APPENDIX

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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 21-60568
CONSOLIDATED WITH
No. 22-60145

[Filed August 21, 2023]

UNITED STATES OF AMERICA, *ex rel*, JAMES ALDRIDGE, *Plaintiff—Appellee*,	)
UNITED STATES OF AMERICA, *Intervenor—Appellee*,	)
versus	)
CORPORATE MANAGEMENT, INCORPORATED, *a Mississippi corporation* (CMI); STONE COUNTY HOSPITAL, INCORPORATED; H. TED CAIN, *professionally and in his individual capacity*; JULIE CAIN; THOMAS KULUZ, *Defendants—Appellants*.	)

Appeals from the United States District Court
for the Southern District of Mississippi
USDC No. 1:16-CV-369

Before JONES, HO, and WILSON, *Circuit Judges*.
CORY T. WILSON, *Circuit Judge*:

This False Claims Act case involves Medicare reimbursements to Stone County Hospital (SCH), a critical access hospital in Wiggins, Mississippi. This appeal follows a nine-week jury trial, which resulted in a $10,855,382 verdict (approximately $32,000,000 trebled) for the Government. At trial, the Government proved that Appellants (a corporate management company, company owner, corporate executives, and SCH)[1] defrauded Medicare out of millions over the span of twelve years by overbilling for the owner's and his wife's compensation despite little or no reimbursable work.

Generally speaking, Appellants' arguments on appeal fail to undercut the jury's verdict. But the Government's dilatory conduct over the protracted procedural history of this case gives pause, even if the Government largely prevails today: The Government sought to extend the seal entered by the district court pursuant to 31 U.S.C. § 3730(b)(3) *eighteen* times and delayed its intervention in the relator's action for eight years, all while conducting one-sided discovery against Appellants. When Appellants interposed the statute of limitations because of the Government's dawdling, the Government maintained its claims were timely. It does the same on appeal. But the Government's own sealed extension request memoranda, which remain sealed to

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[1] The term "Appellants" is used in referring to the defendants collectively; however, defendant Starann Lamier is not part of the appeal.

this day, demonstrate otherwise. As to the district court's final merits judgment, we therefore affirm in large part, reverse in part, and remand.

The district court's judgment in favor of the Government included an order barring Appellants from dissipating their assets. Almost two years later, the district court issued a temporary enforcement order that specifically barred Appellants from selling a piece of real property. Appellants separately appealed the enforcement of this post-judgment injunction. We consolidated the appeals. Because we lack jurisdiction over the district court's enforcement injunction, we dismiss the latter appeal.

I.

A. The FCA

The False Claims Act (FCA) is "the Government's primary litigative tool for combatting fraud" against the Government. S. Rep. No. 99-345, at 2 (1986). The FCA imposes liability on anyone who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" or "knowingly makes, or causes to be made, a false statement or record material to a false claim." 31 U.S.C. §§ 3729(a)(1)(A), (B). Violators of the FCA are liable for civil penalties "plus 3 times the amount of damages which the Government sustains because of" their conduct. *Id.* § 3729(a)(1).

FCA actions may be brought by the Attorney General or by a private party, known as a *qui tam* relator, in the name of the United States. 31 U.S.C. §§ 3730(a), (b)(1). The Government, if it so chooses,

may intervene in a relator's action and "conduct[]" the litigation. *Id.* § 3730(b). If the Government prevails in the litigation, the relator shall be awarded no less than 15 percent but no more than 25 percent of the proceeds of the action or settlement. *Id.* § 3730(d). When a *qui tam* relator brings an action under the FCA, "[t]he complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders." *Id.* § 3730(b)(2). "The Government may, for good cause shown, move the court for an extension of the time during which the complaint remains under seal . . . [and] [t]he defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed[.]" *Id.* § 3730(b)(3).

B. Critical Access Hospitals and Medicare Reimbursement

"Critical access hospitals" serve rural populations who otherwise lack access to healthcare via other nearby hospitals. To incentivize this access to care, Medicare reimburses these hospitals at 101% of cost. 42 C.F.R. § 413.5 (reimbursement parameters); § 413.64 (reimbursement procedures); § 413.70 (critical access hospital reimbursement). According to the Government, the Centers for Medicare and Medicaid Services (CMS) typically continue to reimburse a critical access hospital's costs even when allegations of fraud surface, in order to ensure access to care for underserved Medicare beneficiaries. CMS later seeks recovery of the wrongful overpayments. This practice is commonly known as "pay and chase."

CMS delegates administration of Medicare's critical access hospital program to Medicare Administrative Contractors (MACs). MACs, also called "Fiscal Intermediaries," are contractors that handle provider reimbursement services. 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. Aside from the FCA, which is used to combat fraud, CMS also has an administrative process employed by MACs for recovering payments. *See* CMS Provider Reimbursement Manual (PRM) Chapter 24, available at https://www.cms.gov/Regulations and Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.[2]

Medicare sets reimbursement payments to critical access hospitals using "cost reports," which are statements detailing hospital operating costs for the prior year. 42 C.F.R. § 413.20 (cost reporting

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[2] The PRM provides that "[t]here are generally two ways in which repayment can be made: (l) refund and (2) set-off, or a combination of these two." PRM § 2409. If a MAC finds that a provider furnished "excessive services which were neither reasonable nor medically necessary . . . and has been billing for such services," the MAC investigates the claims and seeks repayment from the provider. PRM § 2409.2. Once the overpayment amount is determined, the MAC arranges for repayment and may allow an extended set-off period to avoid "financial hardship." *Id*. If the provider objects to the MAC's decision, it may pursue an administrative appeal followed by judicial review. *See* 42 C.F.R. §§ 405.1801 *et seq*. (appeal procedures); PRM Chapter 29 (appeal guidance).

principles). Medicare regulations govern reimbursement of owner compensation. 42 C.F.R. § 413.9 (defining what constitutes a reasonable, necessary, and proper cost). Medicare does not use a formula to set hospital owner and administrator compensation. Rather, compensation is subject to a "test of reasonableness" guided by the PRM.

The PRM provides that "[a] reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function." "Necessary" means that "had the owner not furnished the services, the institution would have had to employ another person to perform those services." Such services must be related to patient care and be documented. *See* 42 C.F.R. § 413.20 (governing necessary documentation for cost reimbursement). Owner compensation must be limited to what is paid for comparable services by comparable institutions and is controlled by the fair market value of the services provided on the open market. The PRM disallows costs related to "managing or improving the owner's financial investments." These compensation rules also apply to an owner's relative.

C. Appellants and Medicare Submissions at Issue

SCH is a 25-bed hospital in Wiggins, Mississippi, with a daily census of less than 12 patients. Ted Cain, the sole owner of SCH, acquired the hospital in 2001 and enrolled it as a critical access hospital with CMS. Ted owned or operated multiple nursing homes over his career. Ted's wife Julie Cain served as SCH's hospital administrator from 2003 to 2012. Julie also held a

nursing home administrator's license and a social worker's license.

Corporate Management, Inc. (CMI) served as a management company for SCH and Ted's other businesses. Ted is the owner and chief executive officer of CMI. CMI served as SCH's "home office," providing centralized administrative services, management support, and consulting services for SCH and the other businesses under its management. Tommy Kuluz served as CMI's chief financial officer, and Starann Lamier served as chief operations officer.

Two types of Medicare submissions are at issue in this case: SCH's cost reports and CMI's home office cost reports. CMI annually submitted both types of cost reports on behalf of SCH and itself. Kuluz gathered the information for the cost reports but relied on an outside accounting firm to prepare them. Ted reviewed the cost reports after their preparation.

SCH's cost reports indicated the hospital was a critical access hospital and catalogued hospital-specific costs such as doctors' salaries and supply costs. The reports identified the amounts SCH paid to CMI as a management company but did not separately identify the compensation paid to Ted. CMI's cost reports enumerated its expenses as the management company for numerous entities that Ted owned or controlled. CMI, through Kuluz, allocated Ted's compensation across these entities and, from 2004 to 2009, directly allocated much of Ted's salary to SCH (via the CMI home office report). From 2010 to 2015, CMI included Ted's salary in a "pooled allocation" of home office

costs, meaning that his salary was allocated across all businesses in proportion to their revenues.

D. Procedural History

Relator James Aldridge worked at CMI and served as SCH's CEO from 2005 to 2006. He filed this action under seal in May 2007, alleging the Cains and others had submitted false claims to Medicare.[3] His *qui tam* complaint alleged that Appellants violated the FCA by inflating supply costs, "ping-ponging" patients between nursing homes and SCH to manipulate the facilities' "swing bed" status, and improperly waiving copays and deductibles. Aldridge filed an amended complaint in November 2009, reasserting these allegations.

On August 13, 2007, the United States filed its first motion for an extension of time, and of the initial seal period, to consider its election to intervene. All told, the Government went on to file eighteen sealed motions for extensions of time, the last on June 1, 2015.

On January 20, 2010, the Government moved for a partial lifting of the seal to disclose Aldridge's operative

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[3] On May 31, 2007, the district court granted Aldridge leave to file his first complaint under seal, per 31 U.S.C. § 3730(b)(2). All documents filed in the case were to remain under seal until further order of the district court. The case thus proceeded without Appellants' involvement or knowledge until the Government requested a partial lifting of the seal almost three years later, to disclose Aldridge's complaint to them and request their cooperation in the investigation. Other portions of the case were unsealed over the Government's eight-year investigation, but several documents remain under seal, including the Government's series of seal extension memoranda, as discussed *infra*.

complaint to Appellants, and the district court granted the motion. On March 9, 2010, the Government first notified Appellants that it was investigating sealed *qui tam* allegations against them and requested that they provide information to aid its investigation. Initially cooperating, Appellants voluntarily produced thousands of documents and provided numerous employees for interviews. In October 2011, after Appellants informed the Government they would cease their voluntary compliance, the Government issued Civil Investigative Demands (CIDs) for more materials and information. After objections and motions practice, the district court enforced the CIDs, held Appellants in contempt, and ordered the Cains, Kuluz, and Lamier to give depositions to Government investigators.

Eight years after its initial extension motion, on September 18, 2015, the Government intervened in Aldridge's action. Its intervenor complaint included a common law claim for unjust enrichment. The Government thereafter filed an amended complaint in December 2015, adding a common law claim for payment by mistake of fact. The Government's amended complaint alleged that Ted and Julie Cain and Kuluz took advantage of Medicare's 101% reimbursement rate to SCH to defraud Medicare out of millions of dollars from 2002 to 2013. The fraud was accomplished through a sweetheart contract between SCH and Ted's management company, CMI, which charged SCH almost twice as much as CMI charged for the same services to other entities that were not critical access hospitals (and thus could not bill Medicare at 101% cost). These "management fees" also provided an opportunity to disguise the actual amount

paid as compensation to Ted, which was fifteen times the average compensation for like services. The fees were billed through SCH's Medicare cost report and were not detectable from the face of the report. Moreover, Ted received these inflated amounts even though he did little to no work at SCH. Appellants likewise billed Medicare hundreds of thousands of dollars for work supposedly (but not actually) performed by Julie, first as a hospital administrator and then as a consultant and director.[4]

Following the Government's intervention, Appellants moved to dismiss its claims, arguing that the Government's eight-year delay violated the FCA and prejudiced them. Appellants also moved to unseal the entire record, including the Government's extension request memoranda. After a hearing with all parties and an ex parte conference with the Government, the district court denied the motion to dismiss and unsealed only the Government's pro forma extension motions and the court's orders granting them; it refused to unseal the eighteen extension memoranda. Those memoranda remain sealed.

Beginning January 13, 2020, the district court held a nine-week jury trial. There were 25 witnesses who testified and numerous evidentiary exhibits. Ultimately, the jury found the Cains, Kuluz, SCH, and CMI jointly and severally liable for approximately $10 million. On May 10, 2020, thirteen years after the

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[4] The Government calculated that, from 2004 to 2015, the MAC reimbursed Ted a total of $11,779,551 in compensation. During that same period, the MAC reimbursed Julie $1,598,970.

case began, the district court entered judgment, trebling the damage award to over $32,000,000.

The parties filed several post-trial motions. Appellants renewed their motion to unseal the Government's extension request memoranda. Appellants then moved for post-trial discovery to probe the relator's post-trial disclosures. Last, Appellants moved for a judgment as a matter of law and a new trial. In February 2021, the district court held argument on the pending motions, and in June 2021, the court issued its ruling confirming the judgment.

Appellants timely appealed. They challenge the sufficiency of the evidence proving the FCA claims; the district court's application of the FCA's statute of limitations; the court's grant of eighteen seal extensions, which allowed the Government unilaterally to "investigate" Appellants for eight years; and several evidentiary and post-trial discovery rulings.

II.

We review the denial of a motion for judgment as a matter of law "*de novo*, using the same analysis as the district court." *United States v. Hodge*, 933 F.3d 468, 473 (5th Cir. 2019). We reverse the district court's ruling only if "there is no legally sufficient evidentiary basis for a reasonable jury to have found for [the nonmovant.]" *Id.* (quoting *Flowers v. S. Reg'l Physician Servs. Inc.*, 247 F.3d 229, 235 (5th Cir. 2001)). We review a district court's denial of a motion for a new trial for abuse of discretion. *Fornesa v. Fifth Third Mortg. Co.*, 897 F.3d 624, 627 (5th Cir. 2018). We reverse "only when there is an absolute absence of

evidence to support the jury's verdict." *Wantou v. Wal-Mart Stores Tex., L.L.C.*, 23 F.4th 422, 431 (5th Cir. 2022) (internal quotation marks and citation omitted). In both instances, our review of the jury's verdict is "especially deferential." *Id*.

We review a district court's evidentiary rulings for abuse of discretion. *Seatrax, Inc. v. Sonbeck Int'l, Inc.*, 200 F.3d 358, 370 (5th Cir. 2000). "[T]o vacate a judgment based on an error in an evidentiary ruling, this court must find that the substantial rights of the parties were affected." *Id*. (internal quotation marks and citation omitted). We also review a district court's decision to deny discovery for abuse of discretion. *Crosby v. La. Health Serv. & Indem. Co.*, 647 F.3d 258, 261 (5th Cir. 2011).

III.

The FCA "imposes significant penalties on those who defraud the Government." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 180 (2016). That said, the FCA "is not an all-purpose antifraud statute . . . or a vehicle for punishing garden-variety breaches of contract or regulatory violations." *Id*. at 194 (internal quotation marks and citation omitted). "In determining whether liability attaches under the FCA, this court asks (1) whether there was a false statement or fraudulent course of conduct; (2) made or carried out with the requisite scienter; (3) that was material; and (4) that caused the government to pay out money or to forfeit moneys due (i.e., that involved a claim)." *United States ex rel. Harman v. Trinity Indus. Inc.*, 872 F.3d 645, 653–54

(5th Cir. 2017) (internal quotation marks and citation omitted).

In their first two issues on appeal, Appellants contend that "[t]he Government did not—and cannot—meet its burden on two elements: materiality and scienter." In the alternative, Appellants contend that "[a]t minimum, the FCA judgment against Julie Cain must be reversed because she did not knowingly assist in the presentation of a false claim."

A. Materiality

"A misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government's payment decision in order to be actionable under the FCA." *Escobar*, 579 U.S. at 192. The FCA defines "material" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4). Although the materiality standard is "demanding," *Escobar*, 579 U.S. at 194, "[n]o one factor is dispositive, and our inquiry is holistic," *United States ex rel. Lemon v. Nurses To Go, Inc.*, 924 F.3d 155, 161 (5th Cir. 2019). A non-exhaustive list of the factors we consider includes: (a) whether the alleged violations are conditions of payments; (b) whether the Government would deny reimbursement if it knew of the violations; and (c) whether the noncompliance is substantial or minor. *Id.* at 161–63. As these factors indicate, a misrepresentation is material when it goes "to the very essence of the bargain." *Escobar*, 579 U.S. at 193 n.5 (quoting *Junius Constr. Co. v. Cohen*, 257 N.Y. 393 (1931)).

Appellants assert the Government's "pay and chase" recoupment method, whereby Medicare pays claims upon submission and then pursues violations after the fact, defeats the FCA's materiality requirement. According to Appellants, the fact that Medicare continued to reimburse SCH even as the Department of Justice (DOJ) conducted an eight-year investigation into allegations of fraud belies any contention that Appellants' cost-report certifications influenced the Government's decision to pay. As support for this position, Appellants refer the court to *Escobar*. There, the Supreme Court noted that the Government's regular payment of a claim in full despite actual knowledge that certain requirements were violated "is strong evidence that the requirements [were] not material." *Id.* at 195.

The Government counters that Appellants' position is too narrow under this court's holistic approach to determining materiality. The Government cites *United States ex rel. Longhi v. United States*, 575 F.3d 458, 468–69 (5th Cir. 2009), where this court rejected the "outcome materiality standard," which would require a misrepresentation to affect the Government's ultimate decision to remit funds in order to be material. Regarding its decision to employ the "pay and chase" policy, specifically, the Government contends that various circuits have recognized valid reasons why an agency may continue to pay claims despite allegations of fraud without defeating materiality—for example, public health and safety. The Government asserts that such is the case here where it was important for potential patients of SCH to continue to have access to healthcare. For these reasons, the

Government maintains, its "pay and chase" approach does not neutralize the evidence supporting the jury's finding of materiality. We agree.

Viewing the evidence presented to the jury *in toto* and giving the jury's verdict requisite deference, the record contains sufficient evidence to support a finding of materiality.[5] This is so regardless of the Government's pay and chase policy, which we decline to second-guess in this case. For example, when enrolling SCH as a critical access hospital, Ted certified that he was familiar with Medicare regulations and understood that payments were conditioned on compliance with them. Moreover, Appellants' fraud was substantial, amounting to approximately $10 million over 12 years. And finally, the Appellants' fraud went to the essence of the bargain. The cost reports and statements that Appellants submitted to Medicare

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[5] The jury received lengthy instruction on the term "materiality." In part, the district court explained:

> For purposes of the False Claims Act, the term "materiality" means having a natural tendency to influence or being capable of influencing the payment or receipt of money. A matter is material if, one, a reasonable person would attach importance to it in determining a choice of action in a transaction, or two, that one or more defendants knew or had reason to know that the recipient of the representation would attach importance to the specific matter in determining the choice of action, regardless of whether a reasonable person would do so. Materiality means a holistic analysis without any single factor being dispositive. Minor or insubstantial noncompliance is not material.

were the basis for determining reimbursement amounts owed to SCH and CMI.

While *Escobar* articulated that continued payment despite knowledge of fraud often indicates lack of materiality, "often" does not mean "always." Here, Appellants' reliance on *Escobar* is misplaced. For starters, it is not clear that CMS and the MAC were cognizant of Appellants' fraud.[6] More to the crux, the evidence presented to the jury showed that without continued reimbursements, SCH, a critical access hospital that relied on Medicare for over 70 percent of its revenue, would have probably closed. Stopping reimbursements upon the first allegations of fraud would thus have undermined CMS's goal of sustaining healthcare access for underserved rural patients. "The byzantine laws governing Medicare reimbursement have been aptly described as a 'labyrinth' . . . [but] [e]ven the most complicated labyrinth has an outer boundary[.]" *United States ex rel. Drummond v. BestCare Lab'y Servs., L.L.C.*, 950 F.3d 277, 281 (5th Cir. 2020) (quoting *Biloxi Reg'l Med. Ctr. v. Bowen*, 835

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[6] Appellants rely heavily on *United States ex rel. Janssen v. Lawrence Memorial Hospital*, 949 F.3d 533 (10th Cir.), *cert. denied*, 141 S. Ct. 376 (2020), to counter the district court's "suggest[ion] that 'the *Escobar* Court starts from a point of actual knowledge on the part of the Government, not suspicion nor mere allegations[.]'" But *Janssen* stemmed from a district court's grant of summary judgment, not a jury verdict. Moreover, the *Janssen* court likewise acknowledged that the materiality requirement is holistic, and "[n]one of [the *Escobar* factors] alone are dispositive." *Id*. at 541. To that end, other factors in *Janssen* supported a finding of immateriality. *See id*. at 543. And while *Janssen* involved reimbursements to a hospital, it does not appear to have been a critical access hospital.

F.2d 345, 349 (D.C. Cir. 1987)). Appellants crossed this boundary and may not now interpose Medicare's reimbursements during their fraudulent activities to argue that all was copacetic. We decline to disturb the jury's finding of materiality.

B. Scienter

Appellants next assert that the Government did not carry its burden regarding scienter, which requires proof that Appellants "knowingly" made false or fraudulent claims. Appellants argue that: (1) the FCA requires objective falsity, and the Government did not prove that Appellants made objectively false statements about their salaries; and (2) because this case centers around a disputed interpretation of an ambiguous regulation, Appellants could not have acted "knowingly" to defraud by basing their actions on a reasonable interpretation, particularly when they were not warned away from that interpretation.

The Government responds that there was ample evidence for the jury to find that Appellants acted knowingly under the FCA. This evidence included testimony that Ted and Julie Cain performed little, if any, reimbursable work at SCH or CMI for their grossly inflated salaries. And that testimony was accentuated by Appellants' paucity of evidence showing any substantial, reimbursable work. The Government highlights that Appellants certified that they knew and would follow Medicare's rules, including Medicare's documentation requirements. The Government adds that the FCA does not require "objective falsity," and, even if it did, Appellants forfeited any argument regarding objective falsity by raising it for the first

time on appeal. Finally, the Government contends that Medicare provides clear standards for providers to determine reasonable owner compensation, such that the regulations at issue were not ambiguous and did not require "warning away" Appellants from their excessive billings.

First, objective falsity.[7] Appellants cite *Riley v. St. Luke's Episcopal Hospital*, 355 F.3d 370 (5th Cir. 2004), to support their contention that the FCA requires proof of objective falsity. In *Riley*, we noted that "[t]he *district court* concluded . . . that expressions of opinion or scientific judgments about which reasonable minds may differ cannot be 'false.'" *Id.* at 376 (emphasis added). And we "agree[d] in principle with the district court and accept[ed] that *the FCA requires a statement known to be false*, *which means a lie is actionable but not an error*." *Id.* (emphasis added). But contrary to Appellants' position, *Riley* did not establish an objective falsity standard, and we decline in today's case to address whether the FCA requires it.[8] There

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[7] We disagree that Appellants forfeited their objective falsity argument. Though Appellants did not use the term "objective falsity" in their post-trial motions, they argued that the Government could not prove they made a "knowingly false claim" because, pursuant to Medicare's provider reimbursement manual, an owner's compensation is governed under a test of reasonableness. On appeal, Appellants' objective falsity argument is premised on the corresponding contention that reasonableness is a matter of opinion, and thus cannot be objectively false.

[8] As Appellants acknowledge, there is currently a circuit split on whether the FCA requires objective falsity—and *Riley* has been cited in support of both sides. *Compare United States v. Care Alternatives*, 952 F.3d 89, 95–100 (3d Cir. 2020) (rejecting objective

was sufficient evidence to support the jury's finding of scienter regardless.

"What matters for an FCA case is whether the defendant knew the claim was false." *United States ex rel. Shutte v. Supervalu Inc.*, 143 S. Ct. 1391, 1396 (2023); *see also Riley*, 355 F.3d at 376 ("[T]he FCA requires a statement known to be false[.]"). And there was ample testimony at trial that the Cains performed little, if any, reimbursable work at SCH, yet they knowingly sought reimbursement for inflated compensation.[9] Several employees testified that they never saw Ted do any work at the hospital and that they never communicated with him about anything related to the hospital or its patients. The employees further testified that when they did see Ted, it was "[u]sually in the cafeteria" on "Wednesdays for fried chicken and Fridays for catfish." Along this same line, testimony highlighted that Appellants produced a total of six hospital documents from the years 2004 to 2015 that Ted had signed (not including documents merely stamped with his signature) and virtually no documentation that would allow an audit of Ted's work (despite such being a prerequisite under the PRM). There was similar testimony that Julie was rarely at

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falsity standard), *with United States v. AsercaCare, Inc.*, 938 F.3d 1278, 1296–1301 (11th Cir. 2019) (adopting objective falsity standard).

[9] Appellants' argument that the jurors clearly believed Ted performed *some* work is only speculation. The verdict does not provide any explanation from the jury, and we cannot divine what work the jury credited to Ted.

the hospital, and when she was, she was not doing work related to patient care.

Second, Appellants' "reasonable interpretation" of the regulations. Here again, assuming *arguendo* ambiguity in the reimbursement regulations, we agree with the Government that Appellants' interpretation of them was not reasonable. The Government presented expert testimony that despite the Cains' lack of compensable work, they submitted grossly unreasonable compensation claims to Medicare. The Government showed that Ted received compensation ten to sixteen times the national average for critical access hospital executives.[10] Moreover, Kuluz testified there were no time studies and no supporting documents for Ted's compensation; rather, he "estimated" Ted's hours for the Medicare cost report. Similarly, the Government presented evidence that Julie's salary, as the prior hospital administrator, was at times double that of the incumbent administrator. Based on this evidence, we uphold the jury's finding that Appellants "knowingly" made false or fraudulent claims.[11]

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[10] The Government's exhibits showed that, based on a 2009 IRS report, the national average executive compensation for critical access hospitals was $177,600. But Ted billed Medicare $907,649 for his salary in 2004 and $2,796,045 in 2009. Ted lowered his claimed compensation after the Government notified Appellants of its investigation in 2010, but he still billed Medicare for compensation five times the national average.

[11] Appellants also challenge the jury's verdict on the Government's common law claims—asserting that those claims circumvent the administrative process and because the claims lack merit. The

C. Julie Cain

Appellants next contend that, at a minimum, the jury's FCA verdict against Julie Cain should be reversed. According to Appellants, Julie did not certify cost reports or make statements to Medicare, and "at most [the Government] proved that Julie should have suspected others of submitting false claims and acted to prevent them doing so." Appellants characterize this behavior as "passive acquiescence, not knowing assistance."

The Government responds that Julie played a critical role in setting the fraud in motion, executing "a management agreement on behalf of SCH that allowed CMI to charge SCH up to 15% of revenue despite that CMI charged all the other Cain entities half that." The Government also notes that Julie knew that the costs attributed to SCH had to be reasonable, necessary, and related to patient care, but nonetheless deliberately disregarded the excessive compensation being funneled through the CMI management agreement, including her own.

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district court declined to enter judgment on those claims, concluding they were subsumed in the verdict as to the FCA claims. Because we affirm the FCA judgment, Appellants' challenge is moot. *See Drummond*, 950 F.3d at 284. Moreover, Appellants failed to raise their attack on the common law claims in their motion for judgment as a matter of law or their motion for a new trial. "A party forfeits an argument by failing to raise it in the first instance in the district court—thus raising it for the first time on appeal[.]" *Rollins v. Home Depot USA*, 8 F.4th 393, 397 (5th Cir. 2021).

The record provides sufficient evidence to support the jury's verdict against Julie. "The FCA applies to anyone who knowingly assists in causing the Government to pay claims grounded in fraud, without regard to whether that person has direct contractual relations with the Government." *Riley*, 355 F.3d at 378 (cleaned up). "Knowing assistance" does not require that a person "be the one who actually submitted the claim forms in order to be liable." *Id.* (internal quotation marks and citation omitted).

To the contrary, as district courts have discussed, "[t]he causation standard employs traditional notions of proximate causation to determine whether there is a sufficient nexus between the conduct of the party and the ultimate presentation of the false claim." *U.S. ex rel. Wuestenhoefer v. Jefferson*, 105 F. Supp. 3d 641, 681 (N.D. Miss. 2015) (internal quotation marks and citation omitted); *see also United States v. Hodge*, 933 F.3d 468, 474–75 (5th Cir. 2019) (applying proximate causation in FCA housing case). Such nexus "merely demands more than mere passive acquiescence in the presentation of the claim and some sort of affirmative act that causes or assists the presentation of a false claim." *United States v. Medoc Health Servs. LLC*, 470 F. Supp. 3d 638, 655 (N.D. Tex. 2020) (internal quotation marks and citation omitted). "[M]ere negligence" is not actionable. *U.S. ex rel. Longhi v. Lithium Power Techs., Inc.*, 513 F. Supp. 2d 866, 876 (S.D. Tex. 2007). But "constructive knowledge," or "what has become known as the ostrich type situation where an individual has 'buried [her] head in the sand' and failed to make simple inquiries which would alert [her] that false claims are being submitted" is

sufficient. *Id*. (quoting S. Rep. 99-345, at *21, 1986 U.S.C.C.A.N. 5266, 5286).

Inter alia, the jury could have seen Julie's execution of the management agreement between SCH and CMI, allowing CMI to charge SCH up to 15% of revenue, as an "affirmative act" that facilitated these false claims. And the Government presented evidence that Julie did little to no work for SCH despite the salaries and fees she collected from Medicare. The Government also presented evidence indicative of constructive knowledge, such as Julie's failure to inquire about the management fees ultimately charged by CMI. Sufficient evidence supports the jury's verdict against Julie Cain.

IV.

Should this court decline to reverse and render judgment for them, Appellants assert that the FCA's six-year statute of limitations applies to bar claims accruing before September 2009, such that the judgment should be reduced to $4,590,495.[12] According to Appellants, "the relator's claims made no mention of [excessive] salaries or luxury cars," which they contend is the crux of the Government's intervening complaint, so that the Government's claims do not relate back to the filing date of Aldridge's complaint. Appellants further argue that the FCA's tolling period does not apply because the Government failed to make a diligent investigation. The Government counters that its claims in fact relate back to Aldridge's "Medicare

[12] September 2009 is six years prior to the Government's intervening complaint, filed in September 2015.

cost report fraud" claims, and even if not, the FCA's tolling provision salvage its claims *in toto*.

"[Q]uestions of law, such as whether the statute of limitations has run or whether equitable tolling applies," are reviewed *de novo*. *Newby v. Enron Corp.*, 542 F.3d 463, 468 (5th Cir. 2008). But as to tolling, "[w]hether the Government should have reasonably discovered the alleged [actions] is a mixed question of law and fact that we review for clear error." *United States ex rel. Vavra v. Kellogg Brown & Root, Inc.*, 848 F.3d 366, 383–84 (5th Cir. 2017). Appellants, "as the party asserting the statute-of-limitations defense, [bear] the burden of proving limitations barred the Government's claims." *Id.* at 383.

The FCA's limitations provision states:

> (b) A civil action under section 3730 may not be brought--
>
> > (1) more than *6 years after the date on which the violation of section 3729 is committed*, or
> >
> > (2) more than *3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances*, but in no event more than 10 years after the date on which the violation is committed,
>
> whichever occurs last.
>
> (c) If the Government elects to intervene . . . the Government may file its own complaint or

> amend the complaint of a person who has brought an action under section 3730(b) *to clarify or add detail* to the claims in which the Government is intervening *and to add any additional claims* with respect to which the Government contends it is entitled to relief. For statute of limitations purposes, any such Government pleading shall relate back to the filing date of the complaint of the person who originally brought the action, to the extent that the claim of the Government *arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint* of that person.

31 U.S.C. § 3731 (emphasis added).

A. Relation Back

As under Federal Rule of Civil Procedure 15, "a new [FCA] claim or pleading will not relate back when it asserts a new ground for relief supported by facts that differ in both time and type from those the original pleading set forth." *Vavra*, 848 F.3d at 382 (internal quotation marks and citation omitted). "[T]o relate back, a new claim must be 'tied to a common core of operative facts[.]'" *Id*. (quoting *Mayle v. Felix*, 545 U.S. 644, 664 (2005)).

Because our caselaw on this point is limited, Appellants refer to two out-of-circuit cases, *U.S. ex rel. Miller v. Bill Harbert International Construction, Inc.*, 608 F.3d 871 (D.C. Cir. 2010), and *U.S. ex rel. Bledsoe v. Community Health System, Inc.*, 501 F.3d 493 (6th Cir. 2007). In *Miller*, the D.C. Circuit vacated a district

court's FCA judgment in part based on the statute of limitations. 608 F.3d at 882–83. The *Miller* court concluded that allegations concerning one contract did not fairly encompass two other contracts "because each contract is unique and no two involved the same 'conduct, transaction, or occurrence.'" *Id*. at 882. The court was not persuaded by the Government's argument that the use of "contracts" (plural) in the relator's original complaint was sufficient. "Allowing such broad and vague allegations to expand the range of permissible amendments after the limitation period has run would circumvent the statutory requirement in the FCA that the amendments 'arise out of the conduct, transactions, or occurrences' in the original complaint." *Id*.

In *Bledsoe*, the Sixth Circuit took an even narrower view. 501 F.3d at 516. There, the court found that though a relator's original complaint alleged improper billing under "Code 94799" for services related to "emergency room" and "02 Equip./Daily," the later amended allegations for improper billing *under the same code* for "call back" services did not relate back. *Id*. at 518. The court likewise did not consider the relator's general allegation of fraud "by miscoding and upcoding items billed to Medicare and Medicaid" sufficient to provide the defendants with adequate notice. *Id*. at 516, 523.

Here, unconvinced by Appellants' reading of the relation back doctrine grounded on *Miller* and *Bledsoe*, the district court instead surmised that the Fifth Circuit, via *Vavra*, attached a broader meaning to § 3731(c). Based on its reading of *Vavra*, the district

court concluded that the Aldridge's general allegations regarding cost report fraud were sufficient for relation back because "the FCA allows the Government to add detail or clarify the claims on which it is intervening; and it . . . allows relation back even when the claim of the Government arises out of conduct the [r]elator 'attempted to set forth.'" Appellants contend that the district court erred. We agree.

Vavra's focus was on whether the FCA's relation back provision could attach to other, non-FCA claims, which is not the issue here. 848 F.3d at 381–83. Even so, the *Vavra* panel did not construe § 3731(c) as broadly as the district court did here. Instead, our colleagues cautioned that their conclusion that § 3731(c) allowed the Government to allege non-FCA claims upon intervention was not a free pass to add such claims willy-nilly: "This is not to say that the Government may take advantage of Section 3731(c)'s relation-back provision by adding any claims (FCA or not) to any *qui tam* FCA complaint." *Id*. at 382. And *Vavra* reiterated that new claims must be tied to a common core of operative facts to relate back under § 3731(c). *Id.* By contrast, relation back is generally improper when, though a new pleading shares some elements in common with the original pleading, it faults the defendant for conduct different than that alleged in the original complaint. *Miller*, 608 F.3d at 881. That is the scenario here.

Aldridge initially alleged that Appellants "falsified their claims by engaging in a number of practices including fraudulent cost reporting, inflating supply costs, manipulating the swing bed status of the

hospitals controlled by [CMI] . . . , and improperly waiving co-payments and deductibles." Neither of Aldridge's complaints nor the Government's March 2010 notice letter to Appellants (summarizing the relator's allegations) made any mention of excessive salaries or luxury vehicles. By contrast, the Government's intervening complaint, though generally premised on fraudulent cost reporting, primarily alleged that Appellants "abused the special Medicare rules for Critical Access Hospitals by improperly claiming expenses for the Cains' excessive and unwarranted compensation for work not performed and for Ted Cain's personal luxury automobiles . . . ." Thus, the upshot of the Government's complaint was "to fault [Appellants] for conduct different from that" alleged by Aldridge. *Miller*, 608 F.3d at 881; *accord Vavra*, 848 F.3d at 382. Rather than "clarifying" or "adding detail" to the relator's initial allegations, the Government's intervening complaint set forth *new* ones. Those new claims do not relate back under § 3731(c) to the date of Aldridge's original complaint.

B. Tolling

Relation back unavailing, we next address whether the FCA's tolling provision salvages the Government's pre-September 2009 claims. It does not.

To benefit from the tolling period, the Government must file suit within "3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances." 31 U.S.C. § 3731(b)(2). The Government must also have acted with due diligence to

preserve its claim. *See Baldwin Cnty. Welcome Ctr. v. Brown*, 466 U.S. 147, 151 (1984) (denying tolling because "[o]ne who fails to act diligently cannot invoke equitable principles to excuse that lack of diligence").

Appellants posit that the five-year period from the filing of Aldridge's initial complaint in May 2007 to September 2012, the earliest date the Government could concede knowledge of FCA violations but still benefit from the equitable tolling provision, "is far too long to claim diligence." Appellants assert that neither the Government nor its agent, the MAC, was diligent in investigating its claims. They contend that the MAC knew, or should have known, the facts supporting the Government's claims long before September 2012 because the MAC processed and reviewed Appellants' cost reports each year. They also contend the DOJ knew, or should have known, the facts supporting the Government's claims before then, given that the relator's initial complaint was filed in 2007 and given the Government's protracted and repeated requests for seal extensions while it investigated Appellants.[13] Finally, Appellants point to proof Aldridge produced after trial, in support of his fee petition, that his expert, Rob Church, had notified the DOJ about the salary issues by the fall of 2011.

The Government answers that the relevant "official of the United States charged with responsibility," as

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[13] Appellants also note that the Government's relation back contentions are inconsistent with its tolling contentions: "If [Appellants] should have surmised the Government was investigating excessive salaries in March 2010, then surely the Government *should have known* about its claims by then."

referenced in the FCA's statute of limitations, is the Attorney General or an authorized designee, not the MAC. The Government further responds that the cost reports provided to the MAC could not have triggered notice "given the opaque cost reporting structure [Appellants] engineered for Ted Cain's compensation." And the Government deflects Appellants' assertions that the DOJ knew or should have known the facts supporting the Government's claims before September 2012 as "mere[] allegations," having, "as the district court concluded, . . . no reasonable basis." Similarly, the Government submits that Appellants' contentions regarding Church's post-trial declarations amount only to speculation.[14]

In its order denying Appellants' post-trial motions, the district court sided with the Government, concluding that though it was unnecessary to reach the statute of repose given the relation back of the Government's claims, it was "persuaded that at a minimum, the Government had ten years from the date of the violation within which to bring its Complaint." The district court noted that even if the MAC's auditor had realized the amount of Appellants' salaries and that knowledge could be imputed to the Government, the MAC "still could not have determined, from the documents submitted, that Ted Cain was not actually performing any substantive work." The court found that the Government's position, that it only became aware in December 2013 of Ted's CMI compensation

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[14] Appellants' counsel concededly characterize Church's contradictory declarations as "a train wreck" and acknowledge "[Church] doesn't have any specific recollection of what he did or did not do."

and the amounts Medicare reimbursed SCH for his compensation, was "borne out by the evidence." Additionally, the district court found, "it was not until October 8, 2014, . . . that [the Government] learned Ted Cain had not performed any qualifying work eligible for reimbursement by Medicare." The district court thus concluded "the United States brought its lawsuit within three years of the date it knew or should have known of the violations."

Regardless of whether the Attorney General, his authorized designee, or the MAC was the relevant "official of the United States" for the FCA's statute of limitations accrual, and irrespective of whether the MAC's knowledge could be imputed to the Government, the record does not show that the MAC was contemporaneously aware of Ted's lack of reimbursable work. However, whether the DOJ should have uncovered the basic facts material to the Government's claims during the five years between August 2007 and September 2012 is a different matter.

In particular, the Government's August 2011 memorandum to the district court in support of an extension of the seal period—a memo that remains sealed and thus unavailable to Appellants—indicates that, after reviewing documents from Appellants, an expert recommended intervention in the case.[15] This

[15] It is unclear the expert to which the August 2011 memorandum refers. But Aldridge's expert, in his first post-trial declaration, averred that he provided information to the Government in the fall of 2011 regarding Appellants' salary issues, quite possibly corroborating the Government's August 2011 memorandum to the district court. *See infra* PART VII.

suggests not just that the Government "reasonably should have . . . known" "facts material to the right of action," § 3731(b)(2), but that it likely *did know* such facts by August 2011. And the Government offers no explanation for how, despite this knowledge, it was nonetheless diligent in investigating and asserting its claims. Contrary to the Government's assertion that it learned of the Cains' compensation issues only in 2013, the Government's August 2011 memorandum instead supports Appellants' "mere[] allegations" that the Government either knew or should have known of its basis to intervene before September 2012.

Given that, the Government cannot invoke the FCA's tolling provision. Instead, the FCA's statute of limitations applies to bar the Government's claims against Appellants accruing before September 2009, six years prior to when the Government filed its first intervenor complaint, and the damages awarded against Appellants must be remitted accordingly.

V.

Next, Appellants challenge the Government's repeated requests for extensions of the seal period—and the district court's granting of those extensions—as well as the Government's eight-year delay in intervening in this case. They urge that as a matter of law, eight years is too long to delay intervention, as "[t]here simply is no 'good cause' for such an extraordinary delay." Appellants contend that the district court abused its discretion by indulging the Government's serial requests—so much so that dismissal of the Government's intervening complaint is warranted. 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 Appellants' 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. Nonetheless, we decline Appellants' invitation to dismiss the Government's complaint as sanction.

After the initial 60-day period during which a FCA *qui tam* complaint is sealed, 31 U.S.C. § 3730(b)(2), "[t]he Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal," *id.* § 3730(b)(3). Here, the Government made eighteen such requests, extending the seal period from 60 days to more than eight years. To support their argument that this constituted an abuse of the FCA's seal provisions, Appellants rely on three out-of-circuit district court opinions: *U.S. ex rel. Brasher v. Pentec Health, Inc.*, 338 F. Supp. 3d 396, 403 (E.D. Pa. 2018) ("Clearly, the statute does not condone the granting of extension requests routinely or that submissions in support thereof remain forever sealed."); *U.S. ex rel. Martin v. Life Care Ctrs. of Am., Inc.*, 912 F. Supp. 2d 618, 623 (E.D. Tenn. 2012) ("The length of time this case has remained under seal borders on the absurd."); *U.S. ex rel. Costa v. Baker & Taylor, Inc.*, 955 F. Supp. 1188, 1190 (N.D. Cal. 1997) ("The legislative history of the [FCA] makes abundantly clear that Congress did not intend that the [G]overnment should be allowed to prolong the period in which the file is sealed indefinitely.").

Martin is particularly persuasive in considering whether the seal period was abusively extended here. In *Martin*, the seal period was extended for a total of four years. 912 F. Supp. 2d at 623. Even after the parties agreed to unseal most of the record, the Government requested that certain documents, identifying cooperating witnesses, remain sealed. *Id*. at 622. The *Martin* court addressed the request, stating that "the Government ha[d] stretched the FCA's 'under-seal' requirement to its breaking point." *Id*. at 623. The court noted that "the primary purpose of the under-seal requirement is to permit the Government sufficient time in which it may ascertain the status quo and come to a decision as to whether it will intervene in the case filed by the relator." *Id*. (citation omitted). And "with the vast majority of cases, 60 days is an adequate amount of time to allow Government coordination, review, and decision." *Id*. at 625 (quoting S. Rep. No. 99-345 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5289–90).

Addressing the facts, the *Martin* court did not censor its discontent. It found that the Government's actions—conducting unchecked discovery and attempting to settle with the defendant prior to intervening—were "indicative of significant overreach." *Id*. at 624; *see also Costa*, 955 F. Supp. at 1191 ("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."). Noting regret in granting successive extensions, the *Martin* court concluded that "the Government's stated

reasons were insufficient bases on which to obtain [] interminable extensions" of the seal period, and "[t]o the extent that the Government alleged that the pre-intervention investigation was overly complex, that complexity was likely a product of the Government's own extra-statutory discovery efforts[.]" 912 F. Supp. 2d at 625.

To recount *Martin* is to describe the Government's conduct here. Only, it was twice as egregious in 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 *eight years* of "evaluation." That meant extensive unilateral discovery, document review, and deposition requests; expert analysis, which according to the Government's August 2011 seal extension memorandum, included a recommendation to intervene; and, via selective disclosure of the relator's complaint in 2010, pressure on Appellants to settle, "thereby avoiding protracted litigation." Of course, all this transpired with the acquiescence of the district court.

For its part, the Government offers three counterpoints to Appellants' challenge: (1) Appellants do not point to any prejudice from the extensions (and cannot do so because they had notice of the Government's allegations as early as 2010); (2) Congress did not provide courts with dismissal authority based on the length of the Government's investigation; and (3) the length of the investigation was due to the complexity of the case and Appellants' own discovery violations. The first is, to put it

charitably, not meritorious, for the same reasons the Government loses on the statute of limitations issue; the third is readily disposed of on the same basis as discussed in *Martin*, 912 F. Supp. 2d at 625.

The Government's second point is grounded upon *State Farm Fire & Insurance Company v. U.S. ex rel. Rigsby*, 580 U.S. 26 (2016). In *Rigsby*, the Supreme Court held that "the FCA has a number of provisions that do require, in express terms, the dismissal of a relator's action." 580 U.S. at 34. According to the Government, it follows that, "had Congress intended to require dismissal for a violation of the seal requirement, it would have [likewise] said so." *Id.*

Appellants reply, reasonably, that leaving the Government and the district court unchecked "cannot be the law." They view *Rigsby* as inapposite because the issue there was whether a seal violation (as opposed to abuse of the FCA's seal provision) required mandatory dismissal of a relator's complaint. 580 U.S. at 32–33. And unlike *Rigsby*, Appellants do not seek dismissal of the entire action but rather request dismissal of "the Government's complaint in intervention, allowing the relator to proceed on his original complaint if he so chooses."

We agree with Appellants that *Rigsby* does not dictate the outcome of this case, in which Appellants effectively request dismissal of the Government's complaint for failure to prosecute. Irrespective of the FCA's provisions requiring dismissal of claims in certain instances, "[t]he authority of a federal [] court to dismiss a plaintiff's action with prejudice because of [its] failure to prosecute cannot seriously be doubted."

Link v. Wabash R. Co., 370 U.S. 626, 629 (1962). But the district court here declined to exercise that authority, and Appellants fail to pinpoint when the court's cumulative indulgence of the Government's snail's pace rose to an abuse of discretion. More importantly, Appellants provide no precedent, and we are aware of none, where such an extraordinary sanction as dismissal has been awarded because of the Government's inexcusable delays in intervening in a relator's case. *Cf. Rigsby*, 580 U.S. at 37–38 (noting that lesser sanction short of dismissal may well be warranted where the FCA's seal provisions are abused). We decline to break new ground today by granting such drastic relief. Nevertheless, because of its statute of limitations problems, discussed *supra* Part IV, the Government does not escape unscathed. The consequence of the Government's dilatory conduct is the reduction by over half of the judgment entered against Appellants. That should be consolation enough in this particular case.

VI.

Appellants next attack certain evidentiary rulings by the district court. They contend that the court improperly excluded Kuluz's testimony on two points, depriving them of a fair trial: first, that he relied on the advice of an outside accountant to allocate Ted's salary directly to SCH, and second, that Ted contributed millions of dollars to keep SCH operating.

A. Advice to Allocate Directly

During trial, the district court prevented Kuluz from testifying as summarized in Appellants' briefing on appeal:

> Bill King—who prepared defendants' cost reports—advised Kuluz in 2005 to directly allocate a portion of Ted's salary to SCH because the pooled percentage understated the time Ted spent on SCH matters . . . . King recommended direct allocation, and Kuluz set the allocation percentage based on his knowledge of Cain's work for SCH.

Appellants challenge the district court's conclusion that this testimony would potentially confuse the jurors. They assert that Kuluz's testimony was "directly relevant to the FCA's scienter element" and "could have led jurors to a different finding on scienter, as it supports the point that [Appellants] may have made mistakes in their allocations, but they did not lie to CMS."

However, the district court excluded the subject testimony on multiple grounds, citing prejudice to the Government, lack of reliability, *and* a likelihood of jury confusion. The Government argues that because Appellants do not challenge the district court's other reasons for excluding Kuluz's testimony, they have forfeited any such argument. *See Rollins*, 8 F.4th at 397 ("A party forfeits an argument . . . by failing to adequately brief the argument on appeal."). Tellingly, Appellants do not assert otherwise in their reply.

Regardless, we perceive no abuse of discretion in the district court's ruling. As noted by the court in its post-trial order, King is now deceased and there is no other evidence corroborating that he advised Kuluz; Appellants did not previously disclose this testimony to the Government;[16] and even assuming King had advised Kuluz, Appellants presented no evidence that King knew the amount of time Ted actually spent working at SCH or the amount of Ted's salary that Kuluz allocated to SCH. These findings support the district court's ruling. Moreover, even assuming an abuse of discretion, any error was harmless because there was additional evidence showing Kuluz, also an accountant, acted knowingly and did not properly allocate the Cains' salaries given their lack of work for SCH. *See Abner v. Kan. City S. R.R. Co.*, 513 F.3d 154, 168 (5th Cir. 2008) (applying harmless error analysis). This issue lacks merit.

B. Ted's Contributions to SCH

Appellants also contend "the district court wrongly barred Kuluz from describing Ted's substantial contributions to SCH, including over $4,000,000 in capital contributions and $18,000,000 in personal guarantees for hospital loans." Appellants assert this testimony would have refuted the Government's theme that a "greedy" Ted was diverting money from SCH to the hospital's detriment.

The Government counters that the district court did not abuse its discretion in excluding this testimony,

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[16] Kuluz testified in his discovery deposition that he could not remember why he chose to allocate Ted's salary directly to SCH.

and even if it did, the exclusion did not affect Appellants' substantial rights. According to the Government, the court correctly excluded this testimony based on the best evidence rule. The Government also contends that the testimony was properly excluded as irrelevant and prejudicial.

The district court addressed this evidentiary issue in its post-trial order. The court reasoned that exclusion of this testimony was justified because (1) Appellants did not produce or disclose these matters during discovery; (2) Kuluz could not produce the checks or documents to authenticate these transactions, though he stated that such documents existed; (3) Ted's investments into his business were irrelevant to this action, which solely concerned claims submitted to Medicare for reimbursement; and (4) the jury could have been confused by this information, thinking it entitled Ted to an offset or credit. "A district court abuses its discretion when its ruling is based on an erroneous view of the law or a clearly erroneous assessment of the evidence." *In re: Taxotere (Docetaxel) Prods. Liab. Litig.*, 26 F.4th 256, 263 (5th Cir. 2022) (citation omitted). We discern neither in the district court's reasoning here.

VII.

Appellants also contend the district court committed reversible error in denying their request for post-trial discovery. Following trial, on March 27, 2020, Aldridge filed a motion for attorney's fees and expenses. In support of his petition, he included a declaration and time sheets from his expert, Rob Church. In the declaration, Church attested to the following:

> Exhibit B hereto accurately itemizes the time I actually spent, and the tasks I performed, in the course of my work concerning this case at the request of the [r]elator's attorneys.
>
> . . .
>
> Exhibit D hereto is a "power-point style" document which was created by me in October and November of 2011 as a result of my work in this case, and was used by [Aldridge's attorney] Cliff Johnson and DOJ Attorneys Tom Morris and Angela Williams in order to present the relevant facts to attorneys for the Defendants in this case in September 2011.[17] Pages 9 and 10 of that document itemized for the participants in that meeting my findings as of that time about the salary amounts, paid to Ted Cain and Julie Cain, which had been allocated to [SCH]'s Medicare cost reports.

Church's appended timesheets indicate that he identified the compensation issue and discussed it with Aldridge's attorneys and the Government as early as February 2011. The Government, by contrast, had responded to an interrogatory during pretrial discovery that it did not discover the Cains' salary issues until December 2013, when an expert uncovered it during an analysis of the cost reports.

Based on the conflicting accounts, Appellants filed a motion on May 5, 2020, to conduct post-trial

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[17] The parties acknowledge that these dates appear to be inconsistent.

discovery to determine when the Government became aware of the Cains' salary issues. On May 10, 2020, the district court entered judgment against Appellants. Church filed a supplemental declaration on May 13, 2020, as part of Aldridge's rebuttal in support of his petition for attorneys' fees. In the supplemental declaration, Church appeared to backtrack, stating "Mr. Johnson and I discussed the powerpoint on November 11, 2011 . . . . At no time did I email or mail any 'powerpoint' document to any DOJ attorney."

The district court denied Appellants' motion for post-trial discovery, explaining in a twelve-page order that Appellants provided no authority for withholding entry of judgment to allow Appellants to re-open discovery.[18] The district court analyzed the motion as a request for relief from the judgment based on newly discovered evidence. *See* FED. R. CIV. P. 60(b) ("[T]he court may relieve a party . . . from a final judgment, order, or proceeding for . . . newly discovered evidence that, with reasonable diligence, could not have been discovered in time to move for a new trial under Rule 59(b)[.]").

To prevail on a Rule 60(b) motion based on newly discovered evidence, a movant must demonstrate "(1) that it exercised due diligence in obtaining the information; and (2) that the evidence is material and controlling and clearly would have produced a different result if present before the original judgment." *Hesling v. CSX Transp., Inc.*, 396 F.3d 632, 639 (5th Cir. 2005)

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[18] As noted above, the district court entered judgment prior to the conclusion of the briefing of Appellants' motion for discovery.

(quoting *Goldstein v. MCI WorldCom*, 340 F.3d 238, 257 (5th Cir. 2003)). The district court concluded that Appellants had ample opportunity to explore this issue in discovery yet failed to show the requisite due diligence to merit relief from the judgment. The court likewise concluded that Appellants failed to show the evidence was material.

We apply a highly deferential standard of review to discovery matters. "Our standard of review in [cases where a party seeks to reopen discovery] 'poses a high bar; a district court's discretion in discovery matters will not be disturbed ordinarily unless there are unusual circumstances showing a clear abuse.'" *In re Complaint of C.F. Bean, LLC*, 841 F.3d 365, 370 (5th Cir. 2016) (citing *Marathon Fin. Ins., RRG v. Ford Motor Co.*, 591 F.3d 458, 469 (5th Cir. 2009)); *see also Marathon*, 591 F.3d at 469 (providing we "will disregard a district court's discovery error unless that error affected the substantial rights of the parties" (internal quotation marks and citation omitted)).

Appellants contend the district court erred by denying post-trial discovery "into an obvious discrepancy between the Government's pre-trial claim not to have discovered the salary issues until December 2013 and the relator's post-trial proof that [his] expert advised the Government about the salary issues—in correspondence, telephone calls, and meetings—as early as February 2011." Appellants further argue the district court misapplied the law by applying Rule 60(b)(2) when they moved for discovery "after the verdict, but before judgment was entered." Appellants lastly assert that the district court's

reasoning, i.e., Appellants' lack of diligence and the immateriality of the information sought, was incorrect.

The Government responds that the district court properly denied Appellants' request because the discovery was immaterial; Appellants forfeited the issue by failing to provide specific discovery requests; and Appellants were not diligent in "following-up on the interrogatory response despite 'ample opportunity' in pre-trial discovery or at trial." The Government also asserts that regardless of whether Rule 60 applied to Appellants' request, Appellants still fail to meet the "high bar" of "clear abuse" necessary to re-open discovery.

As discussed *supra*, there is evidence in the record—the Government's own sealed memorandum from August 2011—that seemingly corroborates Church's first version of events, i.e., that he shared information with the Government about the Cains' excessive salaries, well prior to September 2012. Given the importance of such evidence for the Appellants' statute of limitations defense, it is somewhat incongruous for the district court to have foreclosed any chance to resolve the seeming contradictions in Church's declarations, particularly against the backdrop of the Government's own (sealed) statements. That said, we are also mindful of the highly deferential standard we apply in reviewing the district court's discovery rulings—particularly as to whether to reopen discovery.

It is not necessary for us to square this circle. The purpose of Appellants' request for post-trial discovery was plainly to flesh out evidence to support their

statute of limitations defense. Because we have already determined that their defense is well-taken, the post-trial discovery sought by Appellants would only be redundant. We therefore decline to delve further into the issues related to the district court's discovery ruling.

VIII.

In the consolidated appeal, No. 22-60145, Appellants also challenge the district court's March 14, 2022 order enjoining Appellants from transferring certain pieces of property. We lack jurisdiction to review the district court's order, which merely enforces a prior injunction, and therefore dismiss the appeal in the consolidated case.

Following the jury verdict, the district court entered a final judgment, holding Appellants jointly and severally liable to the United States for roughly $32 million. The judgment provided that "[t]he [c]ourt continues its [o]rder forbidding the defendants from transferring, dissipating, selling or disposing of any of their assets." The record does not contain the district court's previous order preventing dissipation of assets, as the district court apparently never issued a formal order doing so. Instead, it appears that the district court was referring to a directive during trial that the parties should "maintain the status quo with regard to all assets, that from this point on, nothing [was] supposed to be done with any asset [that was] the subject of this particular hearing."

Almost two years after final judgment was entered, on March 2, 2022, the district court set a status

conference. The conference was prompted by the Government's discovery that 400 North Beach Blvd., Bay St. Louis, Mississippi, a vacant lot held by HR Properties, LLC, was pending sale for roughly $2.7 million. The Government believed that this violated the district court's anti-dissipation injunction in the final judgment.

Appellants responded that because none of them owned the lot, it was not subject to the injunction the district court had put in place.[19] Appellants sought to cancel the status conference and have the Government file a motion seeking specific relief. The Government responded that a status conference was appropriate because, among other things, facts relating to the ownership of the subject property and the ownership and control of Ted Cain's various entities were still undisclosed as Appellants had resisted related discovery.

The district court required the Government to file a motion to enforce the final judgment and provided Appellants the opportunity to respond.[20] In the interim, the district court entered a temporary enforcement order, specifically enjoining Appellants "from transferring, selling, encumbering, or disposing of any

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[19] Appellants also noted that the Government was not a party to the relator's debt collection action before the district court (No. 1:20-cv-321), wherein the relator alleged fraudulent transfers by Appellants, and that the Government's action, also alleging fraudulent transfers by Appellants, (No. 1:22-cv-11) was pending before another judge.

[20] The district court has not ruled on this motion.

of" a specific list of properties identified by the Government. This list included "all properties believed to be owned or managed by Ted Cain and HTC Elite and its management company, HTC Enterprises,"[21] including the vacant lot at 400 North Beach Blvd. Appellants filed a notice of appeal the same day the order was entered.

Appellants make a straightforward argument: HR Properties holds the vacant lot and was not bound by the district court's initial judgment and injunction. Therefore, any order by the district court applying the injunction to assets held by HR Properties is an expansion of its preexisting injunction, requiring clearly stated grounds and sufficient notice to the affected parties. FED. R. CIV. P. 65(d)(1), (d)(2). Appellants also levy arguments that the Government violated Federal Rule of Civil Procedure 7 by not properly requesting this relief in a motion and that the Government failed to carry the heavy burden of proof for an injunction.

The Government asserts that this court lacks jurisdiction over the appeal. According to the Government, because the Cains own HR Properties, at least indirectly, the district court's March 14, 2022 order merely enforces a preexisting injunction, and no appellate jurisdiction can be asserted over such an order. *See* 28 U.S.C. § 1292(a)(1) ("[T]he courts of

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[21] HR Properties, LLC is owned by HTC Elite, LP and HTC Enterprises, LLC. Julie and HTC Enterprises are part owners of HTC Elite. And Ted and Julie together own 100% of HTC Enterprises.

appeals shall have jurisdiction of appeals from . . . [i]nterlocutory orders of the district courts of the United States . . . granting, continuing, modifying, refusing or dissolving injunctions."). The Government is correct.

"We have refused [] to assert jurisdiction . . . if the district court's order merely enforces or interprets a previous injunction." *In re Seabulk Offshore, Ltd.*, 158 F.3d 897, 899 (5th Cir. 1998) (internal quotation marks and citations omitted). "[A] court has not modified an injunction when it simply implements an injunction according to its terms or designates procedures for enforcement without changing the command of the injunction." *In re Deepwater Horizon*, 793 F.3d 479, 491 (5th Cir. 2015) (internal quotations, brackets, and citation omitted). "Interpretation, then, is not modification." *Id.*

The district court's March 14, 2022 order merely enforces the court's preexisting injunction. Contrary to Appellants' frequent reference to "nonparties" in their briefing, the Cains in fact own, or control, the property in question, albeit through indirect corporate entities. At the end of the day, the only ownership interests beyond Ted's and Julie's in any of the relevant entities are held by trusts for the Cains' children—trusts that Ted controls.

The district court recognized this obfuscation as well. It stated in its March 14, 2022 order that

> Cain's companies are interwoven, with some held by holding companies, but if any companies are subject to Cain family control or ownership,

> this prohibition against dissipation applies to all of them. There is to be no change [in] the status of any of these properties. This court is not going to deal in sophistry. This court order applies if Ted Cain is in control, even if acting through a corporate structure, or in the role of a "manager."

Because the Cains own or manage every entity that has any share in the vacant lot, the vacant lot is plainly subject to the district court's May 2020 injunction.[22] Indeed, during trial, Appellants' counsel conceded that entities owned or directed by Ted were included in the district court's ongoing injunction.[23] This was also the district court's view. In a June 7, 2022 order denying Appellants' request to stay the March 14, 2022 enforcement order, the district court stated, "the injunctive relief ordered by this court is not a new order, but is an order to enforce the injunction already

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[22] "It is axiomatic that that federal courts possess inherent power to enforce their judgments." *Thomas v. Hughes*, 27 F.4th 363, 368 (5th Cir. 2022) (internal brackets, quotation marks, and citation omitted); *see also Test Masters Educ. Servs., Inc. v. Singh*, 428 F.3d 559, 577 (5th Cir. 2005) ("District courts can enter injunctions as a means to enforce prior judgments.").

[23] Counsel stated at trial, "Mr. Cain is absolutely a defendant in this suit, and you have full power over him, as the controlling member of these LLCs, to do whatever is necessary and proper . . . . And given that Mr. Cain has the authority to direct these other entities, you could direct him to direct the other entities." *Accord Thomas*, 27 F.4th at 368–69 (approving order barring business owner "from *causing* [the entity] to effectuate any proscribed transfer indirectly that [owner] could not make directly").

in place as contained in the judgment of this court." *Aldridge on behalf of United States v. Corp. Mgmt. Inc.*, 2022 WL 2046105, at *4 (S.D. Miss. June 7, 2022).

Because we agree with the district court that the injunction is not new or modified, the consolidated appeal in case No. 22-60145 must be dismissed for lack of jurisdiction.

* * *

As to appeal No. 21-60568, we AFFIRM in part, REVERSE in part, and REMAND for proceedings consistent with this opinion.

As to appeal No. 22-60145, we DISMISS for lack of jurisdiction.

JAMES C. HO, *Circuit Judge*, dissenting in part:

I fully appreciate how my distinguished colleagues could reasonably conclude—as they do in Section IV of the majority opinion—that we should not allow the Government's subsequent complaint to relate back to the relator's original complaint for purposes of applying the statute of limitations.

I agree that it's a close question. At the end of the day, it amounts to a judgment call about what it means to present a claim that "arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of that person." 31 U.S.C. § 3731(c). *See also* FED. R. CIV. PROC. 15(c). As our court has observed, "determining when an amendment will relate back" can be "difficult." *FDIC v. Conner*, 20 F.3d 1376, 1386 (5th Cir. 1994). "Courts

have eschewed mechanical tests for determining when relation back is appropriate." *Id.*

Given the circumstances presented here, relation back appears to be contemplated under our precedent. In *Conner*, for example, the original complaint involved "approv[ing] twenty-one specified loans to specified borrowers" that "allegedly caused the bank to lose in excess of $2.8 million." *Id.* at 1378. The agency later "sought to incorporate into the complaint charges that the defendants'[] allegedly wrongful conduct caused [the bank] to suffer losses from several loans that were not identified in the original complaint." *Id.* We held that "the amended complaint should relate back to the date of the original complaint." *Id.* at 1386. "The damage allegedly caused by the loans that the FDIC seeks to include in this case arose out of the same conduct as the damage caused by the twenty-one loans listed in the original complaint. The conduct identified in the original complaint that allegedly caused the defendants to approve the loans listed in that pleading also allegedly caused the defendants to approve the loans that the FDIC seeks to include in this case through the amended complaint." *Id.* "The FDIC's amendment thus seeks to identify additional sources of damages that were caused by the same pattern of conduct identified in the original complaint." *Id.*

Accordingly, I would affirm and hold Defendants liable for pursuing federal reimbursement for luxury cars and compensation for work not performed. Defendants surely knew that luxury cars and excessive salaries are not, to quote the original complaint, "related to qualified services provided for the benefit of

Medicare and Medicaid beneficiaries," but are instead "unallowable costs" "not reimbursable under . . . Medicare and Medicaid."

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

CIVIL ACTION NO. 1:16-CV-369 HTW-LGI

[Filed June 18, 2021]

JAMES ALDRIDGE, RELATOR,
on behalf of UNITED STATES OF AMERICA
PLAINTIFF

V.

CORPORATE MANAGEMENT, INC., et al
DEFENDANTS

ORDER

Before this court are two motions filed by the Defendants herein, Corporate Management, Inc. ("CMI"), Stone County Hospital, Inc. ("SCH"), H. Ted Cain ("Ted Cain"), Julie Cain, and Thomas Kuluz ("Kuluz"): 1) Motion for Judgment as a Matter of Law [ecf doc. no.430]; and 2) Motion for a new Trial [ecf doc. no. 432]. The Plaintiff United States of America ("United States" or "Government") opposes the motions. Briefing has been completed and this court is ready to make its ruling.

FACTUAL AND PROCEDURAL BACKGROUND

The Relator in this case, James Aldridge brought a *qui tam* action against these Defendants under the False Claims Act (FCA). The FCA imposes significant penalties on anyone who "knowingly presents a false or fraudulent claim for payment or approval" to the federal government. 31 U.S.C. §3729(a)(1)(A). "Claim" includes a direct request to the Government for payment, as well as reimbursement requests made to the recipients of federal funds under federal programs. See §3729(b)(2)(A). The Act's scienter requirement defines "knowing and "knowingly" to mean that a person has "actual knowledge of the information," "acts in deliberate ignorance of the truth or falsity of the information," or "acts in reckless disregard of the truth or falsity of the information." §3729(b)(1)(A); *Universal Health Services, Inc., v. Escobar,* 136 S.Ct. 1989 (2016).

Stone County Hospital ("SCH") was a Critical Access Hospital located in Wiggins, Mississippi. Ted Cain, the sole owner of Stone County Hospital, Inc., submitted the application to Medicare in 2001 to convert SCH into a Critical Access Hospital. "Critical Access Hospital" is a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services ("CMS"). This designation was created through the Balanced Budget Act of 1997 (Public Law 105-33) in response to a significant number of closures of rural hospitals in the 1980's and early 1990's. The "Critical Access Hospital" designation and method of reimbursement is designed to reduce the financial vulnerability of rural hospitals, thereby improving access to healthcare in rural communities.

These hospitals, therefore, receive certain benefits, such as cost-based reimbursement for Medicare services.

As part of this conversion, Ted Cain certified that he was familiar with the Medicare or other federal health program laws, regulations, and program instructions governing this type of hospital and that he agreed to abide by them. P-304. He also certified that he "understood that payment of a claim by Medicare or other federal health care program was *conditioned* on the claim and the underlying transaction *complying with such laws, regulations, and program instructions*." *Id.* (emphasis added). These laws, regulations, and program instructions are found in the Provider Reimbursement Manual ("PRM"). 1/16/20 Tr. 7:14-21 (Tisdale).

From 2004 up until he leased the facility to another hospital, Ted Cain held the position of Chief Executive Officer/President of CMI. At all times pertinent to this suit, Ted Cain was the sole owner of CMI and SCH. Ted Cain's wife, Julie Cain held the position of CEO/Administrator of SCH from 2003 to 2012.

Cost reporting process

Payments from Medicare to a Critical Access Hospital are based on the Critical Access Hospital's costs and the share of those costs that are allocated to Medicare patients. As a Critical Access Hospital, Medicare reimbursed SCH at allowable costs plus 1%.

Following the conclusion of each year, SCH, through CMI, prepared and submitted a Medicare cost report, detailing the costs for which SCH sought

reimbursement for that cost reporting year. CMI annually prepared a home office cost statement detailing the management costs CMI allocated to SCH's cost report for purposes of Medicare reimbursement. Throughout the year, SCH received interim payments from Medicare based off the prior year's cost report. At all times pertinent to this suit, SCH submitted its Medicare Cost Reports for each cost reporting year to the applicable Fiscal Intermediary ("FI") or the Medicare Administrative Contractor ("MAC")[1].

Home Office and Allocation

A group of commonly owned or controlled health care providers may share a home office to perform certain centralized administrative services for its component providers. In the instant case, SCH contracted with CMI, the home office, to provide certain administrative services for which SCH pays a fee to CMI. The home office is not a Medicare provider and cannot, therefore, directly receive Medicare reimbursements. See 42 U.S.C. §1395cc. The provider, however, may obtain reimbursement for what it has

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[1] A Fiscal Intermediary, FI, was the entity that the Center for Medicare Services contracted to review the annual cost reports submitted by health care providers seeking reimbursement from Medicare. The name of the contractor was subsequently changed to Medicare Administrative Contractor, or MAC. When Stone County Hospital was initially converted to a Critical Access Hospital, it submitted its cost reports to the FI. In later years, the entity to which SCH submitted its cost reports was referred to as the MAC. The terms were sometimes used interchangeably during the trial.

paid to the home office for these administrative services.

In order for SCH to obtain reimbursement from Medicare for the cost of these services, CMI, as the home office, must also submit a cost report to the FI or the MAC. The home office cost statement must identify the allowable home office costs and how they are allocated among each of its subsidiary companies.

The Defendants

Ted Cain

Ted Cain was the sole owner of SCH, a Critical Access Hospital (CAH) located in Wiggins, Mississippi. A Critical Access Hospital, so designated because it is located in an underserved area, is authorized to bill Medicare for allowable costs plus 1%. This is an advantageous billing practice that is unique to Critical Access Hospitals and is generally unavailable to other kinds of hospitals. 1/16/20 Rough Tr. 15:17-20:18 (Tisdale); 1/28/20 Rough Tr. 5:5-9 (LaRocca); 2/6/20 Rough Tr. 101:8-102:1 (Llewellyn).

When applying for Critical Access Hospital status in 2001, as above stated, Ted Cain certified that he was familiar with, and agreed to abide by, the applicable Medicare laws, regulations, and program instructions. He also certified that he "understood that payment of a claim by Medicare was *conditioned* on the claim and the underlying transaction *complying with such laws, regulations, and program instructions*." *Id.* (emphasis added). These laws, regulations, and program instructions are found in the Medicare Provider Reimbursement Manual (PRM). 1/16/20 Rough

Tr. 7:14-21 (Tisdale). Ted Cain additionally certified that he would not "knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare or submit claims *with deliberate ignorance or reckless disregard of their truth or falsity*." PRM at P 304 (emphasis added).

Ted Cain was also the sole owner of CMI, which was the management company that provided administrative services for Stone County Hospital and several other businesses owned by Ted Cain. The evidence at trial showed that Defendants, Ted Cain, Tommy Kuluz, CMI and SCH, sought Medicare reimbursement for Ted Cain's million-dollar plus salary, despite the absence of any significant work performed by Ted Cain related to patient care. Defendants, by the jury's verdict, made no effort to ensure the reasonableness of Ted Cain's compensation, or otherwise comply with the Medicare Provider Reimbursement Manual (PRM).

Julie Cain

Julie Cain, the wife of Ted Cain, was the administrator of SCH for several of the years at issue, and for other years served on the Board of Directors, or as a paid consultant to the hospital. The evidence convinced the jury that Julie Cain did very little work as administrator of Stone County Hospital. She did virtually no work for the hospital during some years. Testimony showed she was primarily staying at home with her children. At trial, she could not provide any evidence of work done as a member of the board of directors, or as a consultant. Yet, her unadjusted, unmodified salary, compensation as a board member, and

her pay as a consultant were all included in the cost reports submitted to Medicare and reimbursed by Medicare.

Tommy Kuluz

Tommy Kuluz was the Chief Financial Officer of CMI, the company that served as the "home office" for SCH for Medicare purposes, providing administrative services to SCH and other companies owned by Ted Cain. Kuluz was primarily responsible for submission of the annual cost reports by SCH to Medicare. He allegedly obtained his information from SCH personnel, and allegedly coordinated with the cost report preparers.

The jury was not impressed with Kuluz's honesty, finding that he had assisted Ted Cain's fraud, causing the submission of false claims and the making of false records and documents. The jury found he also had falsely certified all but one of the CMI home office statements.

His conduct, found the jury, violated Medicare's conditions of payment because he falsely attested to the truth and accuracy of the information, in order for SCH to bill Medicare. Kuluz also caused SCH officials to sign the SCH cost reports, thereby "causing the making" of false certifications. Testimony by Manuel Pilgrim at trial was that Kuluz billed Medicare for expenses Kuluz knew were not reimbursable, as evidenced by Kuluz's disallowance of those very same expenses in the 2012 and 2013 ***Medicaid*** home office reports.

CMI (Corporate Management Incorporated)

The jury found that CMI had submitted, or caused to be submitted, from 2004 to 2015, twelve (12) false claims related to cost reports. The jury also found that CMI had been unjustly enriched by $381,866 for the years 2012 and 2013, years for which certain expenses were self-disallowed[2] for Medicaid but were submitted for reimbursement to Medicare.

SCH (Stone County Hospital)

The jury found SCH liable for submitting, or causing to be submitted, twelve (12) false cost reports for the years 2004 through 2015. The jury also found that Medicare paid SCH based on a "mistake of fact."

The Alleged Fraudulent Scheme

The fact that Stone County Hospital was a Critical Access Hospital, reimbursed at 101% of allowable costs, played a major role in the Defendants' ability to perpetrate the years-long fraud that gave birth to this litigation. Also critical to Defendants' ability to carry out the fraudulent scheme was the fact that SCH was under the management of CMI, and that CMI also managed quite a few other companies owned by Ted

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[2] According to the testimony of Manuel Pilgrim, a Government expert, self-disallowance occurs when a health care provider, in preparing the cost report to be submitted to either Medicare or Medicaid, has determined that certain costs listed on its cost report were not allowable and should not have been included for reimbursement; therefore, the provider, on its own, shows that cost item as self- disallowed, and does not seek reimbursement for that item.

Cain, both health provider companies and non-health related entities.

During the twelve-year period covered by this litigation, Ted Cain owned numerous other companies, some of which were bought and sold, opened or closed across the relevant time span. Sherla Harville testified that during the period she worked for CMI, Ted Cain owned two critical access hospitals, three nursing homes and three out-patient clinics with which she dealt. The also owned a pharmacy, and a durable medical equipment company, she said. Craig Steen testified by deposition that he was aware of the following companies owned by Cain: Woodland Village Nursing Center; Stone County Nursing and Rehab; Leakesville Rehab Nursing Center; Stone County Hospital; Stone County Family Medical Clinic; Poplarville Medical Clinic; Quest Rehab (at some time in the past); and Quest Medical Services. Among the non-provider companies owned by Cain and managed by CMI were Cain Cattle, Quest Aviation, the Focus Group, and Legacy Landscaping. CMI managed all of these various businesses, and some were housed in the CMI offices. James Williams testified that Ted Cain started an ambulance service while he was at SCH.

A home office is allowed to provide support functions for several providers and it may also serve as the management company for non-provider companies. The Provider Reimbursement Manual ("PRM"), however, includes special regulatory provisions however, regarding related party transactions – regulations seemingly ignored by these Defendants.

The evidence showed that Ted Cain's compensation, totaling millions of dollars, did not meet the criteria to be reimbursed by Medicaid. An owner's salary and compensation is subject to special provisions under Medicare. As will be later discussed, it must be reasonable and necessary, and the services performed must be related to patient care. The services alleged to have been performed by Ted Cain were not related to patient care, and the salary amount was not reasonable nor necessary. There was ample evidence that Ted Cain actually performed virtually no services for SCH, and certainly no reimbursable services.

In addition to providing unreasonable compensation to the owners, these Defendants were able to indirectly shift some of the operating costs of their other companies to SCH and ultimately to Medicare. They did this primarily through the submission of fraudulent claims for Ted Cain's salary and by disproportionately allocating Ted Cain's compensation to SCH relative to his other CMI-managed companies. For most years, CMI and Tommy Kuluz chose the 'direct allocation' method for Ted Cain's salary at CMI, and allocated 80 - 82% of Cain's compensation to SCH, without any substantiation or documentation. This changed to the "pooled" method of allocation after CMI received the Government's letter informing it of this lawsuit.

Additionally, CMI charged SCH higher management fees as compared to the lower fees charged to other Ted Cain entities; thus, SCH and Medicare indirectly subsidized the management fees of the other Cain companies under CMI management.

Julie Cain was also paid an unreasonable and excessive salary as administrator of SCH, especially in light of her lesser qualifications as compared to the other Chief Operating Officers (COO's) and administrators of SCH and similar hospitals, and because she treated the position as a part-time job, at best. Submission of cost reports seeking Medicare reimbursement for her director's fees and for her consultant services were fraudulent because she was shown not to have performed any work in these roles

Moreover, as later discussed in this opinion, Julie Cain's position as administrator of SCH enabled the other Defendants to submit false cost reports, to charge higher management fees to SCH, and enforce requirements that SCH purchase its supplies from a Cain-owned company.

The Plaintiffs, Relator and the Government, were able to prove to the satisfaction of the jury, that Defendants had committed cost-report fraud by falsely certifying that the services identified in their annual cost reports had been provided in compliance with applicable laws and regulations, while knowingly including costs that were not reimbursable under the Medicare program. This resulted in Medicare reimbursing these Defendants in amounts much higher than that to which they were legally entitled.

This court tried this case for almost nine weeks. Over 200 exhibits, consisting of thousands of pages were admitted into evidence, and an equal number were not admitted or withdrawn. The jury heard the testimony of 24 witnesses, and each of the six defendants testified at least twice. Numerous

contentious motions and evidentiary arguments were heard and resolved. The matter was finally placed in the hands of the jury.

The duly constituted jury found five of the six defendants liable for varying amounts totaling over $10 million dollars. These five defendants are jointly and severally liable, up to the limits of their respective liability as found by the jury. Starann Lamier, originally the sixth defendant in this case, was found not liable on all of the claims brought against her; consequently, this court dismissed all claims against her.

It is significant to note that all of the jury instructions were agreed upon by the parties. In accordance with Jury Instruction no. 16, The United States' suit against these Defendants alleged three different False Claims Act causes of action: (1) that Defendants knowingly presented or caused the presentment of false claims (here the Stone County Hospital Medicare cost reports from 2004 through 2015) to the federal Medicare program; 2) that Defendants knowingly made or used, or caused to be made or used, false records or statements to the federal Medicare program; 3) that Defendants knowingly failed to return to the federal Medicare program the overpayments from Medicare to Stone County Hospital resulting from Defendants' false claims, records, and statements.

The jury was further instructed that the first two False Claims Act causes of action relate to whether Defendants' misconduct resulted in improper payments by the United States to Stone County Hospital, and the

third False Claims Act cause of action concerns whether Defendants' misconduct resulted in the failure to refund money to Medicare when a refund payment is obligated. This instruction is taken directly from Title 31 U.S.C. §§ 3729(a)(1)(A)(B) & (G), and as earlier stated, was agreed-upon by all parties.

Jury Instructions 17 informed the jury that to find any Defendant liable under the False Claims Act for knowingly presenting or causing to be presented *false or fraudulent claims* for payment or approval to the Government, the United States must show by the preponderance of the evidence the following: First, the Defendant presented or caused to be presented a false or fraudulent claim for payment to the government; Second, the Defendant presented the claim knowing of its falsity or fraudulence; Third, the falsity was material to a decision to pay the claim; and Fourth, the claim caused the United States to pay out money.

Jury Instructions 18 informed the jury that to find any Defendant liable under the False Claims Act for knowingly making, using, or causing to be made or used*, a false record or statement* material to a false or fraudulent claim, the United States must show by the preponderance of the evidence the following: First, the Defendant made or used or caused to be made or used a false or fraudulent statement or record; Second, the Defendant made or used or caused to be made or used the statement or record knowing of its falsity or fraudulence; Third, the statement or record was material to a decision to pay a false or fraudulent claim; and Fourth, the statement or record caused the United States to pay out money.

Jury Instruction 19 apprised the jury that a Defendant that did not present a false claim or make or use a false record or statement may still be found liable if that Defendant *caused* the presentment of a false claim or *caused* a false record or statement to be made or used. Jury Instruction 20 instructed the jury that even if a Defendant did not make or use a false record or statement, the Defendant may still be liable for *causing* a false record or statement to be made or used *to decrease an obligation to pay money to the United States*.

The above-mentioned instructions – instructions numbers 16, 17, 18, 19 and 20 – are part of the package of instructions, 43 in all, approved by the parties, and given, without objections, to the jury.

After deliberating over several days, the jury returned its verdict [ecf doc. no. 383], finding as follows:

Defendant Ted Cain submitted or caused to be submitted to Medicare twelve (12) false claims from 2004 through 2015, totaling $10,855,382. The jury also found that Ted Cain had been unjustly enriched in the amount of $10,473,516.

Defendant Julie Cain submitted or caused to be submitted to Medicare twelve (12) false claims from 2004 through 2015, totaling $9,137,212. The jury also found that Julie Cain had been unjustly enriched in the amount of $10,473,516.

Defendant Tommy Kuluz submitted or caused to be submitted to Medicare eleven (11) false claims from

2004 through 2007 and 2009 through 2015, totaling $9,853,117.

Defendant Corporate Management, Inc. (CMI) submitted or caused to be submitted to Medicare twelve (12) false claims from 2004 through 2015, totaling $10,855,382. The jury also found that Corporate Management, Inc., (CMI) had been unjustly enriched in the amount of $381,866.

Defendant Stone County Hospital submitted or caused to be submitted to Medicare twelve (12) false claims from 2004 through 2015, totaling $10,473,516. The jury also found that Medicare paid Stone County Hospital (SCH) based on a mistake of fact for the years 2004 through 2015, in the amount of $10,473,516.

Consistent with the jury's verdict and the mandates of the FCA, this court entered its judgment imposing treble damages and civil penalties as follows:

Defendant Ted Cain is liable to the United States in the amount of $32,566,146 in damages and $71,681 in penalties under the False Claims Act.

Defendant Julie Cain is liable to the United States in the amount of $27,411,636 in damages and $71,681 in penalties under the False Claims Act.

Defendant Thomas Kuluz is liable to the United States in the amount of $29,559,351 in damages and $66,181 in penalties under the False Claims Act.

Defendant Corporate Management, Inc. is liable to the United States in the amount of $32,566,146 in

damages and $71,681 in penalties under the False Claims Act.

Defendant Stone County Hospital is liable to the United States in the amount of $31,420,548 in damages and $71,681 in penalties under the False Claims Act.

This court ordered that each defendant shall be jointly and severally liable for the amounts above up to their respective liability, and for post-judgment interest at the legal rate set by 28 U.S.C. § 1961 until the above amounts are paid in full.

The United States, with the court's permission, filed a combined Response to Defendants' Motion for Judgment on the Pleadings and Motion for New Trial. The Defendants filed a combined Reply, as well. Therefore, this court will combine its consideration of the two motions in this one Opinion.

STANDARD OF REVIEW

Rule 50(b) Motion for Judgment as a Matter of Law

A motion for judgment as a matter of law following a jury verdict is "a challenge to the legal sufficiency of the evidence supporting the jury's verdict." *Miss. Chem. Corp. v. Dresser-Rand Co.*, 287 F.3d 359, 365 (5th Cir. 2002). As such, the court is "especially deferential" to the jury's verdict. *Vetter v. McAtee,* 850 F.3d 178, 185 (5th Cir. 2017). The court does not weigh the evidence or make credibility determinations, which are the province of the jury. *Id.* Instead, in reviewing the evidence, the court "must draw all inferences in favor of the nonmoving party." *Id.* And "although the court

should review the record as a whole, it must disregard all evidence favorable to the moving party that the jury is not required to believe." *Reeves v. Sanderson Plumbing Prods.,* 530 U.S. 133, 151 (2000) (emphasis added). "That is, the court should give credence to the evidence favoring the nonmovant as well as that 'evidence supporting the moving party that is uncontradicted and unimpeached, at least to the extent that the evidence comes from disinterested witnesses.'" *Id.* (citation omitted). The court can only grant a motion for judgment as a matter of law "if the facts and inferences point so strongly and overwhelmingly in favor of one party that the Court believes that reasonable people could not arrive at a contrary verdict." *Vetter,* 850 F.3d at 185.

Rule 59 Motion for New Trail

A trial court may order a new trial after a jury verdict "on all or some of the issues." The abuse of discretion standard applies. *See Kennett v. USAA General Indemnity Co.*, 2020 WL 1933950 *2 (5th Cir. Apr. 21, 2020). Rule 59 does not set forth any specific grounds for a new trial, but this Rule "confirms the trial court's historic power to grant a new trial based on its appraisal of the fairness of the trial and the reliability of the jury's verdict." *Briggs v. State Farm Fire and Casualty Co.*, 2016 WL 347018 *2 (S.D. Miss. Jan. 26, 2016) (quotation omitted).

As the Fifth Circuit explained in *Shows v. Jamison Bedding, Inc.*,

> [w]hen the trial judge has refused to disturb a jury verdict, all the factors that govern our

> review of his decision favor affirmance. Deference to the trial judge, who has had an opportunity to observe the witnesses and to consider the evidence in the context of a living trial rather than upon a cold record, operates in harmony with deference to the jury's determination of the weight of the evidence and the constitutional allocation to the jury of questions of fact. When the trial judge sets aside a jury verdict and orders a new trial, however, our deference to him is in opposition to the deference due the jury. Consequently, in this circuit as in several others, we apply broader review to orders granting new trials than to orders denying them.

Id., 671 F.2d 927, 930 (5th Cir. 1982).

Granting a new trial based on the weight of the evidence receives "particularly close scrutiny" from the appellate court "to protect the litigants' right to a jury trial." *Id*. (citations omitted); *see also Stelluti Kerr, LLC v. Mapei Corp.*, 703 Fed. App'x. 214, 232 (5th Cir. 2017) (reversing district court's conditional grant of a new trial based on the weight of the evidence as an abuse of discretion). A trial court should not grant a new trial "unless, at a minimum, the verdict is against the great—not merely the greater—weight of the evidence." *Id.* at 232 (quoting *Shows*, 671 F.2d at 930). On the other hand, "[t]he district court abuses its discretion by denying a new trial only when there is an absolute absence of evidence to support the jury's verdict." *Wellogix, Inc. v. Accenture, LLP,* 716 F.3d 867, 881 (5th Cir. 2013) (quotation and citations omitted) (denying

Rule 50 and 59 motions); *Whitehead ex rel. Whitehead v. K Mart Corp.,* 173 F. Supp.2d 553, 557 (S.D. Miss. 2000) (J. Wingate) (same).

In examining the weight of the evidence under Rule 59, both the trial and appellate courts "view the evidence in the light most favorable to the jury verdict." *Kennett v. USAA General Indemnity Co.,* 2020 WL 1933950 *2 (citing *Wellogix,* 716 F.3d at 881) (standard for appellate court review); *Whitehead*, 173 F. Supp.2d at 557 (standard for trial court review).

ANALYSIS

The FCA is very broad. It is a major tool of the government to combat all types of fraud that would result in financial loss to the government. See *U.S. ex rel. Grubbs v. Kanneganti,* 565 F.3d 180, 184 (5th Cir. 2009) (quotation omitted*); Cook County v. U.S. ex rel. Chandler*, 538 U.S. 119, 129 (2003) (quotation omitted); see *also U.S. v. Neifert-White Co.*, 390 U.S. 228, 233 (1968) (The FCA "reaches . . . all fraudulent attempts to cause the Government to pay out sums of money.").

The False Claims Act, 31 U.S.C. § 3729 *et seq.,* "imposes significant penalties on those who defraud the Government." *Universal Health Services v. United States ex rel. Escobar*, 136 S.Ct. 1989, 1995 (2016). Four elements must be proven in a False Claims Act claim: namely, (1) "there was a false statement or fraudulent course of conduct; (2) made or carried out with the requisite scienter; (3) that was material; and (4) that caused the government to pay out money or to forfeit moneys due. *Id.; Lemon v. Nurses to Go, Inc.,* 924 F.3d 155 (5th Cir 2019); *Abbott v. BP Expl. & Prod.,*

Inc., 851 F.3d 384, 387 (5th Cir. 2017) (citing *United States ex rel. Longhi v. United States, 575* F.3d 458, 467 (5th Cir. 2009)).

Without citing any authority, Defendants make a general argument that the False Claims Act, as applied here, has been stretched beyond its intended purpose. Defendants contend that the FI or the MAC, the entities to which Ted Cain's companies submitted their annual cost reports, did not detect the fraud nor stop it in years past, so Medicare has no right to do so now under the FCA. The only remedy the government has against them, Defendants say, lies with the administrative process – audits through the FI or the MAC –which would limit the remedy to recouping any overpayments the Government made to Defendants.

Defendants make much of the fact that administrative procedures are in place for routine, minor regulatory compliance issues, for failure to achieve perfect compliance. Defendants rely heavily on the case of *United States ex rel. Janssen v. Lawrence Memorial Hospital,* 949 F.3d 533 (10th Cir. 2020). Defendants claim that bringing a lawsuit against them under the FCA creates a danger of turning the FCA into a tool for policing minor regulatory compliance – the very thing that the *Escobar* Court warned against.

Defendants here were not accused of routine, minor regulatory noncompliance, however. Defendants here were accused of and found liable for a multi-million-dollar fraud spanning over a decade.

The Government did not transform a regulatory matter into a False Claims violation. Defendants

committed serious violations under the False Claims Act, which can only be addressed by its provisions.

The jury here disagreed with Defendants' position that the Government was overreaching and that only administrative remedies should have been used to cure the problem of exorbitant, unearned, non-reimbursable salaries. Having been clearly and properly instructed on the requirements that the false claims must be *knowingly* made and *material* to the Government's payment decision, the jury found liability for twelve years of false cost report submissions as to four of the six defendants and false cost report submissions for eleven years by Tommy Kuluz. Defendants' argument that this litigation exceeds the purpose of the FCA is short-sighted. The elaborate fraudulent scheme perpetrated by these Defendants represents precisely the kind of fraud the FCA is meant to prevent and to penalize when it occurs.

Merely allowing an offender to pay back the funds fraudulently received would not deter fraud against the Government. Attempting to defraud the Government would almost always prove to be worth the risk if the only consequence was having to pay the money back, if caught.

Materiality

The first issue Defendants raise in support of their Motion for Judgment as a Matter of Law and their Motion for New Trial is that of materiality. Defendants claim that the statements found to be false by the jury, are not 'material', and thus not actionable under the FCA because, they say, the United States continued to

pay the claims despite the false statements. Medicare, Defendants say, frequently continues to pay Critical Access Hospitals even when their claims are fraudulent or improper. They reference the testimony of William Tisdale, a Government expert in support of this point. [ecf doc. no. 432-1].

William Tisdale's testimony was that the Government sometimes operates pursuant to a "pay and chase" policy when it comes to Critical Access Hospitals, out of a desire not to shut down the hospitals while the Government investigates and attempts to recoup funds. Defendants argue that pursuant to this "pay and chase" policy, under which the Government admittedly operates, any fraudulent statements on SCH's Medicare cost reports would have to be considered immaterial to the Government's payment decision, since the Government pays the claims anyway.

The Government counters that to discontinue Medicare reimbursements would be tantamount to shutting down the hospital. Ted Cain acknowledged that the hospital could not continue to operate without Medicare funds. It is not the Government's goal, it says, to deprive a community of its only source of hospital care, but to stop the fraud. Rather than pursue what it called a draconian alternative, CMS (Center for Medicare and Medicaid Services) and the Department of Justice did not bring a halt to SCH's funding, but at the same time, tried to preserve Medicare's scarce resources by filing this lawsuit.

This court previously has rejected the Defendants' materiality arguments. More importantly, the properly

instructed jury also rejected these arguments. Jury Instruction 17 informed the jury that to find any Defendant liable for knowingly presenting or causing to be presented false or fraudulent claims for payment, the United States must show … "the falsity was ***material*** to a decision to pay the claim." Jury Instruction 18 informed the jury that to find any Defendant liable for knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim, the United States must show ... the statement or record was ***material*** to a decision to pay a false or fraudulent claim. The jury was clearly and correctly instructed.

The Defendants' position is also belied by the very existence of this litigation.

Both sides rely heavily upon the United States Supreme Court case of *Universal Health Services v. United States ex rel Escobar*, 136 S.Ct. 1989 (2016). In *Escobar*, the Supreme Court said, "the term 'material' means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property". *Id.,* at 2002. The *Escobar* Court continued, "[t]he False Claims Act is not "an all-purpose antifraud statute," or a vehicle for punishing garden-variety breaches of contract or regulatory violations."

The multi-million-dollar deception at play in the case *sub judice,* perpetuated by means of an elaborate scheme over a long period of time, hardly falls under the category of a "garden-variety breach"; nor would the fraud here qualify as the "minor or insubstantial" noncompliance that the Supreme Court said in *Escobar,* is not sufficient for a finding of materiality.

In the instant case, the Government acknowledges that its policy, in the face of possible improper claims by a Critical Access Hospital, is to "pay and chase," to pay the claims then seek repayment, in order to keep a hospital open where the community would otherwise not have accessible hospital care. After all, this was the very purpose for the creation of Critical Access Hospitals.

Defendants quote the following section from *Escobar*:

> If the Government pays a particular claim in full despite its *actual* knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material. Or if the Government regularly pays a particular type of claim in full despite *actual* knowledge that certain requirements were violated, *and* has signaled no change in position, that is strong evidence that the requirements were not material.

Id. at 2003-04. (quoting Allison Engine Co. v. United States ex rel. Sanders, 553 U.S. 662, 672 (2008)) (emphasis added).

Important to the discussion is that the *Escobar* Court starts from a point of *actual* knowledge on the part of the Government, not suspicion nor mere allegations, as first existed here. Further, the Government in this case, has shown a change of position. It notified Defendants of the litigation and the accusations against them in 2010, filed its Complaint

in Intervention in 2015, and continued to prosecute this case through to its conclusion in 2020.

The Fifth Circuit also emphasized that continued payment by the federal government after it learns of alleged fraud substantially increases the burden on establishing materiality. In that case, the Mississippi Division of Medicaid continued to make payments to the employer and renewed its contract with the employer several times after being informed about the alleged fraud. The district court had dismissed the Relator's claims because it could not find that Magnolia's staffing of care manager and case manager positions by licensed practical nurses, as opposed to registered nurses, was material to its contracts with the State of Mississippi. The Fifth Circuit agreed. In that case, obviously it was immaterial to the Government's payment decision whether registered nurses or practical nurses performed certain tasks.

The same cannot be said here. It was obviously material to the Medicare program whether Ted and Julie Cain were performing any services for Medicare patients for which they were being extravagantly compensated with federal monies. In spite of continuing to pay SCH, the Government had only the suspicion or knowledge that the salaries being charged to Medicare seemed out of line, not that the salaries were in fact, fraudulent because the work was not being performed as represented in the cost reports.

It is also true, however, that a violation is not material just because "the defendant knows that the Government would be entitled to refuse payment were it aware of the violation." *Id.* at 2004. In other words,

"the Government's decision to expressly identify a provision as a condition of payment is relevant, but not automatically dispositive." *Id.* at 2003. To use the Court's example, just because the government might require contractors to use American-made staplers does not mean that it would be a *material* misrepresentation under the FCA to knowingly use foreign-made ones. *See id.* at 2004. *United States ex rel. Patel v. Cath. Health Initiatives*, 792 F. App'x 296, 301 (5th Cir. 2019).

Again, we are not here dealing with a minor regulatory violation, such as the origin of an inexpensive product..

Lemon v. Nurses to Go

In *Lemon v. Nurses To Go, Inc.,* 924 F. 3d 155 (2019), the Fifth Circuit decided the case on the sole ground of whether the Medicare fraud, as alleged, was material under the False Claims Act. Under the FCA, "the term 'material' means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." *Id.,* at 159; 31 U.S.C. § 3729(b)(4); *United States ex rel. Longhi v. Lithium Power Techs., Inc.,* 575 F.3d 458, 468 (5th Cir. 2009) (citing *Neder v. United States,* 527 U.S. 1, 16, 119 S.Ct. 1827, 144 L.Ed.2d 35 (1999)). In deciding whether the violations alleged against the hospice care providers in that case were material, the Fifth Circuit relied upon the three factors outlined in *Escobar:* : (1) "the Government's decision to expressly identify a provision as a condition of payment"; and (2) "evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on

noncompliance with the particular statutory, regulatory, or contractual requirement." *Escobar,* at 2003. Additionally, (3) materiality "cannot be found where noncompliance is minor or insubstantial." *Id.*

In *Escobar*, the Supreme Court had remanded the case to the First Circuit to reconsider materiality in light of these factors. On remand, the First Circuit Court reversed the district court's grant of Defendant's motion to dismiss. The defendants argued that the Government continued to pay the claims despite knowledge that defendants were not in compliance with the applicable regulations. The First Circuit Court said that even assuming that various state regulators had notice of complaints against Defendants during the time the claims were being paid, "mere awareness of allegations concerning noncompliance with regulations is different from knowledge of actual noncompliance. *United States ex rel. Escobar v. Universal Health Servs., Inc.,* 842 F.3d 103, 112 (1st Cir. 2016)." The First Circuit Court continued, "there is no evidence in the complaint that MassHealth, the entity paying Medicaid claims, had actual knowledge of any of these allegations (much less their veracity) as it paid [defendant's] claims. Id., at 112.

The *Lemon* Court, citing *Escobar*, recognized that no one factor is dispositive, that the inquiry is a holistic one. *United States ex rel. Lemon v. Nurses to Go, Inc.,* 924 at 160. This court, as the Fifth Circuit in *Lemon* did, undertakes to review each of these components.

First, we examine whether the jury-found violations were conditions of payment. The answer is in the affirmative. The PRM requires that the parties certify

as to the truth of the matters submitted and payment is conditioned on that representation. The Government's claims here are based on Defendant's false certifications that salaries paid were reasonable, necessary and reasonably related to patient care, as required by the PRM. These Defendants' fraudulent certifications, then, constituted violations of conditions of payment, which according to the United States Supreme Court in *Escobar,* can constitute violations of the FCA. Violation of conditions of payment, alone, does not conclusively establish that a violation is material, but it is probative evidence of materiality.

Secondly, this court examines whether the Government would deny Defendants' reimbursement payments had it known of the violations.

Thirdly, this court looks at whether the noncompliance was minor or insubstantial. As stated in *Escobar* and *Lemon*, if a reasonable person would attach importance to the violation in determining his choice of action in the transaction, it is material. Even if a reasonable person might not attach importance to the representation, it is still material if the defendant had reason to know that the recipient of the falsity would attach importance to it. *Lemon* at 163 (citing *Escobar* at 2002-2003). A reasonable person would attach significance to an annual salary in excess of a million dollars for an executive of a small 25-bed hospital, especially when the payee did not perform eligible work for the hospital to receive that salary. A reasonable person would also attach significance to a hospital administrator's salary that approached twice what was a reasonable amount for a small 25-bed

hospital, when little work was done that qualified as a Medicare-reimbursable expense. A reasonable person would certainly attach significance to these monies when being paid to the owner of the hospital and his wife. The violations here alleged, are not minor.

Looking at the nature of the violations with this holistic approach, one simply cannot say that these violations were not material. The jury found the violations to be material, and nothing presented here gives this court any basis for disturbing that finding.

At the heart of Defendants' arguments regarding materiality is that Defendants say the Government continued to pay the claims despite thirteen years of investigation and litigation and, that Defendants were not notified that the costs they were claiming were potentially improper. Shortly after the Government made its decision to intervene, however, it notified Defendants of the litigation and the allegations. Yet while the Government was still peeling back the layers of deception, the Defendants not only continued to perpetrate their ongoing fraud, but fought fervently to prevent disclosing information to the Government, to the point of being held in contempt by this court for failing to respond to Investigative Demands served on them by the United States and filing to comply with the orders of this court. While the Defendants knew of the falsities of the statements and reports they were submitting to Medicare, the Government was still discovering the extent and the manner of perpetration of the fraud.

In the cases relied upon by Defendants to show the immateriality of the false claims, either the allegations,

themselves, were minor, inconsequential, or immaterial, without regard to whether they were material to the Government's payment decision, or the Government had not taken any action such as the Government's action here to intervene in the Relator's lawsuit and vigorously prosecute.

Attempts to Conceal

Attempts to conceal false reports or false statements have a bearing on both scienter and materiality. Concealment is evidence of a defendant's subjective knowledge of the importance of that information to the Government. See *United States ex rel. Badr v. Triple Canopy,* 857 F.3d 174, 175-78 (4th Cir. 2017).

Sandra Rose worked for a contracted intermediary, a MAC, described by her as a company contracted by Medicare to perform audits and handle the reimbursement issues. These companies were formerly called Fiscal Intermediaries (FI) and are currently referred to as Medicare Administrative Contractors, or MAC's. In 2009, Sandra Rose, a contract auditor, conducted a "desk audit" of CMI's 2007 cost statement. This is not a full audit, as explained by Sandra Rose in her testimony, but a limited review. The "desk audit" did not involve going to CMI to conduct the review, but was done from her desk. She said they take the information provided to them. They calculate variances to see where they should spend their time to investigate anything that appears unusual.

Rose questioned a huge increase in the salaries of officers and the salaries of others for the year 2007. In response, Defendants informed Rose that CMI had

undertaken management of three new health providers, Green County RHC, Green County Hospital, and Poplarville Family Medical Clinic. This had led to more management salaries, they said. This seemed a reasonable explanation and was accepted by Sandra Rose as justification for the increase in executive compensation. Sandra Rose testified that she had no recollection of reviewing anything concerning Stone County Hospital and the documents she reviewed related to her desk audit did not indicate she had looked at the Stone County Hospital cost report.

While it may have been true that CMI was managing additional companies, it was not true that this was in any way responsible for the huge increase in officer compensation. What Sandra Rose did not realize was that it was Ted Cain's salary that had increased by over one million dollars between 2005 and 2007, and that 82% of that salary was being allotted to SCH. Rose said she did not notice the 2.27 million of Ted Cain's salary being allocated to Stone County Hospital when she was doing her desk audit. She also would not have known, looking at schedule B,[3] that SCH was a critical access hospital, because there were no provider numbers next to the entities. Had she been aware that this particular entity, as a critical access hospital, was allocated over $2 million dollars for salaries, she would have notified a supervisor and requested they go further with potential fraud and abuse.

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[3] According to George Saitta, the Government's expert, Schedule B is the trial balance of expenses on the office cost statement.

Rose testified that two million dollars for administrative purposes for a critical access hospital is not reasonable. Under the regulations, reasonable compensation for physicians is $300,000 or below, and these are the people actually treating the patients. Over $2 million dollars for administrative purposes is not reasonable. Rose thought the figures for CMI officers' compensation related to more than one CMI officer. Officers other than Ted Cain were listed on the CMI home office statements, she noted. Also, her letter to Suzanne Epperson at CMI, referred to "officers" in the plural. *Rose Letter* P-213 [ecf doc. no.436- 9]. Defendants concealed that information, however, by misleading or false statements.

Sandra Rose was distraught that she did not detect the true facts concerning Ted Cain's salary. On cross examination she admitted that Ted Cain's salary amount was contained in another document submitted to MAC, but she did not put all of the information together in a way to understand the true salary.

It was George Saitta's testimony that a review of Schedule B, particularly line 11 for salaries of officers contained nothing that would alert Sandra Rose that there was only one officer there and it does not mention Ted Cain. Saitta also testified that the information about the additional health care providers being managed by CMI, as contained in Sandra Rose's letter of April 7, 2009 to Suzanne Epperson, could only have come from CMI. Only CMI could have provided the names of the providers and the dates they were acquired.

Despite not realizing the full implication of the salary information, Sandra Rose was concerned enough to flag the issue for future auditors, suggesting that they look closely at costs going between entities that are related parties. Trial Exhibit D-34. Rose testified that CMI had provided some information to her, but she did not get information that she could tie back to understand those high salaries and whether they were really applicable to patient care. 1/24/20 Tr. pp. 58-60 (Sandra Rose). She had also recommended that the allocation bases be reviewed in future years. She further explained that for compensation of officers, the basis is generally a time study. The time study would explain the actual hours someone worked, what they did for those hours, what entity was benefitted by that work, and what was being done that benefitted patient care. 1/24/20 Tr. 59:6- 61:25 (Sandra Rose).

The Government's expert, George Saitta, testified that his review of the relevant documents indicated that CMI misinformed Sandra Rose about the reason for the increase in CMI office compensation. 2/5/20 Rough Tr. 182:4-185:5 (George Saitta).

The response provided by the Defendants was untrue. The three additional small health providers did not cause the huge increase in compensation. Defendants then, were clearly aware that the salary amount for Ted Cain would be material to the Government's pay decision. Otherwise, there would have been no reason to fabricate or mislead.

This episode provided the jury with additional evidence on which to base its finding of materiality.

False Certification Theory and
Implied False Certification Theory

The Court of Appeals of the Eleventh Circuit recently tackled the issue of when violation of a condition of payment constituted a False Claims Act violation. In *Ruckh v. Salus Rehab., LLC*, 963 F.3d 1089, 1103–04 (11th Cir. 2020), relying on *Escobar,* the Court said "[t]he FCA is designed to protect the Government from fraud by imposing civil liability and penalties upon those who seek federal funds under false pretenses." *Id.* at 1103-03 (citing *United States ex rel. Lesinski v. S. Fla. Water Mgmt. Dist*., 739 F.3d 598, 600 (11th Cir. 2014)). "Liability under the [FCA] arises from the submission of a fraudulent claim to the government, not the disregard of government regulations or failure to maintain proper internal procedures." *Urquilla-Diaz v. Kaplan Univ.,* 780 F.3d 1039, 1045 (11th Cir. 2015) (quoting *Corsello v. Lincare,* Inc., 428 F.3d 1008, 1012 (11th Cir. 2005)); see also *McNutt ex rel. United States v. Haleyville Med. Supplies, Inc.,* 423 F.3d 1256, 1259 (11th Cir. 2005) ("The [FCA] does not create liability merely for a health care provider's disregard of Government regulations or improper internal policies unless, as a result of such acts, the provider knowingly asks the Government to pay amounts it does not owe.") (quoting *United States ex rel. Clausen v. Lab. Corp. of Am., Inc*., 290 F.3d 1301, 1311 (11th Cir. 2002)). "Simply put, the 'sine qua non of [an FCA] violation' is the submission of a false claim to the government." *Urquilla-Diaz*, 780 F.3d at 1045 (quoting *Corsello,* 428 F.3d at 1012).

The Eleventh Circuit has adopted a false certification theory of liability under the FCA. Under this theory, a defendant may be found liable for falsely certifying its compliance with applicable laws and regulations. To prevail under this theory, the relator or the Government must prove the following: (1) a false statement or fraudulent course of conduct; (2) made with scienter; (3) that was material; (4) and caused the government to pay out money or forfeit moneys due. *Ruckh v. Salus Rehabilitation, LLC* at 1103 (quoting *United States ex rel. Hendow v. Univ. of Phoenix,* 461 F.3d 1166, 1174 (9th Cir. 2006)).

The First Circuit Court of Appeals described what became known as the "implied false certification theory", as follows. Submission of claims for reimbursement does implicitly represent compliance [with the applicable laws and regulations] and an undisclosed violation of a precondition of payment makes a claim false. On appeal, the United States Supreme Court, resolving a split among the circuits concerning implied certification liability, confirmed that failure to disclose a violation could be the basis for an FCA claim, but the failure to disclose the violation must be in fact or likely, material to the decision to pay the claim.

The Supreme Court, in *Escobar*, upheld the implied false certification theory, stating that in at least some circumstance, it can provide a basis for liability under the FCA. *Universal Health Services, Inc. v. United States ex rel. Escobar*, 579 U.S. ——, 136 S.Ct. 1989 (2016). The Court first held that "the implied false certification theory can, at least in some circumstances,

provide a basis for [FCA] liability." *Escobar,* 136 S. Ct. at 1999. The Court explained that the FCA's prohibition against the submission of "false or fraudulent claims" is broad enough to "encompass[ ] claims that make fraudulent misrepresentations, which include certain misleading omissions." Id. "When ... a defendant makes representations in submitting a claim but omits its violations of statutory, regulatory, or contractual requirements, those omissions can be a basis for liability if they render the defendant's representations misleading with respect to the goods or services provided." *Id.*

Accordingly, the Court held that the implied certification theory can serve as a basis for FCA liability where at least two conditions are satisfied: (1) "the claim does not merely request payment, but also makes specific representations about the goods or services provided" and (2) "the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths." *Id*. at 2001.

The Fifth Circuit, in *United States ex rel. Porter v. Magnolia Health Plan, Inc.*, invoked the Supreme Court's recent holding in *Universal Health Servs., Inc. v. U.S. ex rel. Escobar*, in emphasizing the FCA's "demanding" and "rigorous" materiality requirement. In that case, however, the Fifth Circuit noted that no violation had occurred. Contrary to the Relator's allegations, the employer's contracts with the State of Mississippi did not require that "licensed registered nurses" do the jobs the Relator claimed were being done by "licensed practical nurses." The Fifth Circuit

also echoed *Escobar* in saying the mere fact that contracts contain language requiring the employer to comply with "all applicable laws" does not establish the requisite materiality for FCA liability. "[B]road boilerplate language generally requiring a contractor to follow all laws . . . [is] too general to support a FCA claim." *Id.* at * 11-12. Thus, even if the employer had violated Mississippi law, the Fifth Circuit reiterated that was not sufficient to establish the requisite materiality for a FCA case.

An unreported case from the District Court of the District of Columbia is elucidatory. In *U.S. ex rel. Scutellaro v. Capitol Supply, Inc.,* 2017 WL 1422364 (D.D.C. April 19, 2017), the relator alleged that the defendant falsely certified that the products it sold to United States Government agencies were manufactured in compliance with the federal statutes that required that products sold to the government come only from certain countries. The materiality of the misrepresentation was at issue, since the defendant had apparently been given mixed messages about its compliance or non-compliance with these laws and regulations. Capitol Supply Inc. was repeatedly awarded contracts by the regional office of the Government Services Administration (GSA) and receiving excellent ratings from that office; but it was also receiving regular notices for contract breaches for non-compliant products from GSA's New York office. It had received at least seventeen such notices of non-compliance while receiving high marks from the regional office. The notices stressed the importance of complying with these laws and the seriousness of the consequences, including the possibility of a lawsuit

under the FCA. At one point a Cure Notification Letter was sent to the company, declaring its level of performance to be unacceptable. *Id.*

Reviewing this evidence on a motion for summary judgment, the judge in *Scutellaro* stated: "Given GSA's mixed signals, issues of material fact remain as to whether the impliedly false certifications were material, i.e., whether TAA [Trade Agreements Act] compliance had the "natural tendency to influence ... the payment or receipt of money or property." *United States ex rel. Scutellaro v. Capitol Supply, Inc.,* 2017 WL 1422364, at *21 (D.D.C. Apr. 19, 2017) (citing *Escobar,* 136 S. Ct. at 2002). There, as in the instant case, the issue of materiality was a fact question for the jury.

In the case *sub judice* Defendant attempts to characterize the processing of the annual cost reports by the FI or MAC as some sort of approval or legitimization of its efforts. It is clear from the evidence, however, that the MAC was unaware of what the large salary figure on the cost reports and on the home office cost statements represented. Sandra Rose, a MAC employee, testified that she had not been able to discern from the documents that the salary figure represented *only* Ted Cain's salary or that the entire salary amount was allocated to Stone County Hospital. Had she realized that, she would have prompted additional action, she testified.

Ted Cain, it must be remembered, owned several health-related enterprises. The logical assumption in viewing the cost reports and cost statements would be that this salary figure represented salaries for

executives over several of the health care providers managed by CMI, and that the allocation was spread across all of these entities. After the "desk audit" conducted on the 2007 cost reports, Defendants perpetuated this misconception by how they responded to the inquiry.

Certainly by 2010, when the Government informed the Defendants of the Relator's FCA lawsuit, Defendants knew that there were serious compliance issues. These Defendants knew that compliance with regulations regarding owner compensation had the natural tendency to influence the government's payment decisions.

Holistic approach

Escobar made it clear that no one factor was dispositive in deciding the issue of materiality. Materiality, the court said, cannot rest on a "single fact or occurrence as always determinative." *Id*. at 2001 (quoting *Matrixx Initiatives, Inc. v. Siracusano,* 563 U.S. 27, 39, 131 S.Ct. 1309, 179 L.Ed.2d 398 (2011)). Several circuits, including the Fifth Circuit describe this test as "holistic." See *United State ex rel. Harman v. Trinity Indus. Inc.,* 872 F.3d 645, 661 (5th Cir. 2017); *United States ex rel. Escobar v. Universal Health Servs., Inc.*, 842 F.3d 103, 109 (1st Cir. 2016) (*Escobar II*); *United States v. Brookdale Senior Living Cmtys., Inc.*, 892 F.3d 822, 831 (6th Cir. 2018), *cert. denied sub nom. Brookdale Senior Living Cmtys., Inc. v. United States ex rel. Prather*, 139 S. Ct. 1323 (2019); *United States ex rel. Janssen v. Lawrence Mem'l Hosp.*, 949 F.3d 533, 541 (10th Cir. 2020), *cert. denied sub*

nom. United States, ex rel. Janssen v. Lawrence Mem'l Hosp., 141 S.Ct. 376 (2020).

As stated in *Bibby v. Mortgage Investors Corporation,* " the significance of continued payment may vary depending on the circumstances." *Bibby v. Mortgage Investors Corporattion,* 987 F.3d 1340, 1350 (11th Cir. 2021) (citing *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 906 (9th Cir. 2017) (cautioning that "to read too much into the [agency's] continued approval –and its effect on the government's payment decision – would be a mistake" where there were other reasons for that approval). In Bibby, the Court said, there were reasons for the VA's continued payment other than the violations being immaterial. In that case, the VA was required by law to honor the guarantees and to pay holders in due course, even in the face of fraud by the original lender.

In the case before this court, a cessation of Medicare payments would have, in all likelihood, closed the hospital and foreclosed accessible emergency care for residents of Stone County, Mississippi. The United States chose to seek redress by intervening in the Relators' suit. As the *Bibby* Court said, courts must cast their materiality inquiry more broadly to consider "the full array of tools" at the [agency's] disposal "for detecting, deterring, and punishing false statements…" *United States ex rel. Bibby v. Mortg. Invs. Corp.,* 987 F.3d 1340, 1350 (11th Cir. 2021), cert. denied sub nom. *Mortg. Invs. Corp. v. U.S. ex rel. Bibby,* No. 20-1463, 2021 WL 1951877 (U.S. May 17, 2021).

The jury's finding that falsity on the cost reports as to this issue was material, is consistent with the law

and the evidence, and the jury's verdict should not be disturbed.

Unjust Enrichment and Payment by Mistake of Fact

At trial, the jury found Ted Cain, Julie Cain, and CMI to be liable for unjust enrichment. SCH was found to be liable for payment by mistake of fact.

Defendants contend, in their Motion for Judgment as a Matter of Law, that the Government's claims against these Defendants for unjust enrichment and payment by mistake of fact should be dismissed. Defendants further claim, in their Motion for a New Trial, that the findings on these issues were against the clear weight of the evidence.

The *Academy Health* case, cited by both Plaintiff and Defendants, lists three elements of a common law unjust enrichment claim: (1) the Government confers a benefit upon a defendant; (2) the defendant retains the benefit; and (3) any one of the following three alternatives applies: (a) the Government had a reasonable expectation defendant would repay the benefit, (b) defendant should reasonably have expected to repay the benefit to the Government, ***or*** (c) society's reasonable expectations would be defeated if defendant did not do so. *U.S. ex rel. Academy Health Ctr., Inc. v. Hyperion Foundation, Inc.,* 2014 WL 3385189 *46 (S.D. Miss. July 9, 2014); *U.S. ex rel. Roberts v. Aging Care Home Health, Inc*., 474 F. Supp.2d 810, 819-821 (W.D. La. Feb. 16, 2007).

Agreed Jury Instruction No. 30 tracked the language of *Academy Health* exactly, but substituted

"the federal Medicare program" wherever "the Government" appeared. The jury was properly instructed according to the law and this jury instruction, as stated several times above, was agreed upon by both sides. All three elements of unjust enrichment are met. The Government conferred a benefit; defendants kept the benefit; and society's expectations were defeated since Defendants did not make proper repayment under the circumstances here. The jury's findings clearly were not against the weight of the evidence.

The evidence at trial showed that despite being paid over a million dollars in salary most years, as President of CMI, Ted Cain performed almost no work for Stone County Hospital. On those rare occasions when he was present, he did not perform work that was reasonably related to patient care, as required by the PRM. Ted Cain was thoroughly questioned on this point during the trial, but failed to testify as to any meaningful work he had done for Stone County Hospital. The jury found he had not performed any significant work.

The evidence showed that Julie Cain, though receiving a full-time salary as administrator of the hospital, was present on a part-time basis only; and, in other years, she performed little or no work as a paid member of the board of directors. Additionally, neither Julie Cain nor any of the other witnesses could tell the jury of any work she performed as a paid consultant to the hospital. The jury though, credited Julie Cain for the limited work she did as administrator of the hospital, and reduced the amount of her liability downward, accordingly.

Ted Cain was the president of CMI, which served as the home office for SCH, as well as the administrator for other Ted Cain companies. In addition to receiving reimbursement for Ted Cain's unearned salary, CMI was reimbursed by Medicaid for the rent it paid, which included rent for other Ted Cain companies that were housed in that same building, or for which CMI was also performing administrative duties. Ted Cain, Julie Cain and CMI were all unjustly enriched by the Government's payment/reimbursement to them for the exorbitant and unearned salaries paid to Ted and Julie Cain and additional expenses associated with CMI that were incurred by Ted Cain's other businesses. Neither judgment as a matter of law, nor a new trial is appropriate as to this issue. Even if it were, however, the jury also found these Defendants liable for submitting or causing fraudulent cost reports to be submitted in violation of the FCA.

To prevail on a claim for payment by mistake of fact, say Defendants, the Government must show: 1) the Government made payments to a defendant under an erroneous belief; and (2) the erroneous belief was material to the Government's decision to pay a defendant. *U.S. v. Wurts,* 303 U.S. 414, 415-416 (1938); *United States ex rel. Academy Health Ctr., Inc. v. Hyperion Foundation, Inc.,* No. 3:10-cv-552-CWR-LRA, 2014 WL 3385189 at *46 (S.D. Miss. July 9, 2014) (quoting *United States v. Mead,* 426 F.2d 118, 124 (9th Cir. 1970)); *U.S. ex rel. Roberts v. Aging Care Home Health, Inc.*, 474 F. Supp.2d 810, 821 (W.D. La. Feb. 16, 2007). Whereas "materiality" is not an element of unjust enrichment, see *Academy Health*, 2014 WL

3385189 *46; *Roberts,* 474 F. Supp.2d at 820, it is at issue in our discussion of payment by mistake of fact.

Defendants say that the testimony of William Tisdale established that the United States did not pay Defendants in error, but, instead, made a deliberate choice to pay. Thus, say Defendants, the premise for payment was not erroneous.

Defendants again rely on their arguments on materiality to say that the erroneous belief had to be one that was material to the decision-making. This court has earlier resolved the issue of materiality in favor of the Government and against Defendants. This court notes that the Government, through the Department of Justice, investigated the *qui tam* complaints and filed this FCA lawsuit, but with an eye toward protecting Medicare beneficiaries by ensuring that accessible hospital care remained available in Stone County.

Julie Cain's Liability

Defendants contend that Julie Cain had no liability under the FCA because she did not prepare or sign the cost reports. Under the FCA, however, liability is not limited to those who submit the false reports. Those who "cause" false reports to be submitted are also liable. The jury found her liable for portions of her compensation and for all of Ted Cain's compensation during the years that she was the administrator of SCH and for all of her compensation for the consulting work and the director's fees she was paid that evidence showed she did not earn.

Ted Cain, the owner, appointed her, his wife, as administrator of the SCH, despite that she had no experience running a hospital. Her salary was approximately twice that paid to prior and subsequent administrators or Chief Operating Officers who performed the hospital administrator role. It was Julie Cain, as administrator of the hospital, who signed the management agreement with CMI, which allowed the fraudulent scheme to take place. She then turned a blind eye to the costs charged by CMI, including her husband's extravagant salary. Her testimony was that she never tried to see if the costs were reasonable or in compliance with the management agreement. In her testimony she said it was because she knew and trusted the people at CMI. Julie Cain looked the other way when it came to costs from CMI, including her husband's extravagant salary. She admitted that she was unfamiliar with what kind of records were kept of CMI's services rendered to the hospital or the amounts being charged. 2/3/2020 Tr. Deliberate indifference does not remove a defendant from exposure to liability under the FCA.

Julie Cain also collected compensation every year as the hospital administrator that was reimbursed by Medicare, yet testimony showed she was not present very often and did very little work. Lenora Bayes Ramstad, a nurse practitioner formerly employed at SCH, said she saw Julie Cain maybe once a month or every few weeks. She did not know if Julie Cain had an office at the hospital. Sherla Harville, Director of Clinical Operations, testified that she was present five days a week at SCH. She saw Julie Cain sometimes

one or two days a week, and sometimes there were weeks where she didn't see her at all.

According to Harville, when Julie Cain was there, she did not stay all day. Harville also stated that Starann Lamier had told her she [Starann Lamier] knew Julie Cain was not there all the time, but if she was there, Harville should include her. 2/4/2020 Tr. 113:20-25, 119:3-7 (Sherla Harville). An email chain was introduced into evidence between Chief Operating Officer ("COO") Don Kannady, and Starann Lamier, dated June 26, 2007, in which Kannady informed Lamier that he had waited for Julie Cain to come in to the office for the last 2 weeks to discuss an issue and Julie Cain had "not been available for me to communicate with since Monday, June 11, 2007, when she was on site at SCH for just a couple of minutes, and I had not seen nor heard from her since then." Trial Exhibit P-296 [doc. no. 436-20]. Kannady testified that Julie Cian was hardly there that much, roughly 25% of the time. He said he was hired to run the hospital and he did everything he could, so she wouldn't have to worry about it.

Defendants also offered witnesses to show that Julie Cain did perform reimbursable work. Julie Cain, Starann Lamier, Tammy Harrell and Telecia Welborn testified that Julie Cain did the work of a hospital administrator, which included running the day-to-day operations of the hospital, making personnel decisions, involvement in employee evaluations and raises, updating hospital procedures, organizing activities to improve the hospital's public image, and attending at least some weekly meetings. Tammy Harrell. See

Defendants' Ex. 1 to the Motion [doc. no. 432-1 pp. 25-37, 80-93, 94-101,102-29].

For most of the time that Julie Cain held the title of Hospital Administrator, this small hospital also had a Chief Operating Officer (COO) on the payroll. This 25-bed hospital, according to Julie Cain, only had an occupancy rate of between three and twenty patients. Vicky Garrettson estimated it was around ten to fifteen per day. Yet, SCH employed a hospital administrator, a COO and a Chief Financial Officer (COO), in addition to having CMI under contract to provide administrative services. Darlene Odom, SCH's former Business Office Director, testified that the practice of having both an administrator and a COO was put in place only after Ted Cain became owner of the hospital. Prior to Ted Cain's purchase of it, SCH only had an administrator and a CFO (Chief Financial Officer), and no COO. *Id.* at 97:16-98:9

Multiple witnesses, including Donald Kannady, Vicky Garrettson, Jennifer Barringer, and Julie Cornelson, testified that the hospital was not run by Julie Cain but by the COO or by Starann Lamier. Vicky Garretson said the COO ran the quality team meetings most of the time, that Julie Cain only attended about 25% of the time, but she did run some of the meetings if she was there. Lenora Bayes Ramstad testified that she did not know if Julie Cain had an office at SCH, but she knew that Allen Gamble, the COO, had an office there; and whereas she rarely saw Julie Cain, she saw Allen Gamble almost daily. Sherla Harville also testified it was the "little administrators" (as she referred to the COO's) from whom she received follow-

up on her reports, and not Julie Cain, although she had provided copies of the reports to Julie Cain. Former COO Don Kannady referred to Julie Cain in his testimony as an "administrator in absentia." 1/31/2020 Tr. 103:13-18 (Kannady).

When pressed to explain the duties of the COO, Julie Cain listed many of the same duties that she claimed to perform. 2/3/2020 Rough Tr. 25:11-26:18. Mrs. Cain also admitted to not being very computer savvy. Rough Tr. 24:13-25. She did not use email very much she said, preferring to use the telephone or talk to people on the floor. Her own testimony evinced she was not familiar with very much concerning the operation of the hospital, and had virtually no knowledge of the services CMI performed for SCH. 2/3/2020 Rough Tr.30:1- 33:23.

Julie Cain, incredibly, also testified that she did not know how much her salary was, did not know who set her salary, and did not keep up with what went into her checking account. As incredulous as that seems, even if true, she is still held accountable to Medicare for expenditure of hospital funds that Medicare reimburses. She had a duty to ensure that her compensation was reasonable and necessary and that it complied with the rules and regulations of Medicare and the PRM.

Owners of Medicare-reimbursed providers are subject to special provisions under the PRM. Chapter 9 of the Provider Reimbursement manual provides, "A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function (42

CFR 413.102)." PRM § 900. Exhibit P-168 [ecf doc. no. 436-5 p. 3]. Compensation paid to spouses of owners is also reviewable under the test of reasonableness. Id. at §902.5.

The PRM defines "reasonableness" and "necessary" in the context of owners' salaries, as follows:

> 902.3 Reasonableness.--Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions depending upon the facts and circumstances of each case. Reasonable compensation is limited to the fair market value of services rendered by the owner in connection with patient care. Fair market value is the value determined by the supply and demand factors of the open market.
> 902.4 Necessary.--Necessary means that had the owner not furnished the services, the institution would have had to employ another person to perform those services. The services must be pertinent to the sound conduct and operation of the institution.

PRM § 900. Exhibit P-168 [ecf doc. no. 436-5 p. 3].

Julie Cain's compensation while at SCH ranged from a low of $198,917 annually in 2004, to a high of $279,000 in 2011. P-271B [ecf doc. no. 436-16 p.1]. Her compensation in 2012 was even higher, $297,470, but she was the Hospital Administrator for only part of that year, and was paid by CMI for part of that year. The jury heard testimony from some witnesses who related work that Julie Cain did, and from others who

testified that they rarely, if ever, saw her in the building and often could not reach her for hospital business. There was sufficient evidence presented for the jury to find that she received compensation that she did not earn. The jury apparently found that Julie Cain did some reimbursable work for the hospital, however, since the jury did not find her liable for the full amount that the Government argued she was liable for.

After she resigned as the hospital administrator in 2012, Julie Cain continued to receive compensation as a member of the board of directors for SCH as a consultant. In 2012 she was paid over $20,000 as a director's fee. Defendants cite to Julie Cain's own testimony as evidence of her work in these roles. Julie Cain's testimony was that everything she did was reasonable and necessary. Julie Cain's testimony, however, also showed that she was unclear about what director's fees were, she kept no records of any work that she did as a consultant, and despite acknowledging that she had been paid at least $111,000 in 2013 for consulting, she could not recall any matters on which she had worked. [ecf doc. no. 432-1 pp. 62-67].

For the years 2013 through 2015, Julie Cain was paid over $100,00 each year, a portion of which was billed to Medicare,; but when questioned about her work on the board of directors or as a consultant, Julie Cain could not identify what she did to earn these funds.

There was sufficient evidence from which the jury could find that Julie Cain's compensation was not

reasonable or necessary and mostly unearned. The jury's finding against her has a strong legal basis. Julie Cain assisted with the fraud committed by Ted Cain and the others, causing the submission of false claims and the making of false records and documents. Additionally, in her role as hospital administrator, she signed the management agreement with CMI, then (even if she is to be believed) looked the other way, with reckless disregard of its misdeeds. Of course, the jury could reasonably have disbelieved her entire incredible testimony.

The jury correctly found that she was liable under the FCA; she also certainly was unjustly enriched, as the jury ably found, since she had received compensation above and beyond any work she said she performed.

Tommy Kuluz

Tommy Kuluz was the Chief Financial Officer (CFO) of CMI. He assisted Ted Cain in the initial application for Critical Access Hospital status for SCH in 2001, allowing for the hospital to bill for allowable costs plus 1%. Kuluz handled all the financials, and signed all but one of CMI's home office cost statements. The fraud would not have been possible without his participation. Kuluz also executed the CMI management agreement with SCH. This enabled CMI to route Ted Cain's compensation *through* SCH's cost reports by permitting CMI to charge SCH up to 15% of net patient revenue. P-278 [ecf doc. no. 436-19].

According to Tommy Kuluz's testimony, he was the one who received the data gathered by SCH employees

for the cost report and it was he who communicated with, and provided information for, the cost report preparers. Craig Steen, a cost report preparer, testified by deposition that the cost reporting firm would send Kuluz a blank workbook that he [Kuluz] would fill out. Tommy Kuluz owned the cost reporting software and could open the report and change things if wanted, before submitting it to Medicare. *Steen Dep.* 83:15-84:1, On at least one occasion, Steen said, Kuluz did just that, changing the report regarding physician compensation. *Id.* at 25:25-27:1. Tommy Kuluz would then submit the final version of the report, without the preparer seeing it again.

A.V. LaRocca was the cost report preparer for CMI for most of the period at issue here. He testified that he was under the impression that Ted Cain's salary was *not* being charged to the government, and only found out differently during his deposition in 2014. He was under this impression based on the numerous nursing home cost reports he had done where the related party transactions were brought down to fair market value. Related parties are organizations related to the provider by common ownership or control. 42 C.F.R. § 413.17. Ted Cain owns and controls CMI, the management company that pays his salary, and the health care provider, SCH.

Contracts between related parties are not negotiated at arms' length, so the regulations and the PRM have special provisions for dealing with related parties. As Sandra Rose testified, this includes owners' compensation. The compensation for owners and their spouses also has limiting provisions under the

regulations and the PRM, as discussed elsewhere in this Opinion.

A.V. LaRocca had actually erroneously testified at his prior deposition, that Ted Cain's salary was not being charged to the Government, based on that mistaken assumption. He testified that he thought most of Ted Cain's salary was being eliminated through the related party step. It was pointed out to him at that time that the salary was not being eliminated; "it was flowing right through to the direct costs reimbursed." 1/28/20 Tr. 20:18-24 (LaRocca). He later confirmed that for himself, he testified. 1/28/20 Tr. 19:14-20:25 (LaRocca). LaRocca added that he thought the salary was unreasonable because of the amount involved and given the size of the facility.

While being questioned by Attorney Morris about Ted Cain's $1.89 million-dollar salary for 2008, LaRocca said the $1.544 million-dollar figure "represents the amount of Ted Cain's salary, that's allocated directly to Stone County Hospital. Asked who did that direct allocation to Stone County Hospital, LaRocca answered, "[t]hat would have been Tommy Kuluz." *Id.* 19:11-13.

Tommy Kuluz directly allocated a portion of Ted Cain's salary to SCH to be reimbursed by Medicare. On questioning by Attorney Morris about Government's Exhibit 8 (P-8) the 2005 cost report statement, A.V. LaRocca testified as follows:

> Q. Do you see there's the same language here, "Per Tommy Kuluz at the facility, the following costs are to be directly allocated to Stone County

> Hospital." And the direct allocation is 80 percent?
> A. Yes, I see that.
> Q. And again, did your firm have anything to do with determining that direct allocation?
> A. We did not.
> Q. Do you know how Mr. Kuluz determined it?
> A. I do not.
> Q. Did you get any backup or supporting documents for that?
> A. We did not.

1/28/20 Tr. 18:14-25 (A.V. LaRocca).

Tommy Kuluz was a major player in this fraudulent scheme. The jury was presented with sufficient evidence that Tommy Kuluz made or caused to be made false reports to Medicare. Factual and legal liability was unmistakably established.

Claims Regarding Ted Cain's Salary

Defendants next contend that all claims regarding Ted Cain's salary should be dismissed. They cite two reasons for this. Defendants say there is no evidence that (1) Defendants presented a knowingly false claim concerning Ted Cain's salary or (2) the amount of Ted Cain's salary was material to the government's payment decision.

Did Defendants submit a knowingly false claim?

As previously discussed, liability under the FCA requires presentment of a "knowingly" false claim. 31 U.S.C. §3729(a). Defendants seemingly contend that the claim was not "false", since Ted Cain's salary was

listed on each cost report submitted for 2004-2009[4], and the amount was the true and accurate amount of his salary. Furthermore, say Defendants, the FI or MAC never made any adjustment to the Medicare Reimbursement sought for Ted Cain's salary, even after an audit of the salaries of officers for the 2007 cost reporting year, which took place in 2009. Therefore, say the Defendants, they could not have known the salary amount was unreasonable.

The False Claims Act defines "knowing" and "knowingly" as follows:

> (1) the terms "knowing" and "knowingly" –
>
> (A) 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; and
>
> (B) require no proof of specific intent to defraud;

Title 31 U.S.C. § 3729(b)(1).

The United States responds that unlike the FI or the MAC, Ted Cain *knew* he was not doing anything to earn his salary and he *knew* that was in violation of the

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[4] After the Department of Justice had sent a letter to CMI in 2010, informing Defendants of the litigation and the claims against them, Defendants changed the methodology for allocation of Ted Cain's salary from a direct allocation to a "pooled" allocation.

specific requirements for owners' compensation under the PRM. Ted Cain knew, then, that his claims submissions were false. Also, Ted Cain's compensation was difficult to discern from the home office cost statements and *not* disclosed to the FI or the MAC as Defendants maintain. Sandra Rose, a MAC auditor who reviewed the home office cost statements of CMI, was under the impression that Ted Cain's salary amount represented salaries (plural) -- that it represented compensation for executives for several of his health provider companies, as she testified, and as shown by her use of the plural "salaries" in her correspondence with CMI of April 7, 2009 [doc. no. 436-9]. Additionally, since she was not the one reviewing the SCH cost reports, she was not aware that Ted Cain's salary was being allocated primarily to a Critical Access Hospital. That would have raised a red flag, she testified, and she would have alerted her supervisor to the possibility of fraud or abuse. Limits are placed on other kinds of hospitals, Rose said, that would have curtailed the amount of compensation Ted Cain could have received. Only Critical Access Hospitals are reimbursed at 100% of allowable costs, plus 1 percent.

Since the MAC was not aware of the amount of Ted Cain's salary, the MAC was not reviewing the reasonableness of Ted Cain's salary amount. The MAC also would not have been aware that Ted Cain was not actually performing any services for SCH, so it certainly was not passing on whether his services were performed in a necessary function or were related to patient care.

Arguably, even if the amount of Ted Cain's compensation could be considered reasonable for a non-related party, Chapter 9 of the PRM provides additional requirements for owners of a health provider company being paid for services to that provider. The PRM states that: "[a] *reasonable* allowance of compensation for services of owners is an allowable cost, provided the services are *actually performed* in a *necessary* function." *PRM* at §§ 900, 903.4 [ecf doc. no. 436-5 p. 3]; 42 C.F.R.413:102. Ted Cain acknowledged in his testimony that he was familiar with this requirement. Therefore, he "knew" that he was submitting a false claim, because he knew that he had not *actually performed t*he work.

Under the FCA, "knowing" does not required proof of intent to defraud. "Knowing" also includes acting in deliberate ignorance and acting with reckless disregard of the truth or falsity of the information. 31 U.S.C. §3729(b)(1). Defendants knew that Ted Cain's compensation in the amount of millions of dollars was unreasonable, or acted in deliberate ignorance by avoiding conducting any studies or comparisons that would have documented what constitutes a reasonable salary for a person in his position at an institution comparable to SCH. At the very least, Ted Cain and his cohorts acted with reckless disregard of the truth or falsity of that fact.

Further, services performed by an owner, in order to be compensable under Medicare regulations, must be related to patient care. See PRM §§ 902.2 and 902.3, [doc. no. 436-5 p. 3]. The PRM provides as follows:

> Compensation may be included in allowable provider cost only to the extent that it represents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the facility and furnished *in connection with patient care*. Services furnished in connection with patient care include *both direct and indirect activities in the provision and supervision of patient care*, such as administration, management, and supervision of the overall institution. Costs of activities not related to either direct or indirect patient care, e.g., *those primarily for the purpose of managing or improving the owner's financial investment, are not recognized as an allowable cost*. . . .

PRM § 902.2 [doc. no. 436-5 p. 3].

Of the few work related activities Ted Cain allegedly performed, none was related to patient care. They were strictly for the purpose of protecting his investment interest in SCH and/or his other enterprises.

The PRM also required that the provider maintain adequate books and records of cost information, capable of being audited. Section 2304 provides as follows:

> ADEQUACY OF COST INFORMATION
> Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of

> cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

PRM §§ 2304.

According to all of the testimony received, neither Ted Cain, CMI or SCH maintained any auditable documents or records pertaining to Ted Cain's work or the allocation to SCH of Ted Cain's compensation -- no time studies, no description of duties, no records of work performed – nothing to verify the work done for Stone County Hospital.

Ted Cain's compensation was for work not performed at all, for work not performed in relation to patient care, for work that was not necessary, and/or work not performed in compliance with Medicare's record-keeping mandates. Therefore, his compensation was not an allowable cost; and when Defendants submitted claims for reimbursement of Ted Cain's compensation as an allowable cost, that was a false or fraudulent claim.

Ted Cain's work – not reasonable,
not necessary and nonexistent

Most, if not all, of Ted Cain's deposition from 2014 was read to the jury over the course of his examination. That deposition testimony revealed that Ted Cain did not have an office at SCH, did not have a file cabinet or keep records and files in his office at CMI, did not keep timesheets or a calendar, did not regularly communicate with Mr. Williams, SCH's hospital

administrator, and could only describe in very general terms what CMI did for SCH, or what he, himself, did for SCH. He claimed to visit SCH three or four times a month. Asked what he did when he went there, Cain responded that he just looked around. Asked if there was anything else, Cain said that occasionally, he would sit in on meetings that they would have, but he did not direct any meetings. Asked if he had any direct input into purchasing decisions for supplies for SCH, he answered "If it was a day-to-day operation, no, I didn't do that, no." 1/17/2020 Tr. 48:20-49:19 (Ted Cain).

Ted Cain said he made some staffing determinations at the administrative level but was not involved with any other hiring. He said when issues came to him, he discussed them with whomever was going to deal with it. At various times he described his work as "everything in general" and " a lot of things. Cain also said at his 2014 deposition that he did not use the computer until recently, and did not send emails. He could not produce any memoranda, emails, or documents written or generated by him as part of his work activities for SCH.

In his deposition (most of which was read to the jury during his testimony), Cain was unable to describe much at all that he did for the hospital. Likewise, when called as an adverse witness in the Plaintiffs' case, Cain could not describe much that he did for the hospital. When called late in the trial as a witness in the defense case, Cain testified as to some work he said he performed. He said he was involved in approving budgets, reviewed financial reports daily, worked to

improve the hospital's public image in the community, recruited physicians, was involved in all of the big contracts. He said he would go through and observe maintenance issues and he might mention it to Starann Lamier or to the maintenance people to make sure those were taken care of, and that he took steps to get the roof replaced. Cain said that he signed checks, but there was also evidence presented that a signature stamp was also used by others to sign the checks.

On cross Cain could not provide specifics relating to his work and could not point to any documents that would substantiate any of the work he claimed to have done other than some checks and some signed contracts. Ted Cain was on the stand over several days, but in all of that time could not describe in any detail, the work he performed for SCH, and much of the work he claimed to do was not related to patient care.

In his testimony during the trial, Ted Cain said he was at the hospital all the time, that he spent most of his time at the hospital. The jury heard from numerous witnesses who had worked with CMI and SCH, who testified that Ted Cain was rarely present at the hospital, did not conduct any meetings, and did not confer with them. They could not describe anything that Ted Cain did for the hospital.

Tammy Harrell, former Chief Financial Officer (CFO) for SCH, testified that it would be typical to see Ted Cain twice a year at SCH. Lenora Bayes Ramstad, a former nurse practitioner, said she only saw Ted Cain in the cafeteria. It was usually at lunch time, most Fridays, the day they had fish. He would come in the side door, she said, usually wearing his ranch clothes,

then leave by the same side door. Sherla Harville, formerly director of clinical operations for CMI, used SCH as her home base. She too, said she would usually see Ted Cain in the cafeteria or in the hallway as he was coming or going. He was usually there at lunch time, she said, on Wednesdays for fried chicken and Fridays for catfish. Harville said she never worked with him or communicated with him on anything related to patient care or the hospital. If Ted Cain had been doing work related to patient care at SCH she would have known about it, Harville testified.

Vicky Garretson, a former director of medical records for SCH, was asked if she ever saw Ted Cain at the hospital. She saw him in the mornings in the cafeteria, she testified. She, too, said he would typically leave through the door coming out of the cafeteria into the parking lot. She did not know what his role was at SCH other than being the owner, and never worked with him on anything related to SCH. He did not attend the department head meetings, according to Garretson.

Several other witnesses who had worked at SCH and CMI confirmed Ted Cain's lack of work for SCH, including Don Kannady, Darlene Odom and James Williams. Even his wife, Julie Cain, could not state what Ted Cain did at SCH or relating to SCH. Kannady, a former COO, said he saw Ted Cain very little during the time he was there, from around November 2006 to April 2008. When he did see Ted Cain it was in the cafeteria. Kannady, when he was new to SCH, saw Ted Cain in the cafeteria and asked him where his [Cain's] office was. Cain answered,

"right here", referring to the cafeteria. Kannady testified that he never saw Ted Cain do any work at the hospital other than once when they had bought a new ambulance for Ted Cain's ambulance service and once when he was in Julie Cain's office meeting with Julie and Starann Lamier. 1/31/2020 Tr. 89-90. Kannady also testified that they were required to buy supplies for the hospital through Quest Medical, which was also owned by Ted Cain. 1/31/2020 Tr.103:22 -104:14.

James Williams worked for CMI from 2008 until 2012, and became CEO of Stone County Hospital and Nursing Home in 2013, at a salary of $110,000-$115,000 per year. He succeeded Julie Cain who was being paid approximately twice that amount before she left. Williams also had a COO working with him at SCH. Williams said the daily inpatient bed count was around 11 inpatients per day. At the time of his trial testimony in 2020, Williams was the CEO administrator of Pearl River Critical Access Hospital, a 22-bed critical access hospital, at a salary of $146,000 annually (whereas Julie Cain was being paid $250,000 to $270,000 per year).

Williams testified that CMI's management fees seemed high in comparison to fees charged by other management companies for other facilities where he had worked, including a 115-bed nursing home facility and a 95-bed nursing home facility. It must be acknowledged, though, that as testimony showed, operating a hospital is more complicated than operating a nursing home. Nonetheless, Williams, who had worked at both, said he was concerned about the high management fees charged to SCH by CMI, calling

them one of the "big ticket items," "one of the biggest hits we took monthly," and one of the "eye catchers." Williams also testified that Tommy Kuluz called him over to sign the cost report for 2012 and he did not have a chance to review or study it, but was told he needed to sign it so they could get it filed. The same thing happened with the 2013 report. 1/29/2020 Tr. 191-200 (J. Williams).

Williams said they had operational meetings weekly and financial meetings monthly during his tenure. Notably, by this time, the Defendants were aware of this litigation. The Department of Justice had sent a letter to CMI. At the operational meetings, day- to- day operations were discussed, projects, and revenue streams. Starann Lamier would usually chair the operational meetings. Also present were the COO of the hospital, Ted Cain and Tommy Kuluz. The monthly financial meetings were also run by Starann Lamier. In addition to the attendees at the operational meeting, the CFO of the hospital was present. Instructions for any information needed for the meeting would come through Starann Lamier or Tammy, he testified. These were financial meetings.

Other than attending these meetings, Williams said, Ted Cain would occasionally do walk-throughs (once or twice a month), and let him know if cosmetic changes needed to be made. Anything Cain saw he put it on James Williams' list to be done. He could not recall any other interactions with Ted Cain regarding hospital operations or related to patient care.

SCH bought its durable medical equipment from Quest Medical, Williams testified, another company

owned by Ted Cain. He was directed to use them (he thinks by Starann Lamier), but it was more expensive than other companies, maybe two or three times more. Williams brought up in one of the meetings that he could save money if allowed to purchase from other vendors, but he got no response, and nothing changed. 1/29/2020 Tr. 209:15-210:12. Williams also testified that SCH used one particular company for its rehabilitation services, Quest Rehab, another Ted Cain-owned company.

Additionally, the nursing home facility attached to SCH was not allowed to call 911 in case of emergency. They called the number for Stone County Ambulance, a company owned by Ted Cain. 1/29/2020 Tr. 205:19-208:22. The nursing home was attached to the hospital. When called, the ambulance then traveled from the other side of the same building to pick up the patient and transport them to the hospital in another area of the same building. Previously (before Ted Cain started his ambulance company), the patient was simply rolled through from the nursing home through the double doors into the hospital. Medicare reimburses ambulance transportation costs.

Ted Cain failed over the course of many days of testimony to explain what he did at SCH, much less what he did worth millions of dollars. Ted Cain said he was familiar with PRM § 900 which provides that compensation for an owner's services is only an allowable cost if performed in a *necessary* function. He clearly knew that he was not performing any necessary work related to Stone County Hospital, and virtually no work at all. When he submitted a cost report he was

certifying that the costs on that statement, including his salary, were reasonable and *necessary*. He also knew that when submitting these cost reports, they were certifying that they were in compliance with Medicare laws and regulations, including the PRM; but these certifications were false.

The jury had ample evidence, and apparently did find, that Ted Cain was not performing *any* reimbursable work for SCH, and that Ted Cain *knew* he was not performing any reimbursable work for SCH because he was not performing any work at all. Yet by submitting cost reports in an effort to get reimbursement, the Defendants falsely claimed that he was performing reimbursable work. There is no factual or legal basis for disturbing the jury's verdict on this issue.

Unreasonable compensation

The United States presented two bases for Ted Cian's salary violating the FCA. The first, as discussed previously, is that Ted Cain "did not perform work that was necessary and related to patient care to justify the compensation." Secondly, as this court now undertakes to discuss, is that the compensation amount was unreasonable. Not only must the work performed by an owner be necessary, the compensation amount must be reasonable. Had a FI or MAC had actual knowledge of the amount of Ted Cain's compensation, which, based on Sandra Rose's testimony, they did not, they would not have had knowledge that Ted Cain was doing nothing to earn that compensation other than signing or stamping checks (and possibly boosting hospital

revenue by eating consistently in the cafeteria, especially on Wednesdays and Fridays.

The PRM defines reasonableness relative to owners' compensation, as follows:

> Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions depending upon the facts and circumstances of each case. Reasonable compensation is limited to the fair market value of services rendered by the owner in connection with patient care. Fair market value is the value determined by the supply and demand factors of the open market.

PRM §902.3 [doc. no. 436-5 p.3]

Defendants argue that because there was no cap on owner compensation they cannot be expected to know what constitutes a reasonable salary. Additionally, Defendants attempt to shift the responsibility for deciding what constitutes reasonable compensation for Ted Cain onto the MAC. All of the expert witnesses, however, including Defendants' expert, Ralph Llewellyn, testified that it is the provider's responsibility to comply with sections 900 and 902.3. Defendants rely on § 905 .1 to negate their obligation to decide on a reasonable salary amount. The regulations do not allow a provider to seek a salary that far exceeds what anyone would consider reasonable, then wait to see if the MAC catches the fraud. Providers have a duty to comply with sections 900 to 903 *before* the provider submits costs to

the Government. Therefore, by merely submitting the false cost report, Defendants have violated the FCA, even before the MAC even receives it. Each year that Ted Cain did not get caught on falsifying his allowable salary, he became bolder, and increased his compensation over the years.

The experts who testified called Ted Cain's compensation unreasonable. The PRM provides a lot of guidance about what is reasonable, despite defendants' assertions to the contrary. First, the amount should be the same as what is paid for comparable services in comparable institutions. None of the Defendants made any attempt to identify any comparable institutions or make any comparisons whatever. Ted Cain said SCH was the second critical access hospital in the state. There were other small hospitals and rural hospitals in this state and other critical access hospitals in other states. Closely comparable institutions could have and should have been identified, but seemingly Defendants wanted to be able to charge to Medicare as much as they could get away with.

Next, the compensation amount for an owner is limited to "fair market value." The Defendants' own expert, Ralph Llewellyn, testified at his prior deposition that that he advises his clients on direct allocations to conduct time studies. Defendants' cost report preparer, Craig Steen, who testified by deposition, stated that a provider must have time studies.

> Q. What type of recordkeeping is required to do direct allocation?

A. Well, you would have to be able to directly identify that you have costs on your books that pertain solely to this facility.
Q. And how would you go about doing that in the case of compensation?
A. In the case of compensation, that would be if –you could do it a couple of different ways. If you have a person who is on your home office trial balance in your home office costs that works only at one facility, that's fairly easy. But sometimes you will have someone who will work at two or three facilities and then keep time records or time studies so you can split their compensation up.
Q: Is it fair to say that if you're doing direct allocation to Stone County Hospital, you would need to have supporting documentation for that allocation?
A. Yes
Q. Can it be based on estimates?
A. It's not supposed to be based on estimates, a time – although theoretically, a time study is an estimate because you're not doing a time study over the entire twelve months of the year. But no, you can't just say I think I do 50 percent of my time at this hospital at this facility.
Q. Can you say oh, I believe this person works 50 percent of their time at this office because I just know how they work?
A. You're not supposed to use that.

Steen Dep. 30:14-31:13, Ex. 1.

Even Defendants' own expert and Defendants' cost report preparer testified that Defendants were required to determine reasonableness—fair market value—before billing the Government. Experts for the United States, George Saitta and Manuel Pilgrim, similarly testified that it is the provider that must ensure reasonableness.

Ted Cain acknowledged that he was familiar with time studies, but he had not done any such studies relative to his position and the allocation to SCH. He acknowledged that he did not keep time sheets or make any attempt to determine if his salary was reasonable for a hospital of the size of SCH. He said he couldn't ask about the salaries for other Critical Access Hospitals for purposes of comparison, because SCH was only the second Critical Access Hospital in the State of Mississippi. Asked about what he had done to determine reasonableness, Ted Cain consistently said it was up to the MAC to correct or adjust the amount. He testified as follows:

> A. The MAC makes the determination on reasonability. I could have put down there -- like Eric Shell said, I could have put 5 million. It made no difference. It doesn't matter what I put on there. It only matters what they allow. If they allowed it, it's fine. If they didn't, they would adjust it.

1/17/2020 Tr. 74:9-15 (Ted Cain)

This sounds very much like saying that any amount you can get away with is reasonable. The jury would be informed, through the testimony of Sandra Rose and

others, that the MAC was not even aware of the amount of Ted Cain's salary or that it was allocated largely to Stone County Hospital, and that it was difficult to discern that fact from the documents submitted with the CMI home office cost statements.

Ted Cain's Salary and Materiality

Defendants again raise the specter of the Government's continuing to pay without taking any action against Defendants. The materiality question has already been thoroughly discussed.

Medicaid Self-Disallowances

SCH served Medicaid and Medicare patients and received reimbursements from both programs. At trial, Manuel Pilgrim, a Medicaid auditor, testified as an expert for the United States. Pilgrim explained that in 2012 and 2013 (the years for which Pilgrim conducted Medicaid audits on CMI and SCH) Defendants had submitted certain costs to Medicare for reimbursement that they "self-disallowed" on their Medicaid home office cost statements.

"Self-disallowed," Pilgrim stated in his testimony, means that a health care provider, in preparing the cost statement or cost report to be submitted to either Medicare or Medicaid, determined that certain costs were not allowable and should not have been included for reimbursement. The provider itself, then makes the adjustment, removing those expenses from the costs in their general ledger expenses.

Self-disallowing these costs on the Medicaid cost statements meant they should have been self-

disallowed on the Medicare cost reports, as well. Except as it relates to owners' compensation, the PRM regulations apply equally to Medicaid and Medicare, according to Pilgrim's unrefuted testimony on this point. Therefore, for Medicare home office cost statement purposes, Defendants should have self-disallowed the same costs as were self-disallowed for Medicaid. The jury found that CMI was unjustly enriched in the amount of $381,866 for these self-disallowances for 2012 and 2013. [ecf doc. no. 381 p. 25].

Defendants make two main arguments in their motions concerning these Medicaid self-disallowances. First, Defendants say, neither Pilgrim's testimony nor any other evidence established that Medicare actually paid these costs. The Government responds that it is evident from numerous witnesses and exhibits that reimbursement for the administrative costs of CMI were paid, and that at least some of those funds were allocated to SCH. Defendant Tommy Kuluz's own testimony established that these costs were reimbursed. Kuluz testified that Medicare reimbursed SCH for CMI's management fees (which included the pooled costs from the home office cost statements).

Secondly, say the Defendants, the costs listed on the self-disallowance exhibit (P-228), were costs of CMI,[5]

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[5] CMI charged administrative fees to SCH and to the other health care providers that it managed. These providers then sought reimbursement from Medicare for these administrative costs based on the allotment of CMI's fees attributable to each provider. These computations are complicated by the fact that CMI served as the home office for several of Ted Cain's other health-related

and not SCH; only a percentage of CMI's costs were allocated to SCH and only a percentage of SCH's costs were reimbursed by Medicare. The jury found that CMI was unjustly enriched in the amount of $381,866 for "self-disallowances made by CMI to Medicaid but not to Medicare." *Verdict* [ecf doc. no. 381 p. 25]. This court, like Defendants, questions how the jury arrived at this figure, which, as Plaintiff agrees, is not in line with the evidence presented.

Both Manuel Pilgrim and George Saitta, another expert who testified for the Government, presented formulas for calculating the amount of disallowed fees claimed by CMI that were allotted to SCH. They calculated this amount based on the percentage of costs that should be allocated to SCH as compared to the percentage of costs to be allocated to the other health related entities that operated under CMI's administrative umbrella. All of this is complicated by the fact that CMI served as the home office for several of Ted Cain's other health related enterprises, as well as some of his non-health related enterprises.

The jury reasonably found, based on the evidence presented, that CMI committed fraud in the submission of its home office cost statements by claiming items for reimbursement by Medicare that

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companies, and additionally served as the management company for some of Ted Cain's non-health related enterprises. The proportionate amount of fees that should have been charged to Medicare for SCH, as opposed to the various other companies managed by CMI, would prove to be difficult to analyze, separate and assess by those who were not insiders to the Ted Cain enterprises.

they knew were not allowable, as demonstrated by the fact that they self-disallowed these same items on the Medicaid cost statements. However, this court is in agreement with both Plaintiffs and Defendants that the amount of monies for which the jury found Defendants liable in this category of damages is too high, and not borne out by the evidence. The jury award exceeded the amounts Manuel Pilgrim calculated for the two years at issue, as well as the amounts George Saitta determined to be the damages amount for Medicaid disallowances. The Government suggests a remittitur as the only appropriate remedy. Defendants seek a new trial or a judgment dismissing this claim.

The jury's finding that CMI was unjustly enriched by claiming costs that should have been disallowed, was not against the greater weight of the evidence. Only the *amount* of damages found is unsupported by the evidence presented. Therefore, remittitur is the appropriate remedy to address the issue. Therefore, remittitur is the appropriate remedy to address the issue. This court will conduct a hearing to determine the amount of remittitur.

STATUTE OF LIMITATIONS

Defendants next argue that the United States' claims arising out of Defendant's claims for payments submitted before September 18, 2009, should be dismissed because they fall outside the statute of limitations. The limitations period for the FCA is as follows:

> A civil action under section 3730 may not be brought--
> (1) more than 6 years after the date on which the violation of section 3729 is committed, or
> (2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

31 U.S.C. §3731(b).

The Fifth Circuit has said that the statute of limitations begins to run from the "filing of the false claim." *Smith v. United States,* 287 F.2d 299, 304 (5th Cir. 1961). The basic limitations period is six years from the date of the violation. That period is extended however under two circumstances. First, if the suit is filed within three years "after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, the limitations period is extended to ten years from the date of the violation. Secondly, when the United States intervenes in a False Claim Act suit brought by a Relator, the Government's pleading shall relate back to the filing date of the complaint of the relator, to the extent that the Government's claim "arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the [relator's] complaint. 31 U.S.C. §3731(c).

Defendants claim that the bases for extending the statute of limitations are not present and, therefore, the six-year statute of limitations applies. The United States, they say, can only litigate those claims from 2009 and later, the claims that occurred within six years of the United States' Complaint in Intervention.

Relation back

The 2009 amendment to the FCA clarified a split between the circuits as to when the statute of limitations begins to run for the Government to file its complaint-in-intervention. Section 3731(c) permits the Government's complaint to relate back to the date of the Relator's complaint, allowing more time for the Government properly to conduct its investigation and make its decision on intervention. See 31 U.S.C. §3731(c).

The United States says that the claims it brought in this litigation relate back to the Relator's Complaint; so, it can litigate claims up to six years prior to the date of the Relator's Complaint filed in 2007. The Government then, says it was within the limitations period in litigating claims from 2004.

Defendants, on the other hand, argue that the claims brought by the Government do not arise out of the same conduct, transactions or occurrences as the Relator's Complaint, and, thus, do not relate back. "[A] new claim or pleading will not relate back when it 'asserts a new ground for relief supported by facts that differ in both time and type from those the original pleading set forth.' Rather, to relate back, a new claim must be 'tied to a common core of operative facts . . . .'"

United States ex rel. Vavra v. Kellogg Brown & Root, Inc., 848 F.3d 366, 382 (5th Cir. 2017) (quoting *Mayle v. Felix*, 545 U.S. 644, 650 & 664 (2005) (internal citations omitted)).

Defendants say the Relator's initial Complaint, filed in 2007, alleged such things as: Defendants required SCH and a related hospital to purchase medical supplies from a company owned by Ted Cain, inappropriately transferred patients between SCH and a nursing facility owned by Ted Cain to maximize Medicare and Medicaid reimbursement, and failed to collect Medicare copays and deductibles. The United States' Complaint and Amended Complaint, filed in 2015, Defendants say, alleged that SCH and CMI improperly received Medicare reimbursement for the salaries of Ted and Julie Cain and for the 1997 and 2007 BMWs, that CMI performed duplicative and/or unnecessary services for SCH, and related-party expenses were improperly included on the SCH and CMI cost reports. Defendants conclude that the Government's Complaint was different from the Relator's Complaint and cannot relate back.

The Relator's Complaint, however, also alleged cost report fraud, including that SCH cost reports fraudulently included "costs that are not reimbursable under the Medicare program and unallowable costs, resulting in Medicare reimbursements to them that were much higher than that to which they were entitled. The Relator's Complaint, like that of the Government, also alleged "that the services identified in annual cost reports were not provided in compliance

with Medicare laws and regulations." [doc. nos. 2 at ¶33] [doc. no. 6 at ¶¶ 31-33].

The FCA, itself, provides:

> [t]he Government may file its own complaint or amend the complaint of a person who has brought an action under section 3730(b) *to clarify or add detail* to the claims in which the Government is intervening *and to add any additional claims* with respect to which the Government contends it is entitled to relief. For statute of limitations purposes, *any such Government pleading shall relate back* to the filing date of the complaint of the person who originally brought the action, to the extent that the claim of the Government arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of that person.

31 U.S.C. § 3731(c) (emphasis added); See *United States ex rel. Vavra v. Kellogg Brown & Root, Inc.,* 848 F.3d 366 (5th Cir. 2017).

The above provision of the FCA allows the Government to add detail or clarify the claims on which it is intervening; and it does not require perfection or identically worded claims. It allows relation back even when the claim of the Government arises out of conduct the Relator "attempted to set forth."

Defendants cite cases from other jurisdictions; however, the Fifth Circuit, in *Vavra,* attached a broad meaning to §3731(c), even stating that additional claims other than FCA claims can relate back to the

original Complaint. The new claim, however, will not relate back, when it "asserts a new ground for relief supported by facts that differ in both time and type from those the original pleading set forth." *Vavra* at 382 (citing *Mayle v. Felix,* 545 U.S. 644, 650 (2005). The new claim must be "tied to a common core of operative facts…." *Id.,* at 382 (citing *Mayle v. Felix at* 664).

Under the plain language of 31 U.S.C. §3731(c), as interpreted by the Fifth Circuit Court of Appeals in *Vavra,* the claims brought by the Government in the instant case, relate back to the claims of the Relator's original and amended Complaints.

Statute of Repose

The FCA's statute of limitations has a second provision. The Government may bring its lawsuit up to ten years after the date of the violation, *if* it is also brought within 3 years of the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act. In the case *sub judice,* it is not necessary to rely on the ten-year statue of repose, since this court has already determined that the United States' Complaint in Intervention related back to the date of the Relator's Compliant. However, the court is persuaded that at a minimum, the Government had ten years from the date of the violation within which to bring its Complaint.

Defendants contend that the six-year limitations period applies in this instance. They say the Government did not file its Complaint in Intervention within three years of the date on which it knew or

should have known the facts material to its claims, as required by 31 U.S.C. § 3731(b). Therefore, the United States, say Defendants, cannot avail itself of the ten-year statute of repose.

Defendants cite two reasons for this. First, they say the cost reports were submitted annually to the FI or the MAC, contractors for the government, to be processed and reviewed; thus, the Government should have known the material facts when the reports were processed each year. Defendants cite an Eleventh Circuit case for the proposition that a FI's knowledge is tantamount to the government's knowledge, preventing the tolling of the statute of limitations. *United States v. Kass*, 740 F.2d 1493 (11th Cir. 1984). The court there found that Blue Shield, the FI, was aware of the required facts by September 4, 1974, and stated: "At least as early as September 4, 1974, the government, through its agent Blue Shield, had the facts making up the 'very essence of the right of action.'" Id. at 1498. The Eleventh Circuit also stated that the FI or the MAC, in that case Blue Shield, was the official charged with the responsibility to act.

In the instant case, Sandra Rose, an auditor for the MAC, testified that she did not realize the amount of "salaries of officials" on the home office cost statement was actually Ted Cain's salary, and it would not have been easy to detect, since she did not process the reports for SCH, but only for CMI and evidence showed that the information tying the salary amount to Ted Cain was buried deep within the voluminous records for SCH. Even if she had realized this fact and the fact that SCH was a critical access hospital, she still could

not have determined, from the documents submitted, that Ted Cain was not actually performing any substantive work. Arguably, if this court accepted the Eleventh Circuit's view that the MAC was the responsible official, in this case, the MAC was not aware of the facts material to the fraud.

It is telling that despite Defendants' contention that the Government knew of Ted Cain's and Julie Cain's salary issues prior to 2013, Defendants claimed not to know the amount of these salaries reimbursed by Medicare as late as November 30, 2016, when it responded to interrogatories propounded by the United States.

> Interrogatory No. 4: Identify H. Ted Cain's annual compensation relating to Stone County Hospital and the amount of such annual compensation reimbursed by Medicare.
>
> Answer: … Objection is also made that this interrogatory calls for the making of an expert opinion as to the amount of compensation "reimbursed by Medicare,"
>
> Without waiving these objections, Defendants respond as follows: Defendants currently are without knowledge as to the exact amounts that Medicare reimbursed SCH for Ted Cain's salary each year. To the extent the Defendants determine the amount of that "annual compensation" that was reimbursed by Medicare, Defendants will supplement this response.
> Further, Plaintiff is referred to Defendants'

> business records which have been produced or will be produced. Defendants will supplement this response as appropriate,
>
> Interrogatory No. 10: Identify Julie Cain's annual compensation relating to Stone County Hospital and the amount of such annual compensation reimbursed by Medicare.
>
> Answer: …. Objection is also made that this interrogatory calls for the making of an expert opinion as to the amount of compensation "reimbursed by Medicare."
>
> Without waiving these objections, Defendants respond as follows: Defendants currently are without knowledge as to the exact amounts that Medicare reimbursed SCH for Julie Cain's salary each year. To the extent the Defendants determine the amount of that "annual compensation" that was reimbursed by Medicare, Defendants will supplement this response.
>
> Further, Plaintiff is referred to Defendants' business records which have been produced or will be produced. Defendants will supplement this response as appropriate.

Exhibit 3 to United States' Response in Opposition. [doc. no. 436-3 pp. 16-17 and pp. 28-29]

Defendants answered in November of 2016, that it would require an expert opinion for them to determine the amount of Ted Cain's and Julie Cain's salary that was reimbursed by Medicare. Moreover, Defendants

provided no answer to the questions on the amount of annual compensation either received related to SCH. The Defendants were either untruthful or unable to calculate the exact salary and reimbursement amounts. If the Defendants themselves, who were in possession of the business records, employed in-house CFO's, had access to their accountants and cost preparers, and included the salary recipients, could not figure out this information, it would certainly be difficult for an outsider to do so.

The Government says December 20, 2013, is the time when the Department of Justice learned the amounts of Ted Cain's CMI compensation and the amounts Medicare reimbursed to SCH for his compensation. This is borne out by the evidence, Defendants' contentions, notwithstanding. Additionally, it was not until October 8, 2014, after the United States was finally able to depose Ted Cain, that it learned Ted Cain had not performed any qualifying work eligible for reimbursement by Medicare.

These time periods establish that the United States brought its lawsuit within three years of the date it knew or should have known of the violations; thus, the ten-year statue of repose would apply. Despite the Relator's broad allegations, it would take much investigation and discovery to unravel the true nature and extent of the fraud for which Defendants were ultimately found liable.

This court has previously determined that because the Government's Complaint relates back to the Relator's filing, it is not necessary for the Government

to resort to the statute of repose; but it is an option that the court accepts.

Federal Common Law Claims

The United States, in addition to its claims under the FCA, brought common law claims of unjust enrichment and payment by mistake of fact against some of the defendants. Defendants argue that these claims, too, are all barred by the statute of limitations for years prior to 2009. The same arguments that establish the FCA claims are not barred by the statute of limitations for those years apply to these common law claims. The six-year statute of limitations in 28 U.S.C. § 2415(a) governs these federal common law claims. *See In re Cardiac Devices Qui Tam Litig.*, 221 F.R.D. 318, 358-359 (D. Conn. 2004); *U.S. v. Intrados/Int'l Mgmt. Group*, 265 F. Supp.2d 1, 12-13 (D.D.C. 2002) (numerous citations, including *U.S. v. P/B STCO 213*, 756 F.2d 364 (5th Cir. 1985)). The relation back doctrine also applies to these claims. See *In re Cardiac Devices,* 221 F.R.D. at 359.

Similarly, a tolling provision also exists for any federal common law claims that do not relate back to the original complaint. 28 U.S.C. § 2416(c) provides: "For the purpose of computing the limitations periods established in section 2415, there shall be excluded all periods during which-- . . . (c) facts material to the right of action are not known and reasonably could not be known by an official of the United States charged with the responsibility to act in the circumstances"). Therefore, the common law claims before 2009 are also not barred.

CLAIMS AFTER DECEMBER 4, 2015

Defendants next contend that claims submitted after December 4, 2015 should be dismissed because they are not alleged in the Government's Amended Complaint. Defendants devote four sentences of their brief to this argument.

The Government filed its Amended Complaint on December 4, 2015. At that time, the last cost reports filed by CMI and SCH were for 2014. At trial, claims concerning Defendants' 2015 cost reports were presented. Defendants say those claims were not ripe at the time of Plaintiffs' Amended Complaint, since the cost reports were not submitted for payment until May 2016. Defendants cite *United States v. ITT Educ. Servs.,* 284 F. Supp. 2d 487, 495 (S.D. Tex. 2003).

The Government responds that its Amended Complaint alleged that the fraud was ongoing, and Defendants did not object at trial to testimony concerning the 2015 cost reports or introduction into evidence of the 2015 SCH cost report or the CMI 2015 home office cost statement. Defendants do not deny that they failed to object. This court sees no reason to upset the jury's verdict pertaining to the 2015 time period or the 2015 cost report fraud.

Evidentiary Rulings

Defendants, in their Motion for New Trial, take exception to several rulings made by the court during the trial, on evidentiary matters. Defendants allege that: 1) evidence concerning Bill King was improperly excluded; 2) Evidence concerning the termination of James Aldridge was improperly excluded; 3) Evidence

concerning money Ted Cain put into Stone County Hospital was improperly excluded; 4) Evidence concerning Medicaid Cost Reports and Audits of Defendants was improperly admitted; 5) Evidence concerning payment of Defendants' legal expenses was improperly admitted; 6) summary exhibits by George Saitta were improperly admitted; and 7) Plaintiff's Exhibit 167 was improperly redacted.

"Courts do not grant new trials unless it is reasonably clear that prejudicial error has crept into the record or that substantial justice has not been done, and the burden of showing harmful error rests on the party seeking the new trial." *Jordan v. Maxfield & Oberton Holdings, L.L.C.,* 977 F.3d 412, 417 (5th Cir. 2020) (quoting *Sibley v. Lemaire*, 184 F.3d 481, 487 (5th Cir. 1999)). See *Del Rio Distrib., Inc. v. Adolph Coors Co.*, 589 F.2d 176, 179 n.3 (5th Cir. 1979). Generally, any error in admitting or excluding evidence is not grounds for a new trial. Fed.R.Civ.P. 61. The admission or exclusion of evidence is reviewed for abuse of discretion. *Tompkins v. Cyr,* 202 F.3d 770, 779 (5th Cir.2000). Should a district court abuse its discretion, the error is reviewed under the harmless error doctrine. The ruling will be affirmed unless it "affected substantial rights of the complaining party." *Baisden v. I'm Ready Prods., Inc.,* 693 F.3d 491, 508 (5th Cir. 2012) (quoting *Bocanegra v. Vicmar Servs., Inc.,* 320 F.3d 581, 584 (5th Cir.2003).

Evidence concerning Bill King's statements

During the testimony of Tommy Kuluz, Defendants attempted to introduce statements that Kuluz said had been made to him by William King of King &

Associates. King & Associates was the company that prepared the cost reports for SCH and CMI. Kuluz's proffered testimony, heard outside the presence of the jury, was that Bill King, recommended to Kuluz in early 2005 that CMI consider directly allocating a portion of Ted Cain's salary to SCH. Kuluz's proffered testimony was that Bill King informed him that without the direct allocation, Ted Cain's salary would be allocated as part of a pooled allocation, and the pooled percentage would understate the portion of time the Ted Cain spent working on matters related to SCH.

This court denied admission of the testimony. Defendants say this was relevant to Tommy Kuluz's scienter/state of mind, and it should have been admitted. Bill King, deceased, was not available to confirm or refute the statements attributed to him.

This evidence, say Defendants, helps to show Kuluz's state of mind when he made the decision to directly allocate a portion of Ted Cain's salary to SCH. Defendants aimed to show that this allocation was done on the recommendation of King, a person with expertise in the area of cost reporting, who had prepared the cost reports of CMI and SCH. Acting on advice of someone with Bill King's expertise, Defendants say, suggests that Kuluz did not knowingly, deliberately, or recklessly submit a false claim. (Kuluz additionally intended to testify that no one advised him that he needed to have time studies to directly allocate Ted Cain's compensation.)

Plaintiffs challenged the statements and this court heard the testimony outside the presence of the jury. In making it's ruling this court noted that no testimony

was proffered regarding whether Bill King had any knowledge of the portion of time Ted Cain allegedly spent working on SCH matters, but the jury might perceive that Bill King made this recommendation based on hours he knew Ted Cain was actually working. Plaintiffs argued that this was the very purpose for which Defendants were attempting to offer these statements – to plant in the minds of the jury that Bill King knew Ted Cain spent a lot of time on SCH matters and that was the reason for his recommending the use of direct allocation.

This court banned King's alleged statement, convinced that introduction of this statement attributed to Bill King would engender confusion in the minds of the jurors. Additionally, Defendants had not disclosed this statement in disclosure or discovery or prior to trial, or in the pre-trial order. Plaintiffs had no notice of Defendants' reliance on this statement until well into the trial. In fact, during his deposition, Kuluz had contradicted his proffered testimony. During his deposition he stated he did not remember why he chose direct allocation for Ted Cain's salary. Add to this, Bill King is deceased, thus unable to be examined. In sum, this proffered testimony is unreliable, fraught with confusion, and of little or no benefit to Defendant Kuluz in regarding scienter. This court examined whether the statement would be relevant, reliable and admissible and found it would not meet any of these criteria.

If not allowing this testimony to be admitted was error, it was certainly harmless. It was evident, based on extensive testimony and evidence presented, that Ted Cain's services were not properly allocated under

either method (direct or pooled), since, as the jury found, Ted Cain wasn't doing work at all. The jury found Kuluz liable for years where he used direct allocation and years where he used pooled allocation, so providing a reason for using the direct allocation method would not have changed the outcome. A recommendation from Bill King would not have absolved Kuluz of his knowing and deliberate choice to submit cost reports to Medicare for reimbursement for Ted Cain's services, with the knowledge that Ted Cain was not performing any services for SCH that qualified for reimbursement by Medicare.

Termination of James Aldridge

The Relator, James Aldridge did not testify at trial. In FCA cases where the relator does not testify, evidence concerning his motivation for bringing suit, character and alleged employment-related deficiencies and misconduct are not relevant and should be excluded. *U.S. ex rel. Landis v. Tailwind Sports Corp.*, 292 F. Supp. 3d 212, 215 (D.D.C., 2017). Defendants here are aggrieved at the court's denial of the admission of testimony by Julie Cain concerning James Aldridge's separation from employment. Defendants contend they offered this evidence to show that Julie Cain was doing hospital work, that included managing executive-level employees such as relator. This court did allow testimony concerning Julie Cain's management of high level employees and she was able to testify that she is the one who terminated Aldridge. (ECF No. 433) at 18.

Since Aldridge did not testify, his character believability and credibility were not in issue. Yet,

Defense attorney Musgrove, in arguing why the testimony surrounding Aldridge's alleged misconduct and termination would be relevant, argued exactly that point – that the testimony was relevant to Aldridge's credibility and reasons for bringing this lawsuit. In her proffer, Julie Cain related several incidents of misfeasance, accused him of shouting and yelling and of telling her she would be sorry if she terminated him. She indicated she was afraid of him. These things are clearly not allowable under well-settled law. Defendants rely on *U.S. ex rel. Feldman v. van Gorp*, 2010 U.S. Dist. LEXIS 73633, 14-15 (S.D.N.Y., 2010), but that case does not support their position. In that case, the court first reiterated the principles that a relator's character or misconduct should not come into evidence if the relator does not testify; however, the court later found that the relator's reason for leaving his fellowship program early to be relevant, since the relator there was claiming that there were program misrepresentations and deficiencies. In that case, the relator's reasons for leaving were related to the substance of the false claims he was alleging.

Those facts are very different from the case *sub judice*. This Court ruled that those matters concerning the Relator's alleged misconduct were clearly irrelevant to the claims and defenses in this case, and even if there were some slight probative value to those issues, it is clearly outweighed by the prejudicial effect of presenting such evidence to the jury. Fed. R. Civ. P. 401-403.

Money Ted Cain put into Stone County Hospital

This court disallowed Kuluz's testimony regarding cash infusions, loans and guarantees that Ted Cain allegedly put into SCH. Again, Defendants did not produce or disclose these matters during discovery. When Ted Cain was asked to identify the source of the financial transactions on the balance sheet, he could not. Kuluz in his proffered testimony could not state the specific amounts or dates on which these transactions supposedly occurred. Kuluz also could not produce the checks or documents to authenticate these transactions. Defendants say they were not relying on documentary evidence, but upon Kuluz's own personal knowledge.

This court recognizes that financial transactions are evidenced by some kind of document. In particular, a guarantee is always in writing. Unless there is a writing signed by Cain, there is no guarantee of a loan. Therefore, the Best Evidence Rule would certainly apply to guarantees. Kuluz couldn't testify when the alleged contributions were made, how much the contributions were, whether they were in cash form or check form. Kuluz said documents existed, such as checks or deposits, but without those documents the Government would not be able to explore the veracity of Kuluz's testimony. The court had numerous grounds for not allowing the evidence, not the least of which is relevance. It really does not matter what Ted Cain "invested" into his businesses by check loan or guarantee. What he expended does not matter to an FCA case. What matters is what claims he submitted

to Medicare for reimbursement and what he was reimbursed by Medicare.

What Cain invested into his business is not relevant to this lawsuit; however, it had the the potential to confuse the jury, who might have thought Ted Cain was entitled to an offset or credit, because of funds he allegedly put into the business.

Medicaid Cost Reports and Audits of Defendants

This issue is discussed earlier in this opinion. The Government sought to show, through Manuel Pilgrim, that the Defendants knowingly committed fraud, when they self-disallowed certain items on the Medicaid costs reports that they did not self-disallow on the Medicare cost reports. Defendants' only argument seems to be that the information is irrelevant.

It is not. It demonstrates that the Defendants acted knowingly, because if they knew not to include these items on the Medicaid cost report, they knew not to include them on the Medicare cost report. The requirements are identical. The only difference is that Medicaid has a set cap on owner compensation and Medicare does not have a set cap.

The testimony also demonstrated that the self-disallowed Medicaid amounts were fraudulently submitted to Medicare. This testimony was properly allowed.

Payment of Defendants' legal expenses

Defendants say that the Court improperly permitted questioning of the Defendants about who

was paying their legal fees. Defendants do not cite any authority but simply state it was irrelevant. Payment of one's legal fees by one party creates an alignment and could show bias or motivation to protect the interest of the one paying the fees. See *U.S. v. Slough*, 22 F. Supp. 3d 29, 33 (D.D.C. 2014) (citing *U.S. v. Abel,* 469 U.S. 45, 56 (1984); *U.S. v. Lindemann,* 85 F.3d 1232 (7th Cir. 1996). In *Abel,* the United States Supreme Court stated the following.

> Bias is a term used in the "common law of evidence" to describe the relationship between a party and a witness which might lead the witness to slant, unconsciously or otherwise, his testimony in favor of or against a party. Bias may be induced by a witness' like, dislike, or fear of a party, or by the witness' self-interest. Proof of bias is almost always relevant because the jury, as finder of fact and weigher of credibility, has historically been entitled to assess all evidence which might bear on the accuracy and truth of a witness' testimony.

U.S. v. Abel, 469 U.S. at 52.

Summary Exhibits of George Saitta

The court has discretion regarding whether to admit summary exhibits. Once admitted, they are part of the evidence available to the jury for their review in the jury room. *See U.S. v. Hudson*, 550 Fed. App'x. 207, 213 (5th Cir. 2013); *U.S. v. Bishop*, 264 F.3d, 535, 547 (5th Cir. 2001). Rule 1006 is "broadly interpreted" in favor of admissibility. *Shell Offshore, Inc. v. Tesla Offshore, LLC*, 2016 WL 541445 *3 (E.D. La. Feb. 11, 2016)

(citing *Bishop*); *see also Irons v. Aircraft Service Int'l, Inc.*, 392 Fed. App. 305, 314-15 (5th 2010) (emphasizing a district court's "broad discretion" to admit summary exhibits).

This was a complex case with voluminous documents. The Government's expert, George Saitta, created summary exhibits from the cost reports, home office statements, tax returns and records of work time and compensation to help the jury understand his testimony. To help illustrate his testimony for the jury. Saitta explained his calculations and methodology. Kuluz acknowledged that Saitta's figures seemed to be fairly stated. Defendants certainly had the opportunity to cross-examine Saitta and did so. This court admitted the summary exhibits.

The plain language of Rule 1006 of the Federal Rules of Civil Procedure and case law permit experts to make calculations as part of summary exhibits. *See, e.g., U.S. v. Fisher*, 236 Fed. App'x. 54, 61 (5th Cir. 2007) (affirming admission in jury trial of summary exhibit calculating damages based on figures taken from a 248-page exhibit); *Sumitomo Bank of California v. Product Promotions, Inc.*, 717 F.2d 215, 217-19 (5th Cir. 1983) (reversing trial court's [jury trial] retroactive striking of summary exhibits that court previously had admitted and stating "[w]e perceive no error in the trial court's initial decision to admit [two summary exhibits] into evidence" "summarizing inventory accounting calculations based on shipping and receiving records…")

Defendants have not identified any errors or discrepancies in the summary exhibits. *See Irons*, 392

Fed. App'x. at 314-15 (citing *Donovan v. Janitorial Servs., Inc.*, 672 F.2d 528, 531 (5th Cir. 1982) for the proposition that "admission of summaries proper where appellants failed to identify any discrepanc[ies] . . .").

The evidence was helpful to the jury's understanding and was properly admitted. If admission was in error, Defendants have shown no harm that resulted.

Redacted Exhibit 167

It is well-settled that the offering of evidence advising the jury that the damages will be trebled is not relevant. *U.S. ex rel. Laymon v. Bombardier Transp. (Holdings) USA, Inc.*, 656 F. Supp. 2d 540, 547 (W.D. Pa. 2009) (collecting cases and discussing) (granting Plaintiff's motion to exclude evidence of treble damages and penalties for lack of relevance). *Gulfstream III Assocs., Inc. v. Gulfstream Aerospace Corp.,* 995 F.2d 425, 433 (3d Cir. 1993) (treble damages in an antitrust case); *Pollock & Riley, Inc. v. Pearl Brewing Co.,* 498 F.2d 1240, 1242 (5th Cir. 1974) (same); *Liquid Air Corp. v. Rogers,* 834 F.2d 1297, 1308 n. 7 (7th Cir. 1987) (statutory penalties in a RICO case); *Brooks v. Cook,* 938 F.2d 1048 (9th Cir. 1991) (attorney fees under 42 U.S.C. § 1988)).

Particularly in regard to FCA cases, "[T]he United States Supreme Court has strongly implied that a jury in FCA cases is generally not to be instructed on the possibility of treble and civil penalties" because it would be tempted to increase or decrease damages when "its instruction is to return a verdict for actual damages, for which the court alone then determines

any multiplier." *U.S. ex rel. Laymon v. Bombardier Transp. (Holdings) USA, Inc.*, 656 F. Supp. 2d 540, 547-48 (W.D. Pa. 2009. at 547-48 (quoting *Cook County v. U.S. ex rel. Chandler,* 538 U.S. 119, 131-32 (2003)).

Government's Exhibit 167 was referenced several times and published to witnesses and to the jury during witnesses' testimony. Neither the court nor the Government realized that a portion of the document contained the language that damages would be trebled. The language regarding treble damages was not contained in the portion of the document that was highlighted or being discussed by the witnesses. When the Government realized the language had not been redacted on that particular document, the court instructed that it should be redacted and the document relabeled. Plaintiff's Exhibit 167 became Plaintiff's Exhibit 304, and was sent into the jury room with the other exhibits.

Defendants say they had wanted to reference this provision and explain it during closing argument, to insure that the jury knew not to treble the damage award. Defendants did not object during the trial on that basis, however. Defendants only objected on the basis that the document should not be revised after the close of the evidence. In their motion for a new trial, Defendants contend that redacting the document without allowing them an opportunity to explain it to the jury, was error. Again, Defendants do not cite legal authority for their position.

This court pointed out that the treble damages provision was never discussed when the document was used previously *and* discussion of that point later

would conflict with the Court's instruction on how to calculate damages, an instruction on which the parties had agreed. Attempted explanation by the Defendants could have led to jury confusion and could have collided with the instructions this court provided to the jury on the issue of damages.

The redaction and changing the number of the exhibit was appropriate and supported by authority. *See, e.g., U.S. ex rel. Laymon v. Bombardier Transp. (Holdings) USA, Inc.*, 656 F. Supp. 2d 540, 547. Even if in error, however, it was also harmless. The jury did not treble damages, as is obvious from their verdict, broken down by each cost report year.

Sealed Records

Defendants again take issue with the court allowing certain documents in the case to remain under seal. They argue that the records remaining sealed is cause for dismissal of this lawsuit. This court has considered and rejected this argument previously. Defendants had filed a motion to unseal all documents in the case prior to the trial of this lawsuit. The False Claims Act permits, and in fact mandates, *in camera* submissions, but the Act, itself, is silent as to whether the documents are to remain unsealed after the intervention decision is made. This court unsealed the other documents in the case, but maintained the seal on the United States' memoranda in support of its motions for additional time.

This court was informed by the decision in *United States ex rel. Mikes v. Straus,* from the Southern District of New York, which has been cited and

followed by many other courts. The court there said, "[t]he *Qui Tam* statute evinces no specific intent to permit or deny disclosure of *in camera* material as a case proceeds" and "the statute necessarily invests the court with authority to preserve secrecy of such items or make them available to the parties". *United States ex rel. Mikes v. Straus,* 846 F.Supp. 21, 23 (S.D.N.Y.1994). The court in that case exercised its discretion by balancing the need for the disclosures against the harm risked by the access sought by the Defendant. *Mikes,* 846 F.Supp. at 23 as cited in *U.S. ex rel. Coughlin v. Int'l Bus. Machines Corp.,* 992 F. Supp. 137, 140–41 (N.D.N.Y. 1998). After an *in camera* review of the documents at issue, this court determined that the Government had made a compelling showing that the documents at issue contain information, which if disclosed, would reveal confidential investigative methods, thought processes, or jeopardize an ongoing *or future* investigation.

Although Defendants said the documents were pertinent to their statute of limitations defense, this court could not see how disclosure of the information would assist a statute of limitations defense; nor did this court discern any prejudice that would result to Defendants if the information was not disclosed. Additionally, Defendants had discovery available to them to obtain any discoverable information. Information that was not discoverable because of privilege, also should not be disclosed by unsealing the records. After balancing the need for the disclosures against the harm risked by the access sought by the Defendants, this court denied Defendant's motion to unseal the Government's memoranda.

Defendants also rehash their good cause argument and complaints about the time the Government took to complete its investigation, and the fact that the investigation could be conducted in secret. The period of sealing provided for by the FCA allows the Government to investigate the Relator's allegations and coordinate any other law enforcement efforts prior to deciding whether to intervene in the litigation. See, *United States ex re. Coughlin v. International Bus. Machines Corp*., 992 u . 137, 140 (N.D.N.Y. 1998). As this court stated in its Order of May 4, 2018 [doc. no. 214], denying Defendants' Motion to Dismiss, "[t]he Government was not required to reveal its investigative efforts to Defendants. The Government was only required to provide information about its investigation to the court, in camera, each time an extension was requested. This court reviewed each motion and accompanying documents and determined that there was good cause to grant the extension; thus, this court was satisfied that the Government was appropriately engaging in the conduct of its investigation." *Id.* at p. 15.

Defendants repeatedly refer to the government's sealed investigation lasting eight years. This court has found, however, in at least three earlier rulings in this case, that the Government did not abuse the process. In its Order on Defendants' Motion to Dismiss, this court developed a complete chronology of events in the case. The Relator's first Complaint was filed on May 31, 2007. The Government was investigating, requesting extensions of time and reporting to the Court on its investigation. On January 20, 2010, after investigating a little over two and a half years, the Government

requested a partial lifting of the seal [doc. no. 7] in order to share limited information with Defendants for the purpose of discussing the allegations and pursuit of possible settlement. The Department of Justice, on March 9, 2010, sent a letter to all of the Defendants notifying them that they were named as Defendants in a qui tam lawsuit, informing them of the allegations, and asking for voluntary production of certain documents.

Defendants complain about the length of time the Government took before making its intervention decision, but much of the cause for the dealy is laid at the feet of the Defendants in this cause. In October of 2011, the Government sent Civil Investigative Demands to the Defendants. Defendants' fight to avoid answering the CID's accounted for almost all of the time between November 3, 2011 (the date the Government filed its motion to enforce the CID's) and October 15, 2014 (the date this court entered its order setting the dates on which Defendants had to submit to being deposed). As to be expected, the Government sought extensions of time to continue its investigation during this time. Defendants' recalcitrance had reached the point that they were held in contempt by this court [doc. no. 93], and this court was forced to seriously consider holding Defendants' attorneys in contempt, as well. Ten months after the court's order, the United States filed its Notice of Election to Intervene in Part and Decline to Intervene is part. This seems a reasonable period of time in which to conduct depositions, analyze the information obtained, and continue the investigation.

The parties conducted extensive discovery, and the case was tried to a jury for almost nine weeks. After the trial concluded, the Relator filed his motion for attorneys' fees and submitted an itemized statement of fees and costs that included time sheets of the Relator's expert consultant, Robert Church. ("Church"). Defendants then pointed to a perceived discrepancy about when the Government first became aware of the Cains' salary issues. According to Defendants, those time sheets and the accompanying declaration provide different information about when the Government first became aware of the Cains' salary issues. Therefore, they claim they should be able to examine the Government's memoranda for extensions of time, in which the Government reported to the Court on the status of its investigation.

The Relator's expert says he discussed matters concerning the Cains' salaries with the Government attorneys in 2011 and 2012. Government counsel, Tom Morris, in an interrogatory response says he first became aware of Ted Cain's salary amount in December of 2013. This court thoroughly examined this issue in connection with Defendants' motion to re-open discovery, and concluded there was no real discrepancy. There is no new information that would justify re-opening discovery or unsealing the Government's memoranda.

Defendants claim that now that the trial is concluded, the Government's need to keep the memoranda secret from Defendants is lessened. They also contend they should be allowed to examine the information for purposes of appeal, just as they said

they needed the information for purposes of trial preparation previously. This court has done at least two very thorough analyses of this issue. In this court's Opinion and Order entered prior to trial, [doc. no. 216 at 16], this court observed that it could not discern any harm to the Defendants if the memoranda remained under seal – that Defendants would have had ample opportunity to develop the pertinent facts through discovery and to call witnesses and cross-examine witnesses. The Government, on the other hand, said disclosure of the information would be very detrimental, since it could jeopardize not only this investigation, but future investigations, as well. Although the trial has concluded, the balance has not changed in favor of Defendants. The documents will remain sealed.

Revision of the Verdict Form

Defendants make the statement in their brief that revising the jury verdict form after closing arguments was in error, but Defendants did not brief this issue. Their brief cites no authority in support of their position, and does not state how the revision of the verdict form caused any prejudice to them. Additionally, Defendants did not object during the trial, and in, fact, seemed to advocate for revising the verdict form. Ultimately, the revised form created by the Court included some components of the form proposed by the Plaintiffs, but was more consistent with the form proposed by Defendants.

Defendants have waived this issue for failure to brief it; see e.g., *Emerald Coast Finest Prod. Co.*, 2016

WL 1718386, *2; *Simms*, 2010 WL 5184845, *2 n.3, but this court also finds this argument to be without merit.

Speaking with Counsel
During Testimony Breaks

Each Defendant was called as an adverse witness during the Plaintiff's case in chief. At the breaks the court instructed the witnesses not to discuss their testimony with anyone. During Cain's testimony, when the court broke for lunch, Defense counsel asked if Cain could speak with counsel during the lunch recess. The request was denied at that time. Defense counsel provided this court with a copy of the Fifth Circuit case of *Potashnick v. Port City Constr. Co.,* 609 F.2d 1101 (5th Cir. 1980), which this court reviewed. At the afternoon break the counsel for Defendants asked if Cain could speak with his attorneys during the break. This court denied the request.

Potashnick involved a three day weekend during which the witness was deprived of counsel. This court determined that the United States Supreme Court case of *Perry v. Leeke* controlled. *Id.*, 488 U.S. 272 (1989). Based on that case, this court allowed Cain to consult with his lawyer over the weekend, but said there was no denial of the right to counsel for lunch breaks and short breaks. This court also cited *Geders v. U.S.*, 425 U.S. 80 (1976), and *U.S. v. Johnson*, 267 F.3d 376 (5th Cir. 2001), and stated the parties could argue the matter further if need be. The trial reconvened the following week and Defendants did not raise the issue except at the end of the day, when defense counsel asked if they could speak with their client overnight. The court allowed it. During the first fifteen-minute

recess during the testimony of Kuluz, defense counsel raised the issue of speaking with him during breaks in his testimony to preserve the issue for appeal. 1/27/20 Tr. (Kuluz).

Defendants also cite to *United States v. Conway*, 632 F.2d 641 (5th Cir. 1980), but both this Fifth Circuit case and *Potashnick* predate the U.S. Supreme Court case of *Perry v. Leeke*. *Perry* holds that when a defendant assumes the role of witness, he has no constitutional right to consult his lawyer while he is testifying.

Perry's fundamental pronouncements cannot be ignored. They confirm that this Court's decisions in this case were proper and not a basis for a new trial. *Reynolds v. Ala. Dept. of Transp.,* 4 F. Supp. 2d 1055, 1064-1066 (M.D. Ala. 1998) recognized the limitations that *Perry* placed on *Geders* and *Potasnick*. The *Reynolds* court stated, "[a] civil party does not have a right to consult with his counsel at any time about any matter during the course of his or her testimony" and "the trial court['s] broad power to control the progress of testimony before it" is limited only "by a testifying party's right to engage in such non-testimonial matters . . . [that] arise most often during extended recesses—in particular over evenings and weekends.").

CONCLUSION

This court, drawing all inferences in favor of the non-movant, as we must when considering a Rule 50(b) motion, concludes that the evidence at trial permitted a reasonable jury to find that the defendants

committed Medicare-related fraud in violation of the FCA.

Under Rule 59, viewing the evidence in a light most favorable to the jury verdict, this court observes that the trial was fair and the jury's verdict reliable.

This court recognizes, however, that there is one aspect of damages that needs to be corrected by remittitur. The jury found in favor of the United States on the matter of Medicaid disallowances that were not self-disallowed on Medicare for two years. However, the amount of damages found by the jury exceeds the damages established by the proof. Therefore, this court will conduct a hearing on this issue on July 13, 2021 at 9:30 a.m.

For all of the reasons stated herein, Defendants' Motion for Judgment as a Matter of Law **[ecf doc. no. 430] is denied**. For all of the reasons stated herein, Defendants' Motion for New Trial **[ecf doc. no. 432] is denied.**

Defendants also had filed an earlier "Renewed Motion for Judgment as a Matter of Law" [ecf doc. no. 377] at the conclusion of the trial, which the parties agreed would be incorporated into the Motion for Judgment as a Matter of Law here under consideration. [ecf doc. no. 430]. As all issues raised in **[ecf doc. no. 377]** have been resolved, it is **dismissed as moot.**

Defendants also previously had filed a "Motion to Unseal Documents" [ecf doc. no. 397]. As all issues pertaining to the unsealing of documents have been addressed in this Opinion, the request for unsealing

having been denied for all of the reasons stated herein, the Motion to Unseal documents **[ecf doc. no. 397**] is **denied.**

A hearing on the issue of remittitur regarding damages for Medicaid self-disallowances made by Defendants that were not disallowed for Medicare will be conducted on July 13, 2021 at 9:30 a.m.

SO ORDERED AND ADJUDGED, this the 18th day of June, 2021.

s/ HENRY T. WINGATE
UNITED STATES DISTRICT JUDGE

APPENDIX C

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

CIVIL ACTION NO. 1:16-CV-369-HTW-LRA

[Filed May 8, 2020]

JAMES ALDRIDGE, RELATOR ON BEHALF OF UNITED STATES OF AMERICA PLAINTIFF	)
v.	)
CORPORATE MANAGEMENT, INC., ET AL. DEFENDANTS	)

ORDER

BEFORE THIS COURT is the motion of the United States for entry of the judgment on the verdict in this case [doc. no. 390] which was announced on March 12, 2020. The jury found Ted Cain, Julie Cain, Tommy Kuluz, Corporate Management, Inc., and Stone County Hospital, Inc., liable under the False Claims Act. The jury also found Ted Cain, Julie Cain, and Corporate Management, Inc., liable under the common law theory of unjust enrichment, and found Stone County

Hospital, Inc., liable for payment by mistake of fact. The jury found in favor of defendant Starann Lamier, finding that she was not liable for any of the alleged violations.

This court originally scheduled arguments to be heard on March 26, 2020, on the issues of civil penalties, anticipating entry of a judgment shortly thereafter. Because of the Covid-19 pandemic, the hearing had to be continued. This court rescheduled the hearing for May 6, 2020, by videoconference. At that hearing, the court heard the Government's request for entry of the judgment or, alternatively, for prejudgment remedies under the Federal Debt Collection Procedures Act (FDCPA). The United States renewed its concern that as time passes between the jury verdict and entry of the judgment the more time creditors would have to secure any interests they might have and the more time the Defendants would have to draw down assets.

Since this court is prepared to enter its judgment in this case, the court sees no need to invoke the pre-judgment provisions of the FDCPA. Upon entry of the judgment, the United States will be able to avail itself of the usual post-judgment collection procedures.

This court determines that the damages awards for unjust enrichment and for payment by mistake of fact are subsumed within the verdict under the False Claims Act. While the Government may plead alternative theories for relief for the same injury, there can be only one recovery. As the Fifth Circuit stated in *Drummond v. BestCare Laboratory Services, LLC,* "[b]oth sets of awards arise from the same underlying

conduct, so the Government is entitled to recover only once." *Id.,* 950 F.3d 277, 284 (5th Cir. 2020). This court will enter its judgment based on the jury's findings under the False Claims Act only.

This court has determined that the provisions of 31 U.S.C. §3729 require that the trial court apply treble damages for violations of the False Claims Act. The damages amount found by the jury for False Claims violations is multiplied by three to determine the total damages award from each defendant found liable. The court's final judgment will reflect treble damages for each defendant, jointly and severally, up to each defendant's respective liability amount.

This court is also charged with assessing the civil penalty amount under the False Claims Act. In an effort to expedite entry of the judgment, the United States has expressed its willingness to accept the minimum statutory penalty amount for each violation of the False Claims Act. The jury found each cost reporting year to represent one violation. For years 2004 through 2014, the minimum penalty amount is $5500, which the court imposes for each such claim. For the year 2015 the court finds the minimum statutory penalty amount to be $11,181, which the court imposes. All but one defendant was found guilty of twelve violations, including year 2015. Tommy Kuluz was found guilty of eleven violations, including year 2015.

As also represented by the Government in the video hearing of May 6, 2020, the Government agrees that liability for the civil penalties will be joint and several, up to the limits of each defendant's individual liability,

and this court concurs. This civil penalty amount is in addition to the liability for damages under the False Claims Act.

This court additionally awards post-judgment interest at the legal rate set by 28 U.S.C. §1961.

This court hereby **grants, in part,** Plaintiff's motion **[doc. no. 390]** for entry of judgment. The Plaintiff United States of America is directed to prepare a judgment consistent with the jury verdict and this order, for submission to the court for its approval and entry, by 5:00 p.m. on May 9, 2020.

The court will enter, at a later date, detailed findings.

The court continues its order forbidding the defendants from transferring, dissipating, selling or disposing of any of their assets.

SO ORDERED AND ADJUDGED, this the 8th day of May, 2020.

s/ HENRY T. WINGATE
UNITED STATES DISTRICT JUDGE

APPENDIX D

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
SOUTHERN DIVISION

CIVIL ACTION NO. 1:16-CV-369-HTW-LRA

[Filed May 10, 2020]

JAMES ALDRIDGE, RELATOR for and on behalf of THE UNITED STATES OF AMERICA PLAINTIFFS	)
v.	)
CORPORATE MANAGEMENT, INC.; STONE COUNTY HOSPITAL, INC.; TED CAIN; JULIE CAIN; STARANN LAMIER; and THOMAS KULUZ DEFENDANTS	)

JUDGMENT

On March 12, 2020, a jury in this matter unanimously found Defendants Harold "Ted" Cain, Julie Cain, Thomas "Tommy" Kuluz, Corporate Management, Inc., and Stone County Hospital, Inc.

liable under the False Claims Act.[1] The United States filed a motion for entry of judgment on April 17, 2020. The Court heard oral argument on that motion on May 6, 2020, and entered an Order on May 8, 2020 granting in part and denying in part the United States' motion. In its May 8, 2020, Order, the Court determined that treble damages are required under the False Claims Act and that the minimum penalty will be awarded for each false claims found by the jury.

IT IS THEREFORE ORDERED AND ADJUDGED, consistent with the Jury's verdict of March 12, 2020, and this Court's Order of May 8, 2020, that judgment is entered in this matter as follows:[2]

Defendant Ted Cain is liable to the United States in the amount of $32,566,146 in damages and $71,681 in penalties under the False Claims Act.

Defendant Julie Cain is liable to the United States in the amount of $27,411,636 in damages and $71,681 in penalties under the False Claims Act.

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[1] The jury also unanimously found Ted Cain, Julie Cain and Corporate Management, Inc. liable for unjust enrichment and Stone County Hospital, Inc. liable for payment by mistake of fact. Because those claims are subsumed in the False Claims Act verdict, the Court will not enter judgment on those claims unless the False Claims Act verdicts are affected on appeal.

[2] The jury found in favor of Defendant Starann Lamier. She filed a motion for entry of judgment and attorney's fees on May 1, 2020. The Court will render its opinion on that motion at a later date after briefing is complete and there is a hearing on the matter.

Defendant Thomas Kuluz is liable to the United States in the amount of $29,559,351 in damages and $66,181 in penalties under the False Claims Act.

Defendant Corporate Management, Inc. is liable to the United States in the amount of $32,566,146 in damages and $71,681 in penalties under the False Claims Act.

Defendant Stone County Hospital is liable to the United States in the amount of $31,420,548 in damages and $71,681 in penalties under the False Claims Act.

IT IS FURTHER ORDERED AND ADJUDGED that each defendant shall be jointly and severally liable for the amounts above up to their respective liability.

IT IS ALSO FURTHER ORDERED AND ADJUDGED that each defendant shall be liable to the United States for post-judgment interest at the legal rate set by 28 U.S.C. § 1961 until the above amounts are paid in full.

The Court continues its Order forbidding the defendants from transferring, dissipating, selling or disposing of any of their assets.

SO ORDERED AND ADJUDGED, this the 10th day of May, 2020.

s/ HENRY T. WINGATE
UNITED STATES DISTRICT JUDGE

APPENDIX E

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

28 U.S. Code § 1254(1) - Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

28 U.S. Code § 2415(a) - Time for commencing actions brought by the United States

Subject to the provisions of section 2416 of this title, and except as otherwise provided by Congress, every action for money damages brought by the United States or an officer or agency thereof which is founded upon any contract express or implied in law or fact, shall be barred unless the complaint is filed within six years after the right of action accrues or within one year after final decisions have been rendered in applicable administrative proceedings required by contract or by law, whichever is later: Provided, That in the event of later partial payment or written acknowledgment of debt, the right of action shall be deemed to accrue again at the time of each such payment or acknowledgment: Provided further, That an action for money damages brought by the United

States for or on behalf of a recognized tribe, band or group of American Indians shall not be barred unless the complaint is filed more than six years and ninety days after the right of action accrued: Provided further, That an action for money damages which accrued on the date of enactment of this Act in accordance with subsection (g) brought by the United States for or on behalf of a recognized tribe, band, or group of American Indians, or on behalf of an individual Indian whose land is held in trust or restricted status, shall not be barred unless the complaint is filed sixty days after the date of publication of the list required by section 4(c) of the Indian Claims Limitation Act of 1982: Provided, That, for those claims that are on either of the two lists published pursuant to the Indian Claims Limitation Act of 1982, any right of action shall be barred unless the complaint is filed within (1) one year after the Secretary of the Interior has published in the Federal Register a notice rejecting such claim or (2) three years after the date the Secretary of the Interior has submitted legislation or legislative report to Congress to resolve such claim or more than two years after a final decision has been rendered in applicable administrative proceedings required by contract or by law, whichever is later.

28 U.S. Code § 1395ddd. Medicare Integrity Program

(a) Establishment of Program

There is hereby established the Medicare Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote the integrity of the medicare program by entering into contracts in

accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b).

(b) Activities described

The activities described in this subsection are as follows:

(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this subchapter (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this subchapter as of August 21, 1996).

(2) Audit of cost reports.

(3) Determinations as to whether payment should not be, or should not have been, made under this subchapter by reason of section 1395y(b) of this title, and recovery of payments that should not have been made.

(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with

section 1395m(a)(15) of this title which are subject to prior authorization under such section.

(6) The Medicare-Medicaid Data Match Program in accordance with subsection (g).

(c) Eligibility of entities

An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if-

(1) the entity has demonstrated capability to carry out such activities;

(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this subchapter and in other cases arising out of such activities;

(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(4) the entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and

(5) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1395u of this title.

(d) Process for entering into contracts

The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(1) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(2) Competitive procedures to be used-

(A) when entering into new contracts under this section;

(B) when entering into contracts that may result in the elimination of responsibilities of an individual fiscal intermediary or carrier under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(C) at any other time considered appropriate by the Secretary,

except that the Secretary may continue to contract with entities that are carrying out the activities described in this section pursuant to agreements under section

1395h of this title or contracts under section 1395u of this title in effect on August 21, 1996.

(3) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(e) Limitation on contractor liability

The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c-6 of this title.

(f) Recovery of overpayments

(1) Use of repayment plans

(A) In general

If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this subchapter would constitute a hardship (as described in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not

longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

(B) Hardship

(i) In general

For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if-

(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this subchapter to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this subchapter to the provider of services or supplier for the previous calendar year.

(ii) Rule of application

The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this subchapter during the previous year or was paid under this subchapter only during a portion of that year.

(iii) Treatment of previous overpayments

If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

(C) Exceptions

Subparagraph (A) shall not apply if-

(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this subchapter; or

(ii) there is an indication of fraud or abuse committed against the program.

(D) Immediate collection if violation of repayment plan

If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

(E) Relation to no fault provision

Nothing in this paragraph shall be construed as affecting the application of section 1395gg(c) of this title (relating to no adjustment in the cases of certain overpayments).

(2) Limitation on recoupment

(A) In general

In the case of a provider of services or supplier that is determined to have received an overpayment under this subchapter and that seeks a reconsideration by a qualified independent contractor on such determination under section 1395ff(b)(1) of this title, the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1395ff(b)(1) of this title (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

(B) Collection with interest

Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

(C) Medicare contractor defined

For purposes of this subsection, the term "medicare contractor" has the meaning given such term in section 1395zz(g) of this title.

(3) Limitation on use of extrapolation

A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that-

(A) there is a sustained or high level of payment error; or

(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

(4) Provision of supporting documentation

In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

(5) Consent settlement reforms

(A) In general

The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

(B) Opportunity to submit additional information before consent settlement offer

Before offering a provider of services or supplier a consent settlement, the Secretary shall-

(i) communicate to the provider of services or supplier-

(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

(II) the nature of the problems identified in such evaluation; and

(III) the steps that the provider of services or supplier should take to address the problems; and

(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

(C) Consent settlement offer

The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary-

(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

(ii) in order to resolve the overpayment, may offer the provider of services or supplier-

(I) the opportunity for a statistically valid random sample; or

(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

(D) Consent settlement defined

For purposes of this paragraph, the term "consent settlement" means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

(6) Notice of over-utilization of codes

The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this subchapter (or provisions of subchapter XI insofar as they relate to such programs).

(7) Payment audits

(A) Written notice for post-payment audits

Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this subchapter, the contractor shall provide the provider of services or

supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

(B) Explanation of findings for all audits

Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this subchapter, the contractor shall-

(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

(ii) inform the provider of services or supplier of the appeal rights under this subchapter as well as consent settlement options (which are at the discretion of the Secretary);

(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

(C) Exception

Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

(8) Standard methodology for probe sampling

The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

(g) Medicare-Medicaid Data Match Program

(1) Expansion of Program

(A) In general

The Secretary shall enter into contracts with eligible entities or otherwise for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the "Medi-Medi Program") is conducted with respect to the program established under this subchapter and State Medicaid programs under subchapter XIX for the purpose of-

(i) identifying program vulnerabilities in the program established under this subchapter and the Medicaid program established under subchapter XIX through the use of computer algorithms to review claims data to look for payment anomalies (including billing or billing patterns identified with respect to provider, service, time, or patient that appear to be suspect or otherwise implausible);

(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to investigate and recover amounts with respect to suspect claims to protect the Federal and State share of expenditures under the Medicaid program under

subchapter XIX, as well as the program established under this subchapter;

(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures; and

(iv) furthering the Secretary's design, development, installation, or enhancement of an automated data system architecture-

(I) to collect, integrate, and assess data for purposes of program integrity, program oversight, and administration, including the Medi-Medi Program; and

(II) that improves the coordination of requests for data from States.

(B) Reporting requirements

The Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a Medicaid fraud and abuse control unit described in section 1396b(q) of this title). Such information shall be disseminated no less frequently than quarterly.

(2) Limited waiver authority

The Secretary shall waive only such requirements of this section and of subchapters XI and XIX as are necessary to carry out paragraph (1).

(3) Incentives for States

The Secretary shall study and, as appropriate, may specify incentives for States to work with the Secretary for the purposes described in paragraph (1)(A)(ii). The application of the previous sentence may include use of the waiver authority described in paragraph (2).

(h) Use of recovery audit contractors

(1) In general

Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this subchapter with respect to all services for which payment is made under this subchapter. Under the contracts-

(A) payment shall be made to such a contractor only from amounts recovered;

(B) from such amounts recovered, payment-

(i) shall be made on a contingent basis for collecting overpayments; and

(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and

(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

(2) Disposition of remaining recoveries

The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) or paragraph (10) shall be applied to reduce expenditures under this subchapter.

(3) Nationwide coverage

The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010 (not later than December 31, 2010, in the case of contracts relating to payments made under part C or D).

(4) Audit and recovery periods

Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under this subchapter-

(A) during such fiscal year; and

(B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

(5) Waiver

The Secretary shall waive such provisions of this subchapter as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).

(6) Qualifications of contractors

(A) In general

The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this subchapter or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

(B) Ineligibility of certain contractors

The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1395h of this title, a carrier under section 1395u of this title, or a medicare administrative contractor under section 1395kk-1 of this title.

(C) Preference for entities with demonstrated proficiency

In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under subchapter XIX, or under this subchapter.

(7) Construction relating to conduct of investigation of fraud

A recovery of an overpayment to a individual or entity by a recovery audit contractor under this subsection shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(8) Annual report

The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this subchapter.

(9) Special rules relating to parts C and D

The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to-

(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(C) examine claims for reinsurance payments under section 1395w-115(b) of this title to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance

costs permitted under paragraph (2) of that section; and

(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.

(10) Use of certain recovered funds

(A) In general

After application of paragraph (1)(C), the Secretary shall retain a portion of the amounts recovered by recovery audit contractors for each year under this section which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of, subject to subparagraph (B), carrying out sections 1395l(z),1 1395m(l)(16), and 1395kk-1(a)(4)(G) of this title, carrying out section 514(b) of the Medicare Access and CHIP Reauthorization Act of 2015, and implementing strategies (such as claims processing edits) to help reduce the error rate of payments under this subchapter. The amounts retained under the preceding sentence shall not exceed an amount equal to 15 percent of the amounts recovered under this subsection, and shall remain available until expended.

(B) Limitation

Except for uses that support claims processing (including edits) or system functionality for detecting fraud, amounts retained under subparagraph (A) may

not be used for technological-related infrastructure, capital investments, or information systems.

(C) No reduction in payments to recovery audit contractors

Nothing in subparagraph (A) shall reduce amounts available for payments to recovery audit contractors under this subsection.

(i) Evaluations and annual report

(1) Evaluations

The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

(2) Annual report

Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies-

(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Insurance Trust Fund under section 1395t of this title, to carry out this section; and

(B) the effectiveness of the use of such funds.

(j) Expanding activities of Medicare drug integrity contractors (MEDICs)

(1) Access to information

Under contracts entered into under this section with Medicare drug integrity contractors (including any successor entity to a Medicare drug integrity contractor), the Secretary shall authorize such contractors to directly accept prescription and necessary medical records from entities such as pharmacies, prescription drug plans, MA-PD plans, and physicians with respect to an individual in order for such contractors to provide information relevant to the determination of whether such individual is an at-risk beneficiary for prescription drug abuse, as defined in section 1395w-104(c)(5)(C) of this title.

(2) Requirement for acknowledgment of referrals

If a PDP sponsor or MA organization refers information to a contractor described in paragraph (1) in order for such contractor to assist in the determination described in such paragraph, the contractor shall-

(A) acknowledge to the sponsor or organization receipt of the referral; and

(B) in the case that any PDP sponsor or MA organization contacts the contractor requesting to know the determination by the contractor of whether or not an individual has been determined to be an individual described in such paragraph, shall 2 inform such sponsor or organization of such determination on a date that is not later than 15 days after the date on which the sponsor or organization contacts the contractor.

(3) Making data available to other entities

(A) In general

For purposes of carrying out this subsection, subject to subparagraph (B), the Secretary shall authorize MEDICs to respond to requests for information from PDP sponsors and MA organizations, State prescription drug monitoring programs, and other entities delegated by such sponsors or organizations using available programs and systems in the effort to prevent fraud, waste, and abuse.

(B) HIPAA compliant information only

Information may only be disclosed by a MEDIC under subparagraph (A) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note).

28 U.S. Code § 2416(c) - Time for commencing actions brought by the United States—Exclusions

For the purpose of computing the limitations periods established in section 2415, there shall be excluded all periods during which -

(c) facts material to the right of action are not known and reasonably could not be known by an official of the United States charged with the responsibility to act in the circumstances;

31 U.S. Code § 3729. False claims

(a) LIABILITY FOR CERTAIN ACTS.-

(1) IN GENERAL.-Subject to paragraph (2), any person who-

(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;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-4101), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) REDUCED DAMAGES.-If the court finds that-

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation,

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) COSTS OF CIVIL ACTIONS.-A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) DEFINITIONS.-For purposes of this section-

(1) the terms "knowing" and "knowingly"-

(A) 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; and

(B) require no proof of specific intent to defraud;

(2) the term "claim"-

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that-

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government-

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term "obligation" means an 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; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) EXEMPTION FROM DISCLOSURE.-Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

(d) EXCLUSION.-This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

31 U.S. Code § 3730. Civil actions for false claims

(a) RESPONSIBILITIES OF THE ATTORNEY GENERAL.-The Attorney General diligently shall investigate a violation under section 3729. If the Attorney General finds that a person has violated or is violating section 3729, the Attorney General may bring a civil action under this section against the person.

(b) ACTIONS BY PRIVATE PERSONS.-

(1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) 1 of the Federal Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall-

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) RIGHTS OF THE PARTIES TO QUI TAM ACTIONS.-

(1) If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2)

(A) The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Government may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the Government that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as-

(i) limiting the number of witnesses the person may call;

(ii) limiting the length of the testimony of such witnesses;

(iii) limiting the person's cross-examination of witnesses; or

(iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Government so requests, it shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts (at the Government's expense). When a person proceeds with the action, the court, without limiting the status and rights of the

person initiating the action, may nevertheless permit the Government to intervene at a later date upon a showing of good cause.

(4) Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Government has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in such other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the United States, if all time for filing such an

appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(d) AWARD TO QUI TAM PLAINTIFF.-

(1) If the Government proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government 2 Accounting Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(2) If the Government does not proceed with an action under this section, the person bringing the action or

settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of section 3729 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of section 3729, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the United States to continue the action, represented by the Department of Justice.

(4) If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails

in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) CERTAIN ACTIONS BARRED.-

(1) No court shall have jurisdiction over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

(2)

(A) No court shall have jurisdiction over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought.

(B) For purposes of this paragraph, "senior executive branch official" means any officer or employee listed in paragraphs (1) through (8) of section 13103(f) of title 5.

(3) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.

(4)

(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if

substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed-

(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has 3 knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.

(f) GOVERNMENT NOT LIABLE FOR CERTAIN EXPENSES.-The Government is not liable for expenses which a person incurs in bringing an action under this section.

(g) FEES AND EXPENSES TO PREVAILING DEFENDANT.-In civil actions brought under this

section by the United States, the provisions of section 2412(d) of title 28 shall apply.

(h) RELIEF FROM RETALIATORY ACTIONS.-

(1) IN GENERAL.-Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop 1 or more violations of this subchapter.

(2) RELIEF.-Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action under this subsection may be brought in the appropriate district court of the United States for the relief provided in this subsection.

(3) LIMITATION ON BRINGING CIVIL ACTION.-A civil action under this subsection may not be brought more than 3 years after the date when the retaliation occurred.

31 U.S. Code § 3731. False claims procedure

(a) A subpoena requiring the attendance of a witness at a trial or hearing conducted under section 3730 of this title may be served at any place in the United States.

(b) A civil action under section 3730 may not be brought-

(1) more than 6 years after the date on which the violation of section 3729 is committed, or

(2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed,

whichever occurs last.

(c) If the Government elects to intervene and proceed with an action brought under 3730(b),1 the Government may file its own complaint or amend the complaint of a person who has brought an action under section 3730(b) to clarify or add detail to the claims in which the Government is intervening and to add any additional claims with respect to which the Government contends it is entitled to relief. For statute of limitations purposes, any such Government pleading shall relate back to the filing date of the complaint of the person who originally brought the action, to the extent that the claim of the Government arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of that person.

(d) In any action brought under section 3730, the United States shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

(e) Notwithstanding any other provision of law, the Federal Rules of Criminal Procedure, or the Federal Rules of Evidence, a final judgment rendered in favor of the United States in any criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action which involves the same transaction as in the criminal proceeding and which is brought under subsection (a) or (b) of section 3730.