No. _____

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA, ET AL., EX REL., MICHAEL ANGELO AND MSP WB, LLC, PETITIONERS,

v.

ALLSTATE INSURANCE COMPANY, ET AL., RESPONDENTS

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

A relator may bring a False Claims Act ("FCA") action under 31 U.S.C. § 3729(a)(1)(G) when a *qui tam* defendant "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" such an obligation, also known as a "reverse false claim."

Certain circuits have taken different approaches as to what "obligation" may underly a reverse false claim. Most circuits have recognized reverse false claims involving a defendant's direct obligation to the Government. The Fifth Circuit has held that a reverse false claim can also involve a defendant's impairment of a third party's obligation to the Government, or an "indirect reverse false claim." In the decision below, the Sixth Circuit concluded that § 3729(a)(1)(G) only permits reverse false claims based on a defendant's direct obligation.

Additionally, while claims under the False Claims Act are generally required to be pleaded with particularity under Fed. R. Civ. P 9(b), knowledge may be pleaded generally under Rule 9(b). In the decision below, the Sixth Circuit required pleading knowledge with particularity in support of Petitioners' reverse false claims allegations.

The questions presented are:

(1) Whether relators can state a reverse false claim based on defendants' impairment of obligations of third-party government contractors to the Government; and (2) whether knowledge must be pleaded with particularity to state a reverse false claim.

PARTIES TO THE PROCEEDINGS

Petitioners Michael Angelo and MSP WB, LLC were the relators before the district court and appellants before the court of appeals. Respondents Allstate Insurance Company (and affiliated entities)[1] (collectively, "Allstate"); and Insurance Services Offices, Inc. ("ISO") were the defendants in the district court and appellees in the court of appeals.

CORPORATE DISCLOSURE STATEMENT

Petitioner MSP WB, LLC is a Delaware limited liability company. MSP Recovery, LLC, a Florida limited liability company, is the sole member of MSP WB, LLC. MSP Recovery, LLC's sole member is Lionheart II Holdings, LLC, a Delaware limited liability company. Lionheart II Holdings, LLC's parent company is MSP Recovery, Inc. d/b/a LifeWallet, a publicly traded Delaware corporation, which owns 10% or more of the membership interest of Lionheart II Holdings, LLC. Except as stated above,

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[1] Namely, Allstate Cnty Mut. Ins. Co., Allstate Fire & Cas. Ins. Co., Allstate Ind. Co., Allstate NJ Ins. Co., Allstate NJ Prop. & Cas. Ins. Co., Allstate Northbrook Ind. Co., Allstate Prop. & Cas. Ins. Co., Allstate TX Lloyds, Allstate Vehicle & Prop. Ins. Co., Castle Key Ind. Co., Castle Key Ins. Co., Encompass Floridian Ind. Co., Encompass Floridian Ins. Co., Encompass Home & Auto Ins. Co., Encompass Ind. Co., Encompass Independent Ins. Co., Encompass Ins. Co., Encompass Ins. Co. of Amer., Encompass Ins. Co. of MA, Encompass Ins. Co. of NJ, Encompass Prop. & Cas. Co., Encompass Prop. & Cas. Ins. Co. of NJ, Esurance Ins. Co., Esurance Ins. Co. of NJ, Esurance Prop. & Cas. Ins. Co., First Colonial Ins. Co., and North Light Specialty Ins. Co.

there is no publicly held corporation that owns 10% or more of the stock of the entities listed above.

RELATED PROCEEDINGS

United States District Court (E.D. Mich.):

United States v. Allstate Ins. Co., No. 2:19-CV-11615 (Aug. 9, 2022, Jan. 19, 2023, Feb. 23, 2023)

United States Court of Appeals (6th Cir.):

United States ex rel. Angelo v. Allstate Ins. Co., No. 23-1196 (June 27, 2024)

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases Page(s)

Statutes

Rules

Regulations

Other Authorities

PETITION FOR A WRIT OF CERTIORARI

OPINIONS BELOW

The opinion of the court of appeals (App. 1a–22a) is published at 106 F.4th 441.

The district court's order granting in part Respondent Allstate's Motion to Dismiss and Motion for Judicial Notice (App. 48a–84a) is available at 620 F. Supp. 3d 674. The order granting Respondent ISO's Motion to Dismiss, dismissing with prejudice the conspiracy claim against Respondent Allstate, and dismissing without prejudice Petitioners' state law claims (App. 30a–47a) is available at 2023 WL 318447. The order denying Petitioners' Motion to Alter or Amend Judgment or Relief from Judgment (App. 23a–29a) is available at 2023 WL 2186428.

STATEMENT OF JURISDICTION

The judgment of the court of appeals was entered on June 27, 2024. App. 1a–22a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

PROVISIONS INVOLVED

Part of Section 3730 of the FCA, 31 U.S.C. § 3729, is reproduced at App. 85a–89a.

STATEMENT OF THE CASE

This case presents a clear conflict between circuits regarding the statutory construction of a critical form of liability under the False Claims Act ("FCA"): Whether 31 U.S.C. § 3729(a)(1)(G) permits a reverse false claim involving the impairment of a third party's obligation to the Government (i.e., an "indirect reverse false claim").

In the decision below, the Sixth Circuit concluded that a reverse false claim occurs only "where a party engages in a false or fraudulent effort to avoid a payment owed" by that party to the Government and, as a result, held that Petitioners' failed to sufficiently allege "whether and when Allstate incurred an obligation to pay for medical expenses for which it was liable." App. 8a, 10a. The Sixth Circuit reached this holding despite Petitioners raising below that Respondent Allstate's fraudulent conduct impeded the obligations of government contractors, namely Medicare Advantage Organizations ("MAOs"), to the Government.

By excluding indirect reverse false claims, this holding severely limits the types of fraud that the Government can prosecute, undermining Congressional intent in enacting the FCA. Moreover, the decision below sets the stage for radically inconsistent rulings across circuits.

Additionally, in the decision below, the Sixth Circuit held that, in pleading knowledge, Petitioners were required to allege "what information Allstate knew, and when and how it knew it." App. 15a. In other words, the Sixth Circuit required pleading

knowledge with particularity. Not only is this contrary to Rule 9(b) and the caselaw of virtually every circuit, but it also undermines the ability of relators, and by extension the Government, to root out fraud.

This case satisfies the criteria for this Court's review. As to the first question presented, the conflict at issue has divided certain circuits, with at least three circuits foreclosing indirect reverse false claims despite the plain text of the statute and Congressional intent. The arguments have been squarely raised across the circuits to address this issue, and there is no realistic prospect the division will be reconciled without this Court's intervention. This issue was dispositive in the proceedings below, and there are no obstacles to resolving it in this Court. Additionally, the Sixth Circuit's decision to raise the pleading standard for knowledge for reverse false claims conflicts with Rule 9(b) and the caselaw of virtually every other circuit.

The questions presented raise issues of fundamental importance to the FCA, and its correct disposition is essential to supporting the purposes of the FCA and the ability of the Government to prosecute fraud. Because this case presents an optimal vehicle for resolving this significant issue, the petition should be granted.

A. Legal Background

1.a. Before 1980, whenever Medicare had overlapping obligations with a private insurer, Medicare paid first, i.e., was the "primary" payer, and a private insurer was the "secondary" payer, covering

additional costs. *MSPA Claims 1, LLC v. Tenet Fla., Inc.*, 918 F.3d 1312, 1316 (11th Cir. 2019). In 1980, to address rising Medicare costs, Congress enacted the Medicare Secondary Payer Act ("MSP Act"). See *Humana Med. Plan, Inc., v. W. Heritage Ins. Co.*, 832 F.3d 1229, 1234 (11th Cir. 2016) (citing 42 U.S.C. § 1395y(b)). The MSP Act made private insurers the "primary" payer and Medicare or certain government contractors, Medicare Advantage Organizations ("MAOs"), the "secondary" payer. See *Bio-Med. Applications of Tenn., Inc. v. Cent. States Se. & Areas Health & Welfare Fund*, 656 F.3d 277, 278 (6th Cir. 2011). "This means that if payment for covered services has been or is reasonably expected to be made by someone else, Medicare does not have to pay." *Cochran v. U.S. Health Care Fin. Admin.*, 291 F.3d 775, 777 (11th Cir. 2002). If, however, a primary payer "has not made or cannot reasonably be expected to make payment with respect to the item or service promptly," Medicare or an MAO may make a payment on the enrollee's behalf, conditioned on reimbursement from the primary plan. See 42 U.S.C. § 1395y(b)(2)(B)(i). A primary payer is obligated to reimburse Medicare for the conditional payment within 60 days. See *id*. §§ 1395y(b)(2)(B)(ii), 1395w-22(a)(4).

b. To ensure that private insurers satisfy their reimbursement obligations, Congress placed reporting requirements on those insurers under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, 121 Stat. 2492, 2497, codified at 42 U.S.C. § 1395y(b)(7)–(8). Section 111 mandates that private insurers file

quarterly reports with the Centers for Medicare & Medicaid Services ("CMS") that identify beneficiaries seeking coverage for medical expenses from the private insurer who may also be covered under Medicare "regardless of whether or not there is a determination or admission of liability" by the insurer. *Id.* § 1395y(b)(8). These reports allow CMS to "make an appropriate determination concerning coordination of benefits, including any applicable recovery claim." *Id.* § 1395y(b)(8)(B)(ii).

c. Enacted in 1997, the Medicare Advantage program, otherwise known as Medicare Part C, is a Government healthcare program, wherein CMS contracts with and pays MAOs an advance calculated and risk-adjusted capitated rate per member per month ("PMPM") for each Medicare beneficiary enrolled with an MAO. See 42 C.F.R. § 422.304. These capitated payments are paid from the Medicare Trust Fund. See 42 U.S.C. § 1395w-23(f).

By law, the amount of the PMPM payments is regularly adjusted throughout the year based on the claims data and risk-adjustment reports that MAOs are required to submit to CMS. See 42 U.S.C. § 1395w-23(a)(1)(G); 42 C.F.R. §§ 422.308, 422.2460. However, CMS's annual obligation to MAOs is not fixed and is calibrated at the end of every year. When an MAO saves money, the MAO must repay the Medicare Trust Fund between 25% and 50% of what it saved. See 42 C.F.R. §§ 422.264, 422.266, 422.304. CMS performs an end-of-year reconciliation and Risk Adjustment Data Validation ("RADV") audits of MA plans to recoup any overpayments. See *U.S. ex rel.*

Spay v. CVS Caremark Corp., 913 F. Supp. 2d 125, 173 (E.D. Pa. 2012).

Additionally, "[i]f CMS determines for a contract year that an [MAO] has [a Medical Loss Ratio ("MLR")] for a contract that is less than 0.85, the [MAO] has not met the MLR requirement and must remit to CMS an amount equal to the product of the following: (1) The total revenue of the MA contract for the contract year. [and] (2) The difference between 0.85 and the MLR for the contract year." 42 C.F.R. § 422.2410(b). MLR is determined by dividing the cost of medical services over a contract year by the premiums collected from enrollees for that same period. See 42 C.F.R. § 422.2420. In other words, if an MAO's claims expenditures are low enough such that more than 15% of the premium revenue received is used for "administrative costs and profits, including executive salaries, overhead, and marketing," then the MAO must pay CMS a proportion of the excess revenue. See CMS, Medical Loss Ratio, https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio (last visited September 24, 2024).

In determining the cost of medical expenditures, "MA organizations must take into account Part C costs that were or could have been recovered or avoided due to MSP when determining costs in the base period." 74 Fed. Reg. 54634, 54691 (Oct. 22, 2009). There are three ways that an MAO can "take into account" these avoidable expenses (i.e., reduce their medical expenditure calculation): by (1) recovering from the primary payer or other "liable third parties;" (2) avoiding "Part C costs by directing providers to bill liable third parties directly;" or (3)

accounting "for Part C costs that could have been recovered or avoided, but that were actually not recovered or avoided, by not including them in Part C base period costs." *Id*.

2.a. Under the 2009 amendments, the FCA provides that a *qui tam* defendant violates the Act when it either (1) "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"[2] or (2) "knowingly conceals or knowingly and improperly avoids or decreases" such an obligation. 31 U.S.C. § 3729(a)(1)(G).[3] Courts have described this kind of

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[2] Other subsections of Section 3729(a) use the same phrase "causes to be made", 31 U.S.C. § 3729(a)(1)(B), or a similar phrase "causes to be presented", *id*. § 3729(a)(1)(A), in setting out other forms of FCA liability. Courts have found that to mean a defendant need not be the one to submit a false claim when they caused a third party to do so. See, e.g., *United States v. Hawley*, 619 F.3d 886, 893 (8th Cir. 2010) ("We conclude that this evidence creates a genuine issue of material fact regarding whether [defendant] caused [third party] to present claims for reimbursement to the [Government]."); *U.S. ex rel. Hutcheson v. Blackstone Med., Inc.*, 647 F.3d 377, 389 (1st Cir. 2011) ("When the defendant in an FCA action is a non-submitting entity, the question is whether that entity knowingly caused the submission[.]").

[3] Between 1986 and 2009, the FCA contained a substantially similar provision. See 31 U.S.C. § 3729(a)(7) (1986) (prohibiting "knowingly mak[ing], us[ing], or caus[ing] to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government"). However, the FCA at that time did not define the term "obligation."

FCA violation as a "reverse false claim." See, e.g., *United States v. Caremark*, Inc., 634 F.3d 808, 815 (5th Cir. 2011) ("This is known as a reverse false claim because the effect of the defendant's knowingly false statement is a failure to pay the Government when payment is required.").

b. The 2009 amendments added a definition for "obligation", meaning "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." 31 U.S.C. § 3729(b)(3) (emphasis added). The new definition was, in part, a reaction to the Sixth Circuit decision in *Am. Textile Mfrs. Inst., Inc. v. The Ltd, Inc.*, 190 F.3d 729 (6th Cir. 2009), which limited reverse false claims to "an obligation in the nature of those that gave rise to actions of debt at common law for money or things owed" would have arisen. *U.S. ex rel. Customs Fraud Investigations, LLC. v. Victaulic Co.*, 839 F.3d 242, 253–54 (3d Cir. 2016) (quoting *Am. Textile Mfrs. Inst. Inc.*, 190 F.3d at 735). "In effect, [Congress] expressly rejected [the Sixth Circuit's] narrow interpretation of the FCA's reverse false claims provision in favor of a more broadly inclusive definition", which includes encompasses "instance[s] where there is a relationship between the Government and a person that results in the duty to pay the Government money, whether or not the amount owed is yet fixed." *Id.* (quotation omitted).

c. The FCA defines "knowing" and "knowingly" to "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[.]" See 31 U.S.C. § 3729(b)(1).

3. Virtually every circuit has recognized that a relator can state a claim for a reverse false claim involving a defendant's direct obligation to the Government. However, certain circuits have (at least implicitly) precluded reverse false claims involving the impairment of a third party's obligation to the Government, including the Sixth Circuit in the decision below.

a. The Second Circuit has held (at least implicitly) that a reverse false claim *only* involves a defendant's direct obligation to the Government. See *U.S. ex rel. Foreman*, 19 F.4th 85, 119 (2d Cir. 2021) ("Where a complaint 'makes no mention of any financial obligation that the [defendants] owed to the government,' . . . a court should dismiss the reverse false claim." (quotation omitted)); *Miller v. U.S. ex rel. Miller*, 110 F.4th 533, 544 (2d Cir. 2024) ("[A] *qui tam* plaintiff does not state a reverse false claim if the defendant does not have an obligation . . . to pay the government."); but see *U.S. ex rel. Grubea v. Rosicki, Rosicki & Assocs., P.C.*, 318 F. Supp. 3d 680, 703 (S.D.N.Y. 2018) ("The FCA does not require that the obligation to pay or transmit money to the Government be the defendant's obligation—rather, the provision applies whenever a defendant has decreased 'an obligation' to pay the Government." (quotation omitted)). The Eleventh Circuit, too,

concluded that "[t]o sustain a reverse false claim action, relators must show that the defendants owed an obligation to pay money to the United States at the time of the allegedly false statements. *U.S. ex rel. Matheny v. Medco Health Sols., Inc.*, 671 F.3d 1217, 1223 (11th Cir. 2012) (citing *United States v. Pemco Aeroplex, Inc.*, 195 F.3d 1234, 1235–37 (11th Cir. 1999)); but see *U.S. ex rel. Wallace v. Exactech, Inc.*, 2020 WL 4500493, at *21 (N.D. Ala. Aug. 5, 2020) ().

The Sixth Circuit has similarly concluded (and reconfirmed in the decision below) that a reverse false claim *only* involves the defendant's direct obligation to the Government. See also *U.S. ex rel. Ibanez v. Bristol-Myers Squibb Co.*, 874 F.3d 905, 916 (6th Cir. 2017) ("Section 3719(a)(1)(G) requires a relator to allege facts that show defendants received overpayments from the government and failed to refund those payments.") (citations omitted); *Chesbrough v. VPA, P.C.*, 655 F.3d 461, 473 (6th Cir. 2011) (holding relator must allege "'the defendant made a false record or statement at a time that the defendant owed to the government an obligation[.]'") (quoting *Am. Textile Mfrs. Inst., Inc.*, 190 F.3d at 736).

b. By contrast, the Fifth Circuit has held that, as a matter of statutory construction, a relator may bring a *qui tam* action premised on a defendant "knowingly making a false statement that will cause a third party to impair its obligation to the federal government", also known as an "indirect reverse false claim." *Caremark, Inc.*, 634 F.3d at 817 ("[The statute does not require that the statement impair the *defendant's* obligation; instead, it requires that the statement impair '*an* obligation to pay or transmit money or

property to the Government.'") (quoting 31 U.S.C. § 3729(a)(7) (1986)) (emphasis in original). This rule has been adopted by courts across several circuits. See *U.S. ex rel. Thomas v. Care*, 2023 WL 7413669, at *7 (D. Ariz. Nov. 9, 2023); *Spay*, 913 F. Supp. 2d at 172–73; *Wallace*, 2020 WL 4500493, at *21; *Grubea*, 318 F. Supp. 3d at 703; *U.S. ex rel. Koch v. Koch Indus., Inc.*, 57 F. Supp. 2d 1122, 1128–29 (N.D. Okla. 1999); *U.S. ex rel. Hunt v. Merck-Medco Managed Care, L.L.C.*, 336 F. Supp. 2d 430, 444–45 (E.D. Pa. 2004); see also *U.S. ex rel. Landis v. Tailwind Sports Corp.*, 51 F. Supp. 3d 9, 60 (D.D.C. 2014) (citing *Caremark* favorably); *U.S. ex rel. Chepurko v. e-Biofuels, LLC*, 2020 WL 2085071, at *7 (S.D. Ind. Apr. 30, 2020) (same).

4.a. Rule 9(b) provides that "[i]n alleging fraud . . . , a party must state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). Courts frequently use a popular formulation that requires a plaintiff to allege "the who, what, when, where, and how" of the alleged fraud. 5A Fed. Prac. & Proc. Civ. § 1297 (4th ed.) (quotation omitted). Courts have identified a wide variety of reasons for Rule 9(b)'s particularity requirement, including to safeguard defendant's reputation from frivolous and unfounded allegations; to deter the filing of suits solely for discovery purposes or "fishing expeditions"; and to enable defendants to identify the particular fraudulent claim alleged and to effectively prepare a responsive pleading and an overall defense. See *id.* § 1296.

b. By contrast, "[m]alice, intent, knowledge, and other conditions of a person's mind may be alleged

generally." Fed. R. Civ. P. 9(b). "The concept behind this portion of Rule 9(b) is an understanding that any attempt to require specificity in pleading a condition of the human mind would be unworkable and undesirable." 5A Fed. Prac. & Proc. Civ. § 1301 (4th ed.). However, pleading knowledge generally still requires a plaintiff to satisfy Fed. R. Civ. P. 8(a). See *Ashcroft v. Iqbal*, 556 U.S. 662, 686 (2009).

c. In the context of FCA litigation, virtually all circuits have applied Rule 9(b) to reverse false claims. See, e.g., *Foreman*, 19 F.4th at 119; *U.S. ex rel. Petras v. Simparel, Inc.*, 857 F.3d 497, 502 (3d Cir. 2017); *U.S. ex rel. Sibley v. Univ. of Chicago Med. Ctr.*, 44 F.4th 646, 655 (7th Cir. 2022); *Olson v. Fairview Health Servs. of Minnesota*, 831 F.3d 1063, 1073 (8th Cir. 2016).[4] Yet many circuits relax the Rule 9(b) standard under certain circumstances, including when facts are peculiarly within the defendant's knowledge, see, e.g., *Miller*, 110 F.4th at 544; *U.S. ex rel. Doe v. Dow Chem. Co.*, 343 F.3d 325, 330 (5th Cir. 2003); *U.S. ex rel. Lee v. SmithKline Beecham, Inc.*, 245 F.3d 1048, 1052 (9th Cir. 2001); or when the alleged fraudulent scheme is "complex and far-reaching", *U.S. ex rel. Bledsoe v. Cmty. Health Sys.,*

[4] Notably, some circuits and jurists have raised the question whether Rule 9(b) should apply to certain sections of the FCA that do not implicate false statements, including claims based on decreasing or avoiding an obligation under Section 3729(a)(1)(G). See *Miller*, 110 F.4th at 548 n.8; *U.S. ex rel. Takemoto v. Nationwide Mut. Ins. Co.*, 674 F. App'x 92, 96 n.1 (2d Cir. 2017); *Olson*, 831 F.3d at 1075–79 (Riley, C.J., concurring in part, dissenting in part).

Inc., 501 F.3d 493, 509–10 (6th Cir. 2007) (permitting relator to "provide[] examples of specific false claims" within the scheme).

As for knowledge, virtually all circuits require that it be pleaded generally for reverse false claims. See, e.g., *Olson*, 831 F.3d at 1074; *Matheny*, 671 F.3d at 1224; *U.S. ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 679–80 (9th Cir. 2018). Prior to the decision below, this included the Sixth Circuit, which simply required pleading knowledge generally in conformity with Rule 8(a). See *U.S. ex rel. Harper v. Muskingum Watershed Conservancy Dist.*, 842 F.3d 430, 436 (6th Cir. 2016).

5.a. From the outset, Congress intended the FCA "'to reach all types of fraud, without qualification, that might result in financial loss to the Government.'" *Cook Cnty., Ill. v. U.S. ex rel. Chandler*, 538 U.S. 119, 129 (2003) (quoting *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968)). Accordingly, "any time a false statement is made in a transaction involving a call on the U.S. fisc, False Claims Act liability may attach." *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 788 (4th Cir. 1999). This is why Congress added the reverse false claim provision in the FCA: to ensure that one who makes a false statement in order to avoid paying money owed the Government "would be equally liable under the Act as if he had submitted a false claim to receive money." S. Rep. No. 99–345, at 15, 18 (1986), reprinted in 1986 U.S.C.C.A.N. 5266 at 5280, 5283

b. The Government has in statements of interest successfully argued that improper submissions of

payments to MAOs fall within the FCA. See *U.S. ex rel. SW Challenger, LLC v. EviCore Healthcare MSI, LLC*, 2021 WL 3620427, at *7 (S.D.N.Y. Aug. 13, 2021) (noting Government statement of interest stating that "claims made to [Medicare] contractors are encompassed within the meaning of claim under the FCA, and that it is not fatal that the submission of the allegedly false claims were not made directly to the Government" and that "the approval of medically unnecessary treatment could give rise to false claims by causing the provider to bill for unnecessary treatment, billing for review services that were not provided, or indirectly affecting CMS's calculation of capitation rates." (clean up)); *U.S. ex rel. Martinez v. Orange Cnty. Global Med. Ctr., Inc.*, 2017 WL 9482462, at *3 (C.D. Cal. Sept. 14, 2017) (noting Government statement of interest stating "the volume or value of services provided to Part C beneficiaries and the costs incurred by a particular MAO could certainly affect whether a MAO chooses to submit a bid (42 C.F.R. § 422.254), the MAO's bid amount, and the Government's share of the savings for a below-benchmark bid (42 C.F.R. § 422.304(a)(1))." (cleaned up)); *U.S. ex rel. Zafirov v. Fla. Med. Assocs. LLC*, 2022 WL 4134611, at *6 (M.D. Fla. Sept. 12, 2022) ("[T]he government notes in its statement of interest, the diagnosis codes stand at the 'heart of the machinery of the Medicare Advantage Program.'").

B. Facts & Procedural History

1. On May 31, 2019, Petitioner Michael Angelo, the owner of several health care businesses, filed a *qui tam* complaint under seal against Respondent Allstate, alleging that Respondent Allstate defrauded

the Government by submitting false reports in violation of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. See App. 50a–51a. The *qui tam* complaint remained under seal for over a year at the request of the Government, pursuant to 31 U.S.C. § 3730(b)(2). The Government declined intervention. See App. 31a, 49a.

2.a. On June 7, 2021, Petitioner Angelo moved for leave to file a second amended complaint, on behalf of the Government, ten States, and Puerto Rico, to add thirty-two Allstate-affiliated insurance entities and Respondent ISO as defendants and to add a co-relator, Petitioner MSP WB, LLC. See App. 31a, 49a. The second amended complaint raised three claims: (1) reverse false claims violations, (2) conspiracy to violate the FCA, and (3) violations of State false claims laws. See App. 31a.

b. On September 18, 2021, the district court granted the motion for leave to amend. See App. 31a. The Government, States, and Puerto Rico declined intervention. See App. 31a.

3.a. On December 15, 2022, Respondents filed motions to dismiss, and Respondent Allstate filed a motion for judicial notice. See App. 49a.

b. On August 9, 2022, the district court granted in part Respondent Allstate's motion for judicial notice and motion to dismiss. See App. 84a. First, the district court found that Petitioners' allegations, "[t]aken as true, . . . established a fraud injury on the United States due to Defendants' failure to satisfy Section 111's reporting requirements" and, therefore, had standing. See App. 56a. Next, the district court found

that the FCA's first-to-file bar[5] did not bar the addition of Petitioner MSP WB, LLC as a co-relator. See App. 56a–61a. However, the district court found that Petitioners' claims were barred by the FCA's public disclosure bar.[6] See App. 83a. The district court found that two *qui tam* cases—*U.S. ex rel. Hayes v. Allstate Ins. Co.*, No. 1:12-cv-01015 (W.D.N.Y. Apr. 14, 2014) and *U.S. ex rel. Takemoto v. Ace Am. Ins. Co.*, No. 1:11-cv-00613 (W.D.N.Y. Oct. 31, 2014)—constituted prior public disclosures containing allegations that were substantially similar to Petitioners' allegations. See App. 66a–80a. And the district court found that Petitioners did not qualify as original sources. See App. 80a–83a.

b. On January 19, 2023, the district court granted Respondent ISO's motion to dismiss, dismissed with prejudice the conspiracy claims against Respondent Allstate, and dismissed without prejudice Petitioners' state law claims. See App. 46a. The district court found that Petitioners failed to plead factual allegations with sufficient particularity regarding Respondent ISO to support Petitioners' reverse false claim count or conspiracy count. See App. 35a–45a. Last, the district court declined to exercise supplemental jurisdiction over Petitioners' state law claims. See App. 45a–46a.

4.a. On February 16, 2023, Petitioners filed a motion to amend judgment or relief from judgment, requesting that the district court dismiss without

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[5] *See* 31 U.S.C. § 3730(b)(5).

[6] *See* 31 U.S.C. § 3730(e)(4).

prejudice and permit Petitioners to amend the complaint. See App. 24a.

b. On February 23, 2023, the district court denied Petitioners' motion. See App. 29a. On February 24, 2023, Petitioners filed a notice of appeal from the district court's August 9, 2022, January 19, 2023, and February 23, 2023, orders.

5. On June 27, 2024, the Sixth Circuit affirmed the district court's orders, in a published decision, on an entirely different basis than the district court. See App. 22a. The Sixth Circuit concluded that a reverse false claim occurs only "where a party engages in a false or fraudulent effort to avoid a payment owed to the government" by that party. See App. 8a. The Sixth Circuit held that, as such, Petitioners failed to plead with particularity a reverse false claim, as the allegations lacked sufficient detail regarding Respondent Allstate's obligation to the Government. See App. 9a–13a. The Sixth Circuit also held that Petitioners failed to sufficiently plead knowledge "without evidence of what information Allstate knew, and when and how it knew it", i.e., without sufficient particularity. See App. 15a. Next, the Sixth Circuit held that Petitioners failed to sufficiently plead their conspiracy claim and that the district court did not abuse its discretion in denying Petitioners' request for leave to amend. See App. 15a–22a.

REASONS FOR GRANTING THE PETITION

The decision below presents two distinct conflicts with the established law of other circuits. First, the Sixth Circuit has, in effect, foreclosed the possibility of an indirect reverse false claim, despite the plain

text of the statute and Congressional intent, as the Fifth Circuit *Caremark* decision makes clear. Second, the Sixth Circuit has heightened the pleading standard for knowledge for reverse false claims, contrary to Rule 9(b) and the caselaw of other circuits.

As it stands, district courts in different circuits are bound to apply starkly differing standards in (1) evaluating reverse false claims and (2) considering allegations of a defendant's knowledge. The positions on the sides of the circuits are clear; the question is cleanly presented; and this case offers the ideal vehicle for the Court to resolve it. Moreover, the decision below has profound implications for *qui tam* litigation as it severely hampers the Government's ability to prosecute reverse false claims and undermines the relator's ability to allege such claims. Accordingly, the Court should grant the petition.

I. THE COURTS OF APPEALS ARE DIVIDED ON WHETHER AN INDIRECT REVERSE FALSE CLAIM IS COGNIZABLE UNDER 31 U.S.C. § 3729(a)(1)(G)

Three circuits, the Second Circuit, the Sixth Circuit, and Eleventh Circuit have concluded (at least implicitly) that a reverse false claim can only be sustained if it involves the defendant's direct obligation to the Government. The Fifth Circuit, on the other hand, has concluded that, in light of the plain text of the statute and Congressional intent, a reverse false claim can also involve a defendant's impairment of a third party's obligation to the Government, i.e. an indirect reverse false claim.

A. The Fifth Circuit (and Several District Courts) Recognize Indirect Reverse False Claims

The Fifth Circuit (as well as several district courts throughout the circuits) have recognized indirect reverse false claims. The decision below conflicts with these decisions, the plain text of the statute, and Congressional intent.

1. The decision below conflicts with settled law in the Fifth Circuit. In *Caremark*, the Government and several States intervened in a *qui tam* action against a pharmacy conglomerate brought by one of its former employees, who claimed that the pharmacy conglomerate violated the FCA by unlawfully denying requests for reimbursement made by state Medicaid agencies. See 634 F.3d at 810–12. These denials resulted in losses to the Government and the state Medicaid agencies because they had to pay claims that should have been covered by the pharmacy conglomerate. *Id*. at 812. The district court entered a Rule 54(b) final judgment against the Government and granted partial summary judgment against the States. *Id*. at 810.

On appeal, the Fifth Circuit held, in relevant part, that the pharmacy conglomerate violated 31 U.S.C. § 3729(a)(7) (1986) when it denied the reimbursement requests to state Medicaid agencies, even though the pharmacy company did not have an obligation to the Government for such denials. *Id*. at 815. The Fifth Circuit relied on three court decisions—*U.S. ex rel. Hunt v. Merck–Medco Managed Care, L.L.C.*, 336 F. Supp. 2d 430 (E.D. Pa. 2004); *U.S. ex rel. Koch v. Koch*

Indus., Inc., 57 F. Supp. 2d 1122, (N.D. Okla. 1999); and *Smith v. United States*, 287 F.2d 299 (5th Cir. 1961)—to conclude that FCA allows "liability for knowingly making a false statement that will cause a third party to impair its obligation to the federal government." *Id.* at 817.

The Fifth Circuit explained that, in *Hunt*, the relator claimed that a pharmacy benefits manager ("PBM") violated the FCA by making false statements to a health insurance company that provided health insurance to federal employees. *Id.* at 816 (citing *Hunt*, 336 F. Supp. 2d at 444). The *Hunt* Court rejected the PBM's "direct privity" argument that it did not owe an obligation to the Government because its obligation was to the health insurer. *Ibid* Instead, the *Hunt* Court accepted the Government's argument that, because any contractual penalties owing from the PBM to the health insurer were required by law to be turned over to the Government, the consequence of the PBM's actions (or inactions) would and could be to reduce the amount of money owed to the health insurer that that PBM knew was in direct contractual privity with the Government. *Ibid.*

The Fifth Circuit, in addressing *Koch*, explained that the relator argued that the defendants violated 31 U.S.C. § 3729(a)(7) (1986) by making false statements to a party who had mineral leases with the Government. *Ibid.* (citing *Koch*, 57 F. Supp. 2d at 1124). The *Koch* Court rejected the defendants' argument that they could not be held liable under § 3729(a)(7) because they made statements to the lessee, not to the Government. See *Caremark*, 634 F.3d at 816 (citing *Koch*, 57 F. Supp. 2d at 1127). The

Koch Court found that the defendants' false measurements may have caused the lessee or operator to understate its royalty obligation to the Government and that Congress's intent was to expand the FCA to cover indirect reverse false claims. See *Caremark*, 634 F.3d at 816 (citing *Koch*, 57 F. Supp. 2d at 1128–29).

Moreover, the Fifth Circuit observed that it had interpreted a prior version of the FCA to encompass indirect reverse false claims. See *Caremark*, 634 F.3d at 816. The Fifth Circuit explained that, in *Smith*, the defendant made false claims for payment to the Beaumont Housing Authority ("BHA") and also made false statements to the BHA to avoid financial obligations. *Id.* at 816–17 (citing *Smith*, 287 F.2d at 300, 303–04). The *Smith* Court accepted the indirect reverse false claim theory because "'the False Claims Act applies *even where there is no direct liability running from the Government to the claimant*.'" *Caremark*, 634 F.3d at 817 (quoting *Smith*, 287 F.2d at 304) (emphasis in original). The *Smith* Court reasoned that, had the BHA "'not made these payments and had they not been reflected in the quarterly reports, the Government, in one quarter, would have received more rent and in the other would have made a lesser payment. The expenses were therefore ultimately borne by the United States Treasury.'" *Caremark*, 634 F.3d at 817 (quoting *Smith*, 287 F.2d at 304).

Moreover, the Fifth Circuit explained that "[t]he statute does not require that the statement impair the defendant's obligation; instead, it requires that the statement impair '*an* obligation to pay or transmit money or property to the Government.'" *Id.* at 817

(quoting 31 U.S.C. § 3729(a)(7) (1986)) (emphasis in original). As a result, the Fifth Circuit held "that if the Government is able to prove that Caremark knowingly made false statements to the States knowing that these statements could cause the States to impair their obligation to the Government, Caremark will be liable under § 3729(a)(7)." *Ibid.*

2. Several district courts throughout the country have adopted the Fifth Circuit's *Caremark* to recognize indirect reverse false claims in a variety of contexts. See *Thomas*, 2023 WL 7413669, at *7 (finding health care provider caused managed care organization to impair state Medicaid program's obligation to the federal government); *Spay*, 913 F. Supp. 2d at 172–73 (finding pharmacy conglomerate's failure to make accurate annual Medicare Part D reconciliations caused health insurance company to fail to return payments to CMS for false Part D claims); *Wallace*, 2020 WL 4500493, at *21 (finding that a medical device manufacturer caused third-party surgeons to receive overpayments from Medicare and Medicaid); *Grubea*, 318 F. Supp. 3d at 703 (finding mortgage servicers caused Fannie Mae and Freddie Mac to reimburse inflated foreclosure expenses, causing a reduction in the amount of money Fannie Mae and Freddie Mac paid the Treasury); see also *Landis*, 51 F. Supp. 3d at 60 (citing *Caremark* favorably); *Chepurko*, 2020 WL 2085071, at *7 (same).

B. Few Other Circuits, Including the Sixth Circuit, Limit Reverse False Claims to a Defendant's Direct Obligation to the Government

In contrast to this rule, the Second Circuit, Sixth Circuit, and Eleventh Circuit have previously held (at least implicitly) that reverse false claims are only cognizable when they involve the defendant's direct obligation to the Government. However, this is contrary to the plain text of the statute and Congressional intent.

1. The Second Circuit's *Foreman* decision involved a relator, a former employee, that alleged, in relevant part, a defense contractor received overpayments from the Government related to timesheet fraud and labor billing, which were also the basis for his conventional false claim allegations. 19 F.4th at 97–100, 119. However, the *Foreman* Court held that the relator failed to state a reverse false claim because the reverse false claim allegations were duplicative of his conventional false claim allegations, rending the reverse false claims "redundant." *Id.* at 119–20. Relying on unpublished Second Circuit and district court opinions, the *Foreman* Court observed "[t]here a complaint 'makes no mention of any financial obligation that the [defendants] owed to the government,' . . . a court should dismiss the reverse false claim." *Id.* at 119 (quoting *Wood ex rel. U.S. v. Applied Rsch. Assocs.*, Inc., 328 F. App'x 744, 748 (2d Cir. 2009)) (citing also *U.S. ex rel. Hussain v. CDM Smith, Inc.*, 2017 WL 4326523, at *9 (S.D.N.Y. Sept. 27, 2017)). However, *Wood* involved a complaint that failed to allege any obligation at all, see *Wood*, 328 F.

App'x at 748, and *Hussain* (like *Foreman*) merely involved a relator alleging redundant reverse false claims, see *Hussain*, 2017 WL 4326523, at *9. Moreover, *Foreman* did not involve allegations of an impairment of third party's obligation to the Government.

In *Miller* (which also did not involve the impairment of a third party's obligation to the Government), the Second Circuit held, in relevant part, that, because certain statutory penalties for defendant bank's regulatory violations were discretionary, such penalties could not constitute an obligation to the Government. 110 F.4th at 546–47. The Second Circuit relied on three out-of-circuit opinions to conclude that "a *qui tam* plaintiff does not state a reverse false claim if the defendant does not have an obligation . . . to pay the government." *Id.* at 544 (citing *Victaulic Co.*, 839 F.3d 242; *U.S. ex rel. Simoneaux v. E.I. duPont de Nemours & Co.*, 843 F.3d 1033 (5th Cir. 2016); *U.S. ex rel. Barrick v. Parker-Migliorini Int'l, LLC*, 878 F.3d 1224 (10th Cir. 2017)). Yet none of these three out-of-circuit decisions expressly conclude that a reverse false claim is limited solely to a defendant's direct obligation to the Government. And as discussed above, the binding caselaw of the Fifth Circuit has recognized indirect reverse false claims.

Moreover, at least one district court in the Second Circuit has found that "[t]he FCA does not require that the obligation to pay or transmit money to the Government be the defendant's obligation—rather, the provision applies whenever a defendant has decreased 'an obligation' to pay the Government."

Grubea, 318 F. Supp. 3d at 703 (quoting *Landis*, 51 F. Supp. 3d at 60).

2. In the Eleventh Circuit's *Matheny* case, two relators, employees of a pharmacy services provider, alleged that, pursuant to a corporate integrity agreement with the Office of the Inspector General of the U.S. Department of Health and Human Services ("OIG-HHS"), the pharmacy services providers and its subsidiaries were required to remit payments to Government for unsupported, duplicative, or erroneous claims. 671 F.3d at 1219–21. On appeal, the Eleventh Circuit reversed the district court's dismissal, holding, in relevant part, that relators had adequately alleged the existence of an obligation to pay money to the Government. *Id*. at 1223. In so holding, the Eleventh Circuit observed that, "[t]o sustain a reverse false claim action, relators must show that the defendants owed an obligation to pay money to the United States at the time of the allegedly false statements." *Ibid.* (citing *Pemco*, 195 F.3d at 1236–37). However, neither *Matheny* nor *Pemco* (which involved an aircraft maintenance contractor's return or purchase of excess aircraft parts under a government contract) involved the impairment of a third party's obligation to the Government.

Moreover, at least one district court in the Eleventh Circuit has rejected a *qui tam* defendant's argument that a relator must allege that the defendant itself owed an obligation to the Government because such an "interpretation is not supported by the plain language of the statute or by any binding Eleventh Circuit authority." *Wallace*, 2020 WL 4500493, at *21 (citing *Caremark*, 634 F.3d at 817).

3. Prior to the decision below, the Sixth Circuit twice concluded that a reverse false claim only involves a defendant's direct obligation to the Government. In *Chesbrough*, the Sixth Circuit held that the relators, a doctor and his wife, had not identified any concrete obligation owed to the Government by a medical services provider. See *Chesbrough*, 665 F.3d at 473 (quoting *Am. Textile Mfrs. Inst., Inc.*, 190 F.3d at 736). However, *Chesbrough* simply involved a "redundant" reverse false claim, as the relators simply alleged that the medical services provider retained funds received from alleged conventional false claims, and did not implicate a third party's obligation to the Government. See *Chesbrough*, 655 F.3d at 473 ("Rather, they merely allege that VPA is obligated to repay all payments it received from the government.")

In *Ibanez*, relators, former sales representatives, alleged that a pharmaceutical manufacturer engaged in off-label marketing of an antipsychotic drug that was paid for by Government programs. 874 F.3d at 912. On appeal, the Sixth Circuit affirmed the district court's dismissal of relators' second amended complaint, holding, in relevant part, that relators did not plead facts that showed that the pharmaceutical company received or retained an overpayment. *Id.* at 917 (citing 31 U.S.C. § 3729(a)(3) (1986); *Am. Textile Mfrs. Inst.*, 190 F.3d at 741).[7] In so holding, the Sixth

[7] The *Ibanez* Court also affirmed the dismissal of relators' reverse false claim allegations in their third amended complaint because, like *Miller*, the pharmaceutical manufacturer's corporate

Circuit observed that "Section 3719(a)(1)(G) requires a relator to allege facts that show defendants received overpayments from the government and failed to refund those payments." *Ibanez*, 874 F.3d at 916 (citations omitted). However, like *Chesbrough*, *Ibanez* did not implicate a third party's obligation to the Government.

In the decision below, the Sixth Circuit doubled down on the view that a reverse false claim can only involve a defendant's direct obligation to the Government. To wit, the Sixth Circuit defined a reverse false claim as "where a party engages in a false or fraudulent effort to avoid a payment owed to the government" by that party. App. 8a (citing 31 U.S.C. § 3729(a)(1)(G); *Barrick*, 878 F.3d at 1226).[8] As such, the Sixth Circuit concluded Petitioners' "complaint lack[ed] detail as to whether and when Allstate incurred an obligation to pay for medical expenses for which it was liable[.]" App. 10a. The Sixth Circuit reached this holding without any consideration of Petitioners' position below that Respondents caused indirect reverse false claims by impairing the obligations of third-party government contractors, i.e., MAOs, by falsely reporting under Section 111.

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integrity agreement only imposed discretionary penalties. See *Ibanez*, 874 F.3d at 922.

[8] Like *Miller*, the Sixth Circuit's citation to *Barrick* in the decision below overlooks the fact that the Tenth Circuit's decision does not necessarily limit reverse false claims only to scenarios involving a defendant's direct obligation to the Government.

II. THE SIXTH CIRCUIT IS NOW THE ONLY CIRCUIT TO REQUIRE PLEADING KNOWLEDGE WITH PARTICULARITY

The Sixth Circuit's holding, in the decision below, that knowledge must be pleaded with particularity to sustain reverse false claim allegations conflicts with Rule 9(b) and the caselaw of nearly every other circuit.

1. Virtually all circuits require that it be pleaded generally for reverse false claims. See, e.g., *Olson*, 831 F.3d at 1074; *Matheny*, 671 F.3d at 1224; *Silingo*, 904 F.3d at 679–80. For example, the Ninth Circuit, in *Silingo*, concluded that a relator, the former compliance officer of an in-home health care provider that contracted with certain MAOs, sufficiently alleged, under Rule 8(a), that the MAOs actually knew or showed reckless disregard or deliberate indifference towards the in-home health care provider's invalid risk-adjustment data. 904 F.3d at 680. The Ninth Circuit concluded that the relator's general allegations of the in-home health care provider's practices were sufficient to establish that the MAOs actual knew, recklessly disregarded, or were deliberate indifferent towards the faultiness of the data was faulty. *Ibid.* And the Ninth Circuit concluded that additional circumstances supported this holding, including the sophistication of the MAOs, CMS's repeated concerns over in-home assessments, and the MAOs possible incentive to pass along fraudulent data to yield more revenue and profit. *Id.* at 680–81.

Prior to the decision below, this included the Sixth Circuit also simply required pleading knowledge

generally in conformity with Rule 8(a). See *Harper*, 842 F.3d at 436. In *Harper*, relators alleged that a watershed conservancy district's signing of leases for hydraulic fracturing ("fracking") operations on a parcel of land violated a requirement in the deed that the land be used for recreation, conservation, or reservoir-development purposes, thus triggering the land's reversion to the Government. *Id.* at 432–34. On appeal, the Sixth Circuit affirmed the district court's dismissal, holding that realtors failed to plead that the watershed conservancy district actually knew that the deed restrictions required the return of the property to the Government, or that it acted in deliberate ignorance or reckless disregard of that fact, when they signed the fracking leases. *Id.* at 437–38.

2. In the decision below, however, the Sixth Circuit has now raised the pleading standard for knowledge, such that it is now synonymous with the Rule 9(b) particularity standard. To wit, the Sixth Circuit now requires relators to allege "what information [defendants] knew, and when and how it knew it." App. 15a; compare with 5A Fed. Prac. & Proc. Civ. § 1297 (describing "the who, what, when, where, and how" of pleading with particularity).

While the Sixth Circuit attempts to justify this elevated pleading standard by relying on *Harper*, see App. 15a, the allegations of knowledge in this case are entirely distinguishable from those in *Harper*. As generally alleged below, Respondent Allstate had actual knowledge of the requirements of the MSP Act, namely that, as a primary payer, it is obligated to reimburse Medicare for conditional payment within 60 days, see 42 U.S.C. § 1395y(b)(2)(B)(ii), 1395w-

22(a)(4), and/or that it acted in deliberate ignorance or reckless disregard of that fact by willfully blinding itself to its beneficiaries' Medicare status and submitting false or incomplete Section 111 reports (in conjunction with Respondent ISO). What's more, as generally alleged, Respondent Allstate actually knew, or acted in deliberate ignorance or reckless disregard of the fact, that MAOs use such information in determining whether and how much they must reimburse CMS. See 42 C.F.R. §§ 422.264, 422.266, 422.304, 422.2410(b); 74 Fed. Reg. at 54691.

III. THE SIXTH CIRCUIT'S HOLDINGS UNDERMINE THE PURPOSES AND POLICIES OF THE FCA

The Sixth Circuit's holdings also serve to undermine the purpose and policies of the FCA. In particular, the decision below forecloses types of fraud that the Government can prosecute and inhibits relator's ability to raise allegations of fraud against the Government.

According to Congress, the purpose of the FCA is to successfully combat "sophisticated and widespread fraud" that threatens the federal treasury and national security through "a coordinated effort of both the Government and the citizenry." S. Rep. No. 99-345, at 2–3. The clear overall intent was "to encourage more private enforcement suits." *Id.* at 23–24. The goal of the FCA is "to increase the recovery of public monies." *United States v. Cmty. Health Sys., Inc.*, 666 F. App'x 410, 420 (6th Cir. 2015) (Stranch, J., concurring).

Through the FCA, "'Congress has let loose a posse of *ad hoc* deputies to uncover and prosecute frauds

against the government.'" *U.S. ex rel. Taxpayers Against Fraud v. Gen. Elec. Co.*, 41 F.3d 1032, 1042 (6th Cir. 1994) (quoting *U.S. ex rel. Milam v. Univ. of Tex. M.D. Anderson Cancer Ctr.*, 961 F.2d 46, 49 (4th Cir. 1992)) (Congress "gave the Executive Branch the option to allocate its resources elsewhere and permit the relator to prosecute the action on its behalf."). "The goal of the FCA's *qui tam* provisions is to prevent and rectify frauds . . . by incentivizing private individuals to uncover and prosecute FCA claims." *U.S. ex rel. Ladas v. Exelis, Inc.*, 824 F.3d 16, 23 (2d Cir. 2016). This incentive has been massively successful. In 2022, relators recovered nearly $1.2 billion dollars for the government in cases where the government declined to intervene.[9] That amounts to 54 percent of the government's total FCA recoveries—*qui tam* and non-*qui tam*—for the year.

The Sixth Circuit's decision below only serves to insulate sophisticated fraudsters by allowing them to avoid accountability by hiding behind unsuspecting intermediaries. In other words, the would-be defendant can leverage a third-party's obligation to the Government to siphon money from the Government but would not be liable according to the Sixth Circuit. As a result, the Government is thereby unable to "reach all types of fraud, without qualification, that might result in financial loss to the Government." *Chandler*, 538 U.S. at 129 (quotation

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[9] See U.S. Dep't of Just., *False Claims Act Settlements and Judgments Exceed $2 Billion in Fiscal Year 2022* (Feb. 7, 2023), https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-2-billion-fiscal-year-2022.

omitted). And by raising the pleading standard for knowledge, the Sixth Circuit has hamstrung relators' ability to uncover and prosecute FCA claims", particularly where the evidence of a defendant's subjective knowledge may be limited (or intentionally obfuscated) for an otherwise meritorious claim. *Ladas*, 824 F.3d at 23. Thus, by limiting both the Government and relators, the decision below undermines the FCA's goal: "to increase the recovery of public monies." *Cmty. Health Sys., Inc.*, 666 F. App'x at 420 (Stranch, J., concurring).

IV. THIS CASE IS AN IDEAL VEHICLE FOR REVIEWING THESE IMPORTANT QUESTIONS

1. The question presented is of exceptional legal and practical importance. The burgeoning conflict over the cognizability of indirect reverse false claims will undoubtedly proliferate to other circuits. And the Sixth Circuit's heightened pleading standard for knowledge leaves it alone among all circuits. The standard for how courts should approach reverse false claims and the pleading standard for knowledge should be uniform. There is no basis for leaving issues so consequential to *qui tam* litigation to the happenstance of where a *qui tam* action is brought. To leave the circuits so fractured only serves to hamper the Government's ability to prosecute fraud in Michigan, Ohio, Kentucky, and Tennessee and encourage venue shopping by *qui tam* defendants, who may, for example, seek transfers to the Sixth Circuit to simply avoid liability.

2. This case is an ideal vehicle for deciding this significant question. The dispute turns on pure

questions of law: (1) whether indirect false claims are cognizable under the FCA; and (2) whether relators must plead knowledge with particularity in reverse false claims.

This issue was dispositive in the case below. There is no alternative route to reinstating Petitioners' case. The Sixth Circuit rejected Petitioners' indirect reverse claim allegations and imposed a heightened pleading standard for knowledge in a published decision, which now binds every district court within the Circuit and every subsequent Sixth Circuit panel. See *Rutherford v. Columbia Gas*, 575 F.3d 616, 619 (6th Cir. 2009) ("A published prior panel decision remains controlling authority unless an inconsistent decision of the United States Supreme Court requires modification of the decision or this Court sitting *en banc* overrules the prior decision." (internal quotation marks and citation omitted)). Its decision was outcome-determinative: had the Sixth Circuit considered Petitioners' indirect reverse false claim allegations and applied the correct pleading standard for Petitioners' knowledge allegations, it would not have affirmed.

To wit, as generally alleged below, Respondent Allstate had actual knowledge of the requirements of the MSP Act, namely that, as a primary payer, it is obligated to reimburse Medicare for conditional payment within 60 days, see 42 U.S.C. § 1395y(b)(2)(B)(ii), 1395w-22(a)(4), and/or that it acted in deliberate ignorance or reckless disregard of that fact by willfully blinding itself to its beneficiaries' Medicare status and submitting false or incomplete Section 111 reports (in conjunction with Respondent ISO). What's more, as generally alleged, Respondent

Allstate actually knew, or acted in deliberate ignorance or reckless disregard of the fact, that MAOs use such information in determining whether and how much they must reimburse CMS. See 42 C.F.R. §§ 422.264, 422.266, 422.304, 422.2410(b); 74 Fed. Reg. at 54691. In other words, Petitioners sufficiently alleged Respondent Allstate's impairment of obligations of MAOs to the Government.

Moreover, recognizing such indirect reverse false claims is consistent with the statutory scheme set out in 31 U.S.C. § 3729(a), which permits other forms of FCA liability for a third party's submission of claims using the exact same "causes to be" language. 31 U.S.C. § 3729(a)(1)(A), (B); see also *Hawley*, 619 F.3d at 893; *Hutcheson*, 647 F.3d at 389. "[I]dentical words used in different parts of the same act are intended to have the same meaning." *Helvering v. Stockholms Enskilda Bank*, 293 U.S. 84, 87 (1934); see also *Brown v. Gardner*, 513 U.S. 115, 118 (1994) (explaining that the presumption of consistent usage is "surely at its most vigorous when a term is repeated within a given sentence").

The decision below also thoroughly considered the question presented. The Sixth Circuit doubled down on its previous view that a reverse false claim can only implicate a defendant's direct obligation to the Government. See App. 8a, 10a. And the Sixth Circuit closely evaluated whether Petitioners had alleged knowledge with particularity. See App. 15a.

Further deliberation in the lower courts will not aid this Court's consideration of these important questions regarding the scope of Section 3729(a)(1)(G)

or the pleading standard for knowledge for reverse false claims. This case cleanly presents the issue and provides an ideal vehicle for resolving the circuit conflict.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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SEPTEMBER 2024

APPENDIX

TABLE OF APPENDICES

Page

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT, FILED JUNE 27, 2024

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 23-1196

UNITED STATES OF AMERICA, *et al.*
ex rel. MICHAEL ANGELO AND MSP WB, LLC,

Relators-Appellants,

v.

ALLSTATE INSURANCE COMPANY, *et al.*,

Defendants-Appellees.

Appeal from the United States District Court
for the Eastern District of Michigan at Detroit.
No. 2:19-cv-11615—Stephen J. Murphy III, District Judge.

Argued: December 7, 2023
Decided and Filed: June 27, 2024

Before: BOGGS, SUHRHEINRICH,
and READLER, Circuit Judges.

OPINION

CHAD A. READLER, Circuit Judge. Relators allege that Allstate Insurance violated the False Claims Act by

skirting its obligations under the Medicare Secondary Payer Act. After multiple amendments by relators, the district court deemed their second amended complaint deficient in numerous respects and dismissed the case with prejudice. Because the complaint fails to state a claim for a violation of the False Claims Act, we affirm.

I.

A. For some incidents, an individual who has incurred medical expenses can lawfully seek recovery from more than one insurer. Sometimes, those insurers are both private entities. That is the case, for example, when a car accident victim is entitled to recover medical expenses from both her own auto insurer as well as the other driver's auto insurance carrier.

What happens when one of those insurers is Medicare, the federal health insurance program primarily available to Americans sixty-five or older? Formerly, whenever Medicare had obligations that overlapped with the obligations of a private insurer, Medicare paid first and let the private insurer pick up any remaining expenses. Medicare was deemed the "primary" payer, the private insurer the "secondary" payer. *MSPA Claims 1, LLC v. Tenet Fla., Inc.,* 918 F.3d 1312, 1316 (11th Cir. 2019).

That changed in 1980 with the enactment of the Medicare Secondary Payer Act. *Humana Med. Plan, Inc., v. W. Heritage Ins. Co.,* 832 F.3d 1229, 1234 (11th Cir. 2016) (citing 42 U.S.C. § 1395y(b)). To address rising Medicare costs, the Act reversed the primary-secondary order. It

made private insurers the "primary" payer (pay first), and Medicare or a non-governmental Medicare Advantage Organization (MAO) the "secondary" payer (pay only if a balance remains). *See Bio-Med. Applications of Tenn., Inc. v. Cent. States Se. & Areas Health & Welfare Fund,* 656 F.3d 277, 278 (6th Cir. 2011). Medicare, in other words, became "an entitlement of last resort, available only if no private [insurer] was liable." *Netro v. Greater Baltimore Med. Ctr., Inc.,* 891 F.3d 522, 524 (4th Cir. 2018) (citation omitted).

In practice, this two-tiered coverage scheme sometimes complicates how medical expenditures are satisfied. Medical bills can mount quickly, yet payments, especially those from private sources, are not always as swift. So Congress created a solution: when the primary payer/plan does not "promptly meet its obligations," Medicare can pay the expenses up front, so long as the primary payer eventually reimburses Medicare for any amounts it overpaid. *See id.* (citing 42 U.S.C. § 1395y(b)(2)(B)). This scenario arises when, for example, a primary payer is contesting its liability to cover an incurred expense. *MSPA Claims 1, LLC v. Kingsway Amigo Ins. Co.,* 950 F.3d 764, 767 (11th Cir. 2020). To ensure that Medicare does, in fact, get reimbursed for payments it fronts for a primary payer, the Medicare Secondary Payer Act authorizes the government to sue the primary payer when the primary payer fails to reimburse the government. *Id.*

One other aspect of this payment structure bears mention. To enhance the likelihood that private insurers

satisfy their reimbursement obligations, Congress placed reporting requirements on those insurers. The requirements are found in § 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, 121 Stat. 2492, 2497, codified at 42 U.S.C. § 1395y(b)(7)-(8). Section 111 mandates that private insurers file information regarding Medicare beneficiaries' claims in quarterly reports with the federal Centers for Medicare & Medicaid Services (CMS). The reports must identify those beneficiaries seeking coverage for medical expenses from the private insurer who the insurer has determined may also be covered under Medicare. *See id.* § 1395y(b)(8). Reports must be made "regardless of whether or not there is a determination or admission of liability" by the insurer. *Id.* § 1395y(b)(8)(C). Doing so helps CMS "make an appropriate determination concerning coordination of benefits, including any applicable recovery claim." *Id.* § 1395y(b)(8)(B)(ii). If a private insurer violates § 111, the government can impose "a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant." *Id.* § 1395y(b)(8)(E)(i); *see also MSP Recovery Claims, Series LLC v. Hereford Ins. Co.,* 66 F.4th 77, 81-82 (2d Cir. 2023).

B. This statutory scheme has spawned an industry of compliance, data analytics, and litigation, of which the parties here are emblematic. Relator MSP WB, LLC is one of several affiliated entities whose business is to "identify violations of Section 111 [to recover] unreimbursed conditional secondary payments." Appellant Br. at 16. To do so, MSP WB mines public records and "proprietary" data (e.g., medical liens, police reports, Medicare claims

data, hospital records, and litigation documents) to determine whether a Medicare enrollee required medical care and whether the primary payer complied with § 111. MSP WB then partners with an affiliated law firm to "sue scofflaw primary payers." *See* 42 U.S.C. § 1395y(b)(3). A second relator, Michael Angelo, owns and operates a lawyer referral service, as well as health care facilities nationwide, including a medical transportation company, radiology clinics, a pharmacy, and a surgery center.

Turn next to the other side of the caption. Defendant Insurance Services Office, Inc. (ISO) contracts with insurers to assist with, among other needs, § 111 reporting requirements. ISO also offers data analytics, compliance, and fraud prevention services. Consumers of those services are primarily insurance companies, including nearly thirty companies associated with Allstate named as defendants in this proceeding, a group we refer to collectively here as "Allstate."

On behalf of the United States, Michael Angelo and his co-relator filed this qui tam action against defendants, painting in their complaint with a broad brush. They assert a host of claims, including reverse False Claims Act violations, a conspiracy to violate the False Claims Act, and violations of state false claim laws. Starting with their substantive False Claims Act theory, relators allege that Allstate failed to report (or inaccurately reported) to CMS information regarding its beneficiaries, in violation of § 111. Due to those reporting failures, relators say, Allstate either "fail[ed] to provide the government payers with notice of [Allstate's] primary payer obligations" or

"den[ied] all liability" in instances where Allstate had primary payer obligations, allowing it to shortchange the government. This conduct, relators add, resulted in Allstate failing to reimburse Medicare for auto-accident-related medical costs incurred by beneficiaries insured by Allstate, thereby defrauding the government, in violation of the False Claims Act. Relators further assert that this conduct also constituted a False Claims Act conspiracy and violated state law.

Following relators' filing, a host of procedural developments ensued. The United States declined to intervene. Relators twice amended their complaint, largely echoing in their amended complaints the legal theories underlying the first complaint. Following the filing of the second amended complaint, defendants moved for dismissal under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6), asserting pleading defects in the complaint as well as the False Claims Act's public disclosure and first-to-file bars, among other arguments. The district court granted the motions, declined to exercise supplemental jurisdiction over the state law claims, and entered final judgment.

Relators moved for reconsideration, which the district court denied. Next, relators filed a motion to amend or correct under Rule 59(e), asking the district court to amend its judgment to dismiss the case without prejudice to allow relators to file yet another amended complaint. In the alternative, relators moved for relief from judgment under Rule 60(b), asserting that the district court made a legal error by dismissing the complaint with prejudice.

The district court denied the motion on both grounds, teeing up relators' appeal. Relators have abandoned the state law claims by failing to challenge the district court's denial of supplemental jurisdiction over those claims in their opening brief on appeal. *See Doe v. Mich. State Univ.*, 989 F.3d 418, 425 (6th Cir. 2021).

II.

As noted, defendants asserted many grounds for dismissing relators' second amended complaint. Our focus is on relators' failure to state a claim under Federal Rule of Civil Procedure 12(b)(6). *United States ex rel. Harper v. Muskingum Watershed Conservancy Dist.*, 842 F.3d 430, 435 (6th Cir. 2016) (noting that courts of appeal may affirm on any grounds supported by the record). The framework for our review is settled. To state a claim, a complaint must, at a minimum, contain "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). At the pleading stage, we accept well-pleaded factual allegations (as well as reasonable inferences from those allegations) in the complaint as true, and we ask whether those allegations make the claims plausible. *See Patterson v. United HealthCare Ins. Co.*, 76 F.4th 487, 492 (6th Cir. 2023). We need not credit "a legal conclusion couched as a factual allegation" or a "naked assertion devoid of further factual enhancement." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (cleaned up).

Also relevant to our review is the fact that the False Claims Act is, at its core, an anti-fraud statute. Accordingly, relators' complaint must likewise satisfy

Federal Rule of Civil Procedure 9(b)'s requirement that fraud be pled with particularity. *Chesbrough v. VPA, P.C.*, 655 F.3d 461, 466 (6th Cir. 2011); *see also United States ex rel. Ibanez v. Bristol-Myers Squibb Co.*, 874 F.3d 905, 914 (6th Cir. 2017). We review de novo whether the complaint complied with these Rules. *See Ibanez*, 874 F.3d at 914.

A. Relators' claims fall short of these standards. Start with their substantive False Claims Act counts. By way of background, most cases brought under the False Claims Act proceed in a similar way: a relator alleges that the defendant fraudulently sought to obtain overpayment from the government by, for example, making a claim for government payment in an amount greater than what the defendant was entitled to receive. *See generally* Claire M. Sylvia, The False Claims Act: Fraud Against the Government § 4:2 (Aug. 2023). Yet Congress has also authorized False Claims Act actions that seek to impose liability for so-called reverse false claims, that is, where a party engages in a false or fraudulent effort to avoid a payment owed to the government. *See* 31 U.S.C. § 3729(a)(1)(G); *United States ex rel. Barrick v. Parker-Migliorini Int'l, Inc.*, 878 F.3d 1224, 1226 (10th Cir. 2017). Prototypical reverse false claims include underpayment of rent revenue owed to the United States, understatement of postage or customs duties, underpayment of mineral royalties owed to the federal government, and, as alleged here, avoidance of reimbursement to Medicare. *See*, *e.g.*, Sylvia, supra, § 4:18.

Key components of a False Claims Act claim include knowledge and duty. Anyone who "knowingly conceals

or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government," the statute instructs, is civilly liable. 31 U.S.C. § 3729(a)(1)(G); *see Harper,* 842 F.3d at 436. To demonstrate as much, relators must plead, with specificity, that Allstate had an "established duty," *see* 31 U.S.C. § 3729(b)(3), which we have interpreted to mean an "affirmative obligation" "to pay money or property," *Ibanez,* 874 F.3d at 916-17 (citations omitted). Relators must also demonstrate knowledge, that is, that Allstate knew that it violated its established duty to pay. *Harper,* 842 F.3d at 437.

1. Relators' claims fail in multiple respects. Take first the "established duty" requirement. Relators' theory is that Allstate was a "primary payer" for numerous claims for healthcare costs resulting from car accidents, yet failed to report its "primary payer" status to CMS, leading to Allstate under-reimbursing the federal government for payments previously made by Medicare. In considering relators' framing of Allstate as a "primary payer," recall the statutory backdrop. A primary payer obligation arises after Medicare has made a "conditional" (or secondary) payment. 42 U.S.C. § 1395y(b)(2)(B). Conditional payments by Medicare, in turn, are triggered only where a primary insurer "cannot reasonably be expected to make payment with respect to [an] item or service promptly." *Id.* Allstate's obligation as a "primary payer," in other words, arises only once Medicare has made a conditional payment and "it is demonstrated that [Allstate] has or had a responsibility to pay." *Id.* From this statutory regime, relators suggest that Allstate insured individuals who were also covered

by Medicare, were involved in an auto accident, received medical care, and had their medical expenses covered by Medicare. Yet, say relators, Allstate left Medicare to foot the bill, pointing to, as evidence, several "exemplars" of Allstate denying claims to Medicare eligible individuals as evidence, as well as Allstate's failure to make § 111 reports to CMS.

The second amended complaint fails to plead sufficient facts demonstrating as much. To begin with the exemplars, the complaint lacks detail as to whether and when Allstate incurred an obligation to pay for medical expenses for which it was liable and, relatedly, what conditional payments were made by Medicare to fill that void. All relators can state with certainty is that Allstate denied one exemplar's claims for insurance benefits. Relators plead no facts demonstrating that Allstate was responsible for the underlying medical expenses in the first place, let alone facts showing that Medicare made conditional payments for those expenses. In theory, relators' assertions could have merit. But we require more than theoretical musings. Without identifying with particularity a concrete, existing duty to pay money or property owed to the United States, relators' allegations amount to little more than a "formulaic recitation of the elements of a cause of action" coupled with the controlling statutory scheme. *See Ibanez,* 874 F.3d at 917 (citing *Bell Atlantic Corp., et al. v. Twombly,* 550 U.S. 544, 555 (2007)). That is insufficient to state a claim.

An exemplar in the second amended complaint demonstrates these deficiencies. There, relators allege

that E.A., a Medicare beneficiary, was a pedestrian injured in a car accident. Following the accident, E.A. was assigned to Allstate to cover his no-fault related injuries, pursuant to Michigan law. E.A., the complaint adds, received prescription medication that was eventually paid for by Medicare, yet Allstate never reported E.A.'s identity and claims to CMS. Absent here are sufficient allegations that Allstate actually owed an obligation to the government regarding E.A. For instance, we do not know whether the medication paid for by Medicare was tied to accident-related injuries. Nor do we know that Allstate was obligated to make a payment on E.A.'s behalf. *See, e.g.*, 7 Blashfield Automobile Law and Practice § 272:13 (Aug. 2023); Michigan Dep't of Ins. & Fin. Servs., *Brief Explanation of Michigan No-Fault Insurance* (July 2020), [https://perma.cc/TDC3-3Z59]. And even if it were, we do not know that Allstate did not honor its obligation, or that it could not "reasonably be expected" to do so. *See* 42 U.S.C. § 1395y(b)(2)(B)(i). All of these questions need answers before relators can show plausibly that Allstate was the primary payer, yet failed to make reimbursement payments to Medicare.

Nor can we credit relators' allegations that Allstate failed to comply with § 111's reporting requirements, thereby violating a duty owed to the government. According to relators, Allstate makes "systematic" reporting "failures" by "intentionally miss[ing] critical data fields" about beneficiaries while "certify[ing] to the government that they are in compliance with their reporting obligations." Setting aside the fact that relators have not put forward well-pleaded allegations of

insufficient § 111 reports, even had they done so, those allegations would not necessarily show an "obligation" by Allstate to pay money. Return to the statutory puzzle and consider how § 111 fits in. Congress enacted that provision to require insurers to file quarterly reports to CMS identifying those policyholders seeking coverage for medical expenses who are also Medicare beneficiaries. *See* 42 U.S.C. § 1395y(b)(7)-(8). The reports must list all claimants whose claims are unresolved, "regardless [of whether] there is a determination or admission of liability." *Id.* § 1395y(b)(8)(A)-(C).

Fatal to relators' theory is the fact that a § 111 report alone is not a reliable indicator of whether Medicare has made a conditional payment on a beneficiary's behalf. Those reports do not indicate, with any particularity, that an insurer has a financial obligation to the government. After all, § 111 reports must be made "regardless" of the insurer's liability. *See id.* § 1395y(b)(8)(C). In other words, insurers file the reports even when it has not been established that the insurer is the "primary payer." For example, an insurer may make such a filing before there is a finding of liability on the insurer's part regarding the incident giving rise to the claim. Or it may do so where a Medicare beneficiary is treated for medical concerns that are ultimately deemed unrelated to the accident giving rise to the insurer's liability. In those situations, a "belt and suspenders" report of a claim by Allstate to CMS does not show that a conditional payment has been made.

Consider relators' allegations pertaining to Exemplar K.S. Following a car accident, K.S. allegedly received medical care paid for by a private MAO health plan. As

a threshold matter, we note our sister circuits' concerns with assigning False Claims Act liability for payments owed to MAOs, which are private entities, and not the government. *See United States ex rel. Petras v. Simparel, Inc.*, 857 F.3d 497, 504 (3d Cir. 2017); *United States ex rel. Adams v. Aurora Loan Servs., Inc.*, 813 F.3d 1259, 1260-61 (9th Cir. 2016). But even setting that matter to the side, this exemplar is flawed. According to relators, Allstate allegedly covered K.S. via a no-fault policy and reported this claim to ISO—its compliance consultant. To relators, this indicates that Allstate was the "primary payer," yet failed to reimburse the MAO. Here too, relators fail to include details about Allstate's obligations giving rise to its purported status as a "primary payer." *See United States ex rel. Prather v. Brookdale Senior Living Communities, Inc.*, 838 F.3d 750, 771 (6th Cir. 2016) ("Rule 9(b)'s particularity rule serves an important purpose in fraud actions by alerting defendants to the precise misconduct with which they are charged and protecting defendants against spurious charges of immoral and fraudulent behavior." (cleaned up)). As already explained, for a variety of reasons, "an insurer's report under Section 111 does not admit the insurer's liability for the claim reported." *Hereford Ins. Co.*, 66 F.4th at 87. And here, it bears adding, we are one step further removed. Relators' allegation centers on a report made to ISO, not CMS. If a § 111 report to CMS does not itself demonstrate liability, certainly a report made to a private entity for compliance purposes does not either.

2. Nor have relators demonstrated Allstate's understanding that its conduct violated its obligations

under federal law. One who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government" runs afoul of the False Claims Act. 31 U.S.C. § 3729(a)(1)(G). Knowledge "refer[s] to a defendant's awareness of *both* an obligation to the United States *and* his violation of that obligation." *Harper,* 842 F.3d at 436. While Rule 9(b) permits knowledge to be averred generally, we must be satisfied that the alleged factual basis gives rise to a strong inference of fraudulent intent. *See Chesbrough,* 655 F.3d at 470-71; Fed. R. Civ. P. 9(b).

We vigorously enforce the False Claims Act's knowledge requirement. Take *Harper,* for example. 842 F.3d at 438. There, property was deeded to Muskingum Watershed Conservancy District, a political subdivision in Ohio, to be used for recreation, conservation, and reservoir development. *Id.* at 432, 434. The deed contained a reverter clause providing for the return of the property to the federal government if the District alienated the property. *Id.* Decades later, the District entered into a series of leases conveying mineral rights to various businesses for the purpose of conducting horizontal hydraulic fracturing, also known as fracking. *Id.* Two relators filed a qui tam action under the False Claims Act, claiming that the leases had the effect of alienating the property, thereby triggering the reverter clause and entitling the federal government to immediate possession of the lands. Relators alleged that the District, by failing to return the property and by retaining the proceeds of the leases, violated the False Claims Act. *Id.* We disagreed on the basis that relators failed to plead the District's

knowledge adequately. As we explained, it is not enough that a defendant was aware of an obligation; rather, it must also have been aware that its actions violated that obligation. *See id.* at 437-38. And there, the complaint did not demonstrate "how [the District] would have known that the fracking leases violated the deed restrictions." *Id.* at 438.

Relators' second amended complaint falls well short of this standard. With respect to the exemplars, we cannot accept the bare use of the terms "knowingly" or "knowledge" without evidence of what information Allstate knew, and when and how it knew it. *See Harper,* 842 F.3d at 438. As to K.S., for example, relators state that Allstate reported K.S.'s accident to ISO, yet "failed to reimburse" Medicare for K.S.'s claim. Even taking these assertions as true, relators do not explain how and when Allstate was aware of any conditional payments made by Medicare on K.S.'s claim, let alone that Allstate knowingly evaded its duty to pay. In short, without a well-pleaded allegation of an obligation owed to the government, let alone one knowingly shirked, relators have not stated a claim for relief. *See Harper,* 842 F.3d at 438 ("Where the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged—but it has not shown—that the pleader is entitled to relief." (cleaned up)).

B. Relators' claim for conspiracy fares no better. The False Claims Act imposes liability for conspiracies to violate the statute's terms. 31 U.S.C. § 3729(a)(1)(C). As with any conspiracy, there must be plausible facts alleging

an agreement. *See Ibanez,* 874 F.3d at 917. Critically, "it is not enough for relators to show there was an agreement that made it *likely* there would be a violation of the FCA; they must show an agreement was made *in order to* violate the FCA." *Id.* And once again, relators must do so in accordance with Federal Rules of Civil Procedure 8 and 9(b). *See United States ex rel. Marlar v. BWXT Y-12, LLC,* 525 F.3d 439, 446 (6th Cir. 2008). Their complaint, taken as true, must be "plausible on its face," *Twombly,* 550 U.S. at 570, and must "state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b); *see Iqbal,* 556 U.S. at 678; *United States ex rel. Bledsoe v. Cmty. Health. Sys., Inc.,* 501 F.3d 493, 504, 510 (6th Cir. 2007). That is, relators must allege who was party to the agreement, how the agreement was reached, when the agreement was reached, and what were its terms. *See Sanderson v. HCA-The Healthcare Co.,* 447 F.3d 873, 877 (6th Cir. 2006) (explaining that "at a minimum, Rule 9(b) requires that the plaintiff specify the 'who, what, when, where, and how' of the alleged fraud" (cleaned up)).

Relators assert that Allstate conspired with ISO and others to "defraud" Medicare by "failing to provide coordination of benefits data and other information." All seem to agree that Allstate and ISO had a contractual relationship to aid Allstate in filing § 111 reports to CMS. According to relators, that contractual relationship furthered an effort "to evade [Allstate's § 111] reporting requirements and obligations to reimburse the government." Allstate's and ISO's alleged coordinated efforts included "providing boilerplate false and misleading information" to CMS and "purposefully

withholding pertinent data and other information." From this purported scheme, Allstate was able to obscure its primary payer responsibilities and decrease or avoid its payment obligations.

In *Ibanez*, we dismissed a False Claims Act conspiracy claim that alleged two pharmaceutical companies schemed to promote a prescription medication improperly. There, the relators failed to plead a "specific statement showing the plan was made *in order to defraud* the government." 874 F.3d at 917 (emphasis added). Yes, we acknowledged, it may have been "foreseeable that somewhere down the line" a medically unnecessary, fraudulent prescription would be submitted to the government for payment. *Id.* But without facts demonstrating "a plan to get false claims paid," the allegations failed. *Id.* To our eye, the "chain" connecting the "alleged misconduct to the eventual submission of false claims to the government" was "unusually attenuated." *Id.* That attenuation, coupled with "relators' failure to adequately plead a violation of any other section of the FCA, render[ed] insufficient the otherwise bare allegation that there was an FCA conspiracy." *Id.* (citing *Twombly,* 550 U.S. at 556).

So too here. As we have already discussed, relators failed to adequately plead a substantive False Claims Act violation. Nor was there an agreement to violate the False Claims Act. *See* 31 U.S.C. § 3729(a)(1)(C). Relators characterize the ISO/Allstate relationship as nefarious because it allowed the two to "share[ ] in the general conspiratorial objective of defrauding [Medicare] using false statements in [Allstate's §] 111 Reports." Yet relators

fail to provide any specific details regarding this alleged plan or an agreement to execute the plan. Conclusory allegations that "[d]efendants engage[ ] in a concerted scheme" and "plan[ ] to knowingly conceal and knowingly and improperly avoid or decrease their obligations" simply repackage the elements of a False Claims Act conspiracy. By and large, that manner of pleading reflects the attenuation we identified in *Ibanez* as dooming a False Claims Act conspiracy claim. *See* 874 F.3d at 917.

True, as relators emphasize, a contract existed between defendants. Allstate contracted with ISO, who maintains a database of insurance claim information, for assistance with § 111 reporting. Relators' theory boils down to a basic assumption that whoever contracted with Allstate on § 111 matters must have been in cahoots with Allstate. But a contractual relationship alone does not suggest collusion any more than it suggests a legitimate business relationship. *See Twombly,* 550 U.S. at 553-54 ("The inadequacy of showing parallel conduct or interdependence, without more, mirrors the ambiguity of the behavior. . . . "). To relators, if Allstate contracts with ISO for § 111 reporting requirements yet fails to abide by those requirements, the obvious conclusion is that defendants together conspired to defraud the government. We disagree. That conclusion is not just a stretch—it is wholly unsubstantiated.

Relators respond by pointing us to their proposed third amended complaint. It does not save their day. The proposed amendment was filed in February 2023, nearly a month after judgment was entered, and even then only

as an appendix to relators' motion under Rules 59(e) and 60(b). The document was not accepted by the district court, and we will not consider it here. *See Berry v. U.S. Dep't of Labor,* 832 F.3d 627, 637-38 (6th Cir. 2016) (explaining that on a motion to dismiss, "our review is typically limited to the complaint's allegations . . . [and] materials attached to a motion to dismiss if they are referred to in the complaint and central to the claim").

III.

Failing elsewhere, relators say the district court erred in denying them leave to amend their complaint again, and then compounded that error by denying them reconsideration. Not so.

Generally, we review a district court's denial of leave to file an amended complaint for abuse of discretion. *Islamic Ctr. of Nashville v. Tennessee*, 872 F.3d 377, 387 (6th Cir. 2017). We do the same in evaluating the district court's denial of a motion for reconsideration. *In re Greektown Holdings, LLC,* 728 F.3d 567, 573 (6th Cir. 2013). A district court abuses its discretion when it relies upon clearly erroneous factual findings, improperly applies the law, or uses an erroneous legal standard. *Bisig v. Time Warner Cable, Inc.*, 940 F.3d 205, 218 (6th Cir. 2019). Before reversing, we must be left with a "definite and firm conviction that the [district] court committed a clear error in judgment." *Cummins v. BIC USA, Inc.,* 727 F.3d 506, 510 (6th Cir. 2013) (citation omitted). Relators are correct to note that we employ de novo review where a district court's decision was based on the "legal conclusion

that an amended complaint could not withstand a motion to dismiss." *Morse v. McWhorter,* 290 F.3d 795, 799 (6th Cir. 2002). But the district court's decision was not that. *See Cummins,* 727 F.3d at 510. Instead, the court denied leave to amend because relators' late-stage motion was evidence of their bad faith and delay tactics. So we review for an abuse of discretion.

In so doing, it bears repeating the complex procedural path this case traveled in the district court, traversing multiple sections of the Federal Rules of Civil Procedure. After twice amending their complaint under Rule 15 and seeing their second amended complaint dismissed in accordance with Rule 12(b)(6), relators moved for reconsideration, which the district court denied. Next, relators filed a motion to amend under Rule 59(e), asking the district court to dismiss the case without prejudice to allow them to file yet another amended complaint. In the alternative, relators sought relief from judgment under Rule 60(b)(1) because, in their view, the district court made a mistake by dismissing their claims with prejudice. The district court denied the motion in all respects, concluding that leave to amend the complaint for a third time was not justified and that dismissal with prejudice was appropriate.

We are not left with the "definite and firm conviction" that the district court erred in denying relators what was essentially a fourth bite at the apple. For good reason, matters like leave to amend typically are left to the district court's discretion. *Leary v. Daeschner,* 349 F.3d 888, 905 (6th Cir. 2003) (explaining *Foman v. Davis,* 371 U.S. 178,

182 (1962)). Here, despite facing motions to dismiss from all defendants, relators failed to file a motion for leave to amend their operative complaint. The district court in turn dismissed the complaint with prejudice. Doing so where a plaintiff has not sought leave to amend typically is not an abuse of discretion. *United States ex rel. Harper v. Muskingum Watershed Conservancy Dist. (Harper II),* 739 F. App'x 330, 334-35 (6th Cir. 2018); *accord Justice v. Petersen,* No. 21-5848, 2022 WL 2188451, at *4 (6th Cir. June 17, 2022). That is all the more true when, as here, relators failed to file their proposed amended complaint until after judgment was entered. *Ohio Police & Fire Pension Fund v. Standard & Poor's Fin. Servs. LLC,* 700 F.3d 829, 844 (6th Cir. 2012).

While leave to amend should be "freely given," it is not merely a formality, especially in the event of "undue delay, bad faith or dilatory motive on the part of the movant," or "repeated failure to cure deficiencies by amendments previously allowed." *Leary,* 349 F.3d at 905 (quoting *Foman,* 371 U.S. at 182)). Those criticisms fairly describe relators' belated request for leave. *Morse,* 290 F.3d at 800. Their proposed third amended complaint would have been the fourth complaint filed in this action, and the second amendment made after defendants moved to dismiss. Despite sufficient opportunity, relators did not formally seek leave to amend before the entry of judgment. This is, at the very least, dilatory. The district court found relators' belated motion "reminiscent of the notorious litigation strategy employed by other MSP entities with which [MSP WB] is affiliated." Borrowing a quotation from another district court, the district court

here observed "that 'enough is enough . . . [f]ederal court is not a sounding board for litigants to test various theories until they find one allowing the litigation to continue.'" R.111, PageID 3422 (quoting *MAO-MSO Recovery II, LLC v. State Farm Mut. Auto. Ins.,* No. 1:19-cv-1537, 2019 WL 6311987, at *10 (C.D. Ill. Nov. 25, 2019)). Our pleading rules—and the district court's discretion to administer them—exist to keep litigants from sandbagging their opponents until they are on notice of what their allegations lack. On that score, we see no basis to question the district court's assessment.

Relators point us to *Newberry v. Silverman,* 789 F.3d 636 (6th Cir. 2015). There, the plaintiff submitted a ten-page affidavit in opposition to the motion to dismiss that contained "significantly greater detail" than did the complaint, leading us to conclude that the district court should have dismissed "without prejudice and with leave to amend." *Id.* at 645-46. The same is not true for relators. Their proposed third amended complaint arrived only after multiple rounds of amendment and motion practice. The district court rejected it on that basis—not due to an assessment of whether the new allegations would have been sufficient to state a claim. Relators, in short, have had ample opportunity to test their allegations.

* * * * *

For the foregoing reasons, the judgment of the district court is affirmed.

APPENDIX B — OPINION OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION, FILED FEBRUARY 23, 2023

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Case No. 2:19-cv-11615

UNITED STATES OF AMERICA AND STATE OF MICHIGAN, *et al.*,

Plaintiffs,

EX REL. MICHAEL ANGELO AND MSP WB, LLC,

Plaintiffs/Relators,

v.

ALLSTATE INSURANCE CO., *et al.*,

Defendants.

February 23, 2023, Decided;
February 23, 2023, Filed

HONORABLE STEPHEN J. MURPHY, III

Appendix B

OPINION AND ORDER DENYING MOTION TO ALTER OR AMEND JUDGMENT UNDER RULE 59(E) OR RELIEF FROM JUDGMENT UNDER RULE 60(B) [110]

Relators MSP WB and Michael Angelo moved for reconsideration of the Court's opinion and order that granted Defendant Insurance Services Office Inc.'s (ISO) motion to dismiss. ECF 110. Because the Court dismissed the remaining claims in the case with prejudice, ECF 106, PgID 3022, the dismissal was a final order. *See* E.D. Mich. L.R. 7.1(h)(1). The Relators first claimed that the Court should alter or amend its judgment under Federal Rule of Civil Procedure 59(e) and dismiss the case "*without prejudice* because amendment of the Second Amended Complaint is not futile." ECF 110, PgID 3032 (emphasis in original). The Relators then claimed, in the alternative, that the Court should grant relief under Rule 60(b)(1) because the Court did not "assess whether the [second amended complaint] could be saved by amendment." *Id.* 3060 (citations omitted). For the reasons below, the Court will deny the motion for reconsideration.[1]

LEGAL STANDARD

"A district court may grant a Rule 59(e) motion to alter or amend if there is: (1) a clear error of law; (2) newly discovered evidence; (3) an intervening change in controlling law; or (4) a need to prevent manifest injustice."

1. No hearing or response to the motion is needed under Local Rule 7.1(h)(3).

Mich. Flyer LLC v. Wayne Co. Airport Auth., 860 F.3d 425, 431 (6th Cir. 2017) (citation omitted). "A Rule 59 motion may not be used to relitigate old matters, or to raise arguments or present evidence that could have been raised prior to the entry of judgment." *Brumley v. United Parcel Serv., Inc.*, 909 F.3d 834, 841 (6th Cir. 2018) (internal quotation marks and quotation omitted)). Under Rule 60(b), "the [C]ourt may relieve a party or its legal representative from a final judgment, order, or proceeding for . . . mistake, inadvertence, surprise, or excusable neglect"; or "any other reason that justifies relief."

DISCUSSION

The Court will deny the motion for reconsideration because leave to amend the complaint is not justified. Three reasons support that conclusion.

First, the Relators offered no authority to suggest that the Court must give the Relators an opportunity to amend the complaint before a dismissal without prejudice. *See* ECF 110, PgID 3038-41. In fact, to support their sweeping conclusion that "[t]his Court committed a clear error of law by dismissing Relators' federal claims with prejudice when it failed to assess whether the [second amended complaint] could be saved by amendment," the Relators cited *GenCorp, Inc. v. Am. Int'l Underwriters*, 178 F.3d 804, 834 (6th Cir. 1999). *Id.* at 3039. But that case does not suggest that a court commits clear error when it fails to sua sponte afford a prosecuting party with leave to amend a deficient complaint. *See GenCorp, Inc.*, 178 F.3d at 834. What is more, the operative complaint here was the third

iteration of the Relator's original complaint. *See* ECF 1 (complaint); 3 (amended complaint); 41 (second amended complaint). And the Court knows of no binding authority that would *require* the Court to give the Relators a fourth opportunity to cure the defects in the complaint.

Second, the Sixth Circuit is clear that a "district court's dismissal of a complaint with prejudice" is proper when the prosecuting party "d[oes] not seek leave to amend or file a proposed amended complaint." *Justice v. Petersen*, No. 21-5848, 2022 U.S. App. LEXIS 16888, 2022 WL 2188451, at *4 (6th Cir. June 17, 2022) (citing *Ohio Police & Fire Pension Fund v. Standard & Poor's Fin. Servs. LLC*, 700 F.3d 829, 844 (6th Cir. 2012)); *see United States ex rel. Harper v. Muskingum Watershed Conservancy Dist.*, 739 F. App'x 330, 334 (6th Cir. 2018) ("[A] district court does not abuse its discretion by failing to grant leave to amend where the plaintiff has not sought leave and offers no basis for any proposed amendment."). Under Federal Rule of Civil Procedure 15(a)(2), a court should grant a plaintiff leave to amend "when justice so requires." But "the right to amend is not absolute or automatic." *Justice*, 2022 U.S. App. LEXIS 16888, 2022 WL 2188451, at *3 (quoting *Tucker v. Middleburg-Legacy Place*, 539 F.3d 545, 551 (6th Cir. 2008)). And "[w]here a plaintiff fails to file a motion to amend or a proposed amendment indicating how the plaintiff would amend the complaint, a district court does not abuse its discretion by denying the plaintiff leave to amend." *Id.* (collecting cases). After all, "district courts are not required to engage in a guessing game as to what the Relators might plead to save their claim." *Id.* (cleaned up).

Appendix B

Before the Relators filed the present motion, they did not move for leave to amend the complaint despite facing two motions to dismiss. *See* ECF 77; 89. The Relators failed to even make a "bare request" for leave to amend in their briefs opposing the motions to dismiss.[2] *Justice*, 2022 U.S. App. LEXIS 16888, 2022 WL 2188451, at *3; *see* ECF 86 (response to the Insurer Defendants' motion to dismiss); ECF 93 (response to Defendant ISO's motion to dismiss). Yet "it is not the district court's role to initiate amendments." *Total Benefits Plan. Agency, Inc. v. Anthem Blue Cross & Blue Shield*, 552 F.3d 430, 438 (6th Cir. 2008). Accordingly, the Court made no legal error when it declined to provide the Relators, sua sponte, a fourth chance to save their complaint through amendment.

Third, the Relators' request for leave to file a fourth complaint after years of litigation and the final dismissal of its claims is evidence of "undue delay, bad faith[,] or dilatory motive on the part of the movant." *Morse v. McWhorter*, 290 F.3d 795, 800 (6th Cir. 2002). The post-dismissal endeavor to again amend the complaint by Relator MSP is strikingly reminiscent of the notorious litigation strategy employed by other MSP entities with which MSP is affiliated. ECF 110, PgID 3047 (describing MSP Recovery as "an affiliated corporate entity"); *see* ECF 41, PgID 1024-25 ("MSP is based in South Florida and is a part of a family of companies."). Under that

2. It makes no difference that the Relators now seek leave to amend the second amended complaint with supporting briefing on why the amendment would not be futile. *See* ECF 110, PgID 3038-59. The briefing is plainly an untimely, post hoc effort to cure the second amended complaint's pleading deficiencies.

strategy, the entity "throw[s] their allegations into as many federal courts as possible and see[s] what sticks." *MAO-MSO Recovery II, LLC v. State Farm Mut. Auto. Ins. Co.*, No. 1:19-cv-1537, 2019 U.S. Dist. LEXIS 204397, 2019 WL 6311987, at *10 (C.D. Ill. Nov. 25, 2019) (quoting *MSP Recovery Claims, Series LLC v. N.Y. Cent. Mut. Fire Ins. Co.*, No. 6:19-cv-211, 2019 U.S. Dist. LEXIS 151147, 2019 WL 4222654, at *6 (N.D.N.Y. Sept. 5, 2019)).[3] Here, the Relators' allegations have failed to "stick[]." *MAO-MSO Recovery II, LLC*, 2019 U.S. Dist. LEXIS 204397, 2019 WL 6311987, at *10. And the Court agrees that "enough is enough[;] . . . [f]ederal court is not a sounding board for litigants to test various theories until they find one allowing the litigation to continue." *Id.* (quotation omitted). There is simply no reason, under either Rule 59(e) or Rule 60(b), to justify affording the Relators "[y]et another opportunity to cure deficiencies in [their] allegations." *Id.* The motion for reconsideration must be denied.

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3. See also *MSP Recovery Claims, Series LLC v. AIG Prop. Cas. Co.*, No. 20-CV-2102, 2021 U.S. Dist. LEXIS 58343, 2021 WL 1164091, at *6 n.8 (S.D.N.Y. Mar. 26, 2021) ("Plaintiff has no excuse for such sloppiness, and this is not the first time that it has been admonished for these sorts of errors.") (citing *MSP Recovery Claims, Series LLC*, 2021 U.S. Dist. LEXIS 58343, 2019 WL 4222654, at *5 (noting that "the Court is faced with a messy Complaint, improper exhibits, and Plaintiffs' inconsistent arguments")).

Appendix B

ORDER

WHEREFORE, it is hereby **ORDERED** that the motion to alter or amend judgment under Rule 59(e) or relief from judgment under Rule 60(b) [110] is **DENIED**.

SO ORDERED.

/s/ Stephen J. Murphy, III
STEPHEN J. MURPHY, III
United States District Judge

Dated: February 23, 2023

APPENDIX C — OPINION OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION, FILED JANUARY 19, 2023

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Case No. 2:19-cv-11615

UNITED STATES OF AMERICA AND
STATE OF MICHIGAN,

Plaintiffs,

EX REL. MICHAEL ANGELO AND
MSP WB, LLC,

Plaintiffs/Relators,

v.

ALLSTATE INSURANCE CO., *et al.*,

Defendants.

January 19, 2023, Decided;
January 19, 2023, Filed

HONORABLE STEPHEN J. MURPHY, III

Appendix C

OPINION AND ORDER GRANTING DEFENDANT INSURANCE SERVICES OFFICE, INC.'S MOTION TO DISMISS [89] AND DISMISSING CASE

Relator Michael Angelo brought the present False Claims Act (FCA) action against three insurance companies on behalf of the United States and Michigan. ECF 1. After the Government declined to intervene, ECF 12 (under seal), Relator Angelo moved for leave to file a second amended complaint, ECF 32. The Court granted the motion. ECF 35. The second amended complaint added new parties, including: thirty-two insurance entities (insurer Defendants); an insurance service provider, Insurance Services Office (ISO); and a co-Relator, MSP WB. ECF 38 (under seal). The Relators sued on behalf of the federal Government, ten States, and Puerto Rico. *Id.* (under seal). The federal, State, and Puerto Rico Governments jointly declined to intervene in the case. ECF 39 (under seal).

The Relators then filed the unsealed second amended complaint. ECF 41. The second amended complaint included three claims: (1) reverse FCA violations, *id.* at 1073-75; (2) conspiracy to violate the FCA, *id.* at 1075-77; and (3) violations of State false claims laws, *id.* at 1077-86. The insurer Defendants jointly moved to dismiss the case. ECF 77. After a motion hearing, the Court granted the motion in part and dismissed claim one against the insurer Defendants. ECF 102, PgID 2980. Defendant ISO also moved to dismiss the second amended complaint. ECF 89. For the reasons below, the Court will grant the motion to dismiss, dismiss the conspiracy claim against the

insurer Defendants, and decline to exercise supplemental jurisdiction over the remaining State claims.[1]

BACKGROUND[2]

In the interest of judicial economy, the Court will adopt the background section from its previous opinion and order, ECF 102, PgID 2948-51. The Court will add the following facts.

Defendant ISO is a corporation that "provide[s] fraud prevention and data management, compliance, and reporting services to Primary Plans."[3] ECF 41, PgID 1032-33. It manages more than one billion industry-wide insurance claims and "provide[s] Section 111 reporting services" to Primary Payers. *Id.* The insurer Defendants contracted "with ISO to satisfy their mandatory reporting responsibilities." *Id.* at 1046. MSP[4] also contracted

1. Based on the parties' briefing, the Court will resolve the motion on the briefs and without a hearing. *See* Fed. R. Civ. P. 78(b); E.D. Mich. L.R. 7.1(f)(2).

2. Because the Court must view all facts in the light most favorable to the nonmoving party, *see Bassett v. NCAA*, 528 F.3d 426, 430 (6th Cir. 2008), the Court's recitation does not constitute a finding or proof of any fact.

3. As explained in the background section of the Court's previous opinion and order, the insurer Defendants are "Primary Plans." ECF 102, PgID 2948.

4. Relator MSP WB LLC is an affiliate of MSP, which contracted with Defendant ISO. Thus, Relator MSP did not itself contract with Defendant ISO. ECF 89, PgID 2684 n.1.

"with ISO and subscribed to ISO ClaimSearch services to ascertain the status of primary payers' reporting obligations." *Id.* at 1064; *see* ECF 89-1 (ISO ClaimSearch contract).

Before the Relators filed the present lawsuit, Defendant ISO cancelled the contract with MSP after MSP breached a term of agreement. *See* ECF 89, PgID 2684-85 ("ISO's contract with Relator MSP's affiliate explicitly permitted ISO to cancel it upon a breach of the contract (which, based on Relators' allegations, occurred here)."); ECF 94, PgID 2749 ("Relators contest neither the contract's terms nor its breach."); *see also* ECF 89, PgID 2697 ("MSP still had access to ISO ClaimSearch in 2017."). Defendant ISO also revised its terms of agreement to exclude as eligible users "attorneys or firms that practice in debt collection or initiate or participate in class action lawsuits." ECF 41, PgID 1064-65 (alterations omitted). And Defendant ISO required authorized users to obtain "prior express written consent of ISO" before they could "use, share[,] or disclose ClaimSearch information . . . to any third party." ECF 41, PgID 1065.

LEGAL STANDARD

The Court may grant a Rule 12(b)(6) motion to dismiss if the complaint fails to allege facts "sufficient 'to raise a right to relief above the speculative level,' and to 'state a claim to relief that is plausible on its face.'" *Hensley Mfg. v. ProPride, Inc.*, 579 F.3d 603, 609 (6th Cir. 2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555, 570, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007)). The Court views

the complaint in the light most favorable to the plaintiff, presumes the truth of all well-pleaded factual assertions, and draws every reasonable inference in the nonmoving party's favor. *Bassett*, 528 F.3d at 430.

But the Court will not presume the truth of legal conclusions in the complaint. *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S. Ct. 1937, 173 L. Ed. 2d 868 (2009). If "a cause of action fails as a matter of law, regardless of whether the plaintiff's factual allegations are true or not," then the Court must dismiss. *Winnett v. Caterpillar, Inc.*, 553 F.3d 1000, 1005 (6th Cir. 2009)

DISCUSSION

The Court will first resolve the reverse FCA violations claim (claim one) against Defendant ISO. After, the Court will resolve the conspiracy claim (claim two) as to Defendant ISO. The Court will then dismiss the conspiracy claims (claim two) as to the insurer Defendants. Last, the Court will decline to exercise supplemental jurisdiction over the State-law claims (claim three).

I. Reverse FCA Violations Claim Against ISO

In claim one, the Relators alleged that "Defendants' intentional noncompliance with federal reporting laws and secondary payer laws" violated the Reverse False Claims Act, 31 U.S.C. § 3729(a)(1)(G). ECF 41, PgID 1073. The Relators alleged in all but one paragraph that "Defendants" violated the FCA. *Id.* at 1073-75 (naming "Defendants" nineteen times). In the one paragraph

that does not mention "Defendants," the Relators stated that "[t]he Primary Plans' Section 111 report failures are material to the Government Healthcare Programs' decisions to pay for accident-related medical expenses. . . ." *Id.* at 1075. ISO is not specifically mentioned in claim one. *See id.* at 1073-75.

Yet in the second amended complaint, the Relators defined "Defendants" as "the Primary Plan defendants . . . and Insurance Services Offices, Inc." *Id.* at 1015. "Defendants," as named in claim one, should then presumably include ISO. Indeed, the Relators argued as much. ECF 93, PgID 2726 (citing ECF 41, PgID 1015). But the Sixth Circuit has made clear that "a complaint may not rely upon blanket references to acts or omissions by all of the defendants," because "each defendant named in the complaint is entitled to be apprised of the circumstances surrounding the fraudulent conduct with which he individually stands charged." *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 342 F.3d 634, 643 (6th Cir. 2003) (cleaned up). Put simply, the Relators were required to allege some non-conclusory conduct by Defendant ISO that would give rise to liability under claim one. But they failed to do so. Two grounds undergird that finding; the Court will address each in turn.

A. Insufficient Facts

First, the facts alleged about the conduct attributed to Defendant ISO are conclusory and insufficient to raise a right to relief above the speculative level. From the beginning of the second amended complaint through claim

one, Defendant ISO is mentioned thirty-four times. ECF 41, PgID 1017-75. The allegations about Defendant ISO can be organized into three groups: background facts, conclusory facts about civil conspiracy, and facts that fail to show an FCA violation.

In the first grouping, the allegations about Defendant ISO are innocuous background facts. The Relators described Defendant ISO's corporate organization, its corporate purpose, and that it "advertises its massive database of insurance claims, yet it restricts its access to Primary Plans and their third-party administrators." *Id.* at 1032-33. Defendant ISO also allegedly "provides reporting for a majority of the insurance industry, meaning their database is essentially a private industry MMSEA Section 111 clearinghouse." *Id.* at 1064. The Relators added that the insurer Defendants "contract with ISO to satisfy their mandatory reporting responsibilities. Hence, Primary Plans delegated their reporting responsibilities to ISO and relied exclusively on ISO to comply with their Section 111 obligations." *Id.* at 1046; *see id.* at 1019, 1063 (same). And the Relators also claimed that "MSP had a contract with ISO and subscribed to ISO ClaimSearch services to ascertain the status of primary payors' reporting obligations." *Id.* at 1064. In sum, even when presumed true and viewed in the light most favorable to the Relators, the background facts fail to ascribe any wrongdoing to ISO. *Bassett*, 528 F.3d at 430. They merely explain the general corporate dealings of Defendant ISO.

In the second grouping, the Relators' allegations are conclusory as to the issue of civil conspiracy. The

Relators asserted that Defendant ISO facilitates the insurer Defendants' "ability to operate in the shadows." ECF 41, PgID 1018. They also claimed that Defendant ISO allegedly collaborated with the insurer Defendants to "actively conceal[] the [insurer Defendants'] obligation to pay or reimburse billions of dollars to Government Healthcare Programs." *Id.* (footnote omitted). Defendant ISO has also allegedly "done nothing to improve the reporting failures at issue," and instead, "conspires with the Primary Plans by thwarting any investigation into deficient reporting practices." *Id.* at 1019. What is more, the Relators claimed that third parties directed "co-conspirators, including ISO, to withhold data from the governmental agencies and [the Relators] in an effort to obstruct justice." *Id.* at 1066. Each alleged fact amounts to nothing more than a legal conclusion: that Defendant ISO "facilitated," "collaborat[ed]," or "conspire[d] with" the insurer Defendants to "withhold data from governmental agencies." *Id.* at 1018-19, 1066. But the Court will not presume the truth of legal conclusions in the complaint, *Iqbal*, 556 U.S. at 678, so the conclusory allegations here are insufficient to raise a right to relief above the speculative level.

In the third grouping, the Relators alleged facts that are unmoored from the FCA statute or that otherwise fail to show that Defendant ISO plausibly violated the Act. The Relators first claimed that they "are in possession of a substantial number of records demonstrating the *Primary Plans'* liability regarding these reverse false claims," a fact that "[t]he Primary Plans and ISO cannot dispute." *Id.* at 1023 (emphasis added). The allegation suggests no

more than that insurer Defendants, not Defendant ISO, could be liable for reverse false claims.

The Relators also tried to tie facts from a separate lawsuit involving different insurers to the present case. *See id.* at 1059-60. In that lawsuit, ISO was allegedly "unable to report to CMS that a claimant is a Medicare beneficiary." *Id.* The Relator's factual bootstrapping is unavailing, however, because the assertion fails to explain how Defendant ISO's alleged conduct involving a different matter and different insurers is connected to the conduct alleged here.

Finally, the Relators recounted the contractual relationship between Defendant ISO and the affiliate of Relator MSP WB (also called "MSP"). The Relators explained that MSP used ISO's database and "identified rampant *fraud employed by the Primary Plans* by identifying countless instances where the Primary Plans reported a claim to ISO but failed to report the claim to CMS." *Id.* at 1064 (emphasis added). After MSP discovered the alleged fraud "employed by the Primary Plans," *id.*, Defendant ISO allegedly "terminated its relationship with MSP and required that any future user of its service disclaim use of the data to enforce the MSP Laws," *id.* at 1019. Defendant ISO also "changed the terms of its subscription contracts to specifically preclude parties such as MSP . . . from using its data to pursue recovery or subrogation services," and precluded users from sharing the ClaimSearch data with third parties "without the prior express written consent of ISO." *Id.* at 1064-65. Last, the Relators claimed that Defendant ISO's "data is

pivotal in proving that the Defendants, collectively, fail[ed] to accurately report or report at all under Section 111[,] which has proven a lucrative practice for them all." *Id.* at 1065 (footnote omitted).

Taken together, the facts alleged about Defendant ISO's contractual relationship with MSP fail to state a plausible FCA violation claim. The alleged facts show only that Relator MSP allegedly discovered a fraud "employed by the Primary Plans," not Defendant ISO, and that Defendant ISO narrowed its authorized users by excluding attorneys or firms that seek to initiate class action lawsuits. *See id.* at 1064-65. The Relators argued that the Court must take as true that "ISO cancelled MSP's subscription and changed the terms of its subscription contracts to specifically preclude parties such as MSP . . . from using its data to pursue recovery or subrogation services" and "[t]o protect its status as an industry leader in the interests of its clients." ECF 93, PgID 2729 n.9 (emphases omitted). But even taking those conclusory allegations as true, the other facts, as pleaded, fail to show how Defendant ISO "knowingly . . . cause[d] to be made or used[] a false record or statement material to an obligation to pay or transit money or property to the Government." 31 U.S.C. § 3729(a)(1)(G). Indeed, the Court must take several inferential leaps to reach such a conclusion based on Defendant ISO's decision to cease its contractual relationship with MSP. But the Court is only required to draw "reasonable inference[s]" in favor of the Relators. *Bassett*, 528 F.3d at 430. The contractual allegations thus fail to support claim one.

In sum, no facts specific to Defendant ISO support the allegations against it in claim one. *See id.* at 1073-75; 31 U.S.C. § 3729(a)(1)(G). And the Relators' "blanket references to acts or omissions by all of the '[D]efendants,'" do not save the claim. *Bledsoe*, 342 F.3d at 643. Claim one thus fails to "raise a right to relief above the speculative level," as to Defendant ISO. *ProPride, Inc.*, 579 F.3d at 609.

B. Conflicting Claims

The second amended complaint and the Relators' response brief lodged conflicting assertions about whether Defendant ISO is responsible for alleged reporting failures by the insurer Defendants. In the second amended complaint, the Relators claimed that although the insurer Defendants, who are Responsible Reporting Entities, may "delegate reporting responsibility to another entity, such as a data reporting agent (e.g., ISO)," the insurer Defendants "remain ultimately responsible for the reporting, the content of the data, and its validity." ECF 41, PgID 1063 (internal quotation marks omitted); *see id.* at 1047 ("While the Primary Plans may delegate their reporting responsibilities, they maintain responsibility for their submissions."); *see also id.* at 1044 (defining Primary Plans as "Responsible Reporting Entities."). And the insurer Defendants allegedly "delegated their reporting responsibilities to ISO and relied exclusively on ISO to comply with their Section 111 obligations." *Id.* at 1046.

Yet in the Relators' response brief, they contended that "ISO's assistance in and facilitation of the [insurer

Defendants'] false reports makes ISO directly liable under the FCA." ECF 93, PgID 2727. Clearly, the two assertions conflict. The Relators may not on the one hand specifically allege that ISO *is not* ultimately responsible for the validity of its reporting and data, and on the other hand contend in its briefing that ISO *is* directly liable for any reporting failure. At any rate, the text of the complaint controls, and the Relators alleged in the complaint that the insurer Defendants, not ISO, are "ultimately responsible for the reporting, the content of the data, and its validity." *Id.* at 1063; *cf. Jocham v. Tuscola Cnty.*, 239 F. Supp. 714, 732 (E.D. Mich. 2003) ("The pleading contains no such allegation, and the plaintiffs may not amend their complaint through a response brief.") (citation omitted).

To be sure, under 31 U.S.C. § 3729(a)(1)(G), "any person who . . . knowingly . . . causes to be made . . . a false record or statement material to an obligation to pay . . . the Government . . . is liable to the United States Government for a civil penalty." Thus, even if Defendant ISO is not ultimately responsible for reporting under the FCA statute, it could still be liable for *causing* false records to be reported to the government. Yet, as detailed above, Relators alleged no non-conclusory facts showing that Defendant ISO "knowingly" caused the insurer Defendants to submit false insurance reports. *Id.* Thus, the Relators' second amended complaint "fail[s] to state FCA violations with sufficient particularity" as to Defendant ISO. *See Bledsoe* 342 F.3d at 643. Accordingly, the Court will dismiss claim one as to Defendant ISO.

II. Conspiracy Claim Against ISO

In claim two, the Relators alleged that "Defendants violated the FCA by conspiring to submit inaccurate or incomplete Section 111 reporting" under 31 U.S.C. § 3729(a)(1)(C). ECF 41, PgID 1076. To support the allegation, the Relators explained that "[Defendant] ISO, as a data repository, canceled MSP's contract to access its data and implemented user policies to protect the data from being used to enforce, among other things, the MSP Law against the Primary Plans." *Id.* at 1076. For two reasons, the Court finds that the complaint fails to state a valid conspiracy claim against Defendant ISO.

"A civil conspiracy is an agreement between two or more persons to injure another by unlawful action." *Hooks v. Hooks*, 771 F.2d 935, 943-44 (6th Cir. 1985). "Each conspirator need not have known all of the details of the illegal plan or all of the participants involved," nor is "[e]xpress agreement among all the conspirators" required. *Id.* at 944. Rather, "[a]ll that must be shown is that there was a single plan, that the alleged coconspirator shared in the general conspiratorial objective, and that an overt act was committed in furtherance of the conspiracy that caused injury to the complainant." *Id.*

To start, the allegations in the second amended complaint fail to meet the heightened pleading standard under Federal Rule of Civil Procedure 9(b). In the FCA context, the heightened pleading standard may be relaxed "when a relator alleges specific personal knowledge that relates directly to billing practices." *United States ex*

rel. Prather v. Brookdale Senior Living Communities, Inc., 838 F.3d 750, 769 (6th Cir. 2016) (citation omitted). But Defendant ISO's billing practices are not at issue; the insurer Defendants' billing practices are. Thus, the heightened pleading standard applies here.

And the second amended complaint provides only skeletal allegations of fraud by Defendant ISO. Under Rule 9(b), "a party must state with particularity the circumstances constituting fraud or mistake." The Relators argued that because (i) Defendant ISO is "an expert in the [Section 111 reporting] industry," (ii) the insurer Defendants contracted with Defendant ISO to fulfill its reporting obligations, and (iii) the insurer Defendants allegedly failed to fulfill their reporting obligation, the conclusion that Defendant ISO conspired with the insurer Defendants to defraud the government must follow. ECF 93, PgID 2734. The Court disagrees.

To state a violation of the FCA, the Relators needed to show that Defendant ISO shared "a single plan" and a "general conspiratorial objective" with the insurer Defendants. *Hooks*, 771 F.2d at 944. Yet the complaint lacks any facts—even circumstantial facts—that show a plan or agreement to conspire against the government. *See* ECF 41, PgID 1057-73. Indeed, the only connection between Defendant ISO and the insurer Defendants is a contractual one. *See id.* at 1046 ("The Primary Plans contract with ISO to satisfy their mandatory reporting responsibilities. Hence, Primary Plans delegated their reporting responsibilities to ISO and relied exclusively on ISO to comply with their Section 111 obligations."). A

mere contractual relationship that centers on Section 111 reporting does not lead to the conclusion that Defendant ISO took part in "a single plan" or tried to achieve a "general conspiratorial objective" with the insurer Defendants. *Hooks*, 771 F.2d at 944. In short, the Relators relied on conclusory allegations rather than particularized facts to show that Defendant ISO should be liable for fraud. The second amended complaint therefore fails to meet the Rule 9(b) heightened pleading standard.

And even under a more relaxed pleading standard, the Relators' allegations specific to Defendant ISO are conclusory as to the issue of civil conspiracy. The analysis detailed in relation to the civil conspiracy allegations in claim one applies equally to claim two. Thus, even at a lesser pleading standard, the conclusory factual allegations fail to state a claim.

Last, the claim two allegations about the contract between Defendant ISO and MSP, though particularized, do not compel the inference that Defendant ISO conspired to commit fraud on the government. As detailed in the claim one discussion above, the Court must take several inferential leaps to conclude that the Relators sufficiently pleaded a conspiracy based on Defendant ISO's decision to cease its contractual relationship with MSP. *See Bassett*, 528 F.3d at 430. Besides, the Relators never contended that the contract was terminated unlawfully. Thus, if MSP breached the contract, Defendant ISO was free to cancel it at any time. *See* ECF 89-1, PgID 2704; ECF 94, PgID 2749 ("Relators contest neither the contract's terms nor its breach."). The facts show only that Defendant

ISO exercised its lawful right to cancel the contract. The contractual allegations thus fail to support a claim of conspiracy.

III. Conspiracy Claim Against Insurer Defendants

"A civil conspiracy is an agreement between two or more persons to injure another by unlawful action." *Hooks*, 771 F.2d at 943-44. The Relators alleged that Defendant ISO is the only party with whom the insurer Defendants conspired to violate the FCA. ECF 41, PgID 1075. Because the Court has dismissed the conspiracy claim against Defendant ISO, the Court must in turn dismiss the conspiracy claim against the insurer Defendants.

IV. State-Law Claims

"[I]n any civil action of which the district courts have original jurisdiction, the district courts shall have supplemental jurisdiction over all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy." 28 U.S.C. § 1367(a). The Court has original jurisdiction over claims one and two because they raise federal questions. *See* ECF 41, PgID 1073-77; 28 U.S.C. § 1331. Claim three, which alleges State law false claims violations by "the Primary Plans," does not raise a federal question. ECF 41, PgID 1077-84. And the parties here lack complete diversity of citizenship. *Id.* at 1025 (Relator Angelo is a citizen of New Jersey); *id.* at 1027 (Defendant Allstate NJ Prop. & Cas. Ins. Co. has its principal place of business in New Jersey). Thus, the Court has jurisdiction

over claim three based only on supplemental jurisdiction because the claim is "so related to [claims one and two] that they form part of the same case or controversy." 28 U.S.C. § 1367(a); *see* ECF 41, PgID 1034, 1077-86 ("This Court has supplemental jurisdiction over the State-law claims alleged herein pursuant to 28 U.S.C. § 1367(a).") (alterations omitted).

But when "the district court has dismissed all claims over which it has original jurisdiction," it "may decline to exercise supplemental jurisdiction over a claim." 28 U.S.C. § 1367(c)(3); *see Brooks v. Rothe*, 577 F.3d 701, 709 (6th Cir. 2009) (quotation omitted). The Court has dismissed claims one and two against all Defendants. Thus, no claims remain over which the Court has original jurisdiction. The Court will accordingly "decline to exercise supplemental jurisdiction over" the State-law claims. *Id.*

CONCLUSION

The Court will grant Defendant ISO's motion to dismiss in full. And because the Court has dismissed the conspiracy claim against Defendant ISO, the Court must dismiss the conspiracy claims against the insurer Defendants. With no federal claims remaining, the Court will decline to exercise supplemental jurisdiction over the State claims. The State claims are thus dismissed without prejudice.

Appendix C

ORDER

WHEREFORE, it is hereby **ORDERED** that Defendant Insurance Services Office, Inc.'s motion to dismiss [89] is **GRANTED**.

IT IS FURTHER ORDERED that the conspiracy claims against the insurer Defendants are **DISMISSED WITH PREJUDICE**.

IT IS FURTHER ORDERED that the remaining State-law claims are **DISMISSED WITHOUT PREJUDICE**.

SO ORDERED.

/s/ Stephen J. Murphy, III
STEPHEN J. MURPHY, III
United States District Judge

Dated: January 19, 2023

APPENDIX D — OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN, SOUTHERN DIVISION, FILED AUGUST 9, 2022

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Case No. 2:19-cv-11615

UNITED STATES OF AMERICA
AND STATE OF MICHIGAN,

Plaintiffs,

ex rel. MICHAEL ANGELO AND MSP WB, LLC,

Plaintiffs/Relators,

v.

ALLSTATE INSURANCE CO., *et al.*,

Defendants.

Signed August 9, 2022.

OPINION AND ORDER GRANTING IN PART MOTION TO DISMISS [77] AND GRANTING IN PART MOTION FOR JUDICIAL NOTICE [78]

HONORABLE STEPHEN J. MURPHY, III

Relator Michael Angelo brought the present False Claims Act ("FCA") action against three insurance companies on behalf of the United States and Michigan.

ECF 1. After the Government declined to intervene, ECF 12 (under seal), Relator Angelo moved for leave to file a second amended complaint, ECF 32. The Court granted the motion. ECF 35. The second amended complaint added new parties, including: thirty-two insurance entities[1] ("insurer Defendants"); an insurance service provider, ISO; and a co-Relator, MSP WB. ECF 38 (under seal). The Relators sued on behalf of the federal Government, ten States, and Puerto Rico. *Id.* (under seal). Still, the federal, State, and Puerto Rico Governments jointly declined to intervene in the case. ECF 39 (under seal). The Relators then filed the unsealed second amended complaint. ECF 41. The insurer Defendants jointly moved for judicial notice, ECF 78, and to dismiss the case, ECF 77.[2] The parties briefed the motions, and the Court held a motion hearing on July 27, 2022. For the reasons below, the Court will grant in part the motion for judicial notice, ECF 78, and will grant in part the motion to dismiss, ECF 77.

BACKGROUND[3]

Under the Medicare Secondary Payer statute, 42 U.S.C. § 1395y(b)(2), *et seq.*, private insurers are the

1. All insurer Defendants are either Allstate companies or an Allstate "related entit[y]." ECF 41, PgID 1026-32.

2. Defendant ISO separately moved to dismiss. ECF 89. This Order does not resolve that motion.

3. Because the Court must view all facts in the light most favorable to the nonmoving party, *see Bassett v. NCAA*, 528 F.3d 426, 430 (6th Cir. 2008), the Court's recitation does not constitute a finding or proof of any fact.

"primary payers" of treatment for individuals who are covered by both Medicare and private insurance. *Bio-Med. Applications of Tenn., Inc. v. Cent. States Se. & Areas Health & Welfare Fund*, 656 F.3d 277, 278 (6th Cir. 2011). And Medicare is the "secondary payer" of the individual.[4] *Id.* Medicare can still make a "conditional payment" for healthcare "if a primary plan . . . has not made or cannot reasonably be expected to make payment with respect to such item or service promptly." § 1395y(b)(2)(B)(i). When Medicare covers a conditional payment, the primary plan must reimburse Medicare if the "primary plan has or had a responsibility to make payment with respect to such item or service." § 1395y(b)(2)(B)(ii).

A primary plan (private insurance carrier) is also obligated to inform Medicare when it discovers that it is a primary payer of a Medicare beneficiary's health expenses. ECF 41, PgID 1043. Congress enacted the self-reporting obligation in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. *Id.* To satisfy the reporting obligation, primary plans must "(1) determine whether an injured insured is eligible for coverage and is enrolled in Medicare; and, if so, (2) report the insured's identity and claims to [the Centers for Medicare and Medicaid Services]." *Id.* at 1044 (citing Section 111).

The Relators alleged that the insurer Defendants here "do not report pursuant to Section 111"; "they routinely

4. "Similar to the [Medicare Secondary Payer] statute, federal regulation ensures that Medicaid is secondary to other available sources of insurance benefits." ECF 41, PgID 1051 (citing 42 C.F.R. § 433.139).

and intentionally submit incomplete or inaccurate reports. *Id.* at 1063. As a result, the insurer Defendants, as primary payers, either "fail to provide government payers with notice of their primary payer obligations" or "the [p]rimary [p]lans are certain of their obligation to make payment, but they deny all liability regarding the services." *Id.* at 1021.

The Relators offered three "exemplars to demonstrate the reporting failures alleged" in the amended complaint. *Id.* at 1069. The first was Relator Angelo's exemplar. *Id.* at 1069-71. The exemplar detailed that Relator Angelo operates several medical facilities that provide "treatment to auto accident victims who are insured with [p]rimary [payers]." *Id.* at 1069. But his "facilities do not accept Medicare or Medicaid insurance." *Id.* Relator Angelo noted that he "acquired direct knowledge that [p]rimary [p]lans do not provide a medical card for auto-insured [beneficiaries] to use at pharmacies to purchase their medication." *Id.* So the beneficiaries insured by both Medicare and a primary payer must rely on Medicare to pay for the medication, "even though a [p]rimary [p] lan was obligated to provide primary payment." *Id.* at 1070. And Relator Angelo stated that he "has direct knowledge" of times when primary payers refused to cover their beneficiaries' treatment at his medical facilities. *Id.* The beneficiaries therefore were required to seek treatment elsewhere—at a facility that accepted Medicare or Medicaid payments. *Id.* As Relator Angelo put it, the primary plans skirted their obligation to "provide payment for the accident-related medical expenses of government healthcare program beneficiaries." *Id.* at 1071 (cleaned up).

The second exemplar was of E.A., a Medicare and Allstate Insurance Group beneficiary. *Id.* at 1071-72. E.A. was injured in an automobile accident that should have been covered by the Allstate Insurance Group. *Id.* at 1071. But Medicare provided payment for most of his accident-related medical expenses. *Id.* According to E.A., "Allstate Insurance Group never reported E.A.'s identity and claims" under Section 111 "and failed to make primary payments" for E.A. *Id.* In turn, "Medicare paid for prescription medication that Allstate Insurance Group was obligated to pay." *Id.* at 1072.

The last was Relator MSP WB's exemplar. *Id.* at 1089-90. The exemplar detailed an injury to an insured, "K.S.," and similarly explained how Allstate, although being "the primary payer responsible for payment and/or reimbursement of K.S.'s accident-related medical expenses," failed to reimburse conditional payments made by a Medicare Advantage Organization.[5] *Id.*

In all, the Relators claimed that the exemplars showed that "Defendants circumvent their obligations to pay for reasonable and necessary medical bills, at the expense of [g]overnment [h]ealthcare [p]rograms." *Id.* Defendants'

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5. "The [Medicare Secondary Payer] statute 'bars any Medicare payment—including [a Medicare Advantage Organization] payment—when there is a primary plan.'" ECF 41, PgID 1043 (quoting *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229, 1237 (11th Cir. 2016)). And a failure to reimburse a Medicare Advantage Organization affects the Centers for Medicare and Medicaid Services. *See generally* ECF 41, PgID 1042-43.

conduct of "routinely submit[ting] false reports" thus "cause[s] the government[ ] to pay monies and sustain financial loss at an alarming rate," and "impedes the [Government's] ability to recover on payments made." *Id.*

LEGAL STANDARD

The Court may grant a Rule 12(b)(6) motion to dismiss if the complaint fails to allege facts "sufficient 'to raise a right to relief above the speculative level,' and to 'state a claim to relief that is plausible on its face.'" *Hensley Mfg. v. ProPride, Inc.*, 579 F.3d 603, 609 (6th Cir. 2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555, 570, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007)). The Court views the complaint in the light most favorable to the plaintiff, presumes the truth of all well-pleaded factual assertions, and draws every reasonable inference in the nonmoving party's favor. *Bassett*, 528 F.3d at 430.

But the Court will not presume the truth of legal conclusions in the complaint. *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009). If "a cause of action fails as a matter of law, regardless of whether the plaintiff 's factual allegations are true or not," then the Court must dismiss. *Winnett v. Caterpillar, Inc.*, 553 F.3d 1000, 1005 (6th Cir. 2009).

DISCUSSION

To start, he Court will explain why the Relators have standing to sue. After, the Court will detail why the first-to-file bar does not apply to the case. And last, the Court

will grant in part Defendants' motion to dismiss the case based on the public disclosure bar.

I. Standing

Defendants argued that the Relators failed to establish standing for two reasons. First, "Allstate Insurance Group," an alleged insurer in one of the exemplar claims, is neither a named Defendant nor a legal entity. ECF 77, PgID 1236. And the only other entity alleged of wrongdoing in the Relators' exemplars was "Allstate Insurance Company." *Id.* Thus, Defendants argued that the Relators failed to establish standing as to all Defendants other than Allstate Insurance Company. *Id.* Second, because most Defendants did "not even write the type of insurance policies at issue in th[e] case," Defendants contended that the Relators could not show any injury traceable to those Defendants. *Id.* Defendants supported the arguments with a declaration[6] from a "Claims Support and Design Manager." ECF 77-1, PgID 1240-42.

Standing is established when three elements are met. *Vt. Agency of Nat. Res. v. United States ex rel. Stevens*, 529 U.S. 765, 771, 120 S.Ct. 1858, 146 L.Ed.2d 836 (2000) (citing *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992)). First, a qui tam plaintiff must show that he "suffered an injury in

6. The Court may rely on declarations to resolve issues of standing without converting a Rule 12(b)(6) motion into one for summary judgment. *See Rogers v. Stratton Indus., Inc.*, 798 F.2d 913, 915-16 (6th Cir. 1986) (citation omitted).

fact," that is "concrete and particularized" and "actual or imminent, not conjectural or hypothetical." *Lujan*, 504 U.S. at 560, 112 S.Ct. 2130 (internal quotation marks and citations removed). Second, a qui tam plaintiff must show that there is a "causal connection between the injury and the conduct complained of " that is "fairly traceable to the challenged action of the defendant." *Id.* (cleaned up). And third, "it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Id.* at 561, 112 S.Ct. 2130 (internal quotation marks and quotation omitted). Last, a qui tam plaintiff "bears the burden of establishing these three elements." *Id.*

The Relators have standing to sue Defendants. At their core, Defendants' arguments are best framed as a Rule 12(b)(6) motion to dismiss for failure to state a claim. Indeed, both of Defendants' arguments are nearly identical to their substantive argument that the Relators failed to meet Rule 9(a)'s specificity requirement by "lump[ing] all Defendants together based on two exemplars." ECF 77, PgID 1208-10 (footnote omitted). *Compare id.* at 1236, *and* ECF 87, PgID 2653-54, *with* ECF 77, PgID 1208-10.

What is more, the Relators established the three standing elements. Relator MSP WB allegedly has "direct knowledge of tens of thousands of instances wherein the [Defendants] failed to report their primary payer responsibility causing government health programs to reimburse for the beneficiaries' accident-related medical expenses." ECF 41, PgID 1068. And the Relators claimed that Defendants "systematic[ally] fail[ed] to completely or accurately satisfy Section 111's reporting requirements."

Id. at 1018. Taken as true, the Relators established a fraud injury on the United States due to Defendants' failure to satisfy Section 111's reporting requirements. *Stevens*, 529 U.S. at 773-74, 120 S.Ct. 1858. One Relator even has "direct knowledge" of Defendants' reporting failures, ECF 41, PgID 1068, and can trace Defendants to the alleged fraud, *Stevens*, 529 U.S. at 771, 120 S.Ct. 1858. And a favorable decision would likely redress the alleged fraud injury. *See id.* at 773-74, 120 S.Ct. 1858. Because the Relators have standing, the Court will deny the Defendants' motion in regard to standing.

II. First-to-File Bar

Defendants also argued that the Court should dismiss Relator MSP WB's claims under the FCA's first-to-file bar. ECF 77, PgID 1234-35. The first-to-file bar states, "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." 31 U.S.C. § 3730(b)(5). Relator MSP WB joined the litigation when Relator Angelo filed the second amended complaint. ECF 41. Defendants contended that Relator MSP WB could not be added as a co-Relator through a Rule 15 pleading amendment without violating § 3730(b)(5). ECF 77, PgID 1234-35. But the Relators claimed that "the addition of relators via amendment does not run afoul of the first-to-file rule." ECF 86, PgID 2084 (citation omitted). In short, the plain text of the statute favors the Relators' reading, and Subsection (b)(5) does not apply here.

The Sixth Circuit has not addressed whether Subsection (b)(5) bars adding a relator through a Rule 15 amendment. But the Third and Tenth Circuits have explicitly acknowledged that adding a relator through an amendment does not implicate Subsection (b)(5).[7] Those Circuits have read the word 'intervention' narrowly—as the technical term used in Rule 24—rather than broadly—to bar any form of joinder. *Plavix Mktg.*, 974 F.3d at 234; *Precision II*, 31 F.3d at 1017. The Court agrees with the narrow reading.

First, Subsection (b)(5)'s plain text bars only two actions by non-government parties: one, a person may not intervene; and two, a person may not bring a factually related action. But "[i]n normal civil litigation, there are three ways for nonparties with interests relevant to a suit to become parties to a suit." *Plavix Mktg.*, 974 F.3d at 233. Non-parties "can intervene in the existing suit," "[t]hey can file their own related suits based on the same facts," "[o]r they can be added to the exiting suit by the court or the existing parties." *Id.* Subsection (b)(5) does not bar the

7. For example, *In re Plavix Mktg., Sales Pracs. & Prods. Liab. Litig. (No. II)*, 974 F.3d 228, 236 (3d Cir. 2020) ("The [FCA's] first-to-file bar stops new relators from intervening in other parties' suits or bringing their own separate suits based on the same facts. Yet it does not bar parties from amending a complaint to add, remove, or swap relators."); *United States ex rel. Little v. Triumph Gear Sys., Inc.*, 870 F.3d 1242, 1247 (10th Cir. 2017) ("[W]e held that two new relators didn't 'intervene' in violation of § 3730(b)(5) when the original plaintiff added the relators through a Rule 15 amendment.") (citing *United States ex rel. Precision Co. v. Koch Indus., Inc.* (*Precision II*), 31 F.3d 1015, 1017-18 (10th Cir. 1994)).

third option. And the Court will not broaden the statute's text by inserting words Congress chose to omit. *See Plavix Mktg.*, 974 F.3d at 233 ("If Congress had wanted the first-to-file bar to reach more broadly, it would have said so. But it chose a 'narrower' term (intervention), and we must 'respect, not disregard,' that choice.") (quoting *Wis. Cent. Ltd. v. United States*, — U.S. —, 138 S. Ct. 2067, 201 L.Ed.2d 490 (2018)); *see also* Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 93 (2012) (discussing the omitted-case canon and stating that "[n]othing is to be added to what the text states or reasonably implies (casus omissus pro omisso habenendus est)"); *cf. Lomax v. Ortiz-Marquez*, — U.S. —, 140 S. Ct. 1721, 1725, 207 L.Ed.2d 132 (2020) (citation omitted).

Next, "the normal rule of statutory construction dictates that when Congress uses identical words in two different places in a statute, the words are usually read to mean the same thing in both places." *Guillermety v. Sec'y of Educ.*, 241 F. Supp. 2d 727, 732-33 (E.D. Mich. 2002) (citing *Comm'r of Internal Revenue v. Lundy*, 516 U.S. 235, 250, 116 S.Ct. 647, 133 L.Ed.2d 611 (1996)). The term "intervene" appears thrice in § 3730. In all three instances, "intervene" refers to an action the Government may elect to take.[8]

In contrast, addition of a party through a Rule 15 amendment involves a different procedural mechanism.

8. § 3730(b)(2) ("The *Government may elect to intervene* and proceed with the action. . . . "); § 3730(b)(5) ("[N]o person other than the *Government may intervene* . . . "); § 3730(c)(3) ("[T]he court . . . may nevertheless *permit the Government to intervene* at a later date. . . .") (all emphases added).

After all, an already-existing party brings a new party into the case under Rule 15 rather than the new party bringing itself into the case. *See* 6 Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 1504 (3d ed. 2022) ("Litigants also have been allowed to supplement their original pleadings to include new parties when events make it necessary to do so.") (citing *United Pub. Workers of Am. v. Local No. 312*, 94 F. Supp. 538, 542 (E.D. Mich. 1950)). And indeed, when the Government intervenes under § 3730(b)(5), it need not consult a relator. *See* § 3730(b)(2). It need only "decide whether it will 'elect to intervene and proceed with the action.'" *United States ex rel. Eisenstein v. City of New York*, 556 U.S. 928, 932, 129 S.Ct. 2230, 173 L.Ed.2d 1255 (2009) (quoting § 3730(b)(2), (b)(4)).

To be sure, the Federal Rules of Civil Procedure have dedicated Rule 24 to govern "intervention." And Congress twice cited the Federal Rules of Civil Procedure in § 3730(b)(2)-(3). It makes little sense why Congress would have used Rule 24's plain procedural term yet intended "intervene" to include all kinds of joinder under the Civil Rules. § 3730(b)(2)-(3) (citing Fed. R. Civ. P. 4); *see also Intervention*, Black's Law Dictionary (9th ed. 2009) ("The entry into a lawsuit by a third party who, despite not being named a party to the action, has a personal stake in the outcome.") (citing Fed. R. Civ. P. 24).

Plus, the Sixth Circuit has clarified that Subsection (b)(5) "unambiguously establishes a first-to-file bar, preventing *successive* plaintiffs from bringing related actions based on the same underlying facts." *Walburn v.*

Lockheed Martin Corp., 431 F.3d 966, 971 (6th Cir. 2005) (emphasis added) (citing *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1187 (9th Cir. 2001)). It follows that the bar against nonparties "bring[ing] a related action based on the facts underlying the pending action" applies to successive Relators in separate actions, rather than co-Relators in the same action. *See* § 3730(b)(5).

Last, the best case that supports Defendants' reading suffers from flawed analytical reasoning. *United States ex rel. Fry v. Guidant Corp.*, No. 3:03-cv-0842, 2006 WL 1102397 (M.D. Tenn. Apr. 25, 2006); ECF 77, PgID 1234-35; ECF 87, PgID 2664-65. There, although the *Fry* court "agree[d] with the straightforward, exception-free interpretation of Section 3730(b)(5) adopted by the Fourth and Ninth Circuits," those Circuits did not address whether a Rule 15 amendment falls within the first-to-file bar. *Fry*, 2006 WL 1102397, at *6 (citing *Hughes Aircraft Co.*, 243 F.3d at 1187 and *United States ex rel. LaCorte v. Wagner*, 185 F.3d 188, 191 (4th Cir. 1999)). Rather, the Fourth Circuit barred two nonparties who sought "to intervene in a qui tam action brought by two other individuals." *LaCorte*, 185 F.3d at 190-91. Unlike the present case, no party in the Fourth Circuit litigation sought to be added through a Rule 15 amendment. *See id.* And the Ninth Circuit unremarkably concluded—like the Sixth Circuit—that Section "3730(b)(5)'s plain language unambiguously establishes a first-to-file bar, preventing *successive* plaintiffs from bringing related actions based on the same underlying facts." *Hughes Aircraft Co.*, 243 F.3d at 1187 (emphasis added) (collecting cases); *e.g.*,

Walburn, 431 F.3d at 971. Again, no relator in the Ninth Circuit case had sought to add new relators through Rule 15. *Fry*'s reliance on those cases was therefore misplaced, and the Court will not adopt its reasoning.

In sum, § 3730(b)(5)'s plain text does not affect a Rule 15 amendment. The first-to-file bar does not bar Relator MSP WB's claims.

III. Public Disclosure Bar

The public disclosure bar in "[t]he FCA bars qui tam actions that merely feed off prior public disclosures of fraud." *United States ex rel. Holloway v. Heartland Hospice, Inc.*, 960 F.3d 836, 843 (6th Cir. 2020), *aff'g* 386 F. Supp. 3d 884 (N.D. Ohio 2019) (citations omitted); *see* § 3730(e)(4)(A)-(B). A defendant may assert the public disclosure bar as a reason to dismiss a complaint under Rule 12(b)(6). *United States ex rel. Advocs. for Basic Legal Equal., Inc. v. U.S. Bank, N.A.*, 816 F.3d 428, 433 (6th Cir. 2016) (affirming dismissal based on the public disclosure bar under Rule 12(b)(6)).[9]

9. At the motion hearing, the Court asked the parties to focus on the public disclosure bar. Counsel for the Relators strenuously argued that the Court must first decide the merits of the case under Rule 12(b)(6) before it may dismiss the case on public disclosure grounds. The argument is unavailing given Sixth Circuit precedent, *see*, *e.g.*, *id.*, and the statute's plain text, 31 U.S.C. § 3730(e)(4) ("The Court *shall dismiss* an action . . . if substantially the same allegations or transactions as alleged in the action . . . were publicly disclosed.") (emphasis added).

And the Court may take judicial notice of government documents and news articles attached to a Rule 12(b)(6) motion to dismiss. *United States ex rel. Rahimi v. Rite Aid Corp.*, No. 2:11-cv-11940, 2019 WL 10374285, at *2 (E.D. Mich. Dec. 12, 2019) (Murphy, J.) (citation omitted), *aff'd*, 3 F.4th 813 (6th Cir. 2021). Federal Rule of Evidence 201(b) also allows the Court to take judicial notice of "a fact that is not subject to reasonable dispute because it: (1) is generally known within the trial court's jurisdiction; or (2) can be accurately and readily determined from sources whose accuracy cannot be reasonably questioned." To that end, taking judicial "notice of public documents is proper only for the fact of the documents' existence, and not for the truth of the matters asserted therein." *Platt v. Bd. of Comm'rs on Grievances & Discipline of Ohio Sup. Ct.*, 894 F.3d 235, 245 (6th Cir. 2018) (quotation marks and quotation omitted).

To assess whether the public disclosure bar precludes an FCA claim, the Court must apply a three-part test. *Rahimi*, 3 F.4th at 823. First, the Court must "ask whether, before the filing of the qui tam complaint, there had been any public disclosures from which fraud might be inferred." *Id.* (quoting *United States ex rel. Maur v. Hage-Korban*, 981 F.3d 516, 522 (6th Cir. 2020)). Second, the Court must "assess how closely related the allegations in the complaint are to those in the public disclosures." *Id.* (citing *Maur*, 981 F.3d at 522). And if the first two prongs are met, then the Court must "ask whether the qui tam plaintiff is nevertheless an original source of the information." *Id.* (italics omitted) (citing *Maur*, 981 F.3d at 522). The Court will first resolve Defendants' motion for

judicial notice. After, the Court will address each public disclosure prong in turn.

A. Motion for Judicial Notice

To determine whether the public disclosure bar applies here, the Court will take judicial notice of a 2017 news article and case filings attached to Defendant's motion for judicial notice. ECF 78-1 (index of exhibits); ECF 78-10 (Law360 2017 Article); ECF 78-28 (*Takemoto* amended complaint); ECF 78-29 (*Hayes* amended complaint).

The Relators pushed two arguments for why the Court should not take judicial notice of the documents. First, "[n]one [of the documents] are integral to Relators' claims," and therefore cannot be used "to decide disputed factual issues." ECF 85, PgID 1640. Second, Defendants did not meet their burden under Federal Rule of Evidence 201. *Id.* at 1639. The arguments are unpersuasive.

Defendants have met their burden under Federal Rule of Evidence 201(b). Although the Relators argued that Defendants failed to address whether the exhibits' contents and significance are in dispute, ECF 85, PgID 1644-47, Defendants did not submit the documents for the truth of the matters asserted in them. Rather, analysis of the documents may reveal that the information alleged in the Relators' complaint was already publicly known. ECF 88, PgID 2669, 2672. Defendants therefore did not need to address whether the *contents* of the exhibits are disputed. To be clear, the relevant question for the public disclosure bar is whether "substantially the same

allegations or transactions as alleged in the action or claim were publicly *disclosed,"* § 3730(e)(4)(A) (emphasis added), not whether the public disclosures were *truthful. See also United States ex rel. Harper v. Muskingum Watershed Conservancy Dist.*, No. 5:13-cv-2145, 2015 WL 7575937, at *7 (N.D. Ohio Nov. 25, 2015) (collecting cases).

Moreover, the "significance" of the documents (whether the documents show "a public disclosure within the meaning of [§ 3730(e)(4)]"), ECF 85, PgID 1646, is a merits issue. And the Court need not decide the significance of the documents' contents to judicially notice them. *Id.*[10]

What is more, the documents feature readily available information. Still, the Relators' contended that the information in seven exhibits[11] cannot be considered "readily available" because they are "blocked behind a 'paywall'" and "only accessible to subscription-paying customers." ECF 85, PgID 1648. The argument lacks

10. In support, the Relators cited three cases unrelated to the FCA that do not discuss the public disclosure bar. ECF 85, PgID 1646-47. In those cases, the parties that sought to have the documents admitted wished to use the documents' *contents* to their advantage, rather than merely show that public information existed. *See Caudill Seed & Warehouse Co. v. Jarrow Formulas, Inc.*, No. 3:13-CV-82, 2021 WL 863203, at *3-4 (W.D. Ky. Mar. 8, 2021); *Jones v. Prudential Sec., Inc.*, 534 F. Supp. 3d 839, 841-43 (E.D. Mich. 2020); *MacDonald v. City of Detroit*, 434 F. Supp. 3d 587, 600 n.4 (E.D. Mich. 2020) (Cleland, J.). The cases are therefore unpersuasive here.

11. Relevant here is Exhibit 9. *See* ECF 85, PgID 1648 n.3.

merit. Based on the Court's research and the parties' briefing, no Sixth Circuit authority has ever held that subscription-based news media cannot produce "readily available" information. *See generally Mich. State A. Philip Randolph Inst. v. Johnson*, No. 16-cv-11844, 2016 WL 4267828, at *4 (E.D. Mich. Aug. 15, 2016) (judicially noticing national, subscription-based sources "such as the Wall Street Journal and the Washington Post").

The Relators also argued that Defendants failed to show how the documents are "relevant or necessary to resolve the issues before the Court" or show how the documents "reveal all of the essential elements of [the] Relators' fraud allegations." ECF 85, PgID 1649-50. The argument lacks logical discipline. The threshold question is merely whether the Court should judicially notice Defendants' exhibits. It is irrelevant whether the documents actually prove that the public disclosure bar applies.

Beyond that, news articles (specifically, Exhibit 9) are relevant to the public disclosure question because they bear on whether the allegations in the amended complaint were publicly disclosed. *See generally* ECF 78-10. Whether the documents show that the Relators' allegations ultimately fail on the merits is a separate question. *See Rahimi*, 3 F.4th at 824.

And the complaints (Exhibits 27 and 28) are relevant because they allege similar FCA claims about violating Medicare Secondary Payer rules. *See* ECF 41, PgID 1033; ECF 78-28, PgID 1407; ECF 78-29, PgID 1489; *see*

also Clark v. Stone, 998 F.3d 287, 297 n.4 (6th Cir. 2021) ("Courts may take judicial notice of the proceedings of other courts of record.") (citation omitted).

In brief, to resolve the present motion, the Court will take judicial notice of Exhibits 9, 27, and 28. *See* ECF 78-10; ECF 78-28; ECF 78-29. The Court will therefore grant the motion for judicial notice, ECF 78, in part.

B. First Prong of Public Disclosure Analysis

"A disclosure is public if it appears in the news media or is made in a criminal, civil, or administrative hearing, or in a congressional, administrative, or Government Accounting Office report, audit, or investigation." *Rahimi*, 3 F.4th at 823 (cleaned up); *see also* 31 U.S.C. § 3730(e)(4)(A). And "publicly disclosed documents need not use the word 'fraud,' but need merely to disclose information that creates 'an inference of impropriety.'" *Rahimi*, 3 F.4th at 823 (quotation omitted). "[A] public disclosure can also be piecemeal so long as the multiple sources of information reveal the allegation of fraud and its essential elements." *Id.* at 824.

Defendants argued that two qui tam cases (*United States ex rel. Hayes v. Allstate Ins. Co.*, No. 1:12-cv-01015, ECF 21 (W.D.N.Y. Apr. 14, 2014) and *United States ex rel. Takemoto v. Ace Am. Ins. Co.*, No. 1:11-cv-00613, ECF 170 (W.D.N.Y. Oct. 31, 2014)) filed—and unsealed—before the present action publicly disclosed the Relators' allegations. ECF 77, PgID 1224; *see* ECF 78-28; 78-29. The Relators did not dispute that the two cases are "public" under the statute; instead, they countered only that the cases could

not have put the Government on notice of the allegations from the present case. *Id.* at 2075-76. In particular, the Relators reasoned that the cases are "not public disclosures under the amended statute" given that they were dismissed "because the relators proffered nothing more than a theory of fraud that lacked plausible facts to support the allegations." ECF 86, PgID 2075. The Relators also asserted that "stale claims are not public disclosures." *Id.* at 2079. Both arguments are oversold.

First, the Relators cited no authority that stated cases with substantially similar allegations can still be inadequate under the public disclosure doctrine because they were dismissed for failure to state a claim. *See id.* at 2075-76. The Relators believed since cases that are "insufficient under Rule 9(b)," *id.* at 2075, may not bar a successive filing under the first-to-file bar, *Walburn v. Lockheed Martin Corp.*, 431 F.3d 966, 973 (6th Cir. 2005), the same reasoning should apply to the public disclosure bar, ECF 86, PgID 2075-76.

But the Court will not retrofit *Walburn*'s first-to-file bar reasoning into a bright-line rule for scrutiny of the public disclosure bar. As a textual matter, the public disclosure bar's text fails to distinguish between meritorious and unmeritorious claims. *See* § 3730(e)(4). And, as a practical matter, the reasoning conflicts with the FCA's "general purpose of encouraging genuine whistleblower actions while snuffing out parasitic suits." *Holloway*, 960 F.3d at 851 (citation omitted). A suit may still be parasitic when it follows substantially similar claims—meritorious and unmeritorious alike.

Second, the cases that the Relators cite do not create a limitations period on public disclosure sources. *See* ECF 86, PgID 2079-80 (citing *Maur*, 981 F.3d at 528 and *United States ex rel. Ibanez v. Bristol-Myers Squibb Co.*, 874 F.3d 905, 919 (6th Cir. 2017)). *Ibanez* noted that when the defendants agree to cease fraudulent conduct, "the mere resemblance of " allegations describing "with particularity post-agreement, improper [conduct]" by the defendants "to a scheme resolved years earlier is not by itself enough to trigger the public disclosure bar." 874 F.3d at 919. Those facts differ from those in dispute here because no party has suggested that Defendants have resolved allegations of fraudulent conduct like those raised by the Relators. And *Maur* explained that relators do not "add anything material to the prior problematic procedures already disclosed" when their "allegations are neither novel nor so removed from the resolved conduct." 981 F.3d at 528 (cleaned up).

Based on the Court's research, the Sixth Circuit has never announced a standard that delineates when the public disclosure bar may no longer apply based on a case's age. And the Sixth Circuit has affirmed a dismissal[12] under the public disclosure bar based on lawsuits[13] that were

12. See *Holloway*, 960 F.3d at 845, 847-51 *aff 'g Holloway*, 386 F. Supp. 3d at 890 (amended complaint filed in 2018) (prior cases unsealed in 2007). See also *Maur*, 981 F.3d at 526 (noting that the public disclosure bar applied in *Holloway* because the relator's "allegations were substantially the same as those made in three qui tam actions from a decade earlier.") (cleaned up).

13. "The cases are *Litwin v. HCR ManorCare, Inc.*, 2:07CV681 (D.S.C.) (Doc. 82-6); *Olson v. HCR ManorCare, Inc.*,

unsealed eleven years before the amended complaints were filed in a case.

In the end, *Takemoto* and *Hayes* were both unsealed in 2014 and the amended complaints were also filed in 2014. *Takemoto*, No. 1:11-cv-00613, ECF 22 (W.D.N.Y. Apr. 3, 2014) (order unsealing case); *Hayes*, No. 1:12-cv-01015, ECF 16 (W.D.N.Y. Mar. 20, 2014) (order unsealing case); ECF 78-28, PgID 1479 (*Takemoto* amended complaint); ECF 78-29, PgID 1608 (*Hayes* amended complaint). The Relators filed the present amended complaint in 2021. Even if there were a limitations period applicable to the public disclosure bar, a seven-year gap is permissible under *Holloway.*

At any rate, both cases are "public" under the first prong. Section 3730(e)(4)(A)(i) provides that an action is public if it was disclosed "in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party." The Government declined to intervene in both *Hayes* and *Takemoto. Hayes*, No. 1:12-cv-01015, ECF 15 (W.D.N.Y. Mar. 14, 2014); *Takemoto*, No. 1:11-cv-00613, ECF 21 (W.D.N.Y. Mar. 14, 2014). The question, then, must be whether the *Hayes* and *Takemoto* relators are considered "agent[s]" of the Government. § 3730(e)(4)(A)(i).

"District courts are split as to whether a qui tam relator is the government's agent where the government

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2:07CV680 (D.S.C.) (Doc. 82-7); and *Williams v. HCR ManorCare, Inc.*, 2:07CV682 (D.S.C.) (Doc. 82-8)." *Holloway*, 386 F. Supp. 3d at 893 n.5.

opts out of the case." *Holloway*, 386 F. Supp. 3d at 894. "A majority of courts" have found that "a relator acts as the government's agent despite its declination to intervene because it is the real party in interest and the relator is the assignee of the Government's damages claim." *Id.* at 894-95 (internal quotation marks and quotation omitted) (collecting cases). And despite declining to intervene, the Government still retains "a fair amount of control over qui tam litigation." *Id.* (italics and internal quotation marks omitted) (quotation omitted). For instance, "the Government still receives copies of all pleadings and deposition transcripts," it "can move to stay discovery if it interferes with an ongoing criminal or civil investigation," it "has the right to approve or reject a stipulated dismissal," and it "may even intervene at a later date upon a showing of good cause and subsequently dismiss a case over the relators' objections." *United States ex rel. Gilbert v. Va. Coll., LLC*, 305 F. Supp. 3d 1315, 1324 (N.D. Ala. 2018); *cf. Holloway*, 386 F. Supp. 3d at 895 ("To conclude otherwise would render the phrase 'or its agent' in § 3730(e)(4)(A)(i) meaningless. . . . [T]he statute deems a case public if *either* the government or its agent is a party. Who, if not the private relator, is the government's agent?") (emphasis in original).

The Court agrees with "[a] majority of courts" that relators in a qui tam case are considered "agent[s]" under § 3730(e)(4)(A)(i) when the Government declines to intervene. *Holloway*, 386 F. Supp. 3d at 894-95 (collecting cases). Such cases are accordingly "public" under the statute.

Last, the 2017 news article that the Court has judicially noticed, ECF 78-10, is also "public" under § 3730(e)(4)(A)(iii). The article was publicly disclosed "in the news media," *Rahimi*, 3 F.4th at 823 (cleaned up), and as detailed, the information was readily available to the public in 2017.

C. Second Prong

The Court must next weigh "whether the allegations in the complaint are 'substantially the same' as those contained in the public disclosures." *Maur*, 981 F.3d at 522 (quoting *Holloway*, 960 F.3d at 849). Merely "add[ing] some new details to describe essentially the same scheme by the same corporate actor" is not enough to survive the public disclosure bar. *Holloway*, 960 F.3d at 851; *see also Rahimi*, 3 F.4th at 826.

Reading the *Hayes* and *Takemoto* complaints together, the allegations are "substantially the same as those contained in the" presently filed complaint. *Maur*, 981 F.3d at 522 (internal quotation marks and quotation omitted). The Relators claimed that six allegations detailed in their amended complaint were not publicly disclosed. Four of the allegations related only to the insurer Defendants:

- Willful failure to correct inaccurate reporting even after specific notice from Relators; . . .

- Willful failure to report and reimburse for specific exemplars; . . .

> • Failure to report, or report properly, in tens of thousands of instances; . . .
>
> • Critical information intentionally avoided: Defendants created and maintained a system that they know is inadequate because they intentionally do not ask beneficiaries for . . . sources of health insurance coverage, Social Security numbers, Medicare Health Insurance Claim Numbers, or Member Beneficiary Identifiers.

ECF 86, PgID 2072-73 (emphases, internal parentheticals, and internal citations all omitted). But *Hayes* and *Takemoto* show that the Relators' claims against the insurer Defendants have already been alleged.[14]

The Relators first alleged that Defendants "fail[ed] to report[ ] and correct misreporting" even after they were "notified of their failure to satisfy Section 111's reporting requirements." ECF 41, PgID 1018-19. The allegation is nearly identical to the following *Takemoto* claim:

> Defendants were aware of their obligations to make such payments, both due to the well-established nature of the [Medicare Secondary Payer] statute and because Dr. Takemoto

14. The conspiracy allegations involve Defendant ISO. ECF 86, PgID 2072-73. Accordingly, the Court's public disclosure analysis here does not consider the conspiracy allegations; the Court will resolve the conspiracy claim in a separate order. *See* ECF 41, PgID 1075-77 (claim two).

> repeatedly contacted Defendants and provided them with a detailed explanation of their rights and liabilities under the [Medicare Secondary Payer] statute.
>
> Despite such knowledge, Defendant[s] elected to continue to avoid their repayment obligations to the Government and inadequately provide for future medical expenses in settlements.

ECF 78-28, PgID 1426. *Takemoto* therefore disclosed the exact theory of fraud that the Relators' first allegation details. The relators in both *Takemoto* and the present case alleged that they specifically notified the primary plans of their failures, and despite the notice, the primary plans carried on in their allegedly fraudulent schemes. *Compare id., with* ECF 41, PgID 1018-19, *and* ECF 86, PgID 2072.

It is hard to imagine facts that more closely align with the Relators' first allegation than what *Takemoto* detailed. The Relators claimed that no public source previously "identified any instance where Defendants ignored actual notice of underreporting and of reimbursement failures and refused to rectify them." ECF 86, PgID 2073. But the *Takemoto* relator alleged that he met with Allstate and other insurer companies to advise them of their Section 111 reporting requirements. ECF 78-28, PgID 1423. Despite the notice, "none of the defendants [took] meaningful steps . . . to remedy their noncompliance with their [Medicare Secondary Payer] obligations." *Id.* Thus, the insurers were given "specific notice from [the

relator]" in *Takemoto*, and yet "willfully failed to correct inaccurate reporting." ECF 86, PgID 2072 (cleaned up); *see* ECF 78-28, PgID 1423, 1432-34 (allegations against Allstate). The public disclosure bar thus applies.

Second, the Relators appeared to argue that the public disclosure bar cannot apply to their claims because they presented three "specific exemplars." ECF 86, PgID 2073 (emphasis omitted), 2080-84. But the argument is foreclosed by the Sixth Circuit's rule "that a relator's claims cannot survive the public disclosure bar because his allegations added some new details to describe essentially the same scheme by the same corporate actor as the publicly disclosed fraud." *Rahimi*, 3 F.4th at 826 (cleaned up). In other words, the exemplars barely elaborated on the schemes disclosed in *Hayes* and *Takemoto*, and so their corresponding allegations do not clear the public disclosure hurdle.

Relator Angelo's exemplar, ECF 41, PgID 1069-71, falls short because it detailed how the Government would cover payment of controlled substances for Medicare or Medicaid beneficiaries even though a primary plan "was obligated to provide primary payment for those controlled substances." *Id.* at 1070. In turn, the primary plans could fraudulently avoid their legal obligations to pay for "beneficiaries' accident-related medical expenses." *Id.* In short, the exemplar reiterated how "Defendants are routinely failing to repay Medicare conditional payments that they are statutorily required to repay." ECF 78-28, PgID 1424 (*Takemoto* amended complaint).

Relator MSP WB's exemplar fares the same. ECF 41, PgID 1089-90. There, Relator MSP WB detailed the medical payment history of "K.S." *Id.* The exemplar explained that "Allstate is the primary payer responsible for payment and/or reimbursement of K.S.'s accident-related medical expenses," *id.* at 1089, but "Allstate failed to reimburse [the Medicare Advantage Organization]'s conditional payments," *id.* at 1090. Allstate failed to pay, the exemplar claimed, even though "Allstate reported to ISO information regarding K.S.'s accident and admitted its primary payer status." *Id.* Put another way, the insurer Defendants "knowingly avoided and concealed their statutory obligations under the Medicare Secondary Payer Act . . . to fully reimburse [a Medicare Advantage Organization] for the payments that the [ ] program had already made for the[ ] beneficiar[y's] health care." ECF 78-29, PgID 1487 (*Hayes* amended complaint). Thus, Defendants failed to "repay [Medicare] for past conditional payments and protect Medicare's interests for the costs of future care." ECF 78-28, PgID 1424 (*Takemoto* amended complaint).

E.A.'s exemplar is no better. ECF 41, PgID 1071-72. E.A. was injured in a car accident and incurred more than forty accident-related medical expenses. *Id.* at 1071. But "Allstate Insurance Group never reported E.A.'s identity and claims . . . as required by Section 111 and failed to make primary payments relating to E.A.'s accident-related care." *Id.* Thus, "Medicare paid for prescription medication that Allstate Insurance Group was obligated to pay." *Id.* at 1072. *Takemoto* likewise alleged that "Allstate did not have a history of [Medicare Secondary Payer]

compliance," "did not express any desire to actively pursue [Medicare Secondary Payer] compliance," and "knowingly concealed and knowingly and improperly avoided their obligation to pay or transmit money or property to the Government, in the form of their conditional payment repayment obligations under the Medicare Secondary Payer rules." ECF 78-28, PgID 1433-34.

Consider too that *Hayes* alleged primary payers had "knowingly avoided and concealed their statutory obligations under the Medicare Secondary Payer Act . . . to fully reimburse Medicare for the payments that the Medicare program had already made for these beneficiaries[ ] for health care." ECF 72-29, PgID 1487; *see also id.* at 1494 ("Defendant [Allstate Corporation] nevertheless failed to notify, obtain a conditional demand[, and] reimburse Medicare for its expenditures."). Simply put, the Relators' exemplars describe "the same scheme" (fraudulent failure to report and reimburse) by "the same corporate actor" (Allstate and similar insurance companies) as the publicly disclosed fraud. *Rahimi*, 3 F.4th at 826 (cleaned up). Thus, the public disclosure doctrine bars the "willful failure to report and reimburse" allegation. ECF 86, PgID 2073 (emphasis omitted).

Third, the Relators inaccurately contended that there had been no prior disclosure of the broad statement that primary payers "fail[ed] to report, or report properly, in tens of thousands of instances." ECF 86, PgID 2073 (emphasis omitted). The *Takemoto* relator alleged that "[d]efendants either deliberately refuse[d] to learn whether a claimant was a Medicare beneficiary . . . and thus avoid[ed]

reimbursing the Government for its conditional payments or outright refuse[d] such repayment despite knowing that it is owed." ECF 78-28, PgID 1408. As a result, the Relators' claims that "[Defendants] fail[ed] to provide government payers with notice of their primary payer obligations" and that Defendants were "certain of their obligation to make payment, but they den[ied] all liability regarding the services," ECF 41, PgID 1021, share similarities with the *Takemoto* claims that are "impossible to ignore," *Rahimi*, 3 F.4th at 824. Both complaints alleged that: (1) primary payers failed to report or provide notice to the Government under Section 111, *see* ECF 41, PgID 1021, 1043; ECF 78-28, PgID 1408, 1421-24; and (2) primary payers refused to reimburse the Government by falsely denying repayment obligations, *see* ECF 41, PgID 1021, 1072; ECF 78-28, PgID 1408, 1422, 1424.

Contrary to the Relators' arguments, it is irrelevant that "Relator MSP's independent data analysis of its non-public proprietary claims data" revealed the alleged reporting failure. ECF 86, PgID 2073. After all, the *Takemoto* complaint already revealed substantially similar reporting failure claims.

Moreover, a 2017 news article about *Hayes* detailed the widespread "[f]ailure to report" allegation. *Id.* at 2073 (emphasis omitted); ECF 78-10, PgID 1334 (news article). The article first explained that the *Hayes* complaint "accused more than 60 companies"—including Allstate—"of engaging in a nationwide scheme to withhold payments to which Medicare was entitled under the Medicare Secondary Payer Act, in violation of the FCA." ECF

78-10, PgID 1334. Although the lawsuit was ultimately dismissed, the article detailed that the *Hayes* defendants requested that the case be "considered barred under the FCA's first-to-file bar, as another similar lawsuit had been filed before [that] one." *Id.* The 2017 article publicly reported on lawsuits raising FCA claims brought against private insurers and the specific allegations of Medicare Secondary Payer Act fraud raised in the suits. *Id.* Aside from *Takemoto*, the 2017 article detailed the existence of lawsuits raising the same fraud allegations as those lodged here. The Relators' failure-to-report claims therefore "describe essentially the same scheme" as *Takemoto* and in the news media. *Holloway*, 960 F.3d at 851. Those allegations are barred.

The fourth allegation is substantially the same as a *Takemoto* allegation. *See* ECF 41, PgID 1061; ECF 86, PgID 2073. The Relators alleged that Defendants "systematic[ally] fail[ed] to completely or accurately satisfy Section 111's reporting requirements." ECF 41, PgID 1018. And the failure was due to the "systems [Defendants] have in place" that "cannot completely and accurately satisfy their reporting requirements." *Id.* at 1019. Yet "[d]espite knowledge of said reporting failures, the Primary Plans have done nothing to change their conduct," and in turn Defendants "under report and under reimburse the Government Healthcare Programs." *Id.* at 1020.

In the same way, the *Takemoto* defendants allegedly "deliberately refuse[d] to learn whether a claimant was a Medicare beneficiary (or otherwise determine whether any payment to Medicare is owed) and thus avoid[ed]

reimbursing the Government for its conditional payments." ECF 78-28, PgID 1408. And those defendants "either had no [Medicare Secondary Payer] process whatsoever for liability and no-fault cases, or in the event that a process existed, it was randomly followed[ ] and did not lead to full compliance with the statutory requirements." *Id.* at 1422. The *Takemoto* relators explained that compliance procedures could be "as simple as asking the claimant or demanding copies of all paid claims for medical services," or else "contacting . . . either the Social Security Administration or [the Centers for Medicare and Medicaid Services]." *Id.* at 1418.

But even after the *Takemoto* defendants were advised about the "structure of the [Medicare Secondary Payer] program, the potential impact of . . . Section 111 reporting requirements, and the potential liability each insurer faced under the [FCA]," none took "meaningful steps . . . to remedy their noncompliance with their [Medicare Secondary Payer] obligations." *Id.* at 1423. All told, the *Takemoto* relator alleged that "[d]efendants routinely lacked procedures . . . that would allow them—other than sporadically and incidentally—to [ ] identify Medicare beneficiary status of claimants[,] . . . report liability and no-fault settlements . . . involving Medicare beneficiaries[,] . . . determine the amount of conditional payments owed[,] . . . or [ ] repay [the Centers for Medicare and Medicaid Services] for past conditional payments." *Id.* at 1424.

Put simply, the fourth allegation here repeats the same story: primary payers failed to create and enforce a system identifying when their insureds were covered by

Medicare or Medicaid, which led to them underreporting claims to the Government, despite the primary payers knowing that their compliance procedures failed to fulfill their Section 111 obligations. The allegation was already detailed in *Takemoto* and is barred by the public disclosure doctrine.

D. Third Prong

Last, a relator may still pursue a claim if he or she is the original source of it. *Rahimi*, 3 F.4th at 828 (citing 31 U.S.C. § 3730(e)(4)(A)-(B)). A relator may claim that he is an original source when he "has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and [he] has voluntarily provided the information to the Government before filing an action under this section." ECF 86, PgID 2080 (quoting § 3730(e)(4)(B)).[15]

Materiality under § 3730(e)(4)(B) requires the relator "to bring something to the table that would add value for the government." *Maur*, 981 F.3d at 527 (citations omitted). But merely bringing more examples of the publicly disclosed fraud is not enough "to change the government's thinking or decision-making with respect to the alleged fraud." *Rahimi*, 3 F.4th at 831-32 (collecting cases).

Defendants argued that the Relators are not original sources for two reasons. First, the Relators "alleged [no]

15. The Sixth Circuit has read this provision of § 3730(e)(4)(B) as "a safety valve." *Rahimi*, 3 F.4th at 831.

facts demonstrating they provided information to the [G]overnment prior to a public disclosure and before filing this action." ECF 77, PgID 1230 (footnote omitted). Second, the Relators did not provide "any additional material information to the Government." *Id.* at 1232 (cleaned up). The Court will address both arguments in turn.

The Relators did not "voluntarily disclose to the Government the information on which allegations . . . in a claim are based," § 3730(e)(4)(B), before the sources identified in the first prong analysis, above, were disclosed. *Takemoto* and *Hayes* were both unsealed in 2014 and the amended complaints were also filed in 2014. *Takemoto*, No. 1:11-cv-00613, ECF 22 (W.D.N.Y. Apr. 3, 2014) (order unsealing case); *Hayes*, No. 1:12-cv-01015, ECF 16 (W.D.N.Y. Mar. 20, 2014) (order unsealing case); ECF 78-28, PgID 1479 (*Takemoto* amended complaint); ECF 78-29, PgID 1608 (*Hayes* amended complaint). Relator Angelo's disclosure statement to the Government is dated May 2019, ECF 1-1, PgID 75, and the Relators sent their subsequent disclosure statement to the Government in November 2021, ECF 41, PgID 1025. No evidence shows that the Relators disclosed any information to the Government before 2014, when *Takemoto* and *Hayes* were unsealed, and the Relators did not argue that they disclosed any other allegations to the Government before the 2019 and 2021 disclosures. *See* ECF 86, PgID 2080-81. "Because the Relators did not communicate anything to the Government prior to those public disclosures, they do not fit within the first definition of an original source." *Maur*, 981 F.3d at 527 (cleaned up).

Still, the Relators could qualify as original sources if they "ha[ve] knowledge that is *independent* of and *materially* adds to the publicly disclosed allegations." § 3730(e)(4)(B) (emphases added). But the information presented in the present complaint does not materially add to the public disclosures for two reasons.

First, the Relators included three exemplars in their complaint, but "there is nothing significant or new about them." *Maur*, 981 F.3d at 527 (internal quotation marks and quotation omitted). As discussed in prong two, the similarities between the present case and *Takemoto* and *Hayes* are impossible to ignore, and nothing in the present complaint would "offer information of such a nature that knowledge of it would affect the Government's decisionmaking." *Id.* at 528 (cleaned up). The Relators' cursory argument that their allegations are "based on information uniquely available to [them]," ECF 86, PgID 2081, is unpersuasive given that the relators in *Takemoto* and *Hayes* identified a substantially similar fraudulent scheme as the one alleged here.

Second, the Relators countered that they supplied "previously unknown violations through their own business experiences, self-funded litigation, and analysis of their own proprietary non-public data." ECF 86, PgID 2083. But the information derived from Relator MSP WB's "own proprietary non-public data," *id.*, is information apparently belonging to MSP Recovery, LLC—a different entity than Relator MSP WB.[16] Any information from

16. The Relators did not dispute Defendants' assertion that the information comes from an affiliate company, MSP Recovery,

MSP Recovery, then, is attributed to MSP Recovery—not MSP WB. The Relators offered no supporting authority to show that affiliated entities can share institutional knowledge derived from one entity's proprietary system for the purpose of the public disclosure bar's original source safety valve. *See id.* at 2083-84. And the Relators did not suggest that MSP WB and MSP Recovery should be considered the same entity. *See id.*

With no authority or facts showing that the Court should ascribe knowledge possessed by MSP Recovery to Relator MSP WB, the latter cannot claim to be the original source of information collected by a different corporate entity. *See United States ex rel. Fine v. Advanced Scis., Inc.*, 99 F.3d 1000, 1007 (10th Cir. 1996) ("[T]o be independent, the relator's knowledge must not be derivative of the information of others, even if those others may qualify as original sources.") (citation omitted); *cf. United States ex rel. Precision Co. v. Koch Indus., Inc. (Precision I)*, 971 F.2d 548, 554 (10th Cir. 1992) (holding that a company cannot be an original source of information discovered by its president's and majority shareholder's "individual investigations" before the company was formed).

The Relators do not qualify as original sources under the FCA. The public disclosure bar therefore applies and forecloses the reverse FCA violations claim against the insurer Defendants.

LLC. *Id. Compare MSPA Claims I, LLC v. Infinity Prop. & Cas. Grp.*, 374 F. Supp. 3d 1154, 1161 (N.D. Ala. 2019) (employees describing "MSP Recovery's system") *with* ECF 41, PgID 1020 (description of the MSP System).

Appendix D

CONCLUSION

The Court will dismiss the reverse FCA violations claim against all insurer Defendants. *See* ECF 41, PgID 1073-75 (claim one). The Court will resolve the remaining claims in a separate order. The Court will therefore grant the motions to dismiss, ECF 77, and for judicial notice, ECF 78, in part.

ORDER

WHEREFORE, it is hereby **ORDERED** that the motion to dismiss [77] is **GRANTED IN PART**.

IT IS FURTHER ORDERED that the motion for judicial notice [78] is **GRANTED IN PART**.

SO ORDERED.

s/ Stephen J. Murphy, III
STEPHEN J. MURPHY, III
United States District Judge

Dated: August 9, 2022

APPENDIX E — RELEVANT STATUTORY PROVISIONS

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 104–410*[1]), 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*.