

No. 21-1145

IN THE
Supreme Court of the United States

MOLINA HEALTHCARE OF ILLINOIS, INC. and
MOLINA HEALTHCARE, INC.

Petitioners,

v.

THOMAS PROSE,

Respondent.

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

BRIEF IN OPPOSITION

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TABLE OF CONTENTS

TABLE OF AUTHORITIES ii
BRIEF IN OPPOSITION..... 1
STATEMENT OF THE CASE..... 1
REASONS TO DENY THE WRIT 11
 I. The First Question Presented Does Not
 Warrant Certiorari..... 11
 II. The Second Question Presented Does Not
 Warrant Certiorari..... 16
CONCLUSION 21

TABLE OF AUTHORITIES

Cases

<i>In re Baycol Prod. Litig.</i> , 732 F.3d 869 (8th Cir. 2013).....	13
<i>Ruckh v. Salus Rehab., LLC</i> , 963 F.3d 1089 (11th Cir. 2020).....	20
<i>United States v. Eastwick Coll.</i> , 657 F. App'x 89 (3d Cir. 2016).....	19
<i>United States ex rel. Rose v. Stephens Inst.</i> , 909 F.3d 1012 (9th Cir. 2018).....	19
<i>United States ex rel. Smith v. Wallace</i> , 723 F. App'x 254 (5th Cir. 2018).....	18
<i>Universal Health Servs., Inc. v. United States ex rel. Escobar</i> , 136 S. Ct. 1989 (2016).....	<i>passim</i>

Statutes

False Claims Act, 31 U.S.C. §§ 3729-33.....	<i>passim</i>
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Rules

Fed. R. Civ. P. 9(b).....	<i>passim</i>
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BRIEF IN OPPOSITION

The petition presents two questions about the False Claims Act (FCA), 31 U.S.C. §§ 3729-33. The first concerns the application of Federal Rule of Civil Procedure 9(b); the second concerns the elements of implied certification liability, which this Court recognized in *Universal Health Services, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016).

Certiorari should be denied because this case does not turn on any substantial disagreement about what Rule 9(b) or the FCA mean. Instead, petitioners simply disagree with how the Seventh Circuit applied well-settled principles to the specific complaint in this case and are searching high and low for any potential avenue for further review. This Court does not ordinarily grant certiorari simply to give a petitioner another bite at the apple, and this case does not warrant an exception to that rule.

STATEMENT OF THE CASE

1. The allegations in this case are straightforward. Petitioners are Molina Healthcare of Illinois (Molina), a managed care organization (MCO) that participates in the Illinois Medicaid Managed Care program, and Molina's parent company. *See* Pet. App. 3. Respondent Thomas Prose is a physician who operates a health care provider called General Medicine, P.C. (GenMed), which contracted with petitioners to provide services to government beneficiaries and in the process learned that petitioners were charging the State for services they were not providing. *See id.* at 2-3.

The Medicare Managed Care program works like a private-sector Health Maintenance Organization (HMO) plan, where MCOs like Molina provide

insurance coverage to Medicaid beneficiaries, and establish a provider network to furnish services to those beneficiaries. *See* Pet. App. 2. To participate in the program, the MCO and the State agree about which services the MCO's provider network will provide, and the amount the MCO will receive from the State to cover the cost of care. *See id.* at 3-4. Naturally, the more services the MCO agrees to provide, the more money it will receive from the State.

The payments MCOs receive are called "capitation payments" because they are made on a per-member, per-month basis. *See* Pet. App. 4. By law, capitation payment rates must be "actuarially sound." *Ibid.* The payment amounts are thus stratified into "rate cells" based on beneficiaries' age, location, and needs. *See id.* at 4-5. For example, a beneficiary in a nursing facility is likely to use more expensive care than a beneficiary living at home, and so nursing facility beneficiaries have a different "rate cell" that entitles petitioners to a higher capitation payment for those beneficiaries than for beneficiaries who live at home. *See id.* at 5. The differences in rate cells can be stark. For example, the rate for beneficiaries aged 65 and older in nursing facilities was \$3,180.30 per month; the rate for beneficiaries of the same age in the community was \$53.51. *Ibid.*

The State pays MCOs monthly. To get paid, MCOs submit a form to the State identifying the beneficiaries they have enrolled, including by specifying the rate cell for each beneficiary. *See* C.A. App. 63. The State then pays the MCO the agreed rate each month, and the MCO is responsible for covering the agreed services for that beneficiary. *See id.* at 64.

At its core, then, the deal is simple: the MCO provides a basket of services to the State's beneficiaries, and the State makes capitation payments to the MCO in exchange for all of the services in that basket being available. The State also imposes some additional requirements, including reporting obligations designed to ensure that the MCO's network can provide the care the MCO promised to provide. *See, e.g.*, C.A. App. 51-53, 55-56.

2. In 2013, Molina contracted with Illinois to provide a range of services, including "SNFist services," where "SNF" stands for "Skilled Nursing Facility." *See* Pet. App. 5. SNFists are medical practitioners who provide a critically important intermediate level of care—their availability prevents common maladies from becoming acute conditions, ensures that patients who need extra care receive it, and facilitates patients' return to their communities (for example, after hospitalization). *Id.* at 5-6; C.A. App. 38-39. Molina's contract thus defines SNFist services as "intensive clinical management of Enrollees in Nursing Facilities," including providing a "facility-based Provider (Physician or nurse practitioner) who will deliver care in identified Nursing Facilities," as well as "Care Management and care coordination activities." C.A. App. 87; *see also* Pet. App. 26. Molina's Chief Operating Officer, Benjamin Schoen, similarly testified that in addition to care coordination, "part of the SNFist Program" is to "render direct [medical and surgical] care" to beneficiaries. C.A. App. 153; *see also id.* at 155 (acknowledging that a SNFist is "a medical person who takes care of a nursing home resident in the skilled nursing facility").

“Molina’s contract with the [State] emphasized that SNFist services were integral to improving the enrollee’s quality of life and potentially to enabling her to be discharged from the nursing home.” Pet. App. 5-6. In bidding on the contract, Molina stated that it was “aware of the critical impact quality nursing care has on positive health outcomes for its members.” C.A. App. 44. Accordingly, Molina promised that its SNFist program “will be available 24 hours a day, 7 days a week with an on-site presence maintained Monday thru Friday, as well as weekend, if needed.” *Id.* at 43. Any “[c]hanges in level of care, declining health status and all quality of care issues [would] immediately [be] investigated and handled appropriately.” *Id.* at 44. Molina further represented that it would contract with qualified SNFist providers to ensure that members “receive quality care.” *Ibid.* It specifically represented that its “[p]roviders of nursing care must, at a minimum, meet state licensure and certification requirements for providing nursing services”—and that Molina would periodically re-assess all providers’ qualifications. *Id.* at 43-44.

Molina lacked the personnel and licensure to provide SNFist services directly, and so it contracted with respondent’s company, GenMed, to provide the SNFist services. Pet. App. 6. But petitioners didn’t want to pay for those services, and so the contract was terminated. *Ibid.* As of April 2, 2015, GenMed was no longer providing SNFist services to Molina’s beneficiaries. *Ibid.* Schoen admitted on April 5, 2017, that Molina had not replaced GenMed with another SNFist provider, C.A. App. 150—and so for a period of at least two years, petitioners had nobody providing SNFist services, Pet. App. 6-7. Nevertheless, petitioners

continued enrolling nursing facility beneficiaries, and continued charging the State capitation payments that were based on the entire basket of promised services, including SNFist services. *Id.* at 7. The portion of the payment attributable to SNFist services was, “in essence, payments for nothing.” *Ibid.*

From here, it is easy to see how petitioners wronged the State: they charged the State for a very expensive basket of services containing SNFist services, knowing that they were not providing SNFist services, without disclosing that fact to the State. Thus, respondent alleged that, beginning on April 2, 2015, petitioner knowingly overcharged the State for the care of beneficiaries in the nursing home rate cell.

Such overcharging is a textbook FCA violation under the theories of factual falsity and implied false certification. In addition to the foregoing, petitioners renewed their contracts with the State in 2016 and 2017, falsely promising to provide SNFist services that petitioners knew they could not and would not provide. C.A. App. 61-62. The use of false promises to obtain government contracts violates the FCA under the theory of fraudulent inducement. Pet. App. 13 (citing *United States ex rel. Marcus v. Hess*, 317 U.S. 537 (1943)).

In addition to the allegations set forth above, respondent made additional allegations about petitioners’ noncompliance with various reporting requirements and efforts to cover up that noncompliance by providing a subset of the required services in order to create the impression that Molina was providing all of the services, when it wasn’t. *See* C.A. App. 54-61.

Although plaintiffs need not produce evidence at the pleading stage, respondent supplemented his complaint with 15 exhibits substantiating his allegations. These included contracts between Molina and the State, actuarial reports by the State's contractor describing how capitation rates for the various rate cells in Illinois were calculated, and deposition testimony from Molina's Chief Operating Officer admitting that Molina had no ability to offer SNFist services after its contract with GenMed ended.

3. The district court dismissed this action for failure to state a claim, *see* Pet. App. 99, and the Seventh Circuit reversed, *see id.* at 3. The court of appeals acknowledged that “[a] party bringing a case alleging fraud must satisfy the heightened pleading standards set forth in Rule 9(b),” which means that “[t]he complaint must describe the ‘who, what, when, where, and how’ of the fraud to survive a motion to dismiss.” *Id.* at 7-8 (citation omitted). The court elaborated that “Rule 9 represents a policy decision to protect potential fraud defendants from litigation based on nothing but rumor or speculation,” but the rule does not require proof or documentation; instead, “[a]ll that is necessary are sufficiently detailed *allegations.*” *Id.* at 11.

Applying that standard, the Seventh Circuit held that respondent “has adequately stated a claim under the [FCA]” because “[h]is detailed allegations support a strong inference that Molina was making false claims.” Pet. App. 11. The court thus held that respondent’s complaint states a claim under three independent theories of FCA liability. The first is “direct factual falsity—the canonical FCA claim.” *Id.* at 11-12. The court found this claim adequately pled because “[a] direct assertion that Molina had new enrollees

who were in the skilled nursing facility tier, coupled with an assertion that Molina was seeking reimbursement for their SNF services, is not an omission. It is a statement, and in this case a statement that Prose asserts was false.” *Id.* at 12. The court also held that respondent’s complaint “provided numerous details indicating when, where, how, and to whom allegedly false representations were made.” *Ibid.*

Next, the Seventh Circuit held that respondent alleged “promissory fraud, or fraud in the inducement.” Pet. App. 12. For this theory of liability, respondent “needed to alert Molina with the necessary specificity of how it allegedly misrepresented its compliance with a condition of payment in order to induce the government to enter into a contract.” *Id.* at 12-13 (citation omitted). The court explained that respondent “charges that Molina fraudulently induced the [State] to enter into contract renewals with Molina in 2016 and 2017 by affirmatively misrepresenting that it would continue to provide SNF services in its package for NF-category enrollees while not intending to do so.” *Id.* at 13. To satisfy Rule 9(b), respondent “set forth precise allegations about the beneficiaries, the time period, the mechanism for the fraud, and the financial consequences.” *Ibid.*

In light of the details respondent provided, the court held that it was not necessary for respondent also to enumerate statements made in closed-door contract negotiations between petitioners and the State. Pet. App. 13. The court further held that the complaint provided adequate notice of the scienter allegations by referencing the testimony of Molina’s Chief Operating Officer, Benjamin Schoen, who admitted that petitioners’ staff did not have the ability or licensure to render

SNFist services, and also that petitioners had not sought a replacement for GenMed. *Id.* at 13-14. Thus, the court explained, “the complaint asserts that Molina made some representations about actual SNF services that would be offered.” *Id.* at 14.

Finally, the court explained that respondent’s complaint also “was sufficient to state a claim for implied false certification.” Pet. App. 14. The court noted the standard for such claims that this Court announced in *Escobar*, *i.e.*, that “liability can attach when the defendant submits a claim for payment that makes specific representations about the goods or services provided, but knowingly fails to disclose the defendant’s noncompliance with a statutory, regulatory, or contractual requirement. In these circumstances, liability may attach if the omission renders those representations misleading.” Pet. App. 14-15 (quoting *Escobar*, 136 S. Ct. at 1995).

The court explained that “[i]mplied false certification is just another genre of fraud, and so plaintiffs must as usual satisfy Rule 9(b)’s requirements to plead falsity, materiality, and causation with particularity.” Pet. App. 16. The court acknowledged that to satisfy these elements, “[t]he complaint must include specific allegations that show that the omission in context significantly affected the government’s actions.” *Ibid.* Respondent’s complaint did that by “point[ing] to many factual representations that Molina made that, [respondent] charges, amounted to implied false certification.” *Ibid.* Chief among these, “Molina’s contract with the [State] carefully created different rate cells for enrollees based on the level of care they would need; the level of care in turn yields a reasonable estimate of cost for each tier.” *Ibid.* Thus, “each

enrollment form, which constituted a specific request for payment connected to the NF enrollees, was impliedly false because it requested payment of the SNF capitation rate when those services were not being rendered.” *Id.* at 17 (quotation marks omitted). Moreover, the complaint “contains specific allegations showing that Molina was far from a passive recipient of a favorable capitation rate”; instead, “by submitting enrollment forms for *new* enrollees after Molina canceled its contract with GenMed, Molina implicitly falsely certified that Nursing Facility enrollees had access to SNF services,” even though “they did not.” *Id.* at 17-18. The court found that this was “akin to the defendant’s actions in *Escobar*,” where the defendant misleadingly omitted “that its care providers were not qualified to render services for which it nevertheless requested payments.” *Id.* at 18.

The court also rejected petitioners’ principal argument on appeal, which was that the violations could not have been material because the State continued to contract with petitioners after this action was filed. With respect to this, the court acknowledged that “the government’s continued payment of a claim despite ‘actual knowledge’ that certain requirements are not met ‘is very strong evidence that those requirements are not material.’” Pet. App. 18 (quoting *Escobar*, 136 S. Ct. at 2003). But it held that “this argument is better saved for a later stage, once both sides have conducted discovery”—a necessary step in this case “before anyone can say what the government did and did not know about Molina’s provision of SNF services.” *Ibid.*

The court further held that the complaint adequately pleads that petitioners understood that their

violations were material. As the court explained, respondent alleged that Molina is “a highly sophisticated member of the medical-services industry” that was “quite familiar with capitation rates,” and “knew that they are designed to allow the provider to be reimbursed for services rendered.” Pet. App. 20. Again, “[c]onstruing the allegations in [respondent’s] favor, there is ample detail to support a finding that Molina either had actual knowledge that the government would view skilled nursing services as a critical part of the Nursing Facility rate cell (*i.e.*, as material), or that it was deliberately ignorant on this point.” *Id.* at 20-21. Indeed, Molina “knew these services’ cost and their importance, and it knew that it was unable to provide these services.” *Id.* at 21.

Because the Seventh Circuit determined that these allegations were sufficient, it found it unnecessary to “rely on [respondent’s] other arguments,” including allegations that petitioners covered up their noncompliance. Pet. App. 21. Finally, the court rejected petitioners’ remaining arguments. *Id.* at 22-23.

Chief Judge Sykes dissented. The dissent had “no disagreement with the[] basic doctrinal points” set forth by the majority, *i.e.*, the majority’s description of the FCA’s elements and the requirements of Rule 9(b). Pet. App. 27. Instead, the disagreement emerged because “[i]n [the dissent’s] view the complaint does not satisfy the heightened pleading standard.” *Ibid.* The dissent went through respondent’s theories of liability and explained why it would have reached the opposite conclusion.

4. Petitioners sought rehearing *en banc*. The petition for rehearing did not assert an inter-circuit conflict on any question. Instead, the petitioners argued

that the Seventh Circuit’s decision conflicts with this Court’s decision in *Escobar* and with prior Seventh Circuit precedent. *See, e.g.*, C.A. Pet. for Reh’g 9 (arguing that “The Majority Decision Misapplies *Escobar*’s Test for a ‘Half-Truth’”). Petitioners also argued that “The Majority Decision Is Rooted in a Mistaken Factual Premise,” *i.e.*, that the cost of SNFist services accounts for the difference between the higher capitation rate for nursing home beneficiaries and others. *Id.* at 17.

The Seventh Circuit made modifications to its opinion to clarify certain aspects, and then denied rehearing. Pet. App. 109-11.

5. The petition for a writ of certiorari followed.

REASONS TO DENY THE WRIT

I. The First Question Presented Does Not Warrant Certiorari

1. The first question presented is “[w]hether Rule 9(b) requires plaintiffs in False Claims Act cases to plead details of the alleged false claims.” Pet. i. Petitioners argue that the same question is presented in two other cases, *Johnson v. Bethany Hospice & Palliative Care LLC*, No. 21-462, and *United States ex rel. Owsley v. Fazzi Associates, Inc.*, No. 21-936. But that isn’t quite right. The question presented in those cases is phrased differently: “Whether Federal Rule of Civil Procedure 9(b) requires plaintiffs in False Claims Act cases who plead a fraudulent scheme with particularity to also plead specific details of false claims.”

The difference matters because the question presented in *Johnson* and *Owsley* contains a predicate that is missing from petitioners’ formulation of the

question, *i.e.*, that the plaintiff has pleaded a fraudulent scheme with particularity. That predicate is important for two reasons. First, it is important to the circuit split because no court holds that a plaintiff who fails to plead a fraudulent scheme *and* false claims with particularity can survive Rule 9(b). Second, whether a particular complaint pleads a fraudulent scheme with sufficient particularity is plainly a factbound issue that does not itself warrant this Court's review.

In the Seventh Circuit, petitioners focused principally on factbound attacks on the sufficiency of respondent's complaint—such as whether respondent adequately alleged that petitioners made false statements to the State—as opposed to whether respondent pleaded the details of the resulting false claims. Even now, petitioners cannot resist rehashing those arguments. *See* Pet. 10 (four-bullet list of asserted deficiencies in respondent's complaint, the last three of which are not about whether the complaint includes details of false claims). Thus, it is unclear whether petitioners are now conceding that respondent has pleaded a fraudulent scheme with particularity and asking the Court only to decide whether Rule 9(b) also requires details of false claims (the sole question about which a circuit split actually exists)—or whether they instead want to continue to press the factbound attack that respondent has not pleaded a fraudulent scheme with particularity (which would be outside the scope of the question presented, and also would not implicate any circuit split).

That lack of clarity makes this case a bad vehicle to resolve the split over Rule 9(b). Consider, for example, respondent's allegations under the theory of

fraudulent inducement—which holds that any claim for payment sought under a contract that was obtained by fraud is a false claim, even if the claim itself has no false information. Even courts that adopt the strict view of Rule 9(b) have held that in a fraudulent inducement case, the plaintiff need not plead the details of specific false claims. *See, e.g., In re Baycol Prod. Litig.*, 732 F.3d 869, 876-77 (8th Cir. 2013). And that makes sense because the crux of the theory is that the upstream fraud during contracting taints the claims for payment *even if the claims themselves contain no false information*. That is likely why, in the Seventh Circuit, petitioners did not argue that a plaintiff in a fraudulent inducement case must plead the specific details of false claims to survive Rule 9(b). Instead, they argued that the complaint fails to plead the predicate of fraudulent inducement with particularity. Pet'r C.A. Br. 17-18, 41-45.

This creates at least three vehicle issues. First, to the extent petitioners now wish to argue that the fraudulent inducement claim fails because respondent did not plead details of claims in addition to pleading the underlying fraudulent scheme, that argument was forfeited with respect to this theory. Second, to the extent petitioners are conceding that the underlying fraudulent inducement scheme was adequately pleaded, and arguing only that the lack of details of claims compels dismissal, petitioners have not shown that there is any circuit split about whether such details are required in a fraudulent inducement case. And finally, to the extent petitioners want to continue arguing that respondent failed to plead the underlying fraudulent inducement with particularity, that issue

is factbound, not fairly included in the question presented, and does not implicate a circuit split.

With respect to the other two theories of liability (factual falsity and implied false certification), the situation is similar. For these two theories, petitioners may not have forfeited their argument that the complaint does not include details of claims, but they also did not emphasize it. Their focus was instead always on whether respondent pleaded the underlying scheme with sufficient particularity. Those extraneous arguments cloud the question presented and make this case a bad vehicle to decide it. This Court should instead resolve the split over Rule 9(b) in a case where the question is presented cleanly. Either *Johnson* or *Owsley* would be better vehicles for that reason—and petitioners themselves concede that those cases “appear to be suitable vehicles to decide the Rule 9(b) issue.” Pet. 28.

2. Certiorari should also be denied because, contrary to petitioners’ characterization, the Seventh Circuit placed heavy emphasis on Rule 9(b)’s requirements. Thus, the court of appeals acknowledged that “[t]he complaint must describe the ‘who, what, when, where, and how’ of the fraud to survive a motion to dismiss,” Pet. App. 8 (citation omitted), and noted the rule’s purpose of protecting “fraud defendants from litigation based on nothing but rumor or speculation,” *id.* at 11. Then, when the court reviewed respondent’s detailed allegations, it concluded that those requirements were met. Even the dissent acknowledged that on the “doctrinal points,” the majority stated the law correctly. *Id.* at 27. The dissent disagreed with how the majority applied the law to the allegations in this case—but such factbound disputes over application of

the correct standard do not warrant this Court's review.

3. The Court should also deny certiorari because respondent's complaint meets any reasonable standard for applying Rule 9(b). The complaint includes ample specifics about the care Molina provided (or didn't provide)—including details about where, when, and how petitioners enrolled beneficiaries into the nursing facility rate cell even though they were not providing SNFist services. Specifically, the complaint alleges that petitioners enrolled Illinois beneficiaries in the nursing facility rate cell between April 2, 2015 and at least April 5, 2017, even though they had no ability to provide SNFist services during that time. It details the amounts per beneficiary Molina received in capitation payments, and it explains the value and importance of the SNFist services that Molina withheld.

No additional details of false claims are necessary to satisfy Rule 9(b) because the rule only requires the complaint to state the "circumstances constituting fraud" with particularity—and not immaterial facts. When, as here, the details of the claims are not essential to the alleged fraud, the rule does not require the plaintiff to plead them. For example, the names of specific beneficiaries do not matter, because the claims are false regardless of the identity of the beneficiary. Similarly, the exact dates of enrollment for a particular beneficiary do not matter, because each payment covers an entire month of care. And of course, any missing claim- and beneficiary-specific information is *already in petitioners' hands*, and so requiring respondent to learn it and put it in the complaint would not give petitioners any useful information or notice of

the allegations against them; it would only impose an arbitrary burden to fraud enforcement.

In summary, this case has too many extraneous, unusual moving parts to serve as a good vehicle to resolve the Rule 9(b) question—and petitioners themselves have conceded that two alternative vehicles exist. This Court should not grant certiorari to address this question here when superior alternative vehicles are available.

II. The Second Question Presented Does Not Warrant Certiorari

The second question presented is whether, to violate the FCA under the implied false certification theory, the defendant must make specific representations about its goods or services, which were rendered misleading by failure to disclose noncompliance with a legal requirement. This question is not certworthy, and this case is not a good vehicle to address it.

1. This question relates only to the implied false certification theory—and so even taking petitioners' arguments at face value, this question could not be dispositive because the Seventh Circuit held that respondent's complaint also states claims under the factual falsity and false certification theories of liability. The question is accordingly not case-dispositive—or even materially case-narrowing (because the same claims are both factually false and covered by implied false certification), and for that reason does not warrant this Court's review.

2. Certiorari should also be denied because the Seventh Circuit majority held, in black-and-white, that respondent's complaint satisfies the rule that petitioners urge as the correct one. Thus, the court of

appeals block-quoted this Court’s precedent, expressly acknowledging that implied certification liability attaches when “the defendant submits a claim for payment that makes specific representations about the goods or services provided” that are rendered misleading by an omission. Pet. App. 14-15 (quoting *Escobar*, 136 S. Ct. at 1995). The Seventh Circuit held that this requirement was satisfied because “by submitting enrollment forms for new enrollees after Molina canceled its contract with GenMed, Molina implicitly falsely certified that Nursing Facility enrollees had access to SNF services,” when “they did not,” such that Molina was noncompliant “with a contractual requirement to provide SNF services to Nursing Facility enrollees.” *Id.* at 18 (emphasis omitted). The court held that this was “akin to the defendant’s actions in *Escobar*, in which the Court found that the defendant ‘misleadingly omit[ted] [the] critical facts’ that its care providers were not qualified to render services for which it nevertheless requested payments.” *Ibid.* (quoting *Escobar*, 136 S. Ct. at 2001).

To be sure, petitioners disagree with that analysis. In their view, the representations in petitioners’ claims for payment (*i.e.*, the use of the nursing facility rate cell) are not as specific as the representations in *Escobar* (the use of billing codes corresponding to particular services). But that disagreement does not go to what the legal standard is; instead, it constitutes hair-splitting about application of a single legal standard.

Petitioners are also wrong to argue that the representations in *Escobar* were materially more specific than the representations involved here. In *Escobar*, the Court held that when a provider submitted claims for payment for specific counseling services, it was

implicitly representing that the people providing those services were properly qualified and trained. *See* 136 S. Ct. at 2000. This was so because anyone reviewing the claims would “probably—but wrongly—conclude that the clinic had complied” with the training and qualification requirements. *Ibid.* Because the provider’s staff lacked the necessary qualifications and training, the claims were misleading, and therefore false. Here, by submitting enrollment data for Illinois beneficiaries (including rate cells), Molina represented that it was providing the services required by its contract, including SNFist services. Anyone reviewing the enrollment data would probably—but wrongly—conclude that those beneficiaries could access SNFist services, when due to petitioners’ misconduct, they could not. Indeed, respondent’s claim is stronger than the claim in *Escobar* because petitioners did not merely provide substandard SNFist services in violation of an ancillary regulatory requirement; they provided essentially no SNFist services in violation of the very contract that entitled them to payment. Thus, the nexus between the misconduct and the payments is even tighter here than in *Escobar*.

3. The question also does not warrant review because the asserted split on this issue is superficial and likely to resolve itself without this Court’s intervention. Petitioners contend that the Third, Fifth, Ninth, and Eleventh Circuits go their way, but the Third and Fifth Circuit cases petitioners cite are unpublished and do not turn on this issue. *See United States ex rel. Smith v. Wallace*, 723 F. App’x 254, 256 (5th Cir. 2018) (per curiam) (the entire opinion is three paragraphs long, with all the analysis in a single paragraph; and the case failed because the plaintiff “never identifie[d]

any claim that the defendants submitted” at all—even at summary judgment); *United States v. Eastwick Coll.*, 657 F. App’x 89, 94-95 (3d Cir. 2016) (mentioning the “specific representations” language only in passing, and then rejecting implied certification claims for the distinct reason that the plaintiff did “not identify any statutes, regulations, or contractual provisions that the [defendants] violated through their alleged behavior,” and that other implied false certification claims did not comply with Rule 9(b)).

The Ninth Circuit addressed this issue in a published opinion, but it is a tepid one that only shows that any split is shallow and ephemeral. In *United States ex rel. Rose v. Stephens Institute*, 909 F.3d 1012, 1018 (9th Cir. 2018), the Ninth Circuit determined that its prior circuit precedent, which had mentioned *Escobar*’s “specific representations” language in passing, appeared to require specific representations. The court expressed “doubt that the Supreme Court’s decision” actually intended to limit implied certification this way—because this “Court did not state that its two conditions were the *only* way to establish liability under an implied false certification theory”—but it decided to adopt that condition “unless and until our court, *en banc*, interprets *Escobar* differently.” *Ibid.* The court then went on to rule for the plaintiff, obviating any need for the plaintiff to challenge the “specific representations” requirement. *See ibid.* Far from suggesting an entrenched split, the decision in *Rose* signals that further percolation may well change the Ninth Circuit’s view if the issue ever ends up being case-dispositive.

Finally, the Eleventh Circuit case petitioners cite is distinguishable—and on balance supports

respondent. There, the plaintiff alleged that the defendant failed to timely prepare plans of care for nursing facility patients, as required by Medicaid rules. *See Ruckh v. Salus Rehab., LLC*, 963 F.3d 1089, 1108 (11th Cir. 2020). The Eleventh Circuit held, after a full trial and motion for judgment as a matter of law, that the requirement to prepare care plans was not material to the government’s payment decisions. *See id.* at 1109. The court then also issued an alternative holding that “the relator failed to connect the absence of care plans to specific representations regarding the services provided,” and “the relator did not allege, let alone prove, any deficiencies in the Medicaid services provided.” *Ibid.* This case is distinguishable because respondent alleges that petitioners were not providing all of the required services (SNFist services), and it is unlikely that the Eleventh Circuit would have ruled against respondent here. Indeed, when the Eleventh Circuit considered whether the defendant in *Ruckh* defrauded Medicare, it concluded that the answer was “yes” because the defendant’s misconduct caused the government to pay more than it should have—which is what respondent alleges here. *See id.* at 1105.

Put simply, this question is not important enough, and the asserted split is not sufficiently well-developed, to warrant this Court’s attention at this time. Even if the question were ripe for this Court’s consideration, this case is a poor vehicle to address it because the question applies to only part of the case, and because the Seventh Circuit applied the rule petitioners request, and still ruled for respondent.

CONCLUSION

Certiorari should be denied.

Respectfully submitted,

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