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SEVENTH CIRCUIT CLARIFIES THE "KNOWINGLY" STANDARD FOR FALSE CLAIMS ACT LIABILITY

In a recent opinion, the Seventh Circuit Court of Appeals adopted an interpretation of the False Claims Act's "knowledge" requirement based on the Supreme Court's interpretation of a similar provision under the Fair Credit Reporting Act. The Court's application of this interpretation is good news for hospitals and health care systems that must regularly interpret complex regulatory schemes and agency rules in order to remain compliant in the ever changing world of health care.

In *U.S. v. SuperValu Inc.,* No. 20-2021, 2021 WL 3560894 (7th Cir. Aug. 12, 2021), the government, with the assistance of a whistleblower, argued that SuperValu violated the False Claims Act ("FCA") when it billed Medicare a higher amount for prescriptions than what it billed its customers. The government argued that in order to remain competitive in a market where Walmart was offering a $4 per 30-day prescription program for many generic drugs, SuperValu adopted a price-match program. However, when Medicare beneficiaries obtained prescriptions, it billed Medicare at the unmatched price for uninsured patients, asserting this to be the "usual and customary" price even though it was many times higher than what most customers were paying.

Relying on a previous ruling addressing usual and customary prices, the Seventh Circuit affirmed the district court's holding that the Medicare claims were false claims. The Court ruled that Medicare regulations define usual and customary pricing as the price charged to "a customer who does not have any form of prescription drug coverage," and that pharmacies may only bill Medicare at "the lowest prices for which . . . drugs were widely and consistently available." *U.S. ex rel. Garbe v. Kmart Corporation*, 824 F.3d 632, 635 (7th Cir. 2016). Therefore, the price-matched charges were the prices that should have been billed to Medicare.

Despite finding that SuperValu submitted false claims, the Court refused to find that it did so knowingly.

It is the Seventh Circuit's determination that the false claims were not *knowingly* billed to Medicare that makes this decision critical for those entities defending FCA actions. The Court clarified that a false claim is knowingly submitted under the FCA when the entity: (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. SuperValu didn't argue this definition, but asked the Seventh Circuit to apply the Supreme Court's nuanced interpretation of a similar "knowingly" standard under the Fair Credit Reporting Act ("FCRA"). 15 U.S.C. § 1681n(a).

In the context of the FCRA, the U.S. Supreme Court's interpretation addresses the common law concept of "reckless disregard," which does not take into account subjective intent. *Safeco Ins. Co. of America v. Burr,* 551 U.S. 47 (2007). Rather, an objective standard applies, and reckless disregard of a statute does not exist if the statute might reasonably be understood to allow the behavior at issue—even where possible illegality is also recognized. In other words, one can chose to interpret an ambiguous statute in a favorable manner if the interpretation is (1) objectively reasonable, and (2) not rejected in any authoritative guidance.

The Seventh Circuit joined several other circuits in holding that the *Safeco* reasoning applies to FCA claims. Despite SuperValu's internal characterization of its billing practice as "stealthy" and awareness that it's interpretation of "usual and customary price" might be legally incorrect, it could reasonably be argued that its practice complied with the law and with all authoritative interpretations, and thus the district court correctly determined that SuperValu's false claims did not satisfy the scienter element. A strong dissent argued that this holding perversely authorizes false claims to be submitted without FCA liability as long as clever lawyers can come up with any *post hoc* legal justification that passes the laugh test.

This decision may not stretch that far, but it does arm hospitals and health systems with additional tools to defend against whistleblower actions. Particularly, when the crux of the argument is that a provider failed to comply with one of Medicare or Medicaid's complex regulations, the entity may be able to argue that it reasonably interpreted the rule or law to condone its actions and submissions of claims.

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