

Fall 2020

Material Lives: Amending the False Claims Act to Restore Qui Tam Medicaid Enforcement and Protect Our Most Vulnerable Communities

C. Deen

Washington and Lee University School of Law, deen.c21@law.wlu.edu

Follow this and additional works at: <https://scholarlycommons.law.wlu.edu/crsj>



Part of the [Civil Rights and Discrimination Commons](#), [Human Rights Law Commons](#), [Legislation Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

C. Deen, *Material Lives: Amending the False Claims Act to Restore Qui Tam Medicaid Enforcement and Protect Our Most Vulnerable Communities*, 27 Wash. & Lee J. Civ. Rts. & Soc. Just. 273 ().

Available at: <https://scholarlycommons.law.wlu.edu/crsj/vol27/iss1/8>

This Note is brought to you for free and open access by the Washington and Lee Journal of Civil Rights and Social Justice at Washington & Lee University School of Law Scholarly Commons. It has been accepted for inclusion in Washington and Lee Journal of Civil Rights and Social Justice by an authorized editor of Washington & Lee University School of Law Scholarly Commons. For more information, please contact christensena@wlu.edu.

Material Lives: Amending the False Claims Act to Restore Qui Tam Medicaid Enforcement and Protect Our Most Vulnerable Communities

C. Deen*

Abstract

In 2016, the Supreme Court granted cert. in Universal Health Services, Inc. v United States ex rel. Escobar to resolve a circuit split on implied certification under the False Claims Act. The Court's opinion also addressed the issue of materiality under the False Claims Act. The "rigorous standard" expounded by the Court raised the standard of materiality beyond simple contractual or regulatory noncompliance. This heightened standard represents a significant departure from previous jurisprudence. Moreover, the heightened standard frustrates the repeatedly expressed will of Congress to empower qui tam whistleblowers to prosecute fraud perpetrated on the government. The primary focus of this Note is the effect this new materiality standard will have on Medicaid qui tam actions. This Note proposes that post-Escobar Congress should amend the False Claims Act's materiality definition to return the act to the original intention of its drafters. This will allow potential Medicaid fraud perpetrators to again fully face the threat of qui tam enforcement envisioned by Congress, preventing potentially disastrous effects on the United States' most vulnerable communities.

* J.D. Candidate, 2021. This Note is dedicated to the memory of Yaruska Rivera, the young woman whose life and needless death are more than case facts. My personal thanks are extended to Professor Brandon Hasbrouck for the invaluable input, guidance, and mentorship that made this Note possible as well as the countless educators, friends, and family for their support over the years.

Table of Contents

I. Introduction.....	275
II. The History of the False Claims Act.....	278
A. How Guns That Don't Shoot Became Doctors That Don't Care in Today's False Claims Act.....	280
B. The Text of the False Claims Act Today	282
III. <i>Universal Health Services, Inc. v. United States ex rel. Escobar</i>	285
A. The Case.....	285
B. The Supreme Court's Opinion	286
IV. The Current State of the Qui Tam Suit Post- <i>Escobar</i>	288
A. Immediate Reaction in the Legal Sector	289
B. In the Courts.....	291
1. Heightened Materiality Requirements in the False Claims Act have a Particularly Strong Effect Coupled with Federal Rule of Civil Procedure 9(b).....	291
2. The Reality in the Courtroom is Routine Summary Dismissal	292
3. The Supreme Court Has Refused to Clarify the <i>Escobar</i> Standard.....	295
V. The Need for Qui Tam-False Claims Act Oversight in Medicaid	295
A. The Government is Incapable of Adequately Prosecuting or Even Estimating Fraud in Medicaid	296
VI. Medicaid Fraud Inherently Affects and Disadvantages the Most Vulnerable Communities	300
A. Demographic Overviews Reveal Minorities and Disabled Individuals Are Disproportionately Affected.....	300
B. Medicaid Fraud Creates Acute Standard of Care Issues Which Can Kill or Injure the Very Beneficiaries Medicaid is Supposed to Save	302

C. Medicaid Fraud Has a Chronic, Systemic Impact Which Imperils Even Those Medicaid Beneficiaries Receiving Proper Care.....	305
VII. Resurrecting the False Claims Act’s Qui Tam Provision to Combat Medicaid Fraud	306
A. The Status Quo Precludes an Adequate General Judicial Framework of FCA Materiality	307
B. A Statutory Amendment Will Allow for Reliable and Accurate Materiality Determinations in FCA Suits	310
C. The Clear Results of the Proposal’s Effect on a Hypothetical FCA Suit	313
VIII. Conclusion.....	315

“If ever we are ever justified in reading a statute, not narrowly as through a keyhole, but in the broad light of the evils it aimed at and the good it hoped for, it is here.”¹

I. Introduction

Medicaid was created in 1965 as a joint program with state governments to provide health care to groups identified by the federal government as the country’s most vulnerable.² Over 100 years prior to that enactment, the False Claims Act (FCA) was passed in the midst of the Civil War to combat procurement fraud in the war to end slavery.³ The FCA creates a statutory regime for holding fraudulent actors civilly liable in their dealings with the federal government.⁴ These two disparate sections of the law—

1. United States *ex rel.* Marcus v. Hess, 317 U.S. 537, 557 (1943) (Jackson, J., dissenting).

2. See *Medicaid.gov: Keeping America Healthy*, CTRS FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/about-us/program-history/index.html> (last visited Sept. 22, 2020) (explaining the origins and purpose behind Medicaid) [perma.cc/B39N-SPMG].

3. See *infra* Part II (discussing the foundations of the FCA).

4. See 31 U.S.C. §§ 3729–33 (2018) (providing for civil damages for false claims and establishing the procedure involved in actions under the FCA).

their creation separated by over a century—have come together to result in billions of civil settlements and judgments every year to recover government funds and dissuade would-be bad actors in government-funded medical care.⁵ The FCA cases currently being brought throughout the United States overwhelmingly concern healthcare fraud in the systems designed to serve communities that would otherwise be denied healthcare entirely.⁶ The intent of Congress to reorient the FCA from guns that do not shoot to doctors that do not care is clear after repeated amendments to the act.⁷

This Note first explores the history of the FCA and the contentious relationship between the legislative demand for a statute exacting accountability and the judiciary's strictly textualist and originalist reading of it.⁸ This contentious relationship has also resulted in a constant, evolving reorientation of the FCA to ensure the empowerment of private individuals—qui tam relators—with the authority to serve as private attorneys general where fraud is being perpetrated on the government.⁹

The most recent salvo in this 150-plus-year argument is the Supreme Court's decision in *Universal Health Services v. United States ex rel. Escobar*.¹⁰ The Court expounded upon materiality under the False Claims Act as a demanding standard that requires a holistic approach that goes beyond even express contractual terms.¹¹ The opinion will be discussed in greater detail below, but as an introductory matter, it should be noted that the reasoning of the Court explicitly embraces a strict textualist reading and

5. See *infra* Subpart II.A (discussing the interaction between the FCA and government funded medical care).

6. See *infra* Part V (illustrating the majority of FCA cases concern Department of Health and Human Services program).

7. See *infra* Subpart II.A (exploring the amendment history of the FCA specifically in the 1986 and Affordable Care Act amendments).

8. See *infra* Subpart II.A (documenting the back-and-forth battle between Congress and the courts).

9. See *infra* Subpart II.B (pointing to Congress' repeated revision when Courts acted to limit the FCA's qui tam provision).

10. See *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2003–04 (2016) (holding that materiality under the act is derived from demanding common law antecedents).

11. See *id.* at 2002–04 (detailing the materiality standard proscribed the Court to the FCA).

originalist view of contract law derived from English common law sources.¹²

This Note examines the impact of *Escobar*'s demanding materiality standards both in the government contracts legal community generally and in courts hearing Medicaid qui tam suits specifically.¹³ The reception of the legal community outside of the courts is an important aspect of the issue given that the legal community will shape proactive compliance in the Medicaid provider community. The application of the materiality standard by courts will only serve as an effective tool where it serves as a deterrence for future harms; the reaction of the legal sector shapes compliance which may save lives rather than simply monetarily punish the providers who take them.¹⁴

The reality of this standard's effect is illuminated within this Note by attempting to—inherently limited by inadequate government data collection—examine the issues of fraud and quality of care in Medicaid. The limitations on accurately estimating Medicaid fraud are explained through the government's own testimony.¹⁵ The approach to illuminate the dangers of inadequate Medicaid fraud documentation and prosecution is made more whole by examining how the groups who benefit—and therefore suffer when defrauded—the most from the program are our country's most vulnerable communities.¹⁶ The direct danger of inadequate Medicaid fraud prosecution will be faced not by Congressional appropriations but by communities already pushed to the margins of society.¹⁷

12. See *id.* at 1999 (starting the analysis with the statute's language and incorporating "well-settled meaning of common-law terms").

13. See *infra* Subpart IV.A and Section IV.B.2 (examining the reaction to the *Escobar* standard by the legal community and the application of the standard in lower courts).

14. See e.g. John E. Calfee & Richard Craswell, *Some Effects of Uncertainty on Compliance with Legal Standards*, 70 VA. L. REV. 965, 965–1003 (June 1984) (discussing in part the incentivization of undercompliance in sectors with unclear legal standards).

15. See *infra* Subpart V.A (examining the government's inability to quantify the extent of Medicaid fraud).

16. See *Medicaid.gov: Keeping America Healthy*, *supra* note 2 (explaining the purpose of Medicaid is to provide "coverage for the poorest Americans").

17. See *id.* (explaining the purpose of Medicaid is to provide "coverage for the poorest Americans").

Finally, this Note proposes that given the statutory tools according to the Court in *Escobar*, the history of the False Claims Act, and the realities to be faced by vulnerable communities, the only option left is for statutory amendment. The reality that the act covers far more than Medicaid fraud is faced and—what the author hopes is—a novel solution is proposed that will respect that reality while empowering the Act once again to preserve and protect a program which serves as a cornerstone of the Great Society Reforms which sought to help bring racial and social justice in to the American reality.¹⁸

II. The History of the False Claims Act

The False Claims Act was signed in to law by President Abraham Lincoln in 1863 “to combat rampant fraud in Civil War defense contracts.”¹⁹ The statute originally provided for both civil and criminal penalties with a civil penalty of \$2,000 per claim and double damages.²⁰ Despite the context of the Act’s passage, the Act did not specify defense contracts but applied to “any Government agency or instrumentality, quasi-governmental corporation, or nonappropriated fund activity.”²¹ The Act was

[I]ntended to protect the treasury against the hungry and unscrupulous host that encompasses it on every side, and should be construed accordingly. It was passed upon the theory . . . that one of the least expensive and most effective means of preventing frauds . . . [is] the strong stimulus of personal ill will or the hope of gain.²²

Critically, the FCA allowed private citizens—known as relators—to pursue fraudulent activity in stating that “[a suit] may be brought and carried on by any person, as well for himself

18. See generally Lyndon B. Johnson, President of United States of America, Commencement Address at the University of Michigan: The Great Society (May 22, 1964).

19. S. REP. NO. 99-345, at 8 (1986).

20. See *id.* (“The civil penalty provided for payment of double the amount of damages . . . plus a \$2,000 forfeiture for each claim submitted.”).

21. *Id.* at 10.

22. United States v. Griswold, 24 F. 361, 366 (D. Or. 1885) (holding the purpose of the FCA to be construed broadly over all government fraud).

as for the United States.”²³ These private citizens were incentivized by an accompanying provision allowing a relator to collect half of the damages recovered in the action, as well as their costs, if they pursued the suit until final judgment.²⁴ The action brought by the relator originally belonged to the relator alone without any allowance for government intervention.²⁵ Courts went so far in this regard that they viewed the action as a property right which could not be divested from the relator even if the government attempted to settle.²⁶

The relator provision is known as *qui tam* from its Latin name in the common law: *qui tam pro domino rege quam pro si ipso in hac part sequitur*.²⁷ The history of *qui tam* provisions in the United States legal system traces back to the First Continental Congress.²⁸ The concept of *qui tam* itself was an element part of the common law before the founding of the United States and its nature was well understood by both the Founding Fathers and the drafters of the original False Claims Act.²⁹ It was accepted that in executing a *qui tam* action the relator was acting in the public interest as it “would otherwise be advanced by public officials.”³⁰ The *qui tam* provision of the Act was intended by the drafters to be

23. S. REP. No. 99-345, at 10 (1986) (citations omitted).

24. *See id.* (“[T]he private relator who prosecuted the case to final judgment would be entitled to one half of the damages and forfeitures recovered and collected. If successful, the relator would also be entitled to an award of his costs.”).

25. *See id.* (describing a relator’s rights in a *qui tam* action at the time of the 1863 drafting).

26. *See United States v. Griswold*, 30 F. 762, 763 (D. Or. 1887) (holding the prosecution of a *qui tam* action to be a property right).

27. *See Qui Tam Action*, BLACK’S LAW DICTIONARY (11th ed. 2019) (translating the original Latin as: who as well for the king as for himself sues in this matter).

28. *See, e.g., Adams v. Woods*, 6 U.S. 336, 341 (1805) (“Almost every fine or forfeiture under a penal statute, may be recovered by an action of debt [by a *qui tam* plaintiff] as well as by information [by a public prosecutor].”).

29. *See* BLACKSTONE, COMMENTARIES *144, *160–61 (“defining the *qui tam* action in English Common law.”).

30. *See* J. Randy Beck, *The False Claims Act and the English Eradication of Qui Tam Legislation*, 78 N.C. L. REV. 539, 551 (2000) (introducing the changes of the 1986 amendments to the FCA).

key to the efficacy of the act in order to encourage participants in fraud to bring forward the fraud themselves.³¹

A. How Guns That Don't Shoot Became Doctors That Don't Care in Today's False Claims Act

In early years of World War II, a number of “qui tam actions were brought regarding World War II defense procurement fraud.”³² Controversy arose because relators were court watchers initiating qui tam suits based solely on the details of criminal fraud indictments launched by the Federal government without any personal knowledge.³³ In *Marcus v. Hess*,³⁴ “the Government contended that an action brought by an informer who based his civil action on a criminal indictment should be barred.”³⁵ There, the Court refused the government’s invitation to read a personal knowledge requirement into the Act.³⁶ The Court’s opinion drove the Attorney General—who had aggressively been criminally prosecuting procurement fraud—to ask Congress to remove the qui tam provisions from the Act entirely.³⁷ After nearly acquiescing, Congress refused the Attorney General’s request.³⁸ It did, however, amend the plain language of the statute to remove a court’s jurisdiction over qui tam civil actions when the government was

31. See CONG. GLOBE, 37th Cong., 3d Sess. 955–56 (1863) (statement of Sen. Howard) (defending the efficacy of the qui tam provision in the proposed FCA).

32. S. REP. NO. 99-345, at 10 (1986).

33. See *id.* at 10–11 (detailing the controversy surrounding World War II qui tam suits).

34. *United States ex rel. Marcus v. Hess*, 317 U.S. 537, 541 (1943) (holding the statute did not bar civil qui tam actions based on criminal complaints).

35. S. REP. NO. 99-345, at 10 (1986).

36. See *United States ex rel. Marcus v. Hess*, 317 U.S. at 545 (“Even if, as the government suggests, the petitioner has contributed nothing to the discovery of this crime, he has contributed much to accomplishing one of the purposes for which the Act was passed.”).

37. See S. REP. NO. 99-345, at 11 (1986) (“The *Marvus* [sic] v. *Hess* decision prompted then Attorney General Francis Biddle to request that Congress repeal the qui tam provisions of the act).

38. See *id.* (describing the process of compromise between the House and Senate to retain a limited qui tam provision).

already knowledgeable and the relator was not the original source.³⁹

Court's responded to the change in the statute with considerable textual discipline and barred a number of qui tam actions in the decades to come.⁴⁰ The status quo on qui tam actions finally began to crack in 1984 when the state of Wisconsin attempted to file a qui tam action alleging massive Medicaid fraud where the state had already disclosed and the Federal government failed to act on the information.⁴¹ The Seventh Circuit Court of Appeals ruled that despite the Federal government's inaction, the state was barred from bringing the suit having already disclosed the information to the Federal government.⁴² After the decision, the negative reaction was swift—resulting in both a condemnation from the National Association of Attorneys General and a bipartisan effort to introduce reforms which would encourage qui tam suits.⁴³

Congress amended the Act in 1986 in a number of ways including increased penalties, removal of specific intent to defraud, and imposing liability based on reckless disregard for the truth in claims submitted to the government.⁴⁴ Critically, the 1986 amendment also abrogated the language the courts had used to bar many qui tam suits since 1943 by creating standing again for relators submitting information already possessed by the government unless it had already been publicly disclosed.⁴⁵ The 1986 amendment further encourages qui tam relators by guaranteeing costs, expenses, attorneys' fees, and between 15–30%

39. See *id.* at 8 (summarizing the 1943 amendment to the FCA).

40. See, e.g., *United States ex rel. Lapin v. Int'l Bus. Machs. Corp.*, 490 F. Supp. 244, 248 (D. Haw. 1980) (holding a relator suit disqualified despite a lack of government action to correct the fraud).

41. See *United States ex rel. Wisconsin v. Dean*, 729 F.2d 1100, 1103–04 (7th Cir. 1984) (holding the public disclosure bar in the statute removed the Court's jurisdiction).

42. See *id.* at 1104 (finding the plain text of the statute indicates a broad jurisdictional bar).

43. See S. REP. NO. 99-345, at 10 (detailing the reaction by June of 1984 after the Seventh's Circuit decision in March of the same year).

44. See Beck *supra* note 30, at 562 (introducing the changes of the 1986 amendments to the FCA).

45. See *id.* at 562–63 (detailing the differences between the 1943 and 1986 FCA amendments and their justifications).

of the recovery.⁴⁶ The final change in the 1986 amendment was to allow relators to continue as named parties—and beneficiaries—even if the government did intervene in prosecuting the suit.⁴⁷ The changes decentralized government fraud prosecution creating greater access to information for the government; increasing the likelihood of prosecution compared to prosecution by the Department of Justice alone (DOJ); and, increasing the incentives for whistleblowers to expose fraud.⁴⁸

B. The Text of the False Claims Act Today

By 2009 the changes of the 1986 Amendments to the FCA had resulted in \$22 billion in recoveries for the Federal government.⁴⁹ In 2009, however, the Supreme Court read the FCA narrowly to bar suits where fraudulent intent was not present.⁵⁰ This decision was met with a swift reaction from Congress who considered the decision “contrary to the clear language and congressional intent of the FCA.”⁵¹ The Fraud and Enforcement and Recovery Act of 2009 (FERA) was largely aimed at combatting the mortgage fraud leading to the Great Recession of 2008.⁵² Congress felt compelled to revise the False Claims Act in its battle against fraud generally.⁵³ “The effectiveness of the False Claims Act has recently

46. See *id.* at 562 (explaining that the statute directs a two-tier range for relator’s recovery of 15% to 25% if the government and intervenes and 25% to 30% if they do not).

47. See *id.* (“Even if the Justice Department does intervene, the informer can continue as a party.”).

48. See William E. Kovacic, *Whistleblower Bounty Lawsuits as Monitoring Devices in Government Contracting*, 29 LOY. L.A. L. REV. 1799, 1823–34 (1996) (summarizing the effects of the 1986 amendments).

49. See Michael A. Morse & Peter S. Wolff, *Fraud Enforcement and Recovery Act of 2009 Strengthens Federal FCA*, LAWS. J., June 19, 2009, at 5, 10 (“The FCA is widely regarded as the most effective tool in combating fraud against the federal government, resulting in over \$22 billion in recoveries since 1986.”).

50. See *Allison Engine Co. v. United States ex rel. Sanders*, 553 U.S. 662, 668–69 (2008) (holding that the language “to get” then present in 31 U.S.C. § 3729(a)(2) is an intent requirement).

51. S. REP. NO. 111-10, at 10 (2009).

52. See *id.* at 2–4 (describing the context of the financial crisis and the purpose of the act to combat it).

53. See *id.* at 4 (“This legislation also makes a number of important improvements to fraud and money laundering statutes to strengthen prosecutors’

been undermined by court decisions The False Claims Act must be corrected and clarified in order to protect from the fraud the Federal assistance and relief funds expended in response to our current economic crisis.”⁵⁴ Congress clearly intended the False Claims Act to be actively used and sought to overrule the weakening of the Act from the Court’s decision in *Allison Engine Co.*⁵⁵ The Justice Department agreed that revision to the Act was necessary to “aggressively fight fraud in the current economic climate.”⁵⁶ The 2009 bill’s amendments to the Act were intended to encourage qui tam suits to pursue government fraud generally.⁵⁷

Congress amended the Act only a year after FERA when amendments were passed as part of the Patient Protection and Affordable Care Act (ACA) in 2010.⁵⁸ Congress’s concerns for potential fraud in the medical payment systems within the ACA were largely borne out of the decades of experience the Federal government had in pursuing Medicaid and Medicare fraud.⁵⁹ Congress was careful to point out within the ACA that any payments made “by, through, or in connection with an Exchange are subject to the False Claims Act.”⁶⁰

Congress was largely responding to the strict application and narrowing of the statute by the Supreme Court in *Graham County Soil & Water Conservation District v. United States ex rel. Wilson*.⁶¹

ability to combat this growing wave of fraud.”).

54. *Id.* at 4.

55. *See id.* at 10–11 (“[T]he Allison Engine decision[] runs contrary to the clear language and congressional intent of the FCA . . .”).

56. *Id.* at 9 (internal citation omitted).

57. *See* Charles T. Kirchmaier, *Treating the Symptoms but Not the Disease: A Call to Reform False Claims Act Enforcement*, 209 *MIL. L. Rev.* 186, 217–20 (2011) (explaining the effect of the 2009 proposed amendments and their effect of promoting litigation “as a primary remedy”).

58. The False Claims Act was specifically amended in anticipation of increased government healthcare contracts. *See* Pub. L. No. 111-148, 901–02 (2010) (codified as amended at 31 U.S.C. § 3730 (2012)).

59. *See* Lewis Morris, Perspective, *Combating Fraud in Health Care: An Essential Component of Any Cost Containment Strategy*, HEALTH AFFAIRS, Sept./Oct. 2009, at 1352 (discussing federal fraud-control efforts to combat Medicare and Medicaid fraud).

60. Pub L. No. 111-148 at 185.

61. *See* *Graham Cnty. Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 559 U.S. 280, 291 (2010) (holding administrative reports, hearings, audits, and investigations at the federal, state, and local levels all constituted

In order to weaponize the False Claims Act against potential ACA fraud, Congress passed an amendment that substantially altered the public disclosure requirements introduced in the Congressional compromise of the 1943 amendments.⁶² The ACA amendment also provided that the government had the right to oppose dismissal of the action if the court found that the qui tam suit was based on public disclosure.⁶³ The ACA amendment “effectively gutted the Court’s *Graham County* ruling” by redefining public disclosure to mean only the news media, federal materials, and federal proceedings in which the government was a party.⁶⁴ Finally, the ACA modified the original source doctrine to allow relators to bring suits where they had no direct knowledge but still “materially adds” to the public disclosure.⁶⁵ The last provision, removing the jurisdictional bar for relators based on public disclosures, has had a surprising reception from the courts.⁶⁶ The requirement was intended by Congress to ease the burden for relators to qualify as an original source; however, courts have instead used the language to impose a heightened standard for relators to establish standing in a qui tam suit.⁶⁷

sources for disqualifying public disclosure under the False Claims Act).

62. See Brett W. Barnett & Jason S. Greis, *False Claim Act Litigation under the Affordable Care Act*, GPSOLO, Mar./Apr. 2015 at 24 (“Prior to the ACA, the public disclosure bar served as one of the strongest and quickest ways to dismiss a false claims action.”).

63. See *id.* (“[U]nder the ACA the government is given the opportunity to oppose dismissal owing to public disclosure.”).

64. See *id.* (“[T]he statute now clarifies that public disclosure sources are limited to federal criminal, civil, and administrative proceedings in which the government is a party; federal reports, hearings, audits, and investigations; and news media.”).

65. See *id.* at 25 (“The ACA, however, eliminated the “direct” knowledge requirement, and now a relator can qualify as an “original source” so long as a relator has independent knowledge that “materially adds” to the publicly disclosed allegations.”).

66. See *id.* (“[C]ourts thus far have imposed a somewhat heightened standard for relators.”).

67. See *id.* (“Although the ‘materially adds’ requirement was apparently intended to ease the requirements for qualifying as an ‘original source,’ courts thus far have imposed a somewhat heightened standard for relators.”) (citations omitted).

III. Universal Health Services, Inc. v. United States ex rel.
Escobar

This Note approaches the Supreme Court's decision in a contextual manner. The case is grounded first in the facts which gave rise to the Court's decision so that the reader might approach the case from the same social justice focus which is the focus of this scholarship. The legal reasoning and conclusions of the Court should not be divorced from the facts of the particular case as it sheds immediate light on the implications of the decision in the context of Medicaid fraud. Special emphasis is, however, paid to the interpretive tools used by the Court to help frame why the statutory amendment proposal later in the Note is necessary.

A. *The Case*

Yarushka Rivera was 12 years old when she began receiving mental health treatment from Arbour Counseling Services in Lawrence, Massachusetts—owned by Universal Health Services—through Massachusetts' Medicaid program in 2004.⁶⁸ In 2009, at the age of 17, Yarushka suffered an adverse reaction to medication prescribed for a bipolar disorder diagnosis she received at the facility.⁶⁹ After multiple seizures, she died in October of that year.⁷⁰ After her death a counselor at the facility revealed to her parents that few of the employees at the facility were actually licensed.⁷¹ The “psychiatrist” who diagnosed her received a “Ph.D” from an unaccredited internet college, and Massachusetts rejected her application for a medical license.⁷² The “psychiatrist” who prescribed the medication that led to her death was a nurse with

68. *See id.* at 1997 (describing the course of treatment Yarushka Rivera received).

69. *See id.* (“Yarushka had an adverse reaction to a medication that a purported doctor at Arbour prescribed . . . she suffered another seizure and died.”).

70. *See id.* (detailing repeated medically significant seizures).

71. *See id.* (“[O]f the five professionals who had treated Yarushka, only one was properly licensed.”).

72. *See id.* (“[F]ailed to mention that her degree came from an unaccredited Internet college and that Massachusetts had rejected her application to be licensed.”).

no prescription authority. Of the five Arbour employees who treated Yarushka, only one was licensed.⁷³

The employees at Arbour had not just lied to Yarushka’s parents, they fraudulently represented themselves “to the Federal Government to obtain individual National Provider Identification numbers, which are submitted in connection with Medicaid reimbursement claims.”⁷⁴ Yarushka’s stepfather—Julio Escobar—initially reported the facility to various authorities before he filed a *qui tam* suit in federal court based on misrepresentations to Medicaid of Arbour’s “unqualified, unlicensed, and unsupervised staff.”⁷⁵ The District Court granted the defendant’s motion to dismiss on the basis that none of the violations was “a condition of payment.”⁷⁶ The United States Court of Appeals for the First Circuit reversed and remanded the decision based on the lower court’s error to consider that the Medicaid regulations were material.⁷⁷ The District Court then found for the United States and was affirmed by the First Circuit on appeal by Universal Health Services on the basis that regulatory conditions of payment were sufficient as “constitut[ing] dispositive evidence of materiality.”⁷⁸

B. The Supreme Court’s Opinion

The opinion of the Court begins with using a “settled principle” of statutory interpretation that absent a statutory definition within the False Claims Act Congress must have incorporated the meaning of the terms according to the common law to resolve the circuit split on implied certification.⁷⁹ The Court reasons that

73. *See id.* (explaining the depth of licensure fraud at the clinic).

74. *Id.*

75. *See id.* at 1997–98 (explaining that respondents filed the action after discovering that “few Arbour employees were actually licensed to provide mental health counseling and that supervision of them was minimal”).

76. *United States ex rel. Escobar v. Universal Health Servs.*, 2014 WL 1271757, *1, *6–12 (D. Mass. Mar. 26, 2014).

77. *See United States ex rel. Escobar v. Universal Health Servs.*, 780 F.3d 504, 513 (1st Cir. 2015) (holding regulatory provisions to be dispositive of materiality) (citations omitted).

78. *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 1998 (2016).

79. *See id.* at 1999 (“Congress did not define what makes a claim ‘false’ or ‘fraudulent.’ But [i]t is a settled principle of interpretation that, absent other

incorporating the common law definition means “that the implied false certification theory can, at least in some circumstances, provide a basis for liability” under the Act.⁸⁰ The heightened requirement imported from the common law, however, led the Court to restrict the application of implied certification where “the claim does not merely request payment, but also makes specific representations about the good or services . . . [and] the defendant’s failure to disclose noncompliance with *material* statutory, regulatory, or contractual requirements makes those representations misleading half-truths.”⁸¹

The second question, however, is whether a defendant who fails to disclose a violation of a contractual, statutory, or regulatory provision only creates liability when that provision is expressly designated a condition of payment.⁸² The Court finds no basis for this limitation in the text but finds within this question an implicit consideration of the materiality standard of the Act.⁸³ The Court categorizes the materiality simply as “look[ing] to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation.”⁸⁴ The Court does not mince its words when it explains the effect: “The materiality standard is demanding.”⁸⁵

How demanding is the heightened materiality standard in application? In the Court’s approach “when evaluating materiality under the False Claims Act, the Government’s decision to *expressly* identify a provision as a condition of payment is relevant, but not automatically dispositive.”⁸⁶ Rather remarkably, this means even if the government *expressly* designates a condition for payment, that will not impose liability on its own. The Court explicitly rejects automatic materiality even when “the defendant knows that the

indication, Congress intends to incorporate the well-settled meaning of the common-law terms it uses.” (quoting *Sekhar v. United States*, 570 U.S. 729, 732 (2013))).

80. *Id.*

81. *Id.* at 2001 (emphasis added).

82. *See id.* (explaining the question of whether express provision constitutes materiality).

83. *See id.* (“Nothing in the text of the False Claims Act supports [materiality by express provisions].”).

84. *Id.* at 2002 (citing 26 R. Lord, *Williston on Contracts* § 69:12, p. 549 (4th ed. 2003)).

85. *Id.* at 2003.

86. *Id.* (emphasis added).

Government would be entitled to refuse payment were it aware of the violation.”⁸⁷ “The False Claims Act does not adopt such an extraordinarily expansive view of materiality.”⁸⁸ The Court offers only two citations as examples of materiality: lying about collusive bidding and real property title misrepresentations.⁸⁹ On this heightened standard of materiality—which the First Circuit had not applied—the lower court’s finding of adequately pled fraud was vacated.⁹⁰

IV. *The Current State of the Qui Tam Suit Post-Escobar*

This section is explored in roughly chronological order. It begins with a survey of the reaction of the legal community to the materiality standard. The legal community’s response is focused primarily on the lawyers who both represent FCA plaintiffs and the defense bar.⁹¹ The motivation for this approach is based on the idea that it is the practicing legal community that will analyze the standards and shape compliance efforts initially.⁹² These proactive compliance efforts have the potential to save lives within the context of medical practices.⁹³ The Note then moves on to survey lower court decisions applying the *Escobar* standard after clarifying the common procedural posture of initial motions to dismiss under the heightened fraud pleading standard imposed by the federal rules.⁹⁴ Finally, a brief update is provided on requests

87. *Id.* at 2004.

88. *Id.*

89. *See id.* at 2003 (citing as examples *Junius Cons. Co. v. Cohen* 257 N.Y. 393 (1931) and *United States ex rel. Marcus v. Hess* 317 U.S. 537 (1943)).

90. *See id.* at 2004 (“Because both opinions below assessed respondents’ complaint based on interpretations of § 3729(a)(1)(A) that differ from ours, we vacate the First Circuit’s judgment and remand the case for reconsideration of whether respondents have sufficiently pleaded a False Claims Act violation.”).

91. *See infra* Section IV.A (discussing the legal community’s response to the materiality requirement).

92. *See infra* Section IV.A (discussing the legal community’s response to the materiality requirement).

93. *See infra* Section IV.A (discussing the effect heightened materiality requirement).

94. *See infra* Section IV.B.2 (explaining the impact of the application of the *Escobar* standard in lower courts).

for the Supreme Court to offer clarification of a standard applied divergently across the various federal courts of appeal.

A. Immediate Reaction in the Legal Sector

The legal community expressed uncertainty regarding the impact of the heightened materiality standard.⁹⁵ The new materiality standard was seen as “possibly the most significant impact of the Supreme Court decision” as a “higher standard” that would require the government to “develop evidence of its past payment practices.”⁹⁶ Immediately the legal community recognized that “continued payment of claims by the government will provide for a materiality defense.”⁹⁷

Other government contract legal scholars asserted “the [C]ourt actually restricted the FCA’s potential scope through a rigorous and demanding standard of ‘materiality.’”⁹⁸ The impact was expected to provide “protection against an overly zealous interpretation of the FCA.”⁹⁹ Indeed some commentators went so far as to assert:

FCA plaintiffs would be well-advised to recognize that even if a trial court ignores the Court’s holding and applies a less-rigorous pleading standard [on materiality], they face a protracted and expensive litigation only to revisit the issue on summary judgment and, if necessary, where the circuit courts of appeal are far more likely to apply the Court’s test.¹⁰⁰

95. See, e.g., Cynthia A. Howell, *Rough Road Ahead for Businesses?—The Impact of The Supreme Court’s Ruling in Universal Health Services, Inc. v. United States ex. rel. Escobar*, 19 DUQ. BUS. L. J. 97, 114 (2017) (“[T]he Supreme Court also implemented a heightened materiality standard. The decision did not provide a bright-line rule; therefore, courts will need to adjust to the adoption of a subjective materiality standard.”).

96. *Id.*

97. *Id.* at 115.

98. Robyn N. Burrows, *The Supreme Court Uphold Implied Certification Under the False Claims Act but Imposes “Rigorous Materiality” Standard*, FIDELITY & SURETY L. COMMITTEE NEWSL., Fall 2016, at 10.

99. *Id.*

100. David L Douglass, *Defending FCA Claims: Making the FCA Plaintiff*

The commentator even provided a sample letter to send to a relator's counsel advising "it is all too often true that it is one thing to accuse but a different thing to prove" and "[w]e look forward to seeking judicial assistance in resolving this matter; should that become necessary."¹⁰¹

Simply put, lawyers representing defendants in frequent False Claims Act litigation regarded the heightened materiality standard as "welcome news for contractors."¹⁰² These litigators noted that it was not simply continued payment but also that "[g]overnment inaction in the face of noncompliance affords contractors a strong materiality defense."¹⁰³ The added emphasis on materiality and the Court's own admission that the standard was not too fact intensive in note 6 of page 2004 of the opinion had "made its mark on FCA motions practice" and when it came to dismissal or summary judgment, "courts have shown a willingness to do just that."¹⁰⁴ The added emphasis on materiality motion practice leads many practitioners to posit that defendants "must focus [their] efforts on the discovery and presentation of evidence of materiality [by the relator]."¹⁰⁵

The reception was not entirely positive. Government practitioners prosecuting fraud under the False Claims Act detected the potential for a materiality defense just as quickly as defense counsel.¹⁰⁶ These lawyers pointed out that potential for liability under the Act was of great societal importance given the number of elderly receiving elderly care services through

Walk the Talk, FED. LAW., Dec. 2016, at 62.

101. *Id.* at 59.

102. Brian Tully McLaughlin & Jason M. Crawford, Feature Comment, *Materiality Rules! Escobar Changes the Game*, GOV'T CONTRACTOR, May 10, 2017, ¶ 135, 2.

103. *Id.*

104. *Id.*

105. G. Christian Roux & John. D. Hanover, *Implied False Certification Liability Under The False Claims Act: How The Materiality Standard Offers Protection After Escobar*, 38 WTR CONSTR. L. 16, 21 (2018).

106. See Susan Carney Lynch & Ellen Bowden McIntyre, *Seeking Justice: The Department Of Justice's Civil And Criminal Tools And Strategies To Bring To Justice Nursing Homes Who Provide Grossly Substandard Care To Our Nation's Elderly Residents*, 66 DOJ J. FED. L. & PRAC. 113, 121–22 (2018) ("Defense attorneys may also claim that the government continued to pay claims despite negative survey findings and, therefore, the FCA's materiality element cannot be met.").

Medicare.¹⁰⁷ Legal scholars also noted that the Court’s holding on materiality “rejected the position of the majority of circuits” in designating express regulatory compliance requirements to be prima facie evidence of materiality.¹⁰⁸ The heightened materiality standard was generally regarded as a “shift away from the statutory ‘natural tendency’ standard . . . [and] toward a materiality standard that requires evidence that the government was in fact influenced.”¹⁰⁹ Scholars further asserted that the Court created confusion in these limited examples by “not go[ing] far enough in providing sufficient details about liability that may lie between guns that do not shoot and foreign-made staplers.”¹¹⁰

B. In the Courts

1. Heightened Materiality Requirements in the False Claims Act have a Particularly Strong Effect Coupled with Federal Rule of Civil Procedure 9(b)

The heightened materiality standard imposed by the Supreme Court in *Escobar* has a particularly powerful effect in pleadings. The Federal Rules specify “[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake.”¹¹¹ Courts have been flexible in allowing amendments to the initial pleadings given the natural information asymmetry

107. See Michael S. Macko & Bianca Valcarce, *Using the False Claims Act To Combat Fraud By Personal Care Homes*, 66 DOJ J. FED. L. & PRAC. 129, 136 (“Residents of personal care homes depend on their caregivers to provide necessities and assistance for their everyday lives . . . residents can be vulnerable to abuse and neglect . . . traditional criminal remedies might be the first response, the False Claims Act can complement—and, in some cases, even substitute for—those remedies.”).

108. See 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, 1247 (2018) (describing the second major holding in *Escobar*).

109. *Id.* at 1258.

110. *Id.* at 1275; David Kwok, *Is Vagueness Choking The White-Collar Statute?*, 53 GA. L. REV. 495, 527 (2019).

111. See FED. R. CIV. P. 9(b) (specifying the pleading standard for claims of fraud).

of an FCA suit where the party committing the fraud clearly has more information than the plaintiff might.¹¹² Nevertheless, the materiality of the false claim is an essential element of a violation of the False Claims Act and must be adequately pled.¹¹³ Further, while materiality can be a factually intensive inquiry, the Supreme Court expressly rejected the idea that the materiality or immateriality of a false claim was not addressable in a motion to dismiss at the pleading stage.¹¹⁴ As demonstrated in the next section, lower courts have taken this advice from note six of the opinion to heart.

2. *The Reality in the Courtroom is Routine Summary Dismissal*

The potential effect of the heightened materiality standard was not immediately apparent to the circuit courts. The Fourth Circuit explained “[i]f *Universal Health* controlled our decisions on materiality in these appeals, it is unclear what the impact might be” and “the applicable materiality test [from *Universal Health*] verges toward a subjective standard.”¹¹⁵ Nevertheless, applications of the heightened standard in the circuit courts suggested strict enforcement of the demanding standard.¹¹⁶ Perhaps more worryingly to parties on either side, circuit court decisions so far suggest a possible circuit split on the standard.¹¹⁷

112. See TIMOTHY S. JOST & SHARON DAVIES, *MEDICARE AND MEDICAID FRAUD AND ABUSE* 334 (2002-03 ed. 2002) (“[C]ourts have permitted some flexibility in pleading . . . information in these cases is less available to the plaintiff than to the defendant . . . [t]he court may at its discretion permit the plaintiff, however, to amend . . . when 9(b) issues are raised.”).

113. See *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2002 n.6 (2016) (“[P]laintiffs must also plead their claims with plausibility and particularity under Federal Rules of Civil Procedure 8 and 9(b) by, for instance, pleading facts to support allegations of materiality.”).

114. See *id.* (“We reject [the] assertion that materiality is too fact intensive for courts to dismiss False Claims Act cases on a motion to dismiss or at summary judgment.”).

115. See *United States v. Raza*, 876 F.3d 604, 620–21 (4th Cir. 2017) (holding the heightened materiality of the FCA did not apply to criminal prosecutions).

116. See, e.g., *United States ex rel. Dresser v. Qualium*, No. 12-cv-01745, 2016 WL 3880763, at *6 (N.D. Cal. July 18, 2016) (granting defendant’s motion based on a failure to establish materiality on the grounds the government did not explain why the alleged noncompliance was material).

117. See Farringer *supra* note 108, at 1243–44 (describing the circuit splits

In a strict application of the materiality standard, the Fifth Circuit held that a failure to obtain expressly required engineering approvals during construction of a floating oil facility was not material to support a claim.¹¹⁸ Despite the apparent seriousness of failing to obtain required engineering approvals for a floating oil platform, the court found that the government's continued approvals after learning of the failure failed the materiality standard.¹¹⁹ This opinion has seen extensive examination by the government contract's defense bar that sees the heightened materiality as a welcome reprieve from False Claims Act litigation.¹²⁰ The Third Circuit also adopted the view that continued government payments after discovery of noncompliance or fraud are essentially dispositive of immateriality when it dismissed a complaint where the Centers for Medicare and Medicaid Services (CMS) had consistently reimbursed claims with knowledge of noncompliance as well as previous notification to the Federal Drug Administration (FDA) and DOJ, which chose not to act on the false statements.¹²¹

The Fifth and Third Circuits were not alone in their strict application of the new standard. The Seventh Circuit used heightened materiality to affirm the granting of a defendant's summary judgment motion on the grounds that noncompliance was not material even where it would establish the government's right to refuse payment because the relator "offered no evidence that the government's decision to pay would likely or actually have been different had it known of . . . [the] alleged noncompliance with [the] regulations."¹²² The Circuit for the District of Columbia as well found that a claim did not establish materiality when it was not clear that the government actually used fraudulent data

over interpretation of the FCA).

118. See *Abbot v. BP Expl. & Prod., Inc.*, 851 F.3d 384, 388 (5th Cir. 2017) (holding failure to obtain engineering approvals not sufficiently material).

119. See *id.* at 388 (ruling that the district court had correctly granted summary judgment).

120. See, e.g., *McLaughlin*, *supra* note 102, at 3–4 (including a discussion of the *Abbot* decision).

121. See *United States ex rel. Petratos v. Genentech Inc.*, 855 F.3d 481, 489–90 (3d Cir. 2017) (holding continued government payments after the government was knowledge indicated immateriality).

122. See *United States v. Sanford-Brown, Ltd.*, 840 F.3d 445, 447 (7th Cir. 2016) (holding failure to comply with applicable regulations not material).

for payment; even though it was not disputed that fraudulent data had been submitted.¹²³ These decisions are even more strict than the Fifth and Third Circuits' approach in that they found immateriality based on *speculation* that the government would still pay the claims.¹²⁴

While there is apparent potential for a circuit split, it is also true that circuits' applying a more plaintiff-friendly, or even less motion-to-dismiss-friendly, approach are in the clear minority.¹²⁵ The Sixth Circuit reversed a trial court's granting of a motion to dismiss on the grounds of regulatory noncompliance.¹²⁶ The circuit court reasoned that the discussion of immaterial regulatory noncompliance by the Supreme Court did not apply because the regulation in question was both an express condition *and* a mechanism of fraud prevention.¹²⁷ The court considered the government's past payments to offer no support in either direction and—in direct opposition to the Fifth Circuit—expressly overturned the trial court's inferences that government inaction pointed significantly to immateriality.¹²⁸

Perhaps most uniquely the Ninth Circuit has largely taken the approach that the Supreme Court's decision did not change anything.¹²⁹ Prior to the Supreme Court's decision, the Ninth Circuit had looked to its own precedent—*United States ex rel. Hendow v. University of Phoenix*¹³⁰—when examining cases

123. See *United States ex rel. McBride v. Halliburton Co.*, 848 F.3d 1027, 1032 (D.C. Cir. 2017) (holding relator did not adequately plead material facts).

124. See *id.* at 1034 (finding immateriality based on the speculative and generic nature of the statement); see also *United States v. Sanford-Brown, Ltd.*, 840 F.3d 445, 447 (7th Cir. 2016) (stating that speculation was insufficient to survive summary judgement).

125. See Farringer, *supra* note 108, at 1263 (stating that *Escobar* has changed the landscape such that the new standard is dismissing more cases than would have been prior).

126. See *United States ex rel. Prather v. Brookdale Senior Living Cmty.*, 892 F.3d 822, 836 (6th Cir. 2018) (holding relator's pleading of regulatory non-compliance).

127. See *id.* at 836 (emphasizing the regulations role in fraud prevention).

128. See *id.* at 834 (“[T]he government's payment of the claims irrelevant to the question of materiality.”).

129. See *United States ex rel. Rose v. Stephens Inst.*, 909 F.3d 1012, 1019 (9th Cir. 2018) (stating that their existing precedent was not irreconcilable with the reasoning or theory of *Escobar*).

130. See *United States of America ex rel. Hendow v. Univ. of Phx.*, 461 F.3d

sounding in the False Claims Act.¹³¹ As that court explained, “[W]e view *Escobar* as creating a ‘gloss’ on the analysis of materiality. But the four basic elements of a False Claims Act claim, set out in *Hendow*, remain valid.”¹³² While other circuits at least all agreed that materiality was a heavy burden on the plaintiff’s pleading, the Ninth Circuit continues to place the burden instead on the defendant reasoning that “[d]efendant has not established as a matter of law that its violations of the [regulation] were immaterial.”¹³³

3. *The Supreme Court Has Refused to Clarify the Escobar Standard*

It should also be noted that the Supreme Court has received numerous requests to clarify “unprincipled confusion as to when a false claim is sufficiently material to impose liability.”¹³⁴ For at least the third time in the past two years a petitioner requested that the Court clarify the *Escobar* materiality requirement.¹³⁵ These petitions have come from the 5th, 9th, and 10th circuits.¹³⁶

V. *The Need for Qui Tam-False Claims Act Oversight in Medicaid*

The need for qui tam actions to prosecute Medicaid fraud is of special importance.¹³⁷ In the first part of this section, the reality of

1166, 1174 (9th Cir. 2006) (holding the essential elements of FCA liability to be (1) a false statement or fraudulent course of conduct, (2) made with scienter, (3) that was material, causing (4) the government to pay out money or forfeit moneys due).

131. See *United States ex rel. Rose v. Stephens Inst.*, 909 F.3d 1012, 1020 (9th Cir. 2018) (holding the that the *Hendow* elements were not affected by the decision in *Escobar*).

132. See *id.* at 1020 (stating that the *Hendow* elements remain valid).

133. See *id.* (applying the *Escobar* standards of materiality).

134. Daniel Seiden, *Supreme Court Passes on Materiality Issue in Medicare Fraud Case*, BLOOMBERG LAW (Oct. 5, 2020, 9:43 AM), <https://www.bloomberglaw.com/product/blaw/document/XEUCI1G0000000> (last visited Nov. 11, 2020) [perma.cc/6AJS-WC4V].

135. See *id.* (listing denied cert petitions since January 2019).

136. See *id.* (providing a summary of recent cert petitions).

137. See Beck, *supra* note 30, at 562 (describing the nexus between FCA

inadequate government oversight is discussed both in terms of simple documentation as well as government prosecution. Moreover, this section discusses the current DOJ policies, which emphasize the importance of accessibility to justice and the court process where the government is less likely to intervene to bring the full resources of the United States government against those who would perpetrate fraud through a system designed to benefit our most vulnerable.¹³⁸

A. The Government is Incapable of Adequately Prosecuting or Even Estimating Fraud in Medicaid

In testimony provided to the United States Senate, the Government Accountability Office (GAO) reported that Medicaid represented \$596 billion in federal spending in 2017.¹³⁹ The GAO further testified that an estimated \$36.7 billion of those payments were improper.¹⁴⁰ The GAO also testified that Medicaid data reporting was inadequate to effectuate proper oversight.¹⁴¹ This is a significant weakness given the GAO's recommendation that "CMS still needs to conduct a fraud risk assessment and implement a risk-based antifraud strategy for Medicaid."¹⁴²

CMS itself, however, estimates that the Medicaid improper payment rate in 2019 rose to 14.9%, which amounts to improper payments in the amount of \$57.36 billion dollars.¹⁴³ The problem, however, is so systemic that even those numbers are themselves

claims and qui tam suits).

138. See *infra* section V.A.

139. See U.S. GOV'T ACCOUNTABILITY OFF., GAO-18-687T, MEDICAID: CMS HAS TAKEN STEPS TO ADDRESS PROGRAM RISKS BUT FURTHER ACTIONS NEEDED TO STRENGTHEN PROGRAM INTEGRITY 1 (2018) (estimating Medicaid expenditures in fiscal year 2017).

140. See *id.* (exemplifying the challenges of overseeing the program at a federal level).

141. See *id.* (stating the need for improved program oversight).

142. *Id.*

143. See *2019 Estimated Improper Payment Rates for Centers for Medicare & Medicaid Services (CMS) Programs*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 18, 2019), <https://www.cms.gov/newsroom/fact-sheets/2019-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs> (last visited Feb. 20, 2020) (using a table to display the change in improper payment rates) [perma.cc/YP3W-HXWC].

flawed and incapable of tracking well-executed fraud.¹⁴⁴ CMS offers the following disclaimer before disclosing the 2019 improper payment rate:

[I]mproper payment rates are not necessarily indicat[ive] of fraud OMB guidance states that when an agency’s review is unable to discern whether a payment was proper as a result of insufficient or missing documentation, this payment should be considered an improper payment However, if the documentation [of a fraudulent claim] had been submitted and properly maintained, then the payments may have been determined to be proper.¹⁴⁵

CMS does note the rate captures some fraud, but it offers no estimate of what that proportion is to the total it might be nor how it might be found in the data.¹⁴⁶

CMS notes that the 2018 to 2019 improper payment rates are not comparable due to the shifting nature of the data’s collection by sampling of seventeen states at a time with the District of Columbia.¹⁴⁷ Beneath that, however, CMS reveals that it is potential fraud itself which is corrupting the data through “[n]on-compliance with newer requirements for provider revalidation . . . [and] [c]ontinued non-compliance with provider enrollment, screening, and National Provider Information requirements.”¹⁴⁸ The data that should be used to track potential fraud in Medicaid has been rendered potentially incapable of doing so by the sheer rate of non-compliance which may be indicative of fraud.¹⁴⁹

The government is at least aware of the problem’s scope. The GAO’s report to Congressional committees in March of 2019 continues to list Medicaid program integrity as a “high risk

144. *See id.* (outlining the imperfections in data about improper payment rates).

145. *Id.*

146. *See id.* (“A smaller proportion of improper payments are payments that should not have been made or should have been made in different amounts and are considered a monetary loss to the government.”).

147. *See id.* (“[I]mproper payment rates increased between FY 2018 and 2019, these results are not comparable as the measurement as changed dramatically.”).

148. *Id.*

149. *See id.* (listing non-compliance as one of the factors that led to an increase in improper payment rates).

area.”¹⁵⁰ That high risk is due to the previously discussed data issues as well as the prevalence of improper payments and appropriate use of funds.¹⁵¹ While the GAO does accept that CMS has partially met goals to estimate and address fraud, the auditors note that the efforts described are not even capable of adequately reflecting the nature of the risks.¹⁵² Overall “more than 70 of [the GAO’s] recommendations related to Medicaid remain open, and several major steps remain to improve Medicaid program integrity.”¹⁵³

More worrisome is that as Medicaid shifts to managed care—administered by Managed Care Organizations (MCOs)—CMS oversight of those organizations is fundamentally inadequate, given that there is no medical review of services purported to be performed.¹⁵⁴ Examining the issue almost twenty years ago, Malcolm Sparrow pointed out “[f]raud perpetrators understand the dynamics of false claims extremely well . . . They bill their lies correctly.”¹⁵⁵ Administrative review alone ensures that “[t]here is no reason . . . to believe they will uncover false claims whenever false documentation is supplied to match the false claims.”¹⁵⁶ In one example from 1998 Senate testimony, a provider who admitted to committing fraud revealed how easy the administrative-focused review of fraud was to circumvent.¹⁵⁷ Finally, the effect of the shift to MCOs and the accompanying fraud “may be more dangerous to

150. U.S. GOV’T ACCOUNTABILITY OFF., GAO-19-157SP, HIGH-RISK SERIES: SUBSTANTIAL EFFORTS NEEDED TO ACHIEVE GREATER PROGRESS ON HIGH-RISK AREAS 250 (2019).

151. *See id.* (“Our recent work highlights oversight challenges in three areas: [I]mproper payments, appropriate use of program dollars, and data.”).

152. *See id.* at 251 (“However, efforts to date do not ensure CMS can estimate an improper payment rate for managed care that reflects all program risks.”).

153. *Id.* at 250.

154. *See id.* at 252 (“CMS’s estimates of MCO improper payments do not include a medical review of services or reviews of MCO records or data, which likely minimizes the appearance of program risks in Medicaid managed care.”).

155. *See* MALCOLM K. SPARROW, LICENSE TO STEAL: HOW FRAUD BLEEDS AMERICA’S HEALTH CARE SYSTEM 84 (Updated ed., 2000).

156. *Id.* at 92.

157. *See id.* at 92–93 (“In April 1998 . . . Watts, quickly figured out that if all the government ever did was compare claims submitted with the medical documentation provided . . . all he needed to do, when asked, was fabricate documents to match.”).

human health than the types of fraud familiar under traditional fee-for-service arrangements.”¹⁵⁸

The inability to pursue fraud adequately is not limited to CMS.¹⁵⁹ The measure of DOJ suits leading to recovery alone further suggests that initiating civil enforcement is too large a task for the department. The DOJ reported that in 2018 suits pursued under the False Claims Act concerning Health and Human Services, which includes Medicaid, led to settlements and judgments of over \$2.5 billion.¹⁶⁰ The vast majority of those recoveries, however, were launched by qui tam actions and constitute more than \$1.9 billion, or 77.4% of the total.¹⁶¹ The vast majority of the United States’ recovery for fraud perpetrated in the health care field was obtained by qui tam actions prior to government involvement.¹⁶²

It is also not true that qui tam actions are the aggregation of small frauds while the DOJ pursues larger fraudulent programs.¹⁶³ On January 22, 2019, Walgreens announced a \$269.2 million settlement of two qui tam FCA cases.¹⁶⁴ The relators alleged in one case that Walgreens was overcharging the Medicaid program for insulin provided to beneficiaries and in the other that they received discounts which were not disclosed to the government.¹⁶⁵ The fraud

158. See MALCOLM K. SPARROW, FRAUD CONTROL IN THE HEALTH CARE INDUSTRY: ASSESSING THE STATE OF THE ART, NATIONAL INSTITUTE OF JUSTICE 9 (Dec. 1998).

159. See CIV. DIV., U.S. DEP’T OF JUST., FRAUD STATISTICS-OVERVIEW: OCTOBER 1, 1986 - SEPTEMBER 30, 2018 3 (2019) (totaling qui tam suit recoveries).

160. *Id.*

161. See *id.* (offering a total of fraud case recoveries from the spreadsheet).

162. See *id.* (indicating that larger numbers of recovery for fraud was obtained by qui tam actions than those in which the government intervened).

163. See Joan H. Krause, *Reflections on Certification, Interpretation, and the Quest for Fraud That “Counts” Under the False Claims Act*, 2017 U. ILL. L. REV. 1811, 1816 (2017) (stating that qui tam cases are filed by a wide range of individuals and entities).

164. See Johnathan Stempel, *Walgreens pays \$269.2 Million to Settle U.S. Civil Fraud Lawsuits*, REUTERS (Jan. 22, 2019, 5:04 PM), <https://www.reuters.com/article/us-walgreens-boots-settlement/walgreens-pays-269-2-million-to-settle-u-s-civil-fraud-lawsuits-idUSKCN1PG2PF> (last visited Feb. 19, 2020) (“Walgreens Boots Alliance Inc will pay \$269.2 million to settle two whistleblower lawsuits accusing it of civil fraud for overbilling federal healthcare programs over a decade.”) [perma.cc/DR4D-SB3C].

165. See *id.* (describing the nature of the two lawsuits).

perpetrated on Medicaid was so large that “46 states and D.C. have joined with the Federal government” as parties to one of the lawsuits.¹⁶⁶ Despite the immense scope and scale, “the [first] investigation resulted from a *qui tam* action originally filed in 2012.”¹⁶⁷ The second investigation originated with “[t]wo pharmacists . . . [and] insulin pens in July 2015” who also filed a *qui tam* complaint.¹⁶⁸ In cases of legally proven, admitted, or settled fraud, the government is overwhelmingly relying on citizen relators rather than government agencies.¹⁶⁹

VI. Medicaid Fraud Inherently Affects and Disadvantages the Most Vulnerable Communities

This section is the most important of this Note. While Medicaid definitionally benefits our most vulnerable, it is important to document and explicitly talk about what that means. The first section discusses the realities of how Medicaid primarily benefits not simply the poor, but especially administers social justice solutions to racial minorities and those with disabilities. The discussion then moves to discuss how Medicaid fraud is not a benign threat or simply a taxpayer issue—it results in real physical danger to those who use the program for medical care. Finally, a brief discussion is included of the systemic and existential threat posed by Medicaid fraud to the very existence of Medicaid.

A. Demographic Overviews Reveal Minorities and Disabled Individuals Are Disproportionately Affected

166. See Jorge E. Perez-Casellas, Managing Director, Ankura, Puerto Rico False Claims Act: Perspectives and Implications to your Compliance Program, Presentation at HCCA San Juan Regional Compliance Conference (May 16, 2019) (available in HCCA archives) (detailing the national reach of Walgreens fraudulent dealings).

167. *Id.*

168. See *id.* (filing complaint by two pharmacist relators concerning insulin pens).

169. See Krause, *supra* note 163, at 1816 (positing that the *qui tam* mechanism ensures that FCA cases will be filed by a wide range of individuals and entities other than federal prosecutors).

Medicaid by nature is offered to the most at-risk members of the community for whom other health care options are not realistically available, and as a result Medicaid fraud is necessarily an issue for impoverished communities.¹⁷⁰ Mandatory eligibility for Medicaid is limited to low-income families, pregnant women, children, and individuals already qualified for social welfare under the Supplemental Security Income program.¹⁷¹ In addition, there are some individuals eligible for Medicaid who—despite exceeding the poverty threshold—have medical needs so extensive that they are effectively rendered impoverished by the extent of their care or treatment.¹⁷² As a result, the quality of Medicaid care is an issue that unavoidably affects the most vulnerable communities in America given that they must already be living in absolute or effective poverty to even qualify for program participation.¹⁷³

Medicaid fraud ought to be considered a racial justice issue given the disproportionate representation of minorities among Medicaid beneficiaries.¹⁷⁴ For the fiscal year 2013, white populations made up the plurality of Medicaid enrollees at 40%; however, the other 60% was composed of 21% African Americans, 25% Hispanic Americans, and 14% other racial groups.¹⁷⁵ During the same time period the overall racial make-up of the United

170. See *Eligibility*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/eligibility/index.html> (last visited Feb. 21, 2020) (citing low income families as beneficiaries of Medicaid) [perma.cc/Y9KF-KDUL].

171. See *id.* (“Low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups.”).

172. See *id.* (“Once an individual’s incurred expenses exceed the difference between the individual’s income and the state’s medically needy income level (the “spenddown” amount), the person can be eligible for Medicaid.”).

173. See *id.* (listing the groups of individuals who qualify for program participation).

174. See John V. Jacobi, Special Feature: Medicaid Matters: *Medicaid Evolution for the 21st Century*, 102 KY. L. J. 357, 360 (2013/2014) (stating that racial minorities are among a large percent of Medicaid enrollees).

175. See *Medicaid Enrollment by Race/Ethnicity*, KAISER FAMILY FOUND., <https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Feb. 21, 2020) (providing a searchable database of Medicaid demographics) [perma.cc/WE5H-SWGA].

States indicated whites represented 63% of the population, African Americans 12%, Hispanic Americans 17%, and all other groups 8%.¹⁷⁶ This indicates that minority groups, traditionally economically disadvantaged by societal factors too broad to be addressed here, are accordingly disproportionately represented in the Medicaid enrollee numbers.

Moreover, Medicaid fraud is also a significant issue for disability advocates.¹⁷⁷ For the last year in which data is available, the number of Medicaid enrolled children who qualified through a disability pathway totaled almost 1.6 million.¹⁷⁸ Individuals deemed categorically eligible for Medicaid include a number of adult disability groups including: “disabled individuals in 209(b) states;” “disabled individuals eligible in 1973;” “working disabled;” and “qualified disabled” as mandated by sections of the Social Security Act and other government regulation.¹⁷⁹

B. Medicaid Fraud Creates Acute Standard of Care Issues Which Can Kill or Injure the Very Beneficiaries Medicaid is Supposed to Save

176. See *Populations Distribution by Race/Ethnicity*, KAISER FAM. FOUND., <https://www.kff.org/other/state-indicator/distribution-by-raceethnicity/?currentTimeframe=5&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Feb. 21, 2020) (providing a searchable database of demographics for the entire population) [perma.cc/N3H8-KMXW].

177. See *Medicaid Enrollees by Enrollment Group*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-enrollees-by-enrollment-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Sept. 28, 2020) (displaying total enrollment numbers for people with disabilities) [perma.cc/TA3N-LKXE].

178. See *Medicaid Enrollment of Children Qualifying Through a Disability Pathway*, KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-of-children-qualifying-through-a-disability-pathway/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Feb. 21, 2020) (displaying total enrollment numbers for adolescent disabled Medicaid beneficiaries) [perma.cc/HQ3Y-WJCM].

179. See CTRS. FOR MEDICARE & MEDICAID SERVS., LIST OF MEDICAID ELIGIBILITY GROUPS: MANDATORY CATEGORICALLY NEEDY 1–2 (2019) (listing the eligibility groups for categorically needy groups and the corresponding Social Security Act and CFR citations).

The social justice implications of Medicaid fraud should not come as a shock. The unique impact of Medicaid fraud on impoverished racial minorities is demonstrated in the very case that serves as the basis of this Note. The Supreme Court's decision in *Escobar* ultimately began with the tragic death of Yarushka Rivera.¹⁸⁰ Yarushka's parents sought only to help their teenage daughter receive counseling services to resolve behavioral issues.¹⁸¹ Yarushka was a young woman of color, living in poverty, and had she not died after having been wrongfully prescribed, she may have received a diagnosis entitling her to disability protections.¹⁸² The danger of Medicaid fraud perpetrated on America's most vulnerable communities could scarcely find a better example than the young woman whose tragic death launched the very case and subsequent Court opinion that now makes it easier to perpetrate the type of fraud that led to her death.¹⁸³

Yarushka Rivera's story is likely not an anomaly. Data collected by the Kaiser Family Foundation suggest that the rate of Medicaid beneficiaries receiving anti-psychotic medications—the very medication type that caused the seizures which killed Yarushka—is more than four times the overall rate in the country.¹⁸⁴ While there may be a higher incidence of mental health disorders among the impoverished, studies suggest that the current Medicaid payment model incentivizes providers to administer services as “efficiently” as possible—often at the cost of quality of care.¹⁸⁵ Yarushka's case illustrates providers' efforts to provide services at the highest profit margin possible by sometimes employing individuals who work at a lower labor rate than their

180. See *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 1997 (2016) (describing the details of Yarushka's death).

181. See *id.* at 1997 (detailing how Yarushka became a patient at Arbour).

182. See *supra* Subpart III.A (detailing the facts of the *Escobar* decision).

183. See *supra* Subpart III.A (explaining the details of the *Escobar* decision).

184. See LIZ BORKOWSKI ET. AL, *IMPACTS OF PHARMACEUTICAL MARKETING ON HEALTHCARE SERVICES IN THE DISTRICT OF COLUMBIA* 7 (2012) (“[T]he national average percentage of Medicaid beneficiaries receiving antipsychotics for all states was 5.4% . . . [i]n the general population, an estimated 1.2% of the US population filled antipsychotic prescriptions.”).

185. See Sparrow, *supra* note 158, at 7–8 (explaining the dangers of the current CMS payment system which incentivize fraud).

qualified peers and may lack the requisite credentials to do the very jobs they were assigned.¹⁸⁶

One of the most striking aspects of these acute failures in Medicaid-provided care is that the most accurate statistic available is the settlement and judgment rate of FCA suits concerning the Department of Health Services.¹⁸⁷ Those statistics alone, however, have serious shortcomings as indicators of acute mistreatment.¹⁸⁸ That number includes a variety of cases which involve overbilling for otherwise adequate products, and there is no methodical break down of when false claims in medical services cross the line from price fraudulent to the life-threatening fraud which killed Yarushka.¹⁸⁹

Furthermore, the demonstrated inability of the government to track Medicaid fraud will only further incentivize those who wish to engage in fraud.¹⁹⁰ Even before *Escobar* weakened the qui tam provision, studies suggested that “[o]ne of the markers of a physician’s willingness to ‘game’ program rules is whether more than 25% of a physician’s patients are on Medicaid.”¹⁹¹ In other words, providers are more willing to engage in Medicaid fraud when they have large Medicaid practices, only compounding the impact of their willingness to submit false claims. This is a further systemic issue for Medicaid funds in any given year.¹⁹²

186. See *Universal Health Serv.’s, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 1997 (2016) (clarifying that only one of the professionals who had treated Yarushka was licensed).

187. See U.S. DEP’T OF JUST., *supra* note 160 (providing statistics of false claims recovery in suits concerning the DHHS).

188. See U.S. DEP’T OF JUST., *supra* note 160 (failing to include acute mistreatment not captured by the statistics).

189. See U.S. DEP’T OF JUST., *supra* note 160 (lacking analysis of the type of fraud that occurred in *Escobar*).

190. See Sparrow, *supra* note 155, at 102–05 (discussing the incentives of fraud where government enforcement is lacking in Medicaid).

191. See Matthew K. Wynia, *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and Hard Place*, 283 J. AM. MED. ASS’N 1858, 1863 (2000) (analyzing the rates of physician manipulation of reimbursement rate).

192. See U.S. DEP’T OF JUST., *supra* note 160 (showing the figures reported by the DOJ in determining allocation of Medicaid resources).

*C. Medicaid Fraud Has a Chronic, Systemic Impact Which
Imperils Even Those Medicaid Beneficiaries Receiving Proper
Care*

DOJ recovery statistics are an indicator of the provable drawdown of the finite resources available to Medicaid.¹⁹³ Appropriations for Medicaid equaled almost \$420 billion in fiscal year 2019.¹⁹⁴ Even with such large outlays, the borders of Medicaid's capability to adequately serve their legally mandated beneficiaries have been exposed due to financial considerations.¹⁹⁵ In Puerto Rico, for example, funding shortfalls could "trigger coverage losses of one-third to one-half" of the current Medicaid beneficiaries.¹⁹⁶ While these shortfalls in territorial Medicaid funding are not alleged to have been caused by fraud, these examples serve to present the reality that the exhaustion of Medicaid funding is a real possibility and that the result is a loss of medical treatment for beneficiaries.¹⁹⁷

The danger to the current Medicaid appropriations from fraud is not the only funding concern associated with ongoing Medicaid fraud.¹⁹⁸ Every year, appropriations for Medicaid are derived from the political machinations of Congress.¹⁹⁹ Ongoing fraud in Medicaid consistently draws the attention of a number of

193. See, e.g., Kevin D. Williamson, *The Facts about Medicaid Fraud*, NAT'L REV. (Sep. 11, 2016 8:00 AM), <https://www.nationalreview.com/2016/09/medicaid-fraud-staggering-cost-140-billion/> (last visited Feb. 20, 2020) (stating that improper payments under Medicaid are so common that DHHS that it accounted for 12% of total Medicaid spending) [perma.cc/W467-7PLU].

194. See DEP'T OF HEALTH & HUMAN SERV.'S, FY-2020 BUDGET IN BRIEF 98 (2020) (charting the total net outlays of legislative proposals for Medicaid in 2019).

195. See Robin Rudowits, et al., *Medicaid Financing Cliff: Implications for the Health Care Systems in Puerto Rico and USVI*, KAISER FAM. FOUND. (MAY 2, 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-cliff-implications-for-the-health-care-systems-in-puerto-rico-and-usvi/> (last visited Feb. 21, 2020) (detailing the Medicaid financial crisis faces in U.S. territories) [perma.cc/N5W3-WCY7].

196. See *id.* (estimating potential coverage losses due to funding shortfalls).

197. See *id.* (highlighting the financing challenges following natural disasters in U.S. territories).

198. See Rapperport, *infra* note 202 (reporting the possibility of Medicare cuts under the current administration).

199. See DEP'T OF HEALTH & HUMAN SERVS., *supra* note 194, at 12 (recognizing that congress has the authority to implement more sweeping changes).

publications and organizations who use it as political leverage to argue for the diminishment or end of Medicaid entirely.²⁰⁰ Fraud serves as effective ammunition in the argument against the size and expenditure of the Medicaid program even as the number of uninsured children in the country rises for the first time in years.²⁰¹ The danger of ongoing fraud to the Medicaid system is potentially existential in an easily foreseeable political environment.²⁰²

VII. Resurrecting the False Claims Act's Qui Tam Provision to Combat Medicaid Fraud

The clearest path forward to making the False Claims Act effective to combatting Medicaid fraud is to adopt the proven strategy Congress has embraced in FCA's past: Statutory amendment.²⁰³ Congress has regularly amended the False Claims Act in response to Court decisions in order to effectuate the purpose of the act in changing legal and regulatory realities.²⁰⁴ The False Claims Act currently defines materiality as "having the natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."²⁰⁵ In order to resurrect the qui tam provision as an effective tool to combat fraud, preserve Medicaid, and help safeguard our most vulnerable communities, Congress should amend the False Claims Act's materiality definition to provide clarity that the decision of a government agency to expressly designate terms as a condition of payment should be considered automatically material in the courts.

200. See Williamson, *supra* note 193 (mischaracterizing Medicaid payment data to case doubt on the validity of the program).

201. See Joan Alker & Lauren Roygardner, *The Number of Uninsured Children is on the Rise*, GEO. U. CTR. FOR CHILD. & FAM., (Oct. 29, 2019), <https://ccf.georgetown.edu/2019/10/29/the-number-of-uninsured-children-in-on-the-rise-acs/> (last visited Feb. 20, 2020) (showing a rise of 400,000 more uninsured children nationwide between 2016 and 2018) [perma.cc/QKA3-C4W7].

202. See, e.g., Alan Rappeport & Maggie Haberman, *Trump Opens Possibility of Making Medicare Cuts*, N.Y. TIMES, Jan. 23, 2020, at A20 (detailing the potential for large cuts to Medicaid funding).

203. See *supra* Subpart II.A (outlining the history of the statute).

204. See *supra* Subpart II.A (detailing the history of statutory amendment in response Supreme Court decisions).

205. 31 U.S.C. § 3729(b)(4) (2018).

In constructing this proposal, it is important to begin with why a judicial framework alone will not re-effectuate the purpose of the FCA after *Escobar*.²⁰⁶ It is possible that the Court could apply previously utilized reasoning in other complex determinations; however, that will also reveal fundamental flaws.²⁰⁷ Having found the judicially available tools inadequate, this Note will offer a statutory amendment to bring the FCA back to the original intent of Congress.

A. The Status Quo Precludes an Adequate General Judicial Framework of FCA Materiality

In the first instance, judicial adoption of a modified materiality standard is likely impossible. The lower courts are bound by the decision of the Supreme Court, which decisively reasoned in *Escobar*: “[s]ection 3729(b)(4) defines materiality using language that we have employed [previously] This requirement descends from ‘common-law antecedents.’”²⁰⁸ The Court did not discuss what the implications of these common law antecedents are beyond offering citations to well respected legal tracts.²⁰⁹ Paradoxically, the materiality standard the Court offered excludes the black letter rule of the current Restatement on Contracts, which allows for repudiation where express terms are not satisfied.²¹⁰ In a footnote, the Court comes the closest to

206. Cf. *infra* Section VII.A (explaining the inadequacy of the judicial framework to re-effectuate the purpose of the FCA post-*Escobar*).

207. See *infra* Section VII.A (detailing the rationale for arguing that judicial modification of the standard is insufficient).

208. See *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2002 (2016) (citing *Kungys v. United States*, 485 U.S. 759, 769 (1988)) (noting in citation that this language’s application in immigration fraud is considered identical by the Court).

209. See *id.* (explaining materiality through citations to *R. Lord, Williston on Contracts* and the second restatements of torts and contracts respectively and reciting their definitions).

210. Compare *Escobar*, 136 S. Ct. at 2003 (“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.”), with RESTATEMENT (SECOND) OF CONTRACTS § 253(2) (AM. LAW INST. 1981) (“Where performances are to be exchanged under an exchange of promises, one party’s repudiation of a duty to render performance discharges the other party’s remaining duties to render performance.”).

offering a succinct definition when it quotes Cardozo’s maxim that materiality concerns those things that “went to the very essence of the bargain.”²¹¹

The critical question, however, becomes what is “material” under a statute that governs such a wide variety of contracts where the only common feature is federal payment? The government has arguably made a good faith effort to provide such a standard in contractual express conditions of payment.²¹² Yet, the Supreme Court has said that is not indicative of materiality.²¹³ Lower courts applying the new standard have found continued payments to be an indicator.²¹⁴ However, this ignores the reality that inspectors, investigators, and the administrative payment structure are frequently totally disconnected from each other.²¹⁵ It is apparent that efforts to approach materiality across the divergent fields captured by the False Claims Act are hampered by the fixing of materiality in common law antecedents.²¹⁶ Nowhere is this more apparent than in its application to the complexity of Medicaid fraud.²¹⁷

The judiciary has routinely found itself wanting of the precise, technical expertise required for legal solutions to problems within the policy-laden administrative sphere.²¹⁸ The FCA far predates

211. *Escobar*, 136 S. Ct. at 2003 n.5 (citing *Junius Constr. Co. v. Cohen*, 257 N.Y. 393, 400 (1931)).

212. *See id.* at 514 (“The express and absolute language of the regulation in question . . . constitute dispositive evidence of materiality.”) (citations omitted).

213. *See supra* Subpart III.B (explaining how express designations of payment are not indicative of materiality according to the Supreme Court’s opinion in *Escobar*).

214. *See supra* Subpart V.A (exploring the difficulties of compiling reliable data, the complex nature of Medicaid administration, and inadequacy of the “improper payment rate” to capture fraud).

215. *See supra* Section IV.B.2 (documenting lower courts application of the *Escobar* materiality standard).

216. *See generally, Escobar* 136 S. Ct. at 1989 (holding that materiality under the act is derived from demanding common law antecedents).

217. *See supra* Part III.B (establishing that the FCA incorporates the heightened common law definition of materiality); *see also supra* Part VII (arguing that amending the FCA materiality definition needs to be amended to provide clarity).

218. *See e.g., Auer v. Robbins*, 519 U.S. 452, 457–58 (1997) (holding administrative agency’s interpretation of its own regulation as authoritative).

the origination of what is now referred to as administrative law.²¹⁹ From the Court's perspective, the FCA does not implicate administrative law at all, instead developing its foundations from contract common law.²²⁰ This view wholly ignores the complex administrative policy determinations that are the heart of Medicaid's existence.²²¹ It also ignores the complex subject matter of medical care organizations dealing with hundreds or thousands of patients in at-risk communities.²²² Finally, it totally fails to take into account the inherent complexity of a program that is administered under different regimes by each state, territory, and the District of Columbia.²²³

Absent new express language to the contrary within the statute, lower courts must abide by the Supreme Court's interpretation within *Escobar*.²²⁴ The Supreme Court previously adopted a more flexible approach that may have been more appropriate for the current realities of Medicaid fraud and the FCA generally, but that decision's reasoning has never been widely considered and was obviously not part of the Court's reasoning in *Escobar*.²²⁵ Of relevant difference between that decision and the FCA generally, however, is that it concerned an antitrust issue over which Congress had specifically delegated its authority to an

219. See Malcom J. Harkins III, *The Ubiquitous False Claims Act: The Incongruous Relationship Between a Civil War Era Fraud Statute and the Modern Administrative State*, 1 ST. LOUIS U. J. HEALTH L. & POLY 131, 141 (2007) (explaining that the rise of administrative law system postdates the FCA).

220. See *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2002–03 (2016) (using common law sources to explain the materiality requirement).

221. See *supra* Part II (outlining the history of the FCA's revisions in response to Supreme Court decisions considered contrary to the act's intent).

222. See *supra* Part VI (arguing Medicaid fraud leaves patients at risk).

223. See generally CONGRESSIONAL RESEARCH SERVICE, *MEDICAID FUNDING FOR THE TERRITORIES* (2019) (outlining fundamental differences between state and territorial governments' administration of Medicaid).

224. See *supra* Part III.B (outlining the new standard set forth in *Escobar*).

225. See *Ricci v. Chi. Mercantile Exch.*, 409 U.S. 289, 289 (1973) (holding the Seventh Circuit's stay of proceedings until there is a commission ruling to be appropriate) (“[P]roceedings should be stated until the [the commission] can pass on the validity of respondents’ conduct . . . determination of whether the [administrative body]’s rules were violated as petitioner claims or were followed requires a factual determination within the special competence of the Commission.”).

agency.²²⁶ Despite the breadth of the Medicaid program, the relevant federal agencies for its administration are incapable of fully documenting the program and have no adjudicatory powers.²²⁷ The solution might be found in the various state Medicaid regulatory bodies; but, the potential impact of state regulatory bodies in the enforcement of a federal regulation is beyond the scope of this Note.²²⁸ In either event, the controlling decision for the lower courts, *Escobar*, makes no mention of this reasoning.

B. A Statutory Amendment Will Allow for Reliable and Accurate Materiality Determinations in FCA Suits

Given the practical impossibility of adopting a judicial framework to remedy the material problem, the answer is for Congress to amend the FCA's materiality definition to give the courts clear guidance. As discussed earlier this is the generally accepted approach for adapting the FCA to present realities and policy challenges over its more than a century-and-a-half existence.²²⁹ This Note's proposal, however, differs from previous attempts in that it seeks to recognize the wide breadth of the FCA's covering all government contracts while also allowing for a solution to the Medicaid-specific issues that are the focus here.²³⁰ This proposal allows for the government to choose between materiality standards where appropriate. This crucially allows for contracting agencies to select the appropriate standard and provides notice to contractors on which standard they will face.

226. *See id.* at 307 ("Rather, we simply recognize that the Congress has established a specialized agency that would determine [whether a statutory provision] has been violated or that it has been followed.").

227. *See supra* Subpart V.A (discussing the inability of CMS and DHHS to document Medicaid fraud).

228. *See, e.g., Medicaid Fraud Division*, STATE OF N.J. OFF. OF THE STATE COMPTROLLER, <https://www.nj.gov/comptroller/divisions/medicaid/> (last visited Feb. 21, 2020) (describing the work of the Medicaid Fraud Division of the Office of the State Comptroller of New Jersey which could potentially offer its expert guidance to courts considering the materiality of terms in FCA Medicaid suits) [perma.cc/28Y3-36PV].

229. *See supra* Part II (outlining the history of the FCA's revisions in response to Supreme Court decisions considered contrary to the act's intent).

230. *See supra* Parts V, VI (describing issues within the Medicaid system).

This Note proposes that 31 U.S.C. § 3729(b)(4) should be amended to include a new subsection while still leaving the existing definition wholly intact. The amended section would read as follows:

(4) Material

(A) The term “material” will be interpreted by the courts to mean having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property; except where subsection (B) is specified.

(B) When this subsection is specified as governing by the text of the contract in question, “material” will be interpreted by courts to mean all express terms and conditions of payment.

This amendment gives a court that is hearing an FCA suit explicit guidance on the interpretative framework to use for the term “material.” This somewhat unusual solution—in that it provides two alternate materiality definitions in a single statute—creates a number of advantages that overcome potential objections.

The FCA covers everything from the medical care of vulnerable communities discussed in this Note to the building of nuclear propulsion systems for the United States Navy.²³¹ Few—if any—statutes still in the United States Code cover such a huge number of complex and disparate commercial issues.²³² This reflects the reality that the FCA was enacted at a time when the size and responsibilities taken on by the Federal government today would have been unimaginable to the act’s original drafters.²³³ Some contracting agencies may want to continue contracting under the holistic understanding of materiality of “common-law antecedents” as interpreted by the Court in *Escobar*.²³⁴ An agency may wish to do so as a result of negotiation, complexity making

231. See generally 31 U.S.C. § 3729 (2018).

232. See Harkins, *supra* note 219, at 133 (“Federal appellate and trial courts have struggled to apply the FCA in light of these changed circumstances . . . tension between the Civil War era FCA and the modern administrative state [is evident]. . .”).

233. See Calfee & Crawell, *supra* note 19 and accompanying text (describing the history of the FCA as originally enacted to capture defense procurement fraud in 1863).

234. See *Escobar*, 136 S. Ct. at 2003 (2016) (interpreting the materiality standard of the FCA as requiring a holistic and demanding standard).

express terms impracticable, or for any other reason the contracting official deems relevant.

This dual solution, however, also allows for the critical automatic incorporation of express terms as material in Medicaid. This advantage is especially useful in a program like Medicaid where the federal contribution creates FCA liability, but the express contract terms are predominantly the concern of the administering state agency.²³⁵ By giving effect to the express terms selected by the states the courts will also be respecting the realities of varying state medical licensure statutes and the need for local determinations.²³⁶ What amounts to the essence of the bargain concerning a traveling general practitioner working in a remote area of the Mountain West might be different from a specialized out-patient clinic in a major metropolitan area.²³⁷ When the proposed additional material definition is adopted, the decisions particular to each community's needs will be respected through express contract terms.²³⁸ Furthermore, it is impracticable for even a codification as large as the Federal Register to ever accurately capture the detail and constant evolution of the medical field.²³⁹ That detail and responsiveness is more likely within the capability of state regulators responsive to their local community.²⁴⁰

Moreover, this new section may allow for lower compliance costs.²⁴¹ By designating the express terms of the contract as

235. See Harkins, *supra* note 219, at 134 (“*Hendow* permits courts to decide whether a claim is false or fraudulent based on whether a contractor was in compliance with administrative requirements when it claimed payment from the government.”).

236. See *supra* Part IV (arguing uncertainty about the scope of the FCA has created challenges).

237. See *supra* Part VI (discussing systematic problems within Medicaid).

238. See *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2003 (2016) (“The materiality standard is demanding.”).

239. See Harkins, *supra* note 219, at 134 (“Recent cases evidence the difficulties experienced by courts and foreshadow even greater difficulties if the tension between the Civil War era FCA and the modern administrative state is not addressed and resolved.”).

240. See *Medicaid Fraud Division*, STATE OF N.J. OFF. OF THE STATE COMPTROLLER, *supra* note 228 and accompanying text (describing the work of the Medicaid Fraud Division of the Office of the State Comptroller of New Jersey which could potentially offer its expert guidance to courts considering the materiality of terms in FCA Medicaid suits).

241. See Harkins, *supra* note 219, at 165 (describing the prohibitive cost of

material, there will be significantly less uncertainty requiring legal counsel.²⁴² The express terms will capture the Medicaid provider's potential for liability.²⁴³ Providers will have specific notice of the contract terms that would be considered by a court to be material in a potential FCA suit. This enhanced certainty and the lower compliance costs will also effectuate an important Medicaid policy goal: expanding the provider base.²⁴⁴ With clearer compliance standards and lower compliance costs, existing providers will be incentivized to fully participate in Medicaid programs as well as expanding their existing footprints in heavily Medicaid dependent communities.²⁴⁵ Medicaid will be more fully capable of fulfilling its promise of delivering effective medical care to our most vulnerable communities with such wider and effective participation.²⁴⁶

C. The Clear Results of the Proposal's Effect on a Hypothetical FCA Suit

Suppose that a provider is administering treatments in an out-patient clinic to an underprivileged community using unlicensed staff according to state medical licensing standards. The provider's contract with the state Medicaid administering agency specifies "in interpretation of this contract by a court in a False Claims Act suit, 31 U.S.C. § 3729(b)(4)(B) will apply." Members of the community have been using the clinic with

defending an FCA action as a "bet the company cases" which are often settled as a business judgement).

242. See *id.* at 160 (explaining the tremendous potential for liability under the FCA if providers run afoul of the government).

243. See *supra* Part III (discussing *Universal Health Serv.'s, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 1997 (2016)).

244. See John V. Jacobi, *Mission and Markets in Healthcare: Protecting Essential Community Providers for the Poor*, 75 WASH. U. L. Q. 1431, 1431–32 (1997) ("A decade ago, entrepreneurs saw Medicaid services, particularly in primary or comprehensive care, as providing insufficient remunerative benefits to be worthwhile . . . Out of religious or social mission, however, a cadre of community health centers and community-oriented hospitals provided high-quality, culturally sensitive care to these underserved communities.").

245. See *id.* at 1437–38 (describing the general language and lack updating to address this language within the Medicaid system).

246. See *supra* Part VI (discussing the value that Medicaid provides).

unsatisfactory results when suddenly a young woman dies due to a prescription signed by an unlicensed and unqualified practitioner. The father of the young woman learns the staff is unlicensed and wants to bring a qui tam suit to shut down the clinic and the equivalent of punitive damages.²⁴⁷

The would-be relator will need to plead facts sufficient to establish a claim for fraud under the federal rules.²⁴⁸ Under the current *Escobar* materiality test, the relator will need to obtain significant information about the clinic's operation and regulatory know-how to satisfy the "demanding standard" pleading of *Escobar*.²⁴⁹ The relator may find a competent legal aid counsellor, qui tam specialist, or large law firm willing to take his case pro-bono; but still, the filing will surely be delayed as the complex, fact intensive complaint is drawn up.²⁵⁰ Moreover, the relator's ancient legal right to proceed pro se is practically eliminated by these realities.

Under the proposed language of the new section, the relator will only need to allege what he already knows: the staff is engaged in the unlicensed practice of medicine and receiving federal Medicaid funds for doing so. The relator brings his suit with a qui tam FCA complaint that may even be possible to bring pro se. The Medicaid contract specifies the express term materiality language of the new statutory language. The district court quickly finds that Medicaid expressly requires practitioners receiving payments be licensed by state authorities, and the clinic's motion to dismissed is denied.²⁵¹ The DOJ intervenes and uses its full

247. Cf. *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016) (comparing the facts of this hypothetical are similar to those found).

248. See FED. R. CIV. P. 9(b) (establishing the particularity requirements of pleading fraud).

249. See *supra* Subpart IV.B (exploring the application of the *Escobar* standard in lower courts to dismiss FCA suits); see also *supra* note 100 and accompanying text (describing the steps necessary to have a proper FCA claim).

250. See Harkins, *supra* note 219, at 165 (describing the prohibitive cost of defending an FCA action as a "bet the company cases" which are often settled as a business judgement).

251. The reality of how quickly a court can dispose of materiality when express conditions of payment are automatically dispositive of materiality are laid bare in the First Circuit opinion which preceded the Supreme Court's opinion and was noted earlier in this Note. See *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 780 F.3d 504, 514 ("The express and absolute language of

resources to prosecute the suit to the fullest extent of the law. The relator receives his share of damages as granted by statute, which he uses to help his family recover from the loss of their daughter.²⁵² Even if the defendant appeals, the reviewing court will be able to affirm the trial court's determination easily instead of engaging in a complex, holistic review of the finding of materiality.

Importantly, this explicit resolution also provides a clear deterrence effect to other Medicaid providers in the area.²⁵³ Medicaid providers would be strongly disincentivized from providing care that falls short of the express contractual requirements. The standard of care is raised, and the physical and mental health of a previously underserved community is improved. The potential benefits of increased healthcare in underprivileged communities are difficult to overstate and their discussion here is beyond the scope of this Note, but it must suffice to point out that wisdom of such a policy has underwritten Medicaid's fifty-five-year existence across administrations of both political parties, presidents with differing goals, and Congressional appropriations in economic climates both good and bad.

VIII. Conclusion

People want to know under what circumstances and how far they will run the risk of coming against what is so much stronger than themselves You can see very plainly that a bad man has as much reason as a good one for wishing to avoid an encounter with the public force A man who cares nothing for an ethical rule which is believed and practised by his neighbors is likely nevertheless to care a good deal to avoid being made to pay money.²⁵⁴

the regulation in question . . . constitute dispositive evidence of materiality.") (citations omitted).

252. See 31 U.S.C. § 3730(d) (2018) (establishing the award to the qui tam plaintiff).

253. See generally Richard Craswell & John E. Calfee, *Deterrence and Uncertain Legal Standards*, 2 J. L., ECON., & ORG.'S, no. 2 (Fall 1986) (detailing the enhanced deterrence of clear and certain legal standards in complex regulatory environments).

254. Oliver Wendell Holmes Jr., *The Path of the Law*, 10 HARV. L. REV. 457, 459 (1897).

Medicaid was enacted to help provide medical care for our most vulnerable communities.²⁵⁵ It has helped reinforce the social contract and reaffirmed our commitment as a nation of working to ensure that in this country poverty need not be a death penalty. The False Claims Act was enacted to help win a war against slavery.²⁵⁶ Today qui tam relators in Medicaid suits seek to use it to help win a war against poverty and injustice effectuated by those who would use fraud to rob them of adequate medical care.²⁵⁷

A statutory amendment reinstating the clear purpose and intended effect of the act will once again turn Lincoln's Law into a powerful weapon against other common enemies of this country: poverty and social injustice. By providing clear punishment for those who would take advantage of our nation's commitment to those most vulnerable among us, the False Claims Act can once again serve to deliver results and help achieve victory for a country in what has been its longest war.

255. See *supra* note 2 and accompanying text (discussing the goals of Medicaid).

256. See Harkins, *supra* note 219, at 139 ("The FCA is a Civil War era statute . . .").

257. See *supra* Part VII (arguing that the qui tam provision is a means to combat fraud in Medicaid).