No. _____

IN THE

Supreme Court of the United States

JOLIE JOHNSON & ESTATE OF DEBBIE HELMLY,

Petitioners,

v.

BETHANY HOSPICE AND PALLIATIVE CARE LLC,

Respondent.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Federal Rule of Civil Procedure 9(b) provides that "circumstances constituting fraud" must be "state[d] with particularity." The courts of appeals are divided over what Rule 9(b) requires in cases arising under the False Claims Act, 31 U.S.C. § 3729, which prohibits the submission of false or fraudulent claims for payment to the Government.

A commonly recurring fact pattern is that the plaintiff has detailed knowledge of a fraudulent scheme to submit false claims, but does not have firsthand knowledge of actual claims submitted to the Government (for example, because the plaintiff was not personally involved in the billing). In this situation, courts of appeals are divided over whether and when the plaintiff can proceed. Most circuits allow plaintiffs to proceed if the submission of false claims can reasonably be inferred from other well-pleaded facts. But a minority, including the Eleventh Circuit, hold that the submission of claims cannot be inferred from circumstances, and that unless the plaintiff pleads specific details of the claims themselves, the complaint must be dismissed.

The question presented is:

Whether Rule 9(b) requires plaintiffs in False Claims Act cases who plead a fraudulent scheme with particularity to also plead specific details of false claims.

PARTIES TO THE PROCEEDING

The parties to this proceeding are listed in the caption. The entities and individuals listed below were named as defendants in petitioners' original complaint, but after dismissals in the district court, Bethany Hospice and Palliative Care LLC (f.k.a. Bethany Hospice, LLC) is the only remaining defendant/appellee/respondent:

Bethany Hospice and Palliative Care of Coastal Georgia, LLC, f.k.a. Bethany Hospice of Coastal Georgia, LLC; Bethany Benevolence Fund, Inc.; Ava Best; Thomas Miller, M.D.; Justin Harrell, M.D.; David Arnett, M.D.; Stan Sinclair, M.D.; Richard E. Weieeler, M.D.; Berkley M. "Mac" Mackey; St. Joseph's - Candler Health System, Inc.; Joenie Almeida, M.D.; Brian Anderson., M.D.; Memorial Health, Inc.; Memorial Health University Medical Center, Inc.; Provident Health Services, Inc.; MPPG, INC.; Memorial Health University Physicians, LLC; Community Hospice Holdings, LLC; Southern Community Hospice Care, Inc.; Southern Community Hospice, Inc.; Vicki Ryles; Royce Ryles; Jason Colbert; James L. Ray, M.D.; Patrick Byrne, M.D.; Misty Poole, M.D.; Hospice Savannah, Inc.; The Steward Center for Palliative Care, Inc.; Hospice Savannah Foundation, Inc.; Monica Anderson; Bruce Barragan; Chad Carnell; Kelly Erola, M.D., Laura Farless, M.D.; Martin Greenberg, M.D.; Debra Anthony Larson; Appling Healthcare System, Inc.; Comfort Care Hospice, LLC; Ray Leadbetter; Angie Potts; Errol Graham, M.D.; Southcoast Health System; Southcoast Medical Associates, LLC; Southcoast Medical Group, LLC; Theodore Geffen, M.D.; Thomas Moriarity, M.D.; PruittHeath, INC.; Pruitt Health Hospice, Inc.; Neil Pruitt, Jr.

RELATED PROCEEDINGS

United States of America ex rel. Johnson v. Bethany Hospice of Coastal Ga., LLC, No. 4:16-cv-00290-WTM-BKE (S.D. Ga. Mar. 31, 2020)

Estate of Helmly v. Bethany Hospice & Palliative Care of Coastal Ga., LLC, No. 20-11624 (11th Cir. Apr. 26, 2021)

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OPINIONS BELOW

The Eleventh Circuit's opinion (Pet. App. 1a-16a) is not in the *Federal Reporter* but is reprinted at 853 F. App'x 496. The district court's opinion (Pet. App. 17a-44a) is not in the *Federal Supplement* but is available at 2020 WL 1542339.

JURISDICTION

The Eleventh Circuit entered judgment on April 26, 2021. Pet. App. 1a. This petition is timely under this Court's March 19, 2020 order extending the deadline to file any petition for a writ of certiorari to 150 days from the date of the lower court judgment, which applies in this case pursuant to this Court's July 19, 2021 order. This Court has jurisdiction pursuant to 28 U.S.C. § 1254.

RULES AND STATUTORY PROVISIONS

The relevant rule and statutory provisions are reproduced in the appendix at 89a-91a.

STATEMENT OF THE CASE

I. Legal Background

1. The False Claims Act (FCA) imposes civil liability on any person who knowingly presents, or causes to be presented, a false or fraudulent claim to the Government, or who makes or uses a false record or statement material to such a claim. 31 U.S.C. § 3729(a). This statute is "the government's primary civil tool to redress false claims for federal funds and property"; it protects "our military and first responders," "American businesses and workers," and "other critical government programs ranging from the provision of disaster relief funds to farming subsidies." U.S. Dep't of

Justice, *Justice Department Recovers over $3 Billion from False Claims Act Cases in Fiscal Year 2019* (Jan. 9, 2020), https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019. The FCA is designed "to reach all types of fraud, without qualification, that might result in financial loss to the Government." *Cook County v. United States ex rel. Chandler*, 538 U.S. 119, 129 (2003) (quotation marks omitted).

The FCA's most common application is redressing health care fraud. In 2020, for example, more than 80% of all FCA recoveries (over $1.8 billion) related to health care. U.S. Dep't of Justice, *Justice Department Recovers over $2.2 Billion from False Claims Act Cases in Fiscal Year 2020* (Jan. 14, 2021), https://www.justice.gov/opa/pr/justice-department-recovers-over-22-billion-false-claims-act-cases-fiscal-year-2020. That percentage echoes numbers from previous years.

One particularly important form of health care fraud is kickbacks from service providers to physicians, made in exchange for referrals. These "are pernicious because of their potential to subvert medical decision-making." *Justice Department Recovers over $2.2 Billion*, *supra*. The Anti-Kickback Statute (AKS) makes it a crime for any person to "offer[] or pay[] any remuneration . . . directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person" to refer patients for services covered by Federal health care programs—and for any person to accept such remuneration. 42 U.S.C. § 1320a-7b(b)(1), (2).

When claims for payment are tainted by kickbacks, they are false or fraudulent under the FCA. *See, e.g.*, *Guilfoile v. Shields*, 913 F.3d 178, 190 (1st Cir.

2019); *McNutt ex rel. United States v. Haleyville Med. Supplies, Inc.*, 423 F.3d 1256, 1259 (11th Cir. 2005). Congress codified that rule in 2010, amending the AKS to provide that "a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of" the FCA. 42 U.S.C. § 1320a-7b(g). Thus, "if a medical service provider pays kickbacks to a doctor to induce referrals and then submits claims to Medicare for services it provided to patients who were referred by that doctor, the claims are false" because the care was not provided in compliance with the AKS—even if the kickback was not a but-for cause of the referral. *United States ex rel. Greenfield v. Medco Health Sols., Inc.*, 880 F.3d 89, 98 (3d Cir. 2018) (citation omitted).

The FCA allows private citizens, known as *qui tam* relators, to sue on the Government's behalf, and keep a share of the recovery in a successful case. *See* 31 U.S.C. § 3730(b), (d). The *qui tam* provisions seek to "encourage any individual knowing of Government fraud to bring that information forward." S. Rep. No. 99-345, at 2 (1986). Statistics compiled by the Department of Justice show that since 1986, 13,957 *qui tam* cases have been filed (more than 600 each year since 2011), resulting in recoveries exceeding $46.5 billion. U.S. Dep't of Justice, *Fraud Statistics – Overview, October 1, 1986 – September 30, 2020*, at 3 (2021), https://www.justice.gov/opa/press-release/file/1354316/download.

2. Hospice providers assist primary caregivers of terminally ill patients. Most terminally ill people in the United States are aged 65 or older, of limited means, or both, and therefore eligible for Medicare and/or Medicaid, which pay for hospice. The

Government pays hospice providers on a per-patient, per-day basis corresponding to the general class of service (*e.g.*, in-home care, inpatient care, etc.). *See* 42 C.F.R. § 418.302; Pet. App. 47a-48a. The hospice provider uses these payments to cover all the costs of care.

Hospice providers bill the Government using Form 1500, issued by the Centers for Medicare and Medicaid Services (CMS). Pet. App. 49a. Both Form 1500 and Form 855A, which providers must file to establish their eligibility to bill, require providers to certify their compliance with applicable laws, including the AKS. *See id*. at 49a-50a.

Kickbacks in the hospice space are particularly dangerous because patients in hospice care no longer receive curative treatments. Thus, when kickbacks induce physicians inappropriately to refer patients to hospice, they threaten to undermine critical care for a particularly vulnerable population.

3. This case involves the intersection between the FCA and Federal Rule of Civil Procedure 9(b), which provides that "circumstances constituting fraud" must be pleaded "with particularity." Rule 9(b) applies to every FCA case, and is therefore important in hundreds of legally and financially significant cases every year.

II. Factual Background and Procedural History

1. Petitioners' operative Third Amended Complaint (Pet. App. 45a-88a) alleges that respondent Bethany Hospice and Palliative Care of Georgia, LLC (Bethany Hospice) offered kickbacks to doctors to induce referrals of patients to Bethany Hospice, and

then presented claims for payment for the referred patients to the Government in violation of the FCA.

Normally in a petition seeking certiorari, we would not focus on facts or include a complaint in the appendix. But this case is about when complaints are detailed enough to survive Rule 9(b), so it is important to understand how detailed the complaint was. It was 37 pages, including 108 paragraphs of allegations laying out the "who, what, where, when, and how" of the fraudulent scheme.

Regarding "who," petitioners allege that Bethany Hospice's principals, Ava Best and Mac Mackey, offered remuneration to at least four doctors—David Arnett, Conrad Harper, Justin Harrell, and Stan Sinclair, collectively the "Bethany Hospice doctors"—as inducements to refer patients to Bethany Hospice. Pet. App. 3a, 5a, 50a, 62a.

The "where" and "when" are similarly straightforward. Bethany Hospice operates four locations in Georgia, where the Bethany Hospice doctors acted as part-owners and medical directors. Pet. App. 3a, 21a, 46a-47a. The complaint alleges that the kickbacks began in 2007, *id.* at 51a, 61a, and includes especially detailed allegations relating to the period from 2014 through 2018, which are based on petitioners' own observations during their employment (from late 2014 through mid-2015, when petitioners were terminated in retaliation for their whistleblowing activity), their conversations with employees who stayed at Bethany Hospice for longer, and Medicare claims data, *id*. at 63a-66a, 74a-78a.

With respect to "what," the complaint alleges that Best and Mackey offered discounted investment

interests, salaries, and dividend payments to doctors as inducements for referrals. Pet. App. 56a-61a. When negotiating petitioner Helmly's[1] salary, Best revealed that she wanted to incentivize referrals, and therefore always linked compensation to referrals for medical directors. *Id*. at 51a, 56a-57a. Best thus admitted that the medical directors' salary payments were "made to doctors for referrals rather than for the obligation of an appropriate amount of actual work for the hospice." *Id*. at 58a. Best further disclosed that doctor-owners received dividend payments as compensation for patient counts, and not in proportion to amounts invested. *Id*. at 59a.

Best's partner Mackey confirmed that investment interests in Bethany Hospice were designed to induce referrals. *See* Pet. App. 60a. Once, Bethany Hospice was considering offering an investment interest to a doctor. *See ibid.* When it became known that the doctor had never referred patients to the previous hospice where he was a medical director, Mackey decided to forgo the deal, saying, "Forget it. We do not need him if he does not and will not refer patients to Bethany." *Ibid*.

Best also explained that the purpose of the compensation scheme was also to avoid detection. Best previously worked for Odyssey Hospice. Pet. App. 55a. Best revealed that she "knew Odyssey got referrals by giving medical directors kickbacks," which resulted in an enforcement action and settlement of FCA claims. *Id*. at 55a-56a. In March 2015, Best explained that by

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[1] Debbie Helmly died during the pendency of this litigation; her estate is the substituted plaintiff and petitioner here. Pet. App. 18a n.2.

"making potential referral sources medical directors and medical directors 'part owners,'" she could ensure that they "would not get caught." *Id*. at 64a.

The complaint also details "how" the scheme worked. Marketers, including petitioner Johnson, would visit doctors to solicit referrals to Bethany Hospice. "Best insisted that Bethany Hospice and Bethany Coastal patients have either Medicare or Medicaid coverage." Pet. App. 78a. Thus, when marketers sought referrals, they explicitly asked doctors whether the patients they were referring "were covered by Medicare or Medicaid." *Id*. at 79a. The Bethany Hospice doctors, in turn, provided the marketers "with names of patients eligible for Medicare and Medicaid coverage." *Ibid*. The marketers would visit patients and gather more information, including social security numbers, which were used to confirm patients' eligibility for Medicare and Medicaid coverage. *Id*. at 79a-80a.

The marketers tendered this information to an admissions coordinator, such as Tonya Smith at the Douglas location, who would verify patients' Medicare eligibility before enrolling them. *See* Pet. App. 74a. "No patient was admitted to Bethany Hospice in Douglas until Ms. Smith certified that they had Medicare eligibility and she logged the referral source," *i.e.*, the name of the referring physician, "into Consolo," which was the name of Bethany Hospice's computerized billing system. *Id*. at 74a-75a; *see also id*. at 58a (defining Consolo). Smith was not the only employee who entered information into Consolo this way. Petitioner Johnson confirmed that Bethany Hospice's billers in Valdosta followed the same procedure. *Id*. at 80a. Indeed, Johnson confirmed that at every Bethany

Hospice location, "[b]illing personnel would take the information from the marketers and run it through the system to assure coverage before a patient could be admitted." *Id*. at 78a.

Best also used Consolo to generate "weekly and monthly reports detailing how many referrals each physician has made." Pet. App. 59a. Jeneen Cliett, a vice president of Bethany Hospice and clinical director of the Douglas office, and Monica Jones, head of quality assurance for Bethany Hospice, informed petitioner Helmly that "Best uses these reports to determine how much to pay referral sources." *Ibid*. According to Cliett and Jones, Best and Mackey "routinely reviewed the return on investment ('ROI') for their kickbacks." *Ibid*. And according to Best herself, "physicians who refered [sic] the most patients receive the largest payments." *Ibid*.

Bethany Hospice's kickbacks induced the desired referrals. For the four Bethany Hospice doctors, "nearly none of their referrals went to Bethany Hospice before their financial arrangements," but "nearly all" of their referrals afterwards went to Bethany Hospice. Pet. App. 63a. "Dr. Harper, for instance, only referred two such patients to Bethany Hospice prior to receiving kickbacks." *Ibid*. But after the kickbacks began, he referred every patient he could to Bethany Hospice—including 91 Medicare patients from the fourth quarter of 2016 through the third quarter of 2018. *Id*. at 63a, 76a-78.

The Eleventh Circuit held that petitioners' complaint was insufficient because it did not adequately allege that Bethany Hospice actually billed the Government for the care of patients who had been referred by the Bethany Hospice doctors. Pet. App. 12a-15a.

But the complaint's allegations on this point are robust.

First, the complaint alleges that Consolo would automatically bill patients' "per diem on a CMS Form 1500." Pet. App. 74a. Thus, once eligible patients were entered into the system, billing to the Government was effectively automatic. Petitioners knew this because they personally worked with the system. As a marketer, petitioner Johnson interacted with administration and billing personnel at every Bethany Hospice location. *Id*. at 78a. She was also trained on how referrals were input into Bethany Hospice's billing system to ensure *both* that the referrals were recorded and that the patients were eligible for Government-funded health care, *id*. at 79a-80a, and indeed she used this system herself, *id*. at 82a. Petitioner Helmly was an administrator, a high-ranking position. Her "responsibilities entailed overseeing all the billing at Bethany Coastal" (an affiliate of Bethany Hospice). *Id*. at 53a.[2] She "had access to all of the billing information and census reports for every Bethany office," including "all billing and referral data." *Id*. at 80a. Thus, petitioners had "intimate knowledge of Bethany Hospice's and Bethany Coastal's billing protocols and operations," including "the types of patients Bethany Hospice and Bethany Coastal endeavored to put under service, who the primary referral sources for each entity were, and the specific entities that reimbursed Bethany Hospice for hospice services." *Id*. at 73a.

[2] For all practical purposes, Bethany Hospice and Bethany Coastal are one and the same: They have common ownership and share a website, policies, controlling officers, employees, equipment, accounts, and a main office address. Pet. App. 80a-85a.

The complaint also includes Government data showing actual claims for payment. This data "only tracks Medicare patients for which Bethany Hospice has billed Medicare and received payment," and "details how many Medicare referrals a particular physician makes to a particular hospice facility, as well as how many total patient days the hospice received Medicare reimbursement for as a result of that physician's referrals." Pet. App. 76a. The data shows that Bethany Hospice billed and collected millions of dollars from Medicare each year. *See ibid.* It also shows that from the fourth quarter of 2016 through the third quarter of 2018, the Bethany Hospice doctors were four of the top six referring physicians to Bethany Hospice (indeed, they held the top three spots). *Id.* at 76a-77a. For each one of them, it shows the number of patients referred to Bethany Hospice from 2016 to 2018, and the number of patient days of care Bethany Hospice sought reimbursement for from the Government. *Id.* at 77a-78a. Because the data only reflects *actual* payments, it shows conclusively that the Government paid for patients referred by those doctors. *See id.* at 76a.

Other facts confirmed that Bethany Hospice billed the Government for the care of patients who had been referred by the Bethany Hospice doctors. Petitioner Johnson personally reviewed site census reports, which "revealed that federal health care programs covered the hospice expenses for a substantial majority of patients (100% or nearly 100%)." Pet. App. 80a. Petitioner Helmly confirmed through reports and management meetings "that all or nearly all of Bethany Hospice's patients put under service received coverage from Medicare and Medicaid." *Ibid*. Medicare data

likewise confirms that "Bethany Hospice derives nearly all of its revenue from the Medicare program monies." *Id*. at 76a.

Knowledgeable former Bethany Hospice employees confirmed this information. Shanda Jowers, a former clinical director, confirmed "that Bethany Hospice's Douglas facility received the vast majority of its patient referrals from" the four Bethany Hospice doctors. Pet. App. 73a. She confirmed, based on "conversations with Ms. Best and Ms. Cliett both in management meetings and during day-to-day operations," that the patients referred by the four doctors were Medicare and Medicaid patients for whose care Bethany Hospice collected money from the Government. *Id*. at 73a-74a. She also "confirmed that Bethany Hospice's policy was to admit patients only if they had Medicare or Medicaid coverage." *Id*. at 73a.

Robert Clements, a community education representative, had access to referral data, personally received referrals from physicians, and also trained petitioner Johnson. Pet. App. 74a, 79a. Clements, Best, and Cliett, "were a core of the Bethany Hospice billing apparatus." *Id*. at 75a. Clements confirmed that "every single referral" from the Bethany Hospice doctors "was for a Medicare or Medicaid beneficiary." *Id*. at 74a. Clements knew this "because each time he retrieved referrals from these physicians, the physician orders and patient paperwork would denote the payor." *Ibid*. He also confirmed how the information was entered into Consolo. *Ibid*. Clements confirmed other key allegations, including that:

> Bethany Hospice receives nearly all of its referrals from area physicians with a financial interest in Bethany Hospice, that these

> physicians always referred every Medicare and Medicaid patient to Bethany Hospice that they controlled, and that Bethany Hospice billed Government health programs for the services rendered to Medicare and Medicaid patients referred by these physicians.

Id. at 75a. Bethany Hospice accountant Elnita Ginn likewise confirmed that respondent received payments from the Government for patients referred by the Bethany Hospice doctors. *Ibid.*

The complaint also alleges a pattern of harassment against petitioners, including threats, termination, and post-departure harassment. *E.g.*, Pet. App. 67a-71a. Best forbade anybody working for Bethany Hospice and Bethany Coastal from having any contact with petitioners whatsoever, and indeed fired one employee on the false accusation that she had contacted petitioners. *Id.* at 70a. This was to prevent petitioners from gathering evidence of false claims. *Id.* at 71a.

Based on the foregoing, the complaint alleges that Bethany Hospice violated the FCA by: (1) presenting false or fraudulent claims; (2) making or using false records or statements material to false or fraudulent claims; and (3) retaliating against petitioners. Pet. App. 85a-87a. The parties later settled the retaliation claim. *Id.* at 7a n.6.

2. Notwithstanding the level of detail just recited, the district court dismissed petitioners' complaint for lack of particularity under Rule 9(b). The court held that under Eleventh Circuit precedent, the complaint did not plead kickbacks or the submission of false claims with particularity. *See* Pet. App. 29a-43a.

3. The Eleventh Circuit affirmed only on the latter ground, holding that the complaint failed "to plead with particularity the submission of an actual false claim to the government." Pet. App. 3a.

Describing its legal rule, the Eleventh Circuit held that "a complaint must allege actual submission of a false claim, and that it must do so with some indicia of reliability." Pet. App. 11a (quotation marks omitted, but quoting from *Carrel v. AIDS Healthcare Found., Inc.*, 898 F.3d 1267, 1275 (11th Cir. 2018), and *United States ex rel. Clausen v. Lab'y Corp. of Am.*, 290 F.3d 1301, 1311 (11th Cir. 2002)). What this means is that the plaintiff must allege "specifics about actual claims submitted to the government." *Id*. at 12a. The court explained that under its precedents, submission of false claims "cannot be inferred from the circumstances." *Id*. at 11a (quoting *Carrel*, 898 F.3d at 1275, and *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1013 (11th Cir. 2005) (per curiam)). Instead, it must be pleaded directly; the relator must either provide "a sample fraudulent claim," or "particular facts about a representative false claim." *Id*. at 13a.

Under this rule, the Eleventh Circuit deemed petitioners' allegations insufficient. The fact that petitioners held positions that gave them firsthand knowledge of billing practices was not enough, the court reasoned, because they still "failed to provide any specific details regarding either the dates on or the frequency with which the defendants submitted false claims, the amounts of those claims, or the patients whose treatment served as the basis for the claims." Pet. App. 13a-14a (quoting *United States ex rel. Sanchez v. Lymphatx, Inc.*, 596 F.3d 1300, 1302 (11th Cir. 2010) (per curiam)). Moreover, petitioners "did not

claim to have observed the submission of an actual false claim; nor did they personally participate in the submission of false claims." *Id.* at 14a.

The Eleventh Circuit also held that even though Bethany Hospice's business model is to bill the Government for all or nearly all of its patients, that "lends no credence to [petitioners'] allegation that Bethany Hospice submitted a false claim" because, under Eleventh Circuit precedent, "relators cannot 'rely on mathematical probability to conclude that [a defendant] surely must have submitted a false claim at some point.'" Pet. App. 14a (quoting *Carrel*, 898 F.3d at 1277) (alteration in original). According to the Eleventh Circuit, "numerical probability is not an indicium of reliability" that claims were submitted—even when, as here, the defendant "billed the government for almost all its business." *Id*. at 15a. Again, the lack of "specific details about the submission of an actual false claim" was fatal. *Ibid*.

The Eleventh Circuit applied the same objection to the "Medicare claims data," which showed that Medicare had actually paid money to Bethany Hospice for patients referred by the Bethany Hospice doctors. Pet. App. 14a. This, too, was not "reliable" enough under Eleventh Circuit precedent because, even though it included numbers of patients and patient days billed, it did not include "specific details" about individual claims. *Id*. at 15a.

4. This petition followed.

REASONS FOR GRANTING THE WRIT

I. The Circuits Are Split Over What Rule 9(b) Requires in False Claims Act Cases

Certiorari should be granted to resolve a longstanding circuit split about how Rule 9(b) works in FCA cases. In general, the circuits split into three groups. The Eleventh Circuit has the most rigid interpretation of Rule 9(b), requiring relators who have pled a fraudulent scheme with particularity also to plead specific details of false claims; six circuits adopt a flexible approach that allows the submission of claims to be inferred from circumstances (including from a fraudulent scheme); and four circuits have adopted rules that typically require relators to plead details of false claims, but recognize certain exceptions. The split has been repeatedly acknowledged by courts and commentators alike. *See* Tricia L. Forte, *Resolving the Circuit Split: Pleading Healthcare Fraud with Particularity*, 25 Roger Williams U. L. Rev. 16, 17 (2020) ("There is a circuit split regarding pleading standards under Rule 9(b) which has resulted in different outcomes depending on where the suit is brought as to whether the case is allowed to proceed."); Brianna Bloodgood, *Particularity Discovery in Qui Tam Actions: A Middle Ground Approach to Pleading Fraud in the Health Care Sector*, 165 U. Pa. L. Rev. 1435, 1442 (2017) ("[T]he Supreme Court has yet to grant certiorari to resolve the circuit split."); Sara A. Smoter, Note, *Relaxing Rule 9(b): Why False Claims Act Relators Should Be Held to a Flexible Pleading Standard*, 66 Case W. Res. L. Rev. 235, 242 (2015) ("The Eleventh Circuit applies the most inflexible application of Rule 9(b).").

1. The Eleventh Circuit adopts the most rigid approach to Rule 9(b). In *United States ex rel. Clausen v. Laboratory Corp. of America*, 290 F.3d 1301 (11th Cir. 2002), the court held that Rule 9(b) "does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government." *Id*. at 1311. Instead, the plaintiff must identify "actual, and not merely possible or likely, claims" for payment. *See id.* at 1313.

In *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1013 (11th Cir. 2005) (per curiam), the Eleventh Circuit elaborated on its approach, holding that the submission of a fraudulent claim . . . must be pleaded with particularity and not inferred from the circumstances." The Eleventh Circuit specifically rejected the argument "that a pattern of improper practices of the defendants leads to the inference that fraudulent claims were submitted to the government." *Ibid*. Thus, even though the plaintiff was an insider at the company who claimed to be "'aware' of the manner by which the defendants submitted fraudulent claims and had 'learned from his colleagues the national reach of the schemes,'" the court deemed his complaint inadequate because it did not show "that a specific fraudulent claim was in fact submitted to the government." *Id*. at 1013-14; *see also United States ex rel. Atkins v. McInteer*, 470 F.3d 1350, 1359 (11th Cir. 2006) (holding that when plaintiff described scheme in detail, including identifying "particular patients, dates and corresponding medical records for services that he contends were not eligible for government

reimbursement," the claim still failed because the plaintiff was "not a billing and coding administrator responsible for filing and submitting the defendants' claims for reimbursement"—and therefore not privy to the submission of actual false claims); *United States ex rel. Sanchez v. Lymphatx, Inc.*, 596 F.3d 1300, 1302 (11th Cir. 2010) (per curiam) (finding complaint inadequate when relator claiming "direct knowledge of the defendants' billing and patient records" failed to provide "at least some examples of actual false claims") (quotation marks omitted).

In *Carrel v. AIDS Healthcare Foundation, Inc.*, 898 F.3d 1267 (11th Cir. 2018), the Eleventh Circuit held that "even if the relator is an insider who alleges awareness of general billing practices, an accusation of underlying improper practices alone is insufficient absent allegations that a specific fraudulent claim was in fact submitted to the government." *Id*. at 1275 (cleaned up). Under the Eleventh Circuit's rule, it is not enough to allege a scheme to defraud; the plaintiff must also "allege with particularity that" the scheme resulted in "an actual false claim." *Id*. at 1277. Moreover, relators cannot "rely on mathematical probability to conclude that the [defendant] surely must have submitted a false claim at some point"; such allegations are, in the Eleventh Circuit's view, too speculative. *Ibid*.[3]

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[3] The Eleventh Circuit has held that when the plaintiff participated firsthand in the submission of false claims, she could proceed without representative examples. *See Carrel*, 898 F.3d at 1276. But even in this circumstance, the Eleventh Circuit requires "specific details about false claims." *Ibid*. (quotation marks omitted).

Here, relying heavily on these decisions, the Eleventh Circuit concluded that because petitioners "failed to allege any specifics about actual claims submitted to the government," the claim failed as a matter of law—notwithstanding petitioners' insider knowledge and claims data showing that claims for payment were submitted. Pet. App. 12a. Under the Eleventh Circuit's rule, the existence of false claims can never be inferred from circumstances, established by probability, or even shown through aggregated data; the claims themselves be pleaded in detail. *See id*. at 11a.

2. Six circuits—the Third, Fifth, Seventh, Ninth, Tenth, and D.C. Circuits—hold that specific details of false claims are not required, and that the existence of false claims can be inferred from circumstances, including from the existence of a scheme that naturally would lead to the submission of false claims.

While the Eleventh Circuit holds that the submission of false claims cannot be inferred from circumstances, Pet. App. 11a, the Seventh Circuit recognizes that "much knowledge is inferential," and permits complaints to proceed if the allegation that false claims were submitted is a "plausible" inference from the scheme alleged. *United States ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 854 (7th Cir. 2009). Thus, in *Lusby*, an employee who alleged a fraudulent scheme to provide noncompliant products to the Government, but had never seen the defendant's actual bills and certifications of compliance, was permitted to proceed because it was reasonable to infer that the defendant had certified its compliance when it sought payment. *See ibid*.

In subsequent cases, the Seventh Circuit has confirmed that "a plaintiff does not need to present, or

even include allegations about, a specific document or bill that the defendants submitted to the Government." *United States ex rel. Presser v. Acacia Mental Health Clinic, LLC*, 836 F.3d 770, 777 (7th Cir. 2016) (citing *Lusby*, 570 F.3d at 853-54, and *Leveski v. ITT Educ. Servs., Inc.*, 719 F.3d 818, 839 (7th Cir. 2013)). Instead, when the defendant receives money from the Government, while violating conditions for payment, a court may infer the submission of false claims from the juxtaposition of those two facts.

Most recently, the Seventh Circuit reaffirmed that a relator can satisfy Rule 9(b) if his allegations "plausibly support[] the inference that [the defendant] included false information" in its communications with the Government, even if the allegations only provide "circumstantial evidence" of an FCA violation. *United States ex rel. Prose v. Molina Healthcare of Ill., Inc.*, 10 F.4th 765, 774 (7th Cir. 2021). Like this case, *Prose* involved an allegation that the defendant's misconduct (there, failure to make all required services available) tainted a large category of claims for payment *per se*. *See id*. at 769-70. Because that scheme was pleaded with particularity, it was not also necessary to plead details of claims for payment.

The Fifth Circuit applies the same flexible rule. For example, in *United States ex rel. Colquitt v. Abbott Laboratories*, 858 F.3d 365, 371 (5th Cir. 2017), the court of appeals considered a case that, like this one, arose out of alleged kickbacks (there, between a stent manufacturer and the hospitals and physicians that used the stents). The district court held that although the relator "had identified some specific hospitals and doctors that allegedly received kickbacks, he did not plead that any of these hospitals or doctors signed up

to be Medicare providers or submitted certified claims for reimbursement for procedures using Abbott's stents." *Ibid*. The Fifth Circuit determined that this was "too rigid an application of Rule 9(b)," which is "context specific and flexible and must remain so to achieve the remedial purpose of the False Claims Act." *Id*. at 372 (quoting *United States ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009)). The Fifth Circuit held that instead of requiring "the details of an actually submitted false claim," it was enough to allege "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *Ibid*. (quoting *Grubbs*, 565 F.3d at 190).

Applying this rule, the Fifth Circuit determined that the relator's allegations permitted "[a] strong inference that the named hospitals submitted claims to Medicare" because "[n]early every hospital in America participates in Medicare and would most likely have billed Medicare had they performed procedures using Abbott's stents on a person over age 65," a practice the complaint alleged was "common." *Colquitt*, 858 F.3d at 372. Given the nature of the scheme, probability and circumstantial evidence were enough to infer the existence of claims for payment.[4]

In *Grubbs*, the case quoted in *Colquitt*, the Fifth Circuit explained that emphasis on details of claims is misplaced because "[s]tating 'with particularity the circumstances constituting fraud' does not necessarily and always mean stating the contents of a bill. The

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[4] The relator's claim in *Colquitt* failed for the independent reason that he did not allege the underlying scheme with particularity. *See* 858 F.3d at 371-72.

particular circumstances constituting the fraudulent presentment are often harbored in the scheme," and not the bills themselves. 565 F.3d at 190. Thus, when "the logical conclusion of the particular allegations" in a complaint is that "fraudulent bills were presented to the Government," the complaint survives Rule 9(b) even if it does not include details of the bills themselves. *Id*. at 192. The court also recognized that to require details about claims "at pleading is one small step shy of requiring production of actual documentation with the complaint, a level of proof not demanded to win at trial and significantly more than any federal pleading rule contemplates." *Id*. at 190.

The Third Circuit acknowledged a circuit split, and then joined the Fifth Circuit in holding that Rule 9(b) is satisfied if the plaintiff can allege "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153, 156 (3d Cir. 2014) (quoting *Grubbs*, 565 F.3d at 190, and contrasting the Fifth Circuit's approach with that taken by the Fourth, Sixth, Eighth, and Eleventh Circuits). In *Foglia*, the Third Circuit reaffirmed its precedent holding that it was not necessary for a plaintiff to "identify a specific claim for payment at the pleading stage." *Ibid*. (quotation marks and emphasis omitted).

In a case analogous to this one, the Third Circuit has held that when falsity "comes not from a particular misrepresentation, but from a set of circumstances that, if true, makes a whole set of claims at least prima facie false," the complaint satisfies Rule 9(b) if it "allege[s] those circumstances with particularity." *United States ex rel. Bookwalter v. UPMC*, 946 F.3d 162, 176

(3d Cir. 2019), *cert. denied*, 140 S. Ct. 2720 (2020). In *Bookwalter*, the plaintiff alleged that the defendant violated the Stark Act, which generally prohibits hospitals from billing Medicare for certain services when the hospital has a financial relationship with the doctor who asked for those services. *See id.* at 165-66. Like AKS violations, violations of the Stark Act taint claims for payment, thus giving rise to FCA liability. *See id.* at 166. Because the plaintiff was able to plead that the defendant was compensating surgeons for referrals (a fact that, if true, would taint all resulting claims for payment), it was not also necessary to plead the details of false claims. *See id.* at 176-77.

The Ninth Circuit has explicitly "join[ed] the Fifth Circuit," and rejected stricter approaches to Rule 9(b). *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir. 2010) (contrasting the Fifth Circuit's approach with that of the First, Sixth, Eighth, and Eleventh Circuits).

In *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 679 (9th Cir. 2018), the relator alleged that the defendant Medicare Advantage organizations contracted with a third party to provide health assessment reports and diagnoses of their beneficiaries, and that the contractor's approach was to overstate the beneficiaries' health problems, thus increasing the amount of money the Medicare Advantage organizations could seek from the Government for those beneficiaries' care. The Ninth Circuit held that even though the relator did not have firsthand knowledge that the false data was actually submitted to the Government, there was "ample circumstantial evidence from which to infer that the defendant organizations submitted [the contractor's] risk adjustment data and certified

the data's validity." *Ibid*. Even though it was "possible that some Medicare Advantage organization, after paying for [the contractor's] services, might have discovered the fraud and then cut ties with the company and thrown out its data," the allegations were enough to support the contrary inference; indeed, the court held that "it would stretch the imagination to infer" that defendants paid for years for data that they never used. *Ibid*. (quoting *Grubbs*, 565 F.3d at 192) (alteration omitted).

More broadly, the Ninth Circuit has held that Rule 9(b) "does not require absolute particularity or a recital of the evidence," and therefore does not require a complaint to allege "a precise time frame, describe in detail a single specific transaction or identify the precise method used to carry out the fraud." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) (quotation marks omitted). Instead, if the complaint is specific enough to give the defendant notice of the allegations, and to dispel an inference that the allegations are spurious, it satisfies Rule 9(b). *See id.* at 1183 n.11.

The Tenth Circuit has likewise adopted the flexible rule that "claims under the FCA need only show the specifics of a fraudulent scheme and provide an adequate basis for a reasonable inference that false claims were submitted as part of that scheme." *United States ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163, 1172 (10th Cir. 2010). The court also "excuse[s] deficiencies that result from the plaintiff's inability to obtain information within the defendant's exclusive control," including details about claims and billing procedures. *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 745 (10th Cir. 2018). That

is because "Rule 9(b) does not require omniscience; rather the Rule requires that the circumstances of the fraud be pled with enough specificity to put defendants on notice as to the nature of the claim." *Ibid*. (quotation marks omitted). Telling defendants what they already know is not essential to providing notice.

The D.C. Circuit has joined these "sister circuits in holding that the precise details of individual claims are not, as a categorical rule, an indispensable requirement of a viable False Claims Act complaint." *United States ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 126 (D.C. Cir. 2015). As the court recognized, "providing identifying details about specific payments is less important to put the defendant on notice" when the allegations are not about those details. *Id*. at 125.

Under the rule adopted in any of these circuits, petitioners' complaint easily would have survived. The conflict is especially acute vis-à-vis *Prose*, *Colquitt*, *Bookwalter*, and *Silingo*, all of which involved alleged fraudulent schemes that tainted large numbers of unidentified claims for payment.

3. Other courts' approaches fall between the Eleventh Circuit's rigid approach and the more flexible approach taken by the majority of circuits.

The First Circuit follows the Eleventh Circuit by holding that representative examples of false claims are required in most cases. It recognizes an exception, however, when the plaintiff alleges that the defendant caused a third party to submit false claims. *See United States ex rel. Nargol v. DePuy Orthopaedics, Inc.*, 865 F.3d 29, 38-39 (1st Cir. 2017). When, as here, the complaint alleges that the defendant submitted false claims directly, that exception does not apply, and so

the First Circuit's rule is the same as the Eleventh's in a case like this one, and petitioners' complaint would have been wrongly dismissed there, too.

The Eighth Circuit largely models its approach on Eleventh Circuit precedent, but recognizes an exception that might apply here. In *United States ex rel. Joshi v. St. Luke's Hospital, Inc.*, 441 F.3d 552, 557 (8th Cir. 2006), the relator alleged "a systematic practice" of false billing for anesthesia services that, according to the relator, rendered every claim for payment false. The Eighth Circuit affirmed dismissal of the complaint under Rule 9(b) because it failed to provide "representative examples of [the defendants'] alleged fraudulent conduct." *Ibid*. For support, the Eighth Circuit cited the Eleventh Circuit's decision in *Corsello*.

Later, the Eighth Circuit slightly softened its rule, holding that representative examples are not always required. *See United States ex rel. Thayer v. Planned Parenthood of the Heartland*, 765 F.3d 914, 917 (8th Cir. 2014). Instead, when a relator is "able to plead personal, first-hand knowledge of [the defendant's] submission of false claims," that provides the requisite "reliable indicia that lead to a strong inference that claims were actually submitted." *Ibid*. (quotation marks omitted). Under this rule, relators who, by virtue of their job duties, have firsthand knowledge of a defendant's billing practices may sometimes succeed. But other relators may not proceed unless they plead representative example claims. *See United States ex rel. Strubbe v. Crawford Cnty. Mem'l Hosp.*, 915 F.3d 1158, 1163, 1165 (8th Cir.) (holding that relators who were paramedics and EMTs "did not have access to the billing department," and so even though their

complaint alleged a "wide-ranging fraudulent scheme," they did not allege the submission of false claims with the requisite particularity), *cert. denied*, 140 S. Ct. 553 (2019); *United States ex rel. Benaissa v. Trinity Health*, 963 F.3d 733, 740 (8th Cir. 2020) (holding that trauma surgeon was unable to satisfy Rule 9(b), and refusing to hold that inference of false claims was reasonable when the plaintiff alleged that over a quarter of a hospital's revenue came from Medicare, and that every claim submitted by certain physicians was false due to Stark and AKS violations).

The Sixth Circuit's rule is similar to the Eighth's. That court held that "where a relator pleads a complex and far-reaching fraudulent scheme with particularity," the relator must also "provide[] examples of specific false claims submitted to the government pursuant to that scheme." *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 510 (6th Cir. 2007). Under this rule, "it is insufficient to simply plead the scheme;" the relator "must also identify a representative false claim that was actually submitted to the government." *Chesbrough v. VPA, P.C.*, 655 F.3d 461, 470 (6th Cir. 2011). Like the Eighth Circuit, the Sixth has recognized that when the relator has a high degree of billing-related knowledge, that knowledge may serve in the place of representative example bills. *See United States ex rel. Prather v. Brookdale Senior Living Cmtys., Inc.*, 838 F.3d 750, 769-70 (6th Cir. 2016). But this exception is "narrow"; the general rule is that representative examples are required. *United States ex rel. Ibanez v. Bristol-Myers Squibb Co.*, 874 F.3d 905, 920 (6th Cir. 2017).

Although the matter is not free from doubt, it is likely that the result in this case would have been

different in the Sixth and Eighth Circuits because petitioners personally know of Bethany Hospice's billing practices, and also spoke with other knowledgeable employees.

The Fourth Circuit has yet another rule. It allows a complaint alleging the presentment of false claims to satisfy Rule 9(b) in two ways. First, the complaint can describe specific false claims in detail (similar to the Eleventh Circuit's rule). *See United States ex rel. Nathan v. Takeda Pharms. N. Am., Inc.*, 707 F.3d 451, 456 (4th Cir. 2013). Second, the complaint can "allege a pattern of conduct that would necessarily have led to submission of false claims to the government for payment." *United States ex rel. Grant v. United Airlines Inc.*, 912 F.3d 190, 197 (4th Cir. 2018) (cleaned up). The possibility or even probability that the Government was billed is not enough; the fact must be certain.

Petitioners can satisfy the Fourth Circuit's second rule because they know that Bethany Hospice bills essentially all of its services to the Government—and also because they produced claims data showing actual claims for payment for patients referred by the Bethany Hospice doctors.

Finally, the Second Circuit has "decline[d] to require that every *qui tam* complaint allege on personal knowledge specific identified false invoices submitted to the government." *United States ex rel. Chorches v. Am. Med. Response, Inc.*, 865 F.3d 71, 86 (2d Cir. 2017). Instead, "a complaint can satisfy Rule 9(b)'s particularity requirement by making plausible allegations creating a strong inference that specific false claims were submitted to the government," but only if the complaint also alleges "that the information that

would permit further identification of those claims is peculiarly within the opposing party's knowledge." *Ibid*. Under this rule, "those who *can* identify examples of actual claims *must* do so at the pleading stage." *Ibid*.

Commenting on the circuit split, the Second Circuit believed its rule was "clearly consistent with the approach taken by the Third, Fifth, Seventh, Ninth, Tenth, and D.C. Circuits, which have overtly adopted a 'more lenient' pleading standard." *Chorches*, 865 F.3d at 89. Petitioners are not so sure, because the Second Circuit's rule conditions the more flexible standard on the relevant facts being within the opposing party's knowledge, which other circuits do not. Nevertheless, petitioners' complaint would survive under the Second Circuit's rule because the details of Bethany Hospice's actual bills are within its knowledge.

4. In sum, there is an open and acknowledged circuit split about the right way to apply Rule 9(b) in FCA cases. Despite many opportunities to reach unanimity over the years, the circuits have not done so. The split is entrenched and calls out for this Court's review.

II. The Question Presented Is Important and Frequently Recurring

Certiorari should be granted because the question presented is important. Rule 9(b) applies to every FCA complaint, hundreds of which are filed each year. *See* U.S. Dep't of Justice, *Fraud Statistics – Overview, October 1, 1986 – September 30, 2020*, at 3 (2021), https://www.justice.gov/opa/press-release/file/1354316/download (showing more than 600 *qui tam* cases filed each year for the last ten years).

Compliance with Rule 9(b) is also one of the most frequently litigated defenses at the pleading stage of an FCA action. As the summary of circuit cases shows, this issue arises frequently, and it arises everywhere. And the circuit cases only hint at the amount of litigation. A Westlaw search for "false claims /p particularity" yields over 1,950 federal cases. A Westlaw KeyCite search based on the FCA's liability provision, 31 U.S.C. § 3729, narrowed to "12(b) /p 9(b)" (to identify most cases in which a motion to dismiss raises Rule 9(b)), yields over 1,250 federal cases.

Of course, such searches are not perfect fits for the universe of relevant cases, but based on experience litigating in this field, it is safe to say that a Rule 9(b) defense is asserted in most motions to dismiss FCA cases. *See* Claire M. Sylvia, *The False Claims Act: Fraud Against the Government* § 10:59, Westlaw (database updated Apr. 2021) ("Pretrial motions challenging a complaint under Federal Rule 9(b) . . . have become standard practice."). The standard governing such motions is therefore extremely important to relators, the Government, and defendants.

III. This Case Is an Excellent Vehicle to Decide the Question

This case provides an ideal vehicle to decide the question presented because the application of Rule 9(b) is the only issue in the case, and the complaint's allegations bring the contrast between the circuits' rules into stark relief. Under the rules adopted in the majority of circuits, petitioners' complaint would have survived because it provides a reliable basis to infer that false claims were submitted to the Government.

The complaint is also a good representative example of FCA cases, many of which are based on violations of the AKS (which is why Congress made the AKS a *per se* predicate for FCA liability). The result in a case like this one will also be helpful in any other case alleging that a fraudulent scheme or business model resulted in the submission of false claims.

It also does not matter that the decision below was unpublished. Every relevant proposition of law recited below was quoted directly from precedential Eleventh Circuit decisions. Thus, the decision below is merely one more application of the Eleventh Circuit's unusually rigid rule. If anything, the fact that the decision was unpublished is proof that the Eleventh Circuit's rule is so entrenched that further percolation would serve no beneficial purpose.

IV. The Decision Below Is Incorrect

Certiorari should also be granted because the decision below is incorrect. Rule 9(b) requires plaintiffs to plead the "circumstances constituting fraud" with "particularity." The Eleventh Circuit's rigid rule requiring every FCA plaintiff to plead specific details of false claims is arbitrary and inconsistent with the text and purpose of the rule.

As the majority of circuits have recognized, the "circumstances constituting fraud" will vary across cases. Sometimes, the details of a bill will be important. For example, if a plaintiff alleges that a defendant billed the Government for specific goods or services that were not provided, it may be important to identify the contents of the bill. Here, however, the details of the bills submitted to the Government were essentially irrelevant to whether the bills were

fraudulent. What made the bills fraudulent was not some detail on the bills themselves, but instead that the bills related to patients referred by physicians who received kickbacks.

Those circumstances were pleaded with particularity. Petitioners:

- described specific conversations in which Bethany Hospice's principals effectively admitted that they were paying doctors to induce referrals;
- named the doctors who received the kickbacks;
- reported the times and places the doctors were employed and receiving compensation from Bethany Hospice;
- described the form the kickbacks took;
- alleged, with the aid of specific Government data, the effect that the kickbacks had on the doctors' referring practices (taking them from almost no referrals to a massive number of referrals); and
- alleged, based on personal observations while employed at Bethany Hospice, conversations with knowledgeable employees who were personally involved in billing, and Government claims data, that Bethany Hospice billed the Government for patients referred by the Bethany Hospice doctors.

See supra pp.5-12. The Eleventh Circuit did not hold otherwise—but it deemed all of that irrelevant because the Eleventh Circuit does not permit FCA cases to proceed without details of the claims themselves.

That rule is incorrect. As this Court has recognized, even when Rule 9(b) applies, so does Federal Rule of Civil Procedure 11(b)(3), which allows "pleadings based on evidence reasonably anticipated after

further investigation or discovery." *Rotella v. Wood*, 528 U.S. 549, 560 (2000). In cases where the relator can allege the existence of a fraudulent scheme with particularity, and plausibly alleges that claims were submitted pursuant to that scheme, the specific details of the claims are exactly the sort of information that ordinarily would be found later.

Similarly, the Eleventh Circuit's refusal to infer the existence of false claims from circumstances finds no support in any pleading standard. Even later in a case, *i.e.*, at summary judgment or at trial, plaintiffs can prove their case with circumstantial evidence. Indeed, "[c]ircumstantial evidence is not only sufficient, but may also be more certain, satisfying and persuasive than direct evidence" in certain cases. *Desert Palace, Inc. v. Costa*, 539 U.S. 90, 100 (2003) (quotation marks omitted). When a plaintiff alleges a fraudulent scheme, the logical endpoint of which is the submission of false claims, that is strong evidence supporting an inference that claims were, in fact, submitted. Otherwise, why bother devising and executing the scheme? Evidence of such a scheme would be sufficient at summary judgment or trial; it should easily suffice at the pleading stage.

The Eleventh Circuit's rigid requirement also has no logical relationship to the purposes of Rule 9(b), which are to provide defendants with notice of the charges against them, and to prevent spurious claims from moving forward. Here, Bethany Hospice knows exactly what it is accused of doing wrong: it offered kickbacks to the Bethany Hospice doctors, and then billed the Government for the care of patients referred by those doctors. The doctors are named, and Bethany Hospice's system allows it effortlessly to identify who

the patients are and how much it billed for those patients' care. Details about specific claims would add nothing to that understanding.

Nor was dismissal necessary to ward off a spurious or speculative claim. Here, petitioners did far more than the ordinary pre-filing investigation. That investigation established, for certain, that Bethany Hospice submitted claims for payment to the Government for patients referred by the Bethany Hospice doctors. Specifically, petitioners personally observed Bethany Hospice billing practices, personally learned of Bethany Hospice's policy of only enrolling patients eligible for Government health care plans, confirmed with multiple knowledgeable employees that care for all or nearly all of Bethany Hospice's patients was billed to the Government, and provided Medicare claims data showing that Bethany Hospice submitted bills for patients who had been referred by the Bethany Hospice doctors. This is not a case in which a relator is pursuing a fishing expedition into unknown misconduct.

Finally, as explained by the majority of circuits, the Eleventh Circuit's rule undermines the efficacy of the FCA. In most cases, relators will not have specific details of actual false claims—perhaps because the relator's role does not give them access to that information, or because the defendant has effectively concealed it (as in this case, where Best fired petitioners to prevent them from gaining access to evidence). Requiring dismissal in all such cases will ensure that meritorious cases fail. Even worse, it will prevent many meritorious cases from ever being filed because relators and their counsel will know that they cannot meet the Eleventh Circuit's artificially high pleading

burden. The inevitable result is that more fraud on the Government will go unchecked.

V. The Court Should Consider Calling for the Views of the Solicitor General

If the Court does not grant certiorari outright, it should call for the views of the Solicitor General. The application of Rule 9(b) directly implicates the interests of the United States, which is the real party in interest in FCA cases.

This Court previously called for the views of the Solicitor General in *United States ex rel. Nathan v. Takeda Pharmaceuticals North America, Inc.*, No. 12-1349. There, the Government acknowledged that "lower courts have reached inconsistent conclusions about the precise manner in which a *qui tam* relator may satisfy the requirements of Rule 9(b)." U.S. Amicus Br. at 10. The Government thus acknowledged a split between courts that "correctly held that a *qui tam* complaint satisfies Rule 9(b) if it contains detailed allegations supporting a plausible inference that false claims were submitted to the government, even if the complaint does not identify specific requests for payment"—and it rejected a "per se rule that a relator must plead the details of particular false claims," arguing that such a rule "is unsupported by Rule 9(b) and undermines the FCA's effectiveness as a tool to combat fraud against the United States." *Ibid*. The Government opined that if the disagreement among the lower courts "persists," then "this Court's review to clarify the applicable pleading standard may ultimately be warranted in an appropriate case." *Ibid*. That case was "not a suitable vehicle" because the lower courts had thrown out the complaint on multiple

grounds, so that the "suit could not go forward even under the pleading standard most favorable to relators." *Id*. at 11.

The conditions the Government cited all came to pass in this case. Here, the Eleventh Circuit applied a rule the Government disparaged, in a case in which the matter was outcome-determinative. Accordingly, the Court should either grant certiorari, or at a minimum request the Government's views.

CONCLUSION

Certiorari should be granted.

Respectfully submitted,

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