Nos. 21-1326 and 22-111

In The Supreme Court of the United States

UNITED STATES ex rel. TRACY SCHUTTE, et al.,
Petitioners,

v.

SUPERVALU INC., et al.,
Respondents.

UNITED STATES ex rel. THOMAS PROCTOR,
Petitioner,

v.

SAFEWAY, INC.,
Respondent.

On Writs Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF FOR THE STATES OF CONNECTICUT, ALASKA, CALIFORNIA, COLORADO, DELAWARE, DISTRICT OF COLUMBIA, GEORGIA, HAWAII, ILLINOIS, INDIANA, IOWA, KANSAS, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEVADA, NEW HAMPSHIRE, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OKLAHOMA, OREGON, PENNSYLVANIA, RHODE ISLAND, SOUTH DAKOTA, TENNESSEE, VERMONT, WASHINGTON, AND WISCONSIN IN SUPPORT OF PETITIONERS

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INTERESTS OF THE STATE AMICI

All 33 State Amici administer and fund government programs, including state Medicaid programs. Medicaid is an exercise in Congressionally decreed federalism. Each state's program is at least fifty percent funded by the federal government, with the state paying the remaining share. While the federal government broadly oversees Medicaid, each state administers the specifics of its own program. Each state enacts laws specifying what facilities, goods, and services its Medicaid program will pay for, and each state vests authority in a single state agency to codify billing and reimbursement rules.

State Medicaid agencies, tasked with promulgating and administering these rules, issue compliance guidance to providers. These providers are the businesses and professionals who furnish covered goods and services to eligible beneficiaries. Program compliance relies heavily on providers' voluntary cooperation. Both fiscal probity and simple fairness demand consequences for the relatively small number of providers who knowingly misspend public Medicaid money. So, if a provider knowingly submits false claims to Medicaid, it faces liability under the False Claims Act (FCA). *See* 31 U.S.C. § 3729(b)(2) (definition of "claim" includes requests and demands for federal government money).

All the State Amici share a strong interest in the federal courts correctly interpreting the FCA, including

its knowledge provisions,[1] not least because FCA recoveries generate a state share for the jointly financed federal-state Medicaid program. This brief focuses on the federal- and state-funded Medicaid program as the leading, but by no means only, example of the State Amici's interest in protecting the integrity of taxpayer-funded programs and contracts.

Additionally, some State Amici have enacted their own false claims statutes that are analogues to the FCA. *E.g.*, Cal. Gov't Code §§ 12650–12656; Conn. Gen. Stat. §§ 4-274–4-289. As these state FCA analogues are typically younger than—and often modeled on—the federal FCA, courts often interpret them with reference to the persuasive authority of FCA jurisprudence. *See*, *e.g.*, *United States ex rel. Bawduniak v. Biogen Idec Inc.*, No. 1:22-cv-10601-IT, 2022 U.S. Dist. LEXIS 117512, *11 (D. Mass. Jul. 5, 2022) (ruling that ten states' FCA analogues imposed the same requirements as the FCA). These state FCA analogues are a primary civil enforcement tool for recovering taxpayer dollars lost to false claims.

[1] The FCA defines "knowing" and "knowingly" to "mean that a person, with respect to information" (i) "has actual knowledge of the information"; (ii) "acts in deliberate ignorance of the truth or falsity of the information"; or (iii) "acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1)(A).

SUMMARY OF THE ARGUMENT

The FCA imposes liability when a provider "knowingly" submits false claims, a broad and inclusive scienter requirement. But the Seventh Circuit improperly grafted this Court's *Safeco* holding,[2] which interprets the Fair Credit Reporting Act's "willfully" scienter language, onto the FCA. The result is a cramped reading that immunizes bad actors who intend to make false claims, believe they are submitting false information, and in fact do submit false information—so long as they can later propose a post-hoc "objectively reasonable" reading of a Medicaid statute or regulation and argue there was no "authoritative guidance" "specific enough" to directly contradict defense counsel's concocted interpretation. Pet. App. 15a-27a;[3] *United States ex rel. Proctor v. Safeway, Inc.*, 30 F.4th 649, 661-62 (7th Cir. 2022).

The Seventh Circuit's importation of *Safeco* into the FCA is unworkable in the real world of state Medicaid programs. Medicaid is a taxpayer-funded healthcare program administered by single state agencies with limited resources on behalf of people with limited means. Yet it covers a vast array of health-related facilities, goods, and services for over 91 million people across the country. The single state agencies issue guidance covering the most common billing scenarios, and they give providers training and opportunities for clarification. As this Court has long

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[2] *Safeco Ins. Co. of Am. v. Burr*, 551 U.S. 47 (2007).

[3] "Pet. App." refers to the *Schutte* Petitioners' Appendix.

held, persons seeking public funds have a duty to familiarize themselves with the legal requirements for reimbursement. *Heckler v. Community Health Servs.*, 467 U.S. 51, 63-64 (1984).

The Seventh Circuit's opinions turn this rule on its head, putting states at risk of losing public funds to fraud if they do not issue guidance that is both "authoritative" and "sufficiently specific" to every billing scenario. *Proctor*, 30 F.4th at 661. At the same time, the Seventh Circuit's regime creates perverse incentives for Medicaid providers by construing the FCA's "knowledge" requirement to exclude a defendant's subjective understanding of what the law requires. Rather than encouraging providers to seek available clarification about the legality of their practices, the Seventh Circuit's rule rewards providers that put on blinders, take the public's money, and ask questions (or seek forgiveness) later.

Under the Seventh Circuit's approach, it would not matter if a provider tried to follow a state agency's relevant guidance or instead deliberately ignored it, because the lack of guidance "high[ly] specific" to the provider's (post hoc) "interpretation" makes all other guidance—even if it "relate[s] to the question"—irrelevant. Pet. App. 27a, 29a. Any potential evidence showing a provider's bad faith would be shielded from discovery under the Seventh Circuit's rule, which treats a provider who in fact held a reasonable, but wrong, interpretation of a billing rule in the same way as a provider who concocted such an interpretation after the fact. Under the Seventh Circuit's approach,

even a provider's actual "subjective bad faith" would be irrelevant. Pet. App. 32a (Hamilton, J., dissenting). This result is inconsistent with the FCA, which traditionally has treated honest government contractors who sincerely and reasonably believe their claims are accurate differently from unscrupulous contractors who are deliberately ignorant of, or recklessly disregard, warnings from relevant agency guidance.

This Court's *Escobar* opinion counsels sticking with that sensible FCA tradition. In *Universal Health Servs. v. United States ex rel. Escobar*, 579 U.S. 176, 195 (2016), this Court explained the "familiar," "rigorous," and "fact-intensive" approach to FCA materiality while implying that FCA scienter should be treated the same way. The Seventh Circuit, by strictly limiting the scienter inquiry to whether circuit court rulings or highly specific government guidance warned against questionable schemes identical to the defendants', while dismissing other evidence, took the opposite approach.

For these reasons, and for those raised by Petitioners and the United States, State Amici respectfully urge this Court to reverse the Seventh Circuit's *Schutte* and *Proctor* rulings.

ARGUMENT

I. The Seventh Circuit's restrictive scienter test imperils the operation and integrity of state Medicaid programs.

A. States promote integrity and protect public funds by issuing regular guidance and offering support to Medicaid providers.

The jointly financed federal-state Medicaid program covers a vast array of healthcare and related services for over 91 million people.[4] State participation is voluntary, but a state that opts into the program must submit a plan that meets minimum federal requirements. 42 U.S.C. §§ 1396-1396p; *Frew v. Hawkins*, 540 U.S. 431, 433 (2004). Each state must designate a "single state agency" to administer its Medicaid program. 42 C.F.R. § 431.10. The single state agency may not delegate the authority to develop or issue policies, rules, and regulations relating to Medicaid program matters. 42 C.F.R. § 431.10(e). But single state agencies can and do use third-party claims processing agents to assist with billing and reimbursement of claims submitted by providers for payment. Substantive rulemaking authority is vested in the single state agency even when a third-party

[4] Last year, 91,342,256 people were enrolled in Medicaid and the related Children's Health Insurance Program (CHIP). Ctr. for Medicare and Medicaid Servs., *October 2022 Medicaid and CHIP Enrollment Trends Snapshot*, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-2022-medicaid-chip-enrollment-trend-snapshot.pdf.

contractor handles the logistics of claims processing and sending notices on the single state agency's behalf.[5]

As with state participation, provider participation in state Medicaid programs is voluntary and expressly conditioned on providers entering into agreements with the single state agency. 42 C.F.R. § 442.12; *Minn. Assoc. of Health Care Facilities, Inc. v. Minn. Dep't of Pub. Welfare*, 742 F.2d 442, 446 (8th Cir. 1984). These agreements obligate providers to make themselves aware of and abide by all state and federal laws and regulations governing Medicaid, as well as all relevant program manuals, policy bulletins, transmittals, and notices that the single state agencies publish and communicate to providers. *E.g.*, Fla. Stat. Ann. § 409.907; Conn. Agencies Regs. § 17b-262-526.

Single state agencies regularly communicate billing guidance to providers, both individually and collectively, through issuing provider bulletins and hosting webinars and other trainings.[6] These avenues allow single state agencies to clarify Medicaid rules where necessary and instruct providers on claim billing. For example, Connecticut's Medicaid provider

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[5] *See*, *e.g.*, Conn. Dep't of Soc. Servs., *Provider Relations* (last updated Apr. 26, 2022), https://www.ctdssmap.com/CTPortal/Provider/Provider-Services.

[6] *E.g.*, Ind. Family & Soc. Servs. Admin., *Indiana Medicaid for Providers* (last updated 2023), https://www.in.gov/medicaid/providers/provider-education/provider-education-opportunities/.

website publishes guidance about provider enrollment, billing manuals, bulletins, and program regulations.[7]

Providers also can affirmatively seek clarification of a single state agency's interpretation of Medicaid statutes, regulations, policies, and rules. States offer free training, and providers can follow up through calling hotlines to obtain answers about their specific billing questions.[8]

These readily accessible avenues for providers to seek clarification about the application of Medicaid laws and regulations are intended to assist Medicaid providers in fulfilling their obligation to avoid inappropriate billing and to identify, report, and return Medicaid overpayments.[9]

B. The Seventh Circuit's narrow definition of "authoritative guidance" is unworkable for state Medicaid programs.

The term "authoritative guidance" does not exist in the FCA's text or this Court's FCA cases, and the Seventh Circuit's narrow definition is both arbitrary

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[7] *E.g.*, Conn. Dep't of Soc. Servs., *Provider Relations* (last updated Apr. 26, 2022), https://www.ctdssmap.com/CTPortal/Provider/Provider-Services.

[8] *E.g.*, Wash. State Health Care Auth., *Contact Us* (last updated 2023), https://www.hca.wa.gov/billers-providers-partners/contact-us.

[9] Federal law governing Medicaid program integrity requires providers to timely return any identified overpayments. 42 U.S.C. § 1320a-7k(d)(2).

and unworkable. Under the Seventh Circuit's approach, it would be outside the scope of a false claims investigation to inquire whether the provider even tried to follow many forms of relevant guidance. Instead, the Seventh Circuit held that the absence of agency guidance "sufficiently specific" to the provider's "incorrect interpretation" makes all other agency guidance irrelevant and "reject[able]." Pet. App. 27a, 29a; *Proctor*, 30 F.4th at 663 (CMS Manual footnote was "not authoritative guidance in this case").

Neither the FCA's text nor the federal circuit decisions the Seventh Circuit cited support this narrow definition. In those cases, there was no government guidance at all. *United States ex rel. Donegan v. Anesthesia Assocs. of Kansas City, PC*, 833 F.3d 874, 880 (8th Cir. 2016) (relator submitted "no relevant evidence" that a government agency ever warned defendants); *United States ex rel. Purcell v. MWI Corp.*, 807 F.3d 281, 289 (D.C. Cir. 2015), *cert. denied*, 137 S. Ct. 625 (2017) (government did not publish, and defendant did not have, any guidance about the meaning of the undefined contractual term "regular commissions").

The Seventh Circuit's narrow definition of "authoritative guidance" is unworkable and unreasonable for at least three reasons.

First, because Medicaid covers such a wide array of facilities, goods, and services, state agencies cannot be expected to preemptively issue authoritative guidance specific to every billing scenario for every

provider type. Depending on the state, Medicaid can cover nearly the full spectrum of medical and related services, including prenatal care and childbirth, physician visits, dental care, eyeglasses, prescription medicines, mental health and addiction services, laboratory tests, hospital stays, as well as home health care and nursing home care for the infirm and elderly. *See* 42 U.S.C. § 1396d(a).[10] While single state agencies issue guidance documents that cover the most common billing scenarios arising in these many areas of care, their limited resources make it impossible to address every scenario and anticipate and eliminate all possible regulatory ambiguity. *See Heckler*, 467 U.S. at 64 ("There is simply no requirement that the Government anticipate every problem that may arise in the administration of a complex program such as Medicare. . . .").

Second, although the Seventh Circuit held that court decisions could put providers on notice of the correct interpretation of a rule, it wrongly limited the universe to federal appellate court decisions. Pet. App. 28a. Cases affecting the interpretation of states' Medicaid laws and regulations are also appropriately litigated in state court. *E.g.*, *Goldstar Med. Servs. v. Dep't of Soc. Servs.*, 955 A.2d 15, 31-33 (Conn. 2008). Federal courts must follow a state court's settled reading of a state statute or regulation. *Bradshaw v. Richey*, 546 U.S. 74, 78 (2005) (per curiam). The

[10] *See also* Kaiser Family Found., *Medicaid Benefits* (last updated 2023), https://www.kff.org/statedata/collection/medicaid-benefits/.

Seventh Circuit's decisions undercut federal-state comity by denying the significance of state court decisions. *Cf. Levin v. Commerce Energy*, *Inc.*, 560 U.S. 413, 417 (2010) (holding the comity doctrine requires certain types of cases to proceed originally in state court). A decision from any level of the federal or state judiciary should also put providers on notice.

Third, the Seventh Circuit's rule creates unreasonable delay in putting providers on notice. The breadth, availability, and practical utility of an array of real-time provider guidance from state trainings, bulletins, and call center resources noted above stands in stark contrast with the extended period it takes for a select few questions about Medicaid billing to be litigated to verdict and appeal.[11] Rulings from agencies, federal district courts, and state courts can provide much faster guidance than federal circuit court decisions, which can take years to issue after litigation, trial, and appeal.

C. The Seventh Circuit's rule injects perverse incentives into state Medicaid programs.

The Seventh Circuit misconstrued the FCA's knowledge provisions when it treated a defendant who subjectively and sincerely believed a wrong but reasonable interpretation of a billing rule at the time it submitted claims the same as a defendant who intended to defraud the government and concocted a

[11] *See supra*, pp. 7-8.

post-hoc interpretation to justify its actions. Pet. App. 26a. That holding is wrong for the reasons briefed by Petitioners and the United States. The State Amici are especially concerned that the Seventh Circuit created bad incentives for Medicaid providers. *See United States ex rel. Sheldon v. Allergan Sales, LLC*, 24 F.4th 340, 369 (4th Cir. 2022) (Wynn, J., dissenting) (panel majority's rule created "a truly perverse incentive"), *vacated on reh'g en banc*, 49 F.4th 873, *pet. for cert. filed*, No. 22-593 (U.S. Dec. 22, 2022). By rejecting evidence of subjective bad faith, the Seventh Circuit removed important incentives for good faith in Medicaid billing.

As discussed above, Medicaid program integrity depends on providers acting in good faith when they bill claims. The high volume of Medicaid claims requires states to use automated claims processing systems to ensure timely payment. 42 U.S.C. § 1396a(a)(37).[12] Courts recognize that the high volume of Medicaid claims makes claim-by-claim review impracticable for single state agencies. *Illinois Physicians Union v. Miller*, 675 F.2d 151, 155 (7th Cir. 1982) (endorsing single state agency's use of statistical sampling and extrapolation to conduct audits); *Goldstar Med. Servs.*, 955 A.2d at 31-33 (same).

In other words: Medicaid billing necessarily depends on provider truthfulness and integrity,

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[12] CMS E-Bulletin, *Medicaid Management Information System Snapshot* (Aug. 2016), https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-medicaidmanage-infosystem.pdf.

because only the provider is positioned to conduct a claim-by-claim review before payment. Precisely because Medicaid billing operates largely on the honor system, federal law governing Medicaid program integrity recognizes that a provider's knowing failure to return improperly calculated payments may be an FCA violation. 42 U.S.C. § 1320a-7k(d)(3) (2010) (a retained overpayment is an "obligation" under the FCA).

A definition of scienter that fails to distinguish between providers acting in good faith and those acting in bad faith imperils the working of these state programs. This Court has long held that persons "must turn square corners when they deal with the Government"—an observation that "has its greatest force when a private party seeks to spend the Government's money." *Heckler*, 467 U.S. at 63 (quoting *Rock Island, A. & L.R. Co. v. United States*, 254 U.S. 141, 143 (1920)). This Court has taught that a provider who voluntarily participates in a government health program "ha[s] a duty to familiarize itself with the legal requirements for cost reimbursement." *Id.* at 64. A provider's deliberate ignorance or reckless disregard of those requirements should be admitted into evidence to support a finding of the provider's scienter under the FCA. *United States v. Mackby*, 261 F.3d 821, 828 (9th Cir. 2001). The Seventh Circuit sidesteps this Court's directive by discarding any evidence of a provider's deliberate ignorance or reckless disregard of whether its claims are valid.

In fact, the Seventh Circuit's rule encourages Medicaid providers to put on blinders, take the public's money, and ask questions or seek forgiveness later. If the Seventh Circuit were correct, a Medicaid provider that suspected or even knew its billing practices violated a material payment requirement would be incentivized to avoid asking any follow-up questions. If audited or sued, the provider could raise as a defense that the only available guidance at the time was not "sufficiently specific" or otherwise authoritative to the situation. Pet. App. 27a. Further, evidence that the provider deliberately ignored a potential billing issue could be shielded from discovery under the Seventh Circuit's rule. If future defendants were given the benefit of the Seventh Circuit's approach, they could move to limit discovery altogether.

Instead, evidence of potential bad faith by defendants, Pet. App. 33a-38a (Hamilton, J., dissenting), should remain relevant under this Court's longstanding FCA jurisprudence. This Court has consistently laid out an "expansive reading" of the FCA as a "remedial statute" that Congress intended to reach "all fraudulent attempts to cause the Government to pay out sums of money." *United States v. Neifert-White Co.*, 390 U.S. 228, 233 (1968). By strictly limiting the FCA's scienter inquiry to whether circuit court rulings or highly specific government guidance speak directly to the issue, the Seventh Circuit also rejected extending and applying the "familiar," "rigorous," and fact-intensive approach this

Court laid out in *Universal Health Servs. v. Escobar* with respect to FCA materiality.

In *Escobar*, this Court gave guidance for cases that, like those here, involved defendants' violations of Medicaid statutes and regulations. *Escobar*, 579 U.S. at 184-85. This Court held that the materiality analysis includes all the facts the defendant knows, or has reason to know, that are likely to affect the transaction. *Id.* at 193. The standard is "rigorous" but also "familiar" and not hyper-technical. *Id.* at 195 n.6. If a reasonable person would recognize that complying with a condition is important, then the defendant may have acted with scienter "even if the Government did not spell this out." *Id.* at 191. The universe of relevant facts is wide, and "[no] single fact or occurrence [is] always determinative." *Id.* at 191 (quoting *Matrixx Initiatives, Inc. v. Siracusano*, 563 U.S. 27, 39 (2011)). The Seventh Circuit approached the scienter issue in these cases without due regard for the "fact intensive" approach endorsed in *Escobar*. *Id.* at 195 n.6.

This Court should hold, in keeping with *Escobar*, that all evidence of a defendant's awareness of, and contemporaneous beliefs about, relevant guidance issued by a state Medicaid agency should be admitted in FCA cases. And by extension, evidence of a provider's actual knowledge, reckless disregard, or deliberate ignorance of that relevant guidance about state Medicaid program requirements can potentially show scienter.

CONCLUSION

State Amici respectfully urge this Court to reverse the Court of Appeals' judgment.

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