No. 19-1149

IN THE

Supreme Court of the United States

UPMC; UNIVERSITY OF PITTSBURGH PHYSICIANS, D/B/A UPP DEPARTMENT OF NEUROSURGERY,
Petitioners,

v.

UNITED STATES OF AMERICA EX REL. J. WILLIAM BOOKWALTER, III, M.D.; ROBERT J. SCLABASSI, M.D.; ANNA MITINA,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FEDERATION OF AMERICAN HOSPITALS, HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA, AND NEW JERSEY HOSPITAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI CURIAE*[1]

The American Hospital Association (AHA) represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. AHA members are committed to improving the health of the communities they serve and to helping ensure that care is available to and affordable for all Americans. The AHA educates its members on healthcare issues and advocates on their behalf so that their perspectives are considered in formulating health policy. One way in which the AHA promotes the interests of its members is by participating as *amicus curiae* in cases with important and far-ranging consequences for their members—including cases arising under the False Claims Act (FCA). *E.g.*, *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016); *Schindler Elevator Corp. v. United States ex rel. Kirk*, 563 U.S. 401 (2011); *Rockwell Int'l Corp. v. United States*, 549 U.S. 457 (2007)

The Association of American Medical Colleges is a not-for-profit association representing all 155 accredited U.S.; nearly 400 major teaching hospitals and health systems; and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and more than

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[1] Pursuant to Supreme Court Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amici*, their members, and their counsel made a monetary contribution intended to fund the preparation or submission of this brief. The parties have consented to the filing of this brief.

their nearly 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The Hospital and Healthsystem Association of Pennsylvania (HAP) is the statewide membership services organization that advocates for nearly 240 Pennsylvania acute and specialty care, primary care, subacute care, long-term care, home health, and hospice providers, as well as the patients and communities they serve.

The New Jersey Hospital Association (NJHA) has served as New Jersey's premier healthcare association since its inception in 1918. NJHA currently has over 400 members across the healthcare continuum including hospitals, health systems, nursing homes, home health, hospice, and assisted living, all of which unite through NJHA to promote their common interests in providing quality, accessible and affordable healthcare in New Jersey. In furtherance of this mission, NJHA undertakes research and healthcare policy development initiatives, fosters public understanding of

healthcare issues, and implements pilot programs designed to improve clinical outcomes and enhance patient safety. NJHA regularly appears before all three branches of government to provide the judiciary and elected and appointed decision makers with its expertise and viewpoint on issues and controversies involving hospitals and health systems.

Amici's member-hospitals are obvious targets in FCA lawsuits: they are heavily regulated and receive a majority of their reimbursement for providing care from government healthcare programs. Together, those two factors make them vulnerable to abusive FCA lawsuits. For that reason alone, the question presented in this case is of tremendous importance to *amici*'s members.

The Third Circuit's erroneous decision makes *amici*'s participation even more important. If upheld, the Third Circuit's reasoning will likely cause FCA lawsuits to increase dramatically—especially against hospitals. Consequently, the decision poses risks to hospitals of all sizes and forms, and it will almost certainly divert scarce resources from hospitals' core mission of providing care to patients and improving the health of their communities. *Amici* therefore have the strongest possible interest in ensuring that this Court restores the correct application of the FCA.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case presents a question of tremendous importance: whether a plaintiff can plausibly allege a violation of the False Claims Act (FCA) by claiming that the defendant knowingly violated an ambiguous regulatory provision that has not been definitively construed prior to that defendant's case. Here, there is no doubt that the relevant regulatory provision (the Stark Act) is ambiguous, at best. The Third Circuit had never interpreted the provision before this case, and its opinion rightly stated that its interpretation of the Stark Act "may not be obvious on the face of the statute and regulations." *United States ex rel. Bookwalter v. UPMC*, 946 F.3d 162, 171 (3d Cir. 2019). To make matters worse, while the case was pending before the Third Circuit, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that interpreted the Stark Act differently from the Third Circuit's non-obvious interpretation and in exactly the same way as defendants interpreted it. *See Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations*, 84 Fed. Reg. 55,766, 55,795 (Oct. 17, 2019). Nevertheless, the Third Circuit held that the plaintiffs plausibly alleged scienter under the FCA.

As Petitioners explained, the "question this petition presents is relevant to *every* potential FCA defendant." Pet. 26. But it is *especially* important to hospitals. *Amici*'s members are among the most highly regulated entities in the modern economy. Those regulations are complex, technical, and often defy easy interpretation. Yet under the Third Circuit's

rule, hospitals face costly and protracted FCA litigation whenever they choose an interpretation of one of the thousands of ambiguous statutes or regulations that govern them. This is not "fair notice," and it is certainly not a "rigorous" application of the FCA's "scienter requirements." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2002 (2016). Quite the opposite, the Third Circuit's rule is a broad license for relators to bring FCA suits against hospitals and other healthcare providers across the country.

As it is, hospitals face a disproportionate amount of FCA litigation. Statistics show that healthcare entities are already defendants in roughly *two-thirds* of all FCA cases. *See* U.S. Dep't of Justice, *Fraud Statistics - Overview: October 1, 1986 - September 30, 2019*, 1-2, https://www.justice.gov/opa/press-release/file/1233201/download. What is more, even setting aside the costs of litigating these cases, the risks of fighting FCA suits to the finish line are staggering. "The combination of the Stark law and the FCA often yields astronomical exposure for the defendants (recoupment, plus treble damages, attorneys' fees and civil penalties . . .)." American Health Lawyers Association, *A Public Policy Discussion: Taking the Measure of the Stark Law*, at 16 (2009), *available at* https://www.ebglaw.com/content/uploads/2014/06/30455_DMatyas.pdf. Given the sheer volume of FCA suits against hospitals and the "potentially ruinous" consequences of losing them, *id*., the pressure to settle FCA claims that survive a motion to dismiss—even meritless ones—is overwhelming.

Adopting the Third Circuit's rule would make this untenable situation even worse. If all a *qui tam* relator needs to do to survive a motion to dismiss is allege that a hospital violated an ambiguous statute or regulation, then hospitals will routinely face years of FCA litigation, millions of dollars of costs, and immense pressures to settle. This is particularly dangerous because "most U.S. hospitals typically operate on thin margins," and recent financial reporting indicates that "the fiscal fortunes of the nation's hospitals are apparently shrinking." Ron Shinkman, *Ratings agencies issue foreboding reports on hospital finances as AHA seeks $100B to respond to COVID-19*, Health Care Dive (March 20, 2020), https://www.healthcaredive.com/news/ratings-agencies-issue-foreboding-reports-on-hospital-finances-as-aha-seeks/574541/. Exposing hospitals to even greater uncertainty and FCA exposure will only exacerbate this precarious financial state.

Congress could not have intended this result. After all, the "law frowns on playing 'gotcha.'" *LM Ins. Corp. v. ACEO, Inc.*, No. 08-2372, 2010 WL 1655206 (N.D. Ill. April 16, 2010). It cannot be that Congress wished to expose FCA defendants to suit after suit simply because a court later determines they misinterpreted a complicated statute or regulation. *See Escobar*, 136 S. Ct. at 2003 ("The False Claims Act is not . . . a vehicle for punishing garden-variety . . . regulatory violations."). For that reason, the contrary rule set forth by the Eighth and D.C. Circuits better effectuates Congress's intent in enacting a rigorous scienter requirement under the FCA. *See United States ex rel. Purcell v. MWI Corp.*, 807 F.3d 281, 287 (D.C. Cir. 2015);

United States ex rel. Hixson v. Health Mgmt. Sys., Inc., 613 F.3d 1186, 1189 (8th Cir. 2010).

This Court should grant certiorari to reverse the Third Circuit's incorrect and dangerous rule. In so doing, it will ensure that FCA defendants—and especially hospitals—do not face the destructive consequences that flow from the Third Circuit's "gotcha" scienter rule.

ARGUMENT

I. The Third Circuit's Rule Will Harm Hospitals, Causing Limited Resources To Be Shifted Away From Their Core Mission Of Delivering Healthcare

A. *Qui Tam* Lawsuits Disproportionately Target Hospitals and Other Healthcare Entities.

FCA lawsuits have increased substantially in recent decades. *See* U.S. Dep't of Justice, *Fraud Statistics - Overview: October 1, 1986 - September 30, 2019*, 1-2, https://www.justice.gov/opa/press-release/file/1233201/download (371 new FCA matters in FY1987 compared to 782 new FCA matters in FY2019). This growth has been driven primarily by suits in which the government has declined to participate. While the United States has filed slightly less than one hundred and fifty FCA cases in each of the last few years, *qui tam* relators have filed almost five times as many—681 in 2017, 646 in 2018, and 636 in 2019. *See id.* at 2; U.S. Dep't of Justice, *Deputy Associate Attorney General Stephen Cox Gives Remarks to the Cleveland, Tennessee, Rotary Club* (March 12, 2019), https://www.justice.gov/opa/speech/deputy-associate-

attorney-general-stephen-cox-gives-remarks-cleveland-tennessee-rotary ("*Qui tam* filings have been on the rise for many years. We might see 600 or 700 new *qui tam* lawsuits in a given year. The Department takes over—or 'intervenes' in—about 20% of the cases that are filed.").

These suits disproportionately target healthcare entities, including *amici's* members. Of the 782 new FCA matters filed in 2019, for example, 505 involved healthcare defendants. *See id.* at 5 (identifying number of FCA cases involving the Department of Health and Human Services as the primary client agency). That is nearly *two-thirds* of the new matters filed that year. The statistics are even more striking when comparing only relator-filed *qui tam* cases. Nearly *seventy percent* of those case were filed against healthcare entities. *Id.* at 2, 5 (449 of 636 cases). This stands in stark contrast to 1987, when only 15 of the 371 cases—a mere *four percent*—involved healthcare entities. *Id.* at 1, 4.

Hospitals are prime targets for *qui tam* lawsuits. Most important here, hospitals are subject to numerous complicated and ambiguous statutes and regulations. "Almost every aspect of the field is overseen by one regulatory body or another, and sometimes by several." Robert I. Field, *Why Is Health Care Regulation So Complex?,* 33 Pharmacy & Therapeutics 607, 607 (Oct. 2006), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2730786/pdf/ptj33_10p607.pdf. By one count, 130,000 pages of rules govern healthcare providers, with Medicare rules comprising over 100,000 of those pages. Victor E. Schwartz & Phil Goldberg, *Carrots and Sticks: Placing Rewards As Well As Punishment in Regulatory*

and Tort Law, 51 Harv. J. on Legis. 315, 350 (2014). That volume, on its own, would be enough to make hospitals a prime target for FCA suits. But more to the point, those tens of thousands of pages contain uniquely complex rules that frequently defy straightforward interpretation.

Courts consistently recognize the challenge for hospitals, physicians, and other providers in trying to comply with these rules and regulations. This Court, for instance, has referred to the statutes governing Medicare and Medicaid as "among the most intricate ever drafted by Congress." *Schweiker v. Gray Panthers,* 453 U.S. 34, 43 (1981). And one court of appeals may have said it best when it observed that "clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes." *Beverly Cmty. Hosp. Ass'n v. Belshe,* 132 F.3d 1259, 1266 (9th Cir. 1997); *see Abraham Lincoln Mem'l Hosp. v. Sebelius*, 698 F.3d 536, 541 (7th Cir. 2012) (describing the Medicare and Medicaid rules as "among the most completely impenetrable texts within human experience" (internal quotation marks omitted)). With such a confounding regulatory environment, opportunistic relators can easily allege that hospitals violated some ambiguous law and thereby defrauded the government.

In addition, hospitals are uniquely vulnerable to potentially costly FCA litigation because of the way in which healthcare claims are submitted and reimbursed. Specifically, hospitals submit a large number of individual claims to the federal government in connection with healthcare programs like Medicare and Medicaid, and they receive a substantial amount of federal funds for providing care to their patients. In

2018, for example, Medicare spent $147.4 billion on inpatient hospital services alone. Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, 4 (June 2019), http://www.medpac.gov/docs/default-source/data-book/jun19_databook_entirereport_sec.pdf?sfvrsn=0. Moreover, claims typically are submitted in far smaller dollar amounts, since they are broken down by each service provided. *See, e.g.*, Joan H. Krause, *Twenty-Five Years of Health Law Through the Lens of the Civil False Claims Act,* 19 Annals Health L. 13, 15 (2010) ("Unlike in the defense industry, where a contractor may submit a small number of very large payment requests to the government each year, physicians submit thousands of bills for relatively small amounts. In the defense context, treble damages are likely to be the major deterrent, with the additional $11,000 per-claim penalty merely a nuisance. For a physician, in contrast, the per-claim penalties may rise quickly even as treble damages remain small."); Patricia Meador & Elizabeth S. Warren, *The False Claims Act: A Civil War Relic Evolves into a Modern Weapon,* 65 Tenn. L. Rev. 455, 456 (1998) (hospitals are "particularly susceptible to actions under the False Claims Act due to the many [claim] forms health professionals must sign in order to receive compensation from federal health care programs"). This vastly increases the number of claims that can be included in a single FCA suit.

The likelihood of significant penalties and damages further attracts opportunistic *qui tam* relators. Under the FCA's lengthy statute of limitations, literally hundreds of thousands of claims can be at issue. Under its treble damages provision, a hospital could

be held liable for three times the claimed amount (without regard to the costs the provider actually incurred to provide the services). And today's per-claim penalties are up to $22,331 per claim (and in some states *double* that if Medicaid claims are at issue), meaning that even small dollar claims quickly amount to monumental liabilities. Civil Monetary Penalty Inflation Adjustment, 85 Fed. Reg. 1832-01, 1832 (Jan. 13, 2020). Consequently, even where the government suffers little or no actual harm, relators may still seek enormous penalties based on the view that the FCA requires a separate penalty for *each and every* false claim submitted to the government. *See, e.g.,* Joan H. Krause, *"Promises to Keep": Health Care Providers and the Civil False Claims Act,* 23 Cardozo L. Rev. 1363, 1370 (2002) (relators often rely on vast numbers of small-value Medicare or Medicaid claims to threaten astronomical penalties).

Given the complexity of the rules and regulations that govern hospitals and the way hospitals do business with the government, *amici*'s members depend on the FCA's "rigorous" scienter requirement to protect them from unintended FCA exposure. *Escobar*, 136 S. Ct. at 2002. As this Court has explained, the FCA's scienter requirement is supposed to ensure "fair notice" and address concerns that the FCA will impermissibly provide "open-ended liability." *Id*. Even now, however, that standard barely protects hospitals from costly *qui tam* lawsuits that, as explained below, are often meritless. Now imagine what would happen if relators could simply allege that a hospital violated one of the hundreds of ambiguous healthcare provisions that pervade the Code of Federal Regulations or the U.S. Code? The answer is obvious. Adopting the

Third Circuit's "gotcha" scienter rule will make hospitals even more attractive FCA targets.

B. Most *Qui Tam* Suits Lack Merit.

This case shares a common feature with most modern *qui tam* suits: the United States "declined to intervene as to the claims for hospital services, but it let the relators maintain that part of the action in its stead." *UPMC*, 946 F.3d at 167. In fact, despite the growing number of new FCA matters each year, the United States continues to decline to intervene in the overwhelming majority of them. *See* Eric Topor, *Intervention in False Claims Act Lawsuits: Is It Make or Break?,* Bloomberg Law (Apr. 24, 2017); *see also* U.S. Dep't of Justice, *False Claims Act Cases: Government Intervention in Qui Tam (Whistleblower) Suits,* at 2 (June 13, 2012).

As such, in the majority of FCA cases relators are left to pursue their claims—and their own pecuniary interests—in the name of the United States, but unrestrained by government oversight, direction, or prosecutorial discretion. *See Hughes Aircraft Co.* v. *United States ex rel. Schumer,* 520 U.S. 939, 949 (1997) *("Qui tam* relators are . . . less likely than is the Government to forgo an action arguably based on a mere technical noncompliance with reporting requirements that involved no harm to the public fisc."); *see also* Michael Rich, *Prosecutorial Indiscretion: Encouraging the Department of Justice to Rein in Out-of-Control Qui Tam Litigation Under the Civil False Claims Act,* 76 U. Cin. L. Rev. 1233, 1264-65 (2008) ("The result is that the government does not dismiss, and relators are permitted to proceed with, thousands of non-meritorious qui tam suits."). As in this case, such unrestrained use of the government's

false claims authority creates serious financial risks for hospitals.

A substantial number of declined *qui tam* suits are dismissed or resolved pre-trial, but often only after burdensome and expensive dispositive motion litigation and discovery. According to a comprehensive empirical analysis of suits from 1987 to 2004, 92% of cases in which the U.S. declined to intervene were dismissed without recovery. Christina Orsini Broderick, *Qui Tam Provisions and the Public Interest: An Empirical Analysis,* 107 Colum. L. Rev. 949, 974-975 (2007). Thus, *less than 10%* of non-intervened private *qui tam* actions actually result in recovery, with *more than 90%* dismissed as frivolous or otherwise without merit. *Id.* That study concluded that the high rate of dismissal "lends strong support to the conclusion that *qui tam* statutes result in many frivolous claims." *Id.*; *see also Riley v. St. Luke's Episcopal Hosp.,* 252 F.3d 749, 767 n.24 (5th Cir. 2001) (Smith, J., dissenting) (noting that "[o]f the 1,966 [of all *qui tam*] cases that the government has refused to join, only 100 have resulted in recoveries (5%)"); Todd J. Canni, *Who's Making False Claims, The Qui Tam Plaintiff or the Government Contractor? A Proposal to Amend the FCA to Require That All Qui Tam Plaintiffs Possess Direct Knowledge,* 37 Pub. Cont. L.J. 1, 9 (2007) (a statistical analysis of *qui tam* filings evidences that the "majority of *qui tam* actions lack merit.").

DOJ statistics confirm that the vast majority of declined cases do not lead to sizeable recoveries. Since 1987, only 6% of the total amount of recovery from *qui tam* settlements and judgments have come from cases where the government declined to intervene. *See DOJ*

Fraud Statistics, supra, at 3 (calculated by dividing the total recovery in declined *qui tam* cases by the total recovery in all *qui tam* cases). And the amount is *even lower* for healthcare cases. *Id.* at 6 (declined cases account for 6% of recoveries). Indeed, "[t]he bulk of the $2.4 billion recovered by the federal government in 2016 from health-care [FCA] settlements and judgments came from cases in which the Justice Department intervened." Topor, *Intervention in False Claims Act Lawsuits, supra.* Scholars have correctly drawn the only possible conclusion from the "immense disparity between recoveries in *qui tam* actions in which the Government intervened and those in which it did not." Sean Elameto, *Guarding the Guardians: Accountability in Qui Tam Litigation Under the Civil False Claims Act*, 41 Pub. Cont. L.J. 813, 826 (2012). They have found that most *qui tam* actions brought without government intervention assert "meritless or frivolous claims." *Id*.

The Department of Justice itself has admitted that it "declines to intervene in some cases due to the lack of legal or factual support." U.S. Dep't of Justice, *Acting Associate Attorney General Jesse Panuccio Delivers Remarks at the American Bar Association's 12th National Institute on the Civil False Claims Act and Qui Tam Enforcement* (June 14, 2018), *available at* https://www.justice.gov/opa/speech/acting-associate-attorney-general-jesse-panuccio-delivers-remarks-american-bar. A recent example illustrates the point. In late 2018, the United States moved to dismiss 10 meritless FCA complaints filed by 10 different limited liability companies created by National Health Care Analysis Group (NHCA Group) in *qui tam* suits against pharmaceutical companies.

See, e.g., Memorandum of Law in Support of the United States' Motion to Dismiss, *United States ex rel. SMSF, LLC v. Biogen, Inc.*, No. 16-11379 (D. Mass. Dec. 17, 2018), ECF No. 53.[2] In its motion, the government explained that the relator was "a corporate entity created by an investment group that exists solely to file *qui tam* actions," and it had no "inside knowledge" of the relevant industry. *Id*. at 1. In fact, when NHCA Group's managing agent spoke to the media shortly before filing its *qui tam* actions, he explained that CMS's decision to make Medicare claims data available to the public was "a massive

[2] The NHCA case was atypical in one significant respect. Even though the United States has the statutory authority to move to dismiss relator cases under 31 U.S.C. § 3730(c)(2)(A), dismissal motions like those filed in the NHCA cases are exceedingly rare. Indeed, DOJ itself has explained that it historically exercised this dismissal authority "sparingly," *i.e*., "one or two cases in a given year." U.S. Dep't of Justice, *Deputy Associate Attorney General Stephen Cox Gives Remarks to the Cleveland, Tennessee, Rotary Club*, https://www.justice.gov/opa/speech/deputy-associate-attorney-general-stephen-cox-gives-remarks-cleveland-tennessee-rotary. For this reason, Judge Bibas was overconfident when he stated in the panel's *original opinion* that "[f]ederal courts are not the first line of defense against abusive suits; the Justice Department is. Indeed, it recently took a more aggressive approach to dismissing qui tam actions, urging its lawyers to consider dismissal every time the government decides not to intervene." *United States, ex rel. Bookwalter v. UPMC*, 938 F.3d 397, 417 (3d Cir. 2019). Notably, the panel removed that language from its *revised opinion*. And for good reason. Even the author of the DOJ memo referenced in the original panel decision has acknowledged the rarity of DOJ dismissal motions under Section 3730(c)(2)(A), stating that "dismissal will remain the exception rather than the rule." *See* Jeff Overley, *DOJ Atty Warns FCA Targets On Discovery Tactics*, Law360 (Mar. 1, 2019), https://www.law360.com/articles/1134479/doj-atty-warns-fca-targets-on-discovery-tactics.

business opportunity" for firms like his to file *qui tam* suits. J.C. Herz, *Medicare Scammers Steal $60 Billion a Year. This Man is Hunting Them,* Wired (Mar. 7, 2016, 6:45 AM).

The government described why dismissal was appropriate in the NHCA case. It explained that "it would have to spend considerable time and effort monitoring court filings, filing statements of interest, and responding to requests for substantial amounts of discovery." Memorandum at 10, *Biogen, Inc.*, No. 16-11379 (D. Mass. Dec. 17, 2018). It further noted that

> [a]nticipated discovery burdens include the expense of collecting, reviewing, processing, and producing documents from among multiple federal healthcare programs, as well as voluminous prescription drug event data and patient health information for potentially thousands of beneficiaries, which, due to its sensitive nature, may require additional (and costly) screening and redaction. Moreover, the government also likely would spend considerable time preparing numerous agency witnesses for depositions.

Id. at 11.

Critically, the government would have to do these things even though it was *not a party* to the case. Hospitals are not so lucky. Even where the government chooses to decline participation, defendant-hospitals are left to fend off expensive, meritless lawsuits.

The Third Circuit's rule makes this problem far worse. Under the Third Circuit's expansive scienter

rule, an FCA plaintiff's "business opportunity" now becomes a hospital's burden. This Court should grant certiorari to ensure that hospitals do not face such unintended burdens—and their patients do not suffer as limited resources are shifted from patient care to litigation costs.

C. Defending *Qui Tam* Actions Is Expensive And Diverts Resources From The Delivery Of Healthcare Services.

Defending declined *qui tam* cases already is extraordinarily expensive and disruptive. "[M]ost non-intervened suits exact a net cost," as defendants expend financial resources to defend against meritless claims and suffer unwarranted harm to their reputations. Rich, *Prosecutorial Indiscretion, supra,* 76 U. Cin. L. Rev. at 1264; *see* Canni, *Who's Making False Claims, supra,* 37 Pub. Cont. L.J. at 2 ("The casualties of the dismissed suits are not the plaintiffs. Rather, it is the government contractor whose reputation is tarnished and who is now without hundreds of thousands of dollars or possibly on the verge of bankruptcy after having defended against speculative allegations.").

Unsurprisingly, healthcare defendants disproportionately bear the burden of these costs, while also facing different cost-benefit analyses than other FCA defendants. Hospitals must consider defense costs, the magnitude of potential liability, reputational harms, <u>and</u> the possibility of an adverse decision resulting in exclusion from participation in federal healthcare programs. *See, e.g.,* 31 U.S.C. §§ 3729(a)(1), 3730(d); 42 U.S.C. §§ 1320a-7,

1396a(a)(39).[3] *See* David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust "Reposed in the Workmen,"* 30 J. Legal Stud. 531, 552 (2001) ("Providers who believe they are blameless are under tremendous pressure to settle because of . . . the high probability of bankruptcy and professional disgrace if the jury does not see things the same way the provider does."). What is more, for healthcare providers, questionable and meritless FCA cases divert enormous resources away from providers' core responsibility: caring for patients. *See* Keith D. Barber et al., *Prolific Plaintiffs or Rabid Relators? Recent Developments in False Claims Act Litigation,* 1 Ind. Health L. Rev. 131, 172 (2004) ("unjust settlements . . . often include payment of penalties that further divert resources from the provision of health care"); *see generally See Texas Dep't of Housing & Community Affairs v. Inclusive Communities Project, Inc.*, 135 S. Ct. 2507, 2550 (2015) (observing that "the costs of litigation, including the expense of discovery and experts, may push cost-conscious defendants to settle even anemic cases. Defendants may feel compelled to abandon substantial defenses and . . . pay settlements in order to avoid the expense and risk of going to trial" (internal citations and quotation marks omitted)).

There can be no doubt that hospitals have limited resources. "For years, hospitals have struggled to reduce costs amid shrinking patient numbers and slowing revenue growth, while also adjusting to changing reimbursement structures and demands of

[3] Once excluded, entities may not submit claims for items or services and will not be reimbursed for any item or service furnished. 42 C.F.R. § 1001.1901.

other healthcare industry participants such as insurers and employers." Rita Sverdlik et al., *Research Announcement: Moody's - US not-for-profit hospital profitability holds steady in FY 2018 after two years of declines*, Moody's Investors Service (April 25, 2019), *available at* https://www.moodys.com/research/Moodys-US-not-for-profit-hospital-profitability-holds-steady-in--PBM_1172741?showPdf=true. As a result, "most U.S. hospitals typically operate on thin margins" and recent financial reporting indicates that "the fiscal fortunes of the nation's hospitals are apparently shrinking." Shinkman, *Ratings agencies issue foreboding reports on hospital finances as AHA seeks $100B to respond to COVID-19*, *supra*. One recent study of hospital financial wellbeing found that non-profit hospital systems produce average operating margins of only 2.53%, and their investor-owned or managed peers fare little better, earning a margin of only 3.38%. *See* Jeff Goldsmith et al., *Stiffening Headwinds Challenge Health Systems to Grow Smarter,* at 2, Navigant (Sept. 2018), *available at* https://perma.cc/EC88-PR9Y. It therefore comes as no surprise that Moody's Investors Services recently changed its "outlook for the US not-for-profit and public healthcare sector" from stable to negative, concluding that the "difficulties facing hospitals come amid increasing cash flow constraints, such as a greater reliance on reimbursement from governmental programs and a continued shift in treatment to less costly settings" Moody's Investors Service, *Not-for-profit and Public Healthcare - US: Outlook Changes to Negative as Coronavirus Accentuates Cash Flow Constraints*, at 1 (March 18, 2020), *available at* https://www.moodys.com/research/Not-for-profit-and-

public-healthcare-US-Outlook-changes-to--PBM_1219351.

At the same time, the costs of providing care and operating hospitals continue to increase. For example, the average amount spent on drugs for each person admitted to a hospital increased by 18.5 percent between 2015 and 2017, NORC, *Recent Trends in Hospital Drug Spending and Manufacturer Shortages,* at 2 & n.1 (Jan. 15, 2019), *available at* https://www.aha.org/system/files/2019-01/aha-drug-pricing-study-report-01152019.pdf, and an average-sized community hospital spends nearly $7.6 million annually to comply with federal regulations, Am. Hosp. Ass'n, *Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers,* at 4 (October 2017), *available at* https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf. In addition, hospitals continue to be underpaid by Medicare and Medicaid—the very programs that generate FCA lawsuits. For Medicare, hospitals received payment of only 87 cents for every dollar spent by hospitals caring for Medicare patients in 2018; for Medicaid, hospitals received payment of only 89 cents for every dollar spent by hospitals caring for Medicaid patients in 2018. Am. Hosp. Ass'n, *Fact Sheet: Underpayment by Medicare and Medicaid,* at 2 (January 2020), *available at* https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid. In total, combined underpayments were $76.6 billion in 2018. *Id*. With slim margins, increasing operating costs, and less money coming in from the government than hospitals need, the threat posed by the cost of defending against a meritless *qui tam* is self-evident.

A motion to dismiss is often an FCA defendant's last line of defense against substantial litigation or settlement costs. Exposing hospitals to discovery and protracted litigation for good-faith—but ultimately incorrect—interpretations of ambiguous regulations leaves them without important legal protections when they need them most. Regrettably, the Third Circuit's misguided FCA scienter rule eviscerates that vital protection. Hospitals and the patients they serve will be the first to suffer.

II. The Eighth Circuit's and D.C. Circuit's Rule Is More Consistent With the FCA's Intent and Avoids The Deleterious Consequences of the Third Circuit's Rule

Petitioners have persuasively explained how the Third Circuit's decision conflicts with several other courts of appeals, Pet. 19-25, and why that circuit split is especially problematic in light of the FCA's broad venue provision, *id*. at 30; *see* 31 U.S.C. § 3732(a) (permitting a relator to sue wherever a defendant "can be found, resides, transacts business, or in which any act proscribed by" the FCA occurred). *Amici* need not repeat those arguments here. That said, it is important to explain why the Eighth Circuit's and D.C. Circuit's conflicting scienter rule is more consistent with the FCA's intent and will *not* lead to the adverse consequences for hospitals described above.

The Eighth and D.C. Circuits have adopted a rule that is the polar opposite of the Third Circuit's. In those jurisdictions, a defendant does not have the requisite scienter under the FCA if it follows a reasonable interpretation of an ambiguous regulatory

provision, unless a court has already definitively interpreted that provision. *E.g.*, *United States ex rel. Hixson v. Health Mgmt. Sys., Inc.*, 613 F.3d 1186, 1190 (8th Cir. 2010) ("[W]e need not decide whether the defendants correctly interpreted § 147.136 since a statement that a defendant makes based on a reasonable interpretation of a statute cannot support a claim under the FCA if there is no authoritative contrary interpretation of that statute. That is because the defendant in such a case could not have acted with the knowledge that the FCA requires before liability can attach."); *United States ex rel. Purcell v. MWI Corp.*, 807 F.3d 281, 287-288 (D.C. Cir. 2015) ("To be liable under the FCA, a defendant must have made the false claims knowingly. . . . Consistent with the need for a knowing violation, the FCA does not reach an innocent, good-faith mistake about the meaning of an applicable rule or regulation. Nor does it reach those claims made based on reasonable but erroneous interpretations of a defendant's legal obligations. As this court has recognized, establishing 'even the loosest standard of knowledge, i.e., acting in reckless disregard of the truth or falsity of the information' is difficult when falsity turns on a disputed interpretive question." (internal citations and quotation marks omitted)); *United States ex rel. K & R Ltd. P'ship v. Mass. Hous. Fin. Agency*, 530 F.3d 980, 983-984 (D.C. Cir. 2008) ("In this False Claims Act case, we face a similar question involving a mortgage subsidy program initiated in that era: Is this fraud, or is it . . . just confusion? . . . At bottom, K & R and MassHousing simply disagree about how to interpret ambiguous contract language. Given that and K & R's inability to point to anything that might have warned [MassHousing] away from the view it

took, there is no genuine issue as to whether MassHousing knowingly presented false claims to HUD." (internal citation and quotation marks omitted)).

The D.C. Circuit's decision in *Purcell* is instructive. There, the United States brought an FCA suit against MWI Corp. based on certifications it made to the Import-Export Bank to secure loans financing the sale of water pumps to Nigeria. The Import-Export Bank required MWI to certify that it had paid only "regular" commissions to the sales agent responsible for the water pump contract. But at the time, there was no definitive interpretation of the term "regular commission" and the parties themselves agreed that the term "is ambiguous." *Purcell*, 807 F.3d at 288. In fact, the district court found that there could be three different standards for a "regular" commission: "industry-wide, intra-firm, or individual-agent." *Id*. MWI acted in accordance with one of those interpretations. It certified that it had paid only "regular" commissions because their payments for the Nigerian water contracts were "consistent with what MWI had been paying [the sales agent] for over twelve years and were calculated using the same formula MWI used to determine commissions for all of its agents." *Id*. at 288-289. In those circumstances, the court of appeals found, the government could *not* allege FCA scienter because the MWI followed an "objectively reasonable interpretation of an ambiguous provision." *Id*. at 288.

In stark contrast, the government's complaint could have survived a motion to dismiss in the Third Circuit. It would not have mattered that the term "regular commission" was ambiguous. Nor would it

have mattered that there were numerous reasonable interpretations of that term. The government's complaint could have proceeded to discovery so long as the court of appeals decided—for the first time in that very case—that MWI's interpretation of "regular commission" was incorrect. MWI would then face enormous discovery costs, serious litigation risks, and immense pressure to settle.

The contrast between the two rules therefore could not be any clearer. If this case were brought a few hundred miles down I-95, then UPMC could act safely in the knowledge that its reasonable, good-faith interpretation of the Stark Act shielded it from the risks and burdens of FCA litigation. Opportunistic relators would not be allowed to pressure hospitals and healthcare providers—all of whom act in an uncertain and complex regulatory environment—with threats of costly lawsuits and demands for settlement. And hospitals could focus their undivided attention and more of their resources on patient care, rather than abusive FCA suits that some now view as lucrative business opportunities. To avoid the devastating consequences on hospitals that are described above, this Court should grant certiorari and adopt the Eighth Circuit's and D.C. Circuit's rule for FCA scienter.

CONCLUSION

For the reasons stated above and those stated in the Petition for Writ of Certiorari, the Petition should be granted.

Respectfully submitted,

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