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Expert Analysis

False Claims and Mail and Wire Fraud: Implications of 'Universal Health'

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The federal mail and wire fraud statutes prohibit a wide range of false or misleading statements. Sometimes questions arise as to when "omissions" are subject to prosecution. The black letter rule is that omissions give rise to prosecution when an individual has a fiduciary or other duty of disclosure.[1] But sometimes an omission can also be the basis for prosecution without an affirmative duty of disclosure, such as when the omitted information renders statements that have actually been made false or at least misleading.[2]

This past term, the U.S. Supreme Court addressed a thorny issue concerning "omissions" in the context of the civil False Claims Act (FCA),[3] which prohibits false and fraudulent monetary claims for payment made to the federal government. In *Universal Health Services v. United States*,[4] decided in June 2016, the Supreme Court extended the FCA to a new category of omissions by adopting the "implied certification theory"—roughly, that claims for payment from the government can, in certain circumstances, implicitly certify that the payee has satisfied the legal requirements for payment.

In this article, we discuss the Universal Health Services decision and explain how the implied certification theory might also apply to mail and wire fraud cases. As an illustration, we consider how this theory, if it had been invoked, might have affected the outcome in *U.S. ex rel. O'Donnell v. Countrywide Home Loans*,[5] a case premised on violations of the mail and wire fraud statutes.

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Implied Certification Theory

The FCA imposes civil penalties for, among other things, making a "false or fraudulent claim for payment" to the government. Both the government and private litigants, called relators, may assert FCA claims in federal court. While the FCA does not define what makes a claim "false" or "fraudulent," it is clear that the FCA applies to claims for payment that make factual misrepresentations about the goods or services provided to the government.

The issue in *Universal Health Services* concerned the extent to which the FCA applies to omissions about a claimant's compliance with legal or contractual standards of performance—for example, when a medical service provider seeks Medicare reimbursement for a service that is accurately described but does not meet a regulatory requirement for reimbursement. In such circumstances, the claimant would not have made a false statement, but arguably the statement omitted relevant information about non-compliance with a precondition for payment.

Three Approaches

The courts of appeals followed three approaches to the issue before *Universal Health Services*. The U.S. Court of Appeals for the D.C. Circuit

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adopted the implied certification theory, holding that a claim can be "false or fraudulent" if the payee withholds information about its noncompliance with material legal, regulatory or contractual requirements, such as failing to disclose a prohibited conflict of interest.[6]

The U.S. Court of Appeals for the Second Circuit adopted a narrower version of the implied certification theory. In *Mikes v. Straus*,[7] the court held that a claim for payment implicitly certifies compliance with a legal or contractual provision only if that provision "expressly states" that the contractor must comply to receive payment. The relator alleged that the defendant, a medical services provider, had submitted claims for Medicare reimbursement for testing that was not "of a quality which meets professionally recognized standards of healthcare," as required by the Medicare statute. The court held that service provider's "claims" for reimbursement were not "false or fraudulent" because that Medicare statute does "explicitly condition payment upon compliance" with the statute's "professionally recognized standards" provision.

In *United States v. Sanford-Brown*,[8] the U.S. Court of Appeals for the Seventh Circuit rejected the implied certification theory altogether. The court held that the implied certification theory was "untenable" because it lacked a "discerning limiting principle."

'Universal Health Services'

In *Universal Health Services*, the Supreme Court upheld the implied certification theory, at least in certain circumstances. The defendant owned a mental health facility that received payments under the Medicaid program. The relators claimed that the facility failed to disclose violations of Medicaid regulations regarding staffing qualifications, including the provision of treatment by a nurse when regulations required treatment by a doctor.

The facility's claims for reimbursement contained codes corresponding to types of treatment, e.g., "Individual Therapy." The critical issue was whether these claims implicitly (and falsely) certified that the facility's staff satisfied Medicaid licensing requirements.

As a threshold matter, the court clarified that the FCA's prohibition of "false or fraudulent" claims incorporates the common law meaning of fraud. Common law fraud includes not just express falsehoods but also misrepresentations by omission or, put differently, misleading half-truths. The court held that the defendant's claims for Medicaid reimbursement were "misleading in context," reasoning that a person "informed that a social worker at a Massachusetts mental health clinic provided a teenage patient with individual counseling services would probably—but wrongly—conclude that the clinic had complied with" Medicaid's licensing requirements. On this basis the court upheld the implied certification theory as an application of the general rule that misleading half-truths can be fraudulent.

As a threshold matter, the court in 'Universal Health' clarified that the FCA's prohibition of "false or fraudulent" claims incorporates the common law meaning of fraud. Common law fraud includes not just express falsehoods but also misrepresentations by omission or, put differently, misleading half-truths.

The court rejected the Second Circuit's limitation of the implied certification theory to legal and contractual provisions that constitute express conditions on payment, noting that neither the text of the FCA nor the common law contemplates that limitation. But the court also held that "not every undisclosed violation of an express condition of payment automatically triggers liability." Instead of focusing on whether legal or contractual provisions are labeled express conditions of payment, the court attempted to cabin the scope of FCA liability by adopting a "demanding" materiality standard. Under that standard, false certifications are actionable only if a reasonable person would deem it important in the context of the transaction, and "garden-variety breaches of contract or regulatory violations" would not be material.

Implications

The court's analysis in *Universal Health Services* has significant implications for the mail and wire fraud statutes. Like the FCA, these statutes incorporate the common-law definition of fraud and impose liability for misleading half-truths. But the mail and wire fraud statutes are not limited to claims for payment made to the government. Under the implied certification theory, the fraud statutes

could apply to all transactions that implicitly certify compliance with legal or contractual standards.

In *Allstate Ins. Co. v. Lyons*,[9] a private insurance company brought civil RICO claims against medical service providers under an implied certification theory. The RICO claims were predicated on mail fraud violations. Allstate alleged that the defendants submitted fraudulent claims for reimbursement under New York's no-fault insurance laws, which provide reimbursement for medical expenses relating to car accidents. According to Allstate, the defendants were ineligible for payment because they were not owned or controlled by physicians—a prerequisite for reimbursement under New York's no-fault laws.

Judge John Gleeson in the Eastern District of New York applied the implied certification theory to the mail fraud statute, holding that "a health care provider that is fraudulently licensed—because it is in fact owned or controlled by non-physicians—makes a misrepresentation when it claims eligibility," even when the provider did not make an affirmative misrepresentation that it complied with licensing requirements. Judge Gleeson's decision anticipated the reasoning articulated by the Supreme Court in *Universal Health Services*.

Countrywide Revisited

The Second Circuit's Countrywide decision, which reversed a $1.2 billion penalty imposed on Bank of America's Countrywide mortgage unit, illustrates the potential implications of an implied certification theory of fraud. The government proved at trial that Countrywide sold mortgage-backed loans to government-sponsored entities (GSEs), Fannie Mae and Freddie Mac, while knowing that nearly half the loans fell below the quality standards that Countrywide had agreed to in a contract with the GSEs.

A jury found that Countrywide had defrauded the GSEs in violation of the mail and wire fraud statutes. But the Second Circuit reversed the verdict, holding that the government had merely proved that Countrywide had intentionally breached its contract with the GSEs—not that it had defrauded them.

The Second Circuit held that the government's case failed because it did not establish that Countrywide made a misrepresentation to the GSEs with fraudulent intent. The government proceeded on the theory that Countrywide's misrepresentations were contained in its contracts with the GSEs—specifically, the promise to sell investment-quality loans during the term of the contract. Yet the government offered no evidence that, at the time Countrywide entered these contracts and made that promise, Countrywide planned to break its promise or otherwise had fraudulent intent.

Under an implied certification theory of fraud, however, the government could have pointed to misrepresentations made by Countrywide subsequent to its entry into contracts with the GSEs—for example, when Countrywide made requests for payment or sent other correspondence identifying the loans being sold. Even if these communications did not make express representations about the quality of the loans, the government could have argued—under *Universal Health Services*—that through these subsequent actions Countrywide was falsely certifying that its loans met the quality standards in its contracts with the GSEs.

Conclusion

In *Universal Health Services*, the Supreme Court did not decide whether "all claims for payment implicitly represent that the billing party is legally entitled to the payment." Instead, the court held more narrowly that the defendant's Medicare bills were false or fraudulent because they used specific billing codes that constituted deceptive half-truths. Though limited in scope, the decision is subject to an expansive reading that would treat silence, or omissions, in many circumstances as unlawful misrepresentations. Time will tell whether a broad theory of civil liability will become a new outer limit of criminal prosecution.

1. *United States v. Szur*, 289 F.3d 200, 211 (2d Cir. 2002).
2. *United States v. Autuori*, 212 F.3d 105, 118 (2d Cir. 2000).
3. 31 U.S.C. §3729 et seq.
4. *Universal Health Servs. v. United States*, 136 S. Ct. 1989 (2016).
5. *U.S. ex rel. O'Donnell v. Countrywide Home Loans*, 822 F.3d 650 (2d Cir. 2016).
6. *United States v. Sci. Applications Int'l Corp.*, 626 F.3d 1257 (D.C. Cir. 2010).
7. *Mikes v. Straus*, 274 F.3d 687 (2d Cir. 2001).
8. *United States v. Sanford-Brown*, 788 F.3d 710 (7th Cir. 2015).
9. *Allstate Ins. Co. v. Lyons*, 843 F.Supp.2d 358, 367 (E.D.N.Y. 2012).