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Washington Legal Foundation
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2009 Massachusetts Avenue, NW
Washington, DC 20036
202.588.0302 wlf.org

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United States v. AseraCare—Reasonable Opinions Do Not Establish Falsity in FCA Cases

by Stephen A. Wood

Can a medical opinion that serves as the basis for a treatment recommendation and subsequent federal Medicare/Medicaid reimbursement qualify as a false statement subjecting a defendant to liability under the False Claims Act? That was the question at issue in *United States v. AseraCare, Inc.*, 938 F.3d 1278 (11th Cir. 2019). On appeal from the trial court's post-verdict grant of summary judgment for the defendant (that's correct, *post-verdict* summary judgment), the Eleventh Circuit explored the various angles of how statements of opinion could possibly represent false statements leading to FCA liability. The case is important for what it says not only about the requirement of falsity under the FCA, but also the government's enforcement zeal where the defendant's conduct falls short, even well short, of an intent to commit fraud.

United States v. AseraCare—The Facts

The defendants in this case provide end-of-life hospice care services to patients. They operated a network of 60-some facilities located in 19 states, taking in roughly 10,000 patients annually. The vast majority of these 10,000 or so patients were enrolled in Medicare, and Medicare payments represented 95% of the defendants' revenues.

As with all programs administered by Medicare and overseen by the Centers for Medicare and Medicaid Services (CMS), federal statutes and regulations govern reimbursement. Federal law required a patient's attending physician, if any, as well as the medical director of the hospice provider to certify in writing upon admission to hospice that an individual patient was terminal "based on the physician's clinical judgment regarding the normal course of the individual's illness." 42 USC § 1395f(7)(A). A patient is considered terminal if the patient's life expectancy is determined to be 6 months or less. The certification must be accompanied by medical documentation that supports the prognosis.

An initial certification is valid for 90 days. To qualify for continued reimbursement beyond this period, providers must recertify every 90 days as long as the patient remains in hospice. Importantly, the regulations acknowledge that determining how long a terminal individual may live is difficult and prognoses are imprecise. Thus, the regulations permit reimbursement beyond 6 months as long as medical professionals periodically recertify. Just as patients may live in hospice for periods longer than 6 months, the regulations also contemplate that patients may improve and leave hospice. Given these circumstances, federal law imposes no statutory time limit to Medicare reimbursement for hospice care. *AseraCare*, 938 F.3d at 1282-83.

Stephen A. Wood is a Principal with Chuhak & Tecson, P.C. in the firm's Chicago, IL office. He is the *WLF Legal Pulse*'s Featured Expert Contributor on the False Claims Act.

In 2008, three former employees of the defendants filed suit under seal in U.S. District Court for the Eastern District of Wisconsin, pursuant to the *qui tam* provisions of the FCA. These relators alleged that defendants submitted claims for Medicare reimbursement for hospice care for patients who were in fact ineligible. Two subsequent *qui tam* suits were filed, one in the Northern District of Alabama in 2009, another in the Northern District of Georgia in 2010, each claiming that defendants sought reimbursement for care of patients who were not terminal. In 2012, the Wisconsin and Georgia cases were transferred to and consolidated with the Northern District of Alabama action.

The Trial Court Proceedings—A Bifurcated Trial and a Government Victory

This was not an overbilling or false billing case. That is, in the consolidated action, the government did not claim that defendants sought reimbursement for non-existent patients, or that the defendants falsified documentation. In each patient's case, the defendants produced documentation of the patient's medical condition and certification by an appropriate medical professional. *Id.* at 1285. The government's claim was, instead, that defendants' certifications were not medically supportable, that many of the patients were in fact not terminally ill.

The government's analysis concentrated on defendants' billing of Medicare for at least 365 continuous days of hospice care, which yielded a set of 2,180 patients. *Id.* at 1284-85. From this number, the government selected a sample of approximately 10% and submitted their documentation to several retained expert physicians. The government's plan was to contest the medical prognosis of these patients and employ an econometrician to establish damages and penalties as to the larger set using statistical proof. Apart from expert medical testimony, the government also sought to introduce evidence of the defendants' business practices—for example, that the defendants' physicians at times "rubber-stamped" certifications without exercising reasoned judgment based on the patients' medical records.

Defendants moved for summary judgment based on lack of evidence of falsity. They argued that unless the government could show that no reasonable physician would have concluded that a given patient was terminally ill, its claims were not false. Put differently, the defendants argued that if the government's evidence amounted to nothing more than a difference of opinion between doctors, the defendants' certifications could not be false. This motion was denied.[1]

In an interesting procedural turn, over the government's objection, the trial court granted the defendants' motion to bifurcate the trial of the case under F.R.C.P. 42(b). Agreeing with the defendants that falsity was a threshold issue, and that other evidence, primarily of the defendants' allegedly sloppy general-business practices, would only confuse the jury and complicate its evaluation of the falsity of the certifications, the district court limited the trial to the issue of falsity. As the appellate court's opinion stated: "In the [district] court's view, allowing the Government to present knowledge evidence before falsity was determined would be unduly prejudicial to AseraCare, thus warranting separation of the knowledge and falsity elements." *Id.* at 1287. Some evidence of the defendants' business practices was allowed during this phase, but only for the purpose of providing "context," and not for its relevance to the issue of falsity.

[1] After denial of the motion, defendants moved under 28 U.S.C. § 1292 to certify the following issue for interlocutory review: "In a False Claims Act case against a hospice provider relating to the eligibility of a patient for the Medicare hospice benefit, for the Government to establish the falsity element under 31 U.S.C § 3729(a)(1), must it show that, in light of the patient's clinical information and other documentation, no reasonable physician could have believed, based on his or her clinical judgment, that the patient was eligible for the Medicare hospice benefit?" While the district court granted the motion, the Eleventh Circuit declined to hear the appeal.

During the trial, the government presented expert medical evidence contesting the defendants' patient certifications. The government's expert was on the stand for several days walking through his assessment of the medical records of the patients at issue, testifying that the records did not support a prognosis of terminal illness qualifying for hospice care. This expert did not claim that no reasonable doctor could have concluded that the patients at issue were terminally ill. Rather, he testified that in his professional opinion the patients were not terminally ill. Incredibly, during the government expert's testimony, it was revealed (whether on direct or cross is unclear) that he had actually changed his opinion on the terminal condition of several of the patients at issue. That is, he reconsidered his opinions and concluded that some of the patients he had initially deemed not terminally ill were in fact terminal. The defendants offered expert medical testimony of their own supporting the accuracy of the diagnoses made in the patient certifications.

In the face of this battle of the experts, the jury's job, boiled down to its essence, was to determine which expert was the more persuasive. The circumstances of one patient, identified in the appellate opinion as "Elsin K.," illustrate the difficulty confronting the jury. Elsin K. was in hospice care for more than a year before she ultimately died. She had been diagnosed with "debility," also called "adult failure to thrive," a condition characterized by the patient's gradual physical and mental decline due to old age. Elsin's course was not, however, steady or consistent. At times she improved and was able to leave hospice only to return later when her condition deteriorated. The defendants' and the government's medical experts disagreed over her eligibility for hospice even though they agreed on her underlying diagnosis. The government's expert opined that many of Elsin's ailments, including severe infections arising from a joint replacement, were chronic and she did not demonstrate the level of physical debility typically associated with terminally-ill patients. The defendants well-qualified experts disagreed.

After approximately eight weeks of trial, at the close of the evidence, the court instructed the jury to answer special interrogatories regarding the prognoses of each of the 123 patients at issue. In its verdict, the jury found that defendants had submitted false claims for 104 of the 123 patients (despite the government's expert's flip-flop on several of these prognoses).

Post-Trial Proceedings—The Government's Victory is Short-Lived

In their post-trial motion, the defendants again challenged the legal standard upon which the court instructed the jury, contending that a difference of opinion between experts does not establish falsity. Not only did the trial court agree with the defendants' arguments on that point, it went beyond granting a new trial and, under F.R.C.P. 56(f)(3), *sua sponte* reconsidered its denial of the defendants' motion for summary judgment, inviting briefing on the issue noting that the government cannot prevail "if all the Government has as evidence of falsity in the second trial is [the government's expert's] opinion based on his *clinical judgment* and the medical records that he contends do not support the prognoses for the 123 patients at issue in Phase One." *Id.* at 1290. After briefing and argument the district court granted summary judgment in favor of the defendants noting that with the opinions of its experts regarding the prognoses of the patients at issue as the only admissible evidence, the government had failed to establish proof of an objective falsehood.

The Appeal—Affirming a Requirement of Objective Falsity

On appeal, the government sought reinstatement of the jury's verdict. The government argued that falsity is established where an expert opines that a patient's medical records do not support a terminal illness prognosis. Where the parties present competing expert views on prognosis, falsity becomes a question for the jury. In opposition, the defendants argued that where certifying

physicians exercise their reasoned clinical judgment, falsity cannot be established as a matter of fact, and there is no consequent liability under the False Claims Act.

Apart from arguing over the correct standard, the government's appellate argument consisted of a parade of horribles wrought by the district court's reasoning on the legal standard. The government argued that the court's interpretation deferred too much to physicians and that all a hospice need do is enlist a licensed doctor willing to certify for a fee, regardless of the patient's underlying condition. In addition, the government argued that affirming the trial court would invade the province of the jury, which is to decide the facts when there is a factual dispute. Finally, the government complained that a requirement of objective falsehood would result in "under-inclusion," that hospice providers with sloppy or improper admission practices may evade FCA liability. The Eleventh Circuit rejected each of these arguments on its way to affirming the district court's decision to grant defendant a new trial.

After reviewing the statutory and regulatory framework for hospice eligibility, the Eleventh Circuit concluded that physician judgment was the prevailing determinant:

> The language of the statute and implementing regulations makes plain that the clinical judgment of the patient's attending physician (or the provider's medical director, as the case may be) lies at the center of the eligibility inquiry. Under this language, a patient is eligible for the Medicare hospice benefit if the appropriate physician makes a clinical judgment that the patient is terminally ill in light of the patient's complete medical picture, as evidenced by the patient's medical records.

Id. at 1293. The appellate court noted that the regulations themselves recognize that predicting life expectancy "is not an exact science" and that certifying physicians are expected to "use their best clinical judgment." *Id.* at 1294. "It follows that when a hospice provider submits a claim that certifies that a patient is terminally ill 'based on the physician's or medical director's clinical judgment . . . the claim cannot be 'false' . . . if the underlying clinical judgment does not reflect an objective falsehood." *Id.* at 1296-97.

Although the Eleventh Circuit agreed with the district court's analysis on the legal standard to be applied, that did not carry over to the *sua sponte* decision to grant summary judgment for the defendant. In essence, the appellate court stopped short of affirming the trial court's decision to award judgment as a matter of law to defendants because the trial court did not consider additional evidence bearing on the defendants' knowledge of falsity excluded from the trial in its decision to grant summary judgment. This evidence consisted of testimony of a former Director of Clinical Services that one physician signed patient certifications before reviewing any medical documentation whatsoever, that staff typically "just gave him ... a stack of papers to sign, [and] he just signed the papers." *Id.* at 1305. Another former employee testified that another physician "would nod off" while signing certifications. The district court should have considered this among other evidence of defendants' certification practices in determining the existence of an issue of fact. Thus, the grant of summary judgment was reversed, and the case remanded for further proceedings consistent with this holding.

Takeaways From the *AseraCare* Decision

Falsity is the *sine qua non* of a False Claims Act case. True, in many cases falsity may not be seriously contested. For example, where a defendant overbills for a product or service or bills for services or products not provided, falsity will likely not be in question. But where falsity is an issue, it should be taken up as a threshold consideration. In some instances, falsity or lack thereof may not

be obvious from a statement or record, and proof of surrounding circumstances may be necessary. Falsity may also, at times, be entwined with the element of scienter. Nonetheless, falsity should be examined prior to discovery and proof of other elements.

While scienter is generally subjective, falsity is an *objective* requirement. The FCA plaintiff must show that the statement or record at issue is, as a matter of objective proof, false, *i.e.*, not true or not accurate. Most noteworthy in the *AseraCare* opinion is the appellate court's reaffirmation of this requirement for an objective falsehood and rejection of the government's proposed test. The government's argument that a disagreement regarding medical prognosis among professionals gives rise to a jury question threatened to substantially erode the falsity requirement. The standard promoted by the government would have subjected defendants to liability for otherwise reasonable conduct if the government and its experts disagreed with the defendants' judgments without more. This lowering of the liability bar by weakening the falsity requirement could have had wide-ranging consequences.

Falsity in each case may turn on a difference of opinion between witnesses for the government and the defendant. *See, e.g.*, *United States ex rel. Yannacopolous v. General Dynamics*, 652 F.3d 818, 836-37 (7th Cir. 2011) (mere difference of interpretation regarding contract terms not an objective falsehood and not actionable under the FCA); *United States ex rel. Wilson v. Kellogg Brown & Root, Inc.*, 525 F.3d 370, 376 (4th Cir. 2008) ("To satisfy [the] first element of an FCA claim, the statement or conduct alleged must represent an objective falsehood."). Unless the defendant's opinions are objectively unreasonable, no such case should ever proceed past summary judgment. Consider also that the government's falsity argument was an unnecessary and significant prosecutorial stretch. As the *AseraCare* court noted, statements of opinion *per se* are not insulated from a claim of falsity. If it can be shown that the defendant did not hold the opinion stated, did not review the facts upon which the opinion was ostensibly based, or that the opinion was based on information that the defendant knew to be untrue, an opinion could be false.

Finally, it is worth noting that *AseraCare* was a false certification case in that the government contended that the defendants' certifications of hospice eligibility failed to comply with governing regulations and were false. As such, the Supreme Court's decision in *Universal Health Services, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016) comes squarely into play, including the High Court's pronouncements regarding the requirement of materiality. This requirement, expressly stated in only two of the seven liability provisions of the FCA (31 U.S.C. §§ 3729(a)(1)(B) and (G)), is now, by virtue of the *Escobar* holding, a "demanding" requirement in *all* FCA cases. Since *Escobar* involved a claimed violation of §3729(a)(1)(A), the materiality requirement could only have applied to the falsity element of that provision (the only other elements of which are scienter and presentment). The logic of this should be self-evident. The claim at issue must be *materially* false. Technical omissions, marginally relevant regulatory noncompliance, insignificant contractual breaches, differences of opinion, should not render a claim false for purposes of liability under the FCA.

Setting a clear, objective bar for falsity in FCA cases is in keeping with the principle that the False Claims Act is not an all-purpose anti-fraud statute. The Eleventh Circuit's holding here is not only consistent with statutory objectives, not only logical and reasonable, it is in line with other cases. The requirement of falsity in all FCA cases is a requirement that the falsity of a statement or record be more than a debatable point, more than just a factual disagreement between competing positions. Evidence must be brought forth showing that the statement or record is, as a matter of fact, materially wrong.

