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DOJ's New Nationwide Civil Rights Fraud Initiative: Emerging False Claims Act Risk for the Health Care Industry

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On May 19, 2025, Deputy Attorney General Todd Blanche announced a new Civil Rights Fraud Initiative aimed at using the False Claims Act (FCA) to "aggressively pursue" what the Trump administration deems to be violations of federal civil rights laws. According to the memo, "[o]ne of the most effective ways to [enforce federal civil rights law] is through vigorous enforcement of the False Claims Act . . . against those who defraud the United States by taking its money while knowingly violating civil rights laws."

This new initiative will be jointly led by the Department of Justice's (DOJ's) Civil Rights Division and the Civil Division's Commercial Litigation Branch. And each of the 93 U.S. Attorney's Offices throughout the country must designate an Assistant U.S. Attorney to advance these cases. As with other FCA enforcement, DOJ is actively soliciting whistleblowers to bring cases under this initiative through the FCA's qui tam provisions.

Consistent with the administration's focus on alleged discrimination at college campuses, much of the Blanche Memo focuses on conduct by colleges and universities receiving federal funds. Indeed, shortly before the Blanche Memo was published, *The New York Times* reported that the Trump administration was opening an FCA investigation into whether Harvard University had defrauded the government in connection with its admissions practices. But as explained below, the reach of the Civil Rights Fraud Initiative has the potential to be much more significant, especially in the health care sector.

Opening Pandora's Box for the Health Care Industry?

Though the Blanche Memo specifically references coordination with the Department of Health and Human Services (HHS) among other agencies, the Civil Rights Fraud Initiative does not appear to target any specific industry. Given the amount of federal health care expenditures and the role that the FCA has traditionally played in the health care sector, it is virtually certain that the Blanche Memo will have a sizeable impact on the industry, whether directly through federal enforcement or indirectly by promoting new qui tam actions.

Even before the issuance of the Blanche Memo, the Trump administration had explicitly tied the violation of federal nondiscrimination law to violations of the FCA in health care. On May 1, 2025, DOJ filed a Complaint in Partial Intervention in *United States ex rel. Shea v. eHealth, Inc. et al. (eHealth)*, which alleged that three of the nation's largest Medicare Advantage plans paid kickbacks to brokers to steer patients into their plans. DOJ also alleged that two of the Medicare Advantage plans—Aetna and Humana—paid kickbacks to brokers to steer higher cost beneficiaries with disabilities away from their plans in violation of antidiscrimination laws.

In alleging its antidiscrimination claims, DOJ explicitly relied upon the certifications made by Aetna and Humana in Medicare Advantage contracts as well as Assurances of Compliance, submitted under HHS Form 690, in which the plans agreed that compliance with civil rights laws "constitutes a material condition of continued receipt of Federal financial assistance." DOJ summed up its underlying legal theory of "falsity" this way: "Every time that Aetna and Humana submitted beneficiary data and attestations while limiting and otherwise discouraging enrollment of beneficiaries with disabilities . . . [they] falsely represented compliance with material statutory, regulatory, and contractual requirements to comply with anti-discrimination laws."

And although *eHealth* is an insurance case, hospitals and health systems may face similar risks. As with Medicare Advantage plans, providers applying for participation in Medicare Part A must receive clearance from the HHS Office for Civil Rights (OCR). As part of that process, providers must submit the same HHS Form 690 Assurance of Compliance that served as the basis for the DOJ's discrimination-based FCA claims against Aetna and Humana. That form certifies compliance with a panoply of civil rights

laws, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act. The CMS-1450 claim form used by providers to bill Medicare for inpatient services likewise contains an express certification that the provider will comply with the Civil Rights Act of 1964.

To be sure, express certifications such as these do not automatically make compliance with civil rights laws "material" to the government's payment decisions, it is a relevant factor in the materiality analysis under *Escobar*.[1] Therefore, based on these certifications alone, health care providers could face scrutiny under the new Civil Rights Fraud Initiative in a variety of ways. So, while it is impossible to know in advance what health care programs could ultimately face scrutiny under the new initiative, the following examples are illustrative of the emerging risk posed by these new theories.

DEI, Minority Health, or Health Equity Programs. Title VI of the Civil Rights Act and Section 1557 of the ACA prohibit discrimination on the basis of race in federally funded health care. So, consistent with the Blanche Memo's intent to remove "all" instances of what it considers race-based discrimination in federally funded programs, it is possible that DEI programs and other minority-health focused programs in health care could face scrutiny under the new Civil Rights Fraud Initiative. In fact, on March 7, 2025—even before the Blanche Memo was issued—the Trump administration had announced an investigation under Title VI and Section 1557 into four medical schools and hospitals that were alleged to have been operating programs with race-based criteria, including those relating to medical-residency placement and medical school enrollment. And one recent and prominent example of allegations of race-based discrimination under Title VI in connection with minority or health equity programs was a complaint filed against the Clevland Clinic based on its minority stroke program and minority men's center. Under the new Civil Rights Fraud Initiative, these types of programs could draw DOJ's attention in FCA investigations.

Antisemitism and Religious Conscience Protections. Title VI and Section 1557 also prohibit discrimination in health care on the basis of an individual's place of origin, which may extend in certain circumstances to discrimination on the basis of religion. In fact, under the Biden administration, OCR issued a "Dear Colleague" letter to the health care industry focused on ensuring religious nondiscrimination in federally funded health care programs and activities. OCR has also previously entered into Voluntary Resolution Agreements with health systems to address alleged failures to provide sufficient visitation rights for Jewish patients and their rabbis and kosher electronic devices for virtual visits.

But OCR also enforces other federal protections against discrimination based on conscience and religion. Indeed, several federal statutes protect health care conscience rights, including by prohibiting recipients of federal funds from requiring individual providers to participate in actions that they find religiously or morally objectionable. And

in January 2024, OCR promulgated a revised regulation (entitled "Safeguarding the Rights of Conscience as Protected by Federal Statutes") that sets out the process that OCR will use to investigate complaints of conscience discrimination in health care.[2]

Based on these prohibitions, and consistent with OCR's prior announced investigation of a university for discrimination against Jewish students, health systems could face scrutiny under the Civil Rights Fraud Initiative. Although it is difficult to assess what those claims might look like, it is conceivable that DOJ or whistleblowers could allege FCA claims based on complaints of antisemitic hostility on their campuses, the failure to ensure religious nondiscrimination in visitation and other operations, or the failure to accommodate an individual clinician's conscience preferences, most notably in connection with conscience-related objections to providing abortion-related care, gender-affirming care, or other reproductive care.

Sex Discrimination Related to Gender-Affirming Policies. As noted above, by certifying compliance with Title IX and Section 1557, covered entities represent that they do not engage in discrimination on the basis of sex in health care. In light of the new administration's policies directed at certain practices that seek to affirm transgender individuals, health systems that provide gender-affirming care or otherwise promote gender-affirming policies and practices (including as it relates to promoting culturally competent care, assigning rooms, or permitting access to gender-neutral bathrooms) could face scrutiny under the new initiative. Indeed, one of the Trump administration's early executive orders (presently halted by multiple injunctions) indicated an intent to terminate federal financial assistance from medical institutions providing gender-affirming care to minors. It is therefore conceivable that the administration could extend the goal of this now-enjoined executive order to the new Civil Rights Fraud Initiative.

Any FCA action premised on these theories, however, is subject to the ongoing legal dispute regarding the scope of "sex" discrimination under Section 1557. Specifically, several federal courts have held that Section 1557 prohibits discrimination on the basis of sexual orientation and gender identity, while other courts have enjoined OCR from enforcing any such interpretation.[3] So if the Trump administration seeks to enforce the FCA against hospitals or health systems that provide gender-affirming care or adhere to or promote other gender-affirming policies and practices, it is all the more likely that the U.S. Supreme Court will need to resolve the ongoing dispute over whether Section 1557's prohibition on "sex" discrimination should be interpreted in accord with the its earlier decision in *Bostock v. Clayton County*.[4]

The *Escobar* Materiality Problem

Notwithstanding the emerging risk posed by this new initiative, the Trump administration and relators pursuing discrimination-based FCA claims are likely to face significant difficulty establishing that civil rights violations are, as a general proposition, material to

the government's payment decision. Indeed, as recently as 2022, the Second Circuit affirmed a district court's rejection of an FCA claim premised on underlying alleged nondiscrimination violations based on a lack of "materiality" under the U.S. Supreme Court's *Escobar* decision.[5]

In that case, three qui tam relators alleged that their former employer, a Medicaid provider that operated an adult day health center, had discriminated against patients and prospective patients on the basis of national origin.[6] The state and federal governments had declined to intervene, and the court allowed the three relators to proceed to a bench trial on the "implied false certification" theory that the Medicaid provider submitted false claims for reimbursement because it had "impliedly" and falsely certified its compliance with antidiscrimination laws including Title VI of the Civil Rights Act.[7]

The Second Circuit held, however, that "none of the *Escobar* factors supports a finding of materiality here."[8] Specifically, the court held that the relators produced no evidence that compliance with antidiscrimination laws was expressly designated as a condition of payment and no evidence concerning the government's response to the alleged noncompliance "in the mine run of cases."[9]

Notably, the appeals court also rejected the relators' argument that common sense strongly suggests that statutes prohibiting discrimination are objectively likely to affect the government's decision to pay.[10] In the words of the Second Circuit: "where, as here, there is not a tight fit between the implicit misrepresentation and the service provided, 'broad appeals' to common sense and the asserted 'importance of a given regulatory [or statutory] requirement cannot clear the rigorous materiality hurdle.'"[11] The district court helpfully summed it up this way: "If the FCA is not an 'all-purpose antifraud statute' . . . then it surely is not an all-purpose antidiscrimination statute either."[12]

It's also important to note that, although the Second Circuit affirmed only on the lack of "materiality," the lower court had also dismissed the FCA claims on the basis of a lack of *scienter*. This shows that health care providers will likely have multiple defenses to any investigations or enforcement actions brought under the new Civil Rights Fraud Initiative. And although every FCA case is different, the *Lee* case may prove to be a starting place in the analysis for many courts moving forward, even if its analysis is not dispositive in every case.

Other Key Enforcement Considerations

The *Lee* case above demonstrates that covered health care entities are likely to have strong defenses to certain FCA claims premised on nondiscrimination violations. It is nevertheless worth emphasizing that the False Claims Act is not the only remedy available to DOJ or OCR in these cases.

To the contrary, even where an FCA theory is rejected, the traditional remedies for nondiscrimination violations could remain available to DOJ or OCR. Those traditional remedies include pursuing injunctive relief to prevent future violations and seeking compensatory damages for the individuals harmed and civil monetary penalties payable to the government. And of course, the ultimate sanction of seeking to terminate a provider from participating in federally funded health programs is also an established (if seldom used) threat. For these reasons, many health care entities defending a nondiscrimination investigation enter into a Voluntary Resolution Agreement to conclude the matter. It is possible that DOJ or OCR could pursue these more traditional remedies in parallel with (or in the alternative to) any FCA investigation or enforcement proceeding premised on underlying nondiscrimination violations.

Qui tam relators also pose a distinct risk under this new initiative. The Blanche Memo's call for qui tam relators means that the industry will likely see new complaints based on the administration's policy priorities. But with DOJ's sanctioning of discrimination-based qui tam actions, some relators may also pursue their own versions of these theories with policy objectives different from the Trump administration. A qui tam relator could, for example, attempt to impose FCA liability on a health care entity that fails to provide language assistance services to individuals with Limited English Proficiency or auxiliary aids and services to individuals who are deaf or hard of hearing. Indeed, civil rights commentators have long theorized that the FCA could be used in this way to advance or enforce civil rights in health care.[13]

New Risk to the Health Care Industry Requires Increased Vigilance

Undoubtedly, the new Civil Rights Fraud Initiative has increased the risk facing the health care industry by injecting new energy into theories of "falsity" under the False Claims Act premised on violations of federal nondiscrimination law. Covered health care entities should therefore conduct rigorous reviews of nondiscrimination compliance programs and initiatives and create a proactive defense strategy for FCA investigations or litigation borne out of the Blanche Memo.

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[1] *See Universal Health Servs. v. United States*, 579 U.S. 176, 194 (2016) ("[T]he Government's decision to expressly identify a provision as a condition of payment is relevant, but not automatically dispositive.").

[2] *See* 45 CFR Part 88; 89 Fed. R. 2078.

[3] *Compare Neese v. Becerra*, 640 F. Supp. 3d 668 (N.D. Tex. 2022) *with Prescott v. Rady Children's Hosp.-San Diego*, 265 F. Supp. 3d 1090 (S.D. Cal. 2017).

[4] 590 U.S. 644 (2020).

[5] *See Lee v. N. Metro. Found. for Healthcare, Inc.*, No. 21-2155, 2022 WL 17366627 (2d Cir. Dec. 2, 2022).

[6] *See United States ex rel. Lee v. N. Metro. Found. for Healthcare, Inc.*, No. 13-CV-4933(EK)(RER), 2021 WL 3774185, at *4-7 (E.D.N.Y. Aug. 25, 2021).

[7] *See id.* at *2.

[8] *See Lee*, 2022 WL 17366627 at *2.

[9] *Id.*

[10] *Id.*

[11] *Id.*

[12] *See Lee*, 2021 WL 3774185, at *8 n.9.

[13] *See, e.g.*, Dayna Bowen Matthew, *A New Strategy to Combat Racial Inequality in American Health Care Delivery*, 9 DePaul J. Health Care L. 793 (2005).