FRAUD, DEBARMENT AND SUSPENSION

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PART I. FRAUD

A. FEDERAL FALSE CLAIMS ACT

1. Statistics – Fiscal Year 2016

TOTAL RECOVERIES		**FY 2016**	**FY 2015**	**FY 2014**
Total Settlements & Judgments		**$4.76 Billion**	**$3.79 Billion**	**$6.13 Billion**
Qui Tam Settlements & Judgments	Where U.S. Intervened	$2.8 Billion	$1.88 Billion	$4.37 Billion
	Where U.S. Declined	$105 Million	$1.174 Billion	$81.3 Million
	Total Qui Tam	$2.91 Billion	$3.05 Billion	$4.45 Billion
Non-*Qui Tam* Settlements and Judgments		$1.86 Billion	$731 Million	$1.68 Billion
Total Relator Share Awards		$519.6 Million	$667 Million	$709.2 Million
Relator Share Awards Where U.S. Declined to Intervene		$28.4 Million	$336.7 Million	$14.9 Million
Relator Share Awards Where U.S. Intervened		$491.2 Million	$330.3 Million	$694.3 Million
All New Matters		**845**	**749**	**812**
New *Qui Tam* Matters		702	639	715
New Government Led Matters (Non-*Qui Tam*)		143	110	97
Recovery in Healthcare FCA Cases (HHS)		$2.6 Billion	$2.1 Billion	$2.43 Billion
Recovery in Procurement Fraud (DoD)		$122 Million	$283 Million	$69 Million
Recovery in Non-DoD, Non-HHS Cases		$2.04 Billion	$1.4 Billion	$3.33 Billion

HHS FCA RECOVERIES		**FY 2016**	**FY 2015**	**FY 2014**
Total Settlements & Judgments		**$2.6 Billion**	**$2.1 Billion**	**$2.43 Billion**
Qui Tam Settlements & Judgments	Where U.S. Intervened	$2.43 Billion	$1.47 Billion	$2.27 Billion
	Where U.S. Declined	$71.9 Million	$472.6 Million	$66.3 Million
	Total Qui Tam	$2.5 Billion	$1.95 Billion	$2.34 Billion

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Non-*Qui Tam* Settlements and Judgments	$97.5 Million	$154.7 Million	$88.1 Million
Total Relator Share Awards	$450.5 Million	$391 Million	$393.6 Million
Relator Share Awards Where U.S. Declined to Intervene	$19.3 Million	$132.2 Million	$10.9 Million
Relator Share Awards Where U.S. Intervened	$431.2 Million	$258.8 Million	$382.7 Million
All New Matters	**570**	**452**	**502**
New *Qui Tam* Matters	501	426	470
New Government Led Matters (Non-*Qui Tam*)	69	26	32

DoD FCA RECOVERIES		**FY 2016**	**FY 2015**	**FY 2014**
Total Settlements & Judgments		**$122 Million**	**$283 Million**	**$69 Million**
Qui Tam Settlements & Judgments	Where U.S. Intervened	$47.9 Million	$146 Million	$46.2 Million
	Where U.S. Declined	$13.6 Million	$26.6 Million	$9 Million
	Total Qui Tam	$61.5 Million	$172.6 Million	$55.2 Million
Non-*Qui Tam* Settlements and Judgments		$60.6 Million	$110 Million	$14.1 Million
Total Relator Share Awards		$13.7 Million	$27.1 Million	$11.1 Million
Relator Share Awards Where U.S. Declined to Intervene		$3.9 Million	$2.6 Million	$2.7 Million
Relator Share Awards Where U.S. Intervened		$9.8 Million	$24.6 Million	$8.5 Million
All New Matters		**39**	**43**	**53**
New *Qui Tam* Matters		31	36	44
New Government Led Matters (Non-*Qui Tam*)		8	7	9

NON-HHS/NON-DoD RECOVERIES		**FY 2016**	**FY 2015**	**FY 2014**
Total Settlements & Judgments		**$2.04 Billion**	**$1.4 Billion**	**$3.33 Billion**
Qui Tam Settlements & Judgments	Where U.S. Intervened	$323.9 Million	$260.7 Million	$1.75 Billion
	Where U.S. Declined	$19.4 Million	$675.4 Million	$6 Million
	Total Qui Tam	$343.4 Million	$936 Million	$1.76 Billion
Non-*Qui Tam* Settlements and Judgments		$1.7 Billion	$466.7 Million	$1.57 Billion
Total Relator Share Awards		$55.3 Million	$248.8 Million	$256.2 Million
Relator Share Awards Where U.S. Declined to Intervene		$5.3 Million	$201.9 Million	$1.3 Million
Relator Share Awards Where U.S. Intervened		$50.1 Million	$46.9 Million	$254.9 Million
All New Matters		**236**	**254**	**257**
New *Qui Tam* Matters		170	177	201
New Government Led Matters (Non-*Qui*		66	77	56

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Notes about the Government's Recoveries:

- Overall, no surprises; trend line is up.
  - Total recoveries are 30% above average for the last eight years and 15% above average post-FERA.
- Statistics are notable for what they do not say.
  - They do not say how many government investigations were closed without recovery.
  - They do not say how many government cases were dismissed (and on what grounds and at what stage).
  - Nor do they say how many *qui tam* cases failed to recover any money for the federal government. This is an important omission because there are many cases in which the DoJ or relators devote enormous resources to no avail and at significant taxpayer expense.
- Regardless, DoJ's success in non-*qui tam* cases this year is notable: $1.86 billion in non-*qui tam* recoveries, the largest ever. However, it is unclear whether this is indicative of a trend. $1.7 billion of the $1.86 billion is from non-HHS/non-DoD related claims. $1.2 billion of the $1.7 billion is from one settlement (*see* Wells Fargo settlement, below). Big recoveries like the Wells Fargo settlement are rare, so be careful when reading only the bottom line numbers or headlines.
- Health care-related FCA cases continue to constitute the lion's share of FCA recoveries (55% of the $4.7 billion).
- Number of new cases based on DoD contracts continues to decline. Total DoD-related recoveries are also down from last year by ~50%.
- For the third year in a row, DOJ recovered more than $1 billion from non-HHS/non-DoD related matters. Most of these recoveries are coming from the financial industry in cases arising out of allegedly false certifications made in federally insured loans made during the mortgage crisis. It will be interesting to see whether this pace of non-HHS/non-DoD recoveries continues in 2017 and, if so, whether it is in the mortgage industry or in some new non-HHS/non-DoD area.
- Government intervention has a dramatic correlation with recovery.
  - When the government didn't intervene, relators fared poorly, recovering only $104M for the government and $28.4M in relators awards.
  - But when the government does intervene, relators do very well, recovering $2.8B for the government and $491M in relators awards.
  - When compared with historical averages from the last eight years, government intervention resulted in relator recovery 10% higher than average; when the government didn't intervene, relators did 50% worse than average.

2. Notable Settlements

a. Wells Fargo agrees to pay $1.2 billion for improper mortgage lending practices. On April 8, 2016, the Department of Justice (DOJ) announced it had settled civil fraud claims against Wells Fargo Bank, N.A. and

executive Kurt Lofrano arising out of Wells Fargo's participation in the Federal Housing Administration (FHA) Direct Endorsement Lender Program. Wells Fargo acknowledged and accepted responsibility for, among other things, certifying to the Department of Housing and Urban Development (HUD) that certain residential home mortgage loans were eligible for FHA insurance when in fact they were not, resulting in the Government having to pay FHA insurance claims when some of those loans defaulted. This settlement amounts to 60% of the Non-HHS, Non-DOD settlements and judgments from 2016.

b. **Wyeth and Pfizer agree to pay $784.6 million to resolve allegations that Wyeth underpaid drug rebates to Medicaid.** On April 27, 2016, the DOJ announced it had settled civil fraud claims against Wyeth and Pfizer, Inc., arising out of allegations that the companies had knowingly reported to the government false and fraudulent prices on two of its proton pump inhibitor (PPI) drugs, Protonix Oral and Protonix IV.

c. **Olympus Corp. of the Americas (OCA), the largest distributor of endoscopes and related equipment in the United States, agreed to pay $623.2 million to resolve criminal charges and civil claims relating to a scheme to pay kickbacks to doctors and hospitals.** On March 1, 2016, the DOJ announced that it had settled civil and criminal fraud charges against OCA arising out of allegations that OCA had won new business and rewarded sales by giving doctors and hospitals kickbacks, including consulting payments, foreign travel, lavish meals, and millions of dollars in grants and free endoscopes. The various kickbacks alleged in this scheme caused OCA to obtain more than $600 million in sales and realize gross profits of more than $230 million.

d. **Tenet Healthcare Corporation will pay over $513 million to resolve criminal charges and civil claims relating to a scheme to defraud the United States and pay kickbacks in exchange for patient referrals.** On October 3, 2016, the DOJ announced it had settled civil and criminal fraud charges against Tenet arising out of allegations that Tenet told expectant mothers at prenatal care clinics that Medicaid would cover their costs if they gave birth at one of the Tenet hospitals. The clinics received bribes and kickbacks from the hospitals and involved about 20,000 women who received Medicaid benefits.

e. **RehabCare Group, Inc. and its corporate parent agreed to pay $125 million to resolve a government lawsuit alleging that it violated the False Claims Act by knowingly causing skilled nursing facilities (SNFs) to submit false claims to Medicare for rehabilitation therapy services that were not reasonable, necessary and skilled, or that never occurred.** On January 12, 2016, the DOJ announced the settlement. The government's complaint alleged, among other things, that RehabCare had: (1) presumptively placed patients at a higher therapy reimbursement level, rather than relying on individualized evaluations to determine the level of care most suitable for each patient's clinical needs; (2) boosted the amount

of reported therapy during "assessment reference periods," thereby causing and enabling SNFs to bill for care of their Medicare patients at the highest reimbursement level, while providing materially less therapy to those same patients; (3) inflating initial reimbursement levels by reporting time spent on initial evaluations as therapy time rather than evaluation time; (4) reporting skilled therapy had been provided to patients when in fact patients were asleep or were unable to undergo skilled therapy; and (5) reporting estimated or rounded minutes instead of actual minutes of therapy provided; among other allegations.

f. **Freedom Mortgage Corp. agreed to pay $113 million to resolve False Claims Act liability arising from FHA-insured mortgage lending practices.** Due to staffing limitations between 2008 and 2010, Freedom Mortgage allegedly did not always perform timely quality control (QC) reviews or perform audits of all EPD loans, as required by HUD. An EPD is a loan that becomes 60 days past due within the first six months of the loan. The EPD QC reviews that Freedom Mortgage did perform revealed high defect rates, exceeding 30 percent between 2008 and 2010. Yet, between 2006 and 2011, Freedom Mortgage did not report a single improperly originated loan to HUD, despite its obligation to do so. In 2012, after identifying hundreds of loans that "possibly should have been self-reported to HUD," it reported only one. As a result of Freedom Mortgage's conduct, HUD insured hundreds of loans that were not eligible for FHA mortgage insurance under the DEL program, and that HUD would not otherwise have insured and subsequently incurred substantial losses when it paid insurance claims on the ineligible loans approved by Freedom Mortgage.

g. **Education Management Corp. (EDMC), the second-largest for-profit education company in the country, agreed to settle allegations that it had violated federal and state FCA provisions by falsely certifying compliance with Title IV of the Higher Education Act (HEA) and parallel state statutes for $95.5 million.** The government alleged that EDMC unlawfully recruited students, in contravention of the HEA's Incentive Compensation Ban (ICB), by running a high pressure boiler room where admissions personnel were paid based purely on the number of students they enrolled. The settlement resolved four separate FCA lawsuits filed in federal court in Pittsburgh and Nashville under the FCA's *qui tam* provisions. The settlement also resolves a consumer fraud investigation by 40 state Attorneys General into EDMC's deceptive and misleading recruiting practices.

h. **Genentech, Inc. and OSI Pharmaceuticals, LLC, paid $67 million to resolve FCA allegations that they made misleading statements about the drug Tarceva's effectiveness in treating non-small cell lung cancer.** The government alleged that between January 2006 and December 2011, Genentech and OSI made misleading representations to physicians and other health care providers about Tarceva's effectiveness

to treat certain patients with non-small cell lung cancer despite there being little evidence showing that Tarceva was effective in treating those patients unless they also had never smoked or had a mutation in their epidermal growth factor receptor, which is a protein involved in the growth and spread of cancer cells.

i. **M&T Bank Corp. paid $64 million to resolve allegations that it violated the FCA by originating and underwriting mortgage loans insured by HUD's FHA that did not meet the applicable regulatory requirements.** M&T allegedly failed to adhere to HUD's self-reporting requirements. Although M&T identified numerous FHA insured loans with "major errors" as early as 2006, M&T did not report a single loan to HUD until 2008. As a result, HUD insured hundreds of loans approved by M&T that were not eligible for FHA mortgage insurance under the Direct Endorsement program. As part of the settlement, M&T Bank admitted to the following: Between Jan. 1, 2006, and Dec. 31, 2011, M&T certified FHA insurance mortgage loans that did not meet HUD underwriting requirements and did not adhere to FHA's quality control requirements. Prior to 2010, M&T Bank failed to review all Early Payment Default (EPD) loans, which are loans that become 60 days past due within the first six months of repayment. Between 2006 and 2011, M&T also failed to review an adequate sample of FHA loans, as required by HUD.

3. Supreme Court

a. **Supreme Court Validates Implied Certification Theory; "Clarifies" Materiality Standard.** *Universal Health Servs., Inc. v. U.S. ex rel. Escobar*, No. 15-7, 136 S. Ct. 1989 (U.S. June 16, 2016). A teenage beneficiary of Massachusetts's Medicaid program had an adverse reaction to medication prescribed by a health facility operated by Universal Health Services. As a result of the adverse reaction, the teenager died. The teenager's parents later learned that the facility's employees were not actually licensed to provide mental health counseling or authorized to prescribe medications without supervision. The parents filed a *qui tam* action against Universal Health under the implied false certification theory (*i.e.*, that Universal impliedly and falsely certified compliance with Massachusetts Medicaid regulations regarding licensure of facility employees when it submitted claims for the teenager's reimbursement).

The district court granted Universal's Motion to Dismiss, holding that the relators failed to state a claim under the "implied false certification" theory because none of the regulations at issue were conditions of payment. The First Circuit reversed, finding that the regulations at issue were conditions of payment. Universal appealed to the Supreme Court, which granted certiorari.

The Supreme Court made two important holdings: (1) the implied certification theory can be a basis of liability when the defendant submitting a claim violates a statute, regulation, or contractual provision

that was material to the government's decision to pay and (2) liability under the implied certification theory does not turn on whether a statute, regulation, or contractual provision is a "condition of payment," although such a characterization is relevant.

The Supreme Court described several factors that go to materiality. These factors will likely be litigated in the district courts for many years to come. The factors include:

- Importance (An Objective Test) – Whether a "reasonable man [acting on the Government's behalf] would attach importance to [the representation] in determining his choice of action in the transaction." *Id.* at 2003. It follows that a reasonable person would not attach importance to a violation that is "minor or insubstantial." *Id.* at 2003.
- Government Knowledge/Government Treatment of Violations (A Subjective Test) – Whether the Government knew of a claim's falsity and nevertheless paid the claim, which would tend to negate a finding of materiality. *Id.* at 2003. This argument is also known as the so-called "government knowledge" defense. Conversely, "evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance" supports a finding of materiality. *Id.*
- Labels Used – Whether the Government has "expressly identif[ied] a provision as a condition of payment," although such identification is "relevant but not automatically dispositive." *Id.* at 2002.
- Essence of the Bargain – Whether the regulatory, statutory, or contractual violation goes to the "essence of the bargain." *Id.* at 2003 n.5.

Note: There are three cases pending for certiorari seeking a Supreme Court ruling as to whether *Escobar* was properly applied in their case. The cases are *U.S. ex rel. Bishop v. Wells Fargo Bank, NA*, No. 16-578; *U.S. ex rel. Jallali v. Sun Healthcare Group*, No. 16-669; and U*.S. ex rel. Gage v. Davis S.R. Aviation*, LLC, No. 16-694. That there are so many petitions already at the Court regarding the proper application of *Escobar* shows that the *Escobar* decision will, absent further clarification by the Court, result in further litigation in the years to come.

b. A Relator's Violation of the FCA's Seal Requirement Does Not Mandate Dismissal; Whether Dismissal is Appropriate is Left to the "Sound Discretion" of the District Courts. *State Farm Fire & Cas. Co. v. U.S. ex rel. Rigsby*, No. 15-513, 2016 WL 7078622 (U.S. Dec. 6, 2016). Before Hurricane Katrina, State Farm issued both federally-backed flood insurance policies and its own general homeowner insurance policies. The former covered flood damage, while the latter covered wind damage. Characterizing hurricane damage as flood damage, as opposed to wind

damage, would therefore result in the federal government, not State Farm, paying insurance claims.

Cori and Kerri Rigsby, former claim adjusters for a State Farm contractor, together with other adjusters, filed a *qui tam* action against State Farm alleging that the company falsely certified certain instances of hurricane damage as flood damage when the company knew the damage was caused by wind damage. State Farm moved to dismiss the action, arguing that the Rigsbys violated the FCA's seal requirement. 31 U.S.C. § 3730(b)(2). The district court denied State Farm's motion and the Fifth Circuit affirmed.

The Supreme Court agreed to take the case to resolve a circuit split. The Fifth and Ninth Circuits permitted dismissal based on a district court's consideration of the following factors: (1) actual harm to the Government, (2) severity of the violations and (3) evidence of bad faith. The Second and Fourth Circuits authorized dismissal when a seal violation "incurably frustrated" the interests served by the rule. And the Sixth Circuit relied on a *per se* dismissal rule, requiring dismissal for seal violations.

The Supreme Court held "whether dismissal is appropriate should be left to the sound discretion of the district court." This holding is broad enough to permit the Second, Fourth, Fifth, and Ninth Circuit rules to live on, but without question abrogates the Sixth Circuit's *per se* rule.

c. Certiorari petition pending in D.C. Circuit case that held no false certification liability when a contractor relied on its reasonable interpretation of an ambiguous government regulation. *United States ex rel. Purcell v. MWI Corp.*, 807 F.3d 281 (D.C. Cir. 2015), *cert. pending*, No. 16-361 (U.S. Sept. 21, 2016). The D.C. Circuit overturned a jury verdict and ruled in favor of MWI Corporation,[2] in a long-running civil FCA lawsuit in which the government asserted claims for approximately $225 million in trebled damages (plus additional civil penalties).

The Government alleged that false claims and statements were submitted to the Export-Import Bank of the United States in connection with eight loans to the government of Nigeria for the purchase of MWI's water pumps. The key issue was whether MWI's certification that the commissions it paid its sales agent in connection with the sales were "regular" was knowingly false.

MWI argued that its certification could not have been knowingly false because the term "regular commissions" was ambiguous, MWI made the certification based on a reasonable interpretation of the term, and the agency never defined "regular commissions" or authoritatively clarified its meaning.

[2] In the interest of full disclosure, I represent MWI Corporation in this dispute.

A unanimous panel of the D.C. Circuit agreed and held that MWI could not have acted "knowingly" where there was no evidence that the government "had officially warned MWI away from its otherwise facially reasonable interpretation of [an] undefined and ambiguous term," citing the Supreme Court's decision in *Safeco Insurance Co. of America v. Burr*, 551 U.S. 47, 69–70 & n.20 (2007).

In addition, the court rejected the government's subjective intent and "duty to inquire" arguments, explaining both that (1) subjective intent was irrelevant because the defendant's interpretation of the term was reasonable and that (2) a failure to seek a legal opinion from the Bank did not support a finding that MWI acted recklessly under the FCA.

Thus, this case establishes important precedent that, where a defendant adopts an objectively reasonable or plausible interpretation of an ambiguous regulatory term and the agency has not officially warned the defendant from its interpretation via authoritative guidance, the FCA scienter element cannot be established. The government filed its petitions for rehearing and rehearing en banc, which were later denied. On September 19, 2016 the U.S. Solicitor General declined to file a petition for a writ of certiorari to the U.S. Supreme Court thereby abandoning the Government's case against MWI after 18 years and 24 days.

MWI's former employee, however, did file a petition for a writ of certiorari on September 19, 2016. On November 21, 2016, the United States Solicitor General later filed a brief arguing that this was not a case for the Supreme Court to grant certiorari. MWI also filed its brief in opposition on November 21, 2016. The relator filed his reply brief on December 6, 2016. The matter is set for consideration by the Court on January 6, 2017 when it will be distributed for Conference.

4. Courts of Appeals

a. 1st Circuit – *U.S. ex rel. Escobar v. Universal Health Servs., Inc.*, 842 F.3d 103 (1st Cir. 2016) – On remand, the First Circuit found the relators' allegations could be material to the government's decision to pay claims. As the First Circuit put it: "At the core of the MassHealth regulatory program in this area of medicine is the expectation that mental health services are to be performed by licensed professionals, not charlatans." Then paying homage to the FCA's genesis in the Civil War, during which the Army was provided defective military supplies from some unscrupulous contractors, the First Circuit wrote "UHS's violations in the instant case are as central to the bargain as the United States ordering and paying for a shipment of guns, only to later discover that the guns were incapable of firing."

Under these alleged facts and circumstances, the First Circuit was not persuaded by UHS's government knowledge argument. The First Circuit downplayed the argument in this particular case on the ground that the

government did not discover the extent of the allegations until long after the litigation was filed—"mere [government] awareness of allegations concerning noncompliance with regulations is different from knowledge of actual noncompliance." Without evidence of knowledge of actual noncompliance, the First Circuit was not prepared to dismiss the matter at the motion to dismiss stage of the litigation.

b. **2nd Circuit – *United States ex rel. Ladas v. Exelis, Inc.*, No. 14-4155, 2016 WL 3003674 (2d Cir. May 25, 2016).** The relator in Ladas brought FCA claims based on the defendant's allegedly fraudulent certifications that equipment supplied to the government under its procurement contract conformed with applicable contractual requirements. *Id.* at *8. In affirming the district court's dismissal for failure to plead fraud with particularity, the Second Circuit reiterated that the complaint must demonstrate how the alleged contractual violations specifically connect to particular false statements that were material to the alleged false claims for payment. *Id.* at *9. In particular, the Second Circuit criticized the specificity and relevance of the relator's allegations where the complaint cited only to violations of internal company specification requirements outside of the contract and offered "hypotheses" as to how alleged problems could affect ordered products without providing factual allegations "concerning the actual condition of the equipment." *Id.* at *8. While fact specific, the level of scrutiny applied by the Second Circuit in Ladas is encouraging to the extent it demonstrates a demand for something more concrete than allegations built on presumed, or even hypothetical, contractual deficiencies.

c. **3rd Circuit – *U.S. ex rel. Moore & Co., P.A. v. Majestic Blue Fisheries, LLC*, 812 F.3d 294 (3d Cir. 2016)** – In 2010, Congress passed the Affordable Care Act (ACA). Among other things, the ACA expanded the definition of "original source" to include relators who had 'knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions." *Majestic Blue Fisheries* is the first case in the Third Circuit that interpreted the meaning of the phrase "materially adds to the publicly disclosed allegations." "Materially adds," the Third Circuit explained, means contributing "significant, specific" details to the already publicly disclosed information. Reversing the district court which dismissed the action under the Public Disclosure Bar, the Third Circuit held "Specifically, a relator materially adds to the publicly disclosed allegation or transaction of fraud when it contributes information — distinct from what was publicly disclosed — that adds in a significant way to the essential factual background: 'the who, what, when, where and how of the events at issue.'"

d. **4th Circuit – *U.S. ex rel. Beauchamp v. Academi Training Center, LLC*, 816 F.3d 37 (4th Cir. 2016)** – The district court dismissed a relator's action under the public disclosure bar. According to the district court, the operative complaint for public disclosure purposes is the most recent

amended complaint, which was filed after the public disclosure. The Court of Appeals vacated the dismissal. The district court, according to the Court of Appeals, "mechanically applied the statement [in *Rockwell*] that 'courts look to the amended complaint to determine jurisdiction.'" The Court of Appeals concluded "that the determination of when a plaintiff's claims arise for purposes of the public-disclosure bar is governed by the date of the first pleading to particularly allege the relevant fraud and not by the timing of any subsequent pleading."

e. **7th Circuit – *United States ex rel. Nelson v. Sanford-Brown, Ltd.*, No. 14-2506, 2016 WL 6205746 (7th Cir. Oct. 24, 2016)** – Relator brought FCA action in the E.D. Wisconsin against providers of technical education alleging the educators falsified student attendance records, provided misleading and inflated job placement figures and data, and harassed students to attend class in violation of various sections of Title 20 of the United States Code. The district court dismissed the action in part under Fed. R. Civ. P. 9(b) and 12(b)(6) and granted summary judgment to the defendants on the remaining claims, including an implied certification claim. On appeal, the Seventh Circuit affirmed. The Supreme Court granted certiorari, and remanded the case for further consideration following *Escobar*.

On remand, the Seventh Circuit again affirmed the district court's summary judgment and dismissal. The court noted that Sanford-Brown College, one of the defendants, made no representations in connection with its claims for payment, much less a false or misleading representation. The court also observed that the relator offered "no evidence that the government's decision to pay SBC would likely or actually have been different had it known of SBC's alleged noncompliance with Title IV regulations." The court explained that it was not enough that the government could have refused payment—rather, the relator had to show that the government would "likely or actually" have refused payment.

f. **7th Circuit – *United States ex rel. Bogina v. Medline Industries, Inc.*, 809 F.3d 365, 368 (7th Cir. 2016).** The Seventh Circuit applied the new definition of "original source" to a pre-2010 case, holding "that because the earlier definition is inscrutable as well as skimpier than the current one, the current one should be deemed authoritative regardless of when a person claiming to be an original source acquired his knowledge." Applying the new definition, the court determined that relator was not an original source because "he merely 'add[ed] details' to what [was] already known in outline" as a result of a previous lawsuit. *Id.* at 370. As such, the fact that the relator focused on different customers, pertained to different government health care programs, and addressed different time periods did not "materially add" to what had been disclosed in the previous lawsuit. *Id.* at 369–70.

g. 8th Circuit – *U.S. ex rel. Donegan v. Anesthesia Assocs. of Kan. City, PC*, 833 F.3d 874 (8th Cir. 2016). The Eighth Circuit affirmed a district court's grant of summary judgment in favor of a defendant because the relator failed to establish that the defendant knowingly submitted false claims. At issue was whether anesthesiologists were present in the operating room during patients' "emergence" from anesthesia. The parties disagreed over the meaning of the term "emergence," which was undefined in the regulations. The court found the defendant's interpretation of the term reasonable and further held that it had no duty to ask CMS or its local contractors whether its interpretation was proper.

5. District Courts

a. *United States ex rel. Lee v. N. Adult Daily Health Care Ctr.*, No. 13-CV-4933, 2016 WL 4703653 (E.D.N.Y. Sept. 7, 2016) – Relators, who were former employees, brought FCA action in the E.D.N.Y. against an adult day care center that provided cognitive stimulation, arts and crafts, personal hygiene, occupational therapy, and physical therapy to elderly and low-income patients. Prior to *Escobar*, the parties argued over whether the day care center's alleged failure to abide by Title VI and DOH regulations was a condition of payment. Whether compliance with a regulation was a condition of payment is no longer relevant after *Escobar*. The court, applying *Escobar's* materiality standard, considered whether the defendant's alleged misrepresentations "were material and that the government would have refused reimbursement had it known" of the defendant's "noncompliance with Title VI and the cited DOH regulations." The court found that the relator had not shown the government would have withheld payment if it knew of the defendant's noncompliance.

b. *United States ex rel. Williams v. City of Brockton*, No. 12-CV-12193, 2016 WL 4179863 (D. Mass. Aug. 5, 2016) – Relator brought FCA action in the District of Massachusetts against the Brockton Police Department for the department's alleged false of compliance with statutory, regulatory, and contractual requirements in an effort to fraudulently obtain funding from the United States Department of Justice's COPS grant program. The statutes and regulations governing the COPS program prohibited discrimination on the basis of race and required the department to certify that it did not engage in such discrimination. The court found that the statutes and regulations do not call for the withholding of grants until there has been an express finding of discrimination by a court or administrative agency. Therefore, under *Escobar's* materiality standard, any discrimination that occurred before a court or administrative agency makes an express finding of discrimination is not actionable under the implied certification theory. However, in regard to so-called "non-supplanting rules," which mandate that COPS recipients maintain the budgeted number of locally funded officer positions after receiving COPS grants, the court found that the materiality standard had been met. The

court, quoting *Escobar*, cited to the fact that "the Government consistently refuses to pay claims in the mine run of cases based on noncompliance." The court therefore permitted the claims based on the non-supplanting regulations to go forward.

c. ***City of Chicago v. Purdue Pharma L.P.*, No. 14-CV-4361, 2016 WL 5477522 (N.D. Ill. Sept. 29, 2016) –** City brought FCA action against pharmaceutical companies alleging that the companies provided misleading and fraudulent direct marketing to doctors seeking to create, promote, and control the unbranded marketing of opioids to treat chronic pain. The City alleged that the companies knowingly disseminated unbranded marketing messages that were inconsistent with information on defendants' branded marketing materials, thereby causing the City to spend over $13 million on fraudulent claims for opioid prescriptions. Although there were multiple theories of liability raised by the state, the relevant theory for *Escobar* purposes is the implied certification theory. The court dismissed the implied certification claim, noting that the City continues to pay for claims based on the companies' alleged misrepresentations, but granted leave to the City to replead consistent with the standards set forth in *Escobar*.

d. ***Scott Rose v. Stephens Institute*, No. 09-CV-5966, 2016 WL 5076214 (N.D. Cal. Sept. 20, 2016) –** Relator brought FCA action in the Northern District of California against a company that allegedly violated the FCA by submitting claims for payment to the Department of Education when it knew it was not complying with a statutory ban on incentive compensation to student recruiters. The ban, also known as the ICB, is meant to curb the risk that student recruiters will sign up poorly qualified students, who will likely be unable or unwilling to repay federally guaranteed student loans. The Court in this case had denied summary judgement to the defendant; however, the defendant requested reconsideration of that decision in light of *Escobar*. The Court again denied summary judgment, explicitly finding compliance with the ICB to be a material condition of payment under *Escobar*. In rendering this holding, the Court found (1) the DOE's decision to not take action against a company despite its awareness of the allegations in the case to be "not terribly relevant to materiality" because the DOE had not cited any reason for this decision, (2) DOE's corrective actions against schools in the form of partial settlements (*i.e.*, recovering part of the funds paid) supported a materiality finding, and (3) a recent policy change in how DOE enforced ICB violations suggested that past policies should not be considered in determining whether the violations were material.

e. ***U.S. ex rel. Paradies v. Aseracare*, 176 F. Supp. 3d 1282 (N.D. Ala. 2016)** – In AseraCare, the government relied on, and offered the testimony of, its medical expert and the patients' medical records to establish falsity. The expert testified that the patients in question could not be considered terminally ill for purposes of Medicare reimbursement. AseraCare,

meanwhile, had its own medical expert who claimed that the patients at issue were terminally ill. The falsity issue in AseraCare, therefore, boiled down to this: could a fact, such as whether a patient was terminally ill, be "objectively false" when two reasonable experts disagree about the fact? The district court held that it could not, granting summary judgment for Aseracare.

6. Regulatory Developments

a. Civil Monetary Penalty increases from the minimum/maximum of $5,500/$11,000 to $10,781/$21,563. On June 7, 2016, the Civil Monetary Penalties associated with violations of the FCA were increased. The minimum penalties were increased from $5,500 to $10,781. The maximum penalties were increased from $11,000 to $21,563. 81 Fed. Reg. 36454, 36456 (2016) (amending 15 C.F.R. Pt. 6).

B. CRIMINAL CHARGES, CONVICTIONS, AND PLEAS

1. Notable Matters

a. Jury Convicts Home Health Agency Owner in $13 Million Medicare Fraud Conspiracy. On November 11, 2016, the DOJ announced that it had obtained a conviction against Marie Neba of Sugarland, Texas for multiple counts of health care fraud. Neba was the co-owner of Fiango Home Healthcare, Inc. with her husband Ebong Tilong, who pleaded guilty to multiple fraud counts. The couple conspired to defraud Medicare by submitting over $13 million in false and fraudulent claims. They paid illegal kickbacks to physicians in exchange for authorizing medically unnecessary services. They also paid kickbacks to recruiters for referring Medicare beneficiaries for home health services. Their sentencing is in February.

b. South Florida Home Health Agency Owner and Manager was Sentenced to 20 Years In Prison for Role in $57 Million Medicare fraud scheme. Between 2006 and 2013, Khaled Elbeblawy defrauded Medicare through false promises, a kickback and bribery scheme, and submitting false and fraudulent documents. Elbeblawy was the owner of three Miami area health agencies. In addition to the prison sentence, Elbeblawy was ordered to pay more than $36 million in restitution.

c. Three People Charged in $1 Billion Medicare Fraud and Money Laundering Scheme. The owner of more than 30 Miami-area skilled nursing and assisted living facilities, a hospital administrator and a physician's assistant were charged with conspiracy, obstruction, money laundering and health care fraud in connection with a $1 billion scheme involving numerous Miami-area health care providers. According to the

indictment, one of the defendants operated a network of over 30 skilled nursing homes and assisted living facilities (the Esformes Network), which gave him access to thousands of Medicare and Medicaid beneficiaries. Many of these beneficiaries did not qualify for skilled nursing home care or for placement in an assisted living facility; however, Esformes and his co-conspirators nevertheless admitted them to Esformes Network facilities where the beneficiaries received medically unnecessary services that were billed to Medicare and Medicaid. Incredibly, one defendant paid $15.4 million to resolve civil fraud claims for essentially identical conduct. However, the defendants allegedly continued their criminal activity—adapting their fraud scheme to prevent detection after the civil settlement.

d. North Carolina Couple Sentenced for Government Contract Fraud. From November 2005 to April 2013, Ricky and Katrina Lanier of LaGrange, North Carolina, fraudulently obtained federal contracts intended to be awarded to businesses lawfully participating in the Department of Veterans Affairs' Service-Disabled Veteran-Owned Small Business (SDVOSB) program and the Small Business Administration's 8(a) Business Development program. They falsely represented that JMR Investments was eligible as an 8(a) business and that Kylee Construction was a SDVOSB and an 8(a) business. As a result of the false representations, Kylee Construction was awarded over $5 million in government contracts and JMR Investments was awarded over $9 million in government contracts. The Laniers received almost $2 million in financial benefit from the scheme, using accounts of the shell companies for payment of personal expenses.

PART II - SUSPENSION AND DEBARMENT

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