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GIVE AN INCH, TAKE A MILE: THE SEVENTH CIRCUIT EXTENDS ESCOBAR'S IMPLIED FALSE CERTIFICATION THEORY

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INTRODUCTION

Health care is among the largest industries in the United States. In 2019, approximately \$3.8 trillion—17.7% of the country's Gross Domestic Product—was spent on healthcare services in the United States.¹ In 2020, despite a relatively slow year for the Federal Government combating healthcare fraud and abuse, it won more than \$1.8 billion in healthcare fraud and abuse judgments and settlements.² That same year the Department of Justice (“DOJ”) opened 1,148 new criminal investigations for healthcare fraud and abuse and 1,079 civil healthcare fraud investigations.³ The DOJ has recovered over \$62 billion through the False Claims Act (“FCA”) since Congress last amended it in 1986.⁴ The government attempts to restrain and prevent

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¹ NATIONAL HEALTH EXPENDITURE FACT SHEET, CENTS. FOR MEDICARE AND MEDICAID (2019), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet> (last visited Sept. 23, 2021).

² Annual Report of Department of Health and Human Services and Justice, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM FY 2020 1 (2021), <https://oig.hhs.gov/publications/docs/hcfac/FY2020-hcfac.pdf>.

³ *Id.*

⁴ Justice Department Recovers Over \$3 Billion from False Claims Act Cases in Fiscal Year 2019, DEP'T OF JUSTICE. (Jan.9, 2020),

fraud and abuse in health care by promulgating many statutes and regulations with which healthcare companies must comply.

The FCA is the primary tool used to curb fraud and abuse in health care.⁵ Fraud and abuse are perpetrated in health care in several ways, such as by physicians prescribing unnecessary care for patients, by medical and drug manufacturers paying kickbacks to physicians for improperly prescribing their devices and drugs, or by health insurers who submit reimbursements for health services to Medicaid or Medicare that were never actually provided.⁶ Since its inception, Congress has amended the FCA several times increasing civil penalties for fraud and abuse.⁷ Congress significantly strengthened the FCA in 1986⁸, concurrent with the shift towards health managed care—e.g. Preferred Provider Organizations, Health Maintenance Organizations, and Medicare Advantage Plans.

Health managed care plans were invented to restrain healthcare spending, increase the quality of health care, and reduce the fraud and abuse prevalent in the traditional Fee-for-Service (“FFS”) model—where physicians charge patients per service and insurance providers reimburse per service.⁹ In the context of fraud and abuse, the FFS model has been highly criticized for encouraging physicians to prescribe unnecessary medical tests or services to line their pockets;

<https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019>.

⁵ NATIONAL HEALTH EXPENDITURE FACT SHEET, *supra* note 1.

⁶ ALICE G. GOSFIELD & DANIEL F. SHAY, MEDICARE AND MEDICAID FRAUD AND ABUSE § 1:16 (18th ed. 2021).

⁷ Jacob J. Stephens, *Dicta Me This: Implied False Certification to Materiality Under the False Claims Act Post-Escobar*, 44 U. Dayton L. Rev. 273, 278 (2019) (“Congress amended the FCA in 1986 significantly increasing the amount in which the relator was entitled to in recovery and increased the damages from double to treble damages simultaneously raising the statutory penalty from \$2,000 to between \$5,000 and \$10,000 per false claim”).

⁸ *Id.*

⁹ GOSFIELD & SHAY, *supra* note 6 § 1:16.

not to mention medical manufacturers or pharmaceutical companies that may pay physicians kickbacks for sending patients their way.¹⁰

In the last several decades, health care insurance plans have shifted toward the managed care model that was created to decrease the risk fraud and abuse prevalent under the FFS model while providing improved, holistic health care to patients.¹¹ A Managed Care Organization (“MCO”) is a health care plan or company that attempts to focus on integrated care by linking patients with healthcare providers who are incentivized to manage costs that were previously inflated through the FFS model.¹² This model removes the negative incentives that exist in the FFS model because physicians and MCOs are not encouraged to supply more care than is necessary for the patient, thus, the government is less likely to be charged for care that patients do not require.¹³ MCOs are discouraged from overprescribing medical care through conditioning payments for healthcare services based on prearranged capitated amounts for patients rather than getting reimbursed per service—essentially the MCOs bear the risk of underpayment because capitation rates are fixed.¹⁴

Capitation rates are the most common mechanism by which the government pays MCOs.¹⁵ Capitation rates are calculated using actuarially sound methods based on beneficiaries’ health characteristics that make them more or less likely to require certain healthcare

¹⁰ *Id.*; see also Sharon L. Davies & Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?*, 31 Ga. L. Rev. 373, 379 (1997).

¹¹ *How do ACOs vs. MCOs Compare and Contrast?*, GEORGE WASHINGTON UNIV. SCH. OF BUS., (Mar. 3, 2021) <https://healthcaremba.gwu.edu/blog/how-do-acos-and-mcos-compare-and-contrast/>.

¹² *Id.*

¹³ GOSFIELD & SHAY, *supra* note 6 §1:16.

¹⁴ *Id.*; see also Joseph Heaton & Prasanna Tadi, *Managed Care Organization*. (Mar. 6, 2021) <https://www.ncbi.nlm.nih.gov/books/NBK557797/>.

¹⁵ *A Primer on Medicaid Managed Care Capitation Rates: Understanding How MassHealth Pays MCOs*, MASS. MEDICAID POLICY INST., 1 (Oct. 2015) <https://www.bluecrossmafoundation.org/sites/g/files/ksphws2101/files/2020-10/MMPI%20Primer%20on%20MCO%20Capitation%20Rates.pdf>.

services.¹⁶ Once beneficiaries are placed in the tier suited to their health characteristics, they receive access to any of the healthcare services outlined in their respective package (or tier). These types of MCO agreements with the government using capitation rates are termed “assumption of risk contracts” because the MCOs bear the risk of providing care to patients regardless of whether the fixed capitated amount covers the patient’s care.¹⁷ Conversely, if the beneficiaries do not utilize enough health services to max out the capitated amount allotted for their care, the MCO keeps the remaining funds.¹⁸ Fraud and abuse can be perpetrated in these agreements if too many beneficiaries are enrolled into a package that does not have enough resources, by placing beneficiaries in the wrong tier to save costs, or by denying beneficiaries care they are eligible to receive.¹⁹

Several courts have grappled with applying the FCA to MCOs with fixed capitation rates for enrolled beneficiaries. The Supreme Court tackled this issue most recently in *Universal Health Services, Inc. v. United States and Massachusetts, ex rel. Julio Escobar and Carmen Correa* (“*Escobar*”), when it interpreted the FCA to include an implied false certification theory of liability.²⁰ The implied false certification theory provides a basis for liability by stating that an organization’s submission for reimbursement implies that the organization met its obligations to the government when in reality the organization omitted some fact that renders the submission misleading.²¹ Under the implied false certification theory, omissions become false claims only if they are material to the agreement the

¹⁶ Patrick C. Alguire, *Understanding Capitation*, AM. COLL. OF PHYSICIANS, <https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/guidance/understanding-capitation> (Dec. 3, 2021).

¹⁷ *A Primer on Medicaid Managed Care Capitation Rates: Understanding How MassHealth Pays MCOs*, *supra* note 15.

¹⁸ *Id.*

¹⁹ GOSFIELD & SHAY, *supra* note 6 §1:16.

²⁰ 579 U.S. 176, 177 (2016).

²¹ *Id.* at 181. (Clarifying that the FCA implied false certification theory can provide the basis for liability when the defendant submits a claim “for payment that makes specific recommendations about the goods or services provided” and that “liability may attach if the omission renders those representations misleading”).

organization has with the government.²² Proving liability under this theory requires greater evidence than an organization's mere non-compliance with a "particular statutory, regulatory, or contractual requirement as a condition of payment."²³ The Supreme Court in *Escobar* outlined two conditions that must be satisfied to find liability under this theory: "first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant's failure to disclose noncompliance with *material* statutory, regulatory, or contractual requirements makes those representations misleading half-truths."²⁴

While *Escobar* expanded the FCA to include the implied false certification theory of liability, it did not alter the materiality element.²⁵ *Escobar* cited both common law standards of materiality and the statutory definition.²⁶ The Restatement (Second) of Contracts defines materiality as a misrepresentation likely to induce a reasonable person, or the government, to "manifest his assent" to payments.²⁷ The FCA defines materiality as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."²⁸ Justice Thomas's dictum in *Escobar* described several examples of evidence to show materiality at the pleading stage. However, the Seventh Circuit took it upon itself to lessen the claimant's burden to show materiality at the pleading stage by

²² *Id.* at 181.

²³ *Id.* at 194.

²⁴ *Universal Health Servs., Inc. v. U.S. and Mass., ex rel. Julio Escobar and Carmen Correa*, (Escobar), 579 U.S. 176, 188 (emphasis added).

²⁵ *Id.* at 193. See also Deborah R. Farringer, *From Guns That Do Not Shoot to Foreign Staplers Has the Supreme Court's Materiality Standard Under Escobar Provided Clarity for the Health Care Industry About Fraud Under the False Claims Act?*, 83 BROOK. L. REV. 1227, 1232 (2018).

²⁶ *Escobar*, 579 U.S. at 193.

²⁷ *Id.* (citing Restatement (Second) of Contracts § 162(2), and Comment c, pp. 439, 441 (1979)).

²⁸ 31 USCA § 3729(b)(2)(B)(4).

expanding the type of evidence appropriate to meet this burden under the implied false certification theory.²⁹

In *United States ex rel. Prose v. Molina Healthcare of Illinois, Inc.* (“*Prose*”), the Seventh Circuit held that materiality is met where the MCO is a “highly sophisticated member of the medical-services industry.”³⁰ This holding requires an MCO to know whether an omission of non-compliance with a “particular statutory, regulatory, or contractual requirement”³¹ is material to the government’s contract purely by the MCO’s membership in the health care industry—essentially the MCO must guess what is material to the government. The Seventh Circuit loosening the materiality element is contrary to Justice Thomas’ dictum in *Escobar* describing how materiality is to be interpreted under the implied false certification theory.³² In disregarding the examples Justice Thomas laid out in *Escobar*—which lower courts have ascribed to since—the Seventh Circuit lessens the materiality burden at the pleading stage for claimants which will inevitably lead to frivolous FCA litigation. The FCA has a heightened pleading standard for a reason, to prevent the statute from being used as a tool for enforcing breaches of contractual obligations or compliance violations, rather its purpose is to prevent fraudsters from getting the government to pay false claims.³³

This article examines how the *Prose* majority’s implementation of materiality under the FCA’s implied false certification theory deviates from the Supreme Court’s guidance in *Escobar*. By interpreting an MCO’s membership in the medical services industry as evidence that the MCO knew the materiality of a specific contract provision, the Seventh Circuit renders the materiality element toothless and ignores the complexity of issues with which MCOs grapple. This article first discusses the history of MCOs in the context of healthcare fraud and abuse, including the multitude of

²⁹ See *U.S. ex rel. Prose v. Molina Healthcare of Ill., Inc.*, 10 F.4th 765, 770 (7th Cir. 2021).

³⁰ *Id.*

³¹ *Escobar*, 579 U.S. at 194.

³² *Id.* at 195.

³³ *United States ex rel. Prose, Inc.*, 10 F.4th at 772.

governing statutes and regulations demanding MCO compliance. The discussion then turns to an analysis of *Prose* in the context of *Escobar* and post-*Escobar* case law. Finally, this article addresses the continued controversy surrounding the post-*Escobar* evidentiary theories of materiality under the implied false certification theory and the future impact on MCOs facing FCA claims.

BACKGROUND

A. History of Health Managed Care Organizations

Managed healthcare plans are by no means a new concept. In fact, the first managed healthcare plan in the United States dates back to 1929 in a small Oklahoma farm community.³⁴ During the Nixon Administration, Congress enacted the Health Maintenance Organization Act of 1973 to restrain national healthcare spending while encouraging competition in healthcare markets.³⁵ In the 1990s, commercially managed healthcare plans began to take off, especially employer-based managed care plans.³⁶ In 1996, the Health Insurance Portability and Accountability Act established a funds program, which uses funds collected through health fraud and abuse investigations to combat fraud in both public and private health plans.³⁷ Today over 69% of Medicaid³⁸ and approximately 75% of privately insured³⁹ beneficiaries are enrolled in managed healthcare plans.

³⁴ *A Brief History of Managed Care*. NAT'L COUNCIL ON DISABILITY (2015, July 30) <https://www.ncd.gov/policy/appendix-b-brief-history-managed-care>.

³⁵ *Id.*

³⁶ *Id.*

³⁷ 978. *Health Care Fraud and Abuse Control Program and Guidelines*. DEP'T OF JUST. ARCHIVES. (Jan. 21, 2020) [<https://www.justice.gov/archives/jm/criminal-resource-manual-978-health-care-fraud-and-abuse-control-program-and-guidelines#intro#intro>]. [Check Rule 18.2.1(d) for how to cite archival doc].

³⁸ Elizabeth Hinton & Marybeth Musumeci, *Medicaid Managed Care Rates and Flexibilities: State Options to Respond to COVID-19 Pandemic*, KFF (Sept. 9, 2020) <https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/>.

Since the 1980s, private health plans have increasingly shifted to managed care.⁴⁰ Managed care covers many forms of financial arrangements for providing health care in ways meant to control healthcare costs.⁴¹ Healthcare costs are reduced in managed care through adjusting insurance and medical providers' behaviors under best practice clinical standards, introducing financial incentives to limit medical costs, and integrating care delivery practices for beneficiaries.⁴² Capitated MCOs are now the dominant way for states to deliver Medicaid services to beneficiaries.⁴³ While the jury is out on how well MCOs restrain healthcare spending, several early studies conducted by economists at the National Bureau of Economic Research found that MCOs have been successful in decreasing healthcare spending.⁴⁴ For example, one study found private MCOs can reduce spending because for every 10% increase in beneficiary enrollment, health spending was reduced by 0.5% per year; another study found hospital costs went down per admission because MCO beneficiaries had shorter lengths of stay, and a third study found requirements that MCOs update healthcare providers clinical practice standards restrained traditional FFS expenditures.⁴⁵

In the 1990s, several legal scholars considered how this new model for providing health care could reduce fraud and abuse.⁴⁶ The traditional FFS model fosters fraud and abuse through providers who encourage patient overutilization of healthcare services, induce

³⁹ *Managed Care Has Slowed Growth in Medical Spending*. National Bureau of Economic Research. (May 1998) <https://www.nber.org/digest/may98/managed-care-has-slowed-growth-medical-spending>.

⁴⁰ *Id.*

⁴¹ Davies & Stoltzfus Jost, *supra* note 10, at 379.

⁴² *Id.*

⁴³ Hinton & Musumeci, *supra* note 38.

⁴⁴ *Managed Care Has Slowed Growth in Medical Spending*, *supra* note 39.

⁴⁵ *Id.*

⁴⁶ Gail B. Agrawal, *Fraud and Abuse in an Era of Managed Care*, AHLA-PAPERS (Jun. 28, 1998) (arguing that while fraud and abuse still exist under MCOs, MCOs are more incentivized by both contractual and legal obligations to detect and prevent abusive and fraudulent practices within their organizations as compared to the traditional FFS model). *See also* Davies & Stoltzfus Jost, *supra* note 10.

physician referrals for kickbacks, and submit false claims for services that were not rendered—essentially allowing providers to earn more pay for unnecessary or sometimes non-existent health care rather than quality health care.⁴⁷ Although MCOs were created to obviate traditional forms of fraud and abuse pervasive in the FFS model, critics readily pointed out the many ways in which MCOs can still commit fraud and abuse.⁴⁸

The MCO model engenders opportunities for fraud and abuse, such as underutilizing medically necessary services, enrolling too many beneficiaries in an MCO plan, and providing lower-quality healthcare to retain unused funds.⁴⁹ Thus, several statutes and regulations have been enacted to curb the potential for fraud and abuse in MCOs.⁵⁰ Despite skepticism as to how successful the MCO model would be in limiting healthcare fraud and abuse, over thirty-nine states have now adopted MCOs as the major delivery system for their Medicaid programs.⁵¹ MCOs have become so popular in the last few decades because MCOs can provide care that the FFS model does

⁴⁷ James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205, 205 (1996).

⁴⁸ Davies & Stoltzfus Jost, *supra* note 10, at 395 (arguing that fraud and abuse are persistent in the managed care context but it's much harder to detect underutilization of health services and poor-quality health services are more difficult to prove).

⁴⁹ Paul R. DaMuro, *Fraud and Abuse By and Against HMOs and Other MCOs*, AHLA-PAPERS (Oct. 2, 1996). See also Davies & Stoltzfus Jost, *supra* note 10, at 393.

⁵⁰ 901. *Scope of the General Statutes Prohibiting Fraud Against the Government*, DEP'T OF JUST. ARCHIVES. (January 21, 2020) [<https://www.justice.gov/archives/jm/criminal-resource-manual-901-scope-general-statutes-prohibiting-fraud-against-government>] (the Health Care Fraud and Abuse Control Program outlines the many federal, state, and local law enforcement mechanisms for combating healthcare fraud and abuse and is enumerated further in subsection C of this comment).

⁵¹ *Illinois' Massive Shift to Managed Care*, ILL. COMPTROLLER 3 (May 2019) <https://illinoiscomptroller.gov/news/fiscal-focus/illinois-massive-shift-to-managed-care/>.

not.⁵² They do not pay providers per service but offer bundled services that may include preventative services, disease management, and care coordination (i.e., networks of doctors, specialists, and hospitals) to increase beneficiaries' healthcare options.⁵³ As MCOs have become ever more popular due to their success in reducing healthcare spending, they have also been increasingly subject to compliance and regulatory restrictions.

B. Managed Care Organizations in Illinois: A Case Study

Approximately thirty-two states have enacted their versions of the FCA.⁵⁴ The Illinois FCA essentially mirrors the federal FCA.⁵⁵ The Illinois Department of Human Services ("IDHS") defines MCOs as "healthcare provider[s] that provide[] services for a set monthly fee."⁵⁶ IDHS goes on to describe MCOs as Health Managed Care Organizations ("HMOs") and Managed Care Community Networks ("MCCNs"), both risk-bearing entities—meaning they assume the risk of underpayment characteristic of MCOs.⁵⁷ Despite its late start in adopting MCOs in the 2010s, Illinois is now one of the twenty-eight states that have at least 80% of their Medicaid programs delivered through MCOs.⁵⁸ Illinois MCO legislation activities began in earnest

⁵² Robert Book, *Benefits and Challenges of Medicaid Managed Care*, FORBES (Oct. 19, 2012) <https://www.forbes.com/sites/aroy/2012/10/18/benefits-and-challenges-of-medicare-managed-care/?sh=7e628ea7720f>.

⁵³ Book, *supra* note 52. See also Gaby Roman, *What is "Managed care," and how is it working for Illinois' Medicaid program?*, CTR. FOR TAX AND BUDGET ACCOUNTABILITY, (April 22, 2019) <https://budgetblog.ctbaonline.org/what-is-managed-care-and-how-is-it-working-for-illinois-medicare-program-e5229a9ef2dc>.

⁵⁴ *States False Claims Act*, PIETRAGALLO GORDON ALFANO BOSICK & RASPANTI, LLP, (Last visited November 9, 2021) <https://www.falseclaimsact.com/states-municipalities-fcas/>.

⁵⁵ See generally *Illinois False Claims Act, 740 ILCS 175/1, et seq.*

⁵⁶ Policy Manual 20-24-00: Managed Care Organization (MCO). IDHS. (2020) <https://www.dhs.state.il.us/page.aspx?item=18089>.

⁵⁷ *Id.*

⁵⁸ *Illinois' Massive Shift to Managed Care*, *supra* note 51 at 3 (as of 2018, thirty-nine states utilize MCOs for at least part of their Medicaid Programs, twenty-

in 2011 with the goals of increasing efficiency through healthcare coordination and cutting down on waste.⁵⁹ In 2012, the Illinois legislature passed the Save Medicaid Access and Resources Together (“SMART”) Act which increased cost-sharing measures, stringent monitoring standards for MCOs, and an beneficiary eligibility system to accommodate the Affordable Care Act.⁶⁰

In 2019, the Illinois Comptroller, along with other critics, expressed concerns that relying on private MCOs decreases transparency and leads to less government control over the MCOs.⁶¹ Much of the criticism of MCOs concerns the lack of data collected about MCO patient care delivery and the fear that MCOs save money at the expense of denying care to patients in need.⁶² The Illinois Hospital Association, along with other organizations and politicians, has successfully lobbied for renewed transparency and data collection activities required of Illinois MCOs.⁶³ MCOs are still the preferred method for managing Illinois Medicaid and Medicare programs, thus these reforms are vital to assess MCO success at providing improved patient care while saving the state money. MCOs are responsible for adhering to these new state regulations in addition to a multitude of federal statutes and regulations. Illinois’ reliance on private MCOs illustrates both the high potential for fraud and abuse and the need for transparent fraud and abuse laws so that MCOs may ensure their compliance.

eight of which, including Illinois, have 80% of their Medicaid systems under MOCs).

⁵⁹ *Id.* at 5.

⁶⁰ *Id.* at 6.

⁶¹ *Id.*

⁶² *Illinois’ Massive Shift to Managed Care*, *supra* note 51 at 8. *See also* Roman, *supra* note 43. These criticisms can be viewed with some skepticism as they came in the wake of the state’s recovery from a two-year budget standoff between political parties which caused the state to stop paying private MCOs capitated payments for Medicaid beneficiaries which could explain some of their denials for beneficiaries.

⁶³ *Illinois’ Massive Shift to Managed Care*, *supra* note 51; *see also* IHA Summary: Medicaid Managed Care and Prior Authorization Reform Bill, ILL. HEALTH AND HOSP. ASS’N, (July 6, 2021) <https://www.team-iha.org/files/non-gated/advocacy/managed-care-bills-memo-07-06-2021.aspx?ext=.pdf>.

C. Current Laws and Regulations Governing Managed Care Organizations

Many mechanisms exist for policing MCOs in federal, state, and local laws and regulations. MCOs potential for fraud and abuse is closely monitored by state and federal government agencies plus private citizens who can bring FCA claims on behalf of the government. The major mechanism for controlling fraud and abuse in healthcare was created through the Health Insurance Portability and Accountability Act (“HIPAA”) of 1996.⁶⁴ HIPAA established the Health Care Fraud and Abuse Control Program to combat fraud and abuse committed against all health plans.⁶⁵ Congress has enumerated many statutes to combat all types of fraud and abuse against the government, which fall under five general categories: false claims, conspiracy, false statements, mail fraud, and wire fraud.⁶⁶ The most pertinent statute for fraud and abuse in the healthcare industry is the False Claims Act. The FCA, originally enacted during the Civil War, is now integral in policing healthcare fraud and abuse.⁶⁷

The FCA penalizes presenters of false claims for payment or approval against the government.⁶⁸ FCA violations can result in hefty civil penalties for healthcare organizations.⁶⁹ Civil penalties for false claims are hefty, charging no less than \$5,000 and no more than

⁶⁴ 978. *Health Care Fraud and Abuse Control Program and Guidelines*, *supra* note 37.

⁶⁵ *Id.* The program provides many enforcement mechanisms through the coordination of various federal agencies, state regulators, and criminal and civil penalties for violators. Enforcement objectives are supported by required audits, investigations, and evaluations of the delivery and payment of healthcare services to MCOs.

⁶⁶ 901. *Scope of the General Statutes Prohibiting Fraud Against the Government*, *supra* note 50.

⁶⁷ See *Universal Health Servs., Inc. v. U.S. and Mass., ex rel. Julio Escobar and Carmen Correa, (Escobar)*, 579 U.S. 176, 181 (2016).

⁶⁸ 901. *Scope of the General Statutes Prohibiting Fraud Against the Government*, *supra* note 50.

⁶⁹ 31 U.S.C.A. § 3729(a)(1)(G).

\$10,000 per false claim, plus up to three times the amount of damages the government sustains because of such claims.⁷⁰ Several federal agencies are responsible for combating healthcare fraud and abuse and do so by implementing regulations for health care organization compliance. The DOJ is responsible for enforcing criminal fraud and abuse provisions through investigating and bringing FCA claims against health care organizations.⁷¹ The Office of Inspector General together with the Department of Health and Human Services (“HHS”) are charged with investigating and mitigating fraud and abuse in Medicaid and Medicare programs specifically.⁷² The FCA also creates a right of action by which private parties, called relators, can bring an FCA claim against healthcare providers or MCOs on behalf of the government in what is known as a *qui tam* lawsuit.⁷³

In addition to federal and state statutes which govern fraud and abuse claims, the Centers for Medicare and Medicaid Services (“CMS”) also executes regulations and penalties on MCOs that contract with the government.⁷⁴ The ultimate penalty that CMS exacts is exclusion from participation in Medicare and Medicaid for at least five years.⁷⁵ CMS may impose civil liability for deficiencies in MCOs that have adverse effects or have a substantial likelihood of adversely affecting beneficiaries’ care.⁷⁶ For example, an MCO could enroll more beneficiaries than it has the resources to provide for, thus failing to provide proper services to its existing beneficiaries. Compliance

⁷⁰ 31 U.S.C.A. § 3729(a)(1)(G).

⁷¹ 978. *Health Care Fraud and Abuse Control Program and Guidelines*, *supra* note 37.

⁷² *Id.*

⁷³ 31 U.S.C.A. § 3730(c) (in “qui tam” lawsuits relators are entitled to a percentage of any judgments or settlements awarded to the government in a qui tam lawsuit).

⁷⁴ GOSFIELD & SHAY, *supra* note 6, § 1:3.

⁷⁵ Davies & Stoltzfus Jost, *supra* note 10 at 377 (citing 42 U.S.C.A. § 1320a-7(a)-(c)).

⁷⁶ GOSFIELD & SHAY, *supra* note 6, § 1:3 (CMS also imposes civil penalties of \$25,000 for deficiencies that adversely affect or have a substantial likelihood of adversely affecting beneficiaries’ health care and may impose up to \$100,000 for deficiencies that remain uncorrected).

programs are another major requirement CMS imposes on MCOs to help prevent fraud and abuse.⁷⁷ The collective force of all these agencies' efforts to prevent and investigate potential fraud and abuse leads to a veritable minefield of compliance obligations for MCOs. As a result, MCOs are often faced with balancing compliance priorities. Clarity is essential in compliance requirements for MCOs to avoid facing fraud and abuse claims.

D. Legal Landscape of the False Claims Act

The FCA was enacted by Congress at the height of the Civil War in response to dishonest vendors who were defrauding the government through the sale of defective, worthless, and nonexistent goods.⁷⁸ Today the FCA remains focused on actors who “present or directly induce the submission of false or fraudulent claims” to the government.⁷⁹ The FCA imposes civil liability on anyone who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval” to the government.⁸⁰ To prove a claim under the FCA the following four elements must be satisfied: “(1) the defendant made a statement to receive money from the government; (2) the statement was false; (3) the defendant knew that the statement was false; and (4) the false statement was material to the government's decision to pay or approve the false claim.”⁸¹

⁷⁷ GOSFIELD & SHAY, *supra* note 6, § 1:16.

⁷⁸ *Universal Health Servs., Inc. v. U.S. and Mass., ex rel. Julio Escobar and Carmen Correa*, (Escobar), 579 U.S. 176, 181 (2016); *see also* Stephens, *supra* note 7, at 276.

⁷⁹ 31 U.S.C. § 3729(a)(1)(A).

⁸⁰ 31 U.S.C. § 3729(a)–(b). The FCA defines the following relevant terms: “claim” as including direct requests for payment or reimbursement from the government made by recipients of federal funds; “material” as “having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property”; and “knowing” and “knowingly” as anyone with “actual knowledge of the information.”

⁸¹ *United States ex rel. Nedza v. Am. Imaging Mgmt., Inc.*, No. 15 C 6937, 2019 WL 1426013, at 5 (N.D. Ill. Mar. 29, 2019). *See* Part I of this comment for a discussion of the theories of liability under the FCA.

Arguably, the most difficult element for claimants to meet, particularly at the pleading stage, is the materiality requirement.⁸² Under the statute, material “means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.”⁸³ The Restatement (Second) of Torts states a “misrepresentation is material” only if it would “‘likely . . . induce a reasonable person to manifest his assent,’ or the defendant ‘knows that for some special reason [the representation] is likely to induce the particular recipient to manifest his assent’ to the transaction.”⁸⁴ At the pleading stage, the FCA has a heightened pleading requirement under Rule 9(b) of the Federal Rules of Civil Procedure, which requires that the party alleging fraud or mistake “must state with particularity the circumstances constituting fraud or mistake.”⁸⁵ The reason behind the heightened pleading standard for FCA claims is to weed out those claims that are more appropriately brought as a breach of contract action or failure to comply with other statutes or regulations rather than actual attempts at defrauding the government.⁸⁶

The two main theories of liability under the FCA are “express certification” and “implied certification.”⁸⁷ Like their names indicate, “express certification” theory describes those claims based on actual false statements made to the government, whereas “implied certification” occurs when an actor seeks payment from the government without disclosing any violations it made which affect its eligibility for payment.⁸⁸ Until the Supreme Court's decision in *Escobar* in 2016, a circuit split existed as to whether the theory of

⁸² See Stephens, *supra* note 7, at 275.

⁸³ 31 USCA § 3729(b)(4).

⁸⁴ Escobar, 579 U.S. at 188 (citing Restatement (Second) of Torts § 538).

⁸⁵ Fed. R. Civ. P. 9(b) (although the rule clarifies that the scienter requirement may be alleged generally).

⁸⁶ Morgan Gray, *Loosen Up: Breaking Free from Strict “With Particularity” Requirements When Pleading Fraud for Qui Tam Actions Brought Under the FCA*, 49 Creighton L. Rev. 415, 416 (Mar. 2016).

⁸⁷ ROBERT JOHN KANE, *THE LAW OF MEDICAL PRACTICE IN ILLINOIS*, § 18:5 (3d ed. 2021).

⁸⁸ *Id.*

implied false certification was actionable under the FCA.⁸⁹ The circuits were in disagreement on whether to accept the implied false certification theory in whole, in part, or at all.⁹⁰

Prior to *Escobar*, three competing theories on how implied false certifications could be the basis of liability existed: (1) when it violated an express condition of payment; (2) that it should be applied broadly to any omissions; or, (3) that it should never be the basis of liability.⁹¹ This third perspective was articulated by the Fifth, Eighth, and Seventh Circuits who chose not to allow the implied false certification theory.⁹² The Seventh Circuit's view before *Escobar* was that the theory should not be recognized because it is overbroad, granting claimants the ability to use the FCA as a sort of strict liability statute for any failures by organizations to meet all regulatory, statutory, or contractual obligations.⁹³

ESCOBAR RECOGNIZED THE IMPLIED FALSE CERTIFICATION THEORY OF LIABILITY

The Supreme Court settled the circuit split on the implied false certification theory with its holding in *Escobar*.⁹⁴ Justice Thomas, writing on behalf of the majority, stated that “the implied false certification theory can be a basis for liability.”⁹⁵ The FCA claim arose in *Escobar* because a counseling center submitted claims for

⁸⁹ Stephens, *supra* note 7, at 275.

⁹⁰ *Id.*

⁹¹ Doan Phan, *Redefining Lincoln's Law: How to Shape the Theory of Implied Certifications Post-Escobar*, 13 J.L. Econ. & Pol'y 113, 120 (2017).

⁹² See U.S. ex rel. Steury v. Cardinal Health, Inc., 625 F.3d 262, 270 (5th Cir. 2010); see also United States v. Sanford-Brown, Ltd., 788 F.3d 696, 711 (7th Cir. 2015) (holding “we join the Eighth Circuit and hold that FCA liability is not triggered by an institution's failure to comply . . .” to a standard regulation unless the relator proves that the standard to show initial compliance with the regulation was false).

⁹³ Sanford-Brown, *Ltd.*, 788 F.3d at 711 (7th Cir. 2015).

⁹⁴ Universal Health Servs., Inc. v. U.S. and Mass., ex rel. Julio Escobar and Carmen Correa, (Escobar), 579 U.S. 176, 181 (2016).

⁹⁵ *Id.*

reimbursement to Medicaid for its specific services (e.g., family therapy, individual therapy, etc.) that were being provided by unlicensed, uneducated personnel.⁹⁶ The case arose after a teenage beneficiary of Massachusetts's Medicaid program received healthcare services from Arbour Counseling Services where she was a patient of five different medical professionals who diagnosed, treated, and prescribed her medications.⁹⁷ Over time her condition worsened and, eventually, she had a seizure and died.⁹⁸ Upon her death, her mother and stepfather were told by an Arbour employee that 23 of the employees—several of whom treated their daughter—did not have the proper education and licensing required to perform these medical practices.⁹⁹ The Court found that the representations made by the counseling center in its submissions for payment reimbursement for patient services were impliedly false because the staff conducting the services were not licensed to perform them.¹⁰⁰ The Court dismissed the theory that only *express* or *affirmative* falsehoods violate the FCA because that interpretation excludes omissions that can amount to fraudulent misrepresentations.¹⁰¹

The Court clarified under what circumstances the implied false certification theory is applicable: “(1) the claim does not merely request payment, but also makes specific representations about the goods or services provided; and (2) the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths.”¹⁰² The alleged falsity in the claim is not limited to contractual provisions which are conditions of payment but can be based on any non-compliance with contractual, regulatory, or statutory provisions of the contract as long as the claim itself meets the two circumstances

⁹⁶ *Id.* at 183.

⁹⁷ *Id.*

⁹⁸ Escobar, 579 U.S. at 184.

⁹⁹ *Id.* at 184–85.

¹⁰⁰ *Id.* at 189.

¹⁰¹ *Id.* at 187; *see also* United States v. Sanford-Brown, Ltd., 788 F.3d 696, 711-12 (7th Cir. 2015).

¹⁰² *Id.* at 190.

above.¹⁰³ In cases of omissions, this theory of liability attaches if the same circumstances apply to make the omissions misleading.¹⁰⁴

The Supreme Court reiterated that the materiality element must still be met when it wrote, any false claims based on omissions of noncompliance “must be *material* to the Government’s payment decision in order to be actionable” under the FCA.¹⁰⁵ The Court articulated the standard that FCA claimants must show the alleged non-compliance was material to the government’s decision to pay reimbursements, even at the pleading stage, because health care entities are subject to “thousands of complex statutory and regulatory provisions” and “facing [FCA] liability for violating any of them would hardly help would-be defendants anticipate and prioritize compliance obligations.”¹⁰⁶ Thus, the Court insisted that “not every undisclosed violation of an express condition of payment automatically triggers liability.”¹⁰⁷

Escobar demonstrates that materiality is no small obstacle at the pleading stage. The claimants must show that the alleged non-compliance—which led to the implied false certification—was material to the government’s decision to pay reimbursements and that the defendant knew the noncompliance was material.¹⁰⁸ Although knowledge at the pleading stage can be alleged generally, the facts pled must still state particular facts to show materiality.¹⁰⁹ The Court concluded that because proper medical licensing was a condition of payment for participation in Medicaid and Medicare—which the counseling center knew—there was no way the government would have continued to reimburse the counseling centers payments for providing medical care by unlicensed and uneducated personnel.¹¹⁰

¹⁰³ *Escobar*, 579 U.S. at 190.

¹⁰⁴ *Id.* at 187–88.

¹⁰⁵ *Id.* at 192 (emphasis added).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* at 190.

¹⁰⁸ *Escobar*, 579 U.S. at 194–95.

¹⁰⁹ Fed. R. Civ. P. 9(b).

¹¹⁰ *Escobar*, 579 U.S. at 196.

The Court's discussion of the potential difficulty in proving materiality under the implied false certification theory demonstrates that the materiality element is just as demanding under this theory as ever.¹¹¹ While the materiality element is no less exacting under this theory of liability, Justice Thomas on behalf of the majority described several factors plaintiffs may use to demonstrate the materiality of the alleged noncompliance, including:

[E]vidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement. Conversely, if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material. Or, if the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material.¹¹²

In several ways, *Escobar* put an end to confusion and disagreements in the circuits regarding how the implied false certification theory creates liability under the FCA. However, Justice Thomas's dictum on what factors tend to show materiality has led to a new circuit split about how much weight should be given to these factors as evidence of materiality.

A. *The Circuit Split Post-Escobar*

¹¹¹ Samantha L. Groden & Talia Linneman, *Escobar Two Years Out: How Courts Have Interpreted the Escobar Materiality Standard and Implications for Assessing Potential Overpayments*, J. Health Care Compliance 45, 46 (2018); see also Stephens, *supra* note 7 (arguing that despite differing interpretations of what types of evidence of materiality is most dispositive by different circuits, that the Supreme Court did not intend to lessen to any extent the materiality and scienter requirements).

¹¹² *Escobar*, 579 U.S. at 195.

Since *Escobar*, courts have grappled with applying the materiality element under the now-recognized implied false certification theory of liability. Three theories of what type of evidence shows an organization’s noncompliance with a statutory, regulatory, or contractual obligation is material to its agreement with the government have emerged post-*Escobar*.¹¹³ The first theory is that evidence showing the noncompliance must go to the “very essence of the bargain” between the organization and the government to be material.¹¹⁴ The next theory is that evidence showing the noncompliance was more technical to the specific agreement between the organization and government is less likely to be material.¹¹⁵ The third theory is that evidence of the government’s payment history, regardless of an organization’s noncompliance with its agreement with the government, requires a heightened showing of proof to be material.¹¹⁶

I. Essence of the Bargain Theory

Based on its interpretation of the implied false certification theory, the Supreme Court vacated the First Circuit’s judgment in *Escobar* and remanded it back to the appellate court for reconsideration.¹¹⁷ The First Circuit on remand in *Escobar II* interpreted the Supreme Court’s opinion about materiality to mean “materiality is more likely be found where the information at issue goes to the very essence of the bargain.”¹¹⁸ Several circuits and district courts followed in the First Circuit’s footsteps, essentially looking at whether the alleged misrepresentation to the government goes to the essence of the bargain to determine its materiality.¹¹⁹ Two primary

¹¹³ Groden & Linneman, *supra* note 111 at 47.

¹¹⁴ *Id.* (citing United States ex rel. *Escobar v. Universal Health Services, Inc.* (*Escobar II*), 842 F.3d 103, 110 (5th Cir. 2016)).

¹¹⁵ Groden & Linneman, *supra* note 111 at 48.

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 47.

¹¹⁸ *Escobar II*, 842 F.3d at 110.

¹¹⁹ Groden & Linneman, *supra* note 111, at 46.

examples of when courts have determined that misrepresentations go to the essence of the bargain are regulatory requirements that relate to quality-of-care standards and medical necessity, as opposed to purely contractual requirements that are “more technical in nature.”¹²⁰ The logic behind these examples is plain because the government’s primary concerns are that the quality of care patients receive meets the appropriate standards and that beneficiaries should be receiving medically necessary care.¹²¹ For example, the First Circuit in *Escobar II* held that the unlicensed staff providing therapy to patients impaired the quality of care for patients which went to the essence of the bargain with the government—to provide quality therapy to government beneficiaries.¹²²

Similarly, in *U.S. ex rel. Emanuele v. Medicor Associates*, the Western District of Pennsylvania found when the defendants failed to report in writing their Stark Act violations to the government, the omission went to the essence of the bargain because this reporting was required under both the contract and CMS rules.¹²³ The hefty penalties and criminal charges associated with Stark Act violations make the government’s stance abundantly clear to providers that they will not condone such activities.¹²⁴

In *United States ex rel. Brown v. Celgene Corp.*, the Central District of California held that a drug company’s submission of reimbursement claims to CMS for prescribed drugs that were not covered under Medicare Part D was material under the FCA.¹²⁵ In *Celgene*, the drug manufacturer only had approval for the drug to treat specific forms of cancer, but it ran an off-label campaign that

¹²⁰ *Id.* at 48.

¹²¹ See *U.S. ex rel. Emanuele v. Medicor Assocs.*, 242 F. Supp. 3d 409, 431 (W.D. Pa. 2017); see also *United States v. Berkeley Heartlab, Inc.*, No. CV 9:14-230-RMG, 2 (D.S.C. 2017) (holding that Anti-Kickback violations are per se material because they are not a mere technical violation but a felony under fraud and abuse and certainly the government’s knowledge of any violations would go to the essence of the bargain with the violator).

¹²² *Escobar II*, 842 F.3d at 110.

¹²³ 242 F. Supp. 3d 4 at 431.

¹²⁴ *U.S. ex rel. Emanuele*, 242 F. Supp. 3d 4 at 431.

¹²⁵ 226 F. Supp. 3d 1032, 1049 (C.D. Cal. 2016).

encouraged physicians to prescribe the drug for off-label uses while knowing that these physicians would submit reimbursements for such prescriptions to Medicare.¹²⁶ The court found that the Medicare Part D, which determines which drugs Medicare reimbursements cover, sets out more than just a technical requirement in the contract; it included specific limitations on which drugs were available for reimbursement by CMS making it an essential feature under the company's bargain with the government.¹²⁷ Therefore, the drug company's off-label campaign knowing physician prescriptions would be submitted to Medicare for reimbursement was evidence to show the campaign resulted in materially false misrepresentations to the government under the FCA.¹²⁸

In *Smith v. Carolina Medical Center*, the Eastern District of Pennsylvania held that merely because the government has the option to refuse reimbursement based on a contractual violation, that option alone is insufficient evidence to show the contractual obligation was material.¹²⁹ Instead, the standard is evidence that had the government known of the violation it likely would have refused to pay the reimbursements.¹³⁰ In *Smith*, the relator alleged that an individual who had been excluded from participating in Medicaid was involved in the management of the clinics, a fact being concealed by the other clinic leadership which rendered clinic billing statements to Medicaid fraudulent under the FCA.¹³¹ The court found that a complaint, even at the motion to dismiss stage, must allege the clinic did not violate just any Medicare or Medicaid regulation, but one which would cause the government to refuse to pay reimbursements.¹³² The court found that CMS regulations and administrative guidance from Health and Human Services have made clear that when an individual or company that is excluded from participation in Medicaid, yet continues to participate

¹²⁶ *Id.* at 1036.

¹²⁷ *Id.* at 1049.

¹²⁸ *Id.* at 1050.

¹²⁹ 274 F. Supp. 3d 300, 314 (E.D. Pa. 2017).

¹³⁰ *Id.* at 320.

¹³¹ *Id.* at 305.

¹³² *Id.* at 315.

CMS will no longer pay reimbursements.¹³³ Because the individual continued to participate in managing the clinic and the clinic leadership concealed this fact, the court found this evidence of material noncompliance with such an essential CMS regulation goes to the essence of its bargain.¹³⁴

Each of these cases indicates something more than just a technical violation of a contract, regulatory, or statutory obligation to establish that the violation went to the essence of the bargain. Situations involving the type of violations in these cases go to the essence of the bargain because they not only grant the government an option of refusing payment but also provide mechanisms for it to exact hefty penalties. Thus, the government has made clear its policies and positions on such violations and would certainly deny reimbursement if it knew of them.

II. Technical Requirements Theory

Technical requirements are typically those portions of an agreement that are business-related, administrative in nature, and do not on their own rise to the level of materiality.¹³⁵ Allegations of fraud based on breaches of contract are more likely to fit the description of “government traps, zaps, and zingers that permits the government to retain the benefit of a substantially conforming good or service but to recover the price entirely—multiplied by three—because of some immaterial contractual or regulatory non-compliance.”¹³⁶

For example, the Eleventh Circuit held in *Ruckh v. Salus Rehabilitation* that the relators FCA claim that a nursing facility’s failure to maintain comprehensive care plans was not material to its agreement with the government and was not Medicaid fraud.¹³⁷ The relator alleged that the facility’s omission to the government about its

¹³³ *Id.* at 321.

¹³⁴ Smith, 274 F.Supp.3d at 315.

¹³⁵ Groden & Linneman, *supra* note 111 at 48.

¹³⁶ Groden & Linneman, *supra* note 111 at 48 (citing *United States v. Salus Rehabilitation, LLC*, 304 F.Supp.3d 1258, 1263 (M.D.Fla., 2018)).

¹³⁷ *Ruckh v. Salus Rehabilitation, LLC*, 963 F.3d 1089, 1108 (11th Cir. 2020).

failure to maintain the care plans was fraudulent because the plans were labeled as conditions of payment under Medicaid regulations.¹³⁸ The court found the nursing facility's failure to maintain the care plans was not material because the relator failed to show any evidence connecting the noncompliance with specific representations the facility made to Medicaid.¹³⁹ The court stated that the "FCA is not a wide-ranging tool to combat failures to comply with even important government regulations."¹⁴⁰ The relator must connect the noncompliance with specific representations that influenced the government to reimburse when they otherwise would not. Violations of regulatory conditions of payment alone do not prove materiality at the pleading stage.¹⁴¹ The technical violation of a regulatory requirement is not sufficient unless claimants show particular facts that the violation influenced the government's payment decision.

However, the Sixth Circuit held that some technical violations can violate the FCA.¹⁴² In *United States ex rel. Prather v. Brookdale Senior Living Communities Inc.*, the Sixth Circuit held that a senior living center's failure to comply with the timing of the CMS physician certification requirements—that the physicians did not gain certification in the timely manner required under CMS regulations—was enough to establish materiality.¹⁴³ The majority held that the purpose of the CMS certification timeliness requirement is to prevent fraudulent practices, a material matter that was a condition of the contractual relationship with the government.¹⁴⁴ Failure to comply with the certification timeliness was essentially failing to comply with the certification process as a whole—because its main purpose was to prevent fraudulent activities—was material to the government's decision to reimburse.¹⁴⁵

¹³⁸ Ruckh, 963 F.3d at 1104.

¹³⁹ *Id.* at 1109.

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² 892 F.3d 822, 831 (6th Cir. 2018).

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 834.

¹⁴⁵ *Id.* at 835.

Justice McKeague submitted a strong dissent to loosening the materiality element by the majority, pointing out that the relator had no evidence that failure to meet the CMS certification timeliness requirement would have prevented the government from reimbursing claims.¹⁴⁶ Justice McKeague reiterated the *Escobar* holding that not all undisclosed regulatory violations would rise to fraud and abuse.¹⁴⁷ The majority's holding, according to Justice McKeague, would result in a slippery slope where any deviation from the regulatory strictures would be deemed material despite the organization's lack of knowledge that the noncompliance is material to the government.¹⁴⁸

These cases demonstrate courts' differing interpretations of what constitutes an omission of a technical violation that influenced the government's decision to reimburse payments. The factors that Justice Thomas outlined in *Escobar* are not always consistent with one another and often must be balanced against each other.¹⁴⁹ For example, the Third Circuit found that whether a regulation is an express condition of payment is irrelevant when there is evidence the government continued to pay similar claims despite its awareness of a company's failure to comply with the regulation.¹⁵⁰ The Eleventh Circuit found that even if a regulatory violation is a condition of payment, that alone does not show materiality unless some facts show that specific regulatory violation influenced the government's payment decision.¹⁵¹ Yet, the Sixth Circuit has taken the approach of treating noncompliance with a regulation that is a condition of payment as a primary factor in determining materiality, regardless of the impact the specific omission had on the government's decision to continue to reimburse.¹⁵² Regardless of the different weight courts grant to more technical violations, ultimately, the relators still bear the burden of

¹⁴⁶ *Id.* at 838–39 (McKeague, J., dissenting).

¹⁴⁷ Prather, 892 F.3d at 850 (McKeague, J., dissenting).

¹⁴⁸ *Id.* at 841.

¹⁴⁹ Groden & Linneman, *supra* note 111 at 48.

¹⁵⁰ Farringer, *supra* note 25, at 1258 (citing to U.S. ex rel. Kelly v. Serco, Inc., 846 F.3d 325, 334 (9th Cir. 2017) and U.S. ex rel. Petratos v. Genentech Inc., 855 F.3d 481, 489 (3d Cir. 2017)).

¹⁵¹ Ruckh v. Salus Rehabilitation, LLC, 963 F.3d 1089, 1109 (11th Cir. 2020).

¹⁵² Prather, 892 F.3d at 841 (McKeague, J., dissenting).

providing enough detail for courts to determine whether technical noncompliance materially influences the government's payment decisions.

III. Government Payment History Theory

Following *Escobar*, courts look to the government's payment history as a factor in determining whether the misrepresentations were material to the agreement.¹⁵³ The Supreme Court in *Escobar* provided that “if the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material.”¹⁵⁴ Yet, lower courts disagree on how much weight this type of evidence should be given in FCA claims.

The First Circuit has generally ascribed to *Escobar*. The First Circuit in *D'Agostino v. ev3, Inc.*, found that the government's payment history and continuation of allowing the drug to remain on the market was strong evidence showing immateriality.¹⁵⁵ The relator claimed the drug manufacturer made fraudulent misrepresentations to the Food and Drug Administration (“FDA”) which led to improper reimbursements for such drugs by CMS.¹⁵⁶ The court held that “the FDA's failure actually to withdraw its approval of Onyx in the face of D'Agostino's allegations precludes D'Agostino from resting his claims on a contention that the FDA's approval was fraudulently obtained.”¹⁵⁷ The First Circuit noted that even after the omissions to the FDA came to light CMS continued to reimburse for the drug, and, per *Escobar*, that was strong evidence that such omissions were technical and the violations were not material to the government's decision to reimburse.¹⁵⁸

¹⁵³ Groden & Linneman, *supra* note 111, at 46.

¹⁵⁴ *Universal Health Servs., Inc. v. U.S. and Mass., ex rel. Julio Escobar and Carmen Correa, (Escobar)*, 579 U.S. 176, 193-94 (2016).

¹⁵⁵ *D'Agostino v. ev3, Inc.*, 845 F.3d 1, 8 (1st Cir. 2016).

¹⁵⁶ *Id.* at 8.

¹⁵⁷ *Id.*

¹⁵⁸ *Id.* at 7.

However, several lower courts have identified limitations on using government payment history as evidence of materiality. For example, the U.S. District Court for the Central District of California found that general government payment history is not always strong evidence of immateriality.¹⁵⁹ In *Celgene*, the court dismissed the defendant's argument that the government's payment history was enough evidence to show materiality because, while CMS continued to reimburse payments after the case was brought by the relator, that did not mean CMS had actual knowledge of any specific instances of fraudulent billing.¹⁶⁰ The court held the "fact that the FDA knew generally about off-label [prescription drug] use does not mean CMS knew about and agreed to reimburse particular off-label claims."¹⁶¹

Another interpretation for how this type of evidence applies is outlined in *Smith*, where the U.S. District Court for the Eastern District of Pennsylvania held that for government payment history to show immateriality the government must have actual knowledge of the fraudulent claims and paid the claims anyway.¹⁶² The defendant argued the government's payment history showed immateriality because when the clinic improperly billed for therapeutic services completed by people who had not yet finished their master's degrees, the Pennsylvania healthcare administrator knew of the violations.¹⁶³ But the court found that because the defendants failed to allege that the administrator paid the claims anyway, the evidence did not defeat the relator's motion to dismiss.¹⁶⁴ Courts various interpretations for how to evaluate government payment history to show immateriality demonstrates the lack of consensus surrounding how much weight should be placed on this type of evidence.

¹⁵⁹ United States ex rel. Brown v. Celgene Corp., 226 F. Supp. 3d 1032, 1050 (C.D. Cal. 2016).

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Smith v. Carolina Med. Ctr.*, 274 F.Supp. 3d 300, 325 (E.D. Pa. 2017).

¹⁶³ *Id.*

¹⁶⁴ *Id.* at 324.

Recently the government payment history theory of evidence has been criticized by some members of Congress.¹⁶⁵ In 2021, Republican Senator Chuck Grassley introduced a bipartisan bill, S. 2428, which includes several amendments to the FCA, including the following provision, “[i]n determining materiality, the decision of the Government to forego a refund or pay a claim despite actual knowledge of fraud or falsity shall not be considered dispositive if other reasons exist for the decision of the Government with respect to such refund or payment.”¹⁶⁶ This provision essentially codifies the line of cases that argue government payment history is not dispositive evidence of materiality and limits the amount of weight such evidence should be given in FCA cases.¹⁶⁷ The Senate Judiciary Committee voted the bill out of committee in October 2021.¹⁶⁸ Only time will tell if the bill passes and how it might affect the future strength placed on this type of evidence to defeat the FCA’s materiality element.

**OVERVIEW AND ANALYSIS OF UNITED STATES EX REL. PROSE V.
MOLINA HEALTHCARE OF ILLINOIS INC.**

Regardless of the many ways in which district and circuit courts differ in their applications of materiality evidence post-*Escobar*, none of them have diverged so far from *Escobar* as the Seventh Circuit when it declared that an MCO’s mere participation in the healthcare industry is enough to establish materiality. In August 2021, the Seventh Circuit decided *United States ex rel. Prose*, which “conclude[d] that [the relator] plausibly allege[d] that as a

¹⁶⁵ *Senate Judiciary Committee Votes to Approve Amendments to the False Claims Act*. JD SUPRA. (Nov. 2, 2021) <https://www.jdsupra.com/legalnews/senate-judiciary-committee-votes-to-9912224/>.

¹⁶⁶ Christian D. Sheehan & Emily Reeder-Ricchetti, *Senator Grassley Overhauls Proposed FCA Amendments in Advance of Key Committee Vote Later this Week*, ARNOLD & PORTER (Oct. 27, 2021) <https://www.arnoldporter.com/en/perspectives/blogs/fca-qui-notes/posts/2021/10/senator-grassley-overhauls-proposed-fca-amendments>.

¹⁶⁷ *Id.*

¹⁶⁸ *Senate Judiciary Committee Votes to Approve Amendments to the False Claims Act*, *supra* note 165.

sophisticated player in the medical-services industry, Molina was aware that these kinds of services [skilled nursing facility services] play a material role in the delivery of Medicaid benefits.”¹⁶⁹ The Seventh Circuit’s final judgment was filed on August 19, 2021, and Molina Healthcare of Illinois Inc., timely submitted a petition for rehearing en banc on September 2, 2021.¹⁷⁰ As of November 15, 2021, the Seventh Circuit denied rehearing the case en banc and made a few small amendments to the final opinion.¹⁷¹

A. Summary of the Case

This case was a *qui tam* action brought by relator Thomas Prose against Molina Healthcare of Illinois—an MCO.¹⁷² Prose was the founder of GenMed, a company that was subcontracted by Molina to provide skilled nursing facility (“SNF”) services to Molina’s beneficiaries.¹⁷³ Molina contracted with the Illinois Department of Healthcare and Family Services (“HFS”) to provide healthcare services to Illinois Medicaid beneficiaries.¹⁷⁴ Under the contract, Molina was to provide SNF services for nursing facility enrollees.¹⁷⁵ After approximately a year of subcontracting with GenMed for these services, the contract was dissolved in 2015 after price negotiations broke down between GenMed and Molina.¹⁷⁶ Prose then brought this *qui tam* suit in 2017, alleging that Molina violated the FCA by failing to provide SNF services as required under its contract with HFS.¹⁷⁷

¹⁶⁹ U.S. ex rel. Prose v. Molina Healthcare of Ill., Inc., 10 F.4th 765, 770 (7th Cir. 2021)

¹⁷⁰ See United States ex rel. Prose v. Molina Healthcare of Illinois, Inc., 2021 WL 5296454 (C.A.7 (Ill.), 2021).

¹⁷¹ *Id.* at 1 (amending two sentences of majority’s opinion and one sentence in the dissent).

¹⁷² United States ex rel. Prose, 10 F.4th at 770.

¹⁷³ *Id.* at 777.

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* at 771.

¹⁷⁶ *Id.* at 770–71.

¹⁷⁷ United States ex rel. Prose, 10 F.4th at 769–71.

Molina's contract with HFS was a typical risk contract wherein Molina agreed to receive capitation payments from the government determined by calculating a fixed amount per enrollee regardless of whether the services exceeded the capitated amount.¹⁷⁸ The capitation rates for enrollees were calculated based on which rate cell (risk pool) they were assigned to according to their health status.¹⁷⁹ There were five rate cells—split into tiers—with the most expensive, highest tier being enrollees living in a nursing facility.¹⁸⁰ The contract Molina made with HFS specified which services must be provided to which enrollees based on their assigned tier.¹⁸¹

Those living in nursing facilities are entitled to Skilled Nursing Facility, “SNF,” services.¹⁸² SNF services were defined in Molina’s contract with the government as “intensive clinical management of Enrollees in Nursing Facilities.”¹⁸³ The contract goes on to list several types of care covered under this umbrella term “SNF services.”¹⁸⁴ Personnel who deliver SNF services were termed “SNFists” and defined in the contract as medical professionals “whose entire professional focus is the general medical care of individuals residing in a Nursing Facility and whose activities include Enrollee care oversight, communication with families, significant others, [primary-care providers], and Nursing Facility administration.”¹⁸⁵ Essentially, SNFists refer to medical personnel meant to oversee other SNF services available to beneficiaries enrolled in the highest tier. Here it must be noted that the majority and dissent interpreted these terms in the contract in two distinct ways.¹⁸⁶ The Majority concluded that all SNF services are comprehensive so that the lack of any component of the services outlined in the contract is enough to create an FCA

¹⁷⁸ *Id.* at 769.

¹⁷⁹ *Id.* at 771.

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *United States ex rel. Prose*, 10 F.4th at 771.

¹⁸³ *Id.*

¹⁸⁴ *Id.* at n.1.

¹⁸⁵ *Id.* at 771.

¹⁸⁶ *Id.*

claim.¹⁸⁷ The dissent argued that Prose's allegations were limited to a lack of "SNFist" services only and that other SNF services outlined in the contract were still delivered by Molina which made this claim nothing more than a breach of contract rather than fraud under the FCA.¹⁸⁸ Prose's complaint alleged that because Molina failed to notify the government of its inability to continue providing SNFist services to beneficiaries and the omission was a material violation of its contract with the government under the FCA.¹⁸⁹

I. Prose's Allegations

Prose's complaint included allegations of fraud under all three FCA theories of liability: factual falsity, fraud in the inducement, and implied false certification.¹⁹⁰ Prose's allegation of factual falsity was based on the enrollment forms that Molina submitted to the government after its contract was dissolved with GenMed, which showed Molina continued to enroll beneficiaries into the highest tier.¹⁹¹ The highest tier included the option for SNFist services, which Prose contended that Molina could not, nor intended to, provide to those new enrollees.¹⁹² By enrolling any new members into that tier, Prose concluded that Molina submitted factually false enrollment forms to the government.¹⁹³

Prose's allegation of fraud in the inducement, or promissory fraud, was that Molina continued to renew its contracts with the government even after its subcontract with GenMed was dissolved.¹⁹⁴ Prose contended that Molina's omission that it no longer contracted with GenMed induced the government to believe Molina planned to

¹⁸⁷ United States ex rel. Prose, 10 F.4th at 771, n.1.

¹⁸⁸ *Id.* at 779, n.2.

¹⁸⁹ *Id.* at 773.

¹⁹⁰ *Id.*

¹⁹¹ *Id.* at 774.

¹⁹² United States ex rel. Prose, 10 F.4th at 774.

¹⁹³ *Id.*

¹⁹⁴ *Id.* at 775.

provide SNFist services and that the government would not have renewed Molina's contract had it known otherwise.¹⁹⁵

Finally, Prose alleged that Molina violated the FCA under the implied false certification theory of liability when Molina failed to inform the government that it no longer subcontracted with GenMed to provide SNFist services.¹⁹⁶ Because Molina still enrolled beneficiaries into the highest tier which offered SNF services, Prose claimed its omission was a material misrepresentation.¹⁹⁷

The dissent disagreed that the evidence Prose brought for both fraudulent inducement and factual falsity was enough to meet the requirements under Rule 9(b) pleading standards because the evidence made general allegations that lacked particularity.¹⁹⁸ For this article's purpose, only a short discussion of Prose's allegations under the first two theories is included because the focus is primarily on the evidence brought to show materiality under the implied false certification theory of liability—i.e., whether Prose's evidence is enough to prove Molina's omission was material to its agreement with the government.

II. Majority's Opinion

Judge Wood wrote on behalf of herself and Judge Hamilton, the majority.¹⁹⁹ The majority held that submitting enrollment forms for enrollees into the Nursing Facility rate cell was enough evidence of a factually false statement under the FCA.²⁰⁰ The majority agreed with Prose, finding that by submitting enrollment forms for new enrollees in the highest tier—that which includes SNFist services—Molina was making an affirmatively false statement that it would provide all the services available in that rate cell.²⁰¹

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ United States ex rel. Prose, 10 F.4th at 775–76.

¹⁹⁸ *Id.*; see also Fed. R. Civ. P. 9(b).

¹⁹⁹ United States ex rel. Prose, 10 F.4th at 769.

²⁰⁰ *Id.* at 777.

²⁰¹ *Id.*

The majority held that Prose sufficiently pled his allegation of fraudulent inducement.²⁰² Prose's evidence for fraudulent inducement was the contention that when Molina renewed its contract with the government in 2016 and 2017, it induced the government into believing SNFist services were still being provided to beneficiaries in the highest tier.²⁰³ The majority found this evidence convincing and held that Prose met the pleading requirements under Rule 9(b)—that the complaint must specify the “time, place, and content” of the statement.²⁰⁴ Prose alleged that Molina never sought out new SNFists which was enough to show it never intended to supply SNFist services.²⁰⁵ Prose's evidence that Molina never intended to provide SNFist services in 2016 and 2017 was a statement made by Molina's Chief Operating Officer, that Molina's “staff did not have the ability or licensure to render SNF services.”²⁰⁶ The Majority found that Molina knew they could not render SNFist services at the time of the contract was renewed which satisfied the Rule 9(b) general intent standard, despite Prose's lack of evidence of whether Molina tried to replace GenMed.²⁰⁷

III. Majority's Interpretation of Implied False Certification

Both the majority and dissent agreed that Prose's allegations fell under the FCA's implied false certification theory.²⁰⁸ The majority recognized that “material omissions can suffice” as false misrepresentations post-*Escobar*.²⁰⁹ Prose alleged that Molina's omission regarding its inability to provide SNFist services when

²⁰² *Id.* at 775.

²⁰³ *Id.* at 777.

²⁰⁴ United States ex rel. Prose, 10 F.4th at 774.

²⁰⁵ *Id.* at 775.

²⁰⁶ *Id.*

²⁰⁷ *Id.* at 774.

²⁰⁸ *Id.* at 775, 779.

²⁰⁹ United States ex rel. Prose, 10 F.4th at 775 (holding “[i]mplied false certification is just another genre of fraud, and so plaintiffs must as usually satisfy Rule 9(b)'s requirements to plead falsity, materiality, and causation with particularity”).

renewing its contract with the government was a material misrepresentation because by enrolling new beneficiaries into the highest tier Molina falsely certified that those new enrollees would get access to SNFist services.²¹⁰

The majority agreed with Prose that the price difference in capitation rates for tiers demonstrated the importance of the services in each tier to the government's calculation of capitation rates.²¹¹ The majority accepted Prose's inference that SNF services—meaning all services listed under this contract provision—account for the price differential between tiers and that no new members should have been enrolled into the third, highest, tier since Molina could not provide the SNFist services.²¹² Unlike the dissent, the majority did not think it appropriate to differentiate between all SNF services and a subset of SNF services that required SNFists oversight.²¹³ Molina argued that Prose had no particular evidence to support this inference but was merely speculating that the capitation rate calculations were heavily influenced by the SNFist services despite that the rates be actuarially sound and meet many other requirements.²¹⁴ The majority agreed with Prose's assumption that failure to provide SNFist services was a material omission because Molina's membership in the medical services industry grants them the knowledge of how much importance the government places on SNFist services when calculating capitation rates.²¹⁵

IV. Dissent's Opinion

Chief Judge Sykes dissented. While the Seventh Circuit upheld Prose's allegations under all three theories of fraud—factual falsity, fraudulent inducement, and implied false certification—Chief Judge Sykes disagreed, finding that the only appropriate theory under which

²¹⁰ *Id.* at 776.

²¹¹ *Id.* at 777.

²¹² *Id.*

²¹³ *Id.* at 779–80 (Sykes, C.J., dissenting).

²¹⁴ *United States ex rel. Prose*, 10 F.4th at 777.

²¹⁵ *Id.*

Prose's allegations could be analyzed as implied false certification.²¹⁶ The dissent described how Prose's allegations failed all three of the FCA theories of liability under the heightened Rule 9(b) pleading standard—that Prose must state with particularity the circumstances constituting fraud.²¹⁷

The dissent found that Prose's allegations of factual falsity were not available based on the evidence provided in this case because an express factual falsity is a direct or affirmative misrepresentation to the government, not an omission.²¹⁸ However, the enrollment forms submitted by Prose essentially required checking a box stating in which tier a beneficiary would be placed—marking out which services they are eligible for and may receive if needed.²¹⁹ Chief Judge Sykes pointed out that SNFist services were only one of many SNF services that enrollees are provided and eligible for in the highest tier, which did not make the checked box on the form a factually false representation to the government.²²⁰

Prose argued that Molina fraudulently induced the government to renew its contract by omitting that it could not provide SNFist services, nor did it intend to provide SNFist services.²²¹ Chief Judge Sykes pointed out that Prose could provide no particulars about such fraudulent inducement other than that, generally, the contracts were renewed.²²² Chief Judge Sykes found that the statement by the Chief Operating Officer did not imply that Molina never looked to replace GenMed as its SNFist provider nor that it had no intention of replacing GenMed, only that it could not supply those services by 2017.²²³ Thus, Prose failed to provide evidence showing fraudulent inducement under the Rule 9(b) pleading standard.²²⁴

²¹⁶ *Id.* at 779 (Sykes, C.J., dissenting).

²¹⁷ *Id.* at 780; *see also* Fed. R. Civ. P. 9(b).

²¹⁸ United States ex rel. Prose, 10 F.4th at 780-82 (Sykes, C.J., dissenting).

²¹⁹ *Id.* at 782 (Sykes, C.J., dissenting).

²²⁰ *Id.*

²²¹ *Id.* at 781 (Sykes, C.J., dissenting).

²²² United States ex rel. Prose, 10 F.4th at 781 (Sykes, C.J., dissenting).

²²³ *Id.*

²²⁴ *Id.*

V. Dissent's Interpretation of Implied False Certification

Chief Judge Sykes, in her dissent, found that an allegation of implied false certification based only on beneficiary enrollment forms does not meet the *Escobar* conditions.²²⁵ To satisfy the implied false certification theory the relator must show, “first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant's failure to disclose noncompliance with *material* statutory, regulatory, or contractual requirements makes those representations misleading half-truths.”²²⁶

Chief Judge Sykes found Prose failed the first prong of the implied false certification theory under *Escobar*.²²⁷ She pointed out that Molina's enrollment forms enrolling beneficiaries into the highest tier made no specific representations about the services other than which services beneficiaries were eligible to receive.²²⁸ Prose did not allege that Molina put enrollees in the highest tier and then only provides them services mapped out in a lower tier, but that it placed enrollees in the proper tier for their health characteristics and then provided all other benefits in that tier except the SNFist services.²²⁹

Judge Sykes pointed out that Molina could properly bill for services provided to beneficiaries in the highest tier which they properly received that were not SNFist services.²³⁰ Prose had no evidence to show that Molina billed the government for SNFist services in particular when it was in fact not providing them to beneficiaries.²³¹ Judge Sykes disagreed with the majority's opinion that Molina's position in the industry and knowledge of how capitation

²²⁵ *Id.* at 782 (Sykes, C.J., dissenting).

²²⁶ *Id.* (emphasis added).

²²⁷ United States ex rel. Prose, 10 F.4th at 782–83 (Sykes, C.J., dissenting).

²²⁸ *Id.* at 783 (Sykes, C.J., dissenting).

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ *Id.*

rates are calculated is enough to fill in the logical gaps in Prose's evidence.²³²

Prose also failed the second prong of *Escobar*'s implied false certification theory because the enrollment forms did not contain any "misleading half-truth[s]." ²³³ Both the *Escobar* case and Judge Sykes provide several examples of misleading omissions that rise to half-truths.²³⁴ In *Escobar*, the Court found that the reimbursement claims for specific therapies improperly provided to patients, because they were provided by unlicensed practitioners in violation of CMS regulations, were misleading half-truths.²³⁵ CMS would naturally assume the bills that were submitted to it for therapist services were being provided by licensed therapists.²³⁶ Chief Judge Sykes provided another apt example when she stated, "[i]magine that the Green Bay Packers have a bye week and someone makes the statement, 'the Packers didn't win today.' . . . The statement is true as far as it goes, but it directly implies a specific falsehood to an unaware fan: that the Packers lost that day."²³⁷ However, the enrollment forms only asserted that beneficiaries were eligible for services in the highest tier and that is the package of services they were offered.²³⁸

B. Prose's Compliant Failed to Allege Particular Facts to Show Materiality

The enrollment forms alone failed to show with particularity that newly enrolled beneficiaries were being denied the care they required and were eligible to receive.²³⁹ Judge Sykes argued that while rate differentials could in some cases support an inference of a misleading half-truth, to assert that it did here is an oversimplification.

²³² *Id.* at 783–84 (Sykes, C.J., dissenting).

²³³ *Id.* at 783 (Sykes, C.J., dissenting).

²³⁴ *Id.* at 783–84; *see also* *Universal Health Servs., Inc. v. U.S. and Mass., ex rel. Julio Escobar and Carmen Correa*, (Escobar), 579 U.S. 190 (2016).

²³⁵ *Escobar*, 579 U.S. at 190.

²³⁶ *Id.*

²³⁷ *United States ex rel. Prose*, 10 F.4th at 783 (Sykes, C.J., dissenting).

²³⁸ *Id.*

²³⁹ *Id.* at 784.

Think of it this way: If rate cell 1 corresponds to 10 services provided at a rate of \$2,000 and rate cell 2 corresponds to those same 10 services plus SNFist services at a rate of \$3,000, then billing at the level 2 rate while not providing SNFist services would support an inference of materiality at the pleading stage. If SNFist services are not delivered, then the contractor is providing only level 1 services, and a reasonable person would not pay much higher level 2 rates for receiving only level 1 services. But now consider a scenario in which rate cell 2 corresponds to 30 services—the 10 in rate cell 1 plus 20 others, one of which is SNFist services. In that scenario, it doesn't make sense to rely on the \$1,000 price differential in considering whether the omission of SNFist services is material because the differential may be largely explained by the 19 other services separating rate cell 1 and rate cell 2.²⁴⁰

The latter example is more akin to what happened in this case. SNFist's care was only one in an entire host of SNF services that enrollees in the tier may receive.²⁴¹ Chief Judge Sykes found that the enrollment form evidence Prose presented required a logical assumption that the only difference between the highest tier and lower tiers was SNFist services.²⁴² Yet, Prose did not establish with any particularity why this assumption was correct.²⁴³ Indeed, without relying on this assumption, Prose provided no evidence to show the lack of SNFist services was material to the government's decision to reimburse Molina for beneficiaries' care in the highest tier.²⁴⁴

The FCA defines the term material as “having a natural tendency to influence, or be capable of influencing, the payment or receipt of

²⁴⁰ *Id.* at 785 (Sykes, C.J., dissenting).

²⁴¹ *Id.*

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ *Id.*

money or property.”²⁴⁵ The Court in *Escobar* noted that “[u]nder any understanding of the concept, materiality ‘look[s] to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation.’”²⁴⁶ The *Escobar* opinion clarified how materiality was to be applied under the implied false certification theory:

A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defendant's noncompliance.²⁴⁷

At most, Prose’s allegations, based on assumptions, showed that the government would have the option to decline some specific payments—which Prose failed to particularize—to Molina based on its inability to supply SNFist services.²⁴⁸ That alone is not enough to meet the materiality standard.²⁴⁹

The majority’s agreement with Prose’s assumptions illuminates its cavalier treatment of the complexities involved in calculating capitation rates for healthcare beneficiaries. The majority here assumed that the SNFist’s services account for the price differential between rate cells—or at least a substantial amount of the differential.²⁵⁰ As Chief Judge Sykes put it, “[a]lthough the contract may have calibrated the capitation rates to the services the government expected to be delivered, it doesn't follow that the government would withhold payment if a *single one* of those services wasn't provided.”²⁵¹ Prose presented no particular circumstances to show that the

²⁴⁵ 31 U.S.C.A. § 3729(b)(4).

²⁴⁶ *Universal Health Servs., Inc. v. U.S. and Mass., ex rel. Julio Escobar and Carmen Correa, (Escobar)*, 579 U.S. 176,193 (2016) (quoting 26 R. Lord, *Williston on Contracts* S 69:12, p. 549 (4th ed. 2003)).

²⁴⁷ *Id.* at 194.

²⁴⁸ *United States ex rel. Prose*, 10 F.4th at 777 (citing to district court’s holding).

²⁴⁹ *See Escobar*, 579 U.S. at 193.

²⁵⁰ *United States ex rel. Prose*, 10 F.4th at 785 (Sykes, C.J., dissenting).

²⁵¹ *Id.*

government considered the SNFist services to be material to the agreement with Molina.

Chief Judge Sykes endorsed the district court's finding that materiality was not met because Prose's allegations "at most supported a conclusion that Molina's actuarial consultants coordinated the payment scheme with the government. Missing, [the court] thought, was a contention that Molina was involved in calculating the capitation rates."²⁵² Judge Sykes found that something more was required to show materiality, such as evidence of how the capitation rates were calculated or evidence that the SNFist services were a primary difference between the middle and highest tiers as evidence that his assumption is correct.²⁵³

C. The Seventh Circuit Replaces Escobar's Factors for Determining Materiality with its Own

The majority did not follow any of the theories of evidence to show materiality in its decision. The majority opinion at most made an implied argument that the price differentiation between tiers must go to the essence of the bargain with the government because of the significant differences in capitation rates.²⁵⁴ Yet the majority did not analyze the facts under any construction of this theory of evidence. The facts in *Prose* are easily distinguished from cases such as in *Escobar II*²⁵⁵, *Emanuele*²⁵⁶, and *Celgene*²⁵⁷, because Molina's omission might not have undermined its ability to provide any necessary services to its beneficiaries and might not have impacted patients' quality of care. If Prose had alleged some facts of this perhaps the materiality element would have been met under the essence of the

²⁵² *Id.*

²⁵³ *Id.*

²⁵⁴ United States ex rel. Prose, 10 F.4th at 771.

²⁵⁵ United States ex rel. Escobar v. Universal Health Services, Inc. ("Escobar II"), 842 F.3d 103, 110 (1st Cir. 2016).

²⁵⁶ U.S. ex rel. Emanuele v. Medicor Assocs., 242 F. Supp. 3d 409, 431 (W.D. Pa. 2017).

²⁵⁷ United States ex rel. Brown v. Celgene Corp., 226 F. Supp. 3d 1032, 1050 (C.D. Cal. 2016).

bargain theory. Regardless, the majority did not even attempt this type of analysis.²⁵⁸

The Seventh Circuit further departed from *Escobar* when it dismissed the evidence Molina proffered that the government renewed its contract and continued reimbursements even after Prose brought these allegations.²⁵⁹ Instead, the Seventh Circuit stated “[i]t is true that the government's continued payment of a claim despite ‘actual knowledge’ that certain requirements are not met ‘is very strong evidence that those requirements are not material.’ But this argument is better saved for a later stage, once both sides have conducted discovery.”²⁶⁰ This statement deviates from *Escobar* and many post-*Escobar* cases which were also decided at the pleading stage.²⁶¹

Finally, the majority did not refer to the fact that this contractual obligation is highly technical as it involves contractually defined terms, which would weigh against the majority's holding in *Prose*. The facts of this case are more like those in *Ruckh*, where the Eleventh Circuit dismissed the relators FCA claim at the pleading stage because the only evidence of materiality was a vague assumption reliant on generalities which failed to link any specific representations to the technical non-compliance of a regulatory violation.²⁶² Similarly, this case is distinguishable from the Sixth Circuit case *Prather*, which found that an omission of noncompliance was material because the regulation itself, while technical, served the specific purpose of preventing fraud and abuse.²⁶³ Here, the crux of Prose's evidence was based on a vague assumption, without particulars, and the majority rests its decision on the presumed sophistication of an MCO.²⁶⁴ The

²⁵⁸ United States ex rel. Prose, 10 F.4th at 770–779.

²⁵⁹ *Id.* at 777.

²⁶⁰ *Id.* (quoting *Escobar*, 579 U.S. at 195).

²⁶¹ Universal Health Servs., Inc. v. U.S. and Mass., ex rel. Julio Escobar and Carmen Correa, (Escobar), 579 U.S. 176, 195 (2016); see also *Ruckh v. Salus Rehabilitation*, 963 F.3d 1089, 1104 (11th Cir. 2020).; United States ex rel. Prather v. Brookdale Senior Living Communities, Inc., 892 F.3d 822, 826 (6th Cir. 2018); Smith v. Carolina Med. Ctr., 274 F. Supp. 3d 300, 300 (E.D. Pa. 2017).

²⁶² See *Ruckh*, 963 F.3d at 1104.

²⁶³ *Prather*, 892 F.3d at 826.

²⁶⁴ See United States ex rel. Prose, 10 F.4th at 785.

majority's holding disregarded the caution in *Escobar* that not any violation of a contractual, regulatory, or statutory violation should be material because of the enormous amount of regulatory and statutory obligations demanding MCO compliance.²⁶⁵ As Justice Thomas noted, "facing [FCA] liability for violating any of them would hardly help would-be defendants anticipate and prioritize compliance obligations."²⁶⁶ Indeed, the Seventh Circuit's holding rendered the materiality element toothless because it negates the particularity standards required for FCA claims at the pleading stage and ignores the complexity of issues with which MCOs must grapple.

THE SEVENTH CIRCUIT'S DECISION BODES ILL FOR MANAGED CARE ORGANIZATIONS FACING FUTURE FALSE CLAIMS LITIGATION

The Seventh Circuit disregarded the existing theories of evidence and allows relators to skirt their burden of materiality by the mere assertion that an MCO is a highly sophisticated member of the healthcare industry. The Seventh Circuit's interpretation of what constitutes sufficient evidence of materiality at the pleading stage places an enormous burden on MCOs because it does not define what makes an MCO a "highly sophisticated"²⁶⁷ member of the medical services industry. All MCOs will be hard-pressed to show they do not fall under this broad category.

The Seventh Circuit's expectation that MCOs know which single contractual violation would rise to the level of a material omission is untenable. As Chief Judge Sykes correctly put it, "the majority's conclusion that Prose has stated a claim for implied false certification essentially establishes a new rule that *any* claim for payment while in material noncompliance with a contract or governing law is an actionable violation of the FCA."²⁶⁸ Courts should be more cautious when making such sweeping assumptions about what MCOs and other healthcare organizations should know is material to the

²⁶⁵ *Escobar*, 579 U.S. at 192.

²⁶⁶ *Id.*

²⁶⁷ *See* *United States ex rel. Prose*, 10 F.4th at 777.

²⁶⁸ *Id.* at 786 (Sykes, C.J., dissenting).

government when the issue is based on noncompliance with a contractual obligation. Moving forward courts should scrutinize the Seventh Circuit's definition of sufficient materiality evidence closely and consider what evidence relators should be required to show. Future FCA litigants should refocus attention on the factors enumerated in *Escobar* and the evidential theories espoused by lower courts.²⁶⁹

Admittedly, it is difficult to show with particularity that omissions rise to the level of material violations under the implied false certification standard. But the facts in *Escobar* and many post-*Escobar* cases demonstrate that it is not impossible to meet this materiality standard, even at the pleading stage. The Rule 9(b) heightened standard to show materiality with particularity at the pleading stage is still critical to such cases.²⁷⁰ The heightened pleading standard exists precisely to prevent litigious hungry relators from pursuing breach of contract claims under the guise of fraud and abuse so that they might increase their potential damages.

CONCLUSION

MCOs are subject to thousands of pages of regulatory and statutory standards, not to mention those contractual negotiations established in agreements with the government. If all that is necessary for relators to establish an FCA claim at the pleading stage is speculation that any noncompliance is material to the government's reimbursement decision, that shifts the burden on the MCO to show otherwise, which is not the Rule 9(b) standard.²⁷¹ While not all evidence is equal in establishing materiality under the FCA, courts should at least attempt to balance the factors enumerated in *Escobar* and post-*Escobar* case law, rather than delaying such scrutiny until

²⁶⁹ See Groden & Linneman, *supra* note 111 at 48.

²⁷⁰ See Prather, 838 F.3d 750 (6th Cir. 2016) (holding the Rule 9(b) requirement of pleading facts with particularity serves an important purpose "protecting defendants against spurious charges of immoral and fraudulent behavior").

²⁷¹ See Fed. R. Civ. P. 9(b).

after discovery as the Seventh Circuit suggested in *Prose*.²⁷² Such delays will hamper judicial efficiency and increase frivolous litigation attempts to use the FCA for contractual enforcement, detracting from its true purpose of combating fraud and abuse. MCOs will have trouble quashing such frivolous claims at the pleading stage if all relators must establish is an MCOs membership in the medical services industry.

²⁷² See United States ex rel. *Prose*, 10 F.4th at 777.