No. _____

In the
Supreme Court of the United States

CORPORATE MANAGEMENT, INCORPORATED, A MISSISSIPPI CORPORATION (CMI), ET AL.,
Petitioners,

v.

UNITED STATES OF AMERICA,
EX REL, JAMES ALDRIDGE, ET AL.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Where the Centers for Medicare and Medicaid Services (CMS) makes payments pursuant to a "pay and chase" policy, are the certifications of Stone County Hospital, Inc. (SCH) "material" to CMS's payment decisions as required by the False Claims Act (FCA)?

2. Where the Government alleges that Ted and Julie Cain's salaries are excessive and where those salaries were disclosed annually in cost reports submitted to the Government without objection by the Government, did Defendants knowingly make objectively false claims in seeking reimbursement for those disclosed and accepted salaries?

3. When the Government pursues recovery for allegedly "unreasonable" salary claims by bypassing Medicare's administrative process and brings a FCA action in lieu of the statutory administrative remedy, is the Congressionally established administrative remedy the exclusive remedy for recovery of CMS overpayments?

4. Does the FCA's "good cause" requirement for extensions of the election period allow the Government to obtain 18 sealed extensions and conduct a secret investigation for 8 years before intervening, where the reasons for the extensions have never been disclosed, constitute overreaching action by the Government in violation of due process, and permit dismissal of the complaint as a sanction?

PARTIES TO THE PROCEEDING

Petitioners Corporate Management, Incorporated, Stone County Hospital, Inc., H. Ted Cain, Julie Cain, and Thomas Kuluz were defendants in the District Court and appellants in the Court of Appeals.

Respondents United States of America, ex rel., James Aldridge were plaintiffs in the District Court and appellees in the Court of Appeals.

CORPORATE DISCLOSURE STATEMENT

Petitioner Corporate Management, Incorporated has no parent corporation and no publicly held company holds 10% or more of its stock.

Petitioner Stone County Hospital, Inc. has no parent corporation and no publicly held company holds 10% or more of its stock.

STATEMENT OF RELATED PROCEEDINGS

James Aldridge v. Harold T. (Ted) Cain, et al. bearing Civil Action No. 1:20-cv-321-HTW-MTP consolidated with United States of America v. Harold T. (Ted) Cain, et al. bearing Civil Action No. 1:22-cv-00011-HTW-RHWR pending in the United States District Court for the Southern District of Mississippi Southern Division.

Apart from the proceedings directly on review in this case, there are no other directly related proceedings in any court.

TABLE OF CONTENTS

APPENDIX

TABLE OF AUTHORITIES

CASES

STATUTES AND REGULATIONS

PETITION FOR A WRIT OF CERTIORARI

Corporate Management, Incorporated, Stone County Hospital, Inc., H. Ted Cain, Julie Cain and Thomas Kuluz's ("Defendants") petition for a writ of certiorari to review the opinions of the United States Court of Appeals for the Fifth Circuit ("Circuit Court") and the judgment of the United States District Court Southern District of Mississippi ("District Court") in the above-captioned cases.

OPINIONS BELOW

The opinion of the three-judge panel of the Circuit Court is reproduced at App.1. The District Court's judgment is not reported but is reproduced at App.163.

JURISDICTION

The Circuit Court issued its judgment on August 21, 2023. The Supreme Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The constitutional and statutory provisions involved are located in the Appendix at Appendix E.

STATEMENT OF THE CASE

The central dispute in this case is the reasonableness of hospital executive salaries that Medicare reimbursed without disallowance for twelve (12) years. For eight (8) of those years, the United States of America ("Government") was investigating allegations of cost report fraud against Defendants, while reimbursing the salaries of Ted and Julie Cain ("Cains") without objection. At trial, the Government argued that the salaries were not just unreasonable, but "false", and were subject to the False Claims Act ("FCA"), even though all reported salaries honestly represented the amounts paid to the executives. The jury verdict effectively reduced the salaries to figures that the jurors thought were reasonable. Jurors awarded the Government $10,855,382 in overpayments for the 12-year period, which was trebled to $32,566,146. The Circuit Court reduced the Judgment to $4,590,435 due to the applicable statute of limitation, i.e. claims before September 2009 were barred. Said amount was trebled to $13,771,485.

I. Statement of Facts.

Stone County Hospital, Inc. ("SCH") was a small hospital in rural Wiggins, Mississippi. SCH had been closed for two years when Ted Cain ("Ted") acquired the hospital in 2001, assumed its bond debt of about $3,000,000, and invested $1,800,000 to reopen it. ROA.12253-56. Ted enrolled SCH in the Medicare program as a "critical access hospital," a designation by the Centers for Medicare and Medicaid Services ("CMS") for hospitals serving rural populations without access to healthcare. ROA.8817-23. In the application,

Ted certified that he was familiar with Medicare laws and regulations and understood that payments were conditioned on compliance with them. ROA.8825-28; ROA.22070-89 (Ex. G-304).

Ted was the sole owner of SCH. ROA.8966. His wife, Julie Cain ("Julie"), was SCH's hospital Administrator from 2003 to 2012. ROA.10713.

Ted also owned Corporate Management, Incorporated ("CMI"), a management company for SCH and other businesses. ROA.8965. Ted was CMI's Chief Executive Officer. ROA.8966. Tommy Kuluz ("Kuluz") was CMI's Chief Financial Officer, ROA.9730, and Starann Lamier ("Lamier") was Chief Operations Officer, ROA.10165. CMI was SCH's "home office," providing centralized administrative services for SCH and other businesses under its management. ROA.8818-19.

The Government alleged that Defendants defrauded Medicare by claiming unreasonable compensation for Ted and Julie from 2004 through 2015.

As a critical access hospital, SCH was subject to a unique Medicare reimbursement program designed to support rural hospitals. ROA.8817. Medicare reimburses critical access hospitals at 101% of their reasonable costs with interim payments throughout the year. ROA.8816; *see also* 42 C.F.R. § 413.5 (reimbursement principles); § 413.64 (reimbursement procedures); § 413.70 (critical access hospital reimbursement). Payments are set based on "cost reports," statements detailing hospital operating costs

for the prior year. 42 C.F.R. § 413.20 (cost reporting principles).

As the home office, CMI also submitted cost reports detailing its administrative costs and showing how they were allocated to SCH and other entities CMI managed. *See* ROA.16368-20080 (cost reports for 2004-2015); ROA.8813-14, 8818-20. After the annual cost report is filed, the parties engage in a "settlement" process, in which CMS makes a final payment determination—identifying amounts owed to the provider or to be repaid to Medicare. ROA.8830, 8834-35; *see also* 42 C.F.R. § 413.70(c). CMS delegates administration of Medicare's critical access hospital program to Medicare Administrative Contractors (or "MACs"). MACs, also called "Fiscal Intermediaries," are contractors that handle provider reimbursement services. ROA.8810. MACs assist providers in interpretation and application of Medicare reimbursement rules. 42 C.F.R. § 413.20(b). They also act as Medicare's oversight agents, auditing cost reports, setting payment amounts, and identifying potential overpayments or fraudulent claims. ROA. 8844-46.

Three features of Medicare's critical access hospital program are important here. First, the "overarching theory" of the program, as explained by the Government's expert, "is that access to healthcare is the greatest need." ROA.8847. To ensure this access, CMS will continue reimbursing a critical access hospital despite allegations of fraud and seek recovery of overpayments later. ROA.8847-49. The Government's expert called this practice "pay and chase." ROA.8849.

Second, Medicare does not use a formula to set hospital owner and administrator compensation. ROA.11256. Compensation is subject to a "test of reasonableness" guided by CMS's Provider Reimbursement Manual (the "PRM"). ROA.8849-59; ROA.20282-91 (PRM Chapter 9).

Reasonable compensation is "such an amount as would ordinarily be paid for comparable institutions depending upon the facts and circumstances of each case" and with reference to fair market value principles. ROA.20284 (PRM § 902.3). MAC is responsible for "evaluating the reasonableness of owner compensation" by applying PRM criteria, surveying providers to establish compensation ranges, and ascertaining the owner's "actual duties." ROA.20287 (PRM § 905); *see also* ROA.8858- 59, 8882-84.

Third, CMS has an administrative process for recovering payments. *See* PRM Chapter 24. If MAC finds that a provider furnished "excessive services which were neither reasonable nor medically necessary… and has been billing for such services," MAC investigates the claims and seeks repayment from the provider. PRM § 2409.2. Once the overpayment amount is determined, MAC arranges for repayment and may allow an extended set-off period to avoid "financial hardship." *Id.* If the provider objects to MAC's decision, it may pursue an administrative appeal followed by judicial review. *See* ROA.8874-79 (Tisdale testimony); 42 C.F.R. §§ 1801 *et seq.* (appeal procedures); PRM Chapter 29 (appeal guidance).

As the Government's expert noted, the "vast majority" of cost-report disputes are resolved through this administrative process. ROA.8878-79.

CMI submitted cost reports for itself (as the home office) and SCH every year. ROA.16368-20080. Kuluz gathered the information for the cost reports, but relied on an outside accounting firm to prepare them. ROA.9783-85, 12688-92.

The SCH cost reports showed all costs attributable to hospital administration and home office salaries. *See id.*; R.8831-32 (Tisdale testimony). The CMI cost reports showed the total salaries paid to CMI's officers—including Ted—and, of that total, how much was allocated to SCH. From 2004 through 2009, CMI directly allocated a percentage of Ted's salary to SCH.

MAC never asserted that either Ted's or Julie's salaries were excessive, even though the cost reports provided all of the information needed to evaluate the salaries. ROA.11277-78. As Kuluz explained, MAC routinely performed desk audits of cost reports. ROA.12782. During its desk audit of the 2007 cost report, MAC noted that officer salaries had "substantially increased" at CMI from 2005 through 2007. However Sandra Rose ("Rose"), longtime CMS contract auditor, with 35 years of experience performing Medicare audits, ROA.9618, found the increases were explained satisfactorily and "pass[ed] further review." ROA.20943-49 (MAC audit adjustment report).

At trial, Rose claimed she had "missed" the allocations of Cain's salaries to SCH and, in retrospect, thought the salaries were "not reasonable." ROA.9634-

52. Both Government experts agreed that the CMI and SCH cost reports disclosed the salary data for Ted. *See* ROA.8887-90 (Tisdale); ROA.11270-73 (Saitta). William Tisdale ("Tisdale"), a long-time F1/MAC department director, admitted that Ted's direct salary allocations were "apparent" from CMI's 2007 cost report. ROA.8884-85. George Saitta ("Saitta"), a Government expert/CPA, thought that MAC found Ted's salary "passed further review" because "they didn't have time, money, or effort to look at it." ROA.11278. While Saitta agreed the cost reports provided MAC with salary data every year, he said that "doesn't mean they [the MAC] looked at it." ROA.11271.

The Government calculated that, from 2004 through 2015, MAC paid Ted a total of $11,779,551 in owner compensation. ROA.21868 (Ex. P-272B). During that same 12-year period, MAC reimbursed Julie $1,598,970 for work as SCH's administrator or a consultant for CMI. ROA.21865 (Ex. P-271B). Most of those payments were made in the eight years after the relator filed suit, during which the Government was investigating allegations of cost-report fraud, while reimbursing the Cains' salaries without objection.

II. Procedural Background

This *qui tam* suit was precipitated by Julie's firing of James Aldridge ("Aldridge"), SCH's chief operations officer in 2005-2006, who vowed that she would "pay" for firing him. ROA.12102-21.[1] Aldridge filed a relator's

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[1] The District Court excluded Julie's testimony about Aldridge's misconduct and his promise to get even: "If you fire me, you are going to pay for this." ROA.12102-20.

complaint in May 2007, alleging the Cains and others had submitted false claims to Medicare and giving the Government 60 days to intervene in the action. Eight (8) years later, after receiving Eighteen (18) sealed extensions (yes, this is eight years and eighteen extensions) from the District Court (Judge Wingate), the Government intervened.

A. The Government investigated fraud claims against Defendants for eight years, while reimbursing their costs without objection and without a request for reimbursement pursuant to the established administrative procedures.

Aldridge's sealed relator's complaint asserted FCA violations against Defendants and other parties. ROA.9 (docket sheet). The filing triggered a 60-day seal period, during which the Government could investigate the allegations and decide whether to intervene. 31 U.S.C. § 3730(b)(2). The purpose of the seal period is to avoid "tipping off" targets of a criminal investigation and, if needed, to allow coordination of the civil and criminal matters. S. Rep. 99-345, p.24 (1986) (Senate Report on False Claims Amendment Act of 1986). Although courts may extend the seal period for "good cause," 31 U.S.C. § 3730(b)(3), Congress intended that judges "carefully scrutinize" extension requests and not allow the Government to "unnecessarily delay lifting of the seal from the civil complaint or processing of the *qui tam* litigation," S. Rep. 99-345, p.25.

On August 13, 2007, the Government filed its first of many sealed motions to extend its election period. ROA.9. Although the motion was filed outside the 60-day window, Judge Wingate granted it anyway.

Ultimately, the Government requested 18 extensions, all of which Judge Wingate granted in form orders, often just striking through "~~proposed~~" in the Government's draft. *See* ROA.9-20 (docket); ROA.134-44 (motions and orders). No order cited specific reasons showing the required "good cause" for granting the extensions.

In March 2010, the Government notified Defendants that it was investigating sealed *qui tam* allegations against them and requested that Defendants provide information to aid its investigation. ROA.20296-301 (Ex. G-170); ROA.9183-89 (Ted Cain testimony). Defendants cooperated, voluntarily providing over 200,000 documents and producing numerous employees for interviews. ROA.895-907 (describing cooperation efforts). In October 2011, after Defendants informed the Government they had exhausted their voluntary compliance, the Government issued Civil Investigative Demands ("CIDs") for more materials and information. ROA.154-202. After objections and motion practice, the District Court enforced the CIDs, ROA.283, 1146-48, held Defendants in contempt, ROA.1281-82, and ordered the Cains, Kuluz and Lamier to give depositions to Government investigators, ROA.1357, 1368.

While pursuing this discovery, the Government continued seeking extensions of the seal period, which Judge Wingate again granted without explanation.

ROA.9-20. Finally, in August 2015, the Government filed a notice of intervention. ROA.1382-85. Judge Wingate unsealed the relator's complaints and the Government's intervention notice, but not the Government's extension memoranda. R.1386-87.

B. The Government eventually decided to intervene and filed its complaint which asserted claims related to the reasonableness of executive compensation and transportation.

In September 2015, the Government filed its original complaint in intervention, R.1391-1434, and filed an amended complaint in December, 2015. ROA.1439-85. The relator's complaint had accused Defendants of cost report fraud, inflating supply costs, manipulating the "swing bed" status of their hospitals, and improperly waiving copays and deductibles. ROA.93-108 (complaint); ROA.116-33 (amended complaint); ROA.20296 (Government summary of allegations). The relator made no mention of salaries or luxury vehicles. *See id.* Eight years later, the Government alleged that Defendants had submitted "false" claims for excessive salaries and luxury car expenses. ROA.1439-85. Aldridge did not testify at trial, and the Government did not present his claims to jurors.

Defendants moved to dismiss the Government's complaint, arguing that the Government's delay violated the FCA and prejudiced the defendants. ROA.1715-55. Defendants also moved to unseal the entire record, including the Government's extension memoranda, because the information in those records

was obviously vital to their statute of limitations and untimely intervention defenses. ROA.1756-74. The Motion to unseal was denied.

C. The Government tried the case on a theory that Ted and Julie Cain's compensation was unreasonable and that such alleged unreasonableness constituted false claims by Defendants.

The case was tried in early 2020, thirteen years after Aldridge filed suit. The central fact disputes at trial concerned the work performed by Ted and Julie Cain and whether amounts reimbursed for that work were reasonable under Medicare regulations and guidance.

The Government claimed that Defendants committed "cost report" fraud by falsely certifying that the Cains' compensation complied with Medicare laws and regulations when, in the Government's view, their compensation was so "unreasonably high" that it amounted to "bilking" Medicare and "hurting" SCH. ROA.8657-77 (Government opening); ROA.13370-436, 13532-560 (closing). Defendants countered that the Cains' work was related to patient care and their compensation, which MAC never disallowed, was reasonable. Moreover, a disagreement over the reasonableness of salaries should be resolved administratively, not in an FCA suit demanding treble damages. ROA.8679- 702 (Defendants' opening); ROA.13456-531 (closing).

The Government's case relied primarily on calling Defendants adversely and cross-examining them—years after the fact—about the Cains' work for SCH, their certifications to CMS, and whether the Cains' salaries complied with the PRM. Saitta interpreted PRM's reimbursement "principles" for jurors as requiring costs be reasonable and necessary, related to patient care, capable of being audited, and supported by documentation. ROA.11150.

Ted testified for eight days, explaining how he had acquired SCH, invested money and secured financing to restart the hospital and to keep it operating, and devoted an "overwhelming majority" of his time to work for SCH. ROA.8958-9370, 9528-63, 9600-14 (cross-examination); ROA.12244-543 (direct and cross-examination). Cain explained that he was involved in key aspects of the hospital's operations, from managing its finances to ensuring the physical plant was properly maintained to negotiating contracts with physicians and vendors. ROA.12278-303.

The Government portrayed Ted's testimony as incredible because he could not recall details about his work and did not have "records," "notes," or "documents" showing his time spent on hospital matters. The Government insinuated that because it had not seen "documents showing [Cain's] personal guarantee for any of the hospital financing" Ted had made no contributions or guarantees. ROA.9152; *see also* ROA.12336-39, 12377-79. The Government then objected to Kuluz's corroborating that Ted contributed millions of dollars to SCH in personal guarantees and capital contributions. Judge Wingate excluded that key

corroborating evidence. ROA.12616-80 (proffer and ruling).

Julie testified for three days, explaining her work as hospital administrator. ROA.10710-75 (cross-examination); ROA.12058-242 (direct and cross-examination). Julie's responsibilities included day-to-day hospital management, from addressing facility maintenance and cleanliness to assisting with physician recruitment to developing policies and making personnel decisions. ROA.12061-71. The Government portrayed Julie as inattentive to her duties, reliant on others to perform her work, and unknowledgeable about PRM's "test of reasonableness" or whether her salary met it. ROA.10710-75. The Government challenged Julie's testimony as unbelievable because she could not identify "phone records" or "records of [her] communications" with Lamier and others at SCH. ROA.10734, 10738-39.

Lamier, CMI's chief operating officer, testified for three days, describing her work and corroborating Ted and Julie's testimony about their work for SCH. ROA.10163-330 (cross-examination); ROA.11797-12048 (direct and cross-examination). On cross-examination, the Government implied that Lamier did all the work for SCH and the Cains added no value. The Government challenged Lamier by demanding contemporaneous "notes" or "memos" or "phone records" to corroborate her testimony. ROA.11859-61. The Government suggested her testimony about Julie's work was suspect because Lamier did not have "time sheets" or "time studies" for Julie. ROA.11868.

Lamier testified that it was not her habit to document every encounter with the Cains or every contribution they made to running SCH. She rejected the Government's theory as "ludicrous":

> Q. And you know the allegations of our case are that you were doing all the work, and that Julie and Ted Cain weren't. Do you understand that?
>
> A. Yes, I understand that, and I think that that is absolutely ludicrous to think that one person could do all of this by herself.

ROA.11925-26.

Kuluz testified for five days, corroborating much of Ted's testimony and elaborating on Ted's work for SCH. ROA.9730-923 (cross- examination); ROA.12544-13093 (direct and cross-examination). Kuluz testified that Ted played a critical role in managing SCH—from developing new patient services and revenue streams, to negotiating contracts and maintaining vendor relationships, to overseeing finances and securing financing for SCH's continued operation. ROA.12697-748.

As with Lamier and the Cains, the Government challenged Kuluz's testimony based on his personal observations and daily interactions with Ted as unreliable because there were no "time sheets," "notebooks," or "calendars" corroborating his testimony. *See* ROA.12885-88. Critically, the district court blocked Kuluz from testifying on two important issues: (1) an outside accountant who prepared CMI's and SCH's cost reports had advised Kuluz to directly allocate part of Ted's salary to SCH; and (2) Ted had contributed over

$4,000,000 in capital to SCH and personally guaranteed approximately $18,000,000 in loans for the hospital. ROA.12613-80 (proffer and bench ruling excluding testimony).

The Government called Saitta, a MAC auditor, as its expert on how much of the Cains' salaries was reimbursable under Medicare regulations and PRM guidance. ROA.11138-336. Saitta agreed that CMI had disclosed the salary data each year and did not hide anything from MAC, so the parties' disagreement was over the reasonableness of the salaries. RAO.11271-72. In Saitta's opinion, *none* of Ted's compensation was "reasonable and necessary under the provider reimbursement regulations" because there was "no documentation" of his work and, in Saitta's view, Ted "really doesn't do that much related to the hospital." ROA.11181-82. Julie's salary was also unreasonable based on Saitta's view of her testimony and "gaps" in documentation. ROA.11228-29. Saitta allowed Julie a salary of $17,500 per year from 2003 through 2011, opining that her other compensation was unreasonable. ROA.11229-33.

D. The jury returned a damages verdict of $10,855,382.

At the close of trial, the Government argued that Defendants had made 12 false claims, one for each cost report submitted from 2004 through 2015. ROA.13427. The Government requested damages in the full amount that CMS reimbursed Ted, $11,779,551, and the full amount reimbursed to Julie, less a $17,500 annual allowance as a "reasonable administrator's salary," which amounted to a claim for $1,441,470 after the

reduction. ROA.13428-29. It also requested penalties and damages for failing to make "self-disallowances" on two cost reports. ROA.13430.

The jury did not award the requested damages, but calculated its own "reasonable" salaries for Ted and Julie:

The Government requested a total of $11,779.556 from Ted, but the jury awarded $9,619.552. The Government requested $1,598,970 which was reduced to $1,441,470 from Julie, but was awarded $853,964. *See* ROA.7513-45 (verdict); ROA.21865 (Ex. P-271B), 21868 (Ex. P-272B).

The jury decided that a reasonable annual salary for Ted was $180,000, and a reasonable annual salary for Julie ranged from about $75,000 to $100,000. ROA.7513-45. Jurors rejected all claims against Lamier. *Id.*

ARGUMENT

1. Where the Centers for Medicare and Medicaid Services makes payments pursuant to a "pay and chase" policy, the certifications of Stone County Hospital, Inc. are not "material" to Centers for Medicare and Medicaid Service's payment decisions as required by the False Claims Act.

To prevail, the Government must satisfy the FCA's demanding materiality requirements. *Universal Health Services, Inc. v. US ex rel. Escobar*, 579 U.S. 176, 193 (2016). The Government cannot prove materiality because Medicare followed a "pay and chase" policy that provides continuous payment to critical access hospitals even though it expects fraud and waste will occur in the reimbursement process. Medicare will pay claims, as the Government's expert testified, "irrespective of whether the Medicare cost reports containing false or fraudulent statements." ROA. 8869-70. Of even greater note, Medicare continued paying Defendants' claims throughout an Eight-year Department of Justice investigation into alleged fraud by the Defendants. Additionally, all salaries were disclosed in the reports submitted to CMA and/or MAC by Defendants, so the Government knew about the salaries. As a matter of law, Defendants' cost report certifications should be presumed to be not material to the Government as the Government paid same regardless of the disclosure in the certifications.

The Government, by its own admission, continuously reimbursed Defendants pursuant to its "pay and chase" policy under which Medicare pays

claims despite allegations of fraud and then recoups overpayments in the administrative process. This is the administrative remedy that was adopted and continuously employed in the matter *sub judice*. Materiality should be reviewed *de novo*, with deference to the jury verdict, but in light of the "strong presumption against materiality." *U.S. ex rel. Harman v. Trinity Industries Inc.*, 872 F.3d 645, 652 (5th Cir. 2017).

The FCA is not an "all-purpose antifraud statute, or a vehicle for punishing garden-variety breaches of contract or regulatory violations." *Escobar*, 579 U.S. at 194. "A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment." *Id*. Instead, a false certification is actionable only if it likely or actually influence its payment decision. *Id*. at 193 – 94. "Conversely, if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material." *Id.* at 195. "Or, if the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material." *Id.*; *accord Harman*, 872 F.3d 645 ("[C]ontinued payment by the federal government after it learns of the alleged fraud substantially increases the burden on the relator in establishing materiality.")

The materiality inquiry is holistic. *U.S. ex rel. Lemon v. Nurses To Go, Inc.*, 924 F.3d 155, 161 (5th Cir. 2019). But "courts need not opine in the abstract when the record offers insight into the Government's actual payment decisions." *U.S. ex rel. McBride v. Halliburton Co.*, 848 F.3d 1027, 1032 (D.C. Cir. 2017) (cleaned up; quoting *Escobar*, 579 U.S. at 193). In the context of Medicare and Medicaid reimbursement—with its complex thicket of statutes, regulations, and guidance—continuous payment without regard to the accuracy of a submission is strong proof that a provider's certifications are immaterial. *See U.S. ex rel. Porter v. Magnolia Health Plan, Inc.*, 810 F. App'x 237, 242 (5th Cir. 2020); *U.S. ex rel. Janssen v. Lawrence Mem'l Hosp.*, 949 F.3d 533, 541-42 (10th Cir. 2020); *Petratos v. Genentech, Inc.*, 855 F.3d 481, 490 (3d Cir. 2017).

Having elected to pursue liability under the FCA rather than the administrative recoupment process, the Government was required to prove materiality—to show that Defendants' cost-report certifications *actually influenced* its decision to pay. It cannot and did not do so. The Government's actions in this case defeat any notion that Defendants' certifications were material to CMS's payment decisions.

The Government learned of the fraud allegations from Aldridge in May 2007, then spent eight years investigating those allegations. During this time, MAC never disallowed any of Defendants' salary claims. Instead, following its "pay and chase" policy, which prioritizes the payment of claims even where fraud is

alleged, CMS continuously reimbursed the salaries it now says were fraudulent.

The Government's continuous payments are all-the-more telling in this case. Not only did CMS have a policy of reimbursing Medicare claims despite suspicions of fraud, the Government stuck to that policy even as the Department of Justice conducted an eight-year investigation into known allegations of fraud by these particular Defendants. If CMS continues reimbursing claims based on cost reports despite an active Department of Justice investigation into alleged "cost report fraud," the cost report certifications were certainly not *material* to the Government's payment decisions.

This case is close to *Janssen*, in which the Tenth Circuit held that a relator alleging Medicare fraud based on false certifications could not meet the demanding materiality requirement. 949 F.3d at 538-42. There, the relator alleged that a hospital falsified patient data and falsely certified its compliance with the Deficit Reduction Act ("DRA") to obtain Medicare reimbursement. *Id.* at 537-38. CMS conducted a months-long investigation, which confirmed the "quality issues" that the relator alleged. *Id.* at 538-39, 542. Even so, CMS continued to pay the hospital's claims. As *Janssen* explained, the Government's "inaction in the face of detailed allegations from a former employee suggests immateriality." *Id.* at 542. *Janssen* found no evidence that the hospital's false certifications of DRA compliance impacted CMS's payment decisions, noting that the FCA "is not a tool to police everyday regulatory noncompliance." *Id.* at 545-

46. This is "especially true," the Tenth Circuit noted, "where complex regulatory schemes are managed by specific agencies with extensive technical experience." *Id.* at 545.[2]

The case at bar produces an inconsistency of result with *Escobar* and a number of similar cases. In *Petratos v. Genentech Inc.*, 855 F.3d 481 (3d Cir. 2017), the claims that a cancer drug was not "reasonable and necessary" were rejected on materiality grounds because even after learning of the relator's allegations, the Government continued granting regulatory approvals to the drug manufacture and continued reimbursing the physician's drug claims. Id. at 490. See *U.S. ex rel. Porter v. Magnolia Health Plan, Inc.*, 810 F. App'x 237 (5th Cir. 2020) (Medicaid's continuing payment of claims after learning of potential fraud defeated allegations of materiality); *Harman*, 872 F.3d at 665-66 (reversing jury verdict where government continued paying claims despite being aware "of the facts claimed to be fraud"); *United States v. Southland Mgmt. Corp.*, 326 F.3d 669, 679 – 81 (5th Cir. 2003) (*en banc*) (Jones, J., Concurring) (false certification and HUD vouchers were not material given HUD's practice of continuing payments while allowing owners to correct deficiencies).

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[2] In the case before this court, there existed "complex regulatory schemes managed by a specific agency with extensive technical experience.

2. Where the Government alleges that the Cain's salaries are excessive and where those salaries were disclosed annually in cost reports submitted to the Government without objection by the Government, Defendants did not knowingly make objectively false claims in seeking reimbursement for those disclosed and accepted salaries.

The Government did not meet its "scienter" and "false or fraudulent claim" burden, which requires proof of an "objective falsehood". Under the FCA, the Government must prove that Defendants "knowingly" made a "false or fraudulent claim" to CMS. The FCA defines "knowingly" as presenting a claim with "actual knowledge" of its falsity or with "deliberate indifference" or "reckless disregard" to the "truth or falsity of the information." 31 U.S.C. §3729(b)(1)(A). This "*mens rea* requirement is not met by mere negligence or even gross negligence," and "mismanagement—alone—of programs that receive federal dollars is not enough to create FCA liability." *U.S. ex rel. Farmer v. City of Houston*, 523 F.3d 333, 338 (5th Cir. 2008); *accord Urquilla-Diaz v. Kaplan Univ.*, 780 F.3d 1039, 1045 (11th Cir. 2015) (explaining that FCA does not impose liability for "disregard of government regulations").

To meet its burden under the FCA, the Government must prove objective falsity. "[E]xpressions of opinion or scientific judgments about which reasonable minds may differ cannot be 'false.'" *U.S. ex rel. Riley v. St. Luke's Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004). That is, "the FCA requires a statement known to

be false, which means a lie is actionable but not an error." *Id.*; *accord U.S. ex rel. Jamison v. McKesson Corp.*, 784 F. Supp. 2d 664, 675 (N.D. Miss. 2011) ("the statement or conduct alleged must represent an objective falsehood"). As the Eleventh Circuit recently explained, "absent a showing of an objective and knowing falsehood, the FCA is an inappropriate instrument to serve as the Government's primary line of defense against questionable claims for reimbursement of hospice benefits" from CMS. *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1301 (11th Cir. 2019). The Government has other remedies when such questions arise, primarily the administrative recoupment process.

The salaries of Ted and Julie were not subject to precise calculation by some predetermined formula. The salaries are determined on a case-by-case basis applying a test of reasonableness. ROA. 20282-91 (PRM Chapter 9). Such a disagreement as to the reasonableness of salaries should have been resolved through the predetermined administrative process in which an expert intermediary (MAC) works with the provider to set reasonable salaries under Medicare guidelines, but the administrative process was ignored by the Government who then claimed that the salaries were "false." This position of the Government must fail for at least two reasons.

First, the Government did not prove that Defendants made objectively false statements about the salaries. What is a reasonable salary? Who gets to determine what a reasonable salary is? In this case one of the determining bodies was a jury, in retrospect,

after the Government had approved same for more than eight years. MAC never disallowed or reduce the salaries, indicating its view that that the salary was reasonable under the Medicare regulations. Years later, after the Government decided to take a punitive view to the case and proceed under the FCA, rather than prescribed administrative remedies, did a subsequent auditor opine that the salaries were unreasonable. This alone creates the view that there are differing opinions as to reasonableness of the salaries. It appears also that the jurors apparently disagreed with all the opinions submitted to them and made a different determination of reasonableness. All of which goes to show that no opinion could be false as seen in *Riley, Id.* Such differing opinions clearly demonstrate why use of the Medicare administrative scheme was the correct way to proceed and why the FCA should not apply.

A difference in the test of reasonableness does not lead to objectively and knowingly making false claims. It simply means there was a difference of opinion. Such a difference does not support FCA liability. *See Riley*, 355 F.3d at 376; *Jamison*, 784 F. Supp. 2d at 676 ("[T]he Government's contention here rests not on an objective falsehood, as required by the FCA, but rather on its subjective interpretation of Defendants' regulatory duties.").

Second, the Government's case is predicated on a regulatory "test of reasonableness" that is subject to various interpretations and will be applied differently given the auditor (or juror) performing the review. In cases like this, involving a disputed interpretation of

an ambiguous regulation, a defendant's reasonable interpretation of the regulation will defeat the FCA's scienter element. *See U.S. ex rel. Donegan v. Anesthesia Assocs. of Kan. City, PC*, 833 F.3d 874, 879-80 (8th Cir. 2016); *Jamison*, 784 F. Supp. 2d at 676-77. The Government may overcome this result by offering "sufficient evidence of government guidance that warned a regulated defendant away from an otherwise reasonable interpretation of an ambiguous regulation." *Donegan*, 833 F.3d at 879 (cleaned up); *see also U.S. ex rel. Sheldon v. Allergan Sales, LLC*, 2022 WL 211172, *5 (4th Cir. Jan. 25, 2022) ("Under the FCA, a defendant cannot act "knowingly" if it bases its actions on an objectively reasonable interpretation of the relevant statute when it has not been warned away from that interpretation by authoritative guidance.").

Not only is Defendants' interpretation of the PRM reasonable, MAC never took steps to "warn" Defendants that the Cains' salaries were unreasonable. Just the opposite. MAC never established ranges of reasonableness for Defendants that suggested the salaries were unreasonable. MAC never disallowed or reduced the salary claims, which indicated that MAC—after applying the PRM—found the salaries reasonable. MAC continued reimbursing the salaries for twelve years without objection, despite a relator's complaint and an eight-year fraud investigation by the Department of Justice. And when MAC did raise an issue related to Ted's salary, it found that the salaries "passed further review." ROA.20943-49.

No reasonable person familiar with this Medicare reimbursement history would believe that Defendants' interpretation of the PRM was so unreasonable that their salary claims—which had been audited and paid for years—were actually *knowingly false* claims. The Government's case rests on a disagreement about the correct application of a regulatory "test of reasonableness" about which reasonable minds may differ.

3. The Congressionally established administrative remedy is the exclusive remedy for recovery of CMS overpayments.

Congress has delegated authority to implement and oversee the Medicare program to the Department of Health and Human Services ("HHS"). HHS has created an administrative process for resolving payment disputes. That process begins collaboratively with MAC and the provider. If it cannot be resolved at the MAC level, the dispute proceeds through four levels of review by subject-matter experts at HHS, culminating in judicial review of HHS's decision based on an administrative record.

The "Constitution entrusts the political branches, not the judiciary, with making difficult and value-laden policy decisions." *Sahara Health Care, Inc. v. Azar*, 975 F.3d 523, 532 (5th Cir. 2020). Accordingly, courts "start with the assumption that it is for Congress, not federal courts, to articulate the appropriate standards to be applied as a matter of federal law." *City of Milwaukee v. Illinois*, 451 U.S. 304, 314 (1981). When Congress has enacted a statute or an agency has adopted a regulatory regime that "specifically and clearly addresses the

issue, there is no gap to fill" with common law remedies. *Central States, S.E. & S.W. Areas Health & Wel. Fund ex rel. Bunte v. Health Special Risk, Inc.*, 756 F.3d 356, 367 (5th Cir. 2014); *accord City of Milwaukee*, 451 U.S. at 324 n.18 (courts may not "provid[e] a different regulatory scheme" through "creation of federal common law").

Congress and HHS recognized that Medicare might overpay providers and provided a remedy for that. "The Medicare program allows HHS to recoup funds that it overpaid to a health-care provider." *Med-Cert Home Care L.L.C. v. Becerra*, 19 F.4th 828, 829 (5th Cir. 2001) (citing 42 U.S.C. § 1395ddd – the "Medicare Integrity Program").

Recoupment occurs through an administrative remedy that relies on administrative appeals to experts in Medicare reimbursement rules. As discussed above, that remedy begins with a collaborative process, in which MAC and the provider attempt to settle on the overpayment amount and a repayment plan. If the provider is dissatisfied with MAC's overpayment determination, it may pursue a multi-step appeal process, beginning with a hearing before a neutral hearing officer or panel of officers, followed by an appeal to the Provider Reimbursement Review Board, and then an appeal to the HHS Administrator. *See* 42 C.F.R. §§ 405.1801 et seq. (regulations governing provider appeals); PRM Chapter 29 (guidance on provider appeals). An aggrieved provider may seek judicial review. *See* 42 C.F.R. § 405.1877; *see also Med-Cert Home Care*, 19 F.4th at 829 (discussing HHS appeals process generally).

Of course, federal law recognizes the general proposition that the "Government by appropriate action can recover funds which its agents have wrongfully, erroneously, or illegally paid." *United States v. Wurts*, 303 U.S. 414, 415-16 & n.3 (1938). But that starting default, does not foreclose Congress from imposing a statutory "limitation of the Government's long-established right to sue for money wrongfully or erroneously paid from the public treasury." *Id.* at 416.

Congress has done so here. The system Congress chose provides exhaustive statutory procedures, elaborated by regulation and guidance, that allows the Government to pursue Medicare overpayments. That regime involves a multi-step administrative appeal that allows review by people with subject-matter expertise who regularly handle Medicare claims and decide whether reimbursement requests satisfy Medicare statutes and regulations. The process ends in judicial review on an extensive administrative record. *See Janssen*, 949 F.3d at 545. (Medicare reimbursement is subject to a "complex regulatory scheme[]" that is "managed by specific agencies with extensive technical experience").

What Congress did not approve was for Medicare providers to be brought into court on FCA claims that ask lay jurors to make overpayment decisions by interpreting regulations and guidance that an expert agency was meant to apply. This Court should reject the Government's attempt to bypass Congress's administrative scheme.

The Government is not free to ignore administrative remedies provided by Congress. Those remedies give the Government a means to recover overpayments, while also limiting the Government's ability to take other routes. The Government may employ the remedies that Congress has provided, but it may not ignore Congress's plan.

4. The District Court's allowance of 18 sealed extensions and an 8-year delay by the Government constitutes overreach and abuse in violation of due process and the Circuit Court should have exercised its inherent authority to dismiss the Government's action as a sanction.

As we have seen above, the Government repeatedly requested extensions of the seal period, 18 in all, which resulted in the Government's 8-year delay in intervening in the case. The Circuit Court quoting from the brief of the appellant by stating "[t]here simply is no 'good cause' for such an extraordinary delay". Circuit Judge Wilson stated, "we agree that the Government's incessant delay in intervening is inexcusable, as is the Government's tactic of hiding behind its sealed extension memoranda in resisting Appellant's challenge on this score. And we lament that, faced with *eighteen* increasingly rote requests for extension of the seal period, the district court enabled the Government's gamesmanship." Opinion at p. 27.

It is the "gamesmanship" and the hiding behind the sealed extension memoranda that we ask this Court to review and address. We will discuss the extraordinary amount of time the date for intervention was extended below. It is the gamesmanship approach to civil litigation by none other than the Department of Justice that must be seriously addressed and sanctioned at the extreme. How can the public and the members of this profession have faith in our institutions when the Department of Justice plays games with the law and proceeds on its own personal vendetta in the premises. We acknowledge that the negligence of the Department of Justice caused the limitation period to run in part, but that is not a sanction for the Government's wrongful acts. When the Government's "games" are in effect dirty pool, a more direct sanction is needed.

Compounding the unreasonable extensions with the fact that the memoranda were and are held in secret preventing Defendants from reasonably attacking same based on the merits. The whole procedure smacks of Star Chamber proceedings or as Dean Worner described in the movie, National Lampoon's Animal House, as being on "double secret probation". The problem is this is not a movie, this is not a comedy, this is real-life tampering with justice. This Court needs to severely sanction such practices and authorize the dismissal of the case.

After the initial 60-day period during which a FCA complaint is sealed, 31 U.S.C. §3730(b)(2), "the government may, for good cause shown, move the court for extensions of time during which the complaint remains under seal," Id. at §3730(b)(3). The

Government made 18 such requests extending the seal. From 60 days to more than 8 years. In *U.S. ex rel. Brazier v. Pentec Health, Inc.*, 338 F. Supp. 3d 396, 43 (E.D. PA 2018) the court indicated "clearly, the statute does not condone the granting of the extension request routinely or that submissions in support thereof remain forever sealed." In *U.S. ex rel. Martin v. Life Care Ctrs of Am., Inc.*, 912 F. Supp. 2d 618 (E.D. TN 2012) the seal was extended for a total of 4 years. The court stated "the length of time this case has remained under seal borders on the absurd." Id. at 623. Later the *Martin* court indicated that "the government had stretched the FCA's 'under-seal' requirement to its breaking point." Id. at 623. The *Martin* case only involved 50% of the delay seen in the case at bar. Likewise, the *Martin* court noted that "with the vast majority of cases, 60 days is adequate amount of time to allow Government coordination, review and decision." Id. at 625. See also *U.S. ex rel. Costa v. Baker & Taylor, Inc.*, 955 F. Supp. 1188, 1191 (N.D. Cal. 1997) ("This practice of conducting one-sided discovery for months or years while the case is under seal…is not authorized by the FCA.…Congress enacted the seal provision to facilitate law enforcement, not to provide an extra bargaining chip in settlement negotiations.").

One should compare the discussion in the above cited authorities with the facts of this case. Aldridge filed his *qui tam* complaint in May 2007 and an amended complaint in November 2009. Yet the Government delayed its intervention until September 2015 for 8 years of "evaluation!"

The majority opinion in the Circuit Court indicates that there is no precedent to allow the severe sanction of dismissal for such abuses. Part of the thrust of this petition is for this court to provide the precedent which is needed to control the "gamesmanship" and the abusive tactics of the Department of Justice with respect to the FCA. How can such conduct be condoned? How can such abusive practices be permitted within the American judicial system?

THE QUESTIONS PRESENTED ARE IMPORTANT AND COMPELLING

1. There exists a split of authority among the Circuits which calls for the Supreme Court's supervisory power. Supreme Court Rule 10(a).

In the majority opinion of the Circuit Court, Circuit Judge Wilson discusses *scienter* and particularly the "objective falsity" as cited in *U.S. Riley v. St. Luke's Episcopal Hospital,* 355 F.3d 370 (5th Cir. 2004) (expression of opinion on scientific judgments about which reasonable minds may differ cannot be false.)

The Circuit Court acknowledged "there is currently a circuit split on whether the FCA requires objective falsity. Id. at footnote 8. The Circuit Court asked the reader to compare *United States v. Care Alternatives,* 952 F.3d 89 95-100 (3d Cir. 2020) (rejecting objective falsity standard) with *United States v. AseraCare, Inc.,* 938 F.3d 1278, 1296-1301 (11th Cir. 2019) (adopting objective falsity standards and finding that a reasonable disagreement, without more, did not constitute a false statement under the FCA.)

The Ninth Circuit has also rejected the "objective falsehood" requirement, at least with respect to a physician's medical opinions, and has distinguished its view from that of the Eleventh Circuit by asserting that an opinion may be a false statement if it is based upon a false or fraudulent premise, or if it is not honestly held. *Winter ex rel. United States v Gardens Reg'l Hosp. & Med. Ctr.*, 953 F.3d 1108 (9th Cir. 2020). The *Winter* Court also indicated that the FCA has a "knowing" requirement and that knowing something is false does not mean "knowing" that an opinion is scientifically untrue, it means "knowing" it is a lie.

There is a lack of guidance as to the application of the "materiality" element. In the case *sub judice* the claimed salaries were fully disclosed and the Government continued to pay them without objection, even after the *qui tam* action was filed and the Government investigation began. The Government testimony indicated that there was a "pay and chase" policy and the claims were paid without close review as any overpayment could be recovered or addressed in the administrative process. According to *Escobar*, this constitutes strong evidence that the representation of claimant was not "material" to payment of the claim against which it would be difficult for the Government to assert materiality. Defendants contend that this strong presumption should be an insurmountable presumption that the alleged "falsity" of the claim was not material.

The standard which is to be applied must be determined. Given the requirement of "knowledge" in the FCA, "objective falsity" can be, and Defendants

submit often is, determinative of the outcome. The split in Circuits should be resolved. Defendants advocate that "objective falsity" should be applied to the case at bar, along with the strict enforcement of the FCA's scienter and materiality requirement.

2. There is an important question of federal law that should be settled as to excessive delay by the Government before intervention in an FCA case and regarding following provided administrative remedies. Supreme Court Rule 10(c).

In the case *sub judice*, the case was delayed for 8 years and subject to 18 extensions "for good cause" which were secreted from Defendants. The Circuit Court agreed "that the Government's incessant delay in intervening is inexcusable as is the Government's tactic of hiding behind its sealed extension memoranda in resisting Appellant's challenge on this score. And we lament that, faced with eighteen increasingly rote requests for extensions of the seal period, the District Court enabled the Government's gamesmanship." Id. at 27. But, the Circuit Court would not dismiss as a sanction—frankly, the only meaningful sanction available.

This court should provide guidance to the Circuit Courts and District Courts demonstrating that they have an inherent power to curtail Government abuse and overreach. This court should decide how many extensions and how much delay is too much (frankly, it is difficult to argue that any are to be allowed while protecting the constitutional requirement of due process.) As described in *United States ex rel. Martin v.*

Life Care Centers of Am., Inc., 912 F. Supp. 2d 618, 623 (E.D. Tenn. 2012), the case before this Court is more than "indicative of significant overreach." Id. at 624.

The Circuit Court declined to break new ground and grant the relief requested by Defendants to dismiss the case. This Court should authorize such relief and mandate same in the case at bar. Governmental abuse should under no circumstances be tolerated and it is only through the most drastic remedies that such abuse will be curbed and the rights of the public protected.

Therefore, this case cries out for Supreme Court guidance.

As indicated above, the FCA is not an "all-purpose antifraud statute, or a vehicle for punishing garden-variety breaches of contract or regulatory violations." *Escobar*, 579 U.S. at 74, and Congress has established an administrative remedy with respect to CMS payments. Can the Government bypass Medicare's administrative process and bring an FCA action in lieu of the administrative remedy? This is particularly salient where the administrative procedures were long followed prior to the *qui tam* action and were followed during the eight-year "investigation" by the Government and when the alleged misconduct was based upon reasonableness of salaries paid and reimbursed, and therefore approved, by CMA. This Court needs to provide guidance as to whether the Government may bring an FCA action in the face of an administrative remedy that for policy reasons, i.e. the continuous delivery of health care, was in place and functioning. Put another way, may the Government change the procedures and rules contrary to the

congressional intent and will? This is specifically directed to the Medicare procedures described in this petition, but should generally apply where congressional and/or administrative remedies have been provided. This generates the additional consideration of curbing Governmental overreach, "gamesmanship", and abuse when the Government can invoke punitive remedies at its whim. This Court should determine whether the established Medicare administrative remedies are exclusive remedies or is the Government permitted to file FCA actions as an "all-purpose antifraud statute" in order to address reasonableness of disclosed salaries.

CONCLUSION

The Petition for a Writ of Certiorari should be granted. The Court may wish to consider the possibility of summary reversal; in the alternative, the Court should grant plenary review and set the case for briefing and oral argument.

Respectfully submitted,

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