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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

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UNITED STATES OF AMERICA,
ex rel. JENNIFER PUTNAM,

Plaintiff,

v.

NO. CIV. 4:07-192 WBS

MEMORANDUM AND ORDER RE:
MOTIONS FOR PARTIAL SUMMARY
JUDGMENT

EASTERN IDAHO REGIONAL MEDICAL
CENTER; EASTERN IDAHO HEALTH
SERVICES, INC.; THE BOARD OF
TRUSTEES OF MADISON MEMORIAL
HOSPITAL, a/k/a, d/b/a MADISON
MEMORIAL HOSPITAL; IDAHO FALLS
RECOVERY CENTER; MATTHEW
STEVENS; MICHELLE DAHLBERG;
SPEECH AND LANGUAGE CLINIC,
INC.; PREMIER THERAPY
ASSOCIATES, INC., a/k/a THERAPY
SERVICES, INC., a/k/a TETON
SPEECH LANGUAGE PATHOLOGY, INC.;
HCA INC., a/k/a HCA - THE
HEALTHCARE COMPANY; HCA -
MANAGEMENT SERVICES, L.P., HTI
HOSPITAL HOLDINGS, INC.; HEALTH
TRUST, INC. - THE HOSPITAL
COMPANY and DOES 1 through 50,

Defendants.

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1 This action under the False Claims Act, 31 U.S.C. §§
2 3729-3733 ("FCA"), is based on several speech language
3 pathologists' and Medicare and Medicaid providers' alleged
4 practice of billing Medicare or Medicaid for speech language
5 services performed by unlicensed aides or assistants. Now
6 pending before the court are the United States' motion and
7 defendants Matthew Stevens, Premier Therapy Associates, Inc.,
8 also known as Therapy Services, Inc. and Teton Speech Language
9 Pathology, Inc., and Teton Services, Inc.'s ("defendants") cross-
10 motion for partial summary judgment.

11 I. Factual and Procedural Background

12 Stevens is a certified speech language pathologist
13 ("SLP") in Idaho and is the owner of Premier Therapy Associates,
14 Inc., which was formerly known as Teton Services, Inc. (U.S.'
15 Third Corrected Am. Compl. ¶ 14.) On January 14, 1997,
16 defendants entered into a Speech Pathology Services Agreement
17 ("SPS Agreement") with defendant Madison Memorial Hospital
18 ("Madison").¹ (Howe Aff. Ex. A.) Pursuant to the SPS Agreement,
19 defendants provided speech therapy for outpatients of Madison at
20 two different facilities in Idaho. Many of defendants' patients
21 qualified for Medicaid and, even though the existing regulations
22 did not allow SLPs to become Medicaid providers, Madison was able
23 to seek reimbursement from Medicaid for defendants' treatment of
24 its outpatients. Idaho Admin. Code r. 16.03.09.738 (2007); (Howe
25 Aff. Ex. B ("Kearl Dep.") at 28:24-29:1.)

26
27 ¹ The Board of Trustees of Madison Memorial Hospital,
28 also known as and doing business as Madison Memorial Hospital, is
a defendant in this action but is not a party to the pending
motions for summary adjudication.

1 Pursuant to the SPS Agreement, defendants invoiced
2 Madison \$20.00 for each fifteen-minute unit "expended in speech
3 pathology services." (Howe Aff. Ex. A § 4.C.) As discussed in
4 more detail below, defendants often had unlicensed aides or
5 assistants² meet alone with a patient for part of the patient's
6 appointment and invoiced that time to Madison as time "expended
7 in speech pathology services." For example, defendants would
8 schedule two patients for the same hour and have an SLP meet with
9 one patient for the first thirty minutes while the SLP's aide or
10 assistant met with the other patient, and then the SLP and aide
11 or assistant would swap patients for the remaining thirty
12 minutes. When defendants utilized aides or assistants in this
13 fashion, they invoiced Madison for two hours of "speech pathology
14 services" and did not indicate that an aide or assistant
15 performed one hour of the services.

16 To submit their invoices to Madison, defendants'
17 employees entered the number of fifteen-minute units the SLPs
18 indicated were spent with a patient into a program known as
19 "AS400,"³ which Madison provided. (Id. Ex. Aa ("Strayer Dep."))

21 ² Idaho law did not provide for the licensing of SLP
22 aides or assistants until 2005. See Idaho Code Ann. § 54-
23 2903(16)-(17). The parties agree that whether defendants'
24 employees are considered aides or assistants or were licensed
after 2005 is not material to the United States' FCA causes of
action.

25 ³ Defendants also used "REDOC" software to keep track of
26 time spent with a patient. Although it appears the AS400
27 program, not the "REDOC" software, prepared the invoices
28 submitted to Madison, it is not entirely clear from the
witnesses' testimony which program actually created the invoices.
(See, e.g., Howe Aff. Ex. F ("Christensen Dep.") at 96:8-98:5.)
The precise program used is not material to the United States'
FCA causes of action.

1 at 15:17-22.) The invoiced units for each patient were then
2 electronically transmitted to Madison at the end of each month so
3 that Madison could pay defendants and determine the charges to
4 bill Medicaid. (See id. at 15:25-16:5; Christensen Dep. 98:2-3;
5 Howe Aff. Ex. J ("Berrett Aff.") ¶ 4.) In submitting their time,
6 it is undisputed that defendants lumped time spent by aides or
7 assistants with time spent by SLPs, thereby making it impossible
8 for Madison, or even defendants' own employees, to differentiate
9 between units attributable to SLPs and those attributable to
10 aides or assistants. (Kearl Dep. 49:12-14; Christensen Dep.
11 151:12-16, 159:18-160, 165:2-13.) Based on defendants' invoices,
12 Madison billed Medicaid for all of the services defendants
13 provided to Medicaid patients, including the services that were
14 not provided by an SLP.

15 Alleging that claims for services rendered by aides or
16 assistants were not entitled to reimbursement under Medicaid and
17 thus resulted in the submission of false claims to the
18 government, Relator Jennifer Putnam initiated this qui tam
19 action. Pursuant to § 3730(b)(4) of the FCA, the United States
20 intervened on June 19, 2007 and filed the operative Corrected
21 Third Amended Complaint nine months later. (Docket Nos. 111,
22 116.)

23 The United States now moves for summary adjudication on
24 the issue of liability with respect to its § 3729(a)(1) and §
25 3729(a)(2) FCA causes of action for the fiscal years 2003 to
26 2007. Defendants then filed a cross-motion for partial summary
27 judgment, requesting the court to find, as a matter of law, that
28 Medicaid provides for billing of speech therapy services on a per

1 session basis and that defendants are not responsible for the
2 bills Madison submitted to Medicaid because defendants are not
3 Medicaid providers.⁴

4 II. Discussion

5 Summary adjudication is proper "if the pleadings, the
6 discovery and disclosure materials on file, and any affidavits
7 show that there is no genuine issue as to any material fact and
8 that the movant is entitled to judgment as a matter of law."
9 Fed. R. Civ. P. 56(c); see also id. R. 56(a) ("A party claiming
10 relief may move, with or without supporting affidavits, for
11 summary judgment on all or part of the claim."). A material fact
12 is one that could affect the outcome of the suit, and a genuine
13 issue is one that could permit a reasonable jury to enter a
14 verdict in the non-moving party's favor. Scott v. Harris, 550
15 U.S. 372, 380 (2007); Anderson v. Liberty Lobby, Inc., 477 U.S.
16 242, 248 (1986). The party moving for summary adjudication bears
17 the initial burden of establishing the absence of a genuine issue
18 of material fact and can satisfy this burden by presenting
19 evidence that negates an essential element of the non-moving

20
21 ⁴ For the first time at oral argument, defendants
22 indicated that they also requested summary adjudication with
23 respect to the inapplicability of the Fraud Enforcement Recovery
24 Act of 2009 to this case. Although the court must address
25 whether that Act governs this case, defendants did not dispute
26 the applicability of the Act in their memoranda in opposition to
27 the United States' motion or in support of their own motion.

28 Defendants also argued at oral argument that Count II
from the United States' Corrected Third Amended Complaint should
be dismissed because it alleges only that defendants "submitted,"
not "caused to be submitted," false claims. Defendants' motion
and supporting memoranda are silent as to any such request and do
not attack the sufficiency of the allegations in the Corrected
Third Amended Complaint. The court will therefore not address
whether the United States sufficiently plead Count II, which
alleges a claim under § 3729(a)(3).

1 party's case. Celotex Corp. v. Catrett, 477 U.S. 317, 322-23
2 (1986). Alternatively, the moving party can demonstrate that the
3 non-moving party cannot produce evidence to support an essential
4 element upon which it will bear the burden of proof at trial.

5 Id.

6 Once the moving party meets its initial burden, the
7 non-moving party "may not rely merely on allegations or denials
8 in its own pleading," but must go beyond the pleadings and, "by
9 affidavits or as otherwise provided in [Rule 56,] set out
10 specific facts showing a genuine issue for trial." Fed. R. Civ.
11 P. 56(e); Celotex Corp., 477 U.S. at 324; Valandingham v.
12 Bojorquez, 866 F.2d 1135, 1137 (9th Cir. 1989). In its inquiry,
13 the court must view any inferences drawn from the underlying
14 facts in the light most favorable to the nonmoving party, but may
15 not engage in credibility determinations or weigh the evidence.
16 Anderson, 477 U.S. at 255; Matsushita Elec. Indus. Co., Ltd. v.
17 Zenith Radio Corp., 475 U.S. 574, 587 (1986). When, as in this
18 case, parties submit cross-motions for partial summary judgment,
19 the court must "evaluate each motion separately, giving the
20 nonmoving party in each instance the benefit of all reasonable
21 inferences." ACLU of Nev. v. City of Las Vegas, 333 F.3d 1092,
22 1097 (9th Cir. 2003), cert. denied, 540 U.S. 1110 (2004); accord
23 Fair Hous. Council v. Riverside Two, 249 F.3d 1132, 1136 (9th
24 Cir. 2001).

25 A. Fraud Enforcement Recovery Act of 2009

26 Before assessing whether the United States is
27 entitled to summary adjudication on its causes of action under §
28 3729, the court must determine which version of § 3729 controls.

1 In 2009, Congress passed the Fraud Enforcement Recovery Act of
2 2009 ("FERA") and amended both of the subsections of § 3729 that
3 are at issue in the pending motions. In addition to the
4 substantive changes discussed below, FERA also altered the
5 subdivision of the statute, making what was § 3729(a)(1) become §
6 3729(a)(1)(A) and what was § 3729(a)(2) become § 3729(a)(1)(B).
7 Because the court ultimately concludes that FERA's amendments do
8 not govern the United States' FCA causes of actions, the court
9 will refer and cite to the pre-FERA subsections in this Order.

10 With respect to § 3729(a)(1), FERA deleted the
11 following underscored language: "Any person who knowingly
12 presents, or causes to be presented, to an officer or employee of
13 the United States Government or a member of the Armed Forces of
14 the United States a false or fraudulent claim for payment or
15 approval" Pub. L. No. 111-21, § 4(a), 123 Stat. 1617
16 (2009). The amendments to § 3729(a)(1) apply only to conduct
17 that occurred after FERA was enacted on May 20, 2009, id. § 4(f),
18 and thus the pre-FERA version of § 3729(a)(1) governs the United
19 States' cause of action under that subsection.

20 With respect to § 3729(a)(2), FERA amended the
21 underscored provisions for liability from any person who
22 "knowingly makes, uses, or causes to be made or used, a false
23 record or statement to get a false or fraudulent claim paid or
24 approved by the Government" to any person who "knowingly makes,
25 uses, or causes to be made or used, a false record or statement
26 material to a false or fraudulent claim." Id. § 4(a). When
27 enacting FERA, Congress provided that the amendments to §
28 3729(a)(2) "shall take effect as if enacted on June 7, 2008, and

1 apply to all claims under the [FCA] . . . that are pending on or
2 after that date." Id. § 4(f)(1) (emphasis added). In a cursory
3 footnote, the United States contends that the post-FERA version
4 of § 3729(a)(2) controls in this case because its FCA causes of
5 actions (i.e., "claims") were pending on June 7, 2008. The court
6 must therefore determine whether Congress intended "claims" to
7 refer to claims made to the government and governed by the FCA or
8 claims alleged by the government in an FCA lawsuit.

9 In relevant part, § 3729(b)(2) currently defines
10 "claim" as "any request or demand, whether under a contract or
11 otherwise, for money or property . . . [that] is presented to an
12 officer, employee, or agent of the United States" Before
13 FERPA, § 3729(c) similarly defined "claim" as

14 any request or demand, whether under a contract or
15 otherwise, for money or property which is made to a
16 contractor, guarantee, or other recipient if the United
17 States Government provides any portion of the money or
18 property which is requested or demanded, or if the
Government will reimburse such contractor, grantee, or
other recipient for any portion of the money or property
which is requested or demanded.

19 The pre- and post-FERA definitions of "claim" in § 3729
20 unequivocally encompass claims made to the government, not FCA
21 claims or causes of action alleged by the government in an FCA
22 action. The titles of § 3729 ("False Claims") and the Act to
23 which it belongs ("False Claims Act") further underscore that
24 "claims" is a term of art in FCA cases that refers to claims made
25 to the government for money or property.

26 FERA and its legislative history also show that
27 Congress used the term "claims" to refer to requests for money or
28 property made to the government and "cases" to refer to civil FCA

1 actions. For example, immediately following Congress's provision
2 for retroactive application of the amendments to § 3729(a)(2) to
3 claims pending on or after June 7, 2008, it provided for
4 immediate application of a different FERA amendment to "cases
5 pending." See Pub. L. No. 111-21, § f(2) ("[S]ection 3731(b) of
6 title 31, as amended by subsection (b); section 3733, of title
7 31, as amended by subsection (c); and section 3732 of title 31,
8 as amended by subsection (e); shall apply to cases pending on the
9 date of enactment.") (emphasis added); see also, e.g., S. Rep.
10 No. 111-10 (2009), reprinted in 2009 U.S.C.C.A.N. 430, 438
11 ("Following the decision in [United States ex. rel. Totten v.
12 Bombardier Corp., 380 F.3d 488 (D.C. Cir. 2004)] a number of
13 courts have held that the FCA does not reach false claims that
14 are (1) presented to Government grantees and contractors, and (2)
15 paid with Government grant or contract funds. These cases are
16 representative of the types of frauds the FCA was intended to
17 reach when it was amended in 1986."). Congress's use of the
18 words "claims" and "cases" when amending the FCA and providing
19 for retroactive application of certain subsections therefore
20 illustrates that it intended claims to encompass claims for money
21 or property that are governed by the FCA, not cases brought to
22 enforce it.

23 The only two other district courts that have addressed
24 this issue have also rejected the United States' position that
25 the amendments to § 3729(a)(2) apply to FCA cases pending on or
26 after June 7, 2008. See United States ex rel. Sanders v. Allison
27 Engine Co., Inc., --- F. Supp. 2d ----, 2009 WL 3626773, at *4
28 (S.D. Ohio Oct. 27, 2009); United States v. Science Applications

1 Intern. Corp., 653 F. Supp. 2d 87, 107 (D.D.C. Sept. 14, 2009).
2 As the Sanders court discussed at length, application of FERA's
3 amendments to claims for money or property that were submitted to
4 and paid by the government before the effective date of the
5 amendments also raises serious ex post facto concerns. See
6 Sanders, 2009 WL 3626773, at *5-*10 (concluding that "retroactive
7 application of the new FCA language to [claims submitted and paid
8 before June 7, 2008] violates the Ex Post Facto Clause.").

9 Accordingly, because the claims for Medicaid
10 reimbursement at issue in this case were neither pending on nor
11 filed after June 7, 2008, the pre-FERA version of § 3729(a)(2)
12 governs the United States' cause of action under that subsection.

13 B. Subsection 3729(a)(1)

14 Subsection 3729(a)(1) provides for FCA liability if a
15 person "knowingly presents, or causes to be presented, to an
16 officer or employee of the United States Government or a member
17 of the Armed Forces of the United States a false or fraudulent
18 claim for payment or approval." To establish a cause of action
19 under § 3729(a)(1), "the government must prove three elements:
20 (1) a 'false or fraudulent' claim; (2) which was presented, or
21 caused to be presented, by the defendant to the United States for
22 payment or approval; (3) with knowledge that the claim was
23 false." United States v. Mackby, 261 F.3d 821, 826 (9th Cir.
24 2001). Although § 3729 did not expressly contain a materiality
25 requirement before FERA added one in 2009, the Ninth Circuit and
26 at least five other circuit courts previously held that the
27 government must also prove that the false statement was material.
28 United States v. Bourseau, 531 F.3d 1159, 1170-71 (9th Cir.

1 2008).

2 1. False or Fraudulent Claim

3 "The FCA does not define false. Rather, courts decide
4 whether a claim is false or fraudulent by determining whether a
5 defendant's representations are accurate in light of applicable
6 law." Id. at 1164-65. For example, a claim may be false "even
7 if the services billed were actually provided, if the purported
8 provider did not actually render or supervise the service."

9 Mackby, 261 F.3d at 826. Courts have also "interpreted the FCA
10 to cover claims for . . . Medicare cost reports containing
11 nonallowed or inflated costs." Bourseau, 531 F.3d at 1164-65
12 (citing United States v. Halper, 490 U.S. 435, 437 (1989),
13 overruled on other grounds by Hudson v. United States, 522 U.S.
14 93 (1997); United States ex rel. A+ Homecare, Inc. v. Medshares
15 Mgmt. Group, Inc., 400 F.3d 428, 451 (6th Cir. 2005); Shaw v. AAA
16 Eng'g & Drafting, Inc., 213 F.3d 519, 530 (10th Cir. 2000)).

17 The Idaho Administrative Code ("IDAPA") governs
18 reimbursement for services provided to Medicaid patients.
19 Beginning on July 1, 1999 and continuing until July 1, 2006, the
20 IDAPA defined "Speech/Language Pathology And Audiology Services"
21 as "[d]iagnostic, screening, preventative, or corrective services
22 provided by a speech pathologist or audiologist, for which a
23 patient is referred by a physician or other practitioner of the
24 healing arts within the scope of his or her practice under state
25 law." Idaho Admin. Code r. 16.03.09.003.73 (July 1, 1999)
26 (emphasis added). From July 1, 2006 to April 2, 2008, the
27 definition remained substantially the same but added a licensing
28 requirement for speech pathologists based on new state statutory

1 requirements for licensing enacted in 2005. Id. r.
2 16.03.09.012.23, 16.03.10.013.34 (July 1, 2006); Idaho Code Ann.
3 § 54-2903(15).⁵ The Idaho Department of Health and Welfare's
4 Rules and Minimum Standards for Hospitals in Idaho treat speech
5 pathology as a "rehabilitation service" and provide that
6 rehabilitation services "shall be provided in accordance with
7 orders of practitioners who are authorized by the medical staff
8 to order the services and shall be given by qualified
9 therapists." Idaho Admin. Code r. 16.03.04.440.01 (emphasis
10 added).

11 Defendants do not dispute that, at all times relevant
12 to the pending motions, time spent by SLP aides or assistants was
13 not covered by or entitled to reimbursement from Medicaid. In
14 fact, defendants' expert witness, Health Care Compliance Officer
15 Ned Hillyard, explained, "The Regulations . . . require that
16 speech language evaluations and speech language treatment
17 sessions be provided by a qualified and state licensed [SLP] in
18 order for the Provider to be reimbursed for such services."
19 (Howe Aff. Ex. N at Ex. A.) Accordingly, because Medicaid did
20 not cover speech therapy provided by aides or assistants, a claim
21 for reimbursement for such services would constitute a false or
22 fraudulent claim under the FCA.

23 The undisputed evidence before the court establishes
24 that defendants had aides or assistants meet with patients
25

26 ⁵ The IDAPA was further amended on April 2, 2008 to
27 provide that "[s]ervices provided by speech-language pathology
28 assistants are considered unskilled services, and will be denied
as not medically necessary if they are billed as speech-language
pathology services." Idaho Admin. Code r. 16.03.09.732.02.

1 without an SLP and invoiced Madison for those units without
2 distinguishing them from units of therapy administered by SLPs.
3 (See, e.g., Kearl Dep. 26:7-13, 29:13-20, 42:4-44:19, 56:6-14,
4 74:13-18, 143:11-18; Christensen Dep. 88, 150:20-23, 152:3-22,
5 154; Howe Aff. Ex. G at 6; Howe Aff. Ex. I (Stiles Aff.) ¶¶ 5-7;
6 see also Christensen Dep. 88:11-89:5 (testifying that, as
7 Stevens's aide, she treated patients from 2002 until sometime in
8 2004 when Stevens was out of town and the units were invoiced to
9 Madison).)⁶ While it is therefore undisputed that defendants
10 invoiced Madison for services rendered by aides or assistants,
11 the parties dispute whether Madison billed Medicaid--and thereby
12 made false claims to the government--for those services.

13 Defendants claim that any non-SLP units were not billed
14 to Medicaid because the duration of a speech therapy appointment-
15 -and thus the amount of time the SLP spends with a patient--is
16 irrelevant for purposes of Medicaid reimbursement. Assessing
17 defendants' argument and determining whether Madison's bills to
18 Medicaid included false claims for reimbursement of non-SLP time
19 requires a basic understanding of the complicated Medicaid
20 interim reimbursement and reconciliation processes.

21 Reimbursement for services rendered to Medicaid

22 _____
23 ⁶ The parties dispute whether the SPS Agreement's
24 provision for defendants to invoice Madison for "speech pathology
25 services" encompassed services rendered by aides or assistants.
26 (See Howe Ex. A §§ 2, 4.C (omitting a definition of "speech
27 pathology services," but providing that uncapitalized terms "will
28 have the ordinary meaning generally understood in the health care
field".) Even if a genuine issue of fact about the
interpretation of the SPS Agreement exists, the dispute is not
material to defendants' potential liability under the FCA because
the private agreement cannot alter the fact that Medicaid did not
cover services rendered by aides or assistants.

1 patients begins with the interim reimbursement a provider
2 receives after it bills Medicaid for a service. The interim
3 reimbursement is a pre-determined percentage of the total amount
4 charged for the service that is calculated based on the
5 provider's cost-to-charge ratio (i.e., the costs the provider
6 expended providing services compared to the charges it billed
7 Medicaid for those services) from the prior fiscal year. (Carey
8 Dep. at 43:18-44:11.) For example, if a provider billed Medicaid
9 \$200.00 for a service, it might have received only \$160.00 as an
10 interim reimbursement from Medicaid. (Id. at 20:13-18, 25:14-
11 24.)

12 At the end of the fiscal year, Medicaid then conducted
13 a reconciliation process to determine whether the interim
14 payments the provider received during the year were sufficient or
15 in excess of the provider's costs for the services it provided.
16 (Id. at 107:21-108:25); see generally Bourseau, 531 F.3d at 1162
17 (discussing the Medicare reimbursement process). Similar to a
18 tax return, the reconciliation process required Madison to submit
19 a cost report to Medicare that included all of its costs for the
20 services it provided. (Carey Dep. 45:4-21, 60:15-61:6.) Based
21 on the Medicare cost report, Medicaid settled the total
22 reimbursement for the fiscal year by giving a second
23 reimbursement to the provider if its costs exceeded its interim
24 reimbursements or requiring the provider to reimburse Medicaid if
25 its costs were less than its interim reimbursements. (Id. at
26 45:4-21, 60:9-24.)

27 In preparing its billings to receive its interim
28 reimbursements, Madison was required to identify the services it

1 provided according to the American Medical Association's Current
2 Procedural Terminology ("CPT") Codes. Some CPT Codes provide a
3 suggested duration of time for a service or require the provider
4 to identify the duration of the service. However, the CPT Codes
5 used for billing speech language therapy provide for billing on a
6 per session basis without requiring the provider to meet a
7 minimum amount or identify the duration of time for the
8 appointment. (Covert Aff. Exs. A-F.)⁷ Unlike the SPS
9 Agreement's provision for invoicing based on fifteen-minute
10 units, Medicaid provides for billing one speech therapy session
11 regardless of whether the appointment lasted five minutes, forty-
12 five minutes, or one hour. (Id.; Carey Dep. 35:15-19, 36:10-17.)
13 Based on this per session billing system, defendants argue that
14 Madison did not submit false claims to Medicaid because Medicaid
15 entitled Madison to reimbursement for one session of speech
16 therapy regardless of the amount of time an SLP spent with a
17 patient.

18 While the CPT Codes may have allowed Madison to bill
19 one session of therapy regardless of the duration of time the SLP
20 spent with the patient, neither the CPT Codes nor Medicaid
21 regulations established a flat rate for a speech therapy session.
22 To the contrary, the amount of money Madison received during the
23 interim reimbursement and reconciliation processes was directly
24 affected by the amount of time the SLP spent with the patient.

25
26 ⁷ Defendants provided the current CPT Codes, not the
27 codes that were in effect between 2003 and 2007. Nonetheless,
28 the United States has not suggested that the CPT Codes in effect
during the years relevant to its pending motion were materially
different or did not provide for the billing of speech therapy on
a per session basis.

1 First, when preparing its billings to receive its interim
2 reimbursements, Madison may have billed for one session of
3 therapy regardless of duration, but the amount it billed for each
4 session varied depending on the duration of the session. (Carey
5 Dep. 49:8-11, 87:22-88:19; Howe Aff. Ex. J ("Berrett Aff.") ¶ 4.)
6 Therefore, when defendants' invoice for an appointment included
7 time for non-SLP services, Madison used that time to determine
8 the amount it billed Medicaid for the session and thus received
9 greater interim reimbursements than it would have if it did not
10 include non-SLP time in calculating its charge for the session.

11 Second, and more importantly, Madison included all of
12 the units defendants invoiced, including fees for services
13 performed only by aides or assistants, on its annual cost reports
14 during the reconciliation process. (Id. at 45:22-46:18, 59:2-
15 60:8, 60:9-18, 65:15-66:4, 84:12-85:14, 106:3-7, 109:1-13; see
16 Howe Aff. Ex. P ("Hexem Aff.") ¶ 5 (indicating that all of the
17 payments Madison made to defendants between 2004 and 2007 "were
18 included by Madison as reimbursable in the cost reports submitted
19 to Medicare".) Madison's inclusion of payments made to
20 defendants for services rendered by aides or assistants thus
21 resulted in Madison receiving reimbursement for services that
22 were not covered by Medicaid.

23 Consequently, the fact that Medicaid provided for
24 billing on a per session basis did not prevent Madison from
25 billing Medicaid for the services rendered by aides or assistants
26 because the number of units defendants invoiced directly affected
27 the interim reimbursements Madison sought and received and the
28 costs it was reimbursed for during the reconciliation process.

1 Accordingly, Madison's billings and cost reports included false
2 claims because they sought reimbursement for speech therapy
3 services that were rendered by aides or assistants.

4 2. Presentment

5 Under the second element, which addresses causation, §
6 3729(a)(1) requires that a person "presents, or causes to be
7 presented" the false claim "to an officer or employee of the
8 United States Government or a member of the Armed Forces of the
9 United States." 31 U.S.C. § 3729(a)(1); Mackby, 261 F.3d at 827.
10 Although the statute refers specifically to presentment of a
11 claim to "an officer or employee of the United States
12 Government," defendants do not dispute and district courts have
13 almost unanimously held that presentment to the state agency
14 responsible for administering the state's Medicaid program is
15 sufficient because the funds used to pay the claims are
16 predominantly federal. See United States ex rel. Ven-A-Care v.
17 Actavis Mid Atl. LLC, 659 F. Supp. 2d 262, 269 (D. Mass. 2009)
18 (citing five other district court cases that have "found that
19 Medicaid claims are presented to the federal government" and
20 recognizing a Northern District of Alabama case as the only case
21 reaching the opposite conclusion, which the same judge later
22 rejected); see also 31 U.S.C. § 3729(c) (defining "claim" to
23 include "any request or demand . . . for money or property . . .
24 if the United States Government provides any portion of the money
25 or property which is requested or demanded"); Federal
26 Medical Assistance Percentages or Federal Financial Participation
27 in State Assistance Expenditures (FMAP), available at
28 <http://aspe.hhs.gov/health/fmap.htm> (indicating that, during the

1 fiscal years at issue in the pending motions, the federal
2 government provided between 69.91 and 73.97 percent of the
3 Idaho's Medicaid funds). The legislative history of § 3729(a)(1)
4 also confirms that Congress intended the FCA to extend to
5 fraudulent Medicaid claims. See, e.g., S. Rep. No. 99-345
6 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, 5274 ("A false claim
7 for reimbursement under the Medicare, Medicaid or similar program
8 is actionable under the [FCA]").

9 Not only can presentment of a false claim to the state
10 agency responsible for administering Medicaid satisfy the
11 presentment requirement, a defendant "need not be the one who
12 actually submitted the claim forms in order to be liable."
13 Mackby, 261 F.3d at 827. So long as the defendant caused the
14 false claim to be presented to the government, the defendant
15 cannot escape liability merely because the defendant did not
16 submit the claim or have "'direct contractual relations with the
17 government.'" Id. (quoting United States ex rel. Marcus v. Hess,
18 317 U.S. 537, 544-45 (1943)).

19 Here, defendants' invoices to Madison clearly caused
20 Madison to present false claims to Medicaid. The SPS Agreement
21 between defendants and Madison provided for defendants to submit
22 invoices to Madison and for Madison to obtain reimbursement from
23 Medicaid based on those invoices. With respect to "Billing," the
24 SPS Agreement provides:

25 The Hospital shall provide the services of the business
26 office including filing, billing, collecting and carrying
27 accounts receivable. Contractor shall file with the
28 business office of the Hospital daily charge sheets or
records, setting forth the services performed and the
fees determined pursuant to Section 4(A) of this
Agreement. The Hospital will bill the patient and/or his

1 insurance or other responsible party directly for the
2 cost of the services performed. In billing for charges,
3 the Hospital shall include one charge to the patient for
4 speech pathology services rendered to the patient and
5 shall not distinguish between the Hospital and the
6 Contractor's fee.

7 (Howe Aff. Ex. A § 4.B (emphasis added).) The SPS Agreement
8 further provides that defendants' "records must be sufficient to
9 enable the Hospital to obtain payment for its services and
10 facilities [and that t]he Contractor will assist the
11 Hospital to comply with any and all governmental record-keeping
12 and reporting requirements." (Id. § 3.G.) With respect to
13 Medicaid, the SPS Agreement specifically states,

14 The Contractor will comply with those provisions of the
15 law which affect reimbursement to the Hospital and will
16 cooperate fully with the Hospital in Medicare and
17 Medicaid audits and other reimbursement matters. The
18 Contractor will not knowingly and intentionally do
19 anything which will affect adversely such reimbursement
20 or the Medicare/Medicaid provider status of the Hospital.

21 (Id. § 4.E.)

22 Consistent with the provisions of the SPS Agreement,
23 Calvin Carey, Madison's Chief Financial Officer from January 1998
24 to October 2007, testified at his deposition that Madison
25 "relied" on defendants to invoice the number of units of speech
26 pathology services it provided to patients and that Madison
27 "passed" the allowable costs to Medicaid. (Carey Dep. 14:15-18,
28 25:6-13, 26:17-18, 84:12-85:14.) Carey further explained that
the charges Madison billed Medicaid and itemized on its cost
reports were based on the number of units defendants identified
in their invoices. (Id. at 49:8-11, 60:9-18.) Madison's current
Chief Financial Officer, Gregory Hexem, also indicated that all
of the payments Madison made to defendants for speech therapy

1 services between 2004 and 2007 (totaling \$4,428,423.00) "were
2 included by Madison as reimbursable in the cost reports submitted
3 to Medicare." (Hexem Aff. ¶ 5.)

4 Accordingly, because defendants' invoices to Madison
5 were intended to be used and were in fact used by Madison to
6 determine the reimbursements it requested and received from
7 Medicaid, defendants caused false claims to be presented to the
8 government.

9 3. Knowledge of Falsity

10 As defined by § 3729, "knowingly" means that "a person,
11 with respect to information--(1) has actual knowledge of the
12 information; (2) acts in deliberate ignorance of the truth or
13 falsity of the information; or (3) acts in reckless disregard of
14 the truth or falsity of the information." 31 U.S.C. §
15 3729(b)(1)-(3).⁸ Under this requirement, "no proof of specific
16 intent to defraud is required." Id. § 3729(b).

17 The "knowingly" element of an FCA claim provides the
18 requisite degree of scienter and carries forth Congress's intent
19 that the FCA does not punish "'honest mistakes or incorrect
20 claims submitted through mere negligence.'" United States ex
21 rel. Hochman v. Nackman, 145 F.3d 1069, 1073 (9th Cir. 1998)
22 (quoting S. Rep. No. 99-345, at 7 (1986), reprinted in 1986
23 U.S.C.C.A.N. 5266, 5272). A defendant can avoid liability under
24 § 3729(a)(1) if the defendant acted in reliance on "a good faith
25 interpretation of a regulation . . . because the good faith
26

27 ⁸ Although FERA renumbered the entirety of § 3729,
28 including its definition of "knowingly" that is now in §
3729(b)(1)(A), it did not alter the definition.

1 nature of his or her action forecloses the possibility that the
2 scienter requirement is met." United States ex rel. Oliver v.
3 Parsons Co., 195 F.3d 457, 460 (9th Cir. 1999); accord United
4 States ex rel. Lockyer v. Haw. Pac. Health Group Plan for
5 Employees of Haw. Pac., 343 Fed. App'x 279, 281 (9th Cir. 2009).

6 At the same time, however, the definition of
7 "knowingly" reaches "'what has become known as the "ostrich" type
8 situation where an individual has "buried his head in the sand"
9 and failed to make simple inquiries which would alert him that
10 false claims are being submitted.'" Bourseau, 531 F.3d at 1168
11 (quoting S. Rep. No. 99-345, at 21 (1986), reprinted in 1986
12 U.S.C.C.A.N. 5266, 5286). With § 3729, Congress thus "adopted
13 'the concept that individuals and contractors receiving public
14 funds have some duty to make a limited inquiry so as to be
15 reasonably certain they are entitled to the money they seek.'" Id.
16 "While the Committee intends that at least some inquiry be
17 made, the inquiry need only be 'reasonable and prudent under the
18 circumstances.'" Id.; see also Heckler v. Cmty. Health Servs. of
19 Crawford County, Inc., 467 U.S. 51, 63-64 (1984) ("Protection of
20 the public fisc requires that those who seek public funds act
21 with scrupulous regard for the requirements of law As a
22 participant in the Medicare program, respondent had a duty to
23 familiarize itself with the legal requirements for cost
24 reimbursement."); accord Bourseau, 531 F.3d at 1168; Mackby, 261
25 F.3d at 828.

26 In his brief affidavits, Stevens does not assert that
27 he believed services rendered by aides or assistants were
28

1 entitled to reimbursement from Medicaid between 2003 to 2007.⁹
2 Defendants contend, however, that they believed the Medicaid
3 regulations and billing codes provided for Madison to bill
4 Medicaid for one session of therapy even if the SLP did not meet
5 with the patient for the entire appointment. Based on this
6 understanding, defendants claim that their inclusion of any time
7 spent by aides or assistants in their invoices to Madison did not
8 "knowingly" result in Madison's false claims to Medicaid because
9 defendants believed Madison simply billed Medicaid for one
10 session of therapy regardless of the amount of time the SLP did
11 or did not spend with a patient. Although defendants'
12 interpretation ultimately fails for the reasons discussed above,
13

14 ⁹ Defendants have represented that, "At the time of
15 entering into [the SPS Agreement] in 1997, time expended by
16 assistants was billable to Medicaid pursuant to the guidelines."
17 The excerpt from a prior version of the IDAPA that defendants
18 provided to support this assertion references 1999 amendments,
19 thus appears to have been in effect sometime after 1997. (See
20 Defendants' Supplement (Docket No. 241).) In response to
21 defendants' filing, the United States also filed a Motion for
22 Leave to File Complete Legislative History to Supplement
23 Defendants' Post-Hearing Filing, which the court will grant. In
24 its motion, the United States represents that the version
25 defendants filed is from 1999.

26 The excerpt defendants filed states, "Medicaid will
27 only reimburse for services provided by qualified staff. . . .
28 Speech/Audiological therapy evaluation and treatment[:] Must be
provided by or under the direction of a speech pathologist or
audiologist who possesses a certificate of clinical competence
from the American Speech and Hearing Association;" (Id.
at Idaho Admin. Code r. 16.03.09.05.1.) It also states that
"[p]araprofessionals, such as aides or therapy technicians, may
be used by the school to provide . . . speech therapy if they are
under the supervision of the appropriate professional." (Id. at
r. 16.03.09.06 (emphasis added).)

Even assuming defendants' representation about the
content of the 1997 regulations is accurate, it is not relevant
with respect to defendants' knowledge during the years relevant
to the United States' pending motion because defendants do not
assert that they continued to believe that time spent by aides or
assistants was covered by Medicaid between 2003 and 2007.

1 defendants can withstand summary judgment on the knowledge
2 element of § 3729(a)(1) if a disputed issue of fact remains with
3 respect to whether defendants had knowledge of, were deliberately
4 ignorant to, or recklessly disregarded the fact that Madison was
5 billing and receiving reimbursement from Medicaid for services
6 rendered by defendants' aides or assistants.

7 The United States has submitted evidence that suggests
8 defendants did not hold their mistaken beliefs in good faith
9 because they were, at the very least, reckless with respect to
10 their invoices to Madison. First, the United States submitted a
11 hand-written note by Stevens that memorialized a conversation he
12 had with Steve Brown, a "Program Manager for Medicaid," on July
13 12, 2007. Stevens's note states:

14 Asked for clarification on use of aides and/or
15 assistants. Explained that we use assistants, but that
16 we don't bill for their time. (We are contract agency
17 and MMH bills for our time) I am present for a portion of
18 all the therapy services . . . etc. Steve said we are
19 using aids/assistants appropriately.

20 (Howe Aff. Ex. Q (emphasis added).) According to the United
21 States, this note shows Stevens knew that services rendered by
22 aides or assistants were not reimbursable under Medicaid, thus
23 prompting him to intentionally misrepresent defendants' invoicing
24 practices during the phone conversation. However, when all
25 inferences are taken in favor of defendants, it would also be
26 reasonable to infer from the note that Stevens's representation
27 that defendants did not bill for time spent by aides or
28 assistants was based on his belief that Madison was billing on a
per session basis for services at a flat rate regardless of the
duration of the appointment the SLP spent with the patient.

1 The United States also submitted "demand bills," which
2 were patient-specific documents generated by the AS400 program on
3 a monthly basis that identified all of the charges Madison had
4 billed for a patient. (Carey Dep. 80:7-18, 103:9-104:17.) The
5 discovery defendants produced in this case, (Howe Aff. ¶¶ 3-7),
6 which included documents pertaining to patients Stevens treated,
7 included copies of at least seventy-six monthly demand bills for
8 services rendered between 2003 to 2007. (Howe Aff. Ex. D at
9 233287-233307 (patient file of Amy Campbell); id. Ex. E at
10 208309-208071, 208094-208113 (patient file of Andrew Rushton);
11 id. Ex. H at 00305 (patient Hyrum Whittaker), 00159 (patient
12 Mikel Townsley); see Christensen Dep. 170, 173 (indicating that
13 Whittaker and Townsley were Stevens's patients).)

14 The demand bills defendants produced list the duration
15 of time billed for each visit; some of the demand bills indicate
16 the duration of a visit by listing the quantity of fifteen-minute
17 units and others list the total duration of each visit. For each
18 appointment, the demand bills charge a price that corresponds
19 with the duration of the visit. For example, a thirty-minute
20 session was billed at \$79.00, a forty-five-minute session was
21 billed at \$120.00, a sixty-minute session was billed at \$160.00,
22 and a session of six fifteen-minute units (one-and-a-half hours)
23 was billed at \$240.00. (Howe Aff. Ex. E at 208052-208054.)
24 Significantly, the amount charged for each session has a direct
25 correlation to the duration of the session, with Madison billing
26 \$39.50-\$40.00 for every fifteen minutes in 2003, \$40.00 for every
27 fifteen minutes in 2004, and \$40.00-\$41.75 for every fifteen
28 minutes in 2005. (Id. Ex. D at 233287-233307; id. Ex. E at

1 208309-208071, 208094-208113; id. Ex. H at 00305, 00159.)

2 The demand bills also indicate deductions to the
3 balances that are credited to "Allowance Medicaid" and "PMT
4 Medicaid EDS." (Id. Ex. D at 233275-233307; id. Ex. E at 208309-
5 208113; id. Ex. H at 00305, 00159.) In all of the demand bills
6 before the court, the deductions credited to "Allowance Medicaid"
7 or "PMT Medicaid EDS" equal the exact amount of the charges on
8 the particular demand bill, thus bringing the balance on each of
9 the demand bills to zero based solely on allowances or payments
10 attributed to Medicaid. (Id. Ex. D at 233287-233307; id. Ex. E
11 at 208309-208071, 208094-208113; id. Ex. H at 00305, 00159.)

12 Despite defendants' access to these demand bills,
13 Stevens states in his affidavit that "[a]t no[] time did
14 [Madison] inform or involve me or anyone at Premier Therapy
15 Associates, Inc., Teton Speech Language, Inc., or Teton Speech
16 Language Pathology Services of the billing system between
17 [Madison] and Medicaid and Medicare." (Stevens Aff. ¶ 19.) In
18 light of defendants' professed lack of knowledge about Madison's
19 billings to Medicaid, the United States has failed to show that
20 defendants saw or, more importantly, that they understood the
21 demand bills.

22 First, the date noted at the top of each demand bill is
23 August 8, 2007, which corresponds to the production of discovery
24 in this case and suggests that none of the demand bills were
25 printed until discovery commenced in this case. While it is thus
26 undisputed that defendants had access to the demand bills via
27 their computers, a jury could reasonably infer that defendants
28 neither accessed nor viewed the demand bills at the times

1 relevant to the dispute. Based on defendants' purported lack of
2 knowledge about Madison's billing to Medicaid and the knowledge
3 required to understand the demand bills, a jury could also
4 reasonably find that the demand bills were insufficient to put
5 defendants on notice that Madison was billing for services
6 rendered by aides or assistants. Consequently, whether
7 defendants viewed the demand bills and whether they acted
8 knowingly, deliberately ignorant, or recklessly when they
9 continued to invoice Madison for services rendered by aides or
10 assistants despite the information in the demand bills raise
11 disputed issues of fact that must be resolved at trial.

12 The United States also submitted Carey's deposition, in
13 which he explained that, for at least a period of time, Madison
14 sent Stevens daily emails that included a link to an attachment
15 created by the AS400 program that showed the amount Madison
16 billed Medicaid for each patient that day. (Carey Dep. 54:9-15,
17 79:6-15, 102:12-23.) Although Stevens had difficulty opening the
18 link for a certain amount of time, Carey personally went to
19 defendants' office and ensured that the link was working. (Id.
20 at 54:16-56:7, 69:20-70:17.) It is unclear from Carey's
21 testimony, however, whether those emails were sent at the times
22 relevant to this dispute and whether the information was broken
23 down by each visit like the demand bills. Carey's testimony is
24 thus insufficient to establish, as a matter of law, that
25 defendants knew or acted in deliberate ignorance or with a
26 reckless disregard to the fact that Madison was billing Medicaid
27 for time expended by aides or assistants.

28 Lastly, there is no evidence before the court

1 suggesting that Stevens had knowledge about the complicated
2 Medicaid reconciliation process or that Madison included the fees
3 it paid to defendants for non-SLP services in its annual cost
4 reports. In fact, Stevens states in his affidavit, "During the
5 time period at issue in this case, I had no knowledge of
6 [Madison's] cost report procedure, guidelines, or percentages.
7 No one from Madison [] ever discussed the cost report or
8 explained what it was or its purpose to me or anyone with Premier
9 Inc." (Second Stevens Aff. ¶¶ 3-4.)

10 Accordingly, the United States has failed to establish
11 the lack of a genuine issue of material fact with respect to
12 whether defendants knew or acted in deliberate ignorance or with
13 a reckless disregard to the fact that Madison was billing and
14 receiving reimbursement from Medicaid for services rendered by
15 defendants' aides or assistants.

16 4. Materiality

17 A false statement is material if "it has a natural
18 tendency to influence, or [is] capable of influencing, the
19 decision of the decisionmaking body to which it was addressed."
20 Bourseau, 531 F.3d at 1171 (internal quotation marks omitted)
21 (alteration in original). The natural tendency test "focuses on
22 the potential effect of the false statement when it is made
23 rather than on the false statement's actual effect after it is
24 discovered." Id. Based on the court's prior discussion about
25 how the number of units defendants invoiced directly affected the
26 interim and final reimbursements Madison requested and received,
27 defendants' invoices and the resulting billings to Medicaid
28 clearly satisfy the FCA's materiality requirement.

1 C. Subsection 3729(a)(2)

2 Subsection 3729(a)(2) of the FCA provides for liability
3 for “[a]ny person who knowingly makes, uses, or causes to be made
4 or used, a false record or statement to get a false or fraudulent
5 claim paid or approved by the Government.” The court’s
6 conclusions that Madison’s requests for reimbursement for non-SLP
7 services constituted “false or fraudulent” claims and that
8 defendants’ statements satisfy the materiality requirement apply
9 equally to the United States’ § 3729(a)(2) cause of action.

10 Similarly, because the definition of “knowingly” for § 3729(a)(2)
11 is the same as it is for § 3729(a)(1), the court’s conclusion
12 that a genuine issue of material fact remains on that element
13 also applies to the United States’ cause of action under §
14 3729(a)(2). See Wang v. FMC Corp., 975 F.2d 1412, 1420 (9th Cir.
15 1992) (“The Act’s scienter requirement is laid out in section
16 3729(b).”). Thus, the unique element of the United States’ cause
17 of action under § 3729(a)(2) is that the defendants must have
18 caused a false record or statement to be made or used “to get a
19 false or fraudulent claim paid or approved by the Government.”
20 31 U.S.C. § 3729(a)(2); see also Allison Engine Co., Inc. v.
21 United States ex rel. Sanders, 128 S. Ct. 2123, 2130 n.2 (2008)
22 (explaining that the intent deriving from 3729(a)(2)’s “to get”
23 language is distinct from the statute’s “knowing” element).

24 In a recent decision, the Supreme Court held that the
25 “to get” language in § 3729(a)(2) requires an FCA plaintiff to
26 prove that the defendant “intended that the false record or
27 statement be material to the Government’s decision to pay or
28 approve the false claim,” which requires that the defendant had

1 "the purpose of getting a false or fraudulent claim 'paid or
2 approved by the Government.'" Allison Engine Co., Inc., 128 S.
3 Ct. at 2126, 2128 (emphasis added). The Court further explained
4 that "getting a false or fraudulent claim 'paid . . . by the
5 Government' is not the same as getting a false or fraudulent
6 claim paid using 'government funds.' Under § 3729(a)(2), a
7 defendant must intend that the Government itself pay the claim."
8 Id. at 2128 (internal citation omitted).

9 Similar to the case at hand, Allison Engine Co. dealt
10 with claims made by a subcontractor that were submitted to the
11 prime contractor. The Court explained that a subcontractor's
12 submission of a false statement to a private entity is
13 insufficient unless the subcontractor intends for "the Government
14 to rely on that false statement as a condition of payment." As
15 an example, the Court suggested that the "to get" requirement
16 could be satisfied if a subcontractor made a "a request or demand
17 that was originally 'made to' a contractor, grantee, or other
18 recipient of federal funds and then forwarded to the Government."
19 Id. at 2129 n.1 (emphasis added). It would be insufficient,
20 however, to show "merely that '[t]he false statement's use . . .
21 result[ed] in obtaining or getting payment or approval of the
22 claim.'" Id. at 2126 (alterations and omission in original).

23 Here, defendants neither submitted claims to Medicaid
24 nor received payments from Medicaid. As discussed above,
25 defendants' invoices--which indeed caused the submission of false
26 claims to Medicaid--were submitted to and paid only by Madison.
27 There is no evidence that the government ever received those
28 invoices or was even aware they existed. Furthermore, the SPS

1 Agreement did not contemplate that defendants' receipt of payment
2 from Madison was dependent on Madison's receipt of reimbursement
3 from Medicaid, nor did it provide for Madison to receive a
4 reimbursement from defendants if Medicaid denied Madison's claims
5 based on the services defendants provided. (Howe Aff. Ex. A ¶
6 4.C; see also Carey Dep. 78:7-10 (answering affirmatively when
7 asked, "So irrespective of what Medicaid finally compensated you,
8 you paid him pursuant to that contract?").)

9 At most, it would be reasonable to infer that
10 defendants may have wanted Medicaid to reimburse Madison in an
11 amount equal to or exceeding the charges defendants invoiced
12 because Medicaid's reimbursement at a lesser amount may have
13 jeopardized defendants' continued relationship with Madison.
14 Even if defendants harbored such an intent, the "direct link"
15 between defendants' false statement and Medicaid's decision to
16 reimburse Madison is too "attenuated" to establish liability.
17 Allison Engine Co. Inc., 128 S. Ct. at 2130. Therefore, while it
18 is clear that defendants intended Madison to rely on its false
19 statements in their invoices, there is no evidence that
20 defendants intended the government to receive, let alone rely on,
21 their statements. See id. ("If a subcontractor or another
22 defendant makes a false statement to a private entity and does
23 not intend the Government to rely on that false statement as a
24 condition of payment, the statement is not made with the purpose
25 of inducing payment of a false claim 'by the Government.'")
26 (emphasis added).

27 Accordingly, even though defendants' statements in
28 their invoices caused false claims to be submitted to the

1 government, the United States has failed to establish that
2 defendants made the statements with the intent that the
3 government rely on and pay their invoices.

4 III. Conclusion

5 On its § 3729(a)(1) cause of action for fiscal years
6 2003 through 2007, the United States has proven the lack of a
7 genuine issue of material fact with respect to the elements of a
8 false or fraudulent claim and presentment, as well as the
9 materiality requirement. A genuine issue remains for trial,
10 however, with respect to whether defendants had "knowledge," as
11 defined by § 3729(b)(1)-(3), of the false claims they caused
12 Madison to submit to Medicaid. Therefore, the sole issue
13 remaining for trial on the United States' § 3729(a)(1) cause of
14 action is whether defendants had knowledge of, were deliberately
15 ignorant to, or recklessly disregarded the fact that Madison was
16 billing and receiving reimbursement from Medicaid for services
17 rendered by defendants' aides or assistants.

18 On its cause of action under § 3729(a)(2) for fiscal
19 years 2003 to 2007, the United States has also proven the lack of
20 a genuine issue of material fact with respect to the false or
21 fraudulent claim element and materiality requirement. The only
22 two issues remaining for trial on its § 3729(a)(2) cause of
23 action are thus whether defendants had "knowledge," as defined by
24 § 3729(b)(1)-(3), of the false claims they caused Madison to
25 submit to Medicaid and whether defendants caused a false
26 statement to be made or used "to get a false or fraudulent claim
27 paid or approved by the Government."

28 IT IS THEREFORE ORDERED that

1 (1) the United States' Motion for Leave to File
2 Complete Legislative History to Supplement Defendants' Post-
3 Hearing Filing be, and the same hereby is, GRANTED;

4 (2) the United States' motion for partial summary
5 judgment on its causes of action under §§ 3729(a)(1) and (2) for
6 fiscal years 2003 to 2007 be, and the same hereby is, DENIED; and

7 (3) defendants' cross-motion for partial summary
8 judgment be, and the same hereby is, DENIED as moot.

9 Pursuant to the provisions of Rule 56(d) of the Federal
10 Rules of Civil Procedure, the court determines that the elements
11 of a false or fraudulent claim and presentment and the
12 materiality requirement on the United States' cause of action
13 under § 3729(a)(1) and the element of a false or fraudulent claim
14 and the materiality requirement on its cause of action under §
15 3729(a)(2) for fiscal years 2003 to 2007 have been established
16 and are not genuinely at issue.

17 DATED: March 10, 2010

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19 WILLIAM B. SHUBB
20 UNITED STATES DISTRICT JUDGE
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