No. 19-56367

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

UNITED STATES EX REL. INTEGRA MED ANALYTICS LLC,
Plaintiff-Appellee,

v.

PROVIDENCE HEALTH AND SERVICES, ET AL.,
Defendants-Appellants.

Interlocutory Appeal from the United States District Court
for the Central District of California, No. 2:19-cv-08569 (Gutierrez, J.)

MOTION FOR LEAVE TO FILE BRIEF OF AMICUS CURIAE THE UNITED STATES CHAMBER OF COMMERCE IN SUPPORT OF DEFENDANTS-APPELLANTS

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July 8, 2020

CORPORATE DISCLOSURE STATEMENT

The Chamber of Commerce of the United States of America ("Chamber") states that it is a non-profit, tax-exempt organization incorporated in the District of Columbia. The Chamber has no parent corporations, and no publicly held company owns 10% or more of its stock.

Pursuant to Federal Rule of Appellate Procedure 29, the Chamber of Commerce of the United States of America respectfully requests leave to file a Brief of Amicus Curiae in support of Defendants-Appellants. A copy of the proposed Brief of Amicus Curiae is submitted as an attachment to this motion. Defendants-Appellants have consented to the filing of this brief; counsel for Amicus Curiae requested consent from Plaintiff-Appellee by e-mail on July 1, 2020, but received no response.

The Chamber is the world's largest business federation.[1] It represents approximately 300,000 direct members and indirectly represents the interests of more than three million businesses and professional organizations of every size, in every industry, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. One way the Chamber promotes the interests of its members is by participating in cases with important implications for their members—including cases arising under the False Claims Act and its *qui tam* provisions. The Chamber has previously filed amicus briefs in False Claims Act

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[1] No counsel for a party authored this brief in whole or in part, and no entity or person, other than amicus curiae or its members, made a monetary contribution intended to fund the preparation or submission of this brief. All parties consent to the filing of this brief.

cases in this Circuit. *See, e.g.*, Brief of Amicus Curiae the Chamber of Commerce of the United States of America in Support of Defendant-Appellee's Petition for Rehearing or Rehearing En Banc, *United States ex rel. Campie v. Gilead Sciences*, Inc., Ninth Cir. No. 15-16380 (Aug. 31, 2017).

This appeal is important to the Chamber's members because meritless *qui tam* lawsuits pose potentially devastating risks to their businesses, forcing them to divert scarce resources from their core missions. The Chamber's members are frequent targets in lawsuits brought by putative whistleblowers under the FCA, as many are heavily regulated and operate complex organizations that contract with the government or receive reimbursement for providing care from government healthcare programs. These issues are particularly salient in the healthcare industry because approximately two-thirds of the FCA cases filed in a recent two-year period involved healthcare defendants. *See* U.S. Dep't of Justice, Fraud Statistics—Overview: Oct. 1, 1986-Sept. 30, 2018, at 1, 3 (2018), https://www.justice.gov/civil/page/file/1080696/download. It is thus critically important to the Chamber's members that courts correctly enforce federal pleading requirements and dismiss *qui tam* actions that do not satisfy those requirements.

Accordingly, the Chamber respectfully submits this Brief of Amicus Curiae to request reversal of the district court's erroneous and potentially harmful decision.

CONCLUSION

For the reasons set forth above, the Chamber respectfully requests that the Court grant this Motion and grant leave to file the attached Brief of Amicus Curiae in support of Defendants-Appellants.

Dated: July 8, 2020

Respectfully submitted,

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STATEMENT OF RELATED CASES

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

Date: July 8, 2020

/s/ Jonathan Cedarbaum
JONATHAN G. CEDARBAUM

CERTIFICATE OF SERVICE

I hereby certify that on July 8, 2020, I electronically filed the foregoing with the Clerk of the Court of the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

Date: July 8, 2020

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BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS AMICUS CURIAE IN SUPPORT OF APPELLANTS

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INTEREST OF AMICUS CURIAE

The Chamber of Commerce of the United States of America is the world's largest business federation.[1] It represents approximately 300,000 direct members and indirectly represents the interests of more than three million businesses and professional organizations of every size, in every industry, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts.

One way the Chamber promotes the interests of its members and the broader business community is by participating in cases with important implications for their members—including cases arising under the False Claims Act and its *qui tam* provisions.

This appeal is important to the Chamber's members because meritless *qui tam* lawsuits pose potentially devastating risks to their businesses, forcing them to divert scarce resources from their core missions. The Chamber's members are frequent targets in lawsuits brought by putative whistleblowers under the FCA, as many are heavily regulated and operate complex organizations that contract with

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[1] No counsel for a party authored this brief in whole or in part, and no entity or person, other than amicus curiae or its members, made a monetary contribution intended to fund the preparation or submission of this brief. All parties consent to the filing of this brief.

the government or receive reimbursement for providing care from government healthcare programs. These issues are particularly salient in the healthcare industry because approximately two-thirds of the FCA cases filed in a recent two-year period involved healthcare defendants. *See* U.S. Dep't of Justice, *Fraud Statistics—Overview: Oct. 1, 1986-Sept. 30, 2018*, at 1, 3 (2018), https://www.justice.gov/civil/page/file/1080696/download. It is thus critically important to the Chamber's members that courts correctly enforce federal pleading requirements and dismiss *qui tam* actions that do not satisfy those requirements.

INTRODUCTION

The purpose of the False Claims Act's *qui tam* provisions is to provide an incentive for private individuals who possess nonpublic information regarding a fraud on the government to share that information with the government and, by filing a lawsuit on the government's behalf, enable the government to gain compensation for the fraud. Qui tam suits like this one by Relator Integra Med Analytics LLC turn that statutory purpose on its head—in two respects.

First, Integra Med is not the kind of relator envisioned by the False Claims Act: an individual with inside information the government could not have discovered on its own. *See Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 999 (9th Cir. 2010) ("[T]he FCA is geared primarily to encourage insiders to disclose information necessary to prevent fraud on the government."). On the

contrary, it is an organization dedicated to professional bounty-hunting. Thus, it has no actual information regarding any specific allegedly fraudulent acts. Its complaint identifies no actual false claim made by anyone to the government. Instead, Integra Med relies on large-scale statistical analysis regarding *all* claims by hospitals for Medicare-based reimbursement over a six-year period and purports to draw the inference that because Defendants submitted more of certain types of claims than did other hospitals, some unspecified percentage of those claims must be false. This kind of allegation by statistical speculation fails even the general pleading standard of Federal Rule of Civil Procedure 8, let alone Rule 9's heightened standard for alleging fraud. That is especially clear here, where there is an obvious alternative explanation for the increased claims: namely, that the federal government recently shifted its reimbursement scheme and certain hospitals are ahead of others in adjusting to those changes. The presence of such a commonsensical alternative explanation for the patterns Integra Med emphasizes makes plain the inadequacy of fraud allegations resting on nothing but statistical inferences.

Second, all of the information Integra Med relies on is readily accessible to the public. Rather than bring to light privately known facts, the complaint cobbles together information scraped from government-reported claims data. Such websites, which disseminate information to the public in much the same

way their non-digital equivalents do, qualify as "news media" under the False Claims Act's public disclosure bar and thus cannot support *qui tam* claims.

Complaints, like Integra Med's, that rely solely on statistical analyses of public information must be dismissed. Allowing actions of this sort to advance past the pleading stage runs contrary to the purposes of the False Claims Act's qui tam mechanism. And doing so would would open the door to waves of meritless litigation that will tie up the court system and impose substantial costs on legitimate organizations like the defendant hospitals—costs that ultimately will be borne by the healthcare system as a whole.

ARGUMENT

I. STATISTICAL ANALYSES ALONE CANNOT GIVE RISE TO A PLAUSIBLE INFERENCE OF FALSE CLAIMS FOR MEDICARE REIMBURSEMENT

A. Bare Statistics Cannot Establish Falsity In The Face Of An "Obvious Alternative Explanation"

This Court has made clear that "[e]vidence of an actual false claim is 'the *sine qua non* of a False Claims Act violation.'" *United States v. Kitsap Physicians Serv.*, 314 F.3d 995, 1002 (9th Cir. 2002) (quoting *United States ex rel. Clausen v. Laboratory Corp. of Am.*, 290 F.3d 1301, 1311 (11th Cir. 2002)). Here, that would have meant pleading specific instances in which a doctor or a hospital submitted a claim based on a knowingly false coding designation. The complaint does nothing of the sort. Indeed, the entire premise of the complaint is that a relator can plead a

violation of the Act without identifying any particular Medicare reimbursement claim as false. Instead, Integra asserts, it can plead falsity—and satisfy both the general plausibility standard of Rule 8 and the elevated fraud standard of Rule 9(b)—simply by drawing inferences from a series of large-scale statistical analyses.

When a relator fails to plead false claims directly, a complaint can survive only if it contains allegations describing a scheme with sufficient particularly that the complaint "warrants an inference that false claims were part of the scheme alleged." *United States ex rel. Cafasso v. General Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1056 (9th Cir. 2011). Such an inference is not warranted if the facts alleged in the complaint are subject to an "obvious alternative explanation" besides fraud. *Id.* (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 682 (2009)).

Here, the bevy of statistics in the complaint shows, at the very most, no more than that the defendant hospitals used certain codes more than did other hospitals. But nothing in its allegations shows *why* that is the case. Although the complaint repeatedly emphasizes that Integra's statistical analysis allegedly indicates that it is unlikely the hospitals' higher numbers are "due to chance," *see* ER 838 (Compl. ¶¶ 63, 71, 78, 88), it cannot substantiate any well-pleaded allegation as to what *does* cause those higher numbers. Instead, the complaint merely asserts in conclusory fashion that they must be the result of fraud.

Those conclusory assertions ignore the "obvious alternative explanation" for why certain hospitals may have submitted more claims involving secondary diagnoses during the timeframe covered by the complaint (2011 to 2017). As explained in Appellants' brief (at 20, 23), that period followed closely after CMS made an important change in the structure of Medicare reimbursement claims. In 2007, CMS reduced the standardized base amount that it paid out on such claims, while increasing the number of secondary diagnoses classified as complications/comorbidities (CCs) or major complications/comorbidities (MCCs). In other words, CMS changed the reimbursement system such that hospitals had a new financial incentive to report secondary diagnoses in order to receive full reimbursement for their treatment. CMS also issued guidance making clear that it expected total reimbursements ultimately to increase under the new system because hospitals eventually would "focus their documentation and coding efforts to maximize reimbursement." HHS, *Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates*, 72 Fed. Reg. 47,130, 47,181 (Aug. 22, 2007). In fact, the guidance encouraged hospitals to do just that, stating among other things that CMS did "not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record." *Id.* at 47,180.

Thus, the period covered by Integra's complaint—2011 to 2017—was a transition period for hospitals in coding for Medicare reimbursement. Under the outgoing reimbursement system, there was relatively less of an incentive to code for secondary diagnoses like those highlighted in Integra's complaint. When CMS adopted the new system, however, that incentive suddenly increased substantially. It is unsurprising, then, that some hospitals would be ahead of others in implementing new practices to do as CMS had encouraged and take advantage of that new system by increasing the coding of secondary diagnoses. Put more simply: the "obvious alternative explanation" for the statistics in Integra's complaint is that the defendant hospitals were ahead of the curve in following the new CMS guidelines.

The Fifth Circuit recently endorsed this exact alternative explanation as a basis for dismissing a nearly identical False Claims Act complaint this same relator filed against another set of hospitals. *See United States ex rel. Integra Med Analytics, LLC v. Baylor Scott & White Health*, No. 19-cv-50818, 2020 WL 2787652 (5th Cir. May 28, 2020). As the Fifth Circuit put it: "Integra Med's statistical analysis is consistent with both Baylor having submitted fraudulent Medicare reimbursement claims to the government and with Baylor being ahead of most healthcare providers in following new guidelines from CMS." *Id.* at *3. Because the lawful and "obvious alternative explanation" that Baylor "was simply

ahead of the healthcare industry in following CMS guidelines" (*id*. at *4) was just as likely as was any inference of fraud, the Fifth Circuit properly found that Integra had not raised a plausible inference of falsity.

Indeed, the Fifth Circuit noted in *Baylor* that some of Integra's own data made that alternative explanation even more likely than any explanation based in fraud. As the Fifth Circuit recognized, Integra's complaint "show[ed] that the rate at which non-Baylor hospitals were using the MCCs for encephalopathy, respiratory failure, and severe malnutrition"—the same three MCCs Integra has emphasized in this case—"was increasing every year." 2020 WL 2787652, at *4. Those increases demonstrated that "the healthcare industry as a whole" was following the pattern of increasing claims based on MCCs, thereby further supporting the inference that the defendant simply was ahead of the curve in doing so. *Id.*

The same is true of Integra's complaint in this case. The complaint here, just like the complaint in *Baylor*, reflects that even non-defendant hospitals have consistently been increasing the prevalence with which they submit claims based on the three identified MCCs. *See* ER 838 (Compl. ¶¶ 25, 40, 52). In other words, they are following the same trendline as the defendant hospitals. Moreover, with respect to respiratory failure in particular, Integra's data show that non-defendant hospitals were coding it at approximately the same rate in 2017 as defendant

hospitals were in 2013. *See* ER 838 (Compl. ¶ 70). That further suggests, as did similar data in *Baylor*, that Defendants simply were a few years ahead of their peers in properly maximizing its coding for such conditions. *See Baylor*, 2020 WL 2787652, at *4 ("[F]or respiratory failure, non-Baylor hospitals were coding it at a higher rate in 2017 than Baylor was in 2011.").

In short, because the allegations in Integra's complaint support an "obvious alternative explanation" at least as much as, if not more than, they support any fraud-based explanation, those allegations do not "warrant[] an inference that false claims were part of the scheme alleged." *Cafasso*, 637 F.3d at 1056; *see also Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007) (dismissing antitrust claim based on alleged conspiracy to set prices, where allegations in complaint were "consistent with" both the alleged conspiracy and with "obvious alternative explanation" that defendants independently reached business decision not to compete with one another).

B. Statistical Analyses Cannot Support An Inference That Any Disparity In Medicare Claims Is Due To Fraud Rather Than Good-Faith Medical Judgment

Even in the absence of an "obvious alternative explanation," statistics-based allegations of false claims for Medicare reimbursement, like the allegations in this complaint, still would be inadequate. Rule 8 requires that a plaintiff plead facts giving rise to a "plausible" inference of liability; it is not good enough for

allegations merely to be "consistent with" such an inference. *See Twombly*, 550 U.S. at 570. And Rule 9(b) adds another layer to the pleading standards for False Claims Act plaintiffs, requiring them to "state with particularity the circumstances constituting fraud." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) (quoting Rule 9(b)). "This means the plaintiff must allege 'the who, what, when, where, and how of the misconduct charged.'" *Id.* (quoting *Ebeid*, 616 F.3d at 998).

Those rules are especially important in cases, like this one, in which the supposed fraud involves medical judgment. Such judgments by their nature leave room for good-faith disagreement, and a claim made in good faith is not fraudulent. *See United States v. AseraCare, Inc.*, 938 F.3d 1278, 1297 (11th Cir. 2019) ("A properly formed and sincerely held clinical judgment is not untrue even if a different physician later contends that the judgment is wrong."); *cf. Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1119 (9th Cir. 2020) (medical opinion "not honestly held" may give rise to claim of fraud).

To take just one example from this case, Integra's complaint emphasizes Providence's high instance of coding "severe malnutrition." ER 890-897 (Compl. pp. 50-57). But there is no standard definition of that term, leaving doctors to make judgment calls as to what qualifies as "severe" malnutrition. *See* Parrish,

M.S., R.D., *Coding for Malnutrition in the Adult Patient: What the Physician Needs to Know*, Prac. Gastroenterology 56-64 (Sept. 2014). Given that lack of consensus and differences in medical judgment, fluctuation like that identified in Integra's complaint is not surprising; rather, it is consistent with the proper exercise of medical judgment.

More generally, the procedures involved in generating and submitting a claim for Medicare reimbursement all involve some degree of professional discretion. Doctors, as discussed above, differ in their diagnosis of codable conditions. *See* Issar, *More Data Mining for Medical Misrepresentation? Admissibility of Statistical Proof Derived from Predictive Methods of Detecting Medical Reimbursement Fraud*, 42 N. Ky. L. Rev. 341, 362-363 (2015); Buck, *Caring Too Much: Misapplying the False Claims Act to Target Overtreatment*, 74 Ohio St. L.J. 463, 467 (2013). But even after that initial coding stage, there remains space for good-faith variation. The ultimate claims submitted by a hospital will be impacted not only by coding habits, but also by documentation practices. Doctors vary in the extent to which they document their clinical judgments, and coding analysts will vary in how they interpret doctors' notes and convert them into claims data. *See* Issar, 42 N. Ky. L. Rev. at 350.

As a result of all the discretionary steps that go into submission of a Medicare claim, it is no wonder that hospitals will differ—sometimes widely—in

the rates at which they ultimately submit certain claims. And the fact that such differentiation might be present across different codes is consistent less with any sort of fraudulent scheme than it is with standardized coding and documentation practices. Indeed, with the express encouragement of CMS, some hospitals utilize documentation-improvement programs in order to increase the number of CCs and MCCs attached to Medicare claims. Those programs naturally differ in their practices and their efficacy, for reasons having nothing to do with fraud.

That a hospital is an "outlier" in the use of certain diagnosis codes thus does not show that its claims are false. To be sure, such data might in some cases be consistent with the existence of an FCA violation. Perhaps such data could lead the Government to conduct additional inquiry to learn whether there is a basis to bring an FCA claim. But such data cannot by themselves be an adequate basis to bring an FCA claim. Even putting Rule 9(b) aside, a complaint must plead facts that make a violation "plausible," and it is insufficient for a complaint's well-pleaded factual allegations to be merely "consistent with" the existence of liability. *Twombly*, 550 U.S. at 570. A complaint alleging only that a hospital applied certain codes to a high number of Medicare claims cannot cross the line between "conceivable" and "plausible" liability under the FCA. *Id*.

Integra, moreover, had to plead its fraud claim with particularity under Rule 9(b). *See Ebeid*, 616 F.3d at 998-999. That required, at a minimum, detailed

factual allegations of situations where the defendant hospitals used a code that contradicted the doctor's diagnosis or where the doctor rendered a diagnosis that was not merely debatable or incorrect but false—*i.e.*, that the doctor did not believe or no reasonable doctor could have believed—in order to permit the use of an inapplicable code. Integra came nowhere near meeting this requirement.

Thus, while allegations based solely on statistical analyses likely will almost always fall short of pleading fraud, their shortcomings are especially clear when the allegedly false claims involve the exercise of medical judgment. In that context, it is particularly important to require relators to allege *actual* false claims—"the *sine qua non* of a False Claims Act violation." *See Kitsap Physicians*, 314 F.3d at 1002.

II. PUBLICLY ACCESSIBLE WEBSITES THAT DISSEMINATE INFORMATION CONSTITUTE NEWS MEDIA UNDER THE FALSE CLAIMS ACT

The complaint here, and those like it, should be dismissed for a second reason: it relies exclusively on information subject to the False Claims Act's public disclosure bar. Indeed, the district court already reached that ruling with respect to the Medicare claims data and the administrative reports on which Integra attempted to rely. ER 21-26. But the court erred in declining to reach the same ruling with respect to the internet websites from which Integra obtained the remainder of the facts populating its complaint. Those sources, as publicly accessible websites that disseminate information, are "news media" within the

meaning of the Act and thus cannot properly support a claim under the Act (unless the relator qualifies as an "original source"). *See* 31 U.S.C. § 3730(e)(4)(A)(iii) (under Act's public disclosure bar, courts must "dismiss an action . . . if substantially the same allegations or transactions as alleged in the action . . . were publicly disclosed . . . from the news media").

The False Claims Act's text and purposes—as recognized in an overwhelming consensus among other courts—make clear that the term "news media" has a broad scope. The Act's public disclosure bar was enacted "to discourage parasitic suits brought by individuals with no information of their own to contribute to the suit." *United States v. Sprint Commc'ns, Inc.*, 855 F.3d 985, 993 (9th Cir. 2017). Any interpretation of the term "news media," in order to be faithful to the Act, therefore must advance this goal. Thus, as the Supreme Court has instructed, the public disclosure bar was designed to have a "broad[] sweep," as reflected "especially" by the inclusion of "news media." *Schindler Elevator Corp. v. United States ex rel. Kirk*, 563 U.S. 401, 407-408 (2011).

Interpreting "news media" broadly is consistent with the ordinary meaning of that phrase. The term "news" is defined simply as "[i]nformation about recent events or happenings, especially as reported by means of newspapers, *websites*, radio, television, and other forms of media." *See* "News," *The American Heritage Dictionary*, https://ahdictionary.com/word/search.html?q=news

(emphasis added) (visited July 8, 2020); *see also* "Media," *Black's Law Dictionary* (11th ed. 2019) (including "the Internet" as an example of a "means of mass communication"). Thus, "news media" encompasses, at a minimum, websites that publish such information.

Moreover, and as well detailed in the brief of Appellants (at 47-55), courts have reached a broad consensus that publicly accessible websites that disseminate information widely qualify as "news media" under the Act. *See, e.g.*, *United States ex rel. Beauchamp v. Academi Training Ctr., LLC*, 816 F.3d 37, 43 n.6 (4th Cir. 2016) ("[c]ourts have unanimously construed the term 'public disclosure' to include websites and online articles."); *United States ex rel. Osheroff v. Humana Inc.*, 776 F.3d 805, 813 (11th Cir. 2015) ("Because the term 'news media' has a broad sweep, we conclude that the newspaper advertisements and the clinics' publicly available websites, which are intended to disseminate information about the clinics' programs, qualify as news media for purposes of the public disclosure provision."); *United States ex rel. Cherwenka v. Fastenal Co.*, No. 14-cv-00187, 2018 WL 2069026, at *7 (D. Minn. May 3, 2018) ("information publicly available on a website"); *United States ex rel. Hagerty v. Cyberonics, Inc.*, 95 F. Supp. 3d 240, 257 n.7 (D. Mass. 2015) (information includes on "readily accessible websites"); *United States ex rel. Davis v. Prince*, 753 F. Supp. 2d 569,

585 (E.D. Va. 2011) (information generally accessible to the public through website).

The holdings in these decisions and the dozens of others cited by Appellants (*see* Appellants' Br. 50-51 & n.20) are not only consistent with the dictionary definition of "news media," but also properly reflect that the scope of that term has developed since the public disclosure bar was first enacted in 1986. In that pre-Internet age, the ordinary understanding of "news media" included newspapers, television, and radio, precisely because those were the most widespread channels of mass communication. In barring False Claims Act suits based on information published in those channels, Congress plainly intended to sweep in all facts that had been made available to the general public. Suits based on such facts do not serve the purpose of the False Claims Act of bringing to the government's attention fraud known only to a single private individual or small group of individuals. *See Sprint Commc'ns*, 855 F.3d at 993.

While, in 1986, traditional news sources served as the only means of making information available to the general public, today the Internet does so on an even wider scale than do those traditional sources. Indeed, in the offline world, "news media" is not limited to major broadcast networks or newspapers with national circulation. There is no dispute that the term encompasses trade journals, newsletters, and local newspapers with limited circulation—because

they nonetheless make information available to the general public. *See, e.g.*, *Graham Cty. Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 559 U.S. 280, 291 n. 9 (2010) (citing with approval district-court case holding that "the most obscure local news report" would qualify as news media); *United States ex rel. Ondis v. City of Woonsocket*, 587 F.3d 49, 52 (1st Cir. 2009) ("newspapers of general circulation in Woonsocket," Rhode Island, qualify as "news media"); *United States ex rel. Freedom Unlimited, Inc. v. City of Pittsburgh*, No. 12-cv-01600, 2016 WL 1255294, at *17 (W.D. Pa. Mar. 31, 2016) ("'News media' unquestionably includes articles disseminated by local newspapers."), *vacated on other grounds*, 728 F. App'x 101 (3d Cir. 2018). Publicly available websites do the same. As explained by one court, "[g]enerally accessible websites," even those that are "not traditional news sources," qualify as "news media" because they "serve the same purpose as newspapers or radio broadcasts, to provide the general public with access to information." *United States ex rel. Repko v. Guthrie Clinic, P.C.*, No. 3:04CV1556, 2011 WL 3875987, at *7 (M.D. Pa. Sept. 1, 2011), *aff'd*, 490 F. App'x 502 (3d Cir. 2012). In other words, if every print periodical, regardless of circulation, qualifies as "news media" because it disseminates information to the public, so must every website that does the same.

The district court here bucked what it acknowledged to be the "general consensus in the federal courts" and declared that online sources can be "news media" only if they satisfy the court's novel five-factor test. This Court should reject that test, first and foremost, because it reflects an incorrect statutory interpretation. But, as well described in the brief of Appellants (at 55-60), the court's multi-factor test also would create unnecessary complication and thus invite drawn-out litigation and discovery as to whether a particular website satisfies the test. Adopting such a fact-specific test thus would have the effect of extending the life of meritless actions brought by "parasitic" plaintiffs with no genuinely relevant, nonpublic information of their own. *See Sprint Commc'ns*, 855 F.3d at 993. Moreover, for the reasons set forth immediately below, offering that kind of lifeline to such plaintiffs would burden both the court system and the healthcare system in general, with no countervailing benefit.

Thus, for both doctrinal and jurisprudential reasons, this Court should not adopt a complicated multi-factor test to evaluate whether publicly accessible websites that disseminate information to the public qualify as "news media": they unequivocally do.

III. ALLOWING SUITS LIKE THIS ONE TO GO FORWARD WOULD IMPOSE SIGNIFICANT BURDENS ON DEFENDANTS AND COURTS

The complaint in this case, reliant as it is on nothing more than statistical inferences drawn from public information, is typical of those filed by professional

relators like Integra. Lacking access to genuinely inside information, let alone information demonstrating the existence of a fraud, such relators are forced to resort to mining public data in hopes of crafting a statistics-based case for potential fraud. Their aim is solely to reverse-engineer a False Claims Act claim, for the purpose of personal enrichment. They in no way aid the government in its effort to uncover "genuinely valuable information" regarding actual fraud. *See Graham*, 559 U.S. at 294.

But these actions by professional relators are not just unhelpful; they are affirmatively harmful. Besides burdening the court system, these lawsuits impose significant costs on defendant companies and thus ultimately on their customers in the broader public. Defending False Claims Act cases requires a "tremendous expenditure of time and energy," 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, *1 n.66 (2007). Indeed, "[p]harmaceutical, medical devices, and health care companies" alone "spend billions each year" dealing with False Claims Act litigation and discovery. Bentivoglio et al., *False Claims Act Investigations: Time for a New Approach?*, 3 Fin. Fraud L. Rep. 801, 801 (2011); *see also* Buck, 74 Ohio St. L.J. at 495-501 (describing the downside of any data-focused fraud enforcement regime); Barber et al., *Prolific Plaintiffs or Rabid Relators? Recent*

Developments in False Claims Act Litigation, 1 Ind. Health L. Rev. 135, 172 (2004). These costs are amplified by the sheer length of time that False Claims Act cases take, even when the government has declined to intervene. And because False Claims Act cases affect businesses in nearly all industries, the ripple effects of these burdens stretch across the economy.[2]

The significant burdens associated with False Claims Act cases that reach discovery, combined with the threat of treble damages plus per-claim penalties,

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[2] *See, e.g.*, *Mikes v. Straus*, 274 F.3d 687 (2d Cir. 2001) (healthcare services); *United States ex rel. Steury v. Cardinal Health, Inc.*, 735 F.3d 202 (5th Cir. 2013) (per curiam) (medical manufacturing); *United States ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163 (10th Cir. 2010) (waste disposal); *United States v. Sci. Applications Int'l Corp.*, 626 F.3d 1257 (D.C. Cir. 2010) (consulting services); *United States v. Sanford-Brown, Ltd.*, 788 F.3d 696 (7th Cir. 2015) (higher education), *vacated*, 136 S. Ct. 2506 (2016), *reinstated in part, superseded in part*, 840 F.3d 445 (7th Cir. 2016); *United States ex rel. Shemesh v. CA, Inc.*, 89 F. Supp. 3d 36 (D.D.C. 2015) (software development); *United States v. Americus Mortg. Corp.*, No. 12-cv-02676, 2014 WL 4273884 (S.D. Tex. Aug. 29, 2014) (mortgage lending); *United States ex rel. McLain v. Fluor Enters., Inc.*, 60 F. Supp. 3d 705 (E.D. La. 2014) (disaster relief construction services); *In re Kellogg Brown & Root, Inc.*, 756 F.3d 754 (D.C. Cir. 2014) (defense support services), *cert. denied*, 135 S. Ct. 1163 (2015); *United States ex rel. Landis v. Tailwind Sports Corp.*, 51 F. Supp. 3d 9 (D.D.C. 2014) (athletic sponsorship); *United States ex rel. Koch v. Koch Indus., Inc.*, 57 F. Supp. 2d 1122 (N.D. Okla. 1999) (crude oil purchasing); *United States ex rel. Anti-Discrimination Ctr. of Metro N.Y., Inc. v. Westchester Cty.*, 712 F.3d 761 (2d Cir. 2013) (provision of low-income housing); *United States ex rel. Bias v. Tangipahoa Parish Sch. Bd.*, 86 F. Supp. 3d 535 (E.D. La. 2015) (public school Junior ROTC program); *United States ex rel. Pritzker v. Sodexho, Inc.*, 364 F. App'x 787 (3d Cir.) (public school lunch services), *cert. denied*, 562 U.S. 838 (2010); *Grand Union Co. v. United States*, 696 F.2d 888 (11th Cir. 1983) (food stamp program).

see 31 U.S.C. § 3729(a), drive many defendants to settle, even when cases are meritless. *See, e.g.*, *Smith v. Duffey*, 576 F.3d 336, 340 (7th Cir. 2009) (discovery in "complex litigation can be so steep as to coerce a settlement on terms favorable to the plaintiff even when his claim is very weak"); Buck, 74 Ohio St. L.J. at 496; Hyman, *Health Care Fraud and Abuse: Market Changes, Social Norms, and the Trust* "*Reposed in the Workmen*," 30 J. Legal Stud. 531, 552 (2001).

These litigation and settlement costs ultimately are passed on the public. Government contractors may compensate for such costs by charging higher prices to the government. *Cf. United States v. Data Translation, Inc.*, 984 F.2d 1256, 1262 (1st Cir. 1992) (Breyer, C.J.) ("[S]ignificantly increasing competitive firms' costs of doing federal government business[] could result in the government's being charged higher . . . prices.") Importantly, these costs accrue even when defendants prevail: federal regulations permit cost-based contractors to pass on to the government up to 80% of their legal expenses from successfully litigating non-intervened *qui tam* cases.

Allowing meritless suits to proceed past the pleading stage also may have a chilling effect on potential defendants. In the healthcare industry, some doctors have chosen to disassociate from Medicare because of concerns about facing "fraud" liability. *See* Hogberg, Nat'l Center for Pub. Policy Res., *The Next Exodus: Primary-Care Physicians and Medicare* (Aug. 2012),

http://goo.gl/ZseD58. Doctors may also be reluctant to consider diverging from convention (in, for example, coding practices), even in the name of optimal care, for fear that they will trigger a statistics-based lawsuit like this one. Such an outcome has obvious nonfinancial costs for patients. *See* Buck, 74 Ohio St. L.J. at 495, 499-501. In the government-contracting context, some companies may opt out of the bidding process to avoid any risk of having to defend actions brought under the Act. *See* Memo from Michael D. Granston, Dir. Com. Litig. to Com. Litig. Br., Fraud Sec., *Factors for Evaluating Dismissal Pursuant to 31 U.S.C.3730(c)(2)(A)*, at 5 (Jan. 10, 2018), http://goo.gl/rjeGk7. This will drive up government costs. *See, e.g.*, S. Rep. No. 98-50, at 3 (1983) ("[C]ompetition in contracting saves money.").

In sum, although the False Claims Act and federal pleading standards require dismissal of statistics-based, fact-bereft actions in any event, the stakes of enforcing those legal standards are especially high in cases like this one. Allowing such actions to proceed past the pleading stage would skew the intended incentives of the False Claims Act and burden both courts and innocent businesses alike.

CONCLUSION

The Court should reverse the district court's judgment and remand with instructions to grant Defendants' motion to dismiss.

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Respectfully submitted,

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FOR THE NINTH CIRCUIT

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