Nursing Home Liability for Failure of Care under the Federal False Claims Act

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The False Claims Act ("FCA") has been used to increasing accountability amongst the many entities that bill the Federal Government for services. As government spending has increased, it has become essential to control government expenditures and prevent unscrupulous contractors from taking advantage of easily accessible taxpayer dollars. The growth in healthcare spending in recent decades has demonstrated the need for the federal government to have these powerful tools to combat fraud of its programs. However, the FCA has not gone far enough in its protection of federal funds spent on nursing homes, primarily through the Medicaid program. As decisions in recent years show, there is disagreement among the various circuits about what constitutes a false claim made to the government. The circuits have differed on the criteria to establish falsity under the statute. In United States ex rel. Escobar v. Universal Health Services, Inc., the Supreme Court had the opportunity to unify the law nationally and finally granted the broad protections to federal funds initially intended by the creators of the statute. A following of the First Circuit's reasoning will correctly interpret the statute as its creators intended and protect federal funds in all programs, including health care and nursing homes, into the next century.

Throughout the Civil War, immense amounts of government funds were flying out of federal coffers to fund the Union Army, and contractors were lining up to provide anything from "mules to rifles." Many of these contractors supplied sub-standard goods, and were more than willing to

1 See infra Part I (detailing history and creation of FCA).
2 See infra Part I (describing history of FCA and increase in government spending).
3 See infra note 13 (describing need for additional protections).
4 See infra Part 0 (arguing need for additional protections for government funds spent on nursing home care).
5 See infra Parts II and IV (outlining circuit split over definition of false claim).
6 See infra Parts III, IV (discussing variety of interpretations of falsity).
7 780 F.3d 504 (1st Cir. 2015).
8 See infra Parts I, V (explaining holding in Escobar).
9 See infra Part V (discussing First Circuit interpretation).
profit at the government’s expense. Thus, by the conclusion of the war, Abraham Lincoln and the rest of the Federal Government were eager to enact legislation that would protect government expenditures; legislation that eventually became the FCA.12

Today, federal spending on healthcare, via the Medicare, Medicaid, and Children’s Health Insurance (CHIP) programs has become a significant portion of federal dollars paid out to contractors.13 Spending on these programs has consistently grown over the last several decades and it was estimated that in fiscal year 2015, the programs would comprise over 27.7% of all federal spending.14 This trend is projected to continue over the next several decades, particularly given the country’s aging population.15 Coinciding with this increased spending will be an increased demand from the aging population for long-term services and support, particularly spending on nursing facilities.16 Of course, these changing economics will also affect healthcare spending by state governments in their individual Medicaid programs.17 Given these growing areas of spending, many state and local officials have increased their use of the FCA and parallel state statutes to act as a check on unscrupulous contractors.18 However, bringing these cases against long-term care

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11 See id. at 23 (describing frauds which occurred during Civil War).
12 See id. (articulating purpose of Federal False Claims Act).
14 See id. at 1 (demonstrating overall growth in federal healthcare spending and 2015 projections).
15 See The 2015 Long-Term Budget Outlook, CONG. BUDGET OFF., 21 (June 2015), https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50250-LongTermBudgetOutlook-4.pdf (outlining growth in future spending). According to the Congressional Budget Office (CBO), in recent years, spending on mandatory programs, such as the healthcare programs and Social Security, has comprised 60 percent of noninterest spending. Id. Further, most of the growth in noninterest spending is attributable to the healthcare programs, including additional federal spending created by the Affordable Care Act (ACA). Id. The CBO estimated that under current laws, spending on the mandatory programs would outpace overall economic growth and increase from 5.2 to 8.0 percent of gross domestic product by 2040. Id. The increase will be primarily attributable to three major causes: the aging of the population, rising health care spending per beneficiary, and an increased number of recipients of exchange subsidies and Medicaid benefits attributable to the ACA. Id.
16 See Rising Demand for Long-Term Services and Supports for Elderly People, CONG. BUDGET OFFICE (June 2013), https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-LTC.pdf (suggesting that spending will continue to rise if programs are not changed).
17 See id. (outlining increased pressure on state budgets due to aging).
18 See Haron et al., supra note 10, at 24 (noting increased use of FCA in prosecuting healthcare providers).
facilities has presented a challenge in the past, and will continue to do so going forward.\(^\text{19}\)

I. THE FALSE CLAIMS ACT

A key aspect of the FCA is the ability for individuals to bring suit on behalf of the federal government, which is known as a *qui tam.*\(^\text{20}\) The concept of a *qui tam* dates back to the year 695 in England and, generally, is short for “he who prosecutes for himself as well as for the king.”\(^\text{21}\) This provision in the FCA has allowed the government access to cases that would not otherwise be brought, for the government would have no knowledge of the activity and, without the incentive of the *qui tam* action, the whistleblower would have no reason to bring it forward.\(^\text{22}\) *Qui tam* actions came to the United States under the FCA following the Civil War as the government was trying to combat fraud perpetrated by contractors.\(^\text{23}\) The earliest targets of the FCA had provided defective products during the war, causing the government to lose valuable time and money.\(^\text{24}\) In certain cases, the goods were not the actual product to be procured.\(^\text{25}\)

The FCA prohibits any knowing demand for payment to which a defendant in the action is not entitled but makes no direct mention of an express certification of compliance.\(^\text{26}\) An FCA claim is only successful when all elements are proved by a preponderance of the evidence.\(^\text{27}\) Since its creation, the courts have interpreted the reach of the FCA to be broad, covering all types of fraud that may result in a loss to the government.\(^\text{28}\) In order to be found guilty of an FCA violation, the following must be met: an

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\(^{19}\) See infra Part 0.


\(^{22}\) See Cleveland Lawrence III, False Claims Act and *Qui Tam* Quarterly Review, 77 FALSE CL. ACT AND QUI TAM Q. REV. NL 1, 1 (2015). ("Without doubt, False Claims Act cases—both those filed by relators and those filed by the federal government—are on the rise, leading to more court opinions, settlements and judgments."). The FCA touches nearly every industry and government program and enables a wide range of individuals to be whistleblowers, growing the significance of the FCA. Id.

\(^{23}\) See Haron et al., supra note 10, at 22 (reviewing origins of FCA).


\(^{25}\) See id. (describing type of fraud which occurred during Civil War).


\(^{27}\) See 31 U.S.C.A. § 3731(d) (West 2009) (stating elements needed to bring action).

entity must present or cause to be presented a claim for payment or approval; the claim must be false or fraudulent; and the person’s act must be undertaken knowingly, either with actual knowledge of the information or with deliberate ignorance or reckless disregard for the truth or the falsity of the claim. 29 Historically, “a false statement within a claim can only make the entire claim fraudulent if the statement is material to the request or demand for money.” 30 In addition to the courts’ interpretation of the FCA, Congress has been clear that the intention was for the law to be broad, and they have continued to move to expand the scope of the Act. 31 As state governments recognize similar issues with contractors and growing state spending, many enacted laws which mimicked the scope of the FCA. 32 Often times these state laws are so close in language to the FCA that interpretations on scope and intent under the FCA are used by state level courts in interpreting the state statutes. 33

II. WORTHLESS SERVICES UNDER MEDICARE AND MEDICAID

Medicare and Medicaid are essentially health insurance programs for the elderly and low-income or otherwise qualified individuals respectively. 34 Under the Medicaid regulations, a nursing facility provides non-compliant or deficient care when the care does not meet a participation requirement as specified in the relevant statutes or regulations. 35 In order for services to be considered worthless, they must be so deficient that for all practical purposes they are the equivalent of no performance of services at all. 36 Worthless services cases are often pursued civilly under the FCA,
however, actions can be so egregious that criminal action is warranted.\textsuperscript{37} The FCA also allows for certain services to be considered worthless if they were billed as the result of other illegal practices, even if the services themselves had value.\textsuperscript{38} Outside of these other factors, establishing that a service is worthless is a difficult standard to meet as services that are worth at least something, but not full price, are not worthless.\textsuperscript{39} To determine whether the services are worthless, courts use a fact-specific analysis on each case.\textsuperscript{40}

The essential concern is whether the government would have paid for the claim had it known all the facts surrounding it.\textsuperscript{41} Worthless services as a theory of a false claim is distinct from falsity under the FCA generally, however worthless services can still be evidence under the general falsity theory.\textsuperscript{42}

At some very blurry point, a provider of care can cease to maintain this standard by failing to perform the minimum necessary care activities required to promote the patient’s quality of life. When the provider reaches that point, and

\textsuperscript{37} See United States v. Wachter, No. 4:05CR667SNL, 2006 WL 2460790, at *11 (E.D. Mo. Aug. 23, 2006) (holding certain tests billed to government as worthless). Courts have also found that, although some services were provided, if they have no value, they can be considered worthless to the government under the FCA. \textit{Id.}; see also United States v. Smithkline Beecham Clinical Labs, 245 F.3d 1048, 1053 (9th Cir. 2001) (stating plaintiff’s argument that defendant’s tests were worthless, false and, thus, violated FCA).

\textsuperscript{38} See 42 U.S.C.A. § 1395nn (West 1965). This provision, known as the Stark law, prohibits doctors from sending patients to companies in which they have an ownership interest, often laboratories for testing, services rendered as those co-owned businesses are considered worthless since the entire claim is tainted by the relationship. \textit{Id.} at § 1395nn(i)(1)(C)(iii).

\textsuperscript{39} See United States ex rel. Absher v. Momence Meadows Nursing Ctr., Inc., 764 F.3d 699, 710 (7th Cir. 2014) (describing what constitutes “worthless” under FCA).


\textsuperscript{41} See James E. Utterback, Substituting an Iron Fist for the Invisible Hand: The False Claims Act and Nursing Home Quality of Care - A Legal and Economic Perspective, 10 QUINNIPIAC HEALTH L.J. 113, 156 (2007) (supporting necessity for specific facts). “Proof in a worthless services claim should go to the very essence of the basis for which payment was made, supporting the argument that the government would not pay if it had known.” \textit{Id.}

\textsuperscript{42} See Luckey v. Baxter Healthcare Corp., 183 F.3d 730, 732 (7th Cir. 1999) (“[A] claim can be false or fraudulent if the speaker offers a misleading half-truth.”).
still presents claims for reimbursement to Medicare, the provider has simply committed fraud against the United States. 43

The worthless services standard, particularly in nursing home cases, is a difficult one to meet as the services must be shown to be of completely zero value. 44 There must also be specificity as to the extent of the issue in the claim. 45 Inherent in nursing home cases are difficulties that result from the billing of services on a per diem basis. 46 “Even where services are provided per diem, reasonable persons would know that supplying limited, or no, basic services would fail to comport with the very essence of the provider and benefit agreements, and that seeking reimbursement for such deficient services would constitute fraud.” 47

III. FALSITY UNDER THE FEDERAL FALSE CLAIMS ACT

In order to be considered false under the FCA, the false element of the claim must be material to determine whether the government would have made the payment. 48 For the element of knowingly, the courts have developed the terms “implied” or “express” certification of a claim, in order to differentiate how certain behaviors can give rise to the false claim. 49 Express is documenting that a claim specifically meets the requirements for payment, while implied certification continues to do certain actions that are not in compliance generally, without specifically certifying that the provider is in compliance with those regulations. 50 Courts have also used distinctions between aspects of the claim that are


44 See Momence Meadows Nursing Ctr., 764 F.3d at 709 (quoting United States ex rel. Mikes v. Strauss, 274 F.3d 687, 703 (2d Cir. 2001)) (“The performance of the service [must be] so deficient that for all practical purposes it is equivalent of no performance at all.”).

45 See id. at 714 (expressing plaintiff’s burden of proof).

46 See NHC Health Care Corp., 163 F. Supp. 2d at 1055 (discussing fraud in provision of services that are billed per diem).


48 See United States ex rel. Loughren v. Unum Grp., 613 F.3d 300, 307 (1st Cir. 2010) (discussing materiality as element of common law fraud); United States v. Rogan, 517 F.3d 449, 452 (7th Cir. 2008) (discussing importance of material element for FCA claims).


50 See id. at 382-83 (reiterating difference between implied and expressed certification).
factually and legally false. Under an implied certification theory, a violation of a continuing duty to comply with a regulation on which a payment is conditioned is considered one method of establishing falsity under the FCA. This is based on the idea that “the act of submitting a claim for reimbursement itself implies” that the entity is complying with the applicable “rules that are a precondition to payment” for the claim.

IV. PREVIOUS DISTINCTIONS BETWEEN CONDITIONS OF PARTICIPATION AND CONDITIONS OF PAYMENT

Like implied and express certifications, the terms “conditions of participation” and “conditions of payment” are concepts created by the courts that establish falsity under the Act but are outside the language of the FCA. For skilled nursing facilities (SNF), conditions of participation are the requirements that an institution needs to meet in order to participate in the Medicare program as a SNF or in the Medicaid program as a nursing facility. Conditions of participation are not prerequisites for payment of a claim but are instead quality of care standards directed towards the providers’ continued ability to participate in the program. While all

51 See United States ex rel. Conner v. Salina Reg’l Health Ctr., 543 F.3d 1211, 1217 (10th Cir. 2008) (recognizing two types of actionable claims). In Conner, an ophthalmologist brought a qui tam action on behalf of the United States against Salina Regional Health Center. Id. at 1214. Conner alleged that Salina engaged in a variety of violations of Medicare regulations and statutes. Id. Primarily however, the allegations stemmed from the improper submission of annual cost reports. Id. Conner alleged that in reliance on these cost reports, they were certified by the company as compliant with the Medicare laws and regulations; thus Salina obtained unfair payment in violation of the FCA. Id.


54 See United States ex rel. Escobar v. Universal Health Servs., Inc., 780 F.3d 504, 511 (1st Cir. 2015) (indicating required elements of falsity).


56 See United States ex rel. Landers v. Baptist Mem’l Health Care Corp., 525 F. Supp. 2d 972, 978 (W.D. Tenn. 2007) (clarifying “[c]onditions of Participation are not the equivalent of conditions of payment”). In Landers, a registered nurse brought an action regarding a violation of the FCA. Id. at 974-75. Specifically, Landers alleged the corporation maintained improper staffing ratios in the intensive care unit leading to care that violated regulations. Id. She additionally alleged that “scrub technicians” were used in certain instances where nurses were required, thus resulting in a failure to meet the standard of care for sterilization or cleanliness. Id. The court ultimately found that the “[p]laintiff ha[d] failed to present sufficient evidence that [d]efendants’ alleged violations of applicable standards of care were ‘so deficient that for all
courts consider conditions of payment to be terms under which the FCA false claim can be established, there are varying interpretations as to whether conditions of participation can be used to establish falsity. In fact, the circuits remain split on this issue, as the Third, Ninth, and Tenth Circuits have adopted a rule that in cases where an underlying regulation expressly prohibits payment upon non-compliance with its terms, the submission of a claim implicitly certifies compliance with the regulation. The First Circuit and the D.C. Circuit have, however, read this more broadly by stating "a claim can be false or fraudulent due to an implied representation of compliance with a precondition of payment that is not expressly stated in a statute or regulation."

The First Circuit has rejected many of these categorical distinctions between "legally" and "factually" false as well as "express" and "implied" certification, and has instead created a different standard for falsity. The Amgen case reiterated the importance of a fact-intensive and context-specific inquiry of FCA claims. The Amgen and Blackstone cases simplified the structure of the analysis with the goal of returning to the language contained in the FCA itself, as well as aligning the falsity analysis with the broad intent to return money that the government spent on sub-

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58 See United States ex rel. Wilkins v. United Health Grp., Inc., 659 F.3d 295, 309 (3d Cir. 2011) (describing conditions of payment); Ebeid v. Lungwitz, 616 F.3d 993, 998 (9th Cir. 2010) (drawing distinction between expressed and implied certification); United States ex rel. Conner v. Salina Reg’l Health Ctr., 543 F.3d 1211, 1218 (10th Cir. 2008) (holding court must look at underlying statutes to determine whether certification was condition of payment). In Wilkins, former employees took action as relators in a qui tam case claiming that United Health violated several marketing rules related to its business with CMS, Medicare, and Medicaid. Wilkins, 659 F.3d at 300.

59 Hutcheson, 647 F.3d at 387; see also United States v. Sci. Applications Int’l Corp., 626 F.3d 1257, 1268 (D.C. Cir. 2010). These cases argue the requirement that the regulation be “expressly written” in a regulation or statute are not written into the FCA and have been artificially adopted by the courts which is outside the intent of the statute, and which was meant to be broad. See Sci. Applications Int’l Corp., 626 F.3d at 1269-70; Hutcheson, 647 F.3d at 386. As of 2011, the Sixth Circuit had not addressed this issue. See Villaspring Health Care Ctr., 2011 WL 6337455, at *7.


61 See Amgen, 652 F.3d at 111 (recognizing importance of fact-intensive and content-specific inquiry).
standard services. The Blackstone case went further to say that preconditions of payment can be found not only in statutes and regulations, but also in contracts with providers, and that the preconditions of payment need not be expressly stated.

V. AFFIRMATION IMPLIED CERTIFICATION AND A NEW TEST FOR MATERIALITY UNDER ESCOBAR

Recently, the First Circuit in its decision in United States ex. rel. Escobar v. Universal Health Services, Inc. ("Escobar") recommitted to their broadened understanding of falsity. The lower court had incorrectly held that only misrepresentations of compliance with conditions of payment made a statement false under the FCA. In Escobar I, the court found that there was actually no distinction in the case of precondition of participation and a condition of payment, because they were in fact, one in the same. This was in contrast to a decision in a Seventh Circuit case, United States v. Sanford-Brown, Ltd which would come to the opposite conclusion that implied certification is not a doctrine to be followed. The decisions in these 2015 cases set out two divergent theories, which were resolved by the Supreme Court in its 2016 decision in Escobar.

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62 See Kim, supra note 60, at 176-77 (explaining how simplified analysis would be best in FCA claims).
63 See Hutcheson, 647 F.3d at 387-88 (stating preconditions of payment are not expressly stated in FCA).
64 780 F.3d 504.
65 See id. at 512 (outlining various circuits’ distinctions between factually and legally false submissions).
67 See Universal Health Servs., 780 F.3d at 513 (highlighting court’s decision of finding no distinction between conditions of participation and payment).
68 788 F.3d 696, 696 (7th Cir. 2015).
69 See id. at 711-12 (joining Fifth Circuit); see also discussion infra Section V(B) (discussing implied certification).
70 See infra Section V(B) (showing divergent theories); see also infra Section V(0) (discussing impact of decision in Escobar and impact on government contractors).
A. Escobar and the First Circuit’s Acceptance of Implied Certification.

In Escobar, the relators’ daughter, Yanushka Rivera, a recipient of benefits under the state’s Medicaid program, was experiencing behavioral problems and sought treatment.\(^{71}\) The daughter eventually saw several counselors at Arbour Counseling Services (“Arbour”), which was owned and operated by the defendant, Universal Health Services (UHS).\(^ {72}\) The initial counselor who saw Rivera had no professional license to provide mental health therapy and, according to the relators, the counselor lacked supervision.\(^ {73}\) Rivera was eventually transferred to the care of another staff member who was unlicensed as well, and relators again had concerns regarding proper supervision of the treatment.\(^ {74}\) Eventually, Rivera was assigned to a new therapist, who purported to be a psychologist with a Ph.D. before diagnosing her with bipolar disorder.\(^ {75}\) Due to additional attendance requirements from the school, Rivera again changed caretakers, this time staff member named Maribel Ortiz, who Rivera believed was a psychiatrist, however Ortiz was actually only a licensed nurse.\(^ {76}\) Ortiz prescribed Rivera a medication for the bipolar disorder to which she had an

\(^{71}\) See Universal Health Services, 780 F.3d at 509 (detailing relevant facts). The daughter, Yanushka Rivera, was a teenager and was experiencing difficulties at school. \(Id.\) The issues, following unsuccessful treatment, eventually resulted in her prohibition from attending classes. \(Id.\)

\(^{72}\) See \(id.\) at 508 (highlighting key facts). Arbour was a participant in the Massachusetts state Medicaid program known as MassHealth. \(Id.\) Arbour regularly billed MassHealth for services provided to individuals covered under the program. \(Id.\)

\(^{73}\) See \(id.\) at 509 (detailing counselor’s qualifications). The relators met with the counselors, supervisor Maria Pereyra and Clinical Director Edward Keohan following complaints from Rivera that she was not benefiting from the treatment. \(Id.\) The relators became concerned that Keohan was not properly supervising Pereyra because he was not familiar with Rivera’s treatment. \(Id.\)

\(^{74}\) See \(id.\) (delineating facts relevant to relators’ claims against UHS). After the initial meeting with Keohan, Rivera was transferred to the care of another staff member. \(Id.\) The second counselor, Diana Casado, also was supervised by Keohan and, like Pereyra, was not licensed to treat Rivera. \(Id.\)

\(^{75}\) See \(id.\) at 508 (discussing Rivera’s eventual diagnosis). The newly assigned therapist, Anna Fuchu, had been trained at an unaccredited online school. \(Id.\) Additionally, her application for a professional license from the state had been rejected. \(Id.\)

\(^{76}\) See Universal Health Services, 780 F.3d at 508 (explaining how Rivera’s parents believed Ortiz was doctor not nurse). Rivera’s parents referred to Ortiz as “Dr. Ortiz.” \(Id.\) In addition to only being licensed as a nurse rather than a psychiatrist, Ortiz was not under the supervision of staff at Arbour. \(Id.\) Furthermore, the individual who would have been supervising her was herself not board-certified, nor was she eligible for board certification. \(Id.\)
adverse reaction. Rivera on her own opted to discontinue the medication but shortly thereafter suffered a seizure. Rivera later resumed treatment after her parents spoke with staff at Arbour. After continuing on care under Ortiz at Arbour she suffered another seizure, this time fatally.

Relators filed complaints with several state agencies. Relators later filed a complaint in U.S. District Court against UHS under both the federal and Massachusetts False Claims Act for the services billed to MassHealth. The complaint was however dismissed in its entirety as the lower court held that only UHS’s noncompliance with conditions of payment, rather than conditions of participation, could establish the falsity of the claim. Specifically, the district court stated that there was no indication in the text of any of the regulations that they were intended to be conditions of payment rather than conditions of participation. Relators appealed that dismissal to the First Circuit Court.

77 See id.
78 See id. (explaining decision to discontinue medicine).
79 See id. (discussing why Rivera resumed her medication). Rivera’s parents spoke to Keohan who directed a staff psychologist to supervise Ortiz. Id.
80 See United States ex rel. Escobar v. Universal Health Servs., Inc., 780 F.3d 504, 508 (1st Cir. 2015) (describing circumstances of Rivera’s death). Shortly after the seizure, Rivera’s parents met with a social worker who had worked with Rivera. Id. at 510. The social worker informed them that the counselors who had provided care were not licensed to provide treatment without supervision, nor were they permitted to prescribe medication. Id.
81 See id. at 510 (describing where relators filed complaints). Complaints were filed with the Disabled Person’s Protection Commission (“DPPC”), Division of Professional Licensure (“DPL”), and the Department of Public Health (“DPH”). Id. These agencies varied in their findings with DPPC, concluding that there was insufficient evidence of abuse of a disabled person due to leaving the door open to staff members being out of compliance with relevant requirements. Id. DPH, however, found Arbour had violated fourteen distinct regulations regarding staff supervision and licensure. Id. Notably DPH found that, “‘23 therapists were not licensed for independent practice and also . . . were not licensed in their discipline.’” Id. (citing report by DPH attached to Respondent’s brief).
82 See id.
83 See id. (describing lower court’s finding). The court relied on the preamble to chapter 429 of the MassHealth Regulations which “establishes requirements for participation of mental health centers in MassHealth.” 130 MASS. CODE REGS. 429.401 (2017). In full the regulation states:

130 CMR 429.000 establishes requirements for participation of mental health centers in MassHealth and governs mental health centers operated by freestanding clinics, satellite facilities of clinics, and identifiable units of clinics. All mental health centers participating in MassHealth must comply with the MassHealth regulations, including but not limited to MassHealth regulations set forth in 130 CMR 429.000 and 450.000.

84 See id. (considering district court’s reasoning).
85 See United States ex rel. Escobar v. Universal Health Servs., Inc., 780 F.3d 504, 511 (1st Cir. 2015).
In its decision on Escobar, the First Circuit considered the intent of the FCA and acknowledged that it was intended to be expansive in nature, intended “to reach all types of fraud, without qualification, that might result in financial loss to the government.”\(^86\) The court went on to review the definition of “falsity” under the FCA, noting that it is not found in the statute, leaving circuit courts to interpret the definition themselves.\(^87\) The court reviewed their ruling in Blackstone that determined that implied and express certification created “artificial barriers” and Amgen which established the need to comply with a precondition of payment.\(^88\) The court further detailed that the key was to look at “a broad view of what may constitute a false of fraudulent statement to avoid ‘foreclos[ing] FCA liability in situations that Congress intended to fall within the Act’s scope.’”\(^89\) The circuit court recognized that the district court, in the Escobar case, had relied on the term preconditions of payment because the Amgen and Blackstone decisions had been framed on that manner.\(^90\) The circuit court went on to find issue with this analysis and clarify their position stating that, “[W]hile the district court concluded that only claims premised on misrepresentation of compliance with a condition of payment are cognizable under the FCA, we find that any payment/participation

\(^{86}\) Id. at 512 (quoting Cook Cnty., Ill. v. U.S. ex rel. Chandler, 538 U.S. 119, 129 (2003)). The Cook Cnty. case referenced by the First Circuit involved a qui tam action brought against a county that operated a hospital for research on the treatment of drug-dependent pregnant women. 538 U.S. at 119. The Cook Cnty. Court relied on U.S. v. Neifert-White, Co. which concluded that:

[The original False Claims Act was passed in 1863 as a result of investigations of the fraudulent use of government funds during the Civil War. Debates at the time suggest that the Act was intended to reach all types of fraud, without qualification, that might result in financial loss to the Government.


\(^{87}\) See Escobar, 780 F.3d at 512 (discussing generally FCA).

\(^{88}\) See id. (outlining recently established requirements for FCA compliance).

\(^{89}\) Id. (quoting United States ex rel. Jones v. Brigham & Women’s Hosp. 678 F.3d 72, 85 (1st Cir. 2012)).

\(^{90}\) See United States v. Universal Health Servs., Inc., 780 F.3d 504, 513 (1st Cir. 2015) (discussing lower court’s decision). “The [district] court reasoned that, because the holdings of both decisions were framed in terms of conditions of payment, Hutcheson and the subsequent case of Amgen at least implicitly accepted the “condition of payment/condition of participation dichotomy.” Id. (citing U.S. ex rel. Escobar v. Universal Health Services, Inc., CIV. A. 11-11170-DPW, 2014 WL 1271757, at *6 (D. Mass. Mar. 26, 2014). The district court had relied specifically on language from Amgen and Hutcheson that mentioned preconditions of payment while omitting any mention of preconditions of participation. Id. The lower court also relied on cases from the Second and Sixth Circuits, which had adopted the same framework. See id. at *6 n. 1.
distinction is not relevant here. As in Amgen, the provisions at issue in this case clearly impose conditions of payment.91

The court laid out the MassHealth regulations that were applicable to Arbour in the context of the case.92 The court acknowledged that the fact that the supervision at Arbour, "was either grossly inadequate or entirely lacking is the core of Relators' complaint. Insofar as Relators have alleged noncompliance with regulations pertaining to supervision, they have provided sufficient allegations of falsity to survive a motion to dismiss."93 The opinion concluded by saying that:

Compliance with the regulations at issue pertaining to staff supervision and core staffing at satellite centers is a condition of payment by MassHealth. Because our case law makes clear that a healthcare provider's noncompliance with conditions of payment is sufficient to establish the falsity of a claim for reimbursement, we need not address here whether the False Claims Act embraces a distinction between conditions of payment and conditions of participation.94

91 Id.
92 See id. (noting particular portion of MassHealth regulations). The regulations provide that:

[Section 429.439 of the MassHealth regulations expressly provides that “[s]ervices provided by a satellite program are reimbursable only if the program meets the standards described below [in subsections (A) through (D)].” Subsection (A) pertains to parent centers’ supervision of satellite programs, while subsection (B) addresses the supervision that must occur within autonomous satellites, which “must provide supervision and in-service training to all noncore staff employed at the satellite program.” Subsection (C) further demands that all satellites employ a full-time clinical director who meets the qualifications required of core staff members in his or her discipline, as set forth in section 429.424; in addition, supervisors at dependent satellites must “receive regular supervision and consultation from qualified core staff at the parent center.”]

Id. (citations omitted).

93 Id. at 514. This acknowledgement was followed by further analysis of whether the Relators had pled sufficiently to survive a motion to dismiss given the court’s interpretation of the FCA. Id. at 514-17.
94 Id. at 517. The court continued:

[In the final analysis, Relators’ daughter died after receiving treatment that was out of compliance with over a dozen regulations, as determined by an independent report. Relators have carefully compiled information regarding the names of unlicensed and unsupervised providers, and the dates, amounts, and codes of allegedly false claims submitted to MassHealth. As such, they have appropriately stated a claim with particularity under the FCA.]
Essentially, the First Circuit incorporated the regulations governing payment for providers under the MassHealth program as required for providers to receive payment; thus non-compliance with this series of regulations would lead to liability under the FCA. As a result of these findings by the court, the case was remanded for proceedings consistent with the opinion.

B. Sanford-Brown, Limited and the Seventh Circuit’s Rejection of Implied Certification

*United States v. Sanford-Brown, Ltd.* is a case that set the Seventh Circuit apart from its sister circuits in determining falsity under the FCA. The case involved suit between a director of education, Brent Nelson, and Sanford-Brown College, a for-profit institution located in Wisconsin where he had been employed. Nelson alleged that Sanford-Brown received federal subsidies through the Department of Education and that, based on their recruiting and retention practices, thousands of false claims were submitted to the government.

As a requirement to receive federal education subsidies under Title IV of the Higher Education Act (HEA), an institution was required to enter into a program participation agreement with the United States Secretary of Education. The court found that §1094 details that a participation agreement would, “include[] certifications of existing facts and forward-looking promises that the institution [would] abide by certain statutes and

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95 See *United States ex rel. Escobar v. Universal Health Servs., Inc.*, 780 F.3d 504, 517 (1st Cir. 2015) (stating First Circuit implemented regulations).

96 See *id.* (explaining holding).

97 788 F.3d 696 (7th Cir. 2015).

98 See *id.* at 700 (highlighting difference between Seventh Circuit in determining falsity).

99 See *id.* The director only spent six months in the position before resigning. *Id.*

100 See *id.* (explaining Nelson’s argument against Sanford-Brown). The suit noted that the potential liability of the false claims reached into the hundreds of millions of dollars. *Id.*

101 See 20 U.S.C.A. § 1094(a) (West 2008). The statute states in pertinent part:

[[In order to be an eligible institution for the purposes of any program authorized under this title, an institution must be an institution of higher education or an eligible institution (as that term is defined for the purpose of that program) and shall, except with respect to a program under subpart 4 of part A [20 USCS §§ 1700c et seq.], enter into a program participation agreement with the Secretary.]]

*Id.* Section 1094(a) goes on to detail over 29 requirements with which the institution must comply. See *id.*
regulations attendant to Title IV. Nelson specifically alleged that Sanford-Brown violated provisions of the participation agreement that:

i) prohibited them from paying incentive compensation to certain types of employees involved in admissions and recruiting; ii) required them to maintain accreditation; iii) required them to refund to the U.S. Department of Education portions of Title IV funds for certain students who failed to complete at least 60% of a term; iv) prohibited them from harassing students to attend class; v) required students who received Title IV funds to maintain a minimum GPA or other adequate progress towards graduation; and vi) prevented them from admitting students with remedial needs into accelerated programs.

In analyzing the potential liability for Sanford-Brown under the FCA, the Seventh Circuit first turned to the participation agreement signed by the institution. Notably, the court reasoned that the participation agreement incorporated by reference, “thousands of pages of other federal laws and regulations.”

In determining actual liability under the FCA, the Seventh Circuit first discussed three necessary elements: “(1) a false or fraudulent claim; (2) which was presented for payment, or caused to be presented for payment, by the defendant; (3) with knowledge the claim was false.”

\[\text{\textsuperscript{102}} \text{ Sanford-Brown, 788 F.3d at 701.} \]
\[\text{\textsuperscript{103}} \text{ Id. at 702.} \]
\[\text{\textsuperscript{104}} \text{ See id. at 706 (describing how court analyzed their decision). The court noted that bold text on the first page of the fifteen-page document read as follows, "[t]he execution of this Agreement by the Institution and the Secretary is a prerequisite to the Institution’s initial or continued participation in any Title IV, HEA Program." Id.} \]
\[\text{\textsuperscript{105}} \text{ Id.} \]
\[\text{\textsuperscript{106}} \text{ See id. at 709 (citing U.S. ex rel. Fowler v. Caremark RX, L.L.C., 496 F.3d 730, 741 (7th Cir. 2007)). The Fowler case involved fraud in connection with the distribution of prescription drugs to members in a federal health insurance plan. Fowler, 496 F.3d at 733. Allegations included failure to provide refunds, modifying prescriptions without approval, misrepresentation of potential savings, failure to substitute generic drugs, failure to credit prescriptions lost in the mail, and manipulation of mandatory prescription filling times. Id. at 734; United States v. Sanford-Brown, Ltd., 788 F.3d 696, 708 (7th Cir. 2015) (explaining various arguments). Nelson additionally made an argument that Sanford-Brown had created a false record when entering into the agreement itself. While the elements are slightly different here, they would have required Nelson to show that Sanford-Brown had the requisite mens rea intent to defraud the government when completing the participation agreement itself, rather than when submitting the subsequent false claims for reimbursement. Id. The elements in such a case would be as follows: "(1) the defendant made a statement or record in order to receive money from the government; (2) the statement or record was false; and (3) the defendant knew it was false." Id.; United States ex rel. Yannacopoulos v. General Dynamics, 652 F.3d 818, 822 (7th Cir. 2011) (noting necessary
Nelson’s argument was that Sanford-Brown had agreed to comply with all provisions of the participation agreement and not doing so would enact liability under the FCA.\textsuperscript{107} The case hinged on the determination of whether compliance with the participation agreement was not only a condition of participation, but also a condition of payment.\textsuperscript{108} Nelson and the government primarily relied on a Ninth Circuit case which also found that a similarly worded participation agreement would generate liability under the FCA.\textsuperscript{109} In that case, the Ninth Circuit held that a condition of participation and condition of payment were distinctions without a difference.\textsuperscript{110} Sanford-Brown countered that the participation agreement was the key document and that, following the Yannacopoulos case, if it was entered into in good faith it was sufficient to guard against any liability for subsequent claims under the FCA.\textsuperscript{111} The court ultimately ruled against Nelson holding that:

Good-faith entry into the PPA is the condition of payment necessary to be eligible for subsidies under the U.S. Department of Education’s subsidies program. Absent evidence of fraud before entry, nonperformance after entry into an agreement for government subsidies does not impose liability under the FCA.\textsuperscript{112}

According to the Seventh Circuit, “[t]he FCA is simply not the proper mechanism for government to enforce violations of conditions of participation contained in—or incorporated by reference into—a [participation agreement].” The court concluded:

\textsuperscript{107} See Sanford-Brown, 788 F.3d at 708 (describing Nelson’s argument).

\textsuperscript{108} See id. at 710 (highlighting case issues).

\textsuperscript{109} See id. at 710 (comparing circuit court decisions).

\textsuperscript{110} See United States ex rel. Hendow v. Univ. of Phoenix, 461 F.3d 1116, 1176 (9th Cir. 2006) (explaining reasoning). The Ninth Circuit further held that, “if we held that conditions of participation were not conditions of payment, there would be no conditions of payment at all—and thus, an educational institution could flout the law at will.” Id. The strongly worded opinion went on to claim that the university’s argument was merely “semantic” in nature, and that compliance with standards in a participation agreement were “prerequisites” for federal funding. Id. “[I]f the University had not agreed to comply with them, it would not have gotten paid.” Id.

\textsuperscript{111} See Sanford-Brown, 788 F.3d at 708 (stressing importance of participation agreement).

\textsuperscript{112} See id. at 710 (joining Eight Circuit’s holdings). The court held the FCA’s liability was not triggered by failure to comply with the Title IV restrictions subsequent to entry into the participation agreement, similar to the Eight Circuit. Id.

\textsuperscript{113} See id. at 712 (citing Mikes v. Straus, 274 F.3d 687, 699 (2d Cir. 2001)). The court went on to acknowledge the Department of Education’s ability to enforce portions of the participation
In sum, “PPA” is an abbreviation for Program Participation Agreement—not Program Payment Agreement. When entered in good faith, a PPA memorializes conditions of participation (not conditions of payment) in connection with the U.S. Department of Education’s subsidies program. In this case, the agency’s regulations have at all times provided—and continue to provide—a governmental enforcement mechanism in the form of an administrative proceeding before the subsidizing agency, whereby any evidence of violations of conditions of participation may be considered and adjudicated.\textsuperscript{114}

\textbf{C. Escobar at the Supreme Court}

UHS petitioned the Supreme Court on several questions and Escobar was granted certiorari by the Supreme Court on December 4, 2015.\textsuperscript{115} National reaction was that this case could have significant implications for government contractors, as well as the potential to impact those receiving government grants.\textsuperscript{116} The Court’s decision resolved the agreement through administrative mechanisms, including the ability to terminate an institution from one of its programs. \textit{Id.}

\textsuperscript{114} \textit{Id.} The court then rejected Nelson’s theory that any claims sent to the government following non-compliance with the participation agreement were false. \textit{Id.}

\textsuperscript{115} See Petition a for Writ of Certiorari at *ii, Universal Health Servs., Inc. v. United States ex rel. Escobar, 136 S. Ct. 582 (2016) (No. 15-7). The petitioner asked:

1. Whether the First Circuit, by sua sponte identifying and relying upon a regulatory provision not invoked by respondents at any point in the proceedings below to reverse the district court’s dismissal of respondents’ complaint, has so far deviated from the adversary system’s party presentation rule “so as to call for an exercise of this Court’s supervisory power” under this Court’s Rule 10(a).
2. Whether the “implied certification” theory of legal falsity under the FCA—applied by the First Circuit below but recently rejected by the Seventh Circuit—is viable.
3. If the “implied certification” theory is viable, whether a government contractor’s reimbursement claim can be legally “false” under that theory if the provider failed to comply with a statute, regulation, or contractual provision that does not state that it is a condition of payment, as held by the First, Fourth, and D.C. Circuits; or whether liability for a legally “false” reimbursement claim requires that the statute, regulation, or contractual provision expressly state that it is a condition of payment, as held by the Second and Sixth Circuits.

\textit{Id.} The Court agreed to hear questions two and three of the petition. \textit{See Universal Health Services, Inc. v. United States, 136 S. Ct. 582, 582 (2015) (holding court’s decision to hear case); Universal Health Servs., Inc. v. United States ex rel. Escobar, 136 S. Ct. 582 582 (2015) (granting certiorari).}

\textsuperscript{116} See Mark B. Sweet, New Supreme Court Case Could Be a False Claims Act Game-Changer, \textit{WILEY REIN, LLP NEWSLETTERS} (Dec. 2015), http://www.wileyrein.com/newsroom-
issue that has been split amongst the circuits with the First, Second, Third, Fourth, Sixth, Ninth, Tenth, Eleventh, and D.C. Circuits finding that implied certification is a valid FCA theory, while the Fifth and Seventh Circuits disagreed. The ongoing split led to challenges for entities doing business with the government including health care providers. Escobar resolved incongruence between the circuits by recognizing implied certification. For example, the Second Circuit found that “implied false certification is appropriately applied only when the underlying statute or regulation . . . expressly states the provider must comply in order to be paid.”

Sweet discussed the significant impacts and noted how the “expansion” of the FCA under the First Circuit’s interpretation would be sending the statute into the realm of contract law. He further stated that: The case, Universal Health Service v. United States ex rel. Escobar, could have profound effects on how aggressive the government and qui tam relators can be in stretching breaches of contract into false claims, and conversely how much pressure a contractor faces when deciding whether to settle or litigate such a case. He further stated the impact that the case could have on potential litigants in making calculations as to when to fight the government on charges versus when to settle, noting that: Hheightened exposure has changed the calculus for many companies facing a government investigation or a qui tam suit. What may be worth litigating for single damages is simply too risky when damages are trebled. As a result, many companies choose to settle cases where the government or a relator has an aggressive interpretation of the False Claims Act rather than challenge the theory in court.


See Lurie et al., supra note 117 at 1 (explaining uncertainty caused by split). There was also increasing concern among contracting agencies about the risks of treble damages in any FCA case. Furthermore, penalties of $5,500 to $11,000 per claim increased the litigation risk for any corporation facing potential FCA litigation. These concerns lead to the conclusion that Escobar will have a far-reaching impact on any contractor doing business with a government entity, both state and federal. He at 2.

See id. at 3 (describing importance of attention to implied certification theory).

Id. (quoting United States ex rel. Miles v. Strauss, 274 F.3d 687, 700 (2d Cir. 2001)) (explaining Second Circuit’s interpretation of implied false certification).
Respondents to the appeal by UHS in *Escobar* to the Supreme Court argued that the FCA is a statute with plain meaning and that it is actually a separate provision of the FCA than the one at issue that prevents the use of a “false record or statement” in connection with a “false or fraudulent claim.” The respondent’s brief went on to criticize the petitioner’s opinion that a claim may only be false if it is “factually false;” it either mis-describes the good, service, or contains an explicit false statement. Further, the brief goes on to argue the original Congressional intent of the FCA was to prohibit all possible tactics by contractors from stealing from the public.

As expected by many, the Court’s decision in *Escobar* led to a resolution of the multi-circuit split on the issue of express versus implied certification. The Court agreed with the First Circuit and found that claims of misrepresentations were not merely limited to those which concerned express conditions of payment. However, the court created a

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121 See Brief for Respondents at 25, Universal Health Servs. v. United States *ex rel.* Escobar, 136 S. Ct. 582 (2016) (No. 15-7) (outlining Respondent’s interpretation of FCA). The brief details that a “claim” is “an assertion of a legal right to government funds, which carries with it an implied representation that the claimant is legally entitled to payment.” Id. at 23. The brief notes that:

Eighty-seven octane gasoline is not the same as 91-octane gasoline and may cause damage to an engine not designed for lower-grade gasoline. Military guards who cannot shoot straight are inferior to guards with marksmanship training. And psychiatric services provided by unlicensed and unsupervised staff are unsuitable compared to services provided by properly licensed and supervised professionals (and are potentially dangerous to the patient’s health).

Id. at 25-26.

122 See id. at 25 (countering petitioner’s argument).

123 Id. at 23 (comparing misrepresentations regarding quantity of gasoline and proficiency of military guards to medical treatment).

124 See Nibley & Nadler ___ supra note 117 and accompanying sources cited (discussion predictions upon Supreme Court’s grant of certiorari).

125 See Universal Health Serv. v. United States *ex rel.* Escobar, 136 S. Ct. 1989, 1998 (2016) (discussing reasoning for granting certiorari). “We granted certiorari to resolve the disagreement among the Courts of Appeals over the validity and scope of the implied false certification theory of liability.” Id. at 1998; see also Ronald Mann, *Opinion Analysis: Justice Chart Their Own Path in Narrowing Recovery for Implied Fraud Under the False Claims Act*, SCOTUSBLOG (Jun. 16, 2016, 9:39 PM), http://www.scotusblog.com/2016/06/opinion-analysis-opinion-analysis-justices-chart-their-own-path-in-narrowing-recovery-for-implied-fraud-under-the-false-claims-act/ (summarizing *Escobar* and emphasizing importance of resolution). According to Mann, the case resolved a “major dispute” under the FCA amongst the lower courts. Id. Further, the implied certification theory was the “big” question in the case that justified review by the Supreme Court. Id.

126 See Universal Health Servs., 136 S. Ct. at 1994 (holding omissions of critical qualifying information can be misrepresentations). “Section 3729(a)(1)(A), which imposes liability on those presenting ‘false or fraudulent claim[s],’ does not limit claims to misrepresentations about
standard for limiting exposure under the FCA by outlining a materiality requirement specifying that the misinformation from the provider must be material to the government’s decision to pay the claim.127

In holding the implied certification theory was a valid form of action under the FCA, the Court first looked at the statute and its use of the terms “false or fraudulent” and reasoned that it was Congress’s intent for these terms to have their meaning under the common law and thus included certain misrepresentations by omission.128 The focus was then on the parties’ disagreement as to whether submitting a claim without disclosing violations of statutory, regulatory, or contractual requirements constituted an actionable misrepresentation.129 The court declined to review whether all claims for payment implicitly represented that the biller is entitled to payment, instead, the court reasoned that the claims in this case were clearly an example of half-truths.130 Representations made by Universal express conditions of payment.” Id. “What matters is not the label that the Government attaches to a requirement, but whether the defendant knowingly violated a requirement that the defendant knows is material to the Government’s payment decision.” Id. The Court held:

[T]he implied certification theory can be a basis for liability, at least where two conditions are satisfied: first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant’s failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths.

Id. at 2001.

127 See Universal Health Servs., 136 S. Ct. at 1994-95. “A misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government’s payment decision in order to be actionable under the FCA.” Id. at 1994. The court further specified that even violations of express conditions of payment were subject to the materiality requirements. Id. at 2001.

128 See id. at 1999. The Court pointed out the meanings of these terms were well settled. Id. The Court also pointed out both the parties and the Government, in their briefs, agreed that misrepresentations by omission could give rise to liability. Id.

129 See id. at 1999-2000 (describing competing arguments). The government argued that every submission of a claim for payment was an implicit representation that the claimant was legally entitled to payment, and that a lack of disclosures rendered the claim misleading, thus triggering the fraud claim as laid out in the statute. Id. However, Universal Health argued that submitting a claim involved no representations at all, and, thus, the claim would be non-actionable absent a special duty to disclose a legal violation (which was absent in government contracting). Id. at 2000.

130 See id. at 2000 (discussing “half-truth” misrepresentations). The court referenced a “classic example” of an actionable half-truth in contract law of a seller of land revealing that there may be two new roads near the piece of property, yet not disclosing that a third planned road would be bisecting the property for sale. Id.; see also Junius Constr. Co. v. Cohen, 178 N.E. 672 (N.Y. 1931) (discussing misrepresentation elements in contract cases). The Court also provided the example of an applicant for an adjunct position at a college making an actionable misrepresentation by listing retirement on his resume, but failing to disclose that the “retirement” was due to time spent in prison for a $12 million bank fraud. See Universal Health Servs., Inc. v. United States, 136 S. Ct. 1989, 2000 (2016). See also Sarvis v. Vermont State Colls, 772 A.2d
Health, in the form of claims submitted using National Provider Identification numbers corresponding to job titles, were thus determined to be misrepresentations to the Massachusetts Medicaid program. The analysis concluded by specifically spelling out the two necessary conditions for a satisfactory implied certification basis for liability: (1) the claim must do more than request payment, but also in some way must make specific representations about the goods and services provided; and (2) the failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes the representations half-truths.

In continuing to the questions of liability for conditions of payment, the Court seemed to go in the opposite direction by stating that violations were not automatically FCA violations, but they must also pass a materiality test. The materiality test is a demanding standard that "look[s] to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation." The Court advocated for a holistic view of materiality, relying on a number of factors.

This emphasis on materiality as a requirement of claims under the FCA has the potential to generate significant controversy and challenges.
for lower courts. Despite the assertion by the court that the materiality standard will be a rigorous one, there are already questions as to whether it will be so stringent in practice. Because of these questions about the new materiality standard, concerns are arising that Escobar will have merely replaced one circuit split problem with another.

VI. ANALYSIS AND APPLICABILITY OF ESCOBAR TO WORTHLESS CARE IN NURSING HOMES

The Court’s decision in Escobar will have far reaching effects on government contractors from military contractors, to health care providers, to universities. For too long, circuits were divided over what actually constitutes falsity under the Act, leading to a myriad of rules in different geographic areas and ever shifting enforcement standards over time. The intent of the original drafters of the FCA was clear, and a finding parallel to that of the Seventh Circuit would not have been in accordance with the intent of the FCA as its plain words indicate. The increase in government spending in recent years, exacerbated by the spending on outside contractors, particularly in the health care field, makes this issue more important than ever for the continued ability of government agencies to control funds while also providing quality services to all constituents.

The Seventh Circuit’s opinion in Sanford-Brown, finds itself alone amongst the circuits for one particular reason; the other circuits recognize

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137 See Robert W. Miller, Escobar Appears to Open the Door to More “Materially” False Claims, 10 J. HEALTH & LIFE SCI. L. 1, 6, (2016) (suggesting courts may be hesitant to label certain rules as “minor”).

138 See Bentivoglio, supra note 136, at 4 (noting vagueness in defining materiality continues). The circuit courts have already begun to show splits along the materiality standard. Id. at 3. Notably, the Seventh Circuit held that the government’s mere ability to decline payment was not enough to survive summary judgment on the materiality element. Id. Whereas, conversely, the eighth Circuit specified that materiality depended on whether keeping accurate records influenced the government’s decision to enter into a relationship with the defendant. Id.

139 See infra Section V(0) (explaining need to resolve circuit split).

140 See supra Parts III-0 (discussing requirements of FCA claim).

141 See supra Parts I-II (outlining reason for FCA and its importance).

142 See supra Part III and accompanying text (discussing problems with FCA in healthcare field).
the importance of following the intent of the FCA should serve as guidance for the Supreme Court as it contemplates Escobar. Moreover, given the more complex nature of arrangements between the government and its contractors, cases that rely on non-traditional forms of enforcement will be essential, such as participation agreements and provider contracts. As the government partners more and more with contractors, the language of agreements will continue to shift away from regulations and more towards the more business-familiar contracts with its obligations and enrichments detailed within.

The Escobar decision will have a major impact on the nature of worthless quality of care cases in nursing homes which have to this point faced numerous challenges in enforcement ability. The Federal Nursing Home Reform Act governs requirements that skilled nursing facilities under Medicare and nursing homes under Medicaid must meet in order to be eligible to provide services through these programs. Following these regulations can be interpreted as preconditions of payment under the First Circuit’s interpretation of falsity. The Reform Act established certain requirements that must be met, such as: “(A) In general a nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.” Violations of these rules will establish the required falsity under the First Circuit’s interpretation.

Healthcare cases under the FCA, specifically those regarding care provided in nursing homes, will continue to see a rising importance in coming years. The Federal FCA has proved to be an important tool in cost control overall as well as in healthcare programs. This tool, however, has not proven to be completely effective in its administration and recent decisions have put into question the ability of the Federal Government to recoup misspent funds through the FCA. Contemporary cases interpreting the FCA have led to the development of case law that has

\[143\] See supra Sections V(A)-(0) (describing differences between circuit rules).

\[144\] See supra Sections V(A)-(0).

\[145\] See supra Part I (providing history of FCA).

\[146\] See supra Part II (noting difficulty establishing worthless services claims).

\[147\] See 42 U.S.C.A. § 1395i-3 (West 2014); See also 42 C.F.R. §§ 483.13-70 (providing guidelines for care).

\[148\] See supra Part I.

\[149\] See supra Part I.

\[150\] See supra Sections V(A) and V(0) (explaining falsity requirement).

\[151\] See supra notes 13-19 (outlining causes for future increase in importance).

\[152\] See supra Part I (discussing origins of FCA).

\[153\] See United States ex rel. Absher v. Momence Meadows Nursing Ctr., Inc., 764 F.3d 699, 710 (7th Cir. 2014) (explaining difficulties in proving false claims).
complicated the analysis of whether an action is false under the Act. These judicially generated requirements for the Act have unnecessarily complicated the analysis of the FCA that was intended to merely recoup funds spent on services which had diminished value.

Some jurisdiction’s use of preconditions of payment and preconditions of participation have created murky waters where government officials and judicial officials are required to create distinctions in the law where it did not originally exist. Additionally, the very nature of nursing home cases and the requirement of worthless services under the FCA, creates challenges in the long-term care related cases. Worthless services can only be found where there’s no value to the services at all. This creates an issue due to the very nature of long-term care services wherein some services are being provided by the very fact that a consumer is residing in a facility, yet the concern becomes what did the federal government intend to pay for. Alternative theories which have been put forward for interpretation of the FCA have offered a more reasonable interpretation in how the Act should be applied and how it falls closer in line with its original intent, even in long-term care cases.

This added complexity to the law has made it more difficult to recoup misspent funds that would appear to clearly fall within the original intent of the FCA. This differentiation from the application of the Act

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154 See United States ex rel. Hutcheson v. Blackstone Medical, Inc., 647 F.3d 377, 379 (1st Cir. 2011) (describing additional requirements to satisfy falsity). The Blackstone case added language that the regulation being violated must be expressly written in the law. Id. at 387

155 See supra Part I (discussing origins of FCA).

156 See supra Part 0 (outlining distinctions created by requirements).

157 See supra Part II (explaining worthless services). The FCA places strong restrictions on what meets the participation requirements of a valid participant in the program. See supra note 35.

158 See case cited supra note 37 and accompanying text (describing interpretations of “worthless services”).

159 See United States ex rel. Absher v. Momence Meadows Nursing Ctr. Inc., 764 F.3d 699, 710 (7th Cir. 2014) (distinguishing services that are “worth less” from “worthless services”).

160 See Utterback, supra note 41, at 156 and accompanying discussion (suggesting that proof of worthless service should go to reason payment was made). Utterback offers a reasonable alternative in that the government would not have paid for a service had it known what was actually being provided. Id. This falls closer to what was originally intended by the adoption of the FCA. See supra notes 4-10. It additionally addresses the challenges of the long-term care setting in that there are services being provided but, essentially, the government would not have wanted to pay for them had they known what was being done. See supra note 34, at 478.

161 See United States ex rel. Loughren v. Unum Gp., 613 F.3d 300, 307 (1st Cir. 2010) (explaining long-held requirement of materiality); United States v. Rogan, 517 F.3d 449, 452 (7th Cir. 2008) (noting statements or omissions can be material); United States v. Houser, No. 4:10-CR-012-HLM, 2011 WL 2118847, at *10 (N.D. Ga. May 23, 2011) (establishing knowledge requirement). These cases demonstrated that there were services provided that were not what the government intended to pay for. Id. However, there were judicially created hurdles which stood
and the original intent will have practical implications as the need for effective government funded long-term-care continues to rise over the next several decades.\textsuperscript{162} Recent cases have offered opportunities for simplification on the interpretation of the FCA and have given the government more of an ability to control the money they spend and to ensure that it is spent on services that have appropriate value.\textsuperscript{163}

This trend has continued with the \textit{Escobar} case.\textsuperscript{164} This has further broadened the interpretation of the FCA and has allowed the government to recoup money in cases that previously would have been unavailable.\textsuperscript{165} The further aligning of multiple circuits around this interpretation will ease the administration of FCA cases across states and provide both government officials and medical providers with expectations as to what the abilities are of the government to recoup funds.\textsuperscript{166} These cases are of particular importance in long-term care situations where the government had been placed in the precarious position of arguing that even though someone was a resident at a facility, there was no value to the services they received.\textsuperscript{167}

\textbf{VII. CONCLUSION}

Further aligning of the circuits has been achieved by the Supreme Court. As these cases continue to present challenges across several circuits, it becomes clear that there should be a reconciliation of what it actually means to have falsity under the FCA. It is clear that significant spending in this area will lead to more cases in the near and distant future, all of which will be of importance to all manner of parties interested in government spending and health care.

in the way of recoupment of the funds. \textit{Houser}, 2011 WL 2118847, at *10; Rogan, 517 F.3d at 452; Loughren, 613 F.3d at 307. \textsuperscript{162} See supra notes 13-19 (noting future increases in long-term care funding).

\textsuperscript{163} See United States \textit{ex rel. Hutcheson v. Blackstone Med., Inc.}, 647 F.3d 377, 385 (1st Cir. 2011) (arguing FCA was intended to be broad). The \textit{Blackstone} and \textit{Amgen} cases expanded the government's ability to recoup misspent funds by simplifying the previous interpretation of conditions of participation and conditions of payment. See supra Part IV (explaining prior interpretations).

\textsuperscript{164} See United States \textit{ex rel. Escobar v. Universal Health Servs., Inc.}, No. 11-11170-DPW, 2014 WL 1271757, at *5-6 (D. Mass. Mar. 26, 2014) (noting \textit{Escobar}'s citation to First Circuit decisions). \textsuperscript{165} See id. (explaining other courts had similarly found only conditions of payment mattered for falsity).

\textsuperscript{166} See supra Part 0 (showing First Circuit's recommitment to broad definition of falsity). Appeals courts have appropriately recognized a need to return to the statutory intent of the FCA rather than judicially constructed hoops. See supra Part 0. \textit{The Escobar} case aligns several of the circuits together including the First, Second, and Sixth. See supra Part 0(C).

\textsuperscript{167} See supra Part III (outlining certification approaches).
Originally, the FCA was implemented to protect the government from unscrupulous vendors providing inferior goods for a profit. Government spending has continued to rise particularly in the areas of healthcare. Projections show that this increase will continue in coming years and will result in more opportunities for providers to profit off of inferior services. The Supreme Court now has an opportunity in Escobar to follow the First Circuit’s lead and establish strong powers for the government to ensure that quality products are provided when the government is the payor. Developing a national standard that follows the path of the First Circuit will place the nation in concert with the original intent of the FCA. Importantly, it will also grant governmental agencies a powerful tool to recoup wasted money in a time when government spending is under an ever increasingly intense microscope. Expanding the concept of falsity to include conditions of participation and conditions of payment will allow the FCA to continue to function throughout the twenty-first century as it had been intended from its origin.

It is demonstrably clear that as the government continues to contract out services that were previously managed internally, that the FCA will be a more important tool in managing taxpayer dollars. Congress recognized the importance of strong provisions to prevent fraud of the government when it first established the FCA following the Civil War. They notably included plain language that was to be construed broadly, so that the government could always get what it was paying for. One has to question the idea, held by the Seventh Circuit justices, that Congress intended contractors to comply with some requirements of the government, but not others. Whether they be promulgated through statutes or individual agreements. The First Circuit has implicitly recognized the intent of the creators of the law and interprets their words as they should be interpreted, at their face value. The over complication that has taken place in recent decades regarding legal and actual falsity or implied and express certification or conditions of participation versus conditions of payment has.

The Supreme Court has appropriately held to the original intent and language of the statute. With a finding that mirrors the First Circuit’s, requiring a holistic view of falsity rather than a definition marred on political constructs, the federal government, and states as well, will again be able to get the services they are actually paying for. The importance of this in a society where more and more elderly are entering nursing homes, at the government’s expense, cannot be overstated. It not only relates to government spending, but importantly has implications for health and end of life dignity as well. A correct decision by the court will give regulators a tool to keep government contractors in line with their promises.