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The Seventh Circuit Rejects Medicaid False Claims Act Suit

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The United States Court of Appeals for the Seventh Circuit **affirmed the dismissal** of a False Claims Act ("FCA") case against Shopko Operating Stores, LLC, in which a former Shopko pharmacist asserted Medicaid billing violations. The Seventh Circuit agreed "with the district court that [relator's] legal theory is not viable no matter how detailed his factual allegations." Importantly, the appeals court also found that Shopko was "permitted to bill in the fashion that it did." My colleagues from Mintz Levin's health law and litigation practice areas, **Tom Crane**, **Ellen Janos**, and **Bret Leone-Quick**, along with other members of the firm's health law and litigation groups, represented Shopko before both the district court and the Seventh Circuit.

The relator filed a *qui tam* lawsuit in 2010 under the federal FCA and analogous state false claims acts of California, Illinois, Indiana, Michigan, Minnesota, Montana, Tennessee, and Wisconsin. The federal government and the affected states declined to intervene in relator's suit. The lawsuit involved "dual-eligible" beneficiaries: patients who have prescription drug coverage through both private insurance and Medicaid. To reimburse prescription drugs for "dual-eligibles," the private insurer first pays the amount that it has contracted with a pharmacy to pay for a particular prescription, and then Medicaid pays a remaining amount under its program rules.

The relator asserted that, under a provision of federal Medicaid law he referred to as "federal assignment law," 42 U.S.C § 1396k(a)(1)(A), Medicaid is entitled to receive the prescription drug costs that pharmacies may negotiate with private insurance companies. Shopko allegedly violated federal assignment law, and the FCA, because it sought payment for more than the patient's private co-pay amount (according to relator, Shopko could bill Medicaid only the patient's private co-pay amount) and because it did not submit patient co-payment information to Medicaid. The court gave the following hypothetical example to illustrate the allegations: Medicaid agreed to pay $30 for a drug, while a private insurer agreed to pay $25 for the same drug, $20 plus a $5 co-pay. Relator alleged that Shopko collected the $20 payment from the private insurer, and, instead of billing Medicaid for the $5 co-pay, billed the $10 difference between what the insurer paid and what Medicaid agreed to pay.

Upholding the district court's dismissal of relator's claims, the Seventh Circuit first concluded that relator had not alleged falsity. The court rejected relator's theory of falsity, deciding that relator's "strained interpretation" of Medicaid assignment law had little support in the language of the statute, which actually applies to the beneficiary's right to receive payment, and the court found no case law supporting relator's theory of falsity. In addition, in practice, the electronic reimbursement systems that pharmacies were legally required to use to bill state Medicaid programs did not require pharmacies to submit co-pay information.

The court next decided that the allegations did not plausibly allege Shopko's knowledge, which relator based upon the "reckless disregard" standard of knowledge under the FCA. The Seventh Circuit held that a complaint may not sufficiently allege that a corporation acted with reckless disregard "simply by virtue of its size, sophistication, or reach . . . ."

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