PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 20-1583

UNITED STATES EX REL. STEPHEN GUGENHEIM; STATE OF NORTH CAROLINA EX REL. STEPHEN GUGENHEIM,

Plaintiffs – Appellants,

v.

MERIDIAN SENIOR LIVING, LLC; MERIDIAN SENIOR LIVING SERVICES, LLC; CHARLES E. TREFZGER, JR.; WP−ALBEMARLE HEALTH HOLDINGS, LLC; BURLINGTON AL HOLDINGS I, LLC; TAYLORSVILLE HOUSE, LLC; WP−NEWLAND HEALTH HOLDINGS, LLC; WP−WINDSOR HEALTH HOLDINGS, LLC; LELAND HOUSE, LLC; WP−YANCEYVILLE HEALTH HOLDINGS, LLC; HICKORY HEALTH INVESTORS, LLC; WP−HAYESVILLE HEALTH HOLDINGS, LLC; CHI HOLDINGS, LLC; DANBY HOUSE, LLC; WP−WINSTON SALEM HEALTH HOLDINGS, LLC; COUNTRY TIME INN, LLC; WP−GASTONIA HEALTH HOLDINGS, LLC; GATES HOUSE, LLC; GREENSBORO AL HOLDINGS, LLC; GREENSBORO OPCO HOLDINGS, LLC; GREENSBORO HEALTH HOLDINGS, LLC; FUQUAY−VARINA HEALTH HOLDINGS, LLC; HAYWOOD HEALTH HOLDINGS, LLC; AHOSKIE HOUSE, LLC; SKYLAND HOUSE, LLC; CLAYTON HEALTH HOLDINGS, LLC; MACON HEALTH HOLDINGS, LLC; MINT HILL HEALTH HOLDINGS, LLC; WP−CHARLOTTE HEALTH HOLDINGS, LLC; CHARLOTTE HEALTH HOLDINGS, LLC; MITCHELL HOUSE ONE, LLC; WEST END HOLDINGS, LLC; CASTLE HAYNE AL HOLDINGS, LLC; NEW HANOVER HOUSE, LLC; RVHI, LLC; RV ASSISTED LIVING, LLC; SHI−ORANGE, LLC; GRANTSBORO OPCO HOLDINGS, LLC; BURGAW HEALTH HOLDINGS; WP−CLINTON HEALTH HOLDINGS, LLC; ROSE TARA HOLDINGS, LLC; WP−BREVARD HEALTH HOLDINGS, LLC; CARY HEALTH HOLDINGS, LLC; WP−WENDELL HEALTH, LLC; WP−RALEIGH HEALTH, LLC; ZHI, LLC; WILSON HOUSE, LLC; WP−BURNSVILLE HEALTH HOLDINGS, LLC; AFFINITY LIVING GROUP, LLC,

Defendants – Appellees.

Appeal from the United States District Court for the Eastern District of North Carolina, at Raleigh. Terrence W. Boyle, District Judge. (5:16-cv-00410-BO)

Argued: May 5, 2021 Decided: May 26, 2022

Before WILKINSON and RUSHING, Circuit Judges, and TRAXLER, Senior Circuit Judge.

Affirmed by published opinion. Judge Rushing wrote the majority opinion, in which Judge Wilkinson joined. Senior Judge Traxler wrote a dissenting opinion.

ARGUED: Mark Russell Sigmon, SIGMON LAW, PLLC, Raleigh, North Carolina, for Appellants. Jimmie Watkins Phillips, Jr., BROOKS PIERCE, LLP, Greensboro, North Carolina, for Appellees. **ON BRIEF:** Matthew E. Lee, Jeremy R. Williams, WHITFIELD BRYSON LLP, Raleigh, North Carolina; Clifford C. Marshall, Jr., MARSHALL, ROTH & GREGORY, PC, Asheville, North Carolina, for Appellants. Jennifer K. Van Zant, Donald J. O'Brien, III, Kimberly M. Marston, BROOKS PIERCE, LLP, Greensboro, North Carolina, for Appellees.

RUSHING, Circuit Judge:

Stephen Gugenheim, a North Carolina attorney, believes he uncovered fraud perpetrated by forty-five adult care homes upon the United States and the State of North Carolina. According to Gugenheim, Defendants violated a North Carolina Medicaid billing regulation, and did so knowingly, as evidenced by the clarity of the regulation and by the fact Defendants did not ask the regulators for advice. Because we conclude no reasonable juror could find Defendants acted with the requisite scienter on this evidence, we affirm the district court's decision granting Defendants summary judgment on Gugenheim's claims.

I.

A.

Medicaid is a "joint state-federal program in which healthcare providers serve poor or disabled patients and submit claims for government reimbursement." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 183 (2016). One type of expense eligible for reimbursement under North Carolina's Medicaid plan is personal care services (PCS), which assist disabled adults with the activities of daily living, whether they reside at home or in an adult care home. *See generally Pashby v. Delia*, 709 F.3d 307, 313–314 (4th Cir. 2013). The North Carolina Department of Health and Human Services, Division of Health Benefits (NC Medicaid) oversees the State's program.

Before 2013, the provision of in-home PCS was governed by North Carolina's Clinical Coverage Policy 3C. No parallel policy existed for PCS provided in adult care homes. In response to a federal mandate that eligibility requirements for PCS be

comparable regardless of the setting in which services are delivered, North Carolina implemented its Clinical Coverage Policy 3L on January 1, 2013. Policy 3L consolidated PCS benefits into one program that governs both in-home providers and adult care homes.

To determine eligibility for PCS under Policy 3L, the Division of Medical Assistance (DMA), through a contractor, conducts annual assessments of potential beneficiaries by evaluating tasks with which they need assistance, their required assistance level, and the number of days per week they need that assistance. It then rates potential beneficiaries' capacity to perform each so-called "activity of daily living"—bathing, dressing, mobility, toileting, and eating—on a scale from "0 – Totally able" to "4 – Cannot do at all (full dependence)." J.A. 5812–5813. Each activity encompasses subtasks that compose the category; for example, a beneficiary who needs assistance with bathing might need help only with certain tasks within that category, such as "[n]ail care" or "[s]hampoo/hair care." J.A. 5414.

After the assessment is performed and the eligibility requirements satisfied, a beneficiary's monthly authorized PCS hours are calculated using an algorithm based on Policy 3L's service level determination chart. The chart identifies the authorized PCS hours for each activity of daily living depending on whether the beneficiary needs limited assistance (defined as "able to self-perform more than 50 percent of activity"), requires extensive assistance (defined as "able to self-perform less than 50 percent of activity"), or displays full dependence (defined as "unable to perform any of the activity and . . . totally dependent on another to perform all of the activity"). J.A. 5813, 5837. For example, the chart provides that 35 minutes per day are authorized for a beneficiary who requires limited

assistance with bathing, 50 minutes per day for a beneficiary who needs extensive assistance with bathing, and 60 minutes per day for bathing a beneficiary who is fully dependent. Additional time is authorized for medication assistance and exacerbating conditions. Policy 3L originally capped authorized PCS hours at 80 hours per month. But as of October 2013, beneficiaries who require increased supervision, such as those with a memory impairment, can receive up to 50 additional PCS hours per month, referred to as "safeguard hours."

Once a beneficiary is approved for a certain number of PCS hours per month, the provider develops a service plan designed to show a typical week of aide service. The service plan includes each activity of daily living with which the beneficiary needs assistance, the beneficiary's assistance level, subtasks within each activity category, and the required frequency of performance. Providers use the QiRePort template provided by the State, which divides the beneficiary's monthly authorized hours equally into hours per week and day to display the average hours per day based on the monthly PCS authorization. "Unlike [for] in-home providers, where visits need to be scheduled," QiRePort assumes that adult care homes "have the responsibility to provide aide services, 24/7," therefore the daily target hours will fully account for the monthly PCS authorization. J.A. 5671. The template then displays the individual aide tasks required for the beneficiary, and the adult care home identifies which days of the week those tasks will be performed.

Policy 3L requires PCS providers to document the performance of all PCS tasks listed in a beneficiary's service plan at the indicated frequency. Documentation must include the date of service, the tasks performed, and the name of the aide providing the

service. If a scheduled task is not performed for any reason, that deviation must also be documented. It is undisputed, however, that a provider need not document the time spent on each task.

Attachment A to Policy 3L addresses claims and billing. It instructs providers to comply with the "*NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC." J.A. 5839. Under the heading "Billing Units," Attachment A advises providers to "report the appropriate code(s) used which determines the billing unit(s)." J.A. 5840; *see* J.A. 5839 (explaining that a billing code "accurately and completely describes the procedure, product or service provided"). It also carries forward two statements from Policy 3C, which had applied only to in-home PCS providers: "1 unit of service = 15 minutes" and "PCS follows wage and hour requirements for rounding billing units (7/8 rule)." J.A. 5840. Policy 3L does not retain Policy 3C's section describing "[w]hat [m]ay be [b]illed," which authorized in-home PCS providers to bill for time spent in the beneficiary's home "providing the tasks during the times specified" in the service plan, nor does it include any comparable guidance. J.A. 729.

B.

Defendants are forty-five North Carolina adult care homes; Affinity Living Group LLC, which manages those homes; and Charles E. Trefzger, Jr., Affinity's CEO. Defendants' facilities specialize in providing around-the-clock care to high-needs elderly individuals. Many of Defendants' residents suffer from cognitive or memory impairments

and so reside in special care units with greater security and supervision. The vast majority of those residents rarely leave Affinity's facilities other than for doctor's visits or scheduled appointments. Even while outside the facilities, those residents commonly need assistance from a facility employee with tasks like walking from the vehicle to the doctor's office, toileting, eating, or general supervision "to ensure the resident[s] [do] not become disoriented and harm themselves." J.A. 6260.

Many of the residents of Defendants' facilities receive Medicaid benefits. Defendants' employees document in a computerized log the PCS tasks they perform for each resident during their shift. At every shift change, departing staff inform arriving staff about what occurred during the previous shift and any PCS tasks that remain to be done. Managerial staff also assist in tracking PCS tasks and ensuring each beneficiary's service plan is completed every day.

Affinity uses a census method to generate weekly bills for its facilities. The census identifies the residents present in the facility at midnight each day. For every PCS beneficiary present in the facility at midnight, Affinity bills the average daily PCS hours calculated from the total monthly hours authorized for that beneficiary. *See* J.A. 2868–2869 (using spreadsheets coded for months with 28, 29, 30, or 31 days to divide "evenly throughout the month . . . the amount of hours that the residents are allowed"). Every Monday, the billing department uses this method to bill for the prior week.

Upon learning of Defendants' census-based billing practice, Gugenheim sued under the federal False Claims Act, 31 U.S.C. § 3729 et seq., and the North Carolina False Claims Act (NCFCA), N.C. Gen. Stat. § 1-605 et seq., to recover damages and civil penalties on

behalf of the United States and North Carolina. He asserted that Defendants "intentionally submitted false claims for reimbursement to N.C. Medicaid for [PCS] provided to residents of Defendants' Special Care Units and received reimbursements therefrom" in violation of 31 U.S.C. § 3729(a)(1)(A) and the NCFCA.[1] J.A. 79. According to Gugenheim, Policy 3L obligated Defendants to track the time their employees actually spent providing PCS to individual residents and then bill Medicaid for those hours rather than for the beneficiaries' daily authorized PCS hours. The United States and North Carolina declined to intervene in this qui tam action.

After discovery, Gugenheim moved for partial summary judgment and Defendants moved for summary judgment on all claims. The district court granted Defendants' motion, holding that Gugenheim failed to proffer evidence showing "that the bills submitted by [D]efendants to North Carolina Medicaid for PCS reimbursement were materially false or made with the requisite scienter." J.A. 6840. Gugenheim timely appealed.

II.

The district court had jurisdiction over Gugenheim's suit, and we now have jurisdiction to review its final decision. 28 U.S.C. §§ 1291, 1331, 1367. We review an award of summary judgment de novo, "applying the same legal standards as the district court, and viewing all facts and reasonable inferences therefrom in the light most favorable

[1] The district court granted Defendants' motion to dismiss Gugenheim's conspiracy claims and claim under 31 U.S.C. § 3729(a)(1)(B). Gugenheim does not contest that ruling on appeal.

to the nonmoving party." *Carter v. Fleming*, 879 F.3d 132, 139 (4th Cir. 2018) (internal quotation marks omitted). Summary judgment is appropriate "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "[A] scintilla of evidence" in support of the nonmoving party's position is insufficient to defeat summary judgment. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252 (1986). Rather, "[w]here the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no genuine issue for trial." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (internal quotation marks omitted).

When the nonmoving party "has failed to make a sufficient showing on an essential element of [his] claim with respect to which [he] has the burden of proof," summary judgment is warranted. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). This includes a state-of-mind element like scienter. *See Skibo ex rel. U.S. v. Greer Labs., Inc.*, 841 Fed. App. 527, 532 (4th Cir. 2021) (rejecting the argument that "summary judgment is never appropriate on the element of knowledge").

III.

The False Claims Act "is a fraud prevention statute." *United States ex rel. Owens v. First Kuwaiti Gen. Trading & Contracting Co.*, 612 F.3d 724, 728 (4th Cir. 2010) (internal quotation marks omitted).[2] As relevant here, it imposes civil liability on "any

[2] The NCFCA largely parallels the False Claims Act and is interpreted consistent with it. N.C. Gen. Stat. § 1-616(c). We follow the parties' lead and discuss only the False Claims Act, although our analysis and conclusions apply equally to Gugenheim's NCFCA claim.

person who . . . knowingly presents, or causes to be presented" to the federal Government "a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1)(A). "[D]irect requests to the Government for payment as well as reimbursement requests made to the recipients of federal funds under federal benefits programs," such as Medicaid, may give rise to a claim under the Act. *Universal Health*, 579 U.S. at 182. "[C]ertain misleading omissions" about a defendant's "violations of statutory, regulatory, or contractual requirements . . . can [also] be a basis for liability if they render the defendant's representations misleading with respect to the goods or services provided." *Id.* at 187.

The Act's scienter requirement defines "knowingly" to mean that a person "has actual knowledge of the information," "acts in deliberate ignorance of the truth or falsity of the information," or "acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1)(A). It does not require "specific intent to defraud," *id.* § 3729(b)(1)(B), but neither does it punish "honest mistakes or incorrect claims submitted through mere negligence," *Owens*, 612 F.3d at 728 (internal quotation marks omitted). As we have previously observed, "[b]ad math is no fraud, [and] proof of mistakes is not evidence that one is a cheat." *Id.* at 734 (internal quotation marks omitted).

Gugenheim argues that Defendants acted with reckless disregard or deliberate ignorance of the alleged falsity of their bills when they billed Medicaid for PCS based on a census method rather than based on the hours their employees actually spent providing PCS to each beneficiary. Gugenheim bears the burden to prove scienter at trial. Therefore, summary judgment is warranted if Gugenheim has failed to marshal evidence from which a reasonable jury could find that Defendants acted with the requisite state of mind. As

evidence of scienter, Gugenheim relies almost exclusively on the supposed clarity of Policy 3L, which he asserts unambiguously put Defendants on notice that they were required to bill by time. In particular, he highlights the "7/8 rule" in Policy 3L—that seven minutes of service or less rounds down to zero and eight minutes of service or more rounds up to fifteen—as a clear indication that PCS providers were required to track and bill by time. According to Gugenheim, this regulation is so clear that if Defendants violated it, we can infer they did so knowingly.

But Policy 3L's billing requirement for adult care homes is not as clear as Gugenheim claims. Policy 3L advises providers to "comply with . . . any other relevant documents for . . . reimbursement for Medicaid," and other agency guidance undermines Gugenheim's interpretation that Policy 3L requires all providers to track and bill by time. J.A. 5839. For starters, in a QiRePort Frequently Asked Questions document, NC Medicaid advised that providers do not need to record the time spent on each PCS task. This is significant for adult care homes, which, unlike in-home providers, do not limit their care to a time window marked by arrival and departure. In the same document, NC Medicaid explained that the State organizes its reporting software on the assumption that adult care homes, unlike in-home providers, "have the responsibility to provide aide services, 24/7." J.A. 5671. Based on this expectation, the State's reporting software pre-populates the weekly PCS schedule for beneficiaries in adult care homes by "display[ing] the average daily PCS hours/units based on the monthly PCS authorization." J.A. 5671.

Elsewhere in the same document, NC Medicaid responded to a provider's question about whether it must "deduct the time from what I bill for PCS" if "one of the required

aide tasks in a group . . . could not be completed for a given day(s)." J.A. 5684. The agency answered: "If the aide attempted the required task but it could not be completed, this instance should be documented as a deviation. In the same grouping of tasks, if at least one of the remaining tasks could be completed for the same day, there is no requirement that time should be deducted from the billing of PCS hours." J.A. 5684, 490 (explaining that NC Medicaid approved the answers appearing in the frequently-asked-questions document). In other words, so long as the aide completed one of the required tasks within the category, the provider may bill for the full associated PCS hours. This guidance arguably suggests that Policy 3L authorizes providers to bill based on completion of tasks rather than time.[3]

Defendants interpret this and other guidance from NC Medicaid as permitting their census billing method, which functions as a form of task-based billing for their full-time care homes. Given the special needs of their residents and Defendants' obligation to

[3] Gugenheim asserts that task-based billing is impossible because there are no time allotments corresponding to tasks or activities of daily living. But NC Medicaid representatives repeatedly testified that the units of time associated with an activity of daily living in a beneficiary's service plan also correspond to billing. J.A. 428–429; *see*, *e.g.*, J.A. 428 ("[W]hen the provider can document that the task or the [activity of daily living] was performed, they are permitted to bill for that unit."); J.A. 5314–5315 (explaining that "completing the [activity of daily living] service is a proxy for time," and "if you document the completion of the task, the [activity of daily living] service, . . . you're able to bill for the entire time"); J.A. 6461 (testifying that, for adult care homes, "if they completed the task, then they would be allowed to bill," because "they don't have an in and out time similar to the in-home care providers"). We need not address whether the testimony from these deponents could qualify as an authoritative agency interpretation. *See Kisor v. Wilkie*, 139 S. Ct. 2400, 2416–2417 (2019). It is sufficient for scienter purposes to observe that, on this point, the agency witnesses interpret Policy 3L as Defendants do and not in the manner Gugenheim claims it unambiguously requires.

provide around-the-clock care, Defendants use the midnight census to determine the residents who received care on a given day. Defendants' employees track the accomplishment of PCS tasks for their beneficiaries to ensure each beneficiary's service plan is completed on any day he or she receives care. And based on completion of the tasks in a beneficiary's daily service plan, Defendants bill Medicaid for the beneficiary's daily allotment of PCS hours any day he or she was present in the facility.[4]

We need not determine whether Defendants' interpretation of Policy 3L is correct. The policy and related guidance from NC Medicaid are sufficiently ambiguous to foreclose the possibility of proving scienter based solely on the clarity of the regulation. We cannot infer scienter from an alleged regulatory violation itself, and we "especially" will not do so "where there is regulatory ambiguity as to whether" Defendants' conduct even violated the policy. *United States ex rel. Complin v. N.C. Baptist Hosp.*, 818 Fed. App. 179, 184 (4th Cir. 2020). "'[E]stablishing even the loosest standard of knowledge, i.e., acting in reckless disregard of the truth or falsity of the information, is difficult when'"—as here—"'falsity turns on a disputed interpretive question.'" *Id.* (quoting *U.S. ex rel. Purcell v. MWI Corp.*, 807 F.3d 281, 288 (D.C. Cir. 2015)). Gugenheim does not identify any

[4] The dissent is built on a hypothetical case of billing for a beneficiary's full daily allotment when no services were provided. Gugenheim has not identified any such evidence. The closest he comes is showing thirteen instances when certain tasks were not performed for a beneficiary within one eight-hour shift, without evidence about the remaining sixteen hours of the day. *See* Reply Br. 12 n.6. Gugenheim's speculation cannot fill the evidentiary void. *See Sandlands C&D LLC v. County of Horry*, 737 F.3d 45, 54 (4th Cir. 2013) ("[T]he nonmoving party must rely on more than conclusory allegations, mere speculation, the building of one inference upon another, or the mere existence of a scintilla of evidence." (internal quotation marks omitted)).

evidence to suggest that Defendants knew, or had any reason to believe, their interpretation of the regulation was incorrect or that Defendants ignored any relevant agency guidance in reaching their conclusion. Because Policy 3L's billing requirement for adult care homes is ambiguous and Defendants' interpretation of the policy and agency guidance is reasonable, Gugenheim cannot prove, based on the policy alone, that Defendants knowingly submitted false claims. *Cf. United States ex rel. Sheldon v. Allergan Sales, LLC*, 24 F.4th 340, 348 (4th Cir.), *vacated and reh'g en banc granted*, 2022 WL 1467710 (4th Cir. May 10, 2022).

In the alternative, Gugenheim contends that, even if Policy 3L were ambiguous, Defendants "stuck their head[s] in the sand" when they should have sought more guidance from NC Medicaid. Opening Br. 53. For example, Tom Stahlschmidt, Defendants' employee in charge of implementing Policy 3L, testified that, although he "[was] sure it came up in a stakeholders meeting" attended by state agency representatives, he did not recall ever asking anyone at NC Medicaid whether the 7/8 rule applied to adult care homes. J.A. 2074–2075; *see also* J.A. 2042–2043 (explaining stakeholder meetings).

To prove that Defendants knowingly submitted false or fraudulent claims for payment, however, it is not enough to show that Defendants could have sought more guidance about an ambiguous regulation. At a minimum, Gugenheim must show that Defendants acted in "reckless disregard of the truth or falsity" of their bills, as opposed to merely committing an "honest mistake[]" in their interpretation of the policy. *Owens*, 612 F.3d at 728 (internal quotation marks omitted); *see*, *e.g.*, *United States v. Krizek*, 111 F.3d 934, 942 (D.C. Cir. 1997) (holding that psychiatrist acted with reckless disregard by failing

to review bills submitted on his behalf, and his wife acted with reckless disregard by completing claims with "little or no factual basis").

The evidence does not meet this standard. Importantly, Gugenheim does not identify any evidence that Defendants knew, or even suspected, that their interpretation of Policy 3L and the related guidance from NC Medicaid was incorrect (indeed, it may be right). Nor does Gugenheim identify any evidence that Defendants attempted to avoid discovering how the regulation applied to adult care homes or plowed ahead with a dubious interpretation despite serious doubts about its accuracy.

In fact, the evidence suggests to the contrary. Stahlschmidt testified that he asked another stakeholder—from a company that provides billing-related services to other adult care homes in North Carolina—about how Policy 3L's statement on billing units and the 7/8 rule would apply to adult care homes like Defendants' facilities. The stakeholder responded that the rule does not apply because adult care homes are not required to document time spent providing PCS but instead must document the completion of PCS tasks. *Cf.*, *e.g.*, *Skibo*, 841 Fed. App. at 534 (affirming summary judgment on lack of scienter when the record demonstrated that the defendant's interpretation of the regulation accorded with the "common understanding . . . in the industry"). What is more, state and federal regulators audited Defendants' facilities numerous times without incident during the relevant period. During a 2016 audit, a federal contractor requested that Defendants produce, among other things, timesheets and documents showing the total time spent for the units billed to Medicaid. Confused by this request, Stahlschmidt contacted two NC Medicaid officials and explained his understanding that Policy 3L did not require adult

care homes to make or keep time records. *See* J.A. 5925 (stating that "Policy 3L dictates this is not applicable to PCS recipients residing in license[d] residential facilities"). The NC Medicaid officials responded that the auditors would consult North Carolina policies, would "review to see if what was billed . . . met NC policy and billing requirements," and would contact him if any documentation was missing. J.A. 5923. No one ever contacted Stahlschmidt to request further documents or information regarding that audit, nor did the NC Medicaid officials raise any question about the appropriateness of Defendants' billing practices in response to Stahlschmidt's explanation.

These actions do not betoken a deliberate effort to avoid learning the truth. Nor do the facts suggest that Defendants' interpretation of Policy 3L was so off-base as to demonstrate reckless disregard for the truth or falsity of their bills. Viewing the record in the light most favorable to Gugenheim, even if Defendants' interpretation of Policy 3L were incorrect—a question we do not decide—their actions amount, at most, to an error in judgment or mistake. Gugenheim has not identified evidence from which a reasonable jury could conclude that Defendants billed Medicaid for PCS in reckless disregard of the truth or falsity of those bills, much less with deliberate ignorance or actual knowledge of falsity. Given the lack of genuine dispute about whether Defendants acted with the requisite scienter, we need not evaluate the remaining elements of Gugenheim's federal and state claims.

IV.

Gugenheim spotted a disparity between the amount Defendants billed and the time Defendants' employees worked. But that alone cannot support a claim of fraud under

federal and state law. After discovery, there is no issue of material fact as to whether Defendants acted with scienter, which is a "rigorous" requirement we must "strict[ly] enforce[]." *Universal Health*, 579 U.S. at 192 (internal quotation marks omitted). We accordingly hold that the district court appropriately granted Defendants summary judgment on Gugenheim's claims.

AFFIRMED

TRAXLER, Senior Circuit Judge, dissenting:

With respect, I dissent. Plaintiff alleges that Defendants violated the False Claims Act (FCA) by knowingly presenting false or fraudulent Medicaid claims for payment in violation of 31 U.S.C § 3729(a)(1)(A). Plaintiff has presented evidence that Defendants intentionally billed the government for the maximum amount of compensable time for personal care services (PCS) for every Medicaid beneficiary in every one of their adult care homes, without any inquiry whatsoever into what services the beneficiaries actually received. Plaintiff has also presented documentary and expert evidence that for every 8 hours their adult care home aides worked, Defendants billed Medicaid for almost 12 hours of personal care services, resulting in over 1,900,000 false claims being submitted to the Medicaid program for payment. Over a five-year period, the losses to the Medicaid program from this overbilling could exceed $40,000,000.

Plaintiff has also presented evidence that Defendants did next to nothing to educate themselves about how NC Medicaid's new Clinical Coverage Policy 3L affected their billing practices. Policy 3L governs the provision of PCS for Medicaid beneficiaries and the proper billing for such services, both in the home and in adult care facilities. On its face, Policy 3L includes a "Billing Units" provision that requires Medicaid providers to bill for their services in 15-minute units, utilizing the "7/8 rule" for rounding. If a provider provides 0 to 7 minutes of service, it must round down and bill no unit, but if it provides 8 to 15 minutes of service, it may round up and bill a 15-minute unit.

Defendant's representative responsible for implementing Policy 3L testified that he did not understand why the billing units provision was included in Policy 3L or how it

applied in the adult care home setting. But he did not consult NC Medicaid for guidance. Instead, he concluded that it could not apply and that it was appropriate to just charge the government for the maximum number of authorized PCS hours per day without regard to the actual time the beneficiary was in the facility or the time the aides spent providing PCS to the beneficiary.

Defendants argue, and the majority agrees, that it was okay for them to do this because NC Medicaid provided subsequent "guidance" that approved the use of "task-based" billing as opposed to the "time-based" billing required by the language of Policy 3L. Task-based billing, Defendants argue, authorizes them to bill for *all* of the authorized hours associated with a particular PCS if *any* part of the task was attempted. I do not think this is a reasonable interpretation of the Policy or the guidance document upon which Defendants rely. But even if I were to agree that the guidance authorized "task-based" billing, Defendants did not use "task-based" billing.

Defendants' employees responsible for submitting claims to NC Medicaid did not check the computerized task logs to determine whether *any* PCS tasks had been performed or attempted for the individual beneficiaries. Instead, Defendants used a "census-based" billing method to generate weekly bills. If the patient was in the facility at 12:00 midnight on a particular day, Defendants billed Medicaid for every authorized hour for that day of the week. In sum, Defendants' billing had zero to do with time, tasks, or the actual provision of PCS. Medicaid was billed the maximum number of authorized hours even if the beneficiary was absent from the facility for a portion of the day or received no assistance at all with his or her activities of daily living.

Despite this evidence, the majority affirms the grant of summary judgment to Defendants because, in its view, Plaintiff failed to produce sufficient evidence from which a reasonable juror could find that Defendants submitted these false claims "knowingly," as that term is defined in the FCA. In my view, the majority's interpretation of the scienter element of an FCA claim is far too narrow and its affirmance of summary judgment is based upon a review of the evidence in the light most favorable to Defendants, not to Plaintiff.

I.

The FCA imposes liability on one who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1)(A). Under the FCA, a person acts "knowingly" when he "has actual knowledge of the information." 31 U.S.C. § 3729(b). Nonetheless, neither actual knowledge nor specific intent to defraud are required, as the FCA also provides that a person acts knowingly if he or she "acts in deliberate ignorance of the truth or falsity of the information" or "acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b).

The definition of "knowingly" was added in 1986, after the FCA's initial enactment, in order to expand the FCA's reach to "the ostrich type situation where an individual . . . fail[s] to make simple inquiries which would alert him that false claims are being submitted." S. Rep. No. 99-345, at 21 (1986), 1986 U.S.C.C.A.N. 5266, 5286. Accordingly, since the 1986 amendment, courts have recognized that FCA defendants have a "limited duty to inquire" to insure the validity of their claims. *U.S. ex rel. Williams v. Renal Care Grp., Inc.*, 696 F.3d 518, 530 (6th Cir. 2012) (cleaned up). As the Sixth Circuit

has explained, the point of the FCA's expansive definition of knowledge was "to target that defendant who has buried his head in the sand and failed to make some inquiry into the claim's validity. The inquiry, however, need only be reasonable and prudent under the circumstances, which clearly recognizes a limited duty to inquire as opposed to a burdensome obligation." *Id.* (cleaned up).

The FCA is not intended to "punish honest mistakes or incorrect claims submitted through mere negligence." *United States ex rel. Owens v. First Kuwaiti Gen. Trading & Contracting Co.*, 612 F.3d 724, 728 (4th Cir. 2010) (cleaned up). Nevertheless, failing to familiarize oneself with the legal requirements of Medicaid can constitute reckless disregard or deliberate indifference of those requirements. *See, e.g.*, *United States v. Mackby*, 261 F.3d 821, 828 (9th Cir. 2001) ("[The FCA defendant's] claim that he did not know of the Medicare requirements does not shield him from liability. By failing to inform himself of those requirements, particularly when twenty percent of [the defendant's] patients were Medicare beneficiaries, he acted in reckless disregard or in deliberate ignorance of those requirements, either of which was sufficient to charge him with knowledge of the falsity of the claims in question.").

In this case, we consider the FCA claim through the lens of summary judgment. A motion for summary judgment may not be granted unless there are no genuine issues of material fact for trial and the movant is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a). "A dispute is genuine if a reasonable jury could return a verdict for the nonmoving party," and a "fact is material if it might affect the outcome of the suit under the governing law." *Libertarian Party of Va. v. Judd*, 718 F.3d 308, 313 (4th Cir. 2013) (cleaned up).

As we explained more than 50 years ago,

> summary judgment should not be granted unless the entire record shows a right to judgment with such clarity as to leave no room for controversy and establishes affirmatively that the adverse party cannot prevail under any circumstances. Neither should summary judgment be granted if the evidence is such that conflicting inferences may be drawn therefrom, or if reasonable men might reach different conclusions. [The] [b]urden is upon [the] party moving for summary judgment to demonstrate clearly that there is no genuine issue of fact, and any doubt as to the existence of such an issue is resolved against him.

Phoenix Sav. & Loan, Inc. v. Aetna Cas. & Sur., 381 F.2d 245, 249 (4th Cir. 1967) (cleaned up). When considering a summary-judgment motion, this court, like the district court, must view the facts and inferences in the light most favorable to the party opposing the motion. *See Anderson v. Liberty Lobby*, 477 U.S. 242, 249 (1986); *Lone Star Steakhouse & Saloon, Inc. v. Alpha of Va., Inc.,* 43 F.3d 922, 928 (4th Cir. 1995). "[A]t the summary judgment stage the judge's function is not himself to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson*, 477 U.S. at 249.

> Credibility determinations, the weighing of evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge, whether he is ruling on a motion for summary judgment or for a directed verdict. The evidence of the nonmovant is to be believed, and all justifiable inferences are to be drawn in his favor.

Id. at 255.

States of mind, like scienter, are "preeminently factual issues for the trier of fact." *Miller v. Premier Corp.*, 608 F.2d 973, 982 (4th Cir. 1979). Accordingly, "the issue of fraudulent intention is generally not amenable to resolution on summary judgment. . . . [W]hen evidence of intention is ambiguous, summary judgment simply cannot be

awarded." *United States ex rel. Bunk v. Government Logistics N.V.*, 842 F.3d 261, 276-77 (4th Cir. 2016); *see also Skibo ex rel. U.S. v. Greer Labs., Inc.*, 841 F. App'x 527, 532 (4th Cir. 2021) ("[I]n order for summary judgment to be appropriate, it must be clear that there is no issue of material fact as to whether [the defendant] acted with the requisite mental state—here, scienter.")

II.

A.

On January 1, 2013, NC Medicaid implemented Policy 3L because of a federal requirement that the policies for providing PCS in adult care homes be comparable to the policies for providing PCS in the in-home setting. *See* 42 U.S.C. § 1396a(a)(10)(B); *Pashby v. Delia*,709 F.3d 307, 314-15 (4th Cir. 2013). Under Policy 3L, NC Medicaid authorizes a *maximum* number of hours that a provider can bill Medicaid per month for the provision of PCS for each specific patient, based on the needs of the individual beneficiaries, whether those services are performed in a private home or in an adult care home.

Consistent with the comparability requirements of federal law, many of the requirements from former Policy 3C, which applied only in the in-home setting, were carried forward into Policy 3L, including the 15-minute billing units provision and the 7/8 rule. Attachment A to Policy 3L, titled "Claims-Related Information," requires all providers to "comply with the[] *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC." J.A. 5727. Subsection E of Attachment A, titled "Billing Units," requires providers to report the

appropriate codes to determine the billing units and states that "1 unit of service = 15 minutes." J.A. 5728. Subsection E also provides that "PCS follows wage and hour requirements for rounding billing units (7/8 rule)." *Id.* Section 4.2.2 of Policy 3L explicitly states that PCS will *not* be covered by Medicaid when "the PCS is not documented as completed in accordance with this clinical coverage policy" or when "the PCS is not completed on the date the service is billed." J.A. 5935.

When Policy 3L was being developed, NC Medicaid recognized that the new policy would change how adult care homes would have to bill for PCS. Under Policy 3L, in-home providers record the time they arrive at the beneficiary's home and the time they leave, and NC Medicaid presumes that the time in between was all spent providing reimbursable PCS. So, if the providers are preauthorized to provide PCS for 3 hours in a day but finish in 2 hours, they are only allowed to bill for 2 hours, not 3 hours. Adult care home providers cannot use this in/out method for billing PCS services because the authorized PCS are provided at different times throughout the day and week, in accordance with a Service Plan. Policy 3L requires PCS providers to document the performance of all PCS tasks included in the beneficiary's Service Plan with the date of service, the tasks performed, and the name of the aide providing the service. Policy 3L also requires the provider to document deviations from the Service Plan, *i.e.*, the failure or inability to complete a task under the Service Plan.

The dispute in this case centers on whether Policy 3L's billing units provision applies in the adult care home setting. Plaintiff argues that the language of Policy 3L and the billing units provision clearly require time-based billing for the provision of PCS—

whether those services are provided in the home or in an adult care home. Defendants do not really dispute this, as there is no language in Policy 3L that indicates that adult care homes are exempt from compliance with the time-based billing units provision for the submission of claims to Medicaid. Instead, they argue that NC Medicaid, by way of a third-party question-and-answer document, provided subsequent "guidance" that approved of the use of "task-based" billing instead of "time-based" billing. Under Defendants' interpretation of this Q&A document, they are allowed to bill all of the hours allocated for a day so long as the aide attempted to perform an approved PCS task or sub-task associated with an activity of daily living on that day. Defendants argue, and the majority agrees, that this was a reasonable interpretation of Policy 3L and, therefore, that no reasonable jury could find the requisite scienter. For the reasons set forth below, I disagree.

When we view the evidence in the light most favorable to Plaintiff, as we must, there is sufficient evidence from which a reasonable jury could conclude that, in the face of Policy 3L's clear billing units provision, Defendants' interpretation of the Q&A document was not reasonable and that they "act[ed] in deliberate ignorance of the truth or falsity of the information" or "in reckless disregard of the truth or falsity of the information" presented to Medicaid in support of their requests for reimbursement. 31 U.S.C. § 3729(b).

B.

First, the language in Policy 3L is clear. As discussed above, Attachment A to Policy 3L requires providers to report the appropriate codes to determine the billing units, and states "1 unit of service = 15 minutes" and that "PCS follows wage and hour requirements

for rounding billing units (7/8 rule)." J.A. 5728. Providers are also explicitly notified that PCS will not be covered by Medicaid when the PCS "is not documented as completed in accordance with th[e] clinical coverage policy" or "not completed on the date the service was billed." J.A. 5935.

Second, even if I were to assume that the language in Policy 3L is ambiguous, Defendants sought *no* guidance from NC Medicaid, much less engaged in a reasonable and prudent inquiry under the circumstances.

Tom Stahlschmidt, the person within Defendants' organization responsible for answering questions about Policy 3L, testified that he did not understand why the 15-minute billing units and 7/8 rule were included in Policy 3L. But he made no inquiry to, nor did he seek clarification from, NC Medicaid officials. Instead, Stahlschmidt testified that he had a single conversation with a colleague from another adult care home, and they decided between themselves that the new billing units provision simply could not apply to them because, in their opinion, Policy 3L only required in-home providers to document the performance of the PCS tasks in the Service Plan, and not the time spent on performing them. In other words, they chose not to seek clarification or guidance from NC Medicaid, and they chose not to implement the changes. Contrary to the majority's view, Stahlschmidt's testimony about a single conversation with a colleague does not, in my opinion, rise to the level of a "common industry understanding" that would *preclude* a jury from finding the requisite scienter in this case. *Cf. Skibo*, 841 F. App'x at 533 (finding support for summary judgment for the defendant based upon the actions of "nearly the

entire industry" of similarly situated companies, as well as the views of several trade groups on the issue).

Pam Coffey, who is in charge of Defendants' billing department, likewise failed to educate herself about how Policy 3L applied in the adult care home setting or how the billing units provision applied in the adult care home setting. Coffey testified that all she knew about Policy 3L was "the name of it, and that's pretty much it, as far as knowing that it affected the hours in some way or another." J.A. 2921. She never reviewed any Medicaid bulletins about Policy 3L or any provider "questions and answers" about billing issues under Policy 3L, despite being designated as the person responsible for training accounts receivable specialists on how reimbursement claims for PCS should be submitted.

According to Coffey, the billing departments used a pre-populated spreadsheet that assigned a maximum number of daily billing units based upon the maximum number of hours authorized by Medicaid for the beneficiary per month. The daily maximum was determined by dividing the monthly allowance by the number of days (28, 29, 30, or 31) in the particular month. Using this spreadsheet, Coffey billed Medicare the maximum number of hours authorized per day for every beneficiary present at the facility at midnight, regardless of whether the beneficiary received that amount of care, or any care, that day. For example, if Medicaid authorized 90 hours of PCS per month for a particular patient, and the billing month had 30 days, Defendants automatically billed Medicaid for 3 hours of services per day for that patient, regardless of how much time was *actually* spent providing PCS to the patient. If the beneficiary was in the adult care home at midnight, Coffey simply assumed that the person received all the authorized PCS for that day and

billed Medicaid for every pre-authorized hour. That's it. Under what Defendants describe as a "census-based" billing policy, Defendants continued to bill the maximum permitted hours per diem per beneficiary, without consulting the task logs and without regard to whether and to what extent the PCS were provided. Plaintiff proffered evidence that such bills were sent even where Defendants' task logs showed that the beneficiary had been absent from the facility for most of the day.

Cassandra McFadden is a NC Medicaid employee working in the PCS division. When she was made aware of Coffey's billing method, she stated that she "would not agree that that was the correct thing to do." J.A. 6474. McFadden quite reasonably explained that PCS services must be completed for providers to bill for them. *See* J.A. 6472 ("I would say that providers bill for the services that . . . they provided. . . . Meaning if they didn't provide them, they would not bill."); *see also* J.A. 5935 ("Medicaid shall *not* cover PCS when . . . the PCS is not documented as completed in accordance with this clinical coverage policy" or "not completed on the date the service was billed.") (emphasis added).

The majority essentially ignores this evidence and concludes that no reasonable jury could find the requisite scienter because Defendants received "guidance" from NC Medicaid that they reasonably interpreted as approving "task-based" billing. I disagree.

This so-called "guidance" from NC Medicaid is contained in a Q&A document from QiRePort, a third-party entity. One question asked whether time must be deducted from PCS billing if one of the PCS tasks could not be completed on a given day. NC Medicaid responded that the inability to complete a PCS task "should be documented as a deviation," but "if at least one of the remaining tasks could be completed for the same day, there is no

requirement that *time* should be deducted from the billing of PCS hours." J.A. 5684 (emphasis added). The majority concludes that this guidance "arguably suggests that Policy 3L authorizes providers to bill based on completion of tasks rather than time," and that "so long as the aide completed one of the required tasks within the category, the provider may bill for the full associated PCS hours." Majority Op. at 12.[1] In my view, the Q&A document was not sufficient to completely relieve Defendants of their duty to comply with Policy 3L or engage in a reasonable and prudent inquiry into whether their census-based billing method was proper.

First, there is nothing in NC Medicaid's response that indicates it intended to abandon Policy 3L's time-based billing requirements, much less that NC Medicaid intended to authorize adult care homes to bill the *maximum* authorized hours for PCS every day if any sub-task in any category was attempted that day. If Medicaid intended to authorize adult care homes to bill for the maximum number of preauthorized hours regardless of whether *any* assistance was attempted or provided, there was no reason to discuss when time can or cannot be deducted from the maximum, or whether a task within a category had been attempted or completed. NC Medicaid could have just said that time and the completion of tasks was wholly irrelevant as long as the beneficiary was present in the facility for any part of the day. It did not.

[1] The district court relied heavily upon the deposition testimony of NC Medicaid representatives as validating Defendants purported "task-based" billing. Although the majority finds it unnecessary to address the question of whether this testimony also qualifies as authoritative agency interpretation of Policy 3L, I would note that the deposition testimony did not exist at the time of Defendants' billings and therefore could not have served as guidance or a clarification of Policy 3L.

Second, even if I were to agree that the Q&A document authorized "task-based" billing, Defendants did not employ task-based billing. Defendants used a "census-based" billing which had absolutely nothing to do with the completion of any ADL task or sub-task, or whether any such task was attempted but could not be completed that day. When billing, Defendants did not even consult the task logs. Although Defendants argue that they reasonably interpreted the Q&A document as authorizing "task-based" billing, what they really argue is that it approved their use of "census-based" billing. I fail to see how Defendants could have reasonably interpreted the Q&A document as authorizing a "census-based" billing. Nor can I agree with the majority's view that Defendants reasonably decided that their "census billing method . . . functions as a form of task-based billing." Majority Op. at 12. To state the obvious, task-based billing is based on the aide's performance of tasks; census-based billing is based on the beneficiary's presence in the facility at midnight. But, as the record makes clear, Medicaid does *not* cover PCS when the PCS "is not documented as completed in accordance with th[e] clinical coverage policy" or "not completed on the date the service was billed." J.A. 5935.

And, last—but certainly not least—we should not summarily dismiss Plaintiff's significant expert evidence that Defendants' "census-based" billing method resulted in NC Medicaid being billed for more hours than Defendants' employees could have possibly worked. Plaintiff's expert examined Defendants' billing records and compared them to Defendants' staffing records. As a result of Defendants continued use of what essentially remained a per-diem billing method that encompasses every authorized hour, and their practice of always employing the minimal staffing levels required by law, Defendants

billed Medicaid for more PCS hours than their staff members worked. According to the expert, for every 8 hours a nursing home employee worked, Defendants billed Medicaid for almost 12 hours of PCS, resulting in over 1,900,000 false claims being submitted to the Medicaid program for payment, to the tune of over 40 million dollars. And this assumed, quite conservatively, that the employees provided PCS for the *entire* 8 hours, without a single break. *See United States v. Krizek*, 111 F.3d 934, 942 (D.C. Cir. 1997) (finding that physician and his wife, who was in charge of maintaining billing records, displayed reckless disregard under the FCA for "fail[ing] utterly" to review bills submitted on the doctor's behalf, where "even the shoddiest recordkeeping would have revealed" that the claims sought reimbursement for an excessive number of hours, in some cases for more than 24 hours in a day.").

The majority does not engage with this evidence at all, summarily concluding instead that this "disparity" between the amount of time Defendants billed and the amount of time their employees worked cannot alone support a claim of fraud under federal or state law. Although the majority never explains why the disparity alone is not evidence of fraud, this disparity is not the sole basis for the claim of fraud. As explained above, Plaintiff has also submitted evidence that, in several instances, Medicaid was billed for the maximum number of authorized hours in situations where the beneficiary was absent from the facility for a significant portion of the day.[2]

[2] Defendants and the majority also rely upon a 2016 audit, but it too is insufficient to support summary judgment for Defendants in the face of Plaintiff's evidence. NC Medicaid did not request additional information from Stahlschmidt after he questioned

These are material matters for the jury's determination. Plaintiff has produced sufficient evidence from which a reasonable jury could find that Defendants failed to make a reasonable and prudent inquiry into how Policy 3L affected their billing method and, instead, buried their heads in the sand to maximize their billings. A reasonable jury could find that Defendants "census-billing" practice was not a reasonable interpretation of the Policy or guidance document, and not an "honest mistake" or mere negligence on their part. A reasonable jury could find that Defendants ignored the changes that Policy 3L mandated and engaged in a deliberate method to maximize profits at the expense of the government or, at the very least, deliberate indifference to the time-based billing units provision of Policy 3L to reach the same result. Given the language of Policy 3L, Stahlschmidt's lack of effort to understand Policy 3L, Coffey's wholesale lack of knowledge about Policy 3L's requirements, and the fact that the actual billing method employed did not consider whether any PCS tasks were completed, a reasonable jury could conclude that Defendants displayed a reckless disregard or deliberate indifference to the falsity of their reimbursement claims.

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whether time sheets and time spent needed to be provided. But they do not explain the reason for the audit or why the time records were not necessary to determine whether the computerized *task logs* were properly maintained. While I do not dispute the existence of this evidence, this evidence simply does not answer the question of whether Defendants reasonably interpreted Policy 3L as allowing them to continue to bill the maximum amount of authorized time for PCS services *regardless* of whether *any* PCS services were provided or, if such services were provided at all, how much time their employees spent providing them. At most, it is a matter for the jury's consideration, not a determination that Defendants are entitled to summary judgment.

III.

Although the majority addresses only the question of scienter, the district court also concluded that summary judgment was proper because any false statements made by Defendants were not material. I disagree.

A statement is material under the FCA if it has "a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4); *see Universal Health Services v. U.S. ex rel. Escobar*, 136 S. Ct. 1989, 2002–03 (2016) ("Under any understanding of the concept, materiality looks to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation.") (cleaned up). If Policy 3L requires time-based billing, as I believe it does, then Defendants' bills seeking payment for the maximum authorized daily hours for each patient, regardless of time actually spent with the patient, were materially false. But even if Defendants are right that Policy 3L allows task-based billing, the materiality standard is still met. Policy 3L requires documentation of PCS tasks performed; any failure to perform a scheduled PCS task must be documented as a deviation. While Defendants maintain records of the PCS tasks actually performed, the billing department never sees them. Instead, as discussed above, Defendants bill the maximum daily hours for every patient present at the facility on midnight, without regard to whether the patient actually received all or any part of the authorized PCS. Defendants' maximum-hour billing amounts to an assertion that all authorized PCS tasks were completed, and that assertion is clearly material under a task-based reimbursement system.

IV.

For the foregoing reasons, I would hold that Plaintiff has proffered sufficient evidence to establish a genuine dispute of a material fact regarding the scienter and the materiality elements of his FCA claim and reverse the district court's grant of summary judgment to Defendants. Accordingly, I dissent.