No. 21-443

IN THE

Supreme Court of the United States

WILLIAM BEAUMONT HOSPITAL,

Petitioner,

v.

UNITED STATES OF AMERICA, EX REL.
DAVID L. FELTEN, M.D., PH.D.,

Respondent.

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

BRIEF OF *AMICI CURIAE* AMERICAN HOSPITAL ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, MICHIGAN HEALTH & HOSPITAL ASSOCIATION, KENTUCKY HOSPITAL ASSOCIATION, OHIO HOSPITAL ASSOCIATION, AND TENNESSEE HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

The **American Hospital Association** 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 **Federation of American Hospitals** is the national representative for over 1,000 leading taxpaying community 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 across 46 states, plus Washington, DC and Puerto Rico. Its members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals,

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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

and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

Established in 1919, the **Michigan Health & Hospital Association** represents the interests of its members on key issues and supports their efforts to provide quality, cost-effective, and accessible care.

Established in 1929, the **Kentucky Hospital Association** represents hospitals, related health care organizations, and integrated health care systems. It is dedicated to sustaining and improving the health status of Kentucky's citizens.

Established in 1915, the **Ohio Hospital Association** helps its members meet the needs of the communities they serve by influencing health policy, driving healthcare quality improvements, and advocating for economic sustainability among hospitals.

Established in 1938, the **Tennessee Hospital Association** is the premiere organization that promotes and represents the interests of Tennessee hospitals, health systems, and the patients they serve.

Amici's member-hospitals are frequent targets in FCA lawsuits. The reasons why are clear: hospitals are heavily regulated; the regulations governing them are often impenetrable; and they receive a majority of their reimbursement from government healthcare programs. Together, those factors make them uniquely vulnerable to FCA claims, many of which are dismissed as meritless despite having already imposed significant costs on hospitals. The same exposure to costly, groundless FCA claims exposes them to costly, groundless FCA retaliation claims, which are frequently "part and parcel of FCA cases." Pet. 11.

It is therefore unsurprising that Petitioner is a hospital. As the dissenting opinion below indicated, previous cases raising the question presented here demonstrate that hospitals are often forced to defend themselves against baseless retaliation claims brought by former employees. *See* Pet. App 22a n.2 (Griffin, J., dissenting). As such, the legal issue in this case is of considerable importance to *amici*'s members.

The Sixth Circuit's erroneous decision makes *amici*'s participation even more important. If upheld, the decision will vastly expand hospitals' exposure to FCA-retaliation suits, sometimes years after a plaintiff left her job. *Amici*, which include the state hospital associations in every state in the Sixth Circuit, therefore have a strong interest in ensuring that this Court restores the correct reading of the FCA's anti-retaliation provision.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case presents an important question that has divided courts of appeals: whether a former employee may bring a False Claims Act retaliation claim against her former employer based on conduct that occurred after her employment ended. This question is relevant to employers of all kinds. But it is especially important to *amici*'s members.

Hospitals face a disproportionate amount of FCA litigation. The most recent Department of Justice 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, 2020*, https://www.justice.gov/opa/press-release/file/1354316/download. Many of these cases, however, lack merit. Year after year,

the number of FCA cases increases, but the Department of Justice continues to decline participation in the overwhelming majority of them—a clear indicator that these cases never should have been brought in the first place. Given the sheer volume of FCA suits, any erroneous interpretation that expands FCA-related liability is concerning to *amici*'s members—and should be to this Court as well.

Adopting the Sixth Circuit's rule would make this untenable situation even worse. As it is, several features of the FCA's anti-retaliation provision invite excessive and expensive litigation. For example, the definition of protected activity sweeps in acts far short of filing an FCA suit; the statute provides for enticingly high damages; and unlike the FCA itself, the retaliation provision does not permit the United States to weed out unmeritorious suits. And if all of that were not enough, the Sixth Circuit applies an exceedingly broad causation standard for FCA retaliation. Unlike many other circuits, it recognizes retaliation claims if a plaintiff's protected activity was merely a "motivating factor" in the alleged retaliatory act. *Compare McKenzie v. BellSouth Telecomms., Inc.*, 219 F.3d 508, 518 (6th Cir. 2000), *with Lestage v. Coloplast Corp.*, 19-2037, 2020 WL 7238287, at *1 (1st Cir. Dec. 9, 2020). The statute need not be stretched any further. Yet by distorting the FCA's text to permit retaliation claims by former employees, for conduct years after their employment ceased, the Sixth Circuit erroneously exposes employers to virtually-unbounded retaliation liability. *See Potts v. Center for Excellence in Higher Education, Inc.*, 908 F.3d 610, 615 n.2 (10th Cir. 2018) ("a former employee could wait years upon years before whistleblowing and then sue if the employer allegedly retaliated"); Pet. 31 (explaining how a relator

terminated today could bring suit decades later if the Sixth Circuit's decision stands).

This expansion of FCA-retaliation liability is particularly dangerous for *amici*'s members because "most U.S. hospitals typically operate on thin margins." 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/. The ongoing COVID-19 pandemic has only exacerbated hospitals' financial challenges.[2] Exposing *amici*'s members to even broader FCA-retaliation liability will worsen hospitals' precarious financial state, and will almost certainly divert scarce resources from their core mission of providing patient care and improving the health of their communities.

This Court therefore should grant certiorari to reverse the Sixth Circuit's reading of the FCA's anti-retaliation provision. In so doing, it will establish

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[2] *E.g.*, Kaufman Hall, *Financial Effects of COVID-19: Hospital Outlook for the Remainder of 2021* (September 2021), https://www.aha.org/system/files/media/file/2021/09/AHA-KH-Ebook-Financial-Effects-of-COVID-Outlook-9-21-21.pdf (projecting (1) hospitals and health systems to lose $54 billion in net income by the end of 2021; (2) median operating margins to be 10-11% below pre-pandemic levels; and (3) over one-third of hospitals to be operating in the red by the end of 2021).; Lauren Coleman-Lochner, Shaky U.S. Hospitals Risk Bankruptcy in Latest Covid Wave, *Bloomberg* (Oct. 14, 2020), at https://finance.yahoo.com/news/shaky-u-hospitals-risk-bankruptcy-133423429.html ("The growing number of [COVID-19] cases is threatening the very survival of hospitals just when the country needs them most. Hundreds were already in shaky circumstances before the virus remade the world, and the impact of caring for Covid patients has put hundreds more in jeopardy.").

harmony across the circuits and ensure that FCA defendants—especially hospitals—do not face the costly consequences that flow from the Sixth Circuit's atextual interpretation.

ARGUMENT

I. The Sixth Circuit's Atextual Expansion of The FCA's Anti-Retaliation Provision Will Invite Additional Costly, Meritless FCA-Related Litigation

Petitioners have persuasively explained why "the Sixth Circuit's decision will create an unbounded anti-retaliation provision that immensely burdens countless employers." Pet. 30. In addition to the reasons Petitioners offered, several features of the FCA's anti-retaliation provision render it susceptible to the consequences that Petitioners correctly predict. Given those statutory features, that provision need not be judicially-broadened any further. Yet the Sixth's Circuit misinterpretation does just that, compounding the risks of meritless FCA-related litigation discussed in the Petition for Writ of Certiorari (at 30-33) and Section II below.

First, the FCA's anti-retaliation provision protects an extensive range of activity. The statute sets forth two categories of "protected activity": (1) "lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section", and (2) "other efforts to stop 1 or more violations of this subchapter." 31 U.S.C. 3730(h)(1). Critically, these two prongs trigger protections against retaliation for activity far short of filing an actual FCA lawsuit (many of which we know are meritless anyway).

The first prong protects not only retaliation in response to an employee's full-fledged FCA lawsuit,

but also to "steps taken antecedent to a False Claims Act proceeding." *Singletary v. Howard University*, 939 F.3d 287, 295 (D.C. Cir. 2019) (internal quotation marks omitted); *see* Pet. 32. For instance, "[t]he FCA's anti-retaliation provision protects employees 'while they are collecting information about a possible fraud, *before* they have put all the pieces of the fraud together.'" *Jones-McNamara v. Holzer Health Systems*, 630 Fed.Appx. 394, 399 (6th Cir. 2015) (quoting *United States ex rel. Yesudian v. Howard Univ.*, 153 F.3d 731, 740 (D.C. Cir. 1998)).

As broad as that first prong is, the "second prong broaden[s] the universe of protected conduct under [Section] 3730(h)" even further. *United States ex rel. Chorches v. American Med. Response, Inc.*, 865 F.3d 71, 97 (2d Cir. 2017); *see Smith v. Clark/Smoot/Russell*, 796 F.3d 424, 434 (4th Cir. 2015) ("While we have not yet spelled out the contours of 'other efforts to stop' a False Claims Act violation, it plainly encompasses more than just activities undertaken in furtherance of a False Claims Act lawsuit."). "[U]nlike the first [prong], [the second prong] is not tied to the prospect of a False Claims Act proceeding." *Singletary*, 939 F.3d at 295-96. "To put it simply, the focus of the second prong is preventative—stopping 'violations'—while the first prong is reactive to an (alleged) actual violation of the statute." *Id.* at 296. Accordingly, this provision has been interpreted to include activity like mere internal reporting of suspected FCA violations, *see Jones-McNamara*, 630 Fed.Appx. at 399, "and at least one piece of the legislative history appears to indicate that the [second prong] was sufficiently broadened that it included refusals to participate in the scope of protected activity." *United States ex rel. Tran v. Computer Sciences Corp.*, 53 F.Supp.3d 104, 136 (D.D.C. 2014)

(citing 155 Cong. Rec. E1295–03 (Statement of Rep. Berman)); *see Chorches*, 865 F.3d at 96-97 ("Fabula's refusal to falsify the December 2011 PCR so as to hinder the filing of a fraudulent claim in violation of the FCA constitutes protected activity under § 3730(h)."). With so many novel theories of FCA healthcare fraud, *see infra* at 13, and with so many meritless attempts at establishing such fraud as it is, *see infra* at 16-18, the vast scope of these prongs opens the door to a significant amount of additional meritless FCA-retaliation claims.

Second, the sizable damages available under the FCA anti-retaliation provision invite further litigation. The statute permits "reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, *2 times* the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees." 31 U.S.C. 3730(h)(2) (emphasis added). Thus, in broadly providing that retaliation plaintiffs "shall be entitled to all relief necessary to make that employee, contractor, or agent whole," 31 U.S.C. 3730(h)(1), the statute specifically authorizes *double* back pay plus an assortment of other potential damages (*e.g.*, emotional distress, litigation costs, attorney's fees,). The availability of these high-paying damages provides a lucrative incentive for FCA-retaliation suits, particularly given that defendants routinely choose to settle, rather than fight, FCA-related claims. *See infra* at 20; Pet. 32-33.

Third, unlike underlying FCA claims, the United States has no role to play in deciding whether or how an FCA retaliation claim may proceed. When a relator

brings a *qui tam* action, the United States is considered the real party in interest, and the FCA provides the government with significant rights. *See* 31 U.S.C. § 3130(c). But FCA-retaliation claims "are brought on behalf of and for the benefit of the employee." *Clemes v. Del Norte Cty. United School Dist.*, No. C-93-1912, 1996 WL 331096. at *5 (N.D. Cal. May 28, 1996); *see United States ex rel. Foulds v. Texas Tech Univ.*, 171 F.3d 279, 295 (5th Cir. 1999) (the "qui tam plaintiff keeps all of the proceeds from any successful § 3730(h) claim; indeed, only a qui tam plaintiff possesses the right to bring such a claim."). As such, the United States cannot take over FCA-retaliation litigation or filter out meritless claims through dismissal motions. This feature thus enables FCA-retaliation plaintiffs to engage in all sorts of costly litigation without the mature oversight of the United States government.

Fourth, several courts of appeals—including the Sixth Circuit—apply a "plaintiff-friendly" causation standard to FCA-retaliation claims. *Nesbitt v. Candler County*, 945 F.3d 1355, 1358 (11th Cir. 2020). In those circuits, a plaintiff must only show that the protected activity was a "motivating factor" for the alleged retaliatory act, not a "but for" cause of that act. *Compare McKenzie*, 219 F.3d at 518 (motivating factor test), *with Nesbitt*, 945 F.3d at 1361-62 (but-for causation test). It goes without saying that in the circuits that apply the more plaintiff-friendly test, employees are able to bring litigation for a wider range of alleged employer behavior. And even more litigation will be available if plaintiffs are permitted to allege, as they now are in the Sixth Circuit, that a *former* employer took some adverse action because a years-old protected activity was merely a "motivating factor."

Taken together, these features of the FCA's anti-retaliation provision demonstrate how broad it already is, how likely it is to invite meritless litigation, and how unnecessary it is for courts to atextually expand the statute any further by allowing *former* employees to bring suit based on *post*-employment conduct. Given these features, moreover, it is clear that Congress knows how to draft and amend the FCA anti-retaliation provision when it wants to broaden its scope. But as Petitioners and the dissenting judge below explained, the text of the statute makes plain that Congress did *not* do that, *see* Pet. 17-24; Pet. App. 16a-22a (Griffin, J., dissenting), and Congress easily could have done so by explicitly referring to "former" employees, *see* Pet at 29.

II. The Sixth Circuit's Misinterpretation Of The FCA's Anti-Retaliation Provision Will Harm Hospitals By Causing Limited Resources To Be Shifted Away From Their Core Mission Of Delivering Healthcare

The Sixth Circuit's misinterpretation of the FCA's anti-retaliation provision leaves employers vulnerable to almost-unbounded FCA-related litigation. That is highly problematic in itself. But those consequences will unduly impact America's hospitals—and the patients they serve—simply because hospitals *already* suffer from a disproportionate amount of costly, meritless FCA-related litigation. As this Court considers whether to grant certiorari, it should not lose sight of how the FCA has been asserted against hospitals in ways that will be worsened if the Sixth Circuit's decision is allowed to stand.

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

FCA lawsuits have increased tremendously in recent decades. This growth has been driven primarily by suits in which the government has declined to participate—a strong indicator of their lack of merit. 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—646 in 2018, and 638 in 2019, and 672 in 2020. U.S. Dep't of Justice, *Fraud Statistics-Overview: October 1, 1986-September 30, 2020*, *supra*; *see* 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.").

These suits disproportionately target healthcare entities. Of the 922 new FCA matters filed in 2020, for example, 573 involved healthcare defendants. U.S. Dep't of Justice, *Fraud Statistics-Overview: October 1, 1986-September 30, 2020*, *supra* (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.* (456 of 672 cases). This stands in stark

contrast to 1987, when only 15 of the 371 cases—a mere *four percent*—involved healthcare entities. *Id*.[3]

Hospitals are prime targets for *qui tam* lawsuits for several reasons. For starters, hospitals are heavily regulated. "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), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC27307 86/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, is enough to make hospitals a prime target for FCA suits.

What is more, courts consistently recognize the challenge for healthcare providers in trying to comply with these many rules and regulations. This Court, for instance, has referred to the Medicare and Medicaid statutes 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

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[3] These numbers, regrettably, are not likely to change. Just weeks after taking office, the new Administration indicated that healthcare-related FCA cases are among its top priorities. *See* U.S. Dep't of Justice, Acting Assistant Attorney General Brian M. Boynton Delivers Remarks at the Federal Bar Association Qui Tam Conference (Feb. 17, 2021), https://www.justice.gov/opa/speech/acting-assistant-attorney-general-brian-m-boynton-delivers-remarks-federal-bar. The Department of Justice apparently intends to specially target healthcare providers that rely on electronic health records and telehealth services, and it plans to deploy so-called "data analytics" to unearth FCA suspects in the "health care arena." *Id.*

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, employees can easily assert that hospitals violated some ambiguous law and thereby defrauded the government.

As these laws and regulations have piled up, so have the theories of FCA liability in the healthcare space. That, too, has contributed to the steep rise in FCA litigation against hospitals. Historically, the law was applied to cases where services were not rendered to patients and the government was defrauded when reimbursement claims for those non-services were submitted. Today, the law has been "stretched . . . to encompass activities that are increasingly removed from their factual and legal precursors," including "medical necessity fraud, fraud by billing consultants, violations of federal anti-referral statutes and quality-of-care requirements, and Cost Report fraud." Joan H. Krause, *"Promises to Keep": Health Care Providers and the Civil False Claims Act*, 23 Cardozo L. Rev. 1363, 1383 (2002). Hospitals now are forced to reckon with increasingly innovative relators and courts that are all too willing to accept their groundbreaking theories. Accordingly, "[t]o say that participation in the Government health care programs has become a high-risk endeavor would be an understatement." Timothy Blanchard, *Medicare Medical Necessity Determinations Revisited: Abuse of Discretion and Abuse of Process in*

the War Against Medicare Fraud and Abuse, 43 St. Louis U. L.J. 91, 134 (1999).

Hospitals also are uniquely vulnerable to costly FCA litigation because of the way in which healthcare claims are submitted for reimbursement and the sums involved. Specifically, hospitals submit a large number of individual claims to the government in connection with healthcare programs, 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. *Twenty-Five Years Of Health Law Through The Lens Of The Civil False Claims Act*, 19 Ann. 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 *qui tam* relators. As an initial matter, hospitals and "health care providers, unlike many . . . defendants, have a fair amount of assets, making pursuit of a civil action viable." Pamela H. Bucy, *Growing Pains: Using the False Claims Act to Combat Health Care Fraud*, 51 Ala. L. Rev. 57, 59 (1999). In addition, 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 under today's per-claim penalty rules, relators can seek up to $23,606 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. *See* Civil Monetary Penalty Inflation Adjustment, 86 Fed. Reg. 2005, 2006 (Jan. 11, 2021). Consequently, even where the government suffers little or no actual harm, relators may still seek massive penalties based on the view that the FCA requires a separate penalty for *each and every* false claim submitted to the government. *See* Joan H. Krause, *"Promises to Keep": Health Care Providers and the Civil False Claims Act, supra* (relators often rely on vast numbers of small-value Medicare or Medicaid claims to threaten astronomical penalties).

These factors add up to one conclusion: year after year, hospitals are forced to defend against an increasing number of FCA suits, asserting an increasing number of fraud theories. And because the reasons for this have more to do with the laws that govern

hospitals and how hospitals do business, this is unlikely to change any time soon.

B. Most *Qui Tam* Suits Lack Merit.

Although the number of *qui tam* suits has increased in recent years, the quality of those suits hasn't improved in tandem. Quite the contrary. Most *qui tam* suits lack merit.

One indicator of how meritless most *qui tam* suits remain is how infrequently the United States chooses to intervene. 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* 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."); 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."). 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 settled pre-trial, but often only after burdensome and expensive motions practice 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. *See* 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 Riley v. St. Luke's Episcopal Hosp.*, 252 F.3d 749, 767 n.24 (5th Cir. 2001) (Smith, J., dissenting) ("Of 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) (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* (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. 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.*

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), https://www.justice.gov/opa/speech/acting-associate-attorney-general-jesse-panuccio-delivers-remarks-american-bar. Consistent with DOJ's analysis, scholars have 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*.

C. Defending FCA Claims Is Expensive And Diverts Resources From The Delivery Of Healthcare Services.

Defending *qui tam* cases is expensive and disruptive. It is indisputable that most FCA "suits exact a net cost," as defendants expend financial resources to defend against (often meritless) claims and suffer unwarranted harm to their reputations. Rich, *Prosecutorial Indiscretion, supra*; *see* Canni, *Who's Making False Claims, supra* ("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.").

To understand why, consider the following statement from the Department of Justice in a case where it not only declined to participate but also sought to dismiss under 31 U.S.C. § 3730(c)(2)(A). The government explained that to litigate the case "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 of Law in Support of the United States' Motion to Dismiss at 10, *United States ex rel. SMSF LLC v. Biogen, Inc.*, No. 16-11379 (D. Mass. Dec. 17, 2018), ECF No. 53. 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.

Unsurprisingly, healthcare defendants disproportionately bear the burden of these expenses, while also facing different cost-benefit analyses than many other FCA defendants. Hospitals 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). *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."); *see generally Texas Dep't of Housing & Community Affairs v. Inclusive Communities Project, Inc.*, 135 S. Ct. 2507, 2550 (2015) ("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)).[4]

For healthcare providers, the cost of litigating or settling FCA cases diverts resources from their 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). Hospitals have limited resources, and it is an unavoidable fact of life

[4] For this reason, courts in FCA-retaliation cases should make no inferences from the fact that, as here (Pet. App. 29a), a defendant decided to settle an underlying FCA claim.

that dollars spent on litigation and settlements cannot be used for patient care. Plus, FCA cases do not just impose financial costs; they also inflict broader costs on doctors and hospital staff. For example, "[e]mployees and executives may be diverted from their usual duties to deal with the human, logistical, business, public relations and financial issues that arise during an investigation. Employees may leave for a less stressful environment, and recruiting new staff may become difficult." Pamela H. Bucy, *The PATH from Regulator to Hunter: The Exercise of Prosecutorial Discretion in the Investigation of Physicians at Teaching Hospitals*, 44 St. Louis U. L.J. 3, 41 (2000). Put simply, FCA-related claims place considerable burdens on hospitals' finances, time, and human capital, all of which would be otherwise devoted to providing patient care. *See* Joan H. Krause, *"Promises to Keep": Health Care Providers and the Civil False Claims Act, supra* (excessive use of the FCA "divert[s] resources away from the goal of providing high-quality medical care to program beneficiaries").

These costs come as hospitals face enormous financial challenges, which have skyrocketed during the pandemic. "[M]ost U.S. hospitals typically operate on thin margins. Shinkman, *Ratings agencies issue foreboding reports on hospital finances as AHA seeks $100B to respond to COVID-19*, *supra*. Before COVID-19, "hospitals . . . 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 profitability holds steady in FY 2018 after two years of declines*, Moody's Investors Service (April 25, 2019), https://www.moodys.com/

research/Moodys-US-not-for-profit-hospital-profitability-holds-steady-in--PBM_1172741?showPdf=true. Now, "margins of America's hospitals will remain depressed throughout 2021, the percentage of hospitals with negative margins will likely increase, and the financial health of rural hospitals will be significantly affected." Kaufman Hall, *COVID-19 in 2021: The Potential Effect on Hospital Revenues*, *supra*. Indeed, "[p]rior to the pandemic, about one quarter of hospitals had negative margins." *Id*. That was bad enough. But because of COVID-19, "more than a third of U.S. hospitals will maintain negative operating margins through" 2021. Kaufman Hall, *Financial Effects of COVID-19: Hospital Outlook for the Remainder of 2021* (September 2021), https://www.aha.org/system/files/media/file/2021/09/AHA-KH-Ebook-Financial-Effects-of-COVID-Outlook-9-21-21.pdf. Needless to say, forcing hospitals to spend precious dollars on FCA-related litigation only further reduces those margins.

At the same time, the costs of providing care continue to increase. For example, hospital drug expenses have increased 24% from pre-pandemic levels, *see* Kaufman Hall, *National Hospital Flash Report* (September 2021), https://www.kaufmanhall.com/sites/default/files/2021-09/national-hospital-flash-report_sept.-2021_final.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 so many FCA lawsuits. Hospitals were paid only 87 cents for every dollar spent caring for

Medicare patients in 2019, resulting in a $56.8 billion shortfall that year; similarly, hospitals received payment of only 90 cents for every dollar spent caring for Medicaid patients in 2019, resulting in a $19 billion shortfall that year. *See* Am. Hosp. Ass'n, *Fact Sheet: Underpayment by Medicare and Medicaid* (January 2021), https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf. With slim or negative margins, ever-increasing operating costs, and less money coming in from the government than hospitals need, the threat posed by the costs of defending against meritless FCA and FCA-retaliation lawsuits should be self-evident.

* * *

The Sixth Circuit's efforts to widen the reach of 31 U.S.C. 3730(h) were incorrect as a matter of law, created an acknowledged circuit split, and will generate costly and distracting consequences for employers, especially *amici*'s member-hospitals and member-health systems. This Court should grant certiorari to rectify these serious problems.

CONCLUSION

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

Respectfully submitted,

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