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In The

Supreme Court of the United States

ROBERT I. BOURSEAU; RIB MEDICAL MANAGEMENT SERVICES, INC.; RUDRA SABARATNAM; AND NAVATKUDA, INC.,

Petitioners,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

PATRIC HOOPER (SBN 57343)
HOOPER, LUNDY & BOOKMAN, INC.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2799

Tel: (310) 551-8165
Fax: (310) 551-8181

Attorneys for Petitioners

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Whether the Court of Appeals, in conflict with the Eighth Circuit, but consistent with the Fourth and Sixth Circuits, correctly concluded that the "natural tendency test," rather than the "outcome materiality test," should be used to determine if the false Medicare cost reports at issue were material to a payment decision of the government under the Federal False Claims Act ("FCA") 31 U.S.C. § 3729-3733.

2. Whether the Court of Appeals in conflict with the Third, Fifth and District of Columbia Circuits, correctly concluded that the government sustained damages even though the government failed to prove it relied on the false representations in the Medicare cost reports.

3. Whether the Court of Appeals in conflict with an earlier Ninth Circuit decision and relevant decisions of this Court correctly concluded that there is "no law" requiring a district court to award less than treble damages and the maximum amount of allowable civil penalties under the FCA to satisfy the excessive fines clause of the Eighth Amendment and the due process clause of the Fifth Amendment.

PARTIES TO THE PROCEEDINGS

The Petitioners, Defendants/Appellants below, are Robert I. Bourseau; RIB Medical Management, Inc.; Rudra Sabaratnam; and Navatkuda, Inc.

The Respondent, Plaintiff/Appellee below, is the United States of America.

CORPORATE DISCLOSURE

Petitioner RIB Medical Management Services, Inc. ("RIB") is not a publicly held corporation and is wholly owned by Petitioner Robert I. Bourseau. Petitioner Navatkuda, Inc. ("Navatkuda") is not a publicly owned corporation an is wholly owned by Petitioner Rudra Sabaratnam.

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OPINIONS BELOW

The opinion of the Court of Appeals (App. at 1-33) is reported at 531 F.3d 1159. The opinion of the District Court (App. at 34-80) is not published in the official reports but is published at 2006 WL 2961105 and 3949169.

JURISDICTION

The judgment of the Court of Appeals was entered on July 14, 2008. The Order Denying Rehearing (App. at 83-84) was entered on August 19, 2008, and the Mandate (App. at 81-82) issued August 27, 2008. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1). The Court of Appeals exercised jurisdiction to review the District Court's decision under 28 U.S.C. § 1291. The District Court asserted jurisdiction under 31 U.S.C. § 3732(a) and 28 U.S.C. § 1345.

CONSTITUTIONAL PROVISIONS INVOLVED

The Eighth Amendment to the United States Constitution provides, in pertinent part, that excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted. The Fifth Amendment provides, in pertinent

part, that no person shall be deprived of life, liberty or property without due process of law.

THE RELEVANT STATUTES

31 U.S.C. § 3729(a)(7) states in pertinent part that any person who knowingly makes, uses, or causes to be made or uses a false record or statement to conceal, avoid or decrease an obligation to pay money 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, plus three times the amount of damages which the government sustains because of the act of that person.

STATEMENT OF THE CASE

A. The Medicare Reimbursement Process

This case involves the submission of three Medicare cost reports and thus a brief review of the Medicare reimbursement process is necessary. During the period at issue, Medicare reimbursed psychiatric hospitals for the reasonable costs of services provided to Medicare beneficiaries. 42 U.S.C. §§ 1395k, 1395ww(b), 1395x(v)(1)(A); 42 C.F.R. § 412.23. Medicare reimbursed such providers only for the portion of costs that relate to Medicare patients. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.50. *See* Court of Appeals Opinion, App. at 3.

The Medicare program contracts with private insurance companies, known as Medicare fiscal intermediaries, to facilitate the reimbursement process. 42 U.S.C. § 1395h; 42 C.F.R. § 413.64. The fiscal intermediaries pay providers interim amounts periodically throughout the year based on estimated treatment costs for Medicare patients. 42 U.S.C. § 1395g(e); 42 C.F.R. §§ 413.60 and 413.64. At the end of the year, providers submit a final accounting of their actual costs for the year to their intermediaries in a document called a cost report. 42 C.F.R. § 413.20. Court of Appeals Opinion, App. at 3-4.

To reimburse providers for their Medicare costs as quickly as possible, fiscal intermediaries are required to make an initial retroactive adjustment (also known as "tentative settlement") to the aggregate interim payments as soon as they receive the provider's cost report. 42 C.F.R. § 413.64(f)(2); Provider Reimbursement Manual ("PRM") § 2408.2 (App. at 85-86). In making the initial retroactive adjustment, intermediaries accept costs as they are reported on a cost report except for obvious errors and inconsistencies. 42 C.F.R. § 413.64(f)(2); PRM § 2408.2. The cost reports are later subject to audit by the fiscal intermediaries. 42 C.F.R. § 413.64(f)(2). Court of Appeals Opinion, App. at 4.

After fiscal intermediaries audit a cost report, they determine the provider's and the Medicare program's final liability to one another. 42 C.F.R. § 413.64(f)(2). In other words, an intermediary typically uses a cost report to determine whether a

provider or Medicare is owed money at "final settlement" of the cost report based on the difference between the aggregate interim payments already made to the provider and the actual amount that the intermediary determines was actually due the provider based on the audit of the cost report. 42 C.F.R. §§ 405.1803, 413.9(b)(1), 413.60, and 413.64(f). Recoupment of any overpayment made to a provider occurs notwithstanding any request for a hearing to review an intermediary's determination. 42 C.F.R. § 405.1803(c). Court of Appeals Opinion, App. at 4-5.

The Medicare regulations governing reasonable cost reimbursement are voluminous and complex. As of 1994, they consumed 624 pages of the Code of Federal Regulations (Title 42). *Shalala v. Guernsey Memorial Hosp.,* 514 U.S. 87, 90, 96 (1995). Because of their complexity, Congress established the Provider Reimbursement Review Board to resolve disputes pertaining to the definition of reasonable costs. *See United States v. California Care Corp.*, 709 F.2d 1242, 1248, footnote 9 (9th Cir. 1983). For those particular details not addressed by Medicare reasonable costs regulations, the Secretary of Health and Human Services, who administers the Medicare program, relies on "an elaborate adjudicative structure," which includes the Provider Reimbursement Review Board. *See Shalala v. Guernsey Memorial Hosp.,* 514 U.S. at 96, citing 42 U.S.C. § 1395oo(f)(1). Thus, Medicare reasonable cost reimbursement is typically

determined through rulemaking and adjudication. *Id* at 96-97.

Importantly, unlike a federal tax return, a Medicare cost report serves as the beginning point for determining reasonable costs as opposed to the endpoint. In *Shalala v. Guernsey Memorial Hosp.,* 514 U.S. at 94, this Court expressly recognized this fact emphasizing that a provider's Medicare cost reporting is the first step toward reimbursement and certainly not the only or last step. The Medicare fiscal intermediaries must assist providers in interpreting and applying the principles of Medicare reasonable cost reimbursement to the cost reporting process.

In other words, the process for determining Medicare reasonable costs consists of "more than a provider handing over its" cost report to its fiscal intermediary. Numerous subsequent actions, including a thorough review of the cost report, are required to determine the liability of the Medicare program for services previously rendered. 514 U.S. at 94. None of these steps occurred here because, as stressed below, the fiscal intermediary deliberately chose not to act on the cost reports at issue due to the provider's precarious financial status.

Additionally, the courts have interpreted the Medicare Act to hold that unless a provider includes a cost in a cost report, the provider loses its right to pursue reimbursement through the Medicare administrative appeal process. *See Athens Community Hosp., Inc. v. Schweiker,* 743 F.2d 1 (D.C. Cir. 1984).

Indeed, unless a fiscal intermediary makes an "adverse decision" regarding particular costs in a cost report, the provider is precluded from pursuing an appeal of such costs with the Provider Reimbursement Review Board. 743 F.2d at 3, footnote 2.

As discussed further below, it is undisputed in this case that the three Medicare cost reports at issue, were not, in fact, acted on by the Medicare fiscal intermediary, and thus *no payment decisions were made by the responsible government agent* based on the three cost reports, because the fiscal intermediary determined that the Medicare provider was involved in bankruptcy proceedings or otherwise insolvent. Under a Medicare PRM provision, specifically Section 2408.2 (App. at 85-86), no action is taken on a cost report submitted by a provider when the provider is potentially insolvent or is the subject of bankruptcy proceedings.

Although this manual provision appears to be inconsistent with 42 C.F.R. § 413.64(i) (App. at 87-98), which requires an intermediary to adjust interim payments in a bankruptcy or insolvency situation, it is undisputed in this case the fiscal Medicare intermediary chose to take *no such action* in response to the three cost reports because of the hospital's pending bankruptcy and insolvency. In other words, as discussed below and as recognized by the Court of Appeals, the fiscal intermediary made no payment decision, including adjusting Medicare interim rates, based on the receipt of the three cost reports at issue. However, because the Court of Appeals concluded

that the Medicare fiscal intermediary could have potentially taken some payment action, the submission of the false cost reports was material to a Medicare payment decision and thus actionable under the FCA.

B. The Facts

Between 1994 and 2000, Bayview Hospital and Mental Health Systems ("Bayview") was a psychiatric hospital that participated in the Medicare program. Bayview was owned and operated by a California limited partnership, known as California Psychiatric Management Services ("CPMS"), which, in turn, was owned by Mr. Bourseau and Dr. Sabaratnam through their wholly owned corporations, RIB and Navatkuda. Court of Appeals Opinion, App. at 5.

In 1996, well before the cost reports at issue were prepared or even contemplated, CPMS filed for Chapter 11 bankruptcy protection. At the time, its only business was Bayview. By letter dated July 16, 1997, the Medicare fiscal intermediary informed Bayview that it was resetting Bayview's Medicare interim payment rates based on Bayview's 1996 Medicare cost report. Exhibit J-66, App. at 99-100. The 1996 cost report predates the three cost reports at issue here. By a second letter also dated July 16, 1997, the same Medicare fiscal intermediary informed Bayview that because of Bayview's bankruptcy proceedings, no further adjustments would be made to Bayview's cost reports. Defendants' Exhibit A, App. at 101-102.

Although CPMS emerged from bankruptcy in 1998, it sought bankruptcy protection again in 2000. Court of Appeals Opinion, App. at 7. Throughout the period of 1996 through 2000, the Medicare fiscal intermediary treated Bayview as being in bankruptcy or insolvent. Thus, the Medicare fiscal intermediary deliberately chose to *make no payment determinations* based on Bayview's 1997, 1998 or 1999 Medicare cost reports, the three cost reports at issue. In fact, the District Court expressly found that the government failed to prove it expressly relied on the false representations in the three cost reports. Dist. Ct. opinion, App. at 68.

The Court of Appeals thus confirmed that (1) Bayview's Medicare fiscal intermediary, Mutual of Omaha, never made adjustments to Bayview's 1997, 1998 and 1999 cost reports, (2) never audited these three cost reports, and (3) never collected overpayments or paid underpayments based on any of these three cost reports. Court of Appeals Opinion, App. at 7. Indeed, Bayview's interim Medicare payment rates, which had been adjusted in 1997 based on Bayview's 1996 cost report, remained the same between 1997 and 2000 because of the bankruptcy.

However, as discussed below, the Court of Appeals nevertheless concluded that because the false cost report entries in Bayview's 1997, 1998 and 1999 Medicare cost reports had the potential or natural tendency to affect Bayview's interim Medicare payment rates through impeding the fiscal intermediary's ability to adjust the interim rates, they were

material to a Medicare payment decision. Court of Appeals Opinion, App. at 27, 28-29.

C. The Proceedings Below

The government filed suit against Petitioners in the United States District Court for the Southern District of California alleging violations of the FCA, unjust enrichment and common law fraud. After a six day bench trial, the District Court held the Petitioners to be jointly and severally liable to the government under the FCA. The District Court concluded that the 1997, 1998 and 1999 cost reports were false claims which were actionable as both affirmative false claims and reverse false claims. According to the District Court, by including the false costs in the cost reports, Bayview had decreased the amount it owed Medicare by $5,219,195, which required the District Court to impose treble damages of $15,657,585 and $31,000 in civil penalties. Court of Appeals Opinion, App. at 8.[1]

The District Court, however, concluded that the government failed to prove that Petitioners were liable under the unjust enrichment and common law fraud causes of action. Indeed, the District Court

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[1] The District court originally held that treble damages were in excess of $24,000,000. App. at 57. However, the parties pointed out this approximately $9,000,000 mistake in a post-trial motion, and the District Court altered its opinion accordingly. App. at 75.

expressly concluded that the government did not prove it "relied on the false representations" in the cost reports. *See* District Court's September 29, 2006 Decision, App. at 68.[2] Notwithstanding these holdings, the District Court separately concluded that the award of maximum treble damages and civil penalties did not violate either the excessive fines clause or the due process clause of the Constitution. *See* District Court's December 1, 2006 order, App. at 75-79.

Petitioners timely and separately appealed the District Court judgment. The Court of Appeals consolidated the appeals and affirmed the District Court's judgment. However, the Court of Appeals analyzed the Medicare cost reports under the reverse false claims provision of the FCA, 31 U.S.C. § 3729(a)(7) and not under the provisions of (a)(1), (a)(2) or (a)(3).[3]

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[2] The Court of Appeals, however, makes no mention of these conclusions in its opinion and did not rehear or amend its opinion to account for these conclusions, which were again emphasized in the previously filed petition for rehearing.

[3] Although the Court of Appeals analyzed the cost reports under the reverse false claim provision of the FCA, it stated in dicta (*see* footnote 1 of the opinion, App. at 9), that the cost reports were also actionable claims under the affirmative claims provisions of the FCA. Most respectfully, this dicta is plainly erroneous. *See Rabushka ex rel. U.S. v. Crane Co.*, 122 F.3d 559, 565, footnote 8 (8th Cir. 1997), where the Court confirms that every circuit, including the Ninth Circuit, to have considered the issue has concluded that a reverse false claim was not actionable until Subsection (a)(7) was added to the FCA in 1986. Because

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The Court of Appeals concluded that the government proved each and every element necessary to establish liability under the reverse false claim provision of the FCA, 31 U.S.C. § 3729(a)(7), including materiality. In doing so, the Court of Appeals recognized that a materiality requirement existed under the FCA, especially under the reverse false claims provision of the FCA. Court of Appeals Opinion, App. at 25-27. The Court further noted the split of authority among the Courts of Appeals on the test to be used for determining materiality under the FCA. Choosing to side with the Fourth and Sixth Circuits, the Court of Appeals adopted the "natural tendency test" for determining materiality in this case, which focuses on the "potential effect of the false statement when it is made rather than on the false statement's actual effect after it is discovered." The Court noted that the Eighth Circuit had adopted a more restrictive "outcome materiality" standard, which required the government to show that the defendants' actions actually caused the United States to pay out money it was not obligated to pay or actually deprived the United States of money it was lawfully due. Court of Appeals Opinion, App. at 26.

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the three cost reports at issue did not make any actual claim for payment but rather reported costs which had the potential to decrease the amount owing the government, they were reverse false claims, not affirmative false claims. Thus, they were actionable only under (a)(7).

Under the natural tendency test, the Court of Appeals concluded that the false entries in the 1997, 1998 and 1999 cost reports were material because they had the "potential effect, or natural tendency" to decrease the amount Bayview (CPMS) owed Medicare despite the fact the cost reports were never acted upon. Court of Appeals Opinion, App. at 27. This conclusion squarely poses the materiality issue raised by the first question on which review is requested.

Moreover, the Court upheld the District Court's judgment awarding the maximum civil penalties and treble damages calculated by the government's expert witness using a "what if" calculation, which determined the impact of the false cost report entries as if the cost reports had actually been acted and relied upon by the Medicare fiscal intermediary when, in fact, they never were acted or relied upon. Thus, although the Medicare fiscal intermediary did not process the cost reports and did not use them to review or alter Bayview's Medicare's interim payment rates or tentative or final settlements and did not issue any demands for payment upon the receipt of the cost reports (or in the words of the District Court – did not rely on the misrepresentations), the Court of Appeals nevertheless upheld the "what if" damages calculation made by the government's expert at trial. This conclusion poses the damages causation issue raised by the second question on which review is requested.

Finally, even though the District Court concluded that the government failed to prove common law

fraud and failed to prove that any of the Petitioners had been unjustly enriched as a result of the filing of the cost reports and even though there was no *qui tam* relator with whom the government would have to share the proceeds of the judgment, the Court of Appeals concluded that the District Court's judgment was constitutionally sound, i.e., not excessive or disproportional. In doing so, it found "no law requiring a District Court to award less than treble damages and the maximum amount of allowable civil penalties in an FCA case in order to satisfy the Excessive Fines Clause." Court of Appeals Opinion, App. at 81-83. This conclusion poses the excessive damages issue, the third question on which review is requested.

REASONS FOR GRANTING THE PETITION

A. The Importance of the Questions

As this Court has noted, the FCA is the government's primary litigative tool for "recouping losses suffered through fraud." *Vermont Agency of Nat. Resources v. U.S.*, 529 U.S. 765 (2000). The resolution of the questions presented here is critical to the uniform application of the FCA to all types of government contractors. The questions are especially important, however, to the health care industry where health care fraud cases currently surpass all other types in which the FCA is used. *See 1 John T. Boese, Civil False Claims and Qui Tam Actions,* 1-36

through 1-38 (3d Ed. Supp. 2008) and *Robert Salcido, Health Care Fraud and Abuse: Practical Perspectives*, American Bar Association, Health Law Section, Chapter 3.1 (Linda A. Baumann, Editor 2002).

This Court has provided continuing guidance on FCA issues, including those issues regarding the nature of FCA damages and penalties. *See Vermont Agency of Nat. Resources v. United States ex rel. Stevens,* 529 U.S. 765, 784 (2000) and *Cook County v. United States ex rel. Chandler,* 538 U.S. 119, 130-31 (2003). The related question of the limits on punitive damages in civil actions is also of great concern to the Court from a due process standpoint. *See State Farm Mutual Automobile Insurance Company v. Campbell*, 538 U.S. 408, 429 (2003). Indeed, in *Exxon Shipping Company v. Baker,* ___ U.S. ___, 128 S. Ct. 2605 (2008), this Court recently concluded that a one-to-one ratio of punitive to compensatory damages was a fair upper limit in most maritime law cases.

B. The Decision Deepens a Conflict Among the Lower Courts Allowing the Government to Pursue Actions Based on False Claims and Representations Which Do Not Actually Affect Government Payment Decisions

As explained above, the government made no payment decision based on the submission of the three cost reports at issue here. Significantly, this is precisely why the District Court concluded that the government failed to prove common law fraud. *See*

page 21 of the District Court's decision, App. at 58, where among other things, the District Court concludes that the government failed to prove it "relied on the false representations" at issue. Notwithstanding this finding, the Court of Appeals applied the "natural tendency test" to hold that the cost reports were material because they had the potential to affect a government payment decision even though they did not, in fact, do so here.

This application of the natural tendency test demonstrates why it should be rejected as the test for materiality under the FCA. Yet, the Ninth Circuit has now joined the Fourth and Sixth Circuits in adopting the natural tendency test as the basis for determining materiality under the FCA. As the Ninth Circuit recognized, its decision to adopt the natural tendency test is contrary to the Eighth Circuit's decision adopting the "outcome materiality test." Under this latter standard, the government must prove that the false claim or false representation actually deprived the government of money it was lawfully due.[4]

A leading commentator, John T. Boese, on whom this Court and others, including the Ninth Circuit, have relied in interpreting the FCA (*see*, for example, *Hughes Aircraft Co. v. United States ex rel. Schumer,*

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[4] In *U.S. ex rel. Costner v. U.S.,* 317 F.3d 883, 886-87 (8th Cir. 2003), the Court stated that although the Courts disagree about the proper standard for materiality under the FCA, its previous decisions suggest that "outcome materiality" is the proper standard.

520 U.S. 939 (1997)) discusses in detail the need to clarify the standard for determining materiality under the FCA. *See 1 John T. Boese, Civil False Claims and Qui Tam Actions* at 2-158.6 through 2-192 (3d Ed. Supp. 2008). To avoid eliminating the element of causation in FCA litigation, Mr. Boese emphasizes that many courts have applied a heightened materiality concept without necessarily abandoning the "natural tendency" standard. *Id.* at 2-164 through 2-165.

Thus, for example, in *U.S. v. Southland Management Corp.*, 326 F.3d 669, 679-80 (5th Cir. 2003), Circuit Judge Jones, in a concurring opinion, written on behalf of four other circuit judges, pointed out that although the Fifth Circuit seemingly applies the natural tendency test for materiality, the determination for materiality should be "context-specific." As an example, Judge Jones characterizes the Ninth Circuit's decision in *United States ex rel. Hopper v. Anton,* 91 F.3d 1261, 1266 (9th Cir. 1996), as involving the situation in which the responsible government official did not even see or review the allegedly false certification in question in that case. She notes that in such a situation a false certification could not be deemed to be material for FCA liability purposes.[5]

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[5] Actual reliance has also been deemed to be a necessary component of the government's burden of proof in analogous situations, such as securities fraud cases. *See Dura Pharmaceutical v. Broudo*, 544 U.S. 336, 343-44 (2005) [if no reliance on the

(Continued on following page)

This is the precise situation here. The responsible government official, the Medicare fiscal intermediary, did not act or rely on the three cost reports in question, either with respect to processing them or adjusting interim payment rates based on them. While a Medicare regulation, 42 C.F.R. § 413.64(i), seemingly required the fiscal intermediary to use the cost reports to adjust interim payment rates, the fiscal intermediary did not in fact do so because of the Medicare Manual provision, PRM Section 2408.2 (App. at 85-86), which required the fiscal intermediary to put the cost reports "on hold" because the provider was bankrupt or insolvent.

While many courts deem reliance and causation factors to be part of the materiality issue, others analyze it as being relevant to the determination of damages. Thus, in *U.S. ex rel. Schwedt v. Planning Research Corp.*, 59 F.3d 196, 199-200 (D.C. Cir. 1995), the Court held that if an FCA plaintiff cannot prove that the government relied on a false claim or representation in making a payment decision, there will be no damages. However, the defendant would still be liable for civil penalties because of the submission of the false claims or representation. The Court in *Planning Research* further pointed out that it agreed with the Third and Fifth Circuits that damages must

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misinterpretation, then it is not actionable under the Securities laws].

be limited to those that arise from the false claims themselves.

Here, however, the Court of Appeals found the cost reports to be material because they potentially affected Bayview's interim rates but then imposed damages based on a calculation that had nothing to do with any potential adjustment to interim rates. Instead, it affirmed the government's "what if" calculation of the allowable costs in the cost reports, which had nothing to do with any adjustment to interim payment rates made throughout the years.

C. The Ninth Circuit's Decision Also Conflicts With Its Own Previous Decision and the Relevant Decisions of This Court Concerning the Excessive Fines Clause and the Due Process Clause

Notwithstanding expressly recognizing that an award of treble damages and civil penalties under the FCA is subject to review under the Eighth Amendment's excessive fines clause, as determined by the Ninth Circuit in *United States v. Mackby,* 339 F.3d 1013, 1016 (9th Cir. 2003), the Court of Appeals held here that it found no law requiring the District Court to award less than treble damages and the maximum amount of allowable civil penalties to satisfy the excessive fines clause. Court of Appeals opinion, App. at 32.

This conclusion is clearly inconsistent with *U.S. v. Mackby*, *supra*, where the Court of Appeals analyzed the District Court's Award of damages and civil penalties under the excessive fines clause even though they were far less than the maximum amounts that could have been ordered under the statute. In *Mackby*, the Ninth Circuit upheld a judgment of approximately $730,000 even though the maximum amount allowable under the FCA in that case was approximately $85,000,000 in civil penalties and $1,000,000 in treble damages.

Because it held that no law required an award of treble damages to be analyzed under the Eighth Amendment, the Court of Appeals did not analyze the respective culpability of each petitioner and did not consider such critical factors as the District Court's conclusions that none of the petitioners was unjustly enriched or defrauded the government.

The Ninth Circuit's holding that a court is not required to award less than maximum damages and penalties under the FCA regardless of the excessive fines clause effectively undoes its previous holding in *Mackby* acknowledging the applicability of the excessive fines clause to FCA judgments whether or not maximum penalties and treble damages are awarded. In *Mackby*, the Ninth Circuit concluded that the treble damages and civil penalties of the FCA were, at least in part, punitive and therefore subject to the excessive fines clause based on this Court's decision in *United States v. Bajakajian,* 524 U.S. 321 (1998). *See United States v. Mackby,* 261 F.3d 821, 830-31

(9th Cir. 2001). Nothing in *Bajakajian* or *Mackby* supports the conclusion that a District Court is prohibited from reducing a judgment below statutory limits based on the excessive fines clause.

Other courts have agreed with *United States v. Mackby. See,* for example, *Hays v. Hoffman,* 325 F.3d 982, 992 (8th Cir. 2003). Still, other courts have ignored *Mackby*. For example, in *U.S. v. Rogan,* 517 F.3d 449, 453 (7th Cir. 2008), the Seventh Circuit, without mentioning *Mackby*, held "it is far from clear that the Excessive Fines Clause applies to civil actions under the False Claims Act." According to the Seventh Circuit, the law is "unsettled," regarding this issue. *Id.* at 454. Rather than helping to settle the law in this area, the Ninth Circuit's decision leaves it further unsettled, which, most respectfully, requires this Court to act.[6]

In addition to raising issues under the Excessive Fines Clause, the amount of the judgment in this case also triggers due process concerns, which, although raised in the District Court and on appeal, were completely ignored by the Ninth Circuit in its opinion.

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[6] In *Browning-Ferris Industries, Inc. v. Kelco Disposal, Inc.,* 492 U.S. 257, 276 (1989), this Court noted that it had left open the question of whether the Eighth Amendment's excessive fines clause applies to judgments under the FCA. Most respectfully, this case presents the perfect opportunity to settle the question.

Once again, FCA commentator Boese points out that when the trebling provision of the FCA are applied to situations in which single damages are very high, they necessarily lose their remedial effect and any reasonable punitive effect. Under such circumstances, only a single multiplier can be considered reasonable for due process purposes. As pointed out above, this Court has supported this reasoning in other circumstances, especially when, as here, compensatory damages are substantial. *See State Farm Mutual Automobile Ins. Co. v. Campbell*, 538 U.S. at 429.

In essence, the Court of Appeals deferred to the District Court on the excessiveness issue under the mistaken legal impression that no law required the District Court to reduce damages and penalties below the statutory limits. Not only is this conclusion inconsistent with the case law discussed above, it also is inconsistent with this Court's ruling in *Cooper Industries v. Leatherman Tool,* 532 U.S. 436 (2001), reversing the Ninth Circuit because it did not make an independent determination of the relevant factors for determining excessiveness under the Constitution.

THE NINTH CIRCUIT'S DECISION IS PLAINLY WRONG

The Ninth Circuit's adoption of the natural tendency test for determining materiality allowed it to uphold the District Court's liability determination

under the FCA even though the false cost reports had no actual impact on any government payment decision and had not been relied on by the government. Nothing in the FCA suggests that false statements which are not relied on by the government are actionable under the FCA. The mere possibility that a false statement or false claim could be relied on by the government and could therefore potentially affect a payment determination has no textual support for imposing liability under the FCA.

The government will no doubt argue, as it argued below, that petitioners were obligated to submit checks to the Medicare fiscal intermediary along with the cost reports because the cost reports showed an amount owing to the Medicare program when filed.[7] This was, indeed, the case with each cost report even though each cost report contained false entries which lowered the amount owing.

Under the applicable Medicare Manual provision, PRM Section 2409.1.A.2 (App. at 103-105), the Medicare fiscal intermediary was required to make a demand for payment upon a provider which fails to submit payment with its cost report *unless* the provider was in bankruptcy or insolvent, which was the case here. Indeed, the Medicare fiscal intermediary

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[7] The Court of Appeals did not use this argument to support materiality or damages in its opinion. Rather, it spoke only of the potential impact on interim payment rates, which was never addressed at trial.

expressly acknowledged this fact in connection with the 1998 cost report. By letter dated November 17, 1999, it told Bayview (CPMS) that it was prohibited from making demands regarding any debt owing as a result of the filing of the cost report because of CPMS' bankruptcy. *See* Exhibit I, App. at 101-102.

In reality, the situation here is no different than it would have been if the fiscal intermediary had simply thrown the cost reports in the trash can. While such cost reports might contain false cost report entries, they would have had no impact on any payment decision by the government. The Court of Appeals' holding that the cost reports impeded the fiscal intermediary's ability to determine whether it should have decreased interim payments raises nothing more than a potential impact, one that did not actually occur. As indicated above, the cost reports, as filed, showed amounts owing by Bayview to the government and the fiscal intermediary knew Bayview was in bankruptcy or insolvent. Yet, it took no steps to adjust the interim payment rates, and instead, knowingly and deliberately chose to continue to pay Bayview at the interim payment rates determined by Bayview's 1996 Medicare cost report.

The Court of Appeals' opinion is also wrong because the government is not damaged if it does not rely on false representations. As emphasized above, the District Court found that the government failed to prove such reliance in this case. Yet, the District Court and the Court of Appeals concluded that the false representations somehow caused the government to

sustain actual damages. Under the case law established in the District of Columbia, *U.S. ex rel. Schwedt v. Planning Research Corp., supra,* damages are not warranted and the government is limited in such situations only to recovering civil penalties since the government did not prove it relied on the false representations.

In addition to being erroneous because the false cost reports were not material to a government payment decision and did not cause any damages, the Court of Appeals' decision is also wrong because the Court of Appeals did not analyze the amount of the judgment to determine whether it was grossly disproportional to the conduct of the petitioners and the loss purportedly suffered by the government. Rather, as pointed out above, the Court believed such an analysis was not required under the "law" so long as the judgment did not exceed the maximum amount of the penalties and did not exceed treble damages. This "reasoning" effectively means that an FCA judgment may not be scrutinized under the excessive fines clause unless a trial court issues a judgment in excess of the maximum limits permitted under the statute. However, in such a situation, the judgment would violate the statute and would not require analysis under the Constitution.

By definition, the excessive fines clause and the due process clause analysis necessarily are applicable in those situations in which the District Court has acted *within* the limits of the statute but has awarded a judgment which is nevertheless grossly

disproportional to the conduct of the defendant and the loss incurred by the government. The Court of Appeals did not perform that analysis here. Thus, among the important factors ignored by the Ninth Circuit in upholding the amount of the judgment are:

1. The relative culpability of the respective individual petitioners;

2. The fact that the District Court found the government failed to prove common law fraud on the part of any of the petitioners;

3. The fact that the District Court concluded that none of the petitioners had been unjustly enriched; and

4. The fact that the government did not have to share any portion of the judgment with a *qui tam* relator, which is one reason why the statute was amended in 1986 to raise the damages provision from double damages to treble damages (*see Cook County Ill. v. U.S. ex rel. Chandler*, 538 U.S. at 131-32).

The analysis is thus very different from the analysis employed by the Ninth Circuit in *United States v. Mackby,* where the Court carefully analyzed several different factors, including the fact that the judgment awarded in that case was far less than the maximum amount allowed under the FCA. Here, the opposite is true. The Court affirmed the maximum amount of recovery without regard to the factors discussed above and others.

CONCLUSION

The Court is respectfully requested to grant this petition to resolve the important questions presented.

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Respectfully submitted,

HOOPER, LUNDY & BOOKMAN, INC.
PATRIC HOOPER
Attorneys for Petitioners