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FIXED PAYMENT SCHEDULES DO NOT FORECLOSE LIABILITY UNDER THE FALSE CLAIMS ACT

Glen McClain

I. INTRODUCTION

The False Claims Act ("FCA") imposes civil liability on a government contractor who "knowingly makes [or] uses . . . a false record or statement material to a false or fraudulent claim" or who "knowingly makes [or] uses . . . a false record or statement material to an obligation to pay or transmit money or property to the government."[1] Liability can also arise under the FCA for a number of other forms of misconduct. While the FCA was originally enacted as a response to widespread fraud among government defense contractors during the Civil War,[2] it has become one of the government's most powerful tools in combatting fraud across multiple fields [3] including healthcare and education.[4] Indeed, the Act's treble damages and civil monetary penalties[5] make it a particularly effective weapon in the Department of Justice's prosecutorial arsenal.

One of the most extensively litigated elements of the FCA is the materiality requirement. The FCA defines materiality as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."[6] While several recent cases have refined the definition of materiality and clarified how courts should enforce it,[7] ambiguity continues to exist, particularly regarding how the material

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1. 31 U.S.C. §§ 3729(a)(1)(B)-(G) (West 2022).

2. Ryan Winkler, *The Civil False Claims Act and Its Unreasonably Broad Scope of Liability: The Need for Real "Clarifications" Following the Fraud Enforcement and Recovery Act of 2009*. CLEVELAND STATE L. REV. 533, 537 (2012).

3. United States v. Neifert-White Co., 390 U.S. 299, 233 (1968) (holding that the FCA "was intended to reach all types of fraud, without qualification, that might result in financial loss to the Government").

4. Press Release, U.S. Dep't of Just., Justice Department's False Claims Act Settlements and Judgements Exceed $5.6 Billion in Fiscal Year 2021 (Feb. 1, 2022), https://www.justice.gov/opa/pr/justice-department-s-false-claims-act-settlements-and-judgments-exceed-56-billion-fiscal-year (emphasizing that more than $5 billion of the total FCA settlements and judgments came from the healthcare industry).

5. 31 U.S.C. § 3729(a)(1)(G) (West 2022). Any person who violates the Act "is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 . . . plus 3 times the number of damages which the Government sustains because of the act." *Id.*

6. 31 U.S.C. § 3729(b)(4) (West 2022).

7. Universal Health Servs., Inc. v United States *ex rel.* Escobar, 579 U.S. 176 (2016). *See infra* notes 26-34; *see also* United States *ex rel.* Kelly v. Serco, Inc., 846 F.3d 325 (9th Cir. 2017) (holding that defendant's alleged failure to conform with cost report requirements was not substantial enough to be material to the government's payment decision); Ruckh v. Salus Rehab., LLC, 963 F.3d 1089 (11th Cir. 2020) (holding that *Escobar* rejects a "system of traps, zaps, and zingers" that allow the government to continue payment for fraudulent claims but recover for said fraud at a later date).

standard pertains to alternate payment models for government contractors. One such model, the capitation payment system of Medicare Advantage, is acutely relevant, given the Department of Justice's explicit emphasis that Medicare Advantage fraud would be an important priority in its future FCA litigation.[8] Despite the government's recent focus on false claims submitted because of Medicare Advantage plans, disagreement exists regarding whether noncompliance associated with claims for capitated payments, such as those by Medicare Advantage, can be material at all, thus possibly foreclosing FCA liability for Medicare Advantage Organizations ("MAO"). Such ambiguity persists although there is consensus among federal courts that misrepresentation of compliance with government requirements can be material to the government's decision to reimburse claims under Fee-For-Service Medicare ("FFS").[9]

The issue of MAO liability under the FCA is increasingly important. In 2015 alone, patient chart inflation by MAOs intended to increase capitation payments was responsible for nearly $2.3 billion in increased government payments to Medicare Advantage plans.[10] FCA claims against Medicare Advantage plans thus represent a particularly significant potential source of recouperation of misspent government funds. This article briefly reviews Medicare Advantage plans and the FCA materiality standard described by the Supreme Court followed by the current split in federal courts regarding FCA liability for claims for fixed payments from the government. This article then argues that Medicare Advantage and other capitated payment systems for government contractors must face

8. Press Release, U.S. Dep't of Just., Remarks of Deputy Assistant Attorney General Michael D. Granston at the ABA Civil False Claims Act and Qui Tam Enforcement Institute (Dec. 2, 2020), https://www.justice.gov/opa/speech/remarks-deputy-assistant-attorney-general-michael-d-granston-aba-civil-false-claims-act (calling Medicare Advantage fraud the "next frontier" in FCA cases); *see also Department of Justice Announces Two Medicare Advantage Fraud Matters Involving WLC Attorney*, WHISTLEBLOWER L. COLLABORATIVE (Sept. 8, 2021), https://www.whistleblowerllc.com/doj-announces-two-medicare-advantage-fraud-matters (intervention by Department of Justice in six separate FCA cases alleging Medicare Advantage fraud and settlement of one Medicare Advantage FCA case for $90 million).

9. *Supra* note 7. Under traditional Medicare, or Fee-For-Service (FFS) Medicare, the government reimburses providers directly based on a predetermined fee schedule, in which medical services, devices, and testing are assigned specific fees. Under Medicare Advantage, the government pays private insurers a monthly capitated payment based on the demographics of the insurer's beneficiaries, which does not take into consideration the type or amount of services used. See CONGRESSIONAL RESEARCH SERVICE, *Medicare Primer* 8-23 (R40425) https://crsreports.congress.gov/product/pdf/R/R40425.

10. David Meyers & Amal Trivedi. *Medicare Advantage Chart Reviews Are Associated with Billions in Additional Payments for Some Plans.* 59 MED. CARE 96, 98 (2022); *see also* Matthew Bedan et al., *Medicare Advantage Providers Be Aware: Choppy Enforcement Ahead,* BRADLEY (Mar. 10, 2021). https://www.bradley.com/insights/publications/2021/03/medicare-advantage-providers-be-aware-choppy-enforcement-waters-ahead (suggesting that the $2.3 trillion CARES Act funding during the COVID-19 pandemic represents a significant source of MAO fraud since CMS allowed risk adjustments to capitated premiums based on diagnoses given over telehealth).

liability under the FCA for material noncompliance with federal statutory and regulatory provisions.

II. MANAGED CARE ORGANIZATIONS AND MEDICARE

In 1982, the Tax Equity and Fiscal Responsibility Act permitted health maintenance organizations to contract with Medicare to provide services to Medicare recipients, creating what is now known as Medicare Advantage or Medicare Part C.[11] Unlike traditional FFS Medicare, in which providers submit claims to Medicare for individual services, Medicare Advantage uses a capitated payment model, in which private health plans are paid a monthly per-member fixed amount based on the member's expected healthcare expenditures, roughly $1,000 per member.[12] Because capitation payments are fixed regardless of whether the actual cost to the private health plan is higher or lower, plans participating in Medicare Advantage "assume" the risk of providing health services. In theory, assuming such risk encourages these plans to manage enrollee care in a way that minimizes services required, focusing instead on patient outcomes[13]. Such a system stands in stark contrast to FFS payment models, whose volume-based reimbursement schedule encourages providers to overutilize medical services.[14] The inherent value in Medicare Advantage is evidenced by its impressive growth, with a recent Congressional Budget Office projection estimating that Medicare Advantage plans would account for nearly 60% of all Medicare beneficiaries by 2032.[15]

While Medicare Advantage plans were designed to prevent the overutilization of services and minimize fraud, they are certainty not immune to fraud and abuse . Since capitation payments to MAOs are risk

11. Thomas G. McGuire et al., *An Economic History of Medicare Part C*, 89 MILBANK Q. 289, 290-91 (2011).

12. MILKEN INST. SCH. OF PUB. HEALTH, MEDICARE ADVANTAGE AND THE FALSE CLAIMS ACT 7-8 (2019), https://publichealth.gwu.edu/sites/default/files/downloads/HPM/ReportAdvantage.pdf; Susan Kelly, *AHA Urges DOJ to Probe Medicare Advantage Plans*, HEALTHCARE DIVE (May 23, 2022), https://www.healthcaredive.com/news/aha-doj-medicare-advantage-denials/624168. See also Jeannie F. Biniek, et al., *Higher and Faster Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges.* KAISER FAMILY FOUND. (Aug. 17, 2021). https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/ (Noting that in 2019, federal payments to Medicare Advantage averaged $11,844 per enrollee, or roughly $1,000 per month).

13. MILKEN INST. SCH. OF PUB. HEALTH, *supra* note 12, at 4-5.

14. Id., supra note 12, at 8, 10.

15. CONGRESSIONAL BUDGET OFFICE, Medicare Baseline Projections (May 2022). https://www.cbo.gov/system/files/2022-05/51302-2022-05-medicare.pdf. See also Meredith Freed, et al., *Medicare Advantage in 2022: Enrollment Update and Key Trends*, KAISER FAMILY FOUND. (Aug. 25, 2022). https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/.

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adjusted based on patient health and complexity, Medicare Advantage plans receive increased reimbursements for sicker patients and lower payments for healthier enrollees.[16] Consequently, plans that engage in retrospective chart review could add diagnosis codes to patient charts to make them appear sicker, even if such codes were not relevant to the services provided.[17] Further, because capitated payments are fixed, plans could deny beneficiary access to necessary services or deny payments to providers for services already rendered in order to keep a larger share of the government payment.[18] Similarly, FCA liability could be implicated by the submission of falsified enrollees or by certification of compliance with a material government requirement, regardless of knowledge of noncompliance.[19]

Overbilling by Medicare Advantage plans is responsible for billions of dollars of government waste every year, with eight of the top ten largest MAOs found to have engaged in overbilling according to a report by the U.S. Inspector General.[20] According to a report by the Kaiser Family Foundation, average gross margins for Medicare Advantage plans, or the difference between premiums collected and expenses incurred, increased every year from 2006 to 2017, with Medicare Advantage plans receiving almost twice the margins received by other Medicare plans purchased by individuals or employers.[21] In fact, the anywhere from $12 billion to $25 billion in overpayments by MAOs in 2020 could have funded the U.S. Environmental Protection Agency's entire budget or provided hearing

16. McGuire et al., *supra* note 11, at 290-92.

17. Meyers & Trivedi, *supra* note 10, at 96 (2021). The process of retrospective chart review to inflate how sick a plan's enrollees appear has been coined "upcoding." *Id.*

18. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (April 2022, OEI-09-18-00260). https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf (Finding 13% of patient prior authorization request denials and 18% of provider payment request denials by MAOs in June 2019 would have been granted under FFS Medicare).

19. Universal Health Servs., Inc. v United States *ex rel.* Escobar, 579 U.S. 176, 194 (2016) (holding that misrepresentations about compliance with express or implied government provisions must be material to the government's payment decision in order to be actionable under the FCA).

20. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments (September 2021, OEI-03-17-00474). https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf (Also finding that one MAO generated 40% of payments for diagnoses based solely on patient chart review, despite only enrolling 20% of all Medicare Advantage plan beneficiaries). See also Reed Abelson & Margot Sanger-Katz, *'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions*, N.Y. TIMES (Oct. 8, 2022), https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html.

21. Gretchen Jacobson et al., *Financial Performance of Medicare Advantage, Individual, and Group Health Insurance Markets*, KAISER FAMILY FOUND. (Aug. 5, 2019).
https://www.kff.org/report-section/financial-performance-of-medicare-advantage-individual-and-group-health-insurance-markets-issue-brief.

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and dental coverage to all Medicare enrollees during the same year.[22] Thus, despite being designed to disincentivize fraud, Medicare Advantage plans pose a significant public policy challenge, broadening plan choice for Medicare enrollees but also requiring significant financial oversight.

This is not to say that overbilling by Medicare Advantage plans has been immune to government accountability. In an October 2022 press release, the U.S. Department of Justice ("DOJ") announced a civil suit against Cigna and its MAOs, claiming that Cigna collected millions of dollars in false claims through an elaborate system of home visits meant solely to augment patient charts rather than provide services.[23] The DOJ argued that a home visit scheme meant to optimize risk adjustment payments without any clear change to patient treatment or management violated International Classification of Diseases Guidelines, which require medical documentation that support any additional diagnoses.[24] Furthermore, the DOJ accused an operator of several Medicare Advantage plans in 2021 of using a data mining company to engage in a similar scheme of identifying missed diagnoses as a means of pocketing more revenue.[25] By exploiting public funds meant for seniors, many MAOs continue to cost taxpayers billions of dollars and erode the trust of the healthcare community and the public at large.

III. *ESCOBAR* AND THE MATERIALITY STANDARD

In a landmark 2016 ruling, *Universal Health Services, Inc. v. United States* ex rel. *Escobar*,[26] the Supreme Court clarified the materiality requirement under the FCA amidst a wide circuit split on the issue. There, the government alleged that United Health Services provided mental health services to patients despite knowing that the care providers lacked proper licensure as required by state law, thus violating the FCA.[27] The government premised liability for the misrepresentation under the "implied false certification theory," whereby payment requests to the government certified compliance with the relevant statutory and

22. Abelson & Sanger-Katz, *supra* note 20.

23. Press Release, U.S. Dep't of Just., United States Files Civil Fraud Lawsuit Against Cigna for Artificially Inflating Its Medicare Advantage Payments (Oct. 17, 2022), https://www.justice.gov/usao-sdny/pr/united-states-files-civil-fraud-lawsuit-against-cigna-artificially-inflating-its.

24. *Id.*

25. Fred Schulte, *The DOJ Says a Data Mining Company Fabricated Medical Diagnoses to Make Money*, NPR (Sept. 14, 2021). https://www.npr.org/sections/health-shots/2021/09/14/1036776812/medicare-advantage-fraud-data-mining.

26. 579 U.S. 176 (2016).

27. *Id.* at 184, 187 (Under the implied false certification theory, government contractors may not submit claims "without disclosing violations of statutory, regulatory, or contractual requirements.").

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regulatory requirements of the state Medicaid program.[28] United Health Services, however, argued that it could not be held liable for failing to disclose violations of legal requirements unless one of the statutes or regulations violated expressly indicated that reimbursement was conditioned on compliance.[29]

Taking a separate position, the Court held that, regardless of whether a statutory, regulatory, or contractual requirement was an express or implied condition of compliance, any misrepresentation about compliance with the requirement *must be material* to the government's decision to pay the contractor to be actionable under the FCA.[30] In clarifying how materiality would be enforced, the Court emphasized that the government's decision to clearly identify a provision as a condition of payment was not automatically dispositive.[31] Rather, it instructed courts to also examine evidence of the government's likely or actual response with respect to payment of noncompliant claims *and* whether the materiality was substantial,[32] that is, whether it went to the "essence of the bargain."[33] In refining the FCA's materiality standard, the Court noted that evidence that the government continued to pay a claim despite knowledge of noncompliance with certain requirements carried a strong presumption of materiality.[34] In doing so, the Court made the government's decision to pay a claim an essential component of the materiality test. Indeed, the fundamental inquiry is "whether a piece of information is sufficiently important to influence the [government's] behavior..." regarding payment.[35]

IV. CAN NONCOMPLIANT CLAIMS SUBMITTED BY MAOS BE MATERIAL TO THE GOVERNMENT'S PAYMENT DECISION?

A. Misrepresentation by MAOs Cannot *be Material to the Government's Payment Decision*

Given the fact that capitated payments are fixed, some courts have held that misrepresentations made by Medicare Advantage plans cannot be

28. *Id.* at 177.

29. *Id.* at 178.

30. *Id.* at 192.

31. *Id.* at 194.

32. *Id.* ("A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular . . . requirement as a condition of payment. Nor is it sufficient . . . that the Government would have the option to decline to pay if it knew of the . . . noncompliance . . . [or] where noncompliance is minor or insubstantial.").

33. *Id.* at 194 n.5 (quoting Neder v. United States, 527 U.S. 1, 16, 22 n.5 (1999)).

34. *Id.* at 194.

35. United States *ex rel.* Winkelman v. CVS Caremark Corp., 827 F.3d 201, 211 (1st Cir. 2016).

material to the government's payment decision. After all, the government has agreed to pay Medicare Advantage plans a specific amount per enrollee based on annually submitted risk-adjusted patient data.[36] If a Medicare Advantage plan were to submit claims with false certifications, the government would continue to pay the agreed-upon amount. Thus, the misrepresentation would not result in the Medicare Advantage plan receiving more funds. Because *Escobar* highlighted the government's payment decision as a crucial part of the materiality test for FCA liability,[37] it may follow that the government's continued capitation payment creates a strong presumption against materiality. This is precisely what several jurisdictions have concluded.

In *United States* v. *UnitedHealthcare Insurance Co.,* the U.S. District Court for the Northern District of Illinois held that the government is not harmed when Medicare Advantage providers perform unnecessary or uncovered services since those plans assume the risk that would normally be carried by traditional Medicare.[38] There, the relator alleged that United's home health services program was a fraudulent scheme intended to increase United's capitated payments.[39] Claiming that the home health services violated various statutes and regulations applicable to the Medicare Advantage program, the relator alleged that any resulting certifications were false and therefore in violation of the FCA.[40] The court, however, disagreed with the relator's arguments. Unless Medicare Advantage plans knowingly create false diagnoses and report that information to the government, causing the government *to pay a greater capitated amount than it would otherwise pay,* there can be no liability under the FCA.[41] Here, the relator did not claim that United submitted false data but rather data from allegedly uncovered or medically unnecessary services.[42] Instead of being false, the claims were simply noncompliant. Because such conduct did not result in increased government payment to United under the capitated system, the supposedly false claims did not materially affect the government's decision to

36. McGuire et al., *supra* note 11, at 290.

37. Universal Health Servs., Inc. v United States *ex rel.* Escobar, 579 U.S. 176, 194-95 (2016).

38. No. 15-cv-7137, 2018 WL 2933674, at *7, 10-11, (N.D. Ill. June 12, 2018); *see also* United States *ex rel.* Ramsey-Ledesma v. Censeo Health, L.L.C., No. 14-CV-00118, 2016 WL 5661644, at *10 (N.D. Tex. Sept. 30, 2016) (differentiating between FCA claims involving Medicare Advantage plans in which the defendant is the recipient of capitated payments or merely the recipient of funds from an entity that receives capitated payments and emphasizing that the former cannot result in the misrepresenting entity receiving more funds).

39. *UnitedHealthcare Ins. Co.*, 2018 WL 2933674, at *3.

40. *Id.*

41. *Id.* at *7 ("Of course, there is the risk that plans will provide services to affect data to increase their capitated payment amount. But without a false submission, this practice is not a violation of the False Claims Act. After all, a false claim is the '*sine qua non* of a False Claims Act violation.').

42. *Id.*

pay.[43] Thus, there was no FCA liability.[44]

In a similar case, a physician alleged that her employer, a Medicare Advantage plan, performed medically unnecessary surgeries to increase capitated payments, thus resulting in the submission of false claims.[45] The U.S. District Court for the Western District of Washington held that, given the structure of the capitated payment system, "it cannot be said that false claims are being made, since payments remain the same regardless of whether a surgery is performed or not."[46] Rather, it would be the Medicare Advantage plan that would incur the higher cost of the surgery.[47] Since the claims did not result in increased government payments, they were not material to the government's decision to pay.[48]

B. Misrepresentation by MAOs Can *be Material to the Government's Payment Decision*

While some jurisdictions have emphasized the *amount* of payment in determining the materiality of an allegedly false claim, essentially barring FCA liability for government contractors with capitated payment models, others have taken a more holistic approach. In *United States* v. *Visiting Nurse Services of New York,* for instance, the U.S. District Court for the Southern District of New York refuted the idea that the realtor's FCA claim should be dismissed because he failed to allege that the false nursing visits caused the government to pay more than it otherwise would have[49]. Instead, the court clarified that *Escobar's* materiality standard depends not on whether there was actual government overpayment but rather on whether, had it known of the misrepresentation, the government would have tended to pay the claim at all.[50] In a separate case, the U.S.

43. *Id.* at *10.

44. *See* United States v. United Techs. Corp., 782 F.3d 718, 731 (6th Cir. 2015) ("Where the government gets what it paid for despite a contractor's misstatements, it has suffered no 'actual damages.' . . . The only benchmark consistent with this benefit-of-the-bargain theory of damages is "fair market value," by which we meant (and still mean) "what a willing buyer would pay in cash to a willing seller at the time.'" (citations omitted)).

45. United States v. Group Health Coop., No. C09-603, 2011 WL 814261, at *1 (W.D. Wash. Mar. 3, 2011).

46. *Id.* at *2.

47. *Id.*

48. *Id.*

49. United States v. Visiting Nurse Serv. of N.Y., No. 14-CV-5739, 2017 WL 5515860, at *12 (S.D.N.Y. Sept. 26, 2017).

50. *Id.* at * See also United States *ex rel.* Duffy v. Lawrence Mem'l Hosp., No. 14-2256, 2018 WL 4748345, at *6 (D. Kan. Oct. 2, 2018), *aff'd sub nom.* United States *ex rel.* Janssen v. Lawrence Mem'l Hosp., 949 F.3d 533 (10th Cir. 2020) (finding defendant hospital's alleged submission of fraudulent patient arrival time data and false certification of compliance with federal law immaterial, but confirming that the materiality standard depends both on whether the claims actually resulted in increased government payment and on whether knowledge of the claims *would have* caused the government to

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District Court for the Eastern District of Pennsylvania allowed the plaintiff's FCA claim to proceed despite the defendant Managed Care Organization's (MCO) capitated payment reimbursement model.[51] There, the court determined that because the defendant's MCO contract could have been cancelled had the government known of the defendant's defective provider credentialing system, resulting in the government halting payments, the alleged compliance issues could be material to the government's payment decision.[52] In both of these cases, FCA liability hinged not on whether the government actually suffered monetary loss but rather on whether the government *would have* modified its reimbursement had it known of the alleged misrepresentation, thus opening the door for FCA suits against government contractors with capitated payment models.

The most extensive judicial analysis of the issue of the materiality of allegedly false claims involving fixed government payments comes from a case involving the pharmaceutical Trasylol, once used during surgeries to prevent bleeding.[53] There, hospitals routinely submitted claims to Medicare for inpatient services, including for surgeries using Trasylol, based on the Diagnosis Related Group (”DRG”) classification of the beneficiary's inpatient stay, which bundled items and services into one fixed payment.[54] The plaintiff alleged that defendant pharmaceutical manufacturer Bayer "'engaged in unlawful marketing, including off-label marketing and payment of kickbacks, to increase the market share' of Trasylol," in violation of the FCA.[55] Emphasizing that the fixed DRG payment amounts do not change based on whether Trasylol was administered, Bayer argued that the plaintiff could not establish that the allegedly false claims were material to the government's payment decision.[56] In essence, Bayer claimed that because the DRG payment was fixed and non-itemized, the government would not care that an off-label or anti-kickback medication was used.

In an explosive opinion, the U.S. District Court for the District of New Jersey sided with the plaintiff, holding that the fact that Medicare payments were fixed did not mean that the alleged misrepresentations were immaterial to the government's payment decision.[57] It lambasted Bayer's arguments, noting that "the Government suffers a loss *every* time it pays

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modify its payment).

51. Crosbie v. Highmark, Inc., CV 19-1235, 2019 WL 6530990 at *6, *10 (E.D. Pa. Dec. 4, 2019).

52. *Id.* at *6.

53. United States *ex rel.* Simpson v. Bayer Corp., 376 F. Supp. 3d 392 (D.N.J. 2019).

54. *Id.* at 398-99.

55. *Id.* at 399.

56. *Id.* at 401.

57. *Id.* at 415-16.

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a noncompliant claim" because it did not receive that for which it bargained.[58] While the government's decision whether to pay a claim is only one part of the materiality analysis proscribed in *Escobar*, the court made it clear that just because a payment is fixed does not mean that the government could not, or would not, deny a claim "tainted" by noncompliance.[59] Rather, the appropriate question in determining materiality is what the government would have done *had it known* about the alleged noncompliance.[60] Here, the government very likely would have denied the claim, making all claims for payment including Trasylol a loss to the government.[61]

C. Under Escobar*, Capitated Payment Models Cannot Foreclose FCA Liability.*

While it is certainly an interesting argument that capitated payment systems foreclose FCA liability because the government's continued payment bars noncompliant claims from being material to payment decisions, such a conclusion stands in opposition to the ruling in *Escobar*. Though evidence of the government's continued payment of a non-compliant claim can be highly suggestive of immateriality, such evidence is not dispositive.[62] Rather, courts must also consider whether the noncompliant statutory and regulatory provisions were express requirements within the government contract and whether the non-compliance is so substantial that it goes to the "essence of the bargain."[63] In emphasizing the government's continued payment decision, the court in *Group Health Coop* neglected to consider the other elements of the *Escobar* materiality standard.[64] There, a *qui tam* plaintiff brought a case against a MAO that she claimed pressured its physicians to perform unnecessary surgeries.[65] The U.S. District Court for the Western District of Washington found that the capitated payment system necessarily prohibited the plaintiff from bringing a claim under the FCA, failing to

58. *Id.* at 411 (emphasis added).

59. *Id.*

60. *Id.* at 414.

61. *See* United States *ex rel.* Pogue v. Am. Healthcorp, Inc., 914 F. Supp. 1507, 1513 (M.D. Tenn. 1996) (concluding that plaintiff had a valid claim under the FCA when alleged that the defendants concealed their illegal kickbacks and self-referral violations from the government in an effort to defraud the government from paying Medicare claims it would not have otherwise paid, and therefore, the FCA prohibits fraudulent acts even if they do not cause an actual loss to the government).

62. Universal Health Servs., Inc. v United States *ex rel.* Escobar, 579 U.S. 176, 194-95 (2016).

63. *Id.* at 194 n.5 (quoting Neder v. United States, 527 U.S. 1, 16, 22, n.5 (1999)).

64. United States v. Group Health Coop., No. C09-603, 2011 WL 814261, at *3-4 (W.D. Wash. Mar. 3, 2011).

65. *Id.* at *1.

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determine how pervasive the alleged fraudulent scheme was or whether the government would have entered into a contract at all with the MAO had it known of the alleged scheme.[66] While the FCA is not designed to punish every type of fraud committed, continued payment alone cannot foreclose liability.

Furthermore, the *Escobar* decision emphasized the importance of the government's likely or actual behavior in determining materiality, *not* the "effect on the Government['s] [actual] fisc."[67] Indeed, in determining that no FCA violation can be found where an alleged fraudulent scheme causes the government to spend no additional money, *UnitedHealthcare* and *Group Health Coop* miss the mark. The statutory text of the FCA does not require plaintiffs to prove actual or specific damages.[68] However, this is not because such an element is not important in FCA cases. In fact, many instances of fraudulent claims for government payment cause the government to incur actual damages. Rather, actual damages are not a requirement because materially noncompliant claims "taint" the entire claim.[69] Even when the government incurs no financial loss from a noncompliant claim, it does not receive that for which it paid.[70] Particularly where noncompliant provisions are express provisions of payment or so substantial or pervasive that, had the government known of the noncompliance, it likely would not have entered into the legal agreement or paid the claim,[71] actual damages are irrelevant. The fact that the government would not have paid the claim at all is itself a loss to the public "fisc."[72] The fundamental inquiry, after all, is "whether a piece of information is sufficiently important to influence the [government's] behavior," not whether there was a measurable financial impact to the government.[73] Thus, a lack of actual damages in the case of capitated payments cannot foreclose FCA liability.

Notwithstanding the decision in *Escobar*, to hold that MAOs cannot be held liable for noncompliant claims under the FCA goes against the legislative intent of the FCA. In a 2009 Report, the Senate Committee on the Judiciary noted that fraud within the Medicare and Medicaid programs had become some of the most pervasive across all government areas, infecting every function of the healthcare community and representing

66. *Id.* at *3-4.
67. United States *ex rel.* Simpson v. Bayer Corp., 376 F. Supp. 3d 392, 410 (D.N.J. 2019).
68. 31 U.S.C. § 3729(a)(1)(G) (West 2022).
69. *Simpson*, 376 F. Supp. 3d at 411.
70. *Id.* at 411.
71. Universal Health Servs., Inc. v United States *ex rel.* Escobar, 579 U.S. 176, 176 (2016).
72. United States *ex rel.* Simpson v. Bayer Corp., 376 F. Supp. 3d 392, 410 (D.N.J. 2019).
73. United States *ex rel.* Winkelman v. CVS Caremark Corp., 827 F.3d 201, 211 (1st Cir. 2016).

nearly 40% of all FCA recovery.[74] The purpose of the FCA, it noted, was to encourage private citizens to report fraudulent behavior that may never otherwise have come to light and to provide a way for those citizens to participate in recovery.[75] To waive FCA liability for some recipients of federal funds based solely on payment structure would be in direct opposition to this stated purpose. Indeed, the legislative intent of the FCA was to reach *"every* claim submitted under a contract, loan guarantee, or other agreement which was originally obtained by means of . . . fraudulent conduct."[76]

Other avenues for civil liability in these instances, including the Civil Monetary Penalties Law, which creates liability for certain types of fraud and abuse involving federal health programs, lack the *qui tam* provisions promoting whistleblowers and embedding them in the litigation process.[77] If government contractors could avoid FCA liability for noncompliance by contracting for fixed payment schedules, then they would be incentivized to adopt similar payment structures as MAOs. The *qui tam* provision of the FCA goes to the heart of its purpose, encouraging healthcare programs to take whistleblower complaints seriously and creating penalties for retaliation.[78] Without the FCA's incorporation of private citizens into fraud discovery and prosecution, the government would likely uncover less fraud among MAOs, allowing the very rampant fraud the FCA was designed to combat to persist.

V. CONCLUSION

The existence of a capitated or fixed government payment schedule does not foreclose FCA liability. The *Escobar* standard makes it clear that, in addition to the government's actual loss resulting from a fraudulent claim, courts must consider the substantiality of the fraud, whether the condition violated was express or implied, and the government's behavior had it known of the fraud when entering the contract. While the FCA was never intended to be a blanket provision for all types of fraudulent behavior related to government payment, it certainly covers Medicare Advantage-related fraud, as this goes to its very legislative purpose. The FCA clearly prohibits fraudulent acts even if they

74. S. REP. NO. 110-507, at 7 (2008).

75. *Id.*

76. S. REP. NO. 99-345, at 9 (1986) (emphasis added).

77. 42 U.S.C. § 1320(a)-7(a) (West 2022).

78. 31 U.S.C. § 3730 (West 2022) ("Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section.")

do not cause a direct loss to the government. Thus, fraudulent claims submitted by MAOs, when covered by one of the elements outlined in *Escobar,* can be material to the government's payment decision and thus liable under the FCA.