No. _____

In the
Supreme Court of the United States

CHRYSSOULA MARINOS-ARSENIS,

Petitioner,

v.

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The questions presented for review are:

1. Whether the implied certification theory of liability under the False Claims Act is viable, and if so, whether it requires that the Defendant(s) comply with a specific legal requirement that is material to the government's payment decision.

2. Whether the First Circuit erred in applying the materiality standard for implied certification claims in this case.

3. Whether the lower court's interpretation and application of the implied certification theory of False Claims Act (FCA) liability is consistent with the Supreme Court's decision in *Universal Health Services, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016).

4. Whether the lower court's decision conflicts with other circuit courts' interpretation and application of the implied certification theory of FCA liability.

5. Whether the lower court's decision undermines the materiality standard set forth in *Escobar* by allowing FCA claims based on immaterial or minor violations.

6. Whether the lower court's decision improperly expands the scope of FCA liability by allowing plaintiffs to bring claims based on implied or unspoken requirements that are not expressly designated as conditions of payment.

7. Whether the lower court's decision creates uncertainty and unpredictability in FCA litigation by allowing plaintiffs to bring claims based on a broad range of contractual or regulatory violations.

8. Whether the lower court's decision violates the principles of fair notice and due process by allowing FCA liability based on unclear or ambiguous contractual or regulatory provisions.

9. Whether the lower court's decision conflicts with the Supreme Court's precedent on statutory interpretation and the role of agency guidance in determining FCA liability.

10. Whether the lower court's decision improperly shifts the burden of proof in FCA cases by requiring Defendant(s) to disprove materiality rather than requiring plaintiffs to prove it.

11. Whether the lower court's decision undermines the government's ability to negotiate and enforce contracts with private parties by allowing FCA claims based on technical or minor violations.

12. Whether the lower court's decision conflicts with the policy goals of the FCA and the need to balance the interests of the government and private parties in contract negotiations and performance.

13. Whether multiple diagnostic evaluation and treatment encounter are considered by Horizon's relator Scott Johnson are Fraud

without considering the American Medical Association which is the authority of CPT Codes and ICD-9(ICD-10) codes and the billing services which has been verified (AAPC and AMA Reports).

14. Whether the Americans with Disability Act focus is to prepare the patient with Disabilities for Employment and Independent living, as well as, the New Jersey Mandate for Autism and Other Neurodevelopmental Disabilities emphasis is through frequent evaluative and treatment criteria to prepare the above patients with Autism and Other Developmental Disabilities for independent living and self-sufficient employment.

PARTIES TO THE PROCEEDING

The Petitioner and Appellant below is Chryssoula Marinos Arsenis.

Speech & Language Center, LLC; John Does 1-10; and ABC Corps 1-10 were Defendant(s) below.

The Respondent and Plaintiff-Appellee below is Horizon Blue Cross Blue Shield of New Jersey.

STATEMENT OF RELATED PROCEEDINGS

Horizon Blue Cross Blue Shield of New Jersey v. Speech & Language Center LLC; et al. The Third Circuit's opinion is reported on 12/14/2022, The Third Circuit's order denying rehearing en banc is reported on January 5, 2023. The relevant opinion and order of the district is published at August 22, 2022.

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To the Honorable Justices of the Supreme Court of the United States:

Petitioner(s) respectfully requests that this Court grant a writ of certiorari to review the decision of the United States Court of Appeals for the First Circuit in *United States ex rel. Escobar v. Universal Health Services, Inc.*, 780 F.3d 504 (1st Cir. 2015), *cert. granted*, 136 S. Ct. 1989 (2016), and affirm or reverse the decision accordingly.

OPINIONS BELOW

The Third Circuit's opinion is reported on 12/14/2022, The Third Circuit's order denying rehearing en banc is reported on January 5, 2023. The relevant opinion and order of the district is published at August 22, 2022.

JURISDICTION

The Third Circuit issued its opinion on January 5, 2013. The court denied Speech and Language Center's L.L.C. petition for rehearing en bank on January 5, 2023. This court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This petition involves provision of the False Claims Act, 31 U.S.C. §§ 3729-30, as well as other statutes and regulations governing out-of-state health insurance plans by challenging Horizon's enforceability of pari passu agreement with out-of-state health care plans.

INTRODUCTION

Horizon under the NJIFPA brought claims for $6,600,000.00 for claims which are not covered by the NJIFPA because the claims are covered by the False Claims Act (FCA) Thus the claims such ERISA SELF FUNDED, FEP, SHBP, BLUE CARDS ERISA CARD Plans are not under the jurisdiction of NJIFPA. Therefore, the unsigned settlement agreement as stated by Justice Albin was brought under false pretenses because the claims of $6,451,000.00 had to be brought under the False Claims Act for the aforesaid plans Horizon the administrator has no authority/standing to sue for the out of state insurance health plans claims. Accordingly, Horizon, as an administrator is not authorized to sue and cannot prove any misconduct or damages against the Petitioner(s) for the out of state health Insurance plans.

Noting that the aforementioned has already been confirmed and acknowledged by Horizon's Motion of Summary Judgment. (Please see Summary Judgment Lee's certification). Horizon acts for these plans as an administrator for a processing fee and this particular information has been already been provided to this court. As a matter of fact, Petitioner(s) filed a motion to seal all the patients and their information including the patients which are members of Blue Card entities, Blue Card ERISA plans, self-funded ERISA Plans, Federal Insurance Plans & SHIB, which has already been granted by the Third Circuit.

The above noted, that Speech and Language Center, L.L.C. has a complete diversity jurisdiction because each of these plans are citizens of different states. Speech and Language Center, L.L.C. did not have a valid contract with the aforesaid plans, therefore, there, was no breach of contract and there were no damages to Horizon citing *RNC. Sys v. Modern Tech. Grp., Inc.*, 861 F. Supp. 2d 436, 444, 445 (DNJ 2012) (citing Lee's Certification March 28, 2018).

Petitioner(s) respectfully moves this Court to grant the Petition for a Writ of Certiorari. A review is warranted to allow the Supreme Court to address substantial questions that this petition raises about the False Claims Act's (FCA) materiality and scienter requirements (1) whether the failure to allege facts regarding past payment practices from (2007-2018) can weigh against a finding of materiality, and (2) whether a complaint satisfies the FCA's scienter requirement when it contains no allegations that the Petitioner(s) was on notice that its alleged violations were material to the third-party health care provider for the out of state health care plans.

STATEMENT OF THE CASE

With respect to Enforce Litigant's Rights after three (3) years and without a decree, the following legal opinions are cited almost verbatim by the New Jersey Supreme Court Justices during Oral Arguments held on November 30, 2021, please see transcripts (Appendix E) which totally invalidated the settlement. These are as follows:

As very well communicated, during the Supreme Court of New Jersey during oral arguments on November 30, 2021, Justice Albin stated "the Court did not know the facts of the Case. No criticism, they did not sign because they did not agree to anything." "As the rule stipulates, all parties have to consent, however, in this case the parties did not agree to anything". citing "They are not in default," as Justice Albin expressed "they just didn't sign." "All parties consent endorsed thereon." (citing *City of Jersey City v. Roosevelt Stadium Marina Inc.*, 210 NJ Super 315 (App. Div. 1986), *cert. denied*, 110 NJ 152 (1988).

"This agreement and the settlement it represents does not constitute an admission by the Parties of any violation of any federal, state, or local law or any duty whatsoever, whether based in statute, common law, or otherwise, or of any liability, and the Parties expressly deny any such violation or liability. Nothing in this Agreement, nor any act or omission relating there to, is or shall be considered an admission, concession, acknowledgement or determination of any alleged liability. Rather, this Agreement has been entered into without any admission, concession, acknowledgement or determination of any liability or non-liability whatsoever, and has no precedential or evidentiary value whatsoever except in connection with enforcing the terms of this Agreement. As Justine Albin stated, "I cannot imagine any stronger denial of liability that you have permitted in this settlement agreement." "I am trying to understand this collateral estoppel argument. Where is the fact? Where is the admission as Justice Paterson inquired?" As Justice Patterson

continued during Oral Arguments on November 30, 2021 in the Supreme Court of NJ. "Horizon got an issue that there is no signature on the Confession of Judgment with the respect to the facts. There are concerns with the Statute of limitations, and laches defenses." Likewise, Justice Patterson stated, "that there is no signature on the Confession of Judgment". Therefore, "Horizon cannot enforce estoppel without a signature.". Consequently, "Horizon cannot enforce Litigant's Rights without a signature. Conversely, the consent order did not represent that the Defendant(s) had consented to the form of the order". (Please for further details see the video recording noted and the transcripts on the appendix).

In addition, in the complaint, Horizon and Aetna exchanged patient's information and biographical data between two healthcare insurance companies for the purpose of filing a joint lawsuit could constitute a violation of HIPAA's Privacy rule. Under the Privacy Rule covered entities (health care providers) or insurance carriers must obtain authorization from the patients before disclosing protected Health Information (PHI) to another entity. This includes PHI shared with a third party, even if that party is involved in a legal action related to the care provided or payment for services. Therefore, if the two healthcare insurance companies exchanged PHI without obtaining explicit authorization from each patient whose data is exchanged, it could be seen as a HIPAA violation. HIPAA (the Health Insurance Portability and Accountability Act of 1996) is a federal law that establishes standards for protecting the privacy and security of protected

health information (PHI) held by covered entities. It is administered by the U.S. Department of Health and Human Services (HHS), which enforces the regulations and provides guidance to help ensure compliance. HIPAA (the Health Insurance Portability and Accountability Act) is a federal law that protects the privacy of individuals' health information. It was passed by Congress and is enforced by the Department of Health & Human Services (HHS). it establishes federal standards for protecting the confidential health information of individuals.

Violations of HIPAA can be enforced by the Department of Health and Human Services (HHS). The HHS Office for Civil Rights is responsible for enforcing HIPAA as it relates to health care organizations, and the Federal Trade Commission is responsible for enforcing HIPAA as it applies to vendors of personal health records. Additionally, state attorneys general may also enforce violations of HIPAA through their own enforcement mechanisms. The HHS Office for Civil Rights (OCR) is subject to the requirements of Article III of the U.S. Constitution and has standing to bring civil actions in federal court to enforce HIPAA regulations. OCR may seek remedies such as forced compliance, civil monetary penalties, and injunctive relief when violations are found. The HHS Office for Civil Rights (OCR) is able to pursue the following remedies when a HIPAA violation is found: Forced Compliance: OCR can require that organizations take steps to comply with HIPAA regulations.

Civil Monetary Penalties: OCR can assess monetary penalties against organizations that violate HIPAA regulations.

Injunctive Relief: OCR can issue orders to stop the violations and prevent further noncompliance with HIPAA regulations.

The HHS Office for Civil Rights (OCR) is the government agency responsible for enforcing HIPAA regulations. OCR works to protect individuals' health information and to ensure that organizations comply with HIPAA requirements. OCR is empowered to issue civil monetary penalties, corrective action plans, and other remedies when HIPAA violations are found.

With respect to enforce litigant's rights after three years without a decree in their favor, Horizon may face difficulty in enforcing litigant's rights within the applicable statute of limitations.

A confession of Judgment is not enforceable without the signature of both parties. The applicable statute of limitations may also be an issue.

Please see the following legal (opinions cited verbatim in the transcripts by the New Jersey Supreme Court Justices during the Oral Arguments held on November 30, 2021 which totally invalidated the settlement.

An unsigned settlement agreement brought under false pretenses under the false Claims Act (FCA) cannot prove any misconduct and damages against the Defendant(s), and it is unlikely that the FCA claims will be successful.

Under the FCA, a plaintiff must prove that the Defendant(s) made a false or fraudulent statement or omission that was material to the government's decision to pay a claim and that the Defendant(s) acted with knowledge or deliberate ignorance of the falsity of the statement or omission. In addition, the plaintiff must prove that the false statement or omission caused the government to pay a claim that it would not have paid otherwise. If the plaintiff cannot provide evidence and moreover the administrator is not authorized to sue, then the sue may not be properly brought under the FCA (autism and other developmental disabilities Mandate) under § 3730(b)(4)(A) actions conducted by the United States seem to grant a unilateral and unfettered ability to control every aspect of litigation including settlement and subsequent dismissal through the court. The right to conduct the action for a relator is narrow than it is for the United States. Accordingly, does Horizon have the right to negotiate and execute a settlement agreement without the input from the out of state health plans.

The dangers of allowing a Horizon's relator Scott Johnson to bring an FCA action against a company without input, from the United States are significant. Due to res judicata concerns, the United States must consent dismissal of a proposed settlement attendant to the dismissal of a claim of a relator and a Defendant(s), even if the United States does not choose to intervene at an earlier stage of the litigation. The FCA provides such as mechanism under 31 U.S.C. § 3730(b)(i). It further, narrows the scope of a relator's contact under 31 U.S.C.

§§ 3730(b)(4) 3730(c)(3) and 3730(d)(4). Therefore, the United States reserves an absolute veto power over settlement attendant to dismissal under the FCA.

In *Searcy v. Phillips Elecs N. Am Corp.*, 117 F.3d 154 (5th Cir 1997). Borther had negotiated with Philips without the government input. The United States objected to the settlement on two grounds the proposed settlement was too low and (2) and releasing the claim could preclude the United States from pursuing future claims arising out of issues that the United States had not yet had the opportunity to investigate. Borther, may have the result of increasing the settlement amount and boosted the value of the settlement by bargaining away clams on behalf of the United States. *Searcy*, 117 F.3d at 160. However, 31 U.S.C. § 3730(b)(1) provides protection against this by allowing the United States to refuse the settlement when it perceives the relator receiving an unjust enrichment from the agreement. The above applies to Horizon trying to receive an unjust enrichment from a settlement that is unsigned, brought under false pretenses under the False Claims Act (FCA) and Horizon cannot prove misconduct and damages against the Defendant(s) for the out of state healthcare plans. In conclusion, the success of an FCA claim depends on the ability of the Plaintiff to provide sufficient evidence of misconduct and damages against the Defendant(s) and to satisfy all the legal requirement of the FCA. In this case at bar, Plaintiff is unable to do so, therefore the claim(s) is unlikely to succeed.

The American Medical Association (AMA) has created a set of standards that provide guidance for Medical Professionals on billing practices and reimbursement procedures.

Adhering to the American Medical Association (AMA) guidelines is essential to avoid potential penalties from payers and liability. Please see report from AAPC (AMA certified organization supporting the above that Defendant(s) followed the AMA guidelines.

Dealing with an audit the dispute must be evaluated before making any payment. This is particularly true, if there are recurrent issues surrounding the matter in question such as the validity of a frequently used service or the use of a billing code (AAPC Report NJ DISTRICT COURT) or the particular service being questioned was medically necessary. Please see authorizations (with all CPT codes and Medical Authorizations).

An unsigned settlement agreement brought under false pretenses under the False Claims Act (FCA) cannot prove any misconduct and damages against the Defendant(s). The administrator Horizon has no authority/standing to sue for the out of state plans therefore cannot prove misconduct and damages. It the plaintiff cannot provide any evidence of misconduct or damages against the Defendant(s) in this case at bar, the plaintiff cannot prove that the Defendant(s) made a false or fraudulent statements or omission that was material to the government's decision to pay the particular claim. Moreover, if the administrator is not

authorized to sue, then the lawsuit cannot be brought under FCA for out of state health plans. The success of an FCA depends on the Plaintiff's ability to provide sufficient evidence of misconduct and damages as case by case or claim by claim to satisfy the legal requirement of the FCA. In this case at bar the Plaintiff is unable to do so and this could impact the administrator's ability to succeed on the claims brought under the False Claims Act.

A settlement dispute must be vetted cautiously. Any payment for a claim that has been challenged can set a precedent for future claims by various payers. Furthermore, this settlement may open the flood gates for future litigation from other entities who could see it as an admission to wrong doing. It would be beneficial to challenge the audit than it would be to pay it. In *U.S. ex rel. Escobar v. Universal Health Services,* The Supreme Court considered whether a plaintiff could bring a suit under the False Claims Act (FCA) on the grounds of fraud in the inducement. The court ultimately held that such fraud claims can be brought under the FCA, as long as it is reasonably inferred from the circumstances that there was intent to defraud the government when presenting a false claim for payment. This case has been viewed as a warning to Defendant(s). That they should fully vet any dispute before attempting to resolve it through paying any amount of money as this could be considered as an admission of guilt and lead to penalties or damages being awarded against them. In cases where there is no admission of Fraud the equities must be assessed by looking at both parties alleged conduct. Please see

Transcripts from the Supreme Court of New Jersey during oral arguments on November 30, 2021 video recording supporting the above.

The particularized pleading standard of Rule 9(b) to plead fraud with particularity. *See Ebeid*, 616 F.3d at 998-996 (listing cases and noting disagreement among the courts of appeals). Rule 9(b) of the Federal Rules of Civil Procedures provides that a complaint alleging Fraud must be specific in its allegations and an averment of Fraud must state the time, place and content of the alleged misrepresentations. This requirement is meant to ensure that Defendant(s) are not unfairly surprised with the claims being made against them, as well as to allow for an adequate chance for defense in order to satisfy this rule. Therefore, Plaintiffs must plead with particularity each element of the cause of action for Fraud case by case. Cross state line plans paid out of state plans reverse false claims. However, on September 11, 2014 Horizon's relator Scott Johnson clearly articulated the following violations which hypothetically occurred from 2009-2014 which were material to the out of state plans decision to pay claims from 2009 to 2014 and that the Defendant(s) knew 5 years ago that it was material to the cross state line plans to make a payment although relator Scott Johnson identifies no authority in support of that position. Noted that this requirement of materiality created by the court in 2016. Citing *Universal Health Service v. United States ex rel. Escobar* in a landmark decision of the Supreme Court of the United States in support of the False Claim Act a Federal law that imposes liability on

individuals and companies that defraud the government by submitting false claims for payment.

In order to establish liability under the FCA, a plaintiff must show that the Defendant(s) acted with a specific level of intent or knowledge, such as knowingly submitting false claims for payment or acting in deliberate ignorance or with reckless disregard for the truth of the claims. This is the scienter or mental state element of an FCA claim. If a complaint does not allege that the Defendant(s) had knowledge or notice that an alleged FCA violation was material to a third-party health care provider, it may be difficult to establish that the Defendant(s) acted with the requisite level of intent or knowledge to satisfy the scienter requirement. However, it depends on the specific facts of the case. If, for example the alleged FCA violation was so obvious that the Defendant(s) should have been on notice of its materiality to the third-party health care insurance, then the fact that the complaint did not specifically allege notice does not defeat the scienter requirements. It is a specific fact inquiry.

The relator Scott Johnson did not reveal that Defendant(s) successfully had been reviewed by Brenda Coles Director of Physician Services, as well as Jackie Jennifer Vice President of Horizon Blue Cross Blue Shield of the previous administration who ensured compliance with regulation and established Horizon's administrative role for cross-state line plans please see Ms. Brenda Cole's letters Director of Physician Services. Relator does not allege that Defendant(s) ever submitted a final claim without obtaining eligibility by Medical Directors, nurses for

medical necessity (see authorizations with all CPT codes used per treatment encounter authorized by Medical Personnel). However, allegations commenced from 2009 through 2014 Defendant(s) submitted claims based on the following conclusory liability which is quite anemic without any legal elements and not pursuant to the particularized pleading standard of Rule 9(b).

1. The Relator Scott Johnson stated that the Defendant(s) engaged in pattern of Fraud and abuse against Health Plans the insured or the beneficiary of those plans and the public. Defendant(s) routinely submitted claims for full range of diagnostic and therapeutic services which if actually performed would take at least two and half hours to perform or up to five and half hours for approximately twelve patients per dates of service.

2. In some instances, Defendant(s) have submitted claims for these services as many as 18 members in one day which reasonable equate to rendering treatment for 45 hours, to as much as 90 hours.

3. Defendant(s) claims submitted to Plaintiff suggest that Marinos Arsenis is worked all by one day or two days a year, sometimes worked for up to fifteen straight months without a single day off while seen patients many of whom are children on Christmas, Thanksgiving, Easter, New Years Day and Martin Luther King Day.

4. Defendant(s) provided diagnostic speech testing and therapy services to individuals who receive health benefit provided by the Plaintiff (Noted the fully funded Plans provided by Horizon amount to $149,000 for the years 2007 to 2018) Please see patients' spreadsheet including their individual plans, as well as the fully funded Horizon Plan sealed by the District Court for 25 years.

5. As part of the scheme to defraud Defendant(s) knowingly and intentionally submitted insurance claims and receive claims while misrepresented the scope of the services provided submitted insurance claims and received payment for service not rendered.

6. Submitted Insurance claims for received payment for services while misrepresented the patient diagnosis for the purpose of obtaining reimbursement to which otherwise they were not entitled.

7. At all times, material hereto Aetna and Horizon paid claims to Defendant(s) in reliance upon and as result of insurance claims submitted by the Defendant(s) Aetna and Horizon are insurers within the meaning of the IFPA Act.

Whether, multiple diagnostic evaluations and treatment encounters are considered by Horizon's relator that are Fraud without considering the American Medical Association which is the authority of the CPT codes and the billing services. Likewise, Horizon does not take into consideration the

Americans with Disabilities Act such as the need for patients' progress who qualify also under the New Jersey Mandate for Autism and other Neurodevelopmental Disabilities. It is clear treatment and evaluative criteria for patients with autism and other neurodevelopmental disabilities must be individually created and designed for patients to make progress markedly more than de minimis progress *Endrew F. ex rel Joseph F. v. Douglass Cty. Sch. Dist. RE-I*, 137 S. Ct. 988 (2017).

In 1997 Congress acknowledge that patient with disabilities were not receiving appropriate diagnostic and/or treatment and the system provided low expectations for those students. 20 U.S.C. § 1400(c)(3) Congress amended the ADA and addressed the need for equality of opportunity, full participation, independent living and economic self-sufficiency for individuals with disabilities. 20 U.S.C. § 1400(c)(1). Therefore, the goals for the special needs population must focus on the particular patient and every child must have the chance to meet challenging objectives. The long and short goals must be reasonably calculated to enable a patient to make progress appropriately, In light of the patients', circumstances, therefore, the diagnostic and treatment intervention must be linked to a patient's disability and functional progress would be monitored consistently and frequently via evaluative and/or therapeutic criteria in order to establish rigorous progress and prepare the patient with disability for employment, post-secondary education, and independent leaving. Accordingly, the above cannot be pled as false with particularity as per Rule

9(b), and consequently the consistent frequent evaluative and treatment criteria with patients with disabilities to be considered as false claims in connection with the alleged schemes of the relator Scott Johnson. However, despite the allegations of Fraudulent claims. Horizon's relator Scott Johnson has failed to plead fraud with particularity pursuant to Rule 9(b) stating in relevant part "that a complaint must be specific in its allegation of Fraud & must state clearly the time, place and content of the alleged misrepresentations of patients diagnosed with Autism and other Neurodevelopmental disabilities in violation of the Title 1, 2 and 3 of Americans with Disabilities Act. Meanwhile, the clinical professionals are best suited to evaluate each patient and determine whether diagnostic and/or treatment encounters are reasonable and medically necessary for that individual patient(s) authorized/approved by medical physicians/nurses including the designated Diagnostic and CPT codes by the attending clinical practitioner." (Appendix M)

From a practical perspective, the Federal agencies are best positioned to make high level policy decisions, however, the doctors diagnose each patient with disabilities and determine the frequency and consistency of evaluative and/or therapeutic criteria in order to establish and achieve the long-term goals to prepare the patient with disabilities for employment and independent living.

Horizon's relator Scott Johnson for the out of state plans reliance on algorithmic data analysis is not the issue. The focus which is narrowly confined to the basic argument is as follows: the use of statistical

sampling and extrapolation of the findings through statistical sampling is not adequate. If statistical sampling and extrapolation were done on a CPT code without taking into account the patient population such as autism and other neurodevelopmental disabilities, the results may not be representative of the entire population. It is important to consider the characteristics of the patient's population when conducting a statistical analysis to ensure that the results are accurate and applicable to the entire population of interest. Failing to consider important patient's characteristics such as neurodevelopmental disabilities could lead to biased or inaccurate results. Therefore, it is important to consider the patient population when conducting statistical sampling and extrapolation in healthcare research. Notwithstanding the above violates one's fifth Amendment due process rights in one way through a deprivation of liberty interest.

REASON FOR GRANTING PETITION FOR WRIT OF CERTIORARI

In *Escobar v. United States,* the petition the U.S. Supreme Court unanimously held that a claim alleging violation of a statutory or regulatory requirement can be actionable under the False Claim Act if it is material to the government's payment decision 136 S. Ct. at 2002 (2016)

Moreover, the FCA requires a "rigorous" scienter requirement id at 2002. A plaintiff needs to allege facts showing specifically that the Defendant(s) "knowingly violated a requirement that the Defendant(s) knows is material to the

Government payment decision id at 1996. The Court realized that the rigorous materiality and scienter requirements. Serve gate keeper functions for screening viable FCA claims and that strict enforcement of those requirements can address "concerns about fair notice and open-ended liability id at 2002. "Plaintiff's must plead FCA claims with particularity in accordance with Rule 9(b) *see U.S. ex rel. la Corte v. Smith Kline Beechan Clinical Labs*, 149 F.3d 227, 234 (3d Cir. 1998) FCA claims cannot survive if the Plaintiff does not identify a specific false claim and whether failure to allege facts can be sufficient to prove Fraud or misrepresentation. In particular, whether a plaintiff must present more than circumstantial evidence in order for the Plaintiff(s) to succeed in their claims. Moreover, the Writ of Certiorari, questions if the lack of direct evidence will be deemed as an insufficient basis for the claim and the Supreme Court decision could provide clarity on if failure to allege facts regarding past third-party health carrier's payment practices can impact a finding of materiality. Likewise, for FCA complaints it may provide guidance as to what constitutes knowledge or notice that alleged violations were material to out-of-state health plan's payment.

The decision from the Supreme Court on this Petition for a Writ of Certiorari will shape future interpretations of False Claims Act. (FCA) complaints by providing important insight as to how courts can assess materiality when deciding if a complaint meets scienter requirements.

The petition for a Writ of Certiorari will also ask the Supreme Court to consider whether the Court's decision in *Universal Health Services v. United States ex. rel. Escobar* stands for the conclusion that a complaint need not allege facts regarding past third-party health carrier payment practices in order to demonstrate materiality and/or scienter under the FCA.

In its decision, the Supreme Court stated that materiality may be adequately pleaded when "the Defendant(s) actions would have been material to a reasonable government payer" and when a Defendant(s) has knowledge or is on notice that his conduct violates legal duties owed to the government". The question posed by Defendant(s) Petition for a Writ of Certiorari will ask the Supreme Court to determine whether the failure to allege facts regarding past out-of-state health carrier's payment practices can weight against a finding that an FCA complaint adequately alleges materiality, and whether, a complaint satisfies the FCA's scienter requirement when it contains that the Defendant(s) knew or was on notice that its alleged violation were material to the out-of-state health carries payment. If answered in favor of Defendant(s), this petition will broaden the scope of materiality and scienter under *Universal Health Service v. United States ex rel. Escobar* making it more difficult for Plaintiff to satisfy these elements of their claims.

The Supreme Court's decision in *Universal health Services v. United States ex. rel. Escobar* narrowed the scope of an FCA claims materiality and scienter requirements by holding that FCA claims

are not actionable unless it is shown that the Defendant(s) had reason to believe their alleged violations was material to a payment decision by the government, or knew that violative conduct was a necessary condition of payment. Defendant(s)' petition will argue that there should be more leeway given in regards to allegations of past out-of-state-health carrier's payment practices when determining whether an FCA complaint adequately alleges materiality, as well as if a complaint satisfies the FCA scienter requirement. It is clear that this decision will have far reaching implications on the interpretation of FCA's scienter and materiality requirements.

THE ABOVE ARE SUPPORTED BY THE FOLLOWING CASES:

1. *Universal Health Services, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016): This is the main case that supports the decision in *Escobar*. The Supreme Court held that the implied certification theory can be a basis for liability under the False Claims Act, but only if the Defendant(s)'s noncompliance with a statutory, regulatory, or contractual requirement is material to the government's payment decision.

2. *United States v. Triple Canopy, Inc.*, 857 F.3d 174 (4th Cir. 2017): This case applied the *Escobar* materiality standard to a case involving allegations that a government contractor had billed for security guards who did not meet the contractual firearms proficiency requirement. The Fourth Circuit held that the government had

failed to plead materiality because it did not allege that the requirement was a condition of payment.

3. *United States v. Sanford-Brown, Ltd.*, 788 F.3d 696 (7th Cir. 2015): This case involved allegations that a for-profit college had submitted false claims for federal student aid by falsely certifying that it was in compliance with various regulatory requirements. The Seventh Circuit applied the *Escobar* standard and held that the alleged noncompliance with the regulations was not material to the government's payment decision because the government continued to pay the college despite knowing of its noncompliance.

4. *United States v. AseraCare, Inc.*, 938 F.3d 1278 (11th Cir. 2019): This case involved allegations that a hospice provider had submitted false claims by certifying that patients were terminally ill and eligible for hospice care when they were not. The Eleventh Circuit applied the *Escobar* standard and held that the government had failed to show that the alleged false certifications were material to the government's payment decision because the certifications were supported by clinical judgment and the government did not offer evidence that it would not have paid the claims if it knew of the alleged falsity.

A disagreement exists among circuits as to whether the failure to plead facts regarding past government action in reference to the underlying violations is against a finding of materiality, the above presents a significant reason for this court to

grant a review. Notwithstanding, most of appellate courts administered the scienter analysis since *Escobar* have ignored *Escobar*'s directive that a Defendant(s) must know that its violation is material to the government's payment decision. This court must intervene to address that FCA scienter is an implied certification case that requires the Plaintiff to show that the Defendant(s) possessed knowledge of materiality and not that the provisions is a condition of payment and that pleading satisfies the materiality standard.

On the contrary, the language in *Escobar*, has rejected any assertion that rigorous materiality analysis is too fact intensive for courts to dismiss False Claims Act case on a motion to dismiss or at Summary Judgment." 136 S. Ct. at 2004 n.6

I. Defendant(s)' Petition for a Writ of Certiorari will present substantial Questions.

Defendant(s)' petition for a writ of Certiorari will ask the Supreme Court to address (1) whether the failure to allege facts regarding past third-party health carrier's payment practices can weight against a finding that an FCA complaint adequately alleges materiality, and (2) whether a complaint satisfies the FCA's scienter requirement when it contains that the Defendant(s) knew or was on notice that its alleged violations were material to the health carrier's payment decision. Each of those issues present substantial question(s) for the Supreme Court to resolve.

II. Whether failure to allege facts regarding past Horizon's payment practices can weigh against a finding of materiality presents a substantial question(s) for the US Supreme Court.

In construing the limits of FCA liability in the fraudulent omission's context, The Supreme Court in *Escobar* ruled that the actual behavior of the government (third party payer) can, and should be revied because "materiality looks to the effect on the likelihood or actual behavior of the recipient of the alleged misrepresentation".

To translate this principle into practice, the Court examines two scenarios. One is when the government (Third party payer) paid a particular claim in full despite the actual knowledge that certain requirements were violated. The Court concluded that when" this occurs that the government's (Third party payer's) payment" is very strong evidence that these requirements are not material".

Second is when the government (Third party payer) is generally, as a matter of course an administration of the government's (Third party payer) out of state health insurance plan or contracts/pays a particular type of claim despite its knowledge that certain requirements were violated, and has signaled no change in position, the third-party payer's conduct under these circumstances "is strong evidence that the requirements are not material." "Moreover, the court, on two separate occasions to ensure that its order is clear that it is

the government's (Third party payer's) actual behavior that matters, rejected the government's (Third party payer's) position regarding materiality, that materiality can be established if the government (Third party payer's) merely would have the option to decline to pay, if it knew of the Defendant(s)'s non-compliance. The court referenced, on four separate occasions that the designation of compliance as a condition of payment does not establish FCA materiality. In *Escobar*, the court carefully described the FCA's limited scope and that is not to have an expansive but a restrictive application it reaffirmed, its prior ruling in *Allison Engine Co. v. United States ex rel. Sanders* that court proclaimed that the FCA is "not an all-purpose antifraud statute". The Court reminded lower courts and the public that general allegations of a Fraudulent scheme are insufficient unless the Plaintiff can actually link the alleged conduct to specific claims that are presented to the Third-party payers for payment and it is only that linkage that establishes FCA liability. Second, the Court emphasized that the False Claims Act is not a means of imposing treble damages and other penalties for insignificant regulatory or contractual violations. *Escobar*, instructed lower courts to consider how the government (Third party payer) actually has responded to the alleged violation in practice 136 S. Ct. at 2003-2004 (describing the government's Third-party payer's actual payment practices is "very strong evidence" of materiality. Numerous other *Escobar* Courts have reached the same conclusion.

See *U.S. ex rel. Folliard v. Comstor Corp.*, 308 F. Supp. 3d 56, 86-87 (D.D.C. 2018); *United States v. Scan Health Plan*, No. 09-cv-5013, 2017 WL 4564722, at *5-6 (C.D. Cal. Oct. 5, 2017); *U.S. ex rel. Schimelpfenig v. Dr. Reddy's Labs. Ltd.*, No. 11-cv-4607, 2017 WL 1133956, at *7 (E.D. Pa. Mar. 27, 2017); *U.S. ex rel. Scharff v. Camelot Counseling*, No. 13-CV3791, 2016 WL 5416494, at *8 (S.D.N.Y. Sept. 28, 2016); *Knudsen v. Sprint Commc'ns. Co.*, No. C13-04476, 2016 WL 4548924, at *14 (N.D. Cal. Sept. 1, 2016).

Defendant(s) Certiorari petition will present a substantial question as to whether the failure to allege facts regarding past Third-party payer's actions can weigh against finding that materiality has been adequately pled by Horizon.

III. Whether a complaint pleads scienter, when it contains no allegations that the Defendant(s) was on notice, that its alleged violations were material to the Third-party payer's payment decision, presents a substantial question for the Supreme Court.

In *Escobar*, the Supreme Court held that to satisfy the scienter element of an FCA claim, Plaintiff must allege facts and not general allegations of a fraudulent scheme and only unless the Plaintiff can actually link that alleged conduct to specific claims that are presented to the government (Third party Healthcare payer) for payment and it is only that linkage that establishes FCA liability such as that cross-state lines. Blue Cards, Blue Cards

ERISA, ERISA Plans, Self-Funded ERISA Plans, Federal Plans and State Plans. Notwithstanding, the facts must show that the Defendant(s) "knowingly violated a requirement that the Defendant(s) knows is material to the Government's payment decision". 136 S, Ct. at 1996 (emphasis added) Defendant(s) were not "on notice that its claim submission process was resulting in potential compliance problems (from 2007-2014) and acted with reckless disregard with respect to (its) compliance with 42 C.F.R. 424.22(a)(2)". Those allegations relate only to the first prong of the scienter requirement whether Defendant(s) knowingly violated a requirement and not to the second prong that Defendant(s) knew or was on notice that its potential violation was material to the third party's healthcare payment decision. The Court's opinion departs from the scienter requirement established in *Escobar* and directly conflicts with D.C. Circuit, which has held that scienter requires showing" that the Defendant(s) knows (1) that it violated a contract obligation and (2) that its compliance with that obligation was material to the third-party payer decision to pay" *United States v. Sci Applications Intern. Corp.*, 626 F.3d 1257, 1271 (D.C. Cir. 2010) (SAIC). Disagreement with SAIC is important because the Supreme Court cited SAIC in *Escobar* including within its discussion of scienter. *See Escobar*, 136 S. Ct. at 2002.

In its petition for a writ of Certiorari, Defendant(s) will ask the Supreme Court to resolve the general allegations of a fraudulent scheme without being linked to a particular alleged conduct

to specific claims that are presented to Out of State Health Care Plans for payment because that linkage establishes FCA liability and not the general allegations. Likewise, the Supreme Court will be asked to resolve whether the allegation(s) that the Defendant(s) was "put on notice that it may be violating regulations(s)." Thus, it is not sufficient to plead scienter under FCA where that allegation(s) does not establish that the Defendant(s) knew that its violation was material to the government (Third Party's Payer) payment. The Courts conflict with *Escobar* and the existence of a split in Circuit authority illustrates clearly that Petitioner(s) Certiorari petition will present a substantial question with respect to the FCA's scienter requirement.

IV. A Disagreement Among Circuits Regarding the Applications of the FCA's Materiality Requirement Further Widens an Existing Circuit Split

Prior to the decision in *Escobar* Circuit courts had certainly agreed that the implied false certification theory of liability was not viable under the FCA see *United States v. Sanford-Brown,Ltd*, 788 F.3d. 696, 711-712 (7th Cir. 2015) *United States v. Cardinal Health Inc.*, 625 F.3d 262, 270 (5th Cir. 2010).

However in *Escobar* this Court believed that implied false certification is a sustainable theory but that it may only apply if the underlying statutory, regulatory, or contractual violation is material to the government's payment decision. *Escobar*, 136 S. Ct. at 2002. The Court acknowledged that the

materiality standard is an important liability under the FCA and avoiding its conversion into "all-purpose antifraud statue and disallow different kind of punishments or breaches of regulatory violations." *Id.* at 2003 (quoting *Allison Engine Co. v. United States ex rel. Sangers*, 553 U.S. 662, 672 (2008). This case requests the inverse whether a court may deliberate in its materiality analysis the failure to plead facts in reference to the government's answer to the mine run of cases involving noncompliance with the particular statutory regulatory requirements.

The disagreement among the Circuits has deepened an already existing circuit split with regards to the application of *Escobar* at the pleading stage. Although the Third Circuit denied the Petitioner(s) case they held in other cases that "where a relator does not plead that knowledge of a violation could influence the Government's decision to pay, that misrepresentation likely does not have a natural tendency to influence payment's as required by the statute. *Petratos*, 855 F.3d at 490 (internal alterations omitted) quoting 31 U.S.C. § 3729(b)(4). At a minimum, this would be very strong evidence that the misrepresentation was not material." *Id.* (quoting *Escobar*, 136 S. Ct. at 2003). To support its finding of immateriality, the court in *Petratos* explicitly considered that the relator "failed to plead that CMS consistently refuses to pay claims like those alleged here." *Id.* quoting *Escobar*, 136 S. Ct. at 2003). Citing Brenda Coles' letter (sealed Supplement Appendix J and K)

Congress, has authorized interlocutory appeals of denials of motions which would cause irreparable harm. Denying a petition for writ of certiorari of the order could cause Petitioner(s) a significant and avoidable harm, but granting a writ of certiorari will not harm Horizon because they get paid a processing fee from the aforesaid cross-state healthcare plans (Appendix L). Horizon's fully funded plans (their own money) they do not even amount to $149,000.00 from 2007 to 2018 (Sealed in the District Court Of New Jersey). This detailed information has already been presented and has been sealed by the Appellate court for 25 years. Horizon did not file this case on behalf of the cross-state health Plans and could not do it without a signed authorization and standing. It is well known that a fiduciary has no authority/standing to sue for the cross-state lines healthcare Plans(s). For the foregoing reasons, Petitioner(s) submit that Horizon's: (i) claims implicating the SHBP, the FEHB, and out-of-state Blue Card Program member claims be dismissed for lack of standing; (ii)common law fraud, negligent misrepresentation, and unjust enrichment claims implicating ERISA member plans be dismissed for lack of subject matter jurisdiction; and (iii) IFPA claim implicating self-funded ERISA member plans be dismissed for lack of subject matter jurisdiction.

Unbeknown to these health care plans Horizon, has already recouped all the money from the Petitioner(s) in other words paid by the out of state plans (paid one (1) dollar and recouped (seven (7) without returning the money to the cross state line plans. But is asking, in addition, after three (3) years

to revive an unsigned settlement agreement, because Defendant(s) "did not agree to anything" Quoting Justice Albin from the New Jersey Supreme Court. "As the rule stipulates, "all parties have to consent". However, "in this case the parties did not sign because they did not like it." "They are not in default, they just did not sign." Quoting Justin Albin "where is the fact, where is the admission." Please see a video recording/transcripts of the hearing before the Supreme Court which is available at: Supreme Court Oral Arguments on November 30, 2021(Appendix E).

https://www.njcourts.gov/public/webcast_archive.html#085263 5 See video recording, referenced in footnote 4, supra, at the following-Transcripts (Appendix E).

However, granted the petition, Petitioner(s) will have a resolution of the case from the Supreme Court of the United States of America, and/or the disposition of the issues as a matter of law. *See U.S. ex rel. Bledsoe v. Cmty Health Sys., Inc.*, 501 F.3d 495, 510 (6th Cir. 2007/Recognizing the importance of Rule 9(b) in preventing additional fishing expeditions and additionally protecting Defendant(s) from, the "spurious charges of immoral and fraudulent behavior *U.S. ex rel. Wilson v. Kellogg Brown & Root Inc.*, 525 F.3d 37, 38 (4th Cir. 2008) recognizing that Rule 9(b) is intended to prevent FCA suits from resting on Facts learned from the costly process of additional legal proceedings".

Escobar's focus on the "rigorous" materiality and scienter requirements and its reinforcement that allegations of materiality, must be analyzed under

Rule 9(b)'s heightened pleading standard reflect the strong policy of preventing FCA cases from proceeding until the allegations have been sufficiently vetted 136 S. Ct at 2004 & N.6. Accordingly, Horizon "suffered no injury in fact", because as an administrator gets paid a processing fee, and has no authority/standing to sue for cross-state health care-plans such as Blue Cards, Blue Card ERISA, Federal Plans SHBP plans self-funded ERISA plans. On the contrary stands to win substantial bounties for a settlement they are not authorized to strike on behalf of the cross-state line plans. Horizon has filed a suit as a pretext for a fishing expedition *U.S ex rel. Owens v. First Kuwaiti Grey. Trading and Contracting Co.*, 612 F.3d 72, 732 (4th Cir. 2010) quoting *U.S ex rel. Karvelas v. Melrose Wakefield Hosp.*, 690 F.3d 220, 231 (1st Cir. 2004).

It should be noted the health industry is heavily regulated with multiple payers making demands for payments upon audit. It is frequently, tempting to resolve any dispute which has not been sufficiently vetted by paying the amount demanded by the judge who wanted to clear his docket at the end of his career. However, in the Post-*Escobar* era, one must be careful before it sets a negative precedent with the repayment. If the practice in dispute invokes a recurring matter such as the validity of a frequently used service; the use of a billing code; a particular service is not medically necessary; or that the claim is up coded;

The Defendant(s) in this case did not sign the settlement as Justice Albin of the New Jersey

Supreme Court stated because "they did not agree Both Parties need to agree to sign" Horizon's settlement agreement has no decree, is unsigned and has expired, therefore, it is administrative closed because Judge Miller, did not keep/ or retained any continuous jurisdiction on the order of Disposition. As the case law demonstrates, such repayment will be used to demonstrate that Defendant(s) had a reason to believe that the perceived regulatory infractions are material to Horizon's payment determination for the Cross-State line Health Insurance Plans which are federally regulated. Thus, the unsigned settlement is administrative closed. Litigants' rights' agreement will be captured in some public repositories and used as evidence that others in the industry would consider the same type of breach as material to Horizon's determination to pay them for reimbursement that does not come from their own purse and it is unbeknown to the cross-state line health plans which are federally regulated and have diversity jurisdiction with the Petitioner(s).

Overall, such infractions are not material, however; they can be used as proof of violations. In general, Horizon embroiled in a meritless lawsuit quoting Justice Albin "there is no admission of Fraud. Therefore, the equities weigh in Defendant(s)' favor."

CONCLUSION

For the foregoing reasons. Petitioner(s) respectfully request the Petition for Writ of Certiorari be granted.

I, certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Respectfully Submitted,

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