15-3930-cv

In The
United States Court of Appeals
For the Second Circuit

Paul Fabula, ex rel. USA, bringing this action on behalf of himself and the United States of America

Plaintiff-Appellant

Ronald I. Chorches, Trustee for the Bankruptcy Estate,

Plaintiff-Appellant

(caption continued on reverse side)

On Appeal from the United States District Court
for the District of Connecticut
(Hon. Michael P. Shea)

BRIEF OF APPELLANTS PAUL FABULA, EX REL. USA, ET AL.

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To be argued by:
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United States of America,

Plaintiff,

v.

American Medical Response, Inc.

Defendant-Appellee.

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PRELIMINARY STATEMENT

In this False Claims Act ("FCA") case, relator alleges that American Medical Response, Inc. ("AMR"), the nation's largest ambulance company, defrauded the United States government by forcing its ambulance personnel – under threat of suspension or termination – to falsify records used to obtain reimbursement from Medicare and Medicaid (collectively "Medicare"). Medicare only pays for ambulance transport when it is "medically necessary." Relator's Third Amended Complaint herein ("TAC") alleges that AMR – to fraudulently obtain reimbursement from Medicare – forced its ambulance personnel, including Paul R. Fabula ("Fabula"), the original relator in this case, to falsify electronic records known as Patient Care Reports ("PCRs") to make it appear that ambulance transport was "medically necessary" when that was not, in fact, the case.

The TAC alleges AMR's fraudulent scheme in detail. It describes specifically how the scheme was carried out, who at AMR was responsible for it, when and where it took place, and what AMR's objective was in implementing the scheme. The TAC also provides examples of the false statements that were made and identifies, by date and location, specific ambulance runs with respect to which Fabula was ordered by AMR to falsify the associated PCRs to make it appear that the runs were "medically necessary" when they were not. The TAC does not identify specific bills submitted by AMR to Medicare; however, it does allege that

Fabula and other ambulance personnel were prohibited from entering the administrative offices where AMR did its billing, that such personnel did not participate in the billing process, and that the details regarding AMR's billing are peculiarly within AMR's knowledge.

On November 6, 2015, the court below dismissed the TAC with prejudice on the ground that it did not state its FCA claims with the particularity required by Fed. R. Civ. P. 9(b) because "it pleads no factual detail regarding actual requests for payment submitted to the government," including "no specification of invoice numbers, invoice dates, or amounts billed or reimbursed." *United States ex rel. Ronald I. Chorches v. American Medical Response, Inc.*, No. 3:12-cv-921, 2015 WL 6870025 at *1 (D. Conn. Nov. 6, 2015) (Shea, J.) (SA21-22).[1] The district court acknowledged that the TAC describes AMR's fraudulent scheme in some detail, "providing the names of patients and AMR employees, the dates and locations of transports, and some specific facts suggesting a fraudulent scheme." (SA28, 38). However, the court held that – to state a FCA claim with the particularity required by Rule 9(b) – it was also necessary to plead "factual detail regarding actual requests for payment." (SA21-22, 37-39).

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[1] Chorches is Fabula's bankruptcy trustee and intervened as relator in this action in April 2015.

The district court's dismissal of the TAC was based upon an incorrect standard for pleading FCA claims in accordance with Rule 9(b). Although this Court has not decided the issue presented here, (SA37), six other courts of appeal – the Third, Fifth, Seventh, Ninth, Tenth and District of Columbia circuits – have squarely rejected the rule applied by the district court. Those courts have refused to require that specific false claims be identified at the pleading stage and have, instead, upheld complaints so long as they (1) plead the underlying "fraudulent scheme" with specificity, and (2) plead facts that give rise to a "strong inference" that false claims were, in fact, submitted. The remaining circuits that have addressed this issue (the First, Fourth, Sixth, Eighth and Eleventh) – while requiring that specific claims be identified in some decisions – have also acknowledged that false claims can be shown at the pleading stage by inference in appropriate cases.

The rigid rule applied by the district court is unnecessary to achieve the purposes of Rule 9(b), is inconsistent with the purposes of the FCA, and is, in fact, counterproductive insofar as it excludes otherwise meritorious claims based solely on the happenstance that the relator – although aware of a fraud on the government – lacks access to his or her company's billing records. Accordingly,

relator contends that Rule 9(b) should not be construed to require that specific bills be identified at the pleading stage.

The district court also dismissed Fabula's individual claim, asserted in relator's Second Amended Complaint ("SAC"), that AMR terminated his employment for refusing his supervisor's order to falsify a PCR, in violation of 31 U.S.C. § 3730(h)(1), the FCA's anti-retaliation provision. Section 3730(h)(1) authorizes a retaliation claim where an employer takes adverse action against an employee "because of lawful acts done by the employee . . . in furtherance of . . . efforts to stop 1 or more violations" of the FCA. The district court dismissed Fabula's retaliation claim in a March 4, 2015 decision on the ground that Fabula's "mere refusal to participate" in AMR's fraud did not constitute an "effort[ ] to stop 1 or more" FCA violations, as required by § 3730(h). *United States ex rel. Paul Fabula v. American Medical Response, Inc.*, No. 3:12-cv-921, 2015 WL 927548 at *8-10 (D. Conn. Mar. 4, 2015) (SA12-20).

In fact, however, the legislative history of § 3730(h)(1), as amended in 2009, makes it clear that Congress did intend, in so many words, to protect employees who "refuse to participate in the wrongdoing." 155 Cong. Rec. E1295-03, 2009 WL 1544226 (remarks of Rep. Howard L. Berman, an author of the statute). The district court noted this legislative history, but concluded that the

language of § 3730(h) "unambiguously" did not cover "refusals to participate" and that it was, therefore, impermissible for it to consider the legislative history. (SA17-18). Contrary to the district court's decision, however, the language of § 3730(h) unambiguously does cover "refusals to participate" (as Congress intended), and – even assuming that were not completely clear – the language would then be ambiguous, rendering resort to the explicit legislative history appropriate.

JURISDICTIONAL STATEMENT

On June 22, 2012, Fabula filed this *qui tam* action on behalf of the United States of America against AMR pursuant to the FCA, 31 U.S.C. § 3729 *et seq*. Jurisdiction in the district court was founded on 28 U.S.C. §§ 1331, 1345, and 31 U.S.C. § 3732. The district court (Shea, J.) dismissed the case with prejudice pursuant to Fed. R. Civ. P. 12(b)(6) and 9(b), in decisions dated March 4, 2015 (A191) and November 6, 2015 (A291), and a final judgment entered on November 10, 2015. (A317). A timely notice of appeal was filed on December 4, 2015. (A318). This Court has jurisdiction pursuant to 28 U.S.C. § 1291.

STATEMENT OF ISSUES

1. Whether the district court erred in dismissing the TAC with prejudice based on relator's supposed failure to plead violations of the FCA, 31 U.S.C.

§ 3729(a)(1)(A) & (B), in accordance with the requirements of Rule 9(b), including:

a. Whether, in FCA cases, Rule 9(b) requires the identification of specific false claims actually submitted to the government, *e.g.*, by "invoice numbers," "invoice dates," or the specific "amounts billed or reimbursed."

b. Whether the district court erred in refusing to accept, as a reasonable inference from the fraudulent scheme detailed in the TAC, that AMR submitted false claims for Medicare reimbursement for ambulance runs that were not "medically necessary," based, *inter alia*, on the fact that the submission of such false claims was the sole object of AMR's scheme.

c. Whether the district court improperly dismissed the TAC for failure to plead details about bills submitted by AMR to the government for Medicare reimbursement when those details were within the exclusive knowledge of the defendant.

2. Whether the district court erred in dismissing the FCA retaliation claim in Fabula's SAC based on its conclusion that Fabula's refusal to participate in the submission of a false claim by AMR "unambiguously" did not constitute a "lawful act[ ] . . . in furtherance of [an effort] to stop one or more violations" of the FCA, as required by 31 U.S.C. § 3730(h)(1).

STATEMENT OF THE CASE

A. The Nature of the Case and Disposition Below

This is an action brought pursuant to the FCA, 31 U.S.C. § 3729, et seq., in which the relator alleges that AMR falsified, and falsely certified the accuracy of, its PCRs in order to make it appear that ambulance transport was "medically necessary" – and, therefore, obtain unallowable Medicare payments from the Government – when that was not, in fact, the case. Fabula also claims that he was wrongfully terminated in retaliation for his refusal to falsify a PCR, in violation of 31 U.S.C. § 3730(h).

The case was filed in United States District Court for the District of Connecticut (Shea, J.) on June 22, 2012, and dismissed with prejudice in two decisions rendered on March 4, 2015 (SA1) and November 15, 2015 (SA21).

1. Dismissal of the SAC.

The SAC asserted two claims: Count One, alleging that AMR violated § 3729(a)(1)(A)&(B) of the FCA by making false statements and submitting false claims to Medicare, and Count Two, alleging that AMR terminated Fabula's employment in violation of 31 U.S.C. § 3730(h). On March 4, 2015, the district court dismissed Count One on standing grounds, but stayed its order for 30 days to

enable Chorches, the trustee of Fabula's estate in bankruptcy, to intervene and pursue the claim. (SA13).

At the same time, the district court dismissed Fabula's retaliation claim with prejudice for failure to state a claim. (SA19). The SAC alleged that Fabula was suspended, and effectively terminated, based on his refusal, in early 2012, to follow his supervisor's instructions to falsify a PCR. *See* SAC ¶¶ 64-80; 131-40 (A99-102, 112-14).

The district court held that, to state a retaliation claim under § 3730(h), Fabula had to plead that AMR had taken adverse action against him "because he performed (1) a 'lawful act' that was (2) 'in furtherance of' [*inter alia*] . . . 'other efforts to stop 1 or more violations of this subchapter." (SA15). The court found that – although Fabula had alleged that he had engaged in a "lawful act" (*i.e.*, his refusal to fill out the PCR) – that act did not constitute an "effort to stop" a FCA violation. Despite legislative history clearly showing that "Congress intended [in its 2009 amendment of § 3730(h)] to broaden protected conduct to include refusals to participate," (SA17-18), the court concluded that the text of § 3730(h) "unambiguously" failed to give effect to that congressional intent, rendering recourse to legislative history inappropriate. *Id.*

Based on these considerations, the court dismissed Fabula's retaliation claim for failure to state a claim.[2]

2. Dismissal of the TAC.

On November 6, 2015, the district court dismissed the TAC with prejudice based on relator's failure to plead "the actual submission of requests for payment, or 'claims,' to a government payor" with the particularity required by Fed. R. Civ. P. 9(b). (SA21-22). Specifically, the court held that – to state a claim under the FCA – a *qui tam* plaintiff must provide particularity in two separate respects: (1) in describing the fraudulent scheme, and (2) in identifying specific claims for payment. *Id.* The district court concluded:

> The TAC does not meet this standard, as it pleads no factual detail regarding actual requests for payment submitted to the government. There is no specification of invoice numbers, invoice dates, or amounts billed or reimbursed. In short, the TAC alleges no facts indicating that the medically unnecessary ambulance services it describes were actually billed to a government payor.

Id.

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[2] In its March 4, 2015 opinion, the district court stated that it was dismissing Fabula's retaliation count "with prejudice." (SA19). However, on April 3, 2015, the court issued an order permitting relator to "replead both Count One and Count Two of the SAC." [ECF No. 75; A10]. Chorches did not replead the retaliation claim in the TAC and the allegations of the SAC are, therefore, controlling with respect to Fabula's retaliation claim, which was dismissed with prejudice a second time in the district court's November 6, 2015 decision. (SA23).

B. The Allegations of the Complaint

1. Background

AMR is the nation's largest ambulance company. It maintains a branch office in New Haven, Connecticut, where Fabula worked as an Emergency Medical Technician ("EMT") from August 2010 to December 25, 2011. During that period, Fabula provided medical transport services for AMR. TAC ¶¶ 8-11 (A331).

Some, but not all, of the ambulance services provided by AMR are reimbursable by Medicare. Specifically, Medicare reimburses ambulance transport when it is "medically necessary," as that term is defined by Medicare. TAC ¶ 13 (A331).

Medical necessity is established when the patient's condition is such that transportation by means other than an ambulance cannot be used without endangering the patient's health. Absent "medical necessity," transport by ambulance is not reimbursable by Medicare. *Id.* ¶¶ 15-17 (A332). Accordingly, whenever another means of transport can be used without endangering the patient's health, Medicare will not reimburse for ambulance transport. *Id.* ¶ 18 (A332). AMR certified to Medicare that the information it was providing

concerning the condition of its patients was accurate, and Medicare relied on the accuracy of those certifications in deciding whether AMR should be reimbursed. *Id.* ¶¶ 170-80 (A366-67).

2. AMR's Fraudulent Scheme

During his employment at AMR, Fabula witnessed, first hand, an institutionalized scheme by AMR to obtain reimbursement from Medicare by falsely certifying that transportation of persons by ambulance was medically necessary when, in fact, it was not. *See, e.g.*, *id.* ¶¶ 2, 19 (A330, 332-33). The central purpose of these false certifications was to obtain Medicare reimbursement for ambulance "runs" which would not otherwise qualify for Medicare reimbursement. *See, e.g.*, *id.* ¶¶ 2, 30-33, 38-47, 51-52, 90-92, 96, 100-10, 131-32, 136-39, 146-49 (A330, 334-40, 348-53, 357-61).

AMR carried out its fraudulent scheme by requiring its EMTs and paramedics to falsify PCRs. PCRs were created on laptops by Fabula and other EMTs and paramedics, during or immediately following each ambulance run. The information entered on PCRs included the condition of each patient being transported – thereby indicating whether the run was "medically necessary." *Id.* ¶¶ 23-26; 45 (A333, 339).

Fabula fully understood which of the ambulance runs he performed for AMR constituted "medically necessary" transport, and – when he prepared each PCR – he accurately reported the condition of the patient involved in the run. *Id.* ¶ 27 (A333-34). However, he (and other EMTs and paramedics) were frequently required by AMR to alter their PCRs to support AMR's false claims of "medical necessity," thereby enabling AMR unlawfully to obtain Medicare reimbursement. *Id.* ¶¶ 28-31 (A334).

The TAC provides extensive detail about AMR's implementation of its scheme to submit false claims to Medicare. It describes how specific AMR supervisory employees (Director of Clinical Services Jeffrey Boyd, Operations Supervisor Russell Pierson, and Transportation Supervisor Lindsay Martus) – when they determined that a given run could not properly be billed to Medicare – printed out the PCRs that Fabula and others had contemporaneously created based on their first hand observations of each patient's condition and made handwritten revisions on those printouts, re-describing medically unnecessary runs as "medically necessary." These AMR supervisors then ordered Fabula and other EMTs and paramedics – on pain of suspension or termination – to input the supervisor's changes onto the electronic PCR, thereby falsely describing non-reimbursable runs as reimbursable. *Id.* ¶¶ 28-33, 38, 90-92 (A334-35, 348).

AMR's managers were unable to alter PCRs themselves "because Fabula and other ambulance personnel (paramedics and EMTs) had unique log in passwords that were necessary for filing the PCRs . . . ." *Id.* ¶ 48 (A340).

The TAC specifically describes Russell Pierson as the "person in the New Haven operation most responsible for directing the false submission of claims to Medicare." TAC ¶ 116 (A354). The TAC explains that AMR had determined, by May 2011, that its New Haven office lagged behind other AMR offices in the percentage of its runs that were reimbursed by Medicare. Specifically, roughly 40% of AMR's New Haven runs were determined to have received Medicare reimbursement, while AMR's other offices were closer to 70%. *Id.* ¶¶ 131-32 (A357-58). To close this gap, Boyd made Pierson responsible for bringing New Haven's Medicare reimbursement rate up to 70%. *Id.* After Pierson assumed that responsibility, Fabula observed that the number of marked up PCR print-outs increased from 1 to 5 per day to roughly 30 per day. *Id.* ¶¶ 150-52 (A361-62).

The supervisors' paper mark-ups "did not leave the New Haven facility." *Id.* ¶ 36 (A335). The changes were made by ambulance personnel when they first punched in or after a shift before they were allowed to punch out. *Id.* ¶ 52. (A340). Once the changes were made electronically, the paper mark-ups were collected by Boyd, Pierson and/or Martus, deposited in a locked box, and

subsequently shredded, thereby eliminating any paper trail of the changes. *Id.* ¶ 36, 49 (A335, 340).

The EMTs and paramedics "did what they were told" and made the changes they were ordered to make. *Id.* ¶ 35 (A335). Fabula was personally told "by Boyd, Pierson and Martus that the revisions were required to qualify the run for Medicare reimbursement, and [he] was ordered to revise or recreate electronic PCRs under threat of suspension or termination." *Id.* ¶ 33 (A334). Fabula was, in fact, suspended on one occasion, *id.* ¶ 99 (A350), and was ultimately terminated for refusing Pierson's order to alter a PCR. *Id.* ¶¶ 56-82 (A342-46).

The process of falsifying PCRs to qualify otherwise non-reimbursable runs for Medicare reimbursement took place on a daily basis at AMR's New Haven ambulance facility, known as the "garage." *Id.* ¶ 35, 37 (A335).

The TAC identifies a number of commonly encountered medical conditions that resulted in high volumes of ambulance calls and for which AMR developed established routines for obtaining Medicare reimbursement based on fraudulently altered PCRs. *Id.* ¶ 39 (A335-36) (identifying kidney dialysis patients, hip replacement patients, transfers of patients with dementia, and patients who – at some previous time – had been, *e.g.*, unable to walk, but who now no longer

required ambulance transport). For example, in the case of dementia patients, which accounted for a large number of patient transfers:

> . . . AMR supervisors [Boyd, Pierson and Martus] routinely, on a daily basis in the garage, informed the EMTs, when they were being ordered to change the PCR forms, that "Medicare is not paying for the dementia patient the way you have it written." So Fabula and the other ambulance EMTs at AMR were routinely required to change the histories with Alzheimer's patients – so that the history included in the PCR a component of "violence" – in order to qualify for Medicare.

Id. "In fact, the overwhelming majority of the dementia patients were calm and cooperative but simply confused." *Id.*

In the same vein, Fabula was asked, on one occasion, to transport a woman from a hospital to her home. When he asked AMR's "hospital liaison" (Nancy) why the woman needed an ambulance, he was told she had "cancer;" when he told Nancy that cancer would not justify Medicare reimbursement, Nancy wrote down "dementia;" and when Fabula told her that "Dementia is not covered unless the patient is violent or wandering," Nancy – relying on a 3-year-old incident in the patient's history – put down "Today, the patient is violent." *Id.* ¶ 85 (A346-47).

AMR also routinely "milked the files" of patients who had once required medically necessary ambulance transportation, but no longer did. Even though ambulance services were no longer medically required, AMR directed its

ambulance personnel, including Fabula, to modify their PCRs to add "old historic information" to create the false impression that conditions that had once required ambulance transport still existed. *Id.* ¶¶ 43-44 (A338).[3] In the same vein, Fabula worked briefly in AMR's New Haven dispatch center (which has medical histories for patients from all over Connecticut). While at the center, Fabula witnessed hundreds of AMR employees calling in to get a "medical necessity reason." Upon receiving such a call, the dispatcher would look up a patient's past history to find something that could support a claim for Medicare reimbursement. *Id.* ¶ 86-87 (A347).

3. Specific Ambulance Runs Resulting in Falsified PCRs.

The TAC provides extensive detail regarding specific ambulance runs which resulted in the falsification of PCRs to show that the runs at issue were "medically necessary" when, in fact, they were not.

a. Throughout the summer of 2011, Fabula was personally involved in approximately 72 medically unnecessary transports of a named diabetic patient from his residence in New Haven to a medical facility

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[3] *See also* ¶ 105 (A351-52): Fabula called a dispatcher, Tom DellaValle, and told him: "I have a patient and I'm trying to figure out why she needs an ambulance." DellaValle, who had access to patients' medical records, told Fabula: "Well, she had a hip fracture three years ago ," so Fabula wrote on the PCR: "Hip fracture," "as though it had just occurred."

for his daily dose of insulin.[4] Fabula was directed – under threat of being placed on unpaid leave – to falsify the PCRs pertaining to this patient to indicate that he had difficulty remaining in an upright position in order to qualify the runs for Medicare reimbursement. *Id.* ¶ 108 (A352).

b. On July 7, 2011, in response to a 911 call, Fabula performed a medically unnecessary transport of a woman suffering from allergies from a state housing facility in New Haven to a hospital. The woman informed the ambulance crew that she believed she would be able to "skip the line" at the hospital if she arrived by ambulance. On July 22, Fabula was told by AMR that the woman was on Medicaid, and he was required to write in previous surgeries and injuries to justify reimbursement for ambulance transport. *Id.* ¶ 102 (A350-51).

c. On July 7, 2011, Fabula and Schick transported a man from a homeless shelter in New Haven who had "called 911 because he didn't feel like he should have to buy cough syrup." On July 22, Fabula was required to write in previous surgeries and injuries to justify Medicaid reimbursement for ambulance transport. *Id.* ¶ 102 (A350-51).

d. On December 4, 2011, Fabula assisted in the medically unnecessary transport of a named patient from his residence in New Haven to the hospital. The patient "had no medical reason to be sent to the hospital" and "was able to walk himself to the stretcher and climb on unassisted." AMR instructed Fabula to "write down [the patient's] previous surgeries to justify his transport to the hospital." *Id.* ¶ 100 (A350).

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[4] The TAC as it was originally filed identified with specificity several of the patients whose ambulance runs relator contends were medically unnecessary. Due to concerns for patient privacy, a redacted version of the TAC was filed in the district court on March 1, 2016, and that is the version included in the Joint Appendix.

e. On December 16, 2011, Fabula performed a medically unnecessary transport of a patient from New Haven to Guilford, Connecticut. He was informed that the trip would have to be justified for Medicare reimbursement based on a hip fracture and replacement that had taken place over five years earlier, even though the patient had fully recovered. *Id.* ¶ 96 (A349).

These and other runs are alleged to have been "fraudulently submitted to Medicare for payment." *Id.* ¶ 110 (A353).[5]

4. AMR's Corporate Integrity Agreement.

In May 2011, AMR entered into a Corporate Integrity Agreement ("CIA") with the U.S. Department of Health and Human Services, in which AMR promised to promote compliance, *inter alia*, with Medicare and Medicaid rules and regulations. TAC ¶ 118 (A354). In fact, however, the CIA resulted in AMR's adoption "of a more determined and sophisticated means of submitting false claims" through "nationwide electronic changes" in AMR's record-keeping practices. *Id.* ¶ 123 (A355-56). Specifically, AMR implemented new software designed automatically to increase Medicare reimbursement rates, whether or not such reimbursement was justified, by requiring, among other things, that all PCR

[5] The district court incorrectly stated that "there are no allegations that AMR ever submitted any false claims to the federal government" in connection with some of these runs. (SA39). The court may have meant that the specific invoices pertaining to them were not identified.

fields be filled out and then – once a field was clicked – "auto-filling" certain requirements for Medicare reimbursement. *Id.* ¶¶ 134, 136, 138 (A358-59). The new software also defaulted to reflect a "paramedic assessment" (billed to Medicare at roughly $1,200) whenever a paramedic was present in the ambulance, *id.* ¶¶ 142-47 (A360-61), when, under Medicare rules, a reimbursable "paramedic assessment" only occurs when an EKG monitor is employed. *Id.* ¶ 143 (A361). The software also automatically inserted a "Yes" in the field indicating that the patient was "bed-confined," regardless of the actual condition of the patient. *Id.* ¶ 148 (A362). These and other software changes institutionalized the overbilling of Medicare at AMR. *Id.* ¶ 149 (A362).

5. AMR's Billing Facilities.

AMR's billing function was located in a separate administrative office in New Haven, and AMR's ambulance personnel were prohibited from entering that building without authorization. Ambulance personnel were restricted to the "garage." *Id.* ¶ 115 (A353-54). As a result, specific details about AMR's billings to Medicare are "particularly within the knowledge and control of . . . AMR." *Id.* Notably, Russell Pierson – "the person in the New Haven operation most responsible for directing the false submission of claims to Medicare" – also

oversaw the AMR unit responsible for billing quality control. *Id.* ¶¶ 89, 116 (A347, 354).

The TAC further alleges that AMR's Director of Clinical Service, Jeffrey Boyd, told Fabula and others, in mid-2011, that AMR's New Haven office was being reimbursed by Medicare for roughly 40% of its runs, and that AMR wanted was to increase that rate to 70%. *Id.* ¶¶ 131-32 (A357-58). Based on his experience at AMR (from August 2010 to December 25, 2011), Fabula estimates that only 25% of AMR's runs were legitimately billed to Medicare (*i.e.*, were "medically necessary"). *Id.* ¶ 157-59 (A363). Accordingly, as of mid-2011, AMR was improperly billing roughly 15% of its runs to Medicare, and, of course, the closer Boyd got to achieving his 70% objective, the greater the percentage of "medically unnecessary" runs AMR was fraudulently billing to Medicare. *Id.* ¶ 160 (A364).

SUMMARY OF ARGUMENT

A. The TAC Satisfies the Particularity Requirements of Rule 9(b).

The district court's conclusion that the TAC failed to state a claim for violations of the FCA with the particularity required by Rule 9(b) was erroneous for several reasons.

First, the court's determination that FCA relators – to meet the requirements of Rule 9(b) – must identify specific bills submitted for payment to the government at the pleading stage is contrary to the weight of authority in the federal courts of appeals and would, if sustained, undermine the policies supporting both Rule 9(b) and the FCA. As the district court acknowledged, the issue has not been decided by this Court. (SA37).

Among other courts of appeals, six – the Third, Fifth, Seventh, Ninth, Tenth and District of Columbia circuits – have squarely rejected any hard and fast rule that a FCA complaint identify specific bills or invoices to comply with Rule 9(b). Those courts have generally concluded that it is sufficient to plead the "particular details of a fraudulent scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *United States ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009). There are some decisions in five other circuits – the First, Fourth, Sixth, Eighth and Eleventh – that, in particular cases, have required specific requests for payment to be identified at the pleading stage. *See, e.g., United States ex rel. Clausen v. Laboratory Corp. of Am.*, 290 F.3d 1301, 1311-12 (11th Cir. 2002). However, none of those circuits has consistently applied that rule, and all have agreed that,

in some circumstances, it is not necessary to identify specific claims at the pleading stage.

The policies underlying both Rule 9(b) and the FCA are best served by a flexible rule that does not require specific claims for payment at the pleading stage. Rule 9(b) "is designed to provide a defendant with fair notice of a plaintiff's claim, to safeguard a defendant's reputation from 'improvident charges of wrongdoing,' and to protect a defendant against the institution of a strike suit." *O'Brien v. National Property Analysts Partners*, 936 F.2d 674, 676 (2d Cir. 1991). The "specification of invoice numbers" (as the district court put it, (SA21)) and similar details, does not advance any of these purposes. As a practical matter, such details simply eliminate potentially meritorious FCA actions by foreclosing claims by everyone except a limited number of individuals who have access to specific billing data. There is no reason to suppose that such individuals are the only ones who have knowledge of frauds against the government. On the other hand, a rule which requires specificity in the assertion of the "fraudulent scheme" plus facts raising a reasonable inference that false claims were submitted to the government adequately notifies defendants of relators' claims, and protects them against "improvident charges." As for strike suits, they are effectively impossible in *qui tam* actions, because such actions are brought in the name of the United

States government, and they cannot be dismissed without approval of the court and the Attorney General. 37 U.S.C. § 3730(b).

Under the correct pleading standard, the TAC meets the particularity requirements of Rule 9(b). The TAC describes, in detail, a scheme whose *essential purpose* was to submit fraudulent claims for reimbursement to Medicare by falsely representing that ambulance runs were "medically necessary." The TAC describes the mechanics of AMR's scheme (the deliberate falsification of PCRs to fraudulently qualify ambulance runs for Medicare reimbursement); it identifies by name the supervisory personnel at AMR (Boyd, Pierson and Martus) who directed Fabula (and others) to make false statements for submission to Medicare; it states where the scheme took place (AMR's New Haven "garage"); it describes the false statements made both generally (in relation to particular medical conditions) and specifically (in relation to particular runs on particular dates); it explains why Fabula (and other EMTs and paramedics) were unable to gain access to AMR's specific billing information; and it creates a strong inference that false claims for reimbursement were, in fact, made to Medicare because that was the sole purpose of the scheme. This elaborate specification of the fraudulent scheme is more than sufficient to meet the requirements of Rule 9(b).

B. The SAC Stated a Claim for Retaliation Under the FCA.

The district court erred in holding that a "mere refusal to participate in an allegedly fraudulent scheme" cannot support a claim for retaliation under § 3730(h) of the FCA. (SA18). The present language of § 3730(h) is the result of a 2009 amendment that extended the FCA's protections against retaliation to cover "lawful acts done by the employee . . . in furtherance of . . . efforts to stop 1 or more violations" of the FCA.

The legislative history of the 2009 amendment makes it clear that Congress intended to include – within the ambit of § 3730(h) – "refusals to participate in the misconduct that leads to the false claims." As Representative Berman, one of the authors of the 2009 FCA amendments stated:

> To address the need to widen the scope of protected activity, [the amended retaliation provision] provides that § 3730(h) protects all "lawful acts done . . . in furtherance of . . . other efforts to stop 1 or more violations" of the False Claims Act. *This language is intended to make clear that this subsection protects . . . steps taken to remedy the misconduct through methods such as . . . refusals to participate in the misconduct that leads to the false claims . . . .*

155 Cong. Rec. E1295-03, 2009 WL 1544226 (emphasis added).

Undeterred by this extraordinarily clear statement of legislative intent, the district court ruled that resort to legislative history was inappropriate, because the

language of § 3730(h) is "clear" and "unambiguously" excludes refusals to participate in fraud from the ambit of protected conduct. (SA18). However, if anything, the statutory language "unambiguously" means the exact opposite. An express refusal to participate in a fraudulent scheme (here, to falsify a PCR) clearly constitutes an "effort[ ] to stop 1 or more violations" of the FCA, and to the extent there is any ambiguity, it is appropriate to consult the legislative history.

ARGUMENT

I. STANDARD OF REVIEW

This court "review[s]a district court's grant of a motion to dismiss a *qui tam* action *de novo*," *United States v. Quest Diagnostics Inc.*, 734 F.3d 154, 163 (2d Cir. 2013), accepting all factual allegations in the complaint as true and drawing all inferences in plaintiff's favor." *Flagler v. Trainor*, 663 F.3d 543, 546 n.2 (2d Cir. 2011). This standard of review applies to all issues on this appeal.

II. THE TAC STATES A CLAIM FOR VIOLATIONS OF THE FCA.

A. The District Court Erred in Holding that Rule 9(b) Requires Relators in FCA Cases to Identify Specific Claims Submitted to the Government.

1. The Standard for Pleading FCA Claims under Rule 9(b).

The district court based its dismissal of the TAC on the proposition that Rule 9(b) requires that "both the fraudulent scheme and the submission of false claims must be pled with a high degree of particularity." (SA45) (emphasis added) (quoting with approval *United States ex rel. Kester v. Novartis Pharm, Corp*, 23 F. Supp.3d 242, 255 (S.D.N.Y. 2014). While the court conceded that the "TAC alleges, in some detail, a scheme of fraud," it dismissed the complaint because "it does not identify or describe with any particularity any specific false claims that were actually submitted to the federal government for payment." (SA39).

Accordingly, a key issue on this appeal is whether it is, in fact, correct to require FCA relators – on pain of dismissal – to identify, at the pleading stage, "factual detail regarding actual requests for payment submitted to the government," including, *inter alia*, the "specification of invoice numbers," "invoice dates," or "amounts billed or reimbursed." (SA21-22). As the district

court acknowledged, the Second Circuit has not ruled on this issue. (A307).[6] Therefore, the court based its decision primarily on several lower court decisions in this Circuit. (SA37-38).

Of the 11 federal courts of appeal that have addressed the issue of whether FCA complaints must identify specific claims for payment to comply with Rule 9(b), six have flatly rejected any such requirement:

Fifth Circuit: *United States ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009) (rejects strict rule requiring pleading of "actually submitted false claim;" relators can satisfy Rule 9(b) by "alleging particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted");

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[6] The district court referred to this Court's unpublished opinion in *Wood ex rel. United States v. Applied Research Assocs., Inc.*, 328 Fed. Appx. 744 (2d Cir. 2008) (summary order), a case in which the relator claimed that a consulting company had violated the FCA by accepting payment from the government while failing to report, in an investigation of the September 11, 2001 attack on the World Trade Center, that the Twin Towers had been destroyed by "directed energy weapons." The alleged fraud, in effect, consisted of the consulting company's disagreement with relator about his "hypothesis that the Twin Towers was [sic] destroyed by the military's directed energy weapons." *Id.* at 750. Although the district court in *Wood* cited – among many other deficiencies – that the pleading failed to "cite a single identifiable record or billing submission," and this Court also referred to that issue (as well as many others), the decision does not otherwise address the issue here and, in any event, has no precedential effect. *See* Local Rule 32.1.1 ("Rulings by summary order do not have precedential effect").

D.C. Circuit: *United States ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 125 (D.C. Cir. 2015) ("Rule 9(b) does not inflexibly dictate adherence to a pre-ordained checklist of 'must have' allegations;" cites *Grubbs* with approval);

Third Circuit: *Foglia v. Renal Ventures Management, LLC*, 754 F.3d 153, 156-57 (3d Cir. 2014) (rejects "rigid" rule requiring identification of "specific claim for payment at the pleading stage;" applies *Grubbs* standard);

Ninth Circuit: *Ebeid ex rel. United States v. Lungwitz,* 616 F.3d 993, 998-99 (9th Cir. 2010) (rejects "categorical approach" that "would . . . require a relator to identify representative examples of false claims to support every allegation;" applies *Grubbs* standard);

Tenth Circuit: *United States ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163, 1171-72 (10th Cir. 2010) ("claims under the FCA need only show the specifics of a fraudulent scheme and provide an adequate basis for a reasonable inference that false claims were submitted as part of that scheme;" citing *Grubbs*);

Seventh Circuit: *United States ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 854-55 (7th Cir. 2009) ("We don't think it essential for a relator to produce the invoices . . . at the outset of the suit;" submission of false claims can be pleaded based on inferences).

Indeed, the Third Circuit has noted that "it is hard to reconcile the text of the FCA, which does not require that the exact content of the false claims in question be shown," with a strict requirement that specific claims be pleaded. *Foglia,* 754 F.3d at 156. And as the Fifth Circuit stated in *Grubbs*:

> To require these [billing] details at pleading is one small step shy of requiring production of actual documentation with the complaint, a level of proof not demanded to win at trial and significantly more than any federal pleading rule contemplates.

565 F.3d at 190.

The Fifth and District of Columbia circuits have also concluded that it is inappropriate to impose the same pleading requirements on FCA plaintiffs as the courts have imposed on, *e.g.*, common law or securities fraud plaintiffs, because "False Claims Act *qui tam* complaints, unlike common law or securities fraud claims, do not require the plaintiff to prove either that a party relied on a specific representation or that there has been a monetary injury." *Heath*, 791 F.3d at 125; *see also Grubbs*, 565 F.3d at 189. Therefore, a "person that presented fraudulent claims that were never actually paid remains civilly liable," and "[i]n that context, providing identifying details about specific payments is less important to put the defendant on notice." *Heath*, 791 F.3d at 125. Also, the "federal government itself already has records of [its] payments and thus 'rarely if ever needs a relator's

assistance to identify claims for payment that have been submitted,'" and the "greater concern is with the 'other information' relators have 'that shows these claims to be false.'" *Id.* at 126 (quoting Brief for the United States as *Amicus Curiae*).

Courts in five circuits have, in particular cases, required relators to plead specific claims for payment.[7] However, these same courts have acknowledged that specific claims for payment need not always be pleaded. *See, e.g., Clausen*, 290 F.3d at 1311-12 (requirement applies "*under the particular circumstances of this*

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[7] *See United States ex rel. Clausen v. Laboratory Corp. of Am.*, 290 F.3d 1301, 1311-12 (11th Cir. 2002) ("failure to allege with any specificity if – or when – any actual improper claims were submitted to the Government is . . . fatal to [relator's] complaint under the particular circumstances of this case"); *United States ex rel. Nathan v. Takeda Pharm. North Am., Inc.*, 707 F.3d 451, 456-58 (4th Cir. 2013) (applies *Clausen*; dismisses for failure to plead "particular identifiable false claims" that "actually were presented to the government for payment"); *United States ex rel. Dunn v. North Am. Memorial Health Care*, 739 F.3d 417, 419-20 (8th Cir. 2014) (dismisses complaint due to failure to provide "even one example of an actual false claim submitted . . . for reimbursement"); *United States ex rel. Bledsoe v. Community Health Sys., Inc.*, 501 F.3d 493, 509-11 (6th Cir. 2007) (relator must "provide examples of specific false claims submitted to the government pursuant to [the alleged] scheme"); *United States ex rel. Karvelas v. Melrose- Wakefield Hosp.*, 360 F.3d 220, 232-33 (1st Cir. 2004) (applying *Clausen*; "[i]n a case such as this, details concerning the dates of the claims, the content of the forms or bills submitted, their identification numbers, the amount of money charged to the government, the particular goods or services for which the government was billed, the individuals involved in the billing . . . may help a relator to state his or her claims with particularity").

case"); *Nathan*, 707 F.3d at 457-58; *Bledsoe*, 501 F.3d at 504, n.12. And other panels and courts in those same circuits have upheld FCA claims where facts were pleaded from which a reliable inference could be drawn that such claims for payment were, in fact, presented to the Government. *See, e.g., United States ex rel. R&F Properties of Lake County, Inc.*, 433 F.3d 1349, 1359-60 (11th Cir. 2005) (*Clausen* pleading requirement does not apply to claim brought by corporate insider who explains the basis for his or her belief that bills were submitted to the government);[8] *United States ex rel. Duxbury v. Ortho Biotech Prods., L.P.*, 570 F.3d 13, 29-30 (1st Cir. 2009) (reverses dismissal of FCA complaint for failure to plead "details that identify false claims for payment," because claim was that defendant induced third parties to submit such claims; cites *Grubbs* with approval); *United States ex rel. Thayer v. Planned Parenthood of the Heartland,* 765 F.3d 914, 916-19 (8th Cir. 2014) (does not require pleading of specific bills where relator has first hand knowledge of billing system; cites *Grubbs* standard with approval); *United States ex rel. Lane v. Murfreesboro Dermatology Clinic PLC*, 4:07-cv-4, 2010 WL 1926131 at *5-7 (M.D. Tenn. May 12, 2010) (declining

[8] *See also United States ex rel. Willis v. Angels of Hope Hospice, Inc.*, 5:11-cv-041, 2014 WL 684657 at *7-8 (M.D. Ga. Feb. 21, 2014) (describing different standards applied by 11th Circuit courts: rejects rule that relators must, "in every case, allege detailed billing information").

to follow Sixth Circuit's decision in *Bledsoe* where relator had first hand knowledge of billing);[9] *United States ex rel. Michaels v. Agape Senior Community, Inc.*, 0:12-cv-03466, 2014 WL 1319780 at *1-2 (D. S.C. Mar. 28, 2014) (interprets Fourth Circuit's decision in *Nathan* as not adopting a *per se* rule requiring the pleading of specific bills; "a relator may also satisfy the *Nathan* standard by alleging a reasonable inference that false claims were necessarily submitted to the government").[10]

These decisions are fully consistent with the broader proposition that "Rule 9(b)'s ultimate meaning is context-specific, and thus there is no single construction of Rule 9(b) that applies in all contexts." *Heath*, 791 F.3d at 125 (quoting *Grubbs*, 565 F.3d at 188).

In sum, no court of appeals has adopted the strict pleading rule applied by the court below in this case. Rather, to the extent that any single rule can be

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[9] The Sixth Circuit, in *Bledsoe*, acknowledged the "possibility of a court relaxing this rule [requiring the identification of specific bills at the pleading stage] where a relator demonstrates that he cannot allege the specifics of actual false claims that in all likelihood exist." 501 F.3d at 504 n.12.

[10] The Fourth Circuit, in *Nathan*, cited both *Grubbs* and *Duxbury* with approval, explaining that those cases had involved situations in which there were sufficient indicia of reliability to support the inference that the false claims were submitted to the government. 707 F.3d at 457-58.

drawn from the decisions cited above, it appears to be the rule stated by the Fifth Circuit in *Grubbs* – *i.e.*, that relators can satisfy Rule 9(b) by "alleging particular details of a *scheme* to submit false claims" plus "reliable indicia that lead to a strong inference that claims were actually submitted." 565 F.3d at 190 (emphasis added). Indeed, the *Grubbs* standard has been cited with approval by most federal courts of appeal, including some of those which, in particular cases, have required the pleading of specific demands for payment.[11] Thus, while some courts, in some cases, have found that specific billing information must be provided, those same courts uniformly acknowledge that the submission of claims to the government for payment can also be pleaded in other ways, so long as they provide a reasonable inference that they were actually submitted.

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[11] *See Foglia,* 754 F.3d at 156-57 (3d Cir.); *Heath,* 791 F.3d at 125-26 (D.C. Cir.); *Lemmon*, 614 F.3d at 1171-72 (10th Cir.); *Ebeid,* 616 F.3d at 998-99 (9th Cir.); *Duxbury*, 570 F.3d at 29-30 (1st Cir.); *Thayer,* 765 F.3d at 916-19 (8th Cir.); *Nathan*, 707 F.3d at 456-58 (4th Cir.); *see also Lusby,* 570 F.3d at 854-55 (7th Cir.) (submission of false claims can be pleaded based on inference).

2. The Pleading Standard Adopted by the District Court Is Inconsistent with the Policies Underlying Both Rule 9(b) and the FCA.

Since the language of Rule 9(b) does not provide any guidance on whether specific demands for payment must be pleaded in FCA cases, and since there is no binding precedent in this Circuit, it is appropriate for the Court to consider whether the pleading standard adopted by the court below would advance (or retard) the policies underlying both Rule 9(b) and the FCA.[12]

This Court has stated that "[t]he purpose of Rule 9(b) is threefold – it is designed to provide a defendant with fair notice of a plaintiff's claim, to safeguard a defendant's reputation from 'improvident charges of wrongdoing,' and to protect a defendant against the institution of a strike suit." *O'Brien v. National Property Analysts Partners*, 936 F.2d 674, 676 (2d Cir. 1991); *see generally* 5A Wright & Miller, Federal Practice & Procedure § 1296.

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[12] *See Clausen*, 290 F.3d at 1315 (Barkett, J., dissenting):

> Rule (9b) states that "The circumstances constituting fraud or mistake shall be stated with particularity." By itself, of course, that language does not tell us whether the failure to specify the amount of the false claim, or to indicate the precise date on which it was submitted rather than a range of a few days, constitutes a lack of particularity that is fatal to the complaint. It is therefore necessary to look to the purposes of Rule 9(b) . . . .

As to notice, the *Grubbs* standard requires that a complaint must "alleg[e] particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." 565 F.3d at 190 (emphasis added). This standard is more than sufficient to notify parties charged with defrauding the government of the claims against them. As the Fifth Circuit stated in rejecting the argument that specific billing details were required to provide defendants with fair notice:

> Confronting False Claims Act defendants with both an alleged scheme to submit false claims and details leading to a strong inference that those claims were submitted – such as dates and descriptions of recorded, but unprovided, services and a description of the billing system that the records were likely entered into – gives defendants adequate notice of the claims. In many cases, the defendants will be in possession of the most relevant records, such as . . . internal billing records, with which to defend on the grounds that alleged falsely-recorded services . . . were not billed for or were actually provided.

565 F.3d at 190-91; *see also Foglia*, 754 F.3d at 156-57 (*Grubbs* standard sufficient to provide fair notice); *Heath*, 791 F.3d at 125-26 (same; "the point of Rule 9(b) is to ensure that there is sufficient substance to the allegations to both afford the defendant the opportunity to prepare a response and to warrant further judicial process").

The same requirements adequately protect FCA defendants' reputations against "improvident charges of wrongdoing" stemming from baseless claims. The essence of the wrongdoing in a FCA claim, and the associated injury to reputation, lies in the fraudulent scheme – not in the numbers, dates and amounts of particular bills. *Grubbs*, 565 F.3d at 190 ("Standing alone, raw bills – even with numbers, dates, and amounts – are not fraud without an underlying scheme to submit the bills for unperformed or unnecessary work"). Thus, requiring FCA plaintiffs to allege specific bills does not protect reputations against "improvident" claims, but simply results in the dismissal of lawsuits brought by corporate insiders who lack access to the defendant's accounting department.

There is also virtually no risk of "strike suits" in the context of *qui tam* claims brought under the FCA, because they cannot be dismissed without approval of the court and the Attorney General. 31 U.S.C. § 3730(b). Thus, regardless of whether the government chooses to intervene, it has the power under the FCA to withhold consent to the settlement of a *qui tam* action, *Searcy v. Philips Electronics North Am. Corp.*, 117 F.3d 154, 157 (5th Cir. 1997), and it may also dismiss or settle *qui tam* actions over the objection of the relator. 31 U.S.C.

§ 3730(c)(2)(A) & (B). In these circumstances, filing a baseless action to obtain a quick "nuisance" settlement makes no sense.[13]

Finally, the rule adopted by the district court is inconsistent with the policies underlying the FCA because it results in the dismissal, at the pleading stage, of claims on grounds that have little to do with the merits. The purpose of the *qui tam* provisions of the FCA is to provide incentives for "whistle-blowing insiders with genuinely valuable information" about frauds against the government to bring actions in the name of the government. *See Graham County Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 559 U.S. 280, 294-95 (2010). As Congress has recently stated, in connection with its 2009 amendments to the FCA: "Since its inception, the central purpose of the [FCA] has been to enlist private citizens in combating fraud against the U.S. Treasury." 155 Cong. Rec. E1295-03, 2009 WL 1544226.

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[13] The district court stated that Rule 9(b) also serves to "discourage the filing of complaints as a pretext for discovery of unknown wrongs." (SA36). However, that policy concern is also satisfied by the *Grubbs* standard. As the court in *Grubbs* observed, a complaint that pleads both a fraudulent scheme and the likelihood of false claims with the requisite specificity minimizes the inconvenience of discovery by enabling it to be "pointed and efficient." 565 F.3d at 191. And the same particularity ensures that the wrongs alleged – as in the case of the TAC here – are far from "unknown." Rather, those wrongs (*i.e.*, the fraudulent scheme) must be pleaded in great detail.

The pleading standard applied by the district court in this action undermines these policies. As the court in *Grubbs* noted, "overly strict" pleading requirements "discourage[ ] whistleblowers who may have significant information from coming forward." 565 F.3d at 191; *see also Lusby*, 570 F.3d at 854 ("Since a relator is unlikely to have [billing] documents unless he works in the defendant's accounting department, the district court's ruling takes a big bite out of *qui tam* litigation"). Indeed, the strict rule applied by the district court is particularly subversive of the FCA because it fails to discriminate between actions that are meritorious and those that are not. When a relator, like Fabula, "has no pre-discovery means of access to the dates on which the defendant submitted its claims for payment, the lack of that information tells us nothing about the likelihood that the lawsuit is frivolous." *Clausen*, 290 F.3d at 1317 (Barkett, J., dissenting). Rather it simply results in the dismissal of actions brought by relators who lack access to billing information, regardless of the merits of their claims.

B. The Complaint States a FCA Claim in Accordance with the Requirements of Rule 9(b).

Rule 9(b) provides, in pertinent part: "In alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." This Court has held that because the FCA is an anti-fraud statute, claims under the FCA must meet the requirements of Fed. R. Civ. P. 9(b). *Gold v. Morrison-Knudsen Co.*, 68 F.3d 1475, 1476-77 (2d Cir. 1995).

In general, to satisfy Rule 9(b), a complaint must "(1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent." *Anschutz Corp. v. Merrill Lynch & Co.,* 690 F.3d 98, 108 (2d Cir. 2012). In essence, a fraud claim satisfies the Federal Rules if it "plausibly and succinctly alleges the 'who, what, where, when and how' of the fraud." *Wigod v. Wells Fargo Bank, NA*, 673 F3d 547, 569 (7th Cir, 2012); *see also Dukes Bridge LLC v. Security Life of Denver Ins. Co.*, No. 10-cv-5491, 2015 WL 3755945 at *3 (E.D.N.Y. June 16, 2015).

The TAC clearly provides the "particular details" of AMR's "scheme to submit false claims," based on falsified records, to Medicare. As shown above, the TAC alleges:

1. **How AMR's scheme operated**: AMR forced its ambulance personnel – under threat of suspension or termination – to engage in the systematic, institutionalized falsification of PCRs for the purpose of qualifying runs for Medicare reimbursement despite the fact that those runs were not "medically necessary." AMR also developed and used software that increased the likelihood of false claims by automatically defaulting to information that would support the "medical necessity" of runs, regardless of the true condition of the patient. TAC ¶¶ 28-44, 86–87, 96-110, 131-51 (A334-38, 347, 349-53, 357-62).

2. **Who implemented the scheme**: AMR's supervisory personnel in New Haven, Boyd, Pierson and Martus, are all specifically identified as participants in AMR's fraudulent scheme. Pierson is described as the person most responsible for the falsification of PCRs, while Boyd is identified as being partially responsible for the development of AMR's new software. TAC ¶¶ 32-33, 38, 116 (A334-35, 354).

3. **Where the scheme took place**: The unlawful conduct described in the TAC took place either in AMR's "garage" in New Haven or in the environs of New Haven where Fabula and others went out on ambulance runs. TAC ¶¶ 37, 96-109 (A335, 349-52).

4. **When the scheme took place**: All of the conduct alleged in the TAC took place between August 2010 and December 25, 2011, while Fabula was working at AMR as an EMT. The dates of specific ambulance runs that resulted in falsified PCRs are also provided. TAC ¶¶ 9-11, 96-110 (A331, 349-53).

5. **Why AMR engaged in the scheme**: AMRs scheme was carried out for the specific fraudulent purpose of obtaining reimbursement from Medicare for ambulance runs that were not "medically necessary" through the falsification of records to make it appear that those runs were "medically necessary."

TAC ¶¶ 2, 30-33, 38-47, 51-52, 90-92, 96, 100-10, 131-32, 136-39, 146-49 (A330, 334-41, 348-53, 357-61).

The TAC is not based on speculation. Like the relator in *Grubbs*, Fabula was an insider at AMR, and the TAC "alleges his first hand experience of the scheme." 565 F.3d at 191-92. Fabula was personally ordered to falsify PCRs for the purpose of qualifying ambulance runs for Medicare reimbursement; he was personally threatened with dismissal if he refused; he observed other AMR EMTs and paramedics being ordered to falsify PCR for the same purpose; he was given, and observed other AMR EMTs and paramedics being given, outdated medical information to support false claims for Medicare reimbursement; he was told that AMR's corporate objective was to increase New Haven's Medicare reimbursement rate from 40% up to 70%, and he personally observed that – after this objective was set – the number of PCRs required to be altered increased (at least) 6-fold; he observed that falsified hard copy mark-ups of PCRs created by AMR supervisors were shredded after the changes were electronically input; he was personally involved in the specific ambulance runs described in the TAC; he observed the condition of the patients involved; and – based on his observations – he was aware that their condition was being misrepresented on the PCRs he was forced to alter.

The one thing that Fabula could not personally observe was the billing of the medically unnecessary runs described in the TAC; however, the TAC explains that Fabula and other ambulance personnel were "prohibited" from "unauthorized entrance[ ]" into the building in New Haven where AMR's billing was done. TAC ¶ 115 (A353-54). As a result, facts regarding specific bills sent by AMR to Medicare, constitute "information peculiarly within the defendant['s] control," and relator's inability to supply details about those bills should not, at the pleading stage, require dismissal. *See I.U.E. AFL-CIO Pension Fund v. Hermann,* 9 F.3d 1049, 1057 (2d Cir. 1993) ("allegations may be based on information and belief when facts are peculiarly within the opposing party's knowledge"); *In re Computer Assocs. Class Action Securities Litigation*, 75 F. Supp.2d 68, 73-74 (E.D.N.Y. 1999) (inability to plead exact amount of earnings overstatement is "not fatal" because plaintiffs have pleaded a "widespread fraudulent practice" and the precise impact is "the type of information peculiarly within the defendants' control"); *Simington v. Lease Finance Group*, 10-civ-6052, 2012 WL 651130 at *10 (S.D.N.Y. Feb. 28, 2012) ("To strictly construe Rule 9(b)'s pleading requirements . . .where, as here, 'concrete facts are peculiarly within the

knowledge of the party charged with the fraud,' would work a potentially unnecessary injustice").[14]

The district court held that relator is not entitled to the "relaxed" pleading standard that applies "when the relevant facts are not accessible to the pleader," because he "does not plead the factual basis for [his] belief that 'Medicare was billed.'" (SA42). But, in fact, he does. The TAC repeatedly alleges that false claims were submitted, *see, e.g.*, TAC ¶¶ 98, 108, 110 (A350, 352-53), and it provides ample facts to support a "strong inference" that was the case. Most compelling is the fact that the fundamental purpose of the scheme, as alleged, was for AMR to use the falsified PCRs to support its unjustified claims for reimbursement from Medicare. If one accepts the allegations of the TAC as true – which the Court must in ruling on a motion to dismiss, *Bell Atlantic Corp v. Twombly*, 550 U.S. 544, 572 (2007) – there would simply be no reason for the scheme alleged, and the extensive fraudulent conduct observed by Fabula would

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[14] Rule 9(b) should not be applied so as to raise "an insurmountable barrier for any private plaintiff." *Federal Housing Finance Agency v. JP Morgan Chase & Co.*, 902 F. Supp.2d 476, 489-90 (S.D.N.Y. 2012) (if plaintiff must conduct a detailed, pre-complaint asset-level analysis, "it would be a rare complaint that would survive a motion to dismiss"); *see also In re Sumitomo Copper Litig.*, 995 F. Supp. 451, 456 (S.D.N.Y. 1996) (Rule 9(b) "should not be applied in a manner which would, in effect, obstruct all plaintiffs, including those with valid claims, from initiating civil RICO actions").

make no sense if false claims based on AMR's falsified PCRs were never submitted to Medicare. As the court stated in *Grubbs*:

> Taking the allegations of the scheme and the relator's own alleged experience as true, as we must on a motion to dismiss, and considering the complaint's list of dates that specified, unprovided services were recorded amounts to more than probable, nigh [sic] likely, circumstantial evidence that the doctors' fraudulent records caused the hospital's billing system in due course to present fraudulent claims to the Government. It would stretch the imagination to infer the inverse; that the defendant doctors go through the charade of meeting with newly hired doctors to describe their fraudulent practice and that they continually record unprovided services only for the scheme to deviate from the regular billing track at the last moment so that the recorded, but unprovided services never get billed. *That fraudulent bills were presented to the Government is the logical conclusion of the particular allegations in Grubbs' complaint even though it does not include exact billing numbers or amounts.*

565 F.3d at192 (emphasis added); *see also id.* 565 F.3d at 191, n.34 ("[A] doctor can cause the fraud by putting a fraudulent record into a system that he knows will ministerially crank out a fraudulent bill to the Government."); *Foglia*, 754 F.3d at 157 ("While both scenarios are possible [*i.e.* one in which defendant was reimbursed for the fraudulent conduct described in the complaint, and one in which it wasn't] it is unclear what would motivate the second"). The same is true here.

In addition, Fabula was told by Boyd, AMR's Director of Clinical Services, that 40% of the ambulance runs performed by AMR's New Haven office were reimbursed by Medicare as of May 2011; however, Mr. Fabula's personal observation – during the 16 months he worked in that office – was that only about 25% of its runs were medically necessary.[15] Thus, even before AMR initiated its efforts to increase its Medicare reimbursement rate to 70% (TAC ¶ 132; A357-58), at least 15% of the runs AMR billed to Medicare were not medically necessary. *Id.* ¶¶ 158-60 (A363-64).[16]

In sum, virtually all reasonable inferences from the facts pleaded by Fabula – which must be accepted on a motion to dismiss – support the proposition that AMR submitted bills to Medicare that were supported by PCRs that had been

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[15] The TAC alleges that "Fabula fully understood which of the ambulance runs he performed for AMR comprised 'medically necessary' transportation, and which did not, and the electronic PCRs that he prepared in the field accurately reflected whether or not a run was reimbursable by Medicare." TAC ¶ 27 (A333-34). These allegations must be taken as true. *Twombly*, 550 U.S. at 572.

[16] Based on this same data, the district court noted that "roughly fifty percent" of AMR's transports were not billed to Medicare, and argues that this demonstrates the need for specificity with respect to AMR's bills. (SA43). However, this overlooks the "reasonable inference" that the transports billed to Medicare would have been closer to 100% in cases where AMR took the trouble to falsify PCRs to qualify for Medicare reimbursement. The purpose of AMR's fraud was to obtain Medicare reimbursement, therefore, it is reasonable to infer that, where PCRs were falsified, reimbursement was sought.

falsified to make runs which were not "medically necessary" appear to be medically necessary. No other interpretation of the facts makes the slightest sense. As the Seventh Circuit stated in *Lusby*:

> True, it is essential to show a false statement [to prove a FCA claim]. But much knowledge is inferential – people are convicted beyond a reasonable doubt of conspiracy without a written contract to commit a future crime – and the inference that Lusby proposes is a plausible one.
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> . . . . [E]ven a requirement of proof beyond a reasonable doubt need not exclude all possibility of innocence; nor need a pleading exclude all possibility of honesty in order to give the particulars of fraud. It is enough to show, in detail, the nature of the charge, so that vague and unsubstantiated accusations of fraud do not lead to costly discovery and public obloquy.

570 F.3d at 854-55.

C. The District Court Erred in Dismissing the TAC.

The district court's dismissal of the TAC is erroneous for several reasons.

First, as shown above, its conclusion that the TAC must be dismissed because it fails to identify particular false claims submitted to the government is based upon an incorrect legal standard. Virtually all of the federal courts of appeals have upheld complaints in which false claims are pleaded based on reasonable inferences arising from the circumstances of the fraud.

Second, in rejecting the argument that "the purpose of the scheme to revise the PCRs provide[s] an indication of the basis for [relator's] belief that specific transports were being billed to the government" (SA43), the district court failed to observe the cardinal principle that, on a motion to dismiss, it must accept as true all of the complaint's factual allegations and "draw all reasonable inferences in favor of the non-moving party."[17]

The TAC describes, in great detail, an elaborate scheme to defraud Medicare, *inter alia*, (1) by forcing ambulance personnel, on a daily basis, to falsify PCRs by electronically entering marked-up changes created by supervisors, (2) by searching historical patient records to find some ostensibly plausible basis for claiming "medical necessity" when it did not, in fact, exist, and (3) by altering the company's software to create defaults and auto-fills that would, if not corrected, show "medical necessity." All of this was done – as Fabula was repeatedly told by his AMR supervisors – for the purpose of qualifying for Medicare reimbursement runs that he knew were not "medically necessary."

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[17] *See Ashcroft v. Iqbal*, 556 U.S. 662, 678-79 (2009); *Twombly*, 550 U.S. at 570; and *Vietnam Ass'n for Victims of Agent Orange v. Dow Chem. Co.*, 517 F.3d 104, 115 (2d Cir. 2008). While the court recited these principles (SA34), it failed to apply them.

These factual allegations – and all "reasonable inferences" from them– must be accepted by the court in ruling on a motion to dismiss.

In dismissing the TAC, the district court necessarily concluded that these presumptively true facts do not give rise to any "reasonable inference," *Vietnam Ass'n*, 517 F.3d at 117, or "plausible claim," *Iqbal*, 556 U.S.at 678-79, that bills based upon AMR's deliberately falsified PCRs were actually submitted to the government.[18] This conclusion is clearly wrong. "To present a plausible claim at the pleading stage, the plaintiff need not show that its allegations . . . are more likely than not true," *Anderson News, LLC v. American Media, Inc.*, 680 F.3d 162, 184 (2d Cir. 2012):

> Because plausibility is a standard lower than probability, a given set of actions may well be subject to diverging interpretations, each of which is plausible. . . . The choice between or among plausible inferences or scenarios is one for the factfinder. . . .

Id. at 184-85 (emphasis added).

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[18] Rule 9(b)'s particularity requirements must be applied in conjunction with Fed. R. Civ. P. 8(a), which requires only a "short and plain statement of the claim" for relief. *I.U.E. AFL-CIO Pension Fund v. Hermann,* 9 F.3d 1049, 1052-53 (2d Cir. 1993); *Ross v. Bolten*, 904 F.2d 819, 823 (1990) ("When a fraud is asserted the general rule [of Rule 8(a)] is simply applied in light of Rule 9(b)'s particularity requirements"); *see generally* Wright & Miller, § 1298 (Rules 8 and 9(b) "must be read in conjunction with each other"). Accordingly, the requirements of *Iqbal* and *Twombly* are fully applicable to Rule 9(b) analysis. *Id.*

Here, the district court erroneously rejected the "plausible," "reasonable" (and, in fact, obvious) inference from the TAC that AMR – having orchestrated an elaborate scheme to defraud the government by falsifying PCRs – cashed in on that scheme by presenting claims for payment to Medicare based on those falsified records. The reasonableness and plausibility of this inference is demonstrated, *inter alia*, by the fact that the Fifth, Third and District of Columbia circuits have specifically upheld similar inferences. *See, e.g., Grubbs*, 565 F.3d at at192; *Foglia*, 754 F.3d at 157; *Heath*, 791 F.3d at 125-26.[19]

Because the inference that AMR submitted false claims to Medicare based on its falsified PCRs is, at the very least, plausible, the district court was required to deny AMR's motion to dismiss without more – regardless of any contrary

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[19] *See also Clausen,* 290 F.3d at 1317 (Barkett, J., dissenting), where the complaint alleged false claims based on a scheme to obtain reimbursement for medically unnecessary tests:

> Taking as true Clausen's allegations regarding [defendant's] schemes – as we must on a motion to dismiss – his allegations regarding billing would appear to be mere conjecture only if we were willing to attribute to [defendant] a highly unusual business model that consisted in arranging for the systematic administration of medically unnecessary tests for which it never intended to be paid. I see nothing alarmingly conjectural about Clausen's allegation that [defendant] billed for the allegedly unnecessary tests it methodically took the trouble to order.

inferences that might have been advanced by AMR. As this Court has held: "The choice between two plausible inferences that may be drawn from factual allegations is not a choice to be made by the court on a Rule 12(b)(6) motion." *Anderson News*, 680 F.3d at 184-85 (emphasis added). The question at the pleading stage "is not whether there is a plausible alternative to plaintiff's theory; the question is whether there are sufficient factual allegations to make the Complaint's claim plausible." *Id.* at 189. The TAC clearly provides sufficient factual allegations to support a plausible inference that AMR submitted false claims to Medicare.

The district court appears to have rejected that inference, at least in part, because "there are no specific allegations – that is no specification of a date or speaker – that anyone told Fabula that the purpose of requiring him to revise a PCR with respect to a particular transport was so that it could be billed to Medicare." (SA44).

This argument is incorrect for two reasons. First, the TAC does, in fact, identify specific individuals at AMR who told Fabula to fabricate PCR information to qualify specific runs for Medicare reimbursement. *See* TAC ¶ 96 (A349) (December 16, 2011 run: Paul Zarodny, an AMR dispatcher, told Fabula that – to get a desirable "long distance" run – he had to justify the run "to ensure

Medicare would pay the bill" by referring to a five year old hip replacement from which the patient had "fully recovered"); *id.* ¶¶ 56-83 (A342-46) (December 4, 2011 run: Pierson engaged in a months-long effort to force Fabula to create a PCR with information of which Fabula had no knowledge, and effectively terminated him based on his refusal to do so.).[20]

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[20] The district court cited this episode as an allegation that "tend[s] to show that fraudulent bills were *not* submitted" because the TAC (¶ 83) states that Fabula's refusal to cooperate prevented AMR from submitting a claim for the run to Medicare. (SA40). The defendant in *United States ex rel. Brown v. Celgene*, CV 10-3165, 2014 WL 3605896 at *8, n.8 (C.D. Cal. July 10, 2014), made a similar argument based on the fact that the complaint there included "anecdotes of some doctors rebuffing" defendant's efforts to cause them to make claims on Medicare for non-reimbursable services." *Id.* The defendant in *Brown* argued, based on these allegations, that "the only inference that can be drawn from the Complaint[ ] is that physicians did not prescribe [drugs] for off-label uses because of [defendant's] promotion." *Id.* The court rejected this argument as "fatuous," noting that the complaint characterized these anecdotes as "the exception:"

> That the [Complaint] includes the details of these 'exceptional' interactions to highlight the wrongfulness of [defendant's] practices does not mean that we should infer that [defendant's] marketing efforts were wholly unsuccessful – particularly given that Brown alleges otherwise.

So here, the TAC (¶ 83; A346) alleges that Fabula's refusal to cooperate thwarted AMR "for the very first time," and also alleges repeatedly that AMR did, in fact, submit false claims to Medicare. *See, e.g.*, TAC ¶¶ 98, 108, 110 (A350, 352-53).

More importantly, in claiming that the TAC fails to provide specifics about "speaker" and "date," the district court ignored the fact that AMR itself is a "speaker." *See Heath*, 791 F.3d at 125 (for Rule 9(b) purposes, a corporation can be "a specific actor;" "alleging with specificity how the company itself institutionalized and enforced its fraudulent scheme . . . sufficiently identifies who committed the fraud"); *see also Bledsoe*, 501 F.3d at 509. Here, the TAC repeatedly alleges – in connection with specifically identified and dated runs – that "AMR" instructed Fabula to to falsify PCRs. *See, e.g.*, TAC ¶¶ 100 (A350) (December 4, 2011 run: "AMR instructed Fabula to write down [Patient A's] previous surgeries to justify his transport"); 101 (A350) (October 17, 2011 run: "AMR" required Fabula to create two separate PCRs for a single trip). Similarly, AMR is implicitly identified as the speaker in connection with other specifically identified runs. *See, e.g., id.* ¶¶ 102 (A350-51) (two July 7, 2011 runs: "Fabula was told he had to write in previous surgeries and injuries to justify . . . transport" for two different patients); 108 (A352) (72 runs during 2011 for a named diabetic patient: Fabula "was directed under threat of being put on unpaid leave, to change and falsely certify the electronic entry of the PCRs in order to say that [Patient B] had difficulty remaining in an upright position in order to qualify [B's] runs . . . for Medicare/Medicaid reimbursement").

III. THE DISTRICT COURT ERRED IN DISMISSING FABULA'S RETALIATION CLAIM.

A. Standard of Review.

The district court dismissed Fabula's retaliation claim based on the allegations of the SAC. The TAC did not replead Fabula's retaliation claim, and this Court must therefore assess the sufficiency of Fabula's retaliation claims based on the allegations of the SAC.

It is well-established that the particularity requirements of Rule 9(b) do not apply to retaliation claims under the FCA. *United States ex rel. Williams v. Marine-Baker Aircraft Co.*, 389 F.3d 1251, 1259 (D.C. Cir. 2004) (plaintiff's FCA retaliation claim "is unconstrained by the fraud pleading standard; its allegations need satisfy only Rule 8's general pleading standard. . . [O]n a Rule 12(b)(6) motion to dismiss . . . . 'the complaint is construed liberally in the plaintiff's favor, and we grant plaintiff the benefit of all inferences that can be derived from the facts alleged.'"); *Smith v. Clark/Smoot/Russell*, 796 F.3d 424, 433 (4th Cir. 2015) (FCA retaliation claims "need pass only Civil Procedure Rule 8(a)'s relatively low notice pleading muster - in contrast to Rule 9(b)'s specificity requirements"); *see also Weslowski v. Zugibe*, 626 Fed. Appx. 20 (2d Cir. Dec. 16. 2015) (summary order) (on Rule 12(b)(6) motion, FCA retaliation complaint is to be construed

liberally, drawing all reasonable inferences in plaintiff's favor). The complaint need only plead "enough facts to state a claim for relief that is plausible on its face," *Twombly*, 550 U.S. at 570, and "allow[ ] the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678.

B. The Facts Pertaining to Fabula's Retaliation Claim.

The SAC, like the TAC, alleges that AMR engaged in a broad-based scheme to obtain reimbursement from Medicare for ambulance runs that were not medically necessary by forcing its ambulance personnel to falsify PCRs. SAC ¶¶ 43-50, 56-60, 63, 87-123 (A91-92, 94-99, 103-11). The allegations describing this scheme are incorporated by reference in Count Two of the SAC (¶ 131; A112), and, therefore, must be taken as true for purposes of assessing Fabula's retaliation claim.

The specific events resulting in Mr. Fabula's termination are described in paragraphs 64-80 of the SAC. There, it is alleged that, prior to early 2012, Fabula – in order to keep his job at AMR – falsified PCRs when he was instructed to do so by his supervisors. SAC ¶ 64 (A99). However, during February 2012, while Fabula was on sick leave, he was contacted by Russell Pierson, his AMR

supervisor, and told to return to AMR to "recreate" a "lost" PCR pertaining to a run made in early December 2011. Fabula responded that he was not "comfortable with this request" because he did not "believe he could accurately document a run that took place two months earlier." *Id.* ¶¶ 70-71 (A100). Later in February, Pierson, by telephone, directed Fabula to come in to AMR's New Haven garage, and, when he did, Pierson directed Fabula to alter a PCR that had been filled out by another person by adding two paragraphs of handwritten information provided by Pierson. Pierson told Fabula "if he didn't include it, he couldn't come back to work." SAC ¶¶ 72-75 (A101).

"Fabula refused to falsify the PCR because he was no longer willing to participate in AMR's scheme to defraud Medicare." *Id.* ¶ 77 (A101). Fabula was then told "he could not return to work until he completed the [PCR]," and a March 1, 2012 letter from Pierson repeated that threat. *Id.* ¶¶ 78-79 (A101-02). The PCR at issue "was for a run that did not qualify for Medicare reimbursement," and, Fabula was, therefore, "being asked to falsify information on a PCR so that this submission would qualify for Medicare reimbursement." *Id.* ¶ 133 (A112-13). And, "for refusing to do something that he knew violated federal statutes, rules and regulations governing the payment of federal funds via Medicare and

Medicaid, Paul Fabula was placed on administrative leave," and terminated. *Id.* ¶¶ 136, 139 (A113-14).

C. The District Court Erred in Dismissing Fabula's Retaliation Claim.

The applicable FCA retaliation provision states, in pertinent part:

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

31 U.S.C. § 3730(h)(1) (emphasis added) (SA54-55).

District courts in this Circuit have held that, to state a claim for FCA retaliation, a plaintiff must allege (1) that he or she engaged in conduct protected under the statute, (2) that defendants were aware of this conduct, and (3) that he or she was terminated in retaliation for his conduct.[21] Here, the SAC clearly alleges that AMR, through Pierson, was aware of Fabula's conduct in refusing to falsify the PCR in question, and it also clearly alleges that he was terminated because of

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[21] *See, e.g., United States v. Empire Educ. Corp.*, 959 F. Supp. 248, 256 (N.D.N.Y. 2013); *United States ex rel. Sarafoglou v. Weil Med. Coll.*, 451 F. Supp.2d 613, 624 (S.D.N.Y. 2006).

his refusal. Accordingly, the key question is whether Fabula's conduct was "protected" under § 3730(h).

This Court "has yet to articulate a test for deciding when a plaintiff has set forth a claim for retaliation under § 3730(h)," *Weslowski*, 626 Fed. Appx. at 22, so this appeal poses the question of what standard should be applied, particularly in determining what conduct is protected from retaliation.

The district court dismissed Fabula's retaliation based on the proposition that a "mere refusal to participate in an allegedly unlawful scheme" is not protected conduct under the § 3730(h)(1):

> [W]ith rare exceptions, *the mere refusal to participate in an allegedly unlawful scheme is neither an 'act[ ] done' nor 'an effort[ ]' taken*, and such forebearance certainly does not equate with the kind of affirmative activity that the text of the statute conveys.

(SA18) (quoting *United States ex rel. Tran v. Computer Sciences Corp.*, 53 F. Supp.3d 104, 136 (D. D.C. July 3, 2014) (emphasis added).

This decision is incorrect as a matter of law. Section 3730(h), in its current form, is the result of a 2009 amendment that was intended to significantly broaden the protections it affords whistle-blowing employees. Prior to 2009, the statute had enumerated specific "lawful acts" for which an employee was entitled to protection, 31 U.S.C. § 3730(h) (2003); however, in the Fraud Enforcement and

Recovery Act of 2009 ("FERA"), Congress substantially broadened those protections by eliminating the specification of protected activities and expanding the statute to cover not only acts done "in furtherance of" an FCA action, but also "other efforts to stop 1 or more violations of this subchapter." The intent behind these changes was very clearly described by, Rep. Howard L. Berman, an author of the legislation:

> This section [the FCA's retaliation provision] needs to be amended so that it is clear that it covers . . . retaliation not only against those who actually file a qui tam action, but also those who . . . blow the whistle internally or externally without the filing of a qui tam action, *or who refuse to participate in the wrongdoing* . . . .

155 Cong. Rec. E1295-03, 2009 WL 1544226 (emphasis added).

Representative Berman further stated:

> To address the need to widen the scope of protected activity, Section 4(d) of S. 386 provides that § 3730(h) protects all "lawful acts done . . . in furtherance of . . . other efforts to stop 1 or more violations" of the False Claims Act. *This language is intended to make clear that this subsection protects . . . refusals to participate in the misconduct that leads to the false claims*, whether or not such steps are clearly in furtherance of a potential or actual qui tam action.

Id. (emphasis added).

Although the district court acknowledged that "the legislative history of the 2009 amendments to the retaliation provision suggests that Congress intended to broaden protected conduct to include refusals to participate," (SA17-18), it chose

to disregard that intent based on its conclusion that resort to legislative history would be improper because the language of § 3730(h)(1) is "clear," and "unambiguously exclude[s] the type of vaguely articulated refusal to follow an employer's instruction that Mr. Fabula alleges here." *Id.*[22]

However, the statutory language – if anything – unambiguously includes refusals to participate (as one would expect based on the legislative intent). The addition of language to § 3730(h)(1) protecting all "lawful acts done . . . in furtherance of . . . *other efforts to stop 1 or more violations*" clearly covers Fabula's conduct in actively refusing – in the face of great pressure – to falsify the PCR referred to in the SAC. The district court's suggestion that some sort of "affirmative activity" is required and that a refusal to participate, standing alone, is insufficient to warrant protection from retaliation (SA17), is nowhere to be found in the text of the amended statute, and is, in fact, exactly the sort of limiting

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[22] In support of its decision, the district court relied on two cases, *Tran*, 53 F. Supp.3d at 135–37, and *Thomas v. ITT Educational Svcs.*, 517 Fed. Appx. 259262-63 (5th Cir. 2013) (unpublished opinion). Obviously neither decision is controlling here. In *Thomas*, the court specifically noted that it "has not yet issued a published opinion interpreting" the FCA's 2009 retaliation language, and, on the facts, the putative relator was clearly unaware of any relationship between her conduct and claims on the government. *Id.* 263. In *Tran*, the district court – like the court below – simply concluded that "forbearance" to engage in a fraud on the government "does not equate with the kind of affirmative activity that the text of the statute conveys." This is wrong for the reasons stated in the text.

judicial gloss that Representative Berman indicated the 2009 amendments were enacted to overrule.[23]

Finally, assuming there were some ambiguity as to whether § 3730(h)(1) covers the conduct alleged in the SAC, resort to the legislative history would be appropriate, and the legislative history establishes that "refusals to participate" fall squarely within Congress's intended definition of "protected conduct." *See* 155 Cong. Rec. E1295-03, 2009 WL 1544226.

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[23] *See, e.g.*, 155 Cong. Rec. E1295-03, 2009 WL 1544226 at 4 ("over the course of the [FCA's] history, courts have embraced a number of conflicting interpretations that have removed protection for billions of federal dollars and discouraged *qui tam* relators from filing suit under the Act"); 6 ("There are mounting legal divisions and uncertainties among the circuit courts that are jeopardizing Government funds").

CONCLUSION

For the reasons stated above, the Court should reverse the district court's dismissals of relator's FCA claims.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

1. This brief complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B) because it contains 13,837 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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CERTIFICATE OF SERVICE

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