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Collective Corporate Knowledge, the Federal False Claims Act, and the Future of Federal Health Programs

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Articles

Sam F. Halabi^{a1}

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COLLECTIVE CORPORATE KNOWLEDGE AND THE FEDERAL FALSE CLAIMS ACT

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*266 INTRODUCTION

Since 2010, the U.S. Supreme Court has determined that corporations may “speak” in constitutionally protected ways; that they may hold religious beliefs, at least for purposes of the federal Religious Freedom Restoration Act (and perhaps the First Amendment as well); and that they *267 may enjoy other privileges and rights heretofore assumed to be enjoyed only by living, breathing people.¹ Despite the growing human features of otherwise intangible legal entities, what has long been more central to the relationship between corporations and society has been what corporations “know.”² Yet it remains a largely disputed question what factors courts, legislators, and regulators may or should consider when determining whether a corporation “knows” or “should know” something, especially for purposes of drafting and enforcing laws that shape its behavior or effectively divide its conduct from the people who manage it.

Indeed, it is frequently difficult to prove that a human being “knows” or “should have known” something relevant for legal liability to attach; construing “knowledge” from many persons working within an entity committed to a business purpose is far more complex.³ In one case involving a corporate defendant with tens of thousands of employees, a federal trial court instructed the jury that it could find that defendant “liable *268 for the collective knowledge of all employees and agents within the corporation” when determining whether it had defrauded the federal government.⁴ According to the instruction:

[I]f a corporation has many employees or agents, you must consider the knowledge possessed by those employees and agents as if it was added together and combined into one collective pool of information. If that collective pool of information here gives a reasonably complete picture of . . . false or fraudulent claims or false statements, you may find that [Defendant] itself possessed a reasonably complete picture of the false or fraudulent claims or false statements and acted knowingly.⁵

With the instruction, the court captured one of the most vexing problems facing lawmakers, regulators as well as jurists: how do you determine what a corporation “knows”?

Researchers from disciplines ranging from communications, economics, psychology, sociology, as well as law, have endeavored to understand when and under what circumstances a corporation, as an entity, “knows” something or “has knowledge” requisite for it to be held responsible for its action or inaction.⁶ The precise question centers upon how and in what form information is communicated between people within the firm, both across levels of firm hierarchy and as information moves up that hierarchy. Economic theory suggests that information channels, including the language used in those channels, will be shaped by costs and incentives. Rational firms, or at least firms in competitive environments, adopt structures that minimize costs and maximize opportunities for profit *269 exploitation.⁷ These structures are not always welfare-enhancing at an aggregate or societal level. Information may be distorted or lost as it travels through the firm that might improve product safety or provide a more complete picture of risks to investors.⁸ These informational distortions and barriers tend to coincide with cost-minimization and opportunity exploitation.

Judges, legislators, and regulators have always known of these possibilities. They have fashioned tools aimed at effectively ensuring that information relevant to public safety, investor protection, and employee welfare, especially in large organizations, is produced, communicated, and used appropriately with respect to these and other constituencies. The Organizational Sentencing Guidelines issued by the U.S. Sentencing Commission, strict products liability, agent-

principal fiduciary duties, and internal controls provisions of state and federal law have as their broader aim shaping the way that information is created, transmitted, and used within the firm.⁹ Economic, legal, and sociological scholarship exploring the issue is legion.¹⁰

This Article argues that an important source of data for answering the question of collective corporate knowledge has been underappreciated if not ***270** entirely overlooked: the federal False Claims Act. That statute requires that firms submitting claims to the federal government for payment ensure that those claims are not knowingly or recklessly false.¹¹ Because the federal government undertakes its activities, often critical functions like healthcare provision and national defense, through both small and large business entities, litigation under the statute provides a rich source of information about when a corporation is deemed to “know” that its claim is false, how corporate structures and lexicology may adapt to distort or suppress relevant knowledge, and what kinds of deterrence are necessary to effectively control those distortions.¹²

While the broader aim of this Article is to draw attention to an underutilized resource in the interdisciplinary corporate collective knowledge debate, it does so out of two related concerns prompted by federal courts' current treatment of the federal False Claims Act. First, the Article aims to address a split between federal courts on the question of whether the collective corporate knowledge doctrine is authorized by the statutory language and history of the False Claims Act.¹³ The Article not only analyzes statutory text, history, and recent amendments, it also examines pre- and post-claims factors that strongly suggest a collective corporate knowledge instruction is an appropriate and necessary means of effecting the False Claims Act's purpose. Second, a resolution of the judicial disagreement in favor of a collective corporate knowledge doctrine is an important, even essential, aspect of implementation of the 2010 Patient Protection and Affordable Care Act, or, colloquially, Obamacare.¹⁴ Although challenges to the economic structure of the law have focused on mandates for individuals to participate in the insurance pool and subsidies ***271** available through federal and state exchanges, the cost of fraud in the healthcare system as a result of increased utilization represents a key financial challenge for the law.¹⁵ Indeed, the concern Congress expressed for fraud's potential to undermine the law represents an important aspect of how the False Claims Act should be read by courts.¹⁶

Part I of this Article surveys the problem of collective corporate knowledge as it is addressed in the legal literature. This section analyzes the open questions and principal arguments made about the nature of information transmission within the firm and how relevant knowledge may be distorted, suppressed or reframed. Part II introduces the federal False Claims Act, its text, litigation structure, and relevant jurisprudence that shed light on the questions outlined in Part I. Part II also surveys federal judicial treatment of the False Claims Act and the reasons courts have offered for embracing or rejecting the collective corporate knowledge doctrine. Part III sets forth the reasons that the collective corporate knowledge doctrine is not only supported by the text and history of the False Claims Act, but that it represents a critical tool in ensuring the integrity of Obamacare as well as other federal health programs. Using healthcare sectors that comprise the majority of federal spending - hospitals, hospice, and pharmaceuticals - the Article shows that not only are large firms the principal beneficiaries of government payments, but that their systems for aggregating information are, in fact, greater than the sum of any individual employee or agent. In Part IV, the Article places this conclusion in broader context by examining the role collective corporate knowledge litigation under the False Claims Act may play in the broader, multidisciplinary debate.

***272 I. THE PROBLEM OF COLLECTIVE CORPORATE KNOWLEDGE**

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Between 1973 and 1980, at least 27 people died as a result of a structural flaw in the design and positioning of the Ford Pinto gasoline tank that caused the tank to rupture and catch fire during certain common collisions.¹⁷ One of the key questions that faced regulators deciding whether to order a recall as well as judges and juries adjudicating lawsuits filed against the manufacturer was: did Ford “know” about the defect?¹⁸ The answer is not as clear as media coverage nor product liability folklore suggest.¹⁹ Ford introduced the Pinto amid significant competition from overseas automobile manufacturers.²⁰ Attempting to convey the importance of the Pinto in keeping pace with the competition, Lee Iacocca established the “two thousand, two thousand rule.”²¹ “The manager in charge of the entire project . . . articulated the criteria that the car needed to come in under two thousand pounds body weight and should sell for around two thousand dollars to the consumer. When an engineering or design decision was referred to him, he constantly referenced those two standards in deciding the issue.”²² Subordinates learned not to refer decisions to management but to decide them in terms of the short-hand framework provided.²³ Ford's Field Recall Coordinator at the time of the Pinto's *273 release “inherited about 100 active recall campaigns, half of them safety-related.”²⁴ As with most jobs, the enormous workload required him to use both formal, “standard operating procedures,” and informal heuristics to organize and manage information for decision making.²⁵ Nothing about the Pinto's safety profile at the time suggested any special urgency with respect to fires caused by rear-end collisions.²⁶

Contemporaneously, Ford had commissioned a report to influence regulators, *Benefits and Costs Relating to Fuel Leakage Associated with the Static Rollover Test Portion of FMVSS 208*, which assessed each victim of rear end collisions of the type targeted by proposed federal rules at \$200,000.²⁷ Ford's effort to fight new standards for “installation of a special valve in all cars and light trucks to prevent fuel leakage”²⁸ together with the precarious design of the gas tank made Ford appear to have made a calculated decision to favor its competitive position over consumer safety. The design and release of the deadly automobile thus took place through hierarchical work organization, spontaneous ordering of rules and the separation of corporate functions.²⁹ So what, if anything, may be said about what “Ford,” a strictly legal entity, “knew” about the safety of the Pinto?

This problem of knowledge pervades a wide range of legislative and regulatory schemes aimed at ensuring that firms generate relevant knowledge, use it appropriately, and guard it against distortion or destruction. Andrew Fastow “knew” that the specialized investment vehicles he was using to hide Enron's true financial profile were illegal, but did the entity called Enron?³⁰ Wal-Mart's operations in Brazil, China, India and Mexico expanded through bribes and corruption at local levels, so *274 before a whistleblower alerted top executives, did Wal-Mart “know”?³¹ By December 2000, data from 21 trials showed that the risk of a heart- or stroke-related adverse event or death (from all causes) was twice as high in patients taking Merck's analgesic Vioxx - but the finding was just shy of statistical significance - so did Merck “know” about the risks four years before pulling the drug?³²

In each of the aforementioned contexts, illicit or tortious conduct was possible through the loss or distortion of information in large, complex business organizations. The problem is inherent in the structure of profit-seeking firms. Responsibility, whether with federal procurement rules or product safety, is diffused among firm divisions and individual employees.³³ Because information travels from the transaction or person with which it originates to higher-level decision-makers, a range of distorting influences may compromise the integrity of that knowledge or otherwise prevent it from playing a role in legal compliance.³⁴ This aspect of complex business organizations is supported by scholars of communications, economics, psychology, sociology, and law, notwithstanding differing disciplinary assumptions and methods.³⁵

Herbert Simon, for example, used the concept of “bounded rationality” to refer to the limitations and costs humans face in acquiring and processing the full range of information required for optimal decision-making.³⁶ In the *275 context of a business organization, “bounded rationality” means that some individuals will not understand what is being communicated, some individuals will hear or read information as something different than intended by the communicator, or communicating parties will use specific words or phrases to suggest a range of possibilities which might be embraced or denied depending on outcomes and results.³⁷ People within the firm “have to find a common language to describe states of the world and actions with respect to which prior experience may not provide much of a guide.”³⁸ Oliver Williamson coupled Simon's concept of “bounded rationality” with “opportunism”³⁹ to argue that with respect to any given transaction involving a business organization (whether internally or in the course of arms-length contracting) information would be shaped to the advantage of the speaking party. The essence of opportunism “is an individual's aspiration to realize [[his or her] own egoistic interests, accompanied by cunning and deceit.”⁴⁰

Stanley Milgram famously, and controversially, showed that the superior-subordinate relationship generated phrases, justifications, schemas, and heuristics that affected how information, particularly “orders” from superiors would be read or interpreted against information and experience extraneous to that order.⁴¹ In other words, people respond differently to authority (and hierarchy) than they do in other contexts and their roles within an organization shape their communications and conduct.⁴² Philip *276 Zimbardo identified a long list of factors that tended to characterize the authority relationship Milgram identified: presenting an acceptable justification, or rationale, for action; arranging some form of contractual obligation, verbal or written, to enact the behavior; giving participants meaningful roles to play that carry with them previously learned positive values and response scripts; presenting basic rules to be followed, that seem to make sense prior to their actual use, but then can be arbitrarily mindless compliance; diffusing responsibility for negative outcomes; and making “exit costs” high, and the process of exiting difficult by not permitting usual forms of verbal dissent.⁴³ Legal scholars have translated these insights into specific legislative and regulatory regimes like securities regulation, product liability, and organizational crimes to elaborate what the structure and dissemination of knowledge means for legal compliance.

A. The Flow of Knowledge Within Firms

1. Structural Barriers to Effective Information Flow

In any organization, information must flow “upward” from employees that are directly connected to products and customers, to mid-level managers, and finally to executives.⁴⁴ A key task for any firm becomes devising a system that identifies important data and quickly moves it to the desk of the most appropriate manager or executive.⁴⁵ Information arrives at the top of a firm's managerial chain only after having been filtered through multiple layers.⁴⁶ “Positive information will move more quickly to the top,” but “[n]egative information will travel more slowly, if at all, and will be more subject to skewing.”⁴⁷ As relevant information passes through these hierarchical nexuses it may be subject to alteration and thus lose its urgency *277 or relevancy.⁴⁸ Further compounding the information flow problem is the fact that accounting, auditing, and compliance systems are often expensive and only occasionally workable.⁴⁹

Even an affirmative managerial declaration that accurate or unbiased information should be passed upward along the reporting chain may not be enough to overcome the aforementioned problems. As Langevoort notes, “[t]o the extent that any given employee fears the possibility of being fired or dead-ended in light of a candid portrayal of the situation . . .

distortion or concealment becomes a dominant strategy”⁵⁰ Indeed, this problem may be exacerbated by extensive corporate compliance and training programs adopted by business organizations after 1991. An explicit pronouncement that possible failures of compliance should be passed up the managerial chain may be contradicted by the implicit understanding that the firm's compliance program exists to identify such failures, or, worse, merely window dressing.⁵¹

There is also the possibility that a senior manager will cultivate, even unwittingly, an unspoken, implicit order against the upward flow of negative information.⁵² Lee Iacocca did so facing the necessity to produce a *278 small, affordable car to compete with Japanese rivals.⁵³ Writing about the shocking effect of the Enron, Global Crossing, and WorldCom scandals, Langevoort noted, “Senior managers were not candid with the company's directors. Other managers were not candid with their superiors.”⁵⁴

The structure of corporate hierarchy, whether horizontal or vertical, will also exert influence on the generation and processing of knowledge. If a team of peers is responsible for a certain function, introduction of potentially troubling information by one member of a group gives rise to “a threatening form of stress.”⁵⁵ That stress generates an even more permissive and aggressive attempt to rationalize and dismiss the threatening information.⁵⁶ This then inhibits a truly prudent review of the information.⁵⁷

2. Cognitive Barriers to Effective Information Flow

Even without structural barriers to the effective flow of relevant knowledge, human limitations themselves will shape the generation and transmission of knowledge in ways that may risk compliance with law. People commonly construe information in a way that conforms to their prior assumptions, so that it fits within their pre-existing belief systems.⁵⁸ A manager, acting alone, would tend unconsciously to resist the significance of information calling into question the validity of a course of action.⁵⁹ Ambiguous or “potentially troubling” information is likely to be dismissed or rationalized so that it does not conflict with the manager or firm's dominant belief system.⁶⁰ Compounding this problem is the fact that most information is presented in a piecemeal, sequential manner, further *279 empowering a manager to dismiss such information as non-conforming.⁶¹ Despite the caveat that “much information is too unambiguous not to deflect” where information can be interpreted that conforms to the desired belief it often will be.⁶²

Similar to cognitive conservatism is the way in which individuals bend or interpret information so that it conforms to a prior conclusion. Correlations are often exaggerated if they support an initial hypothesis but downplayed if they do not.⁶³ These tendencies reflect a decision-making modality that adheres to theory rather than evidence.⁶⁴ Additionally, the more complex the evidence, the more vulnerable it is to this “confirmation bias.”⁶⁵ In many ways, complex information is more easily dismissed as ambiguous, or more readily discredited than simple, easily quantifiable data.⁶⁶ Once an executive has made a decision, subsequent information is often reviewed and processed in a manner that is biased to support the executive's original choice.⁶⁷ This is likely attributable to the fact that executives and managers are often held accountable for their decisions, and so a natural tendency arises to protect the viability of the original choice from disconfirming evidence.⁶⁸

***280 B. Legal Regimes Endeavoring to Structure Flows of Information Within Firms**

The number of state and federal regulatory efforts addressing these challenges to the effective generation and transmission of information within the firm - with significant costs imposed on consumers, employees, investors, and taxpayers - has proliferated since 1991 and the adoption of the Organizational Sentencing Guidelines.⁶⁹ In 1996, the Delaware Chancery Court - the most important court with respect to the internal governance norms at U.S. publicly traded corporations - issued its consent decree in *In re Caremark Derivative Litigation* which articulated a heightened duty on corporate directors for maintaining "reasonable information and reporting systems" later adopted as law by the Delaware Supreme Court in *Stone v. Ritter*.⁷⁰ In 2002, the federal government adopted the Sarbanes-Oxley Act which expanded requirements for boards of directors of publicly traded corporations, management and public accounting firms as well as certain evidentiary preservation provisions for privately held companies.⁷¹ There are also regimes specific to certain kinds of corporations - e.g. books and records provisions for firms doing business overseas who communicate with foreign officials - but the ones outlined below are the most important for addressing the problems identified in Part I.A.⁷²

1. Common Law Doctrines

Long before the compliance industry developed in the early 1990s, judges had fashioned common law doctrines that provided relatively strong incentives for business organizations to effectively ensure that relevant *281 knowledge would reach decision-makers or that firms would internalize costs imposed if it did not. As Stephen Croley and Jon Hanson noted in their assessment of the tort reform battles of the early 1990s, the line of cases stretching from *MacPherson v. Buick Motor Co.*,⁷³ to *Greenman v. Yuba Power Products, Inc.*,⁷⁴ which expanded the strict liability doctrine for consumer products, had at its core the generation and transmission of relevant information within the manufacturing business organization and from the firm to the consumer:

Holding manufacturers liable for product injuries would solve this information problem . . . by forcing manufacturers to provide greater safety and to be more forthcoming about product risks. Because manufacturers would have to pay for accidents caused by their defective products, manufacturers would be unable to profit from consumer ignorance.⁷⁵

The duty of candor, which operates in both agent-principal and corporate law contexts, similarly requires fiduciaries to disclose relevant information in order to protect a wide range of stakeholders.⁷⁶ This duty most frequently arises when a conflict of interest develops between corporate managers and the corporation. In order to show the fairness of the transaction to the corporation, fiduciaries must fully and effectively disclose it.⁷⁷ Under Delaware law, the duty of candor extends to any situation where directors seek shareholder approval, regardless of conflict.⁷⁸

Professor J.H. Verkerke argues the same with respect to courts' construction of employment contracts, disclosure rules under the Employee Retirement Income Security Act, waivers related to tort liability and warranty provisions of the Uniform Commercial Code as effectively forcing *282 relevant information to customers, employees, and the public.⁷⁹ In Verkerke's analysis:

The common thread that runs through all of these examples is that sophisticated contracting parties respond to legal rules favoring their contractual partners by adopting express terms that shift the balance of legal rights in their own favor. Traditional majoritarian default rule analysis would criticize these doctrines for generating unnecessary transaction costs. On this view, the rules cause wasteful efforts to draft disclaimers,

liability limitations, and other exculpatory clauses that appear in virtually every contract. The theory of legal-information-forcing defaults provides an alternative, potentially more constructive role for these doctrines. According to this perspective, the routine practice of contracting around such rules conveys valuable legal information to comparatively unsophisticated parties.⁸⁰

2. Organizational Sentencing Guidelines

Like sentencing guidelines for individual offenders, the Organizational Sentencing Guidelines were adopted both out of a sense that wide variations in criminal sanctions gave rise to a perception that sentencing of corporations was arbitrary and an even deeper sense that white collar crime was treated more leniently than other kinds of crime.⁸¹ In contrast to sentencing guidelines for individuals, the organizational guidelines focus on providing restitution and an appropriate fine range for the offender *283 organization through far reaching probation provisions.⁸² More importantly, the guidelines are geared toward deterrence, and they provide sentencing benefits for organizations that have an “effective program to prevent and detect violations of law.” Punishment consists of a fine that is calculated post-conviction, based on either the victim's loss or the defendant's gain, multiplied by a factor set forth in the Guidelines promulgated by the United States Sentencing Commission.⁸³ The organizational guidelines were not part of the original set of guidelines the Commission sent to Congress on May1, 1987.⁸⁴ On November 1, 1991, after years of research, debate, and input from several advisory working groups, various federal agencies, and the general public, the Commission promulgated the Organizational Sentencing Guidelines.⁸⁵

The response to the guidelines was a dramatic increase in the number of compliance and ethics programs.⁸⁶ The guidelines gave rise to an independent professional corps which developed its own self-regulatory bodies and corresponding codes of professional ethics.⁸⁷ The Ethics and Compliance Officer Association, which was created in 1992 in direct response to the OSG with 19 members, now count more than 1,200 members exclusively comprised of in-house compliance/ethics professionals--a job category that effectively did not exist in 1991.⁸⁸ The Society of Corporate Compliance and Ethics, a nine-year old group that certifies compliance/ethics professionals, has more than 2,800 members comprised of both in-house and outside compliance/ethics practitioners, including service providers and advisers.⁸⁹ Boards of directors receive regular reports from management on how their respective companies' *284 programs conform to OSG standards, and outside firms evaluate compliance/ethics programs against the OSG model.⁹⁰

Federal agencies, including the Environmental Protection Agency, the Department of Health and Human Services, and the multiple agencies that collaboratively produce the Federal Acquisition Regulations modeled their industry-specific programs on the guidelines.⁹¹ A number of policy-making bodies have incorporated compliance/ethics program expectations within broader corporate standards.⁹² The U.S. Department of Justice recognizes as a matter of policy that a company's compliance program should be a factor in deciding whether or not DOJ will file criminal charges in cases of organizational misconduct.⁹³ Many firms still reasonably look to the OSG in determining whether to monitor, self-report, or cooperate.⁹⁴

Organizations may mitigate penalties through adopting an effective compliance program. This mitigation is contingent upon prompt reporting to the authorities and the non-involvement of high level personnel in the actual culpable conduct.⁹⁵ The OSG outlines seven key criteria for establishing an effective compliance program: oversight by high-

level personnel; due care in delegating substantial discretionary authority; effective communication to all levels of employees; reasonable steps to achieve compliance, which include systems for monitoring, auditing, and reporting suspected wrongdoing without fear of reprisal; consistent enforcement of compliance standards including disciplinary mechanisms; and, reasonable steps to respond to and prevent further similar offenses upon detection of a violation.⁹⁶ The OSG's "seven-step" standards for compliance/ethics programs have become the de facto framework for U.S. corporations and also serve as a reference point for many U.S. regulatory and enforcement agencies.⁹⁷ For example, Section 3 of Health Care Fraud and Abuse Compliance Manual essentially tracks the OSG criteria.⁹⁸

*285 3. Internal Controls

Common law mechanisms and the wave of compliance fostered by the Organizational Sentencing Guidelines failed to prevent major episodes of corporate malfeasance beginning in the early 2000s with discoveries of accounting fraud at several Fortune 500 companies, escalating healthcare fraud costs, and widespread use of corrupt payments to facilitate overseas expansion.⁹⁹ As a result, both state and federal law, as well as sector-specific self-regulatory bodies, developed internal control regimes to monitor risks to the firm's financial profile as well as compliance with applicable law.

a. Federal Law

The Sarbanes-Oxley Act of 2002 regulates the systems a public company employs to collect, process, and disclose financial information to satisfy its statutory reporting requirements.¹⁰⁰ Corporate and accounting frauds like those in Enron, GlobalCrossing, and WorldCom demonstrated the inadequacy of internal controls with regard to accounting practices.¹⁰¹ Under Sarbanes-Oxley, auditors must "test" the scope of a company's internal control procedures and present its findings in its annual audit report.¹⁰² The audit report must include an evaluation of whether the *286 internal controls provide both a system of maintaining records that fairly and accurately reflect the company's transactions, and a reasonable assurance that transactions are recorded in accordance with the preparation of GAAP financial statements.¹⁰³ The audit report must also contain a description of any material weaknesses in the internal controls and any material noncompliance.¹⁰⁴

The Act requires the CEO and CFO to certify, in each annual and quarterly report issued by the company, as to a number of subjects, including internal controls.¹⁰⁵ They must certify that they are responsible for establishing and maintaining internal controls; have designed the internal controls to enable them to obtain all material financial information; have evaluated the effectiveness of the internal controls; and have presented their conclusions about the effectiveness of the internal controls in the report.¹⁰⁶ The CEO and CFO must also certify that they have disclosed to the company's auditors and the audit committee of the board of directors all significant deficiencies in the internal controls that could adversely affect the company's ability to maintain and report financial data, and have identified for the auditors any material weaknesses in internal controls.¹⁰⁷ They must also disclose any fraud, whether material or not, that involves management or other employees that have a significant role in the company's internal controls.

The certification must also state that the CEO and CFO have indicated in the report any significant changes in internal controls or changes in other factors affecting them after the date they were evaluated, including any corrective actions taken to remedy deficiencies and weaknesses.¹⁰⁸ Aside from federal law, stock exchanges impose their own disclosure and internal *287 governance requirements that aim to create and channel relevant information to investors.¹⁰⁹

b. State Law

In 1996, Delaware Chancellor William Allen entered a consent decree approving a settlement between shareholders of CVS/Caremark and the corporation's board of directors based in part on allegations that the directors had breached their duty of care by failing to have in place systems that would effectively prevent illegal kickback arrangements between physicians and CVS/Caremark affiliated pharmaceutical and provider companies.¹¹⁰ While the chancellor's consent decree nudged Delaware law toward greater board responsibility for monitoring financial and legal risks to the corporation (under *Graham v. Allis-Chalmers*, the board was liable only if it “recklessly reposed confidence in an obviously untrustworthy employee . . . or ignored either willfully or through inattention obvious danger signs of employee wrongdoing”), the episode itself shows how little the state law duty affects corporate behavior. Even though the chancellor found CVS/Caremark's system of compliance and ethics training more than adequate to cover a potential breach of fiduciary duty, that system had failed to uncover or manage the illegal arrangements. The Delaware Supreme Court adopted the chancellor's analysis in *Stone v. Ritter*, another case where a corporation's extensive compliance system (there, a bank's compliance with suspicious activity reporting requirements) failed to prevent shareholder losses.¹¹¹ Nevertheless, directors are under duties imposed by state corporation law to implement internal control policies as part of their duty of care.

II. THE STRUCTURE AND PURPOSE OF THE FALSE CLAIMS ACT

As the aforementioned discussion shows, firms of all kinds are under obligations imposed by state and federal law as well as private authorities *288 like stock exchanges to generate and effectively structure the flow of information to protect many constituencies including consumers, employees, and investors. Similarly, the law imposes obligations to protect taxpayers. Like other purchasers of products or securities, the federal government procures massive amounts of goods and services from the private sector to undertake both routine and critical functions including provision of healthcare, national defense, environmental protection, and even promotion of the United States Postal Service.¹¹² In addition, of course, to common law fraud claims, the False Claims Act is the statute the federal government uses to ensure that the corporations (and individuals) from which it purchases goods and services do not perpetrate fraud or jeopardize the integrity of federal programs. Thirty-two states maintain similar statutes for which Congress provided a recovery-based incentive in 2006.¹¹³

Under the False Claims Act regime, originally a Civil War-era statute aimed at preventing fraud against the Union Army, private citizens (“whistleblowers” or “relators”) work closely with the U.S. Department of Justice (DOJ) to identify inappropriate claims submitted to the government for payment.¹¹⁴ In an archetypal case, an employee who witnesses or participates in a fraudulent scheme uses that information as the basis for a lawsuit against the employer on the government's behalf.¹¹⁵ The statute *289 allows whistleblowers to share up to 30 percent of the United States's ultimate recovery.¹¹⁶ While the complaint is under seal, and before it is served on the defendant, DOJ investigates to decide whether to intervene and take over the prosecution of the action or decline to intervene and allow the whistleblower to proceed alone.¹¹⁷ The False Claims Act establishes liability for any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.¹¹⁸ A defendant may be liable if a claim for reimbursement is factually or legally false,¹¹⁹ and, if defendant has “actual knowledge” of the falsity of the claim, or if the defendant acts with “deliberate ignorance,” or “reckless disregard” as to the veracity of the claim.¹²⁰ A factually false claim is rendered not payable because it rests on inaccurate factual information about the product or service billed.¹²¹ Legally false claims are those for which the goods or services are as designated in the agreement with the government,

but the claim violates a legal condition of payment for the product being billed.¹²² Where it establishes liability, the government is entitled to treble damages per claim under the statute.¹²³

***290** The statute is “one of the most successful tools for combating waste and abuse in government spending.”¹²⁴ In 2013 alone, there were over 700 lawsuits brought under the False Claims Act and total monetary recovery exceeding \$3.8 billion in addition to less quantifiable recoveries in terms of settlement provisions regulating corporate behavior.¹²⁵

A. The Textual and Legislative History Behind the False Claims Act's Knowledge Provisions

The provisions of the statute relevant for ascertaining “knowledge” read:

(a) Liability for Certain Acts.--

(1) In general.--Subject to paragraph (2), any person who--

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false or statement material to a false or fraudulent claim;

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

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

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

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

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,¹²⁶

For purposes of defining “knowing” and “knowingly”:

(b) Definitions . . .

(1) the terms “knowing” and “knowingly”--

(A) mean that a person, with respect to information--

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;¹²⁷

The False Claims Act is notorious for generating disagreements between federal courts over virtually every word in the statute and the factors that determine whether a corporation “knowingly” submitted a false claim are similarly opaque.¹²⁸ The principal reason for this is not inattention or thoughtlessness in Congressional drafting committees but rather the difficulty of tailoring language in the statute to the diverse and numerous *292 forms in which claims for payment from the government are made.¹²⁹ “Person” under the statute “include[s] corporations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals.”¹³⁰ While there has been little analysis of the issue, it is almost certainly the case that it is a relevant inquiry as to who the “person” is in False Claims Act litigation. In *SAIC v. U.S.*, in which the U.S. Court of Appeals for the District of Columbia rejected a collective corporate instruction, the panel did so because:

even absent proof that corporate officials acted with deliberate ignorance or reckless disregard for the truth by submitting a false claim as the result of, for instance, a communication failure, the fact-finder could determine that the corporation knowingly submitted a false claim.¹³¹

In other words, the government must be able to prove that at least one employee or corporate official had requisite knowledge, deliberate ignorance, or reckless disregard to prevail.¹³²

But imposing such a requirement narrows the definition of “person” found in 1 U.S. Code § 1: “the words ‘person’ and ‘whoever’ include corporations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals[.]”¹³³ Under their reading, the False Claims Act would *only* apply to individuals, except where that individual were acting as an agent of a corporation or other business entity. The legislative history shows that Congress demonstrated a more sophisticated view of the law (and of corporations) than that, and intended duties imposed by the law to strengthen as the size and sophistication of the party submitting claims increased.

Indeed, where an individual or small business submits a false claim, that falsity is salient and often straightforward. In *U.S. v. Lorenzo*, for example, the defendant dentist was found to have repeatedly ignored warnings that the Medicare claims his company submitted for oral cancer screenings were *293 false.¹³⁴ In several instances, the defendant was warned by his employees that the claims they submitted were likely not covered by Medicare.¹³⁵ At least once, the Medical Director of a group of nursing homes that the defendant serviced challenged the defendant's right to submit Medicare reimbursement claims for the work the defendant performed.¹³⁶ Finally, one of the defendant's carriers consistently refused to provide reimbursement for the healthcare service the defendant billed for.¹³⁷

The U.S. District Court for the Eastern District of Pennsylvania held that this evidence was sufficient to find that the defendant had ignored repeated warnings and “red flags” about the potential falsity of his reimbursement claims and thus had not met his duty to conduct a “reasonable and prudent” inquiry given the apparent possibility that the claims were false.¹³⁸ The *Lorenzo* case suggests that small providers are fairly easily assessed as having ignored “red flags,” or failed to undertake a reasonable investigation.¹³⁹

Yet even in the small provider context, it is easy to see how lax or inattentive management can lead to profitable, if false, billing. In *U.S. v. Krizek*, the defendant operated a small psychiatric practice.¹⁴⁰ The defendant's billing staff approximated the length of the psychotherapy sessions provided to patients.¹⁴¹ Despite sessions that ran anywhere from 20 minutes to over an hour, the billing staff adopted a 50-minute session as the standard billable time.¹⁴² The staff never checked with the doctor to determine the actual amount of time he spent treating patients.¹⁴³ These approximations resulted in obvious over-billings, such as, in several instances, billing for more than 20 hours' worth of work in a 24-hour period.¹⁴⁴ The defendant argued that the small, non-corporate nature of his *294 practice should mitigate his culpability to mere negligence.¹⁴⁵ However, the D.C. District Court disagreed, finding the defendant liable based on the woeful inadequacy of his billing system and his failure to perform even limited supervision of the billing staff.¹⁴⁶ The court stated that, “These were not ‘mistakes’ nor merely negligent conduct . . . [T]he defendants acted with reckless disregard as to the truth or falsity of the submissions.”¹⁴⁷

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While in small provider or contractor cases the requisite level of “knowledge” has been relatively easy to ascertain, the government has tended to procure the largest amount of goods and services through larger business entities and it is cases involving larger firms that have traditionally vexed courts' application of the statute. Before 1986, the False Claims Act imposed liability where a defendant had “actual or constructive knowledge that the claim was false”¹⁴⁸ The constructive knowledge standard was intended to broaden the Act's scope to include persons who sought payment from the government “without regard to . . . eligibility and with indifference for the requirements of eligibility”¹⁴⁹ It was instead largely read by federal appellate courts to impose a higher scienter standard than Congress intended.¹⁵⁰

Congress revisited the False Claims Act in 1986 precisely because fraud against the government had reached alarming levels, draining 1-10% of the entire federal budget.¹⁵¹ Over the course of the 1970s, federal appellate courts had limited the False Claims Act's reach by requiring heightened burdens of proof, constraining damages theories, and excluding claims against Medicaid (as the claims were technically submitted to state, not federal, officials).¹⁵² Attributing the courts' restrictive reading of the scienter requirement to the ambiguity of “constructive knowledge”, Congress replaced the phrase with “deliberate ignorance” and “reckless *295 disregard” to reach conduct greater than “mere negligence but less than specific intent.”¹⁵³ Throughout the legislative history, both the House of Representatives and the Senate displayed a heightened sensitivity to the realities of corporate structures that channeled relevant information - especially about legal compliance - away from firm decision-makers. In a 1986 Report, Senator Strom Thurmond noted the hobbling effect of judicial interpretations:

Currently, in judicial districts observing an “actual knowledge” standard, the Government is unable to hold responsible those corporate officers who insulate themselves from knowledge of false claims submitted by lower-level subordinates. This “ostrich-like” conduct which can occur in large corporations poses insurmountable difficulties for civil false claims recoveries.¹⁵⁴

While the Report somewhat inartfully referred to a “duty to make a limited inquiry,”¹⁵⁵ the accompanying discussion made clear that the “duty” imposed should be tailored to the size and sophistication of the party receiving government funds.¹⁵⁶ An earlier version of the amendments included a duty to investigate that would be “reasonable and prudent to conduct under the circumstances to ascertain the true and accurate basis of the claim or statement.”¹⁵⁷ The Senate Governmental Affairs Committee *296 made clear that, whatever nuances and distinctions might be made for corporate executives' *personal* liability, “the corporation would be held responsible for the collective knowledge of its employees under the doctrine of *respondeat superior*.”¹⁵⁸ In hearings, Senator Bill Cohen not only noted the importance of the False Claims Act to apply to fraud in the defense contracting context where it was prevalent, he specifically cited the check-kiting scandal at the financial institution E.F. Hutton as a situation:

[W]here the top executive said, “we didn't know that that was going on. We didn't know that all that money was being floated out there on these checks. We had no knowledge.” And do you say, wait 1 minute. Do the top executives have a higher obligation? Did they have reason to know? Do they have knowledge or should there have been knowledge? That's the tough issue we're getting at here and it seems to me, in view of the amount of false or fictitious claims that have been, I think, perpetrated against the Government and not prosecuted, that there should be some shifting of the burden there.¹⁵⁹

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Congressional sensitivity to the structure of information channels in corporations and other large organizations was echoed in the testimony of Executive Branch officials. HHS Inspector General Richard Kusserow summarized the False Claims Act's ambit in a 1982 assessment prepared for Congress when he wrote “[a]s to the liability of an organization, e.g. corporation, etc., it is usually the combined knowledge of the employees which is attributed to the organization”¹⁶⁰ Assistant Attorney General Richard K. Willard testified before the Subcommittee on Oversight of Government Management that:

[G]iven the realities of modern corporate structures, responsible officials may arrange deliberately to shield themselves from knowledge or will be reckless in their submission of claims to the Government. We simply have *297 to have a standard that is broader than actual knowledge in order to deal with the realities of the modern contracting process.¹⁶¹

As it applied to healthcare false claims specifically, the Executive's position on the duty to assure accurate claims was eventually codified into a memorandum to all US Attorney's Offices detailing guidelines for the prosecution of healthcare fraud.¹⁶²

Although Congress understood the possibility of benign mistakes where complex agreements governed claims,¹⁶³ it specifically designated complex corporate structures as a principal threat to the integrity of federal procurement programs.¹⁶⁴ The amendment's chief sponsor in the House, Representative Howard Berman, articulated several broad instances where a federal contractor may be found to have breached its duty to investigate.¹⁶⁵ Congressman Berman stated that, “Contractors who ignore or fail to inquire about red flags that should alert them to the fact that false claims are being submitted will be liable for those false claims.”¹⁶⁶ Berman also stated that, contractors who prepare reimbursement claims in a “sloppy or unsupervised fashion” should be held liable for violating the FCA.¹⁶⁷ The drafting committee's refusal to express a rigid definition of the duty that they intended to impose on government contractors was not driven by indifference to collective corporate knowledge, but rather the nearly countless circumstances under which parties submitted claims for payment to the government made it “impossible” to articulate the duty in the statute itself.¹⁶⁸

The 2009 Fraud Enforcement and Recovery Act, passed largely to address fraudulent behavior in the housing market that affected federally regulated and federally insured programs, included amendments to the False Claims Act to expand the reach of corporate agents that submitted *298 false claims or caused those claims to be submitted.¹⁶⁹ In 2008, the U.S. Supreme Court determined that the False Claims Act only reached general contractors, or the party actually presenting the claim to the government, not subcontractors or other parties who intended only to defraud the principal entity submitting claims to the government.¹⁷⁰ FERA overturned the decision, making clear that any party, even if it submitted a claim to an entirely private party, may be subject to False Claims Act liability.¹⁷¹ In other words, Congress stretched outside the typical boundaries of the firm, so that even parties with whom primary claims submitters contracted were potentially liable for False Claims Act violations.

The Affordable Care Act and Dodd-Frank Wall Street Reform Act similarly expanded the types of conduct for which False Claims Act liability would attach, implemented new protections for whistleblowers, and widened FERA's definition of acts protected by the retaliation cause of action.¹⁷² Despite the numerous sources of law that require corporations to effectively aggregate their employees' knowledge as well as the text and legislative history behind the

federal False Claims Act, federal courts have divided on the issue of whether a collective corporate knowledge doctrine is appropriate to determine liability under the law.

B. Collective Corporate Knowledge in the Federal Courts

The use of certain species of collective corporate knowledge doctrines has a long history in the federal courts in both the civil and criminal contexts.¹⁷³ In *U.S. v. T.I.M.E.-D.C., Inc.*, a federal district court imputed *299 the knowledge of dispatchers at a trucking company, who were aware of several drivers' reports of illness, to the corporation for purposes of assessing compliance with the Interstate Commerce Act.¹⁷⁴ T.I.M.E.-D.C., Inc., a motor carrier under federal law, maintained an unexcused absence policy under which, for calling in sick or injured, a letter would issue marking the absence as "unexcused."¹⁷⁵ Upon receipt of medical verification, the company would issue a second, "nullifying" letter.¹⁷⁶ The company posted no notice of the policy, relying on the "word-of-mouth" of its dispatchers, many of whom did not convey all aspects of the policy.¹⁷⁷ The effect was for impaired drivers to call in to dispatchers, be instructed as to the adverse employment action without being informed of the medical verification "exculpation" provision, and then drive while ill or injured.¹⁷⁸ The corporate defendant raised as a defense that it could not have knowingly and willingly violated federal motor carrier regulations because no manager knew impaired drivers were operating motor carriers.¹⁷⁹ The court rejected the defense determining that "a corporation cannot plead innocence by asserting that the information obtained by several employees was not acquired by any one individual employee who then would have comprehended its full import."¹⁸⁰ Under the court's ruling, the government was allowed to meet its evidentiary burden by showing that (1) dispatchers knew of impaired drivers and (2) separate firm managers knew federal law prohibited drivers so impaired from operating motor carriers.¹⁸¹

U.S. v. Bank of New England is considered the seminal case addressing collective knowledge.¹⁸² There, the First Circuit upheld a collective knowledge instruction in a prosecution under the Currency and Foreign Transactions Reporting Act,¹⁸³ allowing the jury to combine the separate *300 knowledge of bank employees who only knew about a client's large transactions and other employees who only knew about regulations requiring the transactions to be reported.¹⁸⁴ The appellate court upheld the trial court's jury instruction that the Bank's ". . . knowledge is the sum of the knowledge of all of the employees. That is, the bank's knowledge is the totality of what all the employees know within the scope of their employment."¹⁸⁵ The court concluded "[t]he aggregate of those components constitutes the corporation's knowledge of a particular operation. It is irrelevant whether employees administering one component of an operation know the specific activities of employees administering another aspect of the operation. . . ." ¹⁸⁶ The court clarified that even if separate employees only knew different parts of the reporting requirement, and never communicated their separate knowledge to each other, the bank was still deemed to know that the requirement existed.¹⁸⁷ "Since the Bank had the compartmentalized structure common to all large corporations, the court's collective knowledge instruction [is] not only proper but necessary."¹⁸⁸

After the First Circuit's decision in *Bank of New England*, several district courts permitted jury instructions allowing the use of the collective knowledge doctrine.¹⁸⁹ A D.C. District Court instructed a jury in a False Claims Act case specifically,¹⁹⁰ noting that it was proper since it had previously been applied in both the criminal and the civil contexts.¹⁹¹ In *United States v. Phillip Morris USA, Inc.*, the district court found that the use of the collective corporate

knowledge doctrine was appropriate in the civil RICO context, relying heavily on *Bank of New England* and tenets of agency law.¹⁹²

*301 1. Corporate Collective Knowledge Is a Logical Extension of Statutory Purpose and Agency Principles

In False Claims Act jurisprudence, collective corporate knowledge doctrines have been used relatively infrequently and their reception by federal appellate courts has been mixed. On one end of the spectrum, federal courts have determined that the legislative history as well as agency principles weigh in favor of the application of a collective corporate knowledge approach in False Claims Act cases. In *UMC Electronics v. United States*, the U.S. Court of Federal Claims referred to Berman's statements on the House floor as part of its support that "at a minimum, every party filing a claim before the contracting officer . . . has a duty to examine its records to determine what amounts the government already has paid or whether payments are actually owed to subcontractors or vendors."¹⁹³ The court held that disavowing such a duty among government contractors would open the door to fraudulent billing.¹⁹⁴

In *Miller v. Holzmann*, a case involving fraud in the award and execution of public works projects in Egypt, the D.C. District Court instructed the jury that "corporations are liable for the collective knowledge of all employees and agents within the corporation so long as those individuals obtained their knowledge acting on behalf of the corporation."¹⁹⁵ The D.C. Circuit affirmed, noting that "under basic principles of agency law, corporate defendants are charged with constructive knowledge of all material facts that their agents and officers learn in the scope of their employment."¹⁹⁶ While its order is less clear, the U.S. Court of Federal Claims, on a False Claims Act counterclaim, rejected the plaintiff's attempt to persuade the court to "follow several non-precedential opinions by other courts, holding that it is inappropriate to aggregate 'collective corporate knowledge' to satisfy the 'knowledge' element of the False Claims Act."¹⁹⁷ In that case, a government contractor argued that it could avoid False Claims Act liability because the person submitting claims for reimbursement from the government did not know *302 that the amounts included illegal rebates for one of the contractor's subsidiaries.¹⁹⁸

2. Collective Corporate Knowledge Is a Plausible (but Unnecessary) Theory

Other courts have accepted the possibility of using a collective corporate knowledge theory to analyze the statute's scienter requirement, but have found it inapplicable or unnecessary to do so.¹⁹⁹ In *United States v. United Technologies Corp.*, the U.S. District Court for the District of Connecticut reviewed the arguments for and against application of the collective corporate knowledge doctrine in a defense contracting context, but ultimately determined that "the facts of [the] case [do not] warrant the use of the collective corporate knowledge doctrine to impute knowledge to [[Defendant]]."²⁰⁰ That court treated the legislative history's vocabulary of "mere negligence" or "mistake" as something like an affirmative defense: "[Defendant] has succeeded in establishing that the facts of this case show that [its] actions were merely negligent, inadvertent or a mistake. . . ."²⁰¹

In *United States ex rel. Harrison v. Westinghouse Savannah River Co.*, the Fourth Circuit found that application of the collective knowledge doctrine was unnecessary, because one firm agent or employee did in fact have requisite knowledge although it left open the possibility of adopting the doctrine later.²⁰² In that case, the defendant corporation was found to have falsely attested to the Department of Energy that it did not have any organizational conflicts of interest that would interfere with the defendant's performance of a government contract.²⁰³ On appeal, the defendant argued for the adoption of a "single actor" standard, whereby scienter could only be proven if a single corporate officer or agent

possessed all the requisite knowledge.²⁰⁴ The court held that adopting the “single actor” standard would incentivize corporations to create offices isolated from the rest of the *303 corporate structure whose only purpose was to certify government contracts in effect shielding them from ever amalgamating the knowledge that might, in a False Claims Act action, be found to prove scienter.²⁰⁵

In the retaliation context, the Seventh Circuit rejected a relator's claim that he was terminated for identifying potential false claims because he could not show that his immediate supervisors ran red flags up to corporate decision-makers.²⁰⁶ The court refused to impute the supervisors' knowledge to the corporation concluding that “the law is clear that it is the decision-makers' knowledge that is crucial . . . companies are not liable under the False Claims Act for every scrap of information that someone in or outside the chain of responsibility might have” but conceded certain exceptions that might result in the application of a collective knowledge doctrine.²⁰⁷

3. Collective Corporate Knowledge Is Inconsistent With the False Claims Act's Language, Structure and Purpose

At the other end of the spectrum, the D.C. Circuit rejected the use of the collective knowledge doctrine in *United States v. Science Applications International Corp.*²⁰⁸ The defendant, a 14,000-employee large projects firm, was found to have violated the False Claims Act by submitting claims for payment on a consulting contract that attested the defendant was not advising other firms in the same field, when in fact it was.²⁰⁹ The purpose of the attestation was to insure that conflicts-of-interest did not interfere with the development of appropriate guidelines to dispose of radioactive waste for the Nuclear Regulatory Commission.²¹⁰ SAIC was advising both the NRC and two firms, British Nuclear Fuels, Ltd. and the Bechtel Jacobs Company, both of which undertook business activities that might be substantially affected by the regulations the NRC was promulgating.²¹¹ After the NRC discovered the conflict, the U.S. Department of Justice brought a False Claims Act suit because SAIC had sought claim for *304 payment that violated the conflict-of-interest terms of its engagement.²¹² The trial court instructed the jury that it could find the defendant liable both through “actual knowledge” and by using the collective knowledge doctrine.²¹³

SAIC argued that in order for the government to prove knowledge under the False Claims Act, it would have to demonstrate “that the defendant knew its claims or statements were false, not merely that the defendant knew underlying facts that were later assembled by the government to construct an allegedly false claim.”²¹⁴ Although the D.C. Circuit conceded that more than one employee at SAIC knew about the NRC's conflicts-of-interest policy and the materiality of that policy for payment of claims, the court nevertheless determined that the collective corporate knowledge instruction might be more than harmless error:

even though the jury might well have accepted SAIC's arguments that its compliance system was generally adequate and that individual employees with knowledge of the company's conflicting business relationships honestly and reasonably believed that these relationships created no potential conflicts, it still might have concluded based on the company's “collective knowledge” that SAIC knew about the conflicts.²¹⁵

The SAIC court determined that the use of the collective knowledge was inappropriate because it was inconsistent with what the court interpreted to be the FCA's language, structure, and purpose.²¹⁶ The court reasoned that this was inappropriate not only because it allowed the fact-finder to elevate negligence to fraud, but that in doing so the defendant

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could be liable for treble damages; something that it would not otherwise be liable for in a regular negligence or breach of contract action.²¹⁷

The D.C. Circuit conceded that False Claims Act liability attaches where a corporate defendant structures itself so as to avoid an amalgamation of the information necessary to prove that a false claim was *305 knowingly submitted.²¹⁸ The court cited the Senate Committee Reports from the 1986 amendments taking aim at corporate compartmentalization²¹⁹ but nevertheless concluded that a collective corporate knowledge instruction risked False Claims Act liability for negligent or even honest mistakes inconsistently with the statute's legislative history.²²⁰

The U.S. District Court for the Western District of Pennsylvania adopted the D.C. Circuit's reasoning in *United States v. Educational Management Corporation*, at least insofar as it rejected a per se collective corporate knowledge theory.²²¹ The district court determined that although the False Claims Act intended “to capture the ostrich-like conduct which can occur in large corporations where corporate officers insulate themselves from knowledge of false claims submitted by lower-level subordinates” it was not necessary since plaintiffs had adequately alleged scienter on the part of top managers.²²²

In *United States v. Fadul*, the government brought a False Claims Act suit against a doctor who owned a medical practice allegedly submitting fraudulent Medicare and Medicaid reimbursement claims.²²³ The defendant was alleged to have knowingly operated a billing system that regularly generated two bills for one medical treatment.²²⁴ The government's complaint further alleged that the defendant had been approached by his billing staff on several occasions with concerns about the operation of the billing system but that the defendant instructed the billing staff to continue billing as they had been.²²⁵ In the government's motion for summary judgment, it argued first that actual knowledge was present, but in the alternative it argued that collective knowledge would suffice to show scienter.²²⁶ The district court rejected the government's attempt to prove scienter through collective knowledge.²²⁷ Although the court followed the *306 *Harrison* holding where the corporate officer who has knowledge of the falsity need not also be the officer who submitted the claim, the *Fadul* court cited the D.C. Circuit Court's holding in *SAIC* in rejecting collective knowledge as an appropriate basis for scienter.²²⁸ The *Fadul* court concluded: “When the Government seeks to hold an entity liable under the False Claims Act, it cannot rely on the collective knowledge of the entity's agents to establish scienter. . . . Instead, the Government must prove an entity's scienter by demonstrating that a particular employee or officer acted knowingly.”²²⁹

C. Solving the Collective Corporate Knowledge Disagreement through Burden Shifting: Mere Negligence or Mistake as Affirmative Defenses

The D.C. Circuit's conclusion in *SAIC* is in tension with the legislative history and statutory purpose behind the False Claims Act, especially when read in light of amendments passed under the Fraud Enforcement and Recovery Act, Dodd-Frank, and the Affordable Care Act, all of which were preoccupied at least in large part with the threat large complex business structures posed to federal programs or federally insured programs. While it is true that Congress did not intend to ensnare firms that committed honest mistakes or “mere negligence”, the broader history suggests that for large business organizations or complex government contracting schemes, the duty to investigate the veracity of claims would grow correspondingly heavier. The effect of the D.C. Circuit's analysis is precisely the opposite of what Congress intended: instead of allowing the size of the firm to influence its duty to investigate, the decision effectively *allows firms to use their large size andlor complexity to evade liability*. Indeed, the decision closely tracks the views expressed by the

National Defense Industrial Association (NDIA) in an amicus curiae brief supporting SAIC.²³⁰ NDIA argued that the collective knowledge doctrine was both impractical and inappropriate in light of modern corporate structure.²³¹ NDIA stressed the problem of developing an infallible method of fusing “disparate pieces of *307 knowledge - particularly in a company with tens of thousands of employees and dozens of offices spread across the globe.”²³²

No court has explicitly tailored a False Claims Act defendant's duty to investigate the veracity of claims to the size and sophistication of the submitting party as Congress envisioned. To some extent this may reflect courts' hesitance to attempt to draw lines between large and small firms or they may simply be relying on the Department of Justice and US Attorneys' offices to filter their cases based on the strength of evidence regardless of entity size or sophistication.

What courts have done as an approximate proxy for entity size is to construct a series of affirmative defenses available to False Claims Act defendants who invoke a given reimbursement scheme's complexity.²³³ For example, in *United States ex rel. Hagood v. Sonoma County Water Agency*, the defendant was accused of submitting a contract that used an impermissible method to perform its cost analysis.²³⁴ The defendant claimed that its use of an improper cost calculation method did not fall within the statutory definition of “knowingly,” because the defendant believed its method was legal.²³⁵ Although the Ninth Circuit determined that the defendant's position was an issue for the fact-finder, it concluded that, “[t]o take advantage of a disputed legal question, as may have happened here, is to be neither deliberately ignorant nor recklessly disregarding.”²³⁶ In *Tyger Const. Co. Inc. v. United States*, in a situation factually similar to *Hagood*, the Court of Federal Claims held that “[a]ttaching . . . FCA liability to expressions of legal opinion would have an impermissibly stifling effect on the legitimate presentation of claims.”²³⁷

Similar to the defense of mistaken legal theory, it is possible, although untested, that a defendant may exculpate itself by arguing that it lacked appropriate guidance on how to properly submit a reimbursement claim or that the guidelines governing the claim were ambiguous.²³⁸ In *United States v. Krizek*, the government contended that the billing code the defendant *308 used covered only time spent working directly with the patient, not time outside the patient's presence working on his or her case.²³⁹ The court held that the government's contention was not supported by the actual language of the code, and that doctors should, “be given clear guidance as to what services are reimbursable.”²⁴⁰

Although implicit in the district court's decision in *United States v. United Technologies Corp.*, the burden-shifting approach to collective corporate knowledge cases effectively advance Congress's interest in holding large business organizations to a higher duty to investigate the veracity of claims while ensuring an adequate defense to genuine instances of mistake by government contractors. The government, of course, does not pursue collective corporate knowledge theories in every False Claims Act case. Indeed, such a theory is unnecessary when there is evidence of actual knowledge on the part of corporate decision-makers. By allowing the government to introduce a theory of collective corporate knowledge but allowing defendants an affirmative defense of mistake or mere negligence, the statutory scheme envisioned by Congress would be better respected than rejecting the theory outright.

It is also true that *after* a False Claims Act complaint is unsealed, law firms representing large firm defendants will assert their representation over current and former employees.²⁴¹ The principal purpose of that assertion (often made without having even contacted the employee in question) is to prevent government attorneys from interviewing the former employee without the primary defendant's knowledge.²⁴² The implication for purposes of the collective corporate knowledge doctrine, however, is clear: a defendant cannot have it both ways. Either the attorneys for the defendant *309 represent current and former employees (and thus are responsible for their collective knowledge) or they are not.

III. THE FALSE CLAIMS ACT AND THE FINANCIAL INTEGRITY OF THE AFFORDABLE CARE ACT

While challenges to the Patient Protection and Affordable Care Act have focused on core mechanisms like compelled participation in the insurance pool and the availability of subsidies for those purchasing insurance from federal exchanges, Congress was just as aware that healthcare fraud accompanying increased utilization, both from criminal activity and from large providers skirting rules on submitting appropriate claims. In 2008, the FBI arrested doctors and patients who submitted over 140,000 false claims for pretending to receive expensive HIV-drug treatments.²⁴³ On October 13, 2010, federal and state law enforcement officials indicted 44 individuals for billing Medicare for over \$100 million for “services” that were never provided at phantom clinics.²⁴⁴ One pharmacist bilked Medicaid for over \$1.8 million in less than a year by submitting phony claims for prescriptions that he never filled.²⁴⁵ Yet not all of the improprieties are committed by easily identifiable perpetrators. Because Medicaid and Medicare “pay and chase” - that is, reimburse claims as a matter of course and then pursue improper billing later - millions are also lost for services, drugs, or supplies that are unnecessary, not performed, or are of a lower quality or more costly than those that are actually administered or provided.²⁴⁶ “Major corporations such as pharmaceutical and medical device manufacturers and institutions such as hospitals and nursing facilities have also committed fraud, sometimes on a grand scale.”²⁴⁷ Physicians may refer patients to ***310** providers with whom they share a financial interest and create incentives to raise costs or pay kick-backs, but Congress has curtailed such practices with the Anti-Kickback Statute and Stark Law.²⁴⁸ In addition, providers benefit from what appear to be even benign mistakes. For example, charging a patient for an “office visit” when he or she only visited for a flu shot, is a tactic known as “upcoding” that results in a higher reimbursement for the health care provider.²⁴⁹

Moreover, insurance offered by private third party payers through state and federal exchanges has been interpreted under the Obama Administration as exempt from relevant fraud prevention laws.²⁵⁰ This interpretation, however, is likely to change as the affordability of the law comes under additional pressure.²⁵¹ For example, if it comes clear that insurers are accepting subsidies from the federal government in exchange for “phantom” enrollees, that interpretation of the law is likely to change.²⁵²

Prior to the passage of the Affordable Care Act, the General Accounting Office issued regular reports which indicated that CMS could not keep pace with enforcement demands. On June 28, 2005, the GAO reported that CMS had only 8 employees devoted to chasing down improper Medicaid billing.²⁵³ On March 3, 2010, the GAO reported that between 2005 and 2008, CMS had failed to ensure that Medicare Part D drug plan providers ***311** had implemented policies to prevent and catch fraud and waste.²⁵⁴ The same month, GAO reported that even where CMS or its agents had identified weaknesses in provider billing processes, CMS failed to act on its recommendations.²⁵⁵ The GAO reports focus generally on the universe of command-and-control and performance standards regulations that are in place but have not been implemented because the HHS OIG or CMS are unable - by virtue of resource scarcity - to coordinate or enforce. With the passage of the Affordable Care Act, Congress increased the budget for HHS's oversight activities by approximately \$35 million per year for ten years and mandated the development of better screening and data-sharing processes.²⁵⁶

A. Fraud Prevention and Enforcement and Healthcare Entitlements

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Despite the contentious, partisan disagreement over the Patient Protection and Affordable Care Act, one basic principle that commentators across the political spectrum agreed upon was the urgent need to address pervasive fraud in government funded health care programs.²⁵⁷ The Centers for Medicare and Medicaid Services (CMS) estimated that the United States spent \$2.4 trillion on health care in 2008, with a projected 5.8% per annum increase through 2022.²⁵⁸ One Government Accountability Office (GAO) report noted that from 1970 until 2009 health care spending in the federal *312 budget increased from approximately 8.3 to 26.9 percent.²⁵⁹ In real dollars “Medicare spending, which represents a large share of federal health care expenditures, is projected to increase from approximately \$519 billion in 2010 to approximately \$922 billion in 2020.”²⁶⁰

Government watchdogs have long known that Medicare and Medicaid are particularly susceptible to fraud, waste, abuse, and improper payments. The GAO has designated both Medicare and Medicaid as “high-risk” government spending programs.²⁶¹ The National Health Care Anti-Fraud Association (NHCAA) recently estimated that losses due to fraud accounted for at least 3% of all federal health care spending.²⁶² The Federal Bureau of Investigation (FBI) places the estimated losses even higher, having assessed that 10% of all federal health care spending was in response to fraudulent claims.²⁶³ In 2009 dollars, those estimates represented between \$70 billion and \$234 billion respectively.²⁶⁴ The GAO reported that hospitals alone accounted for “nearly 20 percent of the 2,339 subjects of civil fraud cases investigated in 2010.”²⁶⁵

In spite of conservative opposition to the passage of the ACA, the focus on health care fraud afforded an opportunity for bipartisanship. The legislative history is replete with both liberal and conservative commentators decrying the levels of fraud and waste within health care *313 systems.²⁶⁶ In floor debates from November through December 2009 Democratic Senators Max Baucus and Patrick Leahy were vocal advocates for the potential of the ACA's anti-fraud provisions to reduce future false claims.²⁶⁷ Conservatives, like Senators Mike Enzi and Tom Coburn argued, not that the ACA would increase fraud, but that the ACA's anti-fraud provisions did not go far enough.²⁶⁸ In testimony on the Senate floor, Senator Coburn argued that \$125 billion dollars a year was lost to “fraud, waste, and abuse” in Medicare/Medicaid.²⁶⁹

While the Affordable Care Act adopted specific measures aimed at the financial risk posed by fraud, those measures largely targeted new providers and those undertaking criminal, sensational, but often less impactful healthcare fraud. The Obama Administration established the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a cabinet level task force designed to reduce fraud.²⁷⁰ The ACA's anti-fraud provisions introduced the use of “sophisticated information-technology platforms, comprehensive data mining, and increased financial and human resources.”²⁷¹ The GAO said as much in a 2012 report: “Although targeting certain types of providers that CMS has identified as high risk may be useful, it may allow other types of providers committing fraud to go unnoticed.”

Together, hospital care, physician and clinical services, and prescription drugs account for approximately 62% of the nation's healthcare expenditures.²⁷² The healthcare sectors described below represent key vulnerabilities for the submission of false claims related to these sectors.

*314 1. Hospitals

Hospitals represent a key source of false claims because of the multiple ways in which claims may be coded, conditions of payment, and conditions of participation imposed by the Centers for Medicare and Medicaid Services and state agencies,

and the large, complex bureaucracy overseeing those processes.²⁷³ Indeed, not only are hospital systems consolidating and becoming larger and more complex, they are adding physicians as direct employees.²⁷⁴ The latter trend provides a larger incentive for hospitals to compensate physicians according to the value of their referrals, a practice that is not only illegal but raises the costs of care generally.²⁷⁵ Hospitals have been found to pay doctors above fair market value and in ways that were not commercially reasonable unless the value of the doctors' referrals was taken into consideration.²⁷⁶ As healthcare providers become larger and more complex, a collective corporate knowledge theory of liability will be necessary to effectively regulate that size and complexity.

In 2015, for example, nearly 500 hospitals nationwide paid more than \$250 million for implanting heart defibrillators in post-surgical patients whose recoveries may have avoided the necessity of such a device.²⁷⁷ The implication was that hospitals were violating standards of clinical care in order to receive the reimbursements Medicare and Medicaid paid for the implantations.²⁷⁸ Hospitals have also been found to double-bill federal reimbursement programs by charging for services provided as part of inpatient care, but also by seeking reimbursement for the same person when *315 he or she becomes an outpatient case.²⁷⁹ A similar scheme allowed hospitals to charge federal reimbursement programs for individual lab tests on a single sample, even when all necessary results could be obtained from a single test.²⁸⁰ “Because the Medicare program involves millions of claims submitted by thousands of providers, the cumulative effect of even small overpayments can involve billions of dollars in . . . losses.”²⁸¹

2. Pharmaceuticals

Prescription drugs account for between 9-10% of all health spending and pharmaceutical firms have long engaged in practices that raise the cost of drugs.²⁸² When contracting with the government directly, for example, for bulk purchases by the Veterans' Administration, pharmaceutical firms have made explicit promises as to favorable pricing that they have later violated.²⁸³ Pharmaceutical firms have paid direct and indirect inducements to physicians and other providers to both prescribe more expensive medications as well as to prescribe medications “off-label” or for conditions other than those approved by the Food and Drug Administration.²⁸⁴ Indeed, pharmaceutical firms have paid billions of dollars in settlements under the False Claims Act for inducements and off-label marketing of pharmaceuticals that raise prices for Medicare, Medicaid, and the Veterans' Administration.²⁸⁵

*316 Relatedly, pharmaceutical firms found guilty of these practices are also large and complex.²⁸⁶ Pfizer, the world's second largest pharmaceutical firm, employs nearly 80,000 people across multiple divisions.²⁸⁷ Merck has nearly 70,000 employees while Johnson & Johnson employs over 125,000 employees in a more complex business structure.²⁸⁸ Detailed below, these large, complex business organizations allow the development of vocabulary, divided roles, and implicit communication channels that facilitate the submission of false and fraudulent claims.

3. Hospice

Although not generally thought of as a core federal health expenditure, hospice - care for those patients with a diagnosis of six months or less to live if a terminal illness runs its normal course - is one of the fastest growing costs of federal reimbursement schemes, which began covering hospice in 1983.²⁸⁹ According to the National Hospice and Palliative Care Organization, the number of people using hospice increased from 495,000 in 1997 to 1.3 million in 2006--an increase of 162% during 10 years.²⁹⁰ While cancer remains the top diagnosis among hospice enrollments, its percentage

is decreasing as more patients are referred to hospice with diagnoses like Alzheimer's, dementia, and failure to thrive. Between 2002 and 2008, four in ten Medicare patients died while under the care of a hospice provider.²⁹¹

*317 The industry has changed form in response to the federal reimbursement scheme. In 1992, 13% of federally certified hospices were for-profit; in 1999 that number swelled to 27%.²⁹² By 2002, that number had grown to 47%.²⁹³ As of 2010, the Medicare Payment Advisory Commission estimated that there were 3,555 Medicare-certified hospices in the United States, over half of which were for-profit providers.²⁹⁴ For-profit providers accounted 'almost entirely' for the increase in providers after 2002.¹² In addition to the growth of for-profit hospices, they are also growing larger and, in those larger hospices, stays are getting longer.²⁹⁵

These numbers are consistent with an aging population that is increasingly burdened by cancer, diabetes, and heart disease. However, the numbers also reflect the enrollment of ineligible patients (in many cases, older people with virtually nothing wrong with them) and provision of care not justified by federal reimbursement rules.

For initial admission to hospice, a patient's status must be certified by his or her attending physician and a physician member of the hospice provider's interdisciplinary group; subsequent hospice periods need only to be certified by either the attending physician or a hospice physician, not both.²⁹⁶ In addition to being certified as terminally ill, when a patient elects to enroll in hospice he or she must agree to forego curative care and receive only palliative care for terminal illness.²⁹⁷ A recipient may initially enroll for two ninety day periods, followed by an unlimited number of sixty day periods.²⁹⁸ The patient must be recertified as terminally ill at the beginning of each period of care after the first.²⁹⁹ After eligibility is established, the federal hospice benefit generally provides four types of care: (1) inpatient respite care, (2) general inpatient care, (3) routine home care, and (4) continuous home care.³⁰⁰ Inpatient respite care allows for short-term *318 inpatient hospice services to provide relief to the patient's primary caregiver. General inpatient care is provided when the patient's pain and other symptoms cannot be adequately managed in any other setting. Routine home care is intended to be the primary type of care that hospice services provide. These are the general services provided to hospice patients; this care is usually given either at home or in a nursing facility. Routine home care provides the lowest daily reimbursement rate to the hospice provider.

Continuous home care is also rendered at the patient's home or a nursing facility; however, it is only furnished when medically necessary during a period of "crisis."³⁰¹ Continuous care is intended to be short term and patients should not generally be able to perform routine tasks or leave their place of care unnecessarily. Continuous or "crisis" care provides the highest level of daily reimbursement to the hospice provider. Hospice providers have been shown not only to enroll ineligible patients and keep ineligible patients on hospice care, but also to characterize their conditions so as to receive higher reimbursements even when there was no clinical indication warranting higher reimbursement level care.

B. The Affordable Care Act's Focus on Healthcare Fraud

To be sure, the Affordable Care Act included provisions aimed at addressing some of the problems posed by the inevitable increase in the submission of false claims, but it did not fundamentally alter the "pay and chase" model whereby claims are paid first and investigated later.³⁰² Indeed, the bulk of Congressional action to address fraud under the ACA was aimed at increasing the effectiveness of the Federal False Claims Act, ensuring that it would be the primary tool to protect against the risk that fraud would jeopardize the integrity of the health care reform law.

1. Affordable Care Act Measures to Screen High-Risk Providers and Add Compliance Requirements

The ACA created screening procedures for new health care providers seeking to obtain reimbursement, and imposed new compliance ***319** requirements on existing providers.³⁰³ The new screening procedures included assessing the risk levels of fraud, waste, and abuse by categories of providers.³⁰⁴ The ACA mandated that the OIG establish standards for provider compliance with reimbursement guidelines.³⁰⁵ Providers could be subject to these compliance programs for repeated suspicious or false claims.³⁰⁶ Additionally, the ACA imposes requirements for providers to disclose any affiliation with a provider that has “uncollected debt; has been or is subject to a payment suspension under a Federal health care program[]; has been excluded from participation under [Medicare], [Medicaid], or [CHIP]; or has had its billing privileges denied or revoked.”³⁰⁷ Upon such a disclosure (which are rarely imposed and, then, only upon small providers), the ACA allows CMS to deny or revoke enrollment if these affiliations pose an undue risk to the program's integrity.³⁰⁸ The Affordable Care Act provides \$350 million over 10 years (FY 2011 through FY 2020) through the Health Care Fraud and Abuse Control Account.

Finally, the ACA expanded the CMS “integrated data repository” to integrate data from all federal health care programs.³⁰⁹ The ACA notably mandated the centralization of claims data from Medicare, Medicaid and CHIP, the Veterans Administration, the Department of Defense, the Social Security Disability Insurance program, and the Indian Health Service in an effort to ease the job of law enforcement officials, such as HEAT strike forces, in identifying fraudulent claims.³¹⁰ The ACA's data sharing provisions also authorized greater access on the part of DOJ and HHS-OIG to claims and payment databases, and created a centralized repository of “false front providers” that have already been identified as nefarious defrauders.³¹¹

The ACA also altered Section 1877 of the Social Security Act, commonly referred to as the physician self-referral, or “Stark” law. The law ***320** forbids a physician from referring a patient to another medical provider or entity with whom the referring physician has a financial relationship.³¹² The law provides exceptions for ancillary services, such as x-rays and lab tests, performed in-office.³¹³ Under the ACA, however, physicians must now inform patients of alternative, out of office, sources for these ancillary services.³¹⁴ This change is predicated on the assumption that patients are rational decision makers and will discount the convenience of the in-office service for a lower cost service elsewhere.³¹⁵ Additionally, the ACA has imposed strict limits and compliance guidelines on physician owned specialty hospitals.³¹⁶ To some extent, this provision of the law may simply drive physician run specialty hospitals out of the market, further pressuring acquisition and consolidation by larger hospital systems.³¹⁷

2. The Affordable Care Act's False Claims Act Enhancements

Yet the attention Congress paid to the False Claims Act made clear that it would remain the centerpiece of Congressional measures under the law to protect against fraud. The False Claims Act is the “the weapon of choice in the federal government's battle against healthcare fraud.”³¹⁸ The Affordable Care Act explicitly expanded access to private litigants suing under the False Claims Act.³¹⁹ First, Congress directly linked the retention of overpayments to false claim liability. Under the Affordable Care Act, “overpayments” are defined as “any [Medicare or Medicaid] funds that a person receives or retains . . . to which the person, after applicable reconciliation, is not entitled.”³²⁰ Health care providers, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and drug plan sponsors must “report and return” any overpayments within 60 days after either the date on which the overpayment was identified or the date any corresponding cost report was due, whichever is later.³²¹ In addition, ***321** members of the health care

industry must submit notification in writing to the entity to which the overpayment was returned as to the reason of the overpayment.³²²

Second, Congress used the Affordable Care Act to expand access to whistleblowers who identify fraudulent practices by allowing them to use publicly disclosed information.³²³ Previously, such information was unavailable to them due to limiting court decisions that fashioned a “Public Disclosure Bar” to claims that relied in significant part on publicly available information.³²⁴ Section 10104(j)(2) of the law replaces the prior version § 3730(e)(4) of the FCA with new language that expands the scope of the original source exception and shifts the Public Disclosure Bar from a jurisdictional prohibition to a more flexible standard, with discretionary power held by the government.³²⁵ One important effect of the change is to enable whistleblowers to use information available from a state Medicaid *322 hearing or process in order to establish a claim under the FCA.³²⁶ These FCA amendments are not limited to qui tam cases involving federal health care programs.³²⁷

In the Fraud Enforcement and Recovery Act of 2009 (FERA), Congress included enhancements to the FCA. Most significantly for purposes of Medicare and Medicaid, Congress expanded the number of actors upon whom fraud would support a “claim” under the FCA; included the retention of government overpayments as a basis for FCA liability; broadened the scope of conspiracy under the FCA; enhanced protections for whistleblowers against retaliation; and, bolstered the government's investigative powers.³²⁸ For example, under judicial interpretations of the FCA prior to FERA, a skilled nursing facility might contract out certain physical therapy treatments.³²⁹ Because the physical therapy provider did not directly submit claims to Medicare or Medicaid, an FCA claim could not stand against the therapist.³³⁰ The amendments to the law corrected this defect. In the Dodd-Frank Wall Street Reform and Consumer Protection Act (financial reform law), Congress created a uniform three-year statute of limitations period for claims of retaliation by whistleblowers and widened FERA's definition of acts protected by the retaliation cause of action.³³¹ These measures demonstrate an identifiable intent from Congress to use “private attorneys general” in the expanding areas in which government payments are made and might be fraudulently obtained.

In 2003, Congress required Medicare (not Medicaid) to enact a pilot program whereby private auditing entities-- recovery audit contractors (RACs)-- would be given incentive to hunt down overpayments or *323 improper billing submissions by health care providers.³³² RACs typically review a sample of a health care provider's claims for a given period and determine an error rate. RACs then generalize the error rate over the universe of claims during the audit period to calculate an alleged overpayment amount.³³³ The amount sought to be recouped by CMS based on the extrapolation from a relatively small sample of claims billed can be large. The RACs are paid a contingency fee based on the overpayment amount, which may provide their auditors with an incentive to find claims that they contend should have been denied. Between 2005 and 2007, the private auditors returned \$693.6 million to the Medicare Trust Funds.³³⁴ The Affordable Care Act required States to contract with RACs for Medicaid audits.³³⁵ As with FERA and the financial reform law, the expansion of the RAC program shows a clear mandate from Congress to mobilize incentive-based regulation of healthcare providers that submit claims for reimbursement under Medicare and Medicaid.³³⁶

The ACA has also made it easier for federal prosecutors to arraign defendants on criminal charges under the federal Anti-Kickback statute. In addition to the traditionally proscribed acts of soliciting or taking bribes, the ACA expanded the law to include any remuneration for referrals paid by a federal health care program.³³⁷

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Read against the backdrop of these changes to the law under the Affordable Care Act and others, it is clear that Congress was focused upon the problem of large healthcare providers or suppliers and how to ensure that they were accountable for increased federal healthcare spending, both through the exchanges and through Medicaid. The use of collective ^{*324} corporate knowledge to achieve this level of accountability is clear when seen in the broader context.

IV. COLLECTIVE CORPORATE KNOWLEDGE AND THE FALSE CLAIMS ACT

Despite the availability of enormous amounts of data available from pleadings and court documents, there has been little if any scholarly effort to use False Claims Act litigation as a source for understanding the collective corporate knowledge problem in any discipline, including law.³³⁸ The government's theories range from deliberate systems design at the management level that avoid effective training of personnel, diffusion of functions within the firm that ensure that relevant knowledge will not reach decision-makers, the creation of specialized language within firms to obfuscate questions relevant to submitting claims, as well as relatively straightforward allegations that one or more persons lied to the government to steal taxpayer money.³³⁹ These theories are equally likely to explain other problems involving what corporations know and how that knowledge is managed--including for tortious conduct related to product liability, concealing relevant information from investors, or averting detection of risks to employee or community safety.³⁴⁰ The phenomena described below correspond to the healthcare sectors outlined above that have a disproportionate influence on U.S. federal health spending. Similar phenomena are likely to occur in sectors that regularly contract with the federal government like defense and munitions businesses, construction and civil engineering companies, technical and management services corporations, as well as financial services firms that cause false claims to be submitted in connection with federally insured or federally subsidized programs including housing and mortgages.

**325 A. Lexicology that Conceals Fraud*

Specific words and phrases play an important role in characterizing fraudulent activity or in encouraging employees to engage in fraudulent activity at the organizational level without knowing it at the individual level. For example, IPC, an employer of hospitalists--physicians who work exclusively within a hospital-- has occupied a role in the market for physicians by recruiting those with "little training or experience with appropriate billing procedures" and then creates a script whereby physicians bill for the highest level of reimbursement from federal programs possible-- even when that is not the accurate billing code.³⁴¹ In addition to encouraging physicians to think of consultations and interactions with other medical providers as "complicated" for purposes of direct billing, IPC also adopts as part of its incentive system language that encourages physicians to "catch up" to or "keep up" with high-billing peers, subtly suggesting that those high performers are doing something right instead of achieving results through illegal upcoding.³⁴²

When marketing its analgesic Bextra to physicians, Pfizer provided "scripts" to its sales agents that implied that Bextra was approved at higher doses than FDA had actually authorized and suggested that evidence supported its superiority to competitors.³⁴³ The sales agents generally had no knowledge about the embedded, implied false statements regarding the medication, which were fashioned by marketing directors who similarly had access to only narrow slices of the overall picture of FDA approvals and safety risks for varying dosages of Bextra.³⁴⁴ Similarly, Pfizer created promotional materials for its sales agents that confused "acute pain" with the medical term for the specific kinds of pain approved by FDA.³⁴⁵ High level managers at Pfizer would distribute questions without answers, encouraging lower-level sales staff to "fill in the blanks" with inaccurate, ^{*326} false answers.³⁴⁶ Sales staff were referred to as "Sharks" when receiving instructions on sales strategies.³⁴⁷

In the hospice sector, the government's complaint alleges that Vitas Hospice Services, LLC, the largest hospice provider in the U.S. and a subsidiary of the larger corporation, Chemed, that also controls Roto-Rooter, aggressively marketed hospice to patients, patients' families, and sources of referrals such as doctors and hospitals, often as a general form of skilled elder care rather than as a benefit intended for the terminally ill.³⁴⁸ Vitas employees misled patients by referring to continuous care--the highest reimbursement category--as "intensive comfort care" and represented that Medicare would routinely cover round-the-clock care in the absence of acute symptoms.³⁴⁹ In fact, hospice employees stated that "intensive comfort care" was available any time the patient was experiencing symptoms which "caus[ed] distress to the patient or family."³⁵⁰ Nurses routinely arrived at the homes or care facilities of continuous care patients to find the patients had left to attend social activities or were able to perform activities of daily living with little or no assistance.³⁵¹ Members of the medical staff were also ordered to begin continuous home care without a physician's order.³⁵² These practices were enabled by either willful or neglectful failures to educate employees as to continuous care eligibility criteria.³⁵³

Even when effective monitoring systems are in place, large business organizations may circumvent those systems by characterizing a practice or service in another way. For example, subsidiaries of Tenet Health Systems, a healthcare provider with 130,000 employees in at least two countries, entered into an agreement to provide "interpreter services" to clinics that served primarily undocumented pregnant Hispanic women when the arrangement appeared to in fact compensate that clinic for referring patients *327 to Tenet for their Medicaid-covered deliveries.³⁵⁴ The characterization allowed the agreement to evade corporate legal review.³⁵⁵

B. Signaling Tolerance of Fraud Through Hiring and Promotion Policies

In large firms, hiring, retention, and promotion decisions may be used to incentivize managers and employees to engage in fraudulent or illegal activity, while leaving scripts promoting those activities unstated and unwritten. These policies are often inextricably linked to the adoption of language structures that mask fraudulent activities described above.

As part of a nationwide scheme to increase inpatient admissions of patients eligible for federal reimbursement, Community Health Systems, Inc., the nation's largest hospital operator, adopted a policy whereby emergency room directors were required to provide written justifications for *not* admitting those patients after they received treatment in an emergency room.³⁵⁶ Hospitals have also relieved employees of their oversight responsibilities where they identified improper billing practices as well as demotion and dismissal.³⁵⁷

During Eli Lilly's campaign to "convert" patients taking competing drugs to its Prozac Weekly, Zyprexa, Evista, and Humulin pharmaceutical lines, sales representatives that engaged in practices that violated its "Red Book" of good sales practices were promoted.³⁵⁸ Relatedly, sales representatives who identified sales practices that suggested unethical or illegal behavior were "reprimanded and . . . forced to resign" from the company.³⁵⁹ Sales representatives' performance was measured by the number of off-label speakers and audio conferences each was able to arrange.³⁶⁰

*328 In the hospice context, patients have been referred to in aggregate as "census" and employees are rewarded for growing "census" and, correspondingly, sanctioned, demoted or fired for not meeting or exceeding "census" expectations.³⁶¹ The effect of the policies is to encourage employees to enroll ineligible patients for hospice care, and to retain those patients on hospice even after it becomes clear that they are not eligible:

Job retention at AseraCare was linked to maintaining census, or the number of patients for whom AseraCare could bill Medicare or other insurance. An auditor that AseraCare hired to review its internal hospice operations observed in its December 28, 2007 report that a decline in the number of patients was accompanied by a “reduction-in-force,” which in turn, made staff, concerned about losing their jobs, resistant to discharging patients. Specifically, the auditor, in its review of the Monroeville, Alabama office, cautioned that “[AseraCare] [s]taff are resistant to patient discharge” and are “concerned about layoffs if census drops.”³⁶²

Another hospice provider “took adverse employment actions against sales representatives who did not meet monthly admissions goals” but paid bonuses based on the number of patient admissions and the length of time they could get a patient to stay on hospice services.³⁶³

C. Shaping False Claims Through Training and Non-Training

Related both to the adoption of specific vocabulary, incentives and sanctions, firms also use the structure and content of training materials, or non-training in relevant federal payment conditions to encourage managers and employees to participate in activities that lead to false claims submissions.

In its complaint against IPC, the Hospitalist Company, the U.S. identified corporate training as an explanatory variable in physician billing practices:

***329** IPC trains and encourages its hospitalists to upcode. IPC's training can be seen by comparing the billing records of IPC hospitalists when they first joined IPC with the billing records of those same IPC hospitalists after they have received IPC's training and become assimilated into IPC's fraudulent culture. A review of the billing records submitted by 51 IPC hospitalists when they initially joined IPC reveals that those hospitalists, in connection with the patient admissions process, billed at the lowest level 6.9% of the time, the intermediate level 58.6% of the time, and the highest level 34.5% of the time. After receiving IPC's training, however, those percentages changed dramatically: those same hospitalists did not submit a single bill at the lowest level; only 8.9% of the bills were at the intermediate level; and over 91% of the bills were submitted at the highest level. The same pattern is evidenced in the bills submitted by those hospitalists in connection with patient discharge services. Before receiving IPC's training, those hospitalists used the lower of two possible discharge codes 93.3% of the time. After receiving IPC's training, those same hospitalists did not submit a single bill at the lowest level.³⁶⁴

This training is not as a general matter provided by physicians, but rather specially-trained staff who conduct one-on-one sessions that are in many ways not consistent with publicly available Medicare guidelines. Similarly Community Health Systems, Inc., the largest publicly traded operator of hospitals in the United States by number of facilities and net operating revenue, adopted an upcoding scheme by replacing medical staff with “case managers” to dictate patient discharge summaries.³⁶⁵ Those case managers received “coding education that was designed to” increase billing to federal programs.³⁶⁶

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In promoting unapproved uses for its blockbuster antidepressant Wellbutrin, GlaxoSmithKline distributed to its salesforce audiotapes from *330 an ostensibly neutral physician for *unapproved* uses of the drug before even fully instructing them on the only indication approved by the FDA-- depression.³⁶⁷ As part of marketing its post-menopausal osteoporosis treatment drug Evista, Eli Lilly promoted the use of free heel scans combined with coupons for free first time prescriptions of Evista.³⁶⁸ The heel scans were known to generate “false positives” for osteoporosis.³⁶⁹ Physicians were provided with the machine, a nurse/operator for the machine, as well as the Medicare reimbursement code for the test.³⁷⁰ “Lilly provided no information to the doctors or its sales representatives describing the severe diagnostic limitations of the heel tests.”³⁷¹

In its complaint against Vitas Hospice Services, LLC, the U.S. government outlines similar behavior with respect to Medicare eligibility rules for hospice admission and retention, noting that “One [medical director] stated that he received no training at all from Vitas on Medicare eligibility requirements for hospice, and that Vitas expected him to certify patients as eligible for hospice without making actual determinations that the patient had a prognosis of six months or less if their illness ran its normal course.”³⁷² In order to ensure that patients would meet the medical criteria to be enrolled in hospice, Vitas either provided their medical staff with inadequate training or no training in the requirements for enrollment under Medicare.³⁷³ Physicians and nurses who were aware of the proper policies were encouraged to bend or ignore Medicare rules.³⁷⁴ Members of the medical staff were expected to enroll patients without regard for their life expectancy or medical necessity.³⁷⁵ Vitas also employed field nurses to provide care to its hospice patients residing in skilled nursing facilities, assisted living facilities, and hospitals, but did not provide them adequate *331 training on the eligibility requirements for the Medicare hospice benefit.³⁷⁶ Vitas directed these untrained field nurses, as part of their job duties, to identify elderly people who were eligible for the Medicare hospice benefit, and to encourage the referral of elderly people to Vitas for end of life care.

D. Federal False Claims Act Litigation as a Source for Understanding How Institutions Shape Individual Behavior

These aspects of firm organization that facilitate illegal activity are intended to represent only three broad observations from false claims act litigation brought against healthcare or pharmaceutical firms. There are no doubt dozens or hundreds of additional patterns, systems, and structures that would inform current scholarship examining how firms affect individual behavior. In 2013 alone, 752 federal False Claims Act suits were filed, providing a trove of information revealed through initial complaints, answers, discovery disputes, dispositive motions, evidentiary submissions, and post-trial motions (although, as with most civil litigation, false claims act cases settle at a high rate).³⁷⁷

Yet neither legal scholars nor academics in other disciplines have fully appreciated the usefulness of False Claims Act litigation for one of the central questions debated across disciplinary lines. In the legal context, scholars are overwhelmingly focused on the False Claims Act's *qui tam* mechanism.³⁷⁸ David Freeman Engstrom has published a number of studies examining the False Claims Act's whistleblower provisions in the context of optimal regulatory design.³⁷⁹ Anthony Casey and Anthony Niblett examined the False Claims Act whistleblower provisions in contrast to the *332 SEC whistleblower provisions adopted as part of the Dodd-Frank Wall Street Reform Act.³⁸⁰ Health law scholars like Zack Buck, Joan Krause and David Kwok have focused on the effectiveness of the False Claims Act in securing the integrity of federally supported health programs generally (or accompanying problems like overtreatment), but have not examined the law for its relevance to how firms organize themselves and how fraud is perpetrated as a matter of economic organization.³⁸¹ Indeed, the body of scholarship devoted to the False Claims Act and collective corporate knowledge is largely written by members of the defense bar.³⁸²

Conversely, few scholars in the business ethics, communications, economics, or sociology disciplines resort to False Claims Act litigation when examining questions related to collective corporate behavior. Some attention is paid to specific episodes that tangentially implicate the False Claims Act-- like Lance Armstrong's liability to USPS for false statements on doping--but for the most part, publicly available litigation documents are not a principal source for scholars studying the problems of a firm's economic organization.³⁸³

What makes False Claims Act litigation even richer as a source for examination of collective corporate behavior is the role of dedicated *333 compliance systems that are intended to prevent violations of the law governing claims submissions. The US Department of Health and Human Services Office of Inspector General has promulgated guidelines for voluntary compliance programs for entities throughout the health care industry which serve as a template for, especially, large providers.³⁸⁴ The forms of fraud perpetrated by the large, complex business organizations analyzed above operate within these compliance systems, and in some cases, because of them.

Even where DOJ or HHS guidance does not provide the source of the compliance mechanism, violations of the False Claims Act are also undertaken by large business organizations operating under corporate integrity agreements, i.e., parts of settlements for prior violations that require adoption of policies intended to thwart reemergence of people or processes that increase the risk of submission of fraudulent claims.³⁸⁵ The purpose of a CIA is to establish a compliance program to, "provide for systemic and meaningful scrutiny of all claims. . .to assure that they will conform to program guidelines and are not fraudulent."³⁸⁶ Corporate integrity agreements are regularly used in settlements against large firms that have defrauded government funded healthcare services.³⁸⁷ Corporate integrity agreements are tailored to meet the specific defendant, but also generally contain the eight following components; 1) the hiring of a compliance officer and/or the appointment of a compliance committee; 2) the development of written standards and policies; 3) the implementation of an employee training program; 4) the retention of an independent auditor; 5) the establishment of a confidential disclosure program; 6) restricting the employment of ineligible persons; 7) the establishment of a system for reporting overpayments or other reportable events; and finally; 8) the establishment of a system to report compliance to the relevant government entity (usually the Office of the Inspector General).³⁸⁸ Thus, not only may specific corporate structures be analyzed using information available *334 through False Claims Act litigation, but also variables specific to firms that already operate substantial compliance regimes.

V. CONCLUSION

This Article has argued that the federal False Claims Act represents both an underappreciated source of data for investigating how firms shape individual behavior as well as a future challenge to the financial security of the 2010 Patient Protection and Affordable Care Act. At the heart of both those oversights is the role of collective corporate knowledge. The Article argues that the legislative history behind the False Claims Act endorse an approach by federal courts whereby the government is allowed to advocate a theory of collective corporate knowledge in proving false claims cases which, in turn, is subject to an affirmative defense available to defendants whereby they plead and prove that a false claim was the result of mistake or mere negligence.

Footnotes

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- 1 [Citizens United v. Fed. Election Comm'n](#), 558 U.S. 310, 394 (2010) (Stevens, J., dissenting) (“The basic premise underlying the Court’s ruling is its iteration, and constant reiteration, of the proposition that the First Amendment bars regulatory distinctions based on a speaker’s identity, including its ‘identity’ as a corporation.”); [Burwell v. Hobby Lobby Stores, Inc.](#), 134 S. Ct. 2751, 2755 (2014) (“Protecting the free-exercise rights of closely held corporations thus protects the religious liberty of the humans who own and control them.”); Tamara R. Piety, *Why Personhood Matters*, 30 CONST. COMMENT. 361, 365 (2015) (“Yet hostility to [distinctions between humans and corporations] is what *Citizens United* and its progeny reflect.”).
- 2 *See* [United States v. Bank of New England](#), 821 F.2d 844, 856 (1987) (“Corporations compartmentalize knowledge, subdividing the elements of specific duties and operations into smaller components. The aggregate of those components constitutes the corporation’s knowledge of a particular operation. It is irrelevant whether employees administering one component of an operation know the specific activities of employees administering another aspect of the operation: ‘[A] corporation cannot plead innocence by asserting that the information obtained by several employees was not acquired by any one individual who then would have comprehended its full import. Rather the corporation is considered to have acquired the collective knowledge of its employees and is held responsible for their failure to act accordingly.’”) (quoting [United States v. T.I.M.E.-D.C., Inc.](#), 381 F. Supp. 730, 738 (W.D. Va. 1974)); *see also* WILLIAM H. SHAW, BUSINESS ETHICS 164 (3d ed. 1998) (arguing that corporate structures dilute moral or ethical reasoning of individuals); Russell Mokhiber, Editor, Corp. Crime Reporter, Address at the Taming the Giant Corporation Conference, Washington D.C. (June 9, 2007), available at <http://www.corporatecrimereporter.com/twenty061207.htm> (“Corporate crime inflicts far more damage on society than all street crime combined.”).
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- 9 Paula Desio, Deputy General Counsel, U.S. SENTENCING COMM’N, *An Overview of the Organizational Guidelines*, <http://www.uscc.gov/sites/default/files/pdf/training/organizational-guidelines/ORGOVERVIEW.pdf>; Michael C. Jensen & William H. Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure*, 3 J. FIN. ECON. 305, 308

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12 See generally COMM. ON ASSURING THE HEALTH OF THE PUB. IN THE 21ST CENTURY, INST. OF MED., *THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY* (2003).

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15 *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2577 (2012); *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015). See generally U.S. GOV'T ACCOUNTABILITY OFF., GAO-14-705T, *PATIENT PROTECTION AND AFFORDABLE CARE ACT: PRELIMINARY RESULTS OF UNDERCOVER TESTING OF ENROLLMENT CONTROLS FOR HEALTH CARE COVERAGE AND CONSUMER SUBSIDIES PROVIDED UNDER THE ACT* (2014).

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138 *See id.* at 1132; *see also* UMC Elecs. Co. v. U.S., 43 Fed. Cl. 776, 793-94 (Fed. Cl. 1999) (adopting *Lorenzo* as controlling precedent and holding that acting in reckless disregard of the truth or falsity of a claim triggers FCA liability).

139 *See* Salcido, *supra* note 120, at 6.

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- 149 *Id.*
- 150 *Id.*
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- 163 *Id.*
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- 325 Under § 10104(j)(2) of the Affordable Care Act, the government now has the ability to control whether a qui tam complaint is dismissed based on publicly disclosed information. Section 10104(j)(2) provides:
Section (4)(A). The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed: (i) in a Federal criminal, civil or administrative hearing in which the Government or its agent is a party;(ii) in a Congressional, Government Accountability Office, or other Federal report, hearing, audit or investigation; or (iii) from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.
The Affordable Care Act also narrows the definition of publicly disclosed information and expands the scope of the original source exception. The new language also widens the definition of an "original source" by eliminating the requirement that a whistleblower have "direct" knowledge of facts underlying his or her allegations. A qui tam whistleblower need only have "knowledge that is independent of and materially adds to the publicly disclosed allegations...." Under the new law, a whistleblower's allegations can now be based on indirect information, provided those allegations add to information that is already contained in the public domain. The public disclosure must also result from a federal report, hearing, audit or investigation. Public disclosures in state or local government reports also no longer bar the whistleblower's claim.
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