No. 19-56367

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

UNITED STATES EX REL. INTEGRA MED ANALYTICS LLC,

Plaintiff-Appellee,

OFFICIAL COMMITTEE OF UNSECURED CREDITORS,

Petitioner-Intervenor,

v.

PROVIDENCE HEALTH AND SERVICES, ET AL.,

Defendants-Appellants.,

Interlocutory Appeal from the United States District Court for the Central District of California, No. 2:17-cv-01694-PSG-SS District Judge Philip S. Gutierrez

BRIEF OF AMICI CURIAE THE AMERICAN HOSPITAL ASSOCIATION, THE CALIFORNIA HOSPITAL ASSOCIATION, AND THE WASHINGTON STATE HOSPITAL ASSOCIATION IN SUPPORT OF DEFENDANTS-APPELLANTS

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CORPORATE DISCLOSURE STATEMENT

Amici Curiae the American Hospital Association, The California Hospital Association, and the Washington State Hospital Association are non-profit organizations. They have no parent corporations and do not issue stock.

Date: July 2, 2020

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STATEMENT OF INTEREST[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) and its *qui tam* provisions.

The California Hospital Association (CHA) is one of the largest hospital trade associations in the nation, serving more than 400 hospitals and health systems and 97 percent of the general acute care and psychiatric acute patient beds in California. CHA's members include all types of hospitals and health systems: non-profit; children's hospitals; those owned by various public entities, including cities/counties, local health care districts, the University of California, and the

[1] In accordance with Federal Rule of Appellate Procedure 29(a)(4)(E), amici certify that (1) this brief was authored entirely by counsel for amici curiae and not by counsel for any party, in whole or part; (2) no party or counsel for any party contributed money to fund preparing or submitting this brief; and (3) apart from amici curiae and their counsel, no other person contributed money to fund preparing or submitting this brief.

Department of Veterans Affairs; as well as investor-owned. The vision of CHA is an "optimally healthy society," and its goal is for every Californian to have equitable access to affordable, safe, high-quality, medically necessary health care. To help achieve this goal, CHA is committed to establishing and maintaining a financial and regulatory environment within which hospitals, health care systems, and other health care providers can offer high-quality patient care. CHA promotes its objectives, in part, by participating as *amicus curiae* in important cases like this one.

The Washington State Hospital Association (WSHA) is a non-profit membership organization that represents 107 member hospitals. WSHA works to improve the health of the people of the State by advocating on matters affecting the delivery, quality, accessibility, affordability, and continuity of health care. One way in which the WSHA advocates on these issues is by participating in legal matters as *amicus curiae*.

Amici's member-hospitals are obvious targets in FCA lawsuits: they are heavily regulated organizations that receive a majority of their reimbursement for providing care from government healthcare programs. For that reason alone, the questions presented in this case are of tremendous importance to *amici*'s members.

The district court's erroneous decision makes the *amici*'s participation even more critical. The opinion's reasoning gives private plaintiffs broad license to file suits under the FCA in ways that Congress never intended and expressly barred. If

upheld, the district court's decision will likely cause FCA lawsuits in the Ninth Circuit to increase dramatically—especially against hospitals. Consequently, the decision below poses devastating 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. The AHA, CHA, and WSHA therefore have the strongest possible interest in ensuring that this Court restore the consistent application of Rule 9(b) and the FCA's "public disclosure bar."

Amici file this brief by leave of the Court.

INTRODUCTION

The False Claims Act (FCA) reflects a careful balance "between encouraging private persons to root out fraud and stifling parasitic lawsuits." *Graham Cty. Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 559 U.S. 280, 295 (2010). Striking that balance hasn't always been easy, however. "Congress has frequently altered its course in drafting and amending the qui tam provisions since initial passage of the FCA over a century ago," and "the history of the FCA qui tam provisions demonstrates repeated congressional efforts to walk a fine line between encouraging whistle-blowing and discouraging opportunistic behavior." *United States ex rel. Springfield Terminal Ry. Co. v. Quinn*, 14 F.3d 645, 649, 651 (D.C. Cir. 1994). The district court's decision upends Congress' hard-earned balance. It

is an open invitation to the very opportunistic FCA plaintiffs that Congress sought to restrain. It should be reversed.

The relator here, Integra Med Analytics LLC ("Integra"), is precisely the kind of plaintiff that Congress intended to bar from bringing suit under the FCA—and this is precisely the kind of speculative lawsuit that Congress intended to squelch. Integra is not an insider. It did not discover the allegations in its complaint from its work for Providence Health & Services or one of its affiliated hospitals. Quite the contrary, Integra is a professional relator. Its website explains that Integra employs "data scientists and forensic analysts"—not doctors, nurses, or other medical professionals. *See* Integra Med Analytics, http://integramedanalytics.com/ (last visited March 31, 2020). Its allegations were largely derived from number-crunching and Google-searching in Integra's offices near the University of Texas at Austin, thousands of miles away from any Providence hospital. *See id*.

To make matters worse, Integra admits that it primarily uses "statistical analysis to uncover and prove fraud." Second Amended Complaint ¶ 11, ECF No. 38. In this respect, Integra is no different from countless other outsiders with access to the same publicly-available information. Anyone—including the government—could have filed a complaint based on publicly-available claims data from the Centers for Medicare & Medicaid Services (CMS) and a bit of additional Internet research. The government already has access to the raw CMS claims data that

outsiders can analyze; the government already analyzes that data to identify patterns that might warrant fraud investigation; and the government already has access to the same public Internet websites that outsiders use to minimally supplement their complaints. Yet that is all Integra offered here. Under well-established FCA law, Integra's statistical speculation and search-engine suspicion is not enough to survive a motion to dismiss. It is therefore no surprise that the Fifth Circuit recently affirmed the dismissal of a statistics-based FCA complaint by Integra Med itself, holding that Integra "failed to meet its pleading requirements." *United State ex rel. Integra Analytics, LLC v. Baylor Scott & White Health*, No. 19-50818, 2020 WL 2787652 at *6 (5th Cir. May 28, 2020).

Congress has imposed several important guardrails against FCA lawsuits based on this kind of supposition and sourcing. Two of those guardrails are at issue here. *First*, Federal Rule of Civil Procedure 9(b) weeds out speculative fraud complaints, like this one, that lack particularized factual allegations. In that respect, Rule 9(b) "serves to deter the filing of complaints as a pretext for the discovery of unknown wrongs, to protect defendants from the harm that comes from being subject to fraud charges, and to prohibit plaintiffs from unilaterally imposing upon the court, the parties and society enormous social and economic costs absent some factual basis." *United States v. United Healthcare Insurance Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) (citation and internal quotation marks omitted). *Second*, the FCA's

"public disclosure bar" blocks plaintiffs from bringing suit based on publicly-available information that the government had access to. The intent of this provision is clear: to achieve "'the golden mean between adequate incentives for whistle-blowing insiders with genuinely valuable information and discouragement of opportunistic plaintiffs who have no significant information to contribute of their own.'" *Graham Cty. Soil & Water Conservation Dist.*, 559 U.S. at 294 (quoting *United States ex rel. Springfield Terminal Ry. Co.*, 14 F.3d at 649). Together, Rule 9(b) and the "public disclosure bar" provide critical protections for defendants—and the legal system as a whole—from baseless and parasitic lawsuits.

Appellants have persuasively explained why the district court's decision misapplied these legal guardrails. Rather than repeating those compelling arguments, *amici* seek to provide this Court with information about the consequences of the district court's decision to weaken these protections and open the courthouse doors to speculative, statistics-based lawsuits. Those consequences are clear: if professional relators like Integra are permitted to bring suit based primarily on statistical analysis, supplemented with only minimal Internet research, then the courts will be flooded with opportunistic FCA cases.

Hospitals, in particular, will become easy targets for these abusive complaints. 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. Adopting the district court's rule will make that untenable situation even worse. There is a wealth of publicly-available claims data about hospitals, including information that is susceptible to the kind of statistical analysis Integra performed here. If all a relator needs to do to survive a motion to dismiss is (1) identify some deviation between a particular hospital's submitted claims and an industry median; and (2) supplement that statistical deviation with minimal publicly-available Internet research, 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. This cannot be what Congress intended.

For this reason, in addition to explaining these deleterious consequences, *amici* offer a simple way to resolve this case. To be clear: Appellants have offered

a number of dispositive bases for deciding this case, and this Court can and should adopt one of the primary bases set forth in Appellants' brief. But to the extent there is any doubt about Appellants' primary arguments, this brief amplifies a further reason why Appellee's complaint should be dismissed. Appellants offer this argument in their opening brief. *See* Appellants' Brief at 38-39 & n.16. *Amici* spell it our further in this brief because this approach, which is grounded in well-established Ninth Circuit precedent, will provide greater clarity to litigants and lower courts about how to best address the growing phenomenon of statistically-driven FCA complaints.

Specifically, this Court can find for Appellants *without* having to address the meaning of "news media" because the add-on Internet information is "substantially the same" as the publicly-disclosed claims data. 31 U.S.C. § 3730(e)(4)(A). Indeed, because the heart of Integra's complaint is based on statistical analysis of publicly-available claims data, *see* Appellants' Brief at 38-45, Part I.B.2, and because the district court correctly concluded that Integra's statistical analysis *alone* was not enough to state a claim upon which relief may be granted, see Order on Motions to Dismiss, *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. 17-1694, 2019 WL 3282619, *8 (C.D. Cal. July 16, 2019), then all of that information should be discounted when considering whether the complaint as a whole survives a motion to dismiss. The remaining information at issue in this

appeal, which Integra obtained from the public Internet, is undoubtedly insufficient to state a claim on its own and adds nothing to the essential transactions underlying Integra's fraud claims. The district court erred, however, by allowing tag-along, Internet-derived information to nudge Integra's complaint over the line. Instead, under the reasoning of this Court's decisions in *A-1 Ambulance Service, Inc. v. California*, 202 F.3d 1238 (9th Cir. 2000), and *United States ex rel. Solis v. Millennium Pharmaceuticals, Inc.*, 885 F.3d 623 (9th Cir. 2018), this Court should adopt a straightforward rule: where an FCA complaint is overwhelmingly based on statistical analysis of publicly-available data, it cannot survive a motion to dismiss simply because a plaintiff alleges some additional facts based on Internet research.

That is all Integra did here, and this Court can reverse on that basis alone. Applying that commonsense rule will prevent outsiders with nothing more than public data, advanced mathematical skills, and access to a search engine from tying up hospitals in endless litigation and harming patients and the medical system as a result.

I. Relaxing Rule 9(b) and Lowering the "Public Disclosure Bar" 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.

Even with important statutory guardrails in place, 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 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 opportunistic *qui tam* lawsuits. As an initial matter, hospitals submit an extraordinary number of 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 individuals. 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_entire report_sec.pdf?sfvrsn=0. Typically, these claims 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.

In addition, 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 sheer volume, on its own, would be enough to make hospitals a prime target for FCA suits. But those tens of thousands of pages contain uniquely complex rules that often defy straightforward interpretation. Courts therefore consistently recognize the challenge for hospitals, physicians, and other providers trying to comply with these rules and regulations. The Supreme 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 this Court may have said it best when it explained 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). With such a confounding regulatory environment, opportunistic relators can easily allege that hospitals violated the law and defrauded the government.

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 to which hospitals are subject and the way they do business with the government, hospitals depend on the FCA's statutory guardrails. Even now, those guardrails barely protect hospitals from costly *qui tam* litigation that, as explained below, is often meritless. Now imagine what would happen if relators could rely on statistics alone (perhaps with some Internet research sprinkled in for good measure) to sue hospitals, simply asserting that a hospital's claims data deviates from some alleged industry norm. The answer is obvious. Relaxing the Rule 9(b) standard and lowering the "public disclosure bar" to Integra's rock-bottom standard will make hospitals even more attractive targets and entice even more opportunistic relators to sue them.

b. Most Qui Tam Suits Are Meritless.

This case shares a common feature with most modern *qui tam* suits: "the United States declined to exercise its statutory right to intervene and prosecute the action." Order on Motions to Dismiss, 2019 WL 3282619, at *3. 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 thus 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 a serious risk of opportunistic and abusive litigation.

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 drawn the obvious 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, involving a relator similar to Integra, 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. 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 NCHA 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 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.[2] It explained that "it would have to spend considerable time and effort monitoring court filings, filing

[2] The NCHA Group case was unique in one respect: the United States took the extra step to move to dismiss the entire case, using its statutory authority under 31 U.S.C. § 3730(c)(2)(A). But dismissal motions are the exception; the DOJ almost always leaves the burden of dismissing these suits to defendants like hospitals, physicians and other healthcare providers. Indeed, DOJ itself has explained that it historically

statements of interest, and responding to requests for substantial amounts of discovery." *Id*. at 10. 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 typically not so lucky. Even where the

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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.

Significantly, DOJ is even less likely to seek dismissal of FCA complaints in this Circuit. There is currently a circuit split regarding the government's authority under Section § 3730(c)(2)(A). *Compare United States ex rel. Sequoia Orange Co. v. Baird-Neece Packing Corp*., 151 F.3d 1139, 1145 (9th Cir. 1998) (holding that the United States must identify a "valid government purpose" that is rationally related to dismissal), *with Swift v. United States*, 318 F.3d 250, 252 (D.C. Cir. 2003) (holding that the United States has an "unfettered right" to dismiss a qui tam action). That is not at issue in this case. But the Ninth Circuit's higher standard for permitting government dismissals of FCA cases only highlights the risks of relaxing two of *the remaining* guardrails against abusive FCA suits. Because relator-only *qui tam* law suits tend to be meritless, and because the government must meet a higher burden to dismiss them in this Circuit, there are even greater risks in relaxing Rule 9(b) and lowering the "public disclosure bar" here.

government chooses to decline participation, defendant-hospitals are left to fend off expensive, meritless lawsuits. With the growth of statistics-based FCA pleading, the problem hospitals face is that one man's "business opportunity" is now a hospital's burden. Relaxing Rule 9(b) and lowering the "public disclosure bar" will only exacerbate that burden.

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 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 analysis than other FCA defendants. Hospitals and other healthcare defendants must consider defense costs, the magnitude of potential liability, reputational harms, *and* 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").

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 other healthcare industry participants such as insurers and employers." Rita Sverdlik et al., *Research Announcement: Moody's - US not-for-profit hospital*

[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.

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; *see* Mara Hoplamazian and Cathie Anderson, California hospitals suffer massive losses from fewer patients, major COVID-19 expenses, *Sacramento Bee*, June 4, 2020, *available at* https://www.sacbee.com/news/local/health-and-medicine/article243234941.html (describing a recent non-profit report "highlight[ing] how dramatically the shutdown orders throughout California damaged the bottom line of hospitals as they cleared space for potential COVID-19 patients at the same time many people avoided trips to the emergency room because the number of coronavirus cases was spiking").

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 is needed, the threat posed to hospitals by the cost of defending against a meritless *qui tam* is self-evident.

A motion to dismiss is often the defendant's last line of defense against substantial litigation or settlement costs. Relaxing Rule 9(b) and lowering the "public disclosure bar" leaves hospitals without important protections when they need them most, and it paves the way for opportunistic relators to pursue meritless *qui tam* suits and unwarranted settlement windfalls. Hospitals and the patients they serve will be the first to suffer.

II. This Case Can Be Easily Resolved By Evaluating The Crux of The Complaint and What Little Integra's Internet Research Adds To Its Allegations

Given the serious consequences for hospitals in relaxing Rule 9(b) and lowering the "public disclosure bar," this case calls out for a simple resolution that

can be easily applied to other statistically-driven FCA complaints. Appellants have provided the Court will several options. For instance, Appellants explain that there is a way to decide this case that can conclusively address the burgeoning trend of statistically-driven FCA complaints *without* having to address the definition of "news media." Appellants' Brief at 39 n.16. The district court had that resolution at its fingertips, but it rejected that commonsense approach. If necessary, this court should not make the same mistake.

Specifically, the FCA expressly provides that a case must be dismissed under the "public disclosure bar" if "substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed." 31 U.S.C. § 3730(e)(4)(A). Here, the district court correctly held that the Medicare claims data was publicly disclosed. Order on Motions to Dismiss, 2019 WL 3282619, at *8. It also correctly held that "the statistics alone are likely not enough to state a viable fraud claim." *Id*. at *17. But the court *incorrectly* held that the minimal facts obtained from the Internet were enough to render Integra's complaint sufficiently different from the publicly-available claims data to avoid being barred under Section 3730(e)(4)(A)'s "substantial similarity" prohibition. Put another way, under the district court's erroneous reasoning, an FCA complaint can be based almost entirely on information that falls within the "public disclosure bar" (*i.e*., statistical analysis of claims data), but the moment a professional relator adds some minimal information that is not

barred in the court's view (*i.e.*, the Internet research)[4], then the complaint can move forward. The position cannot be squared with the plaint text of Section 3730(e)(4)(A) and this Court's clear precedent interpreting it.

The district court's reasoning squarely conflicts with this Court's decisions in *A-1 Ambulance Service, Inc. v. California*, 202 F.3d 1238 (9th Cir. 2000), and *United States ex rel. Solis v. Millennium Pharmaceuticals, Inc.*, 885 F.3d 623 (9th Cir. 2018). Those cases hold that, for purposes of the FCA's "substantial similarity" provision, a court must look to whether the publicly-disclosed materials included the "material transactions giving rise to" the alleged fraud. *A-1 Ambulance Serv., Inc.*, 202 F.3d at 1245. If all of the "essential transactions" underlying a relator's fraud claim were publicly disclosed, this Court's precedent holds that the claim must be dismissed. *See id*. (internal quotation marks omitted).

Here, the relevant "transactions" underlying Integra's FCA claims are those encompassed within its statistical analysis. After all, that statistical analysis indisputably formed the crux of Integra's complaint. *See* Order on Motions to Dismiss, 2019 WL 3282619, at *2, 8; Appellants' Brief at 38-45, Part I.B.2. Even the district court recognized how central Integra's broad-based statistical analysis

[4] *Amici* agree with Appellants that the Internet research at issue here was, in fact, covered by the public disclosure bar. Appellants' Brief at 39. Because Appellees have persuasively and extensively explained why, *amici* need not address those arguments here.

was to its FCA claim. *See* Order Granting Motion to Certify Order for Interlocutory Appeal and Motion to Stay, *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. 17-1694, 2019 WL 6973547, at *2 (C.D. Cal. Oct. 8, 2019) ("In particular, Relator adequately pleaded falsity because, based on its statistical analyses, Defendants' hospitals used MCCs for certain diagnoses at rates disproportionate to other hospitals."). But Integra's decision to rely so heavily on a statistical analysis of claims data means that *every single relevant claim* is an "essential 'transaction[]' underlying [Integra's] fraud claim." *A-1 Ambulance Service*, 202 F.3d at 1245. As such, the reasoning of *A-1 Ambulance Service* compels dismissal .

Without addressing this precedent, however, the district court concluded that Integra's complaint was not "substantially the same" as the publicly-disclosed claims data because the facts taken from Integra's minimal Internet research "explain why the high coding rates … are plausibly attributable to fraud, as opposed to some other cause." Order on Motions to Dismiss, 2019 WL 3282619, at *17. But this, too, runs headlong into *A-1 Ambulance Service*. In that case, this Court held: "[t]hat the disclosed transactions themselves may not have pointed directly to any wrongdoing is simply of no moment." 202 F.3d at 1245. Likewise, this Court's decision in *Solis* rejected a relator's argument that his "claims are not substantially similar because he alleged fraud, while the 2006 complaint alleged only negligence."

885 F.3d at 627. Because the publicly-disclosed information already "revealed the material transactions or allegations giving rise to Solis's later claims," those claims must be dismissed. *Id*.

So, too, here. Integra's minimal Internet research may have provided a possible explanation for the statistical disparities it found in the claims data. But even if that research disclosed fraud as opposed to some other explanation (*e.g*., negligence, proper coding in accordance with CMS recommendations, different patient profiles), this Court's precedent make plain that the addition of this tag-along Internet research is "of no moment" so long as Integra's complaint was based on the same "essential transactions" as what was included in the publicly-available claims data. *A-1 Ambulance Serv., Inc.* , 202 F.3d at 1245. It was. And that dooms Integra's FCA claim.

This well-established rule is particularly appropriate for the growing phenomenon of statistically-based FCA complaints brought by opportunists like Integra. Absent some unique private investigation, these kinds of statistical cases will *always* be based on publicly-available claims data. Stated differently, they will *always* be brought based on an analysis the government itself could have done using the very same information. There is no indication in either the text, history, or purpose of the FCA that Congress would have wanted opportunistic relators to be able to bring suit merely by adding minimal allegations to a complaint almost

entirely based on statistical analysis of publicly-available data. To the contrary, a rule that focuses mainly on the essential transactions covered by a complaint's statistical analysis serves Congress' "twin goals" in the FCA: "rejecting suits which the government is capable of pursuing itself, while promoting those which the government is not equipped to bring on its own." *United States ex rel. Springfield Terminal Ry. Co.*, 14 F.3d at 651.

Accordingly, this Court should apply this straightforward rule—which is grounded in well-established Ninth Circuit precedent—here. In so doing, the Court will send a message to opportunistic plaintiffs like Integra that their business models must change, because much more is needed to leap the FCA guardrails that Congress put in place to protect defendants from speculative, opportunistic lawsuits like this one.

CONCLUSION

For the foregoing reasons, as well as those stated in Appellee's brief, this Court should reverse the district court's decision.

Date: July 2, 2020

Respectfully submitted,

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STATEMENT OF RELATED CASES

Pursuant to Ninth Circuit Rule 28-2.6, undersigned counsel for Amici Curiae is not aware of any other related cases pending before this Court.

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CERTIFICATE OF SERVICE

I hereby certify that on July 2, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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