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No. 79959-2-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

JASON LOWERY and **JANE DOE LOWERY**, and the Lowery community,

Petitioners,

v.

STATE OF WASHINGTON, ex rel. **LISA HUNTER**, an individual,

Respondents,

RELATIONSHIPS TOWARD SELF-DISCOVERY, INC., a Washington corporation; **LAIRD RICHMOND**, **JANE DOE RICHMOND**, and the Richmond community estate,

Additional Defendants.

PETITION FOR REVIEW

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I. IDENTITY OF PETITIONER

Jason Lowery and his marital community (Petitioner or Lowery) bring this Petition for Discretionary Review by the Supreme Court. Petitioner is appellant and one of the defendants in the King County Superior Court case brought by the Relator and the State of Washington (Relator or State).

II. CITATION TO COURT OF APPEALS DECISION

The Court of Appeals, Division I, Case Number 79959-2-I issued a published opinion on November 2, 2020. 2020 WL 6389985. Appendix 1.

III. ISSUES PRESENTED FOR REVIEW

A. Does a case of first impression interpreting application of the Washington Medicaid False Claims Act (Act) involve an issue of substantial public interest requiring determination by the Supreme Court?

B. Did the Court of Appeals err in determining that an employee of a State contracted service provider who did not prepare, review, certify or submit fraudulent cost reports be held liable for causing the false record to be made to a government entity?

C. Should RCW 74.66.020(1)(g) which imposes liability for causing a false record to be submitted to the government entity be limited in application to the parties who prepared, certified and submitted the record?

D. Did the Court of Appeals err in finding joint and several liability after rejecting a finding of conspiracy?

IV. STATEMENT OF THE CASE

This is a case of first impression under the Washington False Claims Act, Chapter 74.66 RCW. Petitioner Lowery appeals the judgment entered against him for causing false reports to be submitted to the State of Washington. Neither statutory interpretation nor the evidence support a judgment against Lowery.

Defendant, Relationships Toward Self-Discovery, Inc. (RTS) contracted with the Washington State Developmental Disabilities Administration (DDA) to provide care services to developmentally disabled clients. Defendant Laird Richmond (Richmond), now deceased, was the owner and administrator of RTS. Lowery was an employee of RTS. Contrary to the assertion in the Court of Appeals opinion, Lowery was not the "Director" of RTS. In 2015 he was appointed Treasurer of RTS responsible for funds and securities.

Relator Lisa Hunter (Hunter) was a bookkeeper for RTS and brings this Qui Tam action. The State of Washington intervened. This action alleges submission of false expense claims in the annual cost reports which reconcile provider costs against monies paid by DDA. Hunter prepared cost reports for 2012, 2013, 2014. Hunter's successor prepared the 2015 report.

Lowery provided Hunter a sleep hours formula based upon a Federal Department of Labor (DOL) audit to determine the number of sleep hours incurred by RTS employees for internal reports. CP 640. If a cost report revealed RTS had been paid for service hours it did not actually provide to clients, it would be required to reimburse DDA for those amounts. Nothing in DDA express policy guidance requires sleep hours to be paid. Appendix 2.

DDA and RTS had regular rate setting meetings to estimate the amount to be paid to RTS for services to each client. The Complaint in this action alleges cost reports submitted by RTS included sleep hours in violation of DDA policy.

All cost reports at issue were prepared by the bookkeeper, Hunter, and submitted to the State by Richmond as owner and administrator of RTS. As administrator for the service provider, Richmond had legal obligations including oversight of all aspects of staffing, policies and procedures, and maintaining financial records. Before assuming duties, an administrator must complete instruction and training. WAC 388-101D-0055.

For each cost report submitted by RTS, administrator Richmond signed a certification which reads:

> MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHBLE BY FINE AND/OR

> IMPRISONMENT UNDER STATE OR FEDERAL LAW. I HEREBY CERTIFY that I have read the statement and that I have examined the accompanying cost report and supporting schedules prepared for [service provider's name] and to the best of my knowledge and belief, it is true, correct and complete statement prepared in accordance with applicable instructions, except as noted.
>
> CP 627; RP 116.

Lowery did not sign the certifications, prepare the reports, nor did he review the reports for accuracy or compliance. RP 115. The Complaint alleges Lowery "permitted" the filing of a false claim. CP 110.

The Court of Appeals opinion finds several errors by the trial court. The Court of Appeals struck findings relative to RCW 74.66.020(1)(a-c) and findings of conspiracy. Instead, the Court of Appeals found Lowery jointly and severally liable with RTS and Richmond for violation of 74.66.020(1)(g). That subsection provides as follows:

> (g) Knowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the government entity, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government entity.

V. ARGUMENT

A. Interpretation of the Washington Medicaid Fraud Statute RCW 74.66 affects a substantial public interest.

Pursuant to Washington Rules of Appellate Procedure 13.4(b), a petition for discretionary review can be granted – if the petition involves an issue of substantial public interest that should be determined by the Supreme Court. RAP 13.4(b)(4) (Westlaw 2020). A substantial public interest exists where the Court of Appeals' holding below will affect numerous other individuals. See, e.g., *State v. Watson*, 155 Wn.2d 574, 577 (2005).

There are no Washington Cases interpreting or applying RCW 74.66 et al - the Medicaid Fraud False Claims Statute. Not only does this case involve a case of first impression but pertains to the application and interpretation of a statute which the Legislature expressly adopted to provide the State with another tool to combat fraud which has resulted in over $5 Billion in total recoveries to the State between 1996 and 2009.

Yet, despite the State’s new arsenal at its disposal, the Legislature also made clear that this statute was not intended to focus on clerical errors or mistakes in interpretation but was to be used as a weapon to lower health care costs across the State.

By failing to review the trial and appeal's Courts errors, the Supreme Court would leave intact a decision by both the Trial and Appeals Court which undercuts the policy goals the statute aims to carry out. Contractors with Medicaid will face increased compliance costs - only increasing the burden of the taxpayer.

The public interest involved at bar requires review and thus the petition must be granted.

The Court of Appeals opinion affirming liability as to RTS, Richmond, and Lowery jointly sets Washington apart from federal False Claim Act decisions. The Court of Appeals specifically rejected the trial court's finding of conspiracy. Nonetheless, the Court of Appeals found RTS, Richmond, and Lowery liable "as individuals for causing false statements material to their obligations to pay the State". Opinion, p. 14. The obligation to pay the State is an obligation of the service provider, RTS. The only party certifying the false report to the State was its owner and administrator, Richmond. Mere knowledge of the submission of claims and knowledge of the falsity of those claims is insufficient to establish liability under the federal False Claims Act. *United States ex rel Sikkenga v. Regence Bluecross Blueshield of Utah*, 472 F.3d 702, 714 (10th Cir 2006).

A proper interpretation of the Act requires that absent of finding of conspiracy, participation in setting corporation policy by an employee or officer of a corporation cannot be the basis of liability under the Act. *Huey v. Summit Healthcare Association, Inc.*, 2011 WL 814898.

B. Lowery did not knowingly make, use, or cause a false record submission to the State.

The evidence is undisputed that the cost reports at issue were not prepared by Lowery. They were prepared by the Relator, Hunter. They were reviewed, certified, and submitted to the State by the RTS administrator Richmond.

The Court of Appeals misinterprets Lowery's position that lack of ownership or control of RTS excludes potential liability. Lowery concedes he is a "person" defined in RCW 74.66.020(1) with potential liability pursuant to RCW 74.66.020(1)(g). The Court of Appeals correctly finds that Lowery is a "person" subject to potential liability.

The State must prove the requisite intent to prevail on a claim under RCW 74.66.020(1)(g). There must be a "knowing" violation.

The legislature defined "knowing" to mean that a defendant 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. RCW 74.66.010(7)(a).

Additionally, the State must show "materiality". In this case of first impression, the Court should look to federal precedent to help guide the interpretation of the Act where the texts of the federal and state statutes are similar. *Barvo v. Dolsen Cos.*, 125 Wash.2d 745, 754 (1955). As federal case law illustrates, materiality is a demanding standard because the False Claims Act is not an "all-purpose anti-fraud" statute. *Universal Health Services v. United States ex rel Escobar*, 136 S.Ct. 1989, 195 L.Ed.2d 348 (2016).

Federal courts have refused to allow the government to prevail on a false claims act violation where the claim is based upon a difference in interpretation of policy. *US ex rel Hindow v. University of Phoenix*, 461 F.3d 1166, 1174 (9th Cir. 2006).

It is undisputed that the Federal Department of Labor (DOL) conducted an audit of RTS in 2000 requiring compliance with federal labor regulations including 29 CFR 785.22. Lowery's testimony and testimony from the State investigators confirmed this audit. RP 118 – 120. The DOL audit formed the basis for Lowery's formula for calculation of sleep hours. The Court of Appeals opinion concludes Lowery acted knowingly because he incorrectly relied upon the federal DOL audit in calculating sleep hours. DOL regulations conflict with DDA policies on sleep hours. See Policy Guide, 6.04. The Court of Appeals opinion concludes the DOL has no "authority to provide guidance on Washington DDA policies concerning reimbursement of patient services". Opinion, p. 13.

The foregoing overlooks the definition of knowing and knowingly at RCW 74.66.010(7). Knowing and knowingly 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. Accepting Relator Hunter's testimony that she brought her "concern" to Lowery continually year after year she nonetheless prepared cost reports for 2012, 2013, 2014. It is undisputed Lowery believed RTS was required to comply with the federal DOL regulations on sleep hours. The evidence does not support a finding of knowingly submitting false statements to the State.

The Act does not define "causation" or "cause" nor how it should be applied. RCW 74.66.010(1)(g) requires a defendant "Knowingly makes, uses, or causes to be made or used a false record or statement . . . ". Applying Washington's common law terms, "caused" is interpreted as "proximate causation". *State v. Pacheco*, 125 Wash.2d 150, 154, 882 P.2d 183 (1994) ("When a term is not defined in a statute, the court may look to common law or a dictionary definition").

In general, proximate cause is defined by two elements, cause in fact and legal causation. *Christen v. Lee*, 113 Wash.2d 459, 507, 780 P.2d 1307 (1989). Cause in fact refers to "but for" consequences, while legal causation is a policy consideration determining whether the connection between the ultimate result and the act of defendant is too remote or too insubstantial to impose liability. See *Schooley v. Pinch's Deli Market Inc.*, 134 Wash.2d 468, 478 – 79, 951 P.2d 749 (1998).

Proximate causation is a standard used in federal courts. *United States v. Luce*, 83 F.3d 999, 1012 – 1013 (7th Cir. 2017). This standard has been adopted because is separates the wheat from the chaff, allowing federal false claim act claims to proceed against those who can be fairly said to have caused a claim to be presented to the government while winnowing out those claims with only an attenuated link between the defendant's specific actions and the presentation of the claim. *Luce*, supra at 1012 – 1013.

Each cost report must be reviewed for accuracy by administrator Richmond prior to submission. The administrator also signs a certification. Lowery did not sign the certifications nor did he review for accuracy or compliance, nor was he under a duty to due so. RP 115. Richmond reviewed, verified and certified for accuracy each cost report. RP 115. Lowery did not prepare the cost reports RP 240 – 251. If liability is extended to Lowery, it is clear the Relator herself should be liable because she actually prepared the reports.

Causation under the act should be clarified to mean proximate cause. Lowery neither caused nor permitted a false record to be made under circumstances where the cost reports were submitted to the RTS administrator who had the regulatory obligation to review the accuracy and ensure compliance with DDA regulations. WAC 388-101D-0055. Richmond was the proximate cause of the submission of any false reporting.

C. Joint and several liability does not apply absent a finding of conspiracy under RCW 74.66.020(1)(c).

The Court of Appeals opinion found error with the trial court's determination that Lowery conspired to violate the act. The trial court's "findings related to conspiracy are error." Opinion, p. 13 – 14. Instead, the Court of Appeals interpreted the trial court's ruling that concerted action by Lowery, Richmond and RTS established individual and joint and several liability.

To the extent the Court of Appeals opinion holds Lowery separately liable for violation of the Act, no such finding by the trial court was made. The trial court found Richmond and Lowery acted together and in concert causing the cost reports to be filed. The trial court concluded Lowery and Richmond "conspired with each other" to violate the Act. CP 646. Additionally, the evidence does not support a finding of individual liability by Lowery where he did not prepare, certify or submit the cost reports.

The Court of Appeals opinion rejects a finding of conspiracy under RCW 74.66.010(1)(c) which imposes liability if a person "Conspires to commit one or more of the violations in this subsection (1)". Yet the court affirms violation of RCW 74.66.010(1)(g) asserting joint and several liability while acknowledging the State did not allege Lowery conspired to violate the Act.

The Act should not be interpreted to adjudge concerted activity under (1)(g) while specifically rejecting conspiracy liability on (1)(c). Federal False Claim Act cases make clear that only a conspiracy to defraud the government renders joint and several liability. See *Peterson v. Weinberger*, 508 F.2d 45, 49 (5th Cir. 1975); *United States v. Bd. of Educ. of City of Union City*, 697 F.Supp. 167, 177 (Dist. N.J. 1988); *United States v. Entin*, 750 F.Supp. 512 (S.D. Fla. 1990).[1]

Substantial public interest of state service providers and employees compels clarification of the applicability of the doctrine of joint and several liability to the Act where a finding of conspiracy is specifically rejected.

Under Washington law RCW 4.22.030 addresses joint and several liability in tort actions. The fault of each defendant is determined and each defendant is normally liable only for its proportionate share of plaintiff's damages. Several liability is the default with joint and several being the

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[1] There are no cases found by counsel for petitioner where joint and several liability is imposed absent a finding of conspiracy to defraud the government.

exception. Joint and several liability may exist if multiple parties were acting in concert or if one party was acting as agent or servant of another. RCW 4.22.070(1)(a). See *Afoa v. Port of Seattle*, 176 Wash.2d 460, 421 P.3d 903 (2018).

Lowery cannot be held independently liable pursuant to the intracorporate conspiracy doctrine. That doctrine holds that the acts of corporate officers in carrying out duties for a corporation are attributed to the corporation itself thereby negating the multiplicity of actors necessary for the formation of a conspiracy or concerted action. *McAndrew v. Lockheed Martin*, 206 F.3d 1031, 1036 (11th Cir. 2000). Simply put, under the doctrine, a corporation cannot conspire with its employees, and its employees, when acting in the scope of their employment, cannot conspire among themselves.

Court have found an exception to this doctrine through the Independent Interest Exception. If the agent had a "wholly separate and independent interest" in carrying out the actions, the doctrine would not apply.

No benefit to Lowery exists justifying the Independent Interest Exception. Courts have rejected the exception when the benefit is a salary, bonus, or commission because compensation is not a sufficient personal interest to trigger the exception. The compensation is directly tied to the corporation's success and those interests cannot be separated. *HRCC, Ltd. v. Hardrock Café International*, 302 F.Supp.3d 1319, 1325 – 26 (M.D. Fl 2016).

Liability as to Lowery, whether individual or joint, is not established in this case absent a finding of conspiracy or an express finding of individual liability.

VI. CONCLUSION

Petitioner requests review of the Court of Appeals decision and order reversing the judgment, dismissing the action as to Jason Lowery and the Lowery community only.

Respectfully submitted this 2nd day of December, 2020.

/s/ Michael F. Sherman
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APPENDIX 1

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

STATE OF WASHINGTON, ex rel. LISA HUNTER, an individual, Respondents, v. JASON LOWERY and JANE DOE LOWERY, and the Lowery community, Appellants, RELATIONSHIPS TOWARD SELF-DISCOVERY, INC., a Washington corporation; LAIRD RICHMOND, JANE DOE RICHMOND, and the Richmond community estate, Defendants.	No. 79959-2-I DIVISION ONE PUBLISHED OPINION

APPELWICK, J. — Lowery appeals the judgment in a bench trial finding him liable for violating the Washington False Claims Act, chapter 74.66 RCW. The judgment is based on the submission of false expense claims in the annual reconciliation against moneys advanced for care of state disability clients. Lowery claims he cannot be liable because (1) he was only an employee and not an owner or control person of RTS; (2) he did not personally prepare the fraudulent reports; and (3) the State was aware of his allegedly false billing practices and continued to pay his claims. He also claims the trial court erred in finding a conspiracy

Citations and pin cites are based on the Westlaw online version of the cited material.

between himself, the owner, and RTS. We strike the findings relating to withdrawn and unstated violations. We otherwise affirm.

FACTS

The Washington State Developmental Disabilities Administration (DDA) contracts with private companies to provide services to developmentally disabled adults. DDA is a division of the Department of Social and Health Services (DSHS). Relationships Toward Self Discovery, Inc. (RTS) was a supported living program that contracted with the DDA to provide staffing and supervision services for this purpose.

DDA and RTS had regular rate setting meetings to estimate the compensation due to RTS per client. This process involved projecting how many hours of care each client needs. It began with DDA determining the base level of support that a client needs. This rate was then adjusted to account for the clients' actual living situation. For clients who live in a group setting, staff are expected to care for multiple clients, such that clients can "share" staff hours. During the night, when clients are presumed to be sleeping, one staff member might be expected to provide support for four clients. Thus, even though a client may require 24 hours of support in a day, the adjusted hours that DDA authorizes during rate setting meetings might be only 12 hours.

DDA paid RTS on a monthly basis. RTS was required to submit an annual cost report that reconciled funds received with services actually provided to clients. If the cost report revealed that RTS had been paid for service hours it didn't actually provide to clients, it would have to reimburse DDA for those services.

RTS clients require 24 hour supervision. RTS provides this supervision with a "live in" staffing model. In this model, staff sleep at residential facilities and are available to assist clients with whatever needs they may have during the night. RTS staff were not paid an hourly wage for sleep hours unless they awoke to care for a client.

RTS was paid for its work through a contract with the DDA. Its mission is to provide home, community, and facility based residential and employment supports. The DDA contracted with RTS to provide these services. As a DDA contractor, RTS received payments through the DDA from Medicaid.

The dispute in this case involves RTS's reporting of sleep hours in cost reports from 2012, 2013, 2014, and 2015. In those cost reports, RTS reported sleep hours as paid hours worked, but it did not pay employees for those hours unless they were awakened to provide care.

Laird Richmond was the owner of RTS. Jason Lowery was the director of RTS. Lisa Hunter was a contracted bookkeeper for RTS from 2004-2015. Hunter prepared the 2012, 2013, and 2014 cost reports. Lowery and Lisa Aird, Hunter's successor, prepared the 2015 report.

Hunter testified that she reported unpaid sleep hours on the cost reports determined by a formula given to her by Lowery. DDA guidelines instruct providers to include only paid hours worked in cost reports as reimbursable service hours. These guidelines appear in a DDA policy manual, rather than the Washington Administrative Code. Sleep hours may be included only to the extent that the number is adjusted to include only actual paid hours worked.

Hunter understood that sleep hours should not be submitted for payment unless they were actually paid to employees. She raised these concerns with Lowery "continually . . . year after year." She also had a meeting with Lowery in April 2015, after several cost reports had been submitted, in which she tried to stop RTS from continuing to submit unpaid sleep hours. She testified that Lowery's response to her objections was to say, "[S]omething has to be done. I'm going to lose my business and my house."

She also raised her concerns with Richmond. On April 15, 2015, she sent a long text message to Richmond outlining why the way in which she was being instructed to report sleep hours was inappropriate. RTS terminated Hunter's contract the following month.

Hunter thereafter filed a qui tam complaint against RTS, Richmond, and Lowery.[1] She alleged that they violated the Washington Medicaid False Claims Act (WAFCA), chapter 74.66 RCW, and employment discrimination. The State intervened, filing its own complaint against the defendants alleging violations of the WAFCA, common law fraud, unjust enrichment, and conversion.

RTS ceased doing business in 2016 and is now defunct. Richmond died in 2017. Both defaulted on the claims against them. Only Lowery actively participated in the defense of these claims.

Both sides moved for summary judgment. The trial court denied both motions. The trial court then held a four day bench trial. At summary judgment,

[1]RCW 74.66.050 allows a person to bring a civil action for a violation of RCW 74.66.020 on behalf of themselves and on behalf of the government. The person bringing the action is known as a "qui tam relator."

the State's counsel orally represented that it was pursuing only its claim that Lowery violated RCW 74.66.020, and not any others. Specifically, the State alleged a violation of RCW 74.66.020(1)(g), that imposes liability for submitting false statements related to an obligation to pay the State. The parties agree that the State submitted only the WAFCA claim for adjudication by the court.

Nevertheless, the trial court entered findings of fact and conclusions of law finding the defendants liable for all the State's original claims. Lowery moved for reconsideration, arguing that he should not be liable for claims the State had abandoned. The trial court requested additional briefing, including any other proposed changes to the findings that Lowery wished to make. The trial court issued new findings accepting that the State had dropped all claims except for a violation of the RCW 74.66.020(1), but affirmed that Lowery was liable under that claim. The trial court found Lowery liable for violating RCW 74.66.020(1) subsections (a)-(b), that relate to claims for payment, subsection (c), related to conspiring to violate the statute, and subsection (g), related to obligations to pay the government.[2]

Lowery appeals.

DISCUSSION

Lowery makes seven arguments. First, he argues that he cannot be liable under the WAFCA because he is not an owner or control person of RTS. Second,

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[2] The trial found that RTS, Laird, and Lowry violated RCW 74.66.020(1) in five ways. Each conclusion of law is labeled as a subsection which mirrors the language of the subsections of RCW 74.66.020(1). Subsections (a)-(d) in the conclusions of law correspond to RCW 74.66.020(1)(a)-(d). Subsection (e) of the conclusions of law corresponds to subsection (g) of the statute.

he claims that he cannot be liable under WAFCA because he did not prepare, review, certify or submit the fraudulent cost reports. Third, he argues that he cannot be liable because the State had prior knowledge of RTS's reporting practices but still paid RTS's claims. Fourth, he argues that the trial court erred in finding he conspired to violate WAFCA without evidence of an agreement to conspire to accomplish an unlawful purpose. Fifth, he claims the intracorporate conspiracy doctrine bars a finding of conspiracy in this case. Sixth, he argues that cost reports are not "claims" under RCW 74.66.020(1)(a). Last, he argues that he did not act "knowingly" under RCW 74.66.020(1).

As an initial matter, Lowery argues that all of his assigned errors are entitled to de novo review. This case presents both legal and factual questions. We review the trial court's conclusions of law and statutory interpretations de novo. McCleary v. State, 173 Wn.2d 477, 514, 269 P.3d 227 (2012). We review the trial court's challenged findings of fact for substantial evidence. Id.

I. Liability for Non-owners

Lowery argues first that he cannot be liable under WAFCA because he is not an owner or control person of RTS.

RCW 74.66.020(1) provides,

> [A] person is liable to the government . . . if the person:
>
> (a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (b) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> . . . .

> (g) Knowingly makes, uses, or causes to made or used a false record or statement material to an obligation to pay or transmit money or property to the government entity, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government entity.

RCW 74.66.010(11) defines "person" as "any natural person, partnership, corporation, association, or other legal entity, including any local or political subdivision of a state." The trial court found that Lowery is a "person" for the purposes of the State's WAFCA claims.

Our goal in interpreting statutes is to ascertain and carry out the legislature's intent. State v. Alvarez, 128 Wn.2d 1, 11, 904 P.2d 754 (1995). If the language is clear on its face, courts must give effect to its plain meaning and assume the legislature means exactly what it says. State v. Chapman, 140 Wn.2d 436, 450, 998 P.2d 282 (2000).

Such is the case here. The statute clearly places liability on any "person" who commits one of the acts listed in RCW 74.66.020. It provides a definition for "person" that includes "natural person[s]." RCW 74.66.010. Lowery would have the court interpret that definition to require that the "person" must be an owner or control person of a company on whose behalf the false claim was submitted. The statute contains no such limitation on liability. And, Lowery cites no case law to support the addition of an "owner" or "control person" requirement to the statute.

We affirm the trial court's finding that Lowery is a "person" subject to liability under WAFCA.

II. Cost Reports as a "Claim"

Lowery argues that the trial court erred in finding him liable under RCW 74.66.020(1)(a)-(c) because the cost reports are not a "claim" as defined by the statute. The trial court found that Lowery violated RCW 74.66.020(1) by "knowingly . . . causing . . . false or fraudulent claims [to be submitted]," and "knowingly making . . . false records or statements material to the false or fraudulent claims."

RCW 74.66.020(1) establishes several bases for liability. Subsections (a)-(b) establish liability when a person submits false claims "for payment" or false statements in support of those claims. The trial court found liability based on fraudulent reporting of sleep hours in cost reports. Lowery is correct that the cost reports were not "claims for payment." Rather, the cost reports reconcile RTS's obligation to reimburse the State for payments already made to RTS.

For this reason, the State made clear at trial that it was not alleging Lowery was liable under subsections RCW 74.66.020(1)(a)-(b). Rather, the State alleged liability attached under RCW 74.66.020(1)(g). That subsection imposes liability on a person who causes a false record or statement "material to an obligation to pay . . . the government entity or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay . . . the government entity." RCW 74.66.020(1)(g). The cost reports fit squarely in that subsection, because they determined the amount RTS was obliged to refund the State for overpayment over the year. The trial court found Lowery was liable under this subsection as well.

We agree that the trial court erred in finding that Lowery submitted false "claims for payment" under RCW 74.66.020(1)(a)-(b), because the cost reports at issue did not cause the State to pay RTS. Therefore, we strike the findings related to subsections (1)(a)-(b).[3] However, the trial court did not err in finding that submission of the cost reports violated RCW 74.66.020(1)(g). Thus, the erroneous findings related to subsections (1)(a)-(b) are harmless. We affirm that providing false information in cost reports was a violation of the statute.

III. Causation

Lowery argues next that he is not liable because he did not prepare, review, certify, or submit the fraudulent cost reports. The trial court found that Richmond and Lowery "caused" the fraudulent cost reports to be submitted to the State. Causation is generally a fact question for the trier of fact. Hertog v. City of Seattle, 138 Wn.2d 265, 275, 979 P.2d 400 (1999). We do not disturb findings of fact that are supported by substantial evidence. McCleary, 173 Wn.2d at 514. Substantial evidence exists if the record contains evidence sufficient to persuade a fair-minded, rational person of the truth of the declared premise. In re Custody of A.T., 11 Wn. App. 2d 156, 162, 451 P.3d 1132 (2019). The party claiming error has the burden of showing that a finding of fact is not supported by substantial evidence. Id.

Lowery seeks to minimize his role in causing the submission of the false statements in the cost reports. He argues that he did not prepare, certify, or review

[3] Those findings are found in the trial court's conclusions of law, section B, paragraph 6, subsections (a)-(b).

the reports. Instead, he characterizes his role as "merely a conduit facilitating a transfer of the required documents between [Hunter] and Richmond."

Lowery's description is not supported by the record. When asked what role Richmond played in the preparation of the reports, Hunter replied, "He signed it." When asked if Richmond did any other work on the reports, she replied, "No." Hunter testified that Lowery was much more "hands on" in the preparation of cost reports than Richmond. She further testified that Lowery gave her the formula with which to determine the number of sleep hours to submit in the cost reports. She also testified that Lowery would adjust the formula to make sure it was "on target" for the appropriate number of hours. Hunter understood that sleep hours should not be submitted for payment unless they were actually paid to employees. She raised these concerns with Lowery "continually . . . year after year." She also had a meeting with Lowery in April 2015, after several cost reports had been submitted, in which she tried to stop RTS from continuing to submit unpaid sleep hours. She testified that Lowery's response to her objections was to say, "[S]omething has to be done. I'm going to lose my business and my house." This evidence is sufficient to persuade a rational, fair-minded person that Lowery caused the false statements in the cost reports to be submitted.

We affirm the trial court's finding that Lowery caused the false report to be submitted.

IV. State's Knowledge

Lowery argues that he cannot be liable because the State was aware of RTS's practices around sleep hours in cost reports and paid anyway.

Whether or not the State actually had knowledge of RTS's billing practices is a question of fact. We review questions of fact for substantial evidence. McCleary, 173 Wn.2d at 514. Lowery points to the "extensive" involvement of the State in the rate setting process with RTS. He claims that RTS was transparent with the State about its billing practices during these rate setting meetings. The State characterizes these meetings differently. It argues that the purpose of these meetings was not to discuss billing practices, but to set the value of services provided to clients. The State argues it was unaware that RTS was submitting unpaid hours for payment by the State.

Substantial evidence supports the State's position. An employee of RTS testified that RTS was "totally transparent" about billing practices concerning sleep hours. But, a DSHS employee who discussed rate setting with RTS testified that billing and reimbursement practices were not discussed at rate setting meetings. And, Lowery points to no documentation that he submitted to the State showing that RTS was submitting unpaid hours for payment by the State.

Hunter confronted Lowery about the cost reports in 2015. Lowery did not assert that he had informed the State of the practice. Rather, he said, "[S]omething has to be done. I'm going to lose my business and my house." Taken together, this evidence is sufficient to convince a fair-minded, rational person that the State was unaware that RTS was submitting unpaid sleep hours for payment by the State.

We affirm the trial court's finding that the State was unaware RTS was submitting unpaid sleep hours for reimbursement.[4]

V. Lowery's Knowledge

The trial court found that Lowery acted "knowingly" in violating WAFCA. Lowery argues this was an error.

We review questions of fact for substantial evidence. McCleary, 173 Wn.2d at 514. RCW 74.66.020 imposes liability only on a person who acts "knowingly." The statute defines "knowing" as actual knowledge of the information, and acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth or falsity of information. RCW 74.66.010(7)(a).

Lowery argues that he did not act knowingly because he believed that RTS's reporting of sleep hours was permissible. He relies primarily on an overtime audit of RTS by the United States Department of Labor (DOL). He claims that, through this audit, DOL confirmed that RTS's practice of not paying sleep hours unless the employee's sleep is interrupted was permissible under DOL regulations. He claims this creates a "conflict" between DOL regulations and DDA policies. This is not so. Whether or not employees may be unpaid for sleep hours under DOL regulations has nothing to do with whether or not RTS may submit those unpaid hours for payment to RTS by the State of Washington.[5] And, Lowery has

[4] Because we find that the State was unaware of RTS's billing practices, we need not address whether such knowledge is a defense to liability under the WAFCA.

[5] At oral argument, Lowry sought to argue that there is also a discrepancy in the DDA policy statement. He claims this is so because, while the DDA policy indicates that only actual paid hours worked may be submitted for reimbursement, a different subsection allows that sleep hours may be submitted in certain

not explained why the federal DOL would have any authority to provide guidance on Washington DDA policies concerning reimbursement for patient services.

Lowery argues that the only evidence in the record that RTS was aware it was not in compliance with DDA policies was a 2015 text message from Hunter to Richmond that Lowery was not aware of. That is not true. Hunter testified that she also brought her concerns directly to Lowery. She testified that she did this "continually . . . year after year." And, the trial court specifically found that Lowery's testimony that he believed the reporting of unpaid sleep hours was permissible was not credible. This evidence is sufficient to persuade a rational, fair-minded person that Lowery acted knowingly with respect to the fraudulent reporting of sleep hours.

We affirm the trial court's finding that Lowery acted knowingly in the fraudulent reporting of sleep hours.

VI. Conspiracy

Lowery argues the trial court erred in finding that he conspired to violate the WAFCA. The trial court found that Lowery and Richmond violated WAFCA by conspiring with each other to do so.[6] The State did not allege Lowery conspired to violate WAFCA. Rather, the State alleged that the defendants were jointly and

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situations. There is no ambiguity. The first subsection establishes a baseline that only paid hours worked may be reported. The following subsections clarify what types of paid hours may be reported. Thus, that a subsection allows that sleep hours may be reported in certain situations, it presumes that those hours must actually be paid to employees in order to be reimbursed.

[6] That finding is found in the trial court's conclusions of law, section B, paragraph 6, subsection (c).

severally liable. Lowery therefore did not have notice to defend himself from a conspiracy charge. The trial court's findings related to conspiracy are error.

However, Lowery does not challenge the trial court's determination that he can be jointly and severally liable under the statute. He has not argued that liability should be apportioned or that he cannot be jointly and severally liable.

The trial court found Lowery, Richmond, and RTS liable as individuals for causing false statements material to their obligations to pay the State. That alone is enough to confer liability on Lowery. RCW 74.66.020(1)(g). A finding of conspiracy was therefore unnecessary. We find that the trial court erred in finding Lowery conspired to violate WAFCA, but that the finding is harmless and does not affect the judgment.

We strike the findings relative to RCW 74.66.020(1)(a)-(c) and to conspiracy. We otherwise affirm the judgment.

Appelwick, J.

WE CONCUR:

Bowman, J. Verellen, J.

APPENDIX 2

DIVISION OF DEVELOPMENTAL DISABILITIES
Olympia, Washington

TITLE:	RESIDENTIAL PROGRAMS COST REPORTING	POLICY 6.04

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DIVISION OF DEVELOPMENTAL DISABILITIES
Olympia, Washington

TITLE:	RESIDENTIAL PROGRAMS COST REPORTING	POLICY 6.04

Authority:	Chapter 71A RCW	*Developmental Disabilities*
	Chapter 388-101 WAC	*Certified Community Residential Services and Support*

PURPOSE

This policy establishes procedures and criteria for cost reporting and the settlement process for Division of Developmental Disabilities (DDD) contracted residential programs.

SCOPE

This policy applies to DDD contracted and certified residential programs, which means Supported Living (SL) programs, Group Homes (GH), and Group Training Homes (GTH).

DEFINITIONS

Administrative Staff means owners, officers or employees of the contractor, including executive directors, administrators, accountants, bookkeepers, clerical support and/or secretaries whose primary job functions require a majority of time for administrative, management and/or operational support. Administrative staff may also include corporate staff whose time is allocated to the contractor.

Arm's-Length Transaction means a transaction resulting from good faith bargaining between a buyer and seller who hold adverse positions in the market place. Arm's-length transactions are presumed to be objective transactions between disinterested parties (meaning neither the buyer nor the seller has a financial incentive to buy or sell at a price more or less than market value).

Client means a person who has a developmental disability and is:

1. Eligible under RCW 71A.10.020; and

2. Authorized by DDD to receive residential services described in Chapter 388-101 WAC.

Client-Specific Staff Add-On means a staffing increase above and beyond the individual instruction and support hours required and allowed in the standard rate provision of a contract, enabling a contractor to increase the individual instruction and support hours provided to a specific client.

Contract means a contract between the department and a contractor for certified community residential services to clients as described in Chapter 388-101 WAC.

Contractor means an entity contracting with the department to provide certified community residential services to clients as described in Chapter 388-101 WAC.

Cost-of-Care Adjustment means a reimbursement adjustment intended to cover the necessary costs of non-variable staff support and administration to provide services to residents during a time when their residence is temporarily not at full capacity.

Department means the Department of Social and Health Services (DSHS) and its employees.

Division means the DSHS Division of Developmental Disabilities and its employees.

Fringe benefits means benefits provided at the employer's expense to all employees who qualify. These may include sick leave, health insurance, paid vacation, holiday pay, retirement plan, and other benefits.

Full Time Equivalent (FTE) means a total of 2,080 hours (52 weeks x 40 hours) worked by one or more employees during a twelve-month period.

Group Home (GH) Program is included within the meaning of residential services described in Chapter 388-101 WAC and contract provisions. For purposes of this policy, “Group Training Home” is synonymous with “Group Home.”

Group Training Home (GTH) means a certified non-profit residential program as per RCW 71A22.020.

Housing Costs for Overnight Coverage means the costs of providing an apartment unit or other dwelling used by staff when working 24-hour or longer duty shifts. The costs incurred by the program for these housing costs are client support costs, and not to be reported as Instruction and Support Services compensation.

Indirect Client Support Costs (ICS) include Maintenance/Repair expenses for client housing, Client Transportation Expenses, and non-Instruction and Support Services Housing Costs for Overnight Coverage.

Instruction and Support Services (ISS) means client services required by Chapter 388-101 WAC and contract provisions. ISS are provided by staff designated as ISS staff (see definition below). ISS may also be provided by the administrator as described in this policy and by other administrative personnel (such as bookkeepers, accountants or maintenance workers) if the provision of ISS is included in their job description.

Instruction and Support Services (ISS) Staff means employees (including counselors, instructors and/or trainers) of the contractor whose primary job function is the provision of instruction and support services to clients. ISS staff shall include employees (e.g., program managers and supervisors) of the contractor whose primary job function is the supervision of ISS staff.

ISS Hours include:

- On the job hours worked by staff designated as ISS staff, including related training time;
- For staff who perform both administrative functions and ISS, the agency may include that portion of the employee's hours that are dedicated to ISS function;
- The administrator's hours worked as ISS as allowed under Section VII.C of this policy;
- Sleep hours may be counted as ISS for staff who are required to sleep over and are on duty in close proximity and are available to respond immediately in person at all times; and
- Call back hours for ISS employees who are required to carry pagers or otherwise are on call outside of their normal work hours. The maximum number of hours that may be counted as ISS are the accumulation of hours per shift for those occurrences from the time a call was received until the employee has been able to return to his/her previous activities, rounded up to the nearest hour.

The division may request verification of hours (e.g., time sheets, etc.) for all staff for which ISS hours are claimed.

ISS Staff Compensation for reporting purposes on the annual cost report includes:

- ISS staff salaries, wages, stipends and other compensation for staff that are designated as ISS, and prorated for those staff whose time is split between ISS and administrative functions;
- Employer paid payroll taxes relating the actual allowable ISS hours worked. For proprietary contractors, the portion of the Business and Occupation (B & O) tax applicable to the revenue received for ISS reimbursement may be included as payroll tax;

- Fringe benefits paid by the employer for ISS staff (prorated for those staff whose time is split between ISS and administrative functions);

- Staff lodging paid by the contractor and as defined in this section; and

- As provided for in section VII.C.2. of this policy, compensation for the administrator time used performing ISS duties. For settlement purposes, compensation is allowed at the benchmark compensation rate for contractors providing Supported Living (SL) services.

MA (Non-MSA) and MSA Counties: MSA means Metropolitan Statistical Area - A large population nucleus, together with adjacent communities that have a high degree of economic and social integration with that nucleus.

MSA: Metropolitan Statistical Area: Relatively freestanding MA that is not closely associated with other MAs. These areas typically are surrounded by non-metropolitan counties. A MSA must include at least:

- One city with 50,000 or more inhabitants; or

- A Census Bureau-defined urbanized area (of at least 50,000 inhabitants) and a total metropolitan population of at least 100,000.

For purposes of determining reimbursement rates as stated in this policy, Counties recognized as MSA counties in Washington are Asotin, Benton, Chelan, Clark, Cowlitz, Douglas, Franklin, Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom and Yakima.

Note: King County is recognized as having unique characteristics relative to other MSA counties for purposes of determining reimbursement rates as stated in this policy.

Professional Services are services provided by staff (either as employees or contracted personnel) including nurses, therapists and other licensed or specialized skills personnel and are reimbursed at a non-standard rate as specified in Exhibit B of the contract.

Related Organization is either an entity, which is under common ownership, and/or control with, has control of, or is controlled by, the contractor. An entity is deemed to "control" another entity if one entity has a five (5) percent or greater ownership interest in the other; or if an entity has the capacity (whether or not exercised) derived from a financial or other relationship to influence directly or indirectly the activities of the other.

Related Party is a spouse; natural parent, child or sibling; adopted child or adoptive parent; stepparent, stepchild, stepbrother, stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law; grandparent or grandchild; uncle, aunt, nephew, niece or cousin of the contractor.

Residential Services Program means a contractor's Group Home and Group Training Home or Supported Living (SL) residential program providing services in accordance with Chapter 388-101 WAC and contract provisions.

Staff Lodging means SL programs that provide the primary residence for a staff person as a part of their compensation package and may include the cost of the residence as ISS cost for cost reporting purposes. Staff lodging does not include the cost of maintaining a residential unit for the use of overnight staff when it is not their primary residence. The reporting of staff lodging cost for this purpose must be consistent with Internal Revenue Service (IRS) rules for reporting housing to employees as income.

Supported Living (SL) is included within the meaning of residential services as described in Chapter 388-101 WAC and contract provisions.

POLICY

A. Contractors shall report costs of operations for purposes of providing data to the division and to determine any settlements due.

B. The division shall:

1. Set standard rates for each cost center for programs covered within this policy;
2. Describe allowable costs and specify the reporting requirements;
3. Describe the rate setting methodology and principles that apply to programs;
4. Describe the settlement process as it applies to residential programs;
5. Describe the summer program requirements and payment procedures; and
6. Provide information on billing and payment requirements and procedures.

PROCEDURES

I. REPORTING

A. Cost Reports

1. In order for a contractor to receive payments under the residential reimbursement system, the contractor must submit an annual DDD cost report covering the completed calendar year.

2. If a contractor terminates from the residential program, the former contractor shall submit a final annual report covering the period the

contract was in effect during the calendar year. The final annual report shall be used for determining a settlement for the final period.

B. Due Date of Report

1. The cost report shall be submitted on or before March 31 of the year following the calendar year covered in the report.

2. Cost Report Extension Provisions

   a. A thirty (30) day extension beyond the date specified above will be granted to contractors upon written notification to the Office of Rates Management (ORM) that the additional time is required to complete the report. The notification shall include a brief explanation of the circumstances that require the extension. An approval from the department will not be required for this thirty (30) day extension.

   b. The department, upon a written request setting forth reasons for the necessity of an extension beyond the thirty (30) day extension specified above, may grant an additional thirty (30) day extension for submitting the cost report. The request must be written and received by the ORM prior to the due date as specified in ‘1’ and ‘2.a.’ above. The ORM will respond to this request within ten (10) working days from the date of receipt.

C. Completing Reports and Maintaining Records

1. Reports shall be completed in accordance with instructions provided by the department. If no specific instruction covers a situation, generally accepted accounting principles shall be followed.

2. The department may analyze the submitted cost report and financial statement of each contractor to determine if the information is correct, complete, and reported in conformance with generally accepted accounting principles and the requirements of this contract and those policies, rules and regulations referenced therein. If the analysis finds that the cost report or financial statements are incorrect or incomplete, the division may make adjustments to the reported information.

3. A schedule of adjustments shall be provided to contractors in writing and shall include an explanation for the adjustments and dollar amounts of the adjustments.

a. If a contractor disagrees with an adjustment made under this section, the contractor shall, in writing, identify specifically the grounds for his/her contention that the adjustment is erroneous and include any documentation that supports the contractor's position.

b. If the contractor wishes to challenge the division's determination of the contractor's contention from subsection ‘a’ above, the contractor may request an administrative review pursuant to Chapter 388-101 WAC and/or the dispute clause as described in the general terms and conditions of the contract.

4. Contractors shall submit a single cost report that includes all business activities related to the cost of providing contracted services.

5. Facilities with joint residential program costs shall allocate and report shared costs to each residential program in accordance with allocation policies prescribed or approved by the department.

6. If a contractor fails to maintain records adequate for audit purposes or fails to allow inspection of such records by authorized personnel, the department may suspend all or part of subsequent payments due under the contract until compliance is forthcoming. Upon compliance, the department shall resume contract payments and shall release suspended payments pursuant to the contractor's contract.

7. Contractors shall maintain cost reports and records adequate for audit purposes. If, at the end of the contract retention period as specified in the work order, there are unresolved audit questions, the report will be retained until such questions are resolved.

D. <u>Report Certification</u>

1. Each required report shall be accompanied by a certification signed on behalf of the contractor responsible to the department during the report period. If the contractor files a federal income tax return, the certification shall be executed by the person normally signing this return. If the report is prepared by someone other than an employee of the contractor, that person’s name and contact information shall be included with the certification.

2. If a contractor knowingly files a report containing false information, such action constitutes cause for termination of the contractor's contract with the department. Contractors filing false reports may be referred for prosecution under applicable statutes.

E. Improperly Completed or Late Reports

1. An annual cost report must be completed in accordance with applicable department regulations and instructions. An annual cost report deficient in any of these respects may be returned in whole or in part to the contractor for proper completion.

2. If a report is not properly completed or is not received by the division on or before the due date of the report, including any approved extensions, all or a part of any payments due under the contract may be held by the department until the improperly completed or delinquent report is properly completed and received by the division.

II. REIMBURSABLE COSTS

A. Reimbursable Costs Definition

Reimbursable costs are documented costs that are necessary, ordinary and related to the provision of client support, training and activities as prescribed in Chapter 388-101 WAC and contract.

B. Depreciable Assets

The following costs shall be reported as depreciable assets:

1. Expenditures for equipment, furnishings or vehicles with historical acquisition cost in excess of $5,000 per unit and a useful life of more than one (1) year from the date of purchase;

2. Expenditures for equipment or furnishings with historical acquisition value of less than $300 per unit if the item was acquired in a group purchase where the total acquisition cost exceeded $5,000 and has a useful life of more than one (1) year from the date of purchase;

3. Expenditures for building, land and/or leasehold improvements which are in excess of $5,000 and which extend the useful life of the asset; and

4. Expenditures for assets as described above with historical acquisition value less than $5,000 may be reported as depreciable assets, or expensed in the year they were purchased.

C. Equipment and Building Expenses

The following costs shall be reported as expenses:

1. Those expenditures for equipment, furnishings, or building, land, or leasehold improvements not subject to classification as a depreciable asset; and

2. Repairs (damages) or maintenance (upkeep) costs that do not extend the useful life or increase the value of the building, equipment, furnishings or vehicles.

D. Reporting Depreciable Assets

1. Depreciable assets may include the following:

   a. *Building* - The basic structure or shell and additions.

   b. *Fixed Equipment* - Attachments to the building such as wiring, plumbing, and heating system.

   c. *Movable Equipment* - Such items as furnishings, beds, stoves, refrigerators, silverware, and dishes.

   d. *Vehicles* - Such items as automobiles or vans used to transport residents to activities, training, or work.

   e. *Land Improvements* - Such items as paving, on-site sewer and water lines, parking areas, shrubbery, fences, government assets, etc., where replacement is the responsibility of the Group Home and Group Training Home.

   f. *Leasehold Improvement* - Improvements and additions made by the lessee (contractor) to the leased property, which become the property of the lessor after the expiration of the lease.

2. Land is not a depreciable asset. Land includes the cost of such items as off-site sewer and water lines, the cost of permanent roadways, curbs and sidewalks, and utility hookups.

3. Depreciable assets shall be reported as follows:

a. The base used to calculate depreciation shall be:

(i) The historical cost to the contractor in acquiring the asset or capitalized expense from an unrelated organization less the estimated salvage value, if any; or

(ii) The fair market value of the donated or inherited asset or asset purchased with restricted donation at the time of donation or death less goodwill and salvage value, if any; or

(iii) Assets or capitalized expenses acquired from a related organization, which shall not exceed the lower of cost to the related organization or the cost of comparable assets purchased elsewhere.

b. The lives used to calculate depreciation expenses shall be:

(i) Building - Not less than thirty (30) years.

(ii) Building Improvements - The remaining useful life of the building as modified by the improvement.

(iii) Other Assets - Lives no shorter than guideline lives published by the IRS or by the American Hospital Association.

(iv) Lives shall be measured from the date of the most recent arm's-length acquisition of the asset.

c. The depreciation expense methodology used shall be acceptable by generally accepted accounting principles and the IRS methodology for the asset class being depreciated.

d. Changes in depreciation methodology during the life of the asset must be disclosed on the annual cost report.

E. <u>Interest</u>

1. Interest is defined as necessary and ordinary interest for working capital and capital indebtedness, which must be incurred for a financial need related to resident care, training, and activities.

2. Interest cost shall be at a rate not in excess of what a prudent borrower would have to pay at the time of the loan in an arm's-length transaction in the financial market.

3. Interest paid to a related organization shall not be reported in excess of the cost to the related organization of obtaining the use of the funds.

F. Donations and Contributions

1. Donations or contributions are classified as:

   a. *Restricted:* Grants, gifts, and income from endowments in the form of purchasing power which must be used only for specific purposes designated by the donor. Items whose nature restricts its use, such as food, supplies, equipment, vehicles or building space.

   b. *Unrestricted:* Grants, gifts, and income from endowments in the form of cash or purchasing power given to the facility without restriction by the donor.

   c. Volunteer time and donated consultant time.

2. Donations or contributions are reported as follows:

   a. The value of a restricted donation/contribution shall not be reported as an expense on the cost report;

   b. The value of an unrestricted donation/contribution shall be reported in the expense account for which it was used through the contractor's normal recording of transactions; and

   c. The value of the volunteer/donated time shall not be reported as an expense on the cost report.

G. Related Organization/Party Costs

1. Costs of services, facilities, and supplies furnished by related organizations to the contractor shall be reported at the lower of the costs to the related organization or the price of comparable services, facilities or supplies purchased elsewhere.

2. The cost of a related party lease shall be reported based on the lower of actual ownership cost (i.e., interest, depreciation, taxes, and insurance) to the related party or the arm's-length lease to the related party.

H. Joint Program Costs

1. Joint program costs are defined as expenses benefiting more than one program, or one program and any other entity.

2. Costs shall be allocated in accordance with cost reporting instructions.

I. Transportation Costs

1. Transportation costs are defined as:

   a. Ordinary and necessary transportation of clients for training and activities.

   b. Ordinary and necessary transportation of employees for program administration and operation.

   c. Ordinary and necessary travel of employees for in-service training and education.

2. The following costs shall be reported:

   a. The costs of operating vehicles limited to automobiles, vans, pickup trucks or buses that are used for the purposes defined in this section, including maintenance, repairs and operation. A mileage log shall be maintained detailing the usage of each vehicle not used 100 percent for the purposes defined in this section.

   b. The costs of public transportation for clients, volunteers and staff, which are for the purposes defined in this section.

   c. The costs of mileage reimbursement of employees and volunteers using their personal vehicle for actual mileage for the purposes defined in this section.

   d. Commuting between an employee's residence and their primary place of employment shall not be included as transportation. If a vehicle is used by any staff for travel that is not defined above, these shall be fringe benefit costs for that employee.

3. The contractor shall not seek or accept additional compensation from or on behalf of a client for any or all contracted residential services except:

   a. The contractor shall notify DDD in writing when the client contributes toward his/her costs for transportation.

b. Costs incurred by the contractor associated with this provision are unallowable costs and shall not be reported on the annual cost report.

J. Instruction and Support Services

1. ISS compensation for performance of ISS duties by an individual shall be reported as ordinary compensation for necessary services actually performed.

2. Compensation is ordinary when it is within a reasonable amount usually paid to an individual with necessary qualifications for similar services within the same or comparable programs.

3. A service is necessary if it would have had to be performed by another person if the individual in question had not performed it.

4. The reported ISS compensation for an individual staff must not exceed the reasonable amount criteria per item 2 above.

5. The division may request job descriptions for employees to verify the primary duties of the positions. Paid hours worked and payroll costs charged to ISS for cost reporting purposes must be verifiable in the agency’s records. The number of ISS paid hours reported for any individual employee or owner of an agency must not exceed 3,120 hours per year (designated live-in staff are exempt from this limitation). ISS staff shall also include contracted personnel whose job function is the provision of instruction and support services.

K. Fringe Benefits

Fringe benefits provided at the employer's expense may include sick leave, health insurance, paid vacation, holiday pay, retirement plan, as well as other benefits, to all employees who qualify.

III. SETTLEMENT

A. Settlement Definition

1. The settlement shall be for under utilization of contracted and paid service hours and dollars in the instruction and support service cost center.

2. Settlements shall be based on department payment system(s) reports, the contractor's financial reports, and/or other department-specified reports or documents.

3. The provisions of this section will apply to the settlement calculation for the entire calendar year in which the contract is effective.

4. A settlement as described in this section is considered an overpayment as defined in DSHS Administrative Policy No. 10.02, *Overpayments and Debts for Providers and Vendors:*

   "**Overpayments and debts**: is any department payment or benefit to a vendor or provider in excess of the amount the provider or vendor was entitled to by law, rule, or contract."

B. Settlement Determination

The contractor shall refund the greater of:

1. All amounts of ISS cost center rate reimbursement in excess of the allowable instruction and support service costs as defined in this policy, and as reported in the contractor's annual cost report and/or department-specified documents.

2. Reimbursement amounts received from DDD for professional services and professional services compensation paid by the contractor shall be included in the settlement calculation. For purposes of the settlement calculation, professional services reimbursement and compensation rates exclude administration amounts that may be included in the hourly professional service rate.

3. The total annual reimbursed hours for ISS and professional/licensed staff minus actual total annual paid hours worked as reported in the contractor's annual cost report and/or department-specified documents, multiplied by the weighted average reimbursement benchmark rate for ISS staff in effect during the settlement period.

4. Staff add-on reimbursements will be subject to the settlement provisions of this policy.

5. Nurse Delegation Core Training Staff Class Hours and dollars that are paid to an agency as reimbursement for agency staff time spent in attending training will be subject to the settlement provisions of this policy.

6. Reimbursement for agency staff time to attend training mandated through legislation or initiative will be subject to the settlement provisions of this policy.

7. Contractors not using all of their contracted ISS hours must provide information as to why the hours were not used and document the attempts to provide those hours. A plan to prevent future occurrences must be submitted.

8. When submitting a cost report that includes a settlement, a contractor that has had extraordinary ISS costs during the year may request to apply those extraordinary costs toward the settlement. The agency making the request may submit narrative justification and a breakdown of associated costs to enable the division to analyze the request.

9. Contractors that have Administrative/ICS or Non-ISS rates above the administrative rate standard for the reporting year will be required to return the administrative dollars associated with unused contracted ISS hours as determined by DDD. A worksheet showing the calculations to determine the settlement is available on the DDD Internet website in the Rates Management section of the Residential Provider Resources page at this address: http://www.dshs.wa.gov/ddd/res_provider_resources.shtml. The contractor may elect to have a two-year option for the administrative rate settlement following the same criteria and procedures as described in section F below.

C. Administrative Staff Hours Counted as ISS for Settlement Purposes

1. GH and GTH program administrators may provide ISS hours.

2. SL and combined programs (GH, GTH and SL):

a. For residential services programs that have twenty (20) or fewer FTE employees that support clients during the settlement period, settlements may include the program administrator's hours worked in an ISS staff capacity. The cost that may be applied in the settlement computation is the total hours worked as ISS staff multiplied by the benchmark compensation rate in effect during the period that the hours were worked.

b. For residential services programs that have more than twenty (20) FTE employees that support clients during the settlement period, settlements may not include administrator's hours worked in an ISS staff capacity in their settlement computation.

c. The hourly rate allowed for the administrator’s cost shall not exceed the contractor’s instruction and support staff compensation rate as specified in the contractor’s contract and rate notification.

d. An exception to item “b” above may be requested by any contractor. A copy of the approved exception to policy (ETP) must accompany the annual cost report if the administrative hours are reported as ISS for settlement purposes.

D. <u>Programs Combined for Settlement</u>

1. Contractors that have contracts with the division for the operation of multiple residential programs within a single region may collapse those contracts into a single contract for any combination of GH and GTH and SL programs. The single contract will identify the type(s) of residential program(s) and all applicable rates.

2. Programs combined under a single contract will be treated as a single entity for purposes of the settlement provisions of this policy. The contractor may combine the total reimbursement for ISS hours and compensation amounts subject to settlement per the contract, and the combined total of paid ISS hours and compensation into a single settlement calculation.

E. <u>Settlement Process</u>

The division will determine a settlement amount for each calendar year.

1. The contractor shall pay a settlement overpayment amount, or shall commence repayment in accordance with a schedule determined by the department, within thirty (30) days after receiving departmental notification of the overpayment amount. If a settlement determination is contested, the contractor shall pay or commence repayment within thirty (30) days after such proceedings are concluded.

2. The department will pay any amount due the contractor as a result of errors in billing or payment disclosed on the settlement within thirty (30) days after issuance of departmental notification of the amount due the contractor.

3. If the contractor does not refund the overpayment or any installment when due, or after the final decision from any administrative or judicial remedy sought by the contractor regarding the amount due, the department may withhold payments from current billings until the overpayment is refunded.

4. A proposed settlement may be revised by the department on the basis of audit findings or DDD certification evaluation findings.

F. Optional Two-Year Settlement Process

1. The contractor may request to have an optional two (2) year settlement. These settlements shall allow a collaborative process in order to minimize settlements due.

2. Contractors will indicate on their first year cost report whether or not they wish to participate in the optional two (2) year settlement process. Contractors may initiate the planning process with the region during the first year if preliminary data indicates that a settlement will materialize.

3. The request for a two-year optional settlement and plan must be sent in writing to the Regional Administrator for review and consideration no later than May 31 of the second settlement year. Example: For settlement 2011-2012, the request would be due by May 31, 2012.

4. A joint plan will be produced by June 15th of the second settlement year. If no plan is agreed upon by this date, the first year settlement amount is due according to the provisions of the previous settlement section.

5. Information derived from the first year's cost report will be used to develop a joint plan for use of the unspent ISS dollars to be followed during the second year of the settlement period. These funds will be used to increase service capacity or extend services to additional people. Funds retained through this process would be expended on direct supports rather than agency administration costs.

EXCEPTIONS

Exceptions to this policy may be approved by the Division Director or her designee based upon information submitted on DSHS 05-010, *Rule Exception Request*.

SUPERSESSION

DDD Policy 6.04
July 1, 2009

Approved: */s/ Linda Rolfe* Date: July 1, 2011
Director, Division of Developmental Disabilities

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: RESIDENTIAL PROGRAMS COST REPORTING POLICY 6.04

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DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	RESIDENTIAL PROGRAMS COST REPORTING	POLICY 6.04

Authority:	[Chapter 71A RCW]()	*Developmental Disabilities*
	[Chapter 388-825 WAC]()	*Developmental Disabilities Services*
	[Chapter 388-101 WAC]()	*Certified Community Residential Services and Support*

PURPOSE

This policy establishes procedures and criteria for cost reporting and the settlement process for the Developmental Disabilities Administration (DDA) contracted residential programs.

SCOPE

This policy applies to DDA contracted and certified residential programs, which means Supported Living (SL), Group Home (GH), and Group Training Home (GTH) services.

DEFINITIONS

Administration means the DSHS Developmental Disabilities Administration (DDA) and its employees.

Administrative Staff means owners, officers or employees of the contractor, including executive directors, administrators, accountants, bookkeepers, clerical support and/or secretaries whose primary job functions require a majority of time for administrative, management and/or operational support. Administrative staff may also include corporate staff whose time is allocated to the contractor.

Arm's-Length Transaction means a transaction resulting from good faith bargaining between a buyer and seller who hold adverse positions in the market place. Arm's-length transactions are presumed to be objective transactions between disinterested parties (meaning neither the buyer nor the seller has a financial incentive to buy or sell at a price more or less than market value).

Client means a person who has a developmental disability and is:

1. Eligible under RCW 71A.10.020; and

2. Authorized by DDA to receive residential services described in Chapter 388-101 WAC.

Client-Specific Staff Add-On means a staffing increase above and beyond the individual instruction and support hours required and allowed in the standard rate provision of a contract, enabling a contractor to increase the individual instruction and support hours provided to a specific client.

Contract means a contract between the Department and a contractor for certified community residential services to clients as described in Chapter 388-101 WAC.

Contractor means an entity contracting with the Department to provide certified community residential services to clients as described in Chapter 388-101 WAC.

Cost-of-Care Adjustment means a reimbursement adjustment intended to cover the necessary costs of non-variable staff support and administration to provide services to residents during a time when their residence is temporarily not at full capacity.

Department means the Department of Social and Health Services (DSHS) and its employees.

Fringe benefits means benefits provided at the employer's expense to all employees who qualify. These may include sick leave, health insurance, paid vacation, holiday pay, retirement plan, and other benefits.

Full Time Equivalent (FTE) means a total of 2,080 hours (52 weeks x 40 hours) worked by one or more employees during a twelve-month period.

Group Home (GH) Program is included within the meaning of residential services described in Chapter 388-101 WAC and contract provisions. For purposes of this policy, "Group Training Home" is synonymous with "Group Home."

Group Training Home (GTH) means a certified non-profit residential program as per RCW 71A.22.020.

Housing Costs for Overnight Coverage means the costs of providing an apartment unit or other dwelling used by staff when working 24-hour or longer duty shifts. The costs incurred by the program for these housing costs are client support costs, and not to be reported as Instruction and Support Services compensation.

Indirect Client Support Costs (ICS) include Maintenance/Repair expenses for client housing, Client Transportation Expenses, and non-Instruction and Support Services Housing Costs for Overnight Coverage.

Instruction and Support Services (ISS) means client services required by Chapter 388-101 WAC and contract provisions. ISS are provided by staff designated as ISS staff (see definition below). ISS may also be provided by the administrator as described in this policy and by other administrative personnel (such as bookkeepers, accountants or maintenance workers) if the provision of ISS is included in their job description.

Instruction and Support Services (ISS) Staff means employees (including counselors, instructors and/or trainers) of the contractor whose primary job function is the provision of instruction and support services to clients. ISS staff shall include employees (e.g., program managers and supervisors) of the contractor whose primary job function is the supervision of ISS staff.

ISS Hours include:

- On the job hours worked by staff designated as ISS staff, including related training time;
- For staff who perform both administrative functions and ISS, the agency may include that portion of the employee's hours that are dedicated to ISS function;
- The administrator's hours worked as ISS as allowed under Section VII.C of this policy;
- Sleep hours may be counted as ISS for settlement for staff who are required to sleep over and are on duty in close proximity and are available to respond immediately in person at all times. If staff sleep hours are reflected in the rate assessment for nighttime support, an agency can only count the adjusted hours and dollars authorized in the rate for ISS cost reporting settlement; and
- Call back hours for ISS employees who are required to carry pagers or otherwise are on call outside of their normal work hours. The maximum number of hours that may be counted as ISS are the accumulation of hours per shift for those occurrences from the time a call was received until the employee has been able to return to his/her previous activities, rounded up to the nearest hour.

The DDA may request verification of hours (e.g., time sheets, etc.) for all staff for which ISS hours are claimed.

ISS Staff Compensation for reporting purposes on the annual cost report includes:

- ISS staff salaries, wages, stipends and other compensation for staff that are designated as ISS, and prorated for those staff whose time is split between ISS and administrative functions;
- Employer paid payroll taxes relating the actual allowable ISS hours worked. For proprietary contractors, the portion of the Business and Occupation (B & O) tax applicable to the revenue received for ISS reimbursement may be included as payroll tax;

- Fringe benefits paid by the employer for ISS staff (prorated for those staff whose time is split between ISS and administrative functions);

- Staff lodging paid by the contractor and as defined in this section; and

- As provided for in section VII.C.2. of this policy, compensation for the administrator time used performing ISS duties. For settlement purposes, compensation is allowed at the benchmark compensation rate for contractors providing Supported Living (SL) services.

MA (Non-MSA) and MSA Counties: MSA means Metropolitan Statistical Area - A large population nucleus, together with adjacent communities that have a high degree of economic and social integration with that nucleus.

MSA: Metropolitan Statistical Area: Relatively freestanding MA that is not closely associated with other MAs. These areas typically are surrounded by non-metropolitan counties. A MSA must include at least:

- One city with 50,000 or more inhabitants; or

- A Census Bureau-defined urbanized area (of at least 50,000 inhabitants) and a total metropolitan population of at least 100,000.

For purposes of determining reimbursement rates as stated in this policy, Counties recognized as MSA counties in Washington are Asotin, Benton, Chelan, Clark, Cowlitz, Douglas, Franklin, Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom and Yakima.

Note: King County is recognized as having unique characteristics relative to other MSA counties for purposes of determining reimbursement rates as stated in this policy.

Professional Services are services provided by staff (either as employees or contracted personnel) including nurses, therapists and other licensed or specialized skills personnel and are reimbursed at a non-standard rate as specified in Exhibit B of the contract.

Related Organization is either an entity, which is under common ownership, and/or control with, has control of, or is controlled by, the contractor. An entity is deemed to "control" another entity if one entity has a five (5) percent or greater ownership interest in the other; or if an entity has the capacity (whether or not exercised) derived from a financial or other relationship to influence directly or indirectly the activities of the other.

Related Party is a spouse; natural parent, child or sibling; adopted child or adoptive parent; stepparent, stepchild, stepbrother, stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law; grandparent or grandchild; uncle, aunt, nephew, niece or cousin of the contractor.

Residential Services Program means a contractor's Group Home and Group Training Home or Supported Living (SL) residential program providing services in accordance with Chapter 388-101 WAC and contract provisions.

Staff Lodging means SL programs that provide the primary residence for a staff person as a part of their compensation package and may include the cost of the residence as ISS cost for cost reporting purposes. Staff lodging does not include the cost of maintaining a residential unit for the use of overnight staff when it is not their primary residence. The reporting of staff lodging cost for this purpose must be consistent with Internal Revenue Service (IRS) rules for reporting housing to employees as income.

Supported Living (SL) is included within the meaning of residential services as described in Chapter 388-101 WAC and contract provisions.

POLICY

A. Contractors shall report costs of operations for the purpose of providing data to the Administration and to determine any settlements due.

B. The **A**dministration shall:

1. Set standard rates for each cost center for programs covered within this policy;
2. Describe allowable costs and specify the reporting requirements;
3. Describe the rate setting methodology and principles that apply to programs;
4. Describe the settlement process as it applies to residential programs;
5. Describe the summer program requirements and payment procedures; and
6. Provide information on billing and payment requirements and procedures.

PROCEDURES

I. REPORTING

A. Cost Reports

1. In order for a contractor to receive payments under the residential reimbursement system, the contractor must submit an annual DDA cost report covering the completed calendar year.

2. If a contractor terminates from the residential program, the former contractor shall submit a final annual report covering the period the

contract was in effect during the calendar year. The final annual report shall be used for determining a settlement for the final period.

B. Due Date of Report

1. The cost report shall be submitted on or before March 31 of the year following the calendar year covered in the report.

2. Cost Report Extension Provisions

a. A thirty (30) day extension beyond the date specified above will be granted to contractors upon written notification to the Office of Rates Management (ORM) that the additional time is required to complete the report. The notification shall include a brief explanation of the circumstances that require the extension. An approval from the Department will not be required for this thirty (30) day extension.

b. The Department, upon a written request setting forth reasons for the necessity of an extension beyond the thirty (30) day extension specified above, may grant an additional thirty (30) day extension for submitting the cost report. The request must be written and received by the ORM prior to the due date as specified in ‘1’ and ‘2.a.’ above. The ORM will respond to this request within ten (10) working days from the date of receipt.

C. Completing Reports and Maintaining Records

1. Reports shall be completed in accordance with instructions provided by the Department. If no specific instruction covers a situation, generally accepted accounting principles shall be followed.

2. The Department may analyze the submitted cost report and financial statement of each contractor to determine if the information is correct, complete, and reported in conformance with generally accepted accounting principles and the requirements of this contract and those policies, rules and regulations referenced therein. If the analysis finds that the cost report or financial statements are incorrect or incomplete, the Administration may make adjustments to the reported information.

3. A schedule of adjustments shall be provided to contractors in writing and shall include an explanation for the adjustments and dollar amounts of the adjustments.

a. If a contractor disagrees with an adjustment made under this section, the contractor shall, in writing, identify specifically the grounds for his/her contention that the adjustment is erroneous and include any documentation that supports the contractor's position.

b. If the contractor wishes to challenge the Administration's determination of the contractor's contention from subsection 'a' above, the contractor may request an administrative review pursuant to Chapter 388-101 WAC and/or the dispute clause as described in the general terms and conditions of the contract.

4. Contractors shall submit a single cost report that includes all business activities related to the cost of providing contracted services.

5. Agencies with joint residential program costs shall allocate and report shared costs to each residential program in accordance with allocation policies prescribed or approved by the Department.

6. If a contractor fails to maintain records adequate for audit purposes or fails to allow inspection of such records by authorized personnel, the Department may suspend all or part of subsequent payments due under the contract until compliance is forthcoming. Upon compliance, the Department shall resume contract payments and shall release suspended payments pursuant to the contractor's contract.

7. Contractors shall maintain cost reports and records adequate for audit purposes. If, at the end of the contract retention period as specified in the work order, there are unresolved audit questions, the report will be retained until such questions are resolved.

D. Report Certification

1. Each required report shall be accompanied by a certification signed on behalf of the contractor responsible to the Department during the report period. If the contractor files a federal income tax return, the certification shall be executed by the person normally signing this return. If the report is prepared by someone other than an employee of the contractor, that person's name and contact information shall be included with the certification.

2. If a contractor knowingly files a report containing false information, such action constitutes cause for termination of the contractor's contract with the Department. Contractors filing false reports may be referred for prosecution under applicable statutes.

E. Improperly Completed or Late Reports

1. An annual cost report must be completed in accordance with applicable Department regulations and instructions. An annual cost report deficient in any of these respects may be returned in whole or in part to the contractor for proper completion.

2. If a report is not properly completed or is not received by the Administration on or before the due date of the report, including any approved extensions, all or a part of any payments due under the contract may be held by the Department until the improperly completed or delinquent report is properly completed and received by the Administration.

II. REIMBURSABLE COSTS

A. Reimbursable Costs Definition

Reimbursable costs are documented costs that are necessary, ordinary and related to the provision of client support, training and activities as prescribed in Chapter 388-101 WAC and contract. The Cost Report will include new schedules. The schedule will require details of the owner/CEO, administrator, and management costs and hours as it pertains to the contract. Schedules for reporting capital building costs, including rent and lease costs, will include the square footage detail.

B. Depreciable Assets

The following costs shall be reported as depreciable assets:

1. Expenditures for equipment, furnishings or vehicles with historical acquisition cost in excess of $5,000 per unit and a useful life of more than one (1) year from the date of purchase;

2. Expenditures for equipment or furnishings with historical acquisition value of less than $300 per unit if the item was acquired in a group purchase where the total acquisition cost exceeded $5,000 and has a useful life of more than one (1) year from the date of purchase;

3. Expenditures for building, land and/or leasehold improvements which are in excess of $5,000 and which extend the useful life of the asset; and

4. Expenditures for assets as described above with historical acquisition value less than $5,000 may be reported as depreciable assets, or expensed in the year they were purchased.

C. Equipment and Building Expenses

The following costs shall be reported as expenses:

1. Those expenditures for equipment, furnishings, or building, land, or leasehold improvements not subject to classification as a depreciable asset; and

2. Repairs (damages) or maintenance (upkeep) costs that do not extend the useful life or increase the value of the building, equipment, furnishings or vehicles.

D. Reporting Depreciable Assets

1. Depreciable assets may include the following:

   a. *Building* - The basic structure or shell and additions.

   b. *Fixed Equipment* - Attachments to the building such as wiring, plumbing, and heating system.

   c. *Movable Equipment* - Such items as furnishings, beds, stoves, refrigerators, silverware, and dishes.

   d. *Vehicles* - Such items as automobiles or vans used to transport residents to activities, training, or work.

   e. *Land Improvements* - Such items as paving, on-site sewer and water lines, parking areas, shrubbery, fences, government assets, etc., where replacement is the responsibility of the Group Home and Group Training Home.

   f. *Leasehold Improvement* - Improvements and additions made by the lessee (contractor) to the leased property, which become the property of the lessor after the expiration of the lease.

2. Land is not a depreciable asset. Land includes the cost of such items as off-site sewer and water lines, the cost of permanent roadways, curbs and sidewalks, and utility hookups.

3. Depreciable assets shall be reported as follows:

   a. The base used to calculate depreciation shall be:

(i) The historical cost to the contractor in acquiring the asset or capitalized expense from an unrelated organization less the estimated salvage value, if any; or

(ii) The fair market value of the donated or inherited asset or asset purchased with restricted donation at the time of donation or death less goodwill and salvage value, if any; or

(iii) Assets or capitalized expenses acquired from a related organization, which shall not exceed the lower of cost to the related organization or the cost of comparable assets purchased elsewhere.

b. The lives used to calculate depreciation expenses shall be:

(i) Building: Not less than thirty (30) years.

(ii) Building Improvements: The remaining useful life of the building as modified by the improvement.

(iii) Other Assets: Lives no shorter than guideline lives published by the IRS or by the American Hospital Association.

(iv) Lives shall be measured from the date of the most recent arm's-length acquisition of the asset.

c. The depreciation expense methodology used shall be acceptable by generally accepted accounting principles and the IRS methodology for the asset class being depreciated.

d. Changes in depreciation methodology during the life of the asset must be disclosed on the annual cost report.

E. <u>Interest</u>

1. Interest is defined as necessary and ordinary interest for working capital and capital indebtedness, which must be incurred for a financial need related to resident care, training, and activities.

2. Interest cost shall be at a rate not in excess of what a prudent borrower would have to pay at the time of the loan in an arm's-length transaction in the financial market.

3. Interest paid to a related organization shall not be reported in excess of the cost to the related organization of obtaining the use of the funds.

F. Related Organization/Party Costs

1. Costs of services, facilities, and supplies furnished by related organizations to the contractor shall be reported at the lower of the costs to the related organization or the price of comparable services, facilities or supplies purchased elsewhere.

2. The cost of a related party lease shall be reported based on the lower of actual ownership cost (i.e., interest, depreciation, taxes, and insurance) to the related party or the arm's-length lease to the related party.

G. Joint Program Costs

1. Joint program costs are defined as expenses benefiting more than one program, or one program and any other entity.

2. Costs shall be allocated in accordance with cost reporting instructions.

H. Transportation Costs

1. Transportation costs are defined as:

a. Ordinary and necessary transportation of clients for training and activities;

b. Ordinary and necessary transportation of employees for program administration and operation; and

c. Ordinary and necessary travel of employees for in-service training and education.

2. The following costs shall be reported:

a. The costs of operating vehicles limited to automobiles, vans, pickup trucks or buses that are used for the purposes defined in this section, including maintenance, repairs and operation. A mileage log shall be maintained detailing the usage of each vehicle not used 100 percent for the purposes defined in this section.

b. The costs of public transportation for clients, volunteers and staff, which are for the purposes defined in this section.

c. The costs of mileage reimbursement of employees and volunteers using their personal vehicle for actual mileage for the purposes defined in this section.

d. Commuting between an employee's residence and their primary place of employment shall not be included as transportation. If a vehicle is used by any staff for travel that is not defined above, these shall be fringe benefit costs for that employee.

e. The agency must keep mileage information that indicates miles driven with or on behalf of the clients. The information must be separated for agency owned/leased vehicles and for staff owned vehicles. The information will be summarized into annual mileage totals to be reported as line items on the cost report.

3. The contractor shall not seek or accept additional compensation from or on behalf of a client for any or all contracted residential services except:

a. The contractor shall notify DDA in writing when the client contributes toward their costs for transportation.

b. Costs incurred by the contractor associated with this provision are unallowable costs and shall not be reported on the annual cost report.

I. Instruction and Support Services

1. ISS compensation for performance of ISS duties by an individual shall be reported as ordinary compensation for necessary services actually performed.

2. Compensation is ordinary when it is within a reasonable amount usually paid to an individual with necessary qualifications for similar services within the same or comparable programs.

3. A service is necessary if it would have had to be performed by another person if the individual in question had not performed it.

4. The reported ISS compensation for an individual staff must not exceed the reasonable amount criteria per item 2 above.

5. The Administration may request job descriptions for employees to verify the primary duties of the positions. Paid hours worked and payroll costs charged to ISS for cost reporting purposes must be verifiable in the agency's records. The number of ISS paid hours reported for any

individual employee or owner of an agency must not exceed 3,120 hours per year (designated live-in staff are exempt from this limitation). ISS staff shall also include contracted personnel whose job function is the provision of instruction and support services.

6. The cost report will include a schedule to report a summary of total employee hours and cost, including ISS and non-ISS. Sleep and standby hours will not be included in this schedule. The provider must maintain on file the details by employee, as this information may be requested by the Department.

J. <u>Fringe Benefits</u>

1. Fringe benefits provided at the employer's expense may include sick leave, health insurance, paid vacation, holiday pay, retirement plan, as well as other benefits, to all employees who qualify.

2. The cost report will include a schedule to report summary of total wages and fringe benefits. The summary will include a breakout of total employee wages and fringe benefits by ISS and total costs. The provider must maintain on file the details by employee (excluding benefits), as this information may be requested by the Department.

III. SETTLEMENT

A. <u>Settlement Definition</u>

1. The settlement shall be for under utilization of contracted and paid service hours and dollars in the instruction and support service cost center.

2. Settlements shall be based on Department payment system(s) reports, the contractor's financial reports, and/or other Department-specified reports or documents.

3. The provisions of this section will apply to the settlement calculation for the entire calendar year in which the contract is effective.

4. A settlement as described in this section is considered an overpayment as defined in DSHS Administrative Policy No. 10.02, *Overpayments and Debts for Providers and Vendors:*

> "**Overpayments and debts** is any Department payment or benefit to a vendor or provider in excess of the amount the provider or vendor was entitled to by law, rule, or contract."

B. Settlement Determination

The contractor shall refund the greater of:

1. All amounts of ISS cost center rate reimbursement in excess of the allowable instruction and support service costs as defined in this policy, and as reported in the contractor's annual cost report and/or Department-specified documents.

2. Reimbursement amounts received from DDA for professional services and professional services compensation paid by the contractor shall be included in the settlement calculation. For purposes of the settlement calculation, professional services reimbursement and compensation rates exclude administration amounts that may be included in the hourly professional service rate.

3. The total annual reimbursed hours for ISS and professional/licensed staff minus actual total annual paid hours worked as reported in the contractor's annual cost report and/or Department-specified documents, multiplied by the weighted average reimbursement benchmark rate for ISS staff in effect during the settlement period.

4. Staff add-on reimbursements will be subject to the settlement provisions of this policy.

5. Nurse Delegation Core Training Staff Class Hours and dollars that are paid to an agency as reimbursement for agency staff time spent in attending training will be subject to the settlement provisions of this policy.

6. Reimbursement for agency staff time to attend training mandated through legislation or initiative will be subject to the settlement provisions of this policy.

7. Contractors not using all of their contracted ISS hours must provide information as to why the hours were not used and document the attempts to provide those hours. A plan to prevent future occurrences must be submitted.

8. When submitting a cost report that includes a settlement, a contractor that has had extraordinary ISS costs during the year may request to apply those extraordinary costs toward the settlement. The agency making the request may submit narrative justification and a breakdown of associated costs to enable the Administration to analyze the request.

9. Contractors that have Administrative/ICS or Non-ISS rates above the administrative rate standard for the reporting year will be required to return the administrative dollars associated with unused contracted ISS hours as determined by DDA. A worksheet showing the calculations to determine the settlement is available on the DDA Internet website's Residential Provider Resources webpage at this address: http://www.dshs.wa.gov/DDA/res_provider_resources.shtml. The contractor may elect to have a two-year option for the administrative rate settlement following the same criteria and procedures as described in section F below.

C. Administrative Staff Hours Counted as ISS for Settlement Purposes

1. GH and GTH program administrators may provide ISS hours.

2. SL and combined programs (GH, GTH and SL):

   a. For residential services programs that have twenty (20) or fewer FTE employees that support clients during the settlement period, settlements may include the program administrator's hours worked in an ISS staff capacity. The cost that may be applied in the settlement computation is the total hours worked as ISS staff multiplied by the benchmark compensation rate in effect during the period that the hours were worked.

   b. For residential services programs that have more than twenty (20) FTE employees that support clients during the settlement period, settlements may not include administrator's hours worked in an ISS staff capacity in their settlement computation.

   c. The hourly rate allowed for the administrator's cost shall not exceed the contractor's instruction and support staff compensation rate as specified in the contractor's contract and rate notification.

   d. An exception to item "b" above may be requested by any contractor. A copy of the approved exception to policy (ETP) must accompany the annual cost report if the administrative hours are reported as ISS for settlement purposes.

D. Programs Combined for Settlement

1. Contractors that have contracts with the Administration for the operation of multiple residential programs within a single region may collapse those contracts into a single contract for any combination of GH and GTH and

SL programs. The single contract will identify the type(s) of residential program(s) and all applicable rates.

2. Programs combined under a single contract will be treated as a single entity for purposes of the settlement provisions of this policy. The contractor may combine the total reimbursement for ISS hours and compensation amounts subject to settlement per the contract, and the combined total of paid ISS hours and compensation into a single settlement calculation.

E. Settlement Process

The Administration will determine a settlement amount for each calendar year.

1. The contractor shall pay a settlement overpayment amount, or shall commence repayment in accordance with a schedule determined by the Department, within thirty (30) days after receiving departmental notification of the overpayment amount. If a settlement determination is contested, the contractor shall pay or commence repayment within thirty (30) days after such proceedings are concluded.

2. The Department will pay any amount due the contractor as a result of errors in billing or payment disclosed on the settlement within thirty (30) days after issuance of departmental notification of the amount due the contractor.

3. If the contractor does not refund the overpayment or any installment when due, or after the final decision from any administrative or judicial remedy sought by the contractor regarding the amount due, the Department may withhold payments from current billings until the overpayment is refunded.

4. A proposed settlement may be revised by the Department on the basis of audit findings or DDA certification evaluation findings.

F. Optional Two-Year Settlement Process

1. The contractor may request to have an optional two (2) year settlement. These settlements shall allow a collaborative process in order to minimize settlements due.

2. Contractors will indicate on their first year cost report whether or not they wish to participate in the optional two (2) year settlement process. Contractors may initiate the planning process with the region during the first year if preliminary data indicates that a settlement will materialize.

3. The request for a two-year optional settlement and plan must be sent in writing to the Regional Administrator for review and consideration no later than May 31 of the second settlement year. Example: For settlement calendar years 2013-2014, the request would be due by May 31, 2014.

4. A joint plan will be produced by June 15th of the second settlement year. If no plan is agreed upon by this date, the first year settlement amount is due according to the provisions of the previous settlement section.

5. Information derived from the first year's cost report will be used to develop a joint plan for use of the unspent ISS dollars to be followed during the second year of the settlement period. These funds will be used to increase service capacity or extend services to additional people. Funds retained through this process would be expended on direct supports rather than agency administration costs.

EXCEPTIONS

Exceptions to this policy may be approved by the Deputy Assistant Secretary or designee based upon information submitted on DSHS 05-010, *Rule Exception Request*.

SUPERSESSION

DDD Policy 6.04
Issued July 1, 2011

Approved: *_/s/ Donald Clintsman_* Date: July 1, 2013
Deputy Assistant Secretary
Developmental Disabilities Administration

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: RESIDENTIAL PROGRAMS COST REPORTING POLICY 6.04

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Washington State Department of Social & Health Services

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	RESIDENTIAL PROGRAMS COST REPORTING	POLICY 6.04

Authority:		
Authority:	Chapter 71A RCW	*Developmental Disabilities*
	Chapter 388-825 WAC	*Developmental Disabilities Services*
	Chapter 388-101 WAC	*Certified Community Residential Services and Support*

PURPOSE

This policy establishes procedures and criteria for cost reporting and the settlement process for the Developmental Disabilities Administration (DDA) contracted residential programs.

SCOPE

This policy applies to the following DDA contracted residential service programs for adults:

- Supported Living (SL)
- Group Homes (GH)
- Group Training Homes (GTH)

DEFINITIONS

Administration means the DSHS Developmental Disabilities Administration (DDA) and its employees.

Administrative Staff means owners, officers or employees of the service provider, including executive directors, administrators, accountants, bookkeepers, clerical support and/or secretaries whose primary job functions require a majority of time for administrative, management and/or operational support. Administrative staff may also include corporate staff whose time is allocated to the service provider.

Arm's-Length Transaction is an accounting term that means a transaction resulting from good faith bargaining between a buyer and seller who hold adverse positions in the market place. Arm's-length transactions are presumed to be objective transactions between disinterested parties (meaning neither the buyer nor the seller has a financial incentive to buy or sell at a price more or less than market value).

Client means a person who has a developmental disability and is:

1. Eligible under RCW 71A.10.020; and

2. Authorized by DDA to receive residential services described in Chapter 388-101 WAC.

Contract means a contract between DDA and a service provider for certified community residential services to clients as described in Chapter 388-101 WAC.

Cost of Care Adjustments (COCA) means the payments intended to cover the necessary costs of ISS staff support and/or operating/administrative costs to continue uninterrupted services to clients when there is a temporary absence of a household member.

Fringe benefits means the employer's expense for benefits provided to all employees who qualify. These may include sick leave, health insurance, paid vacation, holiday pay, retirement plan, and other benefits.

Group Home (GH) Program is a certified residential service as per Chapter 388-101 WAC which is also licensed as an Adult Family Home or Assisted Living Facility.

Group Training Home (GTH) means a certified and non-profit residential program that meets requirements of RCW 71A.22.020 and WAC 388-101-3170.

Housing Costs Paid by Service Providers means the service provider's costs for a dwelling or portion of a dwelling used by staff when working 24-hour or longer duty shifts for the live-in model. This is an administrative cost incurred by the program for housing, not to be reported as Instruction and Support Services compensation.

Instruction and Support Services (ISS) means client services required by Chapter 388-101 WAC and contract provisions. ISS are provided by staff designated as ISS staff (see definition below). ISS may also be provided by the administrator as described in this policy and by other administrative personnel (such as bookkeepers, accountants or maintenance workers) if the provision of ISS is included in their job description.

Instruction and Support Services (ISS) Staff means employees (including counselors, instructors and/or trainers) of the service provider whose primary job function is the provision of instruction and support services to clients. ISS staff shall include employees (e.g., program managers and supervisors) of the service provider whose primary job function is the supervision of ISS staff.

Metropolitan Statistical Area (MSA): Relatively freestanding metropolitan area (MA) that is not closely associated with other MAs. These areas typically are surrounded by non-metropolitan counties. A MSA must include at least:

- One city with 50,000 or more inhabitants; or

- A Census Bureau-defined urbanized area (of at least 50,000 inhabitants) and a total metropolitan population of at least 100,000.

Note: King County is recognized as having unique characteristics relative to other MSA counties for purposes of determining reimbursement rates as stated in this policy.

DSHS currently recognizes the following counties as MSA counties in Washington: Asotin, Benton, Chelan, Clark, Cowlitz, Douglas, Franklin, Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, and Yakima. Final determination for MSA designations are made by DSHS. All other counties are considered as Non-MSA.

Related Organization is either an entity, which is under common ownership, and/or control with, has control of, or is controlled by, the service provider. An entity is deemed to "control" another entity if one entity has a five (5) percent or greater ownership interest in the other; or if an entity has the capacity (whether or not exercised) derived from a financial or other relationship to influence directly or indirectly the activities of the other.

Related Party is a spouse, natural parent, child or sibling, adopted child or adoptive parent, stepparent, stepchild, stepbrother, stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, grandparent or grandchild, uncle, aunt, nephew, niece, or cousin of the service provider.

Residential Professional Services are provided by service provider staff and are included as part of the daily residential rate. These services could include RNs, LPNs, physical or speech therapists, language translators, and Dialectical Behavioral therapy. Reimbursement for professional services is at department established rates where they exist, or at a non-standard rate as determined by the Resource Manager Administrator.

Service provider means an entity contracting with the DDA to provide certified community residential services to clients as described in Chapter 388-101 WAC.

Staff Add-On for Client-Specific Need means a short-term staffing increase above and beyond the individual instruction and support hours required and allowed in the standard rate provision of a contract, enabling a service provider to increase the individual instruction and support hours provided to a specific client when a client's safety and well-being are seriously threatened and/or when a client is at risk of losing residential support services.

Staff Lodging means supported living programs that provide the primary residence for a staff person as a part of their compensation package and may include the cost of the residence as ISS cost for cost reporting purposes. Staff lodging does not include the cost of maintaining a residential unit for the use of overnight staff when it is not their primary residence. The reporting of staff lodging cost for this purpose must be consistent with Internal Revenue Service (IRS) rules for reporting housing to employees as income.

Supported Living (SL) is a contracted and certified residential service as described in Chapter 388-101 WAC.

POLICY

A. Service providers shall report costs of operations for the purpose of certifying the costs of services provided and to determine any settlements due.

B. DDA shall:

1. Set standard rates for each cost center for programs covered within this policy;

2. Describe allowable costs and specify the reporting requirements;

4. Describe the settlement process as it applies to residential programs;

PROCEDURES

I. REPORTING

A. Cost Reports

1. In order for a service provider to receive payments under the residential reimbursement system, the service provider must submit an annual DDA cost report covering the completed calendar year.

2. If a service provider's contract for community residential services is terminated, the former service provider shall submit a final annual DDA cost report covering the period the contract was in effect during the calendar year. The final annual report shall be used for determining a settlement for the final period.

B. Due Date of Cost Report

1. The cost report shall be submitted on or before March 31 of the year following the calendar year covered in the report.

2. Cost Report Extension Provisions

a. If an extension is needed, the service provider must submit a written notification to the DDA Rates Unit in Office of Rates

Management requesting the additional time that is required to complete the report. The notification shall include a brief explanation of the circumstances that require the extension. A thirty (30) day extension beyond the date specified above may be granted by DDA Rates Unit.

b. If an additional extension is needed, the service provider must submit a written request stating the reasons. The request must be received by the DDA Rates Unit prior to the due date. DDA Rates Unit will consult with the Regional Resource Manager Administrator and Community Residential Services Program Manager. An extension may be granted for up to an additional thirty (30) days. DDA Rates Unit will respond to this request within ten (10) working days from the date of receipt.

C. Completing Cost Reports and Maintaining Records

1. Cost reports shall be completed in accordance with instructions provided by DDA. If no specific instruction covers a situation, generally accepted accounting principles shall be followed.

2. DDA Rates Unit will analyze the submitted cost report and financial statement of each service provider to determine if the information is correct, complete, and reported and conforms with generally accepted accounting principles and the requirements of this contract and the referenced policies, rules, and regulations. If the analyst finds that the cost report or financial statements are incorrect or incomplete, DDA may make adjustments to the reported information or request that the service provider makes revisions.

3. Adjustments made to the cost report by DDA Rates Unit will be provided to service providers in writing and will include an explanation and dollar amounts of the adjustments.

a. If a service provider disagrees with an adjustment made under this section, the service provider will identify the specific area of disagreement and include any supporting documentation.

b. DDA will respond to the disagreement with a determination.

c. If the service provider wishes to challenge DDA’s determination of the service provider's contention from subsection ‘a’ above, the service provider may request an administrative review pursuant to Chapter 388-101 WAC and/or the dispute clause as described in the general terms and conditions of the contract.

4. Service providers shall submit a cost report that includes all business activities related to the cost of providing services per contract.

5. Agencies with more than one service within a contract shall allocate and report shared costs to each residential program in accordance with allocation policies prescribed or approved by DDA.

6. Service providers shall maintain reports and records adequate for cost reporting and audit for six (6) years after the expiration or termination of the contract.

7. If a service provider fails to maintain records adequate for audit purposes or fails to allow inspection of such records by authorized personnel, DDA may give written notice and suspend all or part of subsequent payments due under the contract until compliance is forthcoming. Upon compliance, DDA shall resume contract payments and shall release suspended payments pursuant to the service provider's contract.

D. Cost Report Certification

1. Each cost report must include a certification of the accuracy of the report. If the service provider files a federal income tax return, the certification shall be executed by the person normally signing this return. If the report is prepared by someone other than an employee of the service provider, that person’s name and contact information shall be included with the certification.

2. If a service provider knowingly files a report containing false information, such action constitutes cause for termination of the service provider's contract with DDA. Service providers filing false reports may be referred for prosecution under applicable statutes.

E. Improperly Completed or Late Cost Reports

1. An annual cost report must be completed in accordance with applicable regulations and instructions. An annual cost report deficient in any of these respects may be returned in whole or in part to the service provider for proper completion.

2. If a report is not properly completed or is not received by the DDA on or before the due date of the report, including any approved extensions, all or a part of any payments due under the contract may be held by DDA until the improperly completed or delinquent report is properly completed and received by DDA.

II. COST REPORT COMPONENTS

The Cost Report documents expenses that are necessary, ordinary, and related to the provision of client support, training, and activities as prescribed in Chapter 388-101 WAC and contract.

A. Instruction and Support Services

1. ISS compensation for performance of ISS duties by an individual shall be reported as ordinary compensation for necessary services actually worked.

2. Compensation is ordinary when it is within a reasonable amount usually paid to an individual with necessary qualifications for similar services within the same or comparable programs. The reported ISS compensation for an individual staff must not exceed the reasonable amount criteria.

3. A service is necessary if it would have had to be performed by another person if the individual in question had not performed it.

4. DDA may request job descriptions for employees to verify the duties of the positions. Paid hours worked and payroll costs charged to ISS for cost reporting purposes must be verifiable in the service provider's records, including time sheets and schedules for actual worked hours. The number of ISS paid hours reported for any individual employee or owner of a service provider must not exceed 3,120 hours per year (designated live-in staff are exempt from this limitation).

5. ISS staff may also include purchased-service personnel whose job function is the provision of professional instruction and support services. Subcontracting must be approved per the Contract.

6. The cost report will include schedules to report summary totals of employee hours and costs. The provider must maintain on file the details by employee, as this information may be requested by DDA.

7. Allowable ISS Hours include:

   a. Actual paid hours worked by staff designated as ISS staff, including related training time;

   b. For staff who perform both administrative functions and ISS, the service provider may include that portion of the employee's hours that are dedicated to ISS function;

c. The administrator’s hours worked as ISS as allowed under this policy;

d. Sleep hours may be counted as ISS for settlement for staff who are required to sleep over and are on duty in close proximity and are available to respond immediately in person at all times. If staff sleep hours are reflected in the rate assessment for nighttime support, a service provider can only count the adjusted hours and dollars authorized in the rate for ISS cost reporting settlement;

e. The maximum number of call back hours for ISS employees who are on-call outside of their normal work hours that may be counted as ISS are the accumulation of hours per shift for those occurrences from the time a call was received until the employee has been able to return to his/her previous activities, rounded up to the nearest hour.

f. DDA may request verification of hours (e.g., time sheets, etc.) for all staff for which ISS hours are claimed.

8. Allowable ISS Staff Compensation for reporting purposes on the annual cost report includes:

a. ISS staff salaries, wages, stipends and other compensation for staff that are designated as ISS, and prorated for those staff whose time is split between ISS and administrative functions;

b. Employer paid payroll taxes relating the actual allowable ISS hours worked. For proprietary service providers, the portion of the Business and Occupation (B & O) tax applicable to the revenue received for ISS reimbursement may be included as payroll tax;

c. Fringe benefits paid by the employer for ISS staff (prorated for those staff whose time is split between ISS and administrative functions);

1) Fringe benefits provided at the employer's expense may include sick leave, health insurance, paid vacation, holiday pay, retirement plan, as well as other benefits, to all employees who qualify. Fines for violating the Affordable Care Act are not considered a fringe benefit.

2) The cost report will include a schedule to report summary of total wages and fringe benefits. The provider must

maintain on file the details by employee (excluding benefits), as this information may be requested by DDA.

d. Staff lodging paid by the service provider and as defined in this policy; and

e. As provided for in this policy, compensation for the administrator time used performing ISS duties. For settlement purposes, compensation is allowed at the benchmark compensation rate for service providers providing Supported Living (SL) services.

B. Transportation Costs

1. Transportation costs are defined as necessary and ordinary transportation with or on behalf of clients, program operation and training. Transportation costs include:

a. Client transportation expenses (including staff mileage reimbursement) include expenses related to miles calculated on the transportation assessment.

b. Administrative transportation expenses include all other operational related expenses not captured on the transportation assessment.

2. The following costs will be reported:

a. The costs of operating vehicles that are used for the purposes defined in this section, including maintenance, repairs and operation. A mileage log shall be maintained detailing the usage of each vehicle not used 100 percent for the purposes defined in this section.

b. The costs of public transportation for clients, volunteers, and staff, which are for the purposes defined in this section.

c. The costs of mileage reimbursement of employees and volunteers using their personal vehicle for actual mileage for the purposes defined in this section.

d. Commuting between an employee's residence and their primary place of employment shall not be included as transportation. If a vehicle is used by any staff for travel that is not defined above, these shall be fringe benefit costs for that employee.

e. The service provider must keep mileage information that indicates miles driven with or on behalf of the clients. The information must be separated for service provider owned/leased vehicles and for staff owned vehicles. The information will be summarized into annual mileage totals to be reported as line items on the cost report.

3. The service provider shall not seek or accept additional compensation from or on behalf of a client for any or all contracted residential services except as outlined in DDA Policy 6.02, *Rate Setting for Residential Programs*, (IX. Billing and Payment, Section B.2). Costs incurred by the service provider associated with this provision are unallowable costs and shall not be reported on the annual cost report.

C. Depreciable Assets

The following costs shall be reported as depreciable assets:

1. Expenditures for equipment, furnishings or vehicles with historical acquisition cost in excess of $5,000 per unit and a useful life of more than one (1) year from the date of purchase;

2. Expenditures for equipment or furnishings with historical acquisition value of less than $300 per unit if the item was acquired in a group purchase where the total acquisition cost exceeded $5,000 and has a useful life of more than one (1) year from the date of purchase;

3. Expenditures for building, land and/or leasehold improvements which are in excess of $5,000 and which extend the useful life of the asset; and

4. Expenditures for assets as described above with historical acquisition value less than $5,000 may be reported as depreciable assets, or expensed in the year they were purchased.

D. Equipment and Building Expenses

The following costs shall be reported as expenses:

1. Those expenditures for equipment, furnishings, or building, land, or leasehold improvements not subject to classification as a depreciable asset; and

2. Repairs (damages) or maintenance (upkeep) costs that do not extend the useful life or increase the value of the building, equipment, furnishings or vehicles.

E. Reporting Depreciable Assets

1. Depreciable assets may include the following:

   a. *Building* - The basic structure or shell and additions.

   b. *Fixed Equipment* - Attachments to the building such as wiring, plumbing, and heating system.

   c. *Movable Equipment* - Such items as furnishings, beds, stoves, refrigerators, silverware, and dishes.

   d. *Vehicles* - Such items as automobiles or vans used to transport residents to activities, training, or work.

   e. *Land Improvements* - Such items as paving, on-site sewer and water lines, parking areas, shrubbery, fences, government assets, etc., where replacement is the responsibility of the Group Home and Group Training Home.

   f. *Leasehold Improvement* - Improvements and additions made by the lessee (service provider) to the leased property, which become the property of the lessor after the expiration of the lease.

2. Land is not a depreciable asset. Land includes the cost of such items as off-site sewer and water lines, the cost of permanent roadways, curbs and sidewalks, and utility hookups.

3. Depreciable assets shall be reported as follows:

   a. The base used to calculate depreciation shall be:

      1) The historical cost to the service provider in acquiring the asset or capitalized expense from an unrelated organization less the estimated salvage value, if any; or

      2) The fair market value of the donated or inherited asset or asset purchased with restricted donation at the time of donation or death less goodwill and salvage value, if any; or

      3) Assets or capitalized expenses acquired from a related organization, which shall not exceed the lower of cost to

the related organization or the cost of comparable assets purchased elsewhere.

b. The lives used to calculate depreciation expenses shall be:

1) Building: Not less than thirty (30) years.

2) Building Improvements: The remaining useful life of the building as modified by the improvement.

3i) Other Assets: Lives no shorter than guideline lives published by the IRS or by the American Hospital Association.

4) Lives shall be measured from the date of the most recent arm's-length acquisition of the asset.

c. The depreciation expense methodology used shall be acceptable by generally accepted accounting principles and the IRS methodology for the asset class being depreciated.

d. Changes in depreciation methodology during the life of the asset must be disclosed on the annual cost report.

F. Interest

1. Interest is defined as necessary and ordinary interest for working capital and capital indebtedness, which must be incurred for a financial need related to client supports and services, training, and activities.

2. Interest cost shall be at a rate not in excess of what a prudent borrower would have to pay at the time of the loan in an arm's-length transaction in the financial market.

3. Interest paid to a related organization shall not be reported in excess of the cost to the related organization of obtaining the use of the funds.

G. Related Organization/Related Party Costs

1. Costs of services, facilities, and supplies furnished by related organizations to the service provider shall be reported at the lower of the costs to the related organization or the price of comparable services, facilities or supplies purchased elsewhere.

2. The cost of a related party lease shall be reported based on the lower of actual ownership cost (i.e., interest, depreciation, taxes, and insurance) to the related party or the arm's-length lease to the related party.

III. SETTLEMENT

A. Settlement Definition

1. The settlement shall be for underutilization of contracted and paid service hours and dollars in the instruction and support service cost center.

2. Settlements shall be based on DDA payment system(s) reports, the service provider's financial reports, and/or other DDA-specified reports or documents.

3. The provisions of this section will apply to the settlement calculation for the entire calendar year in which the contract is in effect~~ive~~.

B. Settlement Determination

The service provider shall refund the greater of:

1. All amounts of ISS cost center rate reimbursement in excess of the allowable instruction and support service costs as defined in this policy, and as reported in the service provider's annual cost report and/or DDA-specified documents.

2. Reimbursement amounts received from DDA for professional services and professional services compensation paid by the service provider shall be included in the settlement calculation. For purposes of the settlement calculation, professional services reimbursement and compensation rates exclude administration amounts that may be included in the hourly professional service rate.

3. The total annual reimbursed hours for ISS and professional/licensed staff minus actual total annual paid hours worked as reported in the service provider's annual cost report and/or DDA-specified documents, multiplied by the weighted average reimbursement benchmark rate for ISS staff in effect during the settlement period.

4. Staff add-on reimbursements will be subject to the settlement provisions of this policy.

5. The ISS hours and dollars that are paid for staff to attend Nurse Delegation Core Training, legislatively mandated training and continuing education will be subject to the settlement provisions of this policy.

6. When submitting a cost report that includes a settlement, a service provider that has had extraordinary ISS costs during the year may request to apply those extraordinary costs toward the settlement. The service provider making the request may submit narrative justification and a breakdown of associated costs to enable DDA to analyze the request.

7. Service providers that have administrative rates above the administrative rate standard for the reporting year will be required to return the administrative dollars associated with unused contracted ISS hours as determined by DDA. A worksheet showing the calculations to determine the settlement is available on the DDA Internet website's Residential Provider Resources webpage at this address: https://www.dshs.wa.gov/dda/counties-and-providers/residential-provider-resources. The service provider may elect to have a two-year option for the administrative rate settlement following the same criteria and procedures as described in section F below.

C. Administrative Staff Hours Counted as ISS for Settlement Purposes

1. For agencies that only operate GHs or GTHs, the program administrators may include the program administrator's hours worked in an ISS staff capacity.

2. For agencies who provide SL or SL in combination with GHs or GTHs:

   a. For residential services programs that report 41,600 or fewer total paid ISS hours during the settlement period (approximately twenty or fewer full time equivalent employees), settlements may include the program administrator's hours worked in an ISS staff capacity. The cost that may be applied in the settlement computation is the total hours worked as ISS staff multiplied by the benchmark compensation rate in effect during the period that the hours were worked.

   b. For residential services programs that have more than 41,600 ISS hours during the settlement period, settlements may not include administrator's hours worked in an ISS staff capacity in their settlement computation.

   c. The hourly rate allowed for the administrator's cost shall not exceed the service provider's instruction and support staff compensation rate as specified in the service provider's contract and rate notification.

d. An exception to item "b" above may be requested by any service provider. A copy of the approved exception to policy (ETP) must accompany the annual cost report if the administrative hours are reported as ISS for settlement purposes.

D. Programs Combined for Settlement

1. Service providers that have contracts with DDA for the operation of multiple residential programs within a single region may collapse those contracts into a single contract for any combination of GH and GTH and SL programs. The single contract will identify the type(s) of residential program(s) and all applicable rates.

2. Programs combined under a single contract will be treated as a single entity for purposes of the settlement provisions of this policy. The service provider may combine the total reimbursement for ISS hours and compensation amounts subject to settlement per the contract, and the combined total of paid ISS hours and compensation into a single settlement calculation.

E. Settlement Process

DDA will determine if a settlement amount is due for each calendar year.

1. The service provider shall pay a settlement overpayment amount, or shall commence repayment in accordance with a schedule determined by DDA, within thirty (30) days after receiving DDA notification of the overpayment amount. If a settlement determination is contested, the service provider shall pay or commence repayment within thirty (30) days after such proceedings are concluded. Overpayments and debts are defined by DSHS Administrative Policy 10.02, *Overpayments and Debts for Providers and Vendors,* as any DDA payment or benefit to a service provider in excess of the amount the provider or vendor was entitled to by law, rule, or contract.

2. DDA will pay any amount due the service provider as a result of errors in billing or payment disclosed on the settlement within thirty (30) days after issuance of notification of the amount due the service provider.

3. If the service provider does not refund the overpayment or any installment when due, or after the final decision from any administrative or judicial remedy sought by the service provider regarding the amount due, DDA

may withhold payments from current billings until the overpayment is refunded.

4. A proposed settlement may be revised by DDA on the basis of audit findings or DDA certification evaluation findings.

F. Optional Two-Year Settlement Process

1. The service provider may request to have an optional two (2) year settlement. These settlements shall allow a collaborative process in order to minimize settlements due.

2. Service providers will indicate on their first year cost report whether or not they wish to participate in the optional two (2) year settlement process. Service providers may initiate the planning process with the region during the first year if preliminary data indicates that a settlement will materialize.

3. The request for a two-year optional settlement and plan must be sent in writing to the Regional Administrator for review and consideration no later than May 31 of the second settlement year. Example: For settlement calendar years 2015-2016, the request would be due by May 31, 2016.

4. Information derived from the first year's cost report will be used to develop a plan for use of the unspent ISS dollars to be followed during the second year of the settlement period. These funds will be used to increase service capacity or extend services to additional people. Funds retained through this process would be expended on direct supports rather than service provider administration costs.

5. The plan will be submitted to DDA by June 15th of the second settlement year. If the plan is not received by June 15th or if an acceptable plan cannot be negotiated; the first year settlement amount is due according to the provisions of the previous settlement section.

EXCEPTIONS

Exceptions to this policy may be approved by the Deputy Assistant Secretary or designee based upon information submitted on DSHS 05-010, *Rule Exception Request.*

SUPERSESSION

DDA Policy 6.04
Issued July 1, 2013

Approved: * /s/ Donald Clintsman* Date: July 1, 2015
Deputy Assistant Secretary
Developmental Disabilities Administration

APPENDIX 3

29 C.F.R. § 785.22

§ 785.22 Duty of 24 hours or more.

Currentness

(a) General. Where an employee is required to be on duty for 24 hours or more, the employer and the employee may agree to exclude bona fide meal periods and a bona fide regularly scheduled sleeping period of not more than 8 hours from hours worked, provided adequate sleeping facilities are furnished by the employer and the employee can usually enjoy an uninterrupted night's sleep. If sleeping period is of more than 8 hours, only 8 hours will be credited. Where no expressed or implied agreement to the contrary is present, the 8 hours of sleeping time and lunch periods constitute hours worked. (Armour v. Wantock, 323 U.S. 126 (1944); Skidmore v. Swift, 323 U.S. 134 (1944); General Electric Co. v. Porter, 208 F. 2d 805 (C.A. 9, 1953), cert. denied, 347 U.S. 951, 975 (1954); Bowers v. Remington Rand, 64 F. Supp. 620 (S.D. Ill, 1946), aff'd 159 F. 2d 114 (C.A. 7, 1946) cert. denied 330 U.S. 843 (1947); Bell v. Porter, 159 F. 2d 117 (C.A. 7, 1946) cert. denied 330 U.S. 813 (1947); Bridgeman v. Ford, Bacon & Davis, 161 F. 2d 962 (C.A. 8, 1947); Rokey v. Day & Zimmerman, 157 F. 2d 736 (C.A. 8, 1946); McLaughlin v. Todd & Brown, Inc., 7 W.H. Cases 1014; 15 Labor Cases para. 64,606 (N.D. Ind. 1948); Campbell v. Jones & Laughlin, 70 F. Supp. 996 (W.D. Pa. 1947).)

(b) Interruptions of sleep. If the sleeping period is interrupted by a call to duty, the interruption must be counted as hours worked. If the period is interrupted to such an extent that the employee cannot get a reasonable night's sleep, the entire period must be counted. For enforcement purposes, the Divisions have adopted the rule that if the employee cannot get at least 5 hours' sleep during the scheduled period the entire time is working time. (See Eustice v. Federal Cartridge Corp., 66 F. Supp. 55 (D. Minn. 1946).)

SOURCE: 26 FR 190, Jan. 11, 1961; 76 FR 18859, April 5, 2011, unless otherwise noted.

AUTHORITY: 52 Stat. 1060; 29 U.S.C. 201–219; 29 U.S.C. 254. Pub.L. 104–188, 100 Stat. 1755.

Notes of Decisions (105)

Current through November 26, 2020; 85 FR 75828.

APPENDIX 4

302 F.Supp.3d 1319
United States District Court, M.D. Florida,
Orlando Division.

HRCC, LTD., Plaintiff,
v.
HARD ROCK CAFE INTERNATIONAL (USA), INC., Hamish Dodds and Michael Beacham, Defendants.

Case No: 6:14–cv–2004–Orl–40KRS
|
Signed 09/13/2016

Synopsis
Background: Franchisee brought action against franchisor and executives, alleging violation of Florida Deceptive and Unfair Trade Practices Act (FDUTPA) and civil conspiracy. Defendants moved for summary judgment.

Holdings: The District Court, Paul G. Byron, J., held that:

[1] franchisor and executives were not liable for violation of FDUTPA; and

[2] personal stake exception did not apply, and thus intracorporate conspiracy doctrine precluded liability for civil conspiracy.

Motion granted.

Procedural Posture(s): Motion for Summary Judgment.

West Headnotes (13)

[1] **Antitrust and Trade Regulation** Duration, termination, and renewal

Franchisor and executives were not liable for violation of Florida Deceptive and Unfair Trade Practices Act (FDUTPA), absent showing by franchisee of actual damages arising from termination of franchise agreement. Fla. Stat. Ann. § 501.201 et seq.

[2] **Antitrust and Trade Regulation** Reliance; causation; injury, loss, or damage

Actual damages are a required element of a Florida Deceptive and Unfair Trade Practices Act (FDUTPA) claim. Fla. Stat. Ann. § 501.201 et seq.

4 Cases that cite this headnote

[3] **Antitrust and Trade Regulation** Grounds and Subjects

For purposes of Florida Deceptive and Unfair Trade Practices Act (FDUTPA), actual damages must be direct damages, not consequential damages in the form of lost profits. Fla. Stat. Ann. § 501.201 et seq.

6 Cases that cite this headnote

[4] **Antitrust and Trade Regulation** Measure and amount

There are only two possible ways to measure actual damages in a Florida Deceptive and Unfair Trade Practices Act (FDUTPA) claim: (1) the value between what was promised and what was delivered; or (2) the total price paid for a valueless good or service. Fla. Stat. Ann. § 501.201 et seq.

5 Cases that cite this headnote

[5] **Federal Civil Procedure** Amendments by briefs or motion papers

A party may not amend its complaint through argument in a brief opposing summary judgment. Fed. R. Civ. P. 56(c).

[6] **Conspiracy** Corporations and business organizations

Personal stake exception did not apply to executives of franchisor, and thus intracorporate conspiracy doctrine precluded liability for civil conspiracy under Florida law; franchisee failed to show that executives had personal stake in alleged conspiracy, and bonus-earning potential tied to franchise's success was not sufficient personal interest to trigger application of exception, as such interests were not wholly independent from corporation's interest.

1 Cases that cite this headnote

[7] **Conspiracy** Definition and elements of civil conspiracy in general

Under Florida law, the elements of civil conspiracy are: (1) an agreement between two or more parties, (2) to do an unlawful act or to do a lawful act by unlawful means, (3) the doing of some overt act in pursuance of the conspiracy, and (4) damage to plaintiff as a result of the acts done under the conspiracy.

2 Cases that cite this headnote

[8] **Federal Courts** Diversity jurisdiction in general

In diversity cases, a district court applies the law of the state in which it sits.

[9] **Conspiracy** Intracorporate conspiracy doctrine in general

Under Florida law, according to the intracorporate conspiracy doctrine, a civil conspiracy claim will not succeed where the only members of the alleged conspiracy are a corporation and/or its officers; this is because the actions of corporate agents, acting within the scope of their employment, are attributed to the corporation itself, thereby negating the multiplicity of actors needed for a conspiracy.

2 Cases that cite this headnote

[10] **Conspiracy** Personal stake or interest

Under the personal stake exception to the intracorporate conspiracy doctrine, a corporate employee may be liable for conspiring with his or her corporation or with other corporate agents where the agent has a personal stake in the activities that are separate and distinct from the corporation's interest.

4 Cases that cite this headnote

[11] **Conspiracy** Personal stake or interest

Under Florida law, the personal stake exception to intracorporate conspiracy doctrine, under which a corporate employee may be liable for conspiring with his or her corporation or with other corporate agents where the agent has a personal stake in the activities that are separate and distinct from the corporation's interest, requires more than some incidental personal benefit; the exception applies only where corporate employees are shown to have been motivated solely by personal bias.

4 Cases that cite this headnote

[12] **Conspiracy** Personal stake or interest

Under Florida law, where a corporate agent's compensation is directly related to the corporation's success, the two interests cannot be separated and the personal stake exception to intracorporate conspiracy doctrine, under which a corporate employee may be liable for conspiring with his or her corporation or with other corporate agents where the agent has a personal stake in the activities that are separate and distinct from the corporation's interest, does not apply.

2 Cases that cite this headnote

[13] **Conspiracy** Principal and agent

Employees, when acting in the scope of their employment, cannot conspire amongst themselves.

Attorneys and Law Firms

***1321** HRCC, Ltd., Grand Cayman, KY, pro se.

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Christian C. Burden, Cassidy Jones, Quarles & Brady, LLP, Tampa, FL, for Defendants.

ORDER

PAUL G. BYRON, UNITED STATES DISTRICT JUDGE

HRCC, Ltd. ("HRCC") sues Hard Café International (USA), Inc. ("Hard Rock (USA)"), Hamish Dodds, and Michael Beacham (collectively "Defendants") for violating the Florida Deceptive and Unfair Trade Practices Act ("FDUTPA") (Count I) and for civil conspiracy (Count II). Currently before the Court is Defendants' Motion for Summary Judgment. (Doc. 109). Upon consideration and review of the record as cited by the parties in their respective briefs, Defendants' Motion for Summary Judgment will be granted.

I. BACKGROUND

Hard Rock Café is rock-and-roll-themed restaurant and retail business with locations around the world. (Doc. 118, ¶ 1). The majority of Hard Rock businesses located outside of the United States are franchised locations. (*Id.* ¶ 4). Hard Rock Limited—a non-party to this litigation—is a foreign entity that engages in the international franchising of Hard Rock Café businesses. (*Id.* ¶ 2). Defendant Hard Rock (USA) is a Florida corporation formed in 1996 in part to provide franchise support services and management oversight to Hard Rock franchisees. (*Id.* ¶ 3).

Plaintiff HRCC is a British Virgin Islands entity. (*Id.* ¶ 7). In June 2000, HRCC and Hard Rock Limited entered into a franchise agreement (the "Franchise Agreement"). (*Id.* ¶ 8). Under the Franchise Agreement, Hard Rock Limited licensed to HRCC the right to use the Hard Rock Café mark, and HRCC promised to establish and operate a Hard Rock Café business in Nassau, the Bahamas, and to pay Hard Rock Limited a royalty on merchandise and food and beverage sales. (Doc. 105–3, p. 7).

Due to certain business licensure restrictions in the Bahamas, HRCC sub-licensed its rights to operate the Nassau Hard Rock business to separate Bahamian companies. (Doyle Dep.1439:15–18). From 2000 to 2004, pursuant to a sub-franchise agreement with HRCC, Habacoe Limited ("Habacoe") owned and operated the Nassau Hard Rock business. (*Id.* at 1454:3–6). In 2004, when the business relationship between Habacoe and HRCC deteriorated, HRCC formed a separate Bahamian entity, HRCC (Bahamas) Ltd., to continue the Nassau Hard Rock business. (*Id.* at 1455:1–4). HRCC (Bahamas) Ltd. owned and operated the Nassau Hard Rock Café business from April 2004 until March 31, 2014. (Doc. 118, ¶ 12).

Beginning in 2013, HRCC failed to pay Hard Rock Limited all of the royalties that were due under the Franchise Agreement. Hard Rock Limited warned HRCC that if the royalties were not paid as required, the Franchise Agreement would be terminated. ***1322** (Wolszczak Aff. ¶¶ 32–35; Lorenzo Aff., ¶¶ 5–7). HRCC did not pay all of the required loyalties, and Hard Rock Limited accordingly terminated the Franchise Agreement on January 6, 2014. (Doc. 118, ¶ 10). HRCC (Bahamas) continued operating the Hard Rock restaurant in Nassau until a liquidator was appointed on March 31, 2014. (*Id.* ¶ 12).

Throughout the operation of the Bahamian Hard Rock franchise, Hard Rock (USA) provided management and administrative services to HRCC. (Doc. 108–2, ¶ 7). It is the nature of these "services" that gave rise to this lawsuit. HRCC contends that Hard Rock (USA) interfered with the management of the business and prevented HRCC from making a profit. In contrast, Hard Rock (USA) contends that any actions it took with regard to HRCC's Nassau business were based upon valid "business decisions." (Doc. 109, p. 1).

In December 2014, after HRCC lost its Bahamian franchise, HRCC filed this law suit under the Court's diversity jurisdiction. In its Second Amended Complaint, HRCC maintains that Hard Rock (USA), together with Hard Rock executives Hamish Dodds ("Dodds") and Michael Beacham ("Beacham"), caused the franchise to incur financial losses by refusing to provide concessions given to other franchisees; by failing to disclose that other Hard Rock stores were experiencing losses in food sales; by fabricating reasons to justify terminating the Franchise Agreement; and by wrongfully terminating the Franchise Agreement. (Doc. 38, ¶ 95(a)–(h)). Based on these actions, HRCC asserts two claims: In Count I HRCC alleges that Defendants committed deceptive and unfair practices in violation of FDUTPA. In Count II, HRCC alleges that Defendants Dodds and Beacham "conspired with one another to drive HRCC out of business in an effort to wrongfully seize the franchises and re-sell such franchises to a third party for profit." (*Id.*¶ 99). HRCC seeks "recovery of all monies tendered by HRCC in connection with the opening and operation of its Hard Rock Café restaurant franchise." (*Id.* at p. 17). Defendants now move for summary judgment on both the FDUTPA claim and the civil conspiracy claim. (Doc. 109, p. 14–15).

II. STANDARD OF REVIEW

To prevail on a summary judgment motion, the movant must show "that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *see also* *Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). The Court must "view the evidence and all factual inferences therefrom in the light most favorable to the non-moving party, and resolve all reasonable doubts about the facts in favor of the non-movant." *Davila v. Gladden*, 777 F.3d 1198, 1203 (11th Cir. 2015) (quoting *Carter v. City of Melbourne*, 731 F.3d 1161, 1166 (11th Cir. 2013) (per curiam)). "An issue of fact is 'material' if, under the applicable substantive law, it might affect the outcome of the case. An issue of fact is 'genuine' if the record taken as a whole could lead a rational trier of fact to find for the nonmoving party." *Harrison v. Culliver*, 746 F.3d 1288, 1298 (11th Cir. 2014). "A mere 'scintilla' of evidence supporting the opposing party's position will not suffice; there must be enough of a showing that the jury could reasonably find for that party." *Brooks v. Cty. Comm'n of Jefferson Cty.*, 446 F.3d 1160, 1162 (11th Cir. 2006) (quoting *Walker v. Darby*, 911 F.2d 1573, 1577 (11th Cir. 1990)). If, after adequate time for discovery, the nonmoving party "fails to make a showing sufficient to establish the existence of an element essential to that party's case," summary judgment is mandated. *Celotex*, 477 U.S. at 322–23, 106 S.Ct. 2548.

*1323 III. ANALYSIS

A. FDUTPA Claim (Count I)

[1] In Count I, HRCC alleges that Defendants violated FDUTPA through a series of interactions that HRCC characterizes as "unfair or deceptive." In its prayer for relief, HRCC requests actual damages "in amounts to be proven at trial." (Doc. 38, p 17). Defendants move for summary judgment on the FDUTPA claim, arguing, among other things, that HRCC failed to provide any evidence of actual damages—a required element under FDUTPA.

[2] **[3]** **[4]** FDUTPA provides that "[i]n any action brought by a person who has suffered a loss as a result of a violation of this part, such person may recover *actual damages*, plus attorney's fees and court costs ...." § 501.211(2) (emphasis added). It is well established that actual damages are a required element of a FDUTPA claim. *Lustig v. Bear Stearns Residential Mortg. Corp.*, 411 Fed.Appx. 224, 225 (11th Cir. 2011) (per curiam). For purposes of FDUTPA, actual damages must be direct damages, not consequential damages in the form of lost profits. *Hetrick v. Ideal Image Dev. Corp.*, 372 Fed.Appx. 985, 991 (11th Cir. 2010) (per curiam); *Britt Green Trucking, Inc. v. FedEx Nat'l, LTL, Inc.*, No. 8:09-cv-445-T-33TBM, 2014 WL 3417569, at *12 (M.D. Fla. July 14, 2014). Although "actual damages" is not defined in the statute, courts have consistently applied a narrow definition of the term:

> Generally, the measure of actual damages is the difference in the market value of the product or service in the condition in which it was delivered and its market value in the condition in which it should have been delivered according to the contract of the parties. A notable exception to the rule may exist when the product is rendered valueless as a result of the defect—then the purchase price is the appropriate measure of actual damages.

Dem. Rep. Congo v. Air Capital Grp., LLC, 614 Fed.Appx. 460, 472 (11th Cir. 2015) (quoting *Rollins, Inc. v. Heller*, 454 So.2d 580, 585 (Fla. 3d DCA 1984)). Thus, there are only two possible ways to measure actual damages in a FDUTPA claim: (1) the value between what was promised and what was delivered; or (2) the total price paid for a valueless good or service. 614 Fed.Appx. at 472.

In their Motion for Summary Judgment, Defendants state: "HRCC deferred providing its 'actual damages' composition and proof until making its expert disclosures but unaccountably made no expert disclosure or supplementation." (Doc. 109, p. 19).[1] Defendants argue that HRCC cannot maintain its FDUTPA action because HRCC failed to provide any computations or estimates of actual damages—despite ample opportunity to do so through the discovery process.

[5] In order to survive Defendants' Motion for Summary Judgment, HRCC must point to evidence sufficient to allow a jury to reasonably find that it incurred actual damages, as measured under FDUTPA. *See* *Brooks*, 446 F.3d at 1162. In its response to Defendants' summary judgment motion, however, HRCC makes no attempt to clarify the issue of damages and instead focuses its response on the ***1324** issue of whether the Defendants' actions can be considered "unfair or deceptive." (Doc. 108, p. 18). Indeed, in a single paragraph, HRCC responded to Defendants' FDUTPA arguments without any mention of damages at all. Moreover, a careful review of the record reveals that HRCC has avoided providing any meaningful evidence that would satisfy the measure of damages needed for a successful FDUTPA claim. To be sure, HRCC makes several references in the record to damages in the form of lost profits and added expenses.[2] Such references have no bearing on the issue of damages in this case, however, because they do not fall within the two established measures for damages for a FDUTPA claim. Without any response from HRCC regarding its actual damages, the Court is left with nothing but conjecture as to what, if any, its actual damages are. HRCC's burden at this stage of the proceedings is well established: Where a nonmoving party fails to make a showing on an essential element of their claim, "the plain language of Rule 56(c) *mandates* the entry of summary judgment." *Celotex*, 477 U.S. at 322–23, 106 S.Ct. 2548 (emphasis added). In this case, HRCC has failed to provide any evidence of its actual damages—an essential element under FDUTPA. Summary judgment is therefore mandated.[3]

Cases disposing of FDUTPA claims for failing to establish actual damages are numerous. For example, in *National Union Fire Insurance Co. of Pittsburgh v. Tyco Integrated Security., LLC*, No. 13-CIV-80371, 2015 WL 3905018 (S.D. Fla. June 25, 2015), the district court granted summary judgment "[b]ecause [the plaintiff] failed to provide *any* evidence of actual damages despite a protracted and ample discovery period." *Id.* at *33. Similarly, in *Hanson Hams, Inc. v. HBH Franchise Co.*, No. 03-61198-CIV, 2004 WL 5470401 (S.D. Fla. Dec. 21, 2004), the district court granted the defendant's motion for summary judgment, holding in part that the plaintiff had failed to establish actual damages. *Id.* at *11. In both cases, the plaintiffs provided at least some estimation of their alleged damages. Here, conversely, at no point does HRCC provide an estimation, calculation, or even explanation of what, if any, its damages are. As the aforementioned cases instruct, summary judgment of a FDUTPA claim is proper where a defendant fails to make a sufficient showing of actual damages.

Because HRCC has failed to establish an essential element of its FDUTPA claim, Defendants are entitled to summary judgment on Count I.

B. Civil Conspiracy Claim (Count II)

[6] In Count II, HRCC alleges that two of Hard Rock (USA)'s officers, Defendants Dodds and Beacham, engaged in a civil conspiracy to harm HRCC. Defendants move for summary judgment on the grounds that the claim is barred by the intracorporate conspiracy doctrine.

[7] **[8]** **[9]** Under Florida Law,[4] the elements of civil conspiracy are: "(a) an agreement between two or more parties, ***1325** (b) to do an unlawful act or to do a lawful act by unlawful means, (c) the doing of some overt act in pursuance of the conspiracy, and (d) damage to plaintiff as a result of the acts done under the conspiracy." *United Techs. Corp v. Mazer*, 556 F.3d 1260, 1271 (11th Cir. 2009) (applying Florida law). According to the intracorporate conspiracy doctrine, however, a civil conspiracy claim will not succeed where the only members of the alleged conspiracy are a corporation and/or its officers. *See* *Lipsig v. Ramlawi*, 760 So.2d 170, 180 (Fla. 3rd DCA 2000) (finding that "neither an agent nor an employee can conspire with his or her corporate principal or employer"). This is because the actions of corporate agents, acting within the scope of their employment, are attributed to the corporation itself, thereby negating the multiplicity of actors needed for a conspiracy. *See* *Williams v. Michelin N. Am., Inc.*, No. 6:04CV815ORL31DAB, 2005 WL 2708308, at *2 (M.D. Fla. Oct. 21, 2005).

[10] HRCC argues that its civil conspiracy claim is cognizable under the "personal stake exception" to the intracorporate conspiracy doctrine. (Doc. 121, p. 19). Under that exception, a corporate employee may be liable for conspiring with his or her corporation or with other corporate agents where "the agent has a personal stake in the activities that are separate and distinct from the corporation's interest." *Cedar Hills Props. Corp. v. E. Fed. Corp.*, 575 So.2d 673, 676 (Fla. 1st DCA. 1991).

The personal stake exception was first formulated by the Fourth Circuit in an anti-trust case. *Greenville Publ'g Co. v. Daily Reflector, Inc.*, 496 F.2d 391, 399–400 (4th Cir. 1974); *Hackett v. Metro. Gen. Hosp.*, 422 So.2d 986, 988 n.2 (Fla. 2d DCA 1982) (citing *Greenville* as authority for the personal stake exception recognized in Florida). Importantly, the Fourth Circuit subsequently warned against applying the exception too broadly, acknowledging that the exception "threatens to swallow the rule." *Oksanen v. Page Mem'l Hosp.*, 945 F.2d 696, 705 (4th Cir. 1991) (en banc) (declining to extend the exception beyond the rationale underlying the *Greenville* decision).

[11] Other courts that have applied the exception appear to have heeded that warning, choosing to apply the exception narrowly. For example, the Seventh Circuit has found that the intracorporate conspiracy doctrine "is not avoided simply by showing that corporate employees were motivated *in part* by personal bias." *Hartman v. Bd. of Trs. of Cmty. Coll. Dist. No. 508*, 4 F.3d 465, 470 (7th Cir. 1993) (emphasis added). Similarly, the Third Circuit has held that the exception applies "when the employees have acted for their *sole* personal benefit and thus outside the course and scope of their employment." *Heffernan v. Hunter*, 189 F.3d 405, 412 (3d Cir. 1999) (emphasis added) (footnote omitted); *see also* *Buschi v. Kirven*, 775 F.2d 1240, 1253 (4th Cir. 1985) (explaining that while authorized acts of an employee would be protected under the intracorporate conspiracy doctrine, unauthorized acts would not). As these cases instruct, the personal stake exception requires more than some incidental personal benefit—the exception applies only "where corporate employees are shown to have been motivated *solely* by personal bias." *Hartman*, 4 F.3d at 470 (emphasis added).

[12] According to HRCC, the personal stake exception applies to this case because Dodds and Beacham both had bonus-earning potential tied to Hard Rock's success. (Doc. 121, p. 18). Such an interpretation, however, is contrary to a line decisions that have held that higher compensation to a corporate employee is not a sufficient "personal interest" to trigger application of the personal stake exception. ***1326** *See, e.g.,* *Bailey v. Atl. Auto. Corp.*, 992 F.Supp.2d 560, 569 (D. Md. 2014); *United States v. Gwinn*, No. CIVA 5:06-cv-00267, 2008 WL 867927, at *25 (S.D.W. Va. March 31, 2008); *Douty v. Irwin Mortg. Corp.*, 70 F.Supp.2d 626, 633 (E.D. Va. 1999). As explained by the court in *Gwinn*, "any 'personal stake' defendants had in increased commissions was incidental to their employment relationship with [the corporation] because their commissions were determined and paid by [the corporation]." *Gwinn*, at *25. Such interests are not "wholly independent" from the corporation's interest, and therefore cannot be considered a "personal stake." *Id.* This analysis is persuasive. Where, as here, a corporate agent's compensation is directly related to the corporation's success, the two interests cannot be separated and the personal stake exception does not apply. In this case, the personal interest HRCC alleges is a bonus-earning potential "based upon Hard Rock's performance." (Doc. 121, p. 19). By HRCC's own account, the bonus-earning potential is directly related to the corporation's success. Because these interests cannot be separated, the personal stake exception does not apply.

HRCC's only other argument for application of the personal stake exception is that Beacham's own emails "prove that he had a motive to rid the Hard Rock system of Kevin Doyle, who he described as a cancer."[5] (*Id.*). HRCC provides neither an explanation nor legal support for this assertion. Nonetheless, the personal animosity that HRCC suggests is woefully inadequate to support application of the personal stake exception. As previously stated, the personal stake exception requires more than some incidental personal benefit. Any personal satisfaction that Beacham would receive from "ridding" Hard Rock of its interaction with Kevin Doyle simply does not rise to an independent personal gain that would warrant application of the personal stake exception. And other courts agree. In *Cox v. Cache County*, No. 1:08-cv-124 CW, 2013 WL 4854450, at *7 (D. Utah Sept. 11, 2013), the district court found that the defendant's personal animosity against the plaintiff was not a personal stake for civil conspiracy purposes. Also, in *Jones v. City of College Park*, 540 F.Supp.2d 1300 (N.D. Ga. 2007), the district court found that racial animosity against the plaintiff was not a sufficient personal interest, explaining that the exception "would only apply to defendants with independent *economic* stake in the conspiracy." *Id.* at 1321; *see also* *On–Site Dev. Corp. v. Riley*, 564 So.2d 201, 204 (Fla. 5th DCA 1990) (per curiam) (finding that "personal animosity ... cannot of itself constitute the 'stake' "). Similarly here, Beacham's personal animosity—if any—is not a sufficient personal interest to warrant application of the personal stake exception.

[13] To support its personal stake argument, HRCC directs the Court to only one case, *Regions Bank v. Kaplan*, No. 8:12-CV-1837-T-17MAP, 2014 WL 5088889 (M.D. Fla. Sept. 30, 2014). That case involved a motion to dismiss a civil conspiracy claim in a suit against multiple LLCs, all of which consisted of the same sole managing member. *Id.* at *6. The defendant LLCs argued that each entity consisted of the same sole member and, therefore, they collectively lacked the multiplicity of actors necessary for the formation of a conspiracy. *Id.* The court held otherwise, finding that each limited liability company was a separate entity capable of conspiring. *Id.* Thus, the holding in *Regions Bank* does nothing more that reiterate the well-established principle that, for a conspiracy claim, there must be two or more parties. Here, both Defendants ***1327** named in the conspiracy claim were executives of Hard Rock (USA) at all relevant times. Any actions they took within the scope of their employment are attributed to the corporation. No claims have been made, and no facts suggest, that Dodds or Beacham were acting outside the scope of their employment. As it is firmly established: "[E]mployees, when acting in the scope of their employment, cannot conspire amongst themselves." *Williams*, 2005 WL 2708308, at *2 (quoting *McAndrew v. Lockheed Martin Corp.*, 206 F.3d 1031, 1036 (11th Cir.2000)).

Because HRCC fails to show that Dodds and Beacham had a personal stake in the alleged conspiracy, the personal stake exception does not apply and the intracorporate conspiracy doctrine precludes liability for civil conspiracy. Defendants are, therefore, entitled to summary judgment on Count II as well.

C. Defendants' Counter Claim

The Court's ruling on Defendants' Motion for Summary Judgment resolves all remaining claims raised by HRCC in its Second Amended Complaint. There still remains unresolved the counterclaim raised by Defendants in their answer to HRCC's Second Amended Complaint. (Doc. 70). In their counterclaim, Defendants seek recognition under the Florida Uniform Out-of-Country Foreign–Money Judgment Recognition Act, Fla. Stat. §§ 55.601–.607, of two judgments issued in the Royal Court of Jersey. Defendants explain in their Motion for Summary Judgment that they seek recognition not for collection of the judgment, but because the judgments are "fatal to HRCC's claims against Hard Rock (USA)". (Doc. 109, p. 23). In light of the Court's ruling on summary judgment, Defendants are asked to advise the Court as to the status of this remaining counterclaim. Moreover, if Defendants wish to pursue the counterclaim, Defendants are advised to provide the Court with copies of the judgments issued by the Royal Court of Jersey. Although Defendants attempted to attach the judgments to their counterclaim, they appear to have inadvertently provided the Court with only one of the judgments.

IV. CONCLUSION

For the aforementioned reasons, it is **ORDERED AND ADJUDGED** that:

1. Defendants' Motion for Summary Judgment (Doc. 109) is **GRANTED**.
2. The parties are **DIRECTED** to advise the Court of the status of the remaining counterclaim (Docs. 70) in light of this order.

DONE AND ORDERED in Orlando, Florida, on September 13, 2016.

All Citations

302 F.Supp.3d 1319

Footnotes

1 HRCC's response to interrogatories provides:

> Plaintiff has not yet determined all of the "actual damages" that it seeks to recover. Plaintiff intends to retain an expert witness as to damages who will be charged with the responsibility of, *inter alia*, calculating the damages sustained by Plaintiff. Once Plaintiff retains such an expert witness and, consistent with the deadlines for expert disclosures, Plaintiff shall supply Defendants with the amount of "actual damages" that Plaintiff sustained.

(Doc. 106–1, pp. 17–18).

2 For example, HRCC provides that "the costs associated with keeping HRC Nassau open at night resulted in annual losses ranging from $350,000 to $400,000." (Pl.'s Second Am. Compl., ¶ 40).

3 In its response, HRCC appears to ask the Court to amend its complaint to conform to the record evidence in order to assert a new theory of liability. (Doc. 121, p. 17, n.10). However, it is well-settled that "[a] party may not amend [its] complaint through argument in a brief opposing summary judgment." *Gilmour v. Gates, McDonald & Co.*, 382 F.3d 1312, 1315 (11th Cir. 2004).

4 In diversity cases, a district court applies the law of the state in which it sits. *Alexander Proudfoot Co. World Headquarters v. Thayer*, 877 F.2d 912, 916 (11th Cir. 1989).

5 Kevin Doyle is a shareholder of both HRCC and HRCC (Bahamas).

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Declined to Follow by U.S. v. Basroon, 3rd Cir.(N.J.), May 30, 2002

206 F.3d 1031
United States Court of Appeals,
Eleventh Circuit.

Robert E. McANDREW, Plaintiff–Counter–Defendant–Appellant,
v.
LOCKHEED MARTIN CORPORATION, Successor in Interest to Lockheed–Aeronautical Systems Company, a division of Lockheed Corporation, Defendant–Counter–Claimant–Appellee,
J.A. Blackwell, Jr., T.A. Graham, et al., Defendants–Appellees.

No. 97–8483.
|
March 8, 2000.

Synopsis
Employee brought action against employer and various corporate officers, alleging that they engaged in conspiracy to deter him from testifying before federal grand jury investigation and to fire him in retaliation for having testified, and asserting state law claim of intentional infliction of emotional distress. Employer counterclaimed for breach of fiduciary duty and fraud, and each defendant moved to dismiss. The United States District Court for the Northern District of Georgia, No. 96–CV–01584–1–CV–JOF, J. Owen Forrester, J., dismissed employee's claims, and employee appealed. The Court of Appeals, 177 F.3d 1310, affirmed the dismissal of employee's state law claim, reversed the dismissal of the conspiracy claim, and remanded. On rehearing en banc, the Court of Appeals, Marcus, Circuit Judge, held that intracorporate conspiracy doctrine did not apply to bar a claim alleging a criminal conspiracy among a corporation and its employees to prevent by force, intimidation, or threat, an individual from testifying in a federal court.

District court order affirmed in part, reversed in part, and remanded; Court of Appeals panel decision vacated.

Procedural Posture(s): On Appeal; Motion to Dismiss.

West Headnotes (15)

[1] **Conspiracy** Obstructing justice or judicial proceedings

Phrase "court of the United States," as used in statute rendering liable persons who conspire to deprive another of his or her civil rights by obstructing justice or intimidating a party, witness, or juror in any court of the United States, refers only to Article III courts and certain federal courts created by act of Congress, but not to state courts. U.S.C.A. Const. Art. 3, § 1; 28 U.S.C.A. § 451; 42 U.S.C.A. § 1985(2).

7 Cases that cite this headnote

[2] **Conspiracy** Obstructing justice or judicial proceedings

Statute rendering liable persons who conspire to deprive another of his or her civil rights by obstructing justice or intimidating a party, witness, or juror encompasses conspiracies to deter testimony before a federal grand jury. 42 U.S.C.A. § 1985(2).

[3] **Conspiracy** Intracorporate conspiracy doctrine in general

"Intracorporate conspiracy doctrine" holds that acts of corporate agents are attributed to the corporation itself, thereby negating the multiplicity of actors necessary for the formation of a conspiracy.

118 Cases that cite this headnote

[4] **Conspiracy** Intracorporate conspiracy doctrine in general

Under the intracorporate conspiracy doctrine, a corporation cannot conspire with its employees, and its employees, when acting in the scope of their employment, cannot conspire among themselves.

171 Cases that cite this headnote

[5] **Conspiracy** Definition and elements of civil conspiracy in general

"Conspiracy" requires a meeting of the minds between two or more persons to accomplish a common and unlawful plan.

17 Cases that cite this headnote

[6] **Corporations and Business Organizations** Corporation acts through officers or agents

Under basic agency principles, the acts of a corporation's agents are considered to be those of a single legal actor.

20 Cases that cite this headnote

[7] **Conspiracy** Corporations and Business Organizations in General

Just as it is not legally possible for an individual person to conspire with himself or herself, it is not possible for a single legal entity consisting of the corporation and its agents to conspire with itself.

42 Cases that cite this headnote

[8] **Courts** Decisions in other circuits

Fifth Circuit decisions enacted prior to October 1, 1981 are binding precedent in the Eleventh Circuit.

2 Cases that cite this headnote

[9] **Courts** Decisions in other circuits

Although a decision of the former Fifth Circuit was issued on the summary calendar, because it was published, it was precedent in the Eleventh Circuit.

1 Cases that cite this headnote

[10] **Conspiracy** Principal and agent; organizations and entities

Intracorporate conspiracy doctrine does not apply to alleged intracorporate criminal conspiracies arising under statute making it a crime for two or more persons to conspire to commit any offense against the United States or to defraud the United States. 18 U.S.C.A. § 371.

126 Cases that cite this headnote

[11] **Corporations and Business Organizations** Disregarding Corporate Entity; Piercing Corporate Veil

Original purpose of the corporate entity fiction was to expand rather than shrink corporate responsibility by making a corporation answer for the negligent acts of its agents.

[12] **Corporations and Business Organizations** Fraud or illegal acts in general

Corporate entity fiction was never intended to prohibit the imposition of criminal liability by allowing a corporation or its agents to hide behind the identity of the other.

3 Cases that cite this headnote

[13] **Obstructing Justice** Tampering in general

Obstructing Justice Threatening or intimidating in general

Federal witness tampering statute not only makes it a crime to attempt to deter testimony by force, intimidation, or threat, but also makes it a crime to try to deter such testimony through sheer persuasion without the use of physical or economic threat, as long as one does so with a corrupt purpose. 18 U.S.C.A. § 1512(b).

4 Cases that cite this headnote

[14] **Conspiracy** Obstructing justice or judicial proceedings

Conspiracy Civil Rights, Conspiring to Deprive

Obstructing Justice Threatening or intimidating in general

By stating a claim under the statute governing conspiracies to interfere with civil rights, alleging that defendants attempted to deter him by force, intimidation, or threat from testifying before a federal grand jury about employer's activities by threatening him with job-related sanctions, employee also alleged a crime under the federal witness tampering statute and a criminal conspiracy under the statute making it a crime for two or more persons to conspire to commit any offense against the United States or to defraud the United States. 18 U.S.C.A. §§ 371, 1512(b); 42 U.S.C.A. § 1985(2).

10 Cases that cite this headnote

[15] **Conspiracy** Civil rights conspiracies

Intracorporate conspiracy doctrine did not bar action by employee alleging a conspiracy among corporation and senior management employees to interfere with his civil rights by deterring, by force, intimidation, or threat, his federal grand jury testimony; employee's allegations plainly described criminal conduct and a criminal conspiracy, and the criminal conspiracy exception to the doctrine applied regardless of whether the criminal conspiracy arose under the federal criminal code or the federal civil code. 18 U.S.C.A. §§ 371, 1512(b); 42 U.S.C.A. § 1985(2).

78 Cases that cite this headnote

Attorneys and Law Firms

***1033** Edmund M. Kneisel, William H. Boice, Kilpatrick Stockton, L.L.P., Neal S. Berinhout, Chitwood & Harley, W. Christopher Arbery, Kilpatrick & Cody, L.L.P., H. Lane Dennard, Jr. and Todd David Wozniak, King & Spalding, Richard W. Hendrix, Finch, McCranie, Brown & Thrash, Atlanta, GA, for Defendant–Counter–Claimant–Appellee and Defendants–Appellees.

James L. Ford, The Ford Law Firm, Christopher G. Moorman, James L. Ford, P.C., Atlanta, GA, for Robert E. McAndrew.

Appeal from the United States District Court for the Northern District of Georgia.

Before ANDERSON, Chief Judge, TJOFLAT, EDMONDSON, COX, BIRCH, DUBINA, BLACK, CARNES, BARKETT, MARCUS, WILSON, Circuit ***1034** Judges, * and GODBOLD, Senior Circuit Judge. **

Opinion

MARCUS, Circuit Judge:

This case raises the discrete question of the applicability of the intracorporate conspiracy doctrine to claims arising under 42 U.S.C. § 1985(2) and alleging a conspiracy among corporate officers and the corporation itself to deter by force, intimidation, or threat, an individual from testifying in a court of the United States. These allegations plainly describe criminal conduct in violation of 18 U.S.C. § 1512 and a criminal conspiracy in violation of 18 U.S.C. § 371. Accordingly, we hold that just as the intracorporate conspiracy doctrine cannot shield a criminal conspiracy from prosecution under the federal criminal code, the doctrine cannot shield the same conspiracy, alleging the same criminal wrongdoing, from civil liability arising under 42 U.S.C. § 1985(2). Therefore, we reverse the district court's order dismissing McAndrew's § 1985(2) claim as barred by the intracorporate conspiracy doctrine and remand for further proceedings consistent with this opinion.

I.

The facts of this case are straightforward. In 1993, the United States Department of Justice was investigating Lockheed's sale of three C–130 aircraft to the Arab Republic of Egypt for possible violations of the Foreign Corrupt Practices Act, 10 U.S.C. § 2409 *et seq.* Robert McAndrew had served as Lockheed's Director of International Marketing since 1989 and was responsible for negotiating the sale of aircraft to foreign nations.

In the fall of 1993, McAndrew and more than 30 other Lockheed employees were subpoenaed to testify before a federal grand jury. McAndrew alleges that on the morning he was scheduled to appear before the grand jury, June 21, 1994, he received a phone call from T.A. Graham, Vice President of Business Development at Lockheed (and McAndrew's immediate supervisor). During the course of the conversation Graham supposedly expressed his dissatisfaction to McAndrew about McAndrew's appearance before the grand jury, and told him specifically that "the company was very unhappy with [McAndrew's] decision to testify." Indeed, the complaint alleges that Graham made clear to McAndrew that "it would not be in his best interest to testify." McAndrew explained that he had no choice about testifying, that he had been under subpoena since October, 1993, and that he had been ordered by the court to give testimony. McAndrew told Graham, according to the complaint, that McAndrew had to appear and answer truthfully whatever questions were posed to him. Plaintiff alleged that Graham was in Mexico when he called McAndrew and that Graham made it clear by his words that he was not only expressing his own personal sentiments, but was also speaking for Lockheed.

On June 21, 1994, under compulsion of subpoena and a separate court order, McAndrew appeared and testified before the grand jury regarding his knowledge of the sale of aircraft to Egypt. Two days later, McAndrew alleged, he received another call from Graham during which Graham told McAndrew that he, and Defendants A. Goldfarb (Vice President for Administration) and T.F. Powell (Vice President of Human Resources) were discussing what to do about McAndrew. Graham allegedly told McAndrew to take a couple of days off. Thereafter, according to the complaint, on June 28, 1994, Graham fired McAndrew by reading him the following statement: "The company has decided to end our relationship. This is due to your performance in International Marketing."

***1035** In June 1996, McAndrew sued Lockheed and five senior management employees—Graham, Powell, Goldfarb, J.A. Blackwell (Lockheed's Aeronautical Senior President and Chief Executive Officer), and J.S. McLellan (President of Lockheed Martin Aeronautical System Company, a division of Lockheed Martin)—alleging that they conspired to prevent him from testifying and then retaliated against him by firing him after he testified in violation of 42 U.S.C. §§ 1985(2) and 1986, and the United States Constitution. McAndrew also brought supplemental claims alleging violation of the Georgia Constitution and intentional infliction of emotional distress. Lockheed filed counterclaims asserting that McAndrew breached his fiduciary duties to the company and committed fraud in connection with the sale of Lockheed aircraft to Egypt. In addition, each Defendant filed a motion to dismiss.

The district court granted Defendants' motions to dismiss and dismissed the complaint in its entirety. In doing so, the court held: first, that McAndrew's § 1985(2) claim was barred by the intracorporate conspiracy doctrine; second, that his § 1986 claim was derivative of the § 1985 claim and failed for the additional reason that the one year statute of limitations had run; third, that his constitutional claims failed because he did not allege state action; and finally, that his pendent state claim for intentional infliction of emotional distress was barred by the statute of limitations.

McAndrew appealed the district court's rulings dismissing his § 1985(2) claim and his state law claim for intentional infliction of emotional distress but did not appeal the trial court's rulings dismissing his claim under § 1986 and dismissing his federal and state constitutional claims. A panel of this Court affirmed the district court's ruling dismissing McAndrew's state law claim but reversed the ruling dismissing the § 1985(2) claim holding that the intracorporate conspiracy doctrine did not apply to § 1985 claims alleging civil rights violations. *See* *McAndrew v. Lockheed Martin Corp.,* 177 F.3d 1310, 1313 (11th Cir.1999). On August 11, 1999, we vacated this opinion and granted rehearing en banc.

II.

[1] **[2]** The only issue before us [1] is whether the intracorporate conspiracy doctrine applies to and bars a claim arising under Title 42 U.S.C. § 1985(2), [2] alleging a criminal conspiracy among a corporation and its employees to prevent by force, intimidation, or threat, an individual from testifying in a federal court. We hold that it does not. This outcome flows from the long-established conclusion that the intracorporate conspiracy doctrine does not apply to criminal conspiracies. Because a § 1985(2) claim alleging a conspiracy to deter a person by force, intimidation, or threat from testifying in a federal court proceeding squarely and unambiguously ***1036** alleges a criminal conspiracy in violation of 18 U.S.C. §§ 371, 1512, the intracorporate conspiracy doctrine does not apply and, therefore, cannot shield the Defendants from civil liability.

[3] [4] [5] [6] [7] The intracorporate conspiracy doctrine holds that acts of corporate agents are attributed to the corporation itself, thereby negating the multiplicity of actors necessary for the formation of a conspiracy. Simply put, under the doctrine, a corporation cannot conspire with its employees, and its employees, when acting in the scope of their employment, cannot conspire among themselves. The doctrine is based on the nature of a conspiracy and the legal conception of a corporation. It is by now axiomatic that a conspiracy requires a meeting of the minds between two or more persons to accomplish a common and unlawful plan. *See* *Bivens Gardens Office Bldg., Inc. v. Barnett Banks Inc.,* 140 F.3d 898, 912 (11th Cir.1998) (explaining that a civil conspiracy ordinarily requires "an agreement between two or more people to achieve an illegal objective, an overt act in furtherance of that illegal objective, and a resulting injury to the plaintiff"). However, under basic agency principles, the acts of a corporation's agents are considered to be those of a single legal actor. *Dussouy v. Gulf Coast Inv. Corp.,* 660 F.2d 594, 603 (5th Cir.1981); *see also* *United States v. Hartley,* 678 F.2d 961, 970 (11th Cir.1982). Therefore, just as it is not legally possible for an individual person to conspire with himself, it is not possible for a single legal entity consisting of the corporation and its agents to conspire with itself. *See* *Dussouy,* 660 F.2d at 603 (noting that "the multiplicity of actors necessary to conspiracy" is negated when the agents' acts are attributed to the corporation and the corporation and its agents are viewed as a single legal actor); *Nelson Radio & Supply Co. v. Motorola, Inc.,* 200 F.2d 911, 914 (5th Cir.1952) (explaining that "[i]t is basic in the law of conspiracy that you must have two persons or entities to have a conspiracy. A corporation cannot conspire with itself any more than a private individual can, and it is the general rule that the acts of the agent are the acts of the corporation").

Not surprisingly, the intracorporate conspiracy doctrine first developed in the anti-trust context where it seemed particularly logical to conclude that a single corporation could not conspire with itself to restrain trade in the way imagined by Section 1 of the Sherman Antitrust Act.[3] As the former Fifth Circuit explained in *Nelson Radio,* while a single corporation could act in violation of Section 2 of the Sherman Act[4]—which prohibits attempts to monopolize—it could not *alone* form a contract, combination, or conspiracy in restraint of trade so as to violate Section 1 of the Act. *See* *Nelson Radio,* 200 F.2d at 914 (explaining that Section 1 of the Sherman Act "does not purport to cover a conspiracy which consists merely in the fact that the officers of the single defendant corporation did their day to day jobs in formulating and carrying out its managerial policy"). To hold otherwise would render Section 2 of the Act meaningless. *See* *Hartley,* 678 F.2d at 971.

In *Dombrowski v. Dowling,* 459 F.2d 190 (7th Cir.1972), the Seventh Circuit extended the intracorporate conspiracy doctrine to § 1985 claims. The *Dombrowski* court held that when two executives of the same firm make a decision to discriminate in furtherance of the purpose of the business, ***1037** that decision cannot be called a conspiracy for purposes of § 1985(3).[5] *Id.* at 196. *See also* *Hartman v. Board of Trustees,* 4 F.3d 465, 469–70 (7th Cir.1993) (holding the intracorporate conspiracy doctrine is not avoided in § 1985(3) claims by a showing that corporate employees were motivated in part by personal bias); *Travis v. Gary Community Mental Health Ctr., Inc.,* 921 F.2d 108, 110 (7th Cir.1990) (reiterating, in response to plaintiff's § 1985(2) retaliation claim, the holding of *Dombrowski* that "managers of a corporation jointly pursuing its lawful business do not become 'conspirators' when acts within the scope of their employment are said to be discriminatory or retaliatory").

[8] [9] Like a majority of the other circuits,[6] we have followed the Seventh Circuit's extension of the intracorporate conspiracy doctrine to claims arising under § 1985(3). In *Chambliss v. Foote,* 562 F.2d 1015 (5th Cir.1977) (per curiam), the former Fifth Circuit, in binding precedent,[7] affirmed the district court's holding ***1038** that the intracorporate conspiracy doctrine barred plaintiff's § 1985(3) claim alleging that university officials' decision not to renew her teaching contract was the product of a conspiracy to violate her civil rights. *Id.* at 1015. The district court concluded that "the university and its officials are considered as constituting a single legal entity which cannot conspire with itself." *Chambliss v. Foote,* 421 F.Supp. 12, 15 (E.D.La.1976). The former Fifth Circuit affirmed with only the following statement: "We affirm on the basis of the district court's opinion." *Chambliss,* 562 F.2d at 1015.[8] Recently, in *Dickerson v. Alachua County Comm'n,* 200 F.3d 761

(11th Cir.2000), a panel of this Court followed *Chambliss* and held that the intracorporate conspiracy doctrine barred plaintiff's § 1985(3) claim alleging a conspiracy among employees of the same public entity to deprive him of his civil rights. *See id. Chambliss* and *Dickerson* remain the law in this Circuit. We have no occasion to revisit them today because neither case addressed the precise question presented here: whether the intracorporate conspiracy doctrine applies to and bars claims alleging a criminal conspiracy among corporate officers and the corporation itself arising under 42 U.S.C. § 1985(2). Neither case involved a claim brought under § 1985(2) and, more importantly, neither involved allegations of a criminal conspiracy to deter by force, intimidation, or threat an individual from testifying before a federal grand jury.

[10] We have long recognized an exception to the applicability of the intracorporate conspiracy doctrine for intracorporate criminal conspiracies arising under 18 U.S.C. § 371 of the federal criminal code. [9] In *Hartley,* we refused to apply the intracorporate conspiracy doctrine to shield from liability members of the same corporation who were accused of a criminal conspiracy. *Id.,* 678 F.2d at 971–76. We considered an alleged conspiracy between a private food manufacturing company and government inspectors to bypass the government's food inspection guidelines. While we recognized that the conspiracy alleged did not require an analysis of the intracorporate conspiracy doctrine because it involved government inspectors who were not part of the corporation, we noted that "the provocative nature of the issue compels us to rule on its application to the facts of this case." *Id.* at 970. We followed former Fifth Circuit precedent in holding that the intracorporate conspiracy doctrine does not apply to alleged intracorporate criminal conspiracies. We wrote:

> The former Fifth Circuit recognized this exception to the [single corporate entity] fiction in criminal conspiracy cases in *Dussouy v. Gulf Coast Investment Corp.,* 660 F.2d 594 (5th Cir.1981) when it stated: "a corporation can be convicted of criminal charges of conspiracy based solely on conspiracy with its own employees." *Id.* at 603. We now adopt this exception and hold that it is possible for a corporation to conspire with its own officers, agents and employees in violation of 18 U.S.C. § 371.
>
> *Id.* at 972.

The First, Sixth, Eighth, and Ninth Circuits have all ruled similarly. *See* *United States v. Hughes Aircraft Co.,* 20 F.3d 974, 978–79 (9th Cir.1994) (noting that the intracorporate conspiracy doctrine "has never been applied to criminal cases" and holding that "a corporation may be liable under § 371 for conspiracies entered into ***1039** by its agents and employees"); *United States v. Ames Sintering Co.,* 927 F.2d 232, 236 (6th Cir.1990) (noting that " 'in the criminal context a corporation may be convicted of conspiring with its officers' ") (quoting *United States v. S & Vee Cartage Co.,* 704 F.2d 914, 920 (6th Cir.1983)); *United States v. Hugh Chalmers Chevrolet–Toyota, Inc.,* 800 F.2d 737, 738 (8th Cir.1986) (holding that "a corporation may be responsible when two or more high ranking or authoritative agents engage in a criminal conspiracy on its behalf"); *United States v. Peters,* 732 F.2d 1004, 1007–08 (1st Cir.1984) (upholding the convictions of two corporate officers convicted of criminal conspiracy under 18 U.S.C. § 371 because, despite the fact that the defendants were performing actions they were authorized to perform and were doing so with an intent to benefit the corporation, "the corporate veil does not shield them from criminal liability"). *See also* *United States v. Wise,* 370 U.S. 405, 417, 82 S.Ct. 1354, 8 L.Ed.2d 590 (1962) (Harlan, J. concurring) (agreeing with the majority that an individual corporate officer is subject to prosecution under Section 1 of the Sherman Act because "the fiction of corporate entity, operative to protect officers from contract liability, had never been applied as a shield against criminal prosecutions....").

[11] **[12]** The rationale supporting the idea that the intracorporate conspiracy doctrine cannot shield corporate employees and corporations accused of criminal conspiracies is simple enough. As we explained in *Hartley,* the original purpose of the corporate entity fiction was to *expand* rather than shrink corporate responsibility by making a corporation answer for the negligent acts of its agents. *See* *Hartley,* 678 F.2d at 970 (explaining that "[b]y personifying a corporation, the entity [ ][is] forced to answer for its negligent acts and to shoulder financial responsibility for them"); *see also* *Dussouy,* 660 F.2d at 603 (noting that "[t]he original purposes of the rule attributing agents' acts to a corporation were to enable corporations to act, permitting the pooling of resources to achieve social benefits and, in the case of tortious acts, to require a corporation to bear the costs of its business enterprise"). "The fiction was never intended to prohibit the imposition of criminal liability by allowing a corporation or its agents to hide behind the identity of the other." *Hartley,* 678 F.2d at 970. As the Fifth Circuit emphasized in *Dussouy,* in situations where a criminal conspiracy is alleged "the action by an incorporated collection of individuals creates the 'group danger' at which conspiracy liability is aimed, and the view of the corporation as a single legal actor becomes a fiction without a purpose." *Id.,* 660 F.2d at 603.

A claim arising under § 1985(2), such as McAndrew's, alleging a conspiracy to deter by force, intimidation, or threat, an individual from testifying in a federal court, necessarily alleges criminal activity in violation of 18 U.S.C. § 1512—the criminal statute prohibiting tampering with a witness—and a criminal conspiracy in violation 18 U.S.C. § 371. Section 1512(b) specifically provides:

> Whoever knowingly uses intimidation or physical force, threatens, or corruptly persuades another person, or attempts to do so, or engages in misleading conduct toward another person, with intent to—(1) influence, delay, or prevent the testimony of any person in an official proceeding; .... shall be fined under this title or imprisoned not more than ten years, or both.

[13] [14] An "official proceeding," as referred to in § 1512(b), is explicitly defined in 18 U.S.C. § 1515 to include a federal grand jury proceeding. Indeed, § 1512(b) applies to attempts to influence testimony in a broader range of proceedings than does the first clause of § 1985(2). Clause 1 of § 1985(2) applies only to conspiracies to deter or alter testimony in any federal court proceeding. Section 1512, however, applies to attempts to prevent or influence testimony not only in federal courts but also before Congress, federal agencies, and ***1040** insurance regulators. [10] Moreover, § 1512(b) subsumes but is significantly broader than the provision of § 1985(2) making it illegal to "conspire to deter by force, intimidation, or threat" any person from testifying in a pending federal court matter. Section 1512(b) not only makes it a crime to attempt to deter testimony by force, intimidation, or threat, as does § 1985(2), but also makes it a crime to try to deter such testimony through sheer persuasion without the use of physical or economic threat, as long as one does so with a corrupt purpose. *See* *United States v. Shotts,* 145 F.3d 1289, 1301 (11th Cir.1998) (sustaining a conviction under § 1512(b) where an employer told an employee not to talk to investigators so that she would not be bothered, finding that a jury could reasonably have inferred that the employer was attempting with improper motive to persuade the employee not to talk to investigators); *see also* *United States v. Tocco,* 135 F.3d 116, 126–27 (2d Cir.1998) (sustaining defendant's conviction of witness tampering based on evidence showing defendant had substantial influence over witness because he was her landlord and her employer, and had paid for an attorney to help her prepare her testimony); *United States v. Gabriel,* 125 F.3d 89, 102–03 (2d Cir.1997) (holding that defendant's attempt to mislead a client by providing it with false information was illegal witness tampering because defendant was trying to corruptly persuade or mislead the client with the intent of influencing its potential testimony before the grand jury); *United States v. Morrison,* 98 F.3d 619, 629–30 (D.C.Cir.1996) (holding that defendant's corrupt intent to influence testimony and exhortation to witness not to testify truthfully was enough to justify his § 1512(b) conviction, even with no direct threat of either physical or economic harm); *United States v. Altman,* 48 F.3d 96, 99, 104 (2d Cir.1995) (holding that witness's testimony that he lied to investigators because his friend, the defendant, had asked him to do so, was sufficient to sustain the defendant's conviction under § 1512(b)). Plainly, by stating a claim under § 1985(2), alleging that Defendants attempted to deter him by force, intimidation, or threat from testifying before the federal grand jury about Lockheed's activities by threatening him with job-related sanctions, McAndrew also alleged a crime under § 1512(b) and a criminal conspiracy under § 371.

[15] The only real question is whether the criminal conspiracy exception to the intracorporate conspiracy doctrine is somehow limited to cases in which the underlying criminal conspiracy arises under 18 U.S.C. § 371 rather than under 42 U.S.C. § 1985(2). We can discern no basis for drawing this distinction. Indeed both the rationale for the intracorporate conspiracy doctrine and the legislative history of § 1985(2) counsel in favor of a consistent application of the criminal conspiracy exception to the intracorporate conspiracy doctrine regardless of whether the criminal conspiracy arises under the federal criminal or civil code.

As we have explained, the corporate entity fiction was designed to expand corporate liability by holding the corporation liable for the acts of its agents. The intracorporate conspiracy doctrine shielding corporate employees and the corporation itself from unlawful conspiracy claims was a product of this fiction. However, the fiction was never intended nor used to ***1041** shield conspiratorial conduct that was criminal in nature. *See* *Hartley,* 678 F.2d at 970. As the Fifth Circuit explained in *Dussouy,* criminal conspiracies pose the precise group danger at which conspiracy liability is aimed, making the corporate entity doctrine in such cases a "fiction without a purpose." *Id.,* 660 F.2d at 603. Because, the underlying conspiratorial conduct being challenged is precisely the same regardless of whether a criminal conspiracy is alleged under § 371 or under § 1985(2), there is no reason to differentiate between the criminal and civil conspiracy statutes. In either case, when a criminal conspiracy is alleged, the underlying conduct is of a sort that neither the corporate entity fiction nor the intracorporate conspiracy doctrine was intended or used to shield.

Moreover, application of the criminal conspiracy exception to a § 1985(2) claim is altogether consonant with the original purpose of that statute. Section 1985 derives from Section 2 of the Ku Klux Klan Act of 1871 also known as the Civil Rights Act of 1871.[11] The Act was passed in response to a rising tide of Klan terrorism against blacks and Union sympathizers and was designed to proscribe conspiracies "having the object or effect of frustrating the constitutional operations of government through assaults on the person, property, and liberties of individuals." *See* Comment, *A Construction of Section 1985(c) in Light of its Original Purpose,* 46 U. Chi. L.Rev. 402, 402–03 (1979); *see also* *District of Columbia v. Carter,* 409 U.S. 418, 425–26, 93 S.Ct. 602, 34 L.Ed.2d 613 (1973); *Brawer v. Horowitz,* 535 F.2d 830, 837–38 (3rd Cir.1976); *Civil Rights* 591 (Bernard Schwartz ed., 1970); Janet A. Barbiere, *Conspiracies to Obstruct Justice in the Federal Courts: Defining the Scope of Section 1985(2),* 50 Fordham L.Rev. 1210, 1210–1229 (1982). The criminal conspiracy exception to the intracorporate conspiracy doctrine promotes the original purpose of the Act by ensuring that individuals and groups can be prosecuted for their criminal activities regardless of their status of incorporation. The exception ensures that conspiratorial criminal conduct is not shielded from civil liability under § 1985(2) of the Civil Rights Act simply by the expedient of incorporation.

Indeed, even courts that generally apply the intracorporate conspiracy doctrine to § 1985 claims have recognized that an exception should exist when the conspiracy alleged is criminal in nature. For example, in *Dombrowski,* the Seventh Circuit, while extending the intracorporate conspiracy doctrine to § 1985(3) claims generally, suggested in dicta that the doctrine would not shield criminal conspiracies from § 1985 liability. In discussing the scope of § 1985(3), the Seventh Circuit explained: "We do not suggest that an agent's action within the scope of his authority will always avoid a conspiracy finding. Agents of the Klan certainly could not carry out acts of violence with impunity simply because they were acting under orders from the Grand Dragon." *Id.,* 459 F.2d at 196. Similarly, in *Hartman,* the Seventh Circuit noted that, for the reasons it had expressed in *Dombrowski,* not all discriminatory action taken within the scope of employment and attributable to the corporation is exempt from 1985(3). *See* *id.,* 4 F.3d at 470.

Simply put, we conclude that the criminal conspiracy exception to the intracorporate conspiracy doctrine applies regardless of whether the criminal conspiracy arises under 18 U.S.C. § 371 or under 42 U.S.C. § 1985. Because a claim, such as McAndrew's, alleging an intracorporate conspiracy to deter a person from testifying in a court of law by force, intimidation, or threat, necessarily alleges a criminal conspiracy, the intracorporate conspiracy doctrine cannot apply. Accordingly, we reverse the district court's order of dismissal ***1042** on this issue and remand for further proceedings consistent with this opinion.

REVERSED and REMANDED.

All Citations

206 F.3d 1031, 16 IER Cases 25, 13 Fla. L. Weekly Fed. C 507

Footnotes

* Judge Frank M. Hull recused herself and did not participate in this decision.

** Senior U.S. Circuit Judge John C. Godbold elected to participate in this decision pursuant to 28 U.S.C. § 46(c).

1 We adopt the panel's disposition affirming the district court's dismissal of McAndrew's intentional infliction of emotional distress claim.

2 The portion of § 1985(2) at issue in this case provides: "If two or more persons in any State or Territory conspire to deter, by force, intimidation, or threat, any party or witness in any court of the United States from attending such court, or from testifying to any matter pending therein, freely, fully and truthfully, ... the party so injured or deprived may have an action for the recovery of damages occasioned by such injury or deprivation, against any one or more of the conspirators." As defined in Title 28 U.S.C. § 451, the phrase "court of the United States" in § 1985(2) refers only to Article III courts and certain federal courts created by act of Congress, but not to state courts. *See* *Shaw v. Garrison,* 391 F.Supp. 1353, 1370 (E.D.La.1975), *aff'd,* 545 F.2d 980 (5th Cir.1977), *rev'd on other grounds sub nom.,* *Robertson v. Wegmann,* 436 U.S. 584, 98 S.Ct. 1991, 56 L.Ed.2d 554 (1978). Section 1985(2) encompasses conspiracies to deter testimony before a federal grand jury. *See* *Heffernan v. Hunter,* 189 F.3d 405, 409 (3rd Cir.1999); *Brever v. Rockwell Int'l Corp.,* 40 F.3d 1119, 1125 (10th Cir.1994); *McCord v. Bailey,* 636 F.2d 606, 618 (D.C.Cir.1980).

3 Section 1 of the Sherman Act, 15 U.S.C. § 1 provides: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal."

4 Section 2 of the Sherman Act, 15 U.S.C. § 2 provides: "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony...."

5 Title 42 U.S.C. § 1985(3) provides: "If two or more persons in any State or Territory conspire, or go in disguise on the highway ... for the purpose of depriving ... any person or class of persons of the equal protection of the laws ... or for the purpose of preventing or hindering the constituted authorities of any State or Territory from giving or securing to all persons within such State or Territory the equal protection of the laws; or if two or more persons conspire to prevent by force, intimidation, or threat, any citizen who is lawfully entitled to vote, from giving his support or advocacy in a legal manner ...; in any case of conspiracy set forth in this section, if one or more persons engaged therein do, or cause to be done, any act in furtherance of the object of such conspiracy ... the party so injured or deprived may have an action for the recovery of damages, occasioned by such injury or deprivation, against any one or more of the conspirators."

6 *See* *Benningfield v. City of Houston,* 157 F.3d 369, 378 (5th Cir.1998), *cert. denied,* 526 U.S. 1065, 119 S.Ct. 1457, 143 L.Ed.2d 543 (1999) (applying the intracorporate conspiracy doctrine to plaintiffs' § 1985(3) claims alleging defendant supervisors conspired to deprive plaintiffs of their First Amendment and equal protection rights but finding the claims fell within an exception to the doctrine which arises when corporate employees act for their own personal purposes); *Hull v. Cuyahoga Valley Joint Voc. Sch. Dist. Bd. of Educ.,*

926 F.2d 505, 509–10 (6th Cir.1991) (affirming district court's judgment that plaintiff's § 1985(3) claims were barred by the intracorporate conspiracy doctrine and reaffirming the circuit's extension of the doctrine from the context of antitrust litigation to allegations of conspiracy under the Civil Rights Act); *Buschi v. Kirven,* 775 F.2d 1240, 1252–53 (4th Cir.1985) (affirming the applicability of the intracorporate conspiracy doctrine to bar plaintiffs' § 1985(3) claims); *Cross v. General Motors Corp.,* 721 F.2d 1152, 1156–57 (8th Cir.1983) (affirming district court's dismissal of plaintiff's § 1985(3) claim as barred by the intracorporate conspiracy doctrine where the corporate agents' acts "arguably were within the scope of employment"); *Girard v. 94th St. & Fifth Ave. Corp.,* 530 F.2d 66, 71–72 (2d Cir.1976) (holding plaintiff's § 1985(3) claim alleging a conspiracy among a corporation and its directors to discriminate against her on the basis of sex was barred by the intracorporate conspiracy doctrine).

A minority of circuits have, however, refused to apply the doctrine to certain § 1985 claims alleging conspiracies to violate civil rights. *See* *Brever v. Rockwell Int'l Corp.,* 40 F.3d 1119, 1127 (10th Cir.1994) (declining to apply the intracorporate conspiracy doctrine to a § 1985(2) claim because the intracorporate conspiracy doctrine, "designed to allow one corporation to take actions that two corporations could not agree to do, should not be construed to permit the same corporation and its employees to engage in civil rights violations"); *Stathos v. Bowden,* 728 F.2d 15, 21 (1st Cir.1984) (finding that the "boundaries of an 'intracorporate' exception to § 1985(3) conspiracy provision should be narrower than in antitrust" and holding the intracorporate conspiracy doctrine did not apply in the present case because "defendants' activities [ ] went beyond 'a single act' of discrimination"); *Novotny v. Great Am. Fed. Sav. & Loan Ass'n,* 584 F.2d 1235, 1256–59 (3rd Cir.1978) (rejecting the application of the intracorporate conspiracy doctrine to a § 1985(3) conspiracy claim alleging an eight year program of denial of equal opportunity holding that neither the language or § 1985 nor the policies undergirding the section support application of the doctrine to such claims), *vacated on other grounds,* 442 U.S. 366, 99 S.Ct. 2345, 60 L.Ed.2d 957 (1979).

7 Fifth Circuit decisions enacted prior to October 1, 1981 are binding precedent in the 11th Circuit. *See* *Bonner v. City of Prichard,* 661 F.2d 1206, 1209 (11th Cir.1981) (en banc).

8 Although *Chambliss* was issued on the summary calendar, it was published and therefore is precedent in the Circuit. *See* *United States v. Machado,* 804 F.2d 1537, 1543 n. 11 (11th Cir.1986) (rejecting the notion that the prior panel precedent rule does not apply when the challenged panel decision was decided on the non-argument calendar by a per curiam opinion).

9 Title 18 U.S.C. § 371 makes it a crime for two or more persons to conspire to commit any offense against the United States or to defraud the United States.

10 Title 18 U.S.C. § 1515 provides that the term "official proceeding" in § 1512 means: "A) a proceeding before a judge or court of the United States, a United States magistrate, a bankruptcy judge, a judge of the United States Tax Court, a special trial judge of the Tax Court, a judge of the United States Claims Court, or a *Federal grand jury;* B) a proceeding before Congress; C) a proceeding before a Federal Government agency which is authorized by law; or D) a proceeding involving the business of insurance whose activities affect interstate commerce before any insurance regulatory official or agency or any person engaged in the business of insurance whose activities affect interstate commerce" (emphasis added).

11 The official title was "An Act to enforce the provisions of the Fourteenth Amendment to the Constitution of the United States, and for other purposes."

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508 F.2d 45
United States Court of Appeals, Fifth Circuit.

Donald M. PETERSON, Plaintiff-Appellant,
v.
Caspar W. WEINBERGER, Secretary of Health, Education and Welfare, et al., Defendants-Third-Party Plaintiffs-Appellees, v. James E. PETERSON, Third-PartyDefendant-Appellant.

No. 74-1067.
|
Feb. 14, 1975, Rehearing and Rehearing en Banc Denied March 27, 1975.

Synopsis
Physician brought action for alleged wrongful withholding of funds due him under the Medicare Act. The government filed a counterclaim against the physician and a third-party complaint against operator of nursing home for submission of false medicare claims. The United States District Court for the Northern District of Texas, Robert M. Hill, J., 370 F.Supp. 1259, rendered judgment in favor of the government and appeals were taken. The Court of Appeals, Dyer, Circuit Judge, held that conduct of employees of Bureau of Health Insurance in suspending physician from medicare program after investigation revealed possible fraud in submission of medicare claims was not mailcious, negligent or unreasonable; that withholding of funds due physician as offset against false claims under investigation did not deny due process; and that evidence sustained determination that physician and operator were liable to the United States under False Claims Act.

Affirmed.

West Headnotes (16)

[1] **Public Employment** Particular torts
United States Privilege or immunity; good faith

Conduct of employees of Bureau of Health Insurance in suspending physician from medicare program after discovery of possible fraud in connection with submission of medicare claims for services purportedly rendered by the physician and conduct of fiscal intermediaries under medicare program in acting on instructions received from employee of the Bureau were not malicious, negligent or unreasonable and did not render employees or intermediaries liable to physician for wrongful and malicious interference with contractual rights. Social Security Act, §§ 1816, 1842, 42 U.S.C.A. §§ 1395h, 1395u.

19 Cases that cite this headnote

[2] **Constitutional Law** Medicare

Withholding of funds due physician under medicare program as offset against false claims under investigation, without hearing, did not deny physician due process where withheld funds were paid to physician upon his posting of bond to indemnify government.

9 Cases that cite this headnote

[3] **Federal Courts** Controversies to which United States is a party
Public Employment Particular torts
United States Privilege or immunity; good faith

Secretary of Department of Health, Education and Welfare and the United States were immune from liability for malicious prosecution and interference with contractual rights arising from suspension of physician from medicare program following discovery of possible fraud in the submission of medicare claims for services purportedly rendered by the physician and institution of criminal proceedings against the physician, and district court lacked jurisdiction over physician's suit against the Secretary and the United States. 28 U.S.C.A. § 2680(h).

1 Cases that cite this headnote

[4] **Federal Courts** Controversies to which United States is a party

Public Employment Particular torts

United States Privilege or immunity; good faith

Employees of Bureau of Health Insurance of the Department of Health, Education and Welfare were immune from liability arising from their conduct in suspending physician from medicare program after discovery of possible fraud in connection with medicare claims for services purportedly rendered by physician absent indication that any of the employees acted outside their line of duty or scope of their employment, and district court lacked jurisdiction over physician's suit against the employees for interference with contractual relations.

4 Cases that cite this headnote

[5] **Federal Courts** Controversies to which United States is a party

Public Employment Privilege or Immunity; Good Faith

United States Privilege or immunity; good faith

Corporate defendants which, as medicare fiscal intermediaries, acted as agents at sole discretion of Secretary of Health, Education and Welfare in suspending further payments to physician under medicare program were immune from liability to physician, and district court lacked jurisdiction of physician's action for malicious interference with contractual rights. Social Security Act, §§ 1816, 1842, 42 U.S.C.A. §§ 1395h, 1395u.

26 Cases that cite this headnote

[6] **United States** Materiality

Medicare claims which were filed for services actually rendered by nursing home that was not a certified provider of services under Medicare Act and which contained certification that services had been rendered by physician were within purview of False Claims Act despite contentions that services had been performed by qualified people, that patients receiving services were entitled to them under medicare and that physician's certifications were not material to the claims. Social Security Act, §§ 1816, 1842, 42 U.S.C.A. §§ 1395h, 1395u; 31 U.S.C.A. § 231.

18 Cases that cite this headnote

[7] **United States** Injury or financial loss

Claim is within purview of False Claims Act if it is grounded on fraud which might result in financial loss to the government. 31 U.S.C.A. § 231.

13 Cases that cite this headnote

[8] **United States** Intent

United States Particular Actors

Evidence that medicare claims falsely indicating that services had been rendered by physician were prepared by nursing home employee at instruction of nursing home operator and that physician whose name was placed on the forms was not medical director of the nursing home sustained determination that nursing home operator had guilty intent to make false claims against the government and was liable under False Claims Act. 31 U.S.C.A. § 231.

7 Cases that cite this headnote

[9] **United States** False claim

United States Evidence

Evidence sustained determination that conduct of physician in endorsing and depositing for collection checks issued in payment of medicare claims with knowledge that he was not entitled to the proceeds was for purpose of aiding nursing home operator in obtaining payment to which operator was not entitled and that such conduct constituted the making of a false claim as to each check. 31 U.S.C.A. § 231.

1 Cases that cite this headnote

[10] **United States** Particular cases, interest not allowed

Physician from whom funds due under medicare were withheld as offset against false claims under investigation was not entitled to interest for period that sums were withheld prior to payment of the sums to the physician upon his posting of bond to indemnify government for any amount which might ultimately be found due the government. Social Security Act, § 1801, 42 U.S.C.A. § 1395; 28 U.S.C.A. §§ 1331, 1361.

14 Cases that cite this headnote

[11] **Federal Civil Procedure** Separate Trial of Particular Issues

In physician's action against the United States, government officials and others for allegedly wrongful suspension from medicare program, it was within trial court's discretion to initially try issues raised by government's counterclaim against physician for making false medicare claims. 31 U.S.C.A. § 231.

1 Cases that cite this headnote

[12] **Federal Courts** Evidence and Witnesses

Evidentiary errors which were not the subject of objection at trial court could not be raised for first time on appeal.

3 Cases that cite this headnote

[13] **United States** Double or treble damages

United States was not entitled to award of interest on amount of fraudulent medicare claims from date payment was made on the claims in addition to the double damages plus specified sum which the United States recovered under the False Claims Act. 31 U.S.C.A. § 231.

2 Cases that cite this headnote

[14] **United States** Damages

Prejudgment interest should not be assessed on amount recovered under False Claims Act. 31 U.S.C.A. § 231.

4 Cases that cite this headnote

[15] **Federal Courts** Appellees; necessity of filing cross-appeal

United States which did not file cross appeal could not be heard to complain of the judgment entered below.

[16] **United States** Number of "forfeitures"

Award to United States of $100,000 under the False Claims Act for filing of false medicare claims was within district court's discretion, despite contention that since district court found that 120 false claims had been filed, it should have assessed a $2,000 forfeiture for each false claim, or a total of $240,000. 31 U.S.C.A. § 231.

17 Cases that cite this headnote

Attorneys and Law Firms

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Frank D. McGown, U.S. Atty., Ft. Worth, Tex., Kenneth J. Mighell, Asst. U.S. Atty., Dallas, Tex., for U.S.A.

Appeals from the United States District Court for the Northern District of Texas.

Before DYER, SIMPSON and CLARK, Circuit Judges.

Opinion

DYER, Circuit Judge:

James E. Peterson and his brother, Dr. Donald M. Peterson, appeal from a money judgment entered against them for submitting false claims against the Government. Dr. Peterson also appeals from the denial of his entitlement to injunctive relief and tort and breach of contract damages against the defendants. We affirm.

Although much of the complicated statutory and factual background of this and the cognate cases [1] has been treated in the district court's opinion, [2] and in this Court's opinion on the appeal of the criminal trial of the Peterson brothers, [3] a recount of the salient facts is helpful to focus upon the issues raised by the Petersons.

James Peterson was the president, director, and a 69 per cent stockholder of Concord Manor Nursing Home, an extended care facility. He was also the sole owner of Zodiac Enterprises, inc., which contracted with Concord and other nursing homes to provide physical therapy services to their patients. In 1968, Concord was a certified provider of services under Part A of the Medicare program. Medicare payments were handled through a fiscal intermediary, Mutual of Omaha, to whom Concord submitted its bills for services rendered at the nursing home at a daily rate which included physical therapy. Zodiac could not submit bills for its physical therapy services directly to the Medicare intermediary because Zodiac and Concord were related corporation, i.e., James Peterson was the sole owner of one and held the controlling interest in the other. Therefore, the only way Zodiac could be reimbursed by Medicare for its services was for Concord to include physical therapy in its bills to Omaha. Only the cost, without profit, of services, rendered was reimbursable. Concord was required to file cost reports each year with Omaha so it ***48** could determine the appropriate allowable cost. Concord failed to file these reports for 1967, and after three notices and the reduction of allowable daily rates, payments were stopped on March 1, 1969, and it ceased being a provider on August 31, 1969.

Thus, early in 1969, James Peterson was faced with a dilemma regarding physical therapy services: Zodiac could not bill directly for therapy services it had furnished to Concord in the first six months of 1968, and payments to Concord under Part A had been stopped. Thereupon, Peterson directed his employee, Morton, to prepare Part B claim forms and 'get them out as soon as possible so he could get the money back in.' This necessitated the use of a form different from that used for Part A in that it required a physician's personalized provider number and the physician's signature certifying that the service had been rendered by him personally or under his personal direction. Morton and another employee prepared 120 Part B claims, signed Dr. Peterson's name and provider number to them, and put James Peterson's Post Office box number on the forms rather than Dr. Peterson's address. Morton testified that 'Mr. Peterson gave us the instructions on all of the forms.'

The Part B claims for Medicare payments were then sent to Blue Cross/Blue Shield of Texas which operated the Medicare program as an agent of the United States on a non-profit basis pursuant to a written contract executed under the provisions of 42 U.S.C.A. 1395h and 1395u. All of the claims were paid by checks made payable to Dr. Peterson and mailed to him.

The circumstances surrounding Dr. Peterson's receipt and handling of the checks are far from clear. He testified that he assumed the checks were made out and sent to him because he was the medical director of Zodiac. He called his brother to find out why he got checks for physical therapy that he had not billed. James Peterson told him that 'the claims had been filed.' The doctor didn't ask why the checks had been made to him, nor did he contact Group Medical. He simply told James Peterson that he would forward the funds. Instead of endorsing the checks, Dr. Peterson deposited them to his own account and sent his personal check with a notation 'account payable' to James Peterson, who deposited it in the Zodiac account.

Dr. Peterson was not on the payroll of Zodiac. He knew that the 120 checks payable to him did not belong to him. He knew he had never personally rendered any of the services in question. Subsequently and inexplicably, Dr. Peterson received six invoices from Zodiac for the therapy services rendered during the first six months of 1968 at Concord which comprised the 120 claims. Dr. Peterson did not pay the amount of the invoices because he 'didn't think he owed the money.' James Peterson's version was that Dr. Peterson had been billed for physical therapy services rendered while the doctor was medical director of Zodiac. He claimed that Dr. Peterson's check was in payment of the invoices. This is inexplicable because Dr. Peterson sent his check to James Peterson on June 3, 1969, and the Zodiac invoices were not prepared or sent to Dr. Peterson until July, 1969. Moreover, neither James Peterson nor Dr. Peterson could give any plausible explanation why Zodiac should bill its medical director for services its physical therapy department performed. Finally, also without explanation was the notation on Dr. Peterson's check to Zodiac, 'account payable.'

In July, 1969, a complaint was received by Gruninger, Program Integrity Specialist, Bureau of Health Insurance, Department of Health, Education and Welfare. The niece of a Medicare beneficiary at Concord questioned the payment to Dr. Peterson for physical therapy services not rendered by him. There followed an investigation concerning claims filed over the signature of Dr. Peterson for physical therapy rendered at Concord for the first six months of 1968 and submitted for payment in April ***49** of 1969. The investigation revealed that although Dr. Peterson's name appeared on the claim forms, he had not personally rendered the services, nor had they performed under his personal direction. In December, 1969, because of the possibility of fraud, Gruninger issued a letter to Blue Cross/Blue Shield ordering suspension of further payments to Dr. Peterson under the Medicare program. In May, 1970, a conference was held with Dr. Peterson in which he was given an opportunity to respond to accusations made against him. Through counsel he subsequently replied by letter. The suspension, however, remained in effect.

Dr. Peterson responded by filing suit seeking to enjoin the defendants from wrongfully withholding funds due him under the Medicare Act. He also alleged that certain torts precipitated his suspension from the Medicare program. The Government filed a counterclaim against Dr. Peterson and a third party complaint against James Peterson for submission of false claims. A criminal indictment was also returned against the Peterson brothers which resulted in the conviction of both on one count of conspiracy, and of James Peterson on 39 substantive counts of submission of false claims (representing 39 of the 120 claims in the instant suit). On appeal this Court affirmed the conviction of James Peterson on the substantive counts and reversed the conviction of both Petersons on the conspiracy count. [4]

Upon the trial of Dr. Peterson's complaint and the Government's counterclaim and third party claim, the district court found that Dr. Peterson was entitled to neither injunctive relief, nor tort or breach of contract damages against any of the defendants, and dismissed his complaint. The major portion of the trial was then devoted to the Government's claims. The court found that the Peterson brothers had violated the False Claims Act, 31 U.S.C.A. 231, by knowingly submitting to the Government 120 false claims totaling $16,153.44, and thereupon entered a joint and several judgment for $31,606.72 representing double damages, together with the sum of $100,000 representing a $2,000 forfeiture for 50 of the 120 claims in question, with interest awarded from the date of judgment.

DR. PETERSON'S TORT CLAIMS

We first turn to Dr. Peterson's prayer for compensatory and punitive damages for the alleged tortious conduct of the defendants. He asserts that the Government and the individual defendants conspired to destroy him and to make it impossible for him to practice as a physician, and that the defendants took his property without due process, and wrongfully and maliciously interfered with his contractual rights. To support these charges, Dr. Peterson argues that he was wrongfully suspended from the Medicare program without notice or a hearing by employees of the Bureau of Health Insurance, H.E.W., who had no authority to impose sanctions, and that this was accomplished as a part of a conspiracy with the Government. Further, he complains that he was required to respond to criminal indictments and defend himself in a criminal trial as well as defend against the Government's counterclaim for liability under the False Claims Act in the instant suit. [5]

[1] We have combed the record to find some basis for the numerous claims of tortious conduct on the part of the defendants and can find no evidence to support any of them. Evidence of a conspiracy between the Government and the individual and corporate defendants is non-existent. The suspension of Dr. Peterson ***50** and the withholding of payments due him by H.E.W. employees were actions both appropriate and necessary under instructions requiring the immediate suspension of any doctor participating in the Medicare program upon the discovery of possible fraud in the submission of claims under the Act. Bureau of Health Insurance Identical Memorandum No. 176, June 11, 1969. There is not a scintilla of evidence that the actions taken by the Bureau of Health Insurance employees were prompted by any reason other than to protect the integrity of the program. The corporate defendants, as fiscal intermediaries, did no more than act on the instructions received by them. This they were required to do. Convinced, as we are, that Dr. Peterson caused false claims to be made, we agree with the district court that the conduct of the defendants was neither malicious, negligent, nor unreasonable in the circumstances.

[2] Finally, we are unpersuaded that Dr. Peterson's property was taken without due process. His argument, premised upon Goldberg v. Kelly, 1970, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287, is that H.E.W. was not entitled without a hearing to withhold funds due him under Medicare as an offset against false claims then under investigation.

We note that the district court, by preliminary injunction, ordered the withheld funds paid to Dr. Peterson upon his posting of a bond to indemnify the Government should the claims indeed prove false. This was accomplished. Since the funds were no longer held by the Government, this removes this case from the parameters of Goldberg. In any event, Dr. Peterson's argument is laid to rest by our decision in Hilburn v. Butz, 5 Cir. 1972, 463 F.2d 1207. There, the Hilburn family were concededly owed money under various Department of Agriculture programs. After an investigation, the Secretary administratively determined that the Hilburns had been overpaid under the same programs in previous years and that the monies presently owed them should be applied to offset such overpayments. We held that the Secretary had the right to withhold current funds equal to the overpaid funds, at least until the issues relating to the overpayments were judicially determined. Judge Clark, reasoning in a manner eminently appropriate to this case, held Goldberg inapplicable saying:

The result in Goldberg v. Kelly was based on a judicial notice of the fact that welfare recipients as a class would be deprived of their very means of existence while awaiting the outcome of a post-termination hearing. In turn, those recipients' necessary search for daily subsistence would adversely affect their ability to seek redress from the welfare bureaucracy. No evidence of any such dire consequences was adduced in this case. Hilburn v. Butz, 463 F.2d at 1209.

We conclude that there was no denial of due process, and that Dr. Peterson wholly failed to prove tortious conduct on the part of any of the defendants; the district court properly entered judgment in their favor.

IMMUNITY FROM LIABILITY

The defendants urged the district court to dismiss Dr. Peterson's amended complaint for tort liability on the ground of official immunity. The court declined to do so at that stage of the proceedings, but, after hearing all of the evidence, concluded that their claim of immunity was well taken. We agree.

[3] **[4]** With respect to defendants, Secretary of H.E.W. and the United States of America, there can be no question that this was an unconsented suit against the sovereign over which the court lacked jurisdiction. The individual defendants were all employees of the Bureau of Health Insurance, Department of Health, Education and Welfare. McSteen was the Regional Representative responsible for the administration of the Medicare program in five states, including Texas. Adams supervised all of the work on fraud and abuse cases, including Dr. Peterson's case. Gruninger ***51** was a program integrity specialist whose responsibility it was to investigate claims of fraud and abuse and forward them for prosecution where indicated. Chancellor was also on the program integrity staff of the Dallas, Texas, regional office. He had the responsibility of contacting the families of beneficiaries who had been billed for services by Dr. Peterson. Dr. Peterson's case was processed and investigated in precisely the same manner as other suspected fraud cases. His suspension was effected as required by Bureau of Health Insurance Identical Memorandum No. 176, June 11, 1969. [6] Peterson's argument that the individual defendants were guilty of gross negligence in improperly imposing sanctions on the wrong person, without just cause, in conspiracy with one another and with the Government, and outside the scope of their employment, is wholly unfounded. There is not the slightest indication that any of the individual defendants acted outside of their line of duty or the scope of their employment in carrying out their official responsibilities.

We find equally without merit Dr. Peterson's contention that the individual defendants were lower echelon employees who are not entitled to claim immunity. In the seminal case of Barr v. Matteo, the Supreme Court reasoned that:

> The complexities and magnitude of governmental activity have become so great that there must of necessity be a delegation and redelegation of authority as to many functions, and we cannot say that these functions become less important simply because they are exercised by officers of lower rank in the executive hierarchy.
>
> . . .It is not the title of his office but the duties with which the particular officer sought to be made to respond in damages is entrusted— the relation of the act complained of to 'matters committed by law to his control or supervision,' Spaulding v. Vilas, supra, 161 U.S. (483,) at 498, (16 S.Ct. (631,) at page 637), 40 L.Ed. 780— which must provide the guide in delineating the scope of the rule which clothes the official acts of the executive officer with immunity from civil defamation suits. (1959), 360 U.S. 564, 573-574, 79 S.Ct. 1335, 1340-1341, 3 L.Ed.2d 1434.

Pared of distracting shadow contentions, the acts complained of were

> the result of a judgment or decision which it is necessary that the Government official be free to make without fear or threat of vexatious or fictitious suits and alleged personal liability.

Norton v. McShane, 5 Cir. 1964, 332 F.2d 855, 859, citing with approval Ove Gustavsson Contracting Co. v. Floete, 2 Cir. 1962, 299 F.2d 655, cert. denied, 374 U.S. 827, 83 S.Ct. 1862, 10 L.Ed.2d 1050. See also Scheuer v. Rhodes, 1974, 416 U.S. 232, 94 S.Ct. 1683, 40 L.Ed.2d 90; Chafin v. Pratt, 5 Cir. 1966, 358 F.2d 349. The alleged tortious acts were committed by agents of the Government responsible for the integrity of the Medicare program during the course of an investigation of purported violations of the Medicare Act; all the agents were shielded by immunity. Waymire v. Deneve, 5 Cir. 1964, 333 F.2d 149.

[5] We need not tarry long with respect to the asserted tort liability and the immunity of the corporate defendants. They are Medicare fiscal intermediaries who act as agents at the sole direction of the Secretary of Health, Education and Welfare pursuant to 42 U.S.C.A. 1395h and 1395u. [7] In this situation ***52** the United States is the real party in interest. Under the doctrine of sovereign immunity, the district court lacked jurisdiction over all these defendants, both governmental and private as agents of the Government. Cf. Pine View Gardens, Inc. v. Mutual of Omaha Insurance Co., 1973, 158 U.S.App.D.C. 294, 485 F.2d 1073; Johnson v. Johnson, E.D.Pa.1971, 332 F.Supp. 510; Kuenstler v. Occidental Life Insurance Company, C.D.Cal.1968, 292 F.Supp. 532.

GOVERNMENT'S COUNTERCLAIM AND THIRD PARTY COMPLAINT

[6] By its counterclaim and third party complaint, the Government sought recovery against the Peterson brothers under the False Claims Act, 31 U.S.C.A. 231. As a common defense they urge that the Act was not violated because the physical therapy services were performed by qualified people, the patients receiving these services were entitled to them under Medicare, there was no financial loss to the Government, and the monies paid by the Government were therefore a liability which the Government was statutorily obligated to pay. This argument is unsound.

The claim forms here involved contain a place for the signature of physician or supplier, and the statement '(A physician's signature certifies that physician's services were personally rendered by him or under his personal direction).' Each claim submitted bore Dr. Peterson's purported signature (written by Morton) certifying something that simply was not so: Dr. Peterson did not personally render the service, nor was it rendered under his personal supervision. The services were rendered by Zodiac who was not a certified provider. It could not have been paid, had it submitted a bill to Blue Cross. Furthermore, it is abundantly clear that Dr. Peterson was not the medical director of Zodiac, nor had he any supervision over the physical therapist who actually rendered the services. In short, the services billed were plainly not 'covered' services, and the Government thus paid on the basis of the false claims presented.

As a further common defense, the Petersons argue that there is no statutory or regulatory requirement for the physician's certification; thus, they contend, the certification is not material to the claim, so no liability can attach to a false certification. This contention is without merit. It is, of course, true that the statute does not prescribe the type of claim form required, but it does provide that under Part B the services must be performed by a physician or as an incident to a physician's service. It was entirely reasonable and necessary for the Government to require such a certification on the claim forms to implement the Act, and at the same time protect public funds. Obviously, a false certification on the claim form frustrated the Government's attempt to process only valid claims and led to the payment for services which were not covered or payable under the Act.

[7] James Peterson next argues that 'there is no delineation as to whether the court found a 'false' statement or a 'fraudulent' statement. Further, there is no distinction as to the falsity or the fraudulence of the 'claim,' or whether there was a 'claim." This is a futile exercise in semantics. A claim is within the purview of the False Claims Act if it is grounded in fraud which might result in financial loss to the Government. Simply stated:

> This remedial statute reaches beyond 'claims' which might be legally enforced, to all fraudulent attempts to cause the Government to pay out sums of money. United States v.

Neifert-White Co., 1968, 390 U.S. 228, 233, 88 S.Ct. 959, 962, 19 L.Ed.2d 1061.

The inclusiveness of the statute was spelled out in United States ex rel. Marcus v. Hess, 1943, 317 U.S. 537, 63 S.Ct. 379, 87 L.Ed. 443.

These provisions, considered together, indicate a purpose to reach any person who knowingly assisted in causing the government to pay claims which were grounded in fraud, without regard to whether that person had direct contractual relations with the government. ***53** 317 U.S. at 544-545, 63 S.Ct. at 384.

[8] Finally, James Peterson faults the Government for failing to bear its burden of proving scienter; he claims the evidence did not demonstrate his personal knowledge and participation in the false certification of the claims. In restating the applicable test, we said in United States v. Aerodex, Inc., 5 Cir. 1972, 469 F.2d 1003;

The law is settled in this Circuit that to show a violation of the False Claims Act the evidence must demonstrate 'guilty knowledge of a purpose on the part of (the defendant) to cheat the Government,' United States v. Priola, 272 F.2d 589, 594 (5th Cir. 1959), or 'knowledge or guilty intent,' United States v. Ridglea State Bank, 357 F.2d 495, 498 (5th Cir. 1966). See also Henry v. United States, 424 F.2d 677 (5th Cir. 1970). 469 F.2d at 1007.

James Peterson insists that he did not instruct Morton to sign Dr. Peterson's name to the forms but simply told her 'to get them out as soon as possible.' It was Dr. Peterson's responsibility, so James Peterson contends, to prepare and sign the forms as Medical Director of Zodiac, but the preparation of the forms was done by Concord personnel as a convenience because the records were kept there. We are convinced, however, that the record fully supports the district court's finding that morton signed Dr. Peterson's name and provider number and James Peterson's post office box number to the claims at the direction of James Peterson. We are equally convinced, for the reasons we have previously stated, that Dr. Peterson was not the medical director of Zodiac and that this was a title trumped up in an effort to circumvent the requirements of the Act. There was ample evidence to conclude that James Peterson had knowledge or guilty intent to make false claims against the Government. [8]

We have considered the additional attacks made by James Peterson on the findings of fact. They raise immaterial discrepancies that cannot be parlayed into a reversal. The findings are not clearly erroneous. McAllister v. United States, 1954, 348 U.S. 19, 75 S.Ct. 6, 99 L.Ed. 20. On the contrary, they have substantial support in the record. The other errors asserted by James Peterson do not merit discussion.

Dr. Donald Peterson argues (in addition to the common defenses raised with his brother) that he is not personally liable under the False Claims Act because he had neither the intent to cause a financial loss to the Government nor the knowledge that the claims submitted by James Peterson contained a false or fraudulent statement. To support his argument, Dr. Peterson points out that he served as the medical director for Zodiac for the first six months of 1968. He knew the checks he received were for physical therapy services rendered by Zodiac at Concord and therefore thought this money belonged to Zodiac. He paid the money to Zodiac in good faith, knowing nothing about the contents of the claims filed. If this were the end of the story, Dr. Peterson would surely not be liable under the Act. But the parlous journey he began does not come to an end so quickly.

Not later than the first week in Amy of 1969, Dr. Peterson received from Group Medical and Surgical Service 120 individual checks made out to him totaling $15,803.36. Of these, 110 checks were dated April 28, 1969, and 10 checks were dated either May 1 or 2, 1969. Attached ***54** to each check was an 'Explanation of Medicare' which set forth the name of the patient, that the services were provided by D. M. Peterson, D.O., his unique identifying number, the date and amount of the charge submitted, the amount allowed, the fact that the funds were assigned to the doctor, and the total amount of the Medicare payment. This 'Explanation' and the accompanying check, made payable to D. M. Peterson, D.O., were sent to Dr. Peterson at his correct address in Dallas, Texas. For some reason, left unexplained in the record, the checks were not deposited until June 9, 1969, over a month after their receipt. In the meantime, however, on June 3, 1969, six days before depositing the 120 checks, Dr. Peterson sent to James Peterson his personal check made to Zodiac.

[9] We reiterate that the district court was fully justified in finding that Dr. Peterson was not the medical director of Zodiac. He had no basis for assuming that the checks were sent to him because he was the medical director of Zodiac. On the contrary, the Medicare Explanation accompanying each check indicated that the claim was being paid to him personally and that the services were provided by him, under his unique identifying number, when in fact they were not. Under the circumstances, we agree with the district court that the act of Dr. Peterson in endorsing the checks and depositing them with the knowledge that he was not entitled to the proceeds was for the purpose of aiding James Peterson in obtaining payment and constitutes the making of a false claim as to each check. By this maneuver James Peterson and Zodiac ended up obtaining Government funds to which they were not entitled. The payment of the 120 claims would never have been questioned except for the complaints of patients who had never heard of Dr. Peterson.

OTHER ERRORS ASSERTED BY DR. PETERSON

[10] Dr. Peterson complains that the district court erred in refusing to enter judgment for him for the sums, plus interest, due him that were withheld during his suspension from the Medicare program. This issue is no longer viable. The district court granted a preliminary injunction in favor of Dr. Peterson, ordering that the Government pay him all sums due on claims which had been filed, and conditioned upon his posting a bond to secure the amount of any set-off that might ultimately be due the Government on its counterclaim. The bond was posted and Dr. Peterson received his money. Dr. Peterson is not entitled to interest for the period that the sums were withheld. 'It is well established that the United States is not liable for interest in the absence of a contractual or statutory requirement to pay interest.' United States v. Delaware Tribe of Indians, 1970, 427 F.2d 1218, 1222, 192 Ct.Cl. 385. There is no statutory provision for the payment of interest under 42 U.S.C.A. 1395, 28 U.S.C.A. 1331, or 28 U.S.C.A. 1361.

[11] **[12]** Next, Dr. Peterson argues that he was denied a fair trial because the court changed the order of proof, unduly limited his time for presenting his case, and acted as trial attorney for the Government. These charges border on the frivolous. The district court properly required that liability be established before proof of damages was offered, and it was within the court's discretion, which was soundly exercised, to initially try the issues raised by the counterclaim. Each witness offered on that phase of the case was, however, subjected to examination and cross-examination, without time limitation, in support of Dr. Peterson's claims of tortious conduct. Finally, the record is devoid of the slightest suggestion that the court was an advocate for the Government. Moreover, these and other evidentiary errors asserted by Dr. Peterson were not the subject of objection below and cannot be raised for the first time on appeal. D. H. Overmyer Co. v. Loflin, 5 Cir. 1971, 440 F.2d 1213.

Dr. Peterson's contention that he was denied dur process in connection with ***55** the suspension of his Medicare payments is unfounded. There is no administrative procedure prescribed by statute or regulation for suspension of Medicare recipients suspected of fraud. They, of course, have recourse to the courts for review of the action taken. Aquavella v. Richardson, 2 Cir. 1971, 437 F.2d 397. Here Dr. Peterson received a full hearing on the Government's claim of fraud.

Without further extending this opinion it is sufficient to say that we have carefully considered the various other issues raised by Dr. Peterson and find them meritless.

THE GOVERNMENT'S ASSERTED ERRORS

[13] **[14]** The Government urges that the district court erred in refusing to award interest on the fraudulent claims from the date the payment was made to the Petersons. We disagree. We subscribe to the view that since double damages, plus a specified sum, was provided in the False Claims Act for the purpose of making sure that the Government would be made completely whole, it is error to assess prejudgment interest on the recoverable amount. United States v. Foster Wheeler Corp., 2 Cir. 1971, 447 F.2d 100.

[15] **[16]** Finally, the Government argues that since the district court found that 120 false claims had been filed, it should have assessed a $2,000 forfeiture for each false claim, or a total of $240,000, as provided in 31 U.S.C.A. 231, instead of limiting the forfeiture to 50 claims totaling $100,000. The short answer is that the Government did not file a cross-appeal and may not now be heard to complain of the judgment entered below. In any event, the Government tacitly admits that the court may exercise discretion where the imposition of forfeitures might prove excessive and out of proportion to the damages sustained by the Government. The forfeiture should reflect a fair ratio to damages to insure that the Government completely recoups its losses. United States v. Hess, supra; Toepleman v. United States, 4 Cir. 1959, 263 F.2d 697. The district court used sound discretion in the imposition of forfeiture in this case.

We are satisfied that the issues were fully and fairly tried. The findings of fact have substantial support in the record and are not clearly erroneous. Proper legal conclusions were reached by the district court. Finding no error the judgment is

Affirmed.

All Citations

508 F.2d 45

Footnotes

1 Peterson v. Blue Cross and Peterson v. West, 5 Cir. 1975, 508 F.2d 55, this day decided.

2 Peterson v. Richardson, N.D.Tex.1973, 370 F.Supp. 1259.

3 United States v. Peterson, 5 Cir. 1974, 488 F.2d 645.

4 See note 3 supra. The Court found that the jury lacked sufficient evidence to find Dr. Peterson guilty of conspiracy; reversing his conviction removed James Peterson's confederate, so the latter's conviction for conspiracy was also reversed.

5 Dr. Peterson has conceded that the Government is not liable under the Federal Tort Claims Act for malicious prosecution and interference with contract rights. See 28 U.S.C.A. 2680(h).

6 The Memorandum provides in pertinent part: 'Where cases of potential fraud are uncovered, the carrier should be instructed by the R.O. (Regional Office) to withhold payments in all pending assigned claims from the 'suspect' until the investigation is completed and conclusion reached as to whether fraud was perpetrated and, if so, what further action is to be taken.'

7 Under regulations promulgated by the Department it is provided that 'In the performance of their contractual undertakings, the carriers act on behalf of the Secretary, carrying on for him the administrative responsibilities imposed by the law. The Secretary, however, is the real party in interest in the administration of the program . . ..' 20 C.F.R. 405.670 (1973).

8 On almost parallel evidence James Peterson was convicted on 39 counts under 18 U.S.C.A. 1001 of the substantive offenses of unlawfully and knowingly making false statements of material facts to a government agency. This Court held that the overwhelming evidence established that Dr. Peterson did not in fact supervise the administering of physical therapy to any particular Zodiac patients, and that the evidence was sufficient to support the jury's finding that James Peterson had made willful misrepresentations on the claim forms filed with Group Medical and Surgical Service. United States v. Peterson, 5 Cir. 1974, 488 F.2d 645.

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873 F.3d 999
United States Court of Appeals, Seventh Circuit.

UNITED STATES of America, Plaintiff-Appellee,
v.
Robert S. LUCE, Defendant-Appellant.

No. 16-4093
|
Argued May 30, 2017
|
Decided October 23, 2017

Synopsis
Background: United States brought action under False Claims Act (FCA) and Financial Institutions Reform, Recovery, and Enforcement Act (FIRREA) alleging that mortgage company owner defrauded it by falsely asserting that he had no criminal history so that his company could participate in Fair Housing Act's (FHA) insurance program. The United States District Court for the Northern District of Illinois, No. 1:11-cv-05158, John J. Tharp, Jr., J., 2015 WL 5768503, 2016 WL 6892857, granted government's motions for summary judgment, and owner appealed.

Holdings: The Court of Appeals, Ripple, Circuit Judge, held that:

[1] owner's false certification on yearly verification reports submitted pursuant to FHA that he was not currently subject to criminal proceedings was material as matter of law, but

[2] common-law proximate causation test, rather than "but-for" causation test, was applicable in determining liability and damages under FCA, overruling *United States v. First National Bank of Cicero*, 957 F.2d 1362.

Reversed in part and remanded.

Procedural Posture(s): On Appeal; Motion for Summary Judgment.

West Headnotes (7)

[1] **Federal Courts** Summary judgment

Court of Appeals reviews district court's grant of summary judgment de novo.

[2] **Federal Civil Procedure** Absence of genuine issue of fact in general

Federal Civil Procedure Right to judgment as matter of law

Summary judgment is appropriate when, construing record in light most favorable to nonmoving party, there is no genuine issue as to any material fact and moving party is entitled to judgment as matter of law.

12 Cases that cite this headnote

[3] **Federal Courts** Summary judgment

In reviewing district court's grant of summary judgment, Court of Appeals is not required to draw every conceivable inference from record nonmoving party's favor, but only those inferences that are reasonable.

5 Cases that cite this headnote

[4] **United States** Materiality

Mortgage company owner's false certification on yearly verification reports submitted to Department of Housing and Urban Development (HUD) pursuant to Federal Housing Act (FHA) that he was not currently subject to criminal proceedings was material as matter of law, for purposes of determining his liability under False Claims Act (FCA), even though HUD approved insurance on new loans originated by company after learning of reports and owner's pending charges, where certification concerned eligibility requirement that flatly prohibited government from doing business with individuals who had criminal record, and HUD began debarment proceedings, culminating in actual debarment, following its discovery of owner's fraud. 31 U.S.C.A. § 3729(a)(1); 24 C.F.R. § 202.5(j)(2).

4 Cases that cite this headnote

[5] **Fraud** Injury and causation

Generally, under common law, fraudulent misrepresentation is legal cause of pecuniary loss resulting from action or inaction in reliance upon it if, but only if, loss might reasonably be expected to result from reliance.

[6] **Fraud** Injury and causation

Under common law, misrepresentation is legal cause only of those pecuniary losses that are within foreseeable risk of harm that it creates.

[7] **United States** Materiality

United States Damages

Common-law proximate causation test, rather than "but-for" causation test, is applicable in determining liability and damages under False Claims Act (FCA), overruling *United States v. First National Bank of Cicero*, 957 F.2d 1362. 31 U.S.C.A. § 3729(a)(1).

5 Cases that cite this headnote

***1000** Appeal from the United States District Court for the Northern District of Illinois, Eastern Division. No. 1:11-cv-05158—**John J. Tharp, Jr.**, *Judge*.

Attorneys and Law Firms

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Michael Samuel Shapiro, Attorney, SCANDAGLIA & RYAN, Chicago, IL, for Defendant-Appellant.

Before Wood, Chief Judge, and Ripple and Rovner, Circuit Judges.

Opinion

RIPPLE, Circuit Judge.

The Fair Housing Act ("FHA") was enacted in order to increase home ownership. In service of this goal, the Department of Housing and Urban Development ("HUD"), which is statutorily tasked with implementing the FHA, offers insurance to certain mortgage lenders in order to decrease the risk borne by private industry and thus encourage lending. HUD maintains the viability of this scheme through a number of measures. One such measure prohibits individuals with criminal records from owning, or being employed by, a mortgage company.

The United States brought this action against Robert Luce under the False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq.*, and the Financial Institutions Reform, Recovery, and Enforcement Act ("FIRREA"), 12 U.S.C. § 1833a. It alleged that Mr. Luce had defrauded the Government by falsely asserting that he had no criminal history so that his company could participate in the FHA's insurance program. The district court granted summary judgment in favor of the Government. [1]

Mr. Luce now submits that his false certifications were not material and that lingering issues of material fact preclude summary judgment. Furthermore, Mr. Luce urges that the Supreme Court's decision in *Universal Health Services, Inc. v. United States ex rel. Escobar*, ––– U.S. ––––, 136 S.Ct. 1989, 195 L.Ed.2d 348 (2016) ("*Escobar*"), requires that we depart from our traditional "but-for" FCA causation standard. Although we conclude that Mr. Luce's first two submissions are not persuasive, we believe that there is merit to Mr. Luce's view on causation. *Escobar* did not overrule explicitly our circuit precedent, which requires "but-for" rather than proximate causation. Nonetheless, it ***1001** does provide significant guidance and deserves our respectful and careful consideration, especially when all other circuits to address the issue have chosen a path different from our own.

Accepting *Escobar* as a catalyst, we have reviewed the principles of common-law fraud, the FCA's statutory language, and the rationale of our sister circuits; we now join those courts in holding that proximate cause is the appropriate test. Accordingly, the judgment of the district court as to causation is reversed, and the case is remanded to afford the parties an opportunity to address the merits under the proximate cause standard.

I

BACKGROUND

A.

One of the objectives of the FHA is to insure participating lenders against losses incurred in the home mortgage market. To qualify for FHA insurance, a loan must be made and held by an approved mortgagee. One type of covered lender, or mortgagee, is a "loan correspondent." "A loan correspondent is an entity that has as its principal activity the *origination* of mortgages for sale or transfer to other mortgagees." [2] Loan correspondents may apply for mortgage insurance, but cannot "hold, purchase, or service insured mortgages." [3] Rather, they are tasked primarily with soliciting the mortgagor and verifying employment information, earnings, and assets. In short, a loan correspondent "originate[s] and verif[ies] the initial information on an FHA loan." [4]

In order to maintain the integrity of the insurance scheme, mortgagees are required to submit a Yearly Verification Report ("V-form") as part of an annual recertification procedure. During the relevant period, the V-forms read as follows:

> I certify that none of the principals, owners, officers, directors, and/or employees of the above named mortgagee are *currently involved in a proceeding and/or investigation that could result, or has resulted in a criminal conviction*, debarment, limited denial of participation, suspension, or civil money penalty by a federal, state, or local government. [5]

The annual submission of this verification is required for continued program participation. Mortgagees are additionally required to file a 92900-A form with each loan; that form contains a similar criminal history verification. [6]

*1002 B.

Mr. Luce is an attorney who has been employed at various times by the Securities and Exchange Commission and a series of Chicago law firms. Most recently, he was president and owner of his own mortgage company, MDR. Although he owned MDR, he "was not involved in the day-to-day operation of MDR"; rather, he "performed only high-level corporate work on behalf of" the firm. [7]

MDR was a loan correspondent and therefore could originate loans by sending loan applications to a HUD-approved, direct-endorsement mortgagee for underwriting approval prior to closing. The process proceeded roughly as follows:

> 18. MDR loan officers would first talk to potential borrowers to find out what kind of rate they wanted and to learn about the property they wanted to finance. Once the potential borrower decided on the type of mortgage they [sic] wanted, the loan officer would let them [sic] know the rate which MDR would get daily from lenders. The loan officer would then set up an appointment with the borrower, get their w2s, pay stubs, home insurance, lender statement and the necessary documents to process the loan. The loan officer would then complete a loan application ... and when the packet was complete, the loan officer would give it to the loan processing department at MDR.
>
> 19. The processing department would review the package to make sure all the right documents were in it to send to the lender.... Once the loan applications and other documents ... were complete, and the loan file was approved by MDR's processing department, the loan application would be sent to a lender for underwriting.
>
> 20. After the loan package was sent to the lender, MDR would get approval from the underwriter. If the lender needed more information, the package would be sent back to the processing department at MDR to gather the information from the loan officer. [8]

For its involvement, MDR received a nominal processing fee of $450 and a commission.

In April 2005, Mr. Luce was indicted in an unrelated matter for wire fraud, mail fraud, making false statements, and obstruction of justice. Following his indictment, Mr. Luce informed James Passi, his son-in-law and MDR Vice President, of the criminal charges. Nonetheless, MDR continued to state on its V-forms and 92900-A forms that its officers were not currently subject to criminal proceedings. Mr. Luce signed the V-forms; his subordinates signed the 92900-A forms.

Almost three years after Mr. Luce's indictment, in early February 2008, Passi provided information related to the pending criminal charges to HUD's Office of Inspector General. A brief investigation ensued, and, on February 25, 2008, the investigator issued a Referral for Suspension/ Debarment. [9]

In July 2008, Mr. Luce pleaded guilty to obstruction of justice in the separate criminal proceeding. On or about August 8, 2008, Mr. Luce amended his V-forms to reflect the criminal indictment. Thereafter, ***1003** Mr. Luce was debarred, and MDR went out of business. During the period between Mr. Luce's April 2005 indictment and the August 2008 V-form amendments, MDR originated 2,500 loans. Approximately 250 of those loans are now in default; 95% of the defaulted loans were refinances of existing loans previously insured by the FHA.

C.

The United States brought suit against Mr. Luce in July 2011, seeking treble damages and civil penalties under the FCA and the FIRREA. Counts one and two of the complaint alleged violations of the FCA by either submitting false claims or "using a false record or statement to get a false claim paid." [10] Count three of the complaint alleged that Mr. Luce was subject to civil penalties under the FIRREA because he had "unlawfully, willfully and knowingly made, used, or caused to be made or used, false and fraudulent records, statements, or certifications to HUD" in violation of 18 U.S.C. § 1006, one of the predicate offenses identified in the FIRREA, 12 U.S.C. § 1833a. [11] At bottom, the complaint alleged that Mr. Luce personally lied on the V-forms and that his subordinates lied on the 92900-A forms [12] in order to participate fraudulently in the HUD insurance scheme.

Both parties eventually moved for summary judgment on liability, and, on September 30, 2015, the district court ruled on those motions, finding Mr. Luce liable for the false certifications on the 2006, 2007, and 2008 V-forms. In so doing, it noted that "[t]he FCA provides liability for any person who '(A) knowingly presents ... a false or fraudulent claim for payment or approval; [or] (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.' " [13] The court held that there was no question as to Mr. Luce's liability for the false certifications on the relevant V-forms because he had signed those documents while aware of his pending criminal charges. The district court also held that the false certifications on the V-forms were material as a matter of law "[b]ecause the certification on the V-forms constituted fraud in fulfilling a prerequisite to receiving government funds." [14]

Finally, the court noted that FIRREA liability requires "a false statement made by 'an officer, agent or employee of or connected in any capacity with' HUD, with intent to defraud or deceive HUD." [15] The court had no trouble determining that, because he had signed the V-forms while aware of his criminal status, "Luce knowingly made false statements on the V-forms with the intent to deceive HUD." [16] Accordingly, "[b]ecause no reasonable jury could find for Luce on the FIRREA claims relating to the V-forms in 2006, 2007 and 2008," the district court also granted summary judgment "to the government on the FIRREA claims for the V-forms from 2006–2008." [17]

The district court declined to impose liability for the 92900-A forms because "the government's evidence [wa]s far too thin to command a conclusion that Luce ***1004** knew about the requirement to file forms 92900-A." [18] Rather, the court concluded that "[w]hether Luce had actual knowledge or was recklessly or deliberately indifferent to the existence of the 92900-A forms is a credibility determination for a jury that precludes a finding of summary judgment for either party on the 92900-A forms." [19] The district court also held that issues of fact precluded summary judgment on the FIRREA claim related to the 92900-A forms.

Following its entry of summary judgment in favor of the Government on the FCA and FIRREA claims related to the V-forms, the court held a status hearing. During that hearing, the parties discussed the necessity of a trial:

MR. SHAPIRO: I believe we're going to trial, Judge. We tried to work some stuff out but it hasn't been worked out yet. I will continue to try and work it out with the government short of it, but I think the government would like to set a trial date today.

THE COURT: Okay. And so we're only talking now about the 2005 claims based on the *92-900A* [sic] *forms*, correct?

MS. NORTH [for the Government]: Your Honor, actually we're not. We'll go to trial *and not pursue the 2005 claims and go forward on damages and penalties for what has been decided on summary judgment*.[20]

After further discussion, the court expressed some doubt that there was a factual dispute concerning damages. It therefore decided to allow the Government to submit a summary judgment motion directed to the issue of damages to determine if there was a genuine issue of material fact with respect to "the dollar figures"[21] before it empaneled a jury.

In its motion for summary judgment on damages, the Government argued that it was entitled to "FCA damages of $111,195,477 because that amount is equal to three times HUD's net loss on the 237 loans that Luce's MDR Mortgage Corporation originated between the relevant dates."[22] Mr. Luce opposed summary judgment on various grounds, including that the Government was required to establish ***1005** "the foreseeability of the damages it claims" and that "[a] reasonable jury could conclude that it was not foreseeable ... that he would be responsible for future borrower defaults on 237 loans because of his misrepresentations on the V forms."[23]

Before the district court had the opportunity to rule on the Government's motion for summary judgment on damages, the Supreme Court issued its opinion in *Escobar*, which directly addressed the question of materiality in FCA cases. The district court therefore ordered additional briefing on "the Court's ruling as to liability."[24] In response, Mr. Luce contended that his V-form certifications were not material under *Escobar*. He further argued that *Escobar*'s instruction to apply common-law fraud principles required the application of proximate, rather than but-for, causation.

On November 23, 2016, the district court addressed both *Escobar* and the Government's motion for summary judgment on the question of damages. The court, this time applying the heightened materiality standard articulated in *Escobar*, again found material Mr. Luce's false certifications. The district court also rejected Mr. Luce's argument that *Escobar* impliedly overruled our precedent applying but-for causation and instead required proximate causation in FCA cases. It accordingly found that Mr. Luce's false V-form certifications were the but-for cause of the loss and awarded $10,357,497.69 in damages.[25] "Because Luce would be unable to pay any amount (on top of the damages and penalty imposed under the FCA), the Court assesse[d] a penalty of zero on the FIRREA violations."[26] A final judgment was entered on November 23, 2016.[27]

II

DISCUSSION

[1] **[2]** **[3]** We review the district court's grant of summary judgment de novo. *Cent. States, Se. & Sw. Areas Pension Fund v. Fulkerson*, 238 F.3d 891, 894 (7th Cir. 2001). Summary judgment is appropriate when, construing the record in the light most favorable to the nonmoving party, *Canen v. Chapman*, 847 F.3d 407, 412 (7th Cir. 2017), there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law, *Blasius v. Angel Auto., Inc.*, 839 F.3d 639, 644 (7th Cir. 2016). However, we are "not required to draw every conceivable inference from the record" in favor of the nonmoving party, but "only those inferences that are reasonable." *Schwartz v. State Farm Mut. Auto. Ins. Co.*, 174 F.3d 875, 878 (7th Cir. 1999) (quoting *Bank Leumi Le-Israel, B.M. v. Lee*, 928 F.2d 232, 236 (7th Cir. 1991)).

A.

We turn first to Mr. Luce's contention that his false V-form certifications were not material under *Escobar*.

*1006 1.

In *Escobar,* a young woman died after she received mental health treatment by unlicensed and unsupervised caregivers at a clinic operated by one of Universal Health Services' subsidiaries. When submitting reimbursement claims to Medicaid, however, the clinic had used payment codes that corresponded to services provided by licensed professionals. The deceased's parents later sued Universal Health Services under an "implied false certification theory of liability," *Escobar*, 136 S.Ct. at 1997; specifically, the Escobars claimed that the clinic "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 the[ ] claims had it known of these violations," *id.* at 2004.

The district court dismissed the complaint on the ground that none of the regulations that the clinic allegedly violated was a condition of payment. The First Circuit reversed in part and remanded. It reasoned that, "[t]o determine whether a claim is 'false or fraudulent' based on such implicit communications, ... it 'asks simply whether the defendant, in submitting a claim for reimbursement, knowingly misrepresented compliance with a material precondition of payment.' " *Id.* at 1998 (quoting *United States ex rel. Escobar v. Universal Health Servs.*, 780 F.3d 504, 512 (1st Cir. 2015)). According to the First Circuit, "the regulations themselves 'constitute[d] dispositive evidence of materiality,' because they identified adequate supervision as an 'express and absolute' condition of payment and 'repeated[ly] reference[d]' supervision." *Id.* (alterations in original) (quoting *United States ex rel. Escobar*, 780 F.3d at 514).

The Supreme Court vacated and remanded. Initially, it agreed with the First Circuit that a plaintiff could recover under the FCA on the basis of an "implied false certification": "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." *Id.* at 1995. The Court observed that Congress had not defined "false" or "fraudulent" for purpose of the FCA. Nevertheless, the Court continued, "[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." *Id.* at 1999 (quoting *Sekhar v. United States*, ––– U.S. ––––, 133 S.Ct. 2720, 2724, 186 L.Ed.2d 794 (2013)) (alteration in original). "Because common-law fraud has long encompassed certain misrepresentations by omission, 'false or fraudulent claims' include more than just claims containing express falsehoods." *Id.*

Turning to the type of omission that could trigger liability, the Court rejected Universal Health Services' argument that the nondisclosure had to involve program requirements that were "expressly designated as conditions of payment." *Id.* at 1996. "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." *Id.* (emphasis added). The Court explained that the "term 'material' means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property" and had "common-law antecedents." *Id.* at 2002 (quoting *Neder v. United States*, 527 U.S. 1, 16, 119 S.Ct. 1827, 144 L.Ed.2d 35 (1999)). Regardless of its origin, however, "[u]nder any understanding of the concept, materiality 'look[s] to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation.' " ***1007** *Id.* at 2002 (quoting 26 Richard A. Lord, Williston on Contracts § 69:12 (4th ed. 2003)) (second alteration in original).

Given this "demanding" standard, *id.* at 2003, the Court concluded that the label attached to a payment requirement "is relevant to but not dispositive of the materiality inquiry," *id.* at 2001. Instead, the Court explained that proof of materiality includes, but is not 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." *Id.* at 2003. However,

> 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.

Id. at 2003–04. Because the Court's interpretation of the statutory requirements differed from that applied by the First Circuit, it vacated the First Circuit's decision and remanded for further proceedings.

2.

With this understanding of *Escobar*, we consider whether Mr. Luce's misrepresentations on the V-forms meet the materiality standard.

Here, 24 C.F.R. § 202.5(j)(2) affirmatively prohibits *program participation* by loan correspondents who have had a principal "indicted for, or ... convicted of, an offense" bearing on the loan correspondent's integrity. To enforce this prohibition, HUD requires an annual certification of compliance with this requirement so that the loan originator can continue its business relationship with the Government. The certification on the V-form concerns an "eligibility requirement" that flatly prohibits the Government from doing business with individuals who have a criminal record.

HUD's action upon learning of Mr. Luce's indictment and false certifications confirms the centrality of this requirement: It instituted debarment proceedings to end Mr. Luce's participation in the program. It did not simply refuse payment in one instance, but terminated its relationship with the loan originator so that no future payments could be made. [28] At bottom, the false V-form certifications simply were not "minor or insubstantial" violations. *Id.* at 2003. Rather, they were lies that addressed a foundational part of the Government's mortgage insurance regime, which was designed to avoid the systemic risk posed by unscrupulous loan originators. Mr. Luce, as an attorney with significant experience with the Securities and Exchange Commission, certainly understood this reality, further suggesting a finding of materiality. *See* *id.* at 2002–03 (explaining that subjective knowledge of ***1008** the importance attached to the representation by the recipient may serve as the foundation of materiality).

3.

[4] Mr. Luce attempts to attack this conclusion by contending that the district court disregarded "evidence that would allow a reasonable jury to conclude that the V-Forms were not material," [29] including:

> (1) the Government's approval of insurance on new loans originated by MDR after learning of the V-Forms and Mr. Luce's pending charges; (2) allowing MDR to continue operating as a loan correspondent for two years (2005 and 2006) when no V-Forms were on file; (3) the fact that the V-Forms were not considered when making the decision to insure any specific loan; and (4) HUD's decision to stop regulating loan correspondents entirely. [30]

We cannot agree.

First, the Government's actions following its discovery of his fraud support, rather than undercut, a finding of materiality. Although new loans were issued, the Government also began debarment proceedings, culminating in actual debarment. There was no prolonged period of acquiescence.

Second, Mr. Luce's contention that HUD allowed MDR to operate without V-forms for two years is simply not supported by the evidence. Although the V-form for 2006 could not be located, the Government submitted undisputed evidence that, had MDR failed to submit the V-form, HUD would have terminated MDR's FHA-approval. [31]

***1009** Third, Mr. Luce's argument that the certification was not tied to *any particular* loan misses the mark; the V-form certification was a threshold eligibility requirement that, by extension, was tied to *every* loan. That is to say, without the V-form, he could not have originated a single mortgage.

Finally, the contention that HUD stopped regulating loan correspondents in 2010 is simply inaccurate. Rather, the 2010 amendments required that loan correspondents seek a sponsorship relationship with approved mortgagees, who in turn assume responsibility for the loan correspondents. [32] This structural shift in no way suggests that the actions of loan correspondents are not material; if anything, it demonstrates that their actions are of sufficient import that further supervision by an intermediary is required.

The district court did not err in finding that Mr. Luce's false certification on the V-form was material as a matter of law.

B.

Having approved the district court's finding of materiality under *Escobar*, we now turn to the issue at the heart of this appeal: whether *Escobar* requires that we depart from our traditional causation test for FCA cases. Twenty-five years ago, our court created a conflict among the circuits by holding in *United States v. First National Bank of Cicero*, 957 F.2d 1362 (7th Cir. 1992) ("*Cicero*"), that the FCA requires a "but-for" causation test rather than a proximate causation test. In *Cicero*, a bank forwarded a guaranteed loan application to the Small Business Administration ("SBA"); the application contained many falsehoods. When the loan was not repaid, the bank sought, and received, reimbursement ***1010** on the guarantee from the SBA. The United States later sought to recover the payment of the guarantee. Its action was predicated on, among other bases, the FCA. It argued that, if the bank had not submitted the original loan guarantee application to the SBA, the money never would have been disbursed and the Government would not have incurred its loss. In short, the Government's loss did not have to be attributed directly to the bank's false statement.

In *Cicero*, the court focused on the language of the statute. The FCA allows the Government to recover "3 times the amount of damages which the Government sustains *because of the act of that person*." 31 U.S.C. § 3729(a)(1) (emphasis added). The court emphasized that the statute permits recovery of damages that arise "because of" a fraud, not damages " 'occasioned by the cause of the falsity of the claim.' " *Cicero*, 957 F.2d at 1374 (quoting *United States v. Hibbs*, 568 F.2d 347, 354 (3d Cir. 1977) (Meanor, J., dissenting)). In its view, this language justified a broad "but for" causality standard for the question of causation. *Id.* We held that, even if the Government's loss was not caused directly by the false application for a guaranteed loan, the FCA claim was valid because the claim for reimbursement would not have been made if the bank had not transmitted, at an earlier date, the false loan application.

Importantly, the opinion in *Cicero* expressly acknowledged, and disagreed with, the Third Circuit's earlier contrary holding in *United States v. Hibbs*, 568 F.2d 347 (3d Cir. 1977). That case held that "a causal connection must be shown between loss and fraudulent conduct and that a broad 'but for' test is not in compliance with the statute." *Id.* at 349. [33] In arriving at that conclusion, the Third Circuit also had focused on the statutory language, but had reached an entirely different result. It reasoned that

> [t]he statutory limitation, "by reason of" [34] the commission of the unlawful act, compels consideration of the element of causation. That requirement should be liberally construed so as to provide the government restitution from those whose fraud has caused loss. It should not, however, be disregarded completely so as to eliminate the relationship ***1011** between the unlawful act and the injury ultimately sustained.

Id. at 351. The court additionally was concerned with the inequitable result that naturally would flow from a different rule of causation:

> To further illustrate the extreme to which the government's argument would lead—if the mortgagors had defaulted because their houses had been destroyed by a flood or

> some other uninsured catastrophe, the government's theory would nevertheless hold Hibbs liable because he failed to call its attention to defects in the plumbing.

Id. In the twenty-five years since we handed down our opinion in *Cicero*, two additional circuits have adopted proximate causation. No circuit has endorsed our view.

With this background in mind, Mr. Luce submits that the "but-for" test employed by the district court to establish causation, although consonant with this circuit's precedent in *Cicero*, is based on an erroneous interpretation of the FCA. He argues that we ought to adopt the proximate cause test adopted by the other circuits that have faced the question. Realizing that stare decisis concerns present a barrier to such a course, he submits that "[t]he Supreme Court's decision in *Escobar* declared the necessity of applying common-law fraud requirements in FCA cases." [35] Mr. Luce contends that "[c]ommon-law fraud claims do not use 'but for' causation when evaluating a defendant's liability; rather, it is necessary for a plaintiff to prove 'proximate' causation." [36] He accordingly concludes that our but-for test "is no longer viable following *Escobar*'s imperative to apply common-law fraud principles in FCA cases." [37]

We begin our causation analysis where Mr. Luce's argument ends and find it unnecessary to say whether *Escobar,* standing alone, would warrant our revisiting this issue. Nothing in that opinion directly addresses the question of FCA causation or the circuit split; rather, that opinion clearly focuses on the implied certification theory of liability and requires that courts undertake a rigorous materiality inquiry. *See* *Escobar*, 136 S.Ct. at 1995, 1996, 1999–2004. It does not address causation.

Nonetheless, *Escobar* does give us pause. The Court *explicitly* said that, "absent other indication, Congress intends to incorporate the well-settled meaning of the common-law terms it uses" and that "the term 'fraudulent' is a paradigmatic example of a statutory term that incorporates the common-law meaning of fraud." *Id.* at 1999 (internal citations omitted). [38] These two statements, read together, require a careful reevaluation of our FCA precedent with particular focus on the common-law understanding of fraud, the FCA's language, and our sister circuits' understanding of causation.

[5] **[6]** Generally, under the common law, "[a] fraudulent misrepresentation is a legal cause of a pecuniary loss resulting from action or inaction in reliance upon it if, but only if, the loss might reasonably be expected to result from the reliance." Restatement (Second) of Torts § 548A (Am. Law. Inst. 1977). Nonetheless, "[n]ot all losses that in fact result from the reliance are ... legally caused by the representation." *Id.* cmt. A. Instead, "the misrepresentation ***1012** is a legal cause only of those pecuniary losses that are within the foreseeable risk of harm that it creates." *Id.* We similarly have explained, while analyzing the common law of negligence, that

> [p]roximate cause encompasses both cause in fact and legal cause. To establish cause in fact, the plaintiff must show the defendant's "conduct was a material element and a substantial factor in bringing about the injury." Legal cause on the other hand, "is essentially a question of foreseeability," and we must determine "whether the injury is of a type that a reasonable person would see *as a likely result* of his or her conduct."

Blood v. VH-1 Music First, 668 F.3d 543, 546 (7th Cir. 2012) (internal citations omitted).

The statutory language of the FCA does not suggest that Congress sought to depart from the established common-law understanding of causation in fraud cases. The FCA simply allows the Government to recover "damages which the Government sustains *because of* the act of that person." 31 U.S.C. § 3729(a)(1) (emphasis added). Although the phrase "because of" clearly requires causation, [39] nothing in the FCA contains any indication of an intent to depart from the common-law understanding of causation in fraud cases. [40]

We further note that proximate causation comports with the FCA's statutory purpose. The proximate causation standard "separates the wheat from the chaff, allowing FCA claims to proceed against parties who can fairly be said to have caused a claim to be presented to the government, while winnowing out those claims with only attenuated links between the defendants' specific actions and the ***1013** presentation of the false claim." *United States ex rel. Sikkenga v. Regence*

Bluecross Blueshield of Utah, 472 F.3d 702, 714 (10th Cir. 2006).

Given these considerations, it is not surprising that the clear weight of authority among our sister circuits supports the view that "but for" does not fulfill adequately the causation requirement of the statute. Following Hibbs, the Fifth Circuit expressly adopted the Third Circuit's analysis, noting that

> the Third Circuit's reasoning was based upon the phrase in § 231 that anyone violating the Act shall pay to the United States "double the amount of damages which the United States may have sustained *by reason of the doing or committing such* act." ... The Third Circuit held that the default which occurred in that case had not been related to the false statements regarding the conditions of certain residential property.
>
> ...
>
> This court finds no error in the decision[ ] in Hibbs.... The language of the statute clearly requires that before the United States may recover double damages, it must demonstrate the element of causation between the false statements and the loss.

United States v. Miller, 645 F.2d 473, 475–76 (5th Cir. 1981).[41] Similarly, despite our intervening decision in Cicero, the D.C. Circuit adopted the rule articulated in Hibbs and Miller, and saw little reason to elaborate further on the explanation of the other circuits:

> PRC further points to several circuits that have concluded that the Act does not contemplate liability for all damages that would not have arisen "but for" the false statement. *See* United States v. Miller, 645 F.2d 473, 475–76 (5th Cir. 1981); United States v. Hibbs, 568 F.2d 347, 351 (3d Cir. 1977). Surely, we agree.

United States ex rel. Schwedt v. Planning Research Corp., 59 F.3d 196, 200 (D.C. Cir. 1995). Finally, more recently, the Tenth Circuit expressly approved of the Third Circuit's reasoning in Hibbs, noting that the "proximate causation standard strikes the proper analytical balance and comports with the rule requiring strict construction of punitive civil statutes." Sikkenga, 472 F.3d at 715 n.17.[42] At bottom, in contrast ***1014** to Cicero's but-for causation test, each of these four circuits has adopted the common-law understanding of foreseeable, or proximate, causation with respect to the imposition of liability and damages under the FCA. None of these decisions can live in peace with Cicero.

[7] In the years since, an increasing number of our sister circuits have adopted expressly proximate causation as a rule more compatible with the statute's language and purpose. The Supreme Court, as well, has provided new guidance on how we ought to interpret congressional enactments dealing with fraud: Absent other direction from Congress, we should assume that Congress did not stray far from the established common law. Most importantly, our own reading of the statutory language now convinces us that the course charted by our sister circuits is the correct reading of the statutory text. We accordingly overrule Cicero and adopt the proximate cause standard for FCA cases.[43]

C.

There remains the issue of whether, under the proximate cause standard that we have enunciated today, the Government can establish that Mr. Luce's falsehood was the proximate cause of the Government's harm. Our examination of the proceedings in the district court convinces us that this issue was not adequately developed by the parties. The proper course, therefore, is to remand this action to allow the district court to evaluate the evidence according to the new prevailing standard of proximate causation.[44]

Conclusion

We reverse the district court's judgment with respect to causation and remand the case for further proceedings in conformity with this opinion. Mr. Luce shall recover the costs of this appeal.

REVERSED in part and REMANDED

All Citations

873 F.3d 999

Footnotes

1 The district court had jurisdiction pursuant to 31 U.S.C. § 3732 and 28 U.S.C. § 1345. Our jurisdiction is premised on 28 U.S.C. § 1291.

2 Gov't's Br. 5 (emphasis added) (citing 24 C.F.R. § 202.8(a)(2)(2009)). We recognize that some loan correspondents have more expansive roles (*e.g.*, direct endorsement authority), but we do not outline those responsibilities because they are not implicated by this appeal.

3 *Id.* (citing 24 C.F.R. § 202.8(a)(2)(2009)).

4 R.92-3 at 4 (Geary Dep. 27).

5 R.88-7 at 36 (emphasis added) (capitalization removed).

6 The 92900-A forms contained the following certification:

> [T]he undersigned lender makes the following Certifications to induce ... the Department of Housing and Urban Development-Federal Housing Commissioner to issue a firm commitment for mortgage insurance or a Mortgage Insurance Certificate under the National Housing Act....
>
> G. To the best of my knowledge and belief, I and my firm and its principals: ... are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph G(2) of this certification....

R.87 (Gov't's Rule 56.1 Statement of Material Fact) at 8–9 (alteration in original) (internal quotation marks omitted). Paragraph (G)(2) includes the offense of making false statements. *Id*. at 9.

7 R.92-10 at 2 (Luce Aff.).

8 R.87 at 5–6 (internal citations omitted); R.99 at 9–10.

9 A debarment sanction is imposed for criminal or serious HUD program violations; the sanction excludes an individual, organization and its affiliates from conducting business with any federal agency. *See* Debarments, HUD.GOV, https://www.hud.gov/program_offices/enforcement/debarments (last visited Oct. 2, 2017).

10 R.1 at 9–10 (capitalization removed).

11 *Id*. at 11.

12 The 92900-A forms are not at issue in this appeal. *See infra* note 20.

13 R.113 at 8 (third alteration in original) (quoting 31 U.S.C. § 3729(a)(1)).

14 *Id.* at 21.

15 *Id.* at 22 (quoting 18 U.S.C. § 1006).

16 *Id.* at 23.

17 *Id*.

18 *Id.* at 11.

19 *Id.* at 12.

20 R.156-1 at 2 (emphasis added). Contrary to the Government's present stance, *see* Gov't's Br. 10 n.4, it expressly abandoned any FCA claims based on the 92900-A forms in these representations to the district court. After the status hearing, all parties proceeded on the basis that liability on all claims had been settled and the only issue before the court was damages. Indeed, in its supplemental briefing on *Universal Health Services, Inc. v. United States ex rel. Escobar*, ––– U.S. ––––, 136 S.Ct. 1989, 195 L.Ed.2d 348 (2016), *see infra* at 1005, the Government stated: “The court's opinion and *ruling as to liability* in its prior decisions is consistent with the holding in *Escobar*.” R.136 at 1 (emphasis added).

Moreover, following the court's disposition of the Government's motion for summary judgment on damages, the court entered a final judgment. *See* R.143; *see also infra* at 1005. Had there been any lingering claims for the court's consideration, it could not have issued a final judgment as to *any* claims unless it "expressly determine[d] that there [wa]s no just reason for delay." Fed. R. Civ. P. 54(b). The district court made no such finding. Instead, both it—and the parties—proceeded in a manner consistent with the fact that the district court definitively had decided all outstanding claims before it.

The Government's present position is particularly untenable given its jurisdictional statement. In it, the Government stated that the district court's November 23, 2016 order was a final judgment on the merits providing grounds for this court's appellate jurisdiction. *See* Gov't's Br. 2.

21 R.156-1 at 5.

22 R.123 at 1.

23 R.128 at 4, 6 (emphasis removed).

24 R.132 (Minute Entry).

25 The district court calculated that number as follows:

> The loss for the 226 refinanced loans is the difference between the amount the FHA guaranteed on the original loans and the amount guaranteed upon MDR's refinancing of those loans. For the 11 new loans, the damages are the government's net losses.... The total loss amount for the 237 loans is $3,452,499.23. Trebling the damages, as required per the FCA, Luce is liable for $10,357,497.69 in damages.

R.142 at 8–9 (internal citations omitted). The court also imposed a penalty of $16,500 for the FCA violations. *See id.* at 12.

26 *Id*. at 11.

27 *See* R.143.

28 Indeed, the Court made this point in rejecting Universal Health Services' argument that liability should be premised only when a condition of payment is at issue:

> 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.

Escobar, 136 S.Ct. at 2002.

29 Appellant's Br. 15. Mr. Luce also continues to argue that he did not knowingly make a false statement. According to Mr. Luce, the district court "improperly [found] scienter proven as a matter of law by making credibility determinations about Mr. Luce's testimony." *Id*. at 16. Specifically, he makes a linguistic argument that, because the V-form certifications only speak to "a proceeding ... that *could* result ... in a criminal conviction," R.88-7 at 36, and he believed himself to be innocent, he did not knowingly make a false statement. Reply Br. 22–24. We cannot accept this submission. The V-forms ask whether Mr. Luce *could* be convicted, not whether he *should* or *would* be convicted. Furthermore, even if Mr. Luce subjectively believed himself to be innocent, the FCA's knowledge requirement is met by "deliberate ignorance" or "reckless disregard" of the truth. 31 U.S.C. § 3729 (b)(1)(ii)–(iii). Both are present here.

30 Appellant's Br. 15.

31 *See* R.100-1 at 17 (Second Declaration of Julie Shaffer, Director of HUD's Philadelphia Home Ownership Center). Mr. Luce also maintains that the Government failed to establish that he signed and submitted a 2006 V-form. *See* Appellant's Br. 16. We disagree. "The standard for summary judgment is well established: with the court drawing all inferences in the light most favorable to the non-moving party, the moving party must discharge its burden of showing that there are no genuine issues of material fact and that he is entitled to judgment as a matter of law." *Spierer v. Rossman*, 798 F.3d 502, 507 (7th Cir. 2015). Thereafter, "[i]f the moving party has properly supported his motion, the burden shifts to the nonmoving party to come forward with specific facts showing that there is a genuine issue for trial." *Id.*

Here, the Government moved for summary judgment, arguing that Mr. Luce filed a 2006 V-form. The Government could not locate the form, so it introduced (1) evidence that MDR had paid an associated registration fee in 2006, in addition to (2) the declaration of Director Shaffer, who stated that the 2006 form must have been received "because HUD would have terminated MDR's FHA-approval had it not submitted the V-form." R.100-1 at 17. This shifted the burden of production to Mr. Luce.

In support of his burden, Mr. Luce submits that (1) the Government has failed to locate the actual V-form, (2) a Government witness did not recall seeing a V-form in 2006, and (3) Passi was in charge of day-to-day operations at MDR during the relevant time period, so he may have signed the form. *See* Reply Br. 24. Addressing these arguments in order, the first does not sufficiently counter the Government's production of payment records and the affidavit of Director Schaffer; rather, it simply states the Government has failed to meet its burden, which is insufficient. *See* *Szymanski v. Rite-Way Lawn Maint. Co.*, 231 F.3d 360, 364 (7th Cir. 2000) ("[A] party will be successful in opposing summary judgment only when they present definite, competent evidence to rebut the motion." (quoting *Smith v. Severn*, 129 F.3d 419, 427 (7th Cir. 1997)) (alteration in original)). As to the second argument, the fact that a Government witness did not recall seeing the form is tangential to the actual question—whether the form, in fact, was submitted.

Finally, as to the possibility that someone else signed the form, this argument is countered by the submission of the 2003, 2004, 2007, and 2008 forms, which all carried Mr. Luce's signature. We have emphasized that a party "cannot thwart summary judgment by asking a court to make inferences based on flights of fancy." *Kodish v. Oakbrook Terrace Fire Prot. Dist.*, 604 F.3d 490, 508 (7th Cir. 2010). It is difficult to see how Mr. Luce's argument that Passi *may* have signed the 2006 V-form is anything other than a "flight[ ] of fancy" given that all of the other V-forms in the record contained Mr. Luce's signature and given that Mr. Luce refused to testify that he did not sign a 2006 V-form. Notably, Passi (the very individual Mr. Luce contends committed fraud by signing the 2006 V-form) voluntarily alerted the authorities to MDR's fraud. The district court accordingly was correct in granting summary judgment as to the 2006 V-form.

32 Federal Housing Administration: Continuation of FHA Reform; Strengthening Risk Management Through Responsible FHA-Approved Lenders, 75 Fed. Reg. 20,717 (Apr. 20, 2010) (to be codified at 24 C.F.R. pt. 202). In particular, the Government explained that,

> Loan correspondents will no longer be approved participants in FHA programs. Loan correspondents, however, will continue to have the opportunity to participate in FHA programs as third-party originators (TPOs) through sponsorship by FHA-approved mortgagees, as is currently the case, or through application to be approved as an FHA-approved mortgagee. In eliminating FHA's approval of loan correspondents, FHA-approved mortgagees assume full responsibility to ensure that a sponsored loan correspondent adheres to FHA's loan origination and processing requirements.

Id. at 20,718.

33 *United States v. Hibbs*, 568 F.2d 347 (3d Cir. 1977), involved "a real estate broker who submitted certifications to the Federal Housing Administration misrepresenting the condition of certain residential properties." *Id.* at 349. Specifically, "Hibbs procured and filed certificates stating that the plumbing, electrical and heating systems of six houses in Philadelphia met the standards and conditions prescribed by [HUD] regulations," despite the fact that "there were deficiencies." *Id.* Relying on the false certifications, the agency "then insured mortgages on the homes and was later required to pay the mortgages when defaults occurred." *Id.*

Hibbs lost in the district court, but nonetheless won reversal on appeal. In reversing, the Third Circuit held that "a causal connection must be shown between loss and fraudulent conduct." *Id.* The court therefore held that the "damages were sustained by the United States because of defaults by the mortgagors and to some extent were increased by the unexpected diminution of property value caused by [a] lead paint injunction," but emphasized that "[n]either of those events was caused by or related to the false certifications." *Id.*

at 351. At bottom, the court was convinced that "precisely the same loss would have been suffered by the government had the certifications been accurate and truthful." *Id.*

34 We have noted that "[a] 1982 amendment to the statute replaced the words 'by reason of the doing or committing' with the word 'because.' " *United States v. First Nat'l Bank of Cicero*, 957 F.2d 1362, 1373 n.11 (7th Cir. 1992). We have declined to give this change in language any substantive effect, instead "assum[ing] that the Act's meaning as to the causation requirement was unchanged by the 1982 amendment." *Id.*

35 Appellant's Br. 17.

36 *Id*.

37 *Id*. at 19.

38 *See also* *Bank of Am. Corp. v. City of Miami,* ––– U.S. ––––, 137 S.Ct. 1296, 1305, 197 L.Ed.2d 678 (2017) ("We assume Congress 'is familiar with the common-law rule and does not mean to displace it *sub silentio*' in federal causes of action." (quoting *Lexmark Int'l, Inc. v. Static Control Components, Inc.,* ––– U.S. ––––, 134 S.Ct. 1377, 1390, 188 L.Ed.2d 392 (2014))).

39 We note that the Supreme Court has interpreted the phrase "because of" as requiring but-for causation in other circumstances. For example, in *Gross v. FBL Financial Services, Inc.*, 557 U.S. 167, 129 S.Ct. 2343, 174 L.Ed.2d 119 (2009), the Court held that

> the ordinary meaning of the ADEA's requirement that an employer took adverse action "because of" age is that age was the "reason" that the employer decided to act. To establish a disparate-treatment claim under the plain language of the ADEA, therefore, a plaintiff must prove that age was the "but-for" cause of the employer's adverse decision.

Id. at 176, 129 S.Ct. 2343 (internal citation omitted). Nonetheless, these cases do not inform our analysis because they do not involve statutory codifications of common-law concepts; rather, they involve statutory protections enacted to protect interests not implicated by the common law.

40 The only possible authority indicating congressional displeasure with proximate causation is from a 1986 Senate Report, which reads as follows:

> When the Government changes its position, and commits its financial resources based upon a material false statement, it should be able to recover the resulting losses, but, under some court interpretations, it may not. For instance, in *United States v. Hibbs,* 568 F.2d 347 (3rd Cir. 1977), the FHA agreed to insure a mortgage based upon a representation, which was false, that the residence was habitable and in compliance with the housing code. The Government will not issue insurance to a non-code-conforming house. However, the court ruled that the default on the mortgage occurred because the borrower lost his job, and therefore could not meet his monthly payments—that the default was not related to the false statement. *While the court may have been technically correct, the Committee believes that this position is unsound public policy*. The act should cover representations which cause the Government to change its position and pledge its full faith and credit, including the risk of insurable loss, based upon another, but material false statement.

S. Rep. No. 99-345, at 20 (1986) (emphasis added). As an initial matter, we are not convinced that the above is a direct criticism of proximate cause. Nevertheless, even if it were, Congress did nothing to amend the statute's language to suggest that it intended to depart from the common law. It accordingly does nothing to alter meaningfully our conclusion.

41 In *United States v. Miller*, 645 F.2d 473 (5th Cir. 1981), a number of real-estate companies, construction companies, and mortgage companies were accused of filing inaccurate mortgage applications. In particular, "[e]ach application filed on behalf of the purchasers of homes contained materially false statements as to the credit worthiness and net worth of [the] home buyers, the amount of down payment which each home buyer

would make and their past and present debts." Id. at 474. The district court dismissed the complaint, and the Government appealed.

In reversing the district court's dismissal, the Fifth Circuit held that "it is clear that [the complaint] does present a set of facts which could entitle the United States to relief." Id. at 476. In particular, the court noted that "[f]alse statements regarding residential property may not reasonably be a cause for subsequent defaults of mortgagors, as was the case in *Hibbs*." *Id.* "Nonetheless," the court continued, "false statements regarding the ability of purchasers to afford housing could very well be the major factor for subsequent defaults." *Id.* Accordingly, the appellate court concluded that "the district court erred in dismissing the complaint against the developers since the government has clearly alleged the necessary causation factor." *Id.*; *see also* *United States ex rel. Main v. Oakland City Univ.*, 426 F.3d 914, 917 (7th Cir. 2005) (holding that false certification denying that admissions recruiters received fees contingent on enrolling students caused Government loss even though a phase two application from a student is also necessary before Government funds are paid).

42 In *United States ex rel. Sikkenga v. Regence Bluecross Blueshield of Utah*, 472 F.3d 702 (10th Cir. 2006), the Tenth Circuit was not assessing the relationship between an alleged misrepresentation and loss—as we are here and as the Third and Fifth Circuits did in *Hibbs* and *Miller*, respectively. Instead, the Tenth Circuit was assessing whether Regence, the Medicare carrier for Utah, had caused a Medicare provider, ARUP, to present a false or fraudulent claim for purposes of 31 U.S.C. § 3729(a)(1). *See* *id*. at 730. It is in this context that the Tenth Circuit determined that proximate causation was appropriate. The fact that the Tenth Circuit (like the Supreme Court in *Escobar*) invoked common-law principles of causation and also explicitly approved of the Third Circuit's analysis in *Hibbs*, supports the view that proximate cause is the appropriate standard for the determination of loss as well.

43 Because this opinion overrules circuit precedent, we have circulated it to all judges in active service in accordance with Circuit Rule 40(e). No judge favored rehearing en banc.

44 In addition to Mr. Luce's proximate cause argument, he also submits that the amount of his damages should be reduced because "the district court erred in awarding damages for loans approved for insurance after February 25, 2008, the date on which the Government indisputably had full knowledge of Mr. Luce's pending charges and the representations on the V-Forms." Appellant's Br. 16. He submits that he "is entitled to judgment with respect to 73 of the loans that form the basis for the Government's claims that were endorsed for insurance after February 25, 2008," which represents, after trebling, $1,992,686.34. *Id*. at 46. Because Mr. Luce's argument, at bottom, concerns the damages for which he is responsible, we believe that this argument is best directed to the district court as part of its consideration of which, if any, losses were proximately caused by Mr. Luce's misrepresentations.

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Disagreed With by U.S. v. Sanford-Brown, Ltd., 7th Cir.(Wis.), June 8, 2015

461 F.3d 1166
United States Court of Appeals,
Ninth Circuit.

UNITED STATES of America, ex rel. Mary HENDOW; Julie Albertson, Plaintiffs–Appellants,
v.
UNIVERSITY OF PHOENIX, Defendant–Appellee.

No. 04–16247.
|
Argued and Submitted Feb. 15, 2006.
|
Filed Sept. 5, 2006.

Synopsis
Background: Relators, former enrollment counselors at state university, filed action under the False Claims Act, alleging university knowingly made false promises to comply with the incentive compensation ban to become eligible to receive Title IV funds. The United States District Court for the Eastern District of California, Garland E. Burrell, J., 2004 WL 3611690,granted university's motion to dismiss. Relators appealed.

[Holding:] The Court of Appeals, Hall, Senior Circuit Judge, held that relators properly alleged a cause of action under the False Claims Act.

Reversed.

Procedural Posture(s): On Appeal; Motion to Dismiss; Motion to Dismiss for Failure to State a Claim.

West Headnotes (14)

[1] **Education** Loans

Statutory ban on a higher educational institution's paying recruiters on a per-student basis is meant to curb the risk that recruiters will sign up poorly qualified students who will derive little benefit from the subsidy and may be unable or unwilling to repay federally guaranteed loans. Higher Education Act of 1965, § 487(a)(20), 20 U.S.C.A. § 1094(a)(20).

7 Cases that cite this headnote

[2] **United States** Injury or financial loss

False Claims Act is not limited to facially false or fraudulent claims for payment; rather, the Act is intended to reach all types of fraud, without qualification, that might result in financial loss to the Government. 31 U.S.C.A. § 3729 et seq.

39 Cases that cite this headnote

[3] **United States** False certification

False Claims liability attaches because of the fraud surrounding the efforts to obtain the contract or benefit status, or the payments thereunder; that the theory of liability is commonly called "false certification" is no indication that "certification" is being used with technical precision, or as a term of art. 31 U.S.C.A. § 3729 et seq.

6 Cases that cite this headnote

[4] **United States** Intent

So long as a statement is knowingly false when made, it matters not whether it is a certification, assertion, statement, or secret handshake; False Claims liability can attach. 31 U.S.C.A. § 3729 et seq.

34 Cases that cite this headnote

[5] **United States** False certification

The "promissory fraud" or "fraud-in-the-inducement" theory holds that False Claim liability will attach to each claim submitted to the government under a contract, when the contract or extension of government benefit was originally obtained through false statements or fraudulent conduct. 31 U.S.C.A. § 3729 et seq.

53 Cases that cite this headnote

[6] **United States** Elements

Under a False Claim Act promissory fraud theory, the relator must allege a false or fraudulent course of conduct, made with scienter. 31 U.S.C.A. § 3729 et seq.

70 Cases that cite this headnote

[7] **United States** Materiality

As with the False Claims Act's false certification theory, the promissory fraud theory requires that the underlying fraud be material to the government's decision to pay out moneys to the claimant. 31 U.S.C.A. § 3729 et seq.

90 Cases that cite this headnote

[8] **United States** Materiality

The precise logistical details of how a false claim is made, with respect to timing, for instance, or the number of stages involved, are immaterial, under the False Claims Act; if a false statement is integral to a causal chain leading to payment, it is irrelevant how the federal bureaucracy has apportioned the statements among layers of paperwork. 31 U.S.C.A. § 3729 et seq.

12 Cases that cite this headnote

[9] **United States** Submission to government

For there to exist a “claim” for purposes of False Claims Act liability, it must involve merely some sort of request for the government to pay out money or forfeit moneys due. 31 U.S.C.A. § 3729 et seq.

69 Cases that cite this headnote

[10] **United States** Elements

Under either the false certification theory or the promissory fraud theory, the essential elements of False Claims Act liability remain the same: (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 forfeit moneys due. 31 U.S.C.A. § 3729 et seq.

192 Cases that cite this headnote

[11] **United States** Pleading; complaint filed under seal

Relators, former enrollment counselors at state university, alleged a false statement or course of conduct, under the False Claims Act, based on claims that university violated statutory incentive compensation ban, to which it agreed in writing in program participation agreement, that university established policies of violating that requirement, and encouraged its employees to violate that requirement, allegations of specific instances of violation, where higher salaries, benefits, and incentives were given in response to increased enrollment, and claimed that university did so knowingly, and with the specific intent to deceive the government. 31 U.S.C.A. § 3729 et seq.

13 Cases that cite this headnote

[12] **United States** Pleading; complaint filed under seal

Relators, former enrollment counselors at state university, alleged a false statement or course of conduct made knowingly and intentionally, for purposes of False Claims Act liability, by claiming university staff openly bragged about perpetrating a fraud, that university had an established infrastructure to deceive the government, and that university repeatedly changed its policies to hide its fraud. 31 U.S.C.A. § 3729 et seq.

8 Cases that cite this headnote

[13] **United States** Pleading; complaint filed under seal

Relators, former enrollment counselors at state university, properly alleged the University engaged in statements or courses of conduct that were material to the government's decision with regard to funding for purposes of False Claims Act liability, by claiming university fraudulently violated a regulation upon which payment was expressly conditioned in three different ways. 31 U.S.C.A. § 3729 et seq.

22 Cases that cite this headnote

[14] **United States** Pleading; complaint filed under seal

Relators, former enrollment counselors at state university, alleged that university submitted a claim against the government fisc, for purposes of False Claims Act liability, by claiming university submitted requests for Pell Grant funds directly to Department of Education (DOE), resulting in a direct transfer of the funds into a university account, and by submitting requests to private lenders for government-insured loans. 31 U.S.C.A. § 3729 et seq.

1 Cases that cite this headnote

Attorneys and Law Firms

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Charles W. Scarborough, Department of Justice, Civil Division, Washington, DC, for the amicus.

Appeal from the United States District Court for the Eastern District of California; Garland E. Burrell, District Judge, Presiding. D.C. No. CV–03–00457–GEB.

Before: HALL, SILVERMAN, and GRABER, Circuit Judges.

Opinion

HALL, Senior Circuit Judge:

The False Claims Act makes liable anyone who "knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government." 31 U.S.C. § 3729(a)(2). In this case, relators have raised allegations that the University of Phoenix knowingly made false statements, and caused false statements to be made, that resulted in the payment by the federal Department of Education of hundreds of millions of dollars. Despite this axiomatic fit between the operative statute and the allegations made, respondent claims that relators' legal theory holds no water. The district court agreed, dismissing the suit for failure to state a claim upon which relief can be granted. We reverse.

I.

[1] When an educational institution wishes to receive federal subsidies under Title IV and the Higher Education Act, it must enter into a Program Participation Agreement with the Department of Education (DOE), in which it agrees to abide by a panoply of statutory, regulatory, and contractual requirements. One of these requirements is a ban on incentive compensation: a ban on the institution's paying recruiters on a per-student basis. The ban prohibits schools from "provid[ing] any commission, bonus, or other incentive payment based directly or indirectly on success in securing enrollments or financial aid to any persons or entities engaged in any student recruiting or admission activities or in making decisions regarding the award of student financial assistance." 20 U.S.C. § 1094(a)(20). This requirement is meant to curb the risk that recruiters ***1169** will "sign up poorly qualified students who will derive little benefit from the subsidy and may be unable or unwilling to repay federally guaranteed loans." *United States ex rel. Main v. Oakland City Univ.,* 426 F.3d 914, 916 (7th Cir.2005), *cert. denied,* 547 U.S. 1071, 126 S.Ct. 1786, 164 L.Ed.2d 519 (2006). The ban was enacted based on evidence of serious program abuses. *See* S.Rep. No. 102–58, at 8 (1991) ("Abuses in Federal Student Aid Programs") (noting testimony "that contests were held whereby sales representatives earned incentive awards for enrolling the highest number of student[s] for a given period"); H.R.Rep. No. 102–447, at 10, *reprinted in* 1992 U.S.C.C.A.N. 334, 343 (noting that the "new provisions include prohibiting the use of commissioned sales persons and recruiters").

This case involves allegations under the False Claims Act that the University of Phoenix (the University) knowingly made false promises to comply with the incentive compensation ban in order to become eligible to receive Title IV funds. Appellants, Mary Hendow and Julie Albertson (relators), two former enrollment counselors at the University, allege that the University falsely certifies each year that it is in compliance with the incentive compensation ban while intentionally and knowingly violating that requirement. Relators allege that these false representations, coupled with later claims for payment of Title IV funds, constitute false claims under 31 U.S.C. § 3729(a)(1) & (a)(2).

First, relators allege that the University, with full knowledge, flagrantly violates the incentive compensation ban. They claim that the University "compensates enrollment counselors ... based directly upon enrollment activities," ranking counselors according to their number of enrollments and giving the highest-ranking counselors not only higher salaries but also benefits, incentives, and gifts. Relators allege that the University also "urges enrollment counselors to enroll students without reviewing their transcripts to determine their academic qualifications to attend the university," thus encouraging counselors to enroll students based on numbers alone. Relator Albertson, in particular, alleges that she was given a specific target number of students to recruit, and that upon reaching that benchmark her salary increased by more than $50,000. Relator Hendow specifically alleges that she won trips and home electronics as a result of enrolling large numbers of students.

Second, relators allege considerable fraud on the part of the University to mask its violation of the incentive compensation ban. They claim that the University's head of enrollment openly brags that "[i]t's all about the numbers. It will always be about the numbers. But we need to show the Department of Education what they want to see." To deceive the DOE, relators allege, the University creates two separate employment files for its enrollment counselors—one "real" file containing performance reviews based on improper quantitative factors, and one "fake" file containing performance reviews based on legitimate qualitative factors. The fake file is what the DOE allegedly sees. Relators further allege a series of University policy changes deliberately designed to obscure the fact that enrollment counselors are compensated on a per-student basis, such as altering pay scales to make it less obvious that they are adjusted based on the number of students enrolled.

Third and finally, relators allege that the University submits false claims to the government. Claims for payment of Title IV funds can be made in a number of ways, once a school signs its Program Participation Agreement and thus becomes eligible. For instance, in the Pell Grant context, students submit funding requests ***1170** directly (or with school assistance) to the DOE. In contrast, under the Federal Family Education Loan Program, which includes Stafford Loans, students and schools jointly submit an application to a private lender on behalf of the student, and a guaranty agency makes the eventual claim for payment to the United States only in the event of default. Relators allege that the University submits false claims in both of these ways. They claim that the University, with full knowledge that it is ineligible for Pell Grant funds because of its violation of the incentive compensation ban, submits requests for those funds directly to the DOE, resulting in a direct transfer of the funds into a University account. They further claim that the University, again with knowledge that it has intentionally violated the incentive compensation ban, submits requests to private lenders for government-insured loans.

On May 20, 2004, the district court dismissed the relators' complaint with prejudice under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim. Relators appealed on June 15, 2004. The United States Department of Justice submitted a brief as amicus curiae supporting the reversal of the district court. Because this case comes to us on a motion to dismiss, we assume that the facts as alleged are true, and examine only whether relators' allegations support a cause of action under the False Claims Act under either of two possible theories. *See* *Zimmerman v. City of Oakland,* 255 F.3d 734, 737 (9th Cir.2001) ("We review dismissals under Rule 12(b)(6) *de novo,* accepting as true all well-pleaded allegations of fact in the complaint and construing them in the light most favorable to the plaintiffs."). We hold that they do, and that either theory is viable.

II.

The district court below rejected both of relators' theories for why they have validly alleged that the University submitted false or fraudulent claims to the government in violation of the False Claims Act. First, the court rejected relators' claim under the "false certification" theory, as treated by this court in *United States ex rel. Hopper v. Anton,* 91 F.3d 1261, 1266 (9th Cir.1996), because the operative statute here "only requires that [the University] enter into an agreement, and does not require a certification." Second, the district court rejected relators' claim under the "promissory fraud" theory, because they did not "identif[y] any certification which is a prerequisite for [the University] to receive federal funds." These rulings conflated the proper analysis of False Claims Act liability, and so we will discuss the relevant theories in more detail.

[2] 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. *See* *Anton,* 91 F.3d at 1266. The False Claims Act, however, is not limited to such facially false or fraudulent claims for payment. *See id.* Rather, the False Claims Act is "intended to reach all types of fraud, without qualification, that might result in financial loss to the Government." *United States v. Neifert–White Co.,* 390 U.S. 228, 232, 88 S.Ct. 959, 19 L.Ed.2d 1061 (1968). More specifically, in amending the False Claims Act in 1986, Congress emphasized that the scope of false or fraudulent claims should be broadly construed:

> [E]ach and every claim submitted under a contract, loan guarantee, or other agreement which was originally obtained by means of false statements or other corrupt or fraudulent conduct, or in violation ***1171** of any statute or applicable regulation, constitutes a false claim.

S.Rep. No. 99–345, at 9 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5274.

The principles embodied in this broad construction of a "false or fraudulent claim" have given rise to two doctrines that attach potential False Claims Act liability to claims for payment that are not explicitly and/or independently false: (1) false certification (either express or implied); and (2) promissory fraud. *See* *Harrison v. Westinghouse Savannah River Co.,* 176 F.3d 776, 784 (4th Cir.1999).

A. False Certification

Many different courts have held that 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. *See, e.g.,* *id.* at 786; *Mikes v. Straus,* 274 F.3d 687, 697–700 (2d Cir.2001); *United States ex rel. Quinn v. Omnicare Inc.,* 382 F.3d 432, 441 (3d Cir.2004). The leading case on false certification in the Ninth Circuit is *United States ex rel. Hopper v. Anton.*

In *Anton,* a relator-plaintiff brought a False Claims Act suit against the Los Angeles Unified School District (LAUSD) for allegedly submitting false claims for federal funds while in knowing violation of an underlying statute granting funds for special education programs (the Individuals with Disabilities Education Act, "IDEA"). 91 F.3d at 1263. In particular, the relator alleged that LAUSD's method of evaluating potential student eligibility for the program violated the IDEA. *Id.* LAUSD allegedly (1) submitted forms stating the number of eligible students in the district; (2) cashed checks that were partially comprised of federal funds; and (3) submitted triennial certifications averring that LAUSD " 'will meet all applicable requirements of state and federal law and regulations,' including 'general compliance' with the IDEA." *Id.* at 1265. We held that False Claims Act liability can attach under the theory of false certification, although the relators had not presented sufficient evidence of fraud. *Id.*

In *Anton,* we explained the theory of false certification, identifying two major considerations: " '(1) whether the false statement is the cause of the Government's providing the benefit; and (2) whether any relation exists between the subject matter of the false statement and the event triggering Government's [sic] loss.' " *Id.* at 1266 (quoting John T. Boese, *Civil False Claims and Qui Tam Actions* 1–29 to 1–30 (1995)). We also held that "[m]ere regulatory violations do not give rise to a viable FCA action," but rather, "[i]t is the false *certification* of compliance which creates liability when certification is a prerequisite to obtaining a government benefit." *Id.* at 1266–67 (emphasis in original). From the principles underlying these two statements, we created four conditions necessary to succeed on the false certification theory of False Claims Act liability.

First, we emphasized the necessity of a *false* claim, rather than a mere unintentional violation. We did not hold in *Anton* that regulatory violations will go unchecked by the False Claims Act, but we did agree with the lower court's reasoning that for a "breach of contract, or violation of regulations or law, or receipt of money from the government" to give rise to an action under the False Claims Act, "[i]t requires a false claim." 91 F.3d at 1265. We went on to note that the "fatal defect" in *Anton* was not that the claimed infraction was a regulatory violation, but that there was a "lack of a false claim." *Id.* at 1267. Thus, we established that to succeed on a false certification theory, some falsity must be alleged.

Second, we emphasized the central importance of the scienter element to liability ***1172** under the False Claims Act, holding that false claims must in fact be "false when made." *Id.* (citing *United States v. Shah,* 44 F.3d 285, 290 (5th Cir.1995)). In fact, we held, "[f]or a certified statement to be 'false' under the Act, it must be an intentional, palpable lie." *Id.* (citing *Hagood v. Sonoma County Water Agency,* 81 F.3d 1465, 1478 (9th Cir.1996)). We also noted that "some request for payment containing falsities made with scienter (i.e., with knowledge of the falsity and with intent to deceive) must exist." *Id.* at 1265. In short, we made clear that a palpably false statement, known to be a lie when it is made, is required for a party to be found liable under the False Claims Act.

[3] **[4]** We note that the University and the district court below have taken our holdings to mean that the word "certification" has some paramount and talismanic significance, apparently believing that a palpably false *statement* does not bring with it False Claims liability, while a palpably false *certification* will. This facile distinction would make it all too easy for claimants to evade the law. The Fourth Circuit rightly noted that False Claims liability attaches "*because of the fraud* surrounding the efforts to obtain the contract or benefit status, or the payments thereunder." *Harrison,* 176 F.3d at 788 (emphasis added). That the theory of liability is commonly called "false certification" is no indication that "certification" is being used with technical precision, or as a term of art; the theory could just as easily be called the "false statement of compliance with a government regulation that is a precursor to government funding" theory, but that is not as succinct. Furthermore, because the word "certification" does not appear in 31 U.S.C. § 3729(a)(1) or (a)(2), there is no sense in parsing it with the close attention typically attending an exercise in statutory interpretation. So long as the statement in question is knowingly false when made, it matters not whether it is a certification, assertion, statement, or secret handshake; False Claims liability can attach.

Third, we held that the false statement or course of conduct must be material to the government's decision to pay out moneys to the claimant. This is plain from our focus on "(1) whether the false statement is the cause of the Government's providing the benefit; and (2) whether any relation exists between the subject matter of the false statement and the event triggering Government's [sic] loss." *Anton,* 91 F.3d at 1266. We also stated that the relevant certification of compliance must be both a "prerequisite to obtaining a government benefit," *id.,* and a "*sine qua non* of receipt of [government] funding," *id.* at 1267. We further held that the government funding must be "conditioned" upon certifications of compliance. *Id.*

This approach has been followed by a number of other circuits to adopt the false certification theory of false claims liability.[1] *See* *Mikes,* 274 F.3d at 699 (holding that false certification theory applies when "governing federal rules ... are a precondition to payment"); *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.,* 125 F.3d 899, 902 (5th Cir.1997) (holding that false claims liability attaches ***1173** only "where the government has conditioned payment of a claim upon a claimant's certification of compliance with ... a statute or regulation"); *Ab–Tech Constr., Inc. v. United States,* 31 Fed.Cl. 429, 434 (Fed.Cl.1994) (holding that false statement of compliance must be "critical to the decision to pay"), *aff'd,* 57 F.3d 1084 (Fed.Cir.1995). Once again, we note that there is no special significance to the term "certification" in determining materiality; the question is merely whether the false certification—or assertion, or statement—was relevant to the government's decision to confer a benefit.

Fourth and most obviously, for a false statement or course of action to be actionable under the false certification theory of false claims liability, it is necessary that it involve an actual *claim,* which is to say, a call on the government fisc. This is self-evident from the statutory language, of course, which requires a "claim paid or approved by the Government." 31

U.S.C. § 3729(a)(2). In *Anton,* the case involved direct receipt of federal funding, but we agree with the Fourth Circuit that a claim arises whenever the government is asked to "pay out money or to forfeit moneys due." *Harrison,* 176 F.3d at 788.

B. Promissory Fraud

[5] Another approach to finding False Claims Act liability in the absence of an explicitly false claim is the "promissory fraud" or "fraud-in-the-inducement" theory. This theory, rather than specifically requiring a false statement of compliance with government regulations, is somewhat broader. It holds that liability will attach to each claim submitted to the government under a contract, when the contract or extension of government benefit was originally obtained through false statements or fraudulent conduct. *See, e.g., id.,* 176 F.3d at 787; *United States ex rel. Marcus v. Hess,* 317 U.S. 537, 542, 63 S.Ct. 379, 87 L.Ed. 443 (1943). In *Hess,* the Supreme Court found contractors liable under the False Claims Act for claims submitted under government contracts that the defendants obtained via collusive bidding. *Id.* The Court determined that "[t]his fraud did not spend itself with the execution of the contract," and so each claim submitted under the contracts constituted a false or fraudulent claim. *Id.* at 543, 63 S.Ct. 379. In other words, subsequent claims are false because of an *original fraud* (whether a certification or otherwise).

The Seventh Circuit recently adopted a version of the promissory fraud theory in a case almost identical to this one, *United States ex rel. Main v. Oakland City Univ.,* 426 F.3d 914 (7th Cir.2005), *cert. denied,* 547 U.S. 1071, 126 S.Ct. 1786, 164 L.Ed.2d 519 (2006). Relators in *Main* alleged liability under the False Claims Act based on an Oakland City University representation that it would comply with the incentive compensation ban, despite its knowledge of the ban and intent not to comply. *See id.* at 916. As here, the district court dismissed the case for failure to state a claim, ruling that even willful falsehoods in a "phase-one application" do not violate the False Claims Act, because such an application requests a declaration of eligibility rather than an immediate payment from the treasury. *See id.* The district court further ruled that the "phase two" applications for funds are not false, because they do not repeat the assurance that the University abides by the rule against paying contingent fees to recruiters. *See id.*

The Seventh Circuit reversed, analyzing the claim under a promissory fraud theory, and holding that the relators had stated a claim based upon allegations of fraud in the inducement of the original Program Participation Agreement. *See id.* The court did not address the false certification theory directly, although it implicitly recognized ***1174** that the district court had rejected relator's arguments on that ground. Pursuant to the plain language of 31 U.S.C. § 3729(a)(2), the court determined that False Claims Act liability was clear: "[t]he University 'uses' its phase-one application (and the resulting certification of eligibility) when it makes (or 'causes' a student to make or use) a phase-two application for payment. No more is required under the statute." *Id.*

[6] We find the Seventh Circuit's reasoning in adopting the promissory fraud theory persuasive. We also note that the promissory fraud theory, in substance, is not so different from the false certification theory, and even requires the same elements. For instance: first, a claim must be false and, second, that falsity must be knowingly perpetrated. The Seventh Circuit opined eloquently on this point:

> To prevail in this suit [relator] must establish that the University not only knew ... that contingent fees to recruiters are forbidden, but also planned to continue paying those fees while keeping the Department of Education in the dark. This distinction is commonplace in private law: failure to honor one's promise is (just) breach of contract, but making a promise that one *intends* not to keep is fraud.... [I]f the University knew about the rule and told the Department that it would comply, while planning to do otherwise, it is exposed to penalties under the False Claims Act.

Id. at 917 (emphasis in original) (citations omitted). We, too, have held that for promissory fraud to be actionable under the False Claims Act, "the promise must be false when made." *Anton,* 91 F.3d at 1267. We have also noted that "[i]nnocent mistakes, mere negligent misrepresentations and differences in interpretations" are not sufficient for False Claims Act liability to attach. *Id.* In short, therefore, under a promissory fraud theory, relator must allege a false or fraudulent course of conduct, made with scienter.

[7] **[8]** **[9]** Third, as with the false certification theory, the promissory fraud theory requires that the underlying fraud be material to the government's decision to pay out moneys to the claimant. The Seventh Circuit in *Main* stated that the False Claims Act requires "a causal rather than a temporal connection between fraud and payment," 426 F.3d at 916, and we agree. And fourth and finally, there must exist a *claim*—a call on the government fisc. As the Seventh Circuit rightly noted, the precise logistical details of how the claim is made—with respect to timing, for instance, or the number of stages involved—are immaterial: "[i]f a false statement is integral to a causal chain leading to payment, it is irrelevant how the federal bureaucracy has apportioned the statements among layers of paperwork." *Id.* In other words, for there to exist a "claim" for purposes of False Claims Act liability, it must involve merely some sort of request for the government to pay out money or forfeit moneys due.

III.

[10] Thus, as the above analysis shows, under either the false certification theory or the promissory fraud theory, the essential elements of False Claims Act liability remain the same: (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 forfeit moneys due. The question remaining is whether relators in this case have alleged facts satisfying all four of these elements.

A. Falsity

[11] Relators allege a false statement or course of conduct. They allege that the University violates a statutory requirement, ***1175** the incentive compensation ban, to which it agreed in writing in the Program Participation Agreement. They allege that the University establishes policies of violating that requirement, and encourages its employees to violate that requirement. They allege specific instances of violation, where higher salaries, benefits, and incentives were given in response to increased enrollment. And they allege that the University did so knowingly, and with the specific intent to deceive the government. Thus, relators properly allege a false statement or course of conduct.

B. Scienter

[12] Relators allege a false statement or course of conduct made knowingly and intentionally. They allege that University staff openly bragged about perpetrating a fraud, that the University had an established infrastructure to deceive the government, and that the University repeatedly changed its policies to hide its fraud. In other words, relators allege that the University provided statements to the government that were "intentional, palpable lie[s]," made with "knowledge of the falsity and with intent to deceive." *Anton,* 91 F.3d at 1265, 1267.

The University argues that the incentive compensation ban is nothing more than one of hundreds of boilerplate requirements with which it promises compliance. This may be true, but fraud is fraud, regardless of how "small." The University is worried that our holding today opens it up to greater liability for innocent regulatory violations, but that is not the case—as we held above, innocent or unintentional violations do not lead to False Claims Act liability. But that is no reason to innoculate institutions of higher education from liability when they *knowingly* violate a regulatory condition, with the intent to deceive, as is alleged here. Relators properly allege false statements or courses of conduct made with scienter.

C. Materiality

[13] Most of the argument in this case centers on whether and how much the University's alleged fraud was material to the government's decision to disburse federal funds. The parties argue at length over, for instance, the enforcement power of the DOE, and whether its authority to take "emergency action"—to withhold funds or impose sanctions where it has information that statutory requirements are being violated—means that the statutory requirements are causally related to its decision to pay out moneys due.

These questions of enforcement power are largely academic, because the eligibility of the University under Title IV and the Higher Education Act of 1965—and thus, the funding that is associated with such eligibility—is *explicitly* conditioned, in three different ways, on compliance with the incentive compensation ban. First, a federal statute states that in order to be eligible, an institution must

> enter into a program participation agreement with the Secretary [of Education]. The agreement *shall condition* the initial and continuing eligibility of an institution to participate in a program *upon compliance* with the following requirements ... [including the incentive compensation ban.]

20 U.S.C. § 1094(a) (emphasis added). Second, a federal regulation specifies:

> An institution may participate in any Title IV, HEA program ... *only if* the institution enters into a written program participation agreement with the Secretary.... A program participation agreement *conditions* the initial and continued participation of an eligible institution in any Title IV, HEA program *upon compliance* with the provisions of this part [such as the incentive compensation ban.]

***1176** 34 C.F.R. § 668.14(a)(1) (emphasis added). Third and finally, the program participation agreement itself states:

> The execution of this Agreement [which contains a reference to the incentive compensation ban] by the Institution and the Secretary is a *prerequisite* to the Institution's initial or continued participation in any Title IV, HEA program.

(emphasis added). All of the emphasized phrases in the above passages demonstrate that compliance with the incentive compensation ban is a necessary condition of continued eligibility and participation: compliance is a "prerequisite" to funding; funding shall occur "only if" the University complies; funding shall be "condition[ed] ... upon compliance." These are not ambiguous exhortations of an amorphous duty. The statute, regulation, and agreement here all explicitly condition participation and payment on compliance with, among other things, the precise requirement that relators allege that the University knowingly disregarded.

The University argues that the ban is merely a condition of *participation,* not a condition of *payment.* But in this case, that is a distinction without a difference. In the context of Title IV and the Higher Education Act, if we held that conditions of participation were not conditions of payment, there would be no conditions of payment at all—and thus, an educational institution could flout the law at will.

To see why this is so, one only need look at the University's semantic argument, in which it claims that for a condition of participation, an institution says it " '*will* ' comply" with various statutes and regulations, but for a condition of payment, an institution says that it "*has* complied." This grammatical haggling is unmoored in the law, and it is undercut by the Program Participation Agreement itself. In the section that the University concedes contains conditions of payment—the section entitled "Certifications Required From Institutions"—the University agrees that it "will" or "shall" comply with various regulations no less than six times. Under the University's logic, these future-tense assertions could not be conditions of payment, and yet it concedes that they are. Its concession is correct; these, and all other promises to comply with the Program Participation Agreement, are conditions of payment. These conditions are also "prerequisites," and "the *sine qua non* " of federal funding, for one basic reason: if the University had not agreed to comply with them, it would not have gotten paid.

Furthermore, we take the University's argument to mean that it believes if it had signed an agreement that stated "the University of Phoenix certifies that it has complied with the incentive compensation ban," then it would have signed a condition of payment. But the DOE and the United States Congress, as evidenced by the statutes, regulations, and contracts implementing the Title IV and Higher Education Act requirements for funding, quite plainly care about an institution's ongoing conduct, not only its past compliance. For purposes of federal funding, the University is not permitted to merely have a history of compliance with the applicable regulations; it must also agree to comply in the future. The Program Participation Agreement, constraining its ongoing conduct, is the condition of payment that the federal government requires—a promise that the University shall not break the law, not merely an assertion that it has not broken the law *yet.* If such promises were not conditions of payment, the University would be virtually unfettered in its ability to receive funds from the government while flouting the law. This cannot be what Congress and the DOE intend when ***1177** they ask institutions to sign Program Participation Agreements.

Nor was such laissez-faire compliance what the Second Circuit had in mind, we think, when it developed the "participation versus payment" distinction in the first place. The case in which that distinction was first mentioned, *Mikes v. Straus,* is completely distinguishable from the case before us. There, in the Medicare context, the defendant was subject to a statutory requirement that stated:

> "[i]t shall be the obligation" of a practitioner who provides a medical service "for which payment may be made ... to assure" compliance with [42 U.S.C. § 1320c–5(a)].

274 F.3d. at 701. "Compliance," in that instance, meant maintaining an appropriate standard of care, which was ensured by peer review and extensive monitoring. Dereliction of that duty would result in sanctions only where "a violation was especially gross and flagrant." *Id.* at 702. Defendants were accused of not maintaining the appropriate standard of care, but the Second Circuit held that such a violation could not constitute a breach of a condition of payment under the Medicare statute. This makes sense for two interrelated reasons. First, the statutory duty was not to promise *compliance,* but to promise *assurance* of compliance. The fact that defendants did not meet the appropriate standard of care does not necessarily mean that they were ignoring their duty to try their best to comply; rather, it may have indicated merely that they were not doing a very good job. If the allegation had been that the defendants in *Mikes* were not even trying to comply—that they were not only failing to provide the appropriate standard of care, but also affirmatively and knowingly choosing not to—we imagine the *Mikes* case would have come out differently.

And even if it would not have, the *Mikes* court was dealing with the Medicare context, to which the court specifically confined its reasoning. *Id.* at 700. It imposed an additional requirement on Medicare cases: that the underlying statute "expressly" condition payment on compliance. An explicit statement, however, is not necessary to make a statutory requirement a condition of payment, and we have never held as much.

Therefore, because relators have alleged that the University fraudulently violated a regulation upon which payment is expressly conditioned in three different ways, we hold that they have properly alleged the University engaged in statements or courses of conduct that were *material* to the government's decision with regard to funding.

D. Claim

[14] Finally, relators allege that the University submitted a claim against the government fisc. Relators allege that the University submits false claims in a number of ways—either by submitting requests for Pell Grant funds directly to DOE, resulting in a direct transfer of the funds into a University account, or by submitting requests to private lenders for government-insured loans. We agree with the Seventh Circuit that "it is irrelevant how the federal bureaucracy has apportioned the statements among layers of paperwork." *Main,* 426 F.3d at 916. All that matters is whether the false statement or course of conduct causes the government to "pay out money or to forfeit moneys due." *Harrison,* 176 F.3d at 788. Relators have properly alleged that the University submitted a claim, for purposes of False Claims Act liability.

IV.

Accordingly, because relators in this case have properly alleged (1) a false statement ***1178** or fraudulent course of conduct, (2) made with scienter, (3) that was material, causing (4) the government to pay out money or forfeit moneys due, their cause of action under the False Claims Act survives a motion to dismiss, and the decision of the district court is

REVERSED.

All Citations

461 F.3d 1166, 212 Ed. Law Rep. 193, 06 Cal. Daily Op. Serv. 8313, 2006 Daily Journal D.A.R. 12,004

Footnotes

1 Some courts, such as the Court of Federal Claims, have adopted a version of the false certification theory whereby the certification need only be implied, rather than express. In those cases, if a party submits a claim for payment under a government program with requirements for participation, that claim is taken as an implied certification that the party was in compliance with those program requirements. *See* *Ab–Tech Constr., Inc. v. United States,* 31 Fed.Cl. 429, 434 (Fed.Cl.1994). Here, we need not address the viability of this theory, because it is beyond dispute that the University signed the written Program Participation Agreement, thus making an express statement of compliance.

UNITED STATES of America, ex rel. Edyth L. SIKKENGA, and Edyth L. Sikkenga, on her own behalf, Plaintiffs–Appellants,

v.

REGENCE BLUECROSS BLUESHIELD OF UTAH, formerly known as Blue Cross and Blue Shield of Utah; Associated Regional and University Pathologists, Inc.; John P. Mitchell; Jed H. Pitcher; and Frank Brown, Defendants–Appellees.

United States of America; Taxpayers Against Fraud Education Fund; Adminastar Federal, Inc.; Bluecross Blueshield Association; Blue Cross and Blue Shield of Alabama; Blue Cross and Blue Shield of Kansas; Bluecross Blueshield of Montana; Bluecross Blueshield of Nebraska; Bluecross Blueshield of Tennessee; Healthnow New York, Inc.; Mutual of Omaha Insurance Company; Noridian Mutual Insurance Company; Premera Bluecross; United Government Services, L.L.C.; Wisconsin Physicians Service Insurance Corporation; Jon M. Huntsman, Jr., Governor of Utah, Amici Curiae.

No. 05–4088.

United States Court of Appeals,
Tenth Circuit.

Dec. 5, 2006.

Background: Private relator brought qui tam suit under False Claims Act (FCA) against laboratory owned by state university, alleging that laboratory obtained payment from Medicare provider for inadequately documented tests. The United States District Court for the District of Utah, Dale A. Kimball, J., 334 F.Supp.2d 1278, dismissed action. Relator appealed.

Holdings: The Court of Appeals, Lucero, Circuit Judge, held that:

(1) complaint alleged that insurer "caused" illegal presentation of claim;

(2) provider's querying actions did not constitute false claim;

(3) laboratory was not "arm of the state";

(4) tolling provision was inapplicable;

(5) relator failed to identify particular claims that were allegedly false;

(6) provider did not violate FCA whistleblower provision; and

(7) relator alleged violation of clear and substantial public policy.

Affirmed in part, reversed in part, and remanded.

Hartz, Circuit Judge, filed opinion concurring in part and dissenting in part.

1. United States ⟹50.5(5)

Statutory immunity available to Medicare carrier is co-extensive with that of its certifying and disbursing officers, and excludes cases involving fraud and gross negligence. Social Security Act, § 1842(e)(3), 42 U.S.C.A. § 1395u(e)(3).

2. United States ⟹120.1

Mere knowledge of submission of claims and knowledge of falsity of those claims is insufficient to establish liability under False Claims Act (FCA); rather, appropriate focus of inquiry is on specific conduct of person from whom government seeks to collect. 31 U.S.C.A. § 3729(a)(1).

3. United States ⟹122

Qui tam relator who sued laboratory owned by state university, alleging that laboratory obtained payment from Medicare provider for inadequately documented tests, sufficiently alleged "causing to be presented" claim under False Claims Act (FCA); complaint averred that provider agreed to circumvent contractual and statutory requirements, assuring laboratory that it would continue to accept claims with disputed code. 31 U.S.C.A. § 3729(a)(1).

4. United States ⚷120.1

Medicare provider's querying actions did not constitute presentation or knowing, making, or using of false record to get claim to government paid or approved, for purposes of False Claims Act (FCA); query was designed to improve accuracy and timeliness of Medicare claims processing by reducing payment errors and providing carriers with updated entitlement and eligibility data on beneficiaries. 31 U.S.C.A. § 3729(a)(2).

5. United States ⚷122

Eleventh Amendment arm-of-the-state analysis may be used in determining whether entity is part of state or state agency, and therefore not "person" who may be sued under False Claims Act (FCA). U.S.C.A. Const.Amend. 11; 31 U.S.C.A. § 3729 et seq.

6. United States ⚷122

Laboratory, although wholly-owned corporation of state university, was not "arm of the state," due to its anticipated and actual financial independence, and thus was "person" against which suit could be brought by private relator under False Claims Act (FCA); state treasury was not legally liable for any judgment against laboratory, laboratory retained substantial autonomy in its operations, and laboratory generated operating funds and profit through its own commercial activity. 31 U.S.C.A. § 3729 et seq.

See publication Words and Phrases for other judicial constructions and definitions.

7. Limitation of Actions ⚷100(1)

Tolling provision of False Claims Act (FCA) statute of limitations, based on when facts material to action were known or should have been known, was inapplicable to claim brought by qui tam relator against laboratory owned by state university, alleging that laboratory obtained payment from Medicare provider for inadequately documented tests, with respect to purported false budget request; provision was intended to apply only to United States government, not to relators. 31 U.S.C.A. § 3731(b)(2).

8. Federal Civil Procedure ⚷636

Qui tam relator who sued laboratory owned by state university under False Claims Act (FCA), alleging that laboratory obtained payment from Medicare provider for inadequately documented tests, failed to identify particular claims that were allegedly false, as required under federal rules; averments that provider fraudulently avoided Contractor Performance Evaluation Program (CPEP) score reductions were impermissibly speculative and conclusory. 31 U.S.C.A. § 3729 et seq.; Fed. Rules Civ.Proc.Rule 9(b), 28 U.S.C.A.

9. Federal Civil Procedure ⚷636

Underlying schemes and other wrongful activities that result in submission of fraudulent claims, as element of False Claims Act (FCA) claim, are included in "circumstances constituting fraud and mistake" that must be pled with particularity under federal rules. 31 U.S.C.A. § 3729 et seq.; Fed.Rules Civ.Proc.Rule 9(b), 28 U.S.C.A.

See publication Words and Phrases for other judicial constructions and definitions.

10. Labor and Employment ⚷777

Relator who sued laboratory owned by state university, alleging that laboratory obtained payment from Medicare provider for inadequately documented tests, failed to allege that provider for whom she worked was on notice that she was acting in furtherance of private qui tam or government action, as required to state claim under False Claims Act (FCA) whistleblower provision; relator did not aver that she informed superiors of her intention to bring FCA action, or that she was going to report provider's non-compliance to government officials. 31 U.S.C.A. § 3730(h).

11. Labor and Employment ⚷759

In order to prove wrongful discharge under Utah law, plaintiff must show that: (1) her employment was terminated; (2) clear and substantial public policy existed; (3) plaintiff's conduct implicated that policy; and (4) termination and conduct in furtherance of policy are causally connected.

12. Labor and Employment ⚷759

Under Utah law, public policy exception to employment at will presumption, for purposes of wrongful termination claim, is much narrower than traditional notions of public policy, and is to be narrowly construed.

13. Labor and Employment ⚷759

Under Utah law governing wrongful termination, "clear public policy," for purposes of exception to employment at will presumption, must be plainly defined by one of three sources: (1) legislative enactments; (2) constitutional standards; or (3) judicial decisions.

See publication Words and Phrases for other judicial constructions and definitions.

14. Labor and Employment ⚷759

Under Utah law governing wrongful termination, public policy, for purposes of exception to employment at will presumption, is "substantial" only if it is of overreaching importance to public, as opposed to parties only.

See publication Words and Phrases for other judicial constructions and definitions.

15. Labor and Employment ⚷873

Under Utah law, issue whether clear and substantial public policy exists to support employee's wrongful termination claim is question of law.

16. Labor and Employment ⚷858

Qui tam relator who sued laboratory owned by state university, alleging that laboratory obtained payment from Medicare provider for inadequately documented tests, alleged clear and substantial public policy offended by provider's termination of her employment, as required to state claim for wrongful termination under Utah law; complaint averred that provider caused laboratory to present false or fraudulent claims to United States in violation of False Claims Act (FCA). 31 U.S.C.A. § 3729 et seq.

Arthur J. England, Jr., Greenberg Traurig, L.L.C., Miami, Florida; and Daniel L. Day, Murray, Utah (David K. Isom, Greenberg Traurig, L.L.C., Denver, Colorado; Matthew R. Howell, Fillmore Spencer, L.L.C., Provo Utah; Roger H. Hoole, Hoole & King, L.C., Salt Lake City, Utah, with them on the briefs) for Plaintiffs–Appellants.

Robert K. Huffman, Miller & Chevalier Chartered, Washington, D.C., (Randy L. Dryer and James T. Blanch, Parsons Behle & Latimer, Salt Lake City, Utah, with him on the brief), for Defendants–Appellees Regence Bluecross Blueshield of Utah, John P. Mitchell, Jed H. Pitcher, and Frank Brown.

James Jardine, Ray Quinney & Nebeker, P.C., Salt Lake City, Utah for Defendant–Appellee Associated Regional and University Pathologists, Inc.

Charles W. Scarborough, Appellate Division, Department of Justice, Washington, D.C., (Paul M. Warner, United States Attorney, District of Utah, Salt Lake City, Utah; Peter D. Keisler and Douglas N. Letter, Department of Justice, Civil Division, Washington, D.C., with him on the brief), for amicus curiae the United States of America on behalf of Plaintiffs–Appellants.

James Moorman, and Joseph E.B. White, Taxpayers Against Fraud Education Fund, Washington, D.C., filed an amicus curiae brief for Taxpayers Against Fraud Education Fund on behalf of Plaintiffs–Appellants.

Michael S. Lee, General Counsel to the Governor, Salt Lake City, Utah, for amicus curiae Jon M. Huntsman, Jr., Governor of Utah on behalf of Defendant–Appellee Associated Regional and University Pathologists, Inc.

Gary L. Ayers, Foulston Siefkin, L.L.P., Wichita, Kansas, filed an amicus curiae brief for Adminastar Federal, Inc., Bluecross Blueshield Association, Blue Cross and Blue Shield of Alabama, Blue Cross and Blue Shield of Kansas, Bluecross Blueshield of Montana, Bluecross Blueshield of Nebraska, Bluecross Blueshield of Tennessee, Healthnow New York Inc., Mutual of Omaha Insurance Company, Noridian Mutual Insurance Company, Premera Bluecross, United Government Services, L.L.C., and Wisconsin Physicians Service Insurance Corporation on behalf of Defendant–Appellee Regence Bluecross Blueshield of Utah.

Before LUCERO, PORFILIO, and HARTZ, Circuit Judges.

LUCERO, Circuit Judge.

Concerned that "two companies [were] bilking the United States out of millions of dollars," Edyth Sikkenga brought suit under the False Claims Act ("FCA"), 31 U.S.C. § 3729(a), alleging that her former employer, Regence BlueCross BlueShield of Utah ("Regence"), three Regence managers, and Associated Regional and University Pathologists ("ARUP") presented false Medicare claims to the Government. Sikkenga also presented the claim that Regence submitted a false budget payment request to the Health Care Financing Authority ("HCFA"),[1] the agency that manages Medicare, and fraudulently avoided adverse contract action by HCFA by backdating and falsifying documents to manipulate its contract performance ratings. She also alleged that Regence retaliated against her by terminating her employment after she took actions to stop this "fraud." The district court dismissed her claim against ARUP, finding that it was not a "person" subject to liability under the FCA because it is an arm-of-the-state. The court dismissed all claims against Regence and the Regence employees, finding that Regence was immune from suit under 42 U.S.C. § 1395u(e), and that Sikkenga did not trigger the whisteblower provision of 31 U.S.C. § 3730(h) because she did not allege that she notified Regence of her intent to file an FCA claim. Sikkenga's state law claim was also dismissed on the basis that she failed to allege a clear and substantial public policy offended by Regence in Sikkenga's termination. Exercising jurisdiction under 28 U.S.C. § 1291, we **AFFIRM** the district court's dismissal of Sikkenga's false budget claim, its dismissal of her whistleblower claim, and its dismissal of her contract performance score manipulation claim. We **REVERSE** the lower court's dismissal of Sikkenga's claim against ARUP, her claim that Regence and its managers caused false claims to be

1. In 2001 this agency was renamed the Centers for Medicare and Medicaid Services.

presented, and her state law claim for wrongful termination, and **REMAND** for further proceedings consistent with this decision.

I

Medicare is a federal insurance program which provides health benefits for elderly and disabled individuals. *See* 42 U.S.C. §§ 1395 *et seq.* The program is administered through private organizations contracted by the Department of Health and Human Services.[2] Medicare Part A provides for basic in-patient hospital services, nursing home and hospice care, and, in some instances, home health services. Part B, a voluntary supplemental program, provides reimbursement for outpatient hospital services, services of physicians and other health care professionals, and certain durable medical supplies and equipment. For five years, Sikkenga worked for Regence, the Medicare carrier for the State of Utah. Sikkenga's job included reviewing claims submitted by medical service providers, including laboratories such as ARUP, a laboratory entirely owned by, and located at the University of Utah Medical Center. After complaining internally that ARUP was presenting false claims for Medicare reimbursement, and that Regence had failed to take appropriate action to stop this "fraud," Sikkenga filed suit as a qui tam relator[3] under the FCA, 31 U.S.C. § 3729(a), against Regence, three Regence managers,[4] and ARUP. In her individual capacity, Sikkenga also brought an FCA whistleblower retaliation suit and several state law actions against Regence and its managers.

Sikkenga brought four claims under the FCA, including a whistleblower claim, and several state law claims. In her first FCA cause of action ("Claim 1"), Sikkenga alleged that Regence and ARUP violated the FCA when Regence paid claims for laboratory testing submitted by ARUP that were improper under Medicare Part B. Specifically, Sikkenga alleged that ARUP used a diagnostic code to falsely document the medical necessity of thousands of claims where ARUP did not obtain that code from the referring physician and the code did not document the true medical necessity of the test performed. Sikkenga also claimed that ARUP falsely submitted to Regence, a Medicare Part B carrier, various claims related to renal failure under a code suggesting that the patient was involved in a kidney transplant, when such a procedure should have been paid through Medicare Part A, not Part B. After amending her complaint, Sikkenga also asserted that Regence "caused" ARUP to present

2. Prior to 2003, Part A was administered by organizations known as "fiscal intermediaries" and Part B by organizations known as "carriers." *See Blue Cross and Blue Shield of Maryland, Inc. v. United States Dep't of Health & Human Servs.*, 718 F.Supp. 80 (D.D.C. 1989). Carriers and intermediaries are now collectively called "medicare administrative contractors." 42 U.S.C. §§ 1395h(a), 1395u(a), 1395kk–1.

3. Under the FCA, an action can be commenced either by the United States itself, or as a qui tam action, by a private person, or "relator," acting "for the person and for the United States Government" against the alleged false claimant "in the name of the Government." *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765, 768, 120 S.Ct. 1858, 146 L.Ed.2d 836 (2000). Sikkenga filed her Complaint against the Regence defendants and ARUP under seal pursuant to the qui tam provisions of the FCA. The United States declined to intervene and the complaint was unsealed and served on the defendants.

4. The three Regence managers are John Mitchell ("Mitchell"), Jed H. Pitcher ("Pitcher"), and Frank Brown ("Brown").

these false claims.[5] She further argued that Regence's query of a Medicare database amounted to an independent presentation of a false claim to the government, or the use of a false record to get a false claim paid by the government under the FCA.

In her second FCA cause of action ("Claim 2"), Sikkenga alleged that Regence directly submitted a false budget request in 1992, in connection with an Early Claims Review process. Her third cause of action ("Claim 3") alleged that Regence fraudulently avoided Contractor Performance Evaluation Program ("CPEP") score reductions by backdating a letter involving a Comprehensive Medical Review and paying ARUP's claims as "adjustments" rather than "reviews." In essence, Sikkenga claimed that by manipulating its CPEP scores, Regence was able to obtain unmerited renewals of its contract as the Medicare Part B carrier for Utah, and that all claims for administrative costs under the contract thereafter were fraudulent. Finally, Sikkenga also asserted an FCA Whistleblower retaliation claim ("Claim 4"). Sikkenga abandons most of her state law claims, appealing only the district court's dismissal of her wrongful termination in violation of public policy claim.[6]

The district court dismissed Claim 1 because it determined that both Regence and the Regence managers were immune from suit and that ARUP was not a "person" under the FCA; Claim 2 because it was barred by the FCA's statute of limitations; Claim 3 because Sikkenga failed to allege fraud with the particularity required under Federal Rule of Civil Procedure 9(b); and Claim 4 because Sikkenga had not alleged that she had notified Regence of her intent to file an FCA claim. Because there were no grounds to suggest that Sikkenga's termination was in violation of a clear and substantial public policy absent an underlying FCA claim, the court dismissed her state law wrongful termination claim as well. We review Sikkenga's appeal of each of these dismissals.

II

Sikkenga contends that the district court made three errors in dismissing Claim 1, her FCA claim that ARUP submitted "false" claims to Regence and that Regence paid them. First, she argues that the district court erred in ruling that Medicare Part B's immunity provision, 42 U.S.C. § 1395u(e),[7] provided Regence with

5. The district court allowed Sikkenga to amend her complaint to cure failings in the allegations under Federal Rule of Civil Procedure 12(b)(6) and a lack of particularity for her "causing to be presented" FCA claims under Federal Rule of Civil Procedure 9(b). Sikkenga's initial complaint also included a conspiracy allegation. That claim was dismissed by the district court under Rule 12(b)(6), was not reasserted by Sikkenga in her amended complaint, and is not a subject of this appeal.

6. Sikkenga's four state law causes of action were: wrongful termination in violation of public policy, breach of contract for failure to pay accrued vacation pay, intentional infliction of emotional distress, and breach of the implied covenant of good faith and fair dealing in the employment contract.

7. The enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub.L. 108–173, 117 Stat.2066 (2003), alters the language of the immunity provision made applicable to "medicare administrative contractors":

(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—

(A) IN GENERAL.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer, unless in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under the medicare absolute immunity from any suit premised on its payment of ARUP's claims. Second, Sikkenga contends that the court erred when it ruled, under Rule 12(b)(6), that she had failed to adequately allege that Regence had "caused" ARUP to present false claims. Finally, Sikkenga appeals the district court's determination that ARUP was an arm-of-the-state and therefore not a "person" liable under the FCA.

A

Regence has been the major Medicare Part B carrier for Utah since 1987, pursuant to a contract with the Department of Health and Human Services' Health Care Financing Administration ("HCFA"). Under its contract, Regence was responsible for processing and paying Medicare Part B claims submitted by medical care providers. As part of its claims evaluation process, Regence was contractually obligated to ensure that claims were paid only for medically necessary care—a requirement for reimbursement under the Medicare program.

From June 20, 1990, until she was terminated on April 4, 1995, Sikkenga worked for Regence in its Medicare Part B Review and Analysis Division. During her employment, Sikkenga became concerned that Regence was paying ARUP for laboratory testing claims that did not adequately document their medical necessity, and were potentially improper under Medicare Part B. Specifically, Sikkenga was concerned that ARUP was using a generic ICD–9 code 796.4 "other abnormal clinical finding," to document the medical necessity of thousands of claims when a more specific code was applicable.[8] Sikkenga thought that claims using this generic code, when ARUP had not obtained the code from the referring physician, did not document the true medical necessity of the test performed, and as such were not properly payable under Medicare Part B. Sikkenga also suspected that ARUP falsely submitted various ICD–9 codes related to renal failure in connection with CPT code 86317, a code suggesting that the patient was involved in a kidney transplant, a procedure that should have been paid through Medicare Part A, rather than Part B.[9] Because of her concern that these claims were fraudulent, Sikkenga implemented internal audits to more closely

administrative contract or with intent to defraud the United States.

(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code.

42 U.S.C. § 1395kk–1(d)(3).

The 2003 amendments to the Medicare Act did not go into effect until October 2005, and do not apply retroactively to cases alleging fraud by a contractor prior to that date. Additionally, the Centers for Medicare and Medicaid Services, the new name for the reorganized HCFA, has until 2011 to phase in new contracts with medicare administrative contractors. Therefore, our interpretation of the immunity provision under § 1395u(e)(3) will apply to actions brought under existing or older contracts for the near future.

8. ICD–9–CM codes refers to the International Classification of Diseases, Ninth Revision, Clinical Modification codes, a coding system used to describe the diagnosis or medical condition for which medical services are rendered when Medicare claims are submitted to Medicare carriers. Such codes are not required from independent clinical laboratories for non-physician services, but can be used by them to document medical services. *See* 42 C.F.R. §§ 424.3, 424.32.

9. CPT codes refer to "Current Procedural Technology" codes, which describe medical services such as treatments, tests, and procedures, and are an accepted means of reporting such medical services to government and health insurance programs.

evaluate ARUP's claims using the suspect codes, referred the matter to Regence's internal fraud and abuse section, discussed the matter with her supervisors within Regence, and instructed ARUP to change its billing practices. Sikkenga claims that she was ultimately terminated from her position with Regence in April 1995 because of her managers' dissatisfaction with her actions regarding ARUP.

B

The FCA imposes liability on any person who "knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a)(1), or "knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government." 31 U.S.C. § 3729(a)(2). In her first FCA claim, Sikkenga alleged that Regence and the individual defendants had violated the FCA by paying false claims involving the 796.4 codes and renal failure tests. Relying on *United States ex rel. Body v. Blue Cross and Blue Shield of Alabama, Inc.,* 156 F.3d 1098 (11th Cir.1998), the district court interpreted the Medicare immunity provision, 42 U.S.C. § 1395u(e), to provide absolute immunity to Medicare contractors' payments of claims. On that basis, the court found that Regence and the individual defendants were immune from suit as to any claims based on Regence's payment of the allegedly false claims, interpreting that provision to provide absolute immunity to a Medicare contractor's payment of a claim. The version of Medicare's statutory immunity provision in effect at the time of this case states:

> (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.
>
> (2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.
>
> (3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

42 U.S.C. § 1395u(e) (1999).

In *Body,* the Eleventh Circuit held that Medicare's Part A immunity provision, 42 U.S.C. § 1395h(i)(3),[10] unambiguously provided absolute immunity to Medicare fiscal intermediaries, in contrast to the express limitation present in §§ 1395h(i)(1) and (2), which provided immunity for payments by certifying or disbursing officers only in the absence of gross negligence or intent to defraud. *Body,* 156 F.3d at 1112. Sikkenga contends that the district court misinterpreted § 1395u(e)(3), and that the immunity conferred on Medicare carriers by this provision does not extend to circumstances involving gross negligence or an intent to defraud the United States.

10. The statutory language of the Medicare Part A immunity provision is essentially identical to the Part B immunity provision. Section 1395h(i) differs from § 1395u(e) only in substituting "an agreement" for "a contract" and "agency or organization" for "carrier." Under the doctrine of in pari materia we give these statutes the same interpretation and refer to them interchangeably hereinafter. *See United States ex rel. Rahman v. Oncology Assocs.,* 198 F.3d 502, 512 n. 2 (4th Cir.1999) (discussing cases in which courts have treated Part A fiscal intermediaries and Part B carriers equivalently).

"We review the district court's interpretation of a federal statute de novo." *United States v. Quarrell,* 310 F.3d 664, 669 (10th Cir.2002). In interpreting statutes our primary task is to "determine congressional intent, using traditional tools of statutory interpretation." *McGraw v. Barnhart,* 450 F.3d 493, 498 (10th Cir.2006). "When interpreting the language of a statute, the starting point is always the language of the statute itself. If the language is clear and unambiguous, the plain meaning of the statute controls. A statute is ambiguous when it is capable of being understood by reasonably well-informed persons in two or more different senses." *Id. (quoting Quarrell,* 310 F.3d at 669). "If an ambiguity is found, a court may seek guidance from Congress's intent, a task aided by reviewing the legislative history. A court can also resolve ambiguities by looking at the purpose behind the statute." *Id.* at 499.

To decide the extent of immunity conferred upon Medicare Part B carriers, we look to the text of § 1395u(e)(3), specifically, what is meant by its incorporation of the phrase "any payments referred to in paragraph (1) or (2)." *Body* looked solely to the text of § 1395h(i)(3) and held that the absence of the qualifying language present in the first two paragraphs was determinative. Although we agree with the Eleventh Circuit that §§ 1395h(i)(3) and 1395u(e)(3) are unambiguous, we disagree that they do not include the gross negligence and fraud exception. This is made clear by restating § 1395u(e) to avoid the egregious use of the split infinitive:

> (1) In the absence of gross negligence or intent to defraud the United States, no individual designated pursuant to a contract under this section as a certifying officer shall be liable with respect to any payments certified by him under this section.
>
> (2) In the absence of gross negligence or intent to defraud the United States, no disbursing officer shall be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.
>
> (3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

Correctly read, the payments referred to and incorporated by § 1395u(e)(3) are payments made "in the absence of gross negligence or intent to defraud the United States."

[1] To the extent that our disagreement with the Eleventh Circuit can be said to evince ambiguity in the statute, *see Quarrell,* 310 F.3d at 669 ("A statute is ambiguous when it is capable of being understood by reasonably well-informed persons in two or more different senses.") (internal quotations omitted), we find support for our interpretation in the legislative history of this provision. *See United States v. Roberts,* 88 F.3d 872, 877 (10th Cir.1996) ("Only if the statutory language is ambiguous should a court turn to legislative history as an aid in determining the statute's meaning."). In the House Conference Report accompanying the passage of § 1395u(e)(3), the committee stated that this provision provides carriers with "the same immunity from liability for incorrect payments as would be provided their certifying and disbursing officers." [11] H.R.Rep.

11. The language in § 1395u(e)(3) was not included in the original draft of House Resolution 6675 (Social Security Amendments of 1965). H.R.Rep. No. 89–213, at 148, 160 (1965) (Section analysis of §§ 1816(g)(1), (2) and 1842(e)(1), (2)). Section 1842(e)(3) of H.R. 6675, applicable to carriers under Medicare Part B, ultimately became codified at 42

No. 89–682, at 37 (1965) (Conf.Rep.), *as reprinted in* 1965 U.S.C.C.A.N. 2228, 2231. Thus, the legislative history unequivocally resolves any ambiguity that might exist because of the statute's poor grammatical structure. The immunity available to Regence as a Medicare carrier under § 1395u(e)(3) is co-extensive with that of its certifying and disbursing officers—in other words, the immunity excludes cases involving fraud and gross negligence.[12]

U.S.C. § 1395u(e)(3), the provision we are interpreting. Section 1816(g)(3) applied to fiscal intermediaries under Medicare Part A became codified at 42 U.S.C. § 1395h(i)(3). On May 17, 1965, Assistant Secretary of the Department of Health, Education, and Welfare (''HEW''), Wilbur Cohen, fulfilling a promise made to the Senate Finance Committee by the Secretary of HEW, forwarded recommended clarifying and technical changes to the resolution in a letter from HEW to the Chairman of the Committee. The title of the relevant proposed amendment was: ''Provide that an employing agency of certifying or disbursing officer would be excused from liability when such officer is excused.'' The text of the change was: ''(3) No carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).'' *A Bill to Provide a Hospital Insurance Program for the Aged Under the Social Security Act with a Supplementary Health Benefits Program and an Expanded Program of Medical Assistance, to Increase Benefits Under the Old-age, Survivors, and Disability Insurance System, to Improve the Federal–State Public Assistance Programs, and for Other Purposes: Hearings on H.R. 6675 Before the S. Comm. on Fin.*, 89th Cong. 499 (1965) (Letter of the Hon. Wilbur Cohen). Explaining the recommended amendment, Assistant Secretary Cohen stated:

> The changes are needed in order to provide agencies and organizations authorized to make payments under part A and carriers authorized to make payments under part B with the same immunity from liability for incorrect payments as would be provided their certifying and disbursing officers.

Id.

On June 3, 1965, the Senate Finance Committee published these recommended amendments in a committee print. Staff of S. Comm. on Fin., 89th Cong., *Text of and Justifications for Amendments to H.R. 6675 Recommended by the Department of Health, Education, and Welfare* 28–29 (Comm. Print 1965). Cohen's proposed changes were included in the Senate Finance Committee report dated June 30, 1965. S.Rep. No. 89–404, at 165, 177 (1965), *as reprinted in* 1965 U.S.C.C.A.N.1943, 2104, 2117. The language from HEW's letter was included in the Conference Report. H.R.Rep. No. 89–682, at 37 (1965) (Conf.Rep.), *as reprinted in* 1965 U.S.C.C.A.N. 2228, 2231. The amendment of both immunity provisions, in such a short span of time, with the language and explanation included in the committee reports from both the Senate Finance and Conference Committees, strongly indicates the intent of Congress was not to grant absolute immunity to carriers in § 1395u(e)(3), but instead, as stated by the Conference Report, to provide carriers with the same immunity as their certifying and disbursing officers.

12. Further, in contrast to the district court's evaluation below, the legislative history accompanying Congress's 2003 amendment of the Medicare statute indicates that the textual change to the immunity provision, now present at 42 U.S.C. § 1395kk–1(d), was not intended to change the law, but merely to continue to provide the same limited immunity that Medicare carriers enjoyed prior to the amendment:

> Medicare contractor reform will not succeed if contractors are subject to unlimited civil liability for carrying out the payments . . . expected of them. The conference agreement would therefore *continue the past policy of limiting the liability of certifying and disbursing officers, and the Medicare administrative contractors* for whom those officers serve, with respect to certain payments.
>
> In addition, the language contained in [§§ 1395k–1(d) of] the conference agreement clarifies that Medicare administrative contractors are not liable for inadvertent billing errors, but, *as in the past, are liable for all damages resulting from reckless disregard or intent to defraud the United States.* Importantly, the reckless disregard standard is the same as the standard under the False Claims Act. This standard balances the practical need to shelter Medicare administrative contractors from frivolous civil

C

Our interpretation of the statute, however, does not require that we reverse the district court's dismissal of Sikkenga's fraudulent payment claims in their entirety. Because the FCA does not provide a remedy for claims for *payment* of a false or fraudulent claim, dismissal of these claims under Rule 12(b)(6) was appropriate.[13] However, Sikkenga also alleged that Regence *caused* fraudulent claims to be submitted to the federal government. Section 1395u(e)(3), which contains a fraud exception, does not provide immunity for carriers who cause fraudulent claims to be presented.

The district court's order did not recognize immunity for Regence as to Sikkenga's "causing to be presented" claim under the FCA. Instead, acknowledging that "Regence's immunity may not extend to the FCA's prohibition against 'causing' false claims to be presented," the district court dismissed Sikkenga's first FCA cause of action against Regence without prejudice and provided Sikkenga the opportunity to amend her complaint to specifically plead facts that would support her claim that Regence caused ARUP to submit false claims.[14] The district court subsequently rejected Sikkenga's position that her amended allegations were sufficient to allege that Regence "caused" ARUP to present false claims. In doing so, the court interpreted the FCA's "causing to be presented" language as requiring "some sort of affirmative action on the part of the defendant before imposing liability." Interpreting Sikkenga's complaint to allege only passive acceptance of ARUP's claims, the district court found that Sikkenga's allegations had failed to demonstrate an affirmative action, and dismissed the claim against Regence and the Regence defendants under Rule 12(b)(6). On the same grounds, the district court dismissed Sikkenga's argument, presented for the first

> litigation by disgruntled providers or beneficiaries with the Medicare program's interest in protecting itself from contractor fraud.... [The FCA] applies to Medicare fiscal intermediaries and carriers *under current law*.

149 Cong. Rec. S15,606, S15,644 (2003) (emphasis added) (statement of Sen. Grassley during debate on the Medicare Drug, Improvement and Modernization Act of 2003, Pub.L. No. 108–173, 117 Stat.2066 (2003)). Our reading of the statute avoids the potential pitfall created by *Body*—that its broad all-encompassing immunity would render Medicare carriers immune under the FCA for any actions remotely premised on payment—and meets our obligation to construe statutes harmoniously. *See Chemical Weapons Working Group v. Dep't of the Army,* 111 F.3d 1485, 1490 (10th Cir.1997) (stating that we are required to construe apparently conflicting statutes harmoniously when possible). It is important to note that under the normal rule of liability for disbursing and certifying officers and their supervisors, such officers and supervisors are liable even for negligent payments. 31 U.S.C. §§ 3527(a), 3528. The Medicare immunity provision, rather than indicating a complete abandonment of the normal presumption that individuals disbursing government funds are responsible for negligent payments, indicates instead Congress's intent to provide some limitation to this normal default rule, not a "blank check" for Medicare carriers to commit fraud free from the FCA.

13. Similarly, no FCA cause of action exists as to the individual Regence defendants merely for "paying" the claims.

14. The district court instructed Sikkenga to "allege specific facts demonstrating that the Regence Defendants caused ARUP to present false claims rather than merely allowing or accepting such claims." Because the district court dismissed the first cause of action without prejudice for failure to plead fraud with particularity under Federal Rule of Civil Procedure 9(b), it provided Sikkenga sixty days to amend her complaint and plead her first cause of action with the particularity required by Rule 9(b), and instructed her to "identify specific claims that did not properly document medical necessity."

time in her amended complaint, that Regence's actions in querying a Medicare database called the "Common Working File" ("CWF" or "Host"),[15] was either the presentation of a false claim to the government, or, under 31 U.S.C. § 3729(a)(2), the knowing making, or using of a false record to get a false claim paid or approved.[16] We now turn to the dismissal of these claims under Rule 12(b)(6).

1

We review dismissals under Rule 12(b)(6) de novo, and will uphold such a dismissal "only when it appears that the plaintiff can prove no set of facts in support of the claims that would entitle him to relief, accepting the well-pleaded allegations of the complaint as true and construing them in the light most favorable to the plaintiff." *Dubbs v. Head Start, Inc.*, 336 F.3d 1194, 1201 (10th Cir.2003) (quotations omitted). Our role is to assess whether the plaintiff's complaint alone is legally sufficient to state a claim upon which relief may be granted. *Id.*

In her amended complaint, Sikkenga focused on the "resolution" reached between the Regence individual defendants, Regence, and ARUP that "allowed" ARUP to continue to submit claims with the 796.4 code, arguing that:

> by way of this 'resolution' ... [defendants] reached an agreement among themselves to systematically circumvent the requirements of the Contract and the Social Security Act and related regulations for the purpose of getting ARUP's false claims paid by the government with Medicare Part B funds even though these Defendants were fully aware that such claims were not payable.

She also alleged that "[b]y *assuring* ARUP that such claims would continue to be accepted, Regence encouraged, facilitated, and caused ARUP's presentation of false claims for payment." (emphasis added).

2

In order to determine whether Sikkenga's allegations survive a Rule 12(b)(6) challenge, we must first decide what is required for an entity to have "caused" a claim to be presented under the FCA. One case, *United States ex rel. Long v. SCS Bus. & Technical Inst.*, 999 F.Supp. 78, 91 (D.D.C.1998), *rev'd on other grounds,* 173 F.3d 890 (D.C.Cir.1999), supports Sikkenga's view that the failure to prevent a third party from filing false claims after having knowledge that the claims were false is sufficient to state a claim under the FCA.

> Where a defendant has an ongoing business relationship with a repeated false claimant, and the defendant knows of the false claims, yet does not cease do-

15. The Common Working File, or Host, is a computerized database for maintaining Medicare beneficiary information for persons within an assigned geographical area. The CWF/Host is maintained by a separate contractor under contract with the Department of Health and Human Services, and contains Medicare beneficiary entitlement and utilization data. *See Blue Cross & Blue Shield of Maryland, Inc. v. United States Dep't of Health & Human Servs.*, 718 F.Supp. 80, 81 n. 4 (D.D.C.1989).

16. Sikkenga also included two lists of ARUP claims that she alleges were false because they used the ICD–9 code of 796.4 to document medical necessity. Regence continued to assert before the district court that these lists failed to meet the requirements of Fed. R.Civ.P. 9(b) because they failed to specify which claims were false under Sikkenga's theory. Regence argued that merely stating that some of the listed claims were false was not sufficient to meet Rule 9(b)'s particularity requirements. Because the district court held that Sikkenga failed to allege a violation of the FCA under Rule 12(b)(6), it did not decide Regence's pending Rule 9(b) motion.

ing business with the claimant or disclose the false claims to the United States, the defendant's ostrich-like behavior itself becomes "a course of conduct that allowed fraudulent claims to be presented to the government."

United States v. President & Fellows of Harvard College, 323 F.Supp.2d 151, 187 (D.Mass.2004) (*quoting Long,* 999 F.Supp. at 91). Sikkenga asserts that in *United States ex rel. Marcus v. Hess,* the Supreme Court interpreted the "causing to be presented language" of an earlier version of the FCA to "reach any person who knowingly *assisted* in causing the government to pay claims which were grounded in fraud, without regard to whether that person had direct contractual relations with the government." 317 U.S. 537, 544–45, 63 S.Ct. 379, 87 L.Ed. 443 (1943) (emphasis added). However, *Hess* involved consideration of the text of the FCA as a whole, not solely the "causing to be presented" provision. *Id.* at 544–45, 63 S.Ct. 379. We do not consider *Hess's* "assisted" language to be dispositive in analyzing whether she has adequately pled a "causing to be presented" claim.

Relying on *United States ex rel. Shaver v. Lucas W. Corp.,* 237 F.3d 932, 933 (8th Cir.2001), and *United States v. Mackby,* 261 F.3d 821, 827–28 (9th Cir.2001), the defendants argue that the FCA requires an affirmative instruction to present a false claim before imposing liability. The district court rejected both parties' contentions, instead interpreting *Shaver* and *United States ex rel. Glass v. Medtronic, Inc.,* 957 F.2d 605, 606 (8th Cir.1992), to require "some sort of affirmative action on the part of a defendant before imposing liability [under the FCA]." Motivating the district court was its concern that too broad an interpretation of the "causes to be presented" language in the FCA "would impose liability on parties merely for failing to prevent the fraudulent acts of others." We share this concern.

[2] Generally, mere knowledge of the submission of claims and knowledge of the falsity of those claims is insufficient to establish liability under the FCA. *See United States v. Murphy,* 937 F.2d 1032, 1039 (6th Cir.1991). Under § 3729(a)(1)'s requirement that a person "cause" a false claim to be presented, the appropriate focus of the inquiry is on "the specific conduct of the person from whom the Government seeks to collect." *United States v. Bornstein,* 423 U.S. 303, 313, 96 S.Ct. 523, 46 L.Ed.2d 514 (1976). Thus, the appropriate inquiry under § 3729(a)(1) is whether that specific conduct *causes* the presentment of a false claim.

The Third Circuit has borrowed traditional principles of tort law to analyze causation for damages under the FCA. *See United States v. Hibbs,* 568 F.2d 347, 349 (3d Cir.1977) (holding that, in assessing damages under the FCA, "a causal connection must be shown between loss and fraudulent conduct" and that "a broad 'but for' test is not in compliance with the [FCA]"). Such an approach is useful in analyzing causation under § 3729 as well, and provides a familiar test—that of proximate causation—to determine whether there is a sufficient nexus between the conduct of the party and the ultimate presentation of the false claim to support liability under the FCA. Such a test separates the wheat from the chaff, allowing FCA claims to proceed against parties who can fairly be said to have caused a claim to be presented to the government, while winnowing out those claims with only attenuated links between the defendants' specific actions and the presentation of the false claim. Attempting to strike this same balance, the district court required "some sort of an affirmative action on the part of the defendants." We agree that a standard requiring more than mere passive acquiescence is most consistent with the purposes of the FCA. Furthermore, such a standard strikes the appropriate balance between shielding from liability parties who merely fail to prevent the fraudulent acts of others, and ensuring that liability attaches for "affirmative acts" that do cause or assist the presentation of a fraudulent claim.[17]

[3] Applying this standard to Sikkenga's allegations, we disagree with the district court's assessment that Sikkenga failed to sufficiently allege a "causing to be presented" claim under the FCA. Our role in reviewing a Rule 12(b)(6) dismissal is "not to weigh potential evidence that the parties might present at trial, but to assess whether the plaintiff's complaint alone is legally sufficient to state a claim upon which relief may be granted." *Sutton v. Utah State Sch. for the Deaf & Blind,* 173 F.3d 1226, 1236 (10th Cir.1999). Although a close case, Sikkenga's allegations state that Regence engaged in certain actions, specifically, "agreeing to circumvent" contractual and statutory requirements, and "assuring" ARUP that Regence would continue to accept the claims coded with the disputed 796.4 code. Sikkenga alleges that these actions assisted ARUP in continuing to submit the allegedly false claims. She supports her description of the alleged scheme with specific actions taken by Regence that she claims were in support of this "agreement to circumvent." Because we must construe these allegations in the light most favorable to Sikkenga, we cannot conclude that Sikkenga could prove no set of facts in support of her claim that would entitle her to relief against Regence for "causing" ARUP to present the allegedly false claims. Accordingly, we reverse the district court's dismissal of Sikkenga's claim that Regence "caused" ARUP to present false claims under Rule 12(b)(6),[18] and remand for further proceedings consistent with this opinion.[19]

17. Although the partial concurrence and partial dissent would not rule on the scope of causation under the FCA, we consider establishing this standard necessary to resolving the case before us. A bald assertion that a defendant has caused a false claim to be presented would plainly fail to state a claim for relief. *See Hall v. Bellmon,* 935 F.2d 1106, 1109–10 (10th Cir.1991) ("[C]onclusory allegations without supporting factual averments are insufficient to state a claim on which relief can be based."). We therefore must consider whether Sikkenga's factual allegations are sufficient to support a "causes to be presented" FCA claim.

The proximate causation standard strikes the proper analytical balance and comports with the rule requiring strict construction of punitive civil statutes. *See Comm'r v. Acker,* 361 U.S. 87, 91, 80 S.Ct. 144, 4 L.Ed.2d 127 (1959). As noted above, there is no support for the defendants' position that a causing to be presented claim requires a direct order to present a false claim. The only remaining plausible constructions of "causes to be presented" are but for causation and proximate causation. By adopting proximate causation we narrow, rather than enlarge, the field of actions for which FCA liability may be imposed.

18. For the same reason, the dismissal of Sikkenga's "causing to be presented" claims against the individual Regence defendants is also reversed.

19. We caution, however, that we express no opinion as to whether Sikkenga's complaint meets the requirements of Rule 9(b) to plead fraud with particularity. *See United States ex rel. Clausen v. Lab. Corp. of Am.,* 290 F.3d 1301, 1308–09 (11th Cir.2002) (holding that Rule 9(b) applies to actions under the FCA); *Bly–Magee v. California,* 236 F.3d 1014, 1018 (9th Cir.2001) (same); *United States ex rel. Russell v. Epic Healthcare Mgmt. Group,* 193 F.3d 304, 308 (5th Cir.1999) (same); *Harrison v. Westinghouse Savannah River Co.,* 176 F.3d 776, 783–84 (4th Cir.1999) (same); *United States ex rel. LaCorte v. SmithKline Beecham Clinical Labs., Inc.,* 149 F.3d 227, 234 (3d Cir.1998) (same); *Gold v. Morrison–Knudsen Co.,* 68 F.3d 1475, 1476–77 (2d Cir.1995) (same, collecting cases). Although we admit

3

[4] In her amended complaint, Sikkenga introduced a new theory of FCA liability, arguing that Regence's actions in querying the CWF/Host amounted to either the presentation of a false claim to the government, or, under 31 U.S.C. § 3729(a)(2), the knowing, making, or using of a false record to get a false claim paid or approved. The district court rejected this theory, finding that

> Regence's query to the Host and the CWF is not a claim for payment but, rather, a secondary data review within the Medicare claim processing and payment process that is designed to look at an additional body of information to ensure that payments only go to beneficiaries with proper utilization and entitlement status.

We agree with the district court that Regence's query to the Host/CWF was not a separate presentation of a false claim or the making or using of a false record to get a false claim paid. To the contrary, the CWF was designed to improve the accuracy and timeliness of Medicare claims processing by reducing payment errors and providing carriers with updated entitlement and eligibility data on beneficiaries. *See Blue Cross & Blue Shield of Maryland, Inc. v. United States Dep't of Health & Human Servs.,* 718 F.Supp. 80, 81 n. 4 (D.D.C.1989). The Medicare Carrier Manual describes the CWF as a part of the processing of a claim for payment concerned with verifying a portion of the requirement for payment and facilitating the integration of Medicare databases for each eligible beneficiary. *Medicare Carriers Manual,* Part 3, §§ 6000 et. seq. This CWF/Host query is clearly a secondary data review within the payment process. Being such, the district court's dismissal of Sikkenga's claims premised upon Regence's query to the Host/CWF under Rule 12(b)(6) is **AFFIRMED.**[20]

D

We now turn to the district court's decision that ARUP is an arm-of-the-state and thus not subject to liability under the FCA. After according the parties one year of limited discovery on the issue of whether ARUP is a state entity, the district court applied the test we articulated in *Sturdevant v. Paulsen,* 218 F.3d 1160 (10th Cir.2000), and concluded that ARUP was "sufficiently tied to the University of Utah to be considered an arm of the state." The court then dismissed Sikkenga's sole FCA claim against ARUP.[21] In her appeal of this decision, Sikkenga advances two arguments. First, she urges that because ARUP is a corporation, it must be a person and therefore is liable under the FCA. Second, Sikkenga argues that the district court improperly found that ARUP is an arm-of-the-state.

Because the FCA imposes liability for "*[a]ny person* who-(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government ... a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a) (emphasis added), subject matter jurisdic-

to some concern that Sikkenga's allegations are an inadequate attempt to allege a conspiracy under § 3729(a)(3) under the guise of alleging a "causing to be presented" claim, we are confident that a proper Rule 9(b) analysis by the district court on remand can determine if her allegations meet Rule 9(b)'s particularity requirements.

20. To the extent this allegation reaches the individual Regence defendants, its dismissal similarly is affirmed.

21. Because of this determination, the district court did not rule upon ARUP's claim that it was entitled to Eleventh Amendment immunity.

tion for an FCA claim under 28 U.S.C. § 1331 depends on the claim being made against a person as that term is interpreted under the FCA. *See Vermont Agency of Natural Resources v. United States ex rel. Stevens,* 529 U.S. 765, 778–780, 120 S.Ct. 1858, 146 L.Ed.2d 836 (2000). When subject matter jurisdiction is dependent on the same statute which provides the substantive claim in the case, then the jurisdictional question is intertwined with the merits of a case, and a Rule 12(b)(1) motion should be resolved under either Rule 12(b)(6) or Rule 56. *United States ex rel. King v. Hillcrest Health Ctr., Inc.,* 264 F.3d 1271, 1278 (10th Cir.2001). When a court relies on affidavits and other evidentiary material submitted by the parties to resolve disputed jurisdictional facts, a defendant's motion to dismiss should be treated as one for summary judgment under Rule 56(c). *United States ex rel. Ramseyer v. Century Healthcare Corp.,* 90 F.3d 1514, 1518 (10th Cir.1996). Although the district court did not treat ARUP's motion as one for summary judgment, even though it relied on materials outside the complaint, we will exercise our plenary power and consider the defendant's motion as a motion for summary judgment. *See id.* We review the grant of summary judgment de novo, applying the same legal standard used by the district court under Rule 56(c). *Id.* The determination of subject matter jurisdiction is reviewed de novo.[22] *Id.*

Even though we recognize the ordinary presumption of "personhood" that arises from ARUP's incorporation, *see* 1 U.S.C. § 1; *Cook County v. United States ex rel. Chandler,* 538 U.S. 119, 125, 123 S.Ct. 1239, 155 L.Ed.2d 247 (2003), this recognition is tempered by the Supreme Court's express instruction that under the FCA we must apply the longstanding interpretive presumption that the term person does not include a sovereign. *See Stevens,* 529 U.S. at 784, 120 S.Ct. 1858 n. 14; *see also United States ex rel. Adrian v. Regents of the Univ. of California,* 363 F.3d 398, 401 (5th Cir.2004) (holding that the Regents are an arm-of-the-state despite corporate organization through which it managed university laboratory); *Donald v. Univ. of California Bd. of Regents,* 329 F.3d 1040, 1044 (9th Cir.2003) (holding Regents are an arm-of-the-state despite corporate organization through which it managed university hospital). Thus, in *Stevens,* after recognizing the "virtual coincidence of scope" between the statutory inquiry under the FCA and the Eleventh Amendment inquiry, the Court held that the term person in the FCA does not include States. *Stevens,* 529 U.S. at 780, 120 S.Ct. 1858. Subsequently, in *Chandler,* the Court held that municipal corporations were included as potentially liable "persons" under the FCA. 538 U.S. at 133, 123 S.Ct. 1239. This distinction mimics that made by the Court in the Eleventh Amendment context, where it explained: "the bar of the Eleventh Amendment to suits in federal courts extends to States and state officials in appropriate circumstances, but does not extend to counties and similar municipal corporations." *Sturdevant,* 218 F.3d at 1164 (*quoting Mount Healthy City Sch. Dist. Bd. of Educ. v. Doyle,* 429 U.S. 274, 280, 97 S.Ct. 568, 50 L.Ed.2d 471 (1977)). In order to draw this statutory distinction under the FCA, courts have used the Eleventh Amendment's arm-of-the-state doctrine to decide if "entities created by state governments . . . operate as alter egos or instrumentalities of the states." *Id.* at 1164 (*quoting Watson v. Univ. of Utah*

22. We agree with the district court's observation that "the facts regarding ARUP's relationship with the University of Utah do not appear to be in dispute. Rather, it is the legal import to assign certain facts that is in dispute."

Med. Ctr., 75 F.3d 569, 574 (10th Cir. 1996)); *See also Adrian,* 363 F.3d at 402 (using arm-of-the-state language to hold that the University of California Regents, as manager of a university hospital, is not subject to qui tam FCA claims because the Regents are a state entity under *Stevens); United States ex rel. Ali v. Daniel, Mann, Johnson, & Mendenhall,* 355 F.3d 1140, 1146–47 (9th Cir.2004) (discussing use of the arm-of-the-state test for various statutes).

[5] Because of the "virtual coincidence of scope" between the FCA and Eleventh Amendment inquiries, we conclude that the appropriate approach to determine if a state-related entity is subject to liability under the FCA is to apply Eleventh Amendment arm-of-the-state analysis. The question is thus, whether ARUP "is 'more like a county or city than . . . like an arm of the state?' " *Sturdevant,* 218 F.3d at 1164 (*quoting Mount Healthy,* 429 U.S. at 280, 97 S.Ct. 568). In conducting this inquiry, we have cautioned that "[a]lthough ultimately a matter of federal law, arm-of-the-state status must be determined in each case by reference to the particular state laws characterizing the entity." *Id.* at 1164.

In *Sturdevant,* we stated that there are three factors to be considered in the arm-of-the-state analysis: (1) the state's legal liability for a judgment; (2) the degree of autonomy from the state—both as a matter of law and the amount of guidance and control exercised by the state; and (3) the extent of financing the agency receives independent of the state treasury and its ability to provide for its own financing. 218 F.3d at 1164.

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[6] First and foremost, it is clear that the State of Utah's treasury is not legally liable for any judgment against ARUP. Both the record and Utah law establish that any judgment against ARUP would be satisfied out of ARUP's treasury, with no recourse to either the State treasury or the general funds appropriated for the normal operation of the University. Utah Code Ann. § 53B–7–103(3)(d). We recognize that ARUP's property is vested in the State of Utah by operation of Utah statute, Utah Code Ann. § 53B–2–101, and that any depletion of ARUP's general treasury would require, as a practical matter, increased state funding of the University of Utah Medical Center and the University itself. However, we are bound by the Supreme Court's decision in *Regents of California v. Doe,* 519 U.S. 425, 117 S.Ct. 900, 137 L.Ed.2d 55 (1997), which requires us "to focus on legal liability for a judgment, rather than on the practical, or indirect, impact a judgment would have on a state's treasury." *Sturdevant,* 218 F.3d at 1164 (*quoting Duke v. Grady Mun. Schs.,* 127 F.3d 972, 981 (10th Cir.1997)). Analysis of this factor clearly weighs against recognizing ARUP as an arm-of-the-state. Nevertheless, other factors remain relevant to the evaluation of an entity's status, as the absence of legal liability is not determinative. *Id.* at 1166 (*citing Duke v. Grady Mun. Schs.,* 127 F.3d at 978).

2

The second factor—the degree of autonomy from the state—is a bit tricky. Recognizing the difficult nature of the question, the district court relied heavily on our analysis of the factors tying the University Medical Center to the University of Utah in *Watson,* and concluded that ARUP is an arm-of-the-state. We agree that the question is a close one, but come to the opposite conclusion as to ARUP's status.

In 1984, ARUP was incorporated under the Utah Business Corporation Act, and currently exists under the Utah Revised Business Corporation Act. From 1984 to 2002, ARUP was a wholly owned subsidiary of a separate corporate entity, Associated University Pathologists, Inc., ("AUP"), which in turn was owned by the University of Utah. Although AUP was a non-stock membership corporation, ARUP itself issued stock.[23] Until 2002, ARUP's articles of incorporation and by-laws were similar to those that would be adopted by an ordinary business concern. After AUP's 2002 dissolution, ARUP amended its articles of incorporation to explicitly limit its operations to comport with restrictions ARUP contends were required by the operation of Utah law from its inception. Tightening the focus of its argument, ARUP contends that its commercial operations are limited to those that offer a "substantial and valuable educational or research experience for registered students and faculty." [24] Yet, ARUP's actual business operations are much broader than ARUP contends, and are not limited geographically or by the type of testing services it performs.

ARUP engages in nationwide activity as a commercial laboratory. It is licensed in nine states and markets its services in all fifty. In addition to performing laboratory operations for the University of Utah Medical Center, ARUP also provides laboratory testing for third parties.[25] The record does not disclose the percentage of laboratory services provided to third parties that are routine versus those that provide an educational or research benefit, but it is clear from the nature of Sikkenga's claims that ARUP provides a substantial number of tests and earns the bulk of its revenue from its operations outside the University community.[26]

Under Utah Code provisions governing ordinary corporations, and those controlling the State of Utah's higher education system, ARUP may sue and be sued. Utah Code Ann. §§ 16–10a–302(1), 53B–2–101. ARUP is not incorporated as a nonprofit corporation, although it has been granted tax-exempt status as a § 501(c)(3) entity by the IRS. ARUP can enter into contracts with commercial entities, and

23. Belying ARUP's claims that it is an ''integral'' part of the University of Utah, the University has actively considered selling ARUP in the past, and sold ARUP's substance abuse testing division to a commercial laboratory.

24. We recognize that Utah's Revised Business Corporation Act authorizes a corporation engaging in a business that is subject to regulation under another Utah statute to incorporate. The Act specifically states such incorporation is authorized, ''only if permitted by, and subject to all limitations of, the other statute.'' Utah Code Ann. § 16–10a–301(2). ARUP contends that the State Board of Regents has, under its statutory authority, issued regulations that constrain ARUP's business activities to those that offer a ''substantial and valuable educational or research experience for registered students and faculty,'' but such regulations are not pointed to by the parties and are not present in the record. There is some debate between the parties over whether we should evaluate ARUP's status at the time of the 1999 filing of the underlying complaint, or if we can consider the post-filing changes to ARUP's corporate articles of incorporation. In 2002, ARUP changed its articles of incorporation to facilitate its request to be treated as tax-exempt by the Internal Revenue Service. Our determination of ARUP's status is, however, not dependent on any alteration in ARUP's articles of incorporation, so we decline the parties' invitation to wade into this dispute.

25. ARUP provides both routine and esoteric laboratory testing. The more esoteric tests provide an educational or research benefit to the Department of Pathology and School of Medicine.

26. For the fiscal year ending in June 1998, seventy-six percent of ARUP's revenues derived from testing provided to other hospitals.

maintains bank accounts in its own name. *See* Utah Code Ann. § 53B–7–103(3).

Further, the relationship between the University Medical Center's Department of Pathology and ARUP is more than an inter-departmental agreement. Rather than providing services through a more informal operating scheme, the Department of Pathology has routinely entered into commercial contracts with ARUP to provide the services of approximately half of its pathologists to ARUP. At ARUP's inception, the Medical Center sold its existing hospital clinical laboratory operations and assets pursuant to a competitive contract awarded to ARUP. This purchase was funded by a combination of funds contributed by the Department of Pathology and notes payable to various departments of the University. Of ARUP's 1215 employees, barely ten percent are "pathologists," "residents and fellows," or "laboratory science students in AS, BS and MS programs that have operational responsibilities." The bulk of ARUP employees are in "laboratory operations," "general and administrative," "sales and marketing," "customer services," and "handling & logistics." Although the University's Department of Pathology provided the capital to set up ARUP, the bulk of ARUP's revenues flow from ARUP's commercial operations to the University, rather than from the University to ARUP. Retirement plans for ARUP employees, as opposed to those individuals simultaneously occupying positions within ARUP and the University of Utah, are covered under a different private retirement system than the system for University employees.

While it is clear that ARUP is a wholly owned corporation, the stock of which is owned by the University of Utah, its day-to-day operations are independent. Although ARUP's Chairman reports to Senior Vice–President for Health Sciences,[27] who in turn reports directly to the University President, it is ARUP's Board of Directors that "sets policies and operational objectives while providing appropriate oversight of ARUP's business affairs ... [and] monitors ARUP's business operations and financial management to help it compete within the marketplace for laboratory services." The University President provides only "strategic oversight."

We recognize that there are ties between the University and ARUP, but these arise as an incidence of ownership, and are several degrees removed from the direct relationship set up under Utah law between the University of Utah and the State. The entire University, including ARUP, is subject to the governance of the State Board of Regents, which is appointed by the Governor and approved by the State Senate. ARUP's property is vested with the State of Utah through the University and the Utah Board of Regents, and the President of the University, as representative of the owner, appoints ARUP's directors. The Chairman of the University Medical School's Department of Pathology traditionally operates as the Chairman of ARUP. Further, there are some indications that ARUP is connected with the University Medical School on an operational level. Several mandatory pathology courses in the Department of Pathology are offered within ARUP, and ARUP provides hands-on training for the Department of Pathology. ARUP's infusions of funds support functions within the Deparments of Pathology, Obstetrics, and Pediatrics. ARUP also provides office space to other University components at below-market rents. However, when we evaluate the entire relationship between ARUP and the University, ARUP retains sub-

27. Who is also Dean of the University Medical School.

stantial autonomy in its operations, and operates with little, if any guidance or interference from the University or the State.[28]

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As for the third component of financial independence, the record shows a history of complex, intertwined relationships for funding capital improvement projects between the University and ARUP. ARUP's financial statements are audited by independent accountants, and subsequently included as a separate item in the financial statements of the University of Utah. This data is used at some point by the legislature in determining the overall appropriations for the University. Utah Code Ann. § 53B–7–101. Nevertheless, it is clear that since 1989, ARUP has been self-sustaining, generating operating funds and profit through its commercial activity. It is equally clear that ARUP's substantial surplus flows to the University rather than vice-versa. When, as here, an entity is privatized and is structured to achieve financial independence from the state entity which owns it, we will not disregard its structure merely because the state retains proprietorial title to its asset. From our review of the record, we conclude that ARUP was designed to be not only self-sustaining, but a commercial "profit center" for the University Medical Center.

4

As recognized by the Supreme Court, "[w]hen indicators of immunity point in different directions, the Eleventh Amendment's twin reasons for being remain our prime guide." *Hess v. Port Auth. Trans–Hudson, Corp.*, 513 U.S. 30, 47, 115 S.Ct. 394, 130 L.Ed.2d 245 (1994) (recognizing the protection of State treasuries and dignity as sovereigns in our federal system as the Eleventh Amendment's twin reasons for being). As in *Hess*, common sense and the rationale of the Eleventh Amendment do not require that sovereign immunity attach when an agency is structured to be self-sustaining and has a long history of paying its own way. *Id.* at 49–50, 115 S.Ct. 394.

When a state forms an ordinary corporation, with anticipated and actual financial independence, to enter the private sector and compete as a commercial entity, even though the income may be devoted to support some public function or use, that entity is not an arm-of-the-state. We are convinced from our review of the record that ARUP was designed to operate as a commercial enterprise, not as the alter ego of the State of Utah. We find persuasive the reasoning in two recent cases from the Seventh and First Circuits which articulate that:

> strings that tie the [entity] to the state are found in many cases in which a state decides to privatize a formerly state function. They do not require that privatization be treated as a farce in which the privatized entity enjoys the benefits both of not being the state and so being freed from the regulations that constrain state agencies, and of being the state and so being immune from suit in federal court.

28. Although present in the record and potentially relevant in other circumstances, we do not rely on several less compelling and often contradictory indicators of ARUP's status. Among these are whether ARUP has raised Eleventh Amendment immunity as a defense in other cases, whether ARUP is represented by private counsel or by the Utah Attorney General's Office, or how ARUP licenses its few vehicles. As we cautioned in *Sturdevant*, "it is easy to become caught up in the minutiae," but these details "must not eclipse" the distinction between instrumentalities of the state and political subdivisions of a state. 218 F.3d at 1170.

Takle v. Univ. of Wisconsin Hospital & Clinics Auth., 402 F.3d 768, 771 (7th Cir. 2005); *see also Fresenius Medical Care Cardiovascular Res., Inc. v. Puerto Rico,* 322 F.3d 56 (1st Cir.2003).

With the twin rationales for the Eleventh Amendment informing our analysis, we conclude that ARUP, with its anticipated and actual financial independence, is not an arm-of-the-state.[29] Accordingly, we **REVERSE** the district court's dismissal of ARUP, and **REMAND** for further proceedings consistent with this opinion.[30]

III

In her second FCA cause of action, Sikkenga alleged that Regence presented a false budget request to the United States in connection with an Early Claims Review that Regence was to perform in 1992. Sikkenga pleaded that the services covered by the budget request were never performed. The district court dismissed the claim as time-barred under the FCA's statute of limitations, interpreting 31 U.S.C. § 3731(b) to apply only to the United States Government, not to qui tam relators. Although acknowledging that her claim was filed more than seven years after the violation was committed, Sikkenga argues that she is entitled to a ten-year statute of limitations under § 3731(b). We review the district court's analysis of the statute de novo. *UMLIC–Nine Corp. v. Lipan Springs Dev. Corp.*, 168 F.3d 1173, 1177 (10th Cir.1999), using the same standard of review as discussed in section II.B.

In our analysis of this issue, we first turn to the language of the statute, which reads:

> (b) A civil action under [31 U.S.C.] section 3730 may not be brought—
>
> (1) more than 6 years after the date on which the violation is committed, or
>
> (2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed,
>
> whichever occurs last.

31 U.S.C. § 3731(b).

This language has been interpreted by various courts to apply to qui tam FCA actions in three different ways. In the first, courts have held that the three-year tolling provision applies only if the government has intervened in the action, because § 3731(b)(2) only applies to government officials. These courts view § 3731(b)(2) as simply inapplicable to FCA suits brought by a relator, and rely upon the statute's use of the term "official of the United States" as an indication that Congress did not intend the tolling provision of § 3731(b)(2) to apply to private qui tam relators. *See United States ex rel. Amin v. George Washington Univ.*, 26 F.Supp.2d 162, 172 (D.D.C.1998); *United States ex rel. Thistlethwaite v. Dowty Woodville Polymer, Ltd.*, 6 F.Supp.2d 263, 265 (S.D.N.Y.1998).

Other courts have relied on the fact that procedurally qui tam relators are consid-

29. ARUP argues, as an alternative basis to affirm the district court's dismissal, that it is entitled to Eleventh Amendment immunity. Because the analysis is essentially the same as the arm-of-the-state analysis above, it follows that ARUP is not entitled to Eleventh Amendment immunity.

30. We reiterate, in this respect as well, that we express no opinion of whether Sikkenga's allegations as to ARUP's allegedly false claims will survive scrutiny under Rule 9(b).

ered to stand in the place of the United States through the FCA. Thus, even though Congress referred only to the government in the FCA's text or legislative history, the context made it obvious that Congress intended to include qui tam relators in these provisions. These courts have held that, because of this generalized use of the term "government," the statute of limitations should be read to apply as if a relator were an official of the United States under § 3731(b)(2). *See United States ex rel. Downy v. Corning, Inc.,* 118 F.Supp.2d 1160, 1170 (D.Utah 2000); *United States ex rel. Hyatt v. Northrop Corp.,* 91 F.3d 1211, 1214–16 (9th Cir.1996). Under this interpretation, the three year statute of limitations begins running when the relator gains knowledge of the wrongdoing, limited by the ten-year statute of repose in § 3731(b)(2).

The third interpretation, from an unpublished opinion by a district court in Utah, held that the literal text of the statute does not make § 3731(b)(2) inapplicable to relators, and interpreted § 3731(b)(2) such that a relator has until 3 years after a government official learns of a violation to file an FCA claim. *United States ex rel. Colunga v. Hercules Inc.,* 1998 WL 310481, No. 89–CV–954B, 1998 U.S. Dist. LEXIS 21811 (D.Utah Mar.6, 1998). Under this approach, which Sikkenga would have us declare the correct interpretation, if there is no indication that the government ever knew of the wrongdoing, the statute of limitations is ten years.

In examining the text we acknowledge that the statute is ambiguous. The text does not explicitly limit the applicability of § 3731(b)(2) to cases in which the government has intervened; however, the term "the official of the United States charged with responsibility to act in the circumstances" is also more specific than a reference to the United States or the "government" generally, and could be read to exclude qui tam relators when the United States has not intervened. When a statute's plain meaning is ambiguous, courts may seek guidance from legislative intent and statutory purpose to determine congressional intent. *See In re Geneva Steel Co.,* 281 F.3d 1173, 1178 (10th Cir. 2002).

Several courts have examined portions of the legislative history applicable to this provision, but their analysis is of only limited assistance in deciding the issue before us. *See Hyatt,* 91 F.3d at 1214 n. 4, n. 5 (*quoting* H.R.Rep. No. 99–660, at 25 (1986), and S.Rep. No. 99–345, at 30 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5280, 5295); *Amin,* 26 F.Supp.2d at 172–73 (discussing same).

The Senate Report accompanying the legislation, stated:

> Subsection (b) of section 3731 of title 31, as amended by section 3 of the bill, would include an explicit tolling provision on the statute of limitations under the False Claims Act. The statute of limitations does not begin to run until the material facts are known by an official within the Department of Justice with the authority to act in the circumstances.

S.Rep. No. 99–345, at 30 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5295. Additionally, the Senate, when debating the 1986 amendments to the False Claims Act stated:

> The committee has added a tolling provisions [*sic*] to the False Claims Act which is adopted directly from 28 U.S.C. § 2416(c). While section 2416(c) is a provision of general applicability, the committee intends that the False Claims Act tolling provision be liberally construed because the conduct addressed here is so inherently deceptive and carefully concealed. Thus, courts should be

leary of finding that the Government had knowledge of the existence of a possible cause of action based merely upon the discovery of irregularities that fall short of a concrete suspicion that fraud has occurred. Some corroborative information to support that suspicion should be required. Similarly, care should be taken to assure that the information has reached an official in a position both to recognize the existence of a possible violation of this act and to take steps to address it.

132 Cong. Rec. S11,238 (1986) (Senator Grassley's statement explaining amendments).[31] Section 2416(c) establishes a tolling period applicable to the various limitations periods described in § 2415 when an action is brought by the United States to recover monetary damages, and also uses the term "known by an official of the United States charged with responsibility to act in the circumstances." Although these portions of the legislative history directly support the conclusion that § 3731(b)(2) was intended by Congress to apply only to the government, and not qui tam relators, they do not conclusively resolve the issue before us.

Both the text and legislative history of the FCA use the terms "government," and "United States" to refer to suits brought by either the Attorney General or qui tam relators. *See, e.g.,* § 3731(c) ("In any action brought under section 3730, the United States shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence."); S.Rep. No. 99–345, at 6–7 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5271–72 (discussing the scienter requirement and referring to evidence that the "government" must offer). Assuredly the Senate report points to the Department of Justice official "with the authority to act in the circumstances" as the relevant official under § 3731(b), but the report's usefulness is limited by the fact that Congress chose to use a more general term in the FCA's text.[32] This is troubling in light

31. Additionally, in testimony before the House Judiciary Committee concerning proposed changes to the False Claims Act, Mr. Richard K. Willard, Assistant Attorney General, Civil Division, Department of Justice, stated that:

> [T]he bill modifies the statute of limitations to include a discovery rule, to address the situations where the Government does not learn about the falsity of the claim at the time it was submitted .... [and in response to a query by Chairman Glickman asking if there was a precedent in Federal law for such a statute of limitations, replied] Actually, Mr. Chairman, there is. The general statute of limitations for the Federal Government, 28 U.S.C. § 2416(c) does include a tolling provision. The problem is the False Claims Act, as I understand it at least, has its own statute of limitations and is not subject to the general provision. So what we are proposing to do is to conform the False Claims Act to the general rule under common law in most States, and for that matter, for the Federal Government, to provide this limited tolling period where the fraudulent conduct has been concealed, as it frequently is, from the Government, and we don't find out about it until later. I can say Mr. Chairman, that I frequently see requests to sue come in right on the brink of the statute of limitations, and sometimes beyond, causing us to miss out on some claims we could otherwise bring because it has just taken that long to discover the fraud and get a case ready to pursue. This amendment would give us a little more flexibility in bringing some cases that otherwise would be barred.

False Claims Act Amendments: Hearings Before the H. Subcomm. on Admin. Law and Governmental Relations of the H. Comm. on the Judiciary, 99th Cong. 118, 159 (1986) (Statement of Mr. Richard K. Willard, Assistant Attorney General, Dep't of Justice).

32. The choice of language may arise from a desire to align the statutory language with that used in 28 U.S.C. § 2416(c), from which Congress obtained the tolling provision as described above.

of Congress's use of the term "Attorney General" in other sections of the FCA, such as § 3730. *See* § 3730 (instructing the "Attorney General" to investigate a violation under § 3729). It is unclear why Congress would explicitly refer to the "Attorney General" as the person with sole power to perform certain functions under the FCA, and "yet leave unclear on the face of the statute whether 'the official of the United States charged with responsibility to act' is in fact only the Attorney General." *United States v. Island Park,* 791 F.Supp. 354, 363 (E.D.N.Y.1992); *see also United States ex rel. Hyatt v. Northrop Corp.,* 91 F.3d 1211, 1214–15 (9th Cir.1996). However, when the Senate's explanation that § 3731(b) is borrowed directly from 28 U.S.C. § 2416(c) is added to the mix, the clouds clear and resolution of the matter comes into focus: Although intended to be liberally construed as to the government, the tolling provision of § 3731(b) was not intended to apply to private qui tam suits. Rather, it was intended to provide the Department of Justice with "a little more flexibility in bringing some cases that otherwise would be barred." *False Claims Act Amendments: Hearings Before the H. Subcomm. on Admin. Law and Governmental Relations of the H. Comm. on the Judiciary,* 99th Cong. 159 (1986) (Statement of Mr. Richard K. Willard, Assistant Attorney General, Dep't of Justice).

Statutory purposes underlying the 1986 FCA amendments support this interpretation. The purpose in amending the FCA was "not only to provide the Government's law enforcers with more effective tools, but to encourage any individual knowing of Government fraud to bring that information forward." S.Rep. No. 99–345, at 2 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5266–67. Emphasizing that the statute was remedial, the Senate report reviewed the history of the FCA's qui tam provisions, quoting Justice Black:

> [The FCA] is intended to protect the Treasury against the hungry and unscrupulous host that encompass it on every side, and should be construed accordingly. It was passed on the theory, based on experience as old as modern civilization, that one of the least expensive and most effective means of preventing frauds on the Treasury is to make the perpetrators of them liable to actions by private persons acting, if you please, under the strong stimulus of personal ill will or the hope of gain. Prosecutions conducted by such means compare with the ordinary methods as the enterprising privateer does to the slow-going public vessel.

Id. at 11, *as reprinted in* 1986 U.S.C.C.A.N. 5276 (*quoting United States v. Griswold,* 24 F.361, 366 (D.Ore.1885)). Thus, Congress viewed qui tam prosecutions as providing a means to achieve *rapid* exposure of fraud against the public fisc, unencumbered by the lack of resources or the bureaucracy inherent in enforcement by public authorities.

[7] Accordingly, we hold that § 3731(b)(2) was not intended to apply to private qui tam relators at all. We recognize that this interpretation creates the possibility that a relator who learns of fraudulent activity seven years after it occurs would be barred from bringing suit.[33] However, this result is more in accord with the FCA's stated purpose of encouraging prompt action on the part of relators and would discourage those relators who chose to delay on bringing an FCA claim, or refrain from informing the government of

33. The United States, however, could still independently bring an FCA claim as it would be able to avail itself of the tolling provision of § 3731(b)(2).

the fraud, to allow increasing damages to accrue. Congress cannot have intended such a result.

We are also concerned that a contrary interpretation, along the lines of that adopted by the *Hyatt* and *Downy* courts, would result in evisceration of the six-year statute of limitations in § 3731(b)(1) in the vast majority of cases. It is a cardinal principle of statutory construction that our duty is to "give effect, if possible, to every clause and word of a statute rather than to emasculate an entire section." *Lamb v. Thompson,* 265 F.3d 1038, 1051 (10th Cir. 2001) (quotation omitted). If relators could avail themselves of the tolling provisions of § 3731(b)(2), then we are hard pressed to describe a circumstance where the six year statute of limitations in § 3731(b)(1) would be applicable. Moreover, even if the statute was not ambiguous, the reading urged by the partial concurrence and partial dissent, and the court in *Colunga,* would run afoul of the absurdity doctrine. *See Public Citizen v. United States Dep't of Justice,* 491 U.S. 440, 455, 109 S.Ct. 2558, 105 L.Ed.2d 377 (1989) ("Looking beyond the naked text for guidance is perfectly proper when the result it apparently decrees is difficult to fathom or where it seems inconsistent with Congress' intention."). Surely, Congress could not have intended to base a statute of limitations on the knowledge of a non-party. Consequently, we conclude that the district court did not err when it interpreted § 3731(b) to bar Sikkenga's second FCA cause of action, and its dismissal of this claim is therefore, **AFFIRMED.**

IV

[8] Sikkenga's third FCA cause of action alleges that Regence fraudulently avoided CPEP score reductions by backdating a letter to a physician as part of a Comprehensive Medical Review, and by processing claims ARUP had resubmitted after Sikkenga's initial denial as adjustments rather than as reviews. Sikkenga presents two theories to support her claim. First, she argues that by engaging in these two actions, Regence "knowingly failed to perform properly under the Contract but submitted claims for administrative costs as though conforming services had been provided." Second, she contends that by avoiding CPEP score reductions Regence obtained renewals of its Medicare Part B contract, which HCFA would have otherwise terminated, and that each claim for administrative costs under the contract thereafter was therefore false.

In its analysis of this issue, the district court found that Sikkenga's third FCA cause of action failed to identify particular claims that were allegedly false under Federal Rule of Civil Procedure 9(b). The court also determined that Sikkenga's claim that the "alleged misrepresentations would have resulted in HCFA not renewing Regence's contract" was "hopelessly speculative" because there was no indication of whether or when HCFA would have decided not to renew the contract.

In reviewing a district court's dismissal pursuant to Rule 9(b) for failure to plead fraud with particularity, we accept as true all well-pleaded facts, as distinguished from conclusory allegations, and view those facts in the light most favorable to the non-moving party. *See Grossman v. Novell, Inc.,* 120 F.3d 1112, 1118 & n. 5 (10th Cir.1997). We confine our analysis to the text of the complaint. *Koch v. Koch Indus.,* 203 F.3d 1202, 1236 (10th Cir. 2000). Rule 9(b) states that "in all averments of fraud or mistake, the circumstances constituting the fraud or mistake shall be stated with particularity." Fed. R.Civ.P. 9(b). Its heightened pleading requirements apply to actions under the FCA. *See supra,* note 19. "At a minimum, Rule 9(b) requires that a plaintiff set forth the 'who, what, when, where and how' of the alleged fraud." *Thompson v. Columbia/HCA Healthcare Corp.,* 125 F.3d 899, 903 (5th Cir.1997), and must "set forth the time, place, and contents of the false representation, the identity of the party making the false statements and the consequences thereof." *Koch,* 203 F.3d at 1236.

Noticeably absent from Sikkenga's original complaint are any factual allegations supporting her first theory that Regence fraudulently submitted claims for services not performed under the contract. She fails to identify any specific claim made by Regence for administrative costs under its contract. Similarly she does not identify any claims that were presented to the government to support her second theory of FCA liability—that HCFA would have terminated Regence's contract but for their fraud. She insists that her failure to comply with Rule 9(b) should be excused however, because the information is exclusively in the control of Regence, and contends that "[b]y attaching a copy of the Contract and alleging fraudulent inducement [and] how Regence would have subsequently been paid under the contract," she has "sufficiently alleged that Regence submitted false claims for administrative costs to the government." We disagree.

[9] Liability under the FCA requires a false claim—a "defendant's presentation of a false or fraudulent claim to the government is a central element of every False Claims Act case." *United States ex rel. Karvelas v. Melrose–Wakefield Hosp.,* 360 F.3d 220, 232 (1st Cir.2004); *see also United States ex rel. Clausen v. Lab. Corp. of Am.,* 290 F.3d 1301, 1311 (11th Cir.2002); *Harrison v. Westinghouse Savannah River Co.,* 176 F.3d 776, 785 (4th Cir.1999). "Underlying schemes and other wrongful activities that result in the submission of fraudulent claims are included in the 'circumstances constituting fraud and mistake' that must be pled with particularity under Rule 9(b)." *Karvelas,* 360 F.3d at 232. However, unless such pleadings are "linked to allegations, stated with particularity, of the actual false claims submitted to the government," *id.,* they do not meet the particularity requirements of Rule 9(b). We agree with our sibling circuit, that:

> Rule 9(b)'s directive that 'the circumstances constituting fraud and mistake shall be stated with particularity' does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payment must have been submitted, were likely submitted or should have been submitted to the Government.

Clausen, 290 F.3d at 1311. We conclude that Sikkenga's complaint falls woefully short of adequately pleading that false or fraudulent claims were submitted by Regence. As stated by the First Circuit, to satisfy Rule 9(b)'s requirements:

> [A] relator must provide details that identify particular false claims for payment that were submitted to the government. In a case such as this, details concerning the dates of the claims, the content of the forms or the bills submitted, their identification numbers, the amount of money charged to the government, the particular goods and services for which the government was billed, the individuals involved in the billing, and the length of time between the alleged fraudulent practices and the submission of claims based on those practices are the types of information that may help a relator to state his or her claims with particularity. These details do not constitute a checklist of mandatory requirements that must be satisfied for each

> allegation included in a complaint. However, like the Eleventh Circuit, we believe that "some of this information, for at least some of the claims must be pleaded in order to satisfy Rule 9(b)."

Karvelas, 360 F.3d at 232–33 (footnotes omitted) (*citing Clausen,* 290 F.3d at 1312 n. 21). Sikkenga neither alleges the specifics of any actual claims submitted under either of her two theories, nor pleads any false certifications upon which she premises her claim under her first theory—for failing to perform in accordance with the contract, but submitting claims for payment as if Regence had.

We agree with the district court that Sikkenga's second theory—that Regence's alleged fraudulent manipulations of its CPEP scores, would, at some point, have resulted in the HCFA not renewing Regence's contract—was "hopelessly speculative in that there is no basis for the assertion that the alleged misrepresentations would have resulted in HCFA not renewing Regence's contract." Sikkenga's allegations under her second theory are flawed in many respects. The chain of causation required to tie Regence's alleged misrepresentations to a possible contract termination is attenuated, and lacks sufficient factual allegations to be anything more than conjecture.[34]

Sikkenga claims that Rule 9(b)'s requirements should be relaxed because the information is exclusively within the control of the Regence defendants. Although we acknowledge that courts have sometimes relaxed the requirements of Rule 9(b), we agree with the Fifth Circuit's caution that "this exception must not be mistaken for license to base claims of fraud on speculation and conclusory allegations." *Thompson,* 125 F.3d at 903 (quotation omitted). Further, even in circumstances where allegations of fraud may be based on information and belief, because the facts are peculiarly within the opposing party's knowledge, Rule 9(b) continues to require the complaint to "set[ ] forth the factual basis for the plaintiff's belief." *Koch,* 203 F.3d at 1237. Sikkenga's complaint does not state that its allegations regarding her third FCA cause of action are based on information and belief, nor do they set forth any factual basis, apart from the existence of the government contract, to support that any false claims were actually made. Because Rule 9(b) does not excuse the general and speculative nature of Sikkenga's allegations, we **AFFIRM** the district court's dismissal of Sikkenga's third FCA cause of action under Federal Rule of Civil Procedure 9(b).

V

[10] In her fourth and final FCA cause of action, Sikkenga alleges that the Regence defendants retaliated against her in violation of 31 U.S.C. § 3730(h), the FCA's Whistleblower Protection provision. Section 3730(h) states:

> Any employee who is discharged [or] demoted ... by his or her employer 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, shall be entitled to all

34. To follow Sikkenga's theory, one must accept that the two acts she alleges Regence committed would have resulted in a lowering of Regence's CPEP score, and that the lowering of the score alone would have resulted in the HCFA's decision to not renew Regence's contract. She provides no detail on the temporal proximity of the misrepresentation, the possible score reductions, or a time when the HCFA was considering the renewal of Regence's contract. Nor does she tie any specific claim thereafter to this series of events. Such a generalized daisy chain of causation does not meet the requirements of Rule 9(b).

relief necessary to make the employee whole.

31 U.S.C. § 3730(h). This claim was dismissed by the district court under Rule 12(b)(6) because Sikkenga failed to allege that the Regence defendants were on notice that she was acting in furtherance of a private qui tam or government FCA action. In *United States ex rel. Ramseyer v. Century Healthcare Corp.,* we held that,

> [w]hen seeking legal redress for retaliatory discharge under the FCA, plaintiff has the burden of pleading facts which would demonstrate that defendants had been put on notice that plaintiff was either taking action in furtherance of a qui tam action or assisting in an FCA action brought by the government.

90 F.3d 1514, 1522 (10th Cir.1996). This requirement is in full accord with the congressional purpose in passing § 3730(h):

> Section [3730(h)] provides relief only if the whistleblower can show by a preponderance of the evidence that the employer's retaliatory actions resulted 'because' of the whistleblower's participation in a protected activity. Under other Federal whistleblower statutes, the 'because' standard has developed into a two-pronged approach. One, the whistleblower must show the employer had knowledge the employee was engaged in "protected activity" and, two, the retaliation was motivated, at least in part, by the employee's engaging in protected activity.

S.Rep. No. 99–345, at 35 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5300.

In *Ramseyer,* we held that where employees' regular duties include investigation of fraud, such persons must clearly plead notice to their employers of their intentions of bringing or assisting in an FCA action in order to overcome the presumption that they are merely acting in accordance with their employment obligations. 90 F.3d at 1523 n. 7. In this case, as in *Ramseyer,* Sikkenga's duties included monitoring compliance with Medicare requirements. Sikkenga communicated to her superiors within the company and to Regence's internal fraud and abuse division, her belief that violations of these requirements were occurring. On the complaint, the district court determined that Sikkenga "only took actions that she claims she was authorized to take as part of her employment with Regence," and that she failed to allege either that she informed her superiors of her intention to bring an FCA action or that she was going to report Regence's noncompliance to government officials. The district court also found that Sikkenga had not alleged that she had indicated to Regence that she was contemplating a private qui tam action or was assisting in an FCA action brought by the government.

On our review of Sikkenga's complaint, we agree that it fails to allege that the Regence defendants had been put on notice that she was acting in furtherance of a private qui tam or government FCA action. Such an allegation is necessary to establish that Sikkenga's termination was "because" of her protected activity. Because she starkly fails to allege this causal link, we **AFFIRM** the district court's dismissal of her FCA whistleblower retaliation claim.

VI

[11] Ruling that Sikkenga had failed to allege a clear and substantial public policy offended by Regence's termination of her employment in violation of Utah law, the district court dismissed her state law claim as well. Sikkenga argues that this decision was in error.[35] In order to prove a tort of wrongful discharge under Utah law, a plaintiff must prove that "(1) her employment was terminated, (2) a clear and substantial public policy existed, (3) the plaintiff's conduct implicated that clear and substantial public policy, and (4) the termination and conduct in furtherance of the public policy are causally connected." *Rackley v. Fairview Care Ctrs., Inc.*, 23 P.3d 1022, 1026 (Utah 2001).

[12–15] This claim was dismissed by the district court because Sikkenga failed to allege a clear and substantial public policy as a prima facie element of her claim for wrongful termination. Under Utah law, "[t]he public policy exception to the employment at will presumption is much narrower than traditional notions of public policy," and is to be narrowly construed. *Id.* at 1026–27. A "clear" public policy must be plainly defined by one of three sources: (1) legislative enactments, (2) constitutional standards, or (3) judicial decisions, and is "substantial" only if it is of "overreaching importance to the public, as opposed to the parties only." *Id.* at 1027. Whether a clear and substantial public policy exists to support an employee's wrongful termination claim is a question of law. *Id.* at 1026.

[16] The district court determined that, "[w]ithout a valid False Claims Act claim against Regence, . . . Sikkenga has not demonstrated a clear and substantial public policy for her wrongful termination claim against Regence." As discussed in II.B and II.C supra, the district court erred when it dismissed Sikkenga's claims under Rule 12(b)(6) because her complaint adequately alleged that Regence caused ARUP to present false or fraudulent claims to the United States in violation of the FCA—actions for which Regence is not immune.[36] Because the district court's determination that Sikkenga had failed to allege a wrongful termination in violation of public policy was premised on its conclusion that Regence was immune under 42 U.S.C. § 1395u(e), its dependent determination that Sikkenga has failed to allege a clear and substantial public policy necessarily fails as well.[37] Thus, we **REVERSE**

35. The district court exercised supplemental jurisdiction over Sikkenga's state law causes of action under 28 U.S.C. § 1367, finding that her state law claims against Regence for wrongful termination were factually related enough to the FCA claim against ARUP that the principles of judicial economy, fairness, and convenience would be served by allowing Sikkenga's state law claims to remain in the same action. The exercise of this discretion has not been appealed, nor has the district court's disposition of Sikkenga's remaining state law causes of action.

36. We emphasize again that we take no position on whether Sikkenga's allegations, that Regence ''caused'' the false claims to be presented as discussed in II.C *supra*, meet the requirements of adequately alleging a violation of the FCA under Rule 9(b). Because Sikkenga's state law claim is dependent on a ''valid FCA claim'' against Regence, such a determination will also be relevant to resolution of the state law claim on remand. We also note that Sikkenga did not appeal the district court's dismissal of her claim against defendant Mitchell individually, based on its determination that Utah law did not provide for liability against a supervisor for wrongful termination. Our ruling does not disturb that determination as the law of the case.

37. Sikkenga also argues that her wrongful termination allegation identified the public policy of encouraging employees to resist pressure to engage in, facilitate, or conceal illegal activity as established in Utah Supreme Court case law. The district court, however, held that she had failed to allege any criminal conduct in her complaint, only civil wrongs, and accordingly held that this claim did not amount to pleading a clear and substantial public policy, refusing to allow her to overcome deficiencies in stating a claim by ''making arguments that extend beyond the allegations in the complaint.'' *Jojola v. Chavez,* 55 F.3d 488, 494 (10th Cir.1995) (''It is well-the district court's dismissal of Sikkenga's state law wrongful termination claim to the extent that the clear and substantial public policy it alleges is a violation of the FCA, and **REMAND** for further proceedings consistent with this decision.

VII

Accordingly, dismissal of the FCA Claim 1, the "presenting" claim against ARUP and the "causing to be presented" claim against Regence, under Rule 12(b)(6) is **REVERSED;** dismissal of Claim 2, the FCA claim involving the 1992 false budget request submitted by Regence, under Rule 12(b)(6) is **AFFIRMED;** dismissal of Claim 3, the CPEP score manipulations and contract renewal claim, under Rule 9(b) is **AFFIRMED;** dismissal of Claim 4, the FCA Whistleblower Retaliation claim against Regence, under Rule 12(b)(6) is **AFFIRMED;** and dismissal of the state law claim of wrongful termination in violation of public policy against Regence, under Rule 12(b)(6) is **REVERSED.**[38] The case is **REMANDED** for further proceedings consistent with this opinion. 05–4088, *United States ex rel. Sikkenga v. Regence.*

HARTZ, Circuit Judge
concurring/dissenting.

I join Parts I, II(A), II(C)(1), II(C)(3), II(D), IV, and VI of Judge Lucero's opinion. I concur in the result in Parts II(B) and II(C)(2). I dissent from Part III.

I. Special Concurrence Regarding Part II(B) (Regence Immunity)

I agree that Regence is not immunized by 42 U.S.C. § 1395u(e) (1994) from all liability arising from its payment of claims. As I shall try to explain, I think that the most reasonable reading of § 1395u(e)(3) is that it immunizes the carrier from liability for an employee's act when the employee is immunized from liability for that act by paragraph (1) or (2) of § 1395u(e).

Section 1395u(e) states:

> (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.
>
> (2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.
>
> (3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

The thrust of subsection (e) is to eliminate suits based on errors committed without gross negligence or fraudulent intent. Paragraph (1) says that the certifying officer is not liable for certifying a payment unless the officer acted with gross negligence or fraudulent intent. Paragraph (2) states that the disbursing officer is not liable for making a certified payment unless the officer acted with gross negligence

established, however, that in determining whether to grant a motion to dismiss, the district court, and consequently this court, are limited to assessing the legal sufficiency of the allegations contained within the four corners of the complaint.''). We agree that her complaint fails to allege a criminal violation. On appeal, she attempts to argue that her factual pleadings amount to an allegation of participating in a crime. Relying on *Jojola,* we also will not allow Sikkenga to advance arguments before us that extend beyond the allegations in her amended complaint.

38. Any further pending motions before this court are denied.

or fraudulent intent. Then, to avoid suits that skip the middleman and go directly against the carrier, paragraph (3) immunizes the carrier from liability when its employee is immune.

To be sure, paragraph (3)'s language poses difficulties. For one thing, it is unclear what the antecedent of *such* is in the phrase "such carrier." Much more importantly, the phrase "any payments referred to in paragraph (1) or (2)" is ambiguous. Regence would have us read the phrase as encompassing all payments, or at least all payments certified by a certifying officer. This is a possible reading. After all, paragraphs (1) and (2) describe payments certified by a certifying officer for which a certifying or disbursing officer may be liable (when the certifying or disbursing officer acts with gross negligence or intent to defraud) and payments certified by a certifying officer for which the certifying or disbursing officer is immune from liability (when there is no such gross negligence or fraudulent intent). Thus, paragraphs (1) and (2) can be said to "refer to" certified payments for which the officers are immune and certified payments for which they are not—that is, *all* certified payments. Under Regence's reading, carriers would be immune under paragraph (3) from liability for *all* payments certified by a certifying officer.

But if the intent of paragraph (3)—"No ... carrier shall be liable ... for any payments referred to in paragraph (1) or (2)"—were to immunize carriers for *all* payments certified by certifying officers, one wonders why the drafters chose such a peculiar way to say it. A more natural mode of expression would have been, "no carrier shall be liable for any payments *certified by a certifying officer.*" And if the "payments referred to in paragraph (1) or (2)" are both payments for which an officer may be liable and payments for which an officer is immune, why include "or (2)" at the end of the quoted phrase? Nothing would be lost by saying merely "any payment referred to in paragraph (1)," because—if one says that each paragraph "refers to" payments for which there may be liability as well as payments for which there is immunity—the same payments are "referred to" in both paragraphs (1) and (2). Each paragraph, under Regence's reading, addresses *all* certified payments: For each payment, the certifying officer is either subject to liability or immune, and the same goes for the disbursing officer; paragraph (1) addresses the certified payments for which certifying officers are immune or may be liable (that is, all certified payments), and paragraph (2) addresses certified payments for which disbursing officers are immune or may be liable (that is, all certified payments). Thus, in the phrase "payments referred to in paragraph (1) or (2)," the words "or (2)" are surplusage. Ordinarily, we should avoid a construction of a statute that renders portions of the statutory language superfluous. *See Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy,* ––– U.S. ––––, –––– n. 1, 126 S.Ct. 2455, 2460 n. 1, 165 L.Ed.2d 526 (2006) (but noting that "instances of surplusage are not unknown").

I would interpret paragraph (3) differently. First, one must read § 1395u(e) in context. That context is liability for erroneous payments. It makes no sense to provide immunity unless the immunized conduct may otherwise generate liability. Correct payments do not generate liability. The risk of liability arises only when a certifying or disbursing officer, through fault (negligence or otherwise), does something leading to an erroneous payment. Accordingly, when paragraph (1) says that a certifying officer shall not be liable "with respect to any payments certified by him under this section," it is implicitly referring only to payments for which the officer would otherwise be liable—that is, payments based on certifications that were erroneous because of the officer's fault. Immunity would be unnecessary with respect to any other payments.

The purpose of paragraph (1), then, is to carve out from the set of payments for which the certifying officer may be liable those payments for which the officer is immune. Those payments are payments that were erroneously made because of the certifying officer's fault, but when the fault did not rise to gross negligence or intentional fraud. Given that purpose, it is natural to say that the payments "referred to in paragraph (1)" are the carved-out payments, those for which the certifying officer might have been liable (because of fault) but for the immunity provided when the officer did not act with gross negligence or fraudulent intent.

Similarly, the payments "referred to in paragraph . . . (2)" are the certified payments for which the disbursing officer might have been liable but for his statutory immunity. And paragraph (3)'s protection of carriers from liability for "any payments referred to in paragraph (1) or (2)" therefore provides essentially respondeat-superior immunity. If the carrier would otherwise be liable for an erroneous certified payment because of the fault of a certifying or disbursing officer, the carrier is immune when the officer did not act with gross negligence or intent to defraud.

Accordingly, I join the majority in rejecting Regence's defense that it is immune under § 1395u(e) from Sikkenga's claim.

II. Special Concurrence Regarding Part II(C)(2)—Causation

I also agree with the majority that Sikkenga's complaint states a claim that Regence caused ARUP to submit a false claim. In my view, however, we should be wary of applying tort concepts of causation to the False Claims Act because of its long-term congruence with a criminal statute and its present punitive provisions.

I begin with some history of the False Claims Act. The original 1863 Act was a criminal statute which included a provision for civil claims. Section 1 imposed a criminal penalty on military personnel who "present[ed] or cause[d] to be presented for payment or approval . . . any claim upon or against the Government of the United States . . . knowing such claim to be false, fictitious, or fraudulent." (I fail to see a material difference from the present language of 31 U.S.C. § 3729(a): "knowingly presents, or causes to be presented . . . a false or fraudulent claim for payment or approval.") Section 3 of the 1863 statute applied to nonmilitary personnel, imposing civil liability (double damages and a $2,000 penalty) on those "who shall do or commit any of the acts prohibited by any of the foregoing provisions," as well as criminal punishment if convicted. In 1874 the criminal provisions of former sections 1 and 3 were consolidated in Revised Statutes of the United States, Title 70 (Crimes) § 5438, while the civil provisions were moved to Title 36 (Debts Due by or to the United States). But the civil provisions still cross-referenced the criminal statute for a description of the prohibited conduct. *See* Rev. Statutes, Title 36 § 3490 ("any [nonmilitary] person . . . who shall do or commit any of the acts prohibited by any of the provisions of [§ 5438] shall forfeit [$2,000 plus double damages]"). Although § 5438 was repealed in 1909 and replaced by two separate criminal statutes, the repealed statute "ha[d] continued vitality . . . insofar as it specifie[d] the acts giving rise to civil liability under § 3490." *United States v. Bornstein,* 423 U.S. 303, 305 n. 1, 96 S.Ct. 523, 46 L.Ed.2d 514 (1976). Only in 1982 did Congress enact legislation that made the False Claims Act's civil provisions free-standing, without a cross-reference to a criminal statute. *See* Pub.L. No. 97–258, § 3729, 96 Stat. 877, 978 (1982).

Courts strictly construe ambiguous language in criminal statutes in favor of lenity. *See United States v. Kozminski,* 487 U.S. 931, 952, 108 S.Ct. 2751, 101 L.Ed.2d 788 (1988). This rule of strict construction applies even when the language is applied in a civil context. *See Crandon v. United States,* 494 U.S. 152, 158, 110 S.Ct. 997, 108 L.Ed.2d 132 (1990) ("[B]ecause the governing standard is set forth in a criminal statute, it is appropriate to apply the rule of lenity in resolving any ambiguity in the ambit of the statute's coverage."). Thus, at least through 1982 the civil provisions of the False Claims Act were to be construed strictly. Indeed, *United States v. McNinch,* 356 U.S. 595, 78 S.Ct. 950, 2 L.Ed.2d 1001 (1958), in holding that an application for credit insurance was not a "claim" within the meaning of the False Claims Act, stated: "[I]t must be kept in mind ... [that] we are actually construing the provisions of a criminal statute. Such provisions must be carefully restricted, not only to their literal terms but to the evident purpose of Congress in using those terms, particularly where they are broad and susceptible to numerous definitions," *id.* at 598, 78 S.Ct. 950 (internal footnote omitted). To be sure, the civil and criminal provisions have since then been technically divorced; but the pertinent language of the civil provision has not materially changed, so there is no reason to believe that the language should be interpreted any differently now than it should have been in 1909 (or 1982). *See Cook County v. United States ex rel. Chandler,* 538 U.S. 119, 132, 123 S.Ct. 1239, 155 L.Ed.2d 247 (2003) (refusing to infer that 1986 amendments to False Claims Act silently redefined the word *person* in the statute).

Reinforcing this view is that the False Claims Act is a punitive statute, and civil punitive statutes, like criminal statutes, are to be construed strictly. *See Comm'r v. Acker,* 361 U.S. 87, 91, 80 S.Ct. 144, 4 L.Ed.2d 127 (1959). The Act is punitive in two respects. The availability of treble damages, even though it has "a compensatory side," *Cook County,* 538 U.S. at 130, 123 S.Ct. 1239, also has a punitive character, *see Vt. Agency of Natural Res. v. United States ex rel. Stevens,* 529 U.S. 765, 785, 120 S.Ct. 1858, 146 L.Ed.2d 836 (2000). In addition, § 3729(a)(7) of the Act provides for a penalty of $5,000 to $10,000 regardless of actual damages. *See Wood, Walker & Co. v. Evans,* 461 F.2d 852, 855 (10th Cir.1972) (courts strictly construe statutes under which "the amount of the damages is fixed in a somewhat liquidated measure without regard to injury suffered").

Accordingly, I would refrain from "borrow[ing] traditional principles of tort law to analyze causation for damages under the FCA." Op. at 23. At this stage of the case, however, it is unnecessary to explore the precise scope of causation under the False Claims Act. We are reviewing a dismissal for failure to state a claim. The allegations of the Complaint are therefore taken as true. Sikkenga alleges that any claim submitted to Regence with diagnosis code 796.4 is a false claim. I confess to some skepticism about the allegation. I would think that a claim submitted with an improper code is simply an improperly documented claim; the underlying claim may still be proper, and compensable once the documentation is corrected. But Regence has not challenged the allegation, perhaps because it is a matter to be decided after the presentation of evidence, not when ruling on the pleadings. As for causation, Sikkenga's complaint explicitly alleges that Regence "caused ARUP to present false claims for payment or approval." Aplt.App. at 489 (Am. Compl. at ¶ 140). Moreover, Sikkenga describes the manner of causation. She alleges that Regence told ARUP that it would accept claims submitted with a 796.4 code. Given the ongoing relationship between Regence and ARUP, for Regence to inform ARUP that it would process claims that are false on their face could, in my view, constitute causing, in the criminal-law sense, ARUP to submit false claims. The typical context in which "causing" an act to occur arises in criminal cases is when the act is performed by an innocent party rather than by a partner in crime. For example, in a mail-fraud case the defendant "causes" a mailing to take place by handing the envelope to a friend or secretary to take to the post office, or by depositing an out-of-state check in a bank (which, at least in the old days, would need to mail the check to the originating bank for clearance). *See, e.g., Pereira v. United States,* 347 U.S. 1, 8–9, 74 S.Ct. 358, 98 L.Ed. 435 (1954). What the defendant does is to set in motion a process that in the ordinary course will result in the prohibited action, without the need for any intermediary to have a nefarious motive. Sikkenga's complaint appears to encompass an allegation that Regence in this sense caused the filing of false claims by ARUP—perhaps ARUP had a nefarious motive, but false claims would have been submitted regardless of that motive.

I should add, however, that I doubt that causation could be shown by evidence that Regence said only that it would accept claims (that may or may not be legitimate) without adequate documentation substantiating that they are proper. In that circumstance, the submitter of the claims is not being advised to submit false claims, only that it is being trusted not to do so.

III. Dissent Regarding Part III (Statute of Limitations)

Finally, I disagree with the majority's construction of the False Claims Act statute of limitations, 31 U.S.C. § 3731(b). The statute reads:

(b) A civil action under section 3730 may not be brought—

(1) more than 6 years after the date on which the violation of section 3729 is committed, or

(2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed.

whichever occurs last.

I join the majority in rejecting the Ninth Circuit's view in *United States ex rel. Hyatt v. Northrop Corp.,* 91 F.3d 1211 (9th Cir.1996), that a relator can be "the official of the United States charged with responsibility to act" in paragraph (2). But I cannot agree that the statute can be read to say that paragraph (2) does not apply to suits by relators. Our view of what Congress must have intended cannot substitute for statutory language. *See Robbins v. Chronister,* 435 F.3d 1238, 1241 (10th Cir.2006) (en banc) (strictly limiting use of absurdity doctrine to construe statute contrary to its language). Congress may have wanted to limit relators to the six-year limitation period; but it did not say so. I agree with District Judge Benson that there is no ambiguity to resolve. *See United States ex rel. Colunga v. Hercules, Inc.,* No. 89–CV–954B, 1998 WL 310481, *5 (D.Utah Mar.6, 1998). The majority's invocation of the absurdity doctrine makes no attempt to establish the satisfaction of the extremely strict conditions for application of that doctrine set forth in our recent unanimous en banc opinion on the subject. *See Robbins.* In any event, as Judge Benson explained, the plain meaning of § 3731(b) is not absurd. Congress could well have decided that a relator should not be time-barred if the government is not. To bar the relator but not the government may accomplish nothing more than preventing the relator from securing her just reward in bringing the matter to court. I would not foreclose, however, the possibility that an equitable doctrine implicitly incorporated in the statute could bar a relator who delays, for improper reasons, reporting fraud to the Government. *Cf. Young v. United States,* 535 U.S. 43, 49, 122 S.Ct. 1036, 152 L.Ed.2d 79 (2002) (noting that equitable tolling is a background principle generally applied in construing statutes of limitations).

Jean McGOWAN, Plaintiff–Appellant,

v.

CITY OF EUFALA, a municipal corporation, Mayor Billy Ray Day, in his official and individual capacities, and Chad French, in his individual and official capacities, Defendants–Appellees.

No. 04–7083.

United States Court of Appeals,
Tenth Circuit.

Dec. 19, 2006.

Background: City employee, who was police dispatcher and jailer, brought Title VII action against city, mayor, and others alleging retaliation for supporting coworker's allegations of race discrimination. The United States District Court for the Eastern District of Oklahoma, Lee R. West, J., granted summary judgment in favor of defendants and plaintiff appealed.

Holdings: The Court of Appeals, Tymkovich, Circuit Judge, held that:

(1) employer did not take adverse action against employee when it failed to reassign her to day shift;

(2) city did not create a hostile work place for employee;

(3) jailer was not similarly situated with booking officer;

(4) jailer's failure to conduct required visual inspections of prisoner who committed suicide was legitimate, non-retaliatory reason for her termination; and

(5) legal counsel's advise to city to not have employee work with coworker for whom she was going to be a witness was legitimate, non-retaliatory reason for denying employee's request for reassignment.

Affirmed.

1. Civil Rights 🔑1243

To establish a prima facie claim under Title VII for retaliation, an employee must establish three elements: (1) she engaged in protected opposition to discrimination; (2) a reasonable employee would have found the challenged action materially adverse; and (3) a causal connection exists between the protected activity and the materially adverse action. Civil Rights Act of 1964, § 701 et seq., 42 U.S.C.A. § 2000e et seq.

2. Civil Rights 🔑1245

A challenged employment action is adverse for the purposes of a claim for re-

KeyCite Yellow Flag - Negative Treatment
Disagreed With by Tyger Const. Co. Inc. v. U.S., Fed.Cl., March 31, 1993

697 F.Supp. 167
United States District Court, D. New Jersey.

UNITED STATES of America, Plaintiff,
v.
BOARD OF EDUCATION OF the CITY OF UNION CITY, et al., Defendants.

Civ. A. No. 83–2651.
|
Aug. 17, 1988.
|
As Amended Sept. 26, 1988.

Synopsis

United States sought summary judgment on issue of damages in underlying civil suit brought by Government for violations of False Claims Act, common-law fraud, breach of contract, unjust enrichment and conversion. The District Court, Wolin, J., held that: (1) retroactive application of amended False Claims Act to pending case was appropriate; (2) Government's failure to prove, or even allege, what was done with money advanced to local officials for use on certain portions of high school improvement project precluded use by Government of substandard product formula to determine damages under False Claims Act; (3) claims made against city Board of Education were "claims" against United States within meaning of False Claims Act; (4) false quarterly reports and false interim report fell within provision of False Claims Act prohibiting knowing use of false record or statement to get false claim, even though each individual report did not trigger separate payments; and (5) defendants were jointly and severally liable for all damages and penalties.

Partial summary judgment granted.

West Headnotes (15)

[1] **Statutes** Language and Intent; Express Provisions
Statutes Application to pending actions and proceedings

Generally, new statute applies to cases pending on date of its enactment unless manifest injustice would result, or there is statutory directive or legislative history to contrary.

4 Cases that cite this headnote

[2] **United States** Statutory provisions

Retroactive application to pending case of amendment of False Claims Act to increase penalties was appropriate, where defendants had no identifiable legal right as to magnitude of sanctions applicable to violations of law, and defendants received adequate notice that their liability would be considerable. 31 U.S.C.A. §§ 3729–3731.

5 Cases that cite this headnote

[3] **United States** Damages

Where defendants are found responsible for particular false claims, they are jointly and severally liable for penalty under False Claims Act in addition to any damages of theft. 31 U.S.C.A. §§ 3729–3731.

1 Cases that cite this headnote

[4] **United States** Damages

False Claims Act allows United States to recover only damages for harm actually sustained due to defendants' fraudulent acts. 31 U.S.C.A. §§ 3729–3731.

1 Cases that cite this headnote

[5] **United States** Measure of damages

Government's failure to prove, or even allege, what was done with federal money advanced to local officials for use on certain portions of high school improvement project precluded use by Government of substandard product formula to determine damages under False Claims Act. 31 U.S.C.A. §§ 3729–3731.

[6] **United States** Offenses and Prosecutions

Not every false statement made to Government qualifies as claim under False Claims Act; rather, only actions which have purpose or effect of causing Government to pay out money are clearly claims within purpose of Act. Fed.Rules Civ.Proc.Rule 56(c), 28 U.S.C.A.

3 Cases that cite this headnote

[7] **United States** Elements

Claims made against city board of education were "claims" against United States within meaning of False Claims Act, where city and its board of education had applied for funds from the Economic Development Administration, funds were granted and letters of credit were provided to board of education construction account, false requests for funds were paid by checks drawn on that account, and Government control of money remained through requirement that board of education comply with EDA regulations and specifications. 31 U.S.C.A. § 3729(a)(1).

4 Cases that cite this headnote

[8] **United States** Falsity

False quarterly reports and false interim report fell within provision of False Claims Act prohibiting knowing use of false record or statement to get false claim, even though each individual report did not trigger separate payments, where release of funds from United States was predicated upon grant agreement which required periodic submission of accurate reports. 31 U.S.C.A. § 3729(a)(3).

1 Cases that cite this headnote

[9] **United States** Civil penalties

Existence of conspiracy under False Claims Act is separate violation of Act and therefore entitles United States to separate statutory penalty for which each participant in conspiracy is jointly and severally liable. 31 U.S.C.A. § 3729(a)(3).

2 Cases that cite this headnote

[10] **United States** Civil penalties

Penalty under False Claims Act provision concerning conspiracy to defraud may be levied even in event United States suffered no actual damages. 31 U.S.C.A. § 3729(a)(3).

[11] **United States** Damages

Defendants in action to recover damages and penalties under False Claims Act would be held jointly and severally liable for all damages and penalties assessed against them; based upon finding of conspiracy to defraud Government, every act in furtherance of that conspiracy could be attributed to each and every coconspirator. 31 U.S.C.A. §§ 3729–3731.

3 Cases that cite this headnote

[12] **Estoppel** Nature and Application of Estoppel in Pais

Estoppel United States government, officers, and agencies in general

"Estoppel" is equitable doctrine invoked by courts to preclude party from asserting claim or defense which is premised upon that party's wrongdoing; however, showing of affirmative misconduct is necessary to invoke this doctrine against Government.

3 Cases that cite this headnote

[13] **Estoppel** Prejudice to person setting up estoppel

Inability to retain money that should not have been received is not detriment that gives rise to estoppel.

[14] **Estoppel** Particular United States officers, agencies, or proceedings

Actions of government informant under supervision of three Justice Department agents in delivering fraudulent back-dated performance bonds, without which conspiracy to pocket federal funds earmarked for school improvement project arguably may not have been possible, did not bar United States, on grounds of estoppel, from recovering damages under False Claims Act; detriment claim was inability to retain money that should not have been received in first place, and it was not reasonable for defendants to rely upon issuance of fraudulent bonds in breaking law, and Government in no way led defendants to believe their conduct was legal. 31 U.S.C.A. §§ 3729–3731.

3 Cases that cite this headnote

[15] **United States** Damages

Actual reliance is not essential to recovery of damages under False Claims Act. 31 U.S.C.A. §§ 3729–3731.

Attorneys and Law Firms

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OPINION

WOLIN, District Judge.

I. INTRODUCTION

In the instant motion, plaintiff, the United States, seeks summary judgment on the issue of damages in the underlying civil suit brought by the government for violations of the False Claims Act, 31 U.S.C. §§ 3729–3731, common law fraud, breach of contract, unjust enrichment and conversion. The present action follows the criminal convictions of many of the defendants for their roles in a plan to pocket federal funds earmarked for the purpose of improving Union City schools. On October 15, 1985, Judge Sarokin granted partial summary judgment in favor of the United States on the issue of liability against defendants William V. Musto, John J. Powers, Frank Scarafile, Gildo Aimone, Anthony Genovese, Dominick D'Agostino and Lawrence Dentico on Counts I, II, and III of the Complaint. *United States v. Board of Education of Union City, et al.,* Civ. No. 83–2651, slip op. at 3 (D.N.J., filed October 15, 1985).[1] Contemporaneously, summary judgment on the issue of damages was denied without prejudice to the right of the government to file supplemental briefs detailing its claim. *Id.* The current motion by the United States follows its submission of a supplemental brief detailing its damage claim. It seeks to establish damages against defendants Musto, Powers, Scarafile, Aimone, Genovese, D'Agostino and Dentico for their violations of the False Claims Act.

II. BACKGROUND

A. *The Defendants*

The defendants to this suit are: William V. Musto, former Union City Mayor and State Senator; John Powers, former Union City Board of Education President; Frank Scarafile, former school board member and Union City Deputy Police Chief; Gildo Aimone, who acted as the authorized representative of the board in acquiring and ***170** distributing the federal funds; Anthony Genovese and Herbert Maddalene, partners in an architectural firm hired by the Board to supervise the construction projects; the architectural firm of Genovese and Maddalene; Dominick D'Agostino and Lawrence Dentico, both of whom had an interest in and exercised control over construction firms involved in the high school projects; and the Union City Board of Education.

Some of the defendants are currently serving prison terms for racketeering, mail and wire fraud, and other related offenses. These were committed in connection with the conspiracy that existed to defraud the government. The opponents to this motion, Musto, Powers, Aimone, D'Agostino, Genovese, [2] and Scarafile are all acting *pro se;* Dentico is represented by counsel.

B. *The Fraudulent Scheme*

In 1977, Union City and the Union City Board of Education applied to the EDA for funds to improve Union Hill and Emerson High Schools. Defendant Musto, as Mayor, signed the applications, certifying that the funds would be used according to regulations, and that the EDA would be provided with reports on the project's progress and the disbursement of funds. Grants ultimately totalling $4,462,000 were provided. Defendant Powers signed to accept the grants, reaffirming that the funds would only be used for genuine costs incurred in the high school projects.

Thereafter, it is alleged that defendants Musto, Powers, Scarafile and Genovese agreed to “bend the law” to assist the Orlando Construction Co., controlled by defendants Dentico and D'Agostino; that the defendants, through Aimone, advanced funds to Orlando on a fraudulent basis; and that Genovese certified false reports and change orders submitted to obtain funding.

The government maintains that $940,280 in grant money fell victim to this scheme and did not go into improving Union Hill and Emerson High Schools. The government claims that this figure represents the damages sustained as a result of the submission of false or fraudulent claims. As already noted, defendants Musto, Powers, Scarafile, Genovese, Aimone, D'Agostino and Dentico were found liable for such damages under Counts I, II and III. In the instant motion, the United States seeks to establish the amount of damages owed to it under the False Claims Act, for which defendants are jointly and severally responsible. Additionally, the United States seeks to impose a penalty against every defendant for each of the 21 alleged violations of the False Claims Act. For the following reasons this motion is granted in part and denied in part.

III. DISCUSSION

A. *Standard for Summary Judgment*

Summary judgment may be granted only when it has been established that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). The moving party has the burden of establishing that there exists no genuine issue of material fact. *Anderson v. Liberty Lobby,* 477 U.S. 242, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). The opposing party must set forth specific facts showing that a genuine issue exists. *Id.* In deciding a motion for summary judgment, the facts must be viewed in the light most favorable to the non-moving party and any reasonable doubt as to the existence of a genuine issue of fact must be resolved against the moving party. *Continental Ins. Co. v. Bodie,* 682 F.2d 436 (3d Cir.1982).

B. *Application of Amended Statute*

It is appropriate for this Court to apply the current version of 31 U.S.C. § 3729 to the motion before it. The crucial differences between the False Claims Act as it existed when this case was filed and the False Claims Act as amended in 1986 are that treble damages rather than double ***171** damages are now awarded, and that the penalty figure has risen from $2,000 per violation to between $5,000 and $10,000.

[1] Generally, a new statute applies to cases pending on the date of its enactment unless manifest injustice would result, or there is a statutory directive or legislative history to the contrary. *United States v. Fernandez–Toledo,* 749 F.2d 703,705 (11th Cir.1985); *United States v. Ford,* 737 F.2d 1506, 1508 (9th Cir.1984); *Central Freight Lines, Inc. v. United States,* 669 F.2d 1063, 1069 (5th Cir.1982) (citing *Corpus v. Estelle,* 605 F.2d 175, 180 (5th Cir.1979), *cert. denied,* 445 U.S. 919, 100 S.Ct. 1284, 63 L.Ed.2d 605 (1980)) (citing *Bradley v. Richmond School Board,* 416 U.S. 696, 94 S.Ct. 2006, 40 L.Ed.2d476 (1974)). In the instant case, no statutory directive exists indicating that the amended form of 31 U.S.C. § 3729 should not be retroactively applied to pending cases. Legislative history indicates, if anything, that legislators were anxious for the amendments passed in 1986 to go into effect immediately. S.Rep. No. 345, 99th Cong., 2d Sess., *reprinted in* 1986 U.S.Code Cong. & Admin.News 5266. The issue of manifest injustice, however, requires a more detailed analysis.

Bradley sets forth a three part test to determine whether manifest injustice would result from the application of a new law: the nature and identity of the parties, the nature of the parties' rights, and the impact of the change in law on those rights. *Bradley v. Richmond School Board,* 416 U.S. at 716–21, 94 S.Ct. at 2019–21 (1974). In *Central Freight Lines,* this test was applied when a decision of the Interstate Commerce Commission ("ICC") was contested by short haul motor carriers operating in Texas. The decision granted eight new long haul carriers permission to operate in the state. In 1978, the eight long haul carriers applied for this right under the Motor Carrier Act of 1935; they were granted permission under the 1980 version of the Act which had been passed during the pendency of their applications. Despite objections from the short haul carriers, who contended that the 1935 Act should have been used in reviewing the applications, the Court of Appeals affirmed the ICC's use of the new law. 669 F.2d at 1069. Specifically, the Fifth Circuit found that no injustice occurred regarding the second and third parts of the test because the new law did not unfairly deprive the appellants (*i.e.,* the short haul carriers) of any legal rights. The court stated that these carriers did not have the unconditional right to render their services without competition from others, nor did they have any vested right to have such competition determined under the old law. *Id.*

[2] In the case at hand, there exists even less of a chance of injustice; these defendants had no identifiable legal right as to the magnitude of sanctions applicable to violations of the law. Neither the nature of the defendants' rights nor the impact of the change in § 3729 constitutes manifest injustice. Thus, the second and third prongs of the *Bradley* test are satisfied.

As for the nature of the parties, the first prong under *Bradley, Central Freight Lines* states that this factor should be weighed against the second and third. The fact that most of the defendants are acting *pro se,* and that they may not be as capable in the presentation of this case as is plaintiff, is outweighed by the fact that defendants knew they would be responsible for a great deal of money as a result of their unlawful actions in the event that their scheme was found out. Whether this figure is tripled or "merely" doubled, it is still a very large sum. There is no reason to believe that if defendants had known the damages and penalties would be greater (by a factor of one) than those existing at the time of the fraud, then they would have been deterred from their acts. Defendants received adequate notice that their liability would be considerable.

In addition to the lack of manifest injustice, it is well established that statutes relating to remedies are retroactively applicable to pending litigation. *Friel v. Cessna Aircraft Co.,* 751 F.2d 1037, 1039 (9th Cir.1985); *United States v. Blue Sea Line,* 553 F.2d 445, 448 (5th Cir.1977); ***172** *Amoco Production Co. v. Douglas Energy Co., Inc.,* 613 F.Supp. 730, 737 (D.Kan.1985); *Jorae v. Clinton Crop Service,* 465 F.Supp. 952, 955 (D.Mich.1979); *Grenier v. United States Internal Revenue Service,* 449 F.Supp. 834, 842 (D.Md.1978). A statute is remedial if it does not create any new rights, or eliminate any vested ones, but rather it only acts in furtherance of an already existing remedy. *Jorae,* 465 F.Supp. at 955.

C. *False Claims Act,* *31 U.S.C. § 3729 (1986)*

[3] The False Claims Act provides for a civil penalty that equals the combined total of: a $5,000 to $10,000 penalty for *each* violation of the False Claims Act (hereafter, "statutory penalty"), and three times the damages that the government sustains as a result of the violations (hereafter, "statutory damages").[3] Where defendants are found responsible for a particular false claim, they are jointly and severally liable for the penalty in addition to any damages assessed. *United States v. American Packing Corp.,* 125 F.Supp. 788, 797 (D.N.J.1954).

1. *Statutory Damages.*

[4] The False Claims Act allows the United States to recover only damages for harm actually sustained due to defendants' fraudulent acts. *United States v. Cooperative Grain and Supply Co.,* 476 F.2d 47, 63 (8th Cir.1973); *United States v. Collyer Insulated Wire Co.,* 94 F.Supp. 493, 498 (D.R.I.1950). There are two formulas that have been used to calculate actual damages where a benefit has been received from the perpetrator of the fraud, *United States v. Ben Grunstein & Sons Co.,* 137 F.Supp. 197, 205 (D.N.J.1956), either the "substandard product" formula or the "fraudulently inflated price" formula. *Id.* The United States indicated in its brief that the damages it sustained resulted from its receipt of a substandard product. However, inasmuch as it did not allege specifically that the product which it received was substandard, this fact may be gleaned only from the formula the government proposes for the calculation of said damages.[4] Additionally, the government proposes that the court apply the substandard product formula to only the ill-gotten funds, rather than to the relative values of the project as a whole, with and without fraud, despite the general rule that the impact of fraud is usually measured with respect to the cost of the entire project. [5]

The government has not shown that it received zero benefit from the entire sum of illegally procured funds. However, in light of the fact that the government itemized the instances wherein the claimed ***173** damages occurred, it becomes apparent that, as a matter of law, in certain instances zero benefit accrued to the government. They are the following: Change Order No. 11—Union Hill High School, Change Orders 4–8, Change Orders 11–14—Union Hill High School, and Change Order 24—Union Hill High School. Additionally, a portion of the June 1978 advance for $100,000 can be definitively identified as a loss.

(a) Change Order No. 11—Union Hill High School. The government's brief and appended exhibits reveal this change order was "totally false" and that the "work was not done." Change Order No. 11 was in the amount of $35,337. This money was falsely claimed and the government received no benefit from it. The entire figure represents a loss.

(b) Change Orders 4–8. The government was billed twice for the performance of the work covered by Change Orders 4–8. Their costs totalled $38,261. This claim was false and the government could not have received the work requisitioned as it had already been performed. Therefore, the United States suffered $38,261 in damages.

(c) Change Orders 11–14—Union Hill. These were also submitted for payment twice, and resulted in a loss to the government. The work called for by Change Orders 11–14 could not have been rendered twice. Change Order 11, which has been established as having never been performed at all, certainly could not have been done a second time. Change Orders 11–14 cost the United States $113,345, which constitutes the damages suffered on this aspect of the government's claim.

(d) Change Order 24—Union Hill. Change Order 24 was a duplicate of number 11. This represented the third time for which this same false claim was paid. The United States sustained a resu tant loss of $35,337.

(e) June 1978 Advance for $100,000. The June advance was comprised of two checks. One was made out to Mazziota–D'Agostino for $70,000. The other went to Joseph Pissaro Trucking, and was for $30,000. Only a portion of each of these checks may clearly be established as damages, although the claim was undoubtedly false.

The check for $70,000 was delivered to Mazziota–D'Agostino and returned to Orlando the next day. Dominick D'Agostino was paid $18,500 for allowing this money to come down to him and for returning it. This "cut" was a cost for which the United States received no benefit. The $30,000 check met a similar fate. The "cut" taken out of this check was 7% or $2,100. This, too, was also a total loss to the United States.

Other than the $20,600 already accounted for, the balance of the $100,000 advance may not be established as damages as a matter of law. Plaintiff makes no allegations as to where the money went once it was returned to Orlando. There is no evidence offered to indicate the balance did not go into the construction project. The benefit, or lack thereof, that the United States experienced from the remaining $79,400 cannot be determined as a matter of law in the instant motion for summary judgment. Therefore, damages beyond the $20,600 in pay-offs may not be deducted from the $100,000 June 1978 advance and therefore may not be included within that portion of the summary judgment "pool" of damages.

There are other instances wherein the United States' damage claims are not sufficiently documented to be established by summary judgment. These include: (1) March 24, 1978 payment of $153,000; (2) July 31, 1979 advance for $100,000; (3) August 9, 1979 advance for $100,000; (4) August 29, 1979 payment of $25,000; (5) September 25, 1979 advance for $120,000; and (6) November 2, 1979 advance for $120,000.

[5] All of the above are inadequate because of plaintiff's failure to prove, or even allege, what was done with this money. Throughout the entire time these false claims were being presented, work on the projects was being done. Perhaps very little work was in fact accomplished, but if absolutely zero benefit was received by the ***174** government, it must be proved. In order to utilize the formula that determines damages when a substandard product is claimed, the value of that which has been received must be discovered, thus rendering them eligible for inclusion in the summary judgment pool of damage funds. [6]

Accordingly, with respect to actual damages, $242,880 has been established as a matter of law. Pursuant to 31 U.S.C.

§ 3729, this figure shall be tripled. Therefore defendants are jointly and severally liable for $728,640.

2. *Statutory Penalties.* [7]

The False Claims Act provides for a penalty of between $5,000 and $10,000 for each separate violation. The United States claims that 21 violations occurred, and therefore asserts that it is entitled to that same number of penalties. Defendant Genovese claims that only seven acts occurred which may be penalized under the False Claims Act. Other defendants deny that the United States is entitled to any penalties at all.

In determining the appropriate number of penalties, if any, that may be imposed against the defendants, two issues must be addressed: First, what constitutes a violation of 31 U.S.C. § 3729; and, second, each separate violation which occurred must be accounted for. In the name of expediency, these questions are most easily addressed by separately analyzing the three clauses of the False Claims Act with which we are concerned.

(a) 31 U.S.C. § 3729(a)(1): Knowing presentation of a false claim. [8] In a recent case, the Third Circuit listed those elements that constitute a violation of the first clause of the False Claims Act. They are as follows:

> 1. The defendant presented or caused to be presented, for payment or approval, to the Government of the United States a claim upon or against the United States;
>
> 2. The claim was false, fictitious, or fraudulent;
>
> 3. The defendant knew that the claim was false, fictitious, or fraudulent; and
>
> 4. To recover damages, it must be shown that the United States sustained damages by reason of the false claim.
>
> *United States v. Lawson,* 522 F.Supp. 746, 750 (D.N.J.1981) (citations omitted). For the purpose of the current analysis, this Court need not address the fourth element, it has already been discussed, *supra,* in the issue of "damages." Moreover, the third requirement, knowledge, will be discussed *infra.* The first element presents the fundamental question, inasmuch as it addresses what exactly is meant by the word "claim".

[6] Obviously, a claim must necessarily be made upon which to predicate a violation of the False Claims Act. *United States v. Azzarelli Construction Co.,* 647 F.2d 757, 759 (7th Cir.1981). However, not every false statement made to the government qualifies as a claim. *United States v. Greenberg,* 237 F.Supp. 439, 442 (S.D.N.Y.1965). The presentation of a claim for payment or approval "normally connotes a demand for money or for some transfer of public property." *United States v. Lawson,* 522 F.Supp. at 750 (citing *United* ***175** *States v. McNinch,* 356 U.S. 595, 599, 78 S.Ct. 950, 952–953, 2 L.Ed.2d 1001 (1958)). Only "actions which have the purpose and effect of causing the government to pay out money are clearly 'claims' within the purpose of the Act." *Lawson,* 522 F.Supp. at 750 (citing *United States v. Silver,* 384 F.Supp. 617, 620 (E.D.N.Y.1974), *aff'd,* 515 F.2d 505 (2nd Cir.1975)).

Moreover, violations of separate contracts have been found to constitute claims under the False Claims Act. For example, each of the 96 contracts was held to constitute a separate claim in *United States v. American Packing Corp.,* 125 F.Supp. 788 (D.N.J.1954). There, the defendant conspirators violated meat contracts with the Army by fulfilling them with non-conforming carcasses. Accordingly, defendants were found jointly and severally liable for 96 penalties.

[7] In the instant case, defendant Genovese's contention that certain claims were not made against the United States, but rather against the Union City Board of Education, must be put to rest. He asserts that for this reason, a number of the conspirators' acts do not qualify as violations of 31 U.S.C. § 3729. This argument is without merit. Union City and its board of education applied for funds from the EDA. The funds were granted and letters of credit were provided to the Board of Education of Union City Public Works Project Construction Account. The false requests for funds made by Orlandini were paid by checks drawn on this account. Genovese claims that the money in this account was solely in the control of the Union City Board of Education, and therefore, any claims as to said funds were against the Board alone. This is not true.

Although the United States had already placed the funds in the Board of Education's bank account, the government had not relinquished control of this money because in order to use the funds, there still existed the need by the Board of Education to comply with EDA regulations and specifications. Thus, the claims made upon this account may fairly be considered claims against the United States government.

The false claims which were clearly in violation of 31 U.S.C. § 3729(a)(1) and for which defendants are jointly and severally liable, include the following:

1. March 24, 1978, payment of $153,000.

2. June 1978, advance for $100,000.

3. Change Order No. 11, Union Hill High School.

4. Change Order 408.

5. Change Orders 11–14, Union Hill.

6. Change Order 24, Union Hill.

7. September 7, 1977, offer of grant, Emerson High School.

8. September 7, 1977, offer of grant, Union Hill.

9. October 7, 1977, amended offer of grant—Union Hill.

All of the above were claims against the United States under the Act because in each instance there was a demand for money. Accordingly, each of the above-listed fraudulent claims now warrants the imposition of nine (9) statutory penalties.

In contrast, the following claims do not amount to violations of 31 U.S.C. § 3729(a)(1): [9]

1. July 31, 1979 advance for $100,000.

2. September 29, 1979 advance for $120,000.

3. November 2, 1979 advance for $120,000.

Additionally, the August 9, 1979 advance for $100,000 was deficient in that nothing was provided to show that the affidavit which was submitted with the claim was false. Also, the documents the United States refers to in claiming the August 29, 1979 advance as false were missing, causing it to fail.

***176 [8] (b) 31 U.S.C. § 3729(a)(2): Knowing Use of a False Record or Statement to Get a False Claim.** [10] The remaining documents for which the government seeks a statutory penalty are five false quarterly reports and one false interim report. Defendant Genovese challenges three of these reports because they cannot be characterized as a demand for money. A similar challenge was presented by the defendant in *United States v. Greenberg,* 237 F.Supp. 439 (S.D.N.Y.1965). In that case, defendant Greenberg was employed as general contractor for the Department of the Navy. He was not paid for any work until he delivered a voucher for payment. It was stipulated that a voucher would not be paid until payment reports were received. Greenberg prepared 34 falsified payroll reports that were submitted to the Navy. Greenberg argued that because technically, the voucher comprised the request for money and not the payroll reports themselves, the reports did not constitute claims within the meaning of the False Claims Act. The court rejected defendant's argument. It determined that each of the 34 payroll reports was indeed a claim under the Act. Important to the decision was the fact that Greenberg knew the payroll reports were an essential element in subjecting the government to a demand for money. *Greenberg,* 237 F.Supp. at 443.

In a similar case, an application for a bank loan containing a false statement was considered a claim punishable by the False Claims Act. *United States v. Veneziale,* 268 F.2d 504 (3d Cir.1959). The loan application, by itself, did not constitute a false claim. But, because it was an essential document in inducing the Federal Housing Administration to guarantee payment of a bank loan upon which the government had to pay, the loan application was found to be a claim within the purview of the False Claims Act. The court stated, "the wrong of the defendant was an important, even an essential factor in subjecting the government to an enforceable demand for money". *Veneziale,* 268 F.2d at 505.

From these illustrations it becomes clear that the five false quarterly reports and one false interim report may properly be penalized under 31 U.S.C. § 3729(a)(3). Although each individual report did not trigger separate payments, the release of funds was predicated upon the grant agreement which required the periodic submission of accurate reports. It was a condition upon which the funds were granted. The reports were all essential elements in causing the United States to part with its money. Defendants cannot maintain that any one of these reports had no responsibility for causing the release of EDA funds. *See, e.g., United States v. Gardner,* 73 F.Supp. 644 (N.D.Ala.1947) (penalty assessed for each report submitted which contained false information where government required report to be submitted, and thereafter predicated certain actions upon it).

Accordingly, an additional six violations of the False Claims Act occurred with the submission of the aforementioned reports which necessitates the imposition of six additional statutory penalties.

[9] (c) 31 U.S.C. § 3729(a)(3): Conspiracy to Defraud. [11] It is clear that the "establishment of the existence of a conspiracy [to defraud the United States] entitles the United States to recover the forfeiture provided for in the Act." *United States v. Kates,* 419 F.Supp. 846, 852 (E.D.Pa.1976). The existence of the conspiracy is a separate violation of the Act and therefore entitles the United States to a separate statutory penalty. Each participant in the conspiracy is jointly and severally liable for that one statutory penalty. *United States v. Globe Remodeling Co.,* 196 F.Supp. 652, 657 (D.Vt.1961).

In the present case, the existence of a conspiracy to defraud the United States was conclusively established in the prior criminal proceeding. Accordingly, the United States is entitled to one statutory penalty for which each of the defendants are jointly and severally liable.

***177 [10]** Contrary to the contention of defendant Powers, this penalty could be levied even in the event that the United States suffered no actual damages. *United States v. Rohleder,* 157 F.2d 126, 129 (3d Cir.1946); *United States v. Hibbs,* 420 F.Supp. 1365, 1370 (E.D.Pa.1976), *vacated on other grounds,* 568 F.2d 347 (3d Cir.1977).

3. *Conspirator Liability and Knowledge.*

Defendant Dentico raised these related issues in his brief. He denies knowledge of a great number of the separate false claims made, and denies any responsibility for them.

Judge Sarokin, in granting summary judgment as to liability on Counts I, II and III, first had to find that the requisite knowledge to satisfy 31 U.S.C. § 3729 existed. He was able to do so because the jury verdict at trial established that the defendants participated in the scheme "knowingly and with the specific intent to deceive." The issue of knowledge is one that has already been decided, therefore, and it may not be contested at this point.

Moreover, the extent of conspirator liability under the False Claims Act was recently addressed in this district. Judge Brotman, in *United States v. Heck,* Civil Action No. 86–0875, slip op. (D.N.J., filed March 26, 1987) [Available on WESTLAW, 1987 WL 49253], granted partial judgment in the amount of $632,704.74 against defendant Heck who had previously been found guilty of conspiracy to defraud the government, making false statements and mail fraud. [12] On the subject of conspirator liability, Judge Brotman wrote:

> Once liability for a conspiracy under the False Claims Act is established, each defendant conspirator is liable for a [penalty] and twice [now thrice] the government's damages for each false claim submitted pursuant to the conspiracy even if he did not personally submit or cause the claim to be submitted. That liability is joint and several.

> *Heck,* slip op. at 8–9 (citing *United States v. Cripps,* 460 F.Supp. 969,975 (E.D.Mich.1978); *United States v. American Packing Corp.,* 125 F.Supp. 788, 790 (D.N.J.1954); *United States ex rel. Marcus,* 41 F.Supp. 197, 218 (W.D.Pa.1941), *rev'd,* 127 F.2d 233 (3d Cir.1942), *rev'd,* 317 U.S. 537, 635 S.Ct. 379, 87 L.Ed. 443 (1943)). Judge Brotman went on to note that "[i]t is well established that a conspirator is liable for all acts done in furtherance of the conspiracy, even if he did not know the scope of the conspiracy or the identity of each member."

> *Heck,* slip op. at 9 (citing *Blumenthal v. United States,* 332 U.S. 539, 556–57, 68 S.Ct. 248, 256–57, 92 L.Ed. 154 (1947)).

[11] Accordingly, the defendants to the present action will be held jointly and severally liable for *all* of the damages and penalties assessed against each of them. Based upon the finding of a conspiracy to defraud the government in Count I, every act in furtherance of that conspiracy may be attributed to each and every of the co-conspirators.

4. *Estoppel Against the Government.*

Defendant Genovese asserts that the United States is barred from the recovery of damages because it knowingly facilitated the operation of the conspiracy, had actual knowledge damages were being caused as the result of the conspiracy, and took no action to prevent the accrual of those damages. This argument is based upon the actions of Norman Reed, a government informant under the supervision of three Justice Department agents. Reed was responsible for delivering to Orlandini the fraudulent back-dated performance bonds, without which the conspiracy arguably may have been impossible. Defendant Genovese maintains that the above ***178** establishes affirmative misconduct on the part of the government thereby entitling him to invoke the doctrine of estoppel.

[12] Estoppel is an equitable doctrine invoked by the courts to preclude a party from asserting a claim or defense which is premised upon that party's wrongdoing. *Lovell Manufacturing v. Export–Import Bank of United States,* 777 F.2d 894 (3d Cir.1985). According to the Restatement, an appropriate situation in which estoppel may be applied exists:

> If one person makes a definite misrepresentation of fact to another person having reason to believe that the other will rely upon it and the other in reasonable reliance upon it does an act ... the first person is not entitled.
>
> (b) to regain property or its value that the other acquired by the act, if the other in reliance upon the misrepresentation and before discovery of the truth has so changed his position that it would be unjust to deprive him of that which he thus acquired.

Restatement (Second) of Torts § 894(1) (1979). [13] Additionally, a showing of affirmative misconduct is necessary to invoke this doctrine against the government. *Lovell,* 777 F.2d at 899. However, even where there is affirmative misconduct on the part of the government, the traditional elements of estoppel must still be satisfied prior to the invocation of the doctrine. *Heckler v. Community Health Services, Inc.,* 467 U.S. 51, 61 n. 13, 104 S.Ct. 2218, 2234 n. 13, 81 L.Ed.2d 42 (1984). [14]

[13] With respect to defendants' assertion as to their change in position, respondent lost neither a legal right nor anything to which it was entitled. The inability to retain money that should have never been received is not a detriment that gives rise to estoppel. *Heckler,* 467 U.S. at 61–63, 104 S.Ct. at 2224–25. As to the issue of reasonable reliance, in *Heckler* the Supreme Court noted that reliance is inappropriate if (1) respondent had a duty to familiarize itself with the Medicare program and its accompanying legal requirements, and (2) the advice that was relied upon was informal and orally given. 467 U.S. at 64, 65, 104 S.Ct. 2225, 2226. [15]

[14] The instant case, when viewed in light of *Heckler,* clearly does not merit the imposition of estoppel against the government. As in *Heckler,* the detriment claimed is the inability to retain money that should never have been acquired in the first place. The reliance claimed in this case is even more inappropriate. It certainly was not reasonable for the defendants to rely upon the issuance of fraudulent bonds in breaking the law from that ***179** point forward. The government in no way lead the defendants to believe their conduct was legal; defendants were not misled.

Accordingly, in the absence of the prerequisite elements of estoppel, this Court need not reach the issue of affirmative misconduct. Additionally, this Court notes that estoppel is an equitable doctrine whose purpose is to avoid injustice. There is no indication that it would be unjust for the United States to recover the money illegally taken from it. Estoppel against the government in this case is inappropriate.

5. *The Government's Reliance.*

Finally, there is defendants' contention that the government never relied on the defendants' false representations, and therefore, it cannot recover damages under the False Claims Act. Defendant Genovese claimed that when Reed issued the fraudulent bond, the United States acquired knowledge that nullified the requisite element of reliance.

It appears, however, that there is a split of authority on the issue. Defendant Genovese cites a number of cases in support of his position. Many are inapposite. For example, one case concerns the Contract Settlement Act of 1944 as opposed to the False Claims Act. *United States v. Dinerstein,* 362 F.2d 852 (2d Cir.1966). And another is about the acceptance by the government of non-conforming goods. *United States v. Hangar One, Inc.,* 406 F.Supp. 60 (N.D.Ala.1975), *rev'd on other grounds,* 563 F.2d 1155 (5th Cir.1977). However, defendant does cite authority which holds that reliance is necessary under the False Claims Act. *See United States v. Robbins,* 207 F.Supp. 799 (D.Kan.1962). *But see Lawson* (requirements for a violation of 31 U.S.C. § 3729(1) do not include reliance as a necessary element); *United States v. Ehrlich,* 643 F.2d 634 (9th Cir.1981) (specifically eliminating need for government to be deceived in order to recover damages under the False Claims Act). [16]

Although *Ehrlich* was decided under 31 U.S.C. § 231, the predecessor of 31 U.S.C. § 3729, the only difference between these statutes is that the former used the language "by reason of," whereas the latter version now employs the language that a party "is liable to the United States for ... damages which the government sustains *because of* the act of that person." 31 U.S.C. § 3729(a)(7) (emphasis added). If the phrase "by reason of" was not construed to imply the requirement of reliance, it is even less likely that the phrase "because of" would necessitate it. As a final note on reliance, "actual deception of the government has been held not essential to the [violation of the False Claims Act]." C.J.S. U.S. § 168, Vol. 91, p. 379 (citing *United States v. Presser,* 99 F.2d 819 (2d Cir.1938)).

[15] Actual reliance is not essential to the recovery of damages under the False Claims Act. Whether the government relied upon the false representations of the defendants or not, it should be able to recover the money disbursed on account of those representations.

IV. CONCLUSION

For the above-noted reasons, this Court concludes that partial summary judgment on the issue of damages for Counts I and III shall be granted against defendants William V. Musto, John J. Powers, Frank Scarafile, Gildo Aimone, Anthony Genovese, Dominich D'Agostino and Lawrence Dentico. The defendants shall be jointly and severally liable for $728,640 in addition to 16 penalties. Nine penalties were assessed for violations of 31 U.S.C. § 3729(a)(1), six were assessed for violations of 31 U.S.C. § 3729(a)(2), and one was assessed for the violation of 31 U.S.C. § 3729(a)(3). With respect to the $5,000–10,000 range which may be assessed for ***180** each of the sixteen penalties, although the Court is tempted to use the lower limit because the change in the statute enables the government to recover between two and one-half to five times the amount it originally requested, a final determination will not be made until all parties have had the opportunity to submit briefs on this issue. Said briefs to be submitted within thirty (30) days of the date of filing of this opinion.

An appropriate order is to be submitted by the United States Attorney.

All Citations

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Footnotes

1 Counts I and II consisted of allegations of violations of the False Claims Act, 31 U.S.C. §§ 3729–3731. As per Count I, defendants were found to have "combined, conspired and agreed to defraud the United States by obtaining or aiding of payment or approval of false or fraudulent claims." (Verified Complaint ¶¶ 28–57, slip op. at 15). Under Count II, defendants were found to have "knowingly caused to be presented to the Economic Development Administration ("EDA") for payment or approval, false or fraudulent claims, or knowing to be made, used, or caused to be used, false records or statements to get such false or fraudulent claims paid or approved." (Verified Complaint ¶¶ 58–60, slip op. at 15). Count III is an action for common law fraud. (Verified Complaint, ¶¶ 61–63). On November 19, 1985, the opinion was amended so that Musto, Scarafile, D'Agostino and Dentico were relieved of liability for Count II.

2 Genovese, who was represented by counsel when this motion was originally filed, is now proceeding pro se.

3 The relevant section of the False Claims Act, 31 U.S.C. § 3729 provides:

(a) Liability for certain acts.—Any person who—

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of an Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

---

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus three times the amount of damages which the Government sustains because of the act of that person....

4 The formula for substandard product is as follows: damages equals the value of that which plaintiff would have received had there been no fraud minus the value of that which plaintiff actually received. *United States v. Bornstein,* 423 U.S. 303, 316 n. 13, 96 S.Ct. 523, 531, n. 13, 46 L.Ed.2d 514 (1976); *United States v. Ben Grunstein & Sons Co.,* 137 F.Supp. 197, 205 (D.N.J.1956); *United States v. American Packing Corp.,* 125 F.Supp. 788, 791 (D.N.J.1954).

5 The United States alleges that the result of this formula encompasses *all* funds procured through false or fraudulent claims. This assumes that the amount to be subtracted from the value of that which plaintiff would have received had there been no fraud is zero. Although the government contends it received nothing from any of the illegally procured funds it has failed to establish that *none* of the ill-gotten funds actually went into the school projects. Accordingly, the government's recovery must be offset by the value of the benefit it received. *United States v. Ben Grunstein & Sons Co.,* 137 F.Supp. 197, 205 (D.N.J.1956); *United States v. American Packing Corp.,* 125 F.Supp. 788, 791 (D.N.J.1954).

6 In addition, there is no evidence offered to prove that Mr. Orlandini's affidavit in connection with the August 8th advance, which is claimed to be false, is actually false. Nothing appears in the testimony in the appendix to plaintiff's brief to that effect. Similarly, documents referred to in the government's claim for the August 29th payment of $25,000, *i.e.,* government Trial Exhibit 240A and Musto Tr. 9.210–12 to 15 are missing.

7 It should be noted that when this motion was originally filed, the statutory penalty provided by the False Claims Act was $2,000 per violation. Thereafter, the Act was amended and, as noted, it now provides for a statutory penalty of between $5,000 and $10,000 per violation. However, overall fairness would seem to dictate that this Court should invoke the lower bound (*i.e.,* $5,000) inasmuch as it is already two-and-one-half times as great as the statutory penalty in existence at the time of the conspiracy and the filing of this civil action. Nonetheless, the Court will reserve as to the amount assessed per statutory penalty for 30 days from the date of the filing of this opinion, during which time the parties will be entitled to submit their respective positions on this issue.

8 *See supra* note 3 for text of § 3729(a)(1).

9 The United States' brief did not provide the Court with the EDA's regulations that were allegedly violated by the defendants in making these claims. It is stated that supporting documents, applications and certifications were missing with respect to said claims. However, nothing is supplied to show that these documents were required, or that their absence renders a claim to be false.

10 *See supra* note 3 for text of § 3729(a)(2).

11 *See supra* note 3 for text of § 3729(a)(3).

12 Defendant Heck was part of a corporation that sold homes to purchasers whose mortgages were backed by HUD mortgage insurance. The purchasers of these homes obtained HUD insurance by submitting applications containing false information and documentation prepared by Heck or his co-conspirators. Heck was found legally responsible for all of the acts of his co-conspirators, including the purchasers of the homes, that were performed in furtherance of the conspiracy.

13 The Restatement requires that: (1) the party claiming estoppel must have relied in such a manner as to change his position for the worse, and (2) reliance must have been reasonable in that the party claiming estoppel did not know nor should it have known that its adversary's conduct was misleading.

14 In *Heckler,* the respondent, Community Health Services of Crawford County, Inc., provided health care services to Medicare beneficiaries for which it was reimbursed under the Medicare program. Respondent received reimbursement through Travelers Insurance Company. Travelers' Medicare Manager, a government agent, advised respondent that certain employees' salaries were reimbursable under Medicare. This information was incorrect. In reliance, respondent included these costs in its cost reports to Medicare, and was fully reimbursed. Three years later, respondent sought to estop the government from recovering those funds that respondent never should have received.

Although respondent relied on the misinformation of a responsible government agent who expressly authorized its actions, estoppel was held inapplicable. The decision was based upon the determination that the traditional elements of estoppel were not present. *Heckler,* 467 U.S. at 59–66, 104 S.Ct. at 2223–2227.

15 In *Heckler,* Justice Stevens, in elaborating on a comment by Justice Holmes sixty years earlier, wrote:

> Protection of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of the law; respondent could expect no less than to be held to the most demanding standards in its quest for public funds. This is consistent with the general rule that those who deal with the Government are expected to know the law and may not rely on the conduct of Government agents contrary to the law.

467 U.S. at 63, 104 S.Ct. at 2225 (footnote omitted).

16 In *Ehrlich,* a builder of subsidized housing was found to have violated the False Claims Act. He caused excess interest subsidies to be paid by HUD due to his falsification of construction costs. The court ruled against him regardless of the fact that HUD was aware that the cost figures were inflated. Although HUD knew that the cost figures were incorrect, the court found that HUD continued to incur losses by "reason of" the builder's fraudulent acts.

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KeyCite Yellow Flag - Negative Treatment
Distinguished by U.S. ex rel. Haskins v. Omega Institute, Inc., D.N.J., July 2, 1998

750 F.Supp. 512
United States District Court,
S.D. Florida.

UNITED STATES of America, Plaintiff,
v.
Robert M. ENTIN, Gary B. Sack, Richard Gilliam, and Israel Discount Bank, Ltd., Defendants.

No. 84–2422–CIV.
|
Oct. 26, 1990.

Synopsis
United States brought action under False Claims Act against bank and corporate officers who had allegedly made false representations in order to obtain Small Business Administration loan for corporation. The District Court, Scott, J., held that bank and officers were jointly and severely liable for statutory damages.

Judgment for United States.

West Headnotes (7)

[1] **United States** Statutory provisions
False Claims Reform Act was retroactively applicable to allegedly fraudulent conduct perpetrated in order to obtain Small Business Investment Corporation license and, subsequently, to obtain funds from Small Business Administration, absent showing that application would result in manifest injustice. 31 U.S.C.A. §§ 3729–3731.

[2] **Limitation of Actions** Fraud as Ground for Relief
Statute of limitations began to run on federal government's False Claims Act claim against the applicants for Small Business Administration loan once defendants submitted claim for payment to United States. 31 U.S.C.A. § 3731(b).

5 Cases that cite this headnote

[3] **United States** Evidence
Violation of False Claims Act need be established only by preponderance of evidence. 31 U.S.C.A. §§ 3729–3731.

[4] **United States** Intent
To establish civil liability under False Claims Act, Government must establish that defendant has actual knowledge of falsity of information given to Government, that defendant acts in deliberate ignorance of truth or falsity of information, or that defendant acts in reckless disregard of truth or falsity of information. 31 U.S.C.A. § 3729(b).

7 Cases that cite this headnote

[5] **United States** Injury or financial loss
United States False certification
Small Business Administration loan applicants were liable for violation of False Claims Act where their knowingly false representations regarding capitalization resulted in granting of loan which would not otherwise had been made, and loss to Government when corporation became insolvent. 31 U.S.C.A. §§ 3729–3731.

2 Cases that cite this headnote

[6] **United States** False certification
Bank officer's knowingly false representation on behalf of Small Business Administration loan applicant would be imputed to bank, for purpose of imposing liability under False Claims Act, in that officer was acting in course of his employment and for benefit of employer at time representation was made. 31 U.S.C.A. §§ 3729–3731.

2 Cases that cite this headnote

[7] **United States** Costs and fees
United States Double or treble damages
United States Civil penalties

Bank and corporate officers who made false representations in order to obtain Small Business Administration loan for corporation would be held jointly and severally liable for $5,000 civil penalty, costs of lawsuit, and lost loan in amount of $500,000, tripled, with amount recovered by receiver deducted. 31 U.S.C.A. § 3729.

7 Cases that cite this headnote

Attorneys and Law Firms

***512** Lori Miller and Dennis Egan, Dept. of Justice, Washington, D.C., for U.S.

Steven M. Kayman and Steven Stein, Proskauer, Rose, Goetz & Mendelsohn, New York City, Andrew Cotzin, Broad & Cassel, Miami, Fla., for Entin.

***513** MEMORANDUM OPINION

SCOTT, District Judge.

The plaintiff United States of America has brought this action pursuant to the False Claims Act. 31 U.S.C. 3729–3731. Reduced to its least common denominator, this case involves a calculated plan by three individuals and an international banking institution to defraud the United States Government out of a substantial amount of money. Specifically, the fraud was perpetrated in order to obtain a Small Business Investment Corporation license for the Miami Capital Corporation and, subsequently, to obtain funds from the Small Business Administration.

Following a hard fought round of pretrial motions [1] and discovery, this case proceeded to non-jury trial on all issues. Having exhaustively reviewed the entire record and applicable case authority, the Court now enters these findings of fact and conclusions of law pursuant to Federal Rule of Civil Procedure 52(a).

I.

FINDINGS OF FACT

1. Given the complex nature of this action as well as the number of parties involved in the underlying transaction, the Court shall proceed to briefly describe each of the major players involved:

A. The plaintiff, United States of America ("UNITED STATES or GOVERNMENT"), is acting on behalf of the Small Business Administration ("SBA"), one of its governmental agencies.

B. Defendant Robert M. Entin ("ENTIN") was at all times relevant the President and sole shareholder of the Miami Capital Corporation ("MCC").

C. MCC was a Florida corporation licensed and funded by the SBA to assist small businesses owned by socially and economically disadvantaged persons.

D. Defendant Gary B. Sack ("SACK") is an attorney admitted to practice in the state of Florida. At all times relevant, he represented MCC and Entin. In addition, he was a director of MCC.

E. Defendant Richard Gilliam ("GILLIAM") provided consulting services to MCC's principals regarding the licensing, funding and operation of MCC.

F. Defendant Israel Discount Bank, Ltd. ("ISRAEL") is an international bank with its main domestic office in New York. Israel has been registered to do business in Florida since January, 1978.

G. Alexander Halberstein, a non-party in this lawsuit, provided MCC's initial capitalization of $500,000.00.

2. This is a civil action brought by the United States pursuant to the False Claims Act. 31 U.S.C. §§ 3729–3731. The Government seeks damages and civil penalties from defendants Entin, Sack and Gilliam for conspiring to defraud the SBA. These defendants conspired to falsely represent to the SBA that MCC, a Small Business Investment Corporation ("SBIC"), had $500,000.00 of private, unincumbered and

unrestricted capital. This was done in order to obtain a SBIC license for MCC and, subsequently, to obtain "matching funds" in the amount of $500,000.00 from the SBA.

In addition, the United States also seeks to recover damages from Israel and the individual defendants for presenting, or causing the presentation of, a false claim to the SBA. This was done by submitting documents or statements to the SBA knowing such representations to be false or fraudulent in that MCC did not have $500,000.00 in capital available for its use.

3. Pursuant to Section 301(d) of the Small Business Investment Act of 1958, 15 U.S.C. § 681(d), a corporation may become licensed as a Small Business Investment Company ("SBIC"). To be licensed as a SBIC, a licensee must have had in 1978, a minimum private capitalization of $150,000.00. ***514** [2] Borrowed or incumbered funds are not considered private capital. [3] Therefore, such funds cannot be utilized to satisfy the minimum capitalization requirement. 13 C.F.R. 107.3(h).

4. The SBA distributes a document known as "Private Capital Requirements of SBIC's and Section 301(d) Licensees" to each licensee prior to the time of licensing. The purpose of this document is to provide guidance regarding the amount of private capital needed to qualify for licensing.

5. The requirement that a potential licensee for SBIC funds have private capital is a critical element to the SBIC program. As Patricia DiMuzio [4] testified, with private capital at risk there is a "much greater chance for the company to be managed properly and the SBA's funds to be managed properly."

6. In addition to the aforementioned capitalization information, the application for an SBIC license requires that a banking institution send the SBA a letter confirming the existence of deposits of cash or securities to the account of the potential licensee. Additionally, the bank must: (a). Clearly identify any incumbrance or restriction against such deposits; (b). List the names of all persons rendering professional or other services to the licensee and the amount of compensation to be paid for these services.

7. The SBIC Application expressly provides that all statements made in completion of the Application are material for the purpose of inducing the SBA to issue a license and provide funding.

8. On September 21, 1978, in connection with this license application, Ervin H. Golod, First Vice–President of Israel Discount Bank, verified to the SBA that $500,000.00 was on deposit in the name of MCC "without liens, encumbrances or restrictions of any kind." [5] At that time, this information was known to be false by Israel. The evidence at trial was overwhelming in this regard.

9. On March 27, 1978, MCC was incorporated under the laws of the State of Florida. Its principal place of business was Miami, Florida. On that same day, MCC applied for a license with the SBA.

10. Defendants Entin, Sack and Gilliam prepared the application on behalf of this corporation. In connection with this application, the following representations were made:

> (a). MCC had a net paid-in capital and surplus of $495,000.00.
>
> (b). The initial capital would be raised by selling one thousand shares of common stock at $500.00 a share.
>
> (c). No one owned, either directly or indirectly, the corporation's shares nor would such shares be subject to any "loan or pledge incident to the purchase thereof." And,
>
> (d). Defendant Entin had a personal net worth of $1,882,128.00.

This application was signed by Entin and attested to by Sack.

11. Defendant Entin knowingly and willfully submitted a Statement of Net Worth to the SBA on July 25, 1977, that was false and fraudulent in that it listed various shares of common stock and one hundred and twenty-five acres of land—none of which was owned by Entin. [6]

12. As president of MCC, Entin was responsible for having knowledge of the SBA regulations. Both he and Gilliam attended the pre-licensing conference at which the SBA regulations and rules were ***515** discussed, operational requirements detailed, and all questions were answered.

13. Entin was well aware that the material representations made to the SBA were false. In this regard, Entin did not require legal training or other expertise to realize that the representations regarding the source of MCC's funding were entirely false.

14. Defendant Sack was an active participant in the development of MCC and in MCC's dealings with the SBA. Sack also served as a director and attorney for MCC. Therefore, most of the documentation submitted to the SBA, including the Applications for Licensing and Funding, were prepared in Sack's office.

15. Additionally, at trial, defendant Sack admitted that he knew that the funds in question had to be unrestricted and unencumbered in order to qualify for an SBA license and funding. However, given the source of the initial funding, Sack was aware that the money was restricted and that this requirement could not be satisfied.

16. Defendant Gilliam was aware of the SBA regulations. In fact, Gilliam was the only individual associated with MCC that had previous dealings with the SBA or its programs prior to the instant situation. [7]

17. In addition, there was substantial evidence at trial that Gilliam knew the money in question was not unrestricted or unencumbered. Specifically, the following evidence was adduced at trial: (1) Gilliam testified that he had explained the requirements of the SBA program to Entin and Sack prior to the submission of the Application for License; (2) Gilliam reviewed the Application after its completion to assure its accuracy; (3) Gilliam attended the pre-licensing conference in Washington, D.C.; and (4) Defendant Sack recalled that Gilliam attended several meetings at which the source of the initial capitalization was discussed. [8] In fact, Sack testified that it was Gilliam who advised MCC not to disclose the source of the capital to the SBA. [9]

18. The evidence at trial also established that Entin, Sack, and Gilliam assisted MCC in making an unauthorized payment in the amount of $21,000.00 to Gilliam for his consulting services. The Court finds that this payment was not a valid investment in Black Investments, Inc. as Gilliam had asserted.

19. On October 6, 1978, based upon the false or fraudulent representations submitted, or caused to be submitted, by defendants Entin, Sack, Gilliam and Israel Discount Bank, the SBA approved the application and issued a license to MCC.

20. Once an entity is licensed, the SBA is authorized to fund the entity by purchasing its preferred stock.

21. On November 22, 1978, based upon these representations, the SBA purchased $500,000.00 worth of preferred stock from MCC.

22. Unbeknownst to the SBA, MCC had in fact used borrowed or incumbered funds to establish the initial capitalization of $500,000.00 for its licensing and funding.

23. The apparent injection of $500,000.00 in private capital by Entin was accomplished through a joint venture agreement between MCC and Kan Rap Incorporated. Kan Rap, Inc. is a company controlled by Alexander Halberstein.

24. This joint venture agreement, dated September 6, 1978, was signed by Entin and Halberstein both individually and as the respective presidents of their corporations. [10] This agreement provided that Kan Rap, Inc. would, in effect, loan MCC $500,000.00 by creating a certificate of deposit on its behalf. However, Kan Rap, Inc. ***516** retained exclusive control over these funds. [11]

25. Israel was informed of the joint venture and the restrictions associated therewith prior to the time it represented to the SBA that the $500,000.00 in MCC's account was "without liens, encumbrances, or restrictions of any kind."

26. On March 31, 1982, the United States District Court for the Southern District of Florida appointed the SBA as receiver [12] for MCC. [13] In this capacity, the SBA was to pursue and preserve all of the corporation's claims. After satisfying all claims, the SBA recovered $80,044.96—thereby, leaving a net loss to the SBA of $419,955.14.

II.

CONCLUSIONS OF LAW

1. Before addressing the merits of the False Claims Act, a brief description of the history and purpose behind its enactment is necessary. This Act establishes a cause of action against persons making false claims upon the United States. It was originally enacted in 1863 in order to eliminate the wide-spread fraud often associated with Civil War defense contracts. [14] 132 Cong.Rec. H6482 (daily ed. Sept. 9, 1986) (statement of Rep. Rodino); Richard J. Oparil, "The Coming of the Amended False Claims Act," 22 *Akron L.Rev.* 525,

526 (1989). Although the drafters' intent was admirable, the Act's practical effect left much to be desired. In fact, for over one hundred years the Act did little to combat the fraud it was intended to. However, in the 1980's, with "government fraud" apparently in vogue, [15] Congress decided to bolster the Act's effectiveness. In this regard, Senators Charles Grassley, Dennis DeConcini and Carl Levin introduced the False Claims Reform Act. [16] This amended legislation was intended to make The False Claims Act a more effective weapon against fighting fraudulent activity by, *inter alia,* reducing the Government's (or qui tam plaintiff's) burden of proof and standard of liability. The False Claims Reform Act was signed by President Reagan on October 27, 1986.

2. Prior to considering the "nuts and bolts" of the defendants' culpability, the Court must first resolve several threshold legal determinations.

[1] 3. First, the Court must determine whether the 1986 amendments to The False Claims Act should be applied retroactively in this case. An analysis of retroactive legislation must begin with the seminal case of *Bradley v. Richmond School Board,* 416 U.S. 696, 94 S.Ct. 2006, 40 L.Ed.2d 476 (1974). In a unanimous opinion, the Court stated that "a court is to apply the law in effect at the time it renders ***517** its decision, unless doing so would result in manifest injustice or there is a statutory direction or legislative history to the contrary." *Bradley v. Richmond School Board,* 416 U.S. at 711, 94 S.Ct. at 2016, 40 L.Ed.2d at 488; *see also,* *U.S. v. Kolter,* 849 F.2d 541 (11th Cir.1988); *Greer v. Skillcraft,* 704 F.Supp. 1570 (N.D.Ala.1989); *U.S. v. Rent America, Corp.,* 734 F.Supp. 474 (S.D.Fla.1990). Neither the language of the 1986 amendments nor its legislative history addresses the issue of retroactivity. [17] *United States v. Hill,* 676 F.Supp. 1158 (N.D.Fla.1987); *United States v. Bekhrad,* 672 F.Supp. 1529 (S.D.Iowa 1987). Consequently, whether the amendments should be applied retroactively hinges upon whether such application would "result in manifest injustice." No one factor is determinative in considering whether manifest injustice would result. Having considered all of the circumstances involved herein, the Court is thoroughly convinced that such injustice will not result. Courts throughout the country are in agreement with this conclusion. *See e.g.,* *Gravitt v. General Elec. Co.,* 680 F.Supp. 1162 (S.D.Ohio 1988).

Moreover, Congress knows how to limit the immediate applicability of new legislation if it so desires, as it did with two other contemporaneously passed civil fraud remedies. For instance, in the "Program Fraud Civil Remedies Act of 1986," [18] Congress specifically provided that "it was to apply to any claim made, presented, or submitted after the statute's effective date." Additionally, in the "Anti–Kickback Enforcement Act of 1986," [19] Congress provided that the Act shall apply to that conduct which is described as prohibited if it occurs after the date of enactment. Similarly, in the previous session of Congress, amendments to the False Claims Act applicable solely to Department of Defense contracts were specifically made applicable to claims submitted after the date of its enactment. *Department of Defense Authorization Act, 1986,* Pub.L. 99–145, 99 Stat. 583 (1985). The absence of similar language in The False Claims Act amendments of 1986 is indicative of the intent that they have retroactive application.

[2] 4. Next, the defendants argue that the Court determine whether this cause of action is time-barred as a result of the statute of limitations having run. However, by previous Order dated October 6, 1986, the Court held that the statute of limitations had not run prior to the United States filing this lawsuit. Now, four years later, the Court ardently adheres to its previous holding.

The 1986 amendments to The False Claims Act changed the statute of limitations thereunder. The prior version of the Act simply stated that the action must be brought within six years from the date the violation was committed. 31 U.S.C. § 3731(b) (1982). The amended version is more complex:

A civil action under section 3730 may not be brought

> (1) more than 6 years after the date on which the violation of section 3729 is committed, or (2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed,
>
> whichever occurs last.

31 U.S.C. § 3731(b).

In the present action, the statute of limitations began to run once a claim for payment was submitted to the United

States.[20] ***518** That claim was the Application for Funds submitted by defendants Entin, Sack and Gilliam on October 13, 1978.[21] This action was commenced by the filing of the complaint on October 12, 1984. Clearly, under the amended version of the statute of limitations, the present action has been timely brought.

[3] 5. Having resolved these threshold issues, the Court shall now proceed to address the substantive merits of the False Claims Act. A violation of this Act must be established by a mere preponderance of the evidence. *Federal Crop Ins. Corp. v. Hester,* 765 F.2d 723 (8th Cir.1985); *United States v. Thomas,* 709 F.2d 968 (5th Cir.1983); *Thevenot v. National Flood Insurance Program,* 620 F.Supp. 391 (D.C.La.1985); *U.S. v. JT Const. Co., Inc.,* 668 F.Supp. 592 (W.D.Tex.1987). The applicable burden of proof was eased by the amended version of the False Claims Act.[22]

[4] 6. Prior to 1986, the False Claims Act imposed civil liability for "knowingly" submitting a false claim to the SBA. 31 U.S.C. § 3729(1) (1982). However, pursuant to the 1986 amendments to this Act—specific intent to defraud is no longer required. Now, the Government must establish one of the following:

> "(1) [the defendant] has actual knowledge of the information; (2) [the defendant] acts in deliberate ignorance of the truth or falsity of the information; or (3) [the defendant] acts in reckless disregard of the truth or falsity of the information...."

31 U.S.C. § 3729(b). The scienter standard was eased in order to preclude "ostrich" type situations, where an individual has "buried his head in the sand" and failed to make any inquiry which would have revealed the false claim. *See generally, False Claims Reform Act of 1985,* S.Rep.No. 345, 99th Cong., 2nd Sess., reprinted in 1986 U.S.Code Cong. & Admin.News 5266. One congressional sponsor of the amended Act explained the new scienter standard:

> While the Act was not intended to apply to mere negligence, it is intended to apply in situations that could be considered gross negligence where the submitted claims to the government are prepared in such a sloppy or unsupervised fashion that resulted in overcharges to the government. The Act is also intended not to permit artful defense counsel to require some proof of intent as an essential ingredient of proof....

132 Cong.Rec. H9389 (daily ed. Oct. 7, 1986) (statement of Rep. Bermar). Thus, actual knowledge is not a prerequisite to liability—constructive knowledge will suffice.

7. As thoroughly discussed in the foregoing factual section, the actions of each defendant have clearly satisfied the requisite knowledge requirement.

[5] 8. Absent the capital which defendants represented had been deposited with Israel, MCC was ineligible for both the license and the SBA matching funds. 15 U.S.C. § 682(a). Paid-in capital was an explicit, statutory requirement to "assure a reasonable prospect that the company will be operated soundly and profitably, and managed actively and prudently in accordance with its articles of incorporation." 15 U.S.C. § 682(a). Significantly, this requirement that an applicant for federal funding have a substantial stake in the venture is of critical importance in several federal grant and loan programs. *See e.g.,* 13 C.F.R. 120.3(b)(2). Had MCC possessed the additional $500,000.00 in unencumbered funds, it would have greatly reduced the ***519** risk that the Government's investment would become worthless. The Court concludes that but for the defendants' conduct, the SBA, by statute and regulation, could not have disbursed the $500,000.00 and would not have lost any money.

9. The Government has established an adequate causal relationship between the defendants' conduct, the disbursement of funds and the eventual loss. The holding in *United States v. Hibbs* is readily distinguishable. *United States v. Hibbs,* 568 F.2d 347 (3d Cir.1977). In the present action, the defendants' statements regarding the capitalization

of Miami Capital Corporation bear directly on credit worthiness and the value of the stock purchased by the SBA. *See,* *United States v. Miller,* 645 F.2d 473, 476 (5th Cir.1981) (The court held that false statements regarding credit worthiness and value of security have the requisite causal connection to a subsequent default); *United States v. Hill,* 676 F.Supp. 1158 (N.D.Fla.1987). Therefore, *Hibbs* is inapplicable to these facts. [23]

[6] 10. Ervin Golod's knowledge of the falsity of the September 21, 1978 letter that he sent to the SBA is imputed to his employer, defendant Israel. When this letter was written, Golod was acting in the course of his employment and for the benefit of his employer. *United States v. DiBona,* 614 F.Supp. 40 (E.D.Pa.1984); *Donsco, Inc. v. Casper Corp.,* 587 F.2d 602 (3rd Cir.1978); *United States v. Hughes,* 585 F.2d 284 (7th Cir.1978); 10 W. Fletcher, *Cyclopedia Corporation,* 4886, p. 399 (rev. ed. 1978). [24]

[7] 11. Next, the Court must determine the amount of damages suffered by the Government as a result of the defendants' conduct. In this regard, 31 U.S.C. § 3729 provides as follows:

> (a) Liability for certain acts.—Any person who [violates this Act]:
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person.... A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

31 U.S.C. § 3729. [25] Based upon this statutory provision, the Court calculates the damages as follows:

1. A civil penalty of $5,000.00 is imposed against each of the defendants jointly and severally.

2. The Government has sustained damages in the amount of $500,000.00. The case authority holds that such damages should be tripled before any deductions are made. [26] *See e.g.,* *United States v. Bornstein,* 423 U.S. 303, 96 S.Ct. 523, 46 L.Ed.2d 514 (1976). Therefore, under the ***520** directive of the Act the damages are tripled to $1,500,000.00. Next, the Court deducts the $80,044.96 recovered by the receiver. In conclusion, the amount of damages is $1,419,955.14. The defendants are jointly and severally liable for this award of damages.

3. The defendants are jointly and severally liable for the costs of this lawsuit.

III.

LEGAL DETERMINATIONS

Based upon the foregoing analysis and the authorities cited therein, the Court concludes that each defendant acted so as to violate the False Claims Act. 31 U.S.C. §§ 3729–3731. The egregious nature of the conduct at issue constrains the Court from reaching a contrary result. To hold otherwise would be to place the imprimatur of law on nothing short of an intentional looting of the Federal Treasury.

Counsel for the Government shall submit a Final Judgment consistent within this Memorandum Opinion within five (5) days of the date of this Order.

DONE and ORDERED.

All Citations

750 F.Supp. 512

Footnotes

1 The Court commends each of the attorneys for the excellent work product submitted throughout the course of this litigation.

2 This financial condition is imposed in order to assure that the company (SBIC) will be operated soundly and profitably.

3 However, borrowed funds may be used if the individual has a net worth of at least twice the amount borrowed. 13 C.F.R. 107.3. This provision is inapplicable in the present action.

4 Patricia DiMuzio has been a financial analyst with the SBA for the past fourteen years. She presently serves as Chief of Area 3. This area includes the state of Florida.

5 This verification was received in the form of a letter dated September 21, 1978.

6 Attached to this Statement of Net Worth were personal history statements from defendants Entin and Sack.

7 Defendant Gilliam testified that he had previously served as a consultant for at least ten corporations who had dealings with the SBA.

8 Similarly, Gail Columbus, Sack's secretary, testified that she had taken dictation at several meetings where the source of the initial capitalization was discussed.

9 Apparently, Gilliam was concerned that such disclosure would delay the funding from the SBA.

10 Defendant Sack prepared the drafts of the joint venture agreement—including the final signed agreement.

11 Specifically, the joint venture agreement provided as follows:

> Kan Rap, Inc. will immediately place the sum of $500,000.00 in Certificates of Deposit at the Israel Discount Bank in New York City, New York, said certificates to be in the name of Miami Capital Corporation. Said certificates are to be in the sole control of the officers of Kan Rap, Inc.

12 Defendant Entin and his attorneys participated in the initial receivership hearing and agreed to the appointment of a receiver prior to the hearing.

13 Case No. 82–0647–Civ.

14 This legislation was signed into law by President Abraham Lincoln. Act of Mar. 2, 1863, ch. 67 s. 3, 12 Stat. 698.

15 During the 1980's, fraud upon the government was at an all-time high. In fact, the “Pentagon Contract Fraud Scandal” may ultimately prove to cost the federal treasury millions, if not billions, of dollars in unnecessary expenditures. *See e.g.,* “Another Teapot Dome Brewing,” *Wash. Post,* June 17, 1988, at A2; “Contracts Scramble that Spawned a Scandal,” *Financial Times,* June 22, 1988, s. I, at 4; “Payoffs at the Pentagon,” *Newsweek,* June 27, 1988, at 3.

16 The need for this new legislation was vividly expressed by Senator Grassley when he stated the following:

> Current law put the Government at a critical disadvantage in fraud cases. Contractors have us over a barrel. Our choice is inexorably clear. If we like being over a barrel, I would suggest that we leave the law the way it is and instead grin and bear continued rapes and pillages of the Treasury. The alternative is true reform that shifts the advantage back to the Government where it belongs, and deal with fraud as those who elect us would expect.

131 Cong.Rec. 22322 (Aug. 1, 1985).

17 The legislative history does indicate, however, that the legislators were anxious for the new amendments to take effect immediately. S.Rep. No. 345, 99th Cong., 2d Sess., *reprinted in* 1986 U.S.Code Cong. & Admin.News 5266, 5267; *see also,* *United States v. Board of Education of Union City,* 697 F.Supp. 167 (D.N.J.1988).

18 Pub.L. 99–509, Title VI, Subtitle B, Section 6101, 100 Stat. 1874 (October 21, 1986).

19 Pub.L. 99–634, 100 Stat. 3523 (November 7, 1986).

20 In this regard, the Fifth Circuit has stated:

> Little need be said as to the statute of limitations. The six year period is to be computed from the time of the “commission of the act.”.... The “act” in question is the filing of the false claim.

Smith v. United States, 287 F.2d 299, 304 (5th Cir.1961).

21 A letter dated September 21, 1978, submitted by Mr. Golod of IDB to the SBA was a false statement that caused the false claim to be approved.

22 In the past, there had been some question as to the proper burden of proof to be applied in False Claim actions. Circuits split on whether to apply the preponderance of the evidence or the clear and convincing evidence standard. *See e.g., Federal Crop Ins. Corp. v. Hester,* 765 F.2d 723 (8th Cir.1985); *United States v. Thomas,* 709 F.2d 968 (5th Cir.1983); *United States v. Milton,* 602 F.2d 231 (9th Cir.1979); *United States v. Lawson,* 522 F.Supp. 746 (D.N.J.1981).

23 Furthermore, in referring to subsection (b) of 31 U.S.C. § 3729, the Senate Report states:

> When the Government changes its position, and commits its financial resources based upon a material false statement, it should be able to recover the resulting losses, but, under some court interpretations, it may not. For instance, in *United States v. Hibbs,* 568 F.2d 347 (3d Cir.1977), the FHA agreed to insure a mortgage based upon a representation, which was false, that the residence was habitable and in compliance with the housing code. The Government will not issue insurance to a non-code conforming house. However, the court ruled that the default on the mortgage occurred because the borrower lost his job, and therefore could not meet his monthly payments—that the default was not related to the false statement. While the court may have been technically correct, the Committee believes that this position is unsound public policy. The act should cover representations which cause the Government to change its position and pledge its full faith and credit, including the risk of insurable loss, based upon another, but material false statement.

S.Rep. No. 99–345 (1986).

24 The present action is distinguishable from *United States v. Ridglea State Bank,* 357 F.2d 495, 498 (5th Cir.1966), where the bank officials' purpose was most certainly not to benefit his employer bank.

25 This particular section of the False Claims Act may be applied retroactively. *See e.g., U.S. v. Board of Educ. of City of Union City,* 697 F.Supp. 167 (D.N.J.1988).

26 This method of computation most faithfully conforms to the language and purpose of the False Claims Act. The Act speaks of tripling “damages” and not tripling “net damages” or “uncompensated damages.”

End of Document

2011 WL 814898
United States District Court, D. Arizona.

UNITED STATES of America
ex rel. Stephen Huey, Plaintiff,
v.
SUMMIT HEALTHCARE
ASSOCIATION, INC., et al., Defendants.

No. CV–10–8003–PCT–FJM.
|
March 3, 2011.

Attorneys and Law Firms

Ashley D. Adams, Scottsdale, AZ, Tod F. Schleier, Schleier Law Offices PC, Phoenix, AZ, for Plaintiff.

Bradley Jay Stevens, Jennings Strouss & Salmon PLC, Phoenix, AZ, David Honig, Hall Render Killian Heath & Lyman, Indianapolis, IN, Timothy W. Feeley, Hall Render Killian Heath & Lyman, PC, Milwaukee, WI, for Defendants.

ORDER

FREDERICK J. MARTONE, District Judge.

***1** The court has before it defendants Brim Healthcare, Inc.'s, Kevin and "Jane Doe" Hawk's, and Summit Healthcare Association, Inc.'s motions to dismiss (docs. 28, 29, & 37), plaintiff and *qui tam* relator Stephen Huey's responses (docs. 33, 34, & 45), and defendants' replies (docs. 39, 40, & 47). We also have before us the United States' statement of interest (doc. 55) and Summit's response (doc. 58).

I. Background

Plaintiff is a former employee of Summit, which owns and operates a hospital in Show Low, Arizona. He was Summit's Chief Financial Officer and Vice President of Finance from April 2008 until his termination in November 2009. Brim is a national company that provides management services to hospitals, including Summit. Kevin Hawk is a healthcare executive employed by Brim. He was Summit's Chief Executive Officer and President from January 2009 until March 2010. [1]

According to plaintiff, Summit submitted false claims for reimbursement to federal healthcare programs, primarily Medicare. He alleges that Summit and Hawk, acting as a Brim employee, ignored reports of patient admission issues and improperly agreed to retain government payments. Plaintiff also maintains that Summit terminated him because he was investigating its claims practices.

In October 2007, Summit allegedly received a report from Brim advising that its patients were being placed in observation when they did not meet the criteria for medically necessary treatment. The report allegedly noted that Summit was also billing Medicare for inpatient services when patients did not meet Medicare criteria for inpatient admission. This report apparently used data from Summit's Program for Evaluating Payment Patterns Electronic Report ("PEPPER"), a government report that shows how a hospital's Medicare claims differ from similar hospitals.

In August 2008, Brim conducted an audit for Summit and prepared another report in anticipation of a government cost recovery audit. The report allegedly concluded that 46% of Summit's observation patients were converted to inpatient status prior to discharge without meeting the criteria for admission. Based on PEPPER data, Brim also identified Summit as an outlier with respect to the number of claims for "one-day stays," which are inpatient admissions with a duration of less than one day. Brim allegedly reviewed thirty-four charts for one-day stay patients using proprietary guidelines that are designed to screen Medicare claims. Brim concluded that twenty of the thirty-four patients did not meet the criteria for inpatient admission. Brim apparently advised Summit that it had $744,000.00 in potential liability to the government due to one-day stay claims. The report also allegedly noted that many of Summit's patients were otherwise being admitted without meeting the criteria for inpatient admission.

In February 2009, Summit retained an outside consulting firm, AR Systems, Inc., to conduct an audit. Plaintiff says that the audit report identified many of the same issues as Brim's reports. Moreover, plaintiff alleges that he directed Summit's Utilization Review Coordinator, Marion Howe, to audit ten inpatient files per month for admissions between January and June 2009. Howe apparently used the same proprietary screening guidelines as Brim. Plaintiff asserts that 40–50% of the files reviewed did not meet Medicare admission criteria. According to plaintiff, he discussed these results with Summit's Compliance Officer, Ken Allen, who said that the problem had been ongoing for years.

***2** Plaintiff also alleges that Summit was misusing its internal Evaluation and Management codes for emergency room services and billing for levels of service that were not provided. He says that this issue had been identified by two outside consulting firms. In October 2009, Allen allegedly admitted that he had known about the issue for a couple of years. During the same month, plaintiff says that he discussed the issue with Hawk and Summit's Director of Medical Records. In addition, plaintiff claims that emergency room physicians were failing to use a certain Medicare coding modifier that allows separate billing for otherwise related services.

In support of the above allegations, plaintiff offers four exhibits attached to the First Amended Complaint. The first is entitled "Inappropriate Patient Observation" and lists twenty-one patient account numbers with corresponding procedures and dates with a month and a year. The second is entitled "Inpatient Admission Status" and lists twenty-three patient account numbers with procedures and dates with a month and a year. It purports to list one-day stay Medicare patients who did not meet inpatient admission criteria based on screening guidelines. The third is entitled "Medicare Admission." It lists 105 account numbers for patients who purportedly did not meet inpatient admission criteria. Many of the patients are identified as one-day stay patients. It includes a month and a year for about half of the patients, and a year for another third. The fourth exhibit is entitled "Emergency Room Upcoding" and lists ten patient account numbers along with the difference between hours that were billed and hours that were documented. It includes a month and a year for each.

During a Summit board of directors meeting in July 2009, plaintiff allegedly reported that Summit had significant compliance issues and discussed the above audits at length. He says that he recommended that Summit quantify its exposure, self-report, and return any overpayments to the government. Hawk allegedly told the board that it was "the government's problem," and that Summit should not self-report but instead wait to see if Medicare "caught" the issues. *First Amended Complaint* ¶¶ 79, 12. The Chairman of the Board, Neal Thompson, allegedly agreed with Hawk that Summit should not self-report. The board apparently approved $2.4 million in reserves in anticipation of the government cost recovery audit.

During a Summit board meeting in September 2009, plaintiff allegedly raised the issue of Summit's potential legal liability if it did not self-report. The Chairman of the Finance Committee, Paul Watson, allegedly asked plaintiff to explain Summit's risk. According to plaintiff, he attempted to explain Summit's potential liability under the False Claims Act ("FCA"), 31 U.S.C. § 3729, which proscribes efforts to defraud the United States. Hawk allegedly interrupted plaintiff, and Thompson allegedly stated that the board members were "lay persons" who could claim ignorance of the law. *First Amended Complaint* ¶ 82. Plaintiff asserts that Summit did not alter its policies and procedures regarding admissions from October 2007 through his termination in November 2009.

***3** Separately, plaintiff alleges that the Heart Center of Northeastern Arizona ("HCNA") violated a services agreement with Summit by billing it for outpatient services and overbilling for certain procedures. Summit apparently did not seek reimbursement under the services agreement. On information and belief, plaintiff asserts that Summit was receiving federal funds for referrals made by HCNA. Plaintiff also alleges that Summit failed to comply with Medicare Conditions of Participation with respect to the supervision of nurse anesthetists by physicians.

During October and November 2009, plaintiff allegedly made written reports of compliance violations using Summit's internal reporting procedures. In November 2009, plaintiff says that he had a disagreement with Hawk about the disclosure of an alleged conflict of interest on an Internal Revenue Service ("IRS") form. Plaintiff allegedly refused to sign the form unless it disclosed that Thompson was profiting from his service on the board by performing realty services for all incoming executives and physicians. Summit terminated plaintiff about a week later. [2]

II. Claim Structure

Plaintiff contends that Summit, Hawk, and Brim violated the FCA, which permits a person to bring a *qui tam* action on behalf of the United States. 31 U.S.C. § 3730(b). The United States declined to intervene. As amended, the FCA extends civil liability to any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," § 3729(a)(1)(A) ("Subparagraph (A)"), or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." § 3729(a)(1)(B).[3] It also extends liability to a person who "knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government," § 3729(a)(1)(G), or "conspires to commit a violation of subparagraph (A), (B), ... or (G)." § 3729(a)(1) (C).

Under the FCA, the term "claim" includes requests for money "presented to an officer, employee, or agent of the United States." § 3729(b)(2)(A)(i). "[T]he term 'obligation' means an established duty, whether or not fixed, arising ... from the retention of any overpayment." § 3729(b)(3).[4] Although the FCA is targeted at fraud, its "knowingly" scienter requirement does not require "proof of specific intent to defraud." § 3729(b) (1)(B). A person acts "knowingly" with respect to information if he has actual knowledge of the information, or he acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information. § 3729(b)(1)(A).

Plaintiff alleges that Summit violated Subparagraphs (A) and (B) because it falsely certified, either expressly or impliedly, that its claims did not fall within a Medicare exclusion that bars payment for services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. § 1395y(a) (1)(A). In part, plaintiff asserts that Summit was warned repeatedly that it was admitting patients who did not meet Medicare criteria and nevertheless submitted claims for its services without changing its practices. He alleges that Summit violated Subparagraph (G) because it knowingly and improperly avoided an obligation arising from the retention of an overpayment. He apparently claims that Summit acted improperly because it had knowledge of an event affecting its continued right to a government payment and failed to disclose it with fraudulent intent, which is a federal crime. 42 U.S.C. § 1320a–7b(a) (3).

***4** Plaintiff also alleges that Summit, Hawk, and Brim violated Subparagraph (C) because Summit conspired with Hawk and Brim to violate Subparagraphs (A), (B), and (G). This allegation is primarily based on Hawk's conduct during Summit board meetings. Separately, plaintiff alleges that Summit violated Subparagraph (A) because it falsely certified that it was in compliance with Medicare Conditions of Participation and the Medicare anti-kickback statute, 42 U.S.C. § 1320a–7b(b), which criminalizes paying for referrals under certain conditions. Plaintiff alleges that Summit failed to comply with the former due to its nurse supervision practices and with the latter due to its relationship with HCNA. In addition, plaintiff alleges that Summit violated the Medicare anti-kickback statute itself, based on the same conduct. Finally, plaintiff asserts that Summit is liable under the anti-retaliation provisions of the FCA, 31 U.S.C. § 3730(h), for terminating him because he was investigating and reporting violations of the FCA.

III. Rule 9(b), Fed.R.Civ.P.

Defendants assert that plaintiff's FCA claims fail to meet the requirements of Rule 9(b), Fed.R.Civ.P. Aside from retaliation claims, FCA claims sound in fraud. *Mendiondo v. Centinela Hosp. Med. Ctr.,* 521 F.3d 1097, 1103 (9th Cir.2008). Therefore, plaintiff must state the circumstances constituting fraud "with particularity." Rule 9(b), Fed.R.Civ.P. That is, he must include "the who, what, when, where, and how" of the alleged misconduct with enough specificity to enable defendants to answer the allegations without resort to a blanket denial of wrongdoing. *Vess v. Ciba–Geigy Corp. USA,* 317 F.3d 1097, 1106 (9th Cir.2003). This is a pleading requirement, not an evidentiary burden. Thus, although the focus of the FCA is on false claims, plaintiff need not identify representative examples of false claims at the pleading stage. *Ebeid ex rel. United States v. Lungwitz,* 616 F.3d 993, 998 (9th Cir.2010). Instead, "it is sufficient to allege particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *Id.* at 998–99 (quotation omitted).[5]

With respect to plaintiff's FCA claims involving admissions, defendants assert that plaintiff has not met the *Ebeid* pleading standard because he has not alleged why any particular services were unnecessary in light of a patient's complaint, symptom, or illness. They also find fault with the sources upon which plaintiff relies. Defendants contend that Summit's PEPPER data merely identify differences among hospitals' Medicare claims, which can be explained by patient differences and do not necessarily mean that

Summit's claims were improper. They also contend that the proprietary screening guidelines which Brim and Summit allegedly used to evaluate Summit's claims cannot serve as a substitute for a physician's clinical judgment on the medical necessity of services for a particular patient. Moreover, defendants argue that the four exhibits attached to the First Amended Complaint add insufficient specificity because they either do not identify whether the patients were Medicare beneficiaries, they do not identify whether the services were billed to Medicare, they do not identify why the services were inappropriate, or they do not identify a specific date or service. With respect to plaintiff's allegations concerning a Medicare coding modifier, defendants assert that failing to use it would lead to an underpayment by the government, instead of an overpayment. Finally, defendants point out that plaintiff has not identified any specific claims, and they maintain that he does not offer reliable indicia of actual false claims being submitted.

***5** Taking plaintiff's allegations as a whole, we conclude that his FCA claims involving admissions meet the pleading requirements of *Ebeid* and Rule 9(b), Fed.R.Civ.P. Plaintiff offers details from several internal and external investigations and reports which allegedly identified pervasive issues with Summit's practices. As alleged, the reports do not rely solely on PEPPER data to reach their conclusions. While the gap between screening guidelines and a physician's judgment may affect the probative value of plaintiff's allegations, it does not render them too vague or unreliable given the alleged confirmation of longstanding issues by Summit's Compliance Officer. Plaintiff also supports his allegations with a detailed account of several Summit board meetings. Significantly, the attached exhibits provide specific information concerning patients, Medicare beneficiary status, procedures, identified issues, and dates. To be sure, some of the information is not present for each patient account number, and the information could be more specific. For example, plaintiff could identify the Medicare criteria involved and explain why they were not met. Given plaintiff's otherwise detailed allegations, however, an analysis of a particular patient's diagnosis is unnecessary. We note that plaintiff does not provide a detailed account of Summit's claims submission process, which would be helpful to evaluate the presence of reliable indicia of claims submission under *Ebeid.* However, plaintiff's multiple reliable sources, including internal and external audits, and the alleged statements by Summit's Compliance Officer, lead to a strong inference sufficient at the pleading stage.

We reach the opposite conclusion with respect to plaintiff's separate FCA claim based on Summit's compliance with Medicare Conditions of Participation and the Medicare anti-kickback statute, 42 U.S.C. § 1320a–7b(b). As noted above, plaintiff alleges that Summit failed to comply with the former due to its nurse supervision practices and with the latter due to its relationship with HCNA. In the Medicare context, however, conditions of participation, unlike conditions of payment, are insufficiently related to the government's payment decision to form the basis of an FCA claim. *Ebeid,* 616 F.3d at 997–1001 (discussing *Mikes v. Straus,* 274 F.3d 687 (2d Cir.2001)). Moreover, plaintiff's allegations concerning referrals made by HCNA, which he offers on information and belief, are conclusory and unsupported by the remainder of plaintiff's allegations. Because it does not meet the requirements of *Ebeid* and Rule 9(b), Fed.R.Civ.P., we dismiss plaintiff's FCA claim based on Medicare Conditions of Participation and the Medicare anti-kickback statute.

IV. Medicare Anti-kickback Claim

Plaintiff all but concedes that his claim alleged directly under the Medicare anti-kickback statute, 42 U.S.C. § 1320a–7b(b), should be dismissed in the absence of the United States as an intervener because the statute does not grant a private right of action. We agree that the criminal statute does not grant a private right of action, *Donovan v. Rothman,* 106 F.Supp.2d 513, 516 (S.D.N.Y.2000), and grant Summit's motion to dismiss plaintiff's claim under it.

V. Conspiracy Claims

***6** Hawk challenges plaintiff's conspiracy claims under the intracorporate conspiracy doctrine. Generally, the doctrine recognizes that corporate entities must act through their agents and employees and that this collaborative decision-making process is not conspiratorial when the agents and employees are acting within the scope of their duties. *See* *Portman v. Cnty. of Santa Clara,* 995 F.2d 898, 910 (9th Cir.1993) (collecting cases). Based on this recognition, the doctrine bars civil conspiracy claims premised on such conduct. Although the application of the intracorporate conspiracy doctrine is unsettled in the Ninth Circuit, *id.,* plaintiff concedes that it "may very well apply to FCA cases." *Response* at 12.

Plaintiff contends that Hawk conspired with Summit to violate the FCA when he and Summit's Chairman of the Board agreed that Summit should not self-report government overpayments during a board meeting. Plaintiff's specific allegations involving Hawk primarily consist of a CEO listening to a CFO's report during a corporate board meeting and his subsequent advice to the board on the best course of conduct for the corporation. These allegations describe conduct that lies at the core of what is non-conspiratorial under the intracorporate conspiracy doctrine. Even under a narrow interpretation of the doctrine, it applies to "the ministerial acts of several executives needed to carry out a single discretionary decision." *Stathos v. Bowden,* 728 F.2d 15, 21 (1st Cir.1984).

Plaintiff argues that the doctrine is inapplicable because Hawk was employed by Brim, a separate legal entity from Summit, in addition to being Summit's agent. On the facts alleged, however, the scope of Hawk's employment with Brim was to serve as Summit's agent, and he was allegedly acting within the scope of his duties. Thus, Hawk's relationship with separate legal entities does not defeat the doctrine's application to this case. *Cf. Am. Needle, Inc. v. Nat'l Football League,* 560 U.S. 183, ––––, 130 S.Ct. 2201, 2209, 176 L.Ed.2d 947 (2010) (eschewing formalistic distinctions in favor of a functional consideration of similar issues in the antitrust context).

Plaintiff also argues that the doctrine is inapplicable based on an exception for criminal conspiracies. In *United States v. Hughes Aircraft Co.,* 20 F.3d 974, 979 (9th Cir.1994), the court held that the intracorporate conspiracy doctrine does not apply in criminal cases because doing so would prevent a corporation acting on its own behalf, by and through its employees, from being found guilty of conspiracy. Although this is not a criminal case, plaintiff asserts that the exception should be extended to civil conspiracies that could otherwise be prosecuted as criminal. He relies on a case from the Eleventh Circuit extending the exception to a civil conspiracy under the Civil Rights Act of 1871, 42 U.S.C. § 1985(2), where the plaintiff had necessarily alleged a criminal conspiracy in violation of 18 U.S.C. § 371. *McAndrew v. Lockheed Martin Corp.,* 206 F.3d 1031, 1034 (11th Cir.2000) ("[J]ust as the intracorporate conspiracy doctrine cannot shield a criminal conspiracy under the federal criminal code, the doctrine cannot shield the same conspiracy, alleging the same criminal wrongdoing, from civil liability under 42 U.S.C. § 1985(2).").

***7** Here, plaintiff does not affirmatively allege a criminal conspiracy. He also fails to argue that he has necessarily alleged one under *McAndrew.* In any event, we are not persuaded that an extension of the exception for criminal conspiracies to civil cases is workable. In the context of the FCA, a plaintiff could too easily circumvent the intracorporate conspiracy doctrine at the pleading stage by alleging a conspiracy "to defraud the United States" under 18 U.S.C. § 371. The victim of an FCA conspiracy is the United States. It may prosecute corporations and their agents and employees for acting in unison should it find criminal charges warranted. We conclude that the intracorporate conspiracy doctrine bars plaintiff's conspiracy claims against Hawk. In the absence of a claim against Hawk, "Jane Doe" Hawk is subject to dismissal. Therefore, we grant Kevin and "Jane Doe" Hawk's motion to dismiss.

Next, Brim contends that it cannot be liable for conspiring to violate the FCA because, at most, it merely had knowledge that false claims were being submitted. Plaintiff contends primarily that Brim is vicariously liable for the actions of its employee, Hawk. However, because the intracorporate conspiracy doctrine bars plaintiff's claims against Hawk, Brim cannot be vicariously liable for his allegedly conspiratorial conduct. Moreover, we agree with Brim that its alleged knowledge of false claims from its auditing services is insufficient to support an FCA conspiracy claim. "Generally, mere knowledge of the submission of claims and knowledge of the falsity of those claims is insufficient to establish liability under the FCA." *United States ex rel. Sikkenga v. Regence Bluecross Blueshield of Utah,* 472 F.3d 702, 714 (10th Cir.2006). It is plainly insufficient to show a conspiracy to violate the FCA. Therefore, we grant Brim's motion to dismiss. Because plaintiff cannot show that Summit conspired with another, we dismiss the conspiracy claims against Summit as well.

V. FCA Retaliation Claim

Summit contends that plaintiff's FCA retaliation claim fails because he has pled himself out of a claim. To plead such a claim, plaintiff must show that he engaged in protected activity, Summit knew that he engaged in protected activity, and Summit discriminated against him because he engaged in protected activity. *See* *Mendiondo,* 521 F.3d at 1103 (interpreting former version of 31 U.S .C. § 3730(h)). The FCA protects efforts to investigate possible false claims based on a reasonable belief of fraud against the government. *See* *id.* at 1104. Because plaintiff alleges that his dispute with Hawk concerning an IRS form "was a factor which eventually resulted" in his termination, and the dispute was unrelated to plaintiff's FCA allegations, Summit argues that he cannot show that he was terminated because he engaged in protected activity. *First Amended Complaint* ¶ 88. Plaintiff allegedly advised Summit's board of directors to address Medicare compliance issues, directed Summit's Utilization Review Coordinator to investigate these issues, made reports through Summit's internal procedures, and warned Summit's board of directors about potential FCA liability. Summit terminated him within months. Plaintiff's alleged dispute over an IRS form may complicate his ability to prove that he was terminated because of protected activity. But his identification of the dispute as a factor in his termination does not defeat his claim at the pleading stage in light of the other factors alleged. Plaintiff has sufficiently pled that he was terminated because of FCA-protected activity. Therefore, we deny Summit's motion to dismiss plaintiff's FCA retaliation claim.

VI. Schedule

***8** Pursuant to our Amended Rule 16 Scheduling Order (doc. 57), the initial disclosure and motion to amend deadlines are ten and forty days from the date of this Order. Due to the delay in deciding the present motions, the Scheduling Order is further amended as follows. Paragraph 4 is amended such that the respective expert disclosure deadlines are May 6, 2011, June 6, 2011, and July 6, 2011. Paragraph 5 is amended such that final supplementation shall be made no later than August 1, 2011. Paragraph 6 is amended such that all discovery must be completed by September 1, 2011. The remaining dates in the Scheduling order, including the August 5, 2011 dispositive motion deadline, are affirmed. The parties are advised that any additional amendment to the complaint and any subsequent motion practice will not be considered good cause to amend the Scheduling Order further.

IT IS THEREFORE ORDERED GRANTING Brim Healthcare, Inc.'s motion to dismiss (doc. 28).

IT IS FURTHER ORDERED GRANTING Kevin and "Jane Doe" Hawk's motion to dismiss (doc. 29).

IT IS FURTHER ORDERED GRANTING IN PART and **DENYING IN PART** Summit Healthcare Association, Inc.'s motion to dismiss (doc. 37). It is granted on the False Claims Act claim based on Medicare Conditions of Participation and the Medicare anti-kickback statute, the Medicare anti-kickback statute claim, and the conspiracy claims. It is otherwise denied.

IT IS FURTHER ORDERED that the Rule 16 Scheduling Order (doc. 57) is amended as set forth above.

DATED this 2nd day of March, 2011.

All Citations

Not Reported in F.Supp.2d, 2011 WL 814898, Med & Med GD (CCH) P 303,704

Footnotes

1 Plaintiff has also named "Jane Doe" Hawk as Hawk's unknown wife in an effort to reach any community property he may own. *See* A.R.S. § 25–215(D) (requiring spouses to be sued jointly in an action on an obligation arising from acts intended to benefit the community).

2 In his response to Summit's motion to dismiss, plaintiff offers a number of additional allegations and several additional exhibits. For purposes of deciding the present motions, we rely solely on the allegations and exhibits from the First Amended Complaint.

3 The FCA was amended and reorganized by the Fraud and Enforcement Recovery Act of 2009. Pub.L. No. 111–21, § 4, 123 Stat. 1617, 1621 (2009). The amendments generally apply to conduct on or after May 20,

2009. *Id.* § 4(f), 123 Stat. at 1625. For purposes of deciding the present motions, we need not discuss the former provisions.

4 We note that Hawk contends that the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 1320a–7k(d), limits which overpayments may give rise to an "obligation" under the FCA when retained. For purposes of Subsection 1320a–7k(d), "overpayments" are defined as Medicare funds received or retained to which a person is not entitled, after applicable reconciliation. *Id.* § 1320a–7k(d)(4)(B). Such overpayments must be reported and returned by the later of sixty days after they were identified or the date any applicable cost report is due. *Id.* § 1320a–7k(d) (2). Any overpayment retained after this deadline is defined as an "obligation" within the meaning of the FCA. *Id.* § 1320a–7k(d) (3). By its terms, Subsection 1320a–7k(d) does not impose any limitations on the FCA. Because plaintiff sufficiently alleges that Summit retained identified overpayments for a substantial period of time, we need not determine the effect of Subsection 1320a–7k(d) on this action to decide the present motions. We advise the parties to brief this issue in the future, should they find it relevant.

5 Summit contends that the *Ebeid* pleading standard conflicts with the holding in *United States ex rel. Aflatooni v. Kitsap Physicians Service,* 314 F.3d 995 (9th Cir.2002), which emphasized that evidence of an actual false claim is necessary to survive summary judgment in an FCA action. However, there is no conflict between an evidentiary burden at summary judgment and a pleading standard.

KeyCite Yellow Flag - Negative Treatment
Declined to Extend by United States v. Melgen, 11th Cir.(Fla.), July 31, 2020

136 S.Ct. 1989
Supreme Court of the United States

UNIVERSAL HEALTH SERVICES, INC., Petitioner
v.
UNITED STATES and Massachusetts, ex rel. Julio Escobar and Carmen Correa.

No. 15–7.
|
Argued April 19, 2016.
|
Decided June 16, 2016.

Synopsis
Background: Parents, as relators, brought qui tam suit against healthcare provider under the False Claims Act (FCA) after their daughter died of a seizure when she was being treated at a mental health clinic by various unlicensed and unsupervised staff in violation of state Medicaid regulations. The United States District Court for the District of Massachusetts, Douglas P. Woodlock, J., 2014 WL 1271757, dismissed, and parents appealed. The United States Court of Appeals for the First Circuit, Stahl, Circuit Judge, 780 F.3d 504, affirmed in part, reversed in part, and remanded. Certiorari was granted.

Holdings: The Supreme Court, Justice Thomas, held that:

[1] the implied false certification theory can be a basis for liability under the FCA in some circumstances, abrogating *U.S. v. Sanford–Brown, Ltd.*, 788 F.3d 696, and

[2] the FCA does not limit liability only to instances where the defendant fails to disclose the violation of a contractual, statutory, or regulatory provision that the government expressly designated a condition of payment, abrogating *Mikes v. Straus,* 274 F.3d 687.

Vacated and remanded.

Procedural Posture(s): On Appeal; Motion to Dismiss.

West Headnotes (26)

[1] **United States** False certification

The "implied false certification theory," providing that when a defendant submits a claim it impliedly certifies compliance with all conditions of payment, can be a basis for liability under the False Claims Act (FCA), at least where two conditions are satisfied: (1) the claim does not merely request payment, but also makes specific representations about the goods or services provided; and (2) the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths; abrogating *U.S. v. Sanford–Brown, Ltd.*, 788 F.3d 696. 31 U.S.C.A. § 3729(a)(1)(A).

188 Cases that cite this headnote

[2] **United States** False claim

By punishing defendants who submit "false or fraudulent claims," the False Claims Act (FCA) encompasses claims that make fraudulent misrepresentations, which include certain misleading omissions. 31 U.S.C.A. § 3729(a)(1)(A).

68 Cases that cite this headnote

[3] **United States** False certification

When a defendant makes representations in submitting a claim but omits its violations of statutory, regulatory, or contractual requirements, those omissions can, pursuant to the implied false certification theory, be a basis for liability under the False Claims Act (FCA) if they render the defendant's representations misleading with respect to the goods or services provided. 31 U.S.C.A. § 3729(a)(1)(A).

130 Cases that cite this headnote

[4] **Statutes** Statutory terms with common law meanings

Absent other indication, Congress intends to incorporate the well-settled meaning of the common-law terms it uses.

12 Cases that cite this headnote

[5] **United States** Statutory provisions

Although the False Claims Act (FCA) abrogated the common law in certain respects, including that the Act's scienter requirement required no proof of specific intent to defraud, the court would presume, when interpreting common-law terms used in the Act, that Congress retained all other elements of common-law fraud that were consistent with the statutory text, because there were no textual indicia to the contrary. 31 U.S.C.A. § 3729 et seq.

6 Cases that cite this headnote

[6] **United States** False claim

Because common-law fraud has long encompassed certain misrepresentations by omission, "false or fraudulent claims" within the meaning of the False Claims Act (FCA) include more than just claims containing express falsehoods. 31 U.S.C.A. § 3729(a)(1)(A).

22 Cases that cite this headnote

[7] **United States** False claim

"Half-truths," that is, representations that state the truth only so far as it goes, while omitting critical qualifying information, can be actionable misrepresentations under the False Claims Act (FCA). 31 U.S.C.A. § 3729(a)(1)(A).

30 Cases that cite this headnote

[8] **Fraud** Duty to disclose facts

In tort law, if the defendant does speak, he must disclose enough to prevent his words from being misleading.

1 Cases that cite this headnote

[9] **Fraud** Fraudulent Concealment

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.

4 Cases that cite this headnote

[10] **United States** False certification
United States Materiality

The False Claims Act (FCA) does not limit liability only to instances where the defendant fails to disclose the violation of a contractual, statutory, or regulatory provision that the government expressly designated a condition of payment; abrogating *Mikes v. Straus,* 274 F.3d 687. 31 U.S.C.A. § 3729(a)(1)(A).

7 Cases that cite this headnote

[11] **United States** False certification
United States Materiality

Not every undisclosed violation of an express condition of payment automatically triggers liability under the False Claims Act (FCA). 31 U.S.C.A. § 3729(a)(1)(A).

3 Cases that cite this headnote

[12] **United States** Materiality

Whether a provision allegedly violated by the defendant is labeled a condition of payment is relevant to but not dispositive of the materiality inquiry into whether defendant has made an actionable false or fraudulent claim under the False Claims Act (FCA). 31 U.S.C.A. § 3729(a)(1)(A), (b)(4).

69 Cases that cite this headnote

[13] **Fraud** Fraudulent Concealment

A statement that misleadingly omits critical facts is a fraudulent misrepresentation irrespective of whether the other party has expressly signaled the importance of the qualifying information.

5 Cases that cite this headnote

[14] **Statutes** Policy considerations; public policy

Policy arguments cannot supersede the clear statutory text.

4 Cases that cite this headnote

[15] **United States** 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 (FCA). 31 U.S.C.A. § 3729(a)(1)(A), (b)(4).

191 Cases that cite this headnote

[16] **United States** Materiality

Materiality, for purposes of determining whether a misrepresentation is actionable under the False Claims Act (FCA), looks to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation. 31 U.S.C.A. § 3729(a)(1)(A), (b)(4).

47 Cases that cite this headnote

[17] **Fraud** Materiality of matter represented or concealed

In tort law, a matter is "material" in only two circumstances: (1) if a reasonable man would attach importance to it in determining 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.

16 Cases that cite this headnote

[18] **United States** Materiality

The False Claims Act's (FCA) materiality standard for an actionable false or fraudulent claim is demanding. 31 U.S.C.A. § 3729(a)(1)(A), (b)(4).

52 Cases that cite this headnote

[19] **United States** False Claims

The False Claims Act (FCA) is not an all-purpose antifraud statute or a vehicle for punishing garden-variety breaches of contract or regulatory violations. 31 U.S.C.A. § 3729 et seq.

36 Cases that cite this headnote

[20] **United States** Materiality

A misrepresentation cannot be deemed "material," as required to give rise to liability under the False Claims Act (FCA), 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. 31 U.S.C.A. § 3729(a)(1)(A), (b)(4).

113 Cases that cite this headnote

[21] **United States** Materiality

The materiality required for a misrepresentation to be actionable under the False Claims Act (FCA) cannot be found where noncompliance with a particular statutory, regulatory, or contractual requirement is minor or insubstantial. 31 U.S.C.A. §§ 3729(a)(1)(A), (b)(4).

31 Cases that cite this headnote

[22] **United States** Materiality

Proof of the materiality of a misrepresentation about compliance with a statutory, regulatory, or contractual requirement, as required for the misrepresentation to be actionable under the False Claims Act (FCA), 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. 31 U.S.C.A. § 3729(a)(1)(A), (b)(4).

132 Cases that cite this headnote

[23] **United States** Materiality

It is strong evidence that particular statutory, regulatory, or contractual requirements are not material, and thus violations of the requirements do not give rise to liability under the False Claims Act (FCA), if the government pays a particular claim in full despite its actual knowledge that certain requirements were violated, 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. 31 U.S.C.A. § 3729(a)(1)(A), (b)(4).

148 Cases that cite this headnote

[24] **Federal Civil Procedure** Fraud, mistake and condition of mind

United States Materiality

False Claims Act (FCA) plaintiffs must plead their claims with plausibility and particularity by, for instance, pleading facts to support allegations of materiality. 31 U.S.C.A. § 3729 et seq.; Fed.Rules Civ.Proc.Rules 8, 9(b), 28 U.S.C.A.

17 Cases that cite this headnote

[25] **United States** Materiality

A statutory, regulatory, or contractual violation is not "material," and thus cannot give rise to liability under the False Claims Act (FCA), merely because the defendant knows that the government would be entitled to refuse payment were it aware of the violation. 31 U.S.C.A. § 3729(a)(1)(A), (b)(4).

28 Cases that cite this headnote

[26] **United States** Materiality

United States Double or treble damages

The False Claims Act (FCA) is not a means of imposing treble damages and other penalties for insignificant regulatory or contractual violations. 31 U.S.C.A. § 3729 et seq.

6 Cases that cite this headnote

***1993** *Syllabus* [*]

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 noncompliance with material statutory, regulatory, or contractual requirements that ***1994** make those representations misleading with respect to those goods or services. Pp. 1999 – 2001.

(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. ——, ——, 133 S.Ct. 2720, 2724, 186 L.Ed.2d 794. 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. 1999 – 2000.

(b) By submitting claims for payment using payment codes corresponding 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. 2000 – 2001.

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. 2000 – 2004.

(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. 2001 – 2003.

(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. *Junius Constr. Co. v. Cohen,* 257 N.Y. 393, 400, 178 N.E. 672, 674. When evaluating the FCA's materiality ***1995** 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. 2002 – 2004.

780 F.3d 504, vacated and remanded.

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

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Opinion

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.

***1996** 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, 96 S.Ct. 523, 46 L.Ed.2d 514 (1976). "[A] series of sensational congressional investigations" prompted hearings where witnesses "painted a sordid picture of how the United States had been billed for nonexistent or worthless goods, charged exorbitant prices for goods delivered, and generally robbed in purchasing the necessities of war." *United States v. McNinch,* 356 U.S. 595, 599, 78 S.Ct. 950, 2 L.Ed.2d 1001 (1958). Congress responded by imposing civil and criminal liability for 10 types of fraud on the Government, subjecting violators to double damages, forfeiture, and up to five years' imprisonment. Act of Mar. 2, 1863, ch. 67, 12 Stat. 696.

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, 120 S.Ct. 1858, 146 L.Ed.2d 836 (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).

B

The alleged False Claims Act violations here arose within the Medicaid program, a ***1997** 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 Yarushka, 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 Yarushka 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 ***1998** 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. [1] 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., United States ex rel. Hutcheson v. Blackstone Medical, Inc.,* 647 F.3d 377, 385–387 (C.A.1 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 expressly 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 identified adequate supervision as an "express and absolute" condition of payment and "repeated[ly] reference[d]" supervision. *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. ––––, 136 S.Ct. 582, 193 L.Ed.2d 465 (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. § 3729(a)(1)(A). ***1999**

United States v. Sanford–Brown, Ltd., 788 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 conditions of payment. *E.g., Mikes v. Straus,* 274 F.3d 687, 700 (C.A.2 2001). 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 (C.A.D.C.2010) (*SAIC*).

II

[1] **[2]** **[3]** 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.

[4] **[5]** 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, 128 S.Ct. 2123, 170 L.Ed.2d 1030 (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. ——, ——, 133 S.Ct. 2720, 2724, 186 L.Ed.2d 794 (2013) (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, 119 S.Ct. 1827, 144 L.Ed.2d 35 (1999) (the term "actionable 'fraud' " is one with "a well-settled meaning at common law"). [2]

[6] 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 ***2000** 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).

[7] **[8]** 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. [3] 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 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 ***2001** health facilities, Universal Health's claims constituted misrepresentations.

[9] 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. [4]

III

[10] **[11]** **[12]** 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 Government 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

[13] 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 1999 – 2001.

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 2003 – 2004, 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, 131 S.Ct. 1309, 179 L.Ed.2d 398 (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 ***2002** 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.

[14] 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, 133 S.Ct. 596, 607, n. 4, 184 L.Ed.2d 433 (2012). 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

[15] 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, 119 S.Ct. 1827 (using this definition to interpret the mail, bank, and wire fraud statutes); *Kungys v. United States,* 485 U.S. 759, 770, 108 S.Ct. 1537, 99 L.Ed.2d 839 (1988) (same for fraudulent statements to immigration officials). This materiality requirement descends from "common-law antecedents." *Id.,* at 769, 108 S.Ct. 1537. Indeed, "the common law could not have conceived of 'fraud' without proof of materiality." *Neder, supra,* at 22, 119 S.Ct. 1827; 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").

[16] **[17]** 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) "[if] a reasonable man would ***2003** attach importance to [it] in determining 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). [5]

[18] **[19]** **[20]** **[21]** The materiality standard is demanding. The False Claims Act is not "an all-purpose antifraud statute," *Allison Engine,* 553 U.S., at 672, 128 S.Ct. 2123 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. See *United States ex rel. Marcus v. Hess,* 317 U.S. 537, 543, 63 S.Ct. 379, 87 L.Ed. 443 (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).

[22] [23] [24] 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 ***2004** knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material. [6]

[25] 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.

* * *

[26] 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 violation. See *Omnicare, Inc. v. Laborers Dist. Council Constr. Industry Pension Fund,* 575 U.S. ——, ——, 135 S.Ct. 1318, 1332–1333, 191 L.Ed.2d 253 (2015). 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.

All Citations

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Footnotes

* The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.,* 200 U.S. 321, 337, 26 S.Ct. 282, 50 L.Ed. 499.

1 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.

2 The 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, 119 S.Ct. 1827.

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, 131 S.Ct. 1309, 179 L.Ed.2d 398 (2011) (securities law).

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).

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, 119 S.Ct. 1827, 144 L.Ed.2d 35 (1999) (relying on " 'natural tendency to influence' " standard and citing Restatement (Second) of Torts § 538 definition of materiality).

6 We 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, pleading facts to support allegations of materiality.

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