and costs.
To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, and in consideration of the mutual promises and obligations of this Settlement Agreement, the Parties agree and covenant as follows:

**TERMS AND CONDITIONS**

1. BayCare shall pay to the United States $20,000,000 ("Settlement Amount"), of which $10,000,000 is restitution, and interest on the Settlement Amount at a rate of 1.625% per annum from January 14, 2022 until paid no later than 14 days after the Effective Date of this Agreement by electronic funds transfer pursuant to written instructions to be provided by the Civil Division of the United States Department of Justice.

2. Conditioned upon the United States receiving the Settlement Amount and as soon as feasible after receipt, the United States shall pay $5,000,000 to Relator by electronic funds transfer ("Relator’s Share").

3. BayCare shall pay to Relator $25,000.00 (an amount reached by mutual agreement that does not impact or relate to Relator’s potential claims for fees and expenses against non-settling defendants) for expenses, attorneys’ fees and costs ("Relator’s Expenses") pursuant to 31 U.S.C. § 3730(d)(2), no later than 21 days after the Effective Date of this Agreement, in accordance with written instructions to be provided to BayCare’s counsel by Relator’s counsel.

4. Subject to the exceptions in Paragraph 6 (concerning reserved claims) below, and upon the United States’ receipt of the Settlement Amount, plus interest due under Paragraph 1, the United States releases BayCare, together with its current and former parent corporations; direct and indirect subsidiaries; brother or sister corporations; divisions; current or former corporate owners; and the corporate successors and assigns of any of them from any civil or administrative monetary claim the United States has for the Covered Conduct under the False
Claims Act, 31 U.S.C. §§ 3729-3733; the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812 or the common law theories of payment by mistake, unjust enrichment, and fraud.

5. Upon the United States’ receipt of the Settlement Amount, plus interest due under Paragraph 1, Relator, for himself and for his heirs, successors, attorneys, agents, and assigns, releases BayCare together with their predecessors, current and former parent corporations; direct and indirect subsidiaries; brother or sister corporations; divisions; corporate affiliates; current or former corporate members; and the corporate successors and assigns of any of them, and their owners, directors, officers, agents, employees, and counsel from any action, in law or in equity, suits, debts, liens, contracts, agreements, covenants, promises, liability, obligations, claims, demands, rights of subrogation, contribution and indemnity, damages, loss, cost or expenses, direct or indirect, of any kind or nature whatsoever (including without limitation any civil monetary claim the Relator has on behalf of the United States for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-3733 and all civil monetary claims asserted in the Civil Action) known or unknown, fixed or contingent, foreign, state or federal, under common law, statute or regulation, liquidated or unliquidated, claimed or concealed, and without regard to the date of occurrence, which Relator ever had, now has, may assert, or may in the future claim to have, against BayCare by reason of any act, cause, matter, or thing whatsoever from the beginning of time to the date hereof.

6. Notwithstanding the releases given in Paragraph 4 of this Agreement, or any other term of this Agreement, the following claims and rights of the United States are specifically reserved and are not released:

a. Any liability arising under Title 26, U.S. Code (Internal Revenue Code);

b. Any criminal liability;
c. Except as explicitly stated in this Agreement, any administrative liability or enforcement right, including mandatory or permissive exclusion from Federal health care programs;
d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;
e. Any liability based upon obligations created by this Agreement;
f. Any liability of individuals;
g. Any liability for express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services;
h. Any liability for failure to deliver goods or services due;
i. Any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct.

7. Relator and his heirs, successors, attorneys, agents, and assigns shall not object to this Agreement but agree and confirm that this Agreement is fair, adequate, and reasonable under all the circumstances, pursuant to 31 U.S.C. § 3730(c)(2)(B). Conditioned upon Relator’s receipt of the Relator’s Share, Relator and his heirs, successors, attorneys, agents, and assigns fully and finally release, waive, and forever discharge the United States, its agencies, officers, agents, employees, and servants, from any claims arising from the filing of the Civil Action or under 31 U.S.C. § 3730, and from any claims to a share of the proceeds of this Agreement and/or the Civil Action.

8. Relator, for himself, and for his heirs, successors, attorneys, agents, and assigns, releases BayCare, and its officers, agents, and employees, from any liability to Relator arising
9. BayCare waives and shall not assert any defenses BayCare may have to any criminal prosecution or administrative action relating to the Covered Conduct that may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action.

10. BayCare fully and finally releases the United States, its agencies, officers, agents, employees, and servants, from any claims (including attorneys’ fees, costs, and expenses of every kind and however denominated) that BayCare has asserted, could have asserted, or may assert in the future against the United States, its agencies, officers, agents, employees, and servants, related to the Covered Conduct or the United States’ investigation or prosecution thereof.

11. BayCare fully and finally releases the Relator from any claims (including attorneys’ fees, costs, and expenses of every kind and however denominated) that BayCare has asserted, could have asserted, or may assert in the future against the Relator, related to the Covered Conduct and the Relator’s investigation and prosecution thereof.

12. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicare contractor (e.g., Medicare Administrative Contractor, fiscal intermediary, carrier) or any state payer, related to the Covered Conduct; and BayCare agrees not to resubmit to any Medicare or any state payer any previously denied claims related to the Covered Conduct, agree not to appeal any such denials of claims, and agree to withdraw any such pending appeals.
13. BayCare agrees to the following:

   a. **Unallowable Costs Defined:** All costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395lll and 1396-1396w-5; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of BayCare, their present or former officers, directors, employees, shareholders, and agents in connection with:

      (1) the matters covered by this Agreement;

      (2) the United States’ audit(s) and civil investigation(s) of the matters covered by this Agreement;

      (3) BayCare’s investigation, defense, and corrective actions undertaken in response to the United States’ audit(s) and civil investigation(s) in connection with the matters covered by this Agreement (including attorneys’ fees);

      (4) the negotiation and performance of this Agreement; and

      (5) the payment BayCare makes to the United States pursuant to this Agreement and any payments that BayCare may make to Relator, including costs and attorneys’ fees

   are unallowable costs for government contracting purposes and under the Medicare Program, Medicaid Program, TRICARE Program, and Federal Employees Health Benefits Program (“FEHBP”) (hereinafter referred to as “Unallowable Costs”).

   b. **Future Treatment of Unallowable Costs:** Unallowable Costs shall be separately determined and accounted for by BayCare, and BayCare shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost
statement, information statement, or payment request submitted by BayCare or any of their subsidiaries or affiliates to the Medicare, Medicaid, TRICARE, or FEHBP Programs.

c. Treatment of Unallowable Costs Previously Submitted for Payment:

BayCare further agrees that within 90 days of the Effective Date of this Agreement they shall identify to applicable Medicare and TRICARE fiscal intermediaries, carriers, and/or contractors, and Medicaid and FEHBP fiscal agents, any Unallowable Costs (as defined in this paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by BayCare or any of their subsidiaries or affiliates, and shall request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the Unallowable Costs. BayCare agrees that the United States, at a minimum, shall be entitled to recoup from BayCare any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by BayCare or any of their subsidiaries or affiliates on the effect of inclusion of Unallowable Costs (as defined in this paragraph) on BayCare or any of their subsidiaries or affiliates’ cost reports, cost statements, or information reports.

d. Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine BayCare’s books and records to determine that no Unallowable Costs have been claimed in accordance with the provisions of this paragraph.
14. BayCare agrees to cooperate fully and truthfully with the United States’ investigation of individuals and entities not released in this Agreement. Upon reasonable notice, BayCare shall encourage, and agree not to impair, the cooperation of their directors, officers, and employees, and shall use their best efforts to make available, and encourage, the cooperation of former directors, officers, and employees for interviews and testimony, consistent with the rights and privileges of such individuals. BayCare further agrees to furnish to the United States, upon request, complete and unredacted copies of all non-privileged documents, reports, memoranda of interviews, and records in their possession, custody, or control concerning any investigation of the Covered Conduct that they have undertaken, or that has been performed by another on their behalf.

15. This Agreement is intended to be for the benefit of the Parties to this Agreement only. The Parties do not release any claims against any other person or entity, except to the extent provided for in Paragraph 16 (waiver for beneficiaries paragraph), below.

16. BayCare agrees that it waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct.

17. Within ten days of receipt of the payments described in Paragraph 1 above, Relator Bomar and BayCare shall sign and file in the Civil Action a Joint Stipulation of Dismissal with prejudice of all claims against Morton Plant Hospital Association, Inc., Trustees of Mease Hospital, Inc., and St. Anthony’s Hospital, Inc. pursuant to Rule 41(a)(1). At the same time, pursuant to 31 U.S.C. § 3730(b)(1), the United States will file its consent to the dismissal of the Civil Action against Morton Plant Hospital Association, Inc., Trustees of Mease Hospital, Inc., and St. Anthony’s Hospital, Inc. with prejudice to the Relator, and with prejudice to the
United States as to the Covered Conduct released in this Agreement, and otherwise without prejudice to the United States.

18. Except to the extent provided for in Paragraph 3, each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

19. Each party and signatory to this Agreement represents that it freely and voluntarily enters in to this Agreement without any degree of duress or compulsion.

20. This Agreement is governed by the laws of the United States. The exclusive jurisdiction and venue for any dispute relating to this Agreement is the United States District Court for the Middle District of Florida. For purposes of construing this Agreement, this Agreement shall be deemed to have been drafted by all Parties to this Agreement and shall not, therefore, be construed against any Party for that reason in any subsequent dispute.

21. This Agreement constitutes the complete agreement between the Parties. This Agreement may not be amended except by written consent of the Parties.

22. The undersigned counsel represent and warrant that they are fully authorized to execute this Agreement on behalf of the persons and entities indicated below.

23. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Agreement.

24. This Agreement is binding on BayCare’s successors, transferees, heirs, and assigns.

25. This Agreement is binding on Relator’s successors, transferees, heirs, and assigns.

26. All Parties consent to the United States’ disclosure of this Agreement, and information about this Agreement, to the public.
27. This Agreement is effective on the date of signature of the last signatory to the Agreement ("Effective Date of this Agreement"). Facsimiles and electronic transmissions of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.
THE UNITED STATES OF AMERICA

DATED: 4/14/22 BY:
Jonathan Thrope
Trial Attorney
Commercial Litigation Branch
Civil Division
United States Department of Justice

DATED: 3/29/22 BY:
Carolyn B. Tapie
Assistant U.S. Attorney
Middle District of Florida

DATED: 3/29/22 BY:
Lisa M. Re
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services
DATED: 4/1/22  BY: Tommy Inzing
President and Chief Executive Officer
BayCare Health System, Inc.,

Authorized Representative for Morton Plant Hospital Association, Trustees of Mease Hospital, Inc. and St. Anthony's Hospital, Inc.

DATED: 4/1/22  BY: Alice S. Fisher
Katherine A. Lauer
Abid R. Qureshi
LATHAM & WATKINS LLP

Counsel for BayCare
DATED: 3/25/2022  BY: Larry Bomar

DATED:           BY: Stephen S. Stallings
                 The Law Offices of Stephen S. Stallings
                 Counsel for Larry Bomar
DATED: _________  BY: _____________________________
Larry Bomar

DATED: 3-28-22  BY: Stephen Stallings
Stephen S. Stallings
The Law Offices of Stephen S. Stallings
Counsel for Larry Bomar
## FRAUD STATISTICS - OVERVIEW

**October 1, 1986 - September 30, 2021**

Civil Division, U.S. Department of Justice

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# FRAUD STATISTICS - OVERVIEW

October 1, 1986 - September 30, 2021

Civil Division, U.S. Department of Justice

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## FRAUD STATISTICS - OVERVIEW

**October 1, 1986 - September 30, 2021**

**Civil Division, U.S. Department of Justice**

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NOTES:

0. New Matters refers to newly received referrals, investigations, and qui tam actions.
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However, beginning October 1, 2019, non qui tam settlements and judgments include settlements and judgments occurring on or after October 1, 2019 in matters separately handled by the United States Attorneys' Offices when those settlements and judgments have been reported to the Civil Division.
## Fraud Statistics - Health and Human Services

**October 1, 1986 - September 30, 2021**

Civil Division, U.S. Department of Justice

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# FRAUD STATISTICS - HEALTH AND HUMAN SERVICES**

October 1, 1986 - September 30, 2021

Civil Division, U.S. Department of Justice

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**NOTES:**

**The information reported in this table covers matters in which the Department of Health and Human Services is the primary client agency.**

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**FRAUD STATISTICS - DEPARTMENT OF DEFENSE**

October 1, 1986 - September 30, 2021

Civil Division, U.S. Department of Justice

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**FRAUD STATISTICS - DEPARTMENT OF DEFENSE**

October 1, 1986 - September 30, 2021

Civil Division, U.S. Department of Justice

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**NOTES:**

** The information reported in this table covers matters in which the Department of Defense is the primary client agency.

0. New Matters refers to newly received referrals, investigations, and qui tam actions.

1. Settlements and judgments include common law recoveries arising out of our False Claims Act investigations.

2. Relator share awards are calculated on the portion of the settlement or judgment attributable to the relators’ claims, which may be less than the total settlement or judgment. Relator share awards do not include amounts recovered in subsection (h) or other personal claims. See 31 U. S. C. 3730(h).

3. Historically, non qui tam settlements and judgments did not include matters separately handled by the United States Attorneys’ Offices, as the Civil Division did not maintain that data. However, beginning October 1, 2019, non qui tam settlements and judgments include settlements and judgments occurring on or after October 1, 2019 in matters separately handled by the United States Attorneys’ Offices when those settlements and judgments have been reported to the Civil Division.
## FRAUD STATISTICS - OTHER (NON-HHS and NON-DOD)**

October 1, 1986 - September 30, 2021

Civil Division, U.S. Department of Justice

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**FRAUD STATISTICS - OTHER (NON-HHS and NON-DOD)**

October 1, 1986 - September 30, 2021

Civil Division, U.S. Department of Justice

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NOTES:

** The information reported in this table covers matters in which the primary client agency is neither the Department of Health and Human Services nor the Department of Defense.

0. New Matters refers to newly received referrals, investigations, and qui tam actions.

1. Settlements and judgments include common law recoveries arising out of our False Claims Act investigations.

2. Relator share awards are calculated on the portion of the settlement or judgment attributable to the relators' claims, which may be less than the total settlement or judgment.

   Relator share awards do not include amounts recovered in subsection (h) or other personal claims. See 31 U. S. C. 3730(h).

3. Historically, non qui tam settlements and judgments did not include matters separately handled by the United States Attorneys' Offices, as the Civil Division did not maintain that data. However, beginning October 1, 2019, non qui tam settlements and judgments include settlements and judgments occurring on or after October 1, 2019 in matters separately handled by the United States Attorneys' Offices when those settlements and judgments have been reported to the Civil Division.
Plaintiffs-appellants brought this action under the False Claims Act, 31 U.S.C. § 3729 et seq., against defendant-appellee American Medical Response, Inc. (“AMR”), alleging (1) in a qui tam claim, that AMR made false statements and

* The Clerk of Court is directed to amend the official caption as set forth above.
submitted false claims to the government for reimbursement under the Medicare and Medicaid programs, and (2) in an individual claim, that AMR retaliated against plaintiff-appellant Paul Fabula for his refusal to falsify a document. The United States District Court for the District of Connecticut (Michael P. Shea, Judge) dismissed both claims. For the reasons that follow, the judgment of the district court is VACATED and the case is REMANDED for further proceedings consistent with this opinion.

JONATHAN M. LEVINE (David S. Golub, on the brief), Silver Golub & Teitell LLP, Stamford, CT, for Plaintiffs-Appellants.

PAMELA L. JOHNSTON, Foley & Lardner LLP, Los Angeles, CA (Lawrence M. Kraus, Foley & Lardner LLP, Boston, MA, on the brief), for Defendant-Appellee.


GERARD E. LYNCH, Circuit Judge:

Plaintiffs-appellants brought this action under the False Claims Act (“FCA”), 31 U.S.C. § 3729 et seq., against defendant-appellee American Medical Response, Inc. (“AMR”), alleging (1) in a qui tam claim, that AMR made false
statements and submitted false claims to the government for reimbursement
under the Medicare and Medicaid programs, and (2) in an individual claim, that
AMR retaliated against plaintiff-appellant Paul Fabula for his refusal to falsify a
document. The *qui tam* claim is asserted by bankruptcy trustee Ronald I.
Chorches for and on behalf of the United States of America and for the benefit of
Fabula’s bankruptcy estate. The retaliation claim is asserted by Fabula
individually.

The United States District Court for the District of Connecticut (Michael P.
Shea, *Judge*) dismissed both claims: the first on the ground that Chorches failed to
allege with the specificity required by Federal Rule of Civil Procedure 9(b) that
AMR submitted false claims to the government, and the second on the ground
that Fabula’s refusal to falsify a document to effectuate AMR’s alleged scheme to
submit false claims did not constitute protected activity under the FCA’s anti-
retaliation provision. After deciding, as preliminary matters, that the district
court had jurisdiction over Chorches’s *qui tam* claim and that Fabula did not
abandon his retaliation claim, we conclude (1) that Chorches has pled the
submission of false claims with sufficient particularity under Rule 9(b), as
applied in the *qui tam* context; and (2) that Fabula’s refusal to falsify a patient
report, under the circumstances of this case, qualifies as protected activity.

Accordingly, we VACATE the judgment of the district court, and REMAND for further proceedings consistent with this opinion.

BACKGROUND

The following facts are taken largely from the second and third amended complaints filed in this action (the “SAC” and the “TAC,” respectively). As required when reviewing a motion to dismiss a complaint for failure to state a claim, we accept these facts as true for purposes of this opinion. See O’Brien v. Nat’l Prop. Analysts Partners, 936 F.2d 674, 676-77 (2d Cir. 1991).

From August 2010 to December 2011, Fabula worked as an Emergency Medical Technician ("EMT") in the New Haven, Connecticut branch office of AMR, the largest ambulance company in the United States. In February 2011, while he was employed at AMR, Fabula filed for Chapter 7 bankruptcy; he received a discharge of his debts in May 2011; and his bankruptcy case was closed in June 2011.

As an EMT, Fabula provided emergency and non-emergency medical transport services, some of which were reimbursable under Medicare and/or Medicaid. According to the complaints, AMR engaged in a scheme to
fraudulently obtain reimbursement from Medicare by falsely certifying ambulance transports as medically necessary and submitting claims that it knew were not properly reimbursable under the rules and regulations governing payments by Medicare.¹

The execution of the alleged scheme was relatively straightforward. Medicare pays AMR only for ambulance transports that were “medically necessary,” as explained in the Medicare Benefit Policy Manual. Medical necessity is established when the patient’s condition is such that use of any other method of transportation is contraindicated (i.e., inadvisable for the patient’s health). Thus, in any case in which some means of transportation other than an ambulance can be used without endangering the individual’s health, whether or not such other transportation is actually available, Medicare does not pay for ambulance services. Even when the services are deemed medically necessary, moreover, Medicare payments are based on the level of services furnished, not simply on the vehicle used. As a result, in order to receive reimbursement from

¹ Although the TAC alleges that AMR made false statements and submitted false claims for reimbursement under both the Medicare and Medicaid programs, the complaint details the scheme primarily vis-à-vis Medicare. For convenience, we refer only to Medicare in this opinion.
Medicare, AMR was required to review and submit information about the condition of patients and the emergency or non-emergency medical services that it had provided to them.

When AMR dispatched an ambulance to transport someone (in industry parlance, a “run”), the participating paramedics and/or EMTs were required to complete an electronic Patient Care Report (“PCR”). The PCRs documented information such as the date, time, and address of the pickup; the name of the person being transported; the name of the medical facility to which the person was transported; and a description of the condition of the person being transported. They were created electronically on a laptop computer during, or immediately following, a run. The description of the transported person’s condition determines whether a run is treated as “medically necessary.”

The TAC alleges that during the period of Fabula’s employment, AMR routinely made its EMTs and paramedics revise or recreate their field-generated PCRs to include false statements purportedly demonstrating medical necessity to ensure that runs would be reimbursable by Medicare, whether or not ambulance service was in fact medically necessary in the particular case. AMR supervisors provided the EMTs and paramedics with printouts of their original PCRs
prepared at the time of the run, marked up with handwritten revisions that altered the substance of the original PCRs so as to falsely characterize runs as medically necessary. Supervisors at AMR specifically instructed EMTs and paramedics how to modify the PCRs by including false or misleading information, and admitted to Fabula that the purpose of such revisions was to qualify the run for Medicare reimbursement. The participation of the EMTs and paramedics in the revision of the PCRs was required because those employees had unique log-in passwords that allowed them to alter the PCRs and prevented AMR supervisors from revising the PCRs themselves. After the EMTs and paramedics had revised or recreated the original PCRs, AMR supervisors collected and shredded the printouts with the handwritten changes. The falsified electronic PCRs remained in AMR’s database, to be used for billing purposes.

In addition to identifying several general categories of patients who were susceptible to having their runs falsely certified as medically necessary (for example, calm and cooperative dementia patients were routinely written up as having a history of violence), the TAC identifies more than ten specific runs for which Fabula was ordered to alter PCRs to include false or misleading
information. A few examples follow.

On July 7, 2011, Fabula and paramedic William Shick transported several patients to the hospital in response to 911 calls. About two weeks later, Fabula was asked to revise four of the PCRs by adding information about the patients’ previous surgeries and injuries, implying that such history made ambulance service medically necessary, even though one patient with a chronic allergy issue had no medical need for an ambulance but wanted a ride to the hospital because she thought she could avoid a wait at the hospital if she was brought in by an ambulance, and another patient called for an ambulance only because he felt that he should not have to buy his own cough syrup. On October 17, 2011, Fabula was in the midst of transporting a patient to the hospital, when the run was canceled when it was learned that it was not the correct date for the patient’s medical appointment. Nevertheless, AMR made Fabula complete a “return trip PCR,” as if the patient had been transported both to and from the hospital. TAC ¶ 101. On December 4, 2011, Fabula and Douglass Gladstone (also an EMT) assisted in transporting an obese patient who “had no medical reason to be sent to the ________________________

2 In addition to PCRs, the TAC alleges that AMR also falsified Physician Certification Statements (“PCSs”), forms completed by physicians or registered nurses pursuant to Medicare regulations.
hospital, he simply wanted to go there.” TAC ¶ 100. The patient was able to walk himself to the stretcher and climb on unassisted. An AMR supervisor instructed Fabula to insert information about the patient’s previous surgeries to justify his transport to the hospital. That same patient called 911 six dozen times during 2011 for an ambulance to bring him to a medical facility to obtain insulin. AMR directed Fabula, under threat of being placed on unpaid leave, to state falsely in the PCRs for those runs that the patient had difficulty remaining in an upright position.

Another run in December 2011, in which Fabula assisted paramedic Kevin Bodiford, ultimately led to Fabula’s effective termination by AMR.³ For several weeks following the run, an AMR supervisor repeatedly instructed Bodiford, who had completed the original PCR (the “December 2011 PCR”), to revise his PCR so that it could be submitted to Medicare for payment. Bodiford refused to resubmit the PCR and told a supervisor that Fabula was responsible for the run. In February 2012, while Fabula was on medical leave, the supervisor contacted

³ On an earlier occasion, Fabula had been suspended for a day for not completing three PCRs in the manner specified by supervisors, and was ultimately required to complete the forms with information provided to him by AMR in order to be allowed to return to work.
Fabula and “told [him] to return to AMR under the guise of recreating a PCR from a run made in early December of 2011 that [the supervisor] said had been lost.” SAC ¶ 70. Fabula responded by email that he was uncomfortable with the request. Later that same month, when Fabula went to AMR’s offices at the supervisor’s direction, the supervisor told Fabula that “[y]ou should be able to complete the PCR with the information I’ve provided,” SAC ¶ 72, and Fabula was handed the PCR that Bodiford had created as well as a cover sheet that included handwritten additions for Fabula to include in a new PCR. The addition of the handwritten information would have qualified the run for Medicare reimbursement. The words Fabula was instructed to use were not his, however; Fabula in fact did not even know what some of the words meant. No longer willing to participate in AMR’s scheme, Fabula refused to falsify the PCR despite being told that “if he didn’t include [the handwritten information] on the PCR, he couldn’t come back to work.” SAC ¶ 75. In a March 1, 2012 letter, AMR instructed Fabula “immediately to arrange a time for reconciliation and transmission of this [electronic PCR]. Failure to do so will result in corrective action up to and including termination.” SAC ¶ 79. Because Fabula never returned to revise the PCR, his employment was effectively terminated.

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On June 22, 2012, Fabula filed this action as a relator on behalf of the United States, which declined to intervene in 2013. The SAC asserted two claims: Count One alleged that AMR violated 31 U.S.C. § 3729(a)(1)(A) and (B) by making false statements and submitting false claims to the government, and Count Two alleged that AMR fired Fabula in retaliation for his efforts to stop the submission of a false claim in violation of 31 U.S.C. § 3730(h). On March 4, 2015, the district court dismissed the retaliation claim with prejudice for failure to state a claim, holding that Fabula’s refusal to falsify a PCR did not constitute protected activity. It also dismissed the qui tam claim on standing grounds, because the qui tam claim, which pre-dated Fabula’s bankruptcy petition, had become the property of his bankruptcy estate. The district court stayed the dismissal of the qui tam claim, however, to give Chorches, the trustee of Fabula’s bankruptcy estate, the opportunity to intervene and pursue that claim. Subsequently, Chorches joined the action and filed the TAC, which pled only the qui tam claim. On November 6, 2015, the district court dismissed the TAC with prejudice for failure to state a claim, holding that Chorches did not satisfy Rule 9(b)’s heightened pleading requirement. It entered its final judgment dismissing the case on November 10, 2015. Appellants timely appealed the district court’s March
4 and November 6, 2015 rulings.

DISCUSSION

“We review de novo the grant of a [Federal Rule of Civil Procedure] 12(b)(6) motion to dismiss for failure to state a claim, accepting all factual allegations as true and drawing all reasonable inferences in favor of the plaintiff.”

Trs. of Upstate N.Y. Eng’rs. Pension Fund v. Ivy Asset Mgmt., 843 F.3d 561, 566 (2d Cir. 2016). The complaint must plead “enough facts to state a claim to relief that is plausible on its face,” Bell Atlantic Corp. v. Twombly, 550 U.S. 544, 570 (2007), and must “allow[,] the court to draw the reasonable inference that the defendant is liable for the misconduct alleged,” Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009).

Appellants contend that the district court erred in dismissing the FCA qui tam and retaliation claims, as pled in the TAC and the SAC, respectively. For the reasons that follow, we vacate the district court’s judgment and remand for further proceedings.

I. The Qui Tam Claim Was Adequately Pled.

Chorches argues that the district court erred in dismissing the TAC for failure to comply with Rule 9(b). AMR not only challenges that position but also claims that we lack jurisdiction to consider Chorches’s qui tam claim because the
district court did not have subject matter jurisdiction over that claim. AMR argues that because Chorches’s allegations derive from claims made in Fabula’s original complaint, they violate the FCA’s public disclosure bar, which AMR contends is jurisdictional.

A. The District Court Had Jurisdiction over the Trustee’s Claim.

Because “every federal appellate court has a special obligation to satisfy itself not only of its own jurisdiction, but also [of] that of the lower courts in a cause under review,” Arnold v. Lucks, 392 F.3d 512, 517 (2d Cir. 2004) (internal quotation marks omitted), we begin by addressing AMR’s threshold contention that the FCA’s so-called “public disclosure bar” deprived the district court of jurisdiction over Chorches’s qui tam claim.

The public disclosure bar provides that courts “shall dismiss an action or claim under [§ 3730] . . . if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed” in a federal action (amongst other avenues) “unless . . . the person bringing the action is an original source of the information.” 31 U.S.C. § 3730(e)(4)(A). For the first time on appeal, AMR argues that because Chorches — the trustee of Fabula’s bankruptcy estate, to which the qui tam claim belongs — raises the same qui tam claim that was
previously raised by Fabula, Chorches’s claim should be dismissed for lack of subject matter jurisdiction.

Whether the public disclosure bar is jurisdictional matters in this case because of AMR’s failure to raise this argument below. Ordinarily, we will not consider in the first instance arguments not raised in the district court. *In re Nortel Networks Corp. Secs. Litig.*, 539 F.3d 129, 132 (2d Cir. 2008). However, because parties may not, by stipulation or neglect, confer jurisdiction on the federal courts that was denied to us by Congress, we must address any question about our jurisdiction, whether or not it has been properly preserved by the party contesting jurisdiction — or indeed, whether or not any party raises the issue before us. See *Wynn v. AC Rochester*, 273 F.3d 153, 157 (2d Cir. 2001). Accordingly, we turn first to the jurisdictional question. Upon due consideration, we conclude that the FCA’s public disclosure bar is nonjurisdictional, and that AMR has forfeited the public disclosure defense by failing to raise the argument in the district court.

Not every rule that disallows claims under certain conditions affects the jurisdiction of the district courts. To the contrary, the Supreme Court has warned against “profligate use of the term ‘jurisdiction.’” *Sebelius v. Auburn Reg’l Med.*
Courts must “inquire whether Congress has clearly stated that the rule is jurisdictional; absent such a clear statement, [the Supreme Court has] cautioned, courts should treat the restriction as nonjurisdictional in character.” *Id.* (brackets and internal quotation marks omitted). “Under this test, a provision that does not speak in jurisdictional terms or refer in any way to the jurisdiction of the district courts will not be considered jurisdictional.” *U.S. ex rel. Hayes v. Allstate Ins. Co.*, 853 F.3d 80, 86 (2d Cir. 2017) (internal quotation marks omitted). Rather, such rules are construed as denying a cause of action under the specified circumstances, and are subject to the normal rules for preserving nonjurisdictional arguments for appeal.

Our recent decision in *Hayes* is instructive. There, we held that the FCA’s “first-to-file rule” is not jurisdictional; instead, it “bears on the merits of whether a plaintiff has stated a claim.” *Hayes*, 853 F.3d at 85. In so holding, we reasoned that the first-to-file bar did not speak in jurisdictional terms or refer in any way to the jurisdiction of the district courts, and stood “in sharp contrast to other provisions of the FCA that do explicitly invoke the jurisdiction of the district courts.”

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4 “When a person brings an action under [§ 3730], no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.” 31 U.S.C. § 3730(b)(5).
courts.” Id. at 86 (emphasis in original).

The same rationale applies to the public disclosure bar at issue here. As elaborated in Hayes, “[b]ecause the FCA clearly states that other limitations on qui tam actions are jurisdictional, but does not clearly state” that the public disclosure bar is jurisdictional, we must treat the public disclosure bar “as nonjurisdictional in character.” Id. (brackets and internal quotation marks omitted; emphasis in original). Indeed, the evidence that the public disclosure bar is not jurisdictional is especially strong. Not only does the public disclosure bar, like the first-to-file rule at issue in Hayes, not speak in jurisdictional terms (when other provisions of the FCA do) — the public disclosure rule itself was formerly written as a jurisdictional bar, but was amended in 2010 specifically to delete the jurisdictional language. Prior to 2010, the provision expressly denied jurisdiction, specifying that “[n]o court shall have jurisdiction over an action under [§ 3730] based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing . . . unless . . . the person bringing the action is an original source of the information.” 31 U.S.C. § 3730(e)(4)(A) (2006) (emphasis added). But Congress eliminated the reference to “jurisdiction” when it amended the statute in 2010. Thus, when this action was filed in 2012, the public disclosure rule was
no longer jurisdictional in nature. That remains true today.

Therefore, we join the majority of our sister circuits that have addressed the issue in holding that the public disclosure bar is no longer jurisdictional. See, e.g., U.S. ex rel. Advocates for Basic Legal Equality, Inc. v. U.S. Bank, N.A., 816 F.3d 428, 433 (6th Cir. 2016) (since the 2010 amendment, “[t]he public disclosure bar is no longer jurisdictional, as every other circuit to address the question has concluded.”); U.S. ex rel. Moore & Co., P.A. v. Majestic Blue Fisheries, LLC, 812 F.3d 294, 299-300 (3d Cir. 2016); U.S. ex rel. May v. Purdue Pharma L.P., 737 F.3d 908, 916-17 (4th Cir. 2013). But see United States ex rel. Sheet Metal Workers Int’l Ass’n, Local Union 20 v. Horning Investments, LLC, 828 F.3d 587, 591 (7th Cir. 2016) (“It is true that claims that previously have been disclosed may be brought only in limited circumstances, see 31 U.S.C. § 3730(e)(4), and that this rule is jurisdictional.”). Accordingly, because AMR failed to raise the public disclosure bar as an affirmative defense or in connection with its motion to dismiss below, its argument that Chorches’\textsuperscript{\textit{qui tam}} claim is barred by Fabula’s earlier complaints in this action has not been preserved for appellate review.\textsuperscript{5}

\textsuperscript{5} We retain discretion, of course, to consider arguments that are raised for the first time on appeal, where such consideration is in the interest of justice. See Gibeau v. Nellis, 18 F.3d 107, 109 (2d Cir. 1994). No such injustice is apparent here,
B. The *Qui Tam* Claim was Adequately Pled under Rule 9(b).

We turn next to the merits of Chorches’s appeal. “In reviewing a decision to dismiss a complaint on Rule 9(b) grounds, we assume the truth of [a plaintiff’s] allegations.” *O’Brien*, 936 F.2d at 676-77. The TAC alleges on information and belief that specific claims were submitted to Medicare for payment. The district court held, however, that the TAC fails to satisfy Rule 9(b) because it provides neither details, such as invoice numbers, invoice dates, and amounts billed or reimbursed, regarding actual requests for payment made to the government, nor a factual basis for its allegations that AMR submitted false claims. We


however. The public disclosure bar is intended to confine the right to bring *qui tam* actions to those who bring frauds against the public treasury to the attention of the government and the courts; no public purpose is served by allowing opportunistic outsiders to file suit based on allegations of fraud that have already been publicized in lawsuits by others. In this case, however, Chorches brings the *qui tam* claim not for his personal benefit but in his capacity as the trustee of Fabula’s bankruptcy estate, which in turn is the successor in interest to Fabula’s pre-petition claims. His claim is thus simply the continuation of claims originally brought by Fabula, who made allegations of fraud not previously disclosed by anyone else. If the suit is successful, moreover, Fabula will personally benefit, not only by having the moral satisfaction of seeing his debts repaid but also, if Chorches recovers an amount that exceeds the creditor’s claims against the bankruptcy estate, by receiving any residual amount in the estate. We express no view as to whether, under these circumstances, the public disclosure bar should be held applicable if objection had been properly raised in the district court. We are confident, however, that no injustice results from permitting the trustee to proceed in these circumstances when the defendant failed to preserve the issue.
respectfully disagree.

The FCA is an anti-fraud statute that “may be enforced not just through litigation brought by the Government itself, but also through civil *qui tam* actions that are filed by private parties, called relators, ‘in the name of the Government.’” *Kellogg Brown & Root Servs., Inc. v. U.S. ex rel. Carter*, 135 S. Ct. 1970, 1973 (2015), quoting 31 U.S.C. § 3730(b)(1). As relevant to Chorches’s *qui tam* claim, the FCA imposes liability on any person who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval” or who “knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.” 31 U.S.C. § 3729(a)(1)(A), (B).

The FCA defines a “claim” as “any request or demand . . . for money or property” that is presented, directly or indirectly, to the United States. 31 U.S.C. § 3729(b)(2)(A).

*Qui tam* complaints filed under the FCA, because they are claims of fraud, are subject to Rule 9(b). *U.S. ex rel. Ladas v. Exelis, Inc.*, 824 F.3d 16, 26 (2d Cir. 2016).

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6 The district court dismissed the claim because of Chorches’s failure to sufficiently plead the submission of a false claim. On appeal, AMR does not argue that any other element necessary for *qui tam* liability is lacking. Thus, we need not parse the other elements of either subsection.
Rule 9(b) states that “[i]n alleging fraud . . . , a party must state with particularity the circumstances constituting fraud.” Fed. R. Civ. P. 9(b). That ordinarily requires a complaint alleging fraud to “(1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent.”

“Despite the generally rigid requirement [of Rule 9(b)], allegations may be based on information and belief when facts are peculiarly within the opposing party’s knowledge.” Wexner v. First Manhattan Co., 902 F.2d 169, 172 (2d Cir. 1990). “Pleading on information and belief is a desirable and essential expedient when matters that are necessary to complete the statement of a claim are not within the knowledge of the plaintiff but he has sufficient data to justify interposing an allegation on the subject.” 5C C. Wright et al., Fed. Prac. & Proc. § 1224 (3d ed. April 2017 Update). “Where pleading is permitted on information and belief” in a complaint that alleges fraud (and is therefore subject to Rule
9(b)), we require that the complaint “adduce specific facts supporting a strong inference of fraud.” *Wexner*, 902 F.2d at 172.

AMR argues that Chorches has not satisfied Rule 9(b)’s heightened pleading requirements because he has not identified actual invoices that were submitted to the federal government. The TAC, however, adequately pleads — with specificity, albeit on information and belief — that fraudulent claims were submitted to Medicare.

1. The TAC Adequately Alleges that Billing Information was Peculiarly Within the Knowledge of AMR.

Chorches concedes that he cannot identify exact billing numbers, dates, or amounts for claims submitted to the government. However, the TAC sets forth facts establishing specific reasons why such information regarding the particular bills that were submitted for reimbursement is “peculiarly within [AMR’s] knowledge.” *Id.* According to the TAC, all ambulance personnel, including Fabula, “were prohibited from making unauthorized entrances into the administrative building of AMR in New Haven where all the billing was taking place,” and other than “certify[ing] whether ambulance runs were medically necessary,” they were not able to “participate[] in [AMR’s] billing procedures.”
TAC ¶ 115. In fact, EMTs and paramedics were restricted to the “‘garage’ and the ‘window’ where they punched in and punched out each day,” so that any “information about AMR’s submissions to Medicare . . . [was] not accessible by any paramedics or EMTs such as Fabula.” Id.  

The billing procedures established by AMR thus (advertently or inadvertently) made it virtually impossible for most employees to have access to all of the information necessary to certify on personal knowledge both that a particular invoice was submitted for payment and that the facts stated to justify the invoice were false. The EMTs and paramedics who participated in the runs and wrote up the PCRs had knowledge of the facts recited regarding the runs (including any falsifications), which would be the basis for establishing whether the runs were eligible for Medicare reimbursement, but they had no access to the billing records establishing whether the runs with allegedly falsified records were in fact billed to Medicare. Conversely, the accounting personnel who presumably dealt with the billing and reimbursement processes knew which invoices were submitted to Medicare, but had access to PCRs (that the TAC

7 The “garage” was AMR’s office in New Haven, Connecticut where trucks and ambulances were kept when not in use.
alleges were deliberately falsified) only after the falsification was complete; therefore, they presumably were in a position to believe in good faith that, according to the information certified by the EMTs and paramedics, the submitted runs qualified for reimbursement.\(^8\)

In light of those particular circumstances, which are based on specific factual allegations that are within Fabula’s knowledge and that we must assume to be true for present purposes, Fabula (and hence Chorches) was unable, without the benefit of discovery, to provide billing details for claims that AMR submitted to the government for reimbursement. As a result, through no fault or lack of diligence on their part, plaintiffs lacked the ability to identify specific documents containing false claims that AMR submitted to the government. The TAC does, however, make plausible allegations that the bills or invoices actually submitted to the government were uniquely within AMR’s knowledge and control. It therefore establishes a basis for concluding that allegations regarding the actual submission of bills may be made on information and belief. But, as noted above, even where a plaintiff has alleged facts sufficient to permit fraud to

\(^8\) The TAC appears to identify only one managerial employee who both directed the falsification of PCRs and was later promoted to a position overseeing the billing quality control unit.
be pled on information and belief, the complaint must still “adduce specific facts
supporting a strong inference of fraud.” Wexner, 902 F.2d at 172.

2. The TAC Alleges a Basis for a Strong Inference that Specific False
Claims Were Indeed Submitted to the Government.

“[F]raud under the FCA has two components: the defendant must submit
or cause the submission of a claim for payment to the government, and the claim
for payment must itself be false or fraudulent.” U.S. ex rel. Hagerty v. Cyberonics,
Inc., 844 F.3d 26, 31 (1st Cir. 2016). To begin with, there is little dispute that
insofar as AMR’s scheme of falsifying PCRs is concerned — as distinct from its
subsequent submission of any claim for payment — the TAC “state[s] with
particularity the circumstances constituting fraud.” Fed. R. Civ. P. 9(b). Indeed,
even in dismissing the TAC for failure to identify “with particularity any specific
false claims that were actually submitted to the federal government for
payment,” the district court noted that “the TAC alleges, in some detail, a scheme
of fraud, i.e. [AMR’s] falsely completing PCRs.” J.A. 309-10, n.6.

The TAC, over forty pages long, details the specifics of a scheme whereby
AMR falsified PCRs so as to certify runs as “medically necessary” and thus
render them reimbursable by the government. It names supervisory personnel at
AMR’s offices in New Haven who instructed paramedics and EMTs to revise PCRs to insert false information. It identifies not only the time period of Fabula’s employment, August 2010 to December 2011, as that during which the fraudulent scheme took place, but also provides dates, both precise and approximate, with respect to many particular runs for which Fabula was later asked to falsify a PCR. It explains both the scheme itself and the method by which AMR executed the scheme: how Medicare reimbursed AMR only for ambulance transports that qualified as medically necessary; how the EMTs and paramedics were required to complete PCRs to document their runs; and how AMR supervisors provided hard-copy markups (that were later destroyed) to the EMTs and paramedics and ordered them, under threat of suspension or termination, to revise field-generated PCRs with false or misleading information such that runs could be certified as medically necessary.

In addition to alleging that AMR falsified PCRs on a daily basis, and identifying the types of patients whose PCRs were routinely falsified, the TAC details many specific runs — providing information such as the date, patient name, and original reason for the transport — for which Fabula was told to alter a PCR with false or misleading information. These allegations are not merely
general or conclusory. Here, as an example, is one such allegation vis-à-vis a particular set of runs that Chorches claims, upon information and belief, was submitted to Medicare for reimbursement:

[Patient name redacted] (now deceased) of [address redacted] in New Haven, was a grossly overweight man and a diabetic, and he called 911 for an ambulance on a daily basis — six dozen times during 2011 — to bring him to his medical facility — for his insulin. Paul Fabula was directed, under threat of being put on unpaid leave, to change and falsely certify the electronic entry of the PCRs in order to say that [patient] had difficulty remaining in an upright position in order to qualify [patient’s] runs in the ambulance for Medicare/Medicaid reimbursement. Fabula did as he was ordered, and upon information and belief they were submitted to Medicare for payment.

TAC ¶ 108.9

9 We note that it is easy to imagine innocent explanations for at least some of the alterations identified in the TAC. It is not a crime for a medical service provider to endeavor to make sure that its personnel omit no fact about a case that would legitimately render a particular service reimbursable by the patient’s (governmental or private) insurer. Some such facts (such as those about a patient’s history) might not be known by the ambulance personnel responsible for a particular run; other facts might be inadvertently omitted in field-generated reports because their significance to the billing process was not appreciated by an EMT or a paramedic whose principal concern was the immediate health and safety of the patient. Thus, whether discovery will support or refute the TAC’s allegations cannot be known at this time. Nevertheless, the TAC directly and specifically alleges that at least some of the facts that Fabula was asked to insert were flatly false, and that other facts about the patient’s history, while perhaps
Those allegations detail specific and plausible facts from which we may easily infer, for present purposes, that AMR systematically falsified its records to support false claims that ambulance runs were medically necessary and thus reimbursable. Such an inference of falsity is central to alleging the submission of false claims. As the Fifth Circuit has explained,

> [s]tanding alone, raw bills — even with numbers, dates, and amounts — are not fraud without an underlying scheme to submit the bills for unperformed or unnecessary work. It is the scheme in which particular circumstances constituting fraud may be found that make it highly likely the fraud was consummated through the presentment of false bills.

*U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009). Accordingly, Chorches has sufficiently pled the allegation, critical to stating an FCA *qui tam* claim, that records were in fact falsified.

He must also plead, however, that the false records were actually presented to the government for reimbursement. As noted above, although Chorches puts forth particularized allegations of a scheme to falsify records, and describes specific instances of the implementation of that scheme, he does not — and, for literally true, did not provide an accurate reason for the run and were thus misleading. We must assume for present purposes that those allegations are true.
reasons set forth above, he cannot — allege on personal knowledge (of himself or of Fabula) that false claims were submitted to the government. We conclude, however, that the TAC sets forth facts supporting a strong inference that they were.

First, Chorches alleges that Fabula was explicitly “informed by [AMR supervisors who directed the scheme] that the revisions were required to qualify the run for Medicare reimbursement.” TAC ¶ 33. Moreover, the TAC identifies specific instances in which AMR supervisors expressly asked for a PCR to be falsified in order to qualify a run for Medicare reimbursement. These allegations are hardly implausible, or even surprising, in light of the scheme of falsification that Chorches asserts (based on Fabula’s personal knowledge) was effectuated by AMR. Indeed, it is difficult to conceive of a reason why AMR would go through the trouble of qualifying runs as medically necessary if not to claim reimbursement for them.

Thus, in alleging that supervisors specifically referenced Medicare as the provider to whose requirements the allegedly falsified revisions were intended to conform, the TAC supports a strong inference that false claims were submitted to the government. Moreover, in light of the significant share of runs that are
reimbursed by Medicare and Medicaid (as distinct from private insurance), it is highly likely that any systematic scheme for documenting fabricated medical necessity for ambulance services will indeed reach the governmental insurers.\footnote{The TAC alleges that between 40\% and 70\% of AMR’s business in New Haven during the period in question involved Medicare or Medicaid patients. This suggests that any systematic scheme for documenting fabricated medical necessity for ambulance services would indeed reach the governmental insurers. More fundamentally, regardless of the likelihood that any particular run would be billed to Medicare, the key issue is the likelihood that a run associated with a falsified PCR was billed to the government. The supervisors who asked Fabula to falsify PCRs specifically referenced Medicare, suggesting that the falsification of records may have been particularly necessary to secure reimbursement from federal insurance programs. We must take as true that the supervisors made these statements, and we see no basis, at the pleading stage, for failing to take the supervisors at their word that it was Medicare, rather than a private insurer, for which particular falsifications were generated.} While it can be hypothesized, as AMR indirectly suggests, that AMR falsified PCRs for runs that were “billed to payors other than Medicare, billed for a denial, or not billed at all,” Appellee’s Br. 50, any such conclusory defense of the underlying scheme is not persuasive at the pleading stage. If the allegations as to the falsification scheme are true, as we must assume at the pleading stage, it is highly implausible to suggest that the resulting records were never submitted to
the federal government for reimbursement. Accordingly, AMR fails to diffuse the strong inference that it submitted false claims to the government that arises from the admissions allegedly made to Fabula by his supervisors at AMR that Medicare was the specific target of the fabricated medical necessity claims that the alleged scheme generated.

We are therefore satisfied that the TAC makes plausible and particularized factual allegations leading to a strong inference that AMR did in fact submit false claims to the government.

3. Permitting Pleading on Information and Belief on These Facts is Consistent with the Purposes of Rule 9(b) and of the False Claims Act.

In applying Rule 9(b) to the submission of false claims under subsections 3729(b)(2)(A) and (B) of the FCA, we decline to require that every *qui tam*

11 Under analogous circumstances, our sister circuits have reasoned as we do here. See *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153, 158 (3d Cir. 2014) (“While both scenarios are possible, it is unclear what would motivate the second, as it would expose [defendant] to possible sanctions for failure to comply with required procedures, and would not provide any financial incentive.”); *Grubbs*, 565 F.3d at 192 (the particularized allegations “that specified, unprovided services were recorded amounts to more than probable, nigh likely, circumstantial evidence that the doctors’ fraudulent records caused the hospital’s billing system in due course to present fraudulent claims . . . . It would stretch the imagination to infer the inverse; that . . . they continually record unprovided services only for the scheme to deviate from the regular billing track at the last moment so that the recorded, but unprovided, services never get billed.”).
complaint allege on personal knowledge specific identified false invoices submitted to the government. As set forth above, a complaint can satisfy Rule 9(b)’s particularity requirement by making plausible allegations creating a strong inference that specific false claims were submitted to the government and that the information that would permit further identification of those claims is peculiarly within the opposing party’s knowledge.

That standard “must not be mistaken for license to base claims of fraud on speculation and conclusory allegations.” Wexner, 902 F.2d at 172. A relator must make allegations that lead to a strong inference that specific claims were indeed submitted and also plead that the particulars of those claims were peculiarly within the opposing party’s knowledge. Those requirements ensure that those who can identify examples of actual claims must do so at the pleading stage. Cf. U.S. ex rel. Clausen v. Lab. Corp. of Am., 290 F.3d 1301, 1314 n.25 (11th Cir. 2002) (rejecting argument for a “more lenient pleading standard” where relator was “not without avenues for obtaining information” and his “conclusory statements [were] insufficient to justify relaxation”).

The pleading standard we apply accords with the text of Rule 9(b), which requires “the circumstances constituting fraud” to be pleaded with particularity.
Our standard is also mindful of the purposes of both Rule 9(b) and the False Claims Act. An interpretation of Rule 9(b) that requires *qui tam* plaintiffs to plead billing details regarding the submission of specific false claims, even when knowledge of such details is peculiarly within the defendant’s purview, would discourage the filing of meritorious *qui tam* suits that can expose fraud against the government. Under that approach, by simply insulating its accounting department from personnel with operational knowledge, a corporate fraudster could ensure that few employee relators could successfully plead both the falsity of recorded information and the presentment of a claim containing those falsehoods. As in this case, the line workers who falsify paperwork or witness the fraud could not show that claims were in fact submitted, while the accountants who submit the claims would be unaware of the particulars of any falsification, and perhaps to the entire scheme itself. It is not the purpose of Rule 9(b), as applied to FCA *qui tam* actions, to render the FCA toothless as to particularly clever fraudulent schemes. *See U.S. ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 854 (7th Cir. 2009) (any requirement that the relator plead details regarding billing packages “takes a big bite out of *qui tam* litigation”). Instead, Rule 9(b) is “designed to provide a defendant with fair notice of a plaintiff’s claim, to
safeguard a defendant’s reputation from improvident charges of wrongdoing, and to protect a defendant against the institution of a strike suit.” Ladas, 824 F.3d at 25 (internal quotation marks omitted). Allowing the complaint in this case to go forward does no violence to those purposes.

First, “it is the pleading of the circumstances of the alleged fraud with a certain amount of precision that serves [Rule 9(b)’s] purpose by apprising the defendant . . . of the nature of the claim and the acts or statements or failures to disclose relied upon by the plaintiff as constituting the fraud being charged.” 5A C. Wright et al., Fed. Prac. & Proc. § 1297 (3d ed. April 2017 Update). “[T]he point of Rule 9(b) is to ensure that there is sufficient substance to the allegations to both afford the defendant the opportunity to prepare a response and to warrant further judicial process.” U.S. ex rel. Heath v. AT & T, Inc., 791 F.3d 112, 125 (D.C. Cir. 2015). As detailed above, the TAC provides ample details as to the nature of the alleged scheme, as well as to particular instances in which the scheme was, to the personal knowledge of the original relator, allegedly carried out.

While invoice numbers and the dates of their submission would undoubtedly have put AMR on notice of specific claims allegedly submitted to the government, so do details provided in the TAC (such as dates of runs, patient
names, actual reasons for the transport, and the information entered into PCRs) with respect to specific runs for which false claims were allegedly submitted. That level of notice is especially fair and adequate given that AMR — and not its ambulance personnel — is “in possession of the most relevant records, such as . . . internal billing records, with which to defend on the grounds that alleged falsely-recorded services were not recorded [or] were not billed for.” *Grubbs, 565 F.3d at 191.*

Second, while we acknowledge that AMR’s “reputation in the health field is valuable and should not be easily tarnished,” Appellee’s Br. 38, that concern does not inoculate AMR against *qui tam* liability under the FCA such that no relator — even one who, as discussed in the preceding subsections, has overcome our demanding Rule 9(b) pleading requirements — can survive Rule 12(b)(6) dismissal. The allegations of fraud made by the TAC are sufficiently strong to

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12 Moreover, “[s]ubjecting *qui tam* relators to a per se rule requiring the identification of specific false claims” based on personal knowledge is not necessary in FCA *qui tam* cases to provide the government with information necessary to decide whether to intervene in the case, since the government “rarely if ever needs a relator’s assistance to identify claims for payment that have been submitted to the United States. Rather, relators typically contribute to the government’s enforcement efforts by bringing to light other information that shows those claims to be false.” Br. for the United States as Amicus Curiae 16, *U.S. ex rel. Nathan v. Takeda Pharm. N. Am., Inc.*, 134 S. Ct. 1759 (2014).
justify further inquiry to determine whether AMR does or does not deserve an unblemished reputation for integrity, even without further particularization of the invoices or bills submitted to the government.

Third, the allegations in the TAC are also sufficiently robust to allay any fear of undermining Rule 9(b)’s purpose, cited by AMR, of preventing strike suits and the concomitant pressure to settle such suits due to the pressure of litigation costs. The TAC is not, as AMR claims, “an unjustified ticket to discovery” that is founded on “conclusory and insufficient allegations.” Appellee’s Br. 43; see also Madonna v. United States, 878 F.2d 62, 66 (2d Cir. 1989) (“One of the purposes of Rule 9(b) is to discourage the filing of complaints as a pretext for discovery of unknown wrongs.” (internal quotation marks omitted)). To the contrary, by alleging with particularity AMR’s scheme to falsify PCRs in order to qualify runs as medically necessary, and identifying particular cases in which that scheme was carried out, Fabula has “overcome the bar erected by Rule 9(b) to spurious charges or frivolous lawsuits.” Clausen, 290 F.3d at 1317 (Barkett, J., dissenting). Fabula’s plausible and particularized allegations are amenable to a targeted discovery process that could lead to a swift resolution of the lawsuit, especially if
AMR has not committed the fraud alleged.\textsuperscript{13}

Finally, it bears remembering what Rule 9(b) actually requires. The Rule provides that “\textit{[i]n alleging fraud . . . , a party must state with particularity the circumstances constituting fraud.” Fed. R. Civ. P. 9(b). The rule demands specificity, but unlike such substantive reforms as the Private Securities

\textsuperscript{13} “[I]n all matters relating to discovery, the district court has broad discretion to limit discovery in a prudential and proportionate way.” \textit{EM Ltd. v. Republic of Argentina}, 695 F.3d 201, 207 (2d Cir. 2012). Thus, on remand, the district court has the power to tailor a discovery process that suits the case at hand. \textit{See Grubbs}, 565 F.3d at 191 (“Rule 9(b) should not be made to shoulder all the burden of policing abusive discovery. Its balance draws upon the vigilant hand of the district court judge.”). Where a \textit{qui tam} relator identifies representative examples of false claims or, as here, makes allegations leading to a strong inference that specific false claims were submitted, defendants could initially be required to provide discovery only with respect to the cases identified in the complaint. If no genuine dispute of material fact is found to exist as to whether false claims were in fact submitted in that limited set of cases, the lawsuit would be at or near its end. \textit{See id}. (“Discovery can be pointed and efficient, with a summary judgment following on the heels of the complaint if billing records discredit the complaint’s particularized allegations.”). If the initial inquiry produces evidence that seems to bear out the complaint’s assertions, however, the door could be open to broader discovery without fear of subjecting an innocent defendant to burdensome and unjustified inquiries. \textit{See TAC \textsection\textsection 110, 114} (stating that false claims not specifically alleged “can be readily identified by, and from, the existence of multiple versions of electronic PCRs for any particular run that has been submitted to Medicare for payment”). We do not undertake to direct any particular approach to regulating discovery; that is left to the discretion of the district court. We note only that limitations on discovery to prevent open-ended, expensive fishing expeditions are plainly available.
Litigation Reform Act of 1995 (PSLRA), it does not elevate the standard of certainty that a pleading must attain beyond the ordinary level of plausibility.\textsuperscript{14}

Nor does it forbid pleading upon information and belief where, as here, the circumstances justify pleading on that basis. See Wexner, 902 F.2d at 172. Thus, as noted above, Rule 9(b) demands that the pleading specify (1) the fraudulent statements, (2) the speaker, (3) where and when the statements were made, and (4) why the statements were fraudulent. See Ladas, 824 F.3d at 25. The TAC amply satisfies that standard: (1) it contends that AMR falsely stated facts to make specific ambulance runs appear medically necessary when they were not, and explains the nature and significance of those falsified facts; (2) it identifies that the speaker was, broadly, AMR, and more specifically, Fabula or other identified EMTs or paramedics who were required by their supervisors to include such

\textsuperscript{14} The PSLRA requires plaintiffs to state with particularity the facts evidencing scienter: “[T]he complaint shall, with respect to each act or omission alleged to violate this chapter, state with particularity facts giving rise to a strong inference that the defendant acted with the required state of mind.” 15 U.S.C. § 78u–4(b)(2). But unlike Rule 9(b), which remains subject to the plausibility standard, under “the stricter demand [that] Congress sought to convey” in the PSLRA, “an inference of scienter must be more than merely plausible or reasonable – it must be cogent and at least as compelling as any opposing inference of nonfraudulent intent.” Tellabs, Inc. v. Makor Issues & Rights, Ltd., 551 U.S. 308, 314 (2007). Thus, our application of Rule 9(b) in the FCA qui tam context leaves unaffected our interpretation of § 78u–4(b)(2), or its application in future cases.
falsified facts; (3) it states that the statements were made in PCRs that were, on information and belief, submitted to Medicare or Medicaid for reimbursement on dates close in time to the dates of the specified runs within the limited time period during which Fabula knew of and participated in the scheme; and (4) it explains that the statements were fraudulent in that they asserted false facts warranting a false inference that the runs were medically necessary and thus eligible for Medicare reimbursement. Rule 9(b) requires nothing more.

In sum, the TAC satisfies Rule 9(b)’s particularity requirement as applied to FCA *qui tam* claims.

4. *Our Holding in this Case Accords with the Emerging Consensus in our Sister Circuits, and is Fully Consistent with our own Precedents.*

We recently acknowledged — without taking any position of our own — a seeming “circuit split regarding whether, to satisfy Rule 9(b), an FCA relator alleging a fraudulent scheme must provide the details of specific examples of actual false claims presented to the government.” *U.S. ex rel. Polansky v. Pfizer, Inc.*, 822 F.3d 613, 619 (2d Cir. 2016). On further consideration, we conclude that our holding today is consistent with the law as generally stated by a majority of our sister circuits, and that the reports of a circuit split are, like those prematurely
reporting Mark Twain’s death, “greatly exaggerated.” As the various Circuits have confronted different factual variations, differences in broad pronouncements in early cases have been refined in ways that suggest a case-by-case approach that is more consistent than might at first appear.

Our holding today is clearly consistent with the approach taken by the Third, Fifth, Seventh, Ninth, Tenth, and D.C. Circuits, which have overtly adopted a “more lenient” pleading standard. Those courts have allowed a complaint that does not allege the details of an actually submitted false claim to pass Rule 9(b) muster by “alleging particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted.” Grubbs, 565 F.3d at 190 (5th Cir. 2009); U.S. ex rel. Lemmon v. Envirocare of Utah, Inc., 614 F.3d 1163, 1172 (10th Cir. 2010) (adopting Grubbs standard); Ebeid ex rel. U.S. v. Lungwitz, 616 F.3d 993, 998-99 (9th Cir. 2010) (same); Foglia v. Renal Ventures Mgmt., LLC, 754 F.3d 153, 156-57 (3d Cir. 2014) (same); Heath, 791 F.3d at 126 (D.C. Cir. 2015) (same); cf. Lusby, 570 F.3d at 854 (7th Cir. 2009) (“We don’t think it essential for a relator to produce the invoices
(and accompanying representations) at the outset of the suit.”).^{15}

In arguable conflict, at least at first glance, are decisions from circuits that
have professed to apply a “stricter” standard for pleading the submission of false
claims. In Clausesen, the Eleventh Circuit held that Rule 9(b)’s heightened pleading
standard requires “some indicia of reliability . . . to support the allegation of an
actual false claim for payment being made to the [g]overnment.” 290 F.3d at 1311
(emphasis in original). The First, Fourth, and Sixth Circuits have relied on Clausesen
to require, broadly speaking, that a relator allege details identifying actual false
claims submitted to the government.^{16} Similarly, the Eighth Circuit has held that

^{15} AMR argues that the TAC fails to satisfy even the relaxed pleading standard of
Grubbs, Lusby, Lemmon, Ebeid, Foglia, and Heath. While each of those cases
addresses a distinct (and hence potentially distinguishable) set of allegations, we
find unpersuasive AMR’s interpretation of their respective holdings. More
importantly, we are neither bound by, nor do we adopt wholesale, either the
announced pleading standard purportedly adopted in those cases or the
particular results reached in each of them. We simply express our view that a
complaint that satisfies our pleading standard also satisfies that of the Third,
Fifth, Seventh, Ninth, Tenth, and D.C. Circuits, and that our analysis is broadly
consistent with that of those courts.

2004), abrogated on other grounds by Allison Engine Co. v. U.S. ex rel. Sanders, 553
U.S. 662 (2008) (adopting Clausesen standard to hold that “a relator must provide
details that identify particular false claims for payment that were submitted to
the government,” such as “details concerning the dates of the claims, the content
of the forms or bills submitted, their identification numbers, the amount of
a relator’s complaint does not satisfy Rule 9(b) where it “fails to identify even one example of an actual false claim submitted.” *U.S. ex rel. Dunn v. N. Am. Mem’l Health Care*, 739 F.3d 417, 420 (8th Cir. 2014). However, the decisions from those Circuits are in fact more nuanced (as are those from the Circuits adopting a more “lenient” standard) and leave open unresolved possibilities such that any “split” between them and decisions from the more lenient circuits is not, we think, a sharp one.\(^{17}\)

In any event, whether such a split can be identified in the broad language

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\text{money charged to the government”}; U.S. ex rel. Bledsoe v. Comty. Health Sys., Inc., 501 F.3d 493, 510 (6th Cir. 2007) (relying on *Clausen* and *Karvelas* to hold that “where a relator pleads a complex and far-reaching fraudulent scheme,” he must also “provide[ ] examples of specific false claims submitted to the government”); U.S. ex rel. Nathan v. Takeda Pharms. N.A., 707 F.3d 451, 456-58 (4th Cir. 2013) (adopting *Clausen* standard to hold that “when a defendant’s actions, as alleged and as reasonably inferred from the allegations, could have led, but need not necessarily have led, to the submission of false claims, a relator must allege with particularity that specific false claims actually were presented to the government for payment.” (emphasis omitted)).
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\(^{17}\) In a 2014 amicus brief submitted in response to a Supreme Court order inviting the Solicitor General to express the views of the United States on whether a relator must identify specific false claims submitted for payment, the government explained that while circuits “have reached inconsistent conclusions about the precise manner in which a *qui tam* relator may satisfy” Rule 9(b), it is not a “clearly defined” disagreement. Br. for the United States as Amicus Curiae 10, *Nathan*, 134 S. Ct. 1759.
of the cases is not particularly meaningful here. It is far from clear that Circuits
that have adopted the stricter pleading standard — but at the same time declined
to impose an ineluctable bright-line rule that every relator allege details of actual
claims submitted — would disagree with our decision in this case. Indeed, the
TAC includes some details regarding submitted claims that those Circuits have
identified as absent from insufficiently particularized complaints.

The Sixth Circuit, for example, in adopting the “stricter” pleading
standard, expressly noted that it did not “intend to foreclose the possibility of a
court relaxing this rule in circumstances where a relator demonstrates that he
cannot allege the specifics of actual false claims that in all likelihood exist, and the
reason that the relator cannot produce such allegations is not attributable to the
conduct of the relator.” U.S. ex rel. Bledsoe v. Cmty. Health Sys., Inc., 501 F.3d 493,
504 n.12 (6th Cir. 2007); see also Chesbrough v. VPA, P.C., 655 F.3d 461, 471 (6th Cir.
2011) (leaving open a similar possibility). The Sixth Circuit has recently

18 Similarly, the Fourth Circuit did not consider its holding in Nathan to conflict
with that of cases adopting the more lenient pleading standard: “In contrast to
cases such as [Grubbs], [r]elator’s claim does not involve an integrated scheme in
which presentment of a claim for payment was a necessary result.” 707 F.3d at
460, 461 (rejecting relator’s “assertion that, if a patient is insured under a
government program, [a court] reasonably may infer that any prescription the
patient received for an off-label use was filled and that a claim was presented to
suggested that “a relator may . . . survive a motion to dismiss by pleading specific facts based on her personal billing-related knowledge that support a strong inference that specific false claims were submitted for payment.” U.S. ex rel. Prather v. Brookdale Senior Living Communities, Inc., 838 F.3d 750, 773 (6th Cir. 2016). In doing so, it noted more generally that “[e]very circuit that has applied a heightened standard . . . has retreated from such a requirement in cases in which other detailed factual allegations support a strong inference that claims were submitted.” Id. at 772. Furthermore, it appeared to recognize that in a situation in which “specific allegations of the defendant’s fraudulent conduct necessarily led to the plausible inference that false claims were presented to the government,” a plaintiff might survive a motion to dismiss. Id. (internal quotation marks omitted). Such allegations, as detailed above, are present in the instant case.

the government”). It is thus a considerable exaggeration to consider the Fourth Circuit to be in direct conflict with Grubbs. Moreover, the Fourth Circuit appears to have distinguished its holding in Nathan from a case such as the present one, in which plaintiffs have alleged the kind of “integrated scheme in which presentment of a claim for payment was a necessary result” that was not alleged in that case. Id. at 461. Furthermore, in dismissing the qui tam suit in Nathan, it distinguished a case permitting a relator to plead an adequate basis for an inference that false claims were submitted by noting that the relator in that case had pleaded “specific details of false claims,” including, among these details, “the dates of the alleged violations” and “details of the purported violations.” 707 F.3d at 457 n.6. Both of those types of allegations are present in the TAC.
Therefore, we fail to see how our holding can be construed as in conflict with the Sixth Circuit’s precedents.

The standard in the Eleventh Circuit, the originator of the “strict” pleading standard deriving from *Clausen*, has itself evolved in the years following that decision into a “nuanced, case-by-case approach, [whereby] other means are available to present the required indicia of reliability that a false claim was actually submitted.” *U.S. ex rel. Mastej v. Health Mgmt. Assocs., Inc.*, 591 F. App’x 693, 704 (11th Cir. 2014). Indeed, Chorches’s allegations are analogous to those that the Eleventh Circuit, in yet another case, deemed “sufficient to explain why [a relator] believed [the defendant] submitted false or fraudulent claims for services rendered by nurse practitioners and physician assistants.” *U.S. ex rel. Walker v. R&F Properties of Lake Cty., Inc.*, 433 F.3d 1349, 1360 (11th Cir. 2005) (where the relator — unlike *Clausen*’s “corporate outsider” who made speculative assertions but quite like Fabula — was a nurse practitioner in the defendant’s employ whose conversation about billing practices with the office manager formed the basis for her belief that claims were actually submitted).19

19 In a case where plaintiff “was able to plead personal, first-hand knowledge of [the] submission of false claims” given her managerial position, the Eighth Circuit held that “a relator can satisfy Rule 9(b) without pleading representative
Finally, “although [Karvelas] cites Clausen and formulates its own strict standard, the facts before it did not require the [First Circuit] to reach the question of whether all complaints alleging [an FCA] presentment claim must include details of specific bills.” Grubbs, 565 F.3d at 187. Moreover, unlike the complaint dismissed in Karvelas, the TAC here contains many of the “details” that the First Circuit deemed relevant for purposes of “identify[ing] particular false claims for payment:” the supervisors involved in the fraudulent scheme, dates for several runs, and both the contents of PCRs for those runs and particular services for which the government was allegedly billed. Karvelas, 360 F.3d at 232; see id. at 232-35. More recently, in a “qui tam action in which the defendant

examples of false claims if the relator can otherwise plead the ‘particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted.’” U.S. ex rel. Thayer v. Planned Parenthood of the Heartland, 765 F.3d 914, 917-18 (8th Cir. 2014), quoting Grubbs, 565 F.3d at 190; cf. Ebeid, 616 F.3d at 999 (declining to relax “traditional pleading standards for fraud under Rule 9(b)” where relator was an “outsider” because “the FCA is geared primarily to encourage insiders to disclose information necessary to prevent fraud”).

20 The Eighth Circuit has stated that a relator “must provide some representative examples of [defendant’s] fraudulent conduct, specifying the time, place, and content of their acts and the identity of the actors.” Dunn, 739 F.3d at 420, quoting U.S. ex rel. Joshi v. St. Luke’s Hosp., Inc., 441 F.3d 552, 557 (8th Cir. 2006). The TAC makes those types of allegations.
induced third parties to file false claims,” the First Circuit adopted a “more flexible standard” such that “a relator could satisfy Rule 9(b) by providing factual or statistical evidence to strengthen the inference of fraud beyond possibility without necessarily providing details as to each false claim.” *U.S. ex rel. Duxbury v. Ortho Biotech Prods., L.P.*, 579 F.3d 13, 29-30 (1st Cir. 2009) (internal quotation marks omitted; emphasis in original). Although Chorches alleges that AMR, and not a third party, submitted the false claims, the third-party rationale is persuasive where, as here, the complaint is “specific” and “systematic” in alleging the submission of false claims, and the billing department was effectively a separate entity to ambulance personnel who were barred from accessing it. *Hagerty*, 844 F.3d at 32.

In short, we do not view our interpretation of Rule 9(b) to be in conflict with that of our sister Circuits. Nor do we see our holding as adopting a “lenient” pleading standard. 21 We simply apply the basic rules of Rule 9(b) to a particular

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21 The district courts in this Circuit that have confronted this issue have tended to apply the “stricter” pleading standard, reasoning, for example, that “Grubbs would likely not be accepted as the law of this Circuit. *Clausen* and *Karvelas* are more consistent with decades of Second Circuit precedent.” *U.S. ex rel. Corp. Compliance Assocs. v. N.Y. Soc’y. for the Relief of the Ruptured & Crippled, Maintaining the Hosp. for Special Surgery*, No. 07 Civ. 292, 2014 WL 3905742, at *15 (S.D.N.Y. Aug. 7, 2014). However, at least some of those courts have reached that
set of allegations.

For that reason, we reject AMR’s citation of our opinion in *Ladas* as a decision “from this Court [that] is not supportive” of Chorches’s position.

Appellee’s Br. 51. AMR’s reliance on *Ladas* — which issued a week after *Polansky* and did not grapple with the issue of presentment that *Polansky* identified but ultimately left unresolved\(^{22}\) — is misplaced. *Ladas* was an implied false certification case where the relator brought a *qui tam* claim alleging that certain devices were falsely certified as conforming to the terms of a procurement contract with the government. More specifically, he “alleged that required forms relating to quality assurance and payment were filed with the U.S. upon shipping, [falsely] certifying that listed items conform to contract.” *Ladas*, 824

\(^{22}\) Conclusion based on a misunderstanding that applying the *Grubbs* standard is tantamount to *not* applying Rule 9(b). In any event, the standard we apply in this case is distinguishable from that of *Grubbs*.

\(^{22}\) The relator in *Polansky*, alleging that his former employer “improperly marketed [a drug] as appropriate for patients whose risk factors and cholesterol levels fall outside the National Cholesterol Education Program Guidelines,” did not provide details of actual false claims presented to the government. 822 F.3d at 614. But because this Court affirmed the district court’s dismissal of the claims on the basis that “the FDA’s approval of [the drug] was not dependent upon compliance with the Guidelines,” it did not need to, and elected not to, take a position on the issue of presentment. *Id.* at 614, 619.
“This, however, was] the [complaint’s] only express reference to an allegedly false statement made to the government by defendants in connection with a claim for payment.”

As a result, the Court held that the relator’s complaint did not contain plausible allegations of fact that showed, as required for FCA purposes, that any claim for payment submitted by [defendants] was false or that any of the devices delivered to the government failed to meet [contract specifications]. [Also, the] district court found that the [complaint] does not include the specifics of any claims submitted . . . .

Thus, the Ladas complaint, unlike the TAC, failed to sufficiently plead the falsity of any submitted claims. Moreover, that decision, like Polansky, did not address whether “an FCA relator alleging a fraudulent scheme must provide the details of specific examples of actual false claims presented to the government.” Polansky, 822 F.3d at 619. Accordingly, our holding in this case is fully consistent with Ladas.

Similarly, our disposition of U.S. ex rel. Wood v. Applied Research Associates, Inc., 328 F. App’x 744 (2d Cir. 2008) (affirming the district court’s dismissal of a qui tam claim) does not affect the outcome here. The allegations in this case are easily distinguishable from those in Wood (where, as in Ladas, an inference of falsity itself was wanting). Furthermore, unlike Chorches, the relator in Wood “did] not assert any facts that are peculiarly within the knowledge” of defendants such that he could make allegations based on information and belief. Id. at 747 n.1.
In conclusion, Rule 9(b) does not require that every qui tam complaint provide details of actual bills or invoices submitted to the government, so long as the relator makes plausible allegations, as Chorches does in the TAC, that lead to a strong inference that specific claims were indeed submitted and that information about the details of the claims submitted are peculiarly within the opposing party’s knowledge. We therefore reverse the district court’s dismissal of the qui tam claim asserted in the TAC.

II. Fabula Has Adequately Stated a Retaliation Claim.

Fabula argues that the district court erred in holding that the SAC fails to state a claim for retaliation under § 3730(h) of the FCA. We agree.

A. The Retaliation Claim Was Not Abandoned.

Before addressing the substance of the claim, we must first consider AMR’s threshold argument that Fabula has “waived or abandoned his retaliation claim by failing to replead it in the TAC.” Appellee’s Br. 28. Understanding AMR’s position requires a more detailed account of the procedural history in the district court. The SAC, filed by Fabula, pled both the qui tam and the retaliation claims against AMR.
In an opinion dated March 4, 2015, the district court held that Fabula lacked standing to bring the *qui tam* claim, which had become the property of his bankruptcy estate, but stayed dismissal to allow the trustee of the bankruptcy estate to be substituted as plaintiff to bring that claim. As to the retaliation claim, which it concluded Fabula did have standing to pursue, the court held that Fabula “has failed to state a claim for retaliation under the FCA” and it dismissed the claim “with prejudice.” J.A. 209. Subsequently, the district court granted trustee Chorches’s motion to join the case as a plaintiff for purposes of asserting the *qui tam* claim on behalf of the bankruptcy estate, and, on April 3, 2015, issued a text order “allow[ing] Plaintiffs the opportunity to amend both counts of the second amended complaint.” J.A. 10 (emphasis added). However, the TAC, which was filed by Chorches — and whose caption lists Chorches as the sole “[p]laintiff,” “[b]ringing this action on behalf of” the U.S., Fabula’s estate, and

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24 At that point, although the dismissal of the retaliation claim with prejudice was a final disposition of *that claim*, the order was an interlocutory order that was not immediately appealable, since it did not dispose of the entire case, allowing for the possibility, which indeed eventuated, that the case would continue to be litigated in the district court by the bankruptcy trustee. Nor was the substitution of the bankruptcy trustee for Fabula with respect to the *qui tam* case appealable by Fabula at that point. *Ashmore v. CGI Grp., Inc.*, —F.3d—, 2017 WL 2661595, at *3 (2d Cir. June 21, 2017).
Fabula (who retains a residual interest in his estate) — pled only the *qui tam* claim. J.A. 330. Fabula did not file an amended version of his retaliation claim. AMR does not dispute that the retaliation claim, which arose several months after Fabula’s bankruptcy case had been closed, belongs to Fabula individually and not, like the *qui tam* claim, to his bankruptcy estate. Rather, AMR contends, as it did below in support of its motion to dismiss the TAC, that the district court’s April 2015 text order giving plaintiffs the opportunity to replead both counts modified its March 2015 with-prejudice dismissal of the retaliation claim, and that Fabula’s failure to replead his retaliation claim in the TAC thus renders that claim abandoned. Although the district court did not address the issue of abandonment in its November 6, 2015 decision dismissing the TAC, it held that “[b]ecause Chorches makes no attempt [in the TAC] to replead the retaliation claim, that claim is dismissed with prejudice.” J.A. 293.

This Court has previously noted that “[a] dismissal with leave to amend is ordinarily a non-appealable order, but an appeal may be pursued where the plaintiff disclaims any intention to amend or where . . . the district court sets a deadline for amending and the plaintiff does not amend within the deadline.” *Salmon v. Blesser*, 802 F.3d 249, 252 n.2 (2d Cir. 2015) (citation omitted). Therefore,
even assuming that the district court’s April 2015 text order retroactively made its earlier dismissal of the retaliation claim a non-final order that is not ordinarily appealable, by neither joining Chorches in the TAC nor repleading the retaliation claim in a separate amended complaint of his own, Fabula rendered that “non-final order ‘final’ and appealable,” *Slayton v. Am. Exp. Co.*, 460 F.3d 215, 224 (2d Cir. 2006), subject to appeal after a final judgment was entered in the case.25 Accordingly, the filing by Chorches of the TAC, which pleads the *qui tam* claim and undoubtedly superseded the SAC with respect to that claim, did not constitute an abandonment by Fabula of his entirely separate claim of retaliation against AMR. If Fabula believed that his retaliation claim was adequately pled in the SAC, he was fully entitled to stand on the allegations of the SAC, and to appeal the dismissal of that claim (when a final judgment was entered in the

25 AMR’s view, expressed at oral argument, that the TAC was brought by Fabula in addition to Chorches, is borne out neither by the TAC (as noted above in our account of the procedural history) nor by the record more broadly. See J.A. 293 (“On April 24, 2015, Chorches filed the TAC . . . .” (emphasis added)). However, even if AMR were correct, this Court has in the past not “require[d] repleading of a claim or defense that explicitly has been denied.” *In re Crysens/Montenay Energy Co.*, 226 F.3d 160, 162 (2d Cir. 2000) (holding that failure to include an arbitration defense in the amended answers after being denied an initial motion to stay was not a waiver of the defense); *Brown v. Daikin Am. Inc.*, 756 F.3d 219, 223 n.1 (2d Cir. 2014).
case), rather than to attempt to replead his retaliation claim to the district court.

B. Fabula Adequately Pled That He Engaged in Protected Activity.

The FCA’s anti-retaliation provision provides in relevant part that

\[
\text{any employee . . . shall be entitled to all relief necessary to make that employee . . . whole, if that employee . . . is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee . . . in furtherance of an action under this section or other efforts to stop 1 or more violations of [the FCA].}
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31 U.S.C. § 3730(h)(1). The particularity requirement of Rule 9(b) does not apply to retaliation claims under the FCA. See Weslowski v. Zugibe, 626 F. App’x 20, 20 (2d Cir. 2015) (in reviewing the Rule 12(b)(6) dismissal of a § 3730(h) claim, stating, without mentioning Rule 9(b), that the complaint is to be construed “liberally” in accordance with Twombly and Iqbal); accord, Smith v. Clark/Smoot/Russell, 796 F.3d 424, 433 (4th Cir. 2015) (stating that FCA retaliation claims “need pass only [Federal Rule of Civil Procedure] 8(a)’s relatively low notice-pleadings muster – in contrast to Rule 9(b)’s specificity requirements”); Mendiondo v. Centinela Hosp. Med. Ctr., 521 F.3d 1097, 1103 (9th Cir. 2008); U.S. ex rel. Williams v. Martin-Baker Aircraft Co., 389 F.3d 1251, 1259 (D.C. Cir. 2004).
Although “[t]his Court has yet to articulate a test for deciding when a plaintiff has set forth a claim for retaliation under section 3730(h),” Weslowski, 626 F. App’x at 22, district courts in this Circuit, as well as our sister circuits, have generally required a plaintiff to show that (1) he engaged in activity protected under the statute, (2) the employer was aware of such activity, and (3) the employer took adverse action against him because he engaged in the protected activity. In its March 2015 decision dismissing Fabula’s retaliation claim, the district court considered only the first of the three elements outlined above and held that Fabula’s “mere refusal to complete the PCR, without other affirmative acts to stop the alleged fraud, is not protected activity.” J.A. 207. We respectfully disagree.

As relevant to Fabula’s claim, § 3730(h) protects “lawful acts done by the employee . . . in furtherance of . . . efforts to stop 1 or more violations of [the FCA].” 31 U.S.C. § 3730(h)(1); see also Townsend v. Bayer Corp., 774 F.3d 446, 459 (8th Cir. 2014). AMR does not contest that Fabula’s refusal to falsify the PCR was

a lawful act.\textsuperscript{27} It argues, rather, that Fabula’s refusal does not, without more, qualify as an effort to stop a fraudulent scheme. Based on the plain language of the FCA’s anti-retaliation provision, we hold that Fabula’s refusal to engage in the fraudulent scheme, which under the facts as pled was intended and reasonably could be expected to prevent the submission of a false claim to the government, can constitute protected activity under the statute.

As alleged, Fabula’s “refus[al] to falsify the PCR as demanded by” his AMR supervisor, SAC ¶ 135, was plainly in furtherance of an effort to stop an FCA violation. To the extent AMR contends that Fabula’s refusal does not rise to the level of an affirmative act, and so cannot constitute an “effort,” that argument is refuted by the plain language of the statute. Consistent with the word’s everyday use, Webster’s relevantly defines “effort” as a “conscious exertion of physical or mental power.” Webster’s Third New International Dictionary, Unabridged (2002) (“Webster’s”). Fabula did not simply omit, fail, or neglect to fill out the December 2011 PCR after being instructed to do so — he verbally refused to alter the document as requested by AMR and, despite AMR’s threat of

\textsuperscript{27} The district court “assume[d] without deciding that Mr. Fabula’s allegation that he defied his boss’s command to fill out the form constitutes a ‘lawful act.’” J.A. 205. AMR does not contend otherwise.
termination, failed to subsequently “arrange a time for reconciliation and transmission of” that PCR. SAC ¶ 79.28

Nor is this a case of an employee simply declining to play a role in a corrupt scheme engaged in by his fellows. It may well be a reasonable interpretation of § 3730(h)(1) to hold that a doctor whose colleagues in a hospital or medical practice submit inflated Medicare claims for their own services does not engage in protected activity when she merely declines to submit inflated bills herself, while making no effort either to prevent others from doing so or to report their corruption. But that hypothetical — on which we express no final view — is not this case. While refusing to falsify a single PCR could not have put the brakes on AMR’s fraudulent scheme as a whole, on the facts as pled, Fabula had reason to believe that his refusal to alter the December 2011 PCR — which paramedic

28 For that reason, we respectfully disagree with the analysis of the District Court for the District of Columbia in U.S. ex rel. Tran v. Computer Sciences Corp., 53 F. Supp. 3d 104, 136 (D.D.C. 2014), which the district court adopted in dismissing Fabula’s claim. Tran held that the relator could not show that his alleged refusal to participate in a fraudulent pass-through scheme constituted “protected activity” sufficient to trigger the protections of § 3730(h) because with “rare exception, the mere refusal to participate in an allegedly unlawful scheme is neither an ‘act[] done’ nor an ‘effort[]’ taken, and such forbearance certainly does not equate with the kind of affirmative activity that the text of the statute conveys.” 53 F. Supp. 3d at 136 (alterations in original).
Bodiford had refused to alter, leaving only Fabula (who was called in during sick leave for the precise purpose of altering the document) with the credentials to falsify it\textsuperscript{29} — would make it difficult, or even impossible, for AMR to file a false claim for that particular run, thus preventing or hindering at least one violation of the FCA. See Webster’s (in relevant part, defining “stop” as “to hinder or prevent the passage of,” “to get in the way of,” “to interrupt or prevent the continuance or occurrence of,” and “to arrest the progress or motion of”).\textsuperscript{30} Thus, Fabula’s refusal to falsify the December 2011 PCR so as to hinder the filing of a fraudulent claim in violation of the FCA constitutes protected activity under § 3730(h).\textsuperscript{31}

Our conclusion, which is rooted in the plain text of the statute, is bolstered

\textsuperscript{29} The SAC clearly implies that only the personnel (the paramedic and/or EMT) involved in the actual run were empowered to fill out, and later change, the PCR for any given run. See SAC ¶ 55, 57, 86. In fact, with respect to the December 2011 PCR, Fabula alleges that “the PCR form [that the supervisor] wanted Fabula to submit had to have Fabula’s unique login and his electronic signature.” SAC ¶ 73 (emphasis added).

\textsuperscript{30} Indeed, the TAC expressly alleges that as a result of Fabula’s refusal to falsify the December 2011 PCR, AMR was, in fact, thwarted in submitting a claim to Medicare for that run.

\textsuperscript{31} Since we conclude that Fabula has adequately pled that his refusal was a “lawful act[.] . . . in furtherance of . . . [an] effort[ ] to stop” an FCA violation, we need not, and do not, address whether his refusal also qualifies as protected activity on account of its being a “lawful act[.] . . . in furtherance of an action under this section.” 31 U.S.C. § 3730(h)(1).
by the anti-retaliation provision’s drafting history as well as relevant policy considerations. Prior to 2009, § 3730(h) provided a non-exclusive list of specific “lawful acts” done in furtherance of an FCA action that protected an employee, and it did not include the “other efforts to stop . . . violations” language that is now part of the statute. That version read:

Any employee who is discharged, [etc.] . . . by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

31 U.S.C. § 3730(h) (2006). Thus, the 2009 amendment had the effect of broadening the universe of protected conduct under § 3730(h), at least with respect to “efforts to stop” FCA violations. At least one of the authors of the amendment, Congressman Howard L. Berman, contended that § 3730(h) was amended “so that it is clear that it covers . . . retaliation against not only those

32 A blackline comparison of the two versions helps elucidate this point: An employee who is discharged, suspended, or threatened because of “lawful acts done” by the employee “in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, or other efforts to stop 1 or more violations of this subchapter” is entitled to anti-retaliatory relief.
who actually file a qui tam action, but also against those who plan to file a qui tam that never gets filed, who blow the whistle internally or externally without the filing of a qui tam action, or who refuse to participate in the wrongdoing.” 155 Cong. Rec. E1295-03, 2009 WL 1544226, at *E1300 (emphasis added).33

Furthermore, interpreting the anti-retaliation provision to draw an arbitrary boundary between efforts that take the form of “internal reporting to a supervisor or company compliance department” and those that amount to “refusals to participate in the misconduct that leads to the false claims,” id., would make little policy sense. There is, at best, a hair’s-breadth distinction between complaining internally that a practice is illegal under the FCA and advising a supervisor of one’s refusal to engage in that illegal practice. The facts alleged in this case exemplify that point. Fabula, who admits to having falsified numerous PCRs during his employment with AMR, had been told by his supervisors that PCRs were altered in order to render otherwise non-

33 Were the statute ambiguous, that statement would be of limited weight, since it is a part of extended remarks that Congressman Berman submitted on June 3, 2009, almost two weeks after the amendment became law as part of the Fraud Enforcement and Recovery Act of 2009 (FERA). In any event, since we need not rely on the legislative history to resolve any ambiguity in the statute, we note the remark only as an indication of what one sponsor intended.
reimbursable runs reimbursable by the government. Under such circumstances, Fabula’s email and oral refusals to falsify the December 2011 PCR, and his statement to a supervisor who, according to the complaints, was involved in AMR’s fraudulent scheme that he did not “feel comfortable” making the alterations, SAC ¶ 135, are functionally equivalent to raising the issue internally. Any line-drawing between the two, so as to qualify one but not the other as protected activity under § 3730(h), would raise concerns about arbitrariness and encourage the adoption of opaque or burdensome reporting mechanisms that would help FCA violators avoid liability. We therefore decline to interpret the FCA’s anti-retaliation provision to exclude Fabula’s conduct.

The district court, whose analysis AMR repeats on appeal, concluded that because Fabula’s action did not take the form of “complaints to his employer’s management or in-house counsel, reports to the media, or a reasoned explanation to his supervisors that what they were asking him to do violated the law and should cease,” it did not constitute “an ‘effort’ to ‘stop’ . . . ‘[one] or more violations’ of the FCA.” J.A. 206 (alterations in original).34 But that conclusion

34 Following that same logic, the district court also concluded that “because there is no allegation that Mr. Fabula told his employer that what it was doing was illegal, there is no reason to think his ‘lawful act’ was designed to prompt an
both ignores the plain language of the FCA’s anti-retaliation provision — which does not require any of those particular steps but broadly protects efforts to stop even a single violation of the FCA — and undermines, as a practical matter, its capacity to protect persons who assist in the discovery and prosecution of FCA violations.35

While further factual development may well fail to validate Fabula’s claim of retaliation, we must construe the allegations of the complaint in his favor at the pleading stage. We conclude that, on the facts alleged, Fabula has adequately examination of — let alone a change to — AMR’s practices.” J.A. 207. But § 3730(h) does not protect only efforts to prompt an investigation or to change a company’s general practices; it protects an effort to prevent even one violation of the False Claims Act.

35 Contrary to AMR’s position, Thomas v. ITT Educ. Servs., Inc., 517 F. App’x 259 (5th Cir. 2013), which held that a plaintiff who alleged that she was asked to falsify grades did not establish that she engaged in protected activity, does not support the district court’s textual analysis of the anti-retaliation provision. Thomas is readily distinguishable on its facts. Unlike Fabula’s detailed allegations regarding AMR’s scheme to defraud the government, the plaintiff in Thomas failed to establish — post discovery, for purposes of summary judgment — that she had engaged in protected activity because, among other reasons, she “had no knowledge which of her students were receiving federal funds to attend ITT, . . . what effect a failing grade would have on a student’s federal loans, or how many failing grades a student had to receive to lose federal loans,” “was only aware of four grades that were changed, and those grades were changed after ITT terminated her,” and “did not submit evidence that ITT forced her to change grades.” 517 F. App’x at 263.
pled that his refusal to alter the December 2011 PCR satisfies the “protected activity” element of § 3730(h). We therefore vacate the district court’s dismissal of the retaliation claim asserted in the SAC.\textsuperscript{36}

CONCLUSION

For the foregoing reasons, the judgment of the district court is VACATED, and the case is REMANDED for further proceedings consistent with this opinion.

\textsuperscript{36} Although we acknowledge that Fabula has averred facts indicating that AMR was aware of his refusal to falsify the December 2011 PCR and that it threatened to terminate his employment based on that refusal, we leave it to the district court to consider in the first instance, if necessary, whether the SAC satisfies the second and third elements of a § 3730(h) claim.
Yarushka Rivera, a teenage beneficiary of Massachusetts’ Medicaid program, received counseling services for several years at Arbour Counseling Services, a satellite mental health facility owned and operated by a subsidiary of petitioner Universal Health Services, Inc. She had an adverse reaction to a medication that a purported doctor at Arbour prescribed after diagnosing her with bipolar disorder. Her condition worsened, and she eventually died of a seizure. Respondents, her mother and stepfather, later discovered that few Arbour employees were actually licensed to provide mental health counseling or authorized to prescribe medications or offer counseling services without supervision.

Respondents filed a *qui tam* suit, alleging that Universal Health had violated the False Claims Act (FCA). That Act imposes significant penalties on anyone who “knowingly presents . . . a false or fraudulent claim for payment or approval” to the Federal Government, 31 U. S. C. §3729(a)(1)(A). Respondents sought to hold Universal Health liable under what is commonly referred to as an “implied false certification theory of liability,” which treats a payment request as a claimant’s implied certification of compliance with relevant statutes, regulations, or contract requirements that are material conditions of payment and treats a failure to disclose a violation as a misrepresentation that renders the claim “false or fraudulent.” Specifically, respondents alleged, Universal Health (acting through Arbour) defrauded the Medicaid program by submitting reimbursement claims that made representations about the specific services provided by specific types of professionals, but that failed to disclose serious violations of Massachusetts Medicaid regulations pertaining
to staff qualifications and licensing requirements for these services. Universal Health thus allegedly defrauded the program because Universal Health knowingly misrepresented its compliance with mental health facility requirements that are so central to the provision of mental health counseling that the Medicaid program would have refused to pay these claims had it known of these violations.

The District Court granted Universal Health’s motion to dismiss. It held that respondents had failed to state a claim under the “implied false certification” theory of liability because none of the regulations violated by Arbour was a condition of payment. The First Circuit reversed in relevant part, holding that every submission of a claim implicitly represents compliance with relevant regulations, and that any undisclosed violation of a precondition of payment (whether or not expressly identified as such) renders a claim “false or fraudulent.” The First Circuit further held that the regulations themselves provided conclusive evidence that compliance was a material condition of payment because the regulations expressly required facilities to adequately supervise staff as a condition of payment.

Held:

1. The implied false certification theory can be a basis for FCA liability when a defendant submitting a claim makes specific representations about the goods or services provided, but fails to disclose non-compliance with material statutory, regulatory, or contractual requirements that make those representations misleading with respect to those goods or services. Pp. 8–11.

(a) The FCA does not define a “false” or “fraudulent” claim, so the Court turns to the principle that “absent other indication, ‘Congress intends to incorporate the well-settled meaning of the common-law terms it uses,’” Sekhar v. United States, 570 U. S. ___—___. Under the common-law definition of “fraud,” the parties agree, certain misrepresentations by omission can give rise to FCA liability. Respondents and the Government contend that every claim for payment implicitly represents that the claimant is legally entitled to payment, and that failing to disclose violations of material legal requirements renders the claim misleading. Universal Health, on the other hand, argues that submitting a claim involves no representations and that the nondisclosure of legal violations is not actionable absent a special duty of reasonable care to disclose such matters. Today’s decision holds that the claims at issue may be actionable because they do more than merely demand payment; they fall squarely within the rule that representations that state the truth only so far as it goes, while omitting critical qualifying information, can be actionable misrepresentations. Pp. 8–10.

(b) By submitting claims for payment using payment codes corre-
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Responding to specific counseling services, Universal Health represented that it had provided specific types of treatment. And Arbour staff allegedly made further representations by using National Provider Identification numbers corresponding to specific job titles. By conveying this information without disclosing Arbour’s many violations of basic staff and licensing requirements for mental health facilities, Universal Health’s claims constituted misrepresentations. Pp. 10–11.

2. Contrary to Universal Health’s contentions, FCA liability for failing to disclose violations of legal requirements does not turn upon whether those requirements were expressly designated as conditions of payment. Pp. 11–17.

(a) Section 3729(a)(1)(A), which imposes liability on those presenting “false or fraudulent claim[s],” does not limit claims to misrepresentations about express conditions of payment. Nothing in the text supports such a restriction. And under the Act’s materiality requirement, statutory, regulatory, and contractual requirements are not automatically material, even if they are labeled conditions of payment. Nor is the restriction supported by the Act’s scienter requirement. A defendant can have “actual knowledge” that a condition is material even if the Government does not expressly call it a condition of payment. What matters is not the label that the Government attaches to a requirement, but whether the defendant knowingly violated a requirement that the defendant knows is material to the Government’s payment decision. Universal Health’s policy arguments are unavailing, and are amply addressed through strict enforcement of the FCA’s stringent materiality and scienter provisions. Pp. 12–14.

(b) A misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government’s payment decision in order to be actionable under the FCA. The FCA’s materiality requirement is demanding. An undisclosed fact is material if, for instance, “[n]o one can say with reason that the plaintiff would have signed this contract if informed of the likelihood” of the undisclosed fact. Junicus Constr. Co. v. Cohen, 257 N. Y. 393, 400, 178 N. E. 672, 674. When evaluating the FCA’s materiality requirement, the Government’s decision to expressly identify a provision as a condition of payment is relevant, but not automatically dispositive. A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular requirement as a condition of payment. Nor is the Government’s option to decline to pay if it knew of the defendant’s noncompliance sufficient for a finding of materiality. Materiality also cannot be found where noncompliance is minor or insubstantial. Moreover, if the
Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material. The FCA thus does not support the Government’s and First Circuit’s expansive view that any statutory, regulatory, or contractual violation is material so long as the defendant knows that the Government would be entitled to refuse payment were it aware of the violation. Pp. 14–17.

780 F. 3d 504, vacated and remanded.

THOMAS, J., delivered the opinion for a unanimous Court.
JUSTICE THOMAS delivered the opinion of the Court.

The False Claims Act, 31 U. S. C. §3729 et seq., imposes significant penalties on those who defraud the Government. This case concerns a theory of False Claims Act liability commonly referred to as “implied false certification.” According to this theory, when a defendant submits a claim, it impliedly certifies compliance with all conditions of payment. But if that claim fails to disclose the defendant’s violation of a material statutory, regulatory, or contractual requirement, so the theory goes, the defendant has made a misrepresentation that renders the claim “false or fraudulent” under §3729(a)(1)(A). This case requires us to consider this theory of liability and to clarify some of the circumstances in which the False Claims Act imposes liability.

We first hold that, at least in certain circumstances, the implied false certification theory can be a basis for liability. Specifically, liability can attach when the defendant submits a claim for payment that makes specific representations about the goods or services provided, but knowingly
fails to disclose the defendant’s noncompliance with a statutory, regulatory, or contractual requirement. In these circumstances, liability may attach if the omission renders those representations misleading.

We further hold that False Claims Act liability for failing to disclose violations of legal requirements does not turn upon whether those requirements were expressly designated as conditions of payment. Defendants can be liable for violating requirements even if they were not expressly designated as conditions of payment. Conversely, even when a requirement is expressly designated a condition of payment, not every violation of such a requirement gives rise to liability. What matters is not the label the Government attaches to a requirement, but whether the defendant knowingly violated a requirement that the defendant knows is material to the Government’s payment decision.

A misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government’s payment decision in order to be actionable under the False Claims Act. We clarify below how that rigorous materiality requirement should be enforced.

Because the courts below interpreted §3729(a)(1)(A) differently, we vacate the judgment and remand so that those courts may apply the approach set out in this opinion.

I

A

Enacted in 1863, the False Claims Act “was originally aimed principally at stopping the massive frauds perpetrated by large contractors during the Civil War.” United States v. Bornstein, 423 U. S. 303, 309 (1976). “[A] series of sensational congressional investigations” prompted hearings where witnesses “painted a sordid picture of how

Since then, Congress has repeatedly amended the Act, but its focus remains on those who present or directly induce the submission of false or fraudulent claims. See 31 U. S. C. §3729(a) (imposing civil liability on “any person who . . . knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval”). A “claim” now includes direct requests to the Government for payment as well as reimbursement requests made to the recipients of federal funds under federal benefits programs. See §3729(b)(2)(A). The Act’s scienter requirement defines “knowing” and “knowingly” to mean that a person has “actual knowledge of the information,” “acts in deliberate ignorance of the truth or falsity of the information,” or “acts in reckless disregard of the truth or falsity of the information.” §3729(b)(1)(A). And the Act defines “material” to mean “having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” §3729(b)(4).

Congress also has increased the Act’s civil penalties so that liability is “essentially punitive in nature.” Vermont Agency of Natural Resources v. United States ex rel. Stevens, 529 U. S. 765, 784 (2000). Defendants are subjected to treble damages plus civil penalties of up to $10,000 per false claim. §3729(a); 28 CFR §85.3(a)(9) (2015) (adjusting penalties for inflation).
The alleged False Claims Act violations here arose within the Medicaid program, a joint state-federal program in which healthcare providers serve poor or disabled patients and submit claims for government reimbursement. See generally 42 U. S. C. §1396 et seq. The facts recited in the complaint, which we take as true at this stage, are as follows. For five years, Yarushka Rivera, a teenage beneficiary of Massachusetts’ Medicaid program, received counseling services at Arbour Counseling Services, a satellite mental health facility in Lawrence, Massachusetts, owned and operated by a subsidiary of petitioner Universal Health Services. Beginning in 2004, when Yarushka started having behavioral problems, five medical professionals at Arbour intermittently treated her. In May 2009, Yarushka had an adverse reaction to a medication that a purported doctor at Arbour prescribed after diagnosing her with bipolar disorder. Her condition worsened; she suffered a seizure that required hospitalization. In October 2009, she suffered another seizure and died. She was 17 years old.

Thereafter, an Arbour counselor revealed to respondents Carmen Correa and Julio Escobar—Yarushka’s mother and stepfather—that few Arbour employees were actually licensed to provide mental health counseling and that supervision of them was minimal. Respondents discovered that, of the five professionals who had treated Yarushka, only one was properly licensed. The practitioner who diagnosed Yarushka as bipolar identified herself as a psychologist with a Ph. D., but failed to mention that her degree came from an unaccredited Internet college and that Massachusetts had rejected her application to be licensed as a psychologist. Likewise, the practitioner who prescribed medicine to Yarushka, and who was held out as a psychiatrist, was in fact a nurse who lacked authority to prescribe medications absent supervision. Rather than
ensuring supervision of unlicensed staff, the clinic’s director helped to misrepresent the staff’s qualifications. And the problem went beyond those who treated Yarushka. Some 23 Arbour employees lacked licenses to provide mental health services, yet—despite regulatory requirements to the contrary—they counseled patients and prescribed drugs without supervision.

When submitting reimbursement claims, Arbour used payment codes corresponding to different services that its staff provided to Yaruskha, such as “Individual Therapy” and “family therapy.” 1 App. 19, 20. Staff members also misrepresented their qualifications and licensing status to the Federal Government to obtain individual National Provider Identification numbers, which are submitted in connection with Medicaid reimbursement claims and correspond to specific job titles. For instance, one Arbour staff member who treated Yaruskha registered for a number associated with “‘Social Worker, Clinical,’” despite lacking the credentials and licensing required for social workers engaged in mental health counseling. 1 id., at 32.

After researching Arbour’s operations, respondents filed complaints with various Massachusetts agencies. Massachusetts investigated and ultimately issued a report detailing Arbour’s violation of over a dozen Massachusetts Medicaid regulations governing the qualifications and supervision required for staff at mental health facilities. Arbour agreed to a remedial plan, and two Arbour employees also entered into consent agreements with Massachusetts.

In 2011, respondents filed a *qui tam* suit in federal court, see 31 U. S. C. §3730, alleging that Universal Health had violated the False Claims Act under an implied false certification theory of liability. The operative complaint asserts that Universal Health (acting through Arbour) submitted reimbursement claims that made representations about the specific services provided by
specific types of professionals, but that failed to disclose serious violations of regulations pertaining to staff qualifications and licensing requirements for these services.\footnote{Although Universal Health submitted some of the claims at issue before 2009, we assume—as the parties have done—that the 2009 amendments to the False Claims Act apply here. Universal Health does not argue, and we thus do not consider, whether pre-2009 conduct should be treated differently.} Specifically, the Massachusetts Medicaid program requires satellite facilities to have specific types of clinicians on staff, delineates licensing requirements for particular positions (like psychiatrists, social workers, and nurses), and details supervision requirements for other staff. See 130 Code Mass. Regs. §§429.422–424, 429.439 (2014). Universal Health allegedly flouted these regulations because Arbour employed unqualified, unlicensed, and unsupervised staff. The Massachusetts Medicaid program, unaware of these deficiencies, paid the claims. Universal Health thus allegedly defrauded the program, which would not have reimbursed the claims had it known that it was billed for mental health services that were performed by unlicensed and unsupervised staff. The United States declined to intervene.

The District Court granted Universal Health’s motion to dismiss the complaint. Circuit precedent had previously embraced the implied false certification theory of liability. See, e.g., \textit{United States ex rel. Hutcheson v. Blackstone Medical, Inc.}, 647 F. 3d 377, 385–387 (CA1 2011). But the District Court held that respondents had failed to state a claim under that theory because, with one exception not relevant here, none of the regulations that Arbour violated was a condition of payment. See 2014 WL 1271757, *1, *6–*12 (D Mass., Mar. 26, 2014).

The United States Court of Appeals for the First Circuit reversed in relevant part and remanded. 780 F. 3d 504, 517 (2015). The court observed that each time a billing
party submits a claim, it “implicitly communicate[s] that it
conformed to the relevant program requirements, such
that it was entitled to payment.” Id., at 514, n. 14. To
determine whether a claim is “false or fraudulent” based
on such implicit communications, the court explained, it
“asks simply whether the defendant, in submitting a claim
for reimbursement, knowingly misrepresented compliance
with a material precondition of payment.” Id., at 512. In
the court’s view, a statutory, regulatory, or contractual
requirement can be a condition of payment either by ex-
pressly identifying itself as such or by implication. Id., at
512–513. The court then held that Universal Health had
violated Massachusetts Medicaid regulations that “clearly
impose conditions of payment.” Id., at 513. The court
further held that the regulations themselves “constitute[d]
dispositive evidence of materiality,” because they identi-
fied adequate supervision as an “express and absolute”
condition of payment and “repeated[ly] reference[d] su-
 pervision.” Id., at 514 (internal quotation marks omitted).

We granted certiorari to resolve the disagreement
among the Courts of Appeals over the validity and scope of
the implied false certification theory of liability. 577 U. S.
___ (2015). The Seventh Circuit has rejected this theory,
reasoning that only express (or affirmative) falsehoods can
render a claim “false or fraudulent” under 31 U. S. C.
F. 3d 696, 711–712 (2015). Other courts have accepted the
theory, but limit its application to cases where defendants
fail to disclose violations of expressly designated condi-
tions of payment. E.g., Mikes v. Straus, 274 F. 3d 687, 700
(CA2 2011). Yet others hold that conditions of payment
need not be expressly designated as such to be a basis for
False Claims Act liability. E.g., United States v. Science
Applications Int’l Corp., 626 F. 3d 1257, 1269 (CADC
2010) (SAIC).
II

We first hold that the implied false certification theory can, at least in some circumstances, provide a basis for liability. By punishing defendants who submit “false or fraudulent claims,” the False Claims Act encompasses claims that make fraudulent misrepresentations, which include certain misleading omissions. When, as here, a defendant makes representations in submitting a claim but omits its violations of statutory, regulatory, or contractual requirements, those omissions can be a basis for liability if they render the defendant’s representations misleading with respect to the goods or services provided.

To reach this conclusion, “[w]e start, as always, with the language of the statute.” Allison Engine Co. v. United States ex rel. Sanders, 553 U. S. 662, 668 (2008) (brackets in original; internal quotation marks omitted). The False Claims Act imposes civil liability on “any person who . . . knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.” §3729(a)(1)(A). Congress did not define what makes a claim “false” or “fraudulent.” But “[i]t is a settled principle of interpretation that, absent other indication, Congress intends to incorporate the well-settled meaning of the common-law terms it uses.” Sekhar v. United States, 570 U. S. ___, ___ (2013) (slip op., at 3) (internal quotation marks omitted). And the term “fraudulent” is a paradigmatic example of a statutory term that incorporates the common-law meaning of fraud. See Neder v. United States, 527 U. S. 1, 22 (1999) (the term “actionable ‘fraud’” is one with “a well-settled meaning at common law”).

2The False Claims Act abrogates the common law in certain respects. For instance, the Act’s scienter requirement “require[s] no proof of specific intent to defraud.” 31 U. S. C. §3729(b)(1)(B). But we presume that Congress retained all other elements of common-law fraud that are consistent with the statutory text because there are no textual indicia to the contrary. See Neder, 527 U. S., at 24–25.
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Because common-law fraud has long encompassed certain misrepresentations by omission, “false or fraudulent claims” include more than just claims containing express falsehoods. The parties and the Government agree that misrepresentations by omission can give rise to liability. Brief for Petitioner 30–31; Brief for Respondents 22–31; Brief for United States as Amicus Curiae 16–20.

The parties instead dispute whether submitting a claim without disclosing violations of statutory, regulatory, or contractual requirements constitutes such an actionable misrepresentation. Respondents and the Government invoke the common-law rule that, while nondisclosure alone ordinarily is not actionable, “[a] representation stating the truth so far as it goes but which the maker knows or believes to be materially misleading because of his failure to state additional or qualifying matter” is actionable. Restatement (Second) of Torts §529, p. 62 (1976). They contend that every submission of a claim for payment implicitly represents that the claimant is legally entitled to payment, and that failing to disclose violations of material legal requirements renders the claim misleading. Universal Health, on the other hand, argues that submitting a claim involves no representations, and that a different common-law rule thus governs: nondisclosure of legal violations is not actionable absent a special “‘duty . . . to exercise reasonable care to disclose the matter in question,’” which it says is lacking in Government contracting. Brief for Petitioner 31 (quoting Restatement (Second) of Torts §551(1), at 119).

We need not resolve whether all claims for payment implicitly represent that the billing party is legally entitled to payment. The claims in this case do more than merely demand payment. They fall squarely within the rule that half-truths—representations that state the truth only so far as it goes, while omitting critical qualifying
information—can be actionable misrepresentations. A classic example of an actionable half-truth in contract law is the seller who reveals that there may be two new roads near a property he is selling, but fails to disclose that a third potential road might bisect the property. See *Junius Constr. Co. v. Cohen*, 257 N. Y. 393, 400, 178 N. E. 672, 674 (1931) (Cardozo, J.). “The enumeration of two streets, described as unopened but projected, was a tacit representation that the land to be conveyed was subject to no others, and certainly subject to no others materially affecting the value of the purchase.” *Ibid.* Likewise, an applicant for an adjunct position at a local college makes an actionable misrepresentation when his resume lists prior jobs and then retirement, but fails to disclose that his “retirement” was a prison stint for perpetrating a $12 million bank fraud. See 3 D. Dobbs, P. Hayden, & H. Bublick, Law of Torts §682, pp. 702–703, and n. 14 (2d ed. 2011) (citing *Sarvis v. Vermont State Colleges*, 172 Vt. 76, 78, 80–82, 772 A. 2d 494, 496, 497–499 (2001)).

So too here, by submitting claims for payment using payment codes that corresponded to specific counseling services, Universal Health represented that it had provided individual therapy, family therapy, preventive medication counseling, and other types of treatment. Moreover, Arbour staff members allegedly made further representations in submitting Medicaid reimbursement claims by using National Provider Identification numbers corresponding to specific job titles. And these representations

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3 This rule recurs throughout the common law. In tort law, for example, “if the defendant does speak, he must disclose enough to prevent his words from being misleading.” W. Keeton, D. Dobbs, R. Keeton, & D. Owen, Prosser and Keeton on Law of Torts §106, p. 738 (5th ed. 1984). Contract law also embraces this principle. See, e.g., Restatement (Second) of Contracts §161, Comment a, p. 432 (1979). And we have used this definition in other statutory contexts. See, e.g., *Matrixx Initiatives, Inc. v. Siracusano*, 563 U. S. 27, 44 (2011) (securities law).
were clearly misleading in context. Anyone informed that a social worker at a Massachusetts mental health clinic provided a teenage patient with individual counseling services would probably—but wrongly—conclude that the clinic had complied with core Massachusetts Medicaid requirements (1) that a counselor “treating children [is] required to have specialized training and experience in children’s services,” 130 Code Mass. Regs. §429.422, and also (2) that, at a minimum, the social worker possesses the prescribed qualifications for the job, §429.424(C). By using payment and other codes that conveyed this information without disclosing Arbour’s many violations of basic staff and licensing requirements for mental health facilities, Universal Health’s claims constituted misrepresentations.

Accordingly, we hold that the implied certification theory can be a basis for liability, at least where two conditions are satisfied: first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant’s failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths.

III

The second question presented is whether, as Universal Health urges, a defendant should face False Claims Act liability only if it fails to disclose the violation of a contractual, statutory, or regulatory provision that the Govern-

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4 As an alternative argument, Universal Health asserts that misleading partial disclosures constitute fraudulent misrepresentations only when the initial statement partially disclosed unfavorable information. Not so. “[A] statement that contains only favorable matters and omits all reference to unfavorable matters is as much a false representation as if all the facts stated were untrue.” Restatement (Second) of Torts, §529, Comment a, pp. 62–63 (1976).
ment expressly designated a condition of payment. We conclude that the Act does not impose this limit on liability. But we also conclude that not every undisclosed violation of an express condition of payment automatically triggers liability. Whether a provision is labeled a condition of payment is relevant to but not dispositive of the materiality inquiry.

A

Nothing in the text of the False Claims Act supports Universal Health’s proposed restriction. Section 3729(a)(1)(A) imposes liability on those who present “false or fraudulent claims” but does not limit such claims to misrepresentations about express conditions of payment. See SAIC, 626 F. 3d, at 1268 (rejecting any textual basis for an express-designation rule). Nor does the common-law meaning of fraud tether liability to violating an express condition of payment. A statement that misleadingly omits critical facts is a misrepresentation irrespective of whether the other party has expressly signaled the importance of the qualifying information. Supra, at 9–11.

The False Claims Act’s materiality requirement also does not support Universal Health. Under the Act, the misrepresentation must be material to the other party’s course of action. But, as discussed below, see infra, at 15–17, statutory, regulatory, and contractual requirements are not automatically material, even if they are labeled conditions of payment. Cf. Matrixx Initiatives, Inc. v. Siracusano, 563 U. S. 27, 39 (2011) (materiality cannot rest on “a single fact or occurrence as always determinative” (internal quotation marks omitted)).

Nor does the Act’s scienter requirement, §3729(b)(1)(A), support Universal Health’s position. A defendant can have “actual knowledge” that a condition is material without the Government expressly calling it a condition of payment. If the Government failed to specify that guns it
orders must actually shoot, but the defendant knows that the Government routinely rescinds contracts if the guns do not shoot, the defendant has “actual knowledge.” Likewise, because a reasonable person would realize the imperative of a functioning firearm, a defendant’s failure to appreciate the materiality of that condition would amount to “deliberate ignorance” or “reckless disregard” of the “truth or falsity of the information” even if the Government did not spell this out.

Universal Health nonetheless contends that False Claims Act liability should be limited to undisclosed violations of expressly designated conditions of payment to provide defendants with fair notice and to cabin liability. But policy arguments cannot supersede the clear statutory text. *Kloeckner v. Solis*, 568 U. S. ___, ___–___, n. 4 (2012) (slip op., at 13–14, n. 4). In any event, Universal Health’s approach risks undercutting these policy goals. The Government might respond by designating every legal requirement an express condition of payment. But billing parties are often subject to thousands of complex statutory and regulatory provisions. Facing False Claims Act liability for violating any of them would hardly help would-be defendants anticipate and prioritize compliance obligations. And forcing the Government to expressly designate a provision as a condition of *payment* would create further arbitrariness. Under Universal Health’s view, misrepresenting compliance with a requirement that the Government expressly identified as a condition of payment could expose a defendant to liability. Yet, under this theory, misrepresenting compliance with a condition of eligibility to even participate in a federal program when submitting a claim would not.

Moreover, other parts of the False Claims Act allay Universal Health’s concerns. “[I]nstead of adopting a circumscribed view of what it means for a claim to be false or fraudulent,” concerns about fair notice and open-ended
liability “can be effectively addressed through strict enforcement of the Act’s materiality and scienter requirements.” *SAIC*, *supra*, at 1270. Those requirements are rigorous.

**B**

As noted, a misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government’s payment decision in order to be actionable under the False Claims Act. We now clarify how that materiality requirement should be enforced.

Section 3729(b)(4) defines materiality using language that we have employed to define materiality in other federal fraud statutes: “[T]he term ‘material’ means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” See *Neder*, 527 U. S., at 16 (using this definition to interpret the mail, bank, and wire fraud statutes); *Kungys v. United States*, 485 U. S. 759, 770 (1988) (same for fraudulent statements to immigration officials). This materiality requirement descends from “common-law antecedents.” *Id.*, at 769. Indeed, “the common law could not have conceived of ‘fraud’ without proof of materiality.” *Neder*, *supra*, at 22; see also Brief for United States as *Amicus Curiae* 30 (describing common-law principles and arguing that materiality under the False Claims Act should involve a “similar approach”).

We need not decide whether §3729(a)(1)(A)’s materiality requirement is governed by §3729(b)(4) or derived directly from the common law. Under any understanding of the concept, materiality “look[s] to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation.” 26 R. Lord, Williston on Contracts §69:12, p. 549 (4th ed. 2003) (Williston). In tort law, for instance, a “matter is material” in only two circumstances: (1) “[i]f a reasonable man would attach importance to [it] in deter-
mining his choice of action in the transaction”; or (2) if the defendant knew or had reason to know that the recipient of the representation attaches importance to the specific matter “in determining his choice of action,” even though a reasonable person would not. Restatement (Second) of Torts §538, at 80. Materiality in contract law is substantially similar. See Restatement (Second) of Contracts §162(2), and Comment c, pp. 439, 441 (1979) (“[A] misrepresentation is material” only if it would “likely . . . induce a reasonable person to manifest his assent,” or the defendant “knows that for some special reason [the representation] is likely to induce the particular recipient to manifest his assent” to the transaction).

The materiality standard is demanding. The False Claims Act is not “an all-purpose antifraud statute,” Allison Engine, 553 U. S., at 672, or a vehicle for punishing garden-variety breaches of contract or regulatory violations. A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defend-

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5 Accord, Williston §69:12, pp. 549–550 (“most popular” understanding is “that a misrepresentation is material if it concerns a matter to which a reasonable person would attach importance in determining his or her choice of action with respect to the transaction involved: which will induce action by a complaining party[,] knowledge of which would have induced the recipient to act differently” (footnote omitted)); id., at 550 (noting rule that “a misrepresentation is material if, had it not been made, the party complaining of fraud would not have taken the action alleged to have been induced by the misrepresentation”); Junius Constr. Co. v. Cohen, 257 N. Y. 393, 400, 178 N. E. 672, 674 (1931) (a misrepresentation is material if it “went to the very essence of the bargain”); cf. Neder v. United States, 527 U. S. 1, 16, 22, n. 5 (1999) (relying on “natural tendency to influence” standard and citing Restatement (Second) of Torts §538 definition of materiality).
Materiality, in addition, cannot be found where noncompliance is minor or insubstantial. See United States ex rel. Marcus v. Hess, 317 U. S. 537, 543 (1943) (contractors’ misrepresentation that they satisfied a non-collusive bidding requirement for federal program contracts violated the False Claims Act because “[t]he government’s money would never have been placed in the joint fund for payment to respondents had its agents known the bids were collusive”); see also Junius Constr., 257 N. Y., at 400, 178 N. E., at 674 (an undisclosed fact was material because “[n]o one can say with reason that the plaintiff would have signed this contract if informed of the likelihood” of the undisclosed fact).

In sum, when evaluating materiality under the False Claims Act, the Government’s decision to expressly identify a provision as a condition of payment is relevant, but not automatically dispositive. Likewise, proof of materiality can include, but is not necessarily limited to, evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement. Conversely, if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material. Or, if the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material.6

6We reject Universal Health’s assertion that materiality is too fact intensive for courts to dismiss False Claims Act cases on a motion to dismiss or at summary judgment. The standard for materiality that we have outlined is a familiar and rigorous one. And False Claims Act plaintiffs must also plead their claims with plausibility and particularity under Federal Rules of Civil Procedure 8 and 9(b) by, for instance,
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These rules lead us to disagree with the Government’s and First Circuit’s view of materiality: that any statutory, regulatory, or contractual violation is material so long as the defendant knows that the Government would be entitled to refuse payment were it aware of the violation. See Brief for United States as Amicus Curiae 30; Tr. of Oral Arg. 43 (Government’s “test” for materiality “is whether the person knew that the government could lawfully withhold payment”); 780 F. 3d, at 514; see also Tr. of Oral Arg. 26, 29 (statements by respondents’ counsel endorsing this view). At oral argument, the United States explained the implications of its position: If the Government contracts for health services and adds a requirement that contractors buy American-made staplers, anyone who submits a claim for those services but fails to disclose its use of foreign staplers violates the False Claims Act. To the Government, liability would attach if the defendant’s use of foreign staplers would entitle the Government not to pay the claim in whole or part—irrespective of whether the Government routinely pays claims despite knowing that foreign staplers were used. Id., at 39–45. Likewise, if the Government required contractors to aver their compliance with the entire U. S. Code and Code of Federal Regulations, then under this view, failing to mention noncompliance with any of those requirements would always be material. The False Claims Act does not adopt such an extraordinarily expansive view of liability.

*   *   *

Because both opinions below assessed respondents’ complaint based on interpretations of §3729(a)(1)(A) that differ from ours, we vacate the First Circuit’s judgment and remand the case for reconsideration of whether respondents have sufficiently pleaded a False Claims Act pleading facts to support allegations of materiality.
violation. See *Omnicare, Inc. v. Laborers Dist. Council Constr. Industry Pension Fund*, 575 U. S. __, ___ (2015) (slip op., at 19). We emphasize, however, that the False Claims Act is not a means of imposing treble damages and other penalties for insignificant regulatory or contractual violations. This case centers on allegations of fraud, not medical malpractice. Respondents have alleged that Universal Health misrepresented its compliance with mental health facility requirements that are so central to the provision of mental health counseling that the Medicaid program would not have paid these claims had it known of these violations. Respondents may well have adequately pleaded a violation of §3729(a)(1)(A). But we leave it to the courts below to resolve this in the first instance.

The judgment of the Court of Appeals is vacated, and the case is remanded for further proceedings consistent with this opinion.

*It is so ordered.*
Where FCA Litigation Stands 5 Years After Escobar

By Matthew Curley and Brian Roark (June 23, 2021, 4:53 PM EDT)

Few U.S. Supreme Court cases have changed the landscape of litigation concerning a federal statute as the Supreme Court’s June 16, 2016, decision in Universal Health Services Inc. v. Escobar and its groundbreaking discussion of the False Claims Act’s materiality standard.

Practitioners anticipated the Supreme Court’s consideration of whether a government contractor or health care provider’s implied false certification could render a claim false under the FCA after years of consideration of that issue by lower courts.

After easily dispatching with that question by affirming the viability of such a theory of falsity, the Supreme Court unexpectedly turned its attention to the FCA’s requirement that the conduct at issue be material to the government’s decision to pay a claim.

Five years later, the Supreme Court’s discussion of that issue continues to have a profound impact on the manner in which FCA allegations are pleaded in FCA complaints, investigated by the government and litigated by parties to FCA lawsuits.

In Escobar, the Supreme Court described the FCA’s materiality requirement as rigorous and demanding, and set forth a number of nonexclusive considerations to guide the inquiry, which primarily focus on the government’s actual conduct with respect to payment of purportedly false claims.[1]

Importantly, courts generally have agreed with the notion that the materiality analysis requires evaluation of the effect on the likely or actual behavior of the government recipient of the alleged misrepresentation.

As set forth in Escobar, relevant factors in determining materiality include:

- Whether the government has expressly identified compliance with the particular requirement as a condition of payment;

- Whether the government consistently refuses to pay claims in other cases based on noncompliance;

- Whether the government, with actual knowledge of noncompliance, paid claims; and

- Whether noncompliance is minor or insubstantial, or goes to the very essence of the bargain for paying the claim.[2]
Consideration of whether these factors have been pleaded adequately by a qui tam relator or the government in a FCA complaint and the implications concerning the litigation of cases that survive a motion to dismiss have greatly shaped the landscape in district and appellate court decisions following Escobar.

**Impact on Dispositive Motions**

Since Escobar, the government and relators have clashed fiercely with defendants over application of the materiality standard. Although the Supreme Court stated that materiality is not too fact intensive for courts to dismiss FCA cases at the pleading stage, many courts have shied away from dismissing lawsuits for failure to plead materiality.

Given that whether the legal requirement is labeled as a condition of payment is not dispositive to the materiality analysis, most disputes at the pleading stage focus on whether the plaintiff has alleged some basis for concluding that the government consistently refuses to pay claims based on the alleged noncompliance or that the government continued to pay claims even with actual knowledge of the specific defendant's noncompliance.

Many district courts have held that even largely conclusory allegations of materiality are sufficient to survive a motion to dismiss, such as that the government may not have paid the claims had it known of the violation.[3]

These rulings track with efforts by the U.S. Department of Justice to water down and distract from Escobar's focus on whether the Centers for Medicare & Medicaid Services actually denies payment of claims based on noncompliance.

Instead, the DOJ has tended to argue that the standard is not would the government have refused to pay the claim had it known of the alleged falsity but, rather, whether the falsity had the natural tendency to influence a reasonable person.

While these efforts may seek to protect in the short term the DOJ's ability to pursue FCA liability for alleged violations of legal requirements that historically have not impacted payment, such efforts have fallen apart more often than not at the proof stage for lack of evidence of materiality.

In U.S. ex rel. Prather v. Brookdale Senior Living,[4] a former utilization review nurse alleged that the defendant failed to obtain physician signatures on home health certifications as soon as possible after the physician established a plan of care.

The district court granted the defendant's motions to dismiss, ruling that the relator failed to allege any facts supporting that the timeliness of the physician signature on the certification was material to payment.

Following the relator's appeal and the DOJ's amicus brief opposing dismissal, the U.S. Court of Appeals for the Sixth Circuit reversed, holding that the relator sufficiently established materiality where the government designated the regulation as a condition of payment, and where, by the Sixth Circuit's own estimation, the regulation could act as a mechanism for fraud prevention.

Notably, the Sixth Circuit held that the relator's failure to plead any facts about whether the government had ever denied claims based on this regulatory violation had no bearing on the materiality analysis. Following remand, the relator voluntarily dismissed the case after discovery targeted at CMS undermined the relator's entire theory of liability.[5]

Although the DOJ's natural tendency standard has helped some plaintiffs get past motions to dismiss, such a standard has not fared particularly well at the summary judgment stage where courts have tended more to focus on whether the government actually has denied claims based on the noncompliance in question versus whether the noncompliance might affect the government's payment decision.

In one of last year's most significant appellate decisions applying Escobar's materiality standard, the U.S. Court of Appeals for the Tenth Circuit in U.S. ex rel. Janssen v. Lawrence Memorial Hospital...
affirmed the district court's entry of summary judgment for the defendant hospital, explaining that the FCA's materiality analysis requires evaluation of the effect on the likely or actual behavior of the government recipient of the alleged misrepresentation.[6]

The Tenth Circuit rejected the argument made by the relator, which echoed arguments made by relators in numerous other cases, that materiality should be judged based on the likely impact of the legal violation on a reasonable person or on what the defendant knew or had reason to know in connection with making the alleged misrepresentation.

Additionally, the Tenth Circuit rejected the relator's argument that the government's reaction to noncompliance is irrelevant unless the defendant can show that the government had knowledge of actual noncompliance. Rather, the Tenth Circuit held that government inaction in the face of noncompliance was sufficient for summary judgment purposes.

Finally, the Tenth Circuit considered whether compliance with the reporting obligations of the defendant hospital went to the essence of the bargain, in connection with payments made by CMS for the quality and value-based programs at issue.

The Tenth Circuit concluded that the availability of administrative procedures designed to ensure hospitals remained in compliance with the reporting obligations at issue supported the conclusion that those obligations did not go to the essence of the bargain.

To hold otherwise would render the FCA an "all-purpose antifraud statute or a vehicle for punishing garden-variety breaches of contract or regulatory violations."[7]

Efforts by the DOJ and relators to try to wind back the clock to pre-Escobar days by seeking to have courts focus on what the government says as opposed to what it actually does have enabled some relators to survive a motion to dismiss, but it is not in keeping with the clear directives of Escobar.

While it might be understandable for the DOJ to seek to protect favorable case law with respect to motions to dismiss at the pleading stages, the practical effect is to allow relators to take forward implied certification cases that are at odds with CMS' own past practices or interpretation of regulations, which results in expensive litigation for defendants forced to litigate cases to summary judgment that often should have been proactively dismissed by the DOJ.[8]

**Significance of Intervention Decisions**

In assessing the FCA's materiality requirement, courts have increasingly taken divergent approaches regarding the significance of the government's decision about whether to intervene in a qui tam action.

In several decisions following Escobar, district courts have held that the government's decision to intervene in a qui tam action was relevant — even if not dispositive — with respect to the materiality analysis under Escobar.

In such cases, courts have found that the government's decision to intervene in the particular case before it or in similar cases is indicative of the fact that the government considered the alleged violations at issue to be material to payment.[9]

Other courts have drawn an opposite inference from the government's decision to decline to intervene, determining that such a decision is relevant to the materiality analysis. In such cases, courts have noted that the government's declination decision is probative of the lack of materiality of the relator's claims and weighed in favor of such a conclusion.[10]

Given the large number of new qui tam lawsuits filed each year by relators and the relatively low percentage of such lawsuits in which the government chooses to intervene, defendants and relators undoubtedly will continue to debate the significance of the government's declination decision in future False Claims Act litigation.

**Opening the Door to Discovery**
Under Escobar, determining whether compliance with a particular statute, regulation or contractual obligation is material to payment depends not just on how the provision is labeled, but on how the government has enforced the provision in practice.

As a result, government contractors and health care providers facing alleged violations of the FCA have pointed to Escobar as necessitating substantial discovery from the government regarding its past enforcement and payment practices with the relevant provisions.

In cases where the government has intervened, it has meant defendants obtaining party-discovery from the U.S., and typically its contractors. For cases where the government has declined intervention, it has meant relators and defendants seeking discovery through third-party discovery and Touhy requests.

Discovery requests in cases where the FCA theory of liability is based on an alleged implied false certification have focused on the government's knowledge of the allegedly fraudulent scheme, as well as information or documents sufficient to have put the government on notice of any alleged misconduct, such as audits or assessments of a defendant's performance or claims.

At the broadest level, defendants have sought documents or information regarding when certain government officials became aware of the facts or information that serve as the basis of the FCA allegations. Defendants have focused their discovery efforts on the government's knowledge of facts relevant to the particular fraudulent scheme and whether the government continued to pay claims after it became aware of the alleged noncompliance.[11]

Defendants facing FCA liability also have had success in pursuing discovery from the government regarding its knowledge of conduct by third parties that is similar to the defendant's alleged misconduct.

Escobar opened the door to such discovery by explaining that "if the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, that is strong evidence that the requirements are not material."[12]

As a result, defendants have sought discovery related to the government's knowledge of circumstances related to conduct similar to the alleged misconduct, even when the requests pertain to other circumstances or parties that are not at issue in a particular case.[13]

Given the focus that Escobar places on the effect on the likely or actual behavior of the government recipient of the alleged misrepresentation that would render a claim false, the pursuit of discovery from the government will remain a high priority for government contractors and health care providers defending against FCA allegations.

**Intersection With DOJ Dismissal Authority**

The FCA provides the government with broad authority to dismiss qui tam actions. In 2018, the DOJ issued what has become known as the Granston memo, in which DOJ litigators were reminded that the government's dismissal authority under the FCA "remains an important tool to advance government interests, preserve limited resources and avoid adverse precedent."[14]

The Granston memo, which has been formally incorporated into the DOJ's Justice Manual, provides seven factors that DOJ litigators should consider in determining whether a nonintervened case should be dismissed, including controlling litigation brought on behalf of the U.S., preventing interference with agency policies and programs and preserving government resources.[15]

Since the issuance of the Granston memo, perhaps no court filing has illustrated the intersection of Escobar and the government's dismissal authority more plainly than the U.S. Solicitor General's amicus brief in the Supreme Court supporting the relators' opposition to certiorari in Gilead Sciences Inc. v. U.S. ex rel. Campie.[16]

In that case, the U.S. Court of Appeals for the Ninth Circuit reversed the district court's dismissal of the relators' FCA allegations for failure to plead materiality under Escobar.[17] Following Gilead's petition for writ of certiorari to the Supreme Court, the court requested that the government file an

https://www.law360.com/articles/1396615/print?section=aerospace
amicus brief addressing the Ninth Circuit's consideration of the issue of materiality.

Not surprisingly, the solicitor general's brief supported the Ninth Circuit's approach to evaluating materiality under Escobar.

What did stun those watching this case, however, was the brief's representation to the court that the U.S. would dismiss the relator's claim on remand, pointing to the belief that discovery expected to be sought in the lawsuit to determine facts relevant to the materiality analysis likely would be burdensome and interference with the U.S. Food and Drug Administration's responsibilities.[18]

While perhaps appearing on its face to reflect a straightforward application of the government's dismissal authority under the FCA in line with the Granston memo, it nonetheless was exceedingly unusual to see the government belatedly announce that this authority would be exercised in an amicus brief before the Supreme Court more than seven years after the qui tam lawsuit was filed in the district court.

The potential burden associated with discovery on the question of materiality undoubtedly was a valid consideration by the government. Just as likely, however, was the government's desire to leave the Ninth Circuit's favorable opinion on the FCA's materiality requirement intact without review by the Supreme Court.

Conclusion

Five years after the Supreme Court announced its decision in Escobar, the FCA's materiality requirement continues to be at the center of complex issues debated as part of FCA investigations and related litigation. And, with the ever-increasing number of FCA lawsuits filed by relators each year, there is no reason to believe that will change any time soon.

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[2] Id. at 2003-04.
[3] In U.S. ex rel. McIver v. Act for Health, Inc, 2021 WL 50879 (D. Colo. Jan. 6, 2021), relators alleged that defendant hired unqualified and not properly licensed home health workers and otherwise failed to comply with state licensure requirements. Defendants moved to dismiss on the ground that relators had failed to allege that compliance with state licensure requirements was material to payment of claims. The relator argued that it was not necessary for her to allege "conclusively that, were it aware of the falsity, the government would not have paid." Rather, she argued that she need only plead that "the government may not have paid" the claims. The district court agreed and denied the motion to dismiss.
[5] In U.S. ex rel. Lemon v. Nurses to Go, Inc, the Fifth Circuit reversed a district court's order that had dismissed an FCA action on materiality grounds, holding that the relators had plausibly alleged that the hospice regulations at issue were material requirements. 924 F.3d 155 (5th Cir. 2019). In rejecting the district court's conclusion to the contrary, the Fifth Circuit emphasized that Congress and CMS had expressly designated the regulations as conditions of payment and credited the relator's allegations that the government had sought to enforce the regulations in the past both civilly and criminally. Notably, the Fifth Circuit cited the Sixth Circuit's 2018 decision in Prather as
"persuasive" authority for the proposing that "Escobar does not require the relator to allege in the complaint specific prior government actions prosecuting similar claims." Id. at 162.


[7] Id.at 540, 543-44. The Fifth Circuit also demonstrated a willingness to apply the False Claims Act's materiality requirement with rigor in U.S. ex rel. Harman v. Trinity Indus., Inc., 872 F.3d 645 (5th Cir. 2017). There, the Fifth Circuit vacated a $663 million jury verdict against a manufacturer of highway guardrails that allegedly were not manufactured according to government specifications. Relying on a memo produced by the relevant agency on the eve of trial stating that the defendant's guardrails were eligible for reimbursement, the Fifth Circuit had little difficulty reversing the district court's judgment and ordering that summary judgment be entered in favor of the defendant "for want of materiality." Id. at 647. The Fifth Circuit summed up the implications of Escobar on the facts of this case succinctly, explaining that "[w]hen the government, at appropriate levels, repeatedly concludes that it has not been defrauded, it is not forgiving a found fraud – rather it is concluded that there was no fraud at all." Id. at 670.

[8] In Godecke v. Kinetic Concepts, Inc., the Ninth Circuit likewise reversed a district court decision holding that relators had failed to adequately plead the materiality of the alleged false representations. 937 F.3d 1201 (9th Cir. 2019). The relator had alleged that the defendant, a DME supplier, had violated applicable Local Coverage Determinations (LCD) by supplying the relevant equipment to patients before receiving an order from a physician. In finding that the "prior order" requirement was material, the Ninth Circuit stressed that not only did the LCDs explicitly identify the requirement as a condition of payment, but the LCDs also were the product of "extensive negotiation" between the specific defendant and Medicare representatives. The Ninth Circuit also pointed to the lack of any evidence that that the government had paid any claims in full with actual knowledge that the "prior order" requirement had not been followed.


[11] In United States v. DynCorp. Int'l LLC, the defendant sought to compel production of cancelled audit reports and related correspondence and work papers regarding the contract at issue. No. 1:16-cv-01473 (D.D.C.) While DOJ initially asserted the deliberative process privilege over the documents, it ultimately agreed to produce the documents at issue.


[16] Brief of the United States as Amicus Curiae, Gilead Sciences, Inc. v. U.S. ex rel. Campie, No. 17-
936 (U.S.).

[17] 862 F.3d 890 (9th Cir. 2017).

Analyzing FCA Materiality Defense Outcomes Under Escobar

By Brenna Jenny, Matthew Bergs and Paul Kalb (December 13, 2021, 11:50 AM EST)

The U.S. Supreme Court's 2016 decision in Universal Health Services Inc. v. U.S., generally known as the Escobar case,[1] put a spotlight on the government's continued payment in False Claims Act cases, establishing that the government's continued payment despite actual knowledge of a violation is a strong defense against the element of materiality.

To assess the current effectiveness of this defense, we analyzed all published opinions in FCA cases issued from July 1, 2019, to the present that substantively addressed the relevance of the government's continued payment to the materiality inquiry.[2]

Our analysis revealed that Escobar's continued-payment defense is often a winning argument for defendants, although the success rate can vary significantly based on factors such as the stage of litigation, the defendant's industry and the political affiliation of the administration that appointed each judge.

However, these trends may shift if Congress passes a recently proposed amendment to the FCA's materiality standard.

In Escobar, the Supreme Court unanimously held that the implied false certification theory is a valid basis for FCA liability in some circumstances, provided that the requirement at issue was material to the government's payment decision.[3]

The Supreme Court's approval of the implied false certification theory was a victory for whistleblowers and the U.S. Department of Justice, but far from a complete one.

The court rejected the DOJ's position that a violation is material so long as the defendant knew the government would be entitled to refuse payment if it had been aware of the violation, holding that the FCA's materiality requirement is demanding and rigorous, and must be strictly enforced.[4]

The court noted, in particular, that where the government "pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material."[5]

At the same time, the court went out of its way specifically to "reject [the] assertion that materiality is too fact intensive for courts to dismiss False Claims Act cases on a motion to dismiss or at summary judgment."[6]

Escobar's continued-payment defense has posed a particular threat to the DOJ's FCA enforcement in the health care industry because the Centers for Medicare & Medicaid Services rarely halt payment despite knowledge of alleged misconduct.
As a result, over the past few years, the DOJ has frequently attempted to clarify two aspects of the continued-payment defense: which government actors need knowledge, and what knowledge they need.

For example, in statements of interest filed in the wake of Escobar,[7] the DOJ argued that it is not enough for defendants to point to law enforcement's knowledge of violations of law; instead, the relevant government payor, such as CMS, must have that knowledge.

Second, the DOJ argued that the type of knowledge the government payor must have is actual knowledge of misconduct, rather than mere awareness of allegations.

The DOJ has also emphasized that the government's continued payment is but one of many factors relevant to the materiality inquiry — despite the Supreme Court's characterization of such payment history as very strong evidence of a lack of materiality.

Earlier this year, in another statement of interest, the DOJ adopted an even more extreme position on what it views as the general irrelevance of the government's continued payment under Escobar. [8]

According to the DOJ, the government's continued payment is only relevant to the materiality inquiry if the government had “actual knowledge of specific false claims,” rather than actual knowledge of a fraudulent course of conduct.

Even where alleged fraud has "been brought to the attention of the federal agency responsible for making the payment," unless the agency "knew of specific claims that were false and paid those claims notwithstanding such actual knowledge," the DOJ's position is that the continued payment cannot serve as meaningful evidence of a lack of materiality.[9]

The DOJ's campaign to chip away at Escobar's continued-payment defense has generated mixed results.

We identified 45 cases issued from July 1, 2019, to the present that substantively assessed the government's continued payment as part of an inquiry into materiality. In 30 of those 45 cases, the court was deciding a motion to dismiss, or MTD. In the remaining 15 cases, the court was deciding a motion for summary judgment or motion for judgment as a matter of law — SJ or JMOL, respectively.

The government's continued payment is often a winning argument for defendants, both at the MTD stage and the SJ/JMOL stages. Defendants defeated materiality using this defense in 37%, or 11 of 30, of the MTD cases, and 40%, or 6 of 15, of the SJ/JMOL cases.

Courts siding with defendants on materiality at the MTD stage have generally relied on concessions in the pleadings about the government's continued payment, concluding that the complaint pleads its way out of materiality based on the plain meaning of Escobar's guidance.

We further explored the MTD stage data to determine whether there were any identifiable trends based on the filing date of the operative complaints underlying the MTD decisions.[10]
While one may have anticipated that post-Escobar, plaintiffs would be less likely to plead their way out of materiality based on the government's continued payment, there was in fact no correlation between whether the plaintiff or defendant prevailed and how long ago the operative complaint was filed.

There was also no correlation when we arrayed the decisions by the filing date of the original complaint.

Where courts sided with the relator or the government on materiality 63% of the time, or in 19 of 30 rulings, at the MTD stage, courts uniformly found that the continued-payment defense raised issues of fact not properly considered at the MTD stage. They did so despite the Supreme Court's specific admonition in Escobar that materiality may be decided as a matter of law.

To further understand the MTD decisions, we analyzed the outcomes by the defendants' industries.

One might have expected that health care defendants employing the continued-payment defense at the MTD stage would fare worse than defendants in other industries due to the factual complexity of the health care industry and the fact that government payors might be particularly hesitant to deny payment for medically necessary services.

However, defendants in other industries actually fared somewhat worse than defendants in the health care industry at the MTD stage.

Furthermore, once cases involving a court's analysis of the materiality of alleged kickbacks are removed — allegations that uniformly were deemed adequate to plead materiality — the difference is even more significant. Defendants in the health care industry prevailed in 47% of the remaining motions to dismiss, or in 7 of 15 cases, and defendants in other industries prevailed in 30%, or 4 of 13, cases.

These outcomes could reflect how the hyper-regulated nature of the health care industry results in participants more frequently running afoul of one of the many nonmaterial requirements applicable to the industry.
At the SJ/JMOL stages, courts ruling in favor of defendants on materiality commonly found either that: (1) while continued payment is one of many relevant materiality factors, consistent with Escobar, it bears significant weight in favor of defendants, or (2) continued payment during and after the DOJ’s investigation with knowledge of violations is sufficient to negate materiality.

Courts ruling in favor of the relator or the government on materiality at the SJ/JMOL stages typically took one of two approaches, concluding either that: (1) continued payment is one of many materiality factors, but it was outweighed by other relevant factors, or (2) the continued-payment defense was undermined by the fact that the government lacked actual knowledge of wrongdoing, as opposed to awareness of allegations, so its continued payment did not negate materiality.

Our review of the continued payment cases at the SJ/JMOL stages also revealed that judges appointed by Republican administrations appear more likely than judges appointed by Democratic administrations to find in favor of defendants. This pattern was not present in decisions at the MTD stage.\[11\]
These patterns demonstrate that courts have largely been faithful to Escobar's admonition that the materiality standard is a demanding one. But these patterns may shift in the future if Congress passes a set of amendments to the FCA proposed by Sen. Charles Grassley, R-Iowa, this past summer.[12]

As currently structured, the amendments would, among other things, add a new provision titled "Proving Materiality," which states:

In determining materiality, the decision of the Government to forego a refund or to pay a claim despite actual knowledge of fraud or falsity shall not be considered dispositive if other reasons exist for the decision of the Government with respect to such refund or payment.[13]

This provision appears to have been designed specifically to undercut the Supreme Court's position in Escobar regarding the import of the government's continued payment.

Grassley has a long track record of proposing amendments to the FCA that are favorable to relators and the government. He claims primary responsibility for the 1986 amendments to the FCA, which ushered in the modern era of vigorous FCA enforcement,[14] and he has blamed courts for watering down the FCA post-Escobar.

For example, in opening remarks at the Federal Bar Association's 2021 Qui Tam Conference, Grassley criticized lower courts for interpreting Escobar in a way that "read[s] into the law a more stringent materiality standard than the text of the" FCA provides, and stressed the need to "come down with a sledgehammer" on those who commit fraud.[15]

If the proving-materiality amendment is passed, it has the potential to disrupt the relatively pro-defendant gains of the post-Escobar period.

In particular, the amendment seems calculated to eliminate the continued-payment defense at the MTD stage, when it may be easy to assert other — possibly even hypothetical — reasons for the government's continued payment.

The amendment may also create challenges for defendants at the SJ stage, where there may be disputes about whether the other reasons for continued payment proffered by the relators and/or the government truly caused the government's action or are instead merely hypothetical.

Regardless of whether the standard for proving materiality under the FCA is changed, courts will no doubt continue to exhibit a diverse range of approaches to assessing materiality.

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[4] Id. at 2002-03.


[6] Id. at 2004 n.6.


[9] Id. at 2-3.

[10] Three outlier cases were excluded from this analysis.

[11] Cases decided by magistrate judges were excluded from this analysis.


[13] Id. (manager's amendment approved by the Senate Judiciary Committee on October 28, 2021).


Three Ways Escobar Leveled the Playing Field in FCA Cases

Marc A. Van Allen

Abstract

_In Universal Health Services, Inc. v. United States ex rel. Escobar, the Supreme Court established a new framework for determining whether the FCA’s “demanding” materiality requirement is satisfied. Lower courts are now disposing of more _qui tam_ cases where relators have failed to meet Escobar’s strict materiality standard. Because government agencies are the sole custodians of the core materiality evidence identified in Escobar, contractors are now obtaining broad discovery from governmental agencies in _qui tam_ cases. Additionally, the government is dismissing more _qui tam_ case due to the anticipated burden on government agencies of providing discovery related to Escobar’s materiality requirement._

I. Introduction

In 2020, _qui tam_ relators filed 672 complaints alleging fraudulent billing under the False Claims Act (FCA).¹ Even if a _qui tam_ case is meritless, it is not uncommon for these cases to last ten years or more, costing contractors millions of dollars in legal fees before the case is finally disposed of.² Recently, contractors involved in FCA litigation have discovered new ways to fight back. A key weapon in this fight is the Supreme Court’s decision in _Universal Health Services, Inc. v. United_...
actions, in part to avoid the burden of providing discovery to contractors related to Escobar’s materiality requirement.⁷

II. Escobar Imposed a “Demanding” Materiality Standard in FCA Cases.

A government contractor may be liable under the FCA for penalties and trebled actual damages if the contractor either: (i) presents a false or fraudulent claim for payment; or (ii) makes a false record or statement material to a false or fraudulent claim.⁸ Under the FCA, a claim can be fraudulent in one of three ways. First, a claim for payment may be “factually” false if it contains “an incorrect description of goods or services provided” or seeks payment “for goods or services never provided.”⁹ Second, under a false certification theory, a claim for payment may be “legally” false if the contractor certified that it complied with a “statute, regulation, or contractual term when it knew at the time that it did not do so.”¹⁰ Finally, under a “promissory fraud” theory, a claim for payment is false if the “contractor originally certified that it would comply with a law, regulation, or term when it knew at the time that it would not do so.”¹¹

Under a false certification theory, the relator may allege either express or implied false certification.¹² Express false certification cases involve a contractor “falsely certifying that it is in compliance with regulations which are prerequisites to Government payment in connection with the claim for payment of federal funds.”¹³ In implied false certification cases, some relators alleged that compliance with a contract provision or regulation constitutes a “condition of payment”...
out of compliance with a number of licensing, qualification, and supervision requirements.\textsuperscript{18} Under the defendant's care, a patient allegedly died from her reaction to prescribed medication.\textsuperscript{19} After the decedent's parents learned of the defendant's alleged deficiencies, they brought an FCA suit.\textsuperscript{20} The District Court granted the defendant's motion to dismiss and held that "the allegations of [the] complaint raise serious questions about the quality of care provided to the Plaintiffs' daughter[,] but the False Claims Act is not the vehicle to explore those questions."\textsuperscript{21} The First Circuit disagreed and held that the regulations with which the defendant had failed to comply were "conditions of payment" sufficient to give rise to FCA liability based on the "express and absolute language" of the relevant regulations, which that court considered "dispositive."\textsuperscript{22}

Overruling the First Circuit, the Supreme Court announced that FCA liability did not depend upon whether contract requirements are deemed "conditions of payment."\textsuperscript{23} Instead, the Court observed that the "implied certification" fraud theory is really a form of fraud by omission and that an omission can only render a statement false if the omitted fact is material to the statement, such that leaving that fact out renders the claim a "misleading half-truth.\textsuperscript{24} In analyzing what constitutes a material omitted fact, the Court rejected the government's "expansive position" that any regulatory or contractual violation is material "so long as the defendant knows that the Government would be entitled to refuse payment were it aware of the violation.\textsuperscript{25} Rather, the Court explained the importance of enforcing a strict materiality standard:

> The materiality standard is demanding. The False Claims Act is not "an all-purpose antifraud statute" . . . or a vehicle for punishing garden-variety breaches of contract or regulatory violations. A misrepresentation cannot be deemed material merely because the Government . . . would have the option to decline to pay if it knew of the defendant's noncompliance.\textsuperscript{26}

Finally, the Escobar Court opined that this "demanding" materiality standard is not satisfied when two elements are present: government knowledge and government inaction.\textsuperscript{27} In other words,
When filing an FCA complaint, a relator must plead facts “with plausibility and particularity under Federal Rules of Civil Procedure 8 and 9(b).” The Escobar Court also rejected the “assertion that materiality is too fact intensive for courts to dismiss False Claims Act cases on a motion to dismiss or at summary judgment.” To survive a motion to dismiss, a relator cannot simply assert that the alleged non-compliance was “material to the government’s payment decision” or that the government “would not have paid” if it had known of the contractor’s alleged non-compliance.

In other words, a relator needs to identify specific past instances where the government has refused to pay claims following an alleged non-compliance similar to the one alleged in the complaint. For example, in United States ex rel. Gardner v. Vanda Pharmaceutical, the FCA complaint alleged that: (i) the drug uses defendant promoted were not medically accepted; (ii) defendant created misleading sales pitches to convince prescribers that the drugs were effective for unapproved uses; (iii) defendant deceived providers about the drugs’ safety profiles and dangers; and (iv) defendant created a fake target list of physicians. In granting defendant’s motion to dismiss, the court ruled:

[These allegations] concern the means employed by Defendant in furtherance of its alleged scheme to promote off-label uses. They do not speak to whether government payors “consistently refuse[ ] to pay claims in the mine run of cases based on” off-label use of prescription drugs . . . Escobar, 136 S. Ct. at 2003. The inclusion of some allegations addressing these considerations is critical to plausibly pleading materiality, but the Amended Complaint is silent as to them.

Similarly, in United States ex rel. PCA Integrity Assoc. v. NCO Financial Systems, Inc., the court dismissed a complaint for failing to plead with enough specificity to establish materiality under the FCAs demanding standard. As an initial matter, the court noted that the relator did not allege that the government “consistently refuses to pay claims in the mine run of cases based on” the alleged noncompliance. The court also observed that there were “no factual allegations from...
At the summary judgment stage, Escobar’s materiality standard is even more demanding. To survive a motion for summary judgment, a relator must come forward with specific evidence demonstrating that the government consistently refuses to pay claims where it has knowledge of similar alleged violations.39

For example, in United States ex rel. Janssen v. Lawrence Memorial Hospital, the Tenth Circuit ruled that the government’s prior conduct precluded FCA liability.40 The court emphasized that the relator reported her allegations through a whistleblower hotline before filing suit, that a contractor investigated the allegations and flagged a “quality issue” for the government, but that the government nonetheless kept paying the defendant’s claim, even as the lawsuit proceeded.41 Although the government never “independently verified” the allegations, the Tenth Circuit reasoned that such “inaction in the face of detailed allegations from a former employee suggests immateriality.”42 On appeal, the relator had argued that “knowing about allegations” is different from “actual knowledge of noncompliance.”43 However, the Tenth Circuit held that this distinction was unavailing under the more demanding summary judgment standard and given the fact that the government continued to make payments after the suit was commenced.44

In light of the Escobar decision, contractors are now carefully reviewing FCA complaints to see if the relator alleged any specific facts demonstrating that the government has consistently refused to pay contractor claims after the government has learned of similar non-compliances.45 Put another way, contractors are asking whether the relator has offered anything more than the conclusion that the non-compliance was “material to the government’s payment decision” or that the government “would not have paid” if it had known of the non-compliance.46 When contractors identify such conclusory pleadings, they are filing motions to dismiss and motions for summary judgment on grounds that these allegations are insufficient as a matter of law under Supreme Court’s decision in Escobar.47

IV. Contractors Are Taking Broad Discovery from Government Agencies.
serve a subpoena on the agency. However, the standard applied by courts when enforcing a subpoena in these cases varies from circuit to circuit.

On one hand, the First, Second, Third, Fourth, Fifth, Seventh, Tenth, and Eleventh Circuits have held that courts may review an agency’s refusal to comply with a subpoena pursuant to the Administrative Procedure Act (APA). The courts’ rationale for this holding is that, pursuant to the APA, an agency’s choice of whether or not to comply with a third-party subpoena is viewed as a policy decision about the best use of the agency’s resources. In other words, these circuits have adopted a deferential standard that analyzes an agency’s decision to withhold information or testimony under its Touhy regulations by assessing whether the decision was “arbitrary or capricious” under the APA.

On the other hand, in the District of Columbia and Ninth Circuits, the APA’s deferential standard of review does not apply. Rather, in these circuits, the regular federal rules of discovery apply, pursuant to the Federal Rules of Civil Procedure (FRCP), regardless of whether the agency is a party to the underlying action. Therefore, in these circuits, litigants seeking information from the agency must serve an ordinary subpoena upon the agency pursuant to FRCP 45, followed by a motion to compel filed in federal district court pursuant to FRCP 26 and 45. Following these steps, if an agency refuses to produce the subpoenaed discovery, the Department of Justice (DoJ) must seek a protective order and bears the burden to show that the subpoena requires disclosure of privileged material, is unduly burdensome, or is otherwise improper.

Even before Escobar, courts often granted motions to compel against the government in non-intervened FCA cases where the information at issue was relevant to the contractor’s defense. Although the government is technically a non-party in these cases, it is still the real party in interest. This is because the government stands to benefit directly and most substantially from any recovery:

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the Touhy decision—that government information may be disclosed to a third party
without agency knowledge—simply cannot apply in qui tam cases.61

In granting motions to compel in non-intervened cases, courts have stressed that it would be
“unfair in the extreme” if the government could refuse to produce documents relevant to the
contractor’s defense while simultaneously standing to benefit from the FCA litigation.62

For this reason, government agencies will have difficulty withholding evidence that is relevant to
Escobar’s materiality analysis. For example, in United States v. Paramedics Plus LLC, the
government argued that its post-litigation actions—including the continued payments of claims
after the filing of the FCA litigation—were not discoverable.63 The court rejected the government’s
argument, ruling that the government’s “continued payment” of claims after the filing of the
litigation was relevant and discoverable, and that, “[t]his is the exact type of information that is
reasonably calculated to lead to the discovery of admissible evidence regarding the materiality
element after Escobar.”64

Additionally, under Escobar’s materiality test, the breadth of relevant discovery has greatly
expanded. For example, the range of discoverable information now includes the government’s
knowledge and continued payment of claims submitted by other contractors facing similar
compliance issues.65 Accordingly, documents detailing how other contractors were treated by the
government play a central role in Escobar’s materiality analysis. The Arriva Medical court explained that

[i]t could … be the case that [the defendant] was being singled out for enforcement,
while other companies were not subject to the same scrutiny. It would significantly
undermine the holding of Escobar if the government could manufacture an illusion of
indisputable materiality simply by being extra strict ahead of time with whichever
company the government wished to sue.66
Three Ways Escobar Leveled the Playing Field in FCA Cases

investigating whether the agency has continued to pay claims submitted by other contractors despite the agency’s knowledge of similar violations.\textsuperscript{69} Although this wide-ranging discovery may be taxing on government agencies, it is the only way for contractors to ascertain “what the government knew and when it knew it.”\textsuperscript{70}

V. The DoJ Is Affirmatively Dismissing \textit{Qui Tam} Cases.

After the DoJ declines to intervene in a \textit{qui tam} case, the FCA provides that “[t]he Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.”\textsuperscript{71} This gives the government the right to dismiss a \textit{qui tam} action over the relator’s objection.\textsuperscript{72}

In other words, the government has the prerogative to dismiss a \textit{qui tam} case because the government is the real party in interest.\textsuperscript{73} Numerous courts have recognized that “the government can legitimately consider the burden imposed on the taxpayers” by an FCA case and that “the government would continue to incur enormous internal staff costs” if the case proceeded.\textsuperscript{74}

Over the last several years, there has been a marked increase in the number of dismissal motions filed by the government.\textsuperscript{75} Indeed, the DoJ dismissed roughly the same number of cases (forty-five) in the two years following the 2018 DoJ-published memorandum (the Granston Memo) as it had dismissed in the prior thirty years.\textsuperscript{76} This surge in cases dismissed by the government is the result of two factors. First, the Granston Memo directed DoJ attorneys to be more proactive in considering dismissal of \textit{qui tam} cases.\textsuperscript{77} The Granston Memo identified a number of reasons for dismissing \textit{qui tam} actions, including: (i) preventing interference with agency policies, and (ii) preserving government resources.\textsuperscript{78} Further, the Granston Memo explained that “the government expends significant resources in monitoring [non-intervened] cases and sometimes must produce discovery or otherwise participate.”\textsuperscript{79}
the alleged non-compliance. This discovery may be voluminous and will likely cause the government to expend significant resources.

In other words, in every case in which the government does not intervene, the government must now carefully consider whether it should expend substantial resources in responding to discovery relevant to Escobar’s materiality test. For example, in United States ex rel. Polansky Health Resources v. Executive Health Resources, Inc., the government was ordered to produce over 42,000 pages of documents and had to devote resources to litigating numerous discovery disputes with both the relator and the defendant. Over time, the burdens of discovery caused the government to exercise its dismissal authority.

Similarly, in United States v. Gilead Sciences, the court granted the government’s motion to dismiss. In so doing, the court recognized the substantial burden on the government if it were required to respond to discovery requests relevant to Escobar’s materiality test and that this wide-ranging discovery would be unavoidable if the case proceeded. In particular, the court noted that discovery into “exactly what the government knew and when” cannot be avoided and it “will likely entail extensive discovery into government witnesses and documents by either or both parties.”

In the wake of the Escobar decision and the Granston Memo, contractors are looking for opportunities to convince the government to dismiss qui tam cases pursuant to 31 U.S.C. § 3730(c)(2)(A). From the outset of the litigation, a contractor’s legal team will engage in discussions with DoJ lawyers regarding the application of Escobar’s materiality standard and its possible impact on the litigation—both in terms of the relator’s likelihood of success on the merits and the anticipated scope of Touhy discovery directed to governmental agencies. At key junctures in the litigation, the contractor’s lawyers may reach out to the DoJ to discuss the Granston Memo and whether the instant qui tam case might be a candidate for dismissal pursuant to 31 U.S.C. § 3730(c)(2)(A). If the DoJ signals an interest in discussing this topic further, the contractor’s legal team will then...
additional costs on the government, contractors are now obtaining broad discovery from governmental agencies because these agencies are the sole custodians of the critical materiality evidence identified in *Escobar*. Additionally, the government is dismissing more *qui tam* cases due to the anticipated burden on government agencies of providing discovery related to *Escobar*’s materiality requirement. In turn, each of these post-*Escobar* developments has made it easier for contractors to resolve FCA cases expeditiously.

Endnotes


4. *Id.* at 2003.


11. Id.


14. Neighorn v. Quest Health Care, 870 F. Supp. 2d 1069, 1101 (D. Or. 2012) (“[D]elivery ticket signed by the patient was merely internal billing process prerequisite, not condition of payment under” Rotech’s contract with the Department of Veterans Affairs.).

15. Id. at 1094.

16. Compare United States v. Sanford-Brown, Ltd., 788 F.3d 696, 711–12 (7th Cir. 2015) (“Although a number of other circuits have adopted this so-called doctrine of implied false certification . . . we decline to join them”), cert. granted, judgment vacated sub nom., United States ex rel. Nelson v. Sanford-Brown, Ltd., 136 S. Ct. 2506 (2016), opinion reinstated in part, superseded in part, 840 F.3d 445 (7th Cir. 2016), with Mikes ex rel. Mikes v. Straus, 274 F.3d 687, 702 (2d Cir. 2001) (allowing implied false certification claims, but only with regard to requirements expressly identified as conditions of payment), and United States v. Sci. Applications Int'l Corp., 626 F.3d 1257, 1269 (D.C. Cir. 2010) (“The existence of express contractual language specifically linking compliance to eligibility for payment may well constitute dispositive evidence of materiality, but it is not . . . a necessary condition.”).

Three Ways Escobar Leveled the Playing Field in FCA Cases

21. Id. at *13.

22. United States ex rel. Escobar v. Universal Health Servs., 780 F.3d 504, 514 (1st Cir. 2015).


24. Id. at 2001.

25. Id. at 2004.

26. Id. at 2003.

27. Id. at 2003–04.

28. Id.

29. Id. at 2004 n.6.

30. Id.

31. See, e.g., United States ex rel. Kietzman v. Bethany Circle of King's Daughters of Madison, Inc., 305 F. Supp. 3d 964, 977 (S.D. Ind. 2018) (dismissing complaint that “either alleges baldly that a certain alleged act of noncompliance was ‘material,’ or, restating the concept, that the government ‘would not have paid’ had it known of the [defendant’s] alleged noncompliance”); United States ex rel. Dresser v. Qualium Corp., No. 5:12-cv-01745-BLF, 2016 WL 3880763, at *6 (N.D. Cal. July 18, 2016) (dismissing complaint that “alleges in several places that the government would not have paid Defendants’ claims had they known of Defendants’ fraudulent conduct, but does not explain why . . . this does not meet [Escobar’s] heightened materiality standard”).
35. Id. at *24.

36. Id. at *15.

37. Id. at *25.

38. Id. at *26; accord United States ex rel. Emerson Park v. Legacy Heart Care, No. 3:16-CV-0803-S 2019 WL 4450371, at *7 (N.D. Tex. Sept. 17, 2019) (dismissing complaint with prejudice where Relator did not plead sufficient facts to show that “Government would deny Defendants reimbursement payments if it had known of these alleged violations” (quoting United States ex rel. Lemon v. Nurses To Go, Inc., 924 F.3d 155, 161–63 (5th Cir. 2019))); United States v. Somnia, Inc., No. 1:15–cv–00433–DAD–EPG, 2018 WL 684765, at *8 (E.D. Cal. Feb. 2, 2018) (“[T]o sufficiently allege materiality, a plaintiff must plausibly allege that ‘in the mine run of cases,’ the government ‘would not have paid these claims had it known of these violations.’”) (quoting Universal Health Servs., Inc., v. United States ex rel. Escobar, 136 S. Ct. 1989, 2003–04 (2016)); United States ex rel. Ferris v. Afognak Native Corp., No. 3:15-cv-0150-HRH, 2016 U.S. Dist. LEXIS 188709, at *9 (D. Alaska Sept. 28, 2016) (“Thus, post-Escobar, is it not sufficient for a relator to simply allege that a violation of a statutory requirement is material because that violation may influence the government’s decision to pay a claim. The relator must allege some facts that show that the government actually does not pay claims if they involve the statutory violations in question.”) (emphasis added)).


41. Id. at 538–39.

42. Id. at 542.

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49. Id. at 2236.


51. See id. at 464–65.

52. See infra note 53–58.

53. 5 U.S.C. §§ 702, 706(2)(A); see Puerto Rico v. United States, 490 F.3d 50, 70 (1st Cir. 2007); In re S.E.C. ex rel. Glotzer, 374 F.3d 184, 190 (2d Cir. 2004); Davis Enters. v. EPA, 877 F.2d 1181, 1186 (3d Cir. 1989); COMSAT Corp. v. Nat'l Sci. Found., 190 F.3d 269, 274 (4th Cir. 1999); Hasie v. Office of the Comptroller of the Currency, 633 F.3d 361, 365 (5th Cir. 2011); Rimmer v. Holder, 700 F.3d 246, 263 (6th Cir. 2012); Edwards v. U.S. Dep't of Justice, 43 F.3d 312, 316 (7th Cir. 1994); Mobil Expl. & Producing U.S., Inc. v. Dep't of Interior, 180 F.3d 1194, 1197–98 (11th Cir. 1991).

54. See Barreto v. SGT, Inc., 826 F. App'x 267, 269 (4th Cir. 2020) (citing Boron Oil Co. v. Downie, 873 F.2d 67, 71–72 (4th Cir. 1989) for the proposition that “[a]n agency’s refusal [to comply with a subpoena] is not arbitrary, capricious, or unlawful if [the agency] acts in accordance with valid internal regulations concerning third-party subpoenas”).

55. See, e.g., Cabral v. U.S. Dep't of Justice, 587 F.3d 13, 24 (1st Cir. 2009). Notably, courts in these circuits make clear that challenges brought to an agency’s denial of a discovery request are not judicially reviewable if they challenge the validity of the content of the agency’s internal guidelines or regulations. See, e.g., COMSAT Corp. v. Nat'l Sci. Found., 190 F.3d 269, 277 (4th Cir. 1999).
APAs ‘arbitrary and capricious’ standard of review, is the only avenue of relief even in federal court with respect to a federal subpoena.” (emphasis added)).


57. See, e.g., Watts, 482 F.3d at 508 (“We have held, moreover, that government agencies are ‘persons’ subject to Rule 45 subpoenas. . . . Therefore, a challenge to an agency’s refusal to comply with a Rule 45 subpoena should proceed and be treated not as an APA action but as a Rule 45 motion to compel (or an agency’s Rule 45 motion to quash).” (citation omitted)).

58. Id. at 508–09.


60. United States ex rel. Milam v. Univ. of Texas M.D. Anderson Cancer Ctr., 961 F.2d 46, 50 (4th Cir. 1992).


Claims Act case . . . when the Government itself decided to pay certain categories of claims, or was aware of the Defendant's billing practices and knowingly paid the claims anyway).


66. United States ex rel. Goodman v. Arriva Med., 471 F. Supp. 3d 830, 844 (M.D. Tenn. 2020) (emphasis added). The Arriva Medical court ordered the government to produce contract files from twenty-five other contractors even though the government complained that it “would take at least 6,100 to 8,200 hours (and likely more) of manual review of over 1,800 investigative files, costing approximately $500,000 or more.” Id. at 836 (emphasis added).


68. Id. at 2001.

69. Id.


72. Id.

73. Id.

74. United States ex rel. Sequoia Orange Co. v. Baird-Neece Packing Corp., 151 F.3d 1139, 1146 (9th Cir. 1998); see also Chang v. Children's Advoc. Ctr., 938 F.3d 384, 387 (3d Cir. 2019) (highlighting that the government has an interest in minimizing unnecessary or burdensome litigation costs."

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76. Id. “Before we issued the Granston Memo, we identified about 45 cases that the department had dismissed in the previous thirty years since the 1986 amendments, and we looked to those cases to guide our exercise of this authority. In the two years since the Granston Memo, we have moved to dismiss a similar number of about 45–50 cases under (c)(2)(A).” Id.

77. Id. at 1.

78. Id. at 3–6.

79. Id. at 1.


81. Id.


85. Id.

89. See Alex Hontos & Eric Weisenburger, The False Claims Act: Recent Developments in One of GovCon’s Oldest Laws, 55 PROCUREMENT L. 3 (2020).

90. See id.

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued March 3, 2022                Decided May 17, 2022

No. 21-7039

UNITED STATES OF AMERICA, ex rel. VERMONT NATIONAL TELEPHONE COMPANY,

AND

VERMONT NATIONAL TELEPHONE COMPANY,
APPELLANT

v.

NORTHSTAR WIRELESS, LLC, ET AL.,
APPELLEES

Appeal from the United States District Court
for the District of Columbia
(No. 1:15-cv-00728)

Jeffrey A. Lamken argued the cause for appellant. With him on the briefs were Bert W. Rein, Bennett L. Ross, Stephen J. Obermeier, Eugene A. Sokoloff, and Mark W. Kelley.

Seth P. Waxman argued the cause for appellees. With him on the brief were Catherine E. Stetson, Jonathan L. Diesenhau, Ari Q. Fitzgerald, Howard M. Shapiro, Daniel S.
Volchok, Beth S. Brinkmann, Peter B. Hutt II, and Michael M. Maya. Joseph Meyer and Susan Pelletier entered appearances.

Before: ROGERS, TATEL*, and PILLARD, Circuit Judges.

Opinion for the court filed by Circuit Judge TATEL.

TATEL, Circuit Judge: In this qui tam action, Vermont National Telephone Company alleges that several telecommunications companies defrauded the United States Government of $3.3 billion by manipulating Federal Communications Commission rules and falsely certifying their eligibility for discounts on spectrum licenses. The district court dismissed the suit, resting its decision on the False Claims Act’s “government-action bar” and its “demanding materiality standard.” Because neither basis invoked by the district court warrants dismissal, we reverse.

I.

The Communications Act of 1934 authorizes the Federal Communications Commission to grant licenses allowing companies to use portions of the electromagnetic spectrum, “the range of electromagnetic radio frequencies used to transmit sound, data, and video across the country.” SNR Wireless LicenseCo, LLC v. FCC, 868 F.3d 1021, 1025 (D.C. Cir. 2017) (internal quotation marks omitted); see 47 U.S.C. §§ 307, 309. Once licensed, companies may use their allocated radio frequencies to provide television, cell phone, and wireless internet service. SNR Wireless, 868 F.3d at 1025.

To apportion spectrum licenses among competing companies, the Commission holds auctions that involve a

* Judge Tatel assumed senior status after this case was argued and before the date of this opinion.
two-step license application process. See 47 U.S.C. § 309(j)(1); 47 C.F.R. §§ 1.2105, 1.2107. First, applicant companies submit “streamlined, short-form application[s]” providing, under penalty of perjury, information concerning their eligibility to bid in the auction. SNR Wireless, 868 F.3d at 1027 (internal quotation marks omitted); 47 C.F.R. § 1.2105. Companies claiming “bidding credits”—discounts used to cover part of the cost of licenses won at auction—must certify their eligibility for such credits in their short-form applications. See 47 C.F.R. §§ 1.2105(a)(2)(iv), 1.2110(f). Companies determined by the Commission to be “qualified to bid” based on their short-form applications may participate in the auction. See id. § 1.2105.

Second, winning bidders “file a more comprehensive long-form application” to demonstrate their qualifications to hold spectrum licenses and their eligibility for claimed bidding credits. SNR Wireless, 868 F.3d at 1027 (internal quotation marks omitted); 47 C.F.R. § 1.2107. Once the Commission publicly announces its acceptance of a winning bidder’s long-form application, any “party in interest” may file a petition to deny the application on the grounds that granting it would be inconsistent with “the public interest, convenience, and necessity.” 47 U.S.C. § 309(a), (d)(1); see 47 C.F.R. § 1.2108. The winning bidder may, in turn, “file an opposition to any petition to deny, and the petitioner a reply to such opposition.” 47 C.F.R. § 1.2108(c). After reviewing the application and the pleadings filed, the Commission determines whether the winning bidder is qualified to hold a license. 47 U.S.C. § 309(d)(2); 47 C.F.R. § 1.2108(d).

A winning bidder that defaults on its “binding obligation to pay its full bid amount upon acceptance of the winning bid at the close of an auction” is subject to a “default payment.” 47 C.F.R. § 1.2104(g)(2). And a bidder that violates the
Commission’s rules in connection with its participation in the competitive bidding process may be subject to sanctions, including “forfeiture of [its] upfront payment, down payment or full bid amount.” *Id.* § 1.2109(d). Such forfeiture penalties are assessed in a separate “forfeiture proceeding,” initiated by a notice of apparent liability or a notice of opportunity for hearing. *Id.* § 1.80(f)–(h).

This case arose from Auction 97, in which companies bid for “exclusive access to 1,614 Advanced Wireless Services licenses in [three radio frequency] bands.” Am. Compl. ¶ 2. When announcing the auction, the Commission’s Wireless Telecommunications Bureau explained that small businesses would be eligible to receive bidding credits entitling them to either a 15-percent or 25-percent discount on their winning bids. *Id.* ¶ 48; *Auction of Advanced Wireless Services (AWS-3) Licenses Scheduled for November 13, 2014 (Auction Notice)*, 29 FCC Rcd. 8386, 8411–12 (2014). The size of the bidding credits would depend on the business’s attributable revenues over the preceding three years, which includes the revenues of the small business itself as well as those of any entity with “de facto control” over the business. *Auction Notice*, 29 FCC Rcd. at 8412–13; Am. Compl. ¶ 48.

Northstar Wireless, LLC (“Northstar”) and SNR Wireless LicenseCo, LLC (“SNR”) each submitted short-form applications to participate in Auction 97, claiming eligibility for the 25-percent bidding credit offered to “very small businesses” with less than $15 million in attributable revenues. Am. Compl. ¶¶ 3, 48, 82 (internal quotation marks omitted). Their applications disclosed that “they had acquired the capital that they needed to participate in the auction from DISH [Network]—a large, established corporation that was itself ineligible for bidding credits.” *SNR Wireless*, 868 F.3d at 1027. The applications also disclosed that DISH, Northstar, and SNR
had adopted “joint bidding protocols and agreements” pursuant to which the three companies could coordinate their bidding strategies. *Id.* Based on their short-form applications, the Commission found Northstar and SNR “qualified to bid” in Auction 97. *Auction of Advanced Wireless Services (AWS-3) Licenses 70 Bidders Qualified to Participate in Auction 97*, 29 FCC Rcd. 13465, 13465 & n.3, 13477 (2014) (determining that applicants’ short-form applications were “complete and compl[ied] with the Commission’s competitive bidding rules and policies”).

Northstar and SNR were “remarkably successful” in Auction 97, collectively winning 43.5 percent of the licenses in play. *SNR Wireless*, 868 F.3d at 1027–28. After the auction, Northstar and SNR submitted long-form applications for the licenses they won, reiterating that they were “very small businesses” entitled to bidding credits. *Id.* at 1028. The use of such credits would discount the price of Northstar’s and SNR’s winning bids from $13.3 billion to approximately $10 billion. Am. Compl. ¶ 100. Once the long-form applications became public, eight companies petitioned the Wireless Bureau to deny Northstar’s and SNR’s applications. *SNR Wireless*, 868 F.3d at 1028. All eight challengers argued that Northstar and SNR were ineligible for very-small-business credits because DISH effectively controlled them. *Id.* One challenger, VTel Wireless, Inc., also argued that Northstar and SNR withheld from the Commission material information about their relationship with DISH. *Northstar Wireless, LLC (FCC Opinion)*, 30 FCC Rcd. 8887, 8940 (2015).

The Wireless Bureau referred the petitions to the full Commission for “consideration of the questions posed by the petitions to deny.” *SNR Wireless*, 868 F.3d at 1028 (internal quotation marks omitted). The Commission concluded that Northstar and SNR were ineligible for bidding credits because
they were *de facto* controlled by DISH, such that DISH’s large annual revenues were attributable to them. *FCC Opinion*, 30 FCC Rcd. at 8889–90. But based on the record before it, the Commission found no evidence “that SNR and Northstar attempted to mislead the Commission about their respective relationships with DISH” or “that they did not adequately disclose the nature of their relationship and joint bidding arrangements with DISH.” *Id.* at 8890–91, 8941.

After the Commission issued its ineligibility determination, Northstar and SNR “notified the Commission that they would pay the full bid amount for some of the licenses they won [but] would default on their obligation to buy the rest.” *SNR Wireless*, 868 F.3d at 1028. In response, the Commission ordered Northstar and SNR to pay a default payment consisting of (1) compensation for “the difference between their own winning bids in Auction 97 and the amount that the FCC receives when it re-auctions the licenses” and (2) “an additional payment equal to fifteen percent of [Northstar’s and SNR’s] own bids, or fifteen percent of the winning bid when their licenses are re-auctioned, whichever is less.” *Id.* at 1029; see 47 C.F.R. § 1.2104(g)(2).

Northstar and SNR petitioned this court for review of the Commission’s determination that they were ineligible for bidding credits. *SNR Wireless*, 868 F.3d at 1029. Our court upheld the Commission’s ineligibility determination but remanded to the Commission “to give [Northstar and SNR] an opportunity to seek to negotiate a cure for the *de facto* control the FCC found that DISH exercises over them.” *Id.* at 1025. On remand, the Commission directed Northstar and SNR to renegotiate their business arrangements with DISH and then submit revised agreements to the Commission. *Northstar Wireless, LLC*, 33 FCC Rcd. 231, 232–34 (2018). Northstar’s
and SNR’s petition for review of that FCC decision remains pending.

Meanwhile, and setting the stage for this case, Vermont National Telephone Company (“Vermont Telephone”) filed a qui tam action against Northstar, SNR, DISH, and several affiliated companies (collectively, “Defendants”), alleging they violated the False Claims Act (FCA) by making false certifications and manipulating the Commission’s auction rules to secure fraudulent bidding credits on spectrum licenses. Am. Compl. ¶¶ 1–7. As relevant here, the FCA imposes civil penalties on anyone who “knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay . . . money . . . to the Government.” 31 U.S.C. § 3729(a)(1)(G); see also id. §§ 3729(a)(1)(A), (B), (C). The Act authorizes private entities like Vermont Telephone to bring actions on behalf of the government, sharing in the recovery when such actions succeed. Id. § 3730(b), (d). The district court, however, dismissed Vermont Telephone’s suit, relying on the Act’s government-action bar which forecloses qui tam actions “based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.” Id. § 3730(e)(3); U.S. ex rel. Vermont National Telephone Co. v. Northstar Wireless LLC (Vermont Telephone), 531 F. Supp. 3d 247, 251, 264–67 (D.D.C. 2021). The court also held that Vermont Telephone’s allegations failed to satisfy the Act’s “demanding materiality standard.” Id. at 251, 268–70.

Vermont Telephone appeals, arguing that neither basis invoked by the district court supports dismissal. Defendants defend the district court’s decision, and argue that we can affirm on the alternative grounds that Vermont Telephone has failed to plead its FCA claims with the requisite plausibility and particularity needed to satisfy Federal Rules of Civil

II.

Originally enacted during the Civil War, the FCA allows private individuals to bring qui tam actions in the name of the United States in order to “augment[] the government’s limited enforcement resources” and “protect[] federal funds from fraud.” *U.S. ex rel. Totten v. Bombardier Corp.*, 286 F.3d 542, 545–46 (D.C. Cir. 2002); see *Singleton v. Howard University*, 939 F.3d 287, 292–93 (D.C. Cir. 2019) (“Congress enacted the False Claims Act in the 1860s in response to widespread fraud perpetrated by Civil War contractors.”). As noted above, however, the statute’s government-action bar forecloses qui tam suits “which [are] based upon allegations or transactions which are the subject of . . . an administrative civil money penalty proceeding in which the Government is already a party.” 31 U.S.C. § 3730(e)(3).

According to the district court, the Commission’s post-auction licensing proceeding, which reviewed Northstar’s and SNR’s long-form applications for spectrum licenses and the petitions to deny them, triggered the government-action bar. *Vermont Telephone*, 531 F. Supp. 3d at 251, 264–68. Disagreeing, Vermont Telephone argues that the government-action bar is inapplicable because the Commission’s licensing proceeding was not an “‘administrative civil money penalty proceeding.’” Appellant’s Br. 27 (quoting 31 U.S.C. § 3730(e)(3)).

The FCA nowhere defines the phrase “administrative civil money penalty proceeding.” But to state the obvious, an
“administrative civil money penalty proceeding” is a proceeding in which an administrative agency may impose a civil money penalty. Defendants contend that the licensing proceeding qualifies as an “administrative civil money penalty proceeding” because the Commission imposed, or could have imposed, several different civil money penalties during that proceeding.

First, Defendants argue that the Commission levied civil money penalties by subjecting Northstar and SNR to default payments after they selectively defaulted on their winning bids in Auction 97. But even assuming that these default payments are civil money penalties, they have no bearing on whether the Commission’s licensing proceeding is a “civil money penalty proceeding” for a simple reason: The default payments were not assessed during the licensing proceeding. In that proceeding, the Commission determined only whether Northstar and SNR were “qualif[ied]” to hold spectrum licenses and “eligible” for bidding credits. *FCC Opinion*, 30 FCC Rcd. at 8889, 8891. The question of whether to impose default payments arose later, after Northstar and SNR chose to selectively default on their obligations to pay for some of their winning bids. *See* Notice of Interim Default Payment Obligation for Auction 97 Licenses, Joint Appendix 960, 964 (notifying Northstar and SNR of their default payment obligations after they “cho[se] to selectively default”). It would make no sense to conclude that the Commission’s ultimate imposition of default payments, triggered by an event that had not yet occurred at the time of the licensing proceeding, retroactively transformed the licensing proceeding into a civil money penalty proceeding.

Defendants insist that “[t]he fact that weeks passed between the eligibility decision [in the licensing proceeding] and the imposition of the penalties does not mean the latter was
not part of the proceeding, any more than the fact that a
criminal sentence can be imposed weeks or months after a
guilty verdict means [that] sentencing is not part of the criminal
proceeding.” Appellees’ Br. 40. This analogy misses the mark.
Unlike a criminal sentence, the default payments did not
“flow[ ] directly,” id., from the Commission’s determination in
the licensing proceeding that Northstar and SNR were
ineligible for bidding credits. An intervening event—
Northstar’s and SNR’s decisions to selectively default—
ocurred before the Commission assessed default payments
against these companies.

Second, Defendants point out that the Commission may
assess “forfeiture penal[ies]” for willful failure to comply with
any FCC rule or regulation, 47 C.F.R. § 1.80(a), including the
rule prohibiting the intentional submission of false or
misleading statements to the Commission, id. § 1.17(a).
Commission regulations, however, authorize assessment of
forfeiture penalties only in “forfeiture proceed[ing[s],” which
the Commission initiates by issuing either a “notice of apparent
liability” or a “notice of opportunity for hearing.” Id. § 1.80(f)–
(h). Because the Commission issued neither, it never initiated
a forfeiture proceeding and so had no authority to impose
forfeiture penalties. See 47 U.S.C. § 503(b)(3)(a), (4) (“[N]o
forfeiture penalty shall be imposed under this subsection
against any person unless and until . . . the Commission issues
a notice of apparent liability” or provides “notice and an
opportunity for a hearing before the Commission or an
administrative law judge.”).

Third, Defendants allude to “other penal[ies]” that the
Commission may impose, citing language from the
Communications Act and Commission regulations stating that
“[a] forfeiture penalty under this subsection shall be in addition
to any other penalty” provided for by the statute. Id.
§ 503(b)(1) (emphasis added); accord 47 C.F.R. § 1.80 n.1. In search of “other penal[ies]” available to the Commission during its licensing proceeding, 47 U.S.C. § 503(b)(1), Defendants point to several Commission public notices and orders which state that “[s]ubmission of a false certification to the Commission may result in penalties, including monetary forfeitures, license forfeitures, ineligibility to participate in future auctions, and/or criminal prosecution.” Application of Winstar Broadcasting Corp., 20 FCC Rcd. 2043, 2051 n.55 (2005); accord Auction of Broadband PCS Spectrum Scheduled for May 16, 2007, 22 FCC Rcd. 433, 448, 454 (2007). But aside from monetary forfeitures, which the Commission may assess only in separate forfeiture proceedings, none of the penalties listed in these notices and orders is monetary. Defendants cite no authority, nor are we aware of any, that permits the Commission to issue civil money penalties without first initiating forfeiture proceedings.

Because the Commission had no authority to assess civil money penalties during its licensing proceeding, which evaluated only Northstar’s and SNR’s long-form applications and the petitions to deny them, the licensing proceeding was not an “administrative civil money penalty proceeding.” The government-action bar therefore poses no impediment to Vermont Telephone’s suit.

III.

To be actionable under the FCA, “a misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government’s payment decision.” Universal Health Services, Inc. v. U.S. ex rel. Escobar, 579 U.S. 176, 192 (2016). A misrepresentation is “material” under the Act if it has “a natural tendency to influence, or be capable of influencing, the payment or receipt
of money or property.” 31 U.S.C. § 3729(b)(4); accord Cimino, 3 F.4th at 419.

The district court concluded that Vermont Telephone failed to plausibly allege any false claims capable of influencing Northstar’s and SNR’s eligibility for bidding credits in Auction 97. Vermont Telephone, 531 F. Supp. 3d at 270. We disagree. Vermont Telephone alleged that Northstar and SNR “knowingly failed to disclose all of their instruments, agreements, and understandings with . . . DISH” and “falsely certified” that they had disclosed all instruments, agreements, and understandings relevant to their claimed bidding credits in Auction 97. Am. Compl. ¶¶ 125, 128. Specifically, Vermont Telephone alleged that the two companies failed to disclose their agreement to transfer or resell their spectrum to DISH after a five-year non-transfer period. Id. ¶¶ 125–27, 130. Because an applicant’s attributable revenues in Auction 97 included those of any entity to which the applicant had agreed to resell “more than 25 percent of the spectrum capacity of any individual license,” id. ¶ 56, Northstar’s and SNR’s undisclosed spectrum-resale arrangements would have increased their attributable revenues beyond the $15-million cap for very-small-business credits, id. ¶ 48. Northstar’s and SNR’s alleged false certifications and failures to disclose agreements central to their eligibility for bidding credits were certainly “capable of influencing” the Commission’s bidding-credit-eligibility determination. Cimino, 3 F.4th at 423.

Echoing the district court’s reasoning, Defendants argue that the alleged undisclosed agreements would not have changed the Commission’s ultimate decision to deny bidding credits because the Commission found Northstar and SNR ineligible for credits even without the disclosure of any such agreements. But, as other circuits have explained, the FCA’s materiality inquiry “focuses on the potential effect of the false
statement when it is made.” *U.S. ex rel. Loughren v. Unum Group*, 613 F.3d 300, 309 (1st Cir. 2010); *U.S. ex rel. Longhi v. United States*, 575 F.3d 458, 470 (5th Cir. 2009) (focusing on “the potential effect of the false statement when it is made rather than on the false statement’s actual effect after it is discovered,” and noting that the Fourth, Sixth, and Ninth Circuits have adopted the same interpretation of the FCA’s materiality standard (internal quotation marks omitted)). At the time Northstar and SNR submitted their short- and long-form applications, their eligibility for bidding credits depended on their disclosure of all “agreements, arrangements or understandings of any kind relating to the licenses being auctioned.” 47 C.F.R. § 1.2105(a)(2)(viii) (requiring “[c]ertification that the applicant has provided” all agreements, arrangements, and understandings); *id.* § 1.2112 (b)(2)(vii) (requiring applicants to “[l]ist and summarize any agreements in which the applicant has entered into arrangements for the use of any of the spectrum capacity of the license that is the subject of the application”). Moreover, if Northstar and SNR had disclosed their alleged agreements to “[resell] the spectrum purchased during the auction” to DISH, Am. Compl. ¶ 130, they “could not have qualified as ‘very small businesses,’ and thus could not have received the 25 percent [bidding credits],” *id.* ¶ 132; see *id.* ¶ 56. Northstar’s and SNR’s alleged false certifications and failures to disclose agreements therefore had the potential to affect the Commission’s eligibility determinations regarding such bidding credits.

Defendants cite the Supreme Court’s decision in *Escobar* and our decision in *McBride*, urging us to focus on the Commission’s “actual” decision to deny bidding credits rather than the potential effect of Northstar’s and SNR’s misrepresentations. Appellees’ Br. 45, 48 (internal quotation marks omitted) (citing *Escobar*, 579 U.S. at 193 and *U.S. ex rel. McBride v. Halliburton Co.*., 848 F.3d 1027, 1032 (D.C.
Cir. 2017)). But those decisions looked to the government’s “actual behavior” only to assess whether the government attaches importance to a particular statutory, regulatory, or contractual requirement. *Escobar*, 579 U.S. at 193–94 (internal quotation marks omitted); see *McBride*, 848 F.3d at 1033–34 (considering the government’s prior cost determinations as evidence on summary judgment that a contractor’s voluntary disclosure of headcount data had no “connection” or “relevan[ce]” to such cost determinations). “[I]f the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated,” for instance, “that is strong evidence that the requirements are not mate*

ival.


ial.” *Escobar*, 579 U.S. at 195; accord *McBride*, 848 F.3d at 1034. Vermont Telephone’s complaint contains no allegations suggesting that the Commission attached minimal importance to Northstar’s and SNR’s alleged misrepresentations. See *Cimino*, 3 F.4th at 423 (“The question here . . . is whether [the plaintiff] plausibly *pleaded* materiality.”). Rather, the amended complaint suggests just the opposite, emphasizing that an applicant who fails to certify that it has disclosed all agreements relating to auctioned licenses will not be permitted to participate in the auction. Am. Compl. ¶¶ 57–61; 47 C.F.R. § 1.2105 (a)(2)(viii), (b)(1)(i).

Seeking to cast doubt on Vermont Telephone’s allegations, Defendants assert that any misrepresentations in Northstar’s and SNR’s short-form applications could not have affected their “*initial* [discounted] post-auction payments” because the Commission “substantially review[s]” eligibility for bidding credits only after applicants file their long-form applications. Appellees’ Br. 46–47 (internal quotation marks omitted). Any disputes regarding whether the Commission substantially reviews short-form applications, however, should be addressed at a later stage in this litigation. The question
before us at the motion-to-dismiss stage is only “whether [Vermont Telephone] plausibly pleaded materiality.” Cimino, 3 F.4th at 423. For the foregoing reasons, Vermont Telephone has done so.

IV.

Because the FCA is an antifraud statute, plaintiffs alleging claims thereunder must satisfy the “plausibility” pleading standard set forth in Federal Rule of Civil Procedure 8, as well as the heightened “particularity” standard set forth in Rule 9(b). Cimino, 3 F.4th at 421. Under Rule 8, the complaint must “contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face.” Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009) (internal quotation marks omitted). Under Rule 9(b), the complaint “must state with particularity the circumstances constituting fraud or mistake.” Fed. R. Civ. P. 9(b).

Defendants urge us to affirm on the alternative grounds, not reached by the district court, that Vermont Telephone failed to adequately plead its claims under Rules 8 and 9(b). We decline to do so and conclude that Vermont Telephone has adequately pleaded its claims.

Beginning with Rule 8, Vermont Telephone pleaded facts “allow[ing] the court to draw the reasonable inference” that Northstar and SNR falsely certified their disclosure of all agreements related to auctioned licenses when, in fact, they failed to disclose agreements to act on DISH’s behalf and transfer spectrum rights to DISH. Cimino, 3 F.4th at 421. In particular, Vermont Telephone alleged the following: (1) Northstar and SNR were formed as shell companies without any assets or revenues, at DISH’s direction, shortly before the deadline to apply for Auction 97, Am. Compl. ¶¶ 16, 24; (2) Northstar and SNR bid for spectrum licenses in Auction 97
“with financing provided almost exclusively from entities controlled by . . . DISH,” id. ¶ 91; (3) Northstar and SNR bid anonymously for the same licenses 744 times during the auction, id. ¶¶ 67, 92, 95; (4) Northstar and SNR frequently accepted the Commission’s random selection of the winner when they submitted identical winning bids, id. ¶ 96; (5) Northstar and SNR “finished the auction with geographic gaps in their spectrum licenses” which afforded complete coverage only when combined, id. ¶ 97; (6) Northstar’s and SNR’s post-auction selective defaults created “geographic holes in [their] individual coverage” while “promoting the uniformity of spectrum coverage provided by their combined holdings,” id. ¶ 105; (7) Northstar’s and SNR’s dispersed spectrum blocks from Auction 97 “made no sense from the point of view of providing communications services,” id. ¶¶ 117; (8) neither Northstar nor SNR had “taken steps to deploy a wireless system” in the four years since Auction 97 concluded, id. ¶ 120; and (9) DISH guaranteed Northstar’s and SNR’s default payment obligations when each entity selectively defaulted, id. ¶¶ 106–07.

Defendants offer alternative explanations for Northstar’s and SNR’s conduct, asserting that such conduct is “consistent with the absence of any undisclosed agreement(s).” Appellees’ Br. 55. Perhaps so, but the question before us on a motion to dismiss is only whether the alleged undisclosed agreements to act on DISH’s behalf or transfer spectrum rights to DISH are “plausible.” Iqbal, 556 U.S. at 679. They are. As Vermont Telephone alleges in its amended complaint, the aforementioned conduct makes little sense unless Northstar and SNR agreed in advance that DISH would ultimately control the licenses won at auction. Am. Compl. ¶¶ 107, 117.

Vermont Telephone also satisfied Rule 9(b) by setting forth detailed allegations regarding the “time, place, and
manner” of the fraudulent scheme. *U.S. ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 123 (D.C. Cir. 2015). According to the amended complaint, members of the boards of Northstar’s and SNR’s parent companies submitted short-form applications on September 12, 2014, via the Commission’s electronic submission portal, which contained false certifications that Northstar and SNR had disclosed all agreements, arrangements, and understandings related to the licenses in Auction 97. Am. Compl. ¶¶ 83–84, 124–31. The alleged undisclosed agreements, which the parties entered into between August and September 2014, involved Northstar’s and SNR’s procurement of spectrum licenses on DISH’s behalf. *Id.* ¶¶ 16, 24, 108–09, 125–31, 142. On February 13, 2015, Northstar and SNR submitted long-form applications confirming and recertifying all disclosures and representations made in their short-form applications. *Id.* ¶ 90. These allegations satisfy Rule 9(b)’s particularity requirement, as they provide “sufficient substance to . . . both afford [Defendants] the opportunity to prepare a response and to warrant further judicial process.” *Heath*, 791 F.3d at 125.

V.

For the foregoing reasons, we reverse.

*So ordered.*
PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 20-2330

UNITED STATES EX REL. DEBORAH SHELDON, Executrix of the Estate of Troy Sheldon, United States of America, ex rel.,

Plaintiff – Appellant,

v.

ALLERGAN SALES, LLC,

Defendant – Appellee.

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UNITED STATES OF AMERICA; TAXPAYERS AGAINST FRAUD EDUCATION FUND,

Amici Supporting Appellant.

WASHINGTON LEGAL FOUNDATION; CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA; PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA,

Amici Supporting Appellee.

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Appeal from the United States District Court for the District of Maryland, at Baltimore. Ellen L. Hollander, Senior District Judge. (1:14-cv-02535-ELH)

Argued: October 28, 2021          Decided: January 25, 2022

Before WILKINSON, WYNN, and RICHARDSON, Circuit Judges.
Affirmed by published opinion. Judge Wilkinson wrote the opinion, in which Judge Richardson joined. Judge Wynn wrote a dissenting opinion.

Plaintiff Troy Sheldon filed a False Claims Act *qui tam* suit against his employer, Forest Laboratories, LLC. He alleged that Forest engaged in a fraudulent price reporting scheme under the Medicaid Drug Rebate Statute, 42 U.S.C. § 1396r-8, by failing to aggregate discounts given to separate customers for purposes of reporting “Best Price.” Because Forest’s reading of the Rebate Statute was at the very least objectively reasonable and because it was not warned away from that reading by authoritative guidance, it did not act “knowingly” under the False Claims Act. As a result, we affirm the district court’s dismissal of Sheldon’s complaint.

We thank our friend for his thoughtful dissent. We do of course agree with him that “[t]he False Claims Act is the government’s primary litigative tool for the recovery of losses sustained as the result of fraud against the government.” Dissenting Op. at 32 (quoting *Avco Corp. v. U.S. Dep’t of Just.*, 884 F.2d 621, 622 (D.C. Cir. 1989)). Regrettably, despite all protestations, the dissent nullifies the whole concept of scienter about which the Supreme Court has shown an especial solicitude. The FCA unquestionably has a punitive aspect, and the kinship between civil scienter and criminal mens rea in this case is closer than Sheldon or the dissent is willing to acknowledge.

Sheldon’s position takes the FCA a very long step toward a strict liability statute. It conflates factual fraud and legal fraud, thereby facilitating steep liability for those whose factual representations are not alleged to be either false or duplicitous and those whose legal position is not only arguable but correct. Sheldon does not so much as allege reckless disregard or deliberate indifference or nefarious knowledge here with respect to, in the
operative word of the statute, the “information.” 31 U.S.C. § 3729(b)(1)(A). Yet the relator’s position instead makes sinister actors out of parties who have followed the law in every respect and sought administrative guidance where none was ever provided. Given the veritable thicket of Medicaid regulations, it is not too much to expect something more in the way of clarity and direction than was ever offered here. To reward the state with treble damages for this treatment of parties in the private sector is something no court should do.

Sheldon would disregard Judge Hollander’s sound counsel that the Rebate Statute’s “plain and natural reading” did not require aggregating discounts, along with her sensible conclusion that there was not “a single example where CMS explicitly state[d] that manufacturers must aggregate discounts to different customers along the supply chain in a given sale.” United States ex rel. Sheldon v. Forest Laboratories, LLC, 499 F. Supp. 3d 184, 209, 211 (D. Md. 2020). Sheldon in addition recommends we ignore all our sister circuits which have followed the framework that the Supreme Court has set forth in Safeco Insurance Co. of America v. Burr, 551 U.S. 47 (2007), thus opening wide a stark circuit split. See United States ex rel. Schutte v. SuperValu Inc., 9 F.4th 455, 459 (7th Cir. 2021); United States ex rel. Streck v. Allergan, Inc., 746 F. App’x 101, 106 (3d Cir. 2018); United States ex rel. McGrath v. Microsemi Corp., 690 F. App’x 551, 552 (9th Cir. 2017); United States ex rel. Donegan v. Anesthesia Assocs. of Kansas City, PC, 833 F.3d 874, 879–80 (8th Cir. 2016); United States ex rel. Purcell v. MWI Corp., 807 F.3d 281, 290–91 (D.C. Cir. 2015). Moreover, Sheldon proposes to disregard the Supreme Court’s insistence that the concept of scierter be given “rigorous” application, Universal Health Servs., Inc. v.
United States ex rel. Escobar, 136 S. Ct. 1989, 2002 (2016), and the dissent dismisses as “dictum” Supreme Court guidance which it finds inconvenient, Dissenting Op. at 31. All this—at all three levels of the judicial system—Sheldon and the dissent would overturn, in deference to a view that is not sustainable under law or under any notion of notice and due process with which we are familiar.

I.

A.


Under the Rebate Statute, manufacturers seeking to have their drugs covered by Medicaid must enter into Rebate Agreements with the Secretary of Health and Human Services and provide quarterly rebates to states on Medicaid sales of covered drugs. Id. § 1396r-8(a)(1), (c)(1)(A). The manufacturer reports the “Average Manufacturer Price” and the “Best Price” for its covered drugs to the Centers for Medicare & Medicaid Services (CMS); CMS then calculates the rebate amount that the manufacturer must pay to the states for each drug. See id. § 1396r-8(b)(3)(A). For covered drugs, the rebate amount is the greater of two numbers: (1) the statutory minimum rebate percentage, or (2) the difference
between the Average Manufacturer Price and the Best Price. *Id.* § 1396r-8(c)(1)(A). Federal payments to each state are reduced by the rebates that the state receives from manufacturers. *Id.* § 1396r-8(b)(1)(B).

The Rebate Statute defines Best Price as “the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity,” which “shall be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates.” *Id.* § 1396r-8(c)(1)(C)(i), (ii)(I). CMS regulations likewise define Best Price as “the lowest price available from the manufacturer during the rebate period to any entity in the United States,” including “all sales and associated rebates, discounts and other price concessions provided by the manufacturer to any entity.” 42 C.F.R. § 447.505(a) (2007). Best Price “shall be net of cash discounts . . . and any other discounts or price reductions and rebates . . . which reduce the price available from the manufacturer.” *Id.* § 447.505(e)(1) (2007). And the Rebate Agreement defines Best Price as “the lowest price at which the manufacturer sells the [covered drug] to any purchaser in the United States,” which “shall be adjusted by the manufacturer if cumulative discounts, rebates or other arrangements subsequently adjust the prices actually realized.” J.A. 213; see 56 Fed. Reg. 7049, 7050 (Feb. 21, 1991).

Acknowledging Medicaid’s complexity, the Rebate Agreement provides that “[i]n the absence of specific guidance,” manufacturers should “make reasonable assumptions in [their] calculations of . . . Best Price, consistent with the requirements and intent of [the Rebate Statute], Federal regulations and the terms of this agreement.” J.A. 217.
subsequent rulemaking, CMS has reaffirmed the need for manufacturers to make such reasonable assumptions. See, e.g., Medicaid Program; Prescription Drugs, 72 Fed. Reg. 39,142, 39,164 (July 17, 2007).

Because Medicaid involves submitting claims to the government, it implicates the False Claims Act (FCA). Relevant here, the FCA imposes liability if a person “knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation . . . to the Government” or “knowingly conceals or knowingly and improperly avoids or decreases an obligation . . . to the Government.” 31 U.S.C. § 3729(a)(1)(G). The FCA defines “knowingly” to mean that a person “(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information.” Id. § 3729(b)(1)(A). It “require[s] no proof of specific intent to defraud.” Id. § 3729(b)(1)(B).

The FCA allows private individuals known as relators to bring qui tam actions “for the person and for the United States Government.” Id. § 3730(b)(1). The United States can choose to intervene in the relator’s action if it wishes. Id. § 3730(b)(2), (4). When, as here, the government declines to intervene, the relator generally receives 25–30% of any proceeds of the action, plus attorney’s fees and costs. Id. § 3730(d)(2). If an FCA action succeeds, defendants are liable for treble damages as well as a civil penalty of up to $10,000 per claim. Id. § 3729(a).
B.

Relator Troy Sheldon filed this FCA suit against his employer Forest Laboratories, LLC in 2014.¹ In essence, Sheldon alleged that Forest gave discounts to separate customers along distribution chains but failed to account for the combined amount of all discounts in calculating Best Price, which led to the submission of false pricing reports to the government. This allegedly reduced the rebates that Forest paid to participating states and resulted in the federal government paying at least $680 million more than it would have if Forest had accurately reported Best Price.

To give an example: on one covered drug, Sheldon alleged that in FY2013 Forest gave a 20% discount to a patient’s insurance company and a 10% discount to the same patient’s pharmacy—two different entities on the distribution chain. See J.A. 98. Sheldon alleged that Forest was required to aggregate these discounts, report a Best Price of 70%, and give Medicaid a 30% rebate. Instead, Forest did not aggregate these discounts because they were given to different entities, reported a Best Price of 80% (based on the highest discount given to a single entity), and gave Medicaid a 23.1% rebate (the statutory minimum rebate percentage for that year, see 42 U.S.C. § 1396r-8(c)(1)(B)(i)(VI)).

¹ Troy Sheldon died after filing this action and Deborah Sheldon, his wife, was substituted as plaintiff. And in 2018, Forest merged into Allergan Sales, LLC. For clarity, we refer to Troy Sheldon rather than Deborah and to Forest rather than Allergan.

Sheldon sued on behalf of the United States. The suit was initially filed under seal. See 31 U.S.C. § 3730(b)(2). After a five-year investigation and every opportunity to intervene, the government declined to do so, and the suit was unsealed in October 2019.
Sheldon alleges that this led to the federal government paying 6.9% more for this drug than it would have if Forest had accurately reported Best Price.

Forest moved to dismiss Sheldon’s complaint, and the district court in a thoughtful opinion granted Forest’s motion. 499 F. Supp. 3d 184. The district court found that Sheldon had failed to plead both that the claims at issue were false and that Forest had made them knowingly. Relevant here, it held that Forest had offered “a plausible and objectively reasonable interpretation” of the Rebate Statute. Id. at 209. Beginning with the statutory text, the district court found that its “plain and natural reading” did not require aggregating discounts. Id. And looking at the regulatory language and history, the district court did not find “a single example where CMS explicitly state[d] that manufacturers must aggregate discounts to different customers along the supply chain in a given sale.” Id. at 211. The district court then concluded that CMS guidance “was not so clear as to warn Forest away from its interpretation,” especially considering the complexity of the statutory scheme. Id. at 212. So it held that Forest did not act with the requisite scienter when submitting Best Price reports to the government.

II.

We review de novo the dismissal of a relator’s complaint under Rule 12(b)(6). United States ex rel. Rostholder v. Omnicare, Inc., 745 F.3d 694, 700 (4th Cir. 2014). To plead his FCA claim, Sheldon must plausibly allege that Forest (1) made a false statement;
(2) with the requisite scienter ("knowingly"); (3) that was material; and (4) that caused the government to pay out money. *Id.; see also* 31 U.S.C. § 3729(a)(1)(G). Here, we interpret the second element, scienter, in line with the Supreme Court’s guidance in *Safeco*. Applying that analysis, we hold that Forest did not act knowingly under the FCA.

**A.**

1.

We are tasked with “strict enforcement” of the FCA’s “rigorous” scienter requirement. *Escobar*, 136 S. Ct. at 2002. As noted, the FCA defines “knowingly” to mean that a person “(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information.” 31 U.S.C. § 3729(b)(1)(A). Yet it does not further define these terms or signify how they apply in situations where it is unclear if a defendant complied with the law.

Fortunately, we are not without guidance in this area. In *Safeco*, the Supreme Court interpreted the Fair Credit Reporting Act’s analogous scienter provision. Like every other circuit to consider the issue, we hold that *Safeco* applies with equal force to the FCA’s scienter requirement. *See Schutte*, 9 F.4th at 459; *Streck*, 746 F. App’x at 106; *McGrath*, 690 F. App’x at 552; *Donegan*, 833 F.3d at 879–80; *Purcell*, 807 F.3d at 290–91.

*Safeco* interpreted the scienter requirement of the Fair Credit Reporting Act (FCRA), which required defendants to act “willfully.” *See* 15 U.S.C. § 1681n(a). Because the FCRA did not define this common law term, the Court looked to its common law meaning. *Safeco*, 551 U.S. at 58. It interpreted the FCRA’s “willfulness” requirement to
cover both knowing and reckless violations of the statute. Id. at 57. Then it defined
recklessness as “conduct violating an objective standard: action entailing ‘an unjustifiably
high risk of harm that is either known or so obvious that it should be known.’” Id. at 68
(quoting Farmer v. Brennan, 511 U.S. 825, 836 (1994)). Accordingly, it found a
defendant’s subjective intent irrelevant: “To the extent that [plaintiffs] argue that evidence
of subjective bad faith can support a willfulness finding even when the company’s reading
of the statute is objectively reasonable, their argument is unsound.” Id. at 70 n.20.

The Safeco Court set forth a two-step analysis as to reckless disregard, first asking
whether defendant’s interpretation was objectively reasonable and then determining
whether authoritative guidance might have warned defendant away from that reading. Id.
at 69–70. Because defendant’s reading “was not objectively unreasonable” and “ha[d] a
foundation in the statutory text,” it did not act recklessly—even though its reading was
ultimately “erroneous.” Id. And defendant had no guidance from the courts of appeals or
the implementing agency that “might have warned it away from the view it took.” Id. at
70. “Given this dearth of guidance and the less-than-pellucid statutory text, [defendant’s]
reading was not objectively unreasonable, and so falls well short of raising the
‘unjustifiably high risk’ of violating the statute necessary for reckless liability.” Id. Failure
to meet this recklessness standard precluded a finding of knowledge as well: “Where, as
here, the statutory text and relevant court and agency guidance allow for more than one
reasonable interpretation, it would defy history and current thinking to treat a defendant
who merely adopts one such interpretation as a knowing or reckless violator.” Id. at 70
n.20.
As noted above, several of our sister circuits have applied Safeco’s scierter analysis to the FCA. And with good reason. The FCA defines “knowingly” as including actual knowledge, deliberate ignorance, and reckless disregard. 31 U.S.C. § 3729(b)(1)(A). Safeco interpreted “willfully” to include both knowledge and recklessness. 551 U.S. at 57, 68. Given this parallel, we hold that Safeco’s reasoning applies to the FCA’s scierter requirement. Under the FCA, a defendant cannot act “knowingly” if it bases its actions on an objectively reasonable interpretation of the relevant statute when it has not been warned away from that interpretation by authoritative guidance. This objective standard precludes inquiry into a defendant’s subjective intent.

In adopting this standard, we join each and every circuit that has considered Safeco’s applicability to the FCA. For example, the Seventh Circuit reasoned that Safeco “defined a similar common law term . . . which the Court interpreted as encompassing the same common law scierter terms used in the FCA.” 9 F.4th at 465. It rightly concluded that Safeco “announced a standard inquiry for reckless disregard” and found “no reason why the scierter standard established in Safeco (for violations committed knowingly or with reckless disregard) should not apply to the same common law terms used in the FCA.” Id. After all, the Supreme Court has held that the FCA “does employ the common law meaning” for other common law terms like false and fraudulent, so long as there are no textual indicia to the contrary. Id. (citing Escobar, 136 S. Ct. at 1999 & n.2). Finding none here, there was “no barrier to importing the Safeco standard to the FCA.” Id.

Sheldon claims that Safeco should not apply, alluding to Halo Electronics, Inc. v. Pulse Electronics, Inc., 136 S. Ct. 1923 (2016). But that case does not suggest a different
result. See Schutte, 9 F.4th at 466–67 (finding Safeco more analogous to FCA than Halo Electronics). Halo Electronics interpreted § 284 of the Patent Act, which allowed for treble damages in certain infringement cases but did not specify scienter. 136 S. Ct. at 1928; see 35 U.S.C. § 284 (“[T]he court may increase the damages up to three times the amount found or assessed.”). The Court found that such damages “are generally reserved for egregious cases of culpable behavior” and clarified that a showing of objective recklessness was not necessary in a context of “such deliberate wrongdoing.” Id. at 1932. It also emphasized the district court’s discretion and the lack of textual limitations on that discretion. Id. at 1931–32. The Court acknowledged Safeco’s standard but did not apply it in the context of the Patent Act because its “precedents [made] clear that ‘bad-faith infringement’ is an independent basis for enhancing patent damages.” Id. at 1933 n.*. In this situation, a test of objective recklessness “impermissibly encumber[ed] the statutory grant of discretion to district courts.” Id. at 1932 (quoting Octane Fitness, LLC v. ICON Health & Fitness, Inc., 572 U.S. 545, 553 (2014)).

Context matters, and here two differences stand out. First, § 284 did not include a scienter requirement, while the FCA clearly limits liability to claims that are made “knowingly.” And the Supreme Court has instructed that this “rigorous” requirement ought to find “strict enforcement” in the courts. Escobar, 136 S. Ct. at 2002. Second, while § 284 concerned whether district courts could issue a particular amount of damages after finding liability, the relevant provision here concerns whether liability exists at all. Taking these differences into account, the gap between the FCA and the Patent Act is much wider than
that between the FCA and the FCRA—both of which include an explicit scienter standard (covering both knowledge and recklessness) that speaks to liability rather than damages.

Sheldon also argues that Safeco improperly collapses the FCA’s statutory definitions. But applying Safeco does not sap the FCA’s three scienter definitions of independent meaning. Safeco itself recognized that recklessness and knowledge were separate subcategories of willfulness. 551 U.S. at 60. Yet it still held that its standard served as the starting point for both, refusing to treat a defendant who adopted a reasonable interpretation “as a knowing or reckless violator.” Id. at 70 n.20 (emphasis added). The same is true here. That actual knowledge, deliberate ignorance, and reckless disregard are distinct—which we do not dispute—does not preclude them from sharing a threshold requirement. See Schutte, 9 F.4th at 468. Nor does it preclude them from functioning as a hierarchy, as is commonly understood. Reckless disregard has been called the “most capacious,” United States ex rel. Watson v. King-Vassel, 728 F.3d 707, 712 (7th Cir. 2013), the “loosest,” Purcell, 807 F.3d at 288, and the “baseline,” Schutte, 9 F.4th at 465, of the FCA’s scienter standards. So if a defendant has not acted with reckless disregard in its view of the statute, “it follows a fortiori” that it has not acted with deliberate ignorance or actual knowledge, which “plainly demand[] even more culpability.” Urquilla-Diaz v. Kaplan Univ., 780 F.3d 1039, 1058 n.15 (11th Cir. 2015).

2.

Safeco does not apply to all FCA suits. There are two general categories of false claims under the FCA: those that are factually false and those that are legally false. See United States ex rel. Wilkins v. United Health Grp., Inc., 659 F.3d 295, 305 (3d Cir. 2011).
The paradigmatic FCA action targets factually false claims—those in which someone “has submitted an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided.” United States ex rel. Polukoff v. St. Mark’s Hosp., 895 F.3d 730, 741 (10th Cir. 2018) (citation omitted); see, e.g., United States ex rel. Citynet, LLC v. Gianato, 962 F.3d 154, 157 (4th Cir. 2020) (complaint alleged that defendant billed the federal government for “material and labor it did not provide, and for [projects] that were not constructed”); Affinity Living Grp., LLC v. StarStone Specialty Ins. Co., 959 F.3d 634, 636 (4th Cir. 2020) (complaint alleged that defendant “submitted reimbursement claims for resident services that were never provided”). Of a different vintage are legally false claims, which “generally require knowingly false certification of compliance with a regulation or contractual provision as a condition of payment.” Polukoff, 895 F.3d at 741.

Safeco simply does not reach factually false claims, where the law is clear. Instead, it is narrowly cabined to legally false claims—like the one here—which involve contested statutory and regulatory requirements. As we have recognized, “establishing even the loosest standard of knowledge, i.e., acting in reckless disregard of the truth of falsity of the information, is difficult when falsity turns on a disputed interpretive question.” United States ex rel. Complin v. N.C. Baptist Hosp., 818 F. App’x 179, 184 (4th Cir. 2020) (quoting Purcell, 807 F.3d at 288). After all, “[a] defendant might suspect, believe, or intend to file a false claim, but it cannot know that its claim is false if the requirements for that claim are unknown.” Schutte, 9 F.4th at 468.
Nor does Safeco write defendants a blank check. To start, Safeco’s first step requires an objectively reasonable reading of the statute. If a defendant bases its actions on an unreasonable view of the law, it runs a considerable litigation risk. Knowing an FCA claim is waiting in the wings, it takes a serious chance that a court will find liability if it attempts to concoct strained justifications for its actions. Much better to steer clear of danger than to risk it all defending a questionable interpretation in court.

And not every objectively reasonable reading will suffice. Safeco’s second step allows the government to issue authoritative guidance that clarifies its interpretation of the law and so warns defendants away from otherwise reasonable interpretations. The test thus “does not shield bad faith defendants that turn a blind eye to guidance indicating that their practices are likely wrong.” Id. But it does put the burden where it belongs. If the government wants to hold people liable for violating labyrinthine reporting requirements, it at least needs to indicate a way through the maze. See, e.g., Gates & Fox Co. v. OSHRC, 790 F.2d 154, 156 (D.C. Cir. 1986) (Scalia, J.) (citation omitted) (“If a violation of a regulation subjects private parties to criminal or civil sanctions, a regulation cannot be construed to mean what an agency intended but did not adequately express.”).

Safeco’s standard duly ensures that defendants must be put on notice before facing liability for allegedly failing to comply with complex legal requirements. Without such notice, defendants are not likely to receive due process. “A fundamental principle in our legal system is that laws which regulate persons or entities must give fair notice of conduct that is forbidden or required.” FCC v. Fox Television Stations, Inc., 567 U.S. 239, 253 (2012). Such “clarity in regulation is essential to the protections provided by the Due

It is profoundly troubling to impose such massive liability on individuals or companies without any proper notice as to what is required. *Safeco* avoids this trouble by making the government “provide a reasonably clear standard of culpability to circumscribe the discretion of the enforcing authority and its agents.” *United States v. Hoechst Celanese Corp.*, 128 F.3d 216, 224 (4th Cir. 1997) (citation omitted). Rightly so. As the Supreme Court has made clear, “concerns about fair notice and open-ended liability can be effectively addressed through strict enforcement” of the FCA’s “rigorous” scienter requirement. *Escobar*, 136 S. Ct. at 2002 (citation omitted). *Safeco*’s careful analysis is just the right means to further this end. *See, e.g.*, *Purcell*, 807 F.3d at 287 (“Strict enforcement of the FCA’s knowledge requirement helps to . . . avoid[] the potential due process problems posed by penalizing a private party for violating a rule without first providing adequate notice of the substance of the rule.”) (citation omitted). We therefore decline Sheldon’s invitation to make our circuit an outlier.

B.

Applying *Safeco*’s test to Forest’s conduct, we conclude that Forest did not act “knowingly” under the False Claims Act. Forest’s reading of the Rebate Statute was not
only objectively reasonable but also the most natural. And Forest was not warned away from its reading by authoritative guidance from CMS. As a result, Sheldon failed to plead scienter as required by the FCA.\(^3\)

1.

We must first determine whether Forest’s reading was objectively reasonable by examining the text of the statute. \textit{Safeco}, 551 U.S. at 69–70. The Rebate Statute defines Best Price as “the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity.” 42 U.S.C. § 1396r-8(c)(1)(C)(i). The plain language here indicates that Best Price is one offered to a single entity.

Notably, both “price” and all of the entities listed are singular, joined by the disjunctive “or.” And “any” usually means a single member in a class if used with singular nouns. \textit{Any}, Oxford English Dictionary (3d ed. 2021). This linguistic construction (singular

\(^3\) Sheldon argues that it was improper for the district court to decide the scienter question on a motion to dismiss. Yet the Supreme Court has generally urged us to resolve cases on a motion to dismiss when a claim is not “plausible on its face.” \textit{Ashcroft v. Iqbal}, 556 U.S. 662, 678 (2009) (quoting \textit{Bell Atl. Corp v. Twombly}, 550 U.S. 544, 570 (2007)). This plausibility standard “asks for more than a sheer possibility that a defendant has acted unlawfully.” \textit{Id}. And that standard bars Sheldon’s claim, which does not allege any plausible theory of recovery. In addition, we have specifically held that a “district court did not err in deciding the issue of [FCA] scienter at the Rule 12(b)(6) motion-to-dismiss stage,” \textit{Complin}, 818 F. App’x at 183 n.5 (citing \textit{Rostholder}, 745 F.3d at 703)—even when the case involved the question of whether a defendant was warned away from its interpretation, \textit{see id.} at 184 n.6. Other circuits have similarly conducted the \textit{Safeco} analysis in the FCA context of a motion to dismiss. \textit{See, e.g., Streck,} 746 F. App’x 101; \textit{United States ex rel. Hixson v. Health Mgmt. Sys., Inc.}, 613 F.3d 1186 (8th Cir. 2010). This is especially appropriate when, as here, the question of whether a defendant has been warned away depends upon the interpretation of legal materials.
nouns plus the disjunctive) strongly advises against aggregating discounts to multiple entities. Change some nouns to see why. If, when striking a deal for baseball equipment, the thrifty Kansas City Royals asked for “the lowest price available from the manufacturer to any wholesaler, retailer, professional baseball team, minor-league organization, or collegiate program,” no one would think that the equipment company needs to aggregate prices. The Royals are just asking for the best deal that any one of the other entities received. Or imagine you ask a friend about “the lowest apple price available to any wholesaler, grocery store, or restaurant.” You would not expect your friend to aggregate prices between grocery stores and restaurants, but instead report to you the single lowest price at which someone can readily purchase apples.

Finally, “available” means “suitable or ready for use,” “at hand,” or “readily obtainable.” The Random House Dictionary of the English Language 142 (2d ed. 1987). The statute is thus talking about an actual price, not something that is purely hypothetical. A price is not “available” to an entity if the manufacturer must first aggregate other prices.

Overall, this plain language conveys that Forest was not required to aggregate discounts given to separate customers. Yet this does not give Forest a free ride. The Rebate Statute most naturally reads as requiring drug manufacturers to give Medicaid the lowest price that was provided to any single purchaser. This includes aggregating discounts to a single entity even if given at different points in time. But the statute cannot be stretched beyond this singular point.

Other provisions in the Rebate Statute confirm this reading. For example, the Rebate Statute defines Average Manufacturer Price as “the average price paid to the manufacturer
for the drug” by “wholesalers” and “retail community pharmacies.” Id. § 1396r-8(k)(1)(A)(i)–(ii). An “average,” by definition, requires some sort of combination. And something “paid to the manufacturer” might incorporate discounts to different entities. Yet Average Manufacturer Price is also limited to a narrower class of entities than is Best Price, making the reporting problem less onerous. We refuse to ignore such distinctions in the statutory scheme. Congress chose dissimilar language for the two terms, and these linguistic differences must be given legal effect. See, e.g., Soliman v. Gonzales, 419 F.3d 276, 283 (4th Cir. 2005) ("Where Congress has utilized distinct terms within the same statute, . . . we endeavor to give different meanings to those different terms.").

Beyond faithfulness to the statutory text, this reading also accords with practical realities. Well has it been said that Medicaid statutes and regulations “are among the most completely impenetrable texts within human experience.” Rehab. Ass’n of Va., Inc. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994). And discount aggregation in particular raises some of the thorniest issues in government price reporting. See, e.g., Astra USA, Inc. v. Santa Clara Cnty., 563 U.S. 110, 115 (2011) (“Calculation of a manufacturer’s ‘average’ and ‘best’ prices . . . is a complex enterprise.”). Numerous entities—including state Medicaid agencies, Pharmacy Benefit Managers, manufacturers, wholesalers, and pharmacies—are involved in increasingly complicated customer relationships. See, e.g., Rachel Dolan & Marina Tian, Pricing and Payment for Medicaid Prescription Drugs, Kaiser Family Foundation (Jan. 23, 2020), https://www.kff.org/medicaid/issue-brief/pricing-and-payment-for-medicaid-prescription-drugs/ (depicting “complex drug supply and payment chain” for prescription drugs covered by Medicaid). Because of these
complex sales practices, “manufacturers may find it difficult to determine how to treat certain sales practices when calculating prices.” U.S. Department of Health & Human Services, Office of Inspector General, *Reasonable Assumptions in Manufacturer Reporting of AMPs and Best Prices* 3–4 (Sept. 2019), https://oig.hhs.gov/oei/reports/oei-12-17-00130.pdf (OIG Report). Given this considerable difficulty, it makes good sense to think that manufacturers are expected to report a price actually given to a purchaser, rather than cobbling together bits and pieces to fashion a price never “available” to any actual entity.

We turn next to the CMS regulations. Of course, courts, not agencies, are the ultimate interpreters of statutes. *See, e.g.*, *Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984) (limiting deference in statutory interpretation to situations where the law is ambiguous and the agency interpretation is reasonable). And to the extent that CMS regulations are relevant, here they simply mirror the statutory language. CMS defines Best Price as “the lowest price available from the manufacturer during any rebate period to any entity in the United States.” 42 C.F.R. § 447.505(a) (2007). Again, each term is singular, most naturally referring to the lowest price given to a single entity. Likewise, the Rebate Agreement (also promulgated by CMS regulation) defines Best Price as “the lowest price at which the manufacturer sells the [covered drug] to any purchaser in the United States.” J.A. 213; *see* 56 Fed. Reg. at 7050. This straightforward language—“any purchaser,” again singular—counsels in favor of Forest’s interpretation. And while Sheldon makes much of three other words in the Rebate Agreement (“prices actually realized”) to argue that discounts must be aggregated, these words cannot be wrenched out of context or used to subvert the Rebate Statute’s natural meaning. Read
consistently with the governing statute (to which it is subordinate), the Rebate Agreement’s “prices actually realized” simply means prices the manufacturer receives on sales to each individual customer.

Clearly, Forest’s reading “has a foundation in the statutory text.” *Safeco*, 551 U.S. at 69–70. Not only that; it is the best reading of that text. We agree with the district court that the “plain and natural reading” of the Rebate Statute means that Best Price entails “the lowest price available by the manufacturer, including all price concessions, to any one of the listed entities, but not to multiple entities.” *Sheldon*, 499 F. Supp. 3d at 209. There is nothing in the statute to suggest that Best Price requires aggregating discounts given to separate entities. Thus, we hold that Forest has offered, at minimum, an objectively reasonable reading of the Rebate Statute. It in turn becomes more difficult to conclude that a party “knowingly” presented a false claim, 31 U.S.C. § 3729(b)(1)(A), when that claim is premised on such a textually sound view.

2.

Next we ask whether authoritative guidance warned Forest away from its interpretation. *See Safeco*, 551 U.S. at 70. To function as a warning, authoritative guidance requires both the right source and sufficient specificity. When it comes to source, either circuit court precedent or guidance from the relevant agency is required. *See id.; Schutte*, 9 F.4th at 471 (limiting authoritative guidance to these two sources); *Purcell*, 807 F.3d at 289 (considering only these two sources); *Streck*, 746 F. App’x at 106, 108 (considering only these two sources). And the guidance must “canvass the issue” with sufficient specificity to be able to function as a warning. *Safeco*, 551 U.S. at 70 n. 19. It does not
suffice for agency guidance merely to be related to the question at hand; instead, “authoritative guidance must have a high level of specificity to control an issue.” Schutte, 9 F. 4th at 471; see also Safeco, 551 U.S. at 70 n.20 (agency guidance did not warn away when it “allow[ed]” defendant’s interpretation). Because CMS never clearly stated that discount aggregation to different entities was required, it did not act with the specificity necessary to warn Forest away from its interpretation.

CMS knew as early as 2006 that manufacturers were not aggregating discounts given to different entities along supply chains. After CMS submitted its proposed rule on Medicaid drug pricing, several manufacturers, including Forest, offered comments. These comments expressed a uniform view that Best Price “has always been interpreted to mean the single lowest price to a particular customer.” J.A. 239; accord J.A. 271 (“[Best Price] is the single lowest price at which the manufacturer sells the product to a single customer.”); J.A. 285 (“We therefore request that CMS confirm that best price will continue to be the lowest price at which a drug is actually sold.”); J.A. 305 (“Best price is not calculated as a price derived by aggregating price concessions to different customers.”). And the manufacturers asked CMS to “clarify” or “confirm” that it would continue to be so. J.A. 239, 271, 285.

CMS nonetheless failed to clarify and thereby maintained strategic ambiguity. But in all material respects, the final rule adopted the proposed rule’s Best Price definition. 72 Fed. Reg. at 39,242–43. As we have seen, that language simply reflected the Rebate Statute, which most naturally supports Forest’s interpretation.
Sheldon points to two CMS responses to comments that, he says, should have warned Forest away. While both were related to the broad issue here—Best Price reporting and discounts—neither spoke directly to whether manufacturers were required to aggregate discounts given to separate entities on the supply chain. As a result, they were not sufficient to warn Forest away from its objectively reasonable interpretation.

The first scenario involved Pharmacy Benefit Managers (PBMs), which the proposed rule had initially included in Best Price. See Medicaid Program; Prescription Drugs, 71 Fed. Reg. 77,174, 77,197 (Dec. 22, 2006) (proposing that 42 C.F.R § 447.505(c)(2) include PBM rebates). After receiving public comments, CMS agreed to generally remove PBM rebates from Best Price calculation in its final rule but noted one situation where PBM rebates might be included. See 72 Fed. Reg. at 39,198, 39,242; 42 C.F.R § 447.505(d)(13) (2007) (“Best price excludes PBM rebates, discounts, or other price concessions except . . . where such rebates, discounts, or other price concessions are designed to adjust prices at the retail or provider level.”). As Sheldon conceded below, this example has nothing to do with whether discounts should be aggregated in calculating Best Price; instead, “CMS’s comments involving PBMs simply addressed how rebates to an excluded entity might nevertheless fall within Best Price.” D. Ct. Docket 79 at 22. It thus does not provide sufficient specificity to warn Forest away from its position on aggregating discounts to included entities.

The second scenario proves similarly lacking, as it concerned two discounts administered through a single entity. One commenter asked if Best Price calculations required aggregating prompt pay discounts to wholesalers and wholesaler chargeback
agreements, and CMS confirmed that they did. 72 Fed. Reg. at 39,199. Yet as the district court noted, “the different price concessions . . . both actually function as price concessions to [a] single entity—the wholesaler.” Sheldon, 499 F. Supp. 3d at 211. The prompt pay discount lowers the wholesaler’s price at the time of sale. And the chargeback agreement means that “the wholesaler delivers the product to the favored purchaser at the discounted price and then ‘charges back’ the manufacturer for the difference.” In re Brand Name Prescription Drugs Antitrust Litig., No. 94-cv-897, 1996 WL 167350, at *2 (N.D. Ill. Apr. 4, 1996). It thus functions as a lagged price concession to the wholesaler and is properly included in a Best Price calculation because it affects the price available to a single entity. The Rebate Statute, after all, does require aggregating discounts if they are given to a single entity. But as the district court noted, CMS’s comments here “did not actually clarify whether there is a requirement to aggregate concessions from multiple entities in separate arrangements.” Sheldon, 499 F. Supp. 3d at 211. So they were not precise enough to warn Forest away.

Sheldon’s other examples fare no better. Mostly, they involve language about “prices actually realized” or stay at high levels of generality. This is simply insufficient. All told, Sheldon has not, in the words of the district court, “pointed to a single example where CMS explicitly state[d] that manufacturers must aggregate discounts to different

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4 While Sheldon twice alleged that Forest’s conduct continued “to the present,” J.A. 106, 107, his complaint contains no factual allegations concerning Forest’s conduct after 2014 (when Forest terminated Sheldon). Two conclusory references about continuing conduct are simply insufficient to meet Rule 12(b)(6)’s standard, which requires some level of “factual content.” Iqbal, 556 U.S. at 678.
customers along the supply chain in a given sale.” Id. It thus did not warn Forest away from its well-grounded interpretation.\(^5\)

Instead of a warning, CMS issued manufacturers like Forest a permission slip. CMS’s Rebate Agreement provides that “in the absence of specific guidance,” manufacturers should “make reasonable assumptions in their calculations of . . . Best Price, consistent with the requirements and intent of [the Rebate Statute], Federal regulations and the terms of this agreement.” J.A. 217. In the very rulemaking that Sheldon highlights, CMS reaffirmed the need to make reasonable assumptions—not once, not twice, but nine times. See 72 Fed. Reg. at 39,164, 39,166, 39,167, 39,171, 39,191, 39,211. Combine this exhortation with the complex statutory scheme and it is no wonder that reliance on reasonable assumptions is widespread. See OIG Report at 24.

In fact, a 2019 HHS Inspector General report found that eighty percent of manufacturers reported making reasonable assumptions about the precise issue here: whether discounts given to separate entities must be aggregated. Id. at 9. And this issue is far from unique. More than fifty percent of responding manufacturers reported making reasonable assumptions in fourteen different areas identified by the Inspector General. Id. at 9–10. Importantly, it is not the case that manufacturers are taking advantage of CMS’s silence; almost two thirds reported a desire for additional guidance on these very issues. Id. at 11. Facing these requests, CMS demurs. Indeed, “CMS specifically instructs

\(^5\) Because \textit{Safeco} focuses on objective reasonableness and forecloses inquiry into subjective beliefs, see 551 U.S. at 70 n.20, Sheldon’s allegations regarding Forest’s motivation for undertaking a data audit are simply irrelevant.
manufacturers not to submit their assumptions to the agency, and states that if a manufacturer does so, CMS will not review the assumptions.” *Id.* at 20.

What CMS once gave with one hand it now wants to take away with the other. Having told manufacturers to rely on reasonable assumptions, the government cannot receive damages when Forest has done exactly that. Moreover, it cannot do so when CMS has refused to respond to manufacturer requests for clarification. What a troubling result: companies ask for explanation and at first are told to do their best but then are subjected to potentially ruinous liability for following those instructions. How can this—which looks more like Calvinball than the rule of law—possibly qualify as a sufficient warning? *See* Bill Watterson, *The Calvin & Hobbes Tenth Anniversary Book* 129 (1995) (“People have asked how to play Calvinball. It's pretty simple: you make up the rules as you go.”).

Of course, CMS may not wish to specify its position on the issue. From its vantage point, that might be understandable. Clear regulations constrain regulatory power and limit future flexibility, which is why an agency might find them undesirable. *See, e.g., Kisor v. Wilkie,* 139 S. Ct. 2400, 2440–41 (Gorsuch, J., concurring in the judgment) (“Whether purposeful or not, the agency’s failure to write a clear regulation winds up increasing its power.”). To be sure, there are plenty of reasons why agencies might prefer ambiguity. But such reasons are not necessarily permissible. Retaining ambiguity in order to expand potential liability for regulated entities cannot pass muster. In a world where the administrative state “wields vast power and touches almost every aspect of daily life,” *Free Enter. Fund v. Pub. Co. Acct. Oversight Bd.*, 561 U.S. 477, 499 (2010), allowing agencies to take advantage of companies like this would not be right.
CMS did not warn Forest away from its objectively reasonable reading. None of its guidance dealt with aggregating discounts to different entities, and it even invited Forest to make reasonable assumptions. So the district court correctly dismissed Sheldon’s complaint for failure to allege scienter.

III.

Safeco’s two prongs are interrelated; though separate, they are not totally divorced. Looking at both the statute’s text and the agency’s guidance, a coherent picture emerges. Forest made eminently reasonable assumptions based on the statutory text, and CMS invited assumptions precisely of this sort. The False Claims Act does not assess liability through ambush. Companies must instead knowingly submit a false claim to be liable. And Forest simply did not do so here.

We cannot accept the idea that a defendant acts “knowingly” when its reading of a statute is both objectively reasonable and in fact the best interpretation; when the agency’s regulation mirrors, rather than repudiates, that interpretation; when the agency resists attempts to get it to clarify its view; and when the agency explicitly invites regulated parties to make reasonable assumptions. It is not plausible to accuse Forest of acting “knowingly” in these circumstances.

All that said, the government is not without recourse. Should Congress so wish, it can alter the Rebate Statute to require the aggregate reporting of discounts to separate entities. But the burden is on the government to be clear. As the district court recognized, this case presents no sound rationale for the immense consequences the relator would have this court impose.
The judgment of the district court is hereby affirmed.

AFFIRMED
WYNN, Circuit Judge, dissenting:

Those who believe that some judicial decisions usurp the power of elected legislatures by making the law rather than merely interpreting it can add another tally to their ledgers. Today, with the stroke of a pen, my thoughtful friends in the majority opinion effectively neuter the False Claims Act—the Government’s primary tool for fighting fraud—by eliminating two of its three scienter standards (actual knowledge and deliberate ignorance) and replacing the remaining standard with a test (objective recklessness) that only the dimmest of fraudsters could fail to take advantage of.

Over thirty years ago, Congress grew concerned that years of restrictive court interpretations had artificially narrowed the False Claims Act’s scienter requirement. To remedy this problem, Congress crafted three distinct and expansive scienter standards. Today’s majority opinion undoes that work by making a new law that reads two of those three scienter standards right out of existence. In their place, the majority opinion erects its own threshold scienter test that allows fraudsters to escape any liability so long as they can come up with a post hoc legal rationale that passes the smell test.

But the majority opinion’s legal hand-waving cannot cover the stench here. Troy Sheldon plausibly alleges that for years, pharmaceutical giant Forest Laboratories, LLC failed to include stacked rebates when reporting its best drug prices to the Government. When alerted that its scheme was unlawful, Forest hired a data-scrubbing firm to identify and eliminate rebate stacking for many of its customers. However, it continued to pay out stacked rebates to its preferred customers, rebates that it then failed to report in its best
price calculations for years to come. That fraudulent scheme bilked the federal Government out of $680 million.

Yet, the majority opinion finds it unnecessary to even address these facts due to its wholesale revision of the False Claims Act’s scienter standard. But what, you might ask, empowers judges to trade in their judicial robes for congressional pins, rewrite the statute, and ignore the factual record? The underwhelming answer: a dictum single footnote buried at the end of a Supreme Court opinion on credit reporting.

Tellingly, the majority opinion spends 4/5 of its introduction cavalierly dismissing the recognition of its judicial overreach as mere “protestations.” Majority Op. at 3. But the fact that it found the need to say so with a first breath pontification—without providing any context for the reader—says otherwise.

At any rate, that first breath does nothing to dispel the substantive concerns identified in this dissenting opinion: it does not, for example, tangle with the damning facts of this case, explain why importing mismatched common law into the False Claims Act is a good idea, or, most importantly, defend its decision to write two of the Act’s three scienter standards out of existence. Instead, it accuses the dissenting opinion—which seeks to maintain the statutory status quo by keeping the three scienter standards created by Congress—of somehow taking a “very long step toward a strict liability statute.” Id. And without any sense of irony, it protests that the dissenting opinion “nullif[ies] the whole concept of scienter” for the False Claims Act. Id. But as explained below, that is precisely what the majority opinion accomplishes by rewriting the Act’s scienter standard to suit its own policy ends.
Because I cannot join in this judicial overhaul of the False Claims Act—an overhaul that will require further congressional correction—I dissent.

I.


Individuals act “knowingly” if they (1) have “actual knowledge of the [falsity of the] information”; (2) act “in deliberate ignorance of the truth or falsity of the information”; or (3) act “in reckless disregard of the truth or falsity of the information.” *Id.* § 3729(b)(1)(A). Thus, though the Act does “not punish honest mistakes or incorrect claims submitted through mere negligence,” *United States ex rel. Owens v. First Kuwaiti Gen. Trading & Contracting Co.*, 612 F.3d 724, 728 (4th Cir. 2010) (citation omitted), it does require “those doing business with the Government . . . to make a limited inquiry to ensure the claims they submit are accurate,” *United States ex rel. Phalp v. Lincare Holdings, Inc.*, 857 F.3d 1148, 1155–56 (11th Cir. 2017) (quoting S. Rep. No. 99-345, at 7, 1986 U.S.C.C.A.N. at 5272).

A careful review of the full record here reveals no “honest mistakes,” “negligence,” or adequate inquiry. In fact, the record shows a deliberate plan to frustrate the requirements of the Medicaid Rebate Act and bilk the federal Government out of $680 million. Though the majority opinion dismisses these inconvenient facts—and the record itself—as “simply
irrelevant” to its allegedly purely legal inquiry, Majority Op. at 26 n.5, it is worth describing the facts it skimmed over in detail. With this context in mind, I then turn to the majority’s ill-fated application of Safeco Insurance Co. of America v. Burr, 551 U.S. 47 (2007), to the fraud context. Finally, I conclude that even if Safeco applied, the majority erred by finding that Forest wasn’t “warned away” from its stacked-rebate scheme.

A.

When ruling on a Rule 12(b)(6) motion to dismiss, “a judge must accept as true all of the factual allegations contained in the complaint” and must “draw all reasonable inferences in favor of the plaintiff.” E.I. du Pont de Nemours & Co. v. Kolon Indus., 637 F.3d 435, 440 (4th Cir. 2011) (citation omitted). The following facts are largely taken from Sheldon’s amended complaint.

Under the Medicaid Drug Rebate program, drug manufacturers that wish to sell their drugs to state Medicaid agencies must first enter into rebate agreements with the Secretary of Health and Human Services. 42 U.S.C. § 1396r-8(a). These agreements require the manufacturers to provide states with rebates on drugs purchased for Medicaid beneficiaries. Id. § 1396r-8(b). These rebates are then passed along to the federal Government by offsetting them against federal Medicaid assistance provided to the states. Id. § 1396r-8(b)(1)(B).

Calculating these rebates “is a complex enterprise requiring recourse to detailed information about the company’s sales and pricing.” Astra USA, Inc. v. Santa Clara Cnty., 563 U.S. 110, 115 (2011). For most drugs, the rebate amount is equal to the greater of two numbers: (1) the statutory minimum rebate percentage of the “average manufacturer price”
(currently 23.1%) and (2) “the difference between the average manufacturer price and the best price.” 42 U.S.C. § 1396r-8(c)(1)(A), (c)(1)(B)(i)(VI). The “average manufacturer price” means “the average price paid to the manufacturer for the drug in the United States by . . . wholesalers . . . [and] retail community pharmacies.” Id. § 1396r-8(k)(1)(A). The “best price” is “the lowest price available from the manufacturer . . . to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity.” Id. § 1396r-8(c)(1)(C)(i).

Allergan Sales, LLC and its predecessors Forest Laboratories, LLC and Forest Pharmaceuticals (collectively “Forest”) is a leading pharmaceutical-drug manufacturer. In 2014, Forest’s expected annual revenues topped $15 billion. A significant portion of this business is supported by drug reimbursements from state Medicaid programs.

From the 1990s until 2014, relator Sheldon worked at Forest. Sheldon served in several managerial roles and was responsible for billions of dollars in revenue streams. Sheldon was also directly involved in the sale of Forest’s drugs, including the negotiation of discounts, rebates, and other incentives. As a result, he had “direct, personal knowledge of the drug rebates and other discounts given to Forest customers that impact[ed] the reported Best Price for each drug.” J.A. 63.

In 2005, Sheldon discovered that Forest was failing to account for rebates provided to two separate customers on the same dispensed drug unit. Specifically, Forest was providing one rebate to private insurance companies and another to pharmacy providers or group purchasing organizations (“GPOs”). Because some of the patients treated by these pharmacies or GPOs were also covered by these private insurers, Sheldon believed that
Forest was benefiting from double rebates but illegally reporting only one rebate as the basis of its “[b]est [p]rice.” J.A. 67.

Shortly after Sheldon’s discovery, the Centers for Medicare & Medicaid Services (“CMS”) proposed a rule that would codify and clarify the definition of “best price,” among other things. Medicaid Program; Prescription Drugs, 71 Fed. Reg. 77,174 (proposed Dec. 22, 2006). That proposed rule defined best price as “the lowest price available from the manufacturer during the rebate period to any entity in the United States in any pricing structure,” including “all sales and associated discounts and other price concessions provided by the manufacturer to any entity unless . . . specifically excluded by statute or regulation.” Id. at 77,197 (emphases added). It further clarified that best price “shall be [the] net of cash discounts . . . and any other discounts or price reductions and rebates . . . which reduce the price available from the manufacturer,” and required manufacturers to “adjust the best price for a rebate period if cumulative discounts, rebates, or other arrangements subsequently adjust the prices available from the manufacturer.” Id. at 77,198 (emphases added). In the preamble, CMS noted that “any price adjustment which ultimately affects those prices which are actually realized by the manufacturer . . . should be included in the calculation of best price.” Id. at 77,182 (emphasis added).

Forest submitted written comments on the rulemaking, noting that “the proposed rule suggests that CMS views best price as the net amount realized by the manufacturer on a sale rather than the lowest price to a particular customer.” J.A. 239 (emphases added). It urged CMS to clarify that “only discounts and price concessions to the same entity to which a drug is sold should be included in the computation of best price to that entity.”
J.A. 239 (emphasis added). It believed the “statutory definition of best price has always been interpreted to mean the single lowest price to a particular customer,” and that “prices to unrelated entities in the chain of distribution should not be aggregated . . . even if they concern the same unit of a drug.” J.A. 239–40 (emphasis added). Several other drug manufacturers submitted similar comments.

Nearly a year later, CMS published its final rule. Medicaid Program; Prescription Drugs, 72 Fed. Reg. 39,142 (July 17, 2007) (codified at 42 C.F.R. pt. 447). CMS declined to change the offending language identified by Forest or the other drug manufacturers, reiterating that the “best price represents the lowest price available from the manufacturer to any entity . . . [and] any price concession associated with that sale should be netted out of the price received by the manufacturer in calculating best price and best price should be adjusted by the manufacturer if other arrangements subsequently adjust the prices actually realized.” Id. at 39,150 (emphases added).

CMS also took the opportunity to clear up confusion regarding a stacked-rebate situation involving pharmacy benefit managers (“PBMs”). These entities serve as middlemen between drug manufacturers, pharmacies, health insurance companies, and end users. Linda L. Ujifusa & J. Mark Ryan, Pharmacy Benefit Managers: The Mystery Bureaucrats Managing your Prescription Drugs, Uprise RI (Aug. 25, 2021), https://upriseri.com/pharmacy-benefit-managers/. Originally, CMS proposed including rebates paid to PBMs when determining best price. 71 Fed. Reg. at 77,182–83. Some “industry analysts” believed that this proposal obligated manufacturers “to add concessions paid to PBMs to the concessions paid to customers of the PBMs in calculating best price.”
Federal Register at 39,198. Multiple commentators objected, arguing that “if Congress had intended anything other than a customer-by-customer analysis of separate prices, the statute would have combined each customer with the word ‘and’ instead of the disjunctive ‘or.’” Id. (emphasis added). In conclusion, they asked that “CMS reaffirm that best price is the lowest price available from the manufacturers” to a single customer. Id.

In no uncertain terms, CMS replied that “[w]e do not agree with the commenters.” Id. It noted that although the final rule had largely removed any requirement that rebates paid to PBMs be included in best price, the rule reiterated that best price must “reflect the lowest price available from the manufacturer to any purchaser, inclusive of rebates, discounts, or price concessions that adjust the price realized.” Id. (emphasis added).1

In response, top-level managers at Forest prepared reports and held a series of meetings that examined the stacked-rebate issue. As the result of these meetings, Forest decided to hire a data-audit firm to identify stacked rebates claimed by its commercial customers—mostly private insurance companies—”for the same dispensed drug units to the same patient.” J.A. 69. After claims involving double rebates were identified, Forest

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1 The majority argues that this example is irrelevant because, “[a]s Sheldon conceded below, this example has nothing to do with whether discounts should be aggregated in calculating Best Price; instead, ‘CMS’s comments involving PBMs simply addressed how rebates to an excluded entity might nevertheless fall within Best Price.”’ Majority Op. at 24 (quoting Res. in Opp’n to Def.’s Mot. to Dismiss Am. Compl. at 22, United States ex rel. Sheldon v. Forest Lab’ys, (D. Md. 2020), ECF No. 79). However, Sheldon did not concede anything of the sort, see Res. in Opp’n to Def.’s Mot. to Dismiss Am. Compl., supra, at 4 (arguing that this example showed that “CMS explicitly rejected Forest’s interpretation”), and the majority opinion offers no explanation for CMS’s express repudiation of the commentators’ single-customer approach.
paid the first entity that claimed a rebate but refused to pay the second. Forest was able to do this because its sales contracts at the time—for these customers, at least—included a “clause providing that Forest would only pay one company when there are two entities claiming a rebate for the same drug to a single patient.” J.A. 35–36. The purpose of only allowing a single rebate to be claimed was to ensure that stacked “discounts on the same pill would [not] have to be added together” when reporting best prices to CMS. J.A. 69.

But Forest took a different tack with its preferred customers: pharmacy providers, GPOs, and certain private insurance companies. To “avoid negatively impacting its relationships” with these entities, Forest declined to audit their rebates or add a first-come-first-serve rebate clause to their sales contracts. Instead, it continued to pay these entities stacked rebates on the same drug unit “quarter after quarter,” while only reporting one of those rebates as the basis of its best price. J.A. 70. By Sheldon’s calculation, this led to Forest underpaying its rebates to state Medicaid programs—and by extension, the federal Government—by over $680 million between 2005 and 2014.

B.

Although these damning facts strongly suggest that Forest was actually aware it was submitting false best-price reports, the majority finds said facts “simply irrelevant” due to the Supreme Court’s decision in Safeco. Majority Op. at 26 n.5. That decision interpreted the scienter requirement for the Fair Credit Reporting Act. The majority claims that if we import Safeco’s common-law definition of reckless disregard from the Fair Credit Reporting Act into the False Claims Act, then any defendant who “bases its actions on an objectively reasonable interpretation of the relevant statute when it has not been warned
away from that interpretation” “cannot act ‘knowingly.’” Id. at 12; see also id. at 11 (“Failure to meet this [objective] recklessness standard preclude[s] a finding of knowledge as well.” (emphasis added)). In other words, the actual-knowledge and deliberate-ignorance standards are mere surplusage; a purely legal “threshold” recklessness test is now the alpha and the omega of False Claims Act scienter. Id. at 14.

But Safeco itself and the Supreme Court’s subsequent decision in Halo Electronics, Inc. v. Pulse Electronics, Inc., 579 U.S. 93 (2016), counsel against importing Safeco wholesale into a vastly different statutory context. And even if we did, neither Safeco nor the majority opinion’s sketchy logic justifies finding that Safeco’s objective-recklessness test allows us to scrap two of the False Claims Act’s three scienter standards.

1.

Safeco concerned a narrow issue: the proper interpretation of the Fair Credit Reporting Act’s scienter requirement. Safeco, 551 U.S. at 52. While the Fair Credit Reporting Act requires “willful[]” violations, it does not further define this term. Id. at 56–57 (quoting 15 U.S.C. § 1681n(a) (2007)). As a result, the Court looked to the common law and held that “willfulness” includes both “knowing and reckless disregard of the law”—but not before exhaustively examining whether “Congress had something different in mind.” Id. at 59, 69 (emphases added).

To start, the Court pored over the drafting history of the Fair Credit Reporting Act, finding some support for the notion that “liability was supposed to attach only to knowing violations,” but dismissing such evidence as “shaky, and certainly no match for the following clue in the text as finally adopted.” Id. at 58–59. Specifically, the Court noted
that the Fair Credit Reporting Act imposed heightened liability for “knowing[]” violations. *Id.* at 59. But if “willfully” only meant “knowingly,” then this heightened liability standard would be both “superfluous and incongruous.” *Id.* Since the Court’s primary directive was to “[g]ive effect, if possible, to every clause and word of a statute,” the Fair Credit Reporting Act’s scienter term had to encompass both knowing and reckless violations. *Id.* at 60 (quoting *United States v. Menasche*, 348 U.S. 528, 538–39 (1955)).

Next, the Court reasoned that since the Fair Credit Reporting Act did not define recklessness, it made sense to invoke the common law once more—but not before again assessing whether “Congress had something different in mind.” *Id.* at 69 (emphasis added). After concluding it did not, the Court held that “a company subject to [the Fair Credit Reporting Act] does not act in reckless disregard of [that statute],” *id.* (emphasis added), unless it runs an “unjustifiably high risk” of violating the law “that is either known or so obvious that it should be known,” *id.* at 68 (quoting *Farmer v. Brennan*, 511 U.S. 825, 836 (1994)).

Ultimately, the Supreme Court recognized that a scienter term’s “construction is often dependent on the context in which it appears.” *Id.* at 57 (quoting *Bryan v. United States*, 524 U.S. 184, 191 (1998)). Thus, the Court carefully parsed through the Fair Credit Reporting Act’s legislative history, considered appropriate statutory context, and adopted a common-law definition that gave effect to “every clause and word of [the] statute.” *Id.* at 60 (quoting *Menasche*, 348 U.S. at 538). In simple terms, the Supreme Court took the time and effort to truly understand whether any evidence “point[ed] to something different in
[the Fair Credit Reporting Act]” that would require a “deviat[ion] from the common law.” Id. at 58, 69.

2.

The same cannot be said of today’s majority opinion. Its “analysis” of whether it makes sense to import the *Safeco* Court’s common-law definition of recklessness into the False Claims Act spans all of three sentences: “The [False Claims Act] defines ‘knowingly’ as including actual knowledge, deliberate ignorance, and reckless disregard. *Safeco* interpreted ‘willfully’ to include both knowledge and recklessness. Given this parallel, we hold that *Safeco*’s reasoning applies to the [False Claims Act]’s scienter requirement.” Majority Op. at 12 (citations omitted). But what the majority opinion passes off as reasoning is no more than say-so. That should not be sufficient to upend the law of frauds in our Circuit.

Instead, it is necessary to take the time—as the *Safeco* Court said we must—to ask whether “Congress had something different in mind” with the False Claims Act. By doing so, it becomes evident that we should not import the Fair Credit Reporting Act’s objective recklessness standard, for a few reasons.

To start, the Fair Credit Reporting Act’s and False Claims Act’s vastly different contexts make them a poor match for common-law cross-pollination. The Fair Credit Reporting Act is a primarily prescriptive statute intended “to ensure fair and accurate credit reporting, promote efficiency in the banking system, and protect consumer privacy.” *Safeco*, 551 U.S. at 52. The False Claims Act is an entirely proscriptive statute intended to prevent fraud. *Universal Health Servs. v. United States ex rel. Escobar*, 579 U.S. 176, 181–
And fraud often revolves around a defendant’s subjective state of mind. See Restatement (Second) of Torts § 526 cmts. c, e (Am. L. Inst. 1977) (noting scienter for fraud can be established when a defendant has actual “knowledge of falsity,” “believes the representation to be false,” or makes a false representation with “careless [disregard] of whether it is true or false”); see also United States ex rel. Drakeford v. Tuomey, 792 F.3d 364, 384 (4th Cir. 2015) (holding that the “subjective inquiry” of whether a defendant “knew that its claims were in violation of the [law is] covered under the [False Claims Act’s] knowledge element” (emphasis added)).

Therefore, it makes little sense to import the Fair Credit Reporting Act’s objective recklessness test into the False Claims Act—especially when this “threshold” test effectively becomes a be-all-and-end-all scienter requirement. See Halo, 579 U.S. at 104, 106 n.* (declining to import Safeco’s recklessness test into the patent context because “bad faith” was relevant in that context and a “threshold [objective recklessness] requirement excludes from discretionary punishment many of the most culpable offenders”).

The majority opinion’s wholesale adoption of this Fair Credit Reporting Act test makes even less sense when one considers the sources of common law underlying it. In Safeco, those sources were the Restatement (Second) of Torts § 500 (Am. L. Inst. 1963–1964) and the Court’s previous decision in Farmer v. Brennan. But the Restatement (Second) § 500 pertains not to the common law of fraud, but rather to the common law of physical safety. See § 500 (stating that conduct “must involve an easily perceptible danger of death or substantial physical harm” to qualify as reckless). Likewise, Farmer’s “civil-law recklessness” definition—which drew on § 500’s physical-safety standard—also relied
on the common law of physical injury. 511 U.S. at 837; id. at 836 (finding its recklessness
standard equivalent to “deliberate indifference to a substantial risk of serious harm to a
prisoner” (emphasis added)). Both sources, therefore, are inapposite in the fraud context.
In fact, the Restatement (Second) has another section that deals specifically with the
scienter requirement for common-law fraud. See Restatement (Second) of Torts § 526. And
though this directly relevant body of common law surely has bearing on the meaning of
reckless disregard in fraud, the majority opinion ignores it.

The majority opinion counters that “every other circuit to consider the issue” has
“h[e]ld that Safeco applies with equal force to the [False Claims Act]’s scienter
Holdings, Inc., the Eleventh Circuit received extensive briefing on the recklessness
standard recognized in Safeco and declined to import it into the False Claims Act. See 857
F.3d at 1155 (rejecting the conclusion—recognized in Safeco—“that a finding of scienter
can be precluded by a defendant’s identification of a reasonable interpretation of an
ambiguous regulation”).

To be sure, other courts have gone the other way, but most of these cases are either
unpublished or easily distinguishable. See United States ex rel. Streck v. Allergan, Inc., 746
Microsemi Corp., 690 F. App’x 551, 552 (9th Cir. 2017) (unpublished); United States ex

2 Though the Phalp opinion did not explicitly cite to Safeco, it squarely rejected the
very holding the majority claims is commanded by Safeco.
rel. Donegan v. Anesthesia Assocs. of Kansas City, PC, 833 F.3d 874, 879–80 (8th Cir. 2016) (citing Safeco only to explain that the plaintiff had not created a material issue of fact regarding whether the defendant was warned away from its reasonable interpretation); United States ex rel. Purcell v. MWI Corp., 807 F.3d 281, 290–91 (D.C. Cir. 2015) (citing Safeco in holding that a reasonable interpretation of a contract precluded False Claims Act liability). And all but one either predates or fails to distinguish the Supreme Court’s decision in Halo. But see United States ex rel. Schutte v. SuperValu Inc., 9 F.4th 455, 467 (7th Cir. 2021) (foreshadowing the majority opinion’s flawed attempt to distinguish Halo).

Because Halo explicitly declined to import Safeco’s objective recklessness test into an analogous context, it deserves further explanation. In Halo, the Supreme Court interpreted the scienter requirement for enhanced damages under § 284 of the Patent Act. 579 U.S. at 97. Though the Patent Act does not include a specific scienter standard for these damages, for “nearly two centuries” the Supreme Court and the courts of appeal had “[c]onsistent[ly]” interpreted the statute to require “willful misconduct.” Id. at 106. But in 2007, the Federal Circuit created a test for “willful” infringement that wholly relied on Safeco’s definition of objective recklessness. See In re Seagate Tech., LLC, 497 F.3d 1360, 1371 (Fed. Cir. 2007), abrogated by Halo, 579 U.S. 93 (2016). Like the standard crafted by the majority opinion, the Federal Circuit’s objective-recklessness test was a “threshold requirement” for liability. Halo, 579 U.S. at 104; see also id. (“Under Seagate, a district court may not even consider enhanced damages for [a willful] pirate, unless the court first determines that his infringement was ‘objectively’ reckless.”); see Majority Op. at 14.
The *Halo* Court squarely rejected the Federal Circuit’s *Safeco* test. Though the Fair Credit Reporting Act and § 284 share the same scienter requirement—willfulness—the *Halo* Court noted that “‘willfully’ is a word of many meanings whose construction is often dependent on the context in which it appears.” *Halo*, 579 U.S. at 106 n.* (quoting *Safeco*, 551 U.S. at 57). And because the “subjective willfulness of a patent infringer, intentional or knowing, may warrant enhanced damages, without regard to whether his infringement was objectively reckless,” the Federal Circuit erred by crafting a threshold objective test for § 284. *Id.* at 105 (emphasis added); see also *id.* at 106 n.* (rejecting the respondents’ argument that *Safeco*’s footnote required the Court to find that “bad faith was not relevant absent a showing of objective recklessness” because “‘bad-faith infringement’ *is* an independent basis for enhancing patent damages”). *Safeco*’s common-law definition of “willfulness” simply did not apply. *Id.* at 104–106; cf. *Farmer*, 511 U.S. at 840 (declining to adopt an objective-recklessness test for Eighth Amendment violations based on textual and contextual clues).

It’s hard to see much daylight between *Halo* and the present case. Both address the use of a “threshold” *Safeco* test that precludes inquiry into “deliberate wrongdoing.” *Halo*, 579 U.S. at 104. Both concern the application of said test to statutes that revolve around the “subjective willfulness” or subjective knowledge of the statutory violator—unlike the Fair Credit Reporting Act—and punish transgressions with up to treble damages. *Id.* at 105, 109. And in both cases, as explained in more detail below, an unthinking application of *Safeco*’s test would “mak[e] dispositive the ability of the [statutory violator] to muster a reasonable (even though unsuccessful) defense at . . . trial.” *Id.* at 105. Because of these
serious contextual concerns, the Halo Court declined to import Safeco’s test into § 284. See id. at 105–07. We should too.

The majority opinion struggles to explain why Halo should not control. In the end, it lands on two weak distinctions between the False Claims Act and § 284: (1) “§ 284 d[oes] not include a scienter requirement, while the FCA clearly limits liability to claims that are made ‘knowingly,’” and (2) “while § 284 concerned whether district courts could issue a particular amount of damages after finding liability, the relevant provision here concerns whether liability exists at all.” Majority Op. at 13. Neither distinction holds any water.

To start, while § 284 might not include an explicit scienter requirement, for almost two centuries courts have interpreted the Patent Act to require “willful” violations for enhanced damages. Halo, 579 U.S. at 106. When Congress enacted § 284 in 1952, it legislated “against this backdrop.” Id. at 100. Thus, whether the courts, as ratified by Congress, or Congress itself created § 284’s “willful” standard, its standard remains the same as the Fair Credit Reporting Act’s. If anything, § 284 is an even closer analog to the Fair Credit Reporting Act than the False Claims Act; while § 284 and the Fair Credit Reporting Act have the exact same scienter standard—willfulness—the False Claims Act requires only knowing violations. See 31 U.S.C. § 3729(a)(1)(A)–(B). Instead of acknowledging this potentially critical difference, the majority opinion simply ignores it. See Majority Op. at 12 (noting simply that the Fair Credit Reporting Act and False Claims Act have “parallel” scienter requirements).

The majority opinion’s second distinction is even weaker. While it attempts to draw a hard line between scienter terms for “damages after [a] finding [of] liability” and those
for “liability” alone, it does not, and perhaps cannot, explain why this distinction is important. *Id.* at 13 (simply noting that these “differences” create a “gap” between the False Claims Act and the Patent Act). In fact, neither statute suggests that this difference is meaningful at all: a patent infringer is only “liable” for enhanced damages” if they acted willfully, *Halo*, 579 U.S. at 104, just as a fraudster is only “liable” for treble damages if they acted knowingly, 31 U.S.C. § 3729(a).

Nonetheless, the majority opinion doubles down, arguing that the False Claims Act and the Fair Credit Reporting Act are analogs because both “speak[] to liability rather than damages.” Majority Op. at 14. But even if this was a relevant point of analysis, it simply isn’t so. The relevant section of the Fair Credit Reporting Act plainly states that “[a]ny person who willfully fails to comply” with the statute “with respect to any consumer is *liable* to that consumer . . . [for] any actual damages[;] . . . punitive damages as the court may allow; and . . . reasonable attorney’s fees as determined by the court.” 15 U.S.C. § 1681n(a) (emphases added). So if the discussion of § 284 in *Halo* is irrelevant for our purposes in understanding the False Claims Act because § 284 “concern[s] whether district courts [can] issue a particular amount of damages after finding liability” whereas the False Claims Act “concerns whether liability exists at all,” Majority Op. at 13, then the statute upon which the majority hangs its hat—the Fair Credit Reporting Act, as understood in *Safeco*—is irrelevant for precisely the same reason. In other words, the very statute the majority opinion claims to be analogizing to elides the very distinction it attempts to make.

At the end of the day, though the majority opinion ironically spends more time distinguishing the False Claims Act from § 284 than analogizing the False Claims Act to
the Fair Credit Reporting Act, its facile analysis still fails. Nor does it provide any answer for the most troubling concern identified by the Halo Court—that adopting Safeco’s objective recklessness test makes “deliberate wrongdoing” completely irrelevant, despite Congress’s clear intention to impose liability in such circumstances. Halo, 579 U.S. at 104 (“In the context of such deliberate wrongdoing . . . it is not clear why an independent showing of objective recklessness . . . should be a prerequisite” to recovery.).

3.

It would seem to be enough to point out that the majority treads on thin ice by copying and pasting mismatched common law into the False Claims Act. But instead of retreating after hearing the cracking beneath its feet, it takes yet another step and plunges into the depths below.

That next step occurs when the majority opinion holds that if we adopt Safeco’s objective-recklessness test for False Claims Act allegations, then a “[f]ailure to meet this recklessness standard preclude[s] a finding of knowledge as well.” Majority Op. at 11 (emphasis added). The majority opinion claims this result is commanded by Safeco and logic. Failing that, it makes undisguised appeals to notions of public policy. Neither argument withstands even the slightest scrutiny.

i.

The majority opinion’s Safeco argument can be traced to a single footnote at the very end of that opinion. That footnote proclaims that “[w]here, as here, the statutory text and relevant court and agency guidance allow for more than one reasonable interpretation, it would defy history and current thinking to treat a defendant who merely adopts one such
interpretation as a *knowing or reckless violator.*” *Safeco,* 551 U.S. at 70 n.20 (emphasis added). According to the majority opinion, this single footnote gives it permission to strike the “actual knowledge” and “deliberate ignorance” standards from the text of the False Claims Act, at least with regard to “legally false claims.” Majority Op. at 14–15.

But nothing suggests that the Supreme Court intended to upend the law of frauds in a terse footnote in an opinion on credit-reporting requirements. In fact, the Court clarified—in the very same footnote—that it was focused on whether “subjective bad faith must be taken into account in determining whether a company acted knowingly or recklessly for purposes of § 1681n(a)” of the Fair Credit Reporting Act. *Safeco,* 551 U.S. at 70 n.20 (emphasis added). So, the Court’s seemingly broad references to “a defendant,” “knowing or reckless violator[s],” and “subjective bad faith,” *see id.*, are limited to the Fair Credit Reporting Act context—as the Court itself plainly noted in *Halo,* 579 U.S. at 106 n.* (rejecting an analogy to *Safeco*’s footnote because a “showing of bad faith was not relevant absent a showing of objective recklessness” *under the Fair Credit Reporting Act,* while “‘bad-faith infringement’ is an independent basis for enhancing patent damages”).

Even if we ignored this critical context—which we should not—*Safeco*’s conclusory conflation of knowing and reckless violations would be dictum. *Safeco* did not involve any *knowing* violation of the Fair Credit Reporting Act; the plaintiffs’ entire action rested on allegedly *reckless* failures. *Safeco,* 551 U.S. at 52–58. Therefore, the Supreme Court’s discursion on “knowing” violations is a classic example of a “peripheral” statement that “may not have received the full and careful consideration of the court that uttered it” and “that could have been deleted without seriously impairing the analytical foundations

Undeterred, the majority opinion insists that even if *Safeco*’s footnote is not controlling, when “a defendant has not acted with reckless disregard in its view of the statute, ‘it follows *a fortiori*’ that it has not acted with deliberate ignorance or actual knowledge, which ‘plainly demand[] even more culpability.’” Majority Op. at 14 (quoting *Urquilla-Diaz v. Kaplan Univ.*, 780 F.3d 1039, 1058 n.15 (11th Cir. 2015)).

As support, it offers a syllogism with a major premise stating that reckless disregard is the “most capacious,” “loosest,” or “baseline” scienter standard, and a deeply flawed minor premise stating that actual knowledge and deliberate ignorance necessarily fall within the “capacious” reckless-disregard standard. *Id.* at 14 (citations omitted). That minor premise is foreclosed by *Safeco* itself, which said that “action falling within the knowing subcategory *does not simultaneously fall within* the reckless alternative.” *Safeco*, 551 U.S. at 60 (emphasis added); *see also Halo*, 579 U.S. at 105 (“The subjective willfulness of a patent infringer, intentional or knowing, may warrant enhanced damages, *without regard to* whether his infringement was objectively reckless.” (emphasis added)).

And there are even stronger reasons to reject the majority opinion’s overall result. At the outset, it is a “cardinal rule of statutory construction that we are ‘obliged to give
effect, if possible, to every word Congress used.’” Taylor v. Grubbs, 930 F.3d 611, 617 (4th Cir. 2019) (quoting Nat’l Ass’n of Mfrs. v. Dep’t of Def., 138 S. Ct. 617, 632 (2018)); see also Safeco, 551 U.S. at 60 (recognizing its obligation to “[g]ive effect, if possible, to every clause and word of a statute” (citation omitted)). But the majority opinion’s test creates a “threshold requirement” that renders the statutory text’s “actual knowledge” and “deliberate ignorance” standards totally superfluous. Majority Op. at 14. Taking the majority opinion at its word: the objective-recklessness standard is a threshold inquiry. That means that if one can satisfy the majority’s objective-recklessness standard, there is no need to assess actual knowledge or deliberate ignorance, since liability has already been established. If one cannot satisfy the majority’s objective-recklessness standard, then we are precluded from assessing these other scienter standards at all. Id. at 12. There is no escaping this result. Yet, the majority opinion claims that “applying Safeco does not sap the FCA’s three scienter definitions of independent meaning.” Id. at 14. But claiming it to be so does not make it so.

That’s because reading two of the three scienter standards out of the statute is not only inconsistent with a cardinal rule of statutory construction but also inconsistent with Safeco itself. That decision teaches us that “a common law term in a statute comes with a common law meaning” unless “Congress had something different in mind.” Safeco, 551 U.S. at 58, 69 (emphasis added). The fact that Congress crafted three distinct scienter standards—not one threshold objective-recklessness test—compels the conclusion that it did have something different in mind.
In case there was any doubt about this, the drafting history of the False Claims Reform Act confirms it. Over thirty years ago, Congress grew concerned that overly “restrictive court interpretations” of the False Claims Act were “thwart[ing] the effectiveness of the statute.” S. Rep. No. 99-345, at 4, 1986 U.S.C.C.A.N. at 5269. In particular, “inappropriate” narrowing of the Act’s scienter requirement was hamstringing the Government’s ability to fight “rampant fraud.” Id. at 7, 13, 1986 U.S.C.C.A.N. at 5272, 5278. To remedy this problem, Congress crafted three distinct and expansive scienter standards and eliminated any requirement to show bad faith. 31 U.S.C. § 3729(b)(1). The clear intent of these amendments was to adopt a broad, “remedial” scienter standard that would allow the Government to “hold responsible those corporate officers who insulate themselves from knowledge of false claims submitted by lower-level subordinates.” S. Rep. No. 99-345, at 7, 1986 U.S.C.C.A.N. at 5272. In other words, Congress was trying to capture more fraud, not less.

Yet rather than turning to this history, the majority opinion instead repeats the mistakes made by courts before Congress amended the False Claims Act in 1986 by adopting its own overly “restrictive” interpretation of the Act. Id. at 4, 1986 U.S.C.C.A.N. at 5269. Thusly, it reads two of the three scienter standards right out of existence: the actual-knowledge and deliberate-ignorance standards that concern “deliberate wrongdoing.” Halo, 579 U.S. at 104 (emphasis added). By striking these two standards from the statute, the majority effectively “insulat[es] some of the worst [scammers] from any liability” whatsoever. Id. (emphasis added). The majority opinion’s new law thereby frustrates the clear intent of Congress—as evidenced by both the text and legislative
history—to expand False Claims Act liability to cover situations precisely like that alleged by Sheldon today.

Perhaps sensing the weight of authority against it, the majority opinion claims that its redlined version of the Act will “not apply to all [False Claims Act] suits.” Majority Op. at 14. Rather, it contends the opinion “is narrowly cabined to legally false claims—like the one here—which involve contested statutory and regulatory requirements.” Id. at 15 (emphases added). But this is not a minor universe of cases. It might take a lifetime just to list all of the contested statutory and regulatory requirements out there. Even if we only consider what requirements might conceivably be contested for a single program like Medicaid, the mind reels. After all, as the majority itself acknowledges, “Medicaid statutes and regulations ‘are among the most completely impenetrable texts within human experience,’” id. at 20 (quoting Rehab. Ass’n of Va., Inc. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994)), involving “complex” and “labyrinthine reporting requirements” that “raise[] some of the thorniest issues in government price reporting,” id. at 16, 20. If this is true, then what qualifies as a contested Medicaid requirement is only limited by the “ingenuity” of defense attorneys. Halo, 579 U.S. at 105.

In other words, the majority opinion’s “narrow[]” holding is actually as broad as defendants want it to be. Majority Op. at 15. So long as a legal fraudster can “muster a reasonable (even though unsuccessful) defense” at trial—which should not be much of a lift, especially for complex programs like Medicaid—they can “escape any comeuppance.” Halo, 579 U.S. at 105. This creates a truly perverse incentive; the more that defendants
steal via fraud, the easier it is for them to hire high-priced attorneys who can dream up reasonable explanations to justify said fraud after the fact.

Post hoc rationalizations like these are only possible because under the majority opinion’s test, a defendant does not need to have “act[ed] on the basis of the defense” or “even [be] aware of it” at the time the fraud was committed. *Id.* They just need to advance an “objectively reasonable” interpretation that “ha[s] a foundation in the statutory text,” even if that reading is ultimately “erroneous.” Majority Op. at 11 (quoting *Safeco*, 551 U.S. at 69–70). Whether the defendant was actually operating under this interpretation when it committed the alleged fraud is both unnecessary and impossible to discern under the majority’s test because any “inquiry into a defendant’s subjective intent” or “subjective beliefs” is completely precluded. *Id.* at 12, 26 n.5. Forbidding such an inquiry, however, violates another cardinal principle: that “culpability is generally measured against the knowledge of the actor at the time of the challenged conduct.” *Halo*, 579 U.S. at 105. It also allows the “most culpable offenders”—those who commit fraud with actual knowledge and “without any reason to suppose [their] conduct is arguably defensible”—to craft their own get-out-of-jail-free cards whenever they like. *Id.* at 104–105.

The majority opinion counters that any concerns about deliberate fraudsters escaping liability are blunted by *Safeco*’s second step. That step asks “whether authoritative guidance might have warned [the] defendant away from [their objectively reasonable] reading.” Majority Op. at 11. According to the majority opinion, a defendant cannot truly *know* that they are filing a false claim until they obtain authoritative guidance from either the courts of appeal or the relevant agency that “clarifies [their] interpretation of the law
and so warns defendants away from otherwise reasonable interpretations.” *Id.* at 16. Before this point, a “defendant might suspect, believe, or intend to file a false claim, but it cannot *know* that its claim is false.” *Id.* at 15 (quoting *Schutte*, 9 F.4th at 468).

That borders on the nonsensical. It is self-aggrandizing to suppose that the biggest pharmaceutical companies on the planet, with some of the highest-paid experts in health care law, are incapable of reading a statute or regulation and “knowing” they are breaking the law until a court or CMS spells it out for them. And even if a lack of authoritative guidance precludes “*actual* knowledge”—which it shouldn’t—it certainly could not preclude a finding of “*deliberate ignorance.*” 31 U.S.C. § 3729(b)(1)(A) (emphases added). After all, this standard is intended to reach the “‘ostrich’ type situation where an individual has ‘buried his head in the sand’ and failed to make simple inquiries which would alert him that false claims are being submitted.” S. Rep. No. 99-345, at 21, 1986 U.S.C.C.A.N. at 5286. In other words, the False Claims Act’s deliberate-ignorance standard is designed to capture the very conduct the majority says cannot be captured under *Safeco*’s second step: situations where a defendant “suspect[s]” or “believe[s]” they are committing fraud but avoids making inquiries that would confirm their suspicions. Majority Op. at 15 (quoting *Schutte*, 9 F.4th at 468).

Applying *Safeco*’s second step here also leads to absurd results. For example, under the majority opinion’s test, a defendant could *know* they are committing fraud, be told by a *court* that they are doing so, and nevertheless escape liability because (1) they advance a post hoc explanation that, while wrong, is still “reasonable,” and (2) neither the Government nor the court had said anything “authoritative” at the time of the fraud.
It also has the effect of basically freezing judicial interpretation of the statute at issue. Cf. Camreta v. Greene, 563 U.S. 692, 706 (2011) (noting that the doctrine of qualified immunity, as applied to claims under 42 U.S.C. § 1983, “may frustrate the development of constitutional precedent” because courts need not reach the merits of the constitutional claim where qualified immunity applies (internal quotation marks omitted)).

As noted above, under Safeco’s first step, a defendant need only advance an objectively reasonable statutory interpretation. When analyzing this claim, a court does not have to decide what the statute actually says; it only has to determine if the defendant’s reading is “reasonable.” This is precisely what happened below, and precisely what the majority does today. Majority Op. at 22 (“[W]e hold that Forest has offered, at minimum, an objectively reasonable reading of the Rebate Statute.”). The problem is that by doing so, the court necessarily forgoes the opportunity to provide “authoritative guidance,” which is needed at Safeco’s second step to warn the defendant away from their fraudulent scheme. With judicial interpretation stalled, the defendant is free to continue committing knowing fraud as long as they desire unless CMS steps in with new guidance.

And even that might not be enough. For example, though CMS issued new guidance in 2007 that clearly warned Forest away from most of its rebate stacking—as evidenced by its high-level meetings, data scrubbing, sales contracts, and its “first come, first served”
rebate policy—the majority opinion decides, as a matter of law and without considering these facts, that this warning-away could not possibly have occurred.³ Id. at 23.

ii.

Its legal arguments exhausted, the majority opinion next turns to naked considerations of public policy. It accuses CMS—without any basis in the record—of deliberately “maintain[ing] strategic ambiguity” in its Medicaid regulations “in order to expand potential liability for regulated entities.” Majority Op. at 23, 27; see also id. at 27 (“Clear regulations constrain regulatory power and limit future flexibility, which is why an agency might find them undesirable.”). In other words, the majority opinion baldly accuses the executive branch of regulating in bad faith in order to saddle innocent companies with “potentially ruinous liability.”⁴ Id. at 27. Incredibly, the majority opinion then doubles down, alleging that CMS is simply “mak[ing] up the rules as [it] go[es]” along, id. (quoting Bill Watterson, The Calvin & Hobbes Tenth Anniversary Book 129 (1995)), and trying “to take advantage of companies like [Forest]” “through ambush,” id. at 27–28.

³ In 2016, CMS issued a new rulemaking stating that “[i]f a manufacturer offers multiple price concessions to two entities for the same drug transaction . . . all discounts related to that transaction which adjust the price available from the manufacturer should be considered in the manufacturer’s final price of that drug when determining the best price to be reported for the drug.” Medicaid Program; Covered Outpatient Drugs, 81 Fed. Reg. 5170, 5253 (Feb. 1, 2016) (codified at 42 C.F.R. pt. 447). CMS believed this understanding was consistent with the regulation promulgated in 2007. Id. But the majority opinion fails to even mention this rulemaking.

⁴ This is likely an overstatement. As explained above, Forest’s annual revenues top $15 billion per year. Therefore, the majority opinion’s teeth-gnashing over the “potentially ruinous liability” for pharmaceutical companies like Forest is sorely misplaced. Majority Op. at 27.
Finally, the majority opinion circles back to the False Claims Act, finding it “profoundly troubling” that the Act could be used to impose “massive liability on individuals or companies without any proper notice as to what is required.” Id. at 17. The majority opinion then states that since the Act imposes “damages that are essentially punitive in nature,” a lack of appropriate notice means that “defendants are not likely to receive due process.” Id. at 16–17 (citations omitted). However, it says adopting Safeco allows us to “avoid[] this trouble” because it forces courts to “strict[ly] enforce[]” the False Claims Act’s “rigorous” scienter requirement. Id. at 17 (quoting Escobar, 579 U.S. at 192). Having set up this artificial construct, the majority concludes that Safeco’s standard provides “just the right means to further [the majority’s] end”: preventing the ever-expanding “administrative state” from “tak[ing] advantage of companies” like Forest. Id. at 17, 27.

But “[t]he seriousness of [the majority opinion’s] policy concerns cannot justify imposing an artificial construct such as the [Safeco] test on the” False Claims Act. Halo, 579 U.S. at 109. This is especially true when imposing such a construct obviates the clear commands of Congress. Ironically, while it is the majority opinion that accuses CMS of “mak[ing] up the rules as [it] go[es]” along, it is the majority opinion that ends up playing its own version of “Calvinball” by using Safeco to shred two of the Act’s scienter standards. Majority Op. at 27 (quoting Watterson, supra, at 129). The majority opinion claims that this outcome is justified by the Supreme Court’s command to “strict[ly] enforce[]” the Act’s “rigorous” scienter requirement. Id. at 17 (quoting Escobar, 579 U.S. at 192). But there is a big difference between strictly enforcing all three scienter standards created by
Congress and deleting two of them altogether. And because nothing even suggests that the False Claims Act, as currently written, violates due process, we must give effect to all three standards—not rewrite them based on our own notions of a better public policy.

C.

For the reasons explained above, Safeco should not be imported into the False Claims Act. But even if it is, Sheldon has plausibly alleged a claim under the Safeco framework. Under Safeco’s first step, we assess whether Forest’s reading of the Rebate Statute is objectively reasonable. While I agree that its reading would be reasonable if we were interpreting on a blank slate, we aren’t. Even if Forest survives Safeco’s first step, the majority errs by finding—at Safeco’s second step—that Forest was not warned away from its fraudulent scheme.

1.

Though the majority opinion barely mentions it, our interpretation of the Rebate Statute is governed by the familiar framework articulated in Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984). Under Chevron, courts first examine “whether Congress has directly spoken to the precise question at issue.” Id. at 842. If it has, “that is the end of the matter.” Id. But “[i]f the statute is ambiguous, courts then ‘move to Chevron’s second step and defer to the agency’s interpretation so long as it is based on a permissible construction of the statute.’” Sierra Club v. U.S. Army Corps of Eng’rs, 909 F.3d 635, 643 (4th Cir. 2018) (cleaned up) (quoting King v. Burwell, 759 F.3d 358, 367 (4th Cir. 2014), aff’d, 576 U.S. 473 (2015)).
The Rebate Statute’s definition of “best price” is certainly ambiguous. Best price means “the lowest price available from the manufacturer . . . to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity . . . inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates.” 42 U.S.C. § 1396r-8(c)(1)(C) (emphasis added). In general, Congress’s “use of the word ‘any’ suggests an intent to use that term expansively[ly].” Smith v. Berryhill, 139 S. Ct. 1765, 1774 (2019) (quoting Ali v. Fed. Bureau of Prisons, 552 U.S. 214, 218–19 (2008)). “Any” can mean “one, some, or all,” depending on context. Any, Merriam Webster Dictionary, https://www.merriam-webster.com/dictionary/any (last visited Dec. 19, 2021). And the context here is the statute’s broadly remedial purpose: ensuring that Medicaid programs pay the same rate as private entities for prescription drugs. H.R. Rep. No. 101-881, at 96 (1990), reprinted in 1990 U.S.C.C.A.N. 2017, 2108. Therefore, it seems reasonable to read “any” to refer to one or more of the entities listed—especially since Congress did not say “any single” or “any particular” entity, for example. After all, if spreading rebates for the same drug unit around to different entities in the supply chain was not captured in the “best price,” it would not make much sense to call it that.

As the majority opinion notes, two context clues suggest that “any” here means “one” and not “some” or “all.” Majority Op. at 18–19. But neither can bear the weight the majority opinion would place upon them in its bid to render the text unambiguous. First, each of the entities in the statute is listed in the singular form. And “when ‘any’ is used in
context of the singular noun,” it ordinarily refers to a “single” item. *United States v. Dunford*, 148 F.3d 385, 389–90 (4th Cir. 1998) (nonetheless rejecting this reading). But neither Forest nor the majority opinion account for the Dictionary Act—“which supplie[s] rules of construction for all legislation,” *Ngiraingas v. Sanchez*, 495 U.S. 182, 190 (1990) (citation omitted)—which says that “words importing the singular include and apply to several persons, parties, or things.” 1 U.S.C. § 1. Second, the statute includes the disjunctive “or,” which also suggests that each entity must be considered apart from the other. But this is not determinative. “Unsurprisingly, statutory context can overcome the ordinary, disjunctive meaning of ‘or.’” *Encino Motorcars, LLC v. Navarro*, 138 S. Ct. 1134, 1141 (2018); see also *Confederated Tribes & Bands of Yakama Nation v. Yakima Cnty.*, 963 F.3d 982, 990 (9th Cir. 2020) (“[C]ourts are often compelled to construe ‘or’ as meaning ‘and,’ and again ‘and’ as meaning ‘or.’” (quoting *United States v. Fisk*, 70 U.S. 445, 447 (1865))). And again, the context here is Congress’s broad intent to stop “pay[ing] overly inflated prices for prescription drugs.” 136 Cong. Rec. S12,954 (daily ed. Sept. 12, 1990) (statement of Sen. David Pryor).

The majority opinion makes several other arguments, but none clear up the issue. To start, it provides a few simplistic examples using baseballs and apples to suggest “aggregating discounts to multiple entities” cannot be required by the Rebate Statute. Majority Op. at 19. But by their very nature, these everyday examples lack the critical legislative context animating the best-price provision. They do not, for example, assume that the “thrifty Kansas City Royals” or your “friend” have been repeatedly swindled and forced to pay exorbitant amounts for the same goods purchased by everyone else at a much
lower price. *Id.* Nor do they account for the overlapping nature of the supply chain for drug manufacturing and delivery.

Next, the majority opinion suggests that since the statute says “the lowest price *available* from the manufacturer” and “‘available’ means ‘suitable or ready for use,’” the statute must be “talking about an actual price, not something that is purely hypothetical.” *Id.* at 19 (emphasis added). But the majority opinion itself recognizes that “available” is a more elastic word than this argument suggests. For example, it notes that “wholesaler chargeback agreements”—discounts that the wholesaler delivers to its customers and later “charges back” to the manufacturer—can be included in best price, even though they are not “at hand” or immediately “available” from the manufacturer and in fact operate as a “lagged price concession.” *Id.* at 19, 24–25.

The majority opinion also points out differences between the definitions of best price and “[a]verage [m]anufacturer [p]rice.” *Id.* at 19–20. Specifically, the former refers to “the lowest price available *from* the manufacturer” while the latter refers to the “the average price *paid to* the manufacturer.” 42 U.S.C. § 1396r-8(c)(1)(C)(i), (k)(1)(A) (emphases added). The majority opinion vaguely notes that “something ‘paid to the manufacturer’ might incorporate discounts to different entities” but fails to explain why this is true, or how “paid” and “from” create a meaningful “distinction[] in the statutory scheme.” Majority Op. at 20.

It also seems odd to interpret these standards in dramatically different ways since the difference between the two is what determines the manufacturer’s rebate payment. See 42 U.S.C. § 1396r-8(c)(1)(A)(ii). Mathematically, it usually only makes sense to subtract
like terms from each other. *Addition and Subtraction of Algebraic Expressions*, Cuemath, https://www.cuemath.com/algebra/addition-and-subtraction-of-algebraic-expressions/ (last visited Dec. 19, 2021) (“Unlike terms cannot be combined by adding or subtracting.”). But if average manufacturer price could incorporate stacked rebates but best price could not, then drug manufacturers would be stuck subtracting apples from oranges. It also would lead to bizarre results: normally, we would expect the best price to be lower than the average price. But if average price could include rebates from multiple entities but best price cannot, the difference between the two would diminish or even disappear. Such a result would be out of step with Congress’s intent, which was to “achieve significant Medicaid savings” by getting the “same discounts” that private entities enjoy. H.R. Rep. No. 101-881, at 96, 98, 1990 U.S.C.C.A.N. at 2108, 2110.

The majority opinion counters that aggregating prices to different entities is difficult, so it makes sense to read the statute to not require manufacturers to do so. Majority Op. at 21. But that’s not a canon of construction—whether compliance with the law is taxing has no bearing on what the law itself requires.

In sum, the Rebate Statute is ambiguous which means *Chevron’s* second step is implicated.

ii.

Addressing *Chevron’s* second step, it is worth pointing out from the outset that no one debates that CMS has the authority to make rules interpreting the Rebate Statute with the “force of law.” *See United States v. Mead Corp.*, 533 U.S. 218, 226–27 (2001) (limiting *Chevron* deference to interpretations made by agencies acting with the “force of law”
pursuant to that authority). The real question is whether there is any reasonable agency interpretation to defer to in the first place. *See Fogo De Chao (Holdings) Inc. v. U.S. Dep’t of Homeland Sec.*, 769 F.3d 1127, 1135 (D.C. Cir. 2014) (“[W]here ‘the underlying regulation does little more than restate the terms of the statute itself[,]’ the agency has left the statute as it found it, adding nothing material to Congress’s language and providing nothing of its own in which to ground an interpretation to which a court might defer.” (quoting *Gonzales v. Oregon*, 546 U.S. 243, 257 (2006))). The majority opinion finds that CMS’s regulations “simply mirror the statutory language,” so no deference is appropriate. Majority Op. at 21. Not so.

CMS has issued three distinct notice-and-comment rulemakings on best price. In 1991, CMS promulgated the Rebate Agreement, which copied the statutory language on “best price” but added that the “best price for a quarter shall be adjusted by the Manufacturer if cumulative discounts, rebates or other arrangements subsequently adjust the prices actually realized.” Medicaid Program; Drug Rebate Agreement, 56 Fed. Reg. 7049, 7050 (Feb. 21, 1991). In 2007, CMS promulgated a regulation defining “best price” as “the lowest price available from the manufacturer during the rebate period to any entity in the United States in any pricing structure.” 72 Fed. Reg. at 39,242 (emphases added). It further clarified that best price “shall be [the] net of cash discounts . . . which reduce the price available from the manufacturer,” and required manufacturers to “adjust the best price

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5 “When an agency’s interpretation derives from notice-and-comment rulemaking, it will almost inevitably receive *Chevron* deference.” *Sierra Club*, 909 F.3d at 644 (citation and internal quotation marks omitted).
for a rebate period if cumulative discounts, rebates, or other arrangements subsequently adjust the prices available from the manufacturer.” Id. at 39,242–43 (emphases added).

Finally, in 2016, CMS promulgated another regulation that best price must include “all prices, including applicable discounts, rebates, or other transactions that adjust prices either directly or indirectly to the best price-eligible entities” listed in the statutory definition. 81 Fed. Reg. at 5351 (emphases added).

These rulemakings’ broad references to “any entity,” “any pricing structure,” “net” cash discounts, “prices actually realized,” and “other arrangements subsequently adjust[ing] prices” strongly suggest that CMS is focused on the “net” result—the price the manufacturer actually realizes for the sale of a single drug unit. In fact, it is this “net” result language that prompted Forest and other pharmaceutical companies to suggest that “CMS views best price as the net amount realized by the manufacturer on a sale rather than the lowest price to a particular customer.” J.A. 239 (emphases added). I agree with the drug companies that this is precisely what CMS intended. I also find that this interpretation is reasonable for the reasons explained above, as well as the fact that it best comports with our obligation to interpret a statute “in light of its object and policy.” United States v. Turpin, 65 F.3d 1207, 1210 (4th Cir. 1995).

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Forest claims this regulation is irrelevant because Sheldon did not include any particularized factual allegations concerning the company’s conduct after 2014. Response Br. at 27–28. Even if this is true, the regulation still shows that CMS has consistently interpreted the Rebate Act to require stacked rebates be included in best price. 81 Fed. Reg. at 5253 (noting that the 2016 regulation is consistent with the 2007 regulation).
Ultimately, despite the majority opinion’s protestations, we must defer to the reasonable interpretation of CMS. If we do, then we must find that Forest acted under an objectively unreasonable reading of the Rebate Statute.\footnote{A final note on the interpretation of the Rebate Statute. Though the majority opinion’s statutory analysis is couched in absolute terms, its holding is much more modest: it only concludes “that Forest has offered, at minimum, an objectively reasonable reading of the Rebate Statute.” Majority Op. at 22. Therefore, the majority opinion’s reading of the statute is not binding on this or any other court.}

2.

Even if we conclude that Forest’s reading was reasonable, it still falters at \textit{Safeco}’s second step because it was warned away from that reading. But before I get to that, I must first address the majority opinion’s flawed warned-away standard.

According to the majority opinion, a defendant may only be warned away from an erroneous statutory reading by two “authoritative” sources: “circuit court precedent or guidance from the relevant agency.” Majority Op. at 22. As support, it cites \textit{Safeco} and several out-of-circuit cases. \textit{Id.} However, \textit{Safeco} did not expressly limit the warned-away exception to just these two sources. \textit{See} 551 U.S. at 70 (addressing “guidance from the courts of appeals or the [relevant agency]” but not expressly limiting the inquiry to these sources only). And in fact, we have already held that the warned-away exception extends beyond these two sources.

In \textit{United States ex rel. Lutz v. Mallory}, 988 F.3d 730 (4th Cir. 2021), we considered whether a blood-testing lab knowingly violated the Anti-Kickback Statute and thus ran afoul of the False Claims Act. \textit{Id.} at 735–36. At trial, the Government offered evidence that
the defendants’ own attorneys warned them their scheme might violate the statute. *Id.* at 736. In addition, the Government “offered evidence that outside lawyers warned all three [of the] defendants about the illegality of the[ir kickbacks].” *Id.* at 736–37. The jury found the defendants had knowingly violated the Anti-Kickback Statute, and we declined to reverse as a matter of law. *Id.* at 735–36.

The defendants argued that “because the Anti-Kickback Statute is ambiguous, they could have reasonably concluded that the statute did not prohibit [their scheme], and so they cannot have knowingly violated the False Claims Act.” *Id.* at 737. We disagreed, noting that “[the d]efendants were repeatedly ‘warned away from [their] interpretation’ of purportedly ambiguous terms, including by legal practitioners.” *Id.* (emphasis added) (quoting *Purcell*, 807 F.3d at 288). Because the *Mallory* Court expressly held that guidance from legal practitioners can satisfy the “warned-away” exception, the majority opinion’s attempt to limit the same exception to appellate precedent and agency guidance must fail. *United States v. Spinks*, 770 F.3d 285, 290 (4th Cir. 2014) (explaining that “if two circuit precedents conflict, the earlier one . . . controls over the later”).

The majority opinion’s failure to heed our precedent leads it to make yet another error by holding that Forest was not warned away as a matter of law. Majority Op. at 22–28. To wit, because the majority opinion erroneously considers only appellate precedent or agency guidance relevant, it finds it can resolve the entire warned-away issue by interpreting these “legal materials” on its own. *Id.* at 18 n.3. However, *Mallory* forecloses this view. 988 F.3d at 737 (recognizing the fact-intensive nature of the warned-away exception). And other courts, including the D.C. Circuit in *United States ex rel. Purcell v.
MWI Corp.—a case the majority opinion repeatedly relies on—have consistently held that whether an entity was warned away “cannot readily be labeled as a ‘purely legal’ question.” See, e.g., Purcell, 807 F.3d at 288; see also id. at 289 (“[T]he factual question remains whether there was sufficient evidence that [the defendant] was warned away from its interpretation.”); United States ex rel. Brown v. Celgene Corp., 226 F. Supp. 3d 1032, 1051 (C.D. Cal. 2016) (“Whether [the defendant] was warned away from the view it took is a question of fact.”); United States ex rel. Streck v. Bristol-Myers Squibb Co., 370 F. Supp. 3d 491, 497 (E.D. Pa. 2019) (noting “a factual determination remains whether [the defendant] had been warned away from its interpretation by CMS[,]”).

This makes sense when you take the time to think about what being “warned away” means. A full warned-away inquiry might require determining what legal guidance existed, what it said, who said it, how authoritative it was, when the defendant knew or should have known about it, how the defendant responded, and what other advice the defendant might have received from its own or outside attorneys. See, e.g., Mallory, 988 F.3d 736–37 (reviewing a timeline of legal memos, board meetings, emails, agency commentary, judicial opinions, and legal opinions authored by outside lawyers to assess whether the defendants were warned away). At most, this is a mixed question of law and fact. Therefore, the majority opinion errs by finding that Forest could not have been warned away as a pure matter of law.

With the proper framework in mind, there is no doubt that Sheldon plausibly alleged Forest was warned away. As explained at length above, Forest explicitly asked CMS to remove language from the 2007 regulation it believed would require rebate stacking. CMS
refused, and expressly rejected a “customer-by-customer” approach to best price. 8 72 Fed. Reg. at 39,198. In response, Forest held a series of high-level meetings and instituted a data audit to eliminate rebate stacking. It also introduced language prohibiting its customers from claiming stacked rebates and instituted a “first come first serve” policy for rebates on the same drug units to avoid having to report double rebates to CMS. Thus, Forest was not only “warned away” by CMS, but also clearly took that warning to heart—at least for its non-preferred customers. Unfortunately, under the majority opinion’s purely legal—and purely impermissible—warned-away test, the jury will never get to consider these facts and make its own assessment of Forest’s liability under the False Claims Act.

II.

If the majority opinion wants to consider the impact this decision has on policy, then here are some facts from which we can take judicial notice.

Every year, between $100 and $360 billion are lost to health care fraud. See National Health Care Anti-Fraud Association, The Challenge of Health Care Fraud,

8 The majority opinion counters that this same rulemaking repeatedly urged manufacturers like Forest “to make reasonable assumptions” when calculating best price. Majority Op. at 26. But as the majority acknowledges, a manufacturer may only make such assumptions “[i]n the absence of specific guidance,” and such assumptions must be “consistent with the general requirements and the intent of the [Rebate Statute], [and] Federal regulations.” 72 Fed. Reg. at 39,164. For the reasons explained above, the majority opinion errs by finding the 2007 guidance was not specific; after all, it was specific enough to trigger Forest to conduct a data audit, alter its sales-contract language, and refuse to make stacked-rebate payments for most of its customers. Similarly, the majority opinion cannot explain how Forest’s neat trick—directly paying out rebates to different customers instead of paying one rebate to its wholesaler to avoid reporting double rebates to CMS—is consistent with the intent of the Rebate Statute.

In this swelling sea of fraud, the Government is bailing out with an ever-shrinking teaspoon. In fiscal year 2020, the Government recovered only $1.8 billion in settlements and judgments for health care fraud using the False Claims Act. Press Release, U.S. Dep’t of Justice, Justice Department Recovers Over $2.2 Billion from False Claims Act Cases in Fiscal Year 2020 (Jan. 14, 2021) (noting over 80% of the total fraud recovery in 2020 related to the health care industry). This was almost a 30% decline from the amount recovered in 2019, and over a 40% decline from the $3.1 billion high-water mark in 2012. Id. Thus, it is not only the “sad truth . . . that [fraud] against the Government often does pay,” S. Rep. No. 99-345, at 3, 1986 U.S.C.C.A.N. at 5268, but getting away with it is also getting easier.

Unfortunately, today’s majority opinion only worsens this trend. In doing so, the majority opinion joins a long and ignominious line of cases that have “thwart[ed] the effectiveness of the [Act]” by adopting overly “restrictive” scienter standards. Id. at 4, 1986 U.S.C.C.A.N. at 5269.
Thirty years ago, Congress stepped in to correct the worst of these judicial abuses. If the majority decision stands, Congress will be forced—unnecessarily—to do the same again. With respect for my colleagues in the majority, I dissent.9

9 The majority opinion finds it unnecessary to address the district court’s falsity finding because it concludes that Sheldon did not plausibly allege scienter. Majority Op. at 9 n.2. But the falsity finding was plainly inconsistent with the text of the False Claims Act and our precedent.

The district court found that the False Claims Act only punishes “objective falsehoods,” United States ex rel. Sheldon v. Forest Lab’ys, 499 F. Supp. 3d 184, 212 (D. Md. 2020)—those “expressions of fact” that are capable of “empirical verification” and, thus, can be shown to be empirically false, United States ex rel. Wilson v. Kellogg Brown & Root, Inc., 525 F.3d 370, 377–78 (4th Cir. 2008) (quoting Harrison v. Westinghouse Savannah River Co., 176 F.3d 776, 792 (4th Cir. 1999)). Since Forest acted under an objectively reasonable interpretation of the statute, the district court concluded, its best-price reports were not verifiably and objectively “false” for False Claims Act purposes. Sheldon, 499 F. Supp. 3d at 212.

There are three major problems with this analysis. First, on its face, the False Claims Act is not limited to “objective falsehoods”—it merely requires “a false or fraudulent claim” or “statement.” 31 U.S.C. § 3729(a)(1)(A)–(B). And at common law, “false or fraudulent claims” include “more than just claims containing express [or empirical] falsehoods.” Escobar, 579 U.S. at 187; see also id. at 188 (noting that even statements that are technically true can be “actionable misrepresentations”).

Second, injecting “objectivity” at this stage impermissibly conflates scienter with falsity. See Mallory, 988 F.3d at 737 (holding that whether a defendant failed to comply with an “ambiguous” statutory term “go[es] to whether the government proved knowledge” (quoting Purcell, 807 F.3d at 287)); United States ex rel. Oliver v. Parsons Co., 195 F.3d 457, 463 (9th Cir. 1999) (“[W]hile the reasonableness of [a defendant’s] interpretation of the applicable [statute] may be relevant to whether it knowingly submitted a false claim, the question of ‘falsity’ itself is determined by whether [a defendant’s] representations were accurate in light of applicable law.”). Forest “either complied with” the Rebate Statute “or [it] didn’t”; its allegedly “reasonable” reading of the statute plays no part in the falsity inquiry. Drakeford, 792 F.3d at 383–84.

(Continued)
Third, even if we conclude that the False Claims Act requires an “objective falsehood,” the district court erred by concluding that compliance with the law in this case is not empirically verifiable. This Court has held that whether an entity complied with the law is an “objective inquiry.” Id. at 384 (emphasis added). Again, Forest’s statements “either complied with” the Rebate Statute “or [they] didn’t.” Id. at 383–84. And, if they did not, then they would be objectively false. The district court never determined whether that was the case here.
United States Court of Appeals
For the Eighth Circuit

No. 20-2445

United States of America, ex rel.

Plaintiff - Appellee

Paul Cairns; Terry Cleaver, M.D.; Kyle Colle, M.D.; Paul Tolentino, M.D.; Kevin Vaught, M.D.; Daniel Henson, Relators; Barbara Gibbs, Personal Representative of the Estate of Scott Randall Gibbs, M.D.

Relators - Appellees

v.

D.S. Medical LLC; Midwest Family Care, LLC

Defendants

Midwest Neurosurgeons, LLC

Defendant - Appellant

Mount Auburn Medical Group, LLC, doing business as Mount Auburn Aesthetics Group

Defendant

Sonjay Fonn, M.D.

Defendant - Appellant

Deborah Seeger

Defendant
No. 20-2448

United States of America, ex rel.

*Plaintiff - Appellee*

Paul Cairns; Terry Cleaver, M.D.; Kyle Colle, M.D.; Paul Tolentino, M.D.; Kevin Vaught, M.D.; Daniel Henson, Relators; Barbara Gibbs, Personal Representative of the Estate of Scott Randall Gibbs, M.D.

*Relators - Appellees*

v.

D.S. Medical LLC

*Defendant - Appellant*

Midwest Family Care, LLC; Midwest Neurosurgeons, LLC; Mount Auburn Medical Group, LLC, doing business as Mount Auburn Aesthetics Group; Sonjay Fonn, M.D.

*Defendants*

Deborah Seeger

*Defendant - Appellant*

No. 20-3009

United States of America, ex rel.

*Plaintiff–Appellee*
Paul Cairns; Terry Cleaver, M.D.; Kyle Colle, M.D.; Paul Tolentino, M.D.; Kevin Vaught, M.D.; Daniel Henson, Relators; Barbara Gibbs, Personal Representative of the Estate of Scott Randall Gibbs, M.D.

Relators - Appellees

v.

D.S. Medical LLC; Midwest Family Care, LLC

Defendants

Midwest Neurosurgeons, LLC

Defendant - Appellant

Mount Auburn Medical Group, LLC, doing business as Mount Auburn Aesthetics Group

Defendant

Sonjay Fonn, M.D.

Defendant - Appellant

Deborah Seeger

Defendant

___________________________
No. 20-3010

___________________________
United States of America, ex rel.

Plaintiff - Appellee

-3-
There are several ways to prove that a claim is “false or fraudulent” under the False Claims Act. 31 U.S.C. § 3729(a)(1). One of them is to show that it “includes
items or services *resulting from* a violation” of the anti-kickback statute. 42 U.S.C. § 1320a-7b(g) (emphasis added). This case requires us to determine what the words “resulting from” mean. We conclude that it creates a but-for causal requirement between an anti-kickback violation and the “items or services” included in the claim. *See Burrage v. United States*, 571 U.S. 204, 210–11 (2014). The district court did not instruct the jury along these lines, so we reverse and remand for a new trial.

I.

Sonjay Fonn is a neurosurgeon in Cape Girardeau, Missouri. To treat degenerative-disc disease and other spinal disorders, he uses spinal implants. The implants, which stabilize the spine, are made by multiple manufacturers. Deciding which to use has important economic consequences for implant distributors, who earn hefty commissions with every sale. This puts Dr. Fonn and his practice, Midwest Neurosurgeons, in a powerful position.

Dr. Fonn chose to use implants distributed by DS Medical, a company wholly owned by his fiancée, Deborah Seeger. The arrangement was lucrative, even though Dr. Fonn was her only large customer. In just a single year, she made $1.3 million in commissions from one manufacturer alone. For his part, Dr. Fonn received an offer to purchase company stock from the same manufacturer. Once the sale went through, he ordered more implants.

Physicians in other practices grew suspicious of Dr. Fonn’s high implant use, not to mention his cozy financial relationship with Seeger. They filed complaints against him, Midwest Neurosurgeons, Seeger, and DS Medical under the False Claims Act, 31 U.S.C. § 3729 *et seq.*, and other laws. The United States then intervened and filed its own complaint. *See* 31 U.S.C. § 3730(a), (b)(2), (b)(4) (providing that the government may intervene and conduct the litigation).

The complaint consisted of five claims. The first three, which arose under the False Claims Act, alleged that the couple and their businesses submitted false or
fraudulent Medicare and Medicaid claims after violating the anti-kickback statute, 42 U.S.C. § 1320a-7b(b), (g). The last two claims, which were equitable in nature, alleged unjust enrichment and payment under a mistake of fact.

A jury heard the first three claims. After each side presented its case, the district court instructed the jury that the government could establish falsity or fraud once it proved, by a preponderance of the evidence, “that the [Medicare or Medicaid] claim failed to disclose the [anti-]kickback [statute] violation.” The jury returned a verdict for the government on two of the three claims. The district court then awarded treble damages and statutory penalties in the amount of $5,495,931.22.

Following the verdict, the government moved to dismiss its two remaining claims without prejudice, see Fed. R. Civ. P. 41(a)(2), on the ground that any recovery would be “smaller and duplicative of what the court had already awarded.” Unfortunately, the district court “inadvertently failed to rule on the government’s motion” before the defendants filed an appeal, so we remanded. The government got its wish the second time around—a dismissal without prejudice—and the defendants have appealed again.

II.

The without-prejudice dismissal of the two equitable claims requires a closer look at our jurisdiction. As relevant here, we have appellate jurisdiction over “final decisions of the district courts.” 28 U.S.C. § 1291. A “final decision” is one that “ends the litigation on the merits and leaves nothing for the court to do but execute the judgment.” Catlin v. United States, 324 U.S. 229, 233 (1945). To determine whether a decision is final, we look for “some clear and unequivocal manifestation by the trial court of its belief that the decision made, so far as the court is concerned, is the end of the case.” Goodwin v. United States, 67 F.3d 149, 151 (8th Cir. 1995) (quotation marks and brackets omitted).
The odd procedural posture complicates things. On remand, the district court dismissed the government’s equitable claims, but it did so without prejudice, and the government has expressed a clear intent to revive them if we reverse. Ordinarily, “a dismissal without prejudice, coupled with the intent to refile the voluntarily dismissed claims after an appeal of the interlocutory order, is a clear evasion of the judicial and statutory limits on appellate jurisdiction.” Great Rivers Co-op. of Se. Iowa v. Farmland Indus., Inc., 198 F.3d 685, 688 (8th Cir. 1999); see also Riis v. Shaver, 4 F.4th 701, 705 (8th Cir. 2021) (“A dismissal without prejudice leaves the parties free to litigate as though the action never commenced.”) (quotation marks and ellipsis omitted). Among other things, it creates a real risk of piecemeal adjudication. See McLish v. Roff, 141 U.S. 661, 665–66 (1891).

Not so here. The treble-damages award fully compensated the government for its injuries and then some, leaving no doubt that awarding anything more would lead to a duplicative recovery. See Adams v. Toyota Motor Corp., 867 F.3d 903, 921 (8th Cir. 2017) (discussing double recoveries). Even if the dismissal without prejudice left the government with the ability to revive its equitable claims, deciding them on the merits would have been an “academic exercise,” one without any real consequence for the parties. United States ex rel. Miller v. Bill Harbert Int’l Constr., Inc., 505 F. Supp. 2d 20, 24 (D.D.C. 2007) (noting that “any recovery under” these circumstances “would be duplicative”); see also United States ex rel. Drummond v. BestCare Lab’y Servs., L.L.C., 950 F.3d 277, 284 (5th Cir. 2020) (“We need not consider defendants’ challenges to the $10.6 million judgment [on the equitable claims]. That’s because it is subsumed within the second judgment for $30.6 million under the False Claims Act” and consequently “moot.”). Under these circumstances, with no reason to decide what remained, dismissing without prejudice was, as “far as the court [was] concerned, . . . the end of the case,” which is all that is necessary to satisfy the final-judgment rule. Goodwin, 67 F.3d at 151 (quotation marks and brackets omitted).1

1We dismiss the earlier appeals, filed before the district court dismissed the equitable claims without prejudice, as premature.
Satisfied that appellate jurisdiction exists, we now turn to the merits. The couple argues that we must reverse the jury verdict because of two instructional errors. The first is the lack of a beyond-a-reasonable-doubt instruction, allegedly necessary here because the government relied on a criminal statute to prove its case. The second is the lack of an instruction on but-for causation. Reviewing these questions of statutory interpretation de novo, see United States v. Carlson, 787 F.3d 939, 944 (8th Cir. 2015), we conclude that the district court was right on the first point but wrong on the second.

A.

This case involves two statutes. The first is the False Claims Act, which imposes civil liability on anyone who presents or conspires to “present[,] . . . a false or fraudulent claim” to the government. 31 U.S.C. § 3729(a)(1)(A), (C).

One way to prove that a claim is “false or fraudulent” is through a second law, the anti-kickback statute, which imposes criminal liability on anyone who solicits or receives illegal kickbacks for any “item[s] or service[s]” paid “in whole or in part” by Medicare or Medicaid. 42 U.S.C. § 1320a-7b(b)(1), (f), (g). Under a 2010 amendment, submitting a claim to the government that “includes items or services resulting from a[n] [anti-kickback] violation” makes a claim “false or fraudulent” under the False Claims Act. Id. § 1320a-7b(g) (emphasis added).

The government relied exclusively on the 2010 amendment to prove that Dr. Fonn, Seeger, and their businesses submitted “false or fraudulent claim[s].” 31 U.S.C. § 3729(a)(1)(A), (C). According to the government, the kickbacks “tainted” their choice of implants, so their claims for reimbursement through Medicare and Medicaid were “false or fraudulent.” As the government puts it, it “pays only for conflict-free care.”
B.

With that statutory background in mind, we start with what the district court got right: the burden of proof. The False Claims Act requires “the United States . . . to prove all essential elements of the cause of action . . . by a preponderance of the evidence.” 31 U.S.C. § 3731(d) (emphasis added). All means all, not some or most. See Webster’s Third New International Dictionary 54 (2002) (defining “all” as “the whole amount or quantity of” and “every member or individual component of”); The American Heritage Dictionary of the English Language 45 (5th ed. 2016) (defining “all” as “[b]eing or representing the entire or total number, amount, or quantity”).

It makes no difference that the government’s theory depended on proving an anti-kickback violation—itself a criminal act. See 42 U.S.C. § 1320a-7b(b) (providing criminal penalties for taking illegal kickbacks). As the Supreme Court has explained, “conduct that can be punished as criminal only upon proof beyond a reasonable doubt will support civil sanctions under a preponderance standard.” Sedima, S.P.R.L. v. Imrex Co., 473 U.S. 479, 491 (1985) (discussing this “general principle,” which is found in “a number of settings”).

The fact that the False Claims Act expressly provides a preponderance-of-the-evidence standard for all “essential elements” leaves no doubt that this “general principle” applies here. Id. Just as a plaintiff in a civil-racketeering case may establish an underlying criminal violation by a preponderance of the evidence, see Bieter Co. v. Blomquist, 987 F.2d 1319, 1320, 1324 (8th Cir. 1993), so too may the government establish an illegal kickback by a preponderance of the evidence as part of a larger False Claims Act case.

C.

Now on to what the district court got wrong: causation. The jury instruction said “it is enough for the United States to show that the claim failed to disclose the
[a]nti-[k]ickback [s]tatute violation.” This instruction, which brushed aside causation, misinterpreted the 2010 amendment. See 42 U.S.C. § 1320a-7b(g).

1.

When a statute is unambiguous, interpretation both begins and ends with the text. See Food Mktg. Inst. v. Argus Leader Media, 139 S. Ct. 2356, 2364 (2019). The 2010 amendment says that “a claim that includes items or services resulting from a violation of this section [of the anti-kickback statute] constitutes a false or fraudulent claim for purposes of [the False Claims Act].” 42 U.S.C. § 1320a-7b(g) (emphasis added). This case turns on two simple words: “resulting from.” With no statutory definition available, “we turn to the phrase’s plain meaning at the time of enactment.” Tanzin v. Tanvir, 141 S. Ct. 486, 491 (2020).

The Supreme Court undertook this task in interpreting a nearly identical phrase, “results from,” in the Controlled Substances Act. See Burrage v. United States, 571 U.S. 204, 210–11 (2014). The statute in question specified an enhanced sentence whenever “death or serious bodily injury results from the use of [a distributed controlled] substance.” 21 U.S.C. § 841(b)(1)(A)–(C) (emphasis added); see Burrage, 571 U.S. at 209. Looking to dictionary definitions, the Court concluded that the ordinary meaning of “‘results from’ imposes . . . a requirement of actual causality”: the use of drugs had to be a “but-for cause of the death.” Burrage, 571 U.S. at 210–11, 219 (citing 2 The New Shorter Oxford English Dictionary 2570 (1993)); see also Comcast Corp. v. Nat’l Ass’n of Afr. Am.-Owned Media, 140 S. Ct. 1009, 1014 (2020) (“This ancient and simple ‘but for’ common law causation test, we have held, supplies the ‘default’ or ‘background’ rule against which Congress is normally presumed to have legislated . . . .” (citation omitted)).

The context here may be different, but our conclusion is the same. “Resulting,” which is the present-participle form of the verb, has the same meaning as its present-tense cousin, “results.” See The American Heritage Dictionary of the English Language 1497 (5th ed. 2016) (defining “result,” “results,” and “resulting”
as “[t]o happen as a consequence” or “[s]omething that follows naturally from a particular action, operation, or course; a consequence or outcome”); *Webster’s Third New International Dictionary 1937 (2002)* (defining “result,” “results,” and “resulting” as “to proceed, spring, or arise as a consequence, effect, or conclusion,” and noting that all three words are often used with “from”). So we have little trouble concluding that, in common and ordinary usage, the participle phrase “resulting from” also expresses “a but-for causal relationship.” *See Burragge, 571 U.S. at 213* (quoting *Safeco Ins. Co. v. Burr*, 551 U.S. 47, 63 (2007)).

*Burrage* also explains what “a but-for causal relationship” requires. *Id.* “‘In the usual course,’ [it] requires proof ‘that the harm would not have occurred in the absence of—that is, but for—the defendant’s conduct.’” *Id.* at 211 (emphasis added) (quoting *Univ. of Tex. Sw. Med. Ctr. v. Nassar*, 570 U.S. 338, 346–47 (2013)). “It is . . . textbook tort law that an action ‘is not regarded as a cause of an event if the particular event would have occurred without it.’” *Nassar*, 570 U.S. at 347 (quoting W. Keeton, D. Dobbs, R. Keeton, & D. Owen, Prosser and Keeton on Law of Torts 265 (5th ed. 1984) (defining but-for causation)). Tracking the textbook definition, the government had to prove here that the defendants would not have included particular “items or services” absent the illegal kickbacks. 42 U.S.C. § 1320a-7b(g); *see also Burragge, 571 U.S. at 211*.

Backed up against a wall of precedent, the government urges us to adopt an “alternative causal standard[].” *See Paroline v. United States*, 572 U.S. 434, 458 (2014) (explaining that “the availability of alternative causal standards where circumstances warrant is, no less than the but-for test itself as a default, part of the background legal tradition against which Congress has legislated”). In its view, all that is required is that the illegal kickbacks “tainted” the “claim[] for goods or services” or the anti-kickback “violation itself *may* have been a contributing factor.” Appellee’s Br. at 29 (emphasis added).

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2The government unsuccessfully made this same argument in *Burragge*. *See* Brief for the United States at 19, *Burragge, 571 U.S. 204* (No. 12-7515), 2013 WL 5461835, at *19.
These alternative standards, however, are hardly causal at all. A “taint” could occur without the illegal kickbacks motivating the inclusion of any of the “items or services.” Similarly, asking the jury if a violation “may have been a contributing factor” does not establish anything more than a mere possibility. And the district court’s instruction may have been the least causal of all: just because a claim fails to disclose an anti-kickback violation does not mean that there is a connection between the violation and the included “items or services.” 42 U.S.C. § 1320a-7b(g). Causation is an “essential element[]” that must be proven, not presumed. 31 U.S.C. § 3731(d).

Our holding here should be no surprise. After all, “[w]here there is no textual or contextual indication to the contrary, courts regularly read phrases like ‘results from’ to require but-for causality.” Burrage, 571 U.S. at 212; Comcast Corp., 140 S. Ct. at 1014 (calling it the “default” or background” rule against which Congress legislates). With nothing in the text of the 2010 amendment giving us reason to conclude otherwise, we follow Burrage’s example.

2.

Without any “textual . . . indication[s] to the contrary,” the government resorts to two “contextual indication[s].” See Burrage, 571 U.S. at 212 (emphases added). Neither, however, overcomes the statute’s plain language.

a.

The first “contextual indication” is that some pre-2010 cases had concluded that the non-disclosure of an anti-kickback violation was enough to make a claim “false or fraudulent” regardless of whether a causal relationship existed. Mirroring the government’s “taint” argument, those courts reasoned that “compliance with federal health care laws, including the [anti-kickback statute], is a condition of payment by” Medicare or Medicaid. McNutt ex rel. United States v. Haleyville Med. Supplies, Inc., 423 F.3d 1256, 1259 (11th Cir. 2005). Under that reasoning, any
failure to disclose an anti-kickback violation—regardless of the relationship between the illegal kickbacks and the items or services included—was sufficient. See United States ex rel. Wilkins v. United Health Grp., Inc., 659 F.3d 295, 313 (3d Cir. 2011) (holding that plaintiffs “need not allege a relationship between the alleged [anti-kickback] violations and the claims . . . submitted to the Government”), abrogated on other grounds by Universal Health Servs., Inc. v. United States, 579 U.S. 176 (2016). The government argues that the 2010 amendment “simply codified” these holdings.

We disagree, if for no other reason than the text of the 2010 amendment says otherwise. See Food Mktg. Inst., 139 S. Ct. at 2364 (explaining that when the “ordinary meaning and structure” of the law “yields a clear answer, judges must stop”). The phrase “resulting from,” as we have already explained, is unambiguously causal. See Burrage, 571 U.S. at 211–13. If Congress wanted to “codify” the pre-2010 cases, it could have selected different language. The government’s list of “alternative causal standards” provides several examples, including “tainted by” or “provided in violation of.” Cf. id. at 216 (“Congress could have . . . adopted a modified causation test tailored to cases involving concurrent causes, as five States have done.”). Although the government might have preferred one of these other alternatives, it is our job to interpret Congress’s actual words. See SAS Inst., Inc. v. Iancu, 138 S. Ct. 1348, 1355 (2018).

b.

The second indication, characterized by the government as “contextual,” is legislative history. Looking beyond the text of the 2010 amendment, the government relies on the floor statements of two of its sponsors to argue that its purpose was to expand the universe of claims that are “false or fraudulent” under the False Claims Act. 31 U.S.C. § 3729(a)(1).

Starting with legislative history and purpose, however, is no way to read a statute. See Food Mktg. Inst., 139 S. Ct. at 2364; United States v. Trans-Missouri
Freight Ass’n, 166 U.S. 290, 318 (1897) ("[D]ebates in [C]ongress are not appropriate sources of information from which to discover the meaning of the language of a statute passed by that body."). After all, when a statute is unambiguous, we start and end in the same place: with the words of the statute itself. See id.; Owner-Operator Indep. Drivers Ass’n, Inc. v. Supervalu, Inc., 651 F.3d 857, 862 (8th Cir. 2011). The reason is simple: our duty is to “interpret laws,” not “reconstruct legislators’ intentions.” I.N.S. v. Cardoza-Fonseca, 480 U.S. 421, 452–53 (1987) (Scalia, J., concurring in the judgment); see also Epic Sys. Corp. v. Lewis, 138 S. Ct. 1612, 1631 (2018) ("[L]egislative history is not the law.").

We recognize that the Third Circuit came out differently in United States ex rel. Greenfield v. Medco Health Solutions, Inc., 880 F.3d 89 (3d Cir. 2018). Although we understand its point of view, it adopted an approach that we have already rejected: relying on legislative history and “the drafters’ intentions” to interpret the statute. Id. at 96.

* * *

Our ruling today is narrow. We do not suggest that every case arising under the False Claims Act requires a showing of but-for causation. Rather, when a plaintiff seeks to establish falsity or fraud through the 2010 amendment, it must prove that a defendant would not have included particular “items or services” but for the illegal kickbacks. 42 U.S.C. § 1320a-7b(g). Here, given that the government’s sole theory at trial hinged on the 2010 amendment, the district court never instructed the jury on but-for causation, and there is no telling what the jury would have done if it had, we remand for a new trial.

3Although the defendants argue in passing that we should just enter judgment in their favor, the government presented enough evidence on the “essential elements” of the claim, including causation, to receive a new trial. 31 U.S.C. § 3731(d); cf. Schumacher v. Cargill Meat Sols. Corp., 515 F.3d 867, 872 (8th Cir. 2008) (denying a new trial because the plaintiffs had not produced any evidence of intent the first time around).
IV.

We accordingly reverse the judgment of the district court and remand for further proceedings.
In this *qui tam* action, Relator Melina Ebu-Isaac (“Relator”) asserts claims under the False Claims Act, 31 U.S.C. § 3729 et seq. (“FCA”), as well as state- and local-law analogs of the FCA. Relator also asserts two claims, the fourth and fifth causes of action, that are captioned as claims for “Payment by Mistake,” and seek return of monies paid based on restitution or unjust enrichment.

Presently before the Court are two Motions to Dismiss the Second Amended Complaint (“SAC”) in its entirety. The Relator filed two Opposition briefs (Docs. 164-65); and the moving Defendants filed Reply briefs. (Docs. 166-67). These Motions to

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1 There are other Plaintiffs as well. In addition to the Relator, Plaintiffs include the United States, which intervened pursuant to the False Claims Act (see Doc. 30, Intervenor Complaint), a number of States, the City of Chicago, and the District of Columbia.

2 The first Motion to Dismiss was filed by BelHealth Investment Partners, LLC, BelHealth Investment Management, LLC, and BelHealth Investment Fund, LP (collectively, “BelHealth”). (Doc. 142.) The second was filed by Linden Care LLC, Linden Care, Inc., and Linden Care Holdings, Inc. (collectively “Linden Care”). (Doc. 143.)
Dismiss were heard on March 12, 2021, at which time the Court took the matter under submission.

As set forth herein, the Court DENIES BelHealth’s Motion to Dismiss. The Court GRANTS IN PART and DENIES IN PART Linden Care’s Motion to Dismiss, and dismisses without prejudice two state-law claims asserted as the fourth and fifth causes of action.

I. BACKGROUND AS ALLEGED IN THE SAC

The Second Amended Complaint (“SAC”) sets forth the following allegations. The Relator alleges a fraudulent scheme whereby INSYS Therapeutics, Inc. (“INSYS”), BelHealth, and Linden Care promoted and facilitated the widespread off-label use of a prescription opioid pain reliever approved by the United States Food and Drug Administration (“FDA”) for a very limited purpose. (See SAC at 2-3.) As described more specifically below, in carrying out the scheme, Defendants are alleged to have put patients at risk, to have made false statements in claims for payments from Government Health Care Programs, and to have received millions of dollars of payments from the government. (¶ 4.)

A. Defendants

During all times relevant, former Defendant INSYS, developed, marketed, and distributed pharmaceutical products throughout the United States and world. (¶¶ 6-7.) Relevant here is its development of an opioid pain reliever, brand-named SUBSYS, a patented fentanyl spray. (¶ 3.)

The BelHealth Defendants and the Linden Care Defendants are related entities. BelHealth Investment Partners, LLC owns BelHealth Investment Fund, LP, which is a health care-focused private equity firm that in July 2013 acquired Linden Care, LLC; BelHealth Investment Partners thereafter formed Linden Care, Inc. and Linden Care

3 The SAC defines “Government Health Care Programs” as including Medicaid and Medicare and other federal government health programs. (¶ 2.)
4 Throughout, citations to paragraph numbers are to the SAC.
5 INSYS settled the claims against it and is no longer party to this action. (See Doc. 84, Order Dismissing Claims Against INSYS.)
Holdings, Inc. (¶¶ 13, 15; see id. ¶ 23 (alleging that “LINDEN CARE, under direct
instruction, strategic planning, funding, and control by BELHEATH, illegally dispensed
and distributed SUBYS [sic]”), ¶ 231-37 (alleging interaction among BelHealth
Defendants, Linden Care Defendants, and INSYS in developing business practices
underlying the present claims).) BelHealth’s control over Linden Care continued through
July 2017, when it transferred Linden Care’s assets and business to another BelHealth-
owned company, Quick Care Pharmacy, Inc. (“Quick Care”). (¶¶ 3-7, 247-57.) In this
manner, BelHealth, Linden Care, and Quick Care were all allegedly involved in the
distribution of SUBYS produced by INSYS. (¶¶ 18, 253-57.) Quick Care is not a
defendant in this action.

B. Allegations Related to SUBSYS

The SAC alleges that SUBSYS was approved by the FDA in January 2012 solely
for the management of “breakthrough” cancer pain in opioid-tolerant adults. (¶¶ 86-87 &
n.3 (setting forth the FDA’s definition of “opioid tolerance”); id. ¶¶ 92-96.) SUBSYS is
an oral spray form of fentanyl, described by the FDA as a “Transmucosal Immediate
Release Fentanyl” drug, or “TIRF.” (¶ 90.) Patients, physicians, and pharmacists who
use, prescribe, or dispense a TIRF drug must comply with the FDA’s Risk Evaluation and
Mitigation Strategy, or “REMS,” before doing so. (¶ 90; see id. ¶¶ 97-103 (describing in
detail the “TIRF REMS”).) The SAC alleges that fentanyl is 50 to 100 times more potent
than morphine and that, as a result, SUBSYS has a high potential for abuse and addiction.
(¶¶ 88-89.) For the same reason, SUBSYS is also alleged to be a dangerous drug;
“misuse [of SUBSYS] can result in death from respiratory depression.” (¶¶ 89-90.)

C. Defendants’ Alleged Promotion of Off-Label Use of SUBSYS

The SAC alleges extensive marketing for off-label use of SUBSYS by INSYS.6 Specifically, it alleges that INSYS engaged in a number of successful strategies

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6 Prescribers may lawfully prescribe off-label use of prescription drugs, but the promotion of such off-label
use by drug companies is prohibited. The prohibition is well-known to those in the industry, but it is not easily
discerned from statutory and regulatory law. See Coleen Klasmeier & Martin H. Redish, Off-Label Prescription
Advertising, the FDA and the First Amendment: A Study in the Values of Commercial Speech Protection, 37 Am.
to promote the off-label use of SUBSYS such that, within two years of its FDA approval for breakthrough pain in opioid-tolerant cancer patients, SUBSYS accounted for nearly 50% of the market share for TIRF drugs, and over 80% of prescriptions for SUBSYS were for off-label use. (¶¶ 104-05.) Of that market share, by April 2014, Linden Care dispensed more than 40% of the SUBSYS produced by INSYS. (¶ 246.)

Specifically, as part of promoting off-label use over FDA-approved use, INSYS allegedly assigned to the majority of its staff the task of “target[ing] pain management specialists, internists and neurologists,” while devoting fewer staff to the task of marketing to oncologists. (¶ 110.) INSYS also trained its sales staff to employ various methods of promoting off-label uses over FDA-approved uses. (See SAC ¶¶ 111-13.) For instance, INSYS gave its sales staff financial rewards of $500 to $800 for each patient who was switched from another TIRF drug to SUBSYS by a prescriber.7 (¶ 114.) According to Relator, INSYS directed her to provide free samples of SUBSYS to patients in order to encourage their insurers and the Government to pay for SUBSYS prescriptions after the drug companies stopped providing SUBSYS without charge; this practice of providing three months’ to a year’s worth of SUBSYS could also allegedly cause “patients [to] grow dependent on the medication during that time, ensuring a long prescribing relationship.” (¶ 116.)

Sales staff were allegedly directed to encourage physicians and patients to use higher doses of SUBSYS than medically indicated and to prescribe more SUBSYS by prescribing it for continuous use, rather than just emergency use. (¶¶ 117-18.) Sales staff were encouraged to inform physicians that they should disregard the prescribing

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7 INSYS sales representatives are alleged to have had a low-base-salary plus sales commission compensation structure; therefore, they had strong financial incentives to accomplish the objectives defined by their employer to earn greater commissions. (¶ 118.) Higher doses of SUBSYS also resulted in higher commissions to sales representatives. (See ¶ 124 (“During a sales meeting, [INSYS] told sales representatives they would attain their bonuses if the patient titrated closer to 1600 mcg.”).)
information that required the first dose for all patients to “always”\(^8\) be the lowest dose, 100 micrograms,\(^9\) and to instead inform physicians to “double the entry dose,” expect to increase the dosage significantly within a month, and to expect to titrate upward to dosages between 600 and 1000 micrograms.\(^{10}\) (¶¶ 120-21.) Sales representative communicated directly with patients and advised them, contrary to labeling information, to start with a 200-microgram dose (rather than the recommended 100-microgram first dose) and to repeat the 200-microgram dose if still in pain without first communicating with their physicians (as advised by SUBSYS’s label). (¶¶ 121-23.)

INSYS facilitated reimbursement by insurers for off-label use through a related entity, the INSYS Reimbursement Center (“the Center”); the purpose of the Center was to persuade insurers to pay for SUBSYS prescriptions. (¶¶ 126-27.) INSYS also provided prior authorization forms to its sales representatives, an appeal letter template for use by physicians, and free samples during an initial period of use by the patient. (¶ 126.) Specifically, prior authorization forms were sometimes pre-populated with diagnoses likely to receive off-label authorization and an off-label initial dosage. (¶¶ 131-32.) The appeal letter was geared toward obtaining approval for off-label use. (¶ 133.) Where an insurer refused to authorize off-label use of SUBSYS notwithstanding the efforts of the Center, INSYS provided the patient with a supply of SUBSYS. (¶¶ 129, 134-36.) After the patient had taken SUBSYS for three months to a year, insurers were allegedly more willing to approve its future use. (¶ 129.)

INSYS also provided prescribers and pharmacists with “cheat sheets” to enable them to easily pass the FDA online assessment required by the TIRF REMS. (¶¶ 137-143.) These “cheat sheets” were not summaries or other study materials; instead, they were the “A-D” answers to eleven multiple-choice questions. (¶ 140.)

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\(^8\) The SUBSYS label states: “The initial dose of SUBSYS to treat episodes of breakthrough cancer pain is always 100 mcg.” (¶ 119 (emphasis in the original).)

\(^9\) Because fentanyl is an extremely potent drug, dosages are measured in micrograms (“mcg”) rather than the more common measure of milligrams. One milligram is 1,000 micrograms.

\(^{10}\) The Relator alleges that breakthrough pain is managed in approximately 25% of patients at a dosage of 400 micrograms or lower. (¶ 125.)
In addition to promoting the off-label use described above, INSYS also allegedly engaged in a kickback scheme whereby it would reward physicians who routinely prescribed off-label use of SUBSYS. (¶¶ 166-187.) The kickbacks were disguised as “speaker fees,” free labor to perform office work in physicians’ offices, and restaurant- and retail-gift cards.11 (¶ 173; cf. Doc. 30, United States Intervenor Complaint, ¶¶ 43-139 (detailing “speaker fees” paid to seventeen prescribers).) Relator alleges she was trained to identify physicians for whom “money talk[ed],” that is, to identify which physicians seemed willing to write prescriptions in exchange for kickbacks. (¶ 167.) She was also trained to rate physicians on a green-yellow-red scale, where a green rating meant the physician was most likely to accept kickbacks in exchange for writing prescriptions, a red rating meant the physician was unlikely to accept kickbacks, and a yellow rating was somewhere in the middle. (¶ 170.)

Linden Care, as directed by BelHealth, submitted claims to Government Health Care Programs based on physician’s prescriptions for off-label use. (¶ 164.) It did so by filing claim forms (or by causing others to file such claim forms) to seek payment from Government Health Care Programs. (See ¶¶ 165, 269 (referring to the filing of specific claim forms).) Specifically, the Relator alleges that these constitute actionable false claims because Medicare and Medicaid payments for off-label use of a drug must be supported by the following: (1) citation to one of the drug compendia specified in 42 U.S.C. § 1396r-8(g)(1)(B)([i]) (Medicaid); (2) “peer-reviewed medical literature;” (3) a determination that the drug was “medically accepted generally as safe and effective” or “reasonable and necessary” (Medicare); and (4) a coverage determination by other Government Health Care Programs. (¶ 165.) The Relator alleges that SUBSYS did not meet these requirements. (¶¶ 155-65.)

Moreover, the Relator alleges that Linden Care, under the direction of BelHealth, breached TIRF REMS protocols in a number of ways. (¶ 203-09.) These include

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11 The pricing structure of SUBSYS was lucrative. For instance, the Relator alleges that a 20-day, 120-dose, 200 mcg supply of SUBSYS—the next-to-lowest-dosage available—was “priced . . . at approximately $6,667.” (¶ 288.)
“[d]ispensing SUBSYS for contra-indicated and off-label uses, . . . [d]ispensing ‘initial starting doses’ of 200 mcg, rather than the mandated initial maximum dosage of 100 mcg[,] and [d]ispensing SUBSYS with directions to consume the drug six times daily, independent of pain.” (¶ 207 (paragraph structure altered).) The Relator also alleges Linden Care dispensed SUBSYS without following a legal requirement that SUBSYS, as a controlled substance, be dispensed only upon presentation of a written prescription. (¶ 210-19.)

Linden Care’s role, and later Quick Care’s role, under the direction of BelHealth, was to, inter alia, dispense SUBSYS and to help facilitate resolution of any issues associated with the filling of SUBSYS prescriptions. (¶ 223; see ¶¶ 220-57.) Essentially, Linden Care facilitated the dispensing of and payment for SUBSYS pursuant to prescriptions written by physicians who had been encouraged by INSYS to write as many such prescriptions for as many patients as they possibly could. (See id.)

The SAC alleges that INSYS sales representatives were trained to encourage physicians to use Linden Care to fill prescriptions for SUBSYS, to use the Center to resolve any issues with filling those prescriptions, to leave forms to assist office staff to do so, and to follow up with physicians who chose to use Linden Care to fill prescriptions for SUBSYS. (¶ 222.) Sales representatives were also provided with a script for “selling” physicians on the use of Linden Care to resolve any issues in filling prescriptions, which included asking the physician for a three-patient commitment to start the process. (¶ 226.) Linden Care also facilitated the shipping of a free first thirty-unit supply if prior authorization was refused. (¶ 225.)

The SAC alleges that at least one patient died as a result of overdosing on SUBSYS dispensed by Linden Care. (¶¶ 271-312.) After using SUBSYS in a manner advocated by INSYS (and facilitated by Linden Care), Patient #1 died as a result of the drug’s improper use. (¶ 312; see generally ¶¶ 271-312.)

D. Claims Asserted

Against this background, the SAC asserts claims for three separate violations of the False Claims Act. Specifically, the three False Claims Act claims are brought
pursuant to subsections (a)(1)(A), (a)(1)(B) and (a)(1)(G), of 31 U.S.C. § 3729, which in
general impose liability for presenting false or fraudulent claims, using a false record or
statement that is material to a false or fraudulent claim, and engaging in the knowing use
of a false, material record or statement to avoid or decrease an obligation to the United
States. See 31 U.S.C. § 3729(a)(1)(A)-(B), (G). Additionally, the Relator brings twenty-
nine claims under state- and local-law analogs of the FCA. She also asserts claims for
“payment by mistake,” seeking restitution and claiming unjust enrichment.

II. LEGAL STANDARD

A. Standard for Dismissal Pursuant to Rule 12(b)(6)

When evaluating a motion to dismiss under Federal Rule of Civil Procedure
12(b)(6), the Court must accept as true all allegations of material facts that are in the
complaint and must construe all inferences in the light most favorable to the non-moving
party. Moyo v. Gomez, 40 F.3d 982, 984 (9th Cir. 1994). Dismissal of a complaint for
failure to state a claim is not proper where a plaintiff has alleged “enough facts to state a
claim to relief that is plausible on its face.” Bell Atl. Corp. v. Twombly, 550 U.S. 544,
570 (2007). A complaint must (1) “contain sufficient allegations of underlying facts to
give fair notice and to enable the opposing party to defend itself effectively,” and
(2) “plausibly suggest an entitlement to relief, such that it is not unfair to require the
opposing party to be subjected to the expense of discovery and continued litigation.”
Starr v. Baca, 652 F.3d 1202, 1216 (9th Cir. 2011). “Although for the purposes of a
motion to dismiss [the Court] must take all of the factual allegations in the complaint as
true, [it is] not bound to accept as true a legal conclusion couched as a factual allegation.”

B. Pleading Fraudulent Conduct with Particularity Under Rule 9(b)

Claims that sound in fraud, including FCA claims, are subject to the heightened
pleading requirements of Federal Rule of Civil Procedure Rule 9(b), which requires that
allegations of fraud be made “with particularity.” See Fed. R. Civ. P. 9(b). To satisfy
this standard, plaintiffs must allege “the who, what, when, where, and how of the
misconduct charged.” Vess v. Ciba-Geigy Corp. USA, 317 F.3d 1097, 1106 (9th Cir.
2003) (internal quotation marks omitted). However, “[w]hile the factual circumstances
of the fraud itself must be alleged with particularity, the state of mind—or scienter—of
the defendants may be alleged generally.” Odom v. Microsoft Corp., 486 F.3d 541, 554
(9th Cir. 2007) (citing In re GlenFed, Inc. Sec. Litig., 42 F.3d 1541, 1547 (9th Cir. 1994)
en banc)).

C. Liability Under the False Claims Act

The False Claims Act makes liable any “person”12 who “knowingly presents, or
causes to be presented, a false or fraudulent claim for payment or approval” or
“knowingly makes, uses, or causes to be made or used, a false record or statement
material to a false or fraudulent claim.” 31 U.S.C. § 3729(a)(1)(A)-(B). A similar
provision prohibits the use of material records or statements (or concealment thereof) that
“avoids or decreases an obligation to pay or transmit money . . . to the Government.” 31
U.S.C. § 3729(a)(1)(G). “In an archetypal qui tam False Claims action, such as where a
private company overcharges under a government contract, the claim for payment is itself
literally false or fraudulent.” United States v. United Healthcare Ins. Co., 848 F.3d 1161,
1172-73 (9th Cir. 2016) (internal quotation marks omitted). “As [is also] relevant here,
. . . a claim under the False Claims Act can be false where a party merely falsely certifies
compliance with a statute or regulation as a condition to government payment.” Id. at
1173 (internal quotation marks omitted). “Under a false certification theory, it is the false
certification of compliance which creates liability when certification is a prerequisite to
obtaining a government benefit.” Id. (internal quotation marks omitted) (emphasis in the
original). As discussed below, this false certification can be either express or implied,
depending on a defendant’s alleged conduct. See United States ex rel. Rose v. Stephens
Inst., 909 F.3d 1012, 1017 (9th Cir. 2018).

Generally, to state a claim under the FCA, a relator must allege facts sufficient to
satisfy four elements: “(1) a false statement or fraudulent course of conduct, (2) made
with scienter, (3) that was material, causing (4) the government to pay out money or

12 The FCA’s use of “person” includes corporations and other business entities. See Cook County, Ill. v.
forfeit moneys due.” United States ex rel. Campie v. Gilead Sciences, Inc., 862 F.3d 890, 902 (9th Cir. 2017).

III. COLLECTIVE ALLEGATIONS

More than once, the SAC refers to all Defendants collectively. (See, e.g., ¶ 4 (“Through their intentional and reckless acts, which included false statements and claims for payment to the Government Health Care Programs, Defendants have put patients at risk and received millions of dollars in improper government payments.”); ¶¶ 1, 73, 270.) The SAC also refers to three BelHealth entities collectively and three Linden Care entities collectively. (See supra note 2.) BelHealth correctly argues that because these Defendants are all in fact separate entities, liability under the FCA cannot be premised merely upon their relatedness. However, where an entity uses its ability to control or influence another to submit false claims, that entity is not shielded from liability based on its mere status as a separate entity.

Overall, the SAC alleges cooperation among the Defendant entities—all of them—to carry out a joint business venture related to the distribution of SUBSYS. This business venture was allegedly devised by individuals at the highest level of these entities, whereby the separate business entities were managed and used to varying degrees to carry out a common goal. Relator alleges that “BelHealth” was key to the large-scale operation to profit from dispensing SUBSYS to populations of patients for whom SUBSYS was not intended, and to dispense SUBSYS at dosages keyed to profit rather than to compliance with applicable laws and with patient health and well-being. This alleged large-scale operation involved BelHealth’s use of several separate business entities, including three “Linden Care” entities and one “Quick Care” entity.

From these allegations, two specific issues arise as to the remaining Defendants: First, whether BelHealth may be found liable under the FCA even though it was Linden Care (and later Quick Care) that actually dispensed SUBSYS and that actually submitted the claims for reimbursement to the Government; and second, whether the FCA claims are sufficiently alleged against all BelHealth Defendants and all Linden Care Defendants.
As to the first issue, all three subsections of the FCA relied upon by the Relator impose liability where one person or entity commits a violation through its control of the actions of another person or entity. For instance, subsection (a)(1)(A) of § 3729 imposes liability on “any person who . . . knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.” 31 U.S.C. § 3729(a)(1)(A) (emphasis added). Subsections (a)(1)(B) and (a)(1)(G) repeat the emphasized language. 31 U.S.C. § 3729(a)(1)(B), (G); see also United States v. Mackby, 261 F.3d 821, 827-28 (9th Cir. 2001) (“[A] person need not be the one who actually submitted the claim forms in order to be liable.”); see also 31 U.S.C. § 3729(b)(2)(A) (broadly defining “claim” as including “any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property that . . . is presented to an officer, employee, or agent of the United States”).

As summarized above, the SAC alleges that BelHealth caused false claims to be submitted for reimbursement from Government Health Care Programs. For instance, the SAC alleges that BelHealth acquired one Linden Care entity (and then formed two more such entities), acquired Quick Care, and transferred Linden Care’s assets to Quick Care. It alleges that BelHealth promoted the use of Linden Care to INSYS to facilitate the large scale distribution SUBSYS, directed Linden Care to dispense SUBSYS for contraindicated use and off-label use, directed Linden Care to dispense the incorrect initial dosages and to dispense with the instructions that instructed six-time per day use of SUBSYS rather than “as needed” use, and directed Linden Care to submit claims based on the widespread off-label use of SUBSYS. And as discussed below, BelHealth negotiated with INSYS on behalf of Linden Care. Thus, the SAC sufficiently alleges that the BelHealth Defendants worked with or through other entities and thereby caused false claims to be presented for payment.

As to the second issue, BelHealth’s argument that the SAC’s allegations are lacking sufficient specificity as to each BelHealth entity is also unavailing. The SAC does not rely on the mere fact that the three BelHealth entities are related. Instead, as
noted above (see supra note 2), the SAC first identifies the three BelHealth entities: BelHealth Investment Partners, LLC (“Investment Partners”); BelHealth Investment Management, LLC (“Investment Management”); and BelHealth Investment Fund, LP (“Investment Fund”). (¶ 1.) At relevant times, Investment Partners was a limited partnership that owned Investment Fund. (¶ 13.) Investment Fund acquired Linden Care, LLC. (¶ 13.) Investment Management “provided management, oversight, and strategic guidance for the operations of” Linden Care, LLC. (¶ 14.) Similarly, the SAC alleges that Investment Partners, through Investment Fund, acquired Linden Care, LLC “as a portfolio company,” and thereafter formed Linden Care, Inc., and Linden Care Holdings, Inc. (¶ 13, 15.)

Given the scope of the scheme and the manner in which it was alleged to have been carried out, the SAC plausibly alleges involvement by all the entities in presenting false claims or causing such claims to be presented. Communications from the top officials of BelHealth do not distinguish among the various entities and suggest cooperation by all the entities in the common endeavor of expanding the market for SUBSYS far beyond that approved by the FDA.

For instance, the SAC sets forth verbatim a June 19, 2014 email from Harold Blue, Founder and Managing Partner of Investment Fund and Managing Partner of Investment Partners. (¶¶ 230, 234.) There, Blue fails to distinguish among the BelHealth entities, and he appears to speak on behalf of them all. (See ¶ 230.) Therein, in proposing additional business with INSYS, through Linden Care, he touts a new facility, new technology, new robot and phone systems, and “basically everything new.” (¶ 230.) Significantly, that email shows that Blue was attempting to negotiate a better commission for SUBSYS dispensed by Linden Care; in doing so, he uses the collective pronoun “we” to discuss volumes of drugs to be acquired and rebates to be paid. (¶ 230.) In context, this email is one voice speaking collectively for BelHealth and Linden Care about key points of the ongoing business venture between them and INSYS involving distribution of SUBSYS.
And even before that, in July 2013, Investment Partners issued a press release announcing the acquisition of Linden Care, LLC by Investment Partners, again not distinguishing among the BelHealth entities, and quoting Linden Care’s Chief Operating Officer: “BelHealth is the perfect partner to accelerate Linden Care’s growth from a regional company to a national platform. BelHealth’s significant experience as operators and investors, particularly in the pharmacy space, make them the ideal equity partner for our Company.” (¶ 17 (emphasis omitted).)

The allegations that all these entities worked together to facilitate the filing of false claims is made all the more plausible by the overlap of officers and board members for the various entities. (See ¶ 234.) At the pleadings stage, the allegations are sufficient as to each BelHealth and each Linden Care entity.

IV. FALSE CLAIMS ACT CLAIMS

BelHealth and Linden Care move to dismiss the FCA claims. Because, as discussed above, BelHealth is alleged to have caused false claims to be presented through its control of Linden Care, the Court considers their motions together.

Defendants argue that all four elements of the FCA claims are insufficiently pleaded and that once those are dismissed, the Court should dismiss the related state-law claims rather than exercise supplemental jurisdiction over those claims in the absence of any federal claim. See 28 U.S.C. § 1367(c)(3). As set forth below, the Court finds all the elements of the FCA have been sufficiently pleaded. The Court therefore DENIES both Motions to Dismiss as to the FCA claims.

A. FCA Element One: Falsity

Defendants contend Relator has not sufficiently alleged the element of falsity. (BelHealth Mot. at 10-15; Linden Care Mot. at 9-10.) In stating an FCA claim, the element of falsity can be satisfied by either of two ways: (1) express false certification, which “means that the entity seeking payment falsely certifies compliance with a law, rule or regulation as part of the process through which the claim for payment is
submitted,” and (2) “implied false certification, which occurs when an entity has previously undertaken to expressly comply with a law, rule, or regulation but does not, and that obligation is implicated by submitting a claim for payment even though a certification of compliance is not required in the process of submitting the claim.” *Rose*, 909 F.3d at 1017 (internal alteration marks and quotation marks omitted) (emphasis in the original). The latter is at issue here.

An implied false certification claim is sufficiently supported by allegations showing two conditions: “first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant’s failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths.” *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2001 (2016); see also *Rose*, 909 F.3d at 1018 (clarifying that the *Escobar* test, rather than a three-factor test previously employed by the Ninth Circuit, applied to implied certification claims).

To illustrate, in *Escobar*, a patient was treated in a mental health care facility by providers who were not licensed in the manner required by Medicaid regulations. *Id.* at 1997-98. In asserting an FCA claim against the provider, relators alleged that the provider submitted claims for services provided by purportedly qualified professionals, when in fact the professionals lacked the required qualifications. *Id.* “[B]y submitting claims for payment using payment codes that corresponded to specific counseling services, [the provider] represented that it had provided individual therapy, family therapy, preventive medication counseling, and other types of treatment.” *Id.* at 2000. The provider also “made further representations in submitting Medicaid reimbursement claims by using [codes to identify] specific job titles,” which falsely implied that the services were provided by staff with particular licenses. *Id.* These allegations were sufficient to state a claim because there were “specific representations about the . . . services provided” by the use of the billing codes, but those “representations [were]
misleading half-truths” based on the provider’s “failure to disclose noncompliance with material statutory, regulatory, or contractual requirements.”  Id. at 2001.

In Campie, the Ninth Circuit applied Escobar. There, a pharmaceutical company sold to the federal government certain prescription drugs that used ingredients from facilities not approved by the FDA. Campie, 862 F.3d at 895-96. By doing so, the company “established policies and practices [that] violate[d] the FDA’s regulatory requirements . . . [but still] submitt[ed] claims for ‘FDA approved’ drugs.”  Id. at 904. The Ninth Circuit found this to be an example of the misleading “half-truths” that satisfy the FCA’s falsity element.  Id. at 904 (finding that the claims at issue “‘fall squarely within the rule that half-truths—representations that state the truth only so far as it goes, while omitting critical qualifying information’”) (quoting Escobar, 136 S.Ct. at 2000).

In that regard, this case is like Campie. Here, the SAC alleges that Linden Care (as directed by BelHealth) engaged in a course of fraudulent conduct by repeatedly submitting claims for payment without disclosing non-compliance with the FDA, the Medicaid Act, and the Controlled Substances Act (“CSA”). And because the claims at issue here seek reimbursement for a specific drug, those claims, like the ones at issue in Campie, “necessarily refer[red] to specific drugs under the FDA’s regulatory regime,” which by itself makes certain representations about those drugs. See Campie, 862 F.3d at 902-03.

For instance, the SAC alleges that Linden Care dispensed SUBSYS “without ‘adequate directions for use’” in violation of 21 U.S.C. § 352(f), described as “misbranding.” (¶ 36.) The SAC also alleges that Linden Care engaged in misbranding through its non-compliance with the TIRF REMS protocol in three ways. (See ¶¶ 203-209.) Specifically, Linden Care allegedly breached that protocol by dispensing SUBSYS for contra-indicated and off-label uses, without discussing the drug or its safe usage with patients, by dispensing SUBSYS at “initial starting doses” of 200 micrograms rather than the mandated initial maximum dosage of 100 micrograms, and by dispensing SUBSYS with directions to consume the drug six times daily, independent of pain. (¶ 207.)
The SAC also alleges non-compliance with the CSA, 21 U.S.C. § 842(a)(1). (¶¶ 210-19.) Specifically, the CSA makes it unlawful to dispense a controlled substance without a written prescription. 21 U.S.C. § 829(a); (see ¶¶ 211-213). The SAC alleges six instances in which the CSA was violated in this manner. (¶ 213.)

The SAC also alleges Linden Care’s failure to comply with the Medicaid Act. (¶ 267; see ¶¶ 58, 157, 164.) Specifically, it alleges that Linden Care submitted claims for off-label uses of SUBSYS that were not supported by “medically accepted indication[s]” as defined by the Medicaid Act. See 42 U.S.C. § 1396r-8(k)(6) (incorporating subsection (g)(1)(B)(i)).

These failures to disclose its non-compliance with the FDA, the Medicaid Act, and the CSA are sufficient to meet the standard for implied certification, meeting the falsity element of an FCA claim. That is, by “mak[ing] specific representations about the goods . . . provided” by reference to the brand name of an FDA-approved drug, coupled with the “failure to disclose noncompliance with material statutory . . . requirements,” Linden Care made “representations [that were] misleading half-truths.” Escobar, 136 S. Ct. at 2001.

The Rule 9(b) pleading-with-particularity requirement has likewise been fulfilled. The SAC alleges “the who, what, when, where, and how of the misconduct charged.” Vess, 317 F.3d at 1106 (internal quotation marks omitted). The SAC alleges that Linden Care (the “who”) made implied certifications regarding the dispensing of SUBSYS (the “what”) during the time period of July 2013 through June 2014 (the “when”) by submitting claims seeking payment from the United States by the filing of specific claim forms designed to seek such payment (the “where” and “how”).

B. FCA Element Two: Scienter

BelHealth and Linden Care also contend scienter is insufficiently alleged. (BelHealth Mot. at 16-17; Linden Care Mot. at 10-12.) Due to its nature, scienter is not subject to the heightened Rule 9(b) pleading-with-particularity requirement. Odom, 486 F.3d at 554. Instead, it must be pleaded in accordance with the more general pleading
The FCA sets forth a statutory definition of scienter by defining “knowing” and “knowingly” as “(A) mean[ing] that a person, with respect to information—(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information.” 31 U.S.C. §§ 3729(b)(1)(A). Beyond this, the FCA “require[s] no proof of specific intent to defraud.” 31 U.S.C. §§ 3729(b)(1)(B).

For instance, in *Corinthian Colleges*, the court considered an express certification by a college that it was in compliance with certain requirements restricting the payment of bonuses (referred to as an “incentive ban”) to admissions recruiters. 655 F.3d at 990-91. Applying the lower Rule 8(a) standard, the court held that merely reciting that the college either “knowingly” made a false certification (or acted “in deliberate or reckless disregard” as to the falsity of its certification) was insufficient to plead the scienter element. *Id.* at 996-97. Instead, the court required the relator to plead facts sufficient “to support an inference or to render plausible that [a defendant] acted while knowing” its certification of compliance with the incentive ban was untrue. *Id.* at 997.

Here, the SAC alleges Linden Care impliedly certified its compliance with the FDA, the Medicaid Act, and the CSA in dispensing SUBSYS, all while being controlled by the same entities that were advocating for and facilitating the large-scale marketing and distribution of SUBSYS in a manner that violated these laws. The scope of the distribution proposed by BelHealth supports an inference that BelHealth intended that SUBSYS be widely distributed to a patient population that far outstripped the limited market of opioid-tolerant cancer patients experiencing breakthrough pain. (*See, e.g.*, SAC ¶ 230 (Blue’s email to INSYS’s CEO stating “[w]e will likely distribute $120 Million of Subsys in 2014”); ¶ 240 (internal INSYS email estimating Linden Care’s SUBSYS sales in 2015 as $2.85 million per week); ¶ 105 (alleging that during the relevant period, more than 80% of prescriptions for SUBSYS were for off-label use).
The SAC alleges such wide distribution actually occurred, and that SUBSYS was dispensed to patients for whom it was contraindicated, for off-label purposes, with improper instructions, at incorrect dosages.

This case is like Winter. There, the court noted that “[b]ecause medical necessity is a condition of payment, every Medicare claim includes an express or implied certification that treatment was medically necessary.” Winter ex rel. United States v. Gardens Reg’l Hosp. & Med. Ctr., Inc., 953 F.3d 1108, 1114 (9th Cir. 2020), cert. denied sub nom. Rollins Nelson LTC Corp. v. United States ex rel. Winters, 141 S. Ct. 1380 (2021). Therefore, where a relator alleged facts that plausibly supported an inference that providers were knowingly admitting patients to a hospital where it was not medically indicated to do so, she pleaded facts sufficient to support an inference of scienter. Id. at 1120-21; id. at 1114 (“Claims for unnecessary treatment are false claims.”).

In the same manner here, by alleging the dispensing of SUBSYS on a broad scale for off-label purposes, at improper dosages, with improper instructions, and to patients for whom it was contraindicated, the SAC alleges facts that plausibly support the inference that BelHealth and Linden Care acted with the requisite scienter.

C. FCA Element Three: Materiality

BelHealth and Linden Care argue the element of materiality is lacking. (BelHealth Mot. at 17-18; Linden Care Mot. at 13-15.) “[A] misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government’s payment decision in order to be actionable under the False Claims Act.” Escobar, 136 S. Ct. at 2002. Statutorily defined, “the term ‘material’ means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” 31 U.S.C. § 3729(b)(4).

In explaining that “[t]he materiality standard is demanding,” the Court in Escobar elaborated:

The False Claims Act is not “an all-purpose antifraud statute,” . . . or a vehicle for punishing garden-variety breaches of contract or regulatory
violations. A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defendant’s noncompliance. Materiality, in addition, cannot be found where noncompliance is minor or insubstantial.

_id_. at 2003 (citation omitted).

As to materiality, the SAC alleges that had the Government known of Defendants’ noncompliance with a number of federal laws and regulations, it would not have paid the claims. (See ¶¶ 72, 207-09, 213.) Specifically, as discussed below, the SAC alleges materiality in at least three ways.

First, it alleges that Defendants’ actions caused the payment of false or fraudulent SUBSYS reimbursement claims. (¶ 72.) Specifically, the SAC alleges multiple ways in which the Defendants worked to promote and facilitate the widespread, off-label and medically non-indicated uses of SUBSYS (including by Linden Care’s dispensing of SUBSYS in the manner described in the SAC), resulting in the payment of claims by the Government for SUBSYS reimbursement despite Defendants’ and/or claimants’ noncompliance with federal laws. (¶ 72.) Because drug companies are prohibited from marketing or otherwise promoting off-label prescription drug use (see supra note 6), and given the breadth of the marketing and promotion of off-label use of alleged in the SAC, Relator has sufficiently alleged materiality. This conclusion is reinforced by the allegations that Linden Care’s dispensing of SUBSYS for off-label use compromised the safety of the patients who used it, as described in the next paragraph.

Second, the SAC alleges the Government would not have paid the claims had it known of the multiple ways in which Linden Care failed to comply with the TIRF REMS program. (¶¶ 207-09.) The SAC alleges that by failing to comply with TIRF REMS, Linden Care “misbranded” SUBSYS in that the labels on SUBSYS dispensed by Linden
CIVIL MINUTES – GENERAL

Date: June 9, 2021

Case No. 2:16-CV-07937-JLS-ANW

Title: United States ex rel. Ebu-Isaac, et al. v. INSYS Therapeutics, Inc., et al.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Care contradicted the FDA-approved label in ways related to the TIRF REMS protocol. (¶¶ 207-08.) Thereafter, Linden Care sought payment for SUBSYS with the implied certification described above, including that Linden Care dispensed in compliance with TIRF REMS protocol. Relator therefore plausibly alleges materiality on this basis.

Finally, the SAC alleges that the requirement that SUBSYS be dispensed only with a written prescription was material, and the Government would not have paid claims under Medicare Part D had it known of Linden Care’s failure to dispense only upon written prescription. (¶¶ 213-18.) The Ninth Circuit found this kind of failure to be material in Godecke v. Kinetic Concepts, Inc., 937 F.3d 1201, 1205 (9th Cir. 2017). There, the Ninth Circuit reversed the district court’s dismissal of an FCA claim, holding that by alleging delivery of a medical device and supplies without first receiving the written order to do so, in violation of the CSA, the relator sufficiently alleged the materiality element. Id. at 1213. Here, the SAC alleges that Linden Care dispensed SUBSYS without first receiving the paper prescriptions required by applicable law on at least six occasions. (¶¶ 210-13.) This also sufficiently alleges materiality.

D. FCA Element Four: Disbursement or Loss

Finally, Defendants challenge the fourth element of an FCA claim. (BelHealth Mot. at 18-19; Linden Care Mot. at 15-16.) The fourth element is disbursement by the Government or loss to the Government by the forfeiture of moneys due to it. Campie, 862 F.3d at 902. Here, Relator alleges that by 2015, Linden Care dispensed between two- and three-million dollars’ worth of SUBSYS each day. (See ¶ 240 (an estimated $2.85 million each week.).) Most of these prescriptions—80%—were for off-label use. (¶ 105.) Given these allegations, and given the allegations regarding the Government Health Care Programs (¶¶ 58-73), Relator plausibly alleges disbursement by the Government.

And most directly, Relator expressly alleges Government payment of “hundreds of thousands of prescriptions” billed by Linden Care. (¶ 258.) These prescriptions were billed and paid notwithstanding the fact that, when prescribed in the manner alleged in
the SAC, SUBSYS failed to fit within the definition of a “covered outpatient drug” under Medicaid and Medicare Part D and its use was not “reasonable and necessary” under Medicare Part B. (¶¶ 156-61, 164, 259-69.) These allegations sufficiently allege disbursement by the Government.

Therefore, as discussed herein, the Court concludes that the SAC alleges facts sufficient to support all four elements of the FCA claims.

V. FCA SERVICE AND FILING REQUIREMENTS

BelHealth argues that the SAC should be dismissed because Relator has failed to follow the FCA’s mandatory service and filing procedures. (See BelHealth’s Mot. at 19-22); 31 U.S.C. § 3730(b)(2). The Court considered (and rejected) this argument when it granted leave to Relator to file her Second Amended Complaint. (See Doc. 128, Order Granting Relator’s Motion for Leave to Amend the Complaint at 4-5.) The Court declines to revisit this issue now.

VI. CLAIMS FOR RESTITUTION AND UNJUST ENRICHMENT

Linden Care moves to dismiss the fourth and fifth causes of action, both captioned as claims for “payment by mistake.” (Linden Care Mot. at 23-24.) These claims are described as claims for “restitution” and “unjust enrichment,” respectively. (¶¶ 333-42.) The legal basis for these claims is unclear. Although the factual allegations underlying the claims asserted in the SAC are clearly nationwide in scope, Relator fails to describe the source of law upon which she relies, whether it is federal or any particular state law. (Id.) In the Opposition, Relator refers to “a claim for mistake under federal common law,” but she also attempts to distinguish California case law cited by Linden Care without disavowing any reliance on California law. (Opp. to Linden Care Mot. at 23-24.) Thus, the Court is left with the impression that these claims are based on “federal common law” and perhaps California state law.

As to the former, Relator does not cite any source or authority of such “federal common law.” These claims are clearly based upon the same conduct as the FCA claims, and they appear to be alternative claims to recover on an equitable basis if the FCA
claims fail on the element(s) of falsity, scienter, and/or materiality and facts bear out that
claims were instead paid out based on a “mistake.” (See ¶¶ 333-42.)

Relator cites no authority suggesting that she may assert such a back up claim in a
qui tam action. Essentially, Relator brings this action to vindicate an alleged fraud on the
United States. Although she is empowered to do so under the FCA as a matter of
statutory law, her right to do so is circumscribed by the FCA as well. See 31 U.S.C.
§ 3730(b)(1) (authorizing a person to sue “in the name of the Government” pursuant to
“section 3729 for the person and for the United States Government”); Stoner v. Santa
Clara Cty. Off. of Educ., 502 F.3d 1116, 1125-27 (9th Cir. 2007) (“The FCA makes clear
that notwithstanding the relator’s statutory right to the government’s share of the
recovery, the underlying claim of fraud always belongs to the government.”). Here,
Relator attempts to extend that right beyond that authorized by the FCA, to assert two
equitable claims on behalf of the Government that she contends are authorized by
“federal common law.” She cites no authority that empowers her to do so, and the Court
has found none. Cf. id. at 1126-27 (holding that because the FCA did not authorize the
relator to proceed pro se on behalf of the Government, in order to avoid dismissal, the
relator would be required to either identify an alternate source granting him that right or
secure counsel to pursue the FCA claims). Therefore, the Court DISMISSES the fourth
and fifth causes of action.

VII. CONCLUSION

As set forth herein, the Court DENIES BelHealth’s Motion to Dismiss in its
entirety. The Court GRANTS IN PART Linden Care’s Motion to Dismiss and dismisses
without prejudice the fourth and fifth causes of action. In all other respects, Linden
Care’s Motion is DENIED.

13 Because the rationale for dismissing the fourth and fifth causes of action is equally applicable to all
Defendants, these claims are dismissed without prejudice as to all Defendants.
UNITED STATES DISTRICT COURT  
CENTRAL DISTRICT OF CALIFORNIA  

CIVIL MINUTES – GENERAL  

Case No. 2:16-CV-07937-JLS-AJW  
Date: June 9, 2021  
Title: United States ex rel. Ebu-Isaac, et al. v. INSYS Therapeutics, Inc., et al.  

IT IS SO ORDERED. 

Initials of Deputy Clerk: mku
February 13, 2019

Via UPS Mail

Ms. Seema Verma
Acting Administrator for CMS
7500 Security Boulevard
Baltimore, MD 21244


Dear Ms. Verma:

We represent SUPERVALU Inc., New Albertson’s, Inc., and their related entities (the “Defendants”) in connection with a civil action brought against Defendants in United States ex rel. Schutte, et al. v. SUPERVALU Inc., et al., No. 3:11-cv-03290-RH-TSH (C.D. Ill.). By this letter, Defendants ask that the Centers for Medicare and Medicaid Services (“CMS”) authorize Cynthia G. Tudor, Ph.D., former Deputy Center Director of CMS and former Director for the Medicare Drug Benefit and C&D Data Group, among other positions at CMS, to provide specific, limited testimony as a fact witness and/or a potential impeachment witness on behalf of Defendants in the Schutte matter.

Specifically, Dr. Tudor is expected to testify on the following specific topics:

1. Memorandum, dated October 11, 2006, from Cynthia Tudor to All Part D Sponsors, regarding the HPMS Q & A- Lower Cash Price Policy (See Attachment A); and

2. Medicare Part D’s “Lower Cash Price Policy,” including but not limited to CMS’s objectives for the Policy (see Attachment A; see also Medicare Prescription Drug Benefit Manual, Ch. 14, 50.4.2 – Beneficiary Cash Purchases (Rev. 12, 03/19/2010) and (Rev. 17, 08/23/2013)).

Defendants seek testimony from Dr. Tudor on these specific topics at trial in this matter, which is currently set to begin on April 2, 2019 at 2:00 p.m.¹ The trial will be held at the United States District Court for the Central District of Illinois in Springfield, Illinois.

Please note that, in a similar case, United States ex rel. Proctor v. Safeway, Case No. 11-cv-03406 (C.D. Ill.) (“Proctor”), CMS previously denied a request to depose Dr. Tudor on these same topics for the stated reasons that (1) Dr. Tudor had no personal knowledge of the Memorandum; (2) there was a risk she would

¹ It is possible that the Court could modify the trial date over the coming months. To the extent that the case schedule is modified, we will provide the proper representatives from your office with such information as related to this request for testimony.
Ms. Seema Verma  
February 13, 2019  
Page 2

provide opinion testimony; and (3) privileges may protect some of the requested testimony. A copy of CMS’s denial for Dr. Tudor’s deposition testimony in the Proctor matter is attached as Attachment B. The Proctor defendant has commenced an action for judicial review of CMS’s denial on the grounds that it is arbitrary and capricious. That action is still pending in the United States District Court for the Central District of Illinois. See U.S. ex rel. Proctor v. Safeway, Case No. 11-cv-03406 (C.D. Ill.), Dkt. 138-1 (attached as Attachment C). There, the Proctor defendant has argued that the denial was arbitrary and capricious, because the proffered reasons are contrary to the evidence before the agency, and the Central District of Illinois had already rejected all three of CMS’s reasons in a prior ruling. See Id., Dkt. 126, at 7-9 (attached as Attachment D). Specifically, prior to CMS’s denial, the Proctor court had already found that Dr. Tudor had personal knowledge of the Memorandum that she authored, the admissibility of opinion testimony should be addressed at trial, and agency counsel could assert any applicable privilege during the testimony.

In its denial, CMS offered no reason at all why the proposed topics “risk eliciting” privileged testimony. In fact, the testimony Defendants request is not likely to implicate either the deliberative process privilege or the attorney-client privilege. The deliberative process privilege does not protect agency communications or information relating to explaining, interpreting, or applying an existing policy. See, e.g., Holmes v. Hernandez, 221, F. Supp. 3d 1011, 106 (N.D. Ill. 2016) (citing United States v. Farley, 11 F. 3d 1385, 1389 (7th Cir. 1993)). And although the attorney-client privilege does protect attorney-client communications, it does not protect the underlying facts. See Upjohn Co. v. United States, 449 U.S. 383, 395-96 (1981). CMS has not demonstrated that the potential risk of disclosure of privileged information is so great as to preclude Dr. Tudor from giving any testimony at all.

On the other hand, please also note that CMS has previously approved a Touhy request in this matter, thus recognizing the importance of this type of agency testimony, with respect to the expert testimony of Leslie Norwalk, one of Defendants’ experts. Because Ms. Norwalk did not author the “Lower Cash Price Policy” Memorandum and Relators’ counsel has a contrary interpretation of the policy, however, Dr. Tudor’s testimony as to the policy she authored is needed for both factual and impeachment purposes to clarify a key piece of evidence in this matter. A copy of CMS’s approval for Ms. Norwalk’s testimony is attached as Attachment E.

I. Background of the Controversy


On November 30, 2015, Relators filed a First Amended Complaint (“FAC”), which is currently the operative pleading in this action. Discovery has closed, and dispositive motions have been filed. The trial is currently set to begin on April 2, 2019, with the final pretrial proposed order requiring the Parties’ final witness lists due to the Court on March 26, 2019 at the final pretrial conference.

II. Relator’s Claims
Relators allege that Defendants’ pharmacies submitted false claims to federal and state government healthcare programs ("GHPs") by reporting their regular cash price rather than the prices of local competitors, which were periodically matched upon patient request when reporting the “usual and customary price” ("U&C Price") for prescription drugs to government payers.

More specifically, Relators allege that Defendants’ Price Match Program affected the U&C Price for prescription drugs for purposes of Medicaid, Medicare, the Federal Employee Health Benefits Program, and TRICARE reimbursement. Relators contend that Defendants should have submitted the local competitor’s matched price as their U&C Price to GHPs and that by not doing so, Defendants have submitted false claims for payment to the Government and have received reimbursement to which they were not entitled.

III. Request for Testimony

Title 45 C.F.R. § 2.4(a) provides that requests for testimony “must be addressed to the Agency head in writing and must state (1) the nature of the requested testimony, (2) why the information sought is unavailable by any other means, and (3) the reasons why the testimony would be in the interest of the DHHS [Department of Health and Human Services] or the federal government.” Furthermore, 45 C.F.R. § 2.3 provides in relevant part that “[n]o ... former employee of the DHHS may provide testimony ... unless authorized by the Agency head pursuant to this part based on a determination by the Agency head, after consultation with the Office of the General Counsel, that compliance with the request would promote the objectives of the Department.” We address each of these elements below.

A. Nature of the Requested Testimony

As noted above, Defendants seek approval for Dr. Tudor to provide fact witness and/or potential impeachment testimony on two specific, limited topics, which are described in more detail below.

1) Memorandum, dated October 11, 2006, from Cynthia Tudor to All Part D Sponsors, regarding the HPMS Q & A- Lower Cash Price Policy

On this topic, Dr. Tudor is expected to describe the Memorandum that she authored and was published on October 11, 2006, which addresses the Lower Cash Price Policy. This testimony is likely to include Dr. Tudor’s personal understanding of CMS’s intent and objectives in issuing the final version of the Memorandum and Lower Cash Price Policy to the pharmacy. CMS’s objection to the deposition request in the Proctor matter that Dr. Tudor is not likely to have personal knowledge regarding the Lower Cash Price Policy and accompanying Memorandum is contradicted by the fact that she authored the Memorandum and that CMS continues to hold her out as the author on their website. See Attachment F (Printout of CMS webpage holding Dr. Tudor out as the author of the Memorandum). Similarly, Ms. Tudor did not represent that she lacked personal knowledge of the Policy and Memorandum during discussions she had with Safeway's counsel about the meaning of the Policy and Memorandum. See Proctor, Dkt. 138-9 (attached as Attachment G). Moreover, in its denial, CMS failed to identify or even suggest anyone who would be more knowledgeable on this topic than Dr. Tudor.
2) Medicare Part D Lower Cash Price Policy, including but not limited to CMS’s objectives for the Policy

On this topic, Dr. Tudor is expected to describe her personal understating of (1) the final version of CMS’s Medicare Part D Lower Cash Price Policy, (2) the reasons for developing the final version of the Policy, (3) changes to the final, published Policy over time, and (4) explain how this final Policy functions in practice, particularly with respect to prescription drug discount programs.

Relator questioned many of Defendants’ current or former employees about Defendants’ interpretation of the Lower Cash Price Policy discussed in Dr. Tudor’s October 11, 2006 memo and how Defendants complied with the contents of the Policy in depositions taken during fact discovery. In addition, Relator’s expert, Dr. Kenneth Schafermeyer, provided an opinion regarding CMS’s interpretation of the Lower Cash Price Policy in his expert report. Ms. Leslie Norwalk, former Acting Administrator of CMS and Defendants’ expert witness in the Schutte case, has opined that Relator’s interpretation of the Lower Cash Price Policy as applicable to Defendants’ discount pharmacy programs is incorrect. Dr. Tudor, as the author of the memo and an individual with firsthand knowledge regarding the development of the final Policy, is in a unique position to provide specific, limited fact witness and/or impeachment testimony regarding the interpretation and application of CMS’s Lower Cash Price Policy, and such testimony is directly relevant to Relator’s claims in the litigation.2

As a note, Dr. Tudor would not be asked to provide any testimony that would divulge any privileged or confidential information to which she was privy while employed at CMS. Further, she will be instructed not to disclose any privileged or confidential information, and to ensure that each person with whom she works does not disclose such information. Additionally, Dr. Tudor would not testify that she is speaking on behalf of CMS, but instead would be testifying in her personal capacity based not only on her knowledge of the Medicare program, but also based on her personal knowledge of the memorandum she authored.

B. The Information Sought is Unavailable by Other Means

Dr. Tudor is uniquely suited to discuss authoritatively and comprehensively the topics described in Part III.A above. Dr. Tudor worked at CMS for almost 25 years, during which time she served as Deputy Center Director of CMS and as the Director for the Medicare Drug Benefit and C&D Data Group, among others. During her tenure in these high-ranking positions within CMS, Dr. Tudor gained a deep familiarity with the statutes, regulations, and CMS guidance governing Medicare Part D, including the Lower Cash Price Policy for Medicare Part D. With the experience and expertise noted above, Dr. Tudor is in a unique position to accurately and comprehensively educate the finder of fact in the Proctor action regarding the Lower Cash Price Policy and 2006 memorandum regarding the policy, which she authored. These issues are complicated and outside the scope of knowledge of most juries and judges.

2 The court in this matter has found that Dr. Tudor’s testimony as to the Policy and Memorandum is relevant in a companion case that is currently pending in the Central District of Illinois with the same allegations against another pharmacy retailer. See United States ex rel. Proctor v. Safeway Inc., No. 3:11-cv-03406 (C.D. Ill.), Dkt. 126 (“The Lower Cash Price Policy is clearly relevant to the case.”).
C. Granting this Request Would Be in the Interest of DHHS and the Federal Government

It is in the interest of the DHHS to ensure that, when cases are brought that implicate the operation of the Medicare Part D program, and in particular the Lower Cash Price Policy, any testimony about that program be accurate and complete. As explained above, Dr. Tudor’s testimony is essential to achieving both of these results. Similarly, DHHS should take into account the detrimental impact on the Part D program that an inaccurate or incomplete record could have on the interpretation of the relevant Medicare statutes, regulations, and CMS guidance.

Further, the United States government, more broadly, has an interest in this lawsuit, and full disclosure of decision-making information would promote the government’s objectives. Although the United States has not intervened in this lawsuit, it remains a “real party in interest” and thus has a right to share in any resulting damages. See United States ex rel. Eisenstein v. City of New York, 556 U.S. 928, 934-35 (2009). In fact, the United States is entitled to recover at least 70% of any damages recovered as a result of this suit. 31 U.S.C. § 3730(d)(2). It would be inequitable for the United States to refuse to respond to this request or otherwise decline to allow relevant testimony from its former employee in this lawsuit when the United States stands to gain a substantial amount if Relator’s claims are successful.

For these reasons, authorizing Dr. Tudor to testify would be in the interest of DHHS and the federal government, and would also promote DHHS’s broader policy objectives.

IV. Conclusion

Defendants respectfully request that CMS authorize Dr. Tudor to testify at trial as a witness in the Schutte litigation for the reasons discussed herein. Because the final pretrial proposed order containing final witness lists is due to the Court on March 26, 2019, Defendants respectfully request that CMS expedite review of this request.

If you have any questions or concerns about this matter or any of the attached materials, please do not hesitate to contact me at your earliest convenience. We appreciate your prompt consideration and look forward to coordinating with you regarding this request.

Very truly yours,

Frederick Robinson

Attachments
A – October 11, 2006 Memorandum re CMS’s Lower Cash Price Policy
B – CMS Denial of Touhy request for Dr. Tudor’s deposition testimony in the Proctor matter
C – Memorandum in Support of Defendant’s Motion to Compel, Proctor, Dkt. 138-1
D – Opinion and Order on Motion to Quash, Proctor, Dkt. 126
E – CMS Approval of Touhy request for Leslie Norwalk
Ms. Seema Verma  
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F – Printout of CMS webpage holding out Dr. Tudor as the author of the Memorandum  
G – Declaration of Selina Coleman, Proctor, Dkt. 138-9

cc: Selina Coleman (firm)

Via E-Mail to Jill.Abrams@hhs.gov

Jill Abrams  
U.S. Department of Health & Human Services  
200 Independence Avenue, SW, Room 713-F  
Washington, D.C. 20201
UNITED STATES DISTRICT COURT  
CENTRAL DISTRICT OF CALIFORNIA  

UNITED STATES OF AMERICA ex rel. MELINA EBU-ISAAC and the States of CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, FLORIDA, GEORGIA, HAWAII, ILLINOIS, INDIANA, IOWA, LOUISIANA, MASSACHUSETTS, MICHIGAN, MINNESOTA, MONTANA, NEVADA, NEW MEXICO, NEW YORK, NORTH CAROLINA, OKLAHOMA, RHODE ISLAND, TENNESSEE, TEXAS, VERMONT, VIRGINIA, WASHINGTON, the CITY OF CHICAGO and the DISTRICT OF COLUMBIA,  

Relator-Plaintiff,  

v.  

INSYS THERAPEUTICS, INC. and LINDEN CARE, LLC, LINDEN CARE, INC., LINDEN CARE HOLDINGS, INC., BELHEALTH INVESTMENT PARTNERS, LLC, BEHEALTH INVESTMENT MANAGEMENT, LLC, and BELHEALTH INVESTMENT FUND, LP  

Defendants.  

CASE NO. (ASx)  
2:16-cv-07937-JLS-AJW  
Hon. Josephine L. Staton  
PROTECTIVE ORDER  

1. A. PURPOSES AND LIMITATIONS  

Discovery in this action is likely to involve production of confidential, proprietary, or private information for which special protection from public disclosure and from use for any purpose other than prosecuting this litigation may
be warranted. Accordingly, the parties hereby stipulate to and petition the Court to enter the following Stipulated Protective Order. The parties acknowledge that this Order does not confer blanket protections on all disclosures or responses to discovery and that the protection it affords from public disclosure and use extends only to the limited information or items that are entitled to confidential treatment under the applicable legal principles. The parties further acknowledge, as set forth in Section 12.3, below, that this Stipulated Protective Order does not entitle them to file confidential information under seal; Civil Local Rule 79-5 sets forth the procedures that must be followed and the standards that will be applied when a party seeks permission from the court to file material under seal.

B. GOOD CAUSE STATEMENT

This action is likely to involve personal identifying information; personal information that is protected from disclosure by statute, regulation, or is otherwise entitled to protection from public disclosure; information that constitutes or contains “protected health information,” as defined by 45 C.F.R. § 164.501 and/or “individually identifiable health information,” as defined by 45 C.F.R. § 160.103, or information that is otherwise protected from disclosure by the Privacy Act, 5 U.S.C. § 552a, or the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), codified at 42 U.S.C. §§ 1302d et seq. and implemented at 45 C.F.R. §§ 160, 164, (Pub. L. 104-191) (this category herein after collectively referred to as “Confidential Health Information”) and/or other applicable state or federal law or regulation concerning Confidential Health Information; financial and/or proprietary information for which special protection from public disclosure and from use for any purpose other than prosecution of this action is warranted. Such confidential and proprietary materials and information consist of, among other things, Confidential Health Information, personal identifying information, confidential business or financial information, information regarding confidential
business practices, or other confidential commercial information (including
information implicating privacy rights of third parties), information otherwise
generally unavailable to the public, or which may be privileged or otherwise
protected from disclosure under state or federal statutes, court rules, case
decisions, or common law. Accordingly, to expedite the flow of information, to
facilitate the prompt resolution of disputes over confidentiality of discovery
materials, to adequately protect information the parties are entitled to keep
confidential, to ensure that the parties are permitted reasonable necessary uses of
such material in preparation for and in the conduct of trial, to address their handling
at the end of the litigation, and serve the ends of justice, a protective order for such
information is justified in this matter. It is the intent of the parties that information
will not be designated as confidential for tactical reasons and that nothing be so
designated without a good faith belief that it has been maintained in a confidential,
non-public manner, and there is good cause why it should not be part of the public
record of this case.

This Protective Order is a “qualified protective order” under the patient
privacy regulations of HIPAA. The use of protected personal health information
disclosed pursuant to this Protective Order shall comply with the provisions of
HIPAA and the regulations promulgated thereunder, including the HIPAA
Standards for Privacy of Individually Identifiable Health Information and the
HIPAA Security Standards Regulations. See 45 C.F.R. Parts 160 and 164. Any
information that any Party or Non-Party believes in good faith to contain protected
personal health information shall be designated as Confidential Material.

2. DEFINITIONS

2.1 Action: The above-captioned case, styled as U.S. ex rel. Ebu-Isaac, et
al. v. Insys Therapeutics, Inc. et al., No. 2:16-cv-07937-JLS-AJW.
2.2 **Challenging Party**: a Party or Non-Party that challenges the designation of information or items under this Order.

2.3 **“CONFIDENTIAL” Information or Items**: information (regardless of how it is generated, stored or maintained) or tangible things that qualify for protection under Federal Rule of Civil Procedure 26(c), and as specified above in the Good Cause Statement.

2.4 **Counsel**: Outside Counsel of Record and House Counsel (as well as their support staff).

2.5 **Designating Party**: a Party or Non-Party that designates information or items that it produces in disclosures or in responses to discovery as “CONFIDENTIAL.”

2.6 **Disclosure or Discovery Material**: all items or information, regardless of the medium or manner in which it is generated, stored, or maintained (including, among other things, testimony, transcripts, and tangible things), that are produced or generated in disclosures or responses to discovery in this matter.

2.7 **Enforcement Personnel**: Attorneys for the United States of America, Assistant United States Attorneys, United States Department of Justice, state attorneys general, Attorneys for the City of Chicago and Attorneys for the District of Columbia, as well as their support staff.

2.8 **Expert**: a person with specialized knowledge or experience in a matter pertinent to the litigation who has been retained by a Party or its counsel to serve as an expert witness or as a consultant in this Action.

2.8 **House Counsel**: attorneys who are employees of a party to this Action. House Counsel does not include Outside Counsel of Record or any other outside counsel.
2.9 Non-Party: any natural person, partnership, corporation, association, or other legal entity not named as a Party to this action.

2.10 Outside Counsel of Record: attorneys who are not employees of a party to this Action but are retained to represent or advise a party to this Action and have appeared in this Action on behalf of that party or are affiliated with a law firm which has appeared on behalf of that party, and includes support staff.

2.11 Party: any party to this Action, including all of its officers, directors, employees, consultants, retained experts, and Outside Counsel of Record (and their support staffs).

2.12 Producing Party: a Party or Non-Party that produces Disclosure or Discovery Material in this Action.

2.13 Professional Vendors: persons or entities that provide litigation support services (e.g., photocopying, videotaping, translating, preparing exhibits or demonstrations, and organizing, storing, or retrieving data in any form or medium) and their employees and subcontractors.

2.14 Protected Material: any Disclosure or Discovery Material that is designated as “CONFIDENTIAL.”

2.15 Receiving Party: a Party that receives Disclosure or Discovery Material from a Producing Party.

3. **SCOPE**

The protections conferred by this Stipulation and Order cover not only Protected Material (as defined above), but also (1) any information copied or extracted from Protected Material; (2) all copies, excerpts, summaries, or compilations of Protected Material; and (3) any testimony, conversations, or presentations by Parties or their Counsel that might reveal Protected Material. Any
use of Protected Material at trial shall be governed by the orders of the trial judge. This Order does not govern the use of Protected Material at trial.

4. DURATION

Once a case proceeds to trial, all of the information that was designated as confidential or maintained pursuant to this protective order which is introduced as an exhibit at trial becomes public and will be presumptively available to all members of the public, including the press, unless compelling reasons supported by specific factual findings to proceed otherwise are made to the trial judge in advance of the trial. See Kamakana v. City and County of Honolulu, 447 F.3d 1172, 1180-81 (9th Cir. 2006) (distinguishing “good cause” showing for sealing documents produced in discovery from “compelling reasons” standard when merits-related documents are part of court record). Accordingly, the terms of this protective order do not extend beyond the commencement of the trial.

5. DESIGNATING PROTECTED MATERIAL

5.1 Exercise of Restraint and Care in Designating Material for Protection.

Each Party or Non-Party that designates information or items for protection under this Order must take care to limit any such designation to specific material that qualifies under the appropriate standards. To the extent practicable, the Designating Party shall make reasonable efforts to designate for protection only those parts of material, documents, items, or oral or written communications that qualify so that other portions of the material, documents, items, or communications for which protection is not warranted are not swept unjustifiably within the ambit of this Order.

Mass, indiscriminate, or routinized designations are prohibited. Designations that are shown to be clearly unjustified or that have been made for an improper
purpose (e.g., to unnecessarily encumber the case development process or to impose unnecessary expenses and burdens on other parties) may expose the Designating Party to sanctions.

If it comes to a Designating Party’s attention that information or items that it designated for protection do not qualify for protection, that Designating Party must promptly notify all other Parties that it is withdrawing the inapplicable designation.

5.2 Manner and Timing of Designations. Except as otherwise provided in this Order (see, e.g., second paragraph of section 5.2(a) below), or as otherwise stipulated or ordered, Disclosure or Discovery Material that qualifies for protection under this Order must be clearly so designated before the material is disclosed or produced.

Designation in conformity with this Order requires:

(a) for information in documentary form (e.g., paper or electronic documents, but excluding transcripts of depositions or other pretrial or trial proceedings), that the Producing Party affix at a minimum, the legend “CONFIDENTIAL” (hereinafter “CONFIDENTIAL legend”), to each page that contains protected material provided, however, that the CONFIDENTIAL legend may be added to the file name in lieu of the face of the document, as appropriate. If only a portion or portions of the material on a page qualifies for protection, the Producing Party will, to the extent practicable, make reasonable efforts to clearly identify the protected portion(s) (e.g., by making appropriate markings in the margins).

A Party or Non-Party that makes original documents available for inspection need not designate them for protection until after the inspecting Party has indicated which documents it would like copied and produced. During the inspection and before the designation, all of the material made available for inspection shall be deemed “CONFIDENTIAL.” After the inspecting Party has identified the
documents it wants copied and produced, the Producing Party must determine which
documents, or portions thereof, qualify for protection under this Order. Then, before
producing the specified documents, the Producing Party must affix the
“CONFIDENTIAL legend” to each page that contains Protected Material. If only
a portion or portions of the material on a page qualifies for protection, the
Producing Party also must clearly identify the protected portion(s) (e.g., by making
appropriate markings in the margins).

(b) for testimony given in depositions, that the Designating Party use its best
efforts to identify the Disclosure or Discovery Material on the record, before the
close of the deposition all protected testimony, unless alternative measures are
agreed upon prior to deposition.

(c) for information produced in some form other than documentary and for
any other tangible items, that the Producing Party affix in a prominent place on the
exterior of the container or containers in which the information is stored the legend
“CONFIDENTIAL.” If only a portion or portions of the information warrants
protection, the Producing Party, to the extent practicable, shall identify the protected
portion(s).

5.3 Inadvertent Failures to Designate. If timely corrected, an inadvertent
failure to designate qualified information or items does not, standing alone, waive
the Designating Party’s right to secure protection under this Order for such
material. Upon timely correction of a designation, the Receiving Party must make
reasonable efforts to assure that the material is treated in accordance with the
provisions of this Order.

6. CHALLENGING CONFIDENTIALITY DESIGNATIONS

6.1 Timing of Challenges. Any Party or Non-Party may challenge a
designation of confidentiality at any time that is consistent with the Court’s
Scheduling Order.


6.3 The burden of persuasion in any such challenge proceeding shall be on the Designating Party. Frivolous challenges, and those made for an improper purpose (e.g., to harass or impose unnecessary expenses and burdens on other parties) may expose the Challenging Party to sanctions. Unless the Designating Party has waived or withdrawn the confidentiality designation, all parties shall continue to afford the material in question the level of protection to which it is entitled under the Producing Party’s designation until the Court rules on the challenge.

7. ACCESS TO AND USE OF PROTECTED MATERIAL

7.1 Basic Principles. A Receiving Party may use Protected Material that is disclosed or produced by another Party or by a Non-Party in connection with this Action only for prosecuting, defending, or attempting to settle this Action. Enforcement Personnel, as defined in this Order, may use Protected Material in furtherance of legitimate law enforcement purposes. Such Protected Material may be disclosed only to the categories of persons and under the conditions described in this Order. When the Action has been terminated, a Receiving Party must comply with the provisions of section 13 below (FINAL DISPOSITION).

Protected Material must be stored and maintained by a Receiving Party at a location and in a secure manner that ensures that access is limited to the persons authorized under this Order.

7.2 Disclosure of “CONFIDENTIAL” Information or Items. Unless otherwise ordered by the court or permitted in writing by the Designating Party, a
Receiving Party may disclose any information or item designated “CONFIDENTIAL” only to:

(a) the Receiving Party’s Outside Counsel of Record in this Action, as well as employees of said Outside Counsel of Record to whom it is reasonably necessary to disclose the information for this Action;

(b) the Parties to this Action;

(c) the officers, directors, and employees (including House Counsel) and agents of the Receiving Party to whom disclosure is reasonably necessary for this Action;

(d) Enforcement Personnel, who have signed the “Acknowledgement and Agreement to Be Bound” (Exhibit A);

(e) Experts (as defined in this Order) of the Receiving Party to whom disclosure is reasonably necessary for this Action and who have signed the “Acknowledgment and Agreement to Be Bound” (Exhibit A);

(f) the court and its personnel;

(g) court reporters, court videographers, and their staff;

(h) professional jury or trial consultants or potential consultants, mock jurors, and Professional Vendors to whom disclosure is reasonably necessary for this Action and who have signed the “Acknowledgment and Agreement to Be Bound” (Exhibit A);

(i) the author or recipient of a document containing the information or a custodian or other person who otherwise possessed or knew the information;

(j) during their depositions, witnesses or potential witnesses, and attorneys for witnesses, and any person as to which there is a good faith basis to believe that they may be a witness at a deposition or hearing in this Action, to whom disclosure is reasonably necessary provided that the deposing party requests that the witness sign and the witness does sign the form attached as Exhibit A hereto.
transcribed deposition testimony or exhibits to depositions that reveal Protected Material may be separately bound by the court reporter and may not be disclosed to anyone except as permitted under this Stipulated Protective Order; and (i) any mediator or settlement officer, and their supporting personnel, mutually agreed upon by any of the parties engaged in settlement discussions.

8. PROTECTED MATERIAL SUBPOENAED OR ORDERED PRODUCED IN OTHER LITIGATION

If a Party is served with a subpoena or a court order issued in other litigation that compels disclosure of any information or items designated in this Action as “CONFIDENTIAL,” that Party must:

(a) promptly notify in writing the Designating Party. Such notification shall include a copy of the subpoena or court order;

(b) promptly notify in writing the party who caused the subpoena or order to issue in the other litigation that some or all of the material covered by the subpoena or order is subject to this Protective Order. Such notification shall include a copy of this Stipulated Protective Order; and

(c) cooperate with respect to all reasonable procedures sought to be pursued by the Designating Party whose Protected Material may be affected. If the Designating Party timely seeks a protective order, the Party served with the subpoena or court order shall not produce any information designated in this action as “CONFIDENTIAL” before a determination by the court from which the subpoena or order issued, unless the Party has obtained the Designating Party’s permission. The Designating Party shall bear the burden and expense of seeking protection in that court of its confidential material and nothing in these provisions should be construed as authorizing or encouraging a Receiving Party in this Action to disobey a lawful directive from another court.
9. A NON-PARTY’S PROTECTED MATERIAL SOUGHT TO BE PRODUCED IN THIS LITIGATION

(a) The terms of this Order are applicable to information produced by a Non-Party in this Action and designated as “CONFIDENTIAL.” Such information produced by Non-Parties in connection with this litigation is protected by the remedies and relief provided by this Order. Nothing in these provisions should be construed as prohibiting a Non-Party from seeking additional protections.

(b) If any discovery requests are served on a Non-Party, the Party serving the discovery request shall provide the Non-Party with notice of the terms of this Order.

(c) In the event that a Party is required, by a valid discovery request, to produce a Non-Party’s confidential information in its possession, and the Party is subject to an agreement with the Non-Party not to produce the Non-Party’s confidential information, then the Party shall:

(1) promptly notify in writing the Requesting Party and the Non-Party that some or all of the information requested is subject to a confidentiality agreement with a Non-Party;

(2) promptly provide the Non-Party with a copy of the Stipulated Protective Order in this Action, the relevant discovery request(s), and a reasonably specific description of the information requested; and

(3) make the information requested available for inspection by the Non-Party, if requested.

(d) If the Non-Party fails to seek a protective order from this court within 14 days of receiving the notice and accompanying information, the Receiving Party may produce the Non-Party’s confidential information responsive to the discovery request. If the Non-Party timely seeks a protective order, the Receiving Party shall not produce any information in its possession or control that is subject to the confidentiality agreement with the Non-Party before a determination by the court.
Absent a court order to the contrary, the Non-Party shall bear the burden and expense of seeking protection in this court of its Protected Material.

10. **UNAUTHORIZED DISCLOSURE OF PROTECTED MATERIAL**

    If a Receiving Party learns that, by inadvertence or otherwise, it has disclosed Protected Material to any person or in any circumstance not authorized under this Stipulated Protective Order, the Receiving Party must immediately (a) notify in writing the Designating Party of the unauthorized disclosures, (b) use its best efforts to retrieve all unauthorized copies of the Protected Material, (c) inform the person or persons to whom unauthorized disclosures were made of all the terms of this Order, and (d) request such person or person to execute the “Acknowledgment and Agreement to Be Bound” that is attached hereto as Exhibit A.

11. **INADVERTENT PRODUCTION OF PRIVILEGED OR OTHERWISE PROTECTED MATERIAL**

    When a Producing Party gives notice to Receiving Parties that certain inadvertently produced material is subject to a claim of privilege or other protection, the obligations of the Receiving Parties are those set forth in Federal Rule of Civil Procedure 26(b)(5)(B). This provision is not intended to modify whatever procedure may be established in an e-discovery order that provides for production without prior privilege review. Pursuant to Federal Rule of Evidence 502(d) and (e), if information subject to a claim of attorney-client privilege, work product immunity/privilege, common interest privilege, community-of-interest privilege, or any other applicable privilege or immunity (collectively, “Privilege”) is produced inadvertently, the following clawback protocol shall apply:

    (a) Upon learning of the production of any information that a Producing Party believes is subject to a claim of Privilege, the Producing Party shall
immediately notify in writing any Receiving Party of the claimed Privilege, the basis for it, and the produced documents (by Bates number or otherwise with particularity) for which it applies (the “Clawback Notice”). After being so notified by the Producing Party, if all Receiving Parties do not challenge the Clawback Notice, all Receiving Parties shall destroy all copies of such documents subject to the Privilege claim within seven (7) days of receipt of the Clawback Notice and shall not use such documents for any purpose and shall provide notice via email to the Producing Party of such destruction. After being so notified by the Producing Party, if any Receiving Party contests the Producing Party’s claim of Privilege, the Producing Party and any contesting Receiving Party must within seven (7) days from the receipt of any Clawback Notice meet and confer and work in good faith to resolve the dispute. If the Producing Party and the Receiving Party cannot resolve the dispute over the claim of Privilege, the Producing Party shall within seven (7) days from the meet and confer file a motion with the Court, consistent with Local Rules 79-5 and 79-6, for a determination of the claim of Privilege. During the pendency of the period from the Clawback Notice and until the resolution of any disputed claim of Privilege, any Receiving Party of the document subject to the disputed claim of Privilege must sequester it, cease any further review of it, and must not use or disclose it, or create additional copies of it except to the extent the copies are made for the sole purpose of presentation to the Court, either under seal or in camera, for a determination of the claim of Privilege, in accordance with the procedures set forth herein.

(b) If a Party discovers or believes a Producing Party has inadvertently produced a document that is protected by Privilege, that Party shall cease any further review of the document and shall give the Producing Party immediate notice of the suspected inadvertent disclosure, identifying by Bates number, or otherwise with particularity, the document so discovered. If after receiving such notice, the
Producing Party does not respond within seven (7) days from the date of that notice, then any privilege over such document shall be deemed waived. Any such waiver shall not be deemed to extend to any other document, whether dealing with the same subject matter or a different matter. After being noticed of the suspected inadvertent production of a document that is suspected to be privileged, the Producing Party and the Receiving Parties must, within seven (7) days from notification from the Receiving Party, meet and confer and work in good faith to resolve any dispute over a claim of Privilege. If the Producing Party and the Receiving Parties cannot resolve the dispute, the Producing Party shall within seven (7) days from the meet and confer file a motion with the Court, consistent with Local Rules 79-5 and 79-6, for a determination of the claim of Privilege. During the pendency of the period from the notice and until the resolution of any disputed claim of Privilege, any Receiving Party of the document subject to the disputed claim of Privilege must sequester it, cease any further review of it, and must not use or disclose it, or create additional copies of it except to the extent the copies are made for the sole purpose of presentation to the Court, either under seal or in camera, for a determination of the claim of Privilege, in accordance with the procedures set forth herein.

(c) If there is no dispute concerning any Clawback Notice or any claim of Privilege at issue hereunder, or if the Court rules in favor of the Producing Party in the event of a dispute, then unless otherwise ordered by the Court, each Receiving Party who does not hold the privilege must promptly destroy or delete the document and any reasonably accessible copies it has, and provide a confirmation via email to the Producing Party that it will cease further review, dissemination, and use of the document, and that all copies thereof have been destroyed.

(d) The destruction of any document shall not in any way preclude the Receiving Party from moving the Court for a ruling that the challenged document
was not properly withheld.

12. **MISCELLANEOUS**

12.1 **Right to Further Relief.** Nothing in this Order abridges the right of any person to seek its modification by the Court in the future.

12.2 **Right to Assert Other Objections.** By stipulating to the entry of this Protective Order, no Party waives any right it otherwise would have to object to disclosing or producing any information or item on any ground not addressed in this Stipulated Protective Order. Similarly, no Party waives any right to object on any ground to use in evidence of any of the material covered by this Protective Order.

12.3 **Filing Protected Material.** A Party that seeks to file under seal any Protected Material must comply with Civil Local Rule 79-5. Protected Material may only be filed under seal pursuant to a court order authorizing the sealing of the specific Protected Material at issue. If a Party's request to file Protected Material under seal is denied by the court, then the Receiving Party may file the information in the public record unless otherwise instructed by the Court.

13. **FINAL DISPOSITION**

Within sixty (60) days after such time as a Receiving Party’s involvement in this Action is concluded, whether by final adjudication on the merits from which there remains no appeal by right or by other means, the Receiving Party shall, without request, undertake reasonable efforts to return all Protected Material to the Producing Party or destroy such material. As used in this subdivision, “all Protected Material” includes all copies, abstracts, compilations, summaries, and any other format reproducing or capturing any of the Protected Material. Whether the Protected Material is returned or destroyed, the Receiving Party must submit a written certification to the Producing Party (and, if not the same
person or entity, to the Designating Party) by the 60 day deadline that (1) identifies (by category, where appropriate) all the Protected Material that was returned or destroyed and (2) affirms that the Receiving Party has not retained any copies, abstracts, compilations, summaries or any other format reproducing or capturing any of the Protected Material. Notwithstanding this provision, Counsel are entitled to retain an archival copy of all pleadings, motion papers, trial, deposition, and hearing transcripts, legal memoranda, correspondence, deposition and trial exhibits, expert reports, attorney work product, and consultant and expert work product, even if such materials contain Protected Material. Any such archival copies that contain or constitute Protected Material remain subject to this Protective Order as set forth in Section 4 (DURATION).

14. Any violation of this Order may be punished by any and all appropriate measures including, without limitation, contempt proceedings and/or monetary sanctions.

15. This Order governs all discovery in this Action, including documents exchanged prior to the date on which Order is entered and, to the extent that such discovery is designated confidential, this Order shall be applied retroactively in full force and effect.

IT IS SO STIPULATED, THROUGH COUNSEL OF RECORD.

NORTON ROSE FULBRIGHT US LLP
/s/ Jacob Laksin
WILLIAM J. LEONE
William.leone@nortonrosefulbright.com

KANG HAGGERTY & FETBROYT, LLC
/s/ Kandis L. Kovalsky
EKANDER T. KANG
ekang@kanghaggerty.com
KANDIS L. KOVALSKY
FOR GOOD CAUSE SHOWN, IT IS SO ORDERED.

DATED: April 19, 2021

/ s / Sagar
Honorable Alka Sagar
United States Magistrate Judge
EXHIBIT A

ACKNOWLEDGMENT AND AGREEMENT TO BE BOUNDED

I, __________________ [print or type full name], of ____________________________ [print or type full address], declare under penalty of perjury that I have read in its entirety and understand the Stipulated Protective Order that was issued by the United States District Court for the Central District of California on April __, 2021 in the case of U.S. ex rel. Ebu-Isaac, et al. v. Insys Therapeutics, Inc. et al., No. 2:16-cv-07937-JLS(ASx). I agree to comply with and to be bound by all the terms of this Stipulated Protective Order and I understand and acknowledge that failure to so comply could expose me to sanctions and punishment in the nature of contempt. I solemnly promise that I will not disclose in any manner any information or item that is subject to this Stipulated Protective Order to any person or entity except in strict compliance with the provisions of this Order.

I further agree to submit to the jurisdiction of the United States District Court for the Central District of California for the purpose of enforcing the terms of this Stipulated Protective Order, even if such enforcement proceedings occur after termination of this action. I hereby appoint __________________ [print or type full name] of __________________ [print or type full address and telephone number] as my California agent for service of process in connection with this action or any proceedings related to enforcement of this Stipulated Protective Order.

Date: _________________________

City and State where sworn and signed: _________________________

Printed name: _________________________

Signature: _________________________
ATTESTATION PURSUANT TO CIVIL L.R. 5-4.3.4(a)(2)

The filer attests that the other signatories listed, on whose behalf the filing is also submitted, are registered CM/ECF filers and concur in the filing’s content and has authorized the filing.

Dated: April 19, 2021

Kolin C. Tang
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COVID-19 Update: FAQ and Other Information for Clients

KANG HAGGERTY

Firm News

Legal Intelligencer: Nonparty Witness Invoking the Fifth Amendment Privilege in a Civil Case

June 30, 2022 | Edward T. Kang

Practitioners should anticipate when a witness will invoke the privilege and how to deal with or use such invocation applying the principles of fairness and reliability.

In the June 30, 2022 edition of The Legal Intelligencer, Edward T. Kang wrote "Nonparty Witness Invoking the Fifth Amendment Privilege in a Civil Case."

We were in the middle of a deposition examining a former employee of a specialty pharmacy accused of unlawfully dispensing large quantities of fentanyl based opioid pain medication when the employee refused to answer a question about her involvement in dispensing the pain medication to dozens of patients, at least one of whom died of a drug overdose. The basis for her refusal to answer was her invocation of the Fifth Amendment privilege. Over the next hour or so, she refused to answer dozens of questions based on the Fifth Amendment privilege, which, if she had answered, would have likely exposed both her and her former employer to potential criminal liability. The deposition took place in a whistleblower case that we were prosecuting against a drug maker and other related parties including the pharmacy-employer.

The drug maker generated national attention in the past few years as its founder, CEO, and several other people who worked at the company were criminally convicted of unlawfully marketing and selling the pain medication. While the drug maker and its affiliates were charged and convicted, pharmacies that dispensed the drug were not charged criminally. Our whistleblower case was brought by a relator who used to work for the drug maker.

After the deposition ended, we argued with defense counsel about the implication of the former employee’s invoking the Fifth Amendment privilege. We argued that her refusal to answer should result in an adverse inference against the pharmacy-employer. Counsel argued that the former employee’s relationship is too remote to the employer and that no adverse inference is warranted. Counsel also argued the employee improperly invoked the Fifth as some of the questions did not implicate her of any criminal exposure, and I think counsel was correct. Eventually, however, the parties settled the case and the question about adverse inference—i.e., whether drawing adverse inference against the employer is proper when a nonparty witness invokes the Fifth Amendment and, if so, to what extent such inference should be given—was not answered.

The Fifth Amendment to the U.S. Constitution provides that “no person shall be compelled in any criminal case to be a witness against himself.” The Supreme Court has long held that a witness can invoke the protections of the Fifth Amendment in any proceeding where the testimony might incriminate the witness in a future criminal prosecution. See Lefkowitz v. Cunningham, 431 U.S. 801 (1977). That is, the Fifth Amendment can be invoked in a civil proceeding.
This is because a witness may, rightly or wrongly, fear that his testimony may be used against him in a future criminal prosecution. The Fifth Amendment privilege against self-incrimination is applicable to the states via the Fourteenth Amendment. See City of Philadelphia v. Kenny, 28 Pa. Cmwlth. 531 (1977).

The complications that may arise out of invocation of the Fifth Amendment in civil litigation may be divided into two categories: the consequences of the privilege when properly invoked, and the effects when it is abused causing unfair prejudice to the opposing litigant. See Securities and Exchange Commission (SEC) v. Graystone Nash, 25 F.3d 187 (3d Cir. 1994) Because the privilege may be initially invoked and later waived at a time when an adverse party can no longer secure the benefits of discovery, there is the potential for exploitation by litigants. Unlike its application in criminal cases (where reliance on the Fifth Amendment may not be used against the defendant), reliance on the Fifth Amendment in civil cases may give rise to an adverse inference against the party claiming its benefits. At the same time, use of the Fifth Amendment can substantially prejudice an adverse party who is deprived of “a source of information that might conceivably be determinative in a search for the truth.” Therefore, the trial court must carefully balance the interests of the party claiming the protections afforded by the Fifth Amendment and the opposing party’s entitlement to equitable treatment. Because the privilege is constitutionally based, the detriment to the party asserting it should be no more than is necessary to prevent unfair and unnecessary prejudice to the other side.

The inference is similar to the well-established rule in civil proceedings that a party’s failure to testify can support an inference that whatever testimony he would have given would have been unfavorable to him. See Beers v. Muth, 395 Pa. 624 (1959). And, in civil proceedings, the adverse inference has been found to extend to nonparty witnesses. In Rad Services v. Aetna Casualty & Surety, 808 F.2d 271 (3d Cir. 1986), the U.S. Court of Appeals for the Third Circuit allowed the admission of adverse inferences against nonparty employees of the defendant chemical company. There, the witnesses had allegedly dumped toxic waste in violation of environmental laws. At trial, they claimed their Fifth Amendment privilege with respect to questions about their previous work with the defendant and their current employment status. The court held that the mere fact that a witness no longer works for a corporate party should not preclude evidence of his invocation of the Fifth Amendment.

Using a nonparty witness’ invocation of the Fifth Amendment privilege against a party often arises in cases where an employee, or former employee, is testifying due to the action of her employer. Some courts have required that an “identity of interests” must exist between the witness and the party to the lawsuit to draw an adverse inference, many circuits including the Third Circuit “have overwhelmingly found it constitutionally permissible to impute an adverse inference from a non-party to a party in a civil proceeding” without such “identity of interests.” See State Farm Mutual Automobile Insurance v. Abrams, (N.D. Ill. 2000) (collecting cases from the Second, Third, Fifth and Eighth circuits).

In this circuit, the admissibility of a nonparty’s invocation of the Fifth Amendment privilege against a party “should be considered ‘on a case-by-case basis’ and … the ‘overarching concern’ that should guide the admissibility inquiry ‘is fundamentally whether the adverse inference is trustworthy under all of the circumstances and will advance the search for the truth.’” See R.D. v. Shohola, (M.D. Pa. 2019) (citing Rad Services and other cases). The court went on, “On this score, courts have identified four nonexclusive factors for courts to consider: ‘the nature of the relevant relationships; the degree of control of the party over the nonparty witness; the compatibility of the interests of the party and nonparty; and the role of the nonparty witness in the litigation.’” Practitioners should note that whether the court will allow using a non-party’s invocation of the Fifth Amendment privilege against a party and to what extent involves a fact specific inquiry, which varies from case-to-case. The notes to the Pennsylvania standard jury instruction on adverse inference indicate “neither the Supreme Court of the United States nor the Pennsylvania appellate courts have addressed the consequences of a nonparty invoking the Fifth Amendment in a civil case.” It appears the courts are guided by the principles of fairness (to the parties) and reliability (of the nonparty witness).

The adverse inference has also been found to apply at the pleadings stage. In City of Philadelphia v. Kenny, the appellant’s answer responded to some averments in the complaint with an assertion of the privilege against self-incrimination under the Fifth Amendment. The issue before the court was whether the assertions of privilege left unresolved questions of fact which render judgment on the pleadings or summary judgment inappropriate. The court provided “In the absence of statutory prohibitions, a party’s voluntary testimony or statements made in pleadings or other papers filed in a judicial proceeding, may be used against him in a subsequent criminal prosecution.” Accordingly, “a defendant in a civil case must be entitled to assert that privilege in his pleadings, when allegations in the complaint call for answers which may tend to incriminate him.”
The Fifth Amendment privilege is not self-executing. The privilege can be waived by failing to invoke it in a timely manner and by disclosure of incriminating evidence. See Rogers v. United States, 340 U.S. 367, 373 (1951). Once a witness voluntarily reveals an incriminating fact, the privilege cannot be invoked to avoid disclosing the details of that fact unless the witness' answer to the particular question posed would subject him or her to a “real danger” of further incrimination.

A party who properly asserts the Fifth Amendment privilege in a civil proceeding is not automatically barred from later deciding to waive his Fifth Amendment protections. But the party who switches positions will not be permitted to offer testimony as to matters for which the Fifth Amendment privilege had been invoked where this would provide a significant tactical advantage to this party. For example, ordinarily, a party who has avoided discovery by asserting the Fifth Amendment privilege will not be permitted on the eve of trial to waive her Fifth Amendment protections for the purpose of testifying at trial. Also, at the request of a party, a court may set a time, based on a need of the parties to complete discovery, after which the party who has invoked the Fifth Amendment privilege will be barred from offering at trial his testimony on matters for which the Fifth Amendment was invoked to prevent discovery. See Haas v. Bowman, 62 Pa. D. & C. 4th at 15 (Com. Pl. 2003).

I was not surprised when the witness invoked the Fifth Amendment privilege in the whistleblower case. All of the parties anticipated that the witness would likely invoke the privilege going into the deposition. Although there could be a situation when a witness would surprise everyone by invoking the privilege, these situations are rare. Practitioners should anticipate when a witness will invoke the privilege and how to deal with or use such invocation applying the principles of fairness and reliability.

Edward T. Kang is the managing member of Kang Haggerty. He devotes the majority of his practice to business litigation and other litigation involving business entities. Contact him at ekang@kanghaggerty.com.

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Posted in: Whistleblower Actions
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Pennsylvania including Berks County, Bucks County, Chester County, Delaware County, Montgomery County, and Philadelphia County;
STATE OF MINNESOTA
IN COURT OF APPEALS
A21-0054

State of Minnesota, et al., ex rel. Richard Knudsen, Appellant,

vs.

AT&T Mobility National Accounts, LLC, Respondent,

T-Mobile USA, Inc., Respondent,

Sprint Solutions, Inc., Respondent,

Cellco Partnership, d/b/a Verizon Wireless, Respondent.

Filed December 27, 2021
Affirmed
Smith, Tracy M., Judge

Hennepin County District Court
File No. 27-CV-18-16765

Tejinder Singh (pro hac vice), Goldstein & Russell, P.C., Bethesda, Maryland; and

John G. Albanese, Berger Montague PC, Minneapolis, Minnesota (for appellant)

Aaron D. Van Oort, Jeffrey P. Justman, Faegre Drinker Biddle & Reath LLP, Minneapolis, Minnesota (for respondent AT&T Mobility National Accounts, LLC)

Steve Y. Koh (pro hac vice), Perkins Coie LLP, Seattle, Washington; and

S. Jamal Faleel, Blackwell Burke, P.A., Minneapolis, Minnesota (for respondent T-Mobile USA, Inc.)
William P. Ashworth (pro hac vice), Williams & Connolly LLP, Washington, District of Columbia; and

Donald G. Heeman, Jessica J. Nelson, Randi J. Winter, Spencer Fane LLP, Minneapolis, Minnesota (for respondent Sprint Solutions, Inc.)

Libretta P. Stennes, Lindsey N. Schmidt, Greenberg Traurig, LLP, Minneapolis, Minnesota; and

Mathew S. Rosengart (pro hac vice), Greenberg Traurig, LLP, Los Angeles, California (for respondent Verizon Wireless)

Considered and decided by Smith, Tracy M., Presiding Judge; Slieter, Judge; and Gaïtas, Judge.

NONPRECEDENTIAL OPINION

SMITH, TRACY M., Judge

Appellant-relator Richard Knudsen challenges the dismissal of his qui tam claims against respondents—four wireless-communication-service providers—under the Minnesota false claims act (MFCA), Minn. Stat. §§ 15C.01-.16 (2020). Knudsen argues that the district court erred by determining that (1) his claims were not pleaded with particularity as required under Minnesota Rule of Civil Procedure 9.02; (2) his amended complaint failed to state a claim upon which relief can be granted; (3) the public-disclosure bar in the MFCA precludes most of his claims; and (4) the claim against one respondent was precluded by Knudsen’s failure to file his amended complaint under seal as required by the MFCA.

Because we conclude that Knudsen’s amended complaint fails to satisfy the requirement to plead his claims with particularity, we affirm.
FACTS

This case involves contracts between the State of Minnesota and AT&T Mobility National Accounts, LLC (AT&T), T-Mobile USA, Inc. (T-Mobile), Sprint Solutions, Inc. (Sprint), and Cellco Partnership, d/b/a Verizon Wireless (Verizon) (collectively, the carriers) for the provision of wireless-communication services to state and local governmental entities. The essence of Knudsen’s claim is that the carriers promised to provide services to the state at the most favorable rates available but did not do so. Knudsen alleges that the carriers violated the MFCA in two ways: (1) by fraudulently inducing the state to enter into the contracts with them and (2) by making false certifications to the state by presenting bills that were not based on the most favorable rates. The state has declined to intervene in this case and is not a party.

At issue is the legal sufficiency of Knudsen’s amended complaint, and we look to it for the factual allegations made to support Knudsen’s claims. According to the amended complaint, Knudsen worked as a consultant in the wireless industry from 2008 to 2018. Knudsen alleges that, as a consultant, he analyzed hundreds of rate plans and contracts, worked directly with companies and government entities regarding wireless services, and assisted all the carriers at some point. It is through this work that Knudsen claims that he learned of some of the carriers’ often-confidential rate plans and saw that the rates they

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1 When reviewing a dismissal for failing to state a claim, we accept as true all facts as alleged in the complaint and construe all reasonable inferences in favor of the nonmoving party. See Walsh v. U.S. Bank, N.A., 851 N.W.2d 598, 606 (Minn. 2014).
were offering to certain corporate customers were superior to those offered to government customers.

Knudsen alleges that the carriers violated the MFCA in relation to two sets of contracts that the carriers entered into with the Minnesota Office of State Procurement (OSP). The first set consists of contracts that OSP negotiated directly with three of the carriers, Sprint, Verizon, and AT&T, which became effective in 2012 (the Minnesota contracts); T-Mobile is not a party to the Minnesota contracts. The second set consists of contracts that OSP entered into with all four carriers in 2018 through a state purchasing consortium called the Western States Contracting Alliance (the WSCA contracts). Both the Minnesota contracts and the original WSCA master agreements on which Minnesota’s WSCA contracts were based were developed following a request for proposal (RFP), the terms of which were to be integrated into the final contracts along with any agreed-upon modifications.

_The Minnesota Contracts_

At issue in the Minnesota contracts is a provision regarding price decreases. The RFP provision stated as follows:

**PRICE DECREASES.** During the life of the Contract, any or all temporary price reductions, promotional price offers, introductory pricing, or any other offers or promotions that provide prices lower than or discounts higher than those stated in the Contract, must be given immediately to the entities eligible to purchase from the Contract. Invoices for goods

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2 An RFP is an announcement of a project used to solicit proposals from contractors. The RFPs here described the government’s needs for communications services, outlined the proposed contract terms, and communicated the negotiation-and-final-contract process.
ordered or shipped or services performed during the decrease, or promotion, must immediately reflect such pricing.

Under the RFP, the responding contractor was presumed to agree with the RFP’s terms unless the responding contractor brought deviations to the attention of the state.

During the negotiation process with the three carriers, the price-decreases clause was modified. Among the changes was the deletion of the phrase “introductory pricing.”

The language in the final contract stated that

any or all temporary price reductions, promotional price offers, or any other offers or promotions that provide prices lower than or discounts higher than those stated in the Contract, must be given immediately to the [state] . . . if the prices given are based on similar and comparable purchases.

Sprint, Verizon, and AT&T signed the Minnesota contracts in 2012, and the contracts became effective on July 1, 2012. Knudsen alleges that, even as modified, the price-decreases clause obligated the three carriers to immediately offer the state “any offer of a lower price or higher discount” given to a third party for comparable products and services.

The WSCA Contracts

In 2018, OSP started to shift its contracts with wireless-communications carriers away from the Minnesota contracts. That year, all four of the carriers signed contracts with Minnesota through WSCA, the state consortium that had negotiated contracts with the four carriers.\(^3\) Knudsen’s claims relate to the provisions of the WSCA master agreements on

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\(^3\) Sprint signed on March 13, 2018, AT&T on March 23, 2018, T-Mobile on April 25, 2018, and Verizon on October 2, 2018. Verizon’s signing date was three days before the original complaint was filed. The claims against Verizon related to the WSCA contracts were added in the amended complaint.
which Minnesota’s WSCA contracts were based, which, he alleges, require the provision of services at “the lowest cost available.”

The WSCA master contracts were negotiated in 2011 and 2012, with the state of Nevada acting as the lead state on behalf of the consortium. The master contracts followed an RFP process. The RFP, released in 2011, provided that its terms would be incorporated into the contract unless the carrier expressly excluded the provisions in its response. Following the negotiation process, each of the four carriers entered into a WSCA contract in 2012. In 2018, the 2012 WSCA contracts were incorporated into the WSCA contracts that the carriers entered into with Minnesota.

Knudsen relies on three sections in the 2011 RFP that provided for the “lowest cost available.” Section 3.1.2 provided that the carrier would provide “quality wireless voice services, wireless broadband services, equipment and accessories at the lowest cost available in a timely and efficient manner.” In addition, section 3.5.1 provided that the carrier would provide wireless voice services at “the lowest cost available in a timely and efficient manner” and section 3.6.1 provided that the carrier would provide wireless broadband services at the “lowest cost available in a timely and efficient manner.”

In responding to the 2011 RFP, three carriers submitted modifications to some or all of these sections. Sprint deleted section 3.5.1, noting that it does not offer “Most Favored Customer” clauses, and instead offered services that are “not unreasonably dissimilar” from “similarly situated customers.” Sprint did not directly address sections 3.1.2 or 3.6.1. Verizon modified sections 3.5.1 and 3.6.1, stating that it would provide “quality wireless voice services” at “a fair and reasonable cost” but “not lowest cost.” In
response to section 3.1.2, Verizon wrote: “Noted and Understood.” AT&T modified sections 3.1.2 and 3.5.1, promising to provide “competitive prices” and “best value.” AT&T did not modify section 3.6.1. T-Mobile made no changes to any of the three sections. Knudsen alleges that master contracts that resulted from this process—with or without the modifications to the three sections—required the carriers to provide the lowest cost available for all services and that that requirement was incorporated into the 2018 WSCA contracts entered into with Minnesota.

*Alleged Failures to Offer Minnesota the Best Rates*

In support of his MFCA claim, Knudsen in his amended complaint provides four examples in which the best rates that the carriers offered to Minnesota were compared to cheaper rates allegedly offered to other entities. These price lists are for voice services only—not for other services. Some of the plans that Knudsen alleges were offered to other entities precede—even by a number of years—the carriers’ contracts here, but Knudsen alleges that it is standard in the industry for carriers to allow customers to maintain their rate plans until a better rate plan comes along.

Knudsen asserts that there is no reason why the carriers could not have offered the lower-cost price lists to Minnesota. He further alleges that the carriers knew that they were offering better rates to other entities than to Minnesota and thus knew that they were fraudulently not offering the lowest prices or best discounts to Minnesota, as allegedly required by the contracts.
Procedural History

Knudsen filed his original complaint against the four carriers under seal on October 5, 2018. The Minnesota Attorney General declined to intervene, and the case was unsealed on May 21, 2019. In response to the carriers’ motions to dismiss, on January 31, 2020, Knudsen publicly filed an amended complaint that was not submitted to the attorney general for review. The amended complaint contained similar allegations to the original complaint, except for the addition of a claim against Verizon related to the WSCA contracts.

The carriers brought new motions on various grounds. The district court ruled on four bases for dismissal asserted by the carriers. First, the district court concluded that the amended complaint failed to state an MFCA claim with particularity, as required for fraud claims. Second, it concluded that the amended complaint failed to state a claim of knowingly engaging in conduct in violation of the MFCA because the contract terms were ambiguous and there was no other alleged evidence of the parties’ understanding of the terms. Third, the district court determined that, with respect to all claims other than those related to voice services under the 2012 Minnesota contracts, Knudsen’s claims were barred because the claims were previously publicly disclosed and he was not an original source of the information. Finally, with respect to Verizon, the district court concluded that dismissal was warranted because Knudsen added the WSCA contract claim against

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4 The MFCA requires dismissal of an action if the allegations were previously publicly disclosed in certain settings, unless the person bringing the action was the original source of the information. Minn. Stat. § 15C.05(f).
Verizon in the amended complaint without following the MFCA procedural requirement of filing under seal pending review by the attorney general. The district court dismissed the amended complaint in its entirety.

Knudsen appeals.

**DECISION**

We begin our analysis by evaluating whether Knudsen’s amended complaint states the elements of an MFCA claim with sufficient particularity as required by Minn. R. Civ. P. 9.02. We do so bearing in mind that we must accept all facts as alleged in the complaint as true and construe all reasonable inferences in favor of the nonmoving party. See Walsh, 851 N.W.2d at 606. We first outline the legal framework for Knudsen’s claims under the MFCA, Minn. Stat. §§ 15C.01-.16.

The MFCA imposes civil liability on defendants who “wrongfully secure[] monies from the State.” Phone Recovery Servs., LLC v. Qwest Corp., 919 N.W.2d 315, 319 (Minn. 2018) (emphasis omitted); see also Minn. Stat. § 15C.02(a). Under the statute, an individual—called a relator—can bring claims to collect funds due to the government and retain a portion of the litigation proceeds if the suit is successful. Phone Recovery Servs., 919 N.W.2d at 319. The MFCA mirrors the federal false claims act (FCA), 31 U.S.C. §§ 3729-3733 (2018). Olson v. Fairview Health Servs. of Minn., 831 F.3d 1063, 1069 n.6 (8th Cir. 2016). Because federal cases are instructive when a Minnesota statute mirrors a federal one, federal cases interpreting the FCA are relevant to interpreting the MFCA. See In re Commodore Hotel Fire & Explosion Case, 318 N.W.2d 244, 246 (Minn. 1982).
Under the MFCA, a defendant who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval” to the government is civilly liable. Minn. Stat. § 15C.02(a)(1). Additionally, a defendant who “knowingly makes or uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim” in government dealings is also liable. Id. (a)(2). “Knowingly” requires actual knowledge or acting in deliberate ignorance or reckless disregard of the truth or falsity of the information. Minn. Stat. § 15C.01, subd. 3. The MFCA does not require specific intent to defraud, but mere negligence, inadvertence, or mistake will not be enough to have acted knowingly. Id. The Supreme Court has stated about the FCA that it “is not an all-purpose antifraud statute, or a vehicle for punishing garden-variety breaches of contract or regulatory violations.” Universal Health Servs., Inc. v. United States ex rel. Escobar, 579 U.S. 176, 194(2016) (quotation and citation omitted).

Knudsen asserts that the carriers violated the MFCA under two theories—promissory fraud and false certification. Promissory fraud occurs when a defendant makes a promise with “no intention to perform at the time the promise was made.” Int’l Travel Arrangers v. NWA, Inc., 991 F.2d 1389, 1402 (8th Cir. 1993) (quoting Hayes v. Northwood Panelboard Co., 415 N.W.2d 687, 690 (Minn. App. 1987), rev. denied (Minn. Jan. 28, 1988)). False certification occurs when a defendant submits a claim for payment that certifies compliance with a material contractual obligation and the defendant knows that it is not in compliance with that condition. Escobar, 579 U.S. at 190.

Knudsen contends that he pleaded the elements of each of his theories of fraud with the particularity required under Minn. R. Civ. P. 9.02. See United States ex rel. Joshi v.
"St. Luke’s Hosp., Inc., 441 F.3d 552, 556 (8th Cir. 2006) (applying Fed. R. Civ. P. 9(b) to complaints alleging FCA violations). The rule states, “In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally.” Minn. R. Civ. P. 9.02. The federal counterpart uses similar language: “a party must state with particularity the circumstances constituting fraud or mistake. Malice, intent, knowledge, and other conditions of a person’s mind may be alleged generally.” Fed. R. Civ. P. 9(b). Federal cases interpreting rule 9(b) are thus instructive on the interpretation of rule 9.02. See, e.g., Commodore Hotel, 318 N.W.2d at 246.

“To plead with particularity is to plead the ultimate facts or the facts constituting fraud.” Hardin Cnty. Sav. Bank v. Hous. & Redev. Auth. of Brainerd, 821 N.W.2d 184, 191 (Minn. 2012) (citations and quotation marks omitted). A party must plead “facts underlying each element of the fraud claim.” Id. A complaint satisfies rule 9(b) if it pleads “such facts as the time, place, and content of the defendant’s false representations, as well as the details of the defendant’s fraudulent acts, including when the acts occurred, who engaged in them, and what was obtained as a result.” Olson, 831 F.3d at 1070 (citation omitted). The complaint must identify the “who, what, where, when, and how of the alleged fraud.” Id. (citation omitted).

Application of Law to the Amended Complaint

With that background, we turn to the claims here. Knudsen argues that the carriers knowingly made false promises to provide Minnesota with the lowest-cost services.
Knudsen relies on the contracts themselves as evidence of the carriers’ fraud. Because his claims depend on the contracts themselves, we examine their relevant provisions.

In the Minnesota contracts, which all of the carriers except T-Mobile signed, the price-decreases clause in the final contract provided that “any or all temporary price reductions, promotional price offers, or any other offers or promotions that provide prices lower than or discounts higher than those stated in the Contract, must be given immediately to the [state] . . . if the prices given are based on similar and comparable purchases.” Knudsen relies on the “any other offers or promotions” language to argue that this clause applied to all pricing and required the carriers to provide the best prices at all times. The three carriers point to the words “temporary” and “promotional,” arguing that this language would be unnecessary if the clause was meant to apply to all pricing. The three carriers also point to the deletion of “introductory prices” from the RFP provision as further demonstration that the final price-decreases clause does not apply to all pricing because that specific deletion would then be meaningless.

Regarding the WSCA contracts, the 2011 RFP that resulted in the master agreements used by Minnesota as the bases for its 2018 WSCA contracts provided that the carriers would provide services “at the lowest cost available in a timely and efficient manner” in three sections. T-Mobile responded to the RFP without changes to the three sections. The three other carriers responded with modifications to the lowest-cost language. Sprint promised to provide pricing that was not “unreasonably dissimilar” from others. Verizon promised to provide services “at a fair and reasonable cost . . . not lowest cost.” AT&T said it would provide prices at the “best value.”
Contract Ambiguity

The carriers argue that the Minnesota contracts and the WSCA contracts either do not require the lowest prices or are ambiguous. If the contracts are ambiguous, the carriers argue, Knudsen cannot allege an “objective falsehood,” which, they contend, is essential to an MFCA claim. Knudsen counters that the contracts unambiguously require the lowest cost available—even with the modifications—and that, in any event, an ambiguous contract does not defeat MFCA liability as a matter of law.

The district court concluded, and we agree, that at least the Minnesota contracts and the WSCA contracts with three of the carriers are, at best, ambiguous. As for the Minnesota contracts, both interpretations advanced by the parties of the price-decreases provision are reasonable in light of the RFP provision and its modification in the final contracts. As for the WSCA contracts, the price-decreases provision in the Minnesota contracts with Sprint’s, Verizon’s, and AT&T’s attempted modifications render the lowest-cost provisions related to voice and broadband services ambiguous as applied to these three carriers. None of the new language clearly promises to provide the lowest-cost services. Further, it is unclear if the carriers meant to cover all the lowest-cost provisions when they added the modified language. Thus, the WSCA contracts, at least where modified, are at best ambiguous as to whether the carriers promised to provide the lowest cost.

Contract ambiguity, however, does not necessarily mean that a claimant cannot adequately plead that a false promise was made. An ambiguous contract can still show that a defendant made a false promise if the relator can adequately plead that the defendant understood what the ambiguous contract required and knew that the promise was false. See,
e.g., Minn. Ass’n of Nurse Anesthetists v. Allina Health Sys. Corp., 276 F.3d 1032, 1053 (8th Cir. 2002) (holding that an ambiguous regulation will not defeat an MFCA claim but that the relator must show what the defendant thought the regulation required); United States ex rel. Druding v. Care Alts., 952 F.3d 89, 100 (3d Cir. 2020) (holding that “objectivity speaks to the element of scienter, not falsity”); Winter ex rel. United States v. Gardens Reg’l Hosp. & Med. Ctr., Inc., 953 F.3d 1108, 1119 (9th Cir. 2020) (rejecting an “objective falsity” requirement of the FCA and clarifying that the Eleventh Circuit did not consider all subjective statements to be incapable of falsity).

The carriers point to several federal circuit court decisions to argue that an “objective falsehood” is required to sustain a claim under the FCA, but even those cases suggest that a claim could be made if there were additional evidence of fraud. See United States v. AseraCare, Inc., 938 F.3d 1278, 1301 (11th Cir. 2019) (reasoning that an FCA claim requires a falsehood and that “the mere difference of reasonable opinion between physicians, without more, . . . does not constitute an objective falsehood” (emphasis added)); see also United States ex rel. Wilson v. Kellogg Brown & Root, Inc., 525 F.3d 370, 378 (4th Cir. 2008) (“An FCA relator cannot base a fraud claim on nothing more than his own interpretation of an imprecise contractual provision.” (emphasis added)).

5 As another example, the Seventh Circuit requires an “objective falsehood” under the FCA but noted that a contract subject to a disputed legal question could meet the objective-falsehood standard if the relator also presented evidence showing what the defendant thought it was agreeing to. See United States ex rel. Yannacopoulos v. Gen. Dynamics, 652 F.3d 818, 836-37 (7th Cir. 2011).
Thus, Knudsen’s MFCA claims are not defeated merely because the contracts are ambiguous. Knudsen does, however, need to adequately plead the requisite scienter in order to show that the carriers knowingly made a false promise and then submitted false claims under that promise. The knowledge requirement is an essential element of an MFCA claim. See Minn. Stat. § 15C.02(a)(1). Because the knowledge requirement applies to all MFCA claims, it applies whether or not a contract is ambiguous. Thus, we need not determine whether T-Mobile’s WSCA contract—which did not modify the 2011 RFP provisions regarding lowest available price—is ambiguous in order to evaluate whether the amended complaint pleads scienter with sufficient particularity.

Failure to Sufficiently Plead Knowledge

Knudsen alleges that, for some periods of time, the carriers offered better prices for voice services to other entities than those offered to Minnesota under the contracts. Even if these alleged facts could establish a breach of contract, Knudsen needs to do more than allege breach of contract, which is not actionable under the MFCA. See, e.g., Wilson, 525 F.3d at 377 (concluding that the “inefficient management of [one’s] contractual duties” is not an FCA claim); Yannacopoulos, 652 F.3d at 836 (“Although a breached contractual term may be considered a falsehood in a looser sense—a false promise—a mere breach of a contractual duty does not satisfy [the FCA].”). To bring an actionable MFCA claim, Knudsen needs to adequately plead scienter. Though scienter may be alleged generally, the relator cannot rely solely on broad legal conclusions. See Bahr v. Capella Univ., 788 N.W.2d 76, 80 (Minn. 2010) (holding in a Minn. R. Civ. P. 8.01 case—which has a lesser standard for pleading—that a plaintiff “must provide more than labels and conclusions”).
The amended complaint generally alleges that the carriers “knew they were not providing services to [the state] at the ‘lowest cost available,’” and that they “knew what [the] contractual language required, and they knew that they were not abiding by it.” These are broad conclusions of scienter; Knudsen does not allege a single fact in support of these allegations. With respect to his fraudulent-inducement claim, he asserts no contemporaneous facts showing that the carriers entered into the contracts with Minnesota with “no intention to perform” as promised. See Int’l Travel Arrangers, 991 F.2d at 1402; cf. Ambassador Press, Inc. v. Durst Image Tech. U.S., LLC, 949 F.3d 417, 423 (8th Cir. 2020) (affirming dismissal of a common-law fraud claim pursuant to Fed. R. Civ. P. 9(b) for failure to set forth supporting facts demonstrating an intention to defraud when the contractual promises were made). Regarding his false-certification claims, Knudsen alleges no facts showing that the carriers knew when they submitted a claim for payment that the claim is not in compliance with a contractual obligations See Escobar, 579 U.S. at 190-91. Knudsen’s conclusory allegations are not enough under rule 9.02 for a claim under the MFCA.6

6 After oral argument, the carriers notified the court of a recent Seventh Circuit opinion, United States ex rel. Schutte v. Supervalu Inc., 9 F.4th 455, 464 (7th Cir. 2021) (“A defendant who acted under an incorrect interpretation of the relevant statute or regulation did not act with reckless disregard if (1) the interpretation was objectively reasonable and (2) no authoritative guidance cautioned defendants against it.”). This case is distinguishable in that it deals with statutes and regulations, not a contract provision. But at a general level, it requires a relator to show what the defendant thought their obligation was under a statute, regulation, or contract if that obligation is unclear. Here, Knudsen has not alleged anything beyond conclusions of scienter.
Knudsen’s allegations stand in stark contrast to claims in other cases, relied upon by Knudsen, where courts have found that a complaint sufficiently pleaded a claim under the FCA. In *United States ex rel. Heath v. AT&T, Inc.*, the D.C. Circuit Court of Appeals concluded that the relator had satisfied the pleading requirements of Fed. R. Civ. P. 9(b) for its FCA claim. 791 F.3d 112, 115 (D.C. Cir. 2015). The complaint in *Heath* offered substantially more factual support of the alleged fraudulent conduct than Knudsen’s. The relator in *Heath* alleged that AT&T had a scheme to defraud schools and libraries by not enforcing federal regulations that required the provision of telecommunications at the lowest rates. *Id.* at 117. The complaint alleged that AT&T had previously been investigated for violating the regulatory requirement, that it had entered into a consent decree obligating it to institute a plan to ensure compliance, that AT&T had nevertheless chosen not to train its employees regarding the requirement, that AT&T employees therefore remained ignorant of the requirement until AT&T revamped its pricing scheme, and that for ten years AT&T consequently overbilled schools and libraries. *Id.* at 117-18. The complaint included copies of AT&T’s training materials and alleged that an audit of AT&T’s bills to one public school system revealed that—for five years—AT&T overbilled schools by at least $2.8 million. *Id.* at 124. The *Heath* court concluded that the complaint sufficiently pleaded “the fraud of which [AT&T] is accused: That, even in the wake of a consent decree . . ., [AT&T] persisted in knowingly or recklessly failing to comply with the lowest-corresponding-price requirement.” *Id.* Knudsen’s amended complaint asserts no similar facts to establish such a knowingly fraudulent scheme.
Knudsen also cites *Winter*, where the Ninth Circuit concluded that a complaint sufficiently alleged knowing misconduct under the FCA. 953 F.3d at 1120. But, again, the complaint alleged factual support for the knowing scheme. In that case, a former hospital administrator filed an FCA action alleging that the hospital submitted false Medicare claims certifying that patients’ inpatient hospitalizations were medically necessary. *Id.* at 1115-16. The relator’s job included reviewing the hospital’s admissions for medical necessity. *Id.* at 1115. After a company that owned nursing homes acquired an ownership interest in the hospital’s management company, the relator noticed an unusually high number of patients transported from those nursing homes and admitted into the hospital. *Id.* The relator studied the statistics, saw that the spike correlated with the acquisition, and determined that the increase resulted in an increase of admitted Medicare beneficiaries. *Id.* The relator attempted to bring her concerns to hospital management but received no response. *Id.* At a meeting in which management instructed staff not to question admissions, the relator alleged that a co-owner cut her off, using profanity, when the relator tried to speak up. *Id.* at 1115-16. The complaint alleged that the new owner and the hospital operator exerted pressure on physicians to admit patients, including Medicare recipients, and detailed 65 separate patient admissions that were not medically necessary. *Id.* It estimated over $1.2 million in false Medicare claims for a two-month period. *Id.* The Ninth Circuit concluded that the complaint stated a claim, including that the allegations supported an inference of scienter. *Id.* at 1120. In contrast, here, Knudsen only pleaded broad, general conclusions of scienter.
Knudsen does not allege any conversations, communications, or other evidence outside of the contracts, which included modifications to the RFPs, to demonstrate that the carriers fraudulently induced the state to enter into the contracts by knowingly promising to offer the lowest costs without intending to do so. For his claims of false certification, Knudsen again relies on the contractual provisions and also on his examples of lower prices that he alleges were offered to corporate customers for voice services only at some periods of time. But he alleges no conversations, communications, or other evidence to demonstrate that the carriers knowingly falsely certified compliance with their contracts. Again, a claim under the MFCA requires more than just a breach of contract, see Escobar, 579 U.S. at 194 (discussing the FCA), Minn. R. Civ. P. 9.02 demands that the elements of fraud claims must be pleaded with particularity, and a relator cannot solely rely on broad legal conclusions to allege scienter, see Bahr, 788 N.W.2d at 80.

Because the amended complaint fails to allege with particularity facts that would satisfy the knowledge element of an MFCA claim against the carriers, the district court did not err by dismissing the amended complaint. And, because dismissal is warranted on this ground, we need not address the other grounds relied on by the district court in dismissing the amended complaint.

Affirmed.
ORDER GRANTING
MOTION TO DISMISS

State of Minnesota, et al. ex rel. Richard Knudsen, Plaintiff,

v.

AT&T Mobility National Accounts, LLC; T-Mobile USA, Inc.; Sprint Solutions, Inc.; and Cellco Partnership, d/b/a Verizon Wireless. Defendants.

The above-entitled matter came before the Honorable Kristin A. Siegesmund, Judge of District Court, on June 18, 2020. All parties appeared remotely via telephone conference. On August 14, the Defendants submitted correspondence with supplemental authorities, and the Plaintiff submitted responsive correspondence. The Court then took the matter under advisement.

The Plaintiff was represented by attorneys Tejinder Singh and John Albanese.

Defendant AT&T Mobility National Accounts, LLC was represented by attorneys Barbara Berens, Jessica C. Abrahams, Keeran Chauhan, Wayne Mason, Dawn McCord, and Antonio Pozos.

Defendant T-Mobile USA, Inc. was represented by attorneys Jamal Kaleel, Andrew Crowder, and Steve Koh.

Defendant Sprint Solutions, Inc. was represented by attorneys Donald Heeman, William Ashworth, Shauna Kramer, Anna Tsiotsias, and Randi Winter.

Defendant Cellco Partnership d/b/a Verizon Wireless was represented by attorneys Libretta Stennes, David Cheit, and Matthew Rosengart.

Based on the arguments presented and the submissions of the parties, the Court now makes the following:

ORDER

1. The Defendants’ motion to dismiss under the public disclosure bar is hereby \textbf{DENIED in part} and \textbf{GRANTED in part}.
2. The Defendants’ motion to dismiss for failure to state a claim under the False Claims Act is hereby **GRANTED**.

3. T-Mobile’s motion to dismiss is **GRANTED**.

4. Verizon’s motion to dismiss based on the new claim in the amended complaint is **GRANTED**.

5. The complaint is **DISMISSED** in its entirety.

6. The following Memorandum is hereby incorporated into this Order.

LET JUDGMENT BE ENTERED ACCORDINGLY.

DATED: _______  BY THE COURT:

___________________________________
The Honorable Kristin A. Siegesmund
Judge Kristin A. Siegesmund

**MEMORANDUM**

I. **FACTS**

This is a proceeding under the Minnesota False Claims Act, Minn. Stat. § 15C.01 et seq. (“MFCA”), which prohibits the presentment of false or fraudulent claims to state or local government entities in Minnesota. Under certain circumstances that statute allows a private party to bring such a claim, and that party is then called the Relator. The statute requires that the allegations first be sealed and presented to the State Attorney General for the state to evaluate whether the state should intervene. In this case, the State of Minnesota declined to intervene and the case was unsealed by court order dated May 5, 2019. As discussed further, an Amended Complaint was filed on January 31, 2020.
The Relator in this case has brought a claim against the remaining four Defendants, AT&T Mobility National Accounts LLC, T-Mobile USA, Inc. Sprint Solutions, Inc., and Cellco Partnership d/b/a Verizon Wireless, who all provided at some time wireless communication services to state or local government entities in Minnesota. The essence of the complaint is that the providers each promised to provide their services at the most favorable rate but in fact did not do so. In the Amended Complaint Relator claims that the defendants promised to provide the “most favorable rate available” in one of two ways, 1) by contract language requiring them to immediately give the State any offers or promotions offered to others that would provide lower prices or 2) by contract provisions promising to provide wireless services at “the lowest cost available.” Relator claims that Defendants made these promises to provide most favorable rates to fraudulently induce the State to enter into contracts. The subsequent request for payment, which did not contain most favorable rates, was therefore a false claim under the False Claims Act.

Relator Richard Knudsen claims to have a long background in assessing the rates of telecommunications companies to help customers negotiate the best rate plan. He started doing this type of work in 2008 with eOnTheGo and continued in some capacity until 2018. He claims he also has worked with Verizon, AT&T, Sprint and T-Mobile to analyze their services and increase revenue. One of his tasks was to assist working with customers to optimize their rate plans. He claims that because of this exposure he could see that some corporate clients were

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1 On December 9, 2019 a stipulation was filed where Plaintiff/Relator agreed to dismiss T-Mobile US, Inc. On January 31, 2020 a stipulation was filed where the Plaintiff/Relator agreed to dismiss AT&T Mobility LLC, Verizon Communications Inc. and Alltel Communications LLC n/k/a Verizon. On April 30, 2020 Plaintiff/Relator dismissed Sprint Communications Company L.P and Sprint Corporation. The remaining 4 defendants are AT&T Mobility National Accounts LLC, T-Mobile USA, Inc. Sprint Solutions, Inc., and Cellco Partnership d/b/a Verizon Wireless.

2 The original Complaint also claimed that Defendants promised to provide rate optimization services, but failed to do so. However, Relator has dropped the rate optimization allegation. As stated in the original Complaint ¶ 4 “rate plan optimization services” referred to an evaluation as to whether a specific customer is receiving the most cost-effective rate plan.

3 The language referred to in the Amended Complaint ¶ 3 is “offers or promotions that provide prices lower than or discounts higher than those stated in the Contract . . . immediately to the entities eligible to purchase from the Contract.”

4 Amended Complaint ¶ 3.

5 Amended Complaint ¶ 4-7.

6 Amended Complaint ¶ 23.
offered better rates than government clients.\(^7\)

The Minnesota Office of State Procurement (“OSP”) entered into two sets of contracts with Defendants for the purchase of wireless telecommunication services: (1) Contract Release T-535(5) involving OSP’s direct negotiation with Defendants and, starting in early 2018, (2) Contract Release W-215(5) involving OSP’s adoption of contracts negotiated by a state contracting alliance.\(^8\)

**Contract Release T-535, the 2012 Contracts with Sprint, Verizon, and AT&T.**

In regards to the contracts negotiated directly by Minnesota OSP, a Request for Proposals (RFP) was issued for Contract Release T-535(5) in January 2011. Ex 1 to Amended Complaint. The RFP at paragraph 21 required that price promotions be passed on:

**PRICE DECREASES.** During the life of the Contract, any or all temporary price reductions, promotional price offers, introductory pricing, or any other offers or promotions that provide prices lower than or discounts higher than those stated in the Contract, must be given immediately to the entities eligible to purchase from the Contract. Invoices for goods ordered or shipped or services performed during the decrease or promotion, must immediately reflect such pricing.

The RFP at para 32 also said that the terms of the RFP were accepted unless a deviation was brought to the attention of the state.

**MATERIAL DEVIATION.** A responder shall be presumed to be in agreement with these terms and conditions unless it takes specific exception to one or more of the conditions. Submission by the responder of its proposed language shall not be viewed as an exception unless the responder specifically states in the response that its proposed changes are intended to supersede the State’s terms and conditions.

Paragraph 41 of the RFP said the RFP was included within the agreement.

**ENTIRE AGREEMENT.** A written Contract (including the contents of this RFP and the Contract Vendor’s response incorporated therein by reference) and any written addenda thereto constitute the entire agreement of the parties to the Contract.

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\(^7\) Amended Complaint ¶¶ 13-22.

\(^8\) Amended Complaint ¶ 65.
Relator alleges that the terms of the RFP were incorporated into the final contracts, including the Price Decrease term that Relator claims obligated the participating carriers to give state and local government entities any “offers or promotions” that would provide a lower price than the contract.\textsuperscript{9} Relator contends that this contract provision required the providers to charge the state no more than they charged any other customer for same or similar services.\textsuperscript{10}


Relator acknowledges that the final contracts modified the RFP language regarding price decreases, specifically, that the reference to offering “introductory prices” was deleted.\textsuperscript{14} The final contract for AT&T, Sprint and Verizon also specifically provided in the Price Decrease paragraph that the price decrease would apply only “if the prices given are based on similar or comparable purchases.”\textsuperscript{15} But Relator alleges that these three Defendants were still obligated to give the State lower prices that they offered to other entities for comparable products and services.\textsuperscript{16} Relator alleges that the three defendants issued price lists under these contracts that were higher than rates being offered by them to others for comparable products and services. Amended Complaint ¶¶ 77-78.

\textsuperscript{9} Amended Complaint ¶ 74.
\textsuperscript{10} Relator’s Memo in Opposition to Defendants’ Joint Motion to Dismiss the FOA for Failure to State a Claim p 1; Amended Complaint ¶ 67.
\textsuperscript{11} See Ex. 5 (final Sprint contract) to Nelson Decl.
\textsuperscript{12} See. Ex. 1 (Final Verizon contract) to Decl. of David Cheit.
\textsuperscript{13} See Ex. 1 (Final AT&T contract) to Declaration of Wayne Mason in support of Joint Motion to Dismiss filed Dec 10, 2019.
\textsuperscript{14} Amended Complaint ¶ 76
\textsuperscript{15} Mason Declaration in Support of Joint Motion to Dismiss Ex. 1 (Final AT&T contract) ¶ 1.1.4.3(b); Nelson Decl Ex. 5 (final Sprint contract) para 1.1.4.4(b); Cheit Decl. Ex. 1 (final Verizon contract) ¶ 1.1.4.4(b). Verizon also added the language after purchases “as allowed by applicable laws and subject to the terms and conditions of the pricing offer.”
\textsuperscript{16} Amended Complaint ¶ 76
The WSCA Contract signed in 2018

In 2018, OSP started to shift its contracts with telecom providers to a new contract, Contract Release W-215(5). This contract was part of a state consortium called the Western States Contracting Alliance (“WSCA”), now known as the National Association of State Procurement Officials (“NASPO”), that had negotiated a master contract through Nevada acting as the lead state. A government entity, such as Minnesota, can contract though this master agreement with or without modifications. Sprint\(^\text{17}\) signed the addendum with Minnesota on March 3, 2018, AT&T\(^\text{18}\) on April 27, 2018, and T-Mobile\(^\text{19}\) on May 1, 2018.\(^\text{20}\) Verizon\(^\text{21}\) signed the addendum for the WSPA master agreement on October 2, 2018. Amended Complaint ¶ 108. The allegation about Verizon signing the WSCA master agreement was not in the original complaint, and was added to the Amended Complaint.

Although the defendants in this case did not enter into the WSCA master agreement under Contract Release W-215(5) with Minnesota OSP until 2018, the master contract was negotiated many years before. Nevada as the lead state issued an RFP 1907 in 2011 for what would become the master contract for Contract Release W-215(5) in 2011. RFP 1907 is attached to Amended Complaint as Ex 3.

The original WSCA RFP for the master contract called for lowest cost. Under General Requirements at paragraph 3.1.2 RFP 1907 required: “Provide quality wireless voice services, wireless broadband services, equipment and accessories at the lowest cost available in a timely and efficient manner.” Relator claims that the RFP had requirements for lowest cost in other sections.\(^\text{22}\) RFP 1907 also had a clause incorporating the terms of the RFP in the contract but allowed for modifications:

> “11.2.6 Attachment B1 and Attachment B2 of this RFP shall constitute an agreement to all terms and conditions specified in the RFP, except such terms and conditions that the vendor expressly excludes. Exceptions and assumptions will be taken into consideration as part of the evaluation process; however, vendors

\(^{17}\) Ex. 13 to Amended Complaint  
\(^{18}\) Ex 14 to Amended Complaint  
\(^{19}\) Ex 15 to Amended Complaint  
\(^{20}\) The contract period for Contract Release W-215(5) with AT&T, Sprint, and T-Mobile was April 27, 2018 through June 30, 2019. See Amended Complaint Ex. 2  
\(^{21}\) Ex. 16 to Amended Complaint  
\(^{22}\) Amended Complaint ¶¶ 90-93.
Relator contends that the WSCA RFP required carriers to provide lowest prices.23 Relator acknowledges that some defendants added exceptions to the RFP and attempted to modify the lowest prices requirement in the WSCA contracts when they signed the master agreement. Nevada and Sprint agreed in 2012 to delete the requirement for Sprint to provide the lowest cost available for voice services.24 Indeed, Sprint specifically states in the agreed exception to the WSCA master agreement that Sprint did not offer Most Favored Customer clauses.25 Realtor alleges that because Sprint did not specifically modify the General Requirements language at 3.1.2 that required lowest prices, as well as failing to modify other RFP paragraphs mentioning lowest prices, and because Sprint specifically promised to provide “substantially similar prices”, that it has still made false claims by not providing lowest prices. Amended Complaint ¶ 98.

Relator acknowledges that when Verizon entered into a master agreement with Nevada under RFP 1907 in 2012 that it tried to modify the lowest cost requirement. In responding to Section 3.5.1 of the RFP which required providing quality wireless voice services at the lowest cost available, Verizon responded: “Verizon Wireless will provide quality voice services at a fair and reasonable cost available in a timely and efficient manner; not lowest cost.” The same disclaimer was put in the broadband section 3.6.1 requiring lowest cost for broadband.26 But

23 The Amended Complaint at ¶¶ 98-104 alleges that the 4 remaining defendants entered into a master agreement with Nevada in 2012 under RFP 1907, but Minnesota did not adopt this agreement until 2018. Since Nevada was acting on the part of a multistate consortium the defendants could have been providing services to other states under the Nevada contract. But that is not the subject of this lawsuit which only relates to contracts and claims made in Minnesota. Amended Complaint ¶ 98.
24 See Ex. 5 to Amended Complaint (Sprint exceptions to the WSCA master contract) at p. 5. In regard to the WSCA RFP provision 3.5.1 which stated “Provide quality voice services at the lowest cost available in a timely and efficient manner” The agreed exception to that paragraph stated: “The parties agree to delete Section 3.5.1 in its entirety. Sprint has offered pricing that it believes meets the State’s/Customer’s requirements; however, Sprint does not offer Most Favored Customer clauses in its contracts. Sprint will continue to offer highly competitive pricing and discounts for its services in a manner in which the prices Sprint charges its customers for the same services are not unreasonably dissimilar for similarly situated customers with like traffic patterns, volumes, commitment levels and the like.”
26 Ex. 9 to Amended Complaint pp. 19-20,
Plaintiff alleges that its attempt was inadequate to relieve it from the obligation because they did not address the general requirement for lowest cost in 3.2.1. Amended Complaint ¶¶ 101-103, 108.

AT&T took exception to the “lowest cost available” language in WSCA RFP 1907. In Section 3.5.1 of the RFP AT&T stated its exception “Provide competitive prices at the best value to Participating Entities in a timely and efficient manner, as to be set forth in the mutually agreed contract.” Ex 12 to Amended Complaint. But Relator argues that this exception did not address broadband nor the general requirements for lowest cost in 3.2.1 and that best value is the same as lowest cost. Relator alleges that this exception did not alleviate AT&T from providing lowest prices. Amended Complaint ¶104.

T-Mobile did not modify the lowest cost requirement of the WSCA RFP when it entered the master agreement with Nevada.27

Thus Relator alleges that when the four defendants entered into the addendum in 2018, they were agreeing to the terms of their master agreement with Nevada, and Relator argues that despite the exceptions taken by three of the Defendants they all agreed to provide lowest cost. Amended Complaint ¶ 109-123.

Relator alleges that all four Defendants issued price lists under the 2018 WSPA Contract Release W-215(5) that did not provide the lowest prices to Minnesota Government entities. Amended Complaint ¶ 124-5.

Thus the crux of Relator’s claims is that the four defendants were required to offer the best rates, but did not. Relator acknowledges that there is not one type of rate plan that is optimal for every user, but rather an optimal rate plan varies based on the type of usage. Amended Complaint ¶ 141-142. Relator alleges that Defendants overcharged at nearly all levels of usage. Amended Complaint ¶ 142. Because Relator has withdrawn his rate optimization charge, his complaint cannot be based on Defendants failure to provide the best plan, but rather must be based on an assertion that with exactly the same plan, with the same features, based on similar considerations of usage, the Defendants charge more for essentially the same service.

**The Four Examples Provided by Relator**

In support of its claim that Verizon failed to provide the best rate, Relator offers a chart

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27 Amended Complaint ¶ 100. Ex. 6 to the Amended Complaint (T-Mobile WSCA master agreement). Ex. 7 (T-Mobile Part I Technical.)
comparing what it claims is the rate offered by Verizon in 2012 price sheet\textsuperscript{28} for the contract beginning July 1, 2012 to a rate that Relator claims was offered by Verizon to Coca-Cola. The chart shows that Coca-Cola paid no monthly service charge whereas in the unlimited rate for Minnesota, which included roaming, there was an $11.99 monthly fee. And Coca-Cola paid 4.5 cents per minute during peak usage whereas Minnesota, if it used this rate, would pay 25 cents per minute of peak usage. The Relator alleges that Verizon offered Coca-Cola these rates from at least October 2010 until May 2012. He offers no personal information or facts that this rate continued past May 2012 into the period when Verizon set forth its price sheet. He alleges on information and belief, that rate plans are maintained unless something more favorable is offered. There are no facts alleged that the Coca-Cola rate involved the same usage pattern as a Minnesota government entity that used this rate. Nor does he offer any facts that any Minnesota agency used this rate or was actually billed under this rate. No facts are presented about the rates provided by Verizon once the WSCA contract took effect in 2018.

In support of its claim that Sprint failed to provide the best rate, Relator offers a chart comparing what it claims is the rate offered by Sprint in its July 2011 price sheet\textsuperscript{29} for the first Minnesota contract, Contract release T-535(5), which did not begin until July 1, 2012, to a rate that Relator claims was offered by Sprint to Kaiser. The chart shows that Kaiser paid no monthly service charge whereas the Minnesota price sheet showed a $7 monthly fee. And Kaiser paid 6 cents per minute while the Minnesota price sheet showed a cost of 8 cents per minute. Relator alleges that Sprint offered Kaiser these rates from 2008 to at least 2014. He presents no facts that this rate was offered after 2014 except on information and belief that customers maintain their rates unless offered a more favorable option. However, no allegation is made that the Kaiser contract involved the same usage pattern. No allegation is made about the rates provided by Sprint in the new WSCA contract entered in 2018.

In support of its claim that AT&T failed to provide the best rate, Relator offers a chart

\textsuperscript{28} Amended Complaint ¶ 145 -146. Ex. 17 to Amended Complaint. The court notes that there is nothing on Ex. 17 that indicates that it was a price list in effect in 2012. However, it does mention Minnesota.

\textsuperscript{29} Amended Complaint ¶ 154 -155. Ex. 18 to Amended Complaint. Relator claims that Sprint released another price sheet in July 2016 with similar pricing. See Ex. 18 to Amended Complaint.
comparing what it claims is the rate offered by AT&T in its 2012 price sheet for the first Minnesota Contract Release T-535(5), which began on July 1, 2012, to a rate that Relator claims was offered by AT&T to Wells Fargo. The chart shows that Wells Fargo paid no monthly service charge whereas the Minnesota price sheet showed a flat rate of $10.39. Wells Fargo paid 6 cents per minute for peak usage and the Minnesota price sheet showed 7 cents per minute for peak usage. Relator alleges that Wells Fargo was offered this plan from July 2010 until at least “summer” 2012. But there are no facts what Wells Fargo was offered after July 1, 2012 when AT&T started its contract with Minnesota. No allegation is made that the Wells Fargo contract involved the same usage pattern. There is no allegation that AT&T posted a price list that was contrary to its obligations after it entered into the WSCA contract in 2018.

In regard to T-Mobile’s WSCA contract that was entered with Minnesota in 2018, Relator has no contemporaneous comparisons from 2018 or later. Instead, Relator refers to the cost proposal that T-Mobile submitted with its response to Nevada’s RFP to the master contract signed in 2012. He compares one of those rates in the Nevada RFP with one that T-Mobile offered to Chevron. He looks at what T-Mobile called Tier 2 voice plan. Chevron had no flat fee whereas T-Mobile’s Tier 2 proposal in 2012 to Nevada was for a $4.20 flat fee. In his chart, Relator labels this as the Minnesota Flat rate, but he provides no evidence or allegation that this is in fact the rate that Minnesota was charged in 2018 when it first entered into the WSCA contract with T-Mobile. The per-minute charges are the same. Relator states that the Chevron rate was offered to Chevron from 2008 until at least 2012. Again he has no facts pled that this rate was still offered by T-Mobile to Chevron after T-Mobile entered the contract with Minnesota in 2018. He only states that on information on belief rates stay the same. And again he plead no facts that Chevron and the state have the same usage patterns.

Plaintiff makes a sweeping allegation that many of the providers have discount brands that offer cheaper rates, but no examples are provided and no allegation is made that they are for the same usage patterns.

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30 Amended Complaint ¶ 164-165. Ex 19 to Amended Complaint. AT&T put out a new pricing schedule under this contract in 2017. Ex. 19 to Amended Complaint.
31 Ex. 20 to Amended Complaint
32 Indeed he provides no evidence that anything was billed under the WSCA contract to T-Mobile prior to the filing of this lawsuit in October 2018
33 Amended Complaint ¶ 184-190. He also made allegations with no factual basis that employees who had their own phone service were overcharged. Amended Complaint ¶ 193.
All of the examples provided by Relator are for overcharging of voice services. Amended Complaint ¶ 192, Relator claims he has similar examples for data services but did not provide a single one in the Amended Complaint. Amended Complaint ¶ 192.

**Procedural History. The Complaint and Amended Complaint**

The original complaint was filed under seal on October 5, 2018. It raised a number of claims. Count I, II raised claims against AT&T for presenting false claims in violation of Minn. Stat. § 15C.02(a)(1) and(2). Similar claims were made against T-Mobile (Counts III, IV); Sprint (Counts V, VI); and Verizon (Counts VII, VIII)

After the Minnesota Attorney General declined to intervene, the case was unsealed on May 5, 2019. The Relator was allowed to prosecute the matter and was ordered to serve all the parties. The court ordered the parties to keep the state informed of the case. On December 10, 2019 T-Mobile USA, Inc. filed a motion to dismiss the complaint for failure to state a claim. Also on December 10, 2019 the other three remaining defendants34 AT&T Mobility National Accounts LLC, Sprint Solutions, Inc., and Cellco Partnership d/b/a Verizon Wireless, filed a joint motion to dismiss for failure to state a claim. The parties filed a stipulation on November 18, 2019 regarding how to handle the multiple motions to dismiss. The parties agreed in that stipulation that plaintiff would respond to the motions to dismiss by January 31, 2020 either by filing memoranda of law opposing the motions to dismiss, or by filing an amended complaint. Plaintiff/Relator filed an amended complaint on January 31, 2020.

The amended complaint tracks many of the allegations in the original complaint. Its core allegation that the contracts required the defendants to provide lowest prices and they failed to do so remains. Relator continues to allege that the RFP for Contract Release T-535(5) contained language to provide the lowest rates and that this was incorporated into the final contract. Amended Complaint ¶¶ 71-74. Relator now acknowledges that there were modifications made by AT&T, Sprint and Verizon to the RFP Price Decrease language, but alleges that the promise to offer future price incentives was not altered. Amended Complaint ¶ 76. In regard to the WSCA contract in 2018, Relator continues to allege that RFP 1907 required lowest prices and that obligation was incorporated into all contracts. Amended Complaint ¶ 90-97. Relator now

34 The motion was in fact filed on behalf of these three remaining defendants and other named defendants who have subsequently been dismissed.
acknowledges that Defendants made some changes to the RFP but contends that they were insufficient to get rid of the basic obligation to provide lowest rates.

Similar counts were brought in the Amended Complaint. However, the Amended Complaint now adds to the claims against Verizon that they entered into the WSCA contract in October 2018 and are violating that contract. This claim was not sealed and was not presented to the Attorney General for review.

The Defendants have brought a number of motions to dismiss the Amended Complaint. All Defendants join in a motion for failure to state a claim. All Defendants join in a motion to dismiss pursuant the Public Disclosure Bar. T-Mobile brings its own motion to dismiss for failure to allege any illegal conduct by T-Mobile. And Verizon brings a motion to strike all allegations related to the 2018 WSCA contract that was added to the Amended Complaint.

II. CONCLUSIONS OF LAW

A. Motion to Dismiss Standard

Pursuant to the Minnesota Rules of Civil Procedure, the Court may dismiss a complaint upon motion by a defendant if the complaint fails to state a claim upon which relief can be granted. Minn. R. Civ. P. 12.02(e). To survive, a complaint must include “a short and plain statement . . . showing that the pleader is entitled to relief.” Minn. R. Civ. P. 8.01. For claims of fraud, a plaintiff must meet a higher standard by stating the claim with “particularity.” Minn. R. Civ. P. 9.02.

In assessing whether a complaint is sufficient, the Court accepts the facts alleged in the complaint as true and construes “all reasonable inferences in favor of the nonmoving party.” Walsh v. U.S. Bank, N.A., 851 N.W.2d 598, 606 (Minn. 2014). It does not matter whether or not a plaintiff can prove the facts alleged in the complaint, rather a court looks to whether “it is possible on any evidence which might be produced, consistent with the pleader’s theory, to grant the relief demanded.” Martens v. Minnesota Min. & Mfg. Co., 616 N.W.2d 732, 739-40 (Minn. 2000).

Given that many of the cases cited by the Court and the parties are federal cases that apply the federal standard for motions to dismiss, the Court also notes that Minnesota’s standard for motions to dismiss is materially different and more lax than the federal standard.

In Walsh, the Minnesota Supreme Court summarized the development of the Iqbal-Twombly federal standard for motions to dismiss:
In *Twombly*, the Court announced a new pleading standard—the plausibility standard—for civil actions in federal court. Under that standard, a pleading must contain “enough facts to state a claim to relief that is plausible on its face.” *Twombly*, 550 U.S. at 570, 127 S.Ct. at 1973 (emphasis added). Mere “labels and conclusions, and a formulaic recitation of the elements of a cause of action” are not sufficient. *Id.* at 555, 127 S.Ct. at 1964. Instead, a complaint must contain factual allegations that “raise a right to relief above the speculative level.” *Id.*

Two years after *Twombly*, the Court clarified in *Ashcroft v. Iqbal* the two “working principles” that underlie the plausibility standard. *Iqbal*, 556 U.S. at 678, 129 S.Ct. at 1949. “First, the tenet that a court must accept as true all of the allegations contained in a complaint is inapplicable to legal conclusions.” *Id.* Second, if the facts in a complaint do not permit a court to infer more than a mere possibility of misconduct, “the complaint has alleged—but it has not ‘show[n]’—‘that the pleader is entitled to relief.’” *Id.* at 679, 129 S.Ct. at 1950 (quoting Fed.R.Civ.P. 8(a)(2)).

*Walsh*, 851 N.W.2d at 602-03.

The *Walsh* Court then declined to follow *Iqbal-Twombly*. Instead, the Minnesota standard remains as follows: “a claim is sufficient against a motion to dismiss for failure to state a claim if it is possible on any evidence which might be produced, consistent with the pleader's theory, to grant the relief demanded.” *Id.* at 603.

**B. Minnesota False Claims Act**

The Minnesota False Claims Act (“MFCA”), was enacted in 2010. Minn. Stat. § 15C.01 et seq. It mirrors the federal False Claims Act (“FCA”), 31 U.S.C. §§ 3729–3733, and therefore federal FCA case law is persuasive precedent in analyzing MFCA claims. See *Olson v. Fairview Health Servs. of Minn.*, 831 F.3d 1063, 1069 (8th Cir. 2016) (federal and state FCA claims analyzed in tandem given that state act mirrors federal act).

a. Public Disclosure Bar

Both acts exist to “provide cash bounties to private citizens who successfully bring suit against those who defraud the federal government.” *Hays v. Hoffman*, 325 F.3d 982, 987 (8th Cir. 2003). Yet, the state and federal legislatures recognized the need to balance the interest in citizen whistleblowing against the risk that private citizens may exploit the cause of action to bring claims for wrongs that were already under government scrutiny. In recognition of the need to strike this
balance, the FCA and MFCA bar actions where the alleged wrong has been previously publicly disclosed. *Hays v. Hoffman*, 325 F.3d at 987 (public disclosure bar “intended to encourage private enforcement suits by legitimate whistleblowers while barring suits by opportunisti* *que tam* plaintiffs who base their claims on matters that have been publicly disclosed by others”).

Specifically, the MFCA states:

A court must dismiss an action or claim under this section, unless opposed by the prosecuting attorney, if substantially the same allegations or transactions as alleged in the action or claim were *publicly disclosed*:

1. in a criminal, civil, or administrative hearing in which the state or a political subdivision or its agent is a party;
2. in a report, hearing, audit, or investigation of the legislature, the governing body of a political subdivision, the legislative auditor, or the state auditor; or
3. by the news media.

This paragraph does not apply if the action or claim is brought by the prosecuting attorney or the person bringing the action or claim is an original source of the information.

Minn. Stat. § 15C.05 (emphasis added).

Because Relator is alleging false claims back to the contracts that began on July 1, 2012, the court must also consider the language of the statute prior to its amendment on August 1, 2013. The pre-amendment stated:

[U]nless the action is brought by an original source of the information . . . if the action is based upon the public disclosure of allegations or transactions: (i) in a criminal, civil, or administrative hearing; (ii) in an investigation, report, hearing or audit conducted by or at the requests of the house of representatives or the senate; (iii) by an auditor or the governing body of a political subdivision; or (iv) by news media.

Minn. Stat. 15C.05(f) (2009).

All defendants challenge Relator’s pleading as barred by the public disclosure bar. The statute requires the court to analyze public disclosure issues by asking first - was there a public disclosure of substantially the same allegations or transactions as alleged in the action or claim? If there was no public disclosure, the Relator’s case is not barred on public disclosure grounds. If there was a public disclosure, the next issue is whether the disclosure occurred within one of the
three categories (or before August 2013 four categories) for which the public disclosure bar applies. If the public disclosure occurred in one of the three categories, then the case is barred unless the Relator is an original source. This Court’s analysis will proceed along these lines.

A public disclosure takes place when “substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed” in one of three contexts. Minn. Stat. § 15C.05. Here, the parties dispute whether the disclosures identify “substantially the same allegations or transactions.” The Defendants allege that there have been public disclosures that the defendants failed to “provide services at the ‘lowest cost available.’”35 Relator contends that prior disclosures were more narrow, focusing on failure to provide rate optimization, and that this claim, that the Defendants offered secret plans that were cheaper to other customers and thus violated its promise to offer the lowest rates, is new and distinct.36 The parties have not identified, and the Court has not uncovered, any case interpreting the “substantially the same” language of the Minnesota False Claims Act. Thus, the Court will rely on caselaw construing the identical language of the federal False Claims Act. See 31 U.S.C. § 3730(e)(4)(A) (requiring courts to dismiss an action “if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed”).37

The public disclosure bar is intended to bar suits that the government is capable of pursuing itself. U.S. ex rel. Fine v. Sandia Corp., 70 F.3d 568, 571 (10th Cir. 1995). Thus, the fundamental question in analyzing whether an action is substantially similar to a prior public disclosure is whether enough information exists in the public domain to “set government investigators on the trail of fraud.” U.S. ex rel. Springfield Terminal Ry. v. Quinn, 14 F.3d 645, 655 (D.C. Cir. 1994). If the allegations in the public disclosure are identical to the complaint, then there is no issue with

35 Defendants’ Reply Brief in Support of Motion to Dismiss pursuant to Public Disclosure p 5.
36 Relator’s Response p 14.
37 The court recognizes that the pre-amendment statute did not have the words substantially similar but rather use the words “based upon” the public disclosure. The similar federal statute 31 U.S.C. § 3730(e)(4)(A) addressing public disclosure was also amended in 2010. The prior statute barred cases “based upon” public disclosures and the current statute is very similar to the current Minnesota False Claims Act. Both now use the substantially similar language. Federal courts have addressed whether the “based upon” language in the former version created a different standard. The court adopts the majority view, rather than the 4th Circuit view as suggested by Relator, and finds that ‘based upon’ does not require reliance on the public disclosure but rather means ‘supported by’ or ‘substantially similar to.” See cases cited in U.S. ex rel. Mistick PBT v Hous. Auth. of City of Pittsburg, 186 F.3d 376, 386 (3d Cir. 1999)
finding substantial similarity. But if, as is argued here, the public disclosure has some differences from the complaint, the question is more difficult.

Defendants point to a number of documents they contend represent public disclosures that bar Relator’s claims. The documents fall into two general categories. In the first category are reports from the auditors for the City of Los Angeles and the state of Vermont, and news stories about the reports. In the second category are two complaints in a qui tam action in California against several cell phone carriers, and news stories about that lawsuit.

Despite relating to different government entities and different contracts, the documents all describe the same scenario, which may be summarized as follows. A government entity enters into contracts with cell phone carriers. Those contracts require the cell phone carriers to provide rate optimization, that is, reports on which plans would provide the best value based on the patterns of usage. The optimization services are not provided, resulting in excess spending. Someone—either an auditor, in the first category of documents, or a plaintiff, in the second category—notices that the optimization services are not being provided and publicly discloses that fact, either in a report or a lawsuit. News media then report on the failure to provide optimization. The documents publicly disclosed the rate optimization claim that Relator had in the original complaint and has now withdrawn in the Amended Complaint.

Relator argues that the disclosure of rate optimization is not substantially similar to his current complaint which claims that the Defendants did not provide the lowest price for the same usage package. The fraud disclosed by Defendants’ documents turns on cell phone carriers’ failure to provide optimization services. In other words, they failed to help government subscribers choose the plan that best fit the subscribers’ needs. Relator’s claim, in contrast, asserts that Defendants failure to provide a most favored rate. Adherence to a most favored rate clause depends on how much other subscribers are paying for the same services—if other subscribers pay less than the purported recipient of the most favored rate, then the most favored rate clause is violated.

Relator contends that it is improper for the Court to consider these documents on a motion to dismiss, as they do not appear on the face of the complaint. However, judicial notice is appropriate on a motion to dismiss. Minn. R. Evid. 201(f). Because the key question is not the truth of the matters asserted in the documents, but simply whether the documents disclose the allegations, it is appropriate to take judicial notice of the documents—their existence can be accurately and readily determined simply by viewing the documents. See Minn. R. Evid. 201(b).
Defendants argue that this general narrative constitutes public disclosure of the fraud because it asserts that cell phone companies, indeed the same four companies who are defendants in this case, are breaching contracts that require them to provide services at the lowest cost. They argue that Relator here is also claiming that cell phone companies are violating their contractual obligation to provide services at the lowest cost. Because the fraud concerns violation of the same contractual provision, Defendants argue that Relator’s claims have already been disclosed.

The court’s inquiry focuses on the second category of documents, the OntheGO litigation and the subsequent news reports which do specifically state that in addition to failing to meet their obligation to provide rate optimization services the carriers breached another contractual provision to provide services at the “lowest cost”.

The Second Amended Complaint dated May 6, 2016 filed by a number of California political subdivisions and Qui Tam Plaintiff OntheGo, in case file #34-2012-127517, at paragraph 2, specifically alleged that the carriers, the same four as here, Verizon, Sprint, AT&T and T-Mobile, had breached “two interlocking provisions” of their contracts: 1) they had not optimized plans and 2) they had not provided lowest cost available.39

A report on this litigation “Whistleblower Case Against Nation’s Largest Wireless Carriers Moves Forward, Court Rules” published by PR Newswire, dated Sept. 21, 2016,40 stated:

The wireless companies are alleged to have purposefully ignored two cost-saving requirements included in master contracts under which the California state and local government customers bought wireless services. Under the contracts, the carriers were required to determine and report to the government customers which rate-plan selections would result in the lowest cost, referred to as “rate plan optimization,” and to provide wireless services at “the lowest available cost.” Selecting the rate plan that best matches...

39 Ex. 9 to Declaration of Wayne Mason in support of publication bar. (2nd Amended Complaint in OntheGo.) Relator argues that the court should not consider this litigation pleading because it is not in Minnesota. The court does not reach the question of whether litigation in any state meets the public disclosure category of the Minnesota False Claims Act because the litigation is referred to in the news reports, and therefore that question is not critical here. The category of news reports falls squarely within the categories of public disclosures.

IN THE SECOND JUDICIAL DISTRICT COURT
OF THE STATE OF NEVADA
IN AND FOR THE COUNTY OF WASHOE

STATE OF NEVADA et al, ex rel. OnTheGo Wireless, LLC,

v.

CELLCO PARTNERSHIP d/b/a VERIZON WIRELESS, a Delaware general partnership, et al.,

Defendants.

Case No. CV12-03093
Dept. No. B13

NOTICE OF ENTRY OF ORDER OF DEFENDANTS' MOTION TO DISMISS

PLEASE TAKE NOTICE that the Court entered its Order Granting Motion to Dismiss on October 10, 2019, a copy of which is attached hereto as Exhibit "1."
Affirmation Pursuant to NRS 239B.030. The undersigned affirms that the preceding document does not contain the social security number of any person.

Dated this __ day of October, 2019

HUTCHINSON & STEFFEN

By: [Signature]

Jason D. Giannese, Esq.
500 Damonte Ranch Parkway, Suite 980
Reno, Nevada 89521
Co-Counsel for Defendant, New Cingular Wireless National Accounts, LLC D/B/A Cingular Wireless, now known as AT&T Mobility National Accounts LLC
CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of the law firm of HUTCHISON & STEFFEN, LLC and that on this 11th day of October, 2019, I caused service a true and correct copy of the NOTICE OF ENTRY OF ORDER by electronically filing the foregoing with the Clerk of the Second Judicial District Court for the State of Nevada. Electronic service was sent to the following in accordance with the E-Service:

E. Leif Reid, Esq.
Arthur Zorio, Esq.
Michael Hogue, Esq.
Wayne Klomp, Esq.
Paul Matteoni, Esq.
Matthew Sharp, Esq.
William Ashworth Esq.
Alayne Opie, Esq.
Janine Prupas, Esq.
William Cameron Esq.
Michael D. Rounds, Esq.
Joseph Tartakovsky, Esq.

I further certify that on this 11th day of October, 2019, I caused the foregoing document to be served by placing an original or true copy of the REQUEST FOR SUBMISSION in a sealed envelope for collection and mailing in the United States at Reno, Nevada, postage prepaid, following ordinary business practices, addressed as follows:

John E. Joiner
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**LIST OF EXHIBITS**

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IN THE SECOND JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA
IN AND FOR THE COUNTY OF WASHOE

STATE OF NEVADA; STATE OF HAWAII; STATE OF IOWA; STATE OF MONTANA; STATE OF NEW MEXICO, et al., ex rel. ONTHEGO WIRELESS LLC,

Plaintiffs,

vs.

CELLCO PARTNERSHIP D/B/A VERIZON WIRELESS, A DELAWARE GENERAL PARTNERSHIP, SPRINT SOLUTIONS, INC., A DELAWARE CORPORATION; NEW CINGULAR WIRELESS AND NATIONAL ACCOUNTS, LLC, D/B/A CINGULAR WIRELESS N/K/A AT&T MOBILITY NATIONAL ACCOUNTS LLC, A DELAWARE LIMITED LIABILITY COMPANY,

Defendants.

ORDER GRANTING MOTION TO DISMISS

The Court has considered Defendants’ Motion to Dismiss ("the Motion to Dismiss"), the Relator and State of Nevada’s Joint Opposition to Motion to Dismiss ("the Opposition"), Defendants’ Reply in Support of Motion to Dismiss ("the Reply"), the oral argument held on August 7, 2019, and all the relevant papers and pleadings on file herein. The Court finds and orders as follows:

///
BACKGROUND

The two operative complaints in this case are the Relator’s Amended Complaint, filed on April 11, 2016 ("Relator’s Complaint"), and the State of Nevada’s Complaint in Intervention, filed on February 27, 2019 ("Nevada Complaint") (collectively, "the Complaints"). The Relator’s Complaint and the Nevada Complaint make identical allegations against Defendants. The exception being the Relator’s Complaint includes claims by Hawaii, Iowa, Montana, and New Mexico ("the Other States"), and the Nevada Complaint includes claims for breach of contract and unjust enrichment. Neither Plaintiffs nor Defendants draw any distinctions between the allegations at issue in this Motion to Dismiss. Therefore, the Court’s citation to one complaint applies equally to the other, unless otherwise specified.

This action arises out of two contracts for wireless and related services established by the Western States Contracting Alliance ("WSCA"). Nevada Complaint ¶ 15. The two agreements ("WSCA #1523 or WSCA I" and "WSCA #1907 or WSCA II") were negotiated by the State of Nevada acting as the Lead State. Id. States and political subdivisions then executed separate "Participating Addenda" with the carriers incorporating terms from the WCSA purchasing contracts. Nevada Complaint ¶ 33.

Plaintiffs allege the contracts require Defendants, “provide services at the ‘lowest cost available.’” Opp’n at 4; Nevada Complaint ¶ 30. Plaintiffs allege the contracts “require Defendants to provide a rate plan ‘optimization,’ a process that: (1) is used for selecting the most cost-effective rate plan for each wireless subscriber given his or her usage; and (2) constitutes one of the most effective means of reducing the cost of wireless services.” Opp’n at 3; Nevada Complaint ¶ 23, 30. Plaintiffs allege rate plan optimization has a “clear and widely accepted meaning in the wireless industry.” Opp’n at 3; Nevada Complaint ¶ 29.

The WSCA process began with Nevada publishing Requests for Proposals ("RFPs"). Opp’n at 4. Plaintiffs allege the RFPs, “solicited Defendants’ agreement to provide a ‘quarterly optimization report for each wireless service subscriber.’” Nevada
Complaint ¶¶ 44, 56. Defendants’ responses to the RFPs included a description of how the carriers would comply with the optimization reports provision. Relator’s Complaint ¶ 100-109. Plaintiffs allege Defendants did not file a formal exception to the two RFP requirements at issue. Relator’s Complaint ¶¶ 48, 50-51, 64, 66-67. Both contracts incorporated Defendants’ responses to the RFPs. Nevada Complaint, ¶52. Plaintiffs allege that without a formal exception to a provision, the RFP language takes precedence over Defendants’ responses. Nevada Complaint, ¶53.

During the RFP process, Defendants also requested information regarding the detail required for the optimization and other reports, to which Nevada responded “[p]lease refer to Attachment F- Quarterly Reports. Reports should be submitted to the Lead State.” Opp’n at Ex. 13 ¶ 48. The Parties agree Attachment F refers to the form of administrative fee reporting to the Lead State and no additional information was provided to the Defendants regarding optimization reports. Opp’n, pp 10-11.

Plaintiffs allege Defendants’ provision of services at the lowest cost available should have been achieved through quarterly optimization reports. Nevada Complaint, ¶ 58. However, Plaintiffs allege “Defendants provided infrequent reports related to rate plan selections, which did not provide the same cost-saving information found in a true optimization report.” Opp’n, at 5; Nevada Complaint ¶ 87.

STANDARD OF REVIEW

There is a strong presumption against dismissing an action for failure to state a claim. Gilligan v. Jamco Development Corp., 108 F.3d 246, 249 (9th Cir. 1997). “A district court order granting a motion to dismiss, “is rigorously reviewed.” Shoen, 122 Nev. at 634-35, 137 P.3d at 1180. To survive dismissal, a complaint must contain some, “set of facts, which, if true, would entitle [the plaintiff] to relief.” In re Amerco Derivative Litig., 127 Nev. 196, 210-11, 252 P.3d 681, 692 (2011) (quoting Buzz Stew, LLC v. City of N. Las Vegas, 124 Nev. 224, 228, 181 P.3d 670, 672 (2008)). “The district court ‘considers all factual assertions in the complaint to be true and draws all reasonable inferences in favor of the plaintiff.’” Id. (emphasis added). As Nevada is a “notice-pleading” jurisdiction, a
complaint need only set forth sufficient facts to demonstrate the necessary elements of a claim for relief so that the defending party has, "adequate notice of the nature of the claim and relief sought." \textit{Hay v. Hay}, 100 Nev. 196, 198, 678 P.2d 672, 674 (1984); see also \textit{Stockmeier v. Nevada Dep't of Corrections}, 124 Nev. 313, 316, 183 P.3d 133, 135 (2008) (dismissal, pursuant to NRCP 12(b)(5), is proper where the allegations are insufficient to establish the elements of a claim for relief). The Court is not required to give credence to conclusory or speculative allegations. \textit{Bell Atl. Corp. v. Twombly}, 550 U.S. 544, 555, 127 S. Ct. 1955, 1965, 167 L. Ed. 2d 929 (2007) (citing \textit{Papasan v. Allain}, 478 U.S. 265, 286, 106 S.Ct. 2932, 92 L.Ed.2d 209 (1986) ("[O]n a motion to dismiss, courts 'are not bound to accept as true a legal conclusion couched as a factual allegation'"); see also \textit{In re VeriFone Sec. Litig.}, 11 F.3d 865, 868 (9th Cir. 1993) (citing \textit{United States ex rel. Chunie v. Ringrose}, 788 F.2d 638, 643 n. 2 (9th Cir.), \textit{cert. denied}, 479 U.S. 1009, 107 S.Ct. 650, 93 L.Ed.2d 705 (1986)) ("Conclusory allegations of law and unwarranted inferences are insufficient to defeat a motion to dismiss for failure to state a claim.").

"In evaluating a motion to dismiss, courts primarily focus on the allegations in the complaint." \textit{Baxter v. Dignity Health}, 131 Nev. 759, 764, 357 P.3d 927, 930 (2015). "A court 'may also consider unattached evidence on which the complaint necessarily relies if: (1) the complaint refers to the document; (2) the document is central to the plaintiff's claim; and (3) no party questions the authenticity of the document.'" \textit{Id.} (quoting \textit{United States v. Corinthian Colleges}, 655 F.3d 984, 999 (9th Cir.2011) (internal quotation omitted)).

\textbf{ANALYSIS}

1. **Presenting False Claims for Payment in Violation of the Nevada False Claims Act; Making False Records in Violation of the Nevada False Claims Act Nevada Revised Statutes Section 357.040(1)(B)**

Pursuant to NRS 357.040, a person is liable under the FCA if, "with or without specific intent to defraud," he or she "[k]nowingly presents or causes to be presented a false or fraudulent claim for payment or approval." NRS § 357.040(1)(a). A false or fraudulent claim includes those instances where there was fraud in the inducement. \textit{U.S. ex rel. Wilson v. Kellogg Brown & Root, Inc.}, 525 F.3d 370, 376 (4th Cir. 2008).
With regard to a FCA claim, "a person acts 'knowingly' with respect to information if he or she: (a) has knowledge of the information; (b) acts in deliberate ignorance of whether the information is true or false; or (c) acts in reckless disregard of the truth or falsity of the information." NRS 357.040(3).

(a) Plaintiffs fail to plead False Claims Act ("FCA") claims with Particularity

"A plaintiff who claims that a defendant violates Nevada's False Claims Act must plead the claim with the particularity required under Rule 9(b)." Nevada ex rel. Hager v. Countrywide Home Loans Servicing, LP, 812 F. Supp. 2d 1211, 1218–19 (D. Nev. 2011). "Rule 9(b) provides that "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake. Malice, intent, knowledge, and other conditions of a person's mind may be alleged generally." Id. (Citing Fed.R.Civ.P. 9(b))¹. "Under Rule 9(b), a plaintiff must be specific enough to give defendants notice of the particular misconduct so that they can defend against the charge and not just deny that they have done anything wrong." Id. (citing Vess v. Ciba-Geigy Corp. USA, 317 F.3d 1097, 1106 (9th Cir.2003)).

Here, the alleged false claims are based on government contracts against numerous defendants without reference to what contract applies to any of them. The Complaints do not identify which entities conducted business with which Defendants under which contracts. See Nevada ex rel. Hager v. Countrywide Home Loans Servicing, LP, 812 F. Supp. 2d 1211, 1219 (D. Nev. 2011) (holding that without identification of "which particular Defendant did what, when, where, or how" the defendants could "only deny that they did anything wrong over a five-year time span.") Unlike Rocker v. KPMG LLP, 122 Nev. 1185, 1196, 148 P.3d 703, 710 (2006), abrogated on other grounds by Buzz Stew, LLC v. City of N. Las Vegas, 124 Nev. 224, 181 P.3d 670 (2008), the facts are not "peculiarly within the defendant's knowledge." Instead of providing specifics, Plaintiffs allege they

¹ NRCP 9(b) is identical to FRCP (b).
purchased under WCSA form contracts applying "during different time periods from 2006 to the present." Nevada Complaint, ¶ 15. They further claim Defendants "entered into one or more of the form contracts with the Nevada Plaintiffs, or made sales to the Nevada Plaintiffs that were subject to the terms of one or more of the form contracts." Id. The Court finds the government entities have at least equal access to any contracts they allegedly executed that form the basis for the claims.

The Court is not suggesting that Plaintiffs needed to go so far as to specifically allege the details of each invoice submitted for payment. However, neither Complaint provides adequate notice to Defendants of the specific government entity suing them or what contract is at issue. The Court notes that Plaintiffs have had seven years since filing the initial complaint to determine and amend with these details.

(b) Plaintiffs fail to plead Defendants acted knowingly

Plaintiffs alleges "[t]he first provision – the ‘rate plan optimization’ requirement – compelled the carriers to identify, every three months and for every government user, the one rate plan among the many offered that would result in the lowest cost to the government." Relator’s Complaint, ¶ 2. "The second provision – the ‘lowest costs available’ requirement – obligated the carriers to ensure that the Government Plaintiffs received wireless services at the lowest cost available by recommending optimized rate plan assignments." Id. Plaintiffs allege these provisions required Defendants to "rightsize on a quarterly basis the rate plan selected for each wireless line purchased by a government customer." Id. at ¶ 1. Plaintiffs further allege the Defendants knew the contracts required rate plan optimization as that term is "often used in the industry" and knowingly chose to not provide those services." Id. at ¶ 3-4.

To satisfy this first element of an FCA claim, the statement or conduct alleged must represent an objective falsehood. U.S. ex rel. Wilson v. Kellogg Brown & Root, Inc., 525 F.3d 370, 376 (4th Cir. 2008). A FCA claim is not appropriate where a defendant follows a reasonable interpretation of the contract. See Hagood v. Sonoma Cty. Water Agency, 81 F.3d 1465, 1478 (9th Cir. 1996) ("As this court held in Hagood's prior appeal, "[t]o take
advantage of a disputed legal question, as may have happened here, is to be neither
deliberately ignorant nor recklessly disregardful."; see also Safeco Ins. Co. of Am. v. Burr,
551 U.S. 47, 70, 127 S.Ct. 2201, 2216, 167 L.Ed.2d 1045 (2007) ("Where, as here, the statutory
text and relevant court and agency guidance allow for more than one reasonable
interpretation, it would defy history and current thinking to treat a defendant who merely
adopts one such interpretation as a knowing or reckless violator.").

To begin, the Court does not have to accept Plaintiffs’ formulation of contract
language and may review the plain language of the contract referenced in the Complaints.
See State Dep’t of Transportation v. Eighth Judicial Dist. Court in & for Cty. of Clark, 133
Nev. 549, 554, 402 P.3d 677, 682 (2017), reh’g denied (Nov. 29, 2017) (quoting Traffic
Control Servs., Inc. v. United Rentals Nw., Inc., 120 Nev. 168, 175–76, 87 P.3d 1054, 1059
(2004) ("[N]either a court of law nor a court of equity can interpolate in a contract what
the contract does not contain."). Here, the RFPs state2 "[p]rovide quality wireless
equipment and services at the lowest cost available in a timely and efficient manner."
Opposition, Exhibit 6 at 3.1.1. The RFPs also state:

[t]he following reports shall be submitted for the respective quarter: . . . Quarterly optimization report for each wireless
service subscriber. The goal of these optimization reports is
to ensure that each subscriber is utilizing the most
appropriate plan. This includes identifying subscribers that
may be consistently incurring overage charges, and therefore
should move to a more cost effective plan or subscribers
consistently under-utilizing a plan, and therefore should
move to a lower cost plan.

Id. at 3.2.2.2.

The Court finds Plaintiff’s allegation that “rate plan optimization has a clear,
widely accepted meaning in the wireless industry,” Relator’s Complaint, ¶ 31, is not well
pled. Notably, the provision discusses the “goal” of optimization plans and does not
discuss any specifics other than the reports should identify certain subscribers. The

2 The Court notes that RFP 1907 is substantially similar to RFP 1523 regarding these terms. See Opp’n, Ex. 7
at 3.3.
Complaints note the fact Defendants each provided a different narrative response regarding how they proposed to comply with the optimization reporting. Nevada Complaint ¶ 89-97. Neither Nevada nor Defendants, whom Plaintiffs argue are, "the only game in town when it comes to wireless services," Opposition, 21: 10-11, expressed a uniform understanding of what optimization reports were. Defendants' response varied and stated the format and/or content of reports and specified whether the reports would be submitted quarterly or upon request. Id. Defendants' responses to the RFPs were admittedly incorporated into the WSCA contracts. See, e.g., Opp'n Ex. 20 at 1. Furthermore, the plain language of the optimization provision does not require Defendants take any affirmative action to unilaterally change Plaintiffs' plans without Plaintiffs' permission. Plaintiffs do not allege that any government entity reviewed optimization reports and requested something different from Defendants (or requested reports that were designated by Defendants as available upon request).

Plaintiffs' allegations also fail as a matter of law because Defendants could not knowingly provide insufficient reports when Nevada did not specify what was required. In regard to the 2006 RFP, Nevada, acting as the Lead State, was asked: "Please explain what level of detail is required for the reports referenced in Section 3.2.2.2. Also, should these reports be submitted to the Lead State and/or all the participating WSCA states." Opp'n, Ex. at 13 ¶ 48. In response, Nevada answered: "Please refer to attachment F - Quarterly Reports. Reports should be submitted to the Lead State." Id. The Parties agree Attachment F is a template for the Administrative Fee Report. See Opp'n, Exhibit 14. Therefore, at best, Nevada provided no direction regarding what details (if any) were necessary for Defendants to provide. Certainly, the Court cannot infer that either the State of Nevada or the Defendants had a clear understanding of what the RFP was asking for.

Based on the allegations in the Complaint acknowledging at least a difference in opinion regarding how the lowest cost and optimization report language should be interpreted, including what reports should contain, the Plaintiffs' can prove no set of facts establishing the "knowing" element and the claim must be dismissed.
(c) Plaintiffs fail to plead materiality

"[A] misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government's payment decision in order to be actionable under the False Claims Act." Universal Health Servs., Inc. v. United States, 136 S.Ct. 1989, 2002, 195 L.Ed.2d 348 (2016). "If government pays claim in full despite actual knowledge that certain requirements were violated, that is very strong evidence that those requirements were not material." Id. at 2003.

Here, there is no dispute the government entities continued to pay Defendants regardless of whether they received allegedly inadequate optimization reports or none at all. The Court acknowledges that continuing to pay alone would not be dispositive at the pleading stage. However, the Complaints do not allege any other facts that would support materiality. To the contrary, Plaintiffs admit that given the opportunity to explain what should be contained in the optimization reports, the State of Nevada provided no direction. See Opp'n, Ex. at 13 ¶ 48. Plaintiffs also do not allege that any government entity objected to the form of the reporting provided or requested what they now claim the optimization reports should have contained even to the present time. Plaintiffs allege Defendants could not agree to only provide certain reports upon request, but Plaintiffs do not allege a government entity raised this issue or was otherwise denied a report upon request. Each entity would have been well aware if it was receiving line-by-line rate plan recommendations or that it was not receiving what it expected in a report. Given these facts, in combination with Plaintiffs admitted payment in full, during all times material hereto, the Court cannot reasonably infer that the alleged omission was material.3

Plaintiffs' argument regarding fraud in the inducement similarly fails for the above reasons. Defendants did not conceal the fact they were only providing reports through

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3 Plaintiffs' argument regarding fraud concerns the alleged failure to provide line-by-line optimization reports. The Court notes that this is the only basis upon which they allege Defendants failed to provide the lowest cost for wireless services. Providing low cost services is obviously a material part of the deal, but not as it relates to optimization reports. Plaintiffs accept that at least part of the cost savings is lower pricing on plans. See Relator's Complaint ¶ 20.
certain platforms or upon request as stated in their RFP responses. If the type of line-by-line optimization report that Plaintiffs now claim was industry standard was a material term in the deal, then the government entities would have known within a few months whether they were getting the benefit of their bargain. Notably, the second WSCA agreement was accepted with essentially the same narrative responses from Defendants as the first regarding how they would comply with reporting. If Defendants’ fraudulently induced the State of Nevada to sign the first agreement based on a material misrepresentation, then why would Nevada accept another agreement on the same terms knowing – from experience – how Defendants planned to perform the agreement.

The Court finds Plaintiffs’ argument that they had no other choice but to accept whatever Defendants provided unconvincing and without any legal basis. Certainly, the Court cannot be required to infer that requesting information regarding usage and rate plans from the cellular providers pursuant to the contract would risk having the phone lines of first responders turned off. See Opp’n at 20. In sum, the Court cannot reasonably infer that the optimization reports were material to Plaintiffs’ decision to pay.

2. Breach of Contract and Unjust Enrichment

The Nevada Complaint mirrors the Relator’s Complaint in that it alleges, “Defendants breached two material terms of the contracts by failing to provide Plaintiffs with recommendations for the ‘lowest cost available’ rate plans by means of sending ‘quarterly optimization reports.’” Opp’n at 2; See Nevada Complaint ¶ 2, 15. Defendants’ position is the contracts do not require each carrier to provide the lowest cost available based on a line-by-line optimization. Defendants assert that costs savings was provided through discounts off monthly service charges and other accessories and equipment.

As discussed above, the language regarding lowest cost available and optimization reports is susceptible to Defendants’ interpretation. However, to state a claim for breach of contract, the State of Nevada only needs to allege a contract existed, Defendants breached the contact, and the State suffered damages. Even so, the Court finds that the
Nevada Complaint fails to identify what entity contracted with what Defendant (the existence of a contract). The fact a WSCA master contract exists and certain Defendants contracted with certain government entities is not enough to put Defendants on notice of what entity is bringing the claims upon what contract. Similarly, the State of Nevada fails to allege what government entities are alleging unjust enrichment by what Defendant where a written contract does not exist.

3. **Claims by Relator on Behalf of Hawaii, Iowa, Montana, and New Mexico**

   Plaintiffs allege Nevada has specific jurisdiction over Hawaii, Iowa, Montana, and New Mexico’s ("the Other States") claims. Plaintiffs further allege that Defendants consented to jurisdiction pursuant to a forum selection clause. "[S]pecific jurisdiction is proper only where the cause of action arises from the defendant's contacts with the forum." *Dogra v. Liles*, 129 Nev. 932, 937, 314 P.3d 952, 955 (2013). *Id.* "Nevada may exercise specific jurisdiction over a nonresident defendant if the defendant 'purposefully avails' himself or herself of the protections of Nevada's laws, or purposefully directs her conduct towards Nevada, and the plaintiff's claim actually arises from that purposeful conduct." *Id.*

   Here, Plaintiffs state that the WCSA contracts "allow multiple government customers to purchase under the same contract terms and conditions." Opp'n at 3; Relator's Complaint ¶ 18. "The non-Nevada States then executed Participating Addenda ("PAs"), which allowed both state agencies and political subdivisions to purchase wireless services . . . ." Opposition, 4: 18-20; see also Relator's complaint ¶ 35, 68-72. Plaintiffs acknowledge that the non-Nevada states could modify or add additional terms. For example, "Hawaii and AT&T agreed to certain additional terms and conditions, but none of those modified the optimization and lowest cost terms." Relator's Complaint ¶ 69.

   The Court finds the FCA claims at issue concern Defendants' contacts with government entities in the Other States. The Court notes that it is alleged that Defendants presented false claims for payment in these respective states. Thus, the claims alleged on behalf of the Other States arise from out-of-state contact for purported injuries of out-of-
state plaintiffs. Nevada did not review payment requests submitted to the Other States and was not a party to the Participating Addendums.

Nevada does not have a strong public interest in enforcing the Participating Addendums or policing Defendants’ alleged actions simply because they include the terms of the Master Contracts. Notably, the WSCA I contract states, “[v]enue for any claim, dispute or action concerning an order placed against the Contract or the effect of a Participating Addendum shall be in the Participating Entity’s State.” Opp’n, Ex. 17 at 44.2. To the extent the WSCA I contract is at issue regarding the Defendants, the Court finds that the non-Nevada States’ FCA claims arise from the Participating Addenda.

Based on the above reasoning, the Court finds Nevada lacks personal jurisdiction over Defendants for these claims. In addition to dismissing the claims based on a lack of personal jurisdiction, the Court finds that Nevada is an inconvenient forum for the claims. The Other States are the more appropriate venue to apply their own false claims act statutes and related law, and witnesses with knowledge of the Other States’ claims would be located in those states. Because the Court finds that Plaintiffs’ lack personal jurisdiction over Defendants and Nevada is an inconvenient forum, it is unnecessary to address the public disclosure arguments, which would also be more appropriately addressed in the Other States’ courts.

4. **Leave to Amend Complaint**

If the Court finds the complaint does not satisfy the required pleading standard, Plaintiffs argue they should be allowed to amend the complaint to “include the abundant evidence of fraud unearthed in the California Action.” Opp’n at 2.

After granting a motion to dismiss, the Court must decide whether to grant leave to amend. The court should “freely give” leave to amend when there is no “undue delay, bad faith or dilatory motive on the part of the movant ... undue prejudice to the opposing party by virtue of allowance of the amendment, [or] futility of amendment.” Nevada ex rel. Hager v. Countrywide Home Loans Servicing, LP, 812 F. Supp. 2d 1211, 1215 (D. Nev. 2011) (citing Fed.R.Civ.P. 15(a)(2); Foman v. Davis, 371 U.S. 178, 182, 83 S.Ct. 227, 230, 9
Generally, leave to amend is only denied when it is clear that the deficiencies of the complaint cannot be cured by amendment. Id.

Here, the Court finds that amendment regarding Plaintiffs’ FCA claim is futile. As explained above, Plaintiffs can prove no set of facts that Defendants knowingly presented false claims. Further allegations regarding Plaintiffs’ interpretation of the contractual provisions do not create an objective falsity. Plaintiffs’ vague assertion that fraud exists in a related California case is also insufficient to justify allowing leave to amend in this case. Furthermore, the Court denies the request for leave to amend because Plaintiffs had seven years to determine if additional or more specific facts supporting their fraud claims existed.

Amendment regarding the Other States’ claims is also denied. Additional allegations regarding Defendants’ contact with Nevada during the negotiation of the WSCA agreements would not affect the Court’s reasoning regarding jurisdiction over the Other States’ FCA claims. The Court also notes that additional allegations would not change that Nevada is an inconvenient forum to hear the Other States’ claims.

If the State of Nevada wishes to pursue a breach of contract claim, it must amend the complaint to identify what government entity is suing what Defendant on what contract.

CONCLUSION

Accepting all allegations in the complaint as true and drawing all reasonable inferences in favor of the non-moving party, the Court GRANTS Defendants’ Motion to Dismiss. The Relator’s Complaint is DISMISSED WITH PREJUDICE. The Nevada Complaint is DISMISSED WITH LEAVE TO AMEND regarding the Breach of Contract and Unjust Enrichment claims only.

IT IS SO ORDERED.

Dated: October 10, 2019.

[Signature]
District Judge
FINAL RULING ON DEMURRERS

The Court issued tentative rulings in this matter and held oral argument on Friday, September 9, 2016. Counsel for all parties appeared. Wayne T. Lamprey and Anne Hayes Hartman of Constantine Cannon LLP appeared on behalf of Plaintiffs. Ashley W. Hardin and William P. Ashworth of Williams & Connolly LLP appeared on behalf of Sprint Solutions, Inc., Nextel of California, Inc., d/b/a Sprint Nextel and Nextel Communications; Steve Y. Koh of Perkins Coie LLP appeared on behalf of T-Mobile USA; Mathew S. Rosengart of Greenberg Traurig, LLP, and W. Scott Cameron, John Richter and Stephen Goff of King & Spalding LLP appeared on behalf of New Cingular Wireless National Accounts, LLC, d/b/a Cingular Wireless n/k/a AT & T Mobility National Accounts.

Defendants addressed the Court’s tentative ruling on Demurrer #1 (Public Disclosure Bar and Original Source) and 3 (Pleading Deficiencies). The Court then took the matter under submission.

Having considered the pleadings, oral arguments and additional materials submitted by the parties, the Court now confirms its tentative rulings and adds the following to the final ruling below:

With respect to Demurrer #1 (Public Disclosure Bar and Original Source), the following shall be incorporated as part of the Court’s final ruling.

At oral argument Defendants provided the Court with highlighted copies of several state and federal cases, and the recently decided Northern District trial court decision in Knudsen v. Sprint Comm. Co. et al., No. 13-CV-04476 (N.D. Cal. Sept 1, 2016). Plaintiff also advised the Court of the Knudsen decision by letter and email. Both parties provided the court with a copy of the decision.

The highlighted cases, United States ex rel. Springfield Terminal Railway Co., v. Quinn, 14 F.3d 645 (D.C. Cir. 1994), State of California ex rel. Grayson v. Pacific Bell Telephone Co., et al., (2006) 142 Cal. App. 4th 741, United States ex rel., Mateski v. Raytheon Co., 816 F.3d 565 (9th Cir. 2016), U.S. ex rel. Myron Winkelman and Stephani Martinsen v. CVS Caremark Corporation et al., 2016 WL3568145 (1st Cir. 2016), address the public disclosure bar. They all articulate the same rule of law that needs be applied. Each decision is, however, appropriately based on the specific allegations of the complaint before the court.
In the present case it is necessary to look closely at the May 11, 2011 letter and report entitled “Audit of Citywide Cell Phone Usage” in order to correctly apply the rule of law. As discussed below, and as augmented here, the substance of the report and letter is to point out that there is lack of citywide oversight or management of phone cell contracts. “Simply put, nobody is minding the store. Nobody is holding departments accountable nor is anyone providing guidance on the $4.8 million worth of cell phone contracts.” (May 11, 2011 letter, para. 3.) The letter continues: “The audit also found that departments inadequately monitored usage, leading to poor plan selection and unnecessary costs of over $28,000 in extra charges for directory assistance and the like, within only a 3 month period. Without close monitoring, these extra changes could amount to over $100,000 in a year.” It continues: “Further, without centralized oversight of cell phone contracts and individual departments failing to ensure that cell phone carriers complied with requirements to “optimize” the plans to fit the departments’ usage, the City regular paid more for cell phones than necessary....The audit brought to light that current policies for issuing cell phones to city employees are not appropriate for today’s workforce and recommends that ITA determine more cost effective options....Issuing stipends rather than cell phones to most employees who are required to be available by mobile device could save the city $1.2 million immediately...” (May 11, 2011 letter)

Throughout the letter and the report itself there is not even a whiff of fraud, let alone a direct allegation of fraud or a misrepresented state of facts and or a true state of facts so that the listener or reader may infer fraud. There is no mention of intentional misleading statements by carriers in entering into contracts, no allegations that for some of all of the carriers, at the time they entered into the contracts they knowingly lacked the resources or ability to provide optimization on the scale represented. Thus, the court can find no basis under all of the cases provided by Defendants to support their demurrer based on the Los Angeles Audit.

The Court also rejects the oral representation by Defense counsel that Plaintiff OntheGo Wireless has “admitted” or “conceded” it is not an original source. This issue was not addressed by the court or counsel as Plaintiffs, in their papers, and the Court, in its tentative, was not required to address the issue for the reasons stated below.

The Court affirms its tentative ruling overruling Defendants Demurrer #2 (Plain Language of the Contracts). No oral argument was presented on this subject.

The Court affirms its tentative ruling with respect to the Demurrer #3 (Pleading Deficiencies) and the following shall be incorporated as part of the Court’s final ruling.

First, the Court makes clear that its ruling on this third demurrer denies Defendants pleading challenges to all causes of action.

Defendants’ Third Demurrer presents a general challenge to the SAC based on Plaintiffs’ alleged failure to adequately plead the various elements of the causes of action stated against them. Defendants argue that they need to know which Plaintiff alleges each of the theories against them, and under which contract or contracts. Much of Defendants complaints are similar to that in Committee on Children’s Television, Inc. v. General Foods Corp., (1983) 35 Cal. 3d 197, i.e., a lack of specificity or notice that would make more clear the allegations.
Plaintiffs have alleged that each of them have entered in the necessary agreements or contracts identified in the SAC with one or more of the Defendants. As stated in *Committee on Children's Television, Inc., v. General Foods Corp.*, (1983) 35 Cal. 3d 197, 213, "It is not the ordinary function of a demurrer to test the truth of the plaintiff's allegations or the accuracy with which he describes the defendant's conduct. A demurrer tests only the legal sufficiency of the pleading. (Whitcombe v. County of Yolo (1977) 73 Cal.App.3d 698, 702 [141 Cal.Rptr. 189].) It "admits the truth of all material factual allegations in the complaint . . .; the question of plaintiff's ability to prove these allegations, or the possible difficulty in making such proof does not concern the reviewing court." *(Alcorn v. Anbro Engineering, Inc. (1970) 2 Cal.3d 493, 496 [86 Cal.Rptr. 88, 468 P.2d 216].)*"

The same case later states that the specificity pleading requirements of fraud serve two purposes: notice to the defendant to "furnish the defendant with certain definite charges which can be intelligently met and enough specificity to allow a court to "weed out" non-meritorious actions" on the basis of the pleadings. It adds that less specificity is required when "it appears from the nature of the allegations that the defendant must necessarily possess full information concerning the facts of the controversy..." *(Committee on Children's Television, Inc., v. General Foods Corp., (1983) 35 Cal. 3d 197, 216-217.)* It continues that the truth, or lack of the truth of the allegations, (which in the instant case before the undersigned means that all of the Plaintiffs were under contract with one or all or any of the defendants, and thus can complain of the allegations stated in the SAC) must wait until trial.

A review of the SAC reveals that Defendants have been sufficiently appraised of the issues that each must meet under all the theories presented, and, as discussed below, further specifics can await discovery. The same is true for the breach of contract, unjust enrichment and unfair business practices causes of action.

Finally, the Court has made some editorial changes, eliminated some duplicative language and corrected errors in punctuation, etc., in its Tentative Ruling.

**FINAL RULING ON DEFENDANTS DEMURRERS TO THE SECOND AMENDED COMPLAINT**

Defendants New Cingular Wireless National Accounts, LLC d/b/a Cingular Wireless, n/k/a AT&T Mobility National Accounts) (“AT&T”); Sprint Solutions, Inc. (“Sprint”); Nextel of California, Inc., d/b/a Sprint Nextel and Nextel Communications) (“Sprint”); Cellco Partnership d/b/a Verizon Wireless) (“Verizon”); and T-Mobile USA (“T-Mobile”) have filed three separate demurrers to Plaintiffs’ Second Amended Complaint (“SAC”) filed May 6, 2016, in which all Defendants have joined.

The current identified false claims intervening Plaintiffs include over 40 political subdivision government local entities, the Regents of the University of California, the Board of Trustees of California State University, and relator OnTheGo Wireless, LLC, who is described as
a “wireless industry insider” that provided rate plan optimization for Verizon and its largest commercial customers for many years. Exhibit A to the SAC also identifies those who have chosen not to intervene to date.

Plaintiffs and Defendants have requested judicial notice of various documents in support of, and in opposition to, the motions. Both cite to the same statutes in support of their requests.

REQUESTS FOR JUDICIAL NOTICE

Under Evidence Code § 452, the Court may take judicial notice of decisional, constitutional, and statutory law of any state and the resolutions and private acts of Congress of the United States and of the Legislature of this state; regulations and legislative enactments issued by or under the authority of the United States or any public entity in the United States; official acts of the legislative, executive and judicial departments of the United States and of any state of the United States; records of any court of this state or any court of record of the United States or of any state of the United States, and facts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy. Evidence Code § 452 requires the court to take judicial notice of any of these matters if a party requests it and that party gives each adverse party sufficient notice of the request to enable the opposing party to “prepare and meet” the request, and also furnishes the court with sufficient information to enable the court to take judicial notice.

As both parties note, a court may grant a request for judicial notice, but only as to the existence of the cited document, not as to the truth of content. (See, e.g., Professional Engineers v. Cal. Dept. of Transp. (1997) 15 Cal.4th 534, 549; Bach v. McNelis (1989) 207 Cal.App.3d 852, 865; “A court may take judicial notice of the existence of each document in a court file, but can only take judicial notice of the truth of facts asserted in documents such as orders, findings of fact and conclusions of law, and judgments.”) A court may, however, examine the contents of a document for which judicial notice is requested “where there is not or cannot be a factual dispute concerning that which is sought to be judicially noticed.” (Fremont Indemnity Co. v. Fremont General Corp. (2007) 148 Cal.App.4th 97, 114; see Cruz v. County of Los Angeles (1985) 173 Cal.App.3d 1131, 1134.)

In support of Demurrer No. 1, Defendants have submitted extensive factual material with their motion. Among the materials are an Audit Report from the City of Los Angeles Controller’s Office discussing the City’s overspending on cell phones for its employees, various newspaper articles related to same, a State of California Wireless Savings Report from third-party Validas, and other newspaper articles relating to the State’s efforts to cut cell phone charges. Whether these materials are truly and properly the subject of judicial notice upon demurrer is dependent upon the purposes for which they are offered, but may be considered by the Court if they relate to Defendants’ challenge to the Court’s jurisdiction over the claims at issue.

As stated in Unruh-Haxton v. Regents of Univ. of California (2008) 162 Cal.App.4th 343, 365-367: “... ‘In ruling on a demurrer, a court may consider facts of which it has taken judicial
notice. (...) § 430.30, subd. (a.) This includes the existence of a document. When judicial notice is taken of a document, however, the truthfulness and proper interpretation of the document are disputable. [Citation.]' [Citation.]” (Fremont General Corp. (2007) 148 Cal.App.4th 97, 113.) Moreover, "Taking judicial notice of a document is not the same as accepting the truth of its contents or accepting a particular interpretation of its meaning. [Citation.] On a demurrer a court's function is limited to testing the legal sufficiency of the complaint. [Citation.] "A demurrer is simply not the appropriate procedure for determining the truth of disputed facts." [Citation.] The hearing on demurrer may not be turned into a contested evidentiary hearing through the guise of having the court take judicial notice of documents whose truthfulness or proper interpretation are disputable. [Citation.] ... "[Judicial notice of matters upon demurrer will be dispositive only in those instances where there is not or cannot be a factual dispute concerning that which is sought to be judicially noticed." [Citation.]” (Id. at pp. 113–114.)

Defendants argue, as discussed below, that the public disclosure bar they raise in Demurrer no. 1 and contained in the California False Claims Act ("CFCA") is jurisdictional and therefore requires the Court to consider factual material outside the complaint to resolve the dispute.

While the Court concludes that there may be factual issues related to the content of the newspaper article, the Court also notes that Plaintiffs do not oppose judicial notice of these same articles. Accordingly, for the limited purpose on demurrer only, the Court grants the Defendants Request for Judicial Notice in support of Demurrer No. 1.

Defendants' Request for Judicial Notice in support of Demurrer No. 2 seeks judicial notice of the various contracts and agreements at issue in this case (i.e., the CWC, WSCA I and II, and the California Request for Offer, all discussed in greater detail below). It is appropriate to take judicial notice of the fact and legal effect of the governmental contracts and agreements even where they are outside the four corners of the complaint where there is no reasonable factual dispute regarding the stated content of the agreements. (Performance Plastering v. Richmond American Homes of California (2007) 153 Cal.App.4th 659, 666, fn. 2; see also Joslin v. H.A.S. Ins. Brokerage (1986) 184 Cal.App.3d 369, 375.) Here, while Plaintiffs object to Defendants' Request, they object on the grounds that Defendants omitted one of the exhibits to the WSCA, which Plaintiffs contend means that the Court lacks sufficient information to properly consider the request as a whole. Defendants reject this argument, stating that the omission was inadvertent and, in any event, was not something upon which their arguments rely.

While Plaintiffs initially object on the basis that Defendants' omission deprives the court of sufficient information to properly take judicial notice, they provide additional documents, including a document which they assert was left out by Defendants. Between the two separate requests for judicial notice, the Court has sufficient information to enable it to take judicial notice of the contracts and, in the interests of judicial economy and efficiency, does so for the limited purposes of the relevant arguments in the demurrers. Plaintiffs' submission of the same contracts indicates that while there may be differences in the parties' interpretations of the contract, there is no dispute that the contracts and related documents exist and that they are authentic.
For the foregoing reasons, the Court grants the requests for judicial notice by Defendants and Plaintiffs in support of the demurrer and opposition thereto, respectively.

FACTUAL ALLEGATIONS

Plaintiffs in this action are California government entities that purchased wireless services from Defendants pursuant to certain contracts, described below. SAC ¶ 6. These entities include the State of California, its agencies and political subdivisions. SAC ¶ 7. The "whistleblower" Relator/Plaintiff, OnTheGo Wireless LLC, has pursued claims on behalf of the governmental entities under the California False Claims Act (CFCA), as well as other theories. SAC ¶ 6. At one time, Relator was a third-party contractor for Defendant Verizon whose services to Verizon allegedly included optimization reports of the type at issue in this case. SAC ¶ 128. Verizon ultimately discontinued its relationship with Relator. Id.

From approximately 2005 to the present, California state agencies and various political subdivisions – which include cities, counties, and school and municipal districts – have obtained wireless cellular telephone services from the Defendants in this action subject to certain cooperative purchasing agreements. SAC ¶ 13. Cooperative purchasing contracts generally produce lower prices for government purchasers because their size gives the government purchasers significant market power, by which they can secure better pricing and terms. SAC ¶ 17.

The contracts at issue in this case include the California Wireless Contract (CWC) and two versions of the Western States Contracting Alliance (WSCA I and WSCA II).

The cooperative purchasing agreements are intended to reduce the costs of the provision of cell phone usage to the employees of the public entities who are issued the phones. See SAC ¶ 21. Similar to the single purchaser in the private sector, each Defendant has various “rate plans” from which to choose for voice, text and data plans. See id. These plans regularly change in both features and cost and therefore selecting the optimal rate plan is challenging. Id. In addition, the “best” rate plan may change over time based on customer usage. Id. As a means of achieving the most cost-effective rate plan for customers, carriers often utilize “optimization,” a process by which the carriers evaluate, among other factors, the minutes used by the customer during the billing period, the time of day the calls were made, whether the calls were to in- or out-of-network parties, the amount of data used and the number of text messages sent and received in combination with the rate plans available. SAC ¶¶ 22-24.

The California Wireless Contract or “CWC” contract took effect in 2005 when California’s Department of General Services issued a “Request for Proposals” from wireless carriers to provide service to California public entities. SAC ¶ 30. The CWC included a provision requiring Verizon and Sprint to prepare and deliver rate plan optimization analyses each quarter to every California state agency customer. SAC ¶ 32. Part of the RFP (Section 5.11 of the eRFP entitled “Agency Reporting Requirements”) provided that the selected carrier “must provide a quarterly optimization report for each wireless service subscriber.” SAC ¶ 33. This requirement was deemed mandatory and required agreement and a Letter of Acceptance. SAC ¶¶ 36-42. Defendants Verizon and Sprint were selected to provide services. SAC ¶ 30. The RFP
was incorporated into the resulting contracts. SAC ¶¶ 35, 43. All state agencies desiring to purchase wireless services at that time were required to use the CWC absent special circumstances. SAC ¶ 31. The original CWC was extended multiple times past its original two-year term until it expired in October 2010. SAC ¶ 45. Following expiration of the CWC, California began using the WSCA I to purchase its wireless services. SAC ¶ 46. The persons agreeing to the terms are identified in the SAC in paragraphs 42-45.

The Western States Contract Agreement or “WSCA I” commenced approximately October 2006, while the WSCA II, a later version, became available April 2012. SAC ¶ 47. Relevant portions of the WSCA I’s RFP, which later became incorporated into WSCA I, provided as a “mandatory requirement” that quarterly optimization reports must be submitted for each wireless service subscriber. SAC ¶ 60. Representatives from each carrier Defendant agreed to comply with the terms of the RFP. SAC ¶¶ 62-65, 67. Nevada was the lead agency and entered into a Nevada standard form “contract for Services on Independent Contractor” which expressly incorporated the underlying request for proposal, the carriers’ responses to the RFP, and any additional terms agreed upon in writing. Thereafter, states seeking to use the WSCA entered into “Participating Addenda” or PAs, which incorporated the terms of the Nevada contracts and enabled state agencies, and participating political subdivisions, to procure services under the terms of the WSCA contracts. SAC ¶¶48-49. The carriers had to execute a Certification of Compliance with Terms and Conditions of RFP. SAC ¶54. The RFP contained language to the effect that each vendor or carrier understood that representations were to be considered “material” and “important.” SAC ¶57. This included requirements for quarterly optimization reports. SAC ¶60.

The WSCA II also required a certification, and references material requirements and quarterly optimization reports through its RFP. SAC ¶¶ 70-72. The contracts executed with all Defendants expressly incorporated the RFP. SAC ¶¶ 75-76. Defendants’ respective authorized representatives again agreed to the terms of the incorporated RFP. SAC ¶¶78-81.

In SAC ¶75, Plaintiffs identify, per the agreements, which documents form the basis of the total contracts and their order of constructive precedence as to each carrier.

Both WSCA I and II, which were originally negotiated by the State of Nevada, require any state desiring to participate in the contract to execute a “Participating Addendum” (PA) with each carrier from which the state wants to obtain wireless services. SAC ¶ 82. California entered into PAs under WSCA I with AT&T in 2006 and with the remaining Defendant carriers in 2010. SAC ¶ 83. California entered new PAs with each Defendant when WSCA II replaced WSCA I. Id. California’s PAs defined authorized purchasers as all state agencies and political subdivisions. Political subdivisions were defined as cities, counties, districts, other local government bodies or corporations, the CSU and UC systems, K-12 school districts and community colleges. SAC ¶ 84. The PAs incorporated the terms of the WSCA contracts, including the optimization requirements. Id.

In November 2010, California issued a “Request for Offer” (RFO) to the wireless carriers who had WSCA contracts so that California-specific terms could be negotiated with the carriers for inclusion in the PAs and amended PAs under WSCA I. SAC ¶ 85. Included among the RFO
requirements was a mandate for quarterly optimization reporting to the contracting public entities, and specifically each wireless service subscriber, which the carriers accepted. See SAC ¶¶ 87-93.

By approximately 2011, there were about 200,000 state and local California government-paid wireless lines under service as a result of the contracts. SAC ¶ 96. A number of political subdivisions entered into their own PAs with the defendants, who allowed them to incorporate their own terms, but did not relieve the defendants from their obligations to provide quarterly rate plan optimization reports and services at the “lowest cost available.” SAC ¶ 94.

Plaintiffs allege that, despite the requirements of the various applicable contracts, PAs and RFOs, Defendants consistently failed to identify the lowest-cost rate plans in billing the governmental entities for wireless services. SAC ¶ 98. More specifically, Plaintiffs allege that Defendants failed to provide quarterly optimization reports for their California governmental clients, despite promising to do so in the context of the contracts, PAs and RFO. SAC ¶ 100. Plaintiffs allege that while Defendants “sporadically” prepared reports related to rate plan selections, the reports were often prepared in response to governmental client request and that in neither substance nor frequency did they amount to the optimization reports that the contracts required. SAC ¶ 103; see SAC ¶¶ 104-118.

According to Plaintiffs, Defendants’ failure to consistently provide the requested optimization reports was an intentional “fail[ure] to ... fulfill[ ] the ‘contracts’ requirements” (SAC ¶ 120), including statements that were “false and materially misleading, ... contain[ing] deceptive half-truths” because the Defendants “did not then have the ability to comply and had not secured the resources or developed a viable plan to provide the optimization reports” (SAC ¶ 121).

With respect to Verizon, Plaintiffs alleged that “a Verizon employee told OnTheGo that senior Verizon executives refused to fund the optimization work and decided not to prepare optimization reports as the contract required.” SAC ¶ 128 Sprint allegedly didn’t have the capacity at the time to represent that it could comply. SAC ¶ 131. As to T-Mobile, Plaintiffs allege it did not have in place the ability or capacity to provide the required reports when it stated it did. SAC ¶ 131. It appears that T-Mobile may have agreed to provide the reports on a macro level, and on an individual level when requested, according to the SAC, but this was contrary to what they otherwise agreed to. SAC ¶ 132.

As a result of Defendants’ alleged failure to provide the quarterly optimization reports required by the various applicable contracts and agreements, Plaintiffs allege that Defendants ultimately overcharged the governmental Plaintiffs “hundreds of millions of dollars.” (SAC 39:8)

As a result of the foregoing, Plaintiffs and Relator allege claims under various provisions of the California False Claims Act (CFCA) (Govt. Code §12651), for unfair business practices (Bus. & Prof. Code § 17200 et seq.), breach of contract, and unjust enrichment.
LEGAL STANDARD ON DEMURRER

A demurrer challenges the legal sufficiency of the complaint on the ground it fails to state facts sufficient to constitute a cause of action. (CCP § 430.10(e); Rakestraw v. California Physicians’ Service (2000) 81 Cal.App.4th 39, 42–43.) In reviewing a general demurrer, the facts pleaded are assumed to be true and the only issue is whether they are legally sufficient to state a cause of action. (Rope v. Auto-Chlor System of Wash., Inc. (2013) 220 Cal.App.4th 635; Blank v. Kirwan (1985) 39 Cal.3d 311, 318; “[W]e are guided by long-settled rules. ‘We treat the demurrer as admitting all material facts properly pleaded, but not contentions, deductions or conclusions of fact or law. We also consider matters which may be judicially noticed.’ Further, we give the complaint a reasonable interpretation, reading it as a whole and its parts in their context.”) (citations omitted.)

DISCUSSION and RULINGS

Plaintiffs’ First and Third demurrers are based in part on the construction and requirements of the California False Claims Act (Govt. Code §§12650 et seq.) (CFCA). The CFCA authorizes private parties with knowledge of past or present fraud on the State to sue on the government’s behalf to recover civil penalties and damages. It is often common to see recited in cases discussing the CFCA the following language:

“The Legislature designed the CFCA “‘to prevent fraud on the public treasury,’” and it “should be given the broadest possible construction consistent with that purpose. In other words, the CFCA must be construed broadly so as to give the widest possible coverage and effect to the prohibitions and remedies it provides. The CFCA is intended to supplement governmental efforts to identify and prosecute fraudulent claims made against state and local governmental entities. (San Francisco Unified School Dist. ex rel. Contreras v. First Student, Inc. (2014) 224 Cal.App.4th 627, 638 (Contreras II).) Due to the close similarity of the CFCA to the federal False Claims Act, “it is appropriate to turn to federal cases for guidance in interpreting the CFCA.” (City of Pomona v. Superior Court (2001) 89 Cal.App.4th 793, 802; see State of California v. Altus Finance (2005) 36 Cal.4th 1284, 1299 (“the CFCA is patterned on similar federal legislation and it is appropriate to look to precedent construing the equivalent federal [FCA]”).

A. First Demurrer: Public Disclosure Bar and Original Source

1. Public Disclosure Bar

The CFCA requires courts to dismiss false claims suits based on information already disclosed publicly unless the relator is an “original source” of the information. (See Cal. Govt. Code § 12652(d)(3)(A).)

The CFCA’s public disclosure bar requires that courts dismiss a false claims act action, unless opposed by the Attorney General or prosecuting authority of a political subdivision, if “substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed” in either a “criminal, civil, or administrative hearing in which the state or prosecuting
authority of a political subdivision or their agents are a party” (Govt. Code § 12652(d)(3)(A)(i)); a “report, hearing, audit, or investigation of the Legislature, the state or governing body of a political subdivision” (Govt. Code § 12652(d)(3)(A)(ii)); or the news media (Govt. Code § 12652(d)(3)(A)(iii)), or the person is an “original source.” The “substance of the [public] disclosure need not contain an explicit ‘allegation’ of fraud . . . so long as the material elements of the allegedly fraudulent ‘transaction’ are disclosed in the public domain.” (A-1 Ambulance Serv. Inc. v. California (9th Cir. 2000) 202 F.3d 1238, 1243 (interpreting similar provisions of the federal False Claims Act (31 U.S. C. § 3730)). The bar applies “when the prior public disclosures are ‘sufficient to place the government on notice of the alleged fraud’ or practice prior to the filing of the qui tam action.” (State ex rel. Grayson v. Pac. Bell. Tel. Co. (2006) 142 Cal.App.4th 741, 748.) The purpose of the public disclosure bar is to eliminate parasitic suits by persons who merely echo allegations already in the public domain and play no role in exposing the fraud in the first instance. (See People ex rel. Allstate Ins. Co. v. Weitzman (2003) 107 Cal.App.4th 534, 564.) The Act is to be construed broadly “so as to give the widest possible coverage and effect to its prohibitions and remedies.” (Southern Cal. Rapid Transit Dist. v. Superior Court (1994) 30 Cal.App.4th 713, 724.) Thus, the public disclosure bar “should be applied only as necessary to preclude parasitic or opportunistic actions, but not so broadly as to undermine the Legislature’s intent that relators assist in the prevention, identification, investigation and prosecution of false claims.” (City of Hawthorne ex rel. Wohner v. H&C Disposal Co. (2003) 109 Cal.App.4th 1666, 1683.) Dismissal under the Act is warranted “whenever a plaintiff files a qui tam complaint containing allegations or describing transactions substantially similar to those already in the public domain so that the publicly available information is already sufficient to place the government on notice of the alleged fraud.” (Grayson, supra, at 748.)

Defendants point to various articles published as a result of various audits of expenses, including public employee cell phone use at certain governmental entities. The first collective set of documents pertains to a 2011 audit conducted by the City of Los Angeles. The City, which largely delegated stewardship of cell phone issuance, plans and accounts to its department managers, was found to have unnecessarily spent over $1 million on cell phones. In the audit report itself the Los Angeles City Controller makes several conclusions and recommendations: the justification for issuing cell phones to so many employees was lacking; the department managers failed to select the most cost-effective plans and lacked any sort of consistent approach to identify cell phone contracts that were the best value; employees who were issued cell phones incurred unnecessary costs (e.g., call forwarding, directory assistance, etc.); departments were not prohibiting or seeking reimbursement from employees for their personal calls; there was a lack of central oversight regarding the cell phone contracts; and, that “not all departments ensure carriers comply with the optimization contract provision.” Defs. RJN No. 1, Exh. A (Audit at pp. 38-40). Of these conclusions and recommendations, only the last pertaining to optimization has any potential bearing on this litigation.

The Court has reviewed all the documents pertaining to the Los Angeles Audit. At most, the Audit Report states:
The city’s contracts with Verizon, Sprint and AT&T contain an optimization provision which requires the carrier, after the initial plan assignment, to routinely identify those users that are not in the most optimized plan and work with the City Department Telephone coordinators to place users in the most optimized plan.

However, we noted that none of the carriers routinely provided optimization reports to all of departments [sic] reviewed. Only four departments (GSD, ITA, LAPD and DBS) indicated they received the optimization reports, and even then, only one or two times per year. DBS indicated reports were received from AT&T quarterly, but this frequency seems to be the result of the Department requesting to meet with the carrier’s representative to achieve cost savings.

The optimization reports are a critical tool for departments to use to save on cell phone costs. GSD, ITA, LAPD and DBS provided copies of four optimization reports received from July 2009 through December 2010. The carriers identified projected savings ranging from 7.89% to 21% if the suggested plan changes were implemented. [¶] Only DBS confirmed that the carrier’s suggestions were fully implemented.

Without a centralized function for analyzing phone plans and contracts, along with strong contract oversight, the City cannot be assured that the carriers fully comply with optimization provisions and departments take action to ensure cell phone costs are minimized.

(Defs. RJN No. 1, Exh. A, Audit Report at pp. 36-37.)

The Court concludes that the Audit Report cannot represent a public disclosure sufficient to constitute a bar to the prosecution of the False Claims Act causes of action in this case. The Audit Report, being an audit, investigation or report commissioned by government, certainly qualifies as a “public disclosure” of the type included in Government § 12962; however, that fact alone does not immediately mandate a bar to the prosecution of this case. Rather, the Court also must review the content of that report and whether the Audit Report sufficiently discloses the very facts that are the subject of the allegations of this lawsuit. (See Mao’s Kitchen, Inc. v. Mundy (2012) 209 Cal.App.4th 132, 147.) The Court’s review process in this regard is guided by the analysis contained in Mao’s Kitchen, supra, in which the appellate court adopted the public disclosure standard contained in U.S. ex rel. Springfield Terminal Railway v. Quinn (D.C. Cir. 1994) 14 F.3d 645. In Springfield, the Court stated:

[I]f X + Y = Z, Z represents the allegation of fraud and X and Y represent its essential elements. In order to disclose the fraudulent transaction publicly, the combination of X and Y must be revealed, from which readers or listeners may infer Z, i.e., the conclusion that fraud has been committed. The language employed in [the False Claims Act] suggests that ... qui tam actions [are prohibited] only when either the allegation of fraud or the critical elements of the fraudulent transaction themselves were in the public domain....
In terms of the mathematical illustration, when X by itself is in the public domain, and its presence is essential but not sufficient to suggest fraud, the public fisc only suffers when the whistle-blower’s suit is banned. When X and Y surface publicly, or when Z is broadcast, however, there is little need for qui tam actions, which would tend to be suits that the government presumably has chosen not to pursue or which might decrease the government’s recovery in suits it has chosen to pursue.

_U.S. ex rel. Springfield Terminal Railway_, 14 F.3d at 654.

Here, while the Audit Report mentions optimization reports, and notes that certain carriers failed to consistently provide the optimization reports to all city departments, that is all it alleges.

The May 11, 2011 letter and report entitled “Audit of Citywide Cell Phone Usage” point out that there is lack of citywide oversight or management of phone cell contracts. “Simply put, nobody is minding the store. Nobody is holding departments accountable nor is anyone providing guidance on the $4.8 million worth of cell phone contracts.” (May 11, 2011 letter, para. 3.) The letter continues: “The audit also found that departments inadequately monitored usage, leading to poor plan selection and unnecessary costs of over $28,000 in extra charges for directory assistance and the like, within only a 3 month period. Without close monitoring, these extra changes could amount to over $100,000 in a year.” It continues: “Further, without centralized oversight of cell phone contracts and individual departments failing to ensure that cell phone carriers complied with requirements to “optimize” the plans to fit the departments’ usage, the City regular paid more for cell phones than necessary….The audit brought to light that current policies for issuing cell phones to city employees are not appropriate for today’s workforce and recommends that ITA determine more cost effective options….Issuing stipends rather than cell phones to most employees who are required to be available by mobile device could save the city $1.2 million immediately…” (May 11, 2011 letter)

Throughout the letter and the report itself there is not even a whiff of fraud, let alone a direct allegation of fraud or a misrepresented state of facts and or a true state of facts so that the listener or reader may infer fraud. There is no mention of intentional misleading statements by carriers in entering into contracts, no allegations that for some of all of the carriers, at the time they entered into the contracts they knowingly lacked the resources or ability to provide optimization on the scale represented. Thus, the court can find no basis under all of the cases provided by Defendants to support their demurrer based on the Los Angeles Audit.

Likewise, the myriad newspapers articles Defendants submit that discuss the Audit Report merely note that there was a lack of centralized oversight of the City’s cell phone contracts and the individual departments failed to ensure that the cell phone carriers complied with the optimization report requirements. See RJN No. 1 at Exhs. 9, 10, 12.

There is no indication or suggestion in the Audit Report or the related media articles that the carriers’ failure to provide the optimization reports were the result of any sort of fraud, nor does the report state or imply any of the factual elements necessary to state a case of fraud under the CFCA.
In other words, while there was a public disclosure of the carriers’ failure to provide optimization reports to the City of Los Angeles (the potential “X” in the Springfield equation, supra) – and thereby potentially save the City substantial sums of money by providing the optimum rate plan – there were no other facts that would have placed the City of Los Angeles, let alone any of the dozens of public entity and agency interveners and interested non-interveners in this case, on notice of fraud, nor was there any indication that similar failures by the carriers applied to other public entities.

In sum, the information placed in the public domain by the Auditor’s Report and accompanying letter did not present so clear or substantial an indication of wrongdoing as to qualify as either an allegation of fraud (Springfield’s “Y”) or a fraudulent transaction (Springfield’s “Z”) upon which a qui tam suit could be based. Accordingly, the Auditor’s Report and letter and the related media reports cannot constitute prior public disclosures that would operate as a bar to the present lawsuit.

The other category of facts that Defendants contend constitute public disclosures under CFCA pertain to the State of California’s published audit or report regarding its own cumbersome use of employee-issued cell phones and the expenses related thereto. The State’s report, conducted by third-party wireless savings vendor Validas, reveals even less than the Audit Report issued by the City of Los Angeles. Based on the documents submitted to the Court, the State’s Validas report merely breaks down the money spent on state employee cell phone usage in calendar year 2010, both overall and by department, and contains charts noting the amount of fees, potential savings and number of lines. Missing, however, from both the report itself and the various news articles discussing it, is any discussion of optimization reports at all. Thus, under the Springfield analysis, none of the factors are present that would sufficiently create a public disclosure of the type that would serve as a bar to qui tam litigation.

At oral argument, Defendants provided the Court with highlighted copies of several state and federal cases, and the recently decided Northern District trial court decision in Knudsen v. Sprint Comm. Co. et al., No. 13-CV-04476 (N.D. Cal. Sept 1, 2016). Plaintiff also advised the Court of this federal case and decision. Both parties provided the court with a copy of the district court’s decision. The highlighted cases, United States ex rel. Springfield Terminal Railway Co., v. Quinn, 14 F.3d 645 (D.C. Cir. 1994), State of California ex rel. Grayson v. Pacific Bell Telephone Co., et al., (2006) 142 Cal. App. 4th 741, United States ex rel., Mateski v. Raytheon Co., 816 F.3d 565 (9th Cir., 2016), U.S. ex rel. Myron Winkelman and Stephani Martinsen v. CVS Caremark Corporation et al., 2016 WL3568145 (1st Cir. 2016), all address the public disclosure bar. They all express the same general rule of law that needs be applied. Each, however, base their decision on the specific allegations in the complaint before the court with respect to when the bar is, in fact, raised.

Accordingly, Defendant’s Demurrer No. 1 based on the bar of prior public disclosures is OVERRULED.

2. Original Source
Defendants also demur on the grounds that Relator was not an original source of the information provided.

The CFCA defines “original source” as “an individual who has direct and independent knowledge of the information on which the allegations are based, who voluntarily provided the information to the state or political subdivision before filing an action based on that information, and whose information provided the basis or catalyst for the investigation, hearing, audit, or report that led to the public disclosure[.]” Govt. Code § 12652(d)(3)(B).

The Court need not reach this argument, having concluded that neither the City of Los Angeles Audit Report nor the State’s wireless report constituted sufficient public disclosures to bar this lawsuit. (See United States ex rel. Hochman v. Nackman (9th Cir. 1998) 145 F.3d 1069, 1072 fn. 4; In FCA claims, the court reaches the issue of whether the relator was the original source of the information only if the court determines there was a public disclosure in the first instance.)

At oral argument the Court rejected the representation by Defense counsel that Plaintiff OntheGo Wireless “admitted” or “conceded” it is not an original source. There is no such concession in Plaintiffs papers and the Court did not consider or rule upon this issue given its ruling on the public disclosure bar. The Court therefore makes no finding on this issue.

B. Second Demurrer: Plain Language of the Contracts

Defendants’ second demurrer focuses on the language of the various contracts at issue in the case. Specifically, Defendants contend that review of the language of the contracts reveals that the contracts are simply inconsistent with Plaintiffs’ interpretation and therefore (1) warrant dismissal of all “political subdivision” Plaintiffs, as well as any (2) portion of any claim that is based on a purported obligation for Defendants to provide services at the “lowest cost available.”

To a limited extent, a court may interpret a contract at the demurrer stage. Utilizing traditional principles of contract law as the basis for analysis, the court must determine whether the contract at issue is “reasonably susceptible” to the meaning alleged in the complaint. (See Department of Forestry & Fire Protection v. Lawrence Livermore Nat’l Sec., LLC (2015) 239 Cal.App.4th 1060, 1066.) Where the contractual terms plainly differ from the allegations of the complaint, the court may review the contract at the demurrer stage. (See Marzec v. Public Employees’ Retirement Sys. (2015) 236 Cal.App.4th 889, 912.)

What defendants ask the court to do is to assume that all the necessary contracts, addenda, additional agreements, and other communications that form the basis of the contractual documents as to political subdivision plaintiffs are before the court, that there are no possible varying interpretations or further testimony that may be needed to glean the meanings and relationships of these parts, and rule in their favor at this early juncture.

Plaintiffs concede that the express terms of the CWC did not require Defendants to provide quarterly optimization reports to the political subdivisions. (See Pl. Opp. at p. 18.) Thus, the question remains whether those same Plaintiffs were entitled to quarterly optimization reports
under WSCA I or II. At the same time, the CWC clearly discusses the lowest cost available requirements.

Defendants point to various inquiries regarding the meaning or substance of various portions of the requests. Two informational questions included as part of the contracts make inquiry regarding the nature of the reports that the contract addresses and where contract-related reports should be sent. With regard to the former, the question was: “Please explain what level of detail is required for the reports referenced in Section 3.2.2.2.” Defs. RJN No. 2, Exh. 2 (Amendment 1 to WSCA, at p. 9). The State of Nevada, who was the lead state on the contract, responded: “Please refer to Attachment F – Quarterly Reports.” Id. Plaintiffs respond that, per its stated terms, Section 3.2.2.2 of the RFP pertains to four types of reports: reports of usage and purchases under the contract, quarterly optimization reports, voice and combined voice/walkie-talkie related reports, and data-related usage reports. (See Pl. Opp. at 23, fn. 16.) Defendants argue that certain of the responses to questions posed support their position that no optimization reports were required for political subdivisions. They quote this question: “[S]hould these [same] reports be submitted to the Lead and/or all the participating WSCA states.” Defs. RJN No. 2, Exh. 2 (Amendment 1 to WSCA, at p. 9). According to Defendants, the answer by the State of Nevada was that all of the foregoing reports should be submitted to the Lead State – and no others. Id.

In response, Plaintiffs argue that Defendants “fudge not only the question, but the answer too.” And that the answer provided is, at least, ambiguous as to whether it was responding regarding the quarterly optimization reports or just certain other of the documents referenced and calculations for administrative fees. Plaintiffs also point out that Defendants left out from their Request for Judicial Notice the critically important document Attachment F, which establishes this ambiguity. They argue that upon review of Exhibit F, in the context of the question posed, it appears the responding party was advising regarding the necessary components of an administrative fee wherein carriers were required to provide quarterly reports setting out the revenue they received and calculating the fee owed. (See P. RJN, Ex. 1A and 1B)

Finally, whether the optimization reports were to be submitted to the lead agency, and then passed on to the political subdivisions, or directly to the political subdivisions, or directly to individual subscribers, must await a fuller presentation of the evidence.

The documents upon demurrer are reasonably susceptible to the interpretation provided by Plaintiffs. The same is true for Defendants arguments regarding the “lowest cost available.” The documents, at this stage, are reasonably susceptible to the interpretation provided by Plaintiffs, i.e., that the “lowest cost available” was a contractual obligation and not just prefatory language. SAC ¶¶ 1,2, 13, 28-29, 39, 58-59, 71, 157.

The second demurrer is OVERRULED.
C. Third Demurrer: Pleading Deficiencies

In this third demurrer, Defendants’ challenges are as follows:

As to the first cause of action under the CFCA, Gov’t Code § 12651(a)(1) and the second cause of action under Gov’t Code § 12651(a)(2), Plaintiffs have failed to (1) allege facts demonstrating that each Plaintiff purchased wireless service under on the contracts from a specific defendant; (2) allege fraud with particularity, as they have not plead the “who, what, when, where and how” of the alleged fraud; (3) the claims are predicated entirely on alleged contract breaches that lack the “objective falsity” necessary to state a CFCA claim; and they have (4) failed to plead scienter.

As to the third claim for unfair business practices under B & Prof. Code §§ 17200 et seq., the fourth claim for breach of a written contract, and the fifth claim for unjust enrichment, Defendants contend that Plaintiffs have failed to plead facts demonstrating that each Plaintiff purchased wireless services under one of the contracts from a specific defendant.

1. Demonstration that each Plaintiff Purchased Wireless Service under a Specific Contract from a Specific Defendant

Defendants first attack the SAC on the grounds that it improperly alleges that all four Defendants perpetuated an identical fraud on all Plaintiffs (which number over 300), without regard to pleading that these same Plaintiffs ever had enforceable contracts with a particular Defendant or, in some cases, any Defendant. This is a theme they repeat throughout their remaining demurrer, although they address it from different angles.

There are no cases relating to demurrers that are on all fours with this case, including federal cases cited by Defendants.

Plaintiffs respond that Defendants ignore numerous paragraphs that detail the purchase from Defendants under the three master applicable contracts. Plaintiffs point to paragraphs alleging the existence of the CWC written between California, on the one hand, and Sprint and Verizon, on the other (SAC ¶¶ 31, 43-44, 67, 75) under which political subdivisions, including all government plaintiffs and the CSU were authorized to make purchases. With respect to WSCA I and II, the SAC alleges the existence of the master contracts and the PAs entered into between each Defendant and California, which also permitted any authorized purchaser to make purchases under the PA. Authorized purchasers are defined as “any city, county, city and county, district, or other local governmental body or corporation, including the CSU and the University of California Systems, k-12 school[s] and community colleges [,] empowered to expend public funds. And Plaintiffs also allege that the reason why there are not always separate bilateral agreements between Plaintiff and one of more of the carriers is that either they used the master agreement without modification, or entered into their own PAs with the Defendants, and all had the same quarterly rate plan optimization requirements to provide service at the lowest cost available. (SAC ¶¶15, 19, 67,75,83,84,94.)
Plaintiffs contend that the SAC therefore alleges sufficient facts regarding the existence of the master contracts that involved all Plaintiffs, the relevant portions of the master contract at issue, the fact of PAs and the RFPs and that it is sufficient to allege that each Defendant entered into at least one contract with the Government Plaintiffs that were “subject to the terms of one or more of the form contracts.” It is also clear with respect to the bases—i.e., the alleged false representations and false claims—upon which Plaintiffs seek damages from the Defendants, and each of them. (See Pl. Opp. at p. 30.)

As Defendants point out, certain contracts with certain carriers could be subject to disputes regarding individualized or additional contracts and the obligations that arose. The basis for establishing Plaintiffs' entitlement to damages in this case, if any, and specifically Defendants' liability, is the terms of the contracts by which the parties were bound.

To begin, a demurrer should not be sustained if the allegations are sufficiently clear to apprise the defendant of the issues that must be met, even if the allegations of the complaint may not be as clear and as detailed as might be desired. (Gonzales v. State of California (1977) 68 Cal.App.3d 621, 631.) A demurrer for uncertainty, vagueness or ambiguity will only be sustained where the defendant cannot reasonably determine what issues must be admitted or denied or what counts or claims are directed against them. (Khoury v. Maly's of Calif Inc., (1993) 14 Cal.App.4th 612, 616.) If a complaint contains enough facts to apprise a defendant of the issues that it is being asked to meet, uncertainty is not proper grounds for demurrer. (Williams v. Beechmut Nutrition Corp. (1986) 185 Cal.App.3d 135, 139, fn. 2.) The favored approach is to clarify theories in the complaint through discovery. (See Khoury v. Maly's of Calif., Inc. (1993) 14 Cal.App.4th 612, 616) Normally, ambiguities can be clarified under modern discovery procedures. (Khoury v. Maly's of California, Inc. (1993) 14 Cal.App.4th 612, 616.)

Defendants complaints are similar to that in Committee on Children's Television, Inc. v. General Foods Corp., (1983) 35 Cal. 3d 197, i.e., a lack of specificity or notice that would make more clear the allegations, particularly with respect to the fraud based action. However, Plaintiffs have alleged that each of them have entered in the necessary agreements or contracts identified in the SAC with one or more of the Defendants. As stated in Committee on Children's Television, Inc. v. General Foods Corp., (1983) 35 Cal. 3d 197, 213, "It is not the ordinary function of a demurrer to test the truth of the plaintiff's allegations or the accuracy with which he describes the defendant's conduct. A demurrer tests only the legal sufficiency of the pleading. (Whitcombe v. County of Yolo (1977) 73 Cal.App.3d 698, 702 [141 Cal.Rptr. 189].) It "admits the truth of all material factual allegations in the complaint . . . ; the question of plaintiff's ability to prove these allegations, or the possible difficulty in making such proof does not concern the reviewing court." (Alcorn v. Anbro Engineering, Inc. (1970) 2 Cal.3d 493, 496 [86 Cal.Rptr. 88, 468 P.2d 216].)"

It continues that the truth, or lack of the truth of the allegations, (which in the instant case before the undersigned means that all of the Plaintiffs were under contract with one or all or any of the defendants, and thus can complain of the allegations stated in the SAC) must await until trial.

The same case later states that the specificity pleading requirements of fraud serve two purposes: notice to the defendant to "furnish the defendant with certain definite charges which can be intelligently met and enough specificity to allow a court to "weed out" non-meritorious
actions" on the basis of the pleadings. It adds that less specificity is required when "it appears
from the nature of the allegations that the defendant must necessarily possess full information
concerning the facts of the controversy..." Committee on Children's Television, Inc., v. General

A review of the entire extensive complaint reveals that Defendants have been sufficiently
apprised of the issues that each must meet and, further specifics can await discovery.

With respect to the CFCA claims, Plaintiffs’ authority in support of their position that
the current pleading is acceptable is Armenta ex rel. City of Burbank v. Mueller Co. (2006) 142
Cal.App.4th 636. Armenta is a case where a manufacturer and supplier of pipes and other water
distribution parts sold its products directly to municipalities for use in municipal water systems.
The terms of the contract and the Defendant’s catalogues and sales literature represented that all
materials conformed to AWWA standards and contained a certain percentage of copper, tin, lead
and zinc. The trial court refused to grant Plaintiffs, then two cities and the relator, leave to file
an amended complaint naming 47 additional entities before providing confirming discovery into
the identity of every part each governmental entity had purchased whether that entity purchased
it directly from Defendant or a distributor, the date upon which each entity purchased each part,
the locations at which each entity had the part installed, the dates and results of any metal
composition tests, the identity of all governmental employees to whom the defendant made
presentations, what investigations the entities had conducted and when and how the entities each
discovered the false claim, among other items. The appellate court held that the trial court went
too far in conditioning amendment on foundational discovery rather than specificity of
foundational information.

Armenta also found that while the complaint at issue didn’t specify with respect to the
variably named governmental entities, the “dates upon which they contracted to purchase Jones
waterworks parts, the manner in which they received Jones’s false representation and the
invoices evidencing Jones’s false claims, it does detail this information with respect to other real
parties in interest. In addition, the second amended complaint alleges that each of the real parties
in interest purchased Jones's waterworks parts during the requisite time period either directly
from Jones or from Jones’s distributors, that Jones knowingly made the same false
representations to each of them, and that Jones filed the same variety of false claims with each of

The appellate court then concludes: “This is enough. It identifies every false
representation...every contract at issue...It also states when..., where.....and how....Jones made
the false statements to the governmental entities.” (Id. at 655.)

Armenta had multiple plaintiffs who all allegedly purchased under the same set of
representations. Here, we have multiple plaintiffs who all allegedly purchased under one or
more the contract documents in issue.

As stated above, the Court has found the SAC satisfactory in all pleading respects,
including the necessary elements for fraud, while at the same time noting Defendants objection,
which really permeates all bases for demurrer in this number 3 motion, to be lack of specificity
as to which contract each plaintiff is suing on. The Court finds that this factual information reasonably can be obtained through the discovery process. In all other respects, Defendants are clearly on notice of the issues, the who, what, how, when, where, etc., and cannot be heard to complain that they can’t answer or respond with respect to claims directed against them.

Given the totality of the pleading, Defendants’ demurrer is OVERRULED as to all five causes of action based on the Plaintiffs’ asserted failure to identify which specific contracts were entered into by each Plaintiff with each defendant.

A. Pleading Fraud "with Particularity" and the Who, What, When and How

The common law elements of fraud include (1) misrepresentation of a material fact (consisting of false representation, concealment or nondisclosure); (2) knowledge of falsity (scienter); (3) intent to deceive and induce reliance; (4) justifiable reliance on the misrepresentation; and (5) resulting damage. ... It is essential ... that the person complaining of fraud actually have relied on the alleged fraud, and suffered damages as a result.” (Bower v. AT&T Mobility, LLC (2011) 196 Cal.App.4th 1545, 1557 (citations omitted).) As a general principle, every element of a fraud-based cause of action must be specifically pleaded. (Moncada v. West Coast Quartz Corp. (2013) 221 Cal.App.4th 768, 776.) This specificity requirement applicable to fraud claims mandates that a plaintiff plead facts which “show how, when, where, to whom, and by what means the representations were tendered.” Id. When a plaintiff asserts fraud against a corporation, the plaintiff must “allege the names of the persons who made the allegedly fraudulent representations, their authority to speak, to whom they spoke, what they said or wrote, and when it was said or written.” (Tarmann v. State Farm Mut. Auto Ins. Co. (1991) 2 Cal.App.4th 153, 157.)

The Court finds that the SAC satisfies the requirements of the how, when, where, to whom, and by what means requirements for this pleading as discussed above. The court has recited the various SAC paragraphs above and will not repeat them here. The SAC and Plaintiffs make clear that the fraudulent claims at issue are the invoices Defendants submitted when claiming payment from the government Plaintiffs, and Defendants’ responses to the RFP which they allegedly never intended to perform or had the capacity to perform. The contract documents include a signed certification of compliance. Case law establishes that this can form the basis of a CFCA claim. (Contreras v L., (2010) 182 Cal.App. 4th 438, 448-451; City of Pomona v Superior Court (2001) 89 Cal.App. 4th 793, 802-804; Universal Health Servs. v United States ex rel. Escobar, 136 S.Ct. 1989, (June 16, 2016); United States ex rel. Compton Midwest Specialties, 142 F.3d 296, 304 (6th Cir. 1998).)

Plaintiffs identify various persons as representatives of Defendants who Plaintiffs claim made false representations in the responses to the RFP as a means of inducing Plaintiffs to enter contracts. Thus they give at least one person who allegedly made the fraudulent representations and their authority to speak and what they said or wrote and when it was said or written. The specificity requirements for a fraud based action, as well as others, have been met under the tests articulated in Committee on Children’s Television, Inc., v. General Foods Corp. (1983) 35 Cal. 3d 197.
The demurrer on the basis of lack of particularity as to the elements of fraud is OVERRULED.

B. Adequate Pleading of Sciente or Objective Falsity Under the CFCA

The sciente requirement is critical to the operation of the CFCA. In general, the CFCA permits a governmental agency, or a qui tam plaintiff bringing an action on behalf of the governmental agency, to recover civil penalties and damages from any person who knowingly presents to the state or one of its political subdivisions a false claim for payment or approval. Govt. Code § 12651 (a)(1). For purposes of the Act, “[k]nowing” and “knowingly” mean that a person, with respect to information, does any of the following: [¶] (A) Has actual knowledge of the information. [¶] (B) Acts in deliberate ignorance of the truth or falsity of the information. [¶] (C) Acts in reckless disregard of the truth or falsity of the information. [¶] Proof of specific intent to defraud is not required.” (Fassberg Constr. Co. v. Housing Auth. Of City of Los Angeles (2007) 152 Cal.App.4th 720, 7356 (citing § 12650 (b)(1), (2)) (emphasis added.) Unlike pure fraud, a defendant may violate the CFCA by acting with “reckless disregard.” (See Thompson Pacific Construction, Inc. v City of Sunnyvale (2007) 155 Cal.App.4th 525, 548 (reckless disregard standard defined and noted that the standard in federal FCA and CFCA is “indistinguishable”).

As to Defendants’ alleged pre-contractual representations, when each of the Defendants responded to the various contract proposals at issue (i.e., the CWC, WSCA I and II, and RFP), there is a disputed fact as to whether any knowing or intentional or reckless promises were made as to the ability of each Defendant to perform what it allegedly promised to do or whether their responsive documents indicated otherwise or offered alternatives that were accepted.

Plaintiffs have pled that Defendants entered in the contracts knowing that they could not fulfill the terms they promised to fill. They have also expressly alleged that the invoices submitted were false and that Defendants knew that they were false. The documents show that each defendant had to certify compliance with the terms and conditions of the controlling contract documents. This is enough in itself to plead the necessary sciente.

Even if not express, Plaintiffs clearly implied the necessary sciente from the allegations. In San Francisco Unified Sch. Dist. ex rel. Contreras v. Laidlaw (2010) 182 Cal.App.4th 438 (Contreras I), the court considered whether a request for payment under a contract includes an implied certification of compliance with contractual requirements that could form the basis for a CFCA action. Concluding that such a possibility existed, Contreras I found that a CFCA claim was at least possible when a defendant “submitted its monthly invoices” for payment because in doing so it was impliedly certifying that it had complied with all the terms of the contract.” (Contreras I, (2010) 182 Cal.App.4th 438 at p. 448 (relying on Shaw v. AAA Engineering & Drafting, Inc. (10th Cir. 2000) 213 F.3d 519). Contreras I further notes that the legislative history and analysis prior to the passage of the CFCA supports the conclusion that a failure to comply with contractual terms could, depending on the factual circumstances, support a claim under the
CFCA. (See id. at 449-451, also citing federal precedent in support of same.) This analysis “which was provided to the author of the bill and was before the Senate and Assembly Judiciary Committees, states ‘a false claim may take many forms, the most common being a claim for goods or services not provided, or provided in violation of a contract term, statute or regulation.’” Id. at 449 (emphasis in original); see Laraway v. Sutro & Co. (2002 96 Cal.App.4th 266, 275 (also relying on same legislative analysis in interpreting the CFCA); see also Ab-Tech Construction, Inc. v. United States (1994) 31 Fed.Cl. 429-434 (payment vouchers submitted by government contractor were an implied certification of continuing compliance with the terms of the contractual agreement); Daff v. United States (1994) 31 Fed. Cl 682, 689 (finding that contractor’s requests for payment were false under the federal FCA because they misled the government into believing that the contractor fully complied with all terms of the governing contract “when in fact it had not”). This being said, to give rise to a false claim, the contractual provisions allegedly breached “must be sufficiently precise that a false statement relating to compliance can be said to constitute an ‘objective falsehood.’” (Contreras I, 182 Cal.App.4th at 450, fn 9.)

Here, the Court finds at the pleading stage that the allegations are sufficiently precise, for the reasons stated above, such that it can be said that they constitute an objective falsehood.

Defendants’ demurrer to the First and Second Causes of Action under the CFCA on the basis of lack of scienter or objective falsity is OVERRULED.

C. Breach of Contract, Unfair Business Practices and Unjust Enrichment as Sufficient to State Claims

The notice stated that Defendants were demurring to the breach of contract action, unfair business practices and unjust enrichment based on the failure to peg each contract to a specific Defendant in time and substance. The Court has already dealt with this issue above and overruled the demurrer on this ground. To the extent that Defendants argue that Plaintiffs’ claims in this case at most amount to little more than a traditional breach of contract action which does not satisfy the fraud requirements of the CFCA, the Court has already dealt with this issue above and overruled the demurrer on this ground. Similarly, with regard to the actual invoices themselves, the Court incorporates its discussion regarding compliance with contractual provisions as amounting to scienter under the CFCA discussed above and case law that indicates that the actual invoices themselves need not be identified in the SAC.

Defendants’ demurrer to the causes of action for breach of contract, unfair business practices and unjust enrichment are OVERRULED.

CONCLUSION

Based on the foregoing, the Court OVERRULES Defendants’ three demurrers to the various causes of action on the grounds stated.

Defendants shall timely file answers.
The Court is separately issuing a minute order setting a date and time for Case Management Conference.
I certify that I am not a party to this cause. I certify that a true copy of Final Ruling on Demurrers was mailed following standard court practices in a sealed envelope with postage fully prepaid, addressed as indicated below. The mailing and this certification occurred at Sacramento, California, on 09/13/2016.

Clerk of the Court, by: /s/ A. Cruz, Deputy

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V3 1013a (June 2004)
Individual Liability in the Opioid Epidemic: An Examination of Recent Developments

Throughout the past decade, the country has been battling a raging epidemic and public health crisis: opioid addiction. In 2021, over 80,000 people died from opioid overdoses. Pennsylvania has one of the highest rates of opioid overdose deaths in the country. The crisis in Pennsylvania is so severe that decreasing the life expectancy in the commonwealth.

July 29, 2022 at 11:14 AM

By Edward T Kang | July 29, 2022 at 11:14 AM

Corrupt pharmaceutical companies, like Purdue Pharma and Insys Therapeutics that prioritize profits over patient care and safety, have exacerbated the opioid epidemic. The extensive fraud of these two companies was recently highlighted in Hulu’s “Dopesick” and HBO’s “The Crime of the Century.” Through this column, we examine the recent developments in civil and criminal opioid litigation, in an increased effort to hold wrongdoers, at every level, responsible.

In 2015, after receiving criticism for a number of criminal investigations that resulted in high-profile settlements with companies, but not their top executives, the Department of Justice (DOJ) changed course. That year, then-Deputy Attorney General Sally Yates released a policy titled, “Individual Accountability for Corporate Wrongdoing,” which has become known as the “Yates Memo.” The Yates Memo explicitly outlined guidance for the civil and criminal departments of the DOJ that focused on holding individuals responsible for corporate misconduct. The Yates Memo directly encouraged that the best way to combat corporate misconduct and fraud is to “seek accountability from the individuals who perpetrated the wrongdoing to deter future illegal activity, incentivize change in corporate behavior, ensure that the proper parties are held responsible and promote public confidence in the justice system.”

In 2018, the Trump administration narrowed the Yates Memo by only requiring companies to identify individuals “substantially involved” in the misconduct to receive criminal cooperation credit, as opposed to all culpable individuals involved in the corporate misconduct, as required under the Yates Memo. In October 2021, the Biden administration announced that the DOJ was returning to the approach outlined in the Yates Memo, a sure move toward tougher white-collar enforcement. When examining corporate action in pharmaceutical companies, and the opioid crisis since the release of the Yates Memo seven years ago, while there has certainly been a general uptick in the misconduct to receive criminal cooperation credit, as opposed to all culpable individuals involved in the corporate misconduct, as required under the Yates Memo.

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It is now widely known that, for over two decades, Purdue, under the control of the Sackler family, unlawfully marketed OxyContin since it came to market in 1996 by misleading doctors and regulators about the drug’s potency and potential for abuse. In 2020, Purdue pleaded guilty to felony violations for conspiracy to defraud the United States and to violate the anti-kickback statute (AKS), admitting to paying prescribers kickbacks to induce them to prescribe OxyContin and to misrepresenting to the DEA that Purdue maintained an effective anti-diversion program when, in actuality, Purdue marketed OxyContin to over 100 health care providers who the company knew were diverting opioids, and agreed to pay $5.5 in criminal fines and forfeiture—the largest financial penalties ever imposed against a pharmaceutical manufacturer.

Purdue’s 2020 criminal plea was not its first. In 2007, Purdue pleaded guilty to felony charges of misbranding OxyContin in connection with lying about OxyContin’s potential for abuse and addiction, and was fined more than $600 million in criminal penalties. Three executives of Purdue also pleaded guilty, but only to a misdemeanor that did accuse them of wrongdoing. At that time, for executives to face any accountability for corporate wrongdoing was rare. The discrepancy between the punishment imposed on Purdue versus its
then-executives underscores why the DOJ—eight years later—committed to focusing on individual accountability for corporate misconduct. The punishment imposed on Purdue and its then-executives in 2007 was obviously insufficient to stymie the company's illegal activity since, as it admitted in the 2020 plea, the company’s illegal schemes continued for the next decade, directly fueling the opioid crisis.

Despite Purdue’s criminal conduct occurring while members of the well-known Sackler family were at the company’s helm, none of the Sacklers have faced criminal charges, or admitted liability. While it is unclear why the Sacklers were not held criminally responsible in connection with Purdue’s 2020 plea, the issue appears far from over.

In February 2022, seven U.S. senators called on Attorney General Merrick Garland and the DOJ to investigate members of the Sackler family for criminal conduct in connection with Purdue’s admitted criminal wrongdoing in 2020. While acknowledging that the DOJ reached a civil settlement with some of the Sacklers, the senators explained that “real justice in this case means holding individual lawbreakers criminally accountable.” Last month, Connecticut Attorney General William Tong announced that he was asking the state’s top prosecutor to consider criminal charges against members of the Sackler family.

Relatedly, on Dec. 16, 2021, the U.S. District Court for the Southern District of New York rejected a September 2021 bankruptcy court order confirming the Chapter 11 plan of Purdue, which contained broad nonconsensual releases of the Sacklers. In response to appeals from the U.S. trustee, and the states of California, Connecticut, Delaware, Maryland, Oregon, Rhode Island, Vermont, Washington and the District of Columbia, the court held that the Bankruptcy Code does not authorize the plan’s nonconsensual release of third-party nondebtors, like the Sacklers, thus leaving the states’ authority to file further actions against the Sacklers intact.

While the large-level bureaucracy that is Purdue likely made swift results against its leaders more difficult, since the release of the Yates Memo, the DOJ has been able to hold some companies’ bad actors more accountable. In stark contrast to the Purdue saga, at least a dozen Insys employees were criminally prosecuted by the DOJ for Insys’ multiple criminal conspiracies to unlawfully flood the market with an extremely potent liquid fentanyl spray called Subsys. Insys copied many of its illicit strategies from Purdue, including aggressive sales tactics (even hiring a stripper as a regional manager who allegedly gave a Subsys prescriber a lap dance to further induce him to prescribe the drug) and employing a fraudulent “speaker program” through which the company paid dozens of prescribers kickbacks in exchange for prescribing Subsys. Perhaps Insys’ smaller size or the open brazenness with which its employees broke the law (for example, bragging in a rap video about “loving titrations,” and increasing the dose of Subsys for patients while dancing next to a giant 1600 mcg Subsys bottle, a dose that would kill the vast majority of people reading this) made its individual wrongdoers easier for the DOJ to nab than those at the helm of the Purdue empire.

Those criminally prosecuted included Insys’ top executives, including John Kapoor, the founder and chairman. Kapoor, who the DOJ described as the “fulcrum” of Insys’ criminal racketeering scheme, took his criminal RICO case to trial, and after a 51-day trial, was convicted and sentenced to five and half years in federal prison, the harshest sentence in the Insys-employee criminal cases. In January 2022, Kapoor filed a petition for certiorari with the U.S. Supreme Court attempting to appeal his conviction on the basis that a nonphysician cannot be convicted of consenting with a doctor to illegally distribute a controlled substance if the non-physician understood that the doctor believed he was acting in good faith and within the usual course of professional practice in prescribing the controlled substance. In June 2022, the Supreme Court denied Kapoor’s petition for certiorari, leaving the U.S. Court of Appeals for the First Circuit’s 141-page opinion upholding Kapoor’s conviction intact as powerful precedent to use against crooked pharmaceutical executives.

The Insys-related prosecutions also included dozens of high-volume prescribers, who were criminally and civilly prosecuted by the DOJ and state AGs for receiving bribes and kickbacks to prescribe Subsys, and prescribing Subsys outside the usual course of professional practice. Some of these prescribers’ patients died because of their unlawful prescribing. For these prescribers, the sentences have been harsh. For example, U.S. District Court Judge Gregory Wood sentenced Gordon Freedman, who was convicted of receiving kickbacks from Insys, to 17.5 years in federal prison. At least two of Freedman’s patients died from opioid overdoses. At the sentencing, Judge Wood scolded Freedman for contributing to “the scourge of our lifetime, our opioid crisis.”

Xiulu Ruan was another high-volume Subsys prescriber who was convicted for receiving bribes and kickbacks from Insys in violation of the AKS. Ruan was sentenced to over 20 years in prison. The Eleventh Circuit Court of Appeals affirmed the trial court’s decision. Underscoring the importance of opioid-related litigation right now, the Supreme Court granted Ruan’s petition for certiorari on Nov. 5, 2021, and consolidated the appeal with the appeal of another prescriber, Shakeel Kahn.

On June 27, the Supreme Court unanimously ruled in favor of Ruan and Kahn, a decision that went unnoticed in the wake of Dobbs’ overturning of Roe v. Wade. In vacating the convictions of Ruan and Kahn, the Supreme Court upheld the applicability of the traditional “knowingly or intentionally” mens rea, and held that for an individual to be convicted for prescribing controlled substances outside the usual course of professional practice, the government must show beyond a reasonable doubt that the defendant knew his conduct was...
unauthorized, or that the defendant intended to engage in unauthorized conduct. This decision resolved a circuit split over how a physician’s “good faith” in prescribing controlled substances should factor into an analysis relating to a criminal violation of the Controlled Substances Act (CSA). The Supreme Court rejected the Eleventh Circuit’s holding in Ruan’s intermediate appeal that a physician’s “good faith belief that he dispensed a controlled substance in the usual course of his professional practice is irrelevant” to whether he violated the CSA. Now, under the law of the land, physicians who write prescriptions for controlled substances in good faith cannot be convicted under the CSA.

The Supreme Court’s decision was unsurprising, as it was consistent with the concerns raised at the oral argument in March 2022. Justice Brett Kavanaugh, for example, voiced his objection to a doctor being imprisoned for 20 years for violating some objective, rather than subjective, standard of reasonableness where the doctor legitimately believed the standard was different. Kavanaugh also focused on the phrase “legitimate medical purpose,” which is often the subject of heavy debate by dueling experts in civil False Claims Act cases, as he was troubled that a doctor could go to prison for 20 years for being “on the wrong side of a close call” without any consideration of the doctor’s subjective intent.

But given that circumstantial evidence relating to legitimate medical purpose and the usual course of professional practice can be considered in determining a defendant’s knowledge of lack of authorization, as the Supreme Court correctly pointed out in its opinion, in egregious situations, like Ruan’s (for more on this, check out the book “The Hard Sell”), the results are likely to be the same, and individuals will continue to be held criminally responsible.

In discovering which companies and executives are operating corruptly, whistleblowers have proven to be integral to the government. This was the case with Insys. For attorneys who handle qui tam cases on behalf of Relators, it is important to look to the priorities of the DOJ at any given time since the United States remains the real party in interest in any qui tam case. Right now, there is a strong commitment by the government to prosecuting individuals responsible for the opioid crisis. The same is true with respect to health care fraud more generally, as demonstrated by the $5 billion the government collected in healthcare fraud FCA cases last year, and the Biden administration’s commitment to the directives of the Yates Memo. This means that when filing an action under the FCA, attorneys should strongly consider whether the addition of any individual defendants is appropriate. With the opioid epidemic without an end in sight, and health care fraud running rampant, we are likely to continue to see a trend of civil and criminal prosecution of individuals responsible for corporate wrongdoing.
HOW TO WHET UNCLE SAM’S WHISTLE
A Guide to Litigating Cases under the False Claims Act
Agenda

- Overview and Background of the False Claims Act (FCA) and Qui Tam Actions
- FCA Policy Developments under the Biden Administration
- Filing a *Qui Tam* Action and the Investigation Phase
- To Intervene, or Not
- Litigating Declined Cases
- Settlement Strategies
Panelists

Erika Hiramatsu
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United States Attorney’s Office
Assistant United States Attorney

Kolin C. Tang
Miller Shah LLP
Partner
Overview of the FCA and *Qui Tam* Actions

- Purpose of the FCA and Key Provisions
- What is a Relator?
- Overview of Damages/Penalties/Awards
- Key Amendments to the FCA
Facebook Hearings Cold Open - SNL
What is the False Claims Act (FCA)?

• The False Claims Act (FCA), 31 U.S.C. §§ 3729 – 3733, allows the federal government to combat fraud against it.

• Sometimes referred to as “the Lincoln Law,” the FCA was passed in 1863 to combat fraud against the government during the Civil War.

• The FCA prohibits any person to knowingly submit a false claim to the United States for payment.

• The FCA provides for civil penalties between $12,537 to $25,076 and treble damages per claim.

• *Qui Tam* provisions of FCA allow for whistleblowers to file suit on behalf of the United States against the perpetrator of fraud.
## Key FCA Provisions

<table>
<thead>
<tr>
<th>Section</th>
<th>Provision</th>
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<tbody>
<tr>
<td>31 U.S.C. § 3729(a)(1)(A)</td>
<td>Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval</td>
</tr>
<tr>
<td>31 U.S.C. § 3729(a)(1)(B)</td>
<td>Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim</td>
</tr>
<tr>
<td>31 U.S.C. § 3729(a)(1)(C)</td>
<td>Conspires to commit a violation of prior subsections (A); (B) and (G)</td>
</tr>
<tr>
<td>31 U.S.C. § 3729(a)(1)(G)</td>
<td>Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay money to the government</td>
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</tbody>
</table>
Qui Tam Provisions

- Private individual suing on behalf of government is the “relator”.

- The government will investigate the allegations in relator’s complaint. After investigation, the government will either intervene in the action or decline to take over.

- If the government declines to take over, the relator can proceed with their action.

- If the government intervenes, the relator is entitled to receive 15-25% of the government’s recovery.

- If the government declines to intervene, the relator is entitled to 25-30% of the government’s recovery.
The Early Evolution of the False Claims Act

- 1943
  - FCA nearly abolished due to numerous “parasitic lawsuits” filed against defense contractors.
  - Was amended to reduce the recovery of a relator to no more than 10% (with government involvement) or 25% (without government involvement).
  - Added provision barring any *qui tam* action where the Government possessed knowledge of any fraud from proceeding.
  - Effectively eliminated all *qui tam* cases.

- 1986
  - Eliminated “government possession of information” bar against *qui tam* lawsuits.
  - Established a “preponderance of the evidence” standard.
  - Increased awards for relators to between 15-30% of recovered damages, imposed treble damages, and allowed plaintiffs to recover attorneys’ fees.
  - Established employment protection for whistleblowers expanding the issues that they could raise action against.
The Fraud Enforcement and Recovery Act of 2009 (FERA)

• Expanded the reverse false claims provision:
  • Eliminated the need for a false record or statement, instead imposing liability where a person “knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government.”
• Imposed liability for retention of overpayments:
  • Specified that the “retention of any overpayment” can serve as the basis for reverse false claims liability if it is done knowingly and improperly, or if an overpayment is knowingly concealed.
• FERA removed the “presentment” liability requirement:
  • FCA liability now attached to claims presented directly to the United States, but also to claims presented to entities administering government funds.
  • Expanded the FCA to healthcare providers involved with Medicare and Medicaid.

DOJ Statistics On FCA Recoveries Through FY 2013 Reveal Continued Focus On Healthcare And More Direct Government Enforcement
The Patient Protection and Affordable Care Act of 2010 (PPACA)

- Prior to the PPACA, cases based on a public disclosure of information or public media could be totally barred.
- Amended the language of the FCA to grant the Federal Government final say on dismissals of cases based on public disclosure.
  - “The court shall dismiss an action unless opposed by the Government, if substantially the same allegations or transaction alleged in the action or claim were publicly disclosed.”
- Original Source Exception:
  - 1986 FCA Amendment created Public Disclosure Bar, precluding suit based upon publicly disclosed information unless the relator was the “original source” of the information.
  - 2010 Amendment narrowed Public Disclosure Bar
    - “Public Disclosure” narrowed to federal investigations, hearings, reports, and audits.
    - Allows plaintiffs to overcome the bar, if they have “knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions.”
    - Government can oppose dismissal of a case due to Public Disclosure Bar.
- Modified language of the Anti-Kickback Statute.
The Government’s Perspective

- United States
  - Local AUSA
  - Main Justice
- State/Commonwealth/Territory
  - National Association of Medicaid Fraud Units (NAMFCU)
    - NAMFCU’s Executive Committee oversees the Association:
      - Three officers
      - Six regional representatives
      - The director of the New York MFCU
      - All past presidents of the Association
    - NAMFCU officers are elected annually by Unit directors (each Unit is led by one director). Regional representatives are elected annually by members of their region.
    - Medicaid Fraud Control Units are in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. Most, but not all, are in the state’s Office of the Attorney General.
    - Not all states are members of NAMFCU
  - Global NAMFCU Teams – Investigative, Litigation, Settlement
  - Non-NAMFCU cases
    - Few states
    - Municipalities, e.g. cities or counties
FCA Policy Developments and Enforcement Trends Under the Biden Administration
FCA Policy Developments and Enforcement Trends Under the Biden Administration

- Policy Developments and Results in FCA Cases in the Last Two Years
- U.S. DOJ Fraud Statistics
- COVID-19 Relief and the FCA
- The Civil Cyber-Fraud Initiative
- False Claims Amendments Act of 2021
FCA Policy Developments and Enforcement Trends Under the Biden Administration

- During the first half of 2022, the Department of Justice has focused on enforcement actions related to the Paycheck Protection Program and the “Cyber Fraud Initiative.”
  - DOJ reached a settlement with a Virginia-based software development company to resolve allegations that the company fraudulently obtained multiple PPP loans in the year 2020.
  - DOJ announced first settlement under the Cyber Fraud Initiative: Florida-based medical services provider agreed to pay $930,000 to resolve allegations that it failed to disclose to the State Department that it had not consistently stored patients’ medical records in a secure electronic medical record system and that it failed to properly obtain certain controlled substances that were manufactured in accordance with federal quality standards.
Update from the Government

COVID-19 Relief

Regional Trends
### Enforcement Trends in Healthcare

<table>
<thead>
<tr>
<th><strong>U.S. ex rel. Newman v. Foot Care Store, Inc. d/b/a Dia-Foot</strong></th>
<th><strong>U.S. v. Cardinal Health Inc.</strong></th>
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</thead>
<tbody>
<tr>
<td>• A specialized footwear company agreed to pay $5.5 million to settle allegations that the company sold shoe inserts to diabetic patients who received a prescription for the inserts from a physician.</td>
<td>• A healthcare company agreed to pay more than $13 million to settle allegations that it violated the FCA and AKS by providing initial discounts on the purchase of drugs to physician practices.</td>
</tr>
<tr>
<td>• The company billed Medicare and Medicaid as if the inserts provided to patients were customized, but the inserts actually all came from a generic model.</td>
<td>• The government alleged the company used these discounts to persuade the practices to buy federally reimbursable drugs from the company rather than its competitors.</td>
</tr>
<tr>
<td>• The settlement also resolved a qui tam suit brought by a former employee; that individual’s share of the recovery was not reported with the settlement announcement.</td>
<td>• The settlement also resolved qui tam suits brought against the health care company, for which the relators received approximately $2.8 million of the settlement.</td>
</tr>
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</table>
Enforcement Trends in Healthcare

**United States ex rel. Bomar v. Bayfront HMA Medical Center LLC**

- A healthcare system and four affiliated entities agreed to pay $20 million to resolve allegations that they violated the FCA by making donations to a local entity which in turn contributed the money to the state’s Medicaid program—the state ultimately paid back the funds to the healthcare system.

- The settlement also resolved a qui tam suit brought by a former hospital reimbursement manager, who received $5 million of the settlement.

**U.S. v. Snap Diagnostics**

- A diagnostics company that provides home sleep testing agreed to pay $3.5 million to resolve FCA and AKS allegations that it billed Medicare and four other federal health care companies for unnecessary home sleep testing.

- The government further alleged that the company improperly multiplied copays received from Medicare beneficiaries and incentivized physicians to refer all home sleep testing services to the company.

- The allegations in the settlement were part of two qui tam actions.
FCA Recoveries by Year

Source: DOJ Fraud Statistics

Recovery

Non-Qui Tam
Qui Tam
Healthcare and Non-Healthcare FCA Actions

- Healthcare: 39%
- Non-Healthcare: 61%

Source: DOJ Fraud Statistics
Civil Cyber-Fraud Initiative

- Launched in October 2021 to enforce federal cybersecurity requirements
- First settlement under Initiative reached in March 2022 with medical services contractor Comprehensive Health Services after the DOJ determined that the CHS had falsely represented “to the State Department and the Air Force that it had complied with its contract requirements relating to the provision of medical services at State Department and Air Force facilities in Iraq and Afghanistan,” according to the DOJ
- In July 2022, settlement was reached with Aerojet Rocketdyne Holdings, an aerospace and defense company after it violated the False Claims Act “by misrepresenting its compliance with cybersecurity requirements in certain federal government contracts,” according to the Justice Department.

“We expect whistleblowers to play a significant role in bringing to light knowing failures and misconduct in the cyber arena.”

-Brian Boynton, Assistant Attorney General, Department of Justice
False Claims Amendments Act of 2021

Revised Procedures:

• In determining materiality, the decision of the Government to forego a refund or to pay a claim despite actual knowledge of fraud or falsity shall not be considered dispositive if other reasons exist for that decision with respect to such refund or payment.

• In dismissing an action over the objections of the relator, the Government must identify a valid government purpose and a rational relation between dismissal and accomplishment of the purpose. The relator must have the opportunity to show that the dismissal is fraudulent, arbitrary and capricious, or contrary to law.

• Extends relief from retaliatory actions to former employees.

• The Government Accountability Office must report on the effectiveness of the FCA.
Filing a *Qui Tam* Action and the Investigation Phase
Filing a *Qui Tam* Action and the Investigation Phase

- Process of filing a FCA Action under Seal
- The Investigation Process
- Importance of the Damage Model to the Government
- Factual Pleading Standard under FRCP 9(b)
The Investigation Phase:
Pre-Filing Due Diligence

• Vetting the Relator
  • Conduct a careful interview of the relator to test the relator’s credibility and knowledge;
  • Consider engaging private investigators to corroborate and develop the relator’s allegations;
  • If the relator is still employed by the defendant, provide strict instructions to the relator on permissible information-gathering and risk of exposure to individual civil suit.

*Balance between verification/detail and avoiding first-to-file issues

• Relator’s electronically stored information (ESI) and documents:
  • Take immediate steps to preserve all information, including; cloning laptops, cell phones, flash drives, etc.
  • Beware of actual/potential attorney-client privilege issues.
  • Government investigation/complaint can be under seal for an extended period.
    • i.e., 4-5 years, before civil litigation begins in earnest.
Filing a *Qui Tam* Action

- Filing the Complaint (31 U.S.C. § 3730(b))
  - Complaint must be filed under seal and a copy with a disclosure statement, which is a narrative version of the complaint, must be served on the Government.
    - Government has 60 days, subject to extensions with court approval, to begin investigating.
    - Defendant is not served or notified during this process.
    - Jurisdiction-specific rules on under-seal filings (Adhere to local rules).
  - Relator waits for Government instructions/response after complaint is filed.
    - Relator does not conduct a further independent investigation, unless instructed to do so by the Government.
    - The Government may, at its discretion, interview the relator at any time after filing.
Circuit Split on Rule 9(b) Pleading Standard

- Under FRCP 9(b), “[i]n alleging fraud or mistake, a party must state with particularly the circumstances constituting fraud or mistake,” although “[m]alice, intent, knowledge, and other conditions of a person’s mind may be alleged generally.”
- Depending on the circuit, pleading FCA qui tam claims may be subject to either a “strict” or “more lenient” application of FRCP 9(b)

<table>
<thead>
<tr>
<th>The “Strict” Circuits</th>
<th>The “More Lenient” Circuits</th>
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<tbody>
<tr>
<td>Adopted by the First, Fourth, Sixth, Eighth, and Eleventh Circuits, the “strict” standard requires that the relator allege “details that identify particular false claims for payment that were submitted to the government,” such as ‘details concerning the dates of the claims, the content of the forms or bills submitted, their identification numbers, the amount of money charged to the government.’” U.S. ex rel. Karvelas v. Melrose-Wakefield Hosp., 360 F.3d 220, 232-33 (1st Cir. 2004), abrogated on other grounds by Allison Engine Co. v. U.S. ex rel. Sanders, 553 U.S. 662 (2008).</td>
<td>Adopted by the Second, Third, Fifth, Seventh, Ninth, Tenth, and D.C. Circuits, the “more lenient” standard does not require details of “actually submitted” false claims so long as the complaint “alleg[es] particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted.”” U.S. ex rel. Grubbs v. Kanneganti, 565 F.3d 180, 190 (5th Cir. 2009).</td>
</tr>
</tbody>
</table>
Circuit Authorities

The “Strict” Circuits

- **Fourth Circuit**: United States ex rel. Nathan v. Takeda Pharm. N. Am., Inc., 707 F.3d 451, 456-58 (4th Cir.2013);
- **Sixth Circuit**: U.S. ex rel. Bledsoe v. Comty. Health Sys., Inc., 501 F.3d 493, 510 (6th Cir. 2007);
- **Eighth Circuit**: U.S. ex rel. Dunn v. N. Am. Mem’l Health Care, 739 F.3d 417, 420 (8th Cir. 2014);
- **Eleventh Circuit**: U.S. ex rel. Clausen v. Lab. Corp. of Am., 290 F.3d 1301, 1314 n.25 (11th Cir. 2002).

The “More Lenient” Circuits

- **Third Circuit**: Foglia v. Renal Ventures Mgmt., LLC, 754 F.3d 153, 156-57 (3d Cir. 2014);
- **Fifth Circuit**: U.S. ex rel. Grubbs v. Kanneganti, 565 F.3d 180, 190 (5th Cir. 2009);
- **Seventh Circuit**: United States ex rel. Lusby v. Rolls-Royce Corp., 570 F.3d 849, 854 (7th Cir.2009);
- **Ninth Circuit**: Ebeid ex rel. United States v. Lungwitz, 616 F.3d 993, 998–999 (9th Cir.2010);
- **Tenth Circuit**: United States ex rel. Lemmon v. Envirocare of Utah, Inc., 614 F.3d 1163, 1172–1173 (10th Cir.2010).
Nuances to the “Split”

• Despite the general divide, the “strict” circuits have, at times, permitted some flexibility in pleading “actual claims” submitted depending on the circumstances:
  • i.e. United States ex rel. Duxbury v. Ortho Biotech Prods. L.P., 579 F.3d 13, 29 (1st Cir. 2009) (holding that, in actions “in which the defendant induced third parties to file false claims with the government,” it was not necessary to “provid[e] details as to each false claim” if there were “factual or statistical evidence to strengthen the inference of fraud beyond possibility”);
  • i.e. U.S. ex rel. Prather v. Brookdale Senior Living Communities, Inc., 838 F.3d 750, 773 (6th Cir. 2016) (“a relator may ... survive a motion to dismiss by pleading specific facts based on her personal billing-related knowledge that support a strong inference that specific false claims were submitted for payment”).
The Government’s Role in the Investigation Phase
To Intervene, or Not to Intervene
For That is the Question
To Intervene, or Not to Intervene

• Factors considered by Federal and State Governments in Determining whether to Intervene
• The Importance of the Time of Intervention/Decision to Intervene
INTERVENTION DECISION

Will the U.S. Intervene?

NO

Discuss up the chain

YES

Is a joint Intervention Notice &/or Complaint possible?

NO

Draft & file Notice of Intervention & Complaint in Intervention

At any point, (with U.S., through NAMFCU, etc.) discuss possibility of settlement with defense counsel

LITIGATION

YES

Collaboratively draft & file Notice of Intervention & Complaint in Intervention
To Intervene, or Not to Intervene

What the Government likes:
- A clear timeframe for the allegations, or a specific method to determine the timeframe.
- Specific examples:
  - For Medicaid cases, include a state example or a Medi/Medi example
  - Provide code information when relevant, e.g. NDC, NPI, CPT codes
- In the Disclosure Statement, provide full names and contact info whenever possible.
- If possible, provide a suggestion of how to determine damages (damages model).
- Keep the government apprised of other government agency actions (of which you are aware).

What the Government doesn’t like:
- Stacks of documents with no Bates stamp, for which the significance is not clear
  - To the extent documents are provided, beware of attorney-client privileged materials
- Purely speculative claims, e.g., “On information and belief, Medicaid is also implicated.”
To Intervene, or Not to Intervene

After Service to the Government
• If a multi-state action, find out if there are assigned NAMFCU attorneys, and get contact info.
• Keep in touch with the government attorneys; they don’t always communicate.
• Monitor seal dates.

Intervened Cases
• Determine whether it will be a joint intervention.
• If it’s NAMFCU case, determine who is the Team Lead.
Intervention – Defense Perspective

• If Defendant learns of under seal qui tam, it is usually because government has obtained partial lifting.
  • Government’s purpose is to obtain Defendant’s assistance with investigation and/or
  • Trigger settlement discussions, prior to intervention.
• Most critical juncture for Defendant – if DOJ intervenes, extremely likely your client will have to pay, through judgment or more likely settlement.
• Make all-out press to:
  • Earn trust of DOJ and investigators;
  • Assist government with obtaining extensions by helping investigation progress; and
  • Seek opportunities to meet and present white papers to persuade government to decline.
• Settlement opportunity before DOJ attorneys must draft intervention memo.
Litigating Declined Cases
Litigating Declined Cases

• Common Issues on Motion to Dismiss Briefing
• How the Government can Help on Pleading and Discovery Issues
• Touhy Requests to CMS
• HIPAA Information – Qualified Protective Order, Best Practices
• Defense – Differences in Intervened vs. Non-intervened Cases
• Importance of NDC Codes to Government
• Fifth Amendment Concerns
Pleading Issues in Declined Cases: Materiality

• FCA defines materiality as “having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.”

• *Universal Health Services v. United States, ex rel. Escobar*
  • Relators filed suit under the FCA after their daughter suffered a fatal seizure caused by medication improperly prescribed. They alleged that the clinic provider was not properly licensed and that by submitting Medicaid invoices for services performed in violation of licensing regulations, the clinic submitted false and fraudulent claims to the Medicaid program.
  • District Court dismissed, concluding that the complaint did not state any implied falsity because it relied on noncompliance with regulations that were conditions of participation in Massachusetts’ Medicaid program, rather than conditions of payment by the program.
  • “Implied Certification Theory” – Clinic implied regulatory compliance by submitting Medicaid claim.
  • Supreme Court held that implied certification theory could provide a basis for liability.
Effect of *Escobar* on Materiality Analysis

- *Escobar* clarified the strength of the FCA’s materiality requirement and provided guidance on the materiality analysis.
- The Supreme Court identified factors to help courts determine if a false statement or omission would be considered material to the government’s payment decision. These factors include:
  - Whether the government has expressly identified compliance with a specific statutory, regulatory, or contractual requirement as a condition of payment.
  - Whether the government generally refuses to pay claims that fail to meet the specific statutory, regulatory, or contractual requirement.
  - Whether the government has continued to pay claims despite actual knowledge of noncompliance with the requirement.
  - Whether the alleged noncompliance is considered minor or insignificant, or if it goes to the “very essence of the bargain.”
- *Escobar* has made it more difficult for relators or the government to plead materiality in the complaint, while simultaneously offering defendants new avenues to challenge the materiality requirement.
Escobar Circuit Split

**Strict Interpretation:**
Relator must show that the government’s payment decision has or would be affected by violation

- **First:** U.S. ex rel. Nargol v. Depuy Orthopaedics, Inc. (2017)
- **Fourth:** U.S. ex rel. Taylor v. Boyko (2022)
- **Fifth:** U.S. ex rel. Harman v. Trinity Industries (2017)
- **Tenth:** U.S. ex rel. Janssen v. Lawrence Mem’l Hospital (2020)

**Lenient Interpretation:**
Relator must show only that government would have the option to decline payment

- **Second:** United States v. Strock (2019)
- **Sixth:** Brookdale Senior Living v. U.S. ex rel. Prather (2018)
- **Eighth:** U.S. ex rel. Miller v. Weston Educ., Inc. (2016)
- **Eleventh:** U.S. ex rel. Bibby v. Mortgage Investors Corp. (2021)
- **D.C.:** U.S. ex rel. Cimino v. IBM (2021)
Recent Caselaw Highlighting Materiality


- Vermont National Telephone Company alleged that several telecommunications companies violated the FCA and defrauded the U.S. government of $3.3 billion by manipulating Federal Communications Commission (FCC) rules and falsely certifying their eligibility for discounts on spectrum licenses. The district court dismissed Vermont Telephone’s qui tam suit, relying on the FCA’s “demanding materiality standard.” The D.C. Circuit reversed.

- The Court’s materiality analysis focused on the “potential effect of the false statement when it is made,” not on “the false statement’s actual effect after it is discovered.”

- The Court held that Defendants’ failure to disclose agreements central to their eligibility for discounts was certainly “capable of influencing” the FCC’s eligibility determination and, thus, Vermont Telephone plausibly pleaded materiality.

- This appears to conflict with language from Escobar that if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated then “that is very strong evidence” of the immateriality of those requirements.
Pleading Issues in Declined Cases: Scienter (“Knowingly”)

*United States ex. rel. Schutte v. SuperValu Inc.*, 9 F.4th 455 (7th Cir. 2021)
- Applies the “reckless disregard” standard established by the Supreme Court in *Safeco Insurance Co. of America v. Burr*, 551 U.S. 47 (2007)
- A defendant interpreting an ambiguous statute or regulation does not act with reckless disregard if:
  - the interpretation was objectively reasonable; and
  - “authoritative guidance” did not warn the defendant away from the interpretation.

Third Circuit: *U.S. ex rel. Streck v. Allergan, Inc.* 746 F. App’x 101 (3d. Cir. 2018) employed a similar test:
1. whether the relevant statute was ambiguous;
2. whether a defendant’s interpretation of that ambiguity was objectively unreasonable; and
3. whether a defendant was “warned away” from that interpretation by available administrative and judicial guidance.

Ninth Circuit: *U.S. ex rel. McGrath v. Microsemi Corp.*, 690 F. App’x 551 (9th Cir. 2017) Applied the Safeco standard in determining that the defendant’s interpretation of the relevant statute was “reasonable” so defendant did not knowingly fail to comply with the statute.
Pleading Issues in Declined Cases: Causation

- **Link/Connection Causation**
    - “But-for” causation is inconsistent with the drafter’s intentions underlying both the False Claims Act and the Anti-Kickback Statute
    - AKS and FCA were not drafted to cabin healthcare providers’ liability for certain types of false claims or for certain types of illegal kickbacks. Instead, Congress intended both statutes to reach a broad swath of “fraud and abuse” in the federal healthcare system.

- **“But-for” Causation**
    - Eighth Circuit split with the Third Circuit, which previously adopted a more lenient causal standard (Only "a link" or "some connection" is required between the illegal kickback and claim for reimbursement. *United States ex rel. Greenfield v. Medco Health Solutions, Inc.*, 880 F.3d 89 (3d Cir. 2018))
    - Court found that the "ordinary meaning" of the statutory phrase "resulting from" connotes a "but-for causal relationship."
Other Common Pleading Issues:
The Public Disclosure Bar, the “Original Source Exception, and the First-To-File Bar

• 31 U.S.C. § 3730(e)(4): “[t]he public disclosure bar precludes qui tam suits where there has been a public disclosure of the fraud, unless the relator qualifies as an ‘original source’ of the information” United States ex rel. Hartpence v. Kinetic Concepts, Inc., No. 19-55823, 2022 WL 3206685, at *6 (9th Cir. Aug. 9, 2022);

• Public disclosure includes:
  • Federal criminal, civil, or administrative proceeding in which the Government or its agent is a party;
  • Congressional, GOA, or other Federal report, hearing audit, or investigation;
  • or from the news media.

• 31 U.S.C. § 3730(e)(4)(A): “to be an ‘original source’ a relator must (1) have ‘direct and independent knowledge’ of information supporting his claims, and (2) ‘provide [] the information to the Government before filing an action.” U.S. ex rel. Hartpence v. Kinetic Concepts, Inc., 792 F.3d 1121, 1124 (9th Cir. 2015);
Other Common Pleading Issues: The Public Disclosure Bar, the “Original Source Exception, and the First-To-File Bar (Cont.)

- **31 U.S.C. § 3730(b)(5):** “The first-to-file bar precludes civil actions based on complaints which allege the same material facts as an earlier-filed civil complaint.” *U.S. ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1123 (9th Cir. 2015);
- Both the public disclosure and first-to-file bars are “jurisdictional,” and are intended to reduce “parasitic” (i.e., copycat) lawsuits and encourage whistleblowers.
Filing Under Seal

- FCA requires that new lawsuits be kept confidential to prevent defendants from learning of government investigations.
- The procedure, known as “filing under seal,” requires that a complaint “shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders.” 31 U.S.C. § 3730(b)(2)
- Prudent practice is to exercise an abundance of caution when discussing any aspect of a False Claims Act case or the underlying allegations with anyone other than the relator’s counsel and the Government Agents assigned to the case.
- Purpose of filing under seal is for benefit of the government by allowing it to investigate claims for possible intervention, but the requirement may incidentally benefit the defendant. See United States ex rel. Summers v. LHC Group, Inc., 623 F.3d 287 (6th Cir. 2010) (qui tam case dismissed for failure to file under seal)
- Amended Complaints do not have to be sealed if similar to original complaint.
Discovery Issues in Declined Cases: 
Touhy Requests

*Touhy v. Ragen*, 340 U.S. 462 (1951)

- If a party needs a document production or testimony from the U.S. Government and the U.S. is not a party to the case.
- The request is sent to the appropriate U.S. Government Agency.
  - Some agencies have a designated individual for receipt of *Touhy* Requests.
- The request should be sent in letter form and must include all the required information.
Required Information for *Touhy* Request

- A statement that the United States is not reasonably anticipated to be a party in the case;
- The contact information for all counsel of record in the case;
- Whether medical, pay or military service information is being requested;
- A summary of the facts of the case;
- The procedural posture of the case;
- A statement that the records requested are relevant to the case, including a brief explanation as to why the records or testimony are relevant;
- A detailed description of the documents or information sought;
- A time and date for the production of the documents or testimony;
- The location of the records, including name, address, and telephone number, if known, of the person from whom the documents, information, or testimony is sought;
- A statement that you are willing to pay in advance for all reasonable expenses and costs of searching for and producing documents;
- A statement of understanding that the production of the witness, if applicable, will be at no expense to the Government or the witness and that travel expenses, if any, are the responsibility of the requester. An agreement to provide, free of charge to the witness, a copy of the deposition transcript with an opportunity to read, sign, and correct the deposition at no cost to the witness or the Government;
- Whether any depositions or testimony requested will be opinion or expert testimony; and
- A statement that counsel for the requesting party understands that the US reserves the right to have a representative at trial or the deposition.
Touhy Requests to CMS

- Requests to the Center for Medicare & Medicaid Services can raise HIPAA concerns and objections.
- When making such a request, a qualified protective order should be secured, and written assurances should be provided to CMS that the parties have agreed to or requested a qualified protective order.
- The qualified protective order should include provisions that:
  - Prohibit the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which the records are requested;
  - Require the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding;
  - Require notice if protected information is inadvertently disclosed or produced; and
  - Require that all protected information be filed under seal.
Fifth Amendment Issues in Civil Discovery

• Nonparty witnesses may invoke the Fifth Amendment privilege in whistleblower cases

• In cases where a nonparty employee, or former employee, is testifying due to the action of her employer, the nonparty witness’ invocation of the Fifth Amendment privilege may be used against a party
  • Many circuits “have overwhelmingly found it constitutionally permissible to impute an adverse inference from a non-party to a party in a civil proceeding” without “identity of interests.” *State Farm Mutual Automobile Insurance v. Abrams*, (N.D. Ill. 2000)

• A party who has invoked the Fifth Amendment privilege may be barred from offering at trial his testimony on matters for which the Fifth Amendment was invoked to prevent discovery. See *Haas v. Bowman*, 62 Pa. D. & C. 4th at 15 (Com. Pl. 2003).

• **Nonparty Witness Invoking the Fifth Amendment Privilege**
Litigating Declined Case – Defense Perspective

• The Government holds key evidence – goal is to make government documents and witnesses centerpiece of the defense
• In particular, materiality after Escobar: demonstrating that Government knew of the alleged misconduct, did not care or even approved, and/or does not consider itself harmed
• Consider dialogue with affected agency, with approval of government counsel
• “Touhy” requests take time – plan ahead and work your contacts to make progress
• Example: Same allegations in 3 jurisdictions with 3 different results:
  • State of Nevada ex rel. OnTheGo v. Cellco, et al. (dismissal, including on materiality)
  • State of Minnesota ex rel. Knudsen v. AT&T, et al., aff’d on appeal (dismissal on public disclosure and particularity grounds)
  • State of California ex rel. OnTheGo Wireless v. Cellco, et al. (demurrer denied)
• In an extreme unmeritorious case, make run at government intervention to dismiss case – “Granston memo”
Settlement

- Strategies – Good Mediators
- Role of NAMFCU
- Interplay of the DOJ and States
- Challenges with Opioid Cases
- Releases and Alternatives
- Ability to Pay Settlements
- Bankruptcy Risk
Settlement – Common Issues

- Release of defendants
  - Opioid epidemic
    - Individual Liability in Opioid Epidemic
- Cold comfort
- Dismissal (with and without prejudice)
- Confidentiality
- Press release
- Ability to pay
Settlement – Government Perspective

- Typically, negotiations are led by the US
- Was a NAMFCU team or an individual state involved in negotiations?
- Does the total settlement equal $50,000 or more? (IRS Form 1098-F)
- When does Main Justice step in?
Settlement – Relator’s Perspective

• Good Mediators
  o The Government has to approve all settlements in cases involving the False Claims Act. The Government should be invited to participate in the mediation
  o If the Government chooses not to attend, the mediator should be in frequent contact with the Government to help facilitate the Government’s approval
• Relator has limited ability to object to settlements reached by the Government and the defendant, however Government may settle case over relator’s objection 3730(c)(2)
• The government can also dismiss a relator’s suit at any time, which provides incentive to settle a case sooner.
• Under the FCA, a prevailing plaintiff is automatically entitled to attorney’s fees. A settlement agreement should reserve the issue of allocating attorney’s fees.
Settlement – Defense Perspective

• For intervened cases, usually best to limit negotiations to DOJ and exclude relator
  • Three-party negotiations more difficult
  • DOJ most effective in bringing relator on board for FCA settlement
    • DOJ will resist involvement on relator attorneys’ fees and any retaliation claim
• Scope of covered conduct is critical term in settlement agreement
  • DOJ inflexible on most other terms (e.g., tax, cost allowability, criminal, etc.)
  • Strive for release to cover everything government investigated
• Insist on dismissal with prejudice as to relator for everything and as to government for
covered conduct
• Seek agreement on timing and general content of press release
• For anything not released by government, seek “cold comfort” letter
  • DOJ will limit to “facts presently known” and its “present intention” to investigate or
    sue
  • Seek to cover everything in complaint not released, anything else investigated, and
    any cooperation obligation
QUESTIONS?