# Risk and Uncertainty for Health Care Providers and Government Contractors in the Wake of Universal Health Services v. Escobar

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The Supreme Court?s decision in the closely watched case of *Universal Health Services, Inc. v. United States ex rel. Escobar*, decided on June 16, 2016, provides a long-awaited interpretation of the False Claims Act (?FCA?) and the so-called theory of implied certification. In a unanimous opinion, the Court resolved two legal issues of widespread import that have been the subject of numerous conflicting decisions in the courts of appeals. Unfortunately, it did so in a way that invites further litigation and will require judicial parsing of a more fact-intensive legal standard. Particularly for government contractors and health care providers, it creates additional uncertainty about potential FCA exposure.

The Court first held that the theory of implied certification can be a basis for FCA liability, but only in certain circumstances. As framed by the United States and two relators, the theory of implied certification holds that a government contractor?s (in this case a Medicaid provider?s) submission of a claim for payment impliedly certifies that the contractor has satisfied all conditions of payment. If a contractor submits a claim but fails to disclose a known violation of a material legal requirement, so the theory goes, then the contractor has made an implied representation that renders the claim ?false? within the meaning of the FCA. The Court agreed conceptually with the implied certification theory, at least where two conditions are satisfied:

1. The claim does not merely request payment, but also makes specific representations about the goods or services provided; and
2. The contractor?s failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths.

The Court?s formulation of the implied certification theory thus raises at least three important questions upon which liability may turn. When, and how, does a contractor make ?specific representations about the goods or services?? When is a legal or contractual obligation ?material?? And, when does failure to disclose noncompliance result in a ?misleading half-truth?? With respect to these questions, *Universal Health Services* provides a useful example of when, in the Court?s view, a claim may include specific

representations that, through omission (i.e., failure to disclose legal or contractual violations), result in misleading half-truths.

The false claims at issue in *Universal Health Services* arose in the context of the Massachusetts Medicaid program. Universal Health Services, through its subsidiary Arbour Counseling Services (?Arbour?), had submitted claims for behavioral health services using government claim forms that identified the services by CPT (common procedural terminology) code and the individual providers by their NPI (National Provider Identifier) numbers. The claims at issue included mental health counseling services that were required by regulation to be provided by licensed health care professionals with prescribed qualifications. In addition, the regulations required that Arbour have specific types of licensed clinicians on its staff, and that the facility provide a minimum level of supervision over those clinicians. In their complaint, the relators alleged that Arbour had violated these regulations by employing unqualified, unlicensed, and unsupervised staff, which resulted in the claims being false or fraudulent.

Examining the relevant statutory language, 31 U.S.C. § 3729(a)(1)(A), the Court determined that the word ?fraudulent? incorporates the well-settled common law meaning of the term, which includes that a misrepresentation by omission can give rise to liability when the omission results in a misleading half-truth. Applying this standard to the facts alleged, the Court identified two omissions that could have constituted fraud. First, Arbour had allegedly submitted claims using CPT codes associated with mental health services that could only be provided by properly qualified, licensed, and supervised clinicians. Arbour?s failure to disclose that these conditions had not been satisfied resulted in the claims being clearly misleading. Second, because the NPI numbers that Arbour included on the claims could only be assigned to licensed clinicians, and because the clinicians obtained those NPI numbers without first acquiring a license, Arbour?s use of the NPI numbers constituted a misrepresentation. Either of these alleged misrepresentations, in the Court?s view, could result in a violation of the FCA, if material to the government?s decision to pay the claim.

The Court gave additional examples from contract and tort law of when a ?half-truth? can amount to an actionable misrepresentation: First, where a seller?s representation about property for sale revealed the potential for two new roads near the property but failed to disclose that a third potential road might bisect it. Second, where the resume of an applicant for a college position listed prior jobs followed by ?retirement? but failed to disclose that the period of retirement was a prison stint for bank fraud.

The Court?s second holding, and the one that has particular importance for health care providers and government contractors, concerns the materiality concept. Previously, many courts, along with the Department of Justice and the plaintiff?s bar for *qui tam* relators, took the position that a violation of law or contract was material if the existence of the violation would permit the government to deny the claim. In the context of Medicare claims, a material violation was one that resulted in the failure of a condition of payment. A corollary of this position was that violations of other requirements, such as the more voluminous conditions of participation, were not material within the meaning of the FCA.

But the *Universal Health Services* Court rejected this bright-line test in favor of a more fact-intensive and subjective standard not argued by any of the parties. According to the Court, a ?material? violation under the FCA is one that has ?a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.? Under this more flexible standard, ?materiality ?looks to the

effect on the likely or actual behavior of the recipient of the alleged misrepresentation.?? Thus, the fact that a health care provider or contractor has violated a condition of payment is relevant to the materiality determination, but not dispositive.

Having determined that materiality does not turn on how the government may categorize a particular legal or contractual obligation, the Court provided only the broadest of guidance for how materiality should be judged in the context of federal health care programs:

The materiality standard is demanding. The False Claims Act is not ?an all-purpose antifraud statute,? [citation omitted], or a vehicle for punishing garden-variety breaches of contract or regulatory violations. A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defendant?s noncompliance. Materiality, in addition, cannot be found where noncompliance is minor or insubstantial.

For health care providers, this articulation of the materiality standard as applied to Medicare and Medicaid claims is a potential time bomb. For many types of providers, the conditions of participation are vast and intrusive. Hospitals and nursing homes, for example, routinely identify violations of conditions of participation, through internal compliance programs or external audit programs. Under the *Universal Health Services* materiality standard, these sometimes benign violations are now a source of potential FCA liability, if the provider bills for services rendered during the period of noncompliance.

For government contractors the rule is equally unsettling. Contracts are increasingly burdened with far-reaching regulatory requirements and standards (e.g., regarding labor and information security), as to which the compliance burden falls on the contractor. Whether an FCA suit has potential validity now depends only on whether the government (or a relator) can argue that knowledge of the particular legal or contractual violation would have influenced its decision to pay the claim. In essence, contractors and health care providers must now try to predict, looking through the proverbial crystal ball, when the government might view a particular condition of participation or payment as material.

The Court seemed to recognize the uncertainty it was creating and took steps to cabin the concept of materiality. The Court emphasized that an FCA claim cannot be predicated on ?insignificant regulatory or contractual violations,? and that an FCA plaintiff must comply with pleading rules and allege ?facts to support allegations of materiality.? And the Court noted that proof of materiality may include evidence that the claimant knows that ?the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular? legal or contractual requirement, or conversely, that the government routinely ?pays a particular claim in full despite its actual knowledge that certain requirements were violated.? The upshot of these examples seems to be that the government can define as material any legal or contractual requirement that it likes, so long as it consistently denies payment when it knows that the requirement is not satisfied.

Notwithstanding its efforts to limit its holding, the Court?s open-ended and subjective materiality standard portends a potential flood of new and creative theories of FCA liability related to federal health care programs and government contracts. Whereas previously the courts had only to determine whether

a particular violation related to a condition of participation or a condition of payment, now the arguments are more likely to center on whether a regulatory violation is ?garden-variety,? whether noncompliance is ?minor or insubstantial,? and whether the government has historically paid similar claims with knowledge of the relevant violation. *Universal Health Services* reinforces the need for thoughtful and proactive compliance vigilance, and for a plan of action if the government or a *qui tam* relator comes calling.

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