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THE REVERSE FALSE CLAIMS ACT: A Relatively Unknown, But Increasingly Used, Provision of the FCA

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THE REVERSE FALSE CLAIMS ACT: A Relatively Unknown, But Increasingly Used, Provision of the FCA

Volumes have been written about the False Claims Act as a tool to pursue fraud against the government in circumstances where the defendant has allegedly made false statements to receive money from the government. For purposes of our discussion here, we refer to this aspect of the False Claims Act as "affirmative false claims." Westlaw and Lexis are replete with cases addressing the government's and relators' claims seeking recovery for affirmative false claims allegedly perpetrated by defendants. While there are still cases exploring the parameters of materiality and "objective falsity," much about the False Claims Act's affirmative false claims provisions is settled law.

Not so the reverse false claims provision of the False Claims Act. The reverse false claims provision permits the government or relators to pursue defendants who are alleged to have hidden or reduced an obligation to pay the government through false statements, or who have violated the 60-day payment rule's obligation to return "identified overpayments." These claims typically have been raised in the context of cost reporting, Medicare Part C, or related to alleged failures to fulfill obligations under the 60-day payment rule. The government and relators have increasingly relied on the reverse false claims provision to support stand-alone claims or have used it in conjunction with affirmative false claims. However, because the reverse false claims provision is very lightly used compared to affirmative false claims provisions, there is a dearth of case law defining it or exploring its parameters. The case law that does exist is primarily from district courts and, as the survey of case law contained herein illustrates, there is little guidance from the Circuit Courts or the U.S. Supreme Court.[1]

[1] Special thanks to our colleague, Jeremy E. Abay, for his assistance with this Article. Mr. Abay's practice includes healthcare fraud (False Claims Act), wage litigation, consumer fraud, and government enforcement matters.

In this chapter, we cover the legislative history of the reverse false claims provision, the impact of the 2009 Fraud Enforcement and Recovery Act's significant amendments to the reverse false claims provision, a survey of relevant reverse false claims cases, and finally, a discussion of the practical implications of the reverse false claims provision of the False Claims Act for members of the healthcare industry and legal practitioners that represent them.

I. Legislative History of the Reverse False Claims Provision

A. The 1986 Amendments to the False Claims Act

The False Claims Act ("FCA"), 31 U.S.C. §§ 3729-33, was enacted in 1863 "in order to combat fraud and price-gouging in [Civil War] procurement contracts."[2] In its original form, the Government could prove a violation of the FCA only where a defendant affirmatively submitted a fraudulent claim to the government for its money or property. Instances where a defendant submitted false records or statements to the Government to reduce its obligation to pay were not actionable because they involved no "claim." [3]

In 1986, Congress amended the FCA to include a "reverse false claims" provision ("1986 Amendment"), so-called because it assigned liability based on an obligation to return funds to the government. Congress added the reverse false claims provision at the request of the Department of Justice to resolve a dispute, highlighted by cases like *Howell* and *Brethauer* (*see* FN 2), about whether a fraudulent effort to *avoid* payment to the government constituted a false claim under the

[2] *United States ex rel. Springfield Terminal Ry. Co. v. Quinn*, 14 F.3d 645, 649 (D.C. Cir. 1994).

[3] *See, e.g.*, *United States v. Howell*, 318 F.2d 162 (9th Cir. 1963) (court found no FCA liability where concessionaires who contracted with government to clean military bases and provide portion of gross receipts to government mischaracterized those gross receipts to decrease their obligation to pay the government. According to the Court, defendants had not submitted a "claim" to the government and thus there could be no FCA liability); *United States v. Brethauer*, 222 F. Supp 500 (W.D. Mo. 1963) (same).

FCA.[4] In discussing the amendment, the Senate Judiciary Committee Report approvingly cited *United States v. Neifert-White Co.*, in which the Supreme Court stated that the FCA "was intended to reach all types of fraud, without qualification, that might result in financial loss to the Government."[5] According to Congress, it saw no reason to treat a false statement or record submitted to the Government to fraudulently reduce an obligation owed to the Government any differently from one submitted for the purpose of fraudulently obtaining Government money.[6] The new reverse false claims act provision read as follows:

> [K]nowingly mak[ing], us[ing] or caus[ing] to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government. . . .[7]

This earliest version of the reverse false claims provision required knowledge as well as the submission of some form of false claim, record, or statement.[8] It inarguably broadened the scope of the FCA, consistent with the views of the Department of Justice and the Supreme Court. Its requirement of the submission of a false record or statement, however, excepted from liability situations where a defendant knew that it had an obligation to pay money to the Government, and concealed that obligation without the use of a false record or statement.

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[4] H.R. Rep. No. 99-660, at 20 (1986); Claire M. Sylvia, *The False Claims Act: Fraud Against the Government* § 4:16 (April 2021 Update).

[5] 390 U.S. 228, 232 (1968)

[6] H.R. Rep. No. 99-660, at 20.

[7] 31 U.S.C. §§ 3729(a)(1)(G).

[8] The FCA defines "knowing" as when a person has "actual knowledge" of the information or acts in "deliberate ignorance" or "reckless disregard" of the truth or falsity of the information. 31 U.S.C. §§ 3729(b)(1)(A)-(B).

B. The 2009 Fraud Enforcement and Recovery Act Clarifies and Broadens Reverse FCA Liability

From 1986 to 2009, the reverse false claims provision of the FCA was used by the Government to prosecute defendants in limited situations where the defendant submitted false records or statements to reduce or conceal a fixed duty to pay money owed to the Government, such as a judgment or tariffs on imports.[9] In 2009, the Senate sought to again expand the reverse false claims provision to apply to a defendant's knowing avoidance of an obligation to pay the government, whether or not a false statement or record was used, and to clarify and enlarge the definition of "obligation." On February 5, 2009, Senators Patrick Leahy and Chuck Grassley introduced Senate Bill 386, which proposed to add the following language to Subsection G of the FCA:

> [K]nowingly 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, ***or knowingly conceals, avoids, or decreases an obligation to pay or transmit money or property to the Government. . . .***

In addition to closing the "false record or statement" loophole and establishing liability for any knowing failure to pay an obligation owed to the government, Senate Bill 386 also defined the term "obligation" to include:

> [A] fixed duty, or a contingent duty arising from an express or implied contractual, quasi-contractual, grantor-grantee, licensor-licensee, fee-based, or similar relationship*, and the retention of any overpayment*.[10] (emphasis added).

On March 5, 2009, the Senate Judiciary Committee issued its Report wherein it further clarified the language of the reverse false claims provision and Congress' intent behind its revisions. The Senate proposed to further revise Subsection G of the FCA as follows:

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[9] S. Rep. No. 111-10 at 14.

[10] 155 Cong. Rec. S. 1684 (daily ed. Feb. 5, 2009)

> [K]nowingly 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, or knowingly conceals, ***or knowingly and improperly*** avoids or decreases an obligation to pay or transmit money or property to the Government. . . .

The intent behind this change was to make clear that the statute only reached wrongful conduct. By clarifying that the reverse false claims provision covered only "knowing and improper" avoidance of an obligation to pay, Congress ensured that lawful attempts to avoid or decrease an obligation to pay the Government, such as through an audit appeal, would not subject a person to FCA liability.[11]

Finally, on April 22, 2009, the Senate Bill received its final round of revisions during statements on the Senate floor by Senator Jon Kyl. Sen. Kyl proposed, and the Senate accepted, the following revisions to the Bill's definition of the term "obligation:"

> ***[A]n established*** duty, ***whether or not fixed***, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based, or similar relationship, ***from statute or regulation*** or from the retention of any overpayment.

According to Sen. Kyl, the previous version of the definition was too broad in that it included "contingent" obligations, such as duties to pay potential fines or penalties. This type of "potential" duty could arise, or at least become a "contingent obligation" for purposes of the statute, "as soon as the conduct that is the basis for the fine has occurred." Sen. Kyl reasoned that it was not in the public interest to allow the Government, or anyone else, to sue under the FCA to treble a fine before the duty to pay such fine had been formally established. While Sen. Kyl believed it was unlikely the Government would ever pursue such a claim, he nevertheless advocated to change "contingent duty" to "established duty." He reasoned that the FCA can also

[11] S. Rep. No. 111-10 at 4.

be enforced by private relators "who often may be motivated by personal gain and not always exercise the same good judgment that the Government usually does."[12] This version became law.

C. The Affordable Care Act ("ACA") Further Defines "Obligation" in the Context of Medicare Fraud

One year after the FERA amendments to § 3729(a)(1)(G), Congress again modified the statute, this time to clarify reverse FCA liability in the context of Medicare fraud. In 2010, Congress enacted the ACA, which, among other things, required persons who received overpayments from Medicare or Medicaid to report and return such overpayments within sixty (60) days:

> An overpayment must be reported and returned . . . by the later of—
>
> (A) the date which is 60 days after the date on which the overpayment was identified; or
> (B) the date any corresponding cost report is due, if applicable.[13]

Importantly for reverse FCA purposes, the ACA is clear that this duty to return overpayments within 60 days is an "obligation" for reverse FCA purposes:

> Any overpayment retained by a person after the deadline for reporting and returning the overpayment . . . is an obligation (as defined in section 3729(b)(3) of Title 31) for purposes of section 3729 of such title.[14]

The ACA further defined "overpayment" for purposes of reverse FCA liability under § 3729(a)(1)(G) as:

> [A]ny funds that a person receives or retains under subchapter XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such subchapter.[15]

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[12] 155 Cong. Rec. S. 4539, amendment 985 (daily ed. Apr. 22, 2009) (statement of Sen. J. Kyl).

[13] 42 U.S.C. § 1320a-7k(d)(2).

[14] 42 U.S.C. § 1320a-7k(d)(3).

[15] 42 U.S.C. § 1320a-7k(d)(4)(B).

Thus, the ACA requires persons who receive Medicare overpayments to repay such overpayments within sixty days ("60 day rule") and attaches FCA liability to any knowing retention of the overpayments once the party knows of its obligation to repay, whether or not the party submits a false claim or statement.

II. Important Elements of Reverse False Claims Actions

In its current form, the reverse false claims provision of the FCA, as amended by FERA, imposes liability on any person who:

> [K]nowingly makes, uses, or causes to be used, a false record or statement material to an obligation to pay or transmit money or property to the Government or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government. . . .

Thus, to establish reverse FCA liability under the first prong, a plaintiff must demonstrate that the defendant: (1) knowingly; (2) made, used, or caused to be made or used, a false record or statement, (3) that is material to; (4) an obligation to pay or transmit money or property to the Government.[16] Under the second prong, a plaintiff must show that the defendant: (1) knowingly; (2) concealed; or (3) knowingly and improperly avoided or decreased; (4) an obligation to pay or transmit money or property to the Government.[17] Additionally, the FCA currently defines an "obligation" to pay as:

> [A]n established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from retention of any overpayment.[18]

[16] *U.S. ex rel. Simms v. Austin Radiological Ass'n*, 292 F.R.D. 378, 382 (W.D. Tex. 2013).

[17] *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1056 (N.D. Cal. 2020).

[18] 31 U.S.C. § 3729(a)(1)(G), (b)(3).

Finally, in the Medicare fraud context, the ACA specifically states that any knowing failure to return a Medicare overpayment which a person is not entitled to is an "obligation" for reverse FCA purposes.[19]

While the reverse false claims provision of the FCA has generated litigation in a variety of contexts since 2009, most of the disputes between litigants, and even amongst the courts, revolve around two specific questions: (1) what is the scienter standard for reverse FCA liability and (2) what exactly constitutes an "obligation."

A. Reverse FCA Scienter Requirements

1. "Knowing" and "Knowingly"

Under the reverse false claims provisions of the FCA, liability only attaches for "knowing" use of false statements or "knowing" avoidance or concealment of an obligation to pay the Government. According to the FCA, the terms "knowing and knowingly" mean that a person, with respect to information:

> (i) has actual knowledge of the information;
> (ii) acts in deliberate ignorance of the truth or falsity of the information; or
> (iii) acts in reckless disregard of the truth or falsity of the information.[20]

Thus, while "innocent mistakes, mere negligent representations and differences in interpretations" do not constitute knowledge for the purposes of reverse FCA liability, the "knowing" scienter may be established through actual knowledge, deliberate indifference, or reckless disregard.[21] Courts have found the requisite knowledge for reverse false claims purposes in instances where a defendant failed to conduct a proper investigation before making a false statement[22], disregarded

[19] 42 U.S.C. § 1320a-7k(d)(3).

[20] 31 U.S.C. § 3729(b)(1)(A)-(B).

[21] *Kane ex rel. U.S. v. Healthfirst, Inc.*, 120 F. Supp. 3d 370, 395 (S.D.N.Y. 2015).

[22] *United States v. Raymond & Whitcomb Co.*, 53 F.Supp.2d 436, 447 (S.D.N.Y.1999).

the findings of an investigator who had identified claims that were potentially overpayments[23], and had a "don't ask, don't tell" policy to only refund overpayments when requested by the payor.[24] Additionally, proof of knowledge does not require "proof of specific intent to defraud."[25] Thus, the plaintiff must demonstrate only that the defendant had the requisite knowledge at any point while it was in the process of retaining overpayments or had some other obligation to repay. The plaintiff is not required to prove specific knowledge of specific claims.[26]

2. "Avoidance"

Courts have also grappled with the meaning of "avoidance" in the second prong of the reverse false claims provision. As set forth in Section I.A. above, the legislative history of § 3729(a)(1)(G) shows that Congress recognized the need to specify that only "knowing and improper" avoidance of an obligation to pay is actionable under the FCA. Congress did this in order to exempt from FCA liability certain legal and proper methods or avoiding or decreasing an obligation to pay. Nevertheless, it has fallen to the courts to determine whether, under a given set of circumstances, a Defendant actually avoided repaying an obligation. Several Courts that have dealt with the issue have concluded that "avoidance" can be demonstrated where a defendant "intentionally refused to investigate the possibility that it was overpaid."[27] Once a Relator has provided evidence of defendant's retention of an overpayment, courts will allow a jury to determine whether the defendant "had knowledge of and knowingly retained overpayments."

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[23] *Kane*, 120 F. Supp. 3d at 395.

[24] *United States of Am. & State of Texas v. Austin Radiological Ass'n*, No. A-10-CV-914-LY, 2012 WL 12850250, at *5 (W.D. Tex. Aug. 29, 2012).

[25] 31 U.S.C. § 3729(b)(1)(A)-(B).

[26] James W. Adams, Jr., Proof of Violation Under the False Claims Act, 78 Am. Jur. Proof of Facts 3d 357 (originally published in 2004)

[27] *United States v. Lakeshore Med. Clinic, Ltd.*, No. 11-CV-00892, 2013 WL 1307013, at *4 (E.D. Wis. Mar. 28, 2013); *see also Kane*, 120 F. Supp. 3d at 393-94.

Graves v. Plaza Medical Centers, Corp., 276 F.Supp.3d 1335, 1348 (S.D. Fl. 2017) (where Relator alleges that Defendants "knowingly retained overpayments for improper diagnostic codes . . . and subsequently submitted to CMS for reimbursement after the reverse false claims statute was enacted.").

In *United States ex rel. Ormsby v. Sutter Health*, the District Court for the Northern District of California analyzed the avoidance element of § 3729(a)(1)(G) and found that plaintiff had stated a claim where it alleged that defendants had essentially "buried their head in the sand" with respect to the question of whether they had been overpaid. The Court found that plaintiff had not alleged that defendants "knew" they had been overpaid due to the submission of false diagnosis codes. However, plaintiff had properly pled that defendants had assigned the task of reviewing and deleting unsupported diagnosis codes to doctors they knew would not actually delete the codes, whether due to lack of knowledge, lack of time, or pressure from defendants to keep coding levels high, and therefore they had knowingly avoided their obligation to repay the Government.[28]

3. *Kane ex rel. U.S. v. Healthfirst, Inc.*: An Instructive Case Study

In 2015, the District Court for the Southern District of New York engaged in a detailed analysis of the scienter issues discussed above when it denied the defendants' motion to dismiss a complaint alleging violations of state and federal FCAs under a reverse false claims theory. In the case, the defendant, Healthfirst, Inc., was a New York-based health insurance company that received monthly payments from the NY Department of Health ("DOH") in exchange for providing certain hospital and physician services to Medicaid-eligible enrollees. Healthfirst, Inc. suffered a "software glitch," which caused it to send remittances to its participating providers telling them they could seek additional payment for the covered services from secondary payors,

[28] 444 F. Supp. 3d 1010, 1081 (N.D. Cal. 2020).

which was false. This caused improper claims to be submitted to DOH on behalf of hospitals seeking these additional payments, which DOH mistakenly paid.[29] Once alerted to the issue, the health network that operated the hospitals who sought the additional payments, Continuum, tasked the Relator, its employee, with ascertaining which claims had been improperly billed to Medicaid. According to the Relator, he sent a report to Continuum's management identifying more than 900 erroneous claims totaling over $1 million. Four days later, Continuum fired the Relator.[30] The Relator claimed that Defendants ignored his analysis and only reimbursed DOH for a handful of improperly submitted claims. Defendants waited over two years to reimburse DOH for additional claims. It was not until three years after the Relator was fired, and only in response to a Civil Investigation Demand, that Defendants reimbursed DOH for the remaining claims. The Relator alleged that Defendants "intentionally or recklessly" failed to take necessary steps to timely identify claims affected by the glitch and reimburse DOH. [31]

The Court engaged in an extensive analysis of the legislative history, plain meaning, and agency rulemaking related to the reverse false claims scienter terms "knowing," "avoidance," and "identify." Defendants argued that they could not be found to have "knowingly avoided" an obligation since the allegation was that they had simply not responded quickly enough. Defendants argued the delay was because they had viewed the Relator's report as preliminary and incomplete, but the Court was not swayed. The Court pointed to the fact that Continuum had fired the Relator a few days after the report. The Court concluded from its analysis of the scienter terms that there was sufficient evidence to reflect that Defendants had, at the least, been sufficiently reckless when

[29] *Kane*, 120 F. Supp. 3d at 376-78.

[30] *Id.*

[31] *Id.*

it disregarded the Relator's warnings and refused to do any additional investigation. The Court also found that the Relator had sufficiently alleged that Defendants had an obligation to repay the government because Defendants had "identified" overpayments and failed to return them within sixty days. In doing so, the Court rejected Defendants' argument that Congress intended "identify" to mean that a person "classified with certainty" that it had received an overpayment. Rather, the Court found that "identify" was synonymous with the FCA's definition of "knowing." According to the Court, a person identifies an overpayment, such that the sixty-day clock begins ticking, when they are "put on notice of a potential overpayment," rather than "when an overpayment is conclusively ascertained."[32]

B. What Constitutes an "Obligation" Under the FCA's Reverse False Claims Provision?

Of all the litigation surrounding the reverse false claims provision of the FCA, the issue most disputed and analyzed is what constitutes an "obligation" to repay the Government. As set forth above, one of the major objectives behind the 2009 FERA amendment to the FCA was to clarify what an obligation is and when it arises. Following several tweaks and revisions, Congress decided on the following definition:

> ***[A]n established*** duty, ***whether or not fixed***, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based, or similar relationship, ***from statute or regulation*** or from the retention of any overpayment.

In the healthcare context, the ACA additionally defines "obligation" to include a failure to report and return an "identified" overpayment within sixty days. While these definitions clarified the law, particularly in comparison to the 1986 amendments, which failed to define the term "obligation" in any meaningful way, Courts have still been required to fill in some gaps left open

[32] *Id.*

by Congress. The main issues dealt with by the courts include: (1) whether contingent obligations can ever form the basis for an alleged reverse false claim; (2) whether the same conduct underlying a plaintiff's claim that a defendant violated the FCA can also form the basis for a reverse false claim; and (3) what constitutes "identification" in the context of whether a healthcare defendant retained an overpayment.

1. "Contingent" and "Non-Fixed" Duties

As set forth above, as Congress was debating Senate Bill 386, which would eventually become the 2009 FERA amendments to the FCA, it defined "obligation," for a brief time, as a fixed or "contingent duty."[33] The term "contingent duty" was eventually removed from the final version of the statute, in part due to the floor statements of Senator Jon Kyl. However, Congress' addition of the phrase "an established duty, *whether or not fixed*," has caused some disputes in the courts over what constitutes a "non-fixed duty" and how it differs, if at all, from a "contingent duty."

Generally, in cases that hinge on the question of whether or not a contingent duty is an obligation for FCA purposes, relators and the Government have argued that the language "whether or not fixed" was meant to incorporate contingent duties, such as fees that may be owed to the Government only if and when the Government decides to pursue such fees.[34] Defendants on the other hand point to the language "established duty." They argue that contingent duties like potential fees and fines were specifically excepted from liability as they cannot be considered,

[33] 155 Cong. Rec. S. 1684.

[34] *See, e.g.*, *United States ex rel. Boise v. Cephalon, Inc.*, 2015 WL 4461793, at *1 n. 1, 2015 U.S. Dist. LEXIS 94448, at *3 n. 1 (E.D. Pa. July 21, 2015) (unadjudicated and unassessed statutory fines are not obligations under the reverse FCA); *Zelenka v. NFI Indus., Inc.*, 436 F. Supp. 2d 701, 706 (D.N.J. 2006), aff'd, 260 F. App'x 493 (3d Cir. 2008) (obligation to pay inspection fees was contingent upon government agency's decision to inspect shipments and it was therefore not an obligation under the reverse false claims provision).

under any definition of the word, "established."[35] Post-FERA, Courts have tended to agree with defendants. They have found that the phrase "whether or not fixed" refers to "whether or not the amount owed was fixed at the time of the violation rather than whether an obligation to pay was fixed," i.e. contingent.[36] In other words, Congress removed the term "contingent duty" because it felt such duties should not be considered obligations under the FCA. It included reference to non-fixed duties, however, as an acknowledgement that an obligation "could be for an uncertain sum."[37]

The District Court for the District of New Mexico's decision in *U.S. ex rel. Kuriyan v. Health Care Services Corp.*, is instructive on the fine line that courts must walk between non-actionable contingent duties and FCA obligations that are "non-fixed." In *Kuriyan*, the relator alleged that the defendant Managed Care Organizations ("MAOs") had committed reverse false claims by retaining overpayments caused by their failure to spend at least 85% of their capitated Medicaid payments on healthcare costs, as required by their Medicare contracts.[38] Defendants countered that the 85% threshold was a contingent duty, and thus not actionable as a reverse false claim, because the contract allowed the government discretion to change the percentage. The court disagreed. It reasoned that the 85% threshold could be a contingent duty if the Government had discretion under the contract over whether or not to require it. But because the contract only allowed the Government to change the threshold, the duty was not fixed, but also not contingent.

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[35] *United States v. Southland Gaming of the Virgin Islands, Inc.*, 182 F. Supp. 3d 297, 315 (D.V.I. 2016).

[36] *Boise*, 2015 WL 4461793, at *1, n. 1.

[37] *United States ex rel. Simoneaux v. E.I. duPont de Nemours & Co.*, 843 F.3d 1033, 1038 (5th Cir. 2016) (stating that "[t]he fact that Congress deleted the word 'contingent,' added the 'whether or not' modifier to 'fixed,' and inserted the word 'established' suggests that it did not intend to cover contingent penalties).

[38] No. CV 16-1148 JAP/KK, 2020 WL 8079811, at *3 (D.N.M. Sept. 9, 2020).

According to the Court, "under the FCA an obligation must be an existing one, but it need not be a fixed one."[39]

2. The Reverse False Claims "Anti-Duplication" Rule

Prior to the 2009 FERA amendments, a plaintiff could not state a claim under § 3729(a)(1)(G) for merely retaining money from the Government that was fraudulently obtained in the first place.[40] This meant that plaintiffs could not assert that the same wrongful conduct constituted a false claim under §§ 3729(a)(1)(A) and (B) and a reverse false claim under § 3729(a)(1)(G). However, when Congress amended the FCA in 2009, it added "retention of an overpayment" to the statute's definition of "obligation." While this suggested to some that Congress may have intended to open up the possibility of double recovery for a single wrongful act, Courts have been clear since 2009 that the "anti-duplication rule" survives.

> A person is liable for a violation of the False Claims Act if he or she:
>
> (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;

On its face then, the reverse false claims provision's definition of an "obligation" as, in part, "retention of an overpayment" seems like it could apply to the same conduct as the underlying false claim, i.e. a person could be liable under the FCA for receiving money from the government through the knowing presentment of a false claim and additionally be liable for a reverse false claim for failing to return that same money to the government. While plaintiffs in reverse false claims cases have attempted to make that argument in the wake of the 2009 FERA amendments,

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[39] *Id.* at *7.

[40] *See Sturgeon v. Pharmerica Corp.*, 438 F. Supp. 3d 246, 281 (E.D. Pa. 2020).

courts have generally been consistent that plaintiffs "may not use § 3729(a)(1)(G) as a 'redundant basis' for liability."[41]

As one court reasoned[42], rather than permitting double recovery for (1) obtaining the payment and (2) knowingly retaining the payment, the "retention of overpayments" language instead imposes liability in two distinct situations not covered under 1986 amendment's false claims provision. First, the language allows for liability "when a party unknowingly presents a false claim, realizes its mistake, and knowingly retains the resulting overpayment."[43] In this situation there would be no redundancy or threat of double recovery. The unknowing submission of a false claim would not meet the scienter requirement of §§ 3729(a)(1)(A) or (B) (i.e. knowingly), so there would be no false claims liability. However, the requisite scienter would be present under § 3729(a)(1)(G) for knowingly retaining the resulting overpayment. The second situation that the "retention of overpayments" language imposes liability is when a government contractor "receive[s] money from the government incrementally based upon cost estimates" and retains "money that is overpaid during the estimate process." Both of these situations are actionable because they are "different from fraudulently obtaining the money in the first place."[44]

According to most Courts that have considered the issue, the anti-duplication rule is the only interpretation of the interplay between the FCA and reverse FCA that keeps both theories of recovery intact. Allowing recovery for retention of the same money fraudulently received due to

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[41] *Sturgeon*, 438 F. Supp. at 281; *see also Pencheng Si v. Laogai Research Found.*, 71 F. Supp. 3d 73, 97 (D.D.C. 2014); *United States ex rel. Scharber v. Golden Gate Nat'l Senior Care LLC*, 135 F. Supp. 3d 944, 966 (D. Minn. 2015) ("Finding the defendants liable under a reverse FCA theory based on these claims would amount to double punishment for the same allegedly wrongful act: submitting fraudulent, false claims to the government.")

[42] A more detailed summary of *Sturgeon* follows this section.

[43] *Sturgeon*, 438 F. Supp. at 281.

[44] *Id.*

false statements would mean that "*any* traditional false statement . . . would give rise to a reverse false claim action," which cannot have been the intention of Congress.[45]

When analyzing whether a plaintiff has properly pled both a false claim and a reverse false claim, courts generally require proof of an "independent obligation" to repay that arose separate from the affirmative false claims. While plaintiffs are unable to do this in the majority of cases, some courts have found that false statements by a healthcare facility in their annual cost reports to Medicare can constitute an "independent obligation."[46] The reasoning in these cases is that the cost report is an obligation owed by healthcare facilities separate and apart from any obligation to return identified overpayments. Thus, any submission of a cost report that contains a false statement concealing the overpayment is an obligation independent from the general obligation created when an entity simply retains an overpayment.[47]

Whether an independent obligation is found or not, the above cases all recognize that an FCA plaintiff may not recover both for money paid out on a false claim and for a reverse false claim for failure to return that same money. Outliers do exist, however. For instance, in August 2020, the District Court for the Northern District of Alabama found that relators had sufficiently pled reverse false claims in addition to their false claims. In that case, relators had simply alleged that the defendant had submitted false claims to the government for reimbursement of misbranded orthopedic devices and had not returned the resulting payment.[48] Despite engaging in a fairly

[45] *Pencheng Si*, 71 F. Supp. 3d at 97.

[46] *U.S. ex rel. Schaengold v. Mem'l Health, Inc.*, No. 4:11-CV-58, 2014 WL 6908856, at *21 (S.D. Ga. Dec. 8, 2014).

[47] *See, e.g.*, *id.*; *see also U.S. ex rel. Saldivar v. Fresenius Med. Care Holdings, Inc.*, 906 F. Supp. 2d 1264, 1273 (N.D. Ga. 2012).

[48] *United States ex rel. Wallace v. Exactech, Inc.*, No. 2:18-CV-01010-LSC, 2020 WL 4500493, at *21 (N.D. Ala. Aug. 5, 2020).

extensive review of cases applying the "anti-duplication" rule, including cases from its own Circuit Court of Appeals, the court nevertheless allowed relators' reverse false claims to survive a motion to dismiss. In doing so, the Court found that relators' claims "may be redundant of the affirmative false claims." The Court was reluctant, however, to dismiss a "novel theory of liability" on the pleadings and reasoned that the facts could be ascertained through pretrial discovery.[49] While cases like this are certainly outside the norm, they are a good reminder to healthcare companies to tightly monitor their receipt of overpayments. Courts may be willing to allow relators, or the Government, two attempts to recover for alleged overpayments.

3. When is an Overpayment "Identified" Such That It Becomes an Obligation Under the ACA?

As set forth above, when Congress enacted the ACA in 2010, it created a "60-day rule." This rule requires, in part, that overpayments be reported and returned by "the date which is 60 days after the date on which the overpayment was identified. . . ." The rule further mandates that retention of such overpayment after sixty days constitutes an "obligation" for reverse false claims purposes. However, Congress did not define the "pivotal word 'identified,'" which triggers the sixty-day clock. The legislative history shows that Congress did carefully considered the inclusion of the term. The initial health reform bill introduced by the House of Representatives in 2009 included a similar provision to the one ultimately enacted with the ACA, but stated that "known," rather than "identified," overpayments had to be reported and returned within sixty days. At least one Court has found that this legislative history, the plain meaning of the term, and the purpose

[49] *Id.*; *see also United States ex rel. Johnson v. Golden Gate Nat'l Senior Care, L.L.C.*, No. CV 08-1194 (DWF/HB), 2020 WL 1915612, at *11 (D. Minn. Apr. 20, 2020), motion to certify appeal denied, No. CV 08-1194 (DWF/HB), 2020 WL 3072315 (D. Minn. June 10, 2020) (denying defendants' motion for summary judgment despite recognizing that relators had not alleged "specific facts" in their reverse false claims count separate from those alleged in their affirmative false claims count)

behind the FCA all suggest that Congress meant "identify" to be synonymous with FCA's definition of "knowing."[50]

Agency rulemaking indicates the same. On May 23, 2014, CMS issued its final rule implementing the ACA's "60-day rule" with respect to the Part C Medicare Advantage ("MA") program and the Part D Prescription Drug program. In that final rule, CMS stated that an MA organization or Part D sponsor "has identified an overpayment when [it] has determined or should have determined through the exercise of reasonable diligence, that [it] has received an overpayment."[51] CMS further explained that "reasonable diligence might require an investigation conducted in good faith and in a timely manner by qualified individuals in response to credible information of a potential overpayment." CMS made it clear, however, that "identify" was not synonymous with "actual knowledge." Such an interpretation, according to CMS, would allow organizations to "easily avoid returning improperly received payments," which would defeat the purpose of the ACA. A few years later, CMS issued its final rule on Medicare Parts A and B overpayments. It similarly stated that a person "identifies" an overpayment when he or she "should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment."[52]

III. Survey of Reverse False Claims Act Cases

The following section will provide a survey of relevant reverse false claims litigation and identify cases that provide an insight into how courts have handled such claims over the years.

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[50] *Kane*, 120 F. Supp. 3d at 376-78.

[51] Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 FR 29844 (May 23, 2014).

[52] Final Rule on the Reporting and Return of Medicare Parts A and B Overpayments, 81 FR 7654 (Feb. 12, 2016).

First, this section will focus on cases discussing the anti-duplication rule and whether an "independent obligation" is required to form the basis of a reverse false claims action. Next, this section will highlight the minority of courts that have allowed reverse false claim actions to proceed despite the potential redundancy with the alleged affirmative false claim. Finally, this section will conclude with a case that is instructive in identifying whether an obligation is "contingent" for purposes of finding an "established duty" of repayment as the basis of an FCA claim.

A. Anti-Duplication Cases and Cases That Discuss an "Independent Obligation"

1. *United States ex rel. R.C. Taylor III v. Gabelli et al.,* 345 F. Supp. 2d 313 (S.D. N.Y. 2004)

This pre-FERA case is instructive because it demonstrates that the anti-duplication rule pre-dated the FERA amendments and Courts utilized a similar reasoning to dismiss redundant claims.

Beginning in 1995, the Government alleged that Gabelli defrauded the Government by utilizing friends and family members to create several sham companies to "acquir[e] valuable spectrum licenses at substantial federal discounts." For years, Gabelli and his sham companies participated in the bidding process at various government auctions to obtain licenses. Instead of using the licenses awarded "as assets to develop for the provision of telecommunication services" Taylor alleged "that defendants acquired the licenses 'as arbitrage opportunities.' Taylor claimed that Gabelli used the companies to operate as "the broker or finder of the purchasing party and received a fee as a result."

In his complaint, Taylor averred that Defendants violated the False Claims Act by bidding on federal licenses and "falsely certifying compliance with the Federal Communication Commission's (FCC) regulations" in the applications. In Count Three of the Complaint, Taylor

asserted a reverse false claims action alleging that by falsely certifying compliance with the FCC, the Defendants "reduced their obligation to pay," the government in violation of section 3729(a)(7). From these facts, Taylor advanced two theories of recovery under the False Claims Act: "that Defendants falsely certified eligibility to: (1) receive federal monies, and (2) decrease their contractual obligations."

In analyzing Taylor's claims, the Court reasoned that "[a] bid by its very nature does not request or demand monetary compensation. . . [therefore, defendants] did not 'make' (or cause or conspire to be presented) a 'claim' within the meaning of the FCA." Without an underlying obligation to the Government, Defendants "had no payment to avoid, conceal, or decrease. . . ." The Court ultimately dismissed the reverse false claim action because "the reduction in money owed to the Government in this scenario is the very same money that the defendants will procure from the U.S. Treasury (as a government payment) . . . " In so concluding, the Court noted that Taylor's reverse false claim act was "redundant – two ways of describing the same transaction."

The following post FERA cases are illustratively robust in that, as described above, they make clear that the anti-duplication rule survives the FERA amendments and effectively keeps claims out of court with its sweeping prohibition on redundant claims. Courts typically reference the anti-duplication rule, or the absence of an "independent obligation," but the cases in this section almost always involve a discussion of both.

2. *Pencheng Si v. Laogai Research Foundation, et al.*, 71 F.Supp.3d 73 (D.D.C. 2014)

Defendants, non-profit corporations that "educate Chinese people about the Laogai system," received federal grant funds from "the State Department's National Endowment for Democracy program." Relator worked for Defendants as a computer technician for five years before he was fired in 2008. Relator contended that he was fired because he "began learning more

about the inner workings of the organization and became increasingly concerned about what he viewed as unlawful conduct." The complaint alleged that Defendants violated the FCA by "making gross overstatements regarding the qualifications of Wu and other employees in grant applications, engaging in improper lobbying activities, and using grant funding for personal expenses."

In Count III of the Complaint, Relators claimed that Defendants violated the reverse false claim section of the FCA by concealing their fraudulent activity. Relator claimed this concealment constituted a reverse false claim, because Defendants "knowingly made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government and/or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government."

The parties disagreed about whether Defendants actually owed any "obligation" to return money to the government. Defendants argued that any alleged original violation occurred prior to the FERA Amendment, therefore, the expanded definition of obligation would not apply. Therefore, in the absence of a pre-FERA obligation - "an existing, concrete obligation to pay, whether through contract, regulation, or judgment" – there is no basis for a reverse false claim provision. Relator claimed that the post-FERA understanding of obligation should apply. The court, choosing not to weigh in on the "parties 'obligation' dispute," and refusing to consider factors not pled, dismissed Relator's reverse false claim action. The court concluded that Relator's Complaint failed to allege a violation separate from the FCA claim. Relying on *Gabelli*, the Court noted that a claim under section 3729(a)(1) and (2) of the FCA "cannot also form the basis for a claim under subsection (a)(7)." Ultimately, if "the conduct that [gave] rise to a traditional presentment or false statement action also satisfies the demands of section 3729(a)(1)(G),

[accordingly] there [is] nothing 'reverse' about an action brought under that latter section of the FCA."[53]

3. *United States ex rel. Laporte, et al., v. Premier Education Group, L.P. et al.,* 2016 WL 2747195 (D. N.J May 11, 2016)

Relators, a group of school employees from different schools, brought an action against Premier Education Group ("Premier") and its affiliated schools for violations of the False Claims Act, and the reverse false claim under the FCA. Relators alleged that Premier and the affiliated schools (collectively referred to as "PEG") "made or caused to be made false claims and statements in order to participate in the Federal student financial aid programs . . . from 2006 onward" in violation of the FCA.

Beginning in 2006, PEG violated "contractual agreements" by falsely certifying compliance with Program Participation Agreements, which required PEG to expend student aid monies in accordance with the Program Participation Agreements. Each time PEG received federal student monies, it certified that it was in compliance with all the applicable regulations. Specifically, Relators claim that "PEG made false statements and concealed material information . . . in order to ensure that it would maintain its state licenses and accreditation status for each of its campuses in order to continue to receive Federal program funding."

[53] The anti-duplication rule overwhelmingly results in dismissal of reverse false claim actions when there is no independent obligation upon which the reverse false claim is based. *See U.S. ex rel. Thomas v. Siemens AG, et al*., 708 F. Supp. 2d 505 (E.D. Pa. 2010) (where relator allege a reverse false claim action based on defendant manufacturer's failure to refund payments and failure to disclose subsequent price reductions it offered customers after the government awarded them contracts. The court ultimately dismissed relators reverse false claims action noting that relators created "a redundant false statement claim" by simply recasting their FCA claim); *United States ex rel. Scollick v. Narula, et al*., 215 F.Supp. 3d 26 (D.D.C. 2016) (where the court dismissed relators reverse false claim action because the fraudulent action alleged does not trigger an obligation to repay the fraudulently obtained money.)

From these allegations, Relators claimed that Premier and PEG violated the FCA by submitting fraudulent claims to the government in order to receive Federal Student Aid. Additionally, Relators claimed that Premier violated the reverse false claims provision of the FCA when it failed to return or refund to the government the money it received as a result of its false statements of compliance. The court agreed with Premier, finding that Relators' reverse false claim was redundant of its FCA claim. Abiding by anti-duplication precedent, the Court reasoned that the "reverse false claims provision is not a vehicle to simply recast an identical claim under a traditional false claim provision."[54]

4. *Sturgeon v. PharMerica Corp*., 438 F. Supp. 246 (E.D. Pa. 2020)

PharMerica, a long-term care facility, entered into a Corporate Integrity Agreement ("CIA") with the Office of the Inspector General ("OIG") after it came under scrutiny for dispensing drugs without a valid prescription, a violation of the False Claims Act. In 2015, PharMerica again came under scrutiny. This time, in addition to violating the False Claim Act for altering valid prescriptions, Relators brought two claims under 31 U.S.C. § 3729(a)(1)(G). First, Relators alleged that PharMerica violated the reverse false claims provision when it failed to "pay the ensuing penalties to the government," in violation of its CIA. Second, Relators alleged that

[54] Despite a relators effort to point to a defendants 'concealment' or 'avoidance' of an obligation to return a payment as evidence of a reverse false claim provision violation, absent proof that defendants obligation to repay money was separate from the money that forms the basis of the FCA claim, courts overwhelmingly dismiss the reverse false claims action. *See United States ex rel. Groat v. Boston Heart Diagnostics Corp.*, 255 F. Supp. 3d 13 (D.D.C. 2017) (where the court held that a reverse false claim action may not rest on the allegation that an obligation arose out of defendants concealment of their allegedly fraudulent activity); *United States ex rel. Meyers v. America's Disabled Homebound, Inc*., 2018 WL 1427171 (N.D. Ill. March 22, 2018) (where relator alleged that defendant's violated the reverse false claim provision by retaining payments and avoiding the subsequent obligation to return such payment. The court determined that relator's claim was merely duplicative because the same funds improperly received are the same funds upon which relators base their reverse false claim provision action.)

PharMerica violated the reverse false claims provision through its fraudulent retention of payments that "form the basis of Relators claim under" the False Claims Act.

In 2013, Reliant Health Management Services (Reliant), owner and operator of "more than twenty nursing homes in Pennsylvania . . . began using PharMerica as its institutional pharmacy." Shortly after switching, Reliant began noticing a "significant increase in pharmacy costs." Sturgeon, PharMerica's Executive Vice President started looking into the cost increase. Sturgeon concluded that PharMerica "dispensed medications different from those prescribed" and in each instance, PharMerica's bottom line was benefitted. Upon reporting her findings to Mark Lindemoen, PharMerica's Senior Vice President for Sales and Marketing, Sturgeon was met with indifference. Sturgeon was eventually "removed from the Mid-Atlantic region sales and marketing strategies and development initiatives," a move Sturgeon called 'retaliatory,' and resigned. Sturgeon went on to work as a "consultant in the home and pharmacy industries," through her work she "confirmed the discrepancies she had identified while employed at PharMerica . . . [and] alleges that [PharMerica] alter[ed] prescriptions systematically so as to increase reimbursements" in violation of the FCA. Sturgeon based the reverse false claim on PharMerica's violation of the CIA, as well as the retention of payments received through the "prescription alteration scheme."

Unpersuaded by Sturgeon's argument, the court looked to the "touchstone of the reverse false claims provision," the "obligation" to pay money, in its analysis. Even though the reverse false claims provision creates a separate actionable basis for liability, according to the Court, it may not be used as a "redundant basis" for establishing liability. Thus, even after the FERA Amendment, the anti-duplication rule exists. The court provided two instances where "the retention of overpayments" language imposes liability post-FERA: (1) when a party unknowingly presents a false statement, realizes its mistake, and knowingly retains the resulting overpayment;

and (2) when a government contractor 'receive[s] money from the government incrementally based upon cost estimates' and retains 'money that is overpaid during the estimate process.'"

Relying on those two instances, the court found no independent obligation and dismissed the reverse false claims provision claim. In so concluding, the court agreed with PharMerica that Relators simply "recast" their original FCA claim into a reverse false claims action.[55]

B. Cases Where Courts Allowed Reverse False Claim Actions to Survive Dismissal

The following cases represent the minority of courts that have allowed reverse false claims actions to proceed beyond the motions stage despite the reverse false claim action appearing duplicative of the original false claim act violation.

1. *United States ex rel. Dr. Harry F. Fry v. The Health Alliance of Greater Cincinnati, et al.*, 2008 WL 5282139 (S.D. Ohio Dec. 18, 2008)

Relator, Dr. Harry Fry, former Assistant Director of Cardiology at The Christ Hospital ("THC"), filed a qui tam action against Defendants on March 7, 2003. In his complaint, Relator alleged that Defendants "engaged in a pay to play" scheme in violation of the FCA. Four years prior to filing suit, on December 29, 1999, Relator wrote a letter to THC informing it that he was "being shoved to the side because he didn't have sufficient referrals to the hospital, being a sole practitioner." He described this as a "referral for referral," alleging that Defendants "knew it was improper, [and] they were told it was improper, and they acted . . . to cover it up."

Ultimately, Relator alleged that Defendants initiated practices that "favored Defendant Ohio Heart and Vascular Center, which was the dominant cardiology group at THC, by ensuring

[55] When relators' claim would amount to "double punishment for the same allegedly wrongful act" courts have dismissed the reverse false claim action. *United States ex rel. Johnson v. Golden Gate National Senior Care, L.L.C.*, 2020 WL 1915612 (D. Minn. April 20, 2020) (where the court determined that even after the 2009 FERA Amendment, the goal of the reverse false claim provision is not to allow duplication of the original violation in an attempt to recover under two similar claims.)

a continuous flow of referrals between Ohio Heart and THC, to the exclusion of other hospitals and cardiology groups." To cover up their "referral for referral" scheme, Defendants engaged with Medical Diagnostic Associates, Inc, ("MDA") "a billing company under their control to help conceal its scheme. When Relator continued to complain to Defendants, his position was terminated.

The government joined the suit on July 29, 2008, and brought both a claim under the FCA, and under the reverse false claims provision of the FCA. First, the Complaint alleged that Defendants "knowingly presented or caused to be presented false claims, including Medicare claims for reimbursement for services rendered to patients referred to THC under Defendants' system . . . ." Second, it alleged Defendants' "use of false records or statements to avoid an obligation to refund" in violation of the reverse false claims provision of the FCA.

The Complaint based its assertions on Defendants' submission of claims for reimbursement to Ohio's Medicaid program, which in turn is paid out by CMS, a federal agency. Accordingly, "Defendants have caused a claim to be submitted to the federal government, making all false Medicaid claims actionable under the FCA." To sustain their "pay to play" scheme, Defendants actively concealed their fraud using "false statements intending to obtain reimbursements for Medicaid claims." Ultimately, the complaint alleged, Defendants' fraudulent conduct is actionable under the reverse false claims provision because "Defendants' submission of false claims in the course of their kickback scheme achieved concealment of their obligation to repay amounts due."

In deciding Defendants' Motion, the Court determined that Defendants' claims for reimbursement from the federal government were "tainted by anti-kickback violations" and were actionable under the FCA. Additionally, the court allowed the reverse false claim provision

allegation to proceed, concluding that Defendants' "submissions of false claims in the course of their kickback scheme[s] achieved concealment of their obligation to repay the amount due."

2. *United States, ex rel. Phillip S. Schaengold v. Memorial Health, Inc., et al.,* 2014 WL 6908856 (S.D. Ga. Dec. 8, 2014)

In *Schaengold*, the Southern District of Georgia went through pains to distinguish the myriad anti-duplication cases that came before it, and determined that the Government's reverse false claim action survived Defendants' motion to dismiss. The Court, identifying an 'independent obligation' of Memorial Hospital, a wholly owned subsidiary of the Defendant, concluded that "the Government's reverse false claim cause of action is not a redundant basis to state an affirmative false claim, but rather is a basis for liability independent of the Government's affirmative false statement claims."

The Complaint alleged the following: from 2007 – 2014, Memorial System and St. Joseph/Candler Health System, Inc. ("St. Joseph's") "competed for referrals from local physicians" as the "two major hospital systems in the Savannah market." In January 2008, during a Board Meeting, Memorial Health senior management discussed "keeping referrals within Memorial family" to combat recent financial problems. To accomplish this, Memorial Health planned to "expand its employed physician base," and purchase Eisenhower Medical Associates (EMA). After internal reviews, Memorial System's Board approved base salaries for Drs. Bradley, Corse, and Gaskin (hereinafter "the physicians"), owners of EMA, "well in excess of the 90th percentile of market benchmarks."

The Complaint further alleged: on June 25, 2008, the acquisition of the physicians was finalized. Despite efforts to increase hospital revenue, Memorial System continued to experience "significant losses." Shortly after Relator "became the Chief Executive Officer of Memorial Health and Memorial Hospital" in June 2009, he began an investigation to evaluate Memorial

System's financial losses. As early as 2010 the inflated salaries of the physicians was determined to be "out of proportion to [their] work productivity," however, due to fear of "lose[ing] paying referrals to the hospital," the "Board delayed making any changes to the existing compensation structure."

The Complaint's allegations continued as follows: Relator, concerned that the upcoming deadline to file a Certificate of Compliance Agreement[56] (hereinafter "CCA") was approaching, "recommended that Memorial System retain independent counsel to prepare a CCA report . . . [f]orty-eight hours later, the Board terminated Relator's employment. Relator subsequently filed a False Claim Act violation against Memorial Health. The government, joining suit, alleged that while the physicians were compensated above fair market value, Memorial Hospital billed Medicare, in violation of the False Claims Act.

Count Three of the Government's Complaint sought recovery under the reverse false claims act. Defendants moved to dismiss Count Three arguing that "the Government 'has not alleged that any Defendant's had a clear and established obligation to pay money to the government" separate and apart from the false claims act violation action. Unpersuaded by Defendants' arguments, the Court found a 'definite and clear obligation' to the Government. The Court analyzed the four cases[57] Defendants cited in their brief and distinguished the facts, noting that "the cause of action here is distinguishable. . . ." In so concluding, the Court relied on the

[56] Memorial Health was required to "submit to OIG/HHS any 'matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to an Federal health program for which penalties or exclusion may be authorized, including the Stark Statute" "pursuant to a previous settlement agreement."

[57] *United States ex rel. Ruscher v. Omnicarem Inc*., 201 WL 2618158 (S.D. Tex. June 12, 2014); *United States ex rel. Thomas v. Siemens AG*, 708 F.Supp. 2d 505 (E.D. Pa. 2010); *United States ex rel. Porter v. HCA Health Servs. Of Okla. Inc*., 2014 WL 4590791 (N.D. Tex. Sept. 30, 2011); and *United States ex rel. Taylor v. Gabelli*, 345 F.Supp. 2d 313 (S.D. N.Y. 2004).

Government's Complaint, which "identified obligations that arose *independent of the alleged false certifications in Memorial Hospital's cost reports* i.e., obligations to refund payments received for services provided pursuant to prohibited referrals."

3. *United States, et al., v. Mariner Health Care, Inc., et al.*, 2021 WL 4259907 (N.D. Calif. Aug. 5, 2021).

Mariner Health Care, Inc. ("Mariner") operated "a network of Skilled Nursing Facilities." Relator, Integra Med Analytics, LLC ("Integra"), specialized in using statistical analysis to uncover and prove fraud. Integra claimed that Mariner billed for services it did not provide, such as billing for a therapy session with a "completely healthy and independent patient;" and "double-dipped" by billing for eight hours of therapy at two Mariner facilities on the same day. Integra further alleged that Mariner covered up its overbilling practices by "suppressing efforts" to return money to the government by telling Mariner employees to "keep quiet about the situation."

In the complaint, Integra brought two claims against Mariner: (1) submission of false claims to Medicare (the direct FCA claim), and (2) a later failure to return the fraudulently-received money to the Government (the reverse FCA claim). The court, finding that these claims are "separate and distinct violations of the FCA" denied Mariner's motion to dismiss because "Integra alleges a separate wrong committed by Mariner for its reverse FCA claim, [thus] it does not fail as redundant."[58]

[58] One court went as far as acknowledging the "redundancy" of relator's reverse false claim provision action, but ultimately allowed the action to proceed. *United States ex rel. Wallace v. Exactech, Inc*., 2020 WL 4500493 (N.D. Ala. August 5, 2020) (where relators alleged that defendant medical manufacturers violated the false claim act by submitting false statements for reimbursement, then failed to return the "overpayments." The court denied defendant's motion to dismiss reasoning that "district courts should be reluctant to dismiss on the basis of the pleadings when the asserted theory of liability is novel, because it is important that new legal theories be explored and assayed in the light of actual facts rather than a pleader's suppositions.")

C. Contingent Versus Discretionary Obligations

This final case outlines the first factor courts will consider when determining whether an obligation is contingent, and thus not actionable, namely, whether a payment is mandatory or discretionary. In the event of the latter, the overwhelming majority of courts have determined that there is no liability under the FCA if the imposition of a penalty, fine, or other obligation to repay money, is merely discretionary.[59]

1. *United States ex rel. Kasowitz Benson Torres LLP v. BASF Corp. et al.,* 929 F.3d 721 (D.C. 2019)

Relators alleged that as early as the late 1970's, Defendants intentionally failed to disclose to the EPA the adverse health effects of isocyanate chemicals despite their participation in the Compliance Audit Program. Defendants "manufacture isocyanate chemicals, which are used to produce various polyurethane-based materials such as paint, adhesives, rigid foam for insulation, flexible foam for mattresses and cushions, and parts for automotive interiors." Under the Toxic Substances Control Act (TSCA), chemical manufactures are required to "inform the EPA of substantial risk information" such as information "which reasonably supports the conclusion that [a] substance or mixture presents a substantial risk of injury to health or the environment." The TSCA enables the EPA to take "administrative action against any individual or entity that violates the duty to disclose and to impose a civil penalty on a violator."

Relators, joined by the government, contended that Defendants violated the TSCA "by repeatedly failing to inform the [EPA] of information regarding the dangers of isocyanate chemicals" and that failure amounted to a violation of the FCA. Relators further alleged that in failing to disclose to the EPA, Defendants "knowingly concealed" or "improperly avoided" an

[59] *Supra* note 33, 34, 35

obligation to pay money to the government in violation of the reverse false claims provision of the FCA.

The court dismissed the Complaint in its entirety. Analyzing both the affirmative and reverse false claims, the court was unpersuaded by Relators' allegation that Defendants defrauded the Government out of money and property. First, relying on precedent, the court found no obligation of Defendants to pay money to the government because "an unassessed potential penalty for regulatory noncompliance does not constitute an obligation that gives rise to a viable FCA claim." Because the EPA never assessed "TSCA penalties against the Defendants for failing to report substantial risk information . . . [there was no] FCA 'obligation'" for the defendants to conceal or avoid." Second, the court analyzed whether "the TSCA obligation to inform the EPA of a substantial risk information qualifi[ed] as an obligation to transmit property." Answering that question in the negative, the court found that Defendants' failure to disclose the harmful effects of isocyanate did not result in a violation of the reverse false claim provision of the FCA.

IV. Practical Considerations for the Healthcare Industry

It is important for healthcare providers to familiarize themselves with the reverse false claims provision of the FCA, as amended by FERA and the ACA. This is because, more so than most other industries, healthcare providers routinely receive payments from the government for services provided to patients under Federal healthcare programs. Failure to maintain a robust compliance process that expeditiously identifies and returns overpayments from the Government under these programs can subject healthcare providers to significant penalties under the FCA as well as additional costs in both time and money to resolve enforcement actions and respond to Government investigations. Moreover, given the dearth of appellate opinions reviewing and

defining the reverse false claims act provision, there are several open issues that defense counsel may raise in defense of reverse false claims act claims.

A. The Department of Health and Human Services' Office of Inspector General Has Prioritized the Collection of Outstanding Overpayments to Healthcare Providers

Since at least 2012, the Department of Health and Human Services' Office of Inspector General ("HHS-OIG") has prioritized the auditing of healthcare providers for potential overpayments, though CMS has not always followed through to recover such overpayments. In its Work Plan for FY 2017, HHS-OIG identified the following areas where additional scrutiny was warranted to determine if overpayments had been made and not reported:

- Incorrect Medical Assistance days claimed by hospitals;
- Acute care hospitals' compliance with selected billing requirements;
- Medicare reimbursement to hospitals for noncovered dental services;
- Payments made to inpatient rehabilitation facilities whose billing may not have been in compliance with Medicare documentation and coverage requirements;
- Independent clinical laboratories that submit improper claims.[60]

In a report issued in 2019, HHS-OIG made it clear that CMS needed to redouble its efforts to collect overpayments in those and other areas. HHS-OIG's review of CMS's overpayment collection efforts from FY 2010 through 2015 revealed that CMS had not collected over $1.6 billion in overpayments identified in prior audits. HHS-OIG recommended that CMS immediately begin the process of collecting those overpayments stating that "CMS's prompt recovery of overpayments helps ensure that Federal funds are effectively and efficiently used to carry out the

[60] Department of Health and Human Services, Office of the Inspector General: Work Plan for Fiscal Year 2017, available at https://oig.hhs.gov/reports-and-publications/archives/workplan/2017/HHS%20OIG%20Work%20Plan%202017.pdf.

activities for which they are authorized. CMS's failure to collect and States' failure to pay illustrates a significant financial stewardship vulnerability."[61]

It is important for healthcare providers to be aware that HHS-OIG and CMS have identified the collection of overpayments as a priority and to ensure that they both identify and return any overpayments they may have already received, and institute safeguards to identify such overpayments going forward.

B. Healthcare Providers May Face Significant Exposure for Failure to Identify and Return Overpayments

A provider who fails to abide by the ACA's 60-day rule for identifying and returning overpayments from the government may face liability under both the FCA and the Civil Monetary Penalties Law ("CMPL"), 42 U.S.C. § 1320a–7a. Pursuant to the FCA, a provider found liable for a reverse false claim faces: (1) treble damages (i.e. three times the amount of actual damages suffered by the Government); (2) a civil penalty between $5,000 and $10,000 for *each* false claim or knowing failure to return an overpayment; and (3) reasonable attorney's fees and costs to the successful relator.[62] Under the CMPL, as amended by the ACA, a provider who "knows of an overpayment [as defined by the ACA] . . . and does not report and return the overpayment" may be liable for: (1) civil penalties ranging from $20,000 to $100,000 for each violation, depending on the nature of such violation; (2) three times the amount of the overpayment; and (3) potential exclusion from participation in Federal healthcare programs.[63] With the vast number of payments some healthcare providers receive from the government under Federal healthcare programs, and

[61] Department of Health and Human Services, Office of the Inspector General, The Centers for Medicare & Medicaid Services Had Not Recovered More Than a Billion Dollars in Medicaid Overpayments Identified by OIG Audits, Dec. 2018, available at https://oig.hhs.gov/oas/reports/region5/51700013.pdf.

[62] 31 U.S. Code §§ 3729(a)(1), 3730(d)(1).

[63] 42 U.S.C. § 1320a–7a(10).

the fact that the FCA and CMPL assess penalties for each violation, any systematic failure to identify and return overpayments could easily result in damages assessments in the millions of dollars.

C. Recent Enforcement Actions Against Healthcare Providers for Failure to Return Overpayments

Even in situations where a failure to identify and return an overpayment does not ultimately result in liability under the FCA or CMPL, it can still have significant consequences for healthcare providers, including precipitating qui tam lawsuits and triggering government investigations. Two recent government enforcement actions against healthcare facilities highlight these risks.

In July 2020, Florida Cancer Specialists & Research Institute, LLC ("FCS"), a cancer treatment center located in Fort Myers, Florida, settled a qui tam suit brought by one of its claims resolution specialists and agreed to return over $2.34 million that was overpaid by the Department of Veteran's Affairs ("VA").[64] The Relator claimed that FCS failed to act with reasonable diligence after she alerted it to the fact that it had been overpaid by the VA for physician-administered drugs due to a mistake in the claims processing system. Following the settlement, the U.S. Attorney for the Middle District of Florida, Chapa Lopez, stated that the Government was "pleased that Florida Cancer Specialists cooperated with the investigation and will return the overpayment back to the VA. Any other providers who received such overpayments should follow suit." Even though FCS had worked with the Government to identify overpayments by the VA and subsequently was only required to return those overpayments, the effort it expended to respond to the qui tam complaint and cooperate with the lengthy government investigation no doubt required significant expenditures of both time and money.

[64] Department of Justice, U.S. Attorney's Office, Middle District of Florida, *Cancer Treatment Center Repays More Than $2.34 Million to Resolve Civil Claims Pertaining to Physician Administered Drugs in VA Healthcare System* July 7, 2020.

More recently, in June 2021, California's second largest skilled nursing facility operator, Plum Healthcare Group LLC ("PHG"), agreed to pay more than $450,000 to resolve allegations that they, *inter alia*, violated the reverse false claims provision of the FCA.[65] Specifically, a former PHG employee alleged that PHG had learned that an employee knowingly created false billing records and failed to properly investigate, refund Medicare, or otherwise disclose its false billings to the Government. The Acting U.S. Attorney for the Eastern District of California, Phillip A. Talbert summed up the case, stating that "Medicare participants who fail to voluntarily disclose fraud risk significant consequences . . . [a]s this settlement makes clear, knowingly retaining Medicare funds obtained by fraud is itself a violation of the law, and this office is committed to pursuing enforcement actions to remedy this conduct."

D. Defending Health Care Practitioners in Reverse False Claims Matters

While reverse false claims cases are not nearly as prevalent as cases involving affirmative false claims, the Department of Justice and HHS-OIG have lately been demonstrating an increased (1) awareness of issues involving overpayments to health care facilities and (2) willingness to pursue reverse false claims actions to recover those overpayments and punish alleged wrongdoing. For attorneys defending health care providers, this increased aggressiveness by the government requires an understanding of the most prevalent issues in reverse false claims cases and the potential pitfalls of reverse false claims litigation.

Chief among these issues, as outlined at length above, is whether the client owes an obligation to the government, which in the health care context generally manifests as an obligation to identify and return an overpayment. Attorneys defending health care practitioners should

[65] Department of Justice, U.S. Attorney's Office, Eastern District of California. *California's Second-Largest Skilled Nursing Facility Operator Pays $450,000 to Resolve False Claims Act Allegations* June 29, 2021.

counsel their clients to proactively monitor for overpayments and establish internal procedures for reporting and returning such overpayments to the government in a timely fashion.

In the event the government has commenced an investigation, attorneys should be particularly mindful that a reverse false claim act matter requires an "independent obligation." Cases where the government alleges a reverse false claim for the concealment or avoidance of the same payment it alleged was improperly received under the False Claims Act are particularly ripe for challenge during the investigation stage, and for dismissal should a complaint be unsealed, pursuant to the court-established anti-duplication rule discussed at length above.