

October 2021

Proof of Objective Falsehood: Liability Under the False Claims Act for Hospice Providers

Sebastian West

Follow this and additional works at: <https://scholarship.law.uc.edu/uclr>



Part of the [Civil Procedure Commons](#), [Courts Commons](#), [Elder Law Commons](#), [Insurance Law Commons](#), and the [Judges Commons](#)

Recommended Citation

Sebastian West, *Proof of Objective Falsehood: Liability Under the False Claims Act for Hospice Providers*, 90 U. Cin. L. Rev. (2021)

Available at: <https://scholarship.law.uc.edu/uclr/vol90/iss1/9>

This Student Notes and Comments is brought to you for free and open access by University of Cincinnati College of Law Scholarship and Publications. It has been accepted for inclusion in University of Cincinnati Law Review by an authorized editor of University of Cincinnati College of Law Scholarship and Publications. For more information, please contact ronald.jones@uc.edu.

PROOF OF OBJECTIVE FALSEHOOD: LIABILITY UNDER THE FALSE CLAIMS ACT FOR HOSPICE PROVIDERS

Sebastian West

I. INTRODUCTION

Hospice care can offer important end-of-life services for individuals suffering from terminal illnesses, such as palliative care and the opportunity to spend one's final days in the company of loved ones.¹ Hospice care enables individuals to reflect on their lives and helps them transition to the next chapter. Medicare coverage for hospice care is available to individuals certified as terminally ill.² To certify patients as terminally ill, Congress requires physicians to exercise their clinical judgment based on clinical information and supporting medical documentation.³ When individuals are falsely or fraudulently certified, private citizens can file claims under the False Claims Act to recoup payment for services fraudulently billed to Medicare.⁴ Nevertheless, courts struggle to create a standard for determining whether a certification is false or fraudulent.

This Note discusses the requisite legal standard individuals must satisfy when claiming hospice providers violated the False Claims Act. Although the Eleventh and Third Circuits have addressed this issue, they applied different standards. This Note argues that the Eleventh Circuit's approach is the appropriate standard regarding the burden of production required at the summary judgment stage in these lawsuits.

Section II of this Note discusses the Medicare Health Benefit, the False Claims Act, and lower court decisions that influenced the Eleventh Circuit's holding in *United States v. Aseracare*. Section III addresses the circuit split and discusses how the "objective falsehood" standard has been interpreted to prove liability under the False Claims Act. Section IV argues that the standard adopted by the Eleventh Circuit is adequate but cautions that it fails to sufficiently guide the lower courts. Next, Section IV recommends that courts should analyze falsity under the Medicare Health Benefit's ("MHB's") reasonable and necessary standard to decide if hospice providers falsely certified patients. Finally, Part V contemplates whether courts need a new legal standard to apply to false hospice certification suits filed under the False Claims Act.

1. MEDICARE PAYMENT ADVISORY COMMITTEE, REPORT TO THE CONGRESS: REFORMING THE DELIVERY SYSTEM 207 (June 2008).

2. *Id.*

3. *Id.*

4. 31 U.S.C. §3730(b).

II. BACKGROUND

Hospice programs provide quality, compassionate care for individuals facing terminal illness.⁵ Because individuals forego curative treatment when they enroll in hospice care,⁶ hospice provides a holistic approach to end-of-life care.⁷ Individuals seeking hospice treatment through Medicare, however, must satisfy regulatory requirements and be certified as terminally ill by a physician. Although most certifications are proper, the government can challenge the certification in a civil action under the False Claims Act (“FCA”) against hospice providers who billed Medicare. This Section discusses the MHB, the False Claims Act, and other lower court decisions laying the groundwork for the Eleventh and Third Circuit’s split over the appropriate legal standard to survive a motion for summary judgment when the government alleges the hospice provider violated the FCA because a physician falsely certified a patient as terminally ill.

A. Medicare Hospice Benefit

In 1983, Congress established the MHB,⁸ which designated the Center for Medicare and Medicaid Services (“CMS”) to promulgate rules and administer the MHB.⁹ Under the rules, MHB allows CMS to pay private hospice care providers for their services rendered.¹⁰ Understanding individuals’ changing needs surrounding end-of-life care, Congress enacted the MHB and recognized that impending death warrants a change from curative to palliative treatment.¹¹ Thus, hospice care helps “terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment.”¹²

To be eligible for hospice care, an individual must be certified as

5. NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION, FACTS AND FIGURES 2 (2020 ed., August 20, 2020) [hereinafter NHPCO, Facts and Figures].

6. Medicare Program; Proposed Hospice Wage Index for Fiscal Year 2010, 74 Fed. Reg. 18912 (Apr. 24, 2009) (to be codified at 42 C.F.R. §418.22(b)(3)).

7. See NHPCO, Facts and Figures, *supra* note 5, at 3 (providing hospice care involves physicians, nurses, therapists, hospice aides, spiritual and bereavement counselors, social workers, and the patient’s family).

8. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §122, 96 Stat. 324, 356-64 (1982) (codified at 42 C.F.R. pt. 400, 405, 408, 409, 418, 420, 421, and 489).

9. See 42 U.S.C. §1395f (Conditions of and limitations on payment for services) and 42 C.F.R. §§418.20-418.22.

10. See 42 U.S.C. §1395d(d)(1).

11. Medicare Program, 79 Fed. Reg. 50452, 50454 (Vol. 79, No. 163, Part III, August 22, 2014) (to be codified at 42 C.F.R. pt. 405 and 418).

12. *Id.*

“terminally ill,”¹³ defined by the statute as a medical prognosis of life expectancy of six months or less.¹⁴ This certification must be based on a physician’s or medical director’s “clinical judgment of the normal course of the individual’s illness” and must satisfy two requirements,¹⁵ including: (1) the “certification must specify that the individual’s prognosis is for a life expectancy of [six] months or less if the terminal illness runs its normal course;”¹⁶ and (2) “[c]linical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record.”¹⁷ Additionally, the certification must include a “brief narrative explanation of the clinical findings that supports a life expectancy of [six] months or less as part of the certification and recertification forms.”¹⁸ This certification must occur within two days of initiating care or the physician cannot be repaid.¹⁹

To submit payment, MHB requires both an individual’s attending physician and either the medical director or physician member of the interdisciplinary group²⁰ to certify in writing at the beginning of the initial ninety-day treatment period that, based on clinical judgments, the individual is terminally ill.²¹ Although there is no statutory limit to the number of periods through which a patient may be certified,²² to receive payment for each successive period, the physician or medical director must recertify “at the beginning of the [ninety- or sixty-day] period that the individual is terminally ill based on such clinical judgment.”²³ While CMS acknowledges that prognostication is “not an exact science,” it requires the prognosis and certification to be rooted in clinical observations.²⁴ CMS requires that clinical judgments “be supported by

13. 42 C.F.R. §418.20(b) (current through the September 14, 2020 issue of the Federal Register with the exception of the amendments appearing at 85 Fed. Reg. 56686).

14. 42 U.S.C. §1395x(dd)(3)(A).

15. 42 C.F.R. §418.22(b) (current through the September 14, 2020 issue of the Federal Register with the exception of the amendments appearing at 85 Fed. Reg. 56686).

16. *Id.* §418.22(b)(1).

17. *Id.* §418.22(b)(2).

18. *Id.* §418.22(b)(3).

19. Medicare Program; Hospice Care, 48 Fed. Reg. 56,008, Cmt. D: Certification of Terminal Illness, but subject to exceptions under 42 C.F.R. §418.22(a)(3).

20. 42 U.S.C. §1395x(dd)(2)(B) (“has an interdisciplinary group of personnel which (i) includes at least (I) one physician (as defined in subsection (r)(1)), (II) one registered professional nurse, and (III) one social worker,

employed by or, in the case of a physician described in subclause (I), under contract with the agency or organization, and also includes at least one pastoral or other counselor.”).

21. *Id.* §1395f(a)(7)(A)(i)(I)-(II); *See* also 42 C.F.R. §418.22(c)(1) (stating that for the first ninety-day treatment period, the hospice must obtain written certification from both the medical director and the individual’s attending physicians, if the individual has an attending physician).

22. 42 U.S.C. §1395d(d)(1).

23. *Id.* §1395f(a)(7)(A)(ii).

24. *See supra* text accompanying note 11.

clinical information and other documentation that provide a basis for the [hospice] certification.”²⁵

B. *The False Claims Act*

Given the complex statutory requirements for MHB eligibility, certification requires several pairs of reviewing eyes. Noncompliance with certification, however, is possible. When the hospice provider falsely asserts compliance with the statutory and regulatory requirement for certification, the federal government or a private citizen, called a “relator,” can bring a civil action pursuant to the FCA under a “false certification” theory of liability.²⁶

The FCA allows the federal government and relators to impose civil liability on individuals who made false claims to the United States for payment of services rendered.²⁷ The FCA provides that any person who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval” or “knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim” is liable to the United States Government for a civil penalty and treble damages.²⁸

When relators bring a *qui tam* action, the government can intervene.²⁹ Should the government fail to intervene, the relators can continue the action, but the court may allow the government to intervene at a later date for good cause.³⁰

Although the FCA has explicit definitions for what constitutes “knowingly” making a false claim or statement,³¹ there is no definition for “false.” Courts therefore look to the common law to define “false” claims or statements.³² However, because medical professionals conduct

25. See *supra* text accompanying note 11.

26. See *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S.Ct. 1989, 1999 (2016) (providing that when a party makes a representation for reimbursement, but omits certain statutory or regulatory requirements, those omissions can be a basis for False Claims Act liability). The Attorney General brings the FCA action for the federal government. 31 U.S.C. §3730(a). Private citizens, called relators, bring a *qui tam* action. 31 U.S.C. §3730(b)(1). *Qui tam* is defined as “an action brought under a statute that allows a private person to sue for a penalty, part of which the government or some specified public institution will receive.” *Qui Tam Action*, BLACK’S LAW DICTIONARY (5th pocket ed. 1996).

27. 31 U.S.C. §§3729-33 (2020).

28. 31 U.S.C. §3729(a)(1)(A)-(B) (2020).

29. *Id.* §3730(b)(2).

30. *Id.* §3730(c)(3). Should the government fail to intervene, the relator can continue the suit on the government’s behalf and is entitled to a percentage of the proceeds of the action or settlement. *Id.* at §3730(d). The FCA also protects the relator against retaliation by rewarding all relief necessary to make the relator whole. *Id.* at §3730(h)(1).

31. See *id.* §3729(b)(1) (providing the statute’s definition of “knowingly”).

32. See *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S.Ct. 1989, 1999-2000 (2016) (holding courts have looked to common law to fill definitional gaps, and without indication

the certifications, lower courts have adopted an “objective falsity” standard for FCA challenges to allegedly unlawful hospice certification and repayment.³³

C. Lower Court Decisions

In *United States ex rel. Geschrey v. Generations Healthcare, LLC.*, the Northern District of Illinois held that to assert false claims, relators must allege facts that “[demonstrate] that the certifying physician did not or could not have believed, based on his or her clinical judgment, that the patient was eligible for hospice care.³⁴ The relators alleged the hospice provider recruited and later certified several patients ineligible for certification because those certifications occurred with only a review of patients’ records and no physical patient interaction.³⁵ The relators argued these certifications were false because had patients been examined by physicians, the physicians should have realized these patients were not terminally ill.³⁶ Nevertheless, the court dismissed the relators’ claim,³⁷ reasoning that to survive a Rule 9(b) motion, certifying physicians only need to confirm that their basis for certification was their review of the record.³⁸

In *United States v. AseraCare Inc.* (“*AseraCare I*”), the Northern District of Alabama ruled that, to survive a motion for summary judgment, the relator must prove objective falsehood, and that a mere difference of opinion *without more* is not enough to show falsity.³⁹ The government, and relators, alleged AseraCare submitted false claims to Medicare for certified patients who were not terminally ill as defined by the statute.⁴⁰ The government offered a single medical expert’s testimony

otherwise, Congress intends to incorporate the well-settled, common-law meanings).

33. See *infra* note 78.

34. 922 F. Supp. 2d 695, 703 (N.D. Ill. 2012).

35. *Id.* at 700. Relators allege that they would visit patients and prepare certifications to be signed off by the medical director, who never visited the patients him/herself and conclude their own medical judgment.

36. *Id.*

37. See *id.* at 703 (dismissing relators claims at pleading stage because 42 C.F.R. §418.22(b)(3)(iii) was improperly interpreted).

38. *Id.* However, the court did let one claim proceed because relators did not merely claim a difference of opinion but plead with particularity the hospice provider’s misrepresentation. *Id.* at 704.

39. 153 F. Supp. 3d 1372, 1381 (N.D. Ala. 2015) (“*AseraCare I*”). To reach this conclusion, the court relied on *United States ex rel. Parato v. Unadilla Health Care Ctr. Inc.*, 787 F. Supp. 2d 1329, 1339 (M.D. Ga. 2011) for the “proof of objective falsehood” component and *United States ex rel. Phalp v. Lincare Holdings, Inc.*, 116 F. Supp. 3d 1326, 1360 (S.D. Fla. 2015) for the “mere difference of opinion” component because that court held “[e]xpressions of opinion, scientific judgments, or statements as to conclusions about which reasonable minds may differ cannot be false.”

40. *AseraCare I*, 153 F. Supp. at 1375.

to prove the certifications were false.⁴¹ That expert testified that over 100 AseraCare patients were erroneously certified as terminally ill based on his clinical review of 233 records.⁴²

The jury instructions were crucial to the court's ultimate decision. They explained that "a claim is 'false' if it is an assertion that is untrue when made or when used" and "practices that may be improper, standing alone, are insufficient to show falsity without proof that specific claims were in fact false when submitted to Medicare."⁴³ After a verdict for the relators,⁴⁴ the court granted a motion for a new trial and ruled that the relators needed to demonstrate proof of an objective falsehood, and without more, a mere difference of opinions regarding terminal illness status was insufficient to prove falsity.⁴⁵ Ultimately, the court resisted an approach that would undermine the clinical judgment of the certifying physician.⁴⁶

In *United States ex rel. Wall v. Vista Hospice Care, Inc.*, the Northern District of Texas relied on *Aseracare II* and applied the objective falsehood standard.⁴⁷ The court ruled that an expert's subjective

41. *Id.*

42. *See id.* at 1375-76 (stating the government's expert reviewed a total of 233 patient records who receiving continuous care for over 365 days and determined that 123 patient certifications did not support a prognosis of terminal illness).

43. *Id.* at 1382. Before the jury verdict, the court denied AseraCare's motion for summary judgment urging the court to adopt the falsity standard articulated in *Geshrey*. The court denied the motion because the standard focused too much on certifying physicians' beliefs, and the court believed the government should be able to link witness testimony to show physicians lacked sufficient information to make clinical judgments. The case was bifurcated to first determine the falsity element and then the remaining FCA elements: knowledge, materiality, and government forfeiture. The bifurcated trial had important implications for the Eleventh Circuit's decision because at trial, the government could only rely on some of the record to argue the falsity element. The district court did not allow the government to present the entire record that was going to be used in the combined knowledge, materiality, and forfeiture trial.

44. *See AseraCare I*, 153 F. Supp. at 1379 (noting after the government's case-in-chief, AseraCare moved for judgment as a matter of law and renewed its motion at the close of evidence; however, the court reserved ruling on the motions and submitted special interrogatories to the jury, who ruled in favor for the government on 104 of the 123 patient records).

45. *Id.* at 1385. Additionally, the court granted summary judgment *sua sponte* because it determined that even under the correct legal standard, the government would not have been able to prove objective falsehood. The government only had presented testimony of an expert who reviewed old certifications yet failed to prove that simply because reasonable minds may differ does not mean the initial certification was false. *Id.* at 1387. Importantly, the court noted that the relator's expert could look at the patient records at two different occasions and come to different conclusions about the prognoses, yet not be incorrect on either review, meant his "contradiction of the certifying physician's clinical judgment alone cannot constitute sufficient evidence of falsity." *U.S. v. AseraCare Inc. ("AseraCare II")*, 176 F. Supp. 3d 1282, 1285-86 (N.D. Ala. 2016) (granting new trial and summary judgment in Aseracare's favor), *aff'd in part and remanded in part*, 938 F.3d 1278 (11th Cir. 2019).

46. *See AseraCare II*, 176 F. Supp. 3d at 1285 (granting summary judgment *sua sponte* for AseraCare) The court refused to allow the government to retain an expert to present contradictory testimony to prove falsity because it previously ruled that expressions of opinions that reasonable minds can differ cannot be false.

47. No. 3:07-cv-00604-M, 2016 U.S. Dist. LEXIS 80160, at *59-61 (N.D. Tex. June 20, 2016).

testimony regarding certification, without more and in the absence of objective falsehood, was insufficient to allege “falsity.”⁴⁸ In this case, the relator attempted to satisfy the burden of proof by presenting a single medical expert’s testimony regarding proper certifications.⁴⁹ The court explained that the expert’s testimony that ninety-percent of the reviewed records were ineligible for certification⁵⁰ failed to present a triable issue of fact.⁵¹ Nevertheless, the court noted that had the relators linked the expert testimony to the corporate scheme to falsify records, there might have been a triable issue on the “falsity” element.⁵²

In *Druding v. Care Alternatives, Inc.*, the District Court of New Jersey relied on *AseraCare I* and *Vista Hospice* and held that relators must present evidence of a claim’s objective falsehood, and that a mere difference of opinions without more is not enough to show falsity.⁵³ Here, the relators alleged the defendant engaged in a concerted effort to recruit patients and then fraudulently certify them as MHB-eligible.⁵⁴ The relators relied on examples of FCA violations as well as their expert’s report.⁵⁵ Their expert reviewed forty-seven patient records and opined that twenty-six of those patients were eligible for their entire treatment periods, while sixteen were only eligible for part of their respective periods.⁵⁶ Additionally, the expert opined that any reasonable physician

48. *Id.* at *59-61.

49. *Id.* at *31. First, relator had a statistician select 12,000 patients to be in the population, select a stratified sample of 291 patients for the medical expert to evaluate, and then extrapolate the expert’s evaluations to form an opinion of the 12,000 claims in the population that were false.

50. *Id.* at *33-34.

51. *Id.* at *59. The court ruled extrapolation cannot establish FCA liability because hospice certification is a subjective process for each patient’s eligibility, which depends on the clinical judgment of the certifying physician. *Id.* at *36. The court continued to explain that Medicare allows certifying physicians to use subjective medical findings. As there are no objective standards for eligibility, the contrary subjective opinion of the relator’s expert was insufficient to prove certifying physicians erred in evaluating life expectancies and whether those physicians failed to exercise their clinical judgments during those certifications. *Id.* at *58.

52. *See id.* at *60-62 (suggesting that relators link the scheme of false certifications to expert testimony to prove falsity).

53. 346 F. Supp. 3d 669, 685 (D.N.J. 2018) (ruling mere difference of expert opinion on clinical judgments is insufficient for falsity under the FCA), *rev’d*, 952 F.3d 89 (3rd Cir. 2019). The court relied on the premise that medical opinions are subjective and cannot be false as Fifth Circuit similarly held in *United States ex rel. Riley v. St. Luke's Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004) (holding “expressions of opinion or scientific judgments about which reasonable minds may differ cannot be ‘false’”). *Id.*

54. *Id.* at 672. After relators filed the lawsuit in April 2009, the government stayed the lawsuit for further investigation, and after seven years, finally informed the court that it would not intervene in the action. *Id.* at 676.

55. *See id.* at 677-79 (discussing relators’ testimony).

56. *Id.* at 681. Relators had the expert review the forty-seven records that were produced during discovery. The expert explained the difficulty in prognostication, but he relied on guidelines from experts at the National Hospice and Palliative Care Organization and other criteria utilized in the field to perform his review. At the end of his review, 214 out of 603 periods (~35%) of the hospice certification periods

would have reached the same conclusion.⁵⁷ However, Care Alternatives' own expert reviewed the relators' expert's findings and testified that, based on his clinical judgment and analysis, a reasonable physician *would* have certified each of the forty-seven patients.⁵⁸ The court ruled that diverging opinions do not create a genuine issue of material fact when there is no factual evidence that certifying doctors knowingly made false determinations.⁵⁹

After the *Druding* opinion's release in 2018, FCA claims for hospice certification followed a well-reasoned rule of law. To survive a motion for summary judgment, the relator must prove that the defendant engaged in objective falsehoods when certifying patients, and a mere difference of opinion among medical experts would not suffice to prove claims of falsity.

III. THE CIRCUIT SPLIT

The *Druding* standard circulated in the lower courts until the Eleventh and Third Circuits considered it, which resulted in the circuit split. This Section examines the Eleventh Circuit's ruling in *United States v. AseraCare, Inc.*, which adopted the *Druding* standard. Next, this Section explains how the Third Circuit rejected the *Druding* standard in *United States ex rel. Druding v. Druding* and instead held that a difference of opinion among medical experts is tantamount to a genuine issue of material fact.⁶⁰

A. *AseraCare III*

In *AseraCare III*, the Eleventh Circuit adopted the "objective falsehood" standard but remanded the case with direction.⁶¹ In *AseraCare III*, the court reasoned the government's case was weakened because the expert failed to affirmatively testify that, "in his opinion, no reasonable

lacked documentation supporting hospice care. He also found that some medical records were incomplete for the certified patients.

57. *Id.* Although the expert opined that any reasonable physician would have reached the same conclusion, the relators' expert failed to show any falsity in the certifications.

58. *Id.*

59. *Id.* at 688.

60. 952 F.3d 89, 95 (3rd Cir. 2019) (holding differing medical expert testimony that opines patient certifications did not support patients' prognoses can be considered false creates a dispute of material fact).

61. *U.S. v. AseraCare, Inc. ("AseraCare III")*, 938 F.3d 1278, 1281 (11th Cir. 2019) (ruling that falsity under Medicare for FCA liability cannot be proved when there is only a reasonable disagreement between medical experts and no other evidence to prove falsity). The Eleventh Circuit remanded the case because the government should have been able to rely on the entire record and not merely what was argued during the falsity element of the bifurcated trial.

doctor could have concluded that the identified patients were terminally ill at the time of certification.”⁶² Instead of affirmatively testifying that no doctor would have given a prognosis of terminally ill, the expert relied solely on his clinical judgment and a review of patient records, which conflicted with those of AseraCare’s expert.⁶³ In addition, the court considered how the experts reached their conclusions. The government’s expert used a ‘checkbox approach’ by relying on his clinical judgments and medical guidelines for MHB eligibility, whereas AseraCare’s expert took a more holistic approach to certifying patients.⁶⁴ Although the experts agreed on the underlying diagnoses, they diverged regarding their conclusions for the patients’ eligibilities.⁶⁵ The court reasoned that the experts’ conflicting testimonies and the lower court’s insufficient jury instruction forced the jury to decide which expert was “more persuasive, with the less persuasive opinion being deemed to be false.”⁶⁶

Next, the Eleventh Circuit emphasized that the term “clinical judgment” permeates the statutory and regulatory requirements for certification.⁶⁷ The court therefore found that hospice certification must be based on the certifying physician’s clinical judgment regarding a holistic patient medical record.⁶⁸ The court noted that the regulations do not require clinical judgments to prove terminal illness as a matter of medical fact or that patients’ records demonstrate to a reviewing and unaffiliated physician that the patients were terminally ill upon certification.⁶⁹ Rather, the regulations merely state that “clinical information and other [supporting documentation for certification] . . .

62. *Id.* at 1287.

63. *Id.* at 1284-85, 1287. The government’s expert testified that 123 of the 233 records he reviewed did not satisfy hospice eligibility requirements.

64. *See id.* at 1288 (articulating the fundamental difference in how experts should analyze patients for eligibility).

65. *See id.* at 1289 (providing an illustration of how the experts starkly disagreed with patient eligibility even though they agreed on the patient’s diagnoses).

66. *Id.* at 1288-89. As a case of first impression, the Eleventh Circuit had to resolve eligibility issues when the “certifying physician exercised genuine clinical judgment [to determine] a patient’s prognosis” and if the accuracy of that judgment was “susceptible to being proven as true or false as a factual matter.” *See id.* at 1291-92 (conceding no other circuit had considered falsity for a MHB violation and summarizing the issue for review).

67. *See id.* at 1292-93 (emphasizing that 42 U.S.C. §1395f(a)(7)(A) requires that for the initial 90-day hospice period, signatures of both the individual’s physician and the medical director each certify eligibility based on their clinical judgments, and that for subsequent hospice periods, recertification requires clinical judgment. Also, 42 C.F.R. §418.22(b) states terminal illness is determined by the certifying physician’s clinical judgement).

68. *See AseraCare III*, 938 F.3d at 1293 (noting that given the requirements of 42 C.F.R. §418.22(b)(2)-(3) and the 79 Fed. Reg. 50452, 50471 (Aug. 22, 2014), clinical judgments lie at the center for certification and patient records help physicians make informed decisions regarding certification).

69. *See id.* at 1293-94 (noting the absence of language in the statute and regulations to require that clinical judgments prove terminal illness as a matter of medical fact and patient records to prove to any reviewing expert that the patient was objectively terminally ill when she was certified by the physician).

accompany the certification” and “be filed in medical record.”⁷⁰ So, clinical judgments regarding eligibility only require a “reasonable interpretation of those relevant medical records.”⁷¹ The court further noted that because prognostication is not an exact science, Congress granted deference to certifying physicians to make clinical judgments regarding certification⁷² but still required physicians to rely on subjective and objective medical findings of patients’ conditions before arriving at clinical judgments.⁷³

Recognizing that reasonable doctors may disagree regarding a patient’s condition, the court ruled that two physicians exercising their clinical judgment of a patient’s prognosis could disagree without either of them being incorrect.⁷⁴ As long as the underlying clinical judgment did not reflect objective falsehood, there could be no FCA liability.⁷⁵

The court then provided three examples that would satisfy objective falsehood: (1) the certifying physician held an ill-informed clinical judgment by failing to familiarize herself with the patient’s records before certification; (2) the certifying physician did not subjectively believe the patient was terminally ill; or (3) expert evidence proves that no reasonable physician could conclude that the patient was terminally ill given the medical records.⁷⁶ In sum, if relators only present evidence of differing expert opinions regarding certification, without providing evidence of objective falsehoods, the claim fails as a matter of law and granting summary judgment is proper.⁷⁷

70. *See id.* at 1294 (quoting 42 C.F.R. §418.22(b)(2)).

71. *Id.* at 1294. The court also noted that CMS did not use the word “objective” to demonstrate terminally illness in patients’ medical records; CMS only used “support[ing]”. *Id.*

72. *See id.* at 1295 (according to 79 Fed. Reg. 50452, 50470, CMS knows “predicting life expectancy is not an exact science,” and thus well-founded clinical judgments should be granted deference). Later in its opinion, the court also notes that “‘terminally ill’ presents, by design, a question of debatable clinical judgement that may not, in all circumstances, lend itself to just one determination as to the proper exercise of that judgment.” *Id.* at 1299.

73. *See id.* at 1295 (relying on 42 C.F.R. §418.102(b), the court ruled clinical judgments cannot disregard patient’s underlying medical conditions; they must consider factors like “subjective and objective medical findings”).

74. *See id.* at 1296 (accepting the district’s court post-verdict conclusion that physicians could disagree on projected life expectancy, and thus eligibility, but neither physician be wrong). Here the court mentions that the government’s own witness, a former head of the company who processes claims for MHB reimbursement, testified that “two doctors using their clinical judgment could come to different conclusions about a patient’s prognosis and neither be right or wrong.” *Id.*

75. *See id.* at 1297 (relying on CMS commentary, the court stated the legal framework for MHB did not require exact certitude for prognostication but only required that certifying physicians exercise their best judgment for eligibility when considering all the relevant medical records).

76. *See id.* (providing various methods to prove objective falsehood for eligibility).

77. *See id.* at 1297 (holding that without evidence of objective falsehood, FCA claims fail as a matter of law). The court relied on several circuit court decisions where FCA liability could only be asserted by plaintiffs proving objective falsity. *See e.g.*, *United States ex rel. Yannacopoulos v. General Dynamics*, 652 F.3d 818, 836 (7th Cir. 2011); *United States ex rel. Loughren v. Unum Grp.*, 613 F.3d

AseraCare III requires that relators produce evidence of objective falsehood to survive a motion for summary judgment. An array of opposing experts does not prove false certifications because reasonable minds can differ on clinical judgments, and Congress has granted deference to certifying physicians when determining whether a patient has a terminal illness.

B. *United States ex rel. Druding v. Druding*

In contrast, the Third Circuit held that differing expert testimony creates a triable issue of material fact under the MHB.⁷⁸ The court ruled expert testimony can establish FCA falsehood when the testimony opines that patient records do not support a prognosis of terminal illness.⁷⁹ Rejecting the Eleventh Circuit's analysis, the Third Circuit held differing clinical judgments *can* prove falsity, thereby establishing FCA liability and the chance to survive a motion for summary judgment.⁸⁰

First, the court noted that Congress did not define the terms false or fraudulent under the FCA, and therefore courts have looked to the common law for guidance.⁸¹ The court reasoned that because other courts have held expert opinions can be false, the subjective nature of opinions in conjunction with contradictory medical expert opinions can show falsity under the FCA.⁸² Moreover, the court criticized conflating the scienter and falsity elements into the "objective falsity" standard to

300, 310 (1st Cir. 2010); *United States ex rel. Wilson v. Kellogg Brown & Root, Inc.*, 525 F.3d 370, 376-77 (4th Cir. 2008); *United States ex rel. Burlbaw v. Orenduff*, 548 F.3d 931, 959 (10th Cir. 2008); *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 792 (4th Cir. 1999); *Hooper v. Lockheed Martin Corp.*, 688 F.3d 1037, 1047-49 (9th Cir. 2012); *Omnicare, Inc. v. Laborers Dist. Council Constr. Indus. Pension Fund*, 575 U.S. 175, 186 (2015). *Aseracare III*, 938 F.3d 1297 at n. 10.

78. *See United States ex rel. Druding v. Druding* ("Druding II"), 952 F.3d 89, 91 (3rd Cir. 2019) (holding that plaintiffs who bring an FCA lawsuit do not need to prove objective falsehood to survive a motion for summary judgment because differing expert opinions regarding MHB eligibility do create a genuine dispute of material fact as to falsity).

79. *See id.* at 95 (holding contradictory expert testimony regarding patient MHB eligibility can be considered false under the FCA and establish a triable issue of liability).

80. *See id.* (ruling the district court erred when it relied on the N.D. Ala. and N.D. of Tex. cases which adopted the "objective falsehood" standard) (emphasis added).

81. *See id.* (relying on *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S.Ct. 1989, 1999-2000 (2016), courts have looked to common law to fill definitional gaps, and without indication otherwise, Congress intends to incorporate the well-settled, common-law meanings).

82. The court relied on several cases where opinions are considered "false" for purposes of liability under common law. *See e.g. Omnicare*, 575 U.S. at 183-85 (2015) (finding opinions may be false statements in determining liability under the securities law); *Hersckowitz v. Nutri/Sys., Inc.*, 857 F.2d 179, 184 (3rd Cir. 2015) (finding "an opinion . . . will be deemed untrue for purposes of the federal securities laws if it is issued without reasonable genuine belief or if it has no basis"); *See also* RESTATEMENT (SECOND) OF TORTS §§525 cmt. c, 539 cmt. a (Am. L. Inst. 1977) ("instructing that an opinion may be false when the speaker makes an express statement contrary to the opinion he or she actually holds"). *See Druding II*, 952 F.3d at 95-96.

determine FCA liability.⁸³ The court noted that scienter limits hospice providers' exposure to FCA liability when the government or relator can find any expert who disagrees with the certifying physician.⁸⁴ Thus, conflating the two requirements is "inconsistent with the text and application of the statute."⁸⁵

Second, the Third Circuit rejected the lower court's ruling that falsity could only be established if experts' judgments were factually incorrect—not just legally false because of expert disagreements regarding certification.⁸⁶ The court explained that a theory of legal falsity is sufficient for establishing FCA liability when claims submitted for reimbursement are not reimbursable because they fail to meet regulatory requirements.⁸⁷

Because experts could disagree on a patient's prognosis and eligibility, these disagreements can be evidence that a certification is non-compliant with regulations and therefore legally false.⁸⁸ Accordingly, different expert opinions create a genuine issue of material fact that is triable.⁸⁹ Moreover, because the court established that subjective medical opinions can be false for purposes of the FCA, and are therefore not immune to scrutiny,⁹⁰ the court held that differing opinions can create triable issues regarding FCA falsity.⁹¹

As mentioned, the Third Circuit criticized other courts for adopting the "objective falsehood" standard and mistakenly conflating falsity and scienter when ruling on motions for summary judgment.⁹² The court

83. *See id.*, 952 F.3d at 96 (noting that the FCA denotes falsity and scienter elements independently for a proving liability under 31 U.S.C. §3729(a)(1)(A)).

84. *See id.* (relying on *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 734 (10th Cir. 2018) (noting scienter requirements can be used to address excessive liability concerns)).

85. *Id.*

86. *See id.* at 97 (rejecting the rigid position that clinical judgments are subjective in nature, and thus, different opinions cannot be false).

87. *See id.* (relying on *United States ex rel. Walker v. R&F Props. Of Lake Cty., Inc.*, 433 F.3d 1349, 1356 (11th Cir. 2005) (holding "[m]edicare claims may be false if they claim reimbursement for services or costs that either are not reimbursable or were not rendered as claimed").

88. *See id.* (reasoning that certification requirements under 42 C.F.R. §§418.20 and §418.22(b)(2) articulate strict regulatory guidelines, and the fact that experts could look at the same medical records and come to different clinical judgments on a patient's prognosis meant there was evidence that hospice providers failed to meet regulatory guidelines for certification and thus reimbursement for treatment).

89. *See id.* at 98 (stating expert opinions can be false at times and the reliability and believability of expert testimony should be left to the jury to establish a FCA liability under the legally false theory). The court continued to say that subjective medical opinions can be considered false and medical opinions are not shielded for judicial scrutiny.

90. *See id.* at 100 (relying on *United States v. Paulus*, 894 F.3d 267, 276-77 (6th Cir. 2018) (providing that the common law definition of fraud permits that medical opinions may be considered false and are not shield from judicial scrutiny)).

91. *Id.*

92. *See id.* at 100-01 (reversing the district court's grant of summary judgment for Care Alternatives and specifying that Third Circuit courts must analyze "falsity" and "scienter" elements

therefore decided that differing medical expert opinions regarding certification should be sent to the jury to determine whether they were indeed false.

IV. DISCUSSION

Although the Eleventh Circuit's proof of objective falsehood requirement was appropriate, a better way to assess expert review of recertifications would be to determine whether the initial certification was "reasonable and necessary for the . . . management of terminal illness."⁹³ Part A of this Section argues that the Eleventh Circuit adopted the correct legal standard. Part B of this Section argues that the Third Circuit's holding was misplaced because it requires more than what is written in the regulations. Part C of this Section argues that the Eleventh Circuit should have scrutinized the expert's review of the certifications against the reasonable and necessary provision for treating terminally ill patients. Under that standard, the Eleventh Circuit could have found examples of objective falsehoods. Part D of this Section emphasizes the importance of the 2011 changes for hospice certification and suggests that if the changes were enacted before the relators brought suit against AseraCare, they could have been successful in their claim. Finally, Part E of this Section argues that the Eleventh Circuit's analysis provides some immunity for hospice providers against future FCA liability and discusses potential policy and legal implications of the decision.

A. The Eleventh Circuit Adopted the Correct Legal Standard

The Eleventh Circuit was correct in deciding that, to survive a motion for summary judgment on the element of falsity, relators must prove objective falsehood.⁹⁴ As the court noted, the FCA's statutory language and regulatory framework both support an "objective falsehood" standard.⁹⁵ Because nothing in the language or framework requires certifying physicians to be certain that patients would die at the end of six months,⁹⁶ CMS gave physicians deference regarding patient certifications. The law *only* requires that physicians look to the accompanying clinical information and other documents in patients' medical records to make certification decisions.⁹⁷ Because the physicians

independently when adjudicating FCA lawsuits).

93. 42 U.S.C. §1395y(a)(1)(C).

94. *See supra* text accompanying note 78.

95. *AseraCare III*, 938 F.3d at 1298.

96. *Id.* 1296.

97. *See* 42 C.F.R. §418.22(b)(2) requiring that clinical information and other documentation

in *AseraCare III* exercised their clinical judgment and relied on the patients' medical records, the physicians complied with the legal requirements and properly certified patients.⁹⁸

Congress did not require physicians' clinical judgments to be incontrovertible when making their certifications, and thus, physicians could not have falsified any records when they demonstrably satisfied the legal requirements.⁹⁹ The law does not require anything more for hospice providers. Unless relators can present more than conflicting expert testimony, there are no factual issues for juries to resolve.¹⁰⁰ Allowing the jury to assess differing expert opinions contradicts the wide latitude Congress granted physicians to exercise their clinical judgments to make an informed decision without fear of future liability.¹⁰¹ Regardless, the split between the Third Circuit's and Eleventh Circuit's interpretations of falsity under the FCA unnecessarily complicated FCA hospice jurisprudence.¹⁰²

B. Critique of Third Circuit's Ruling

The Third Circuit wrongly held that differing expert opinions are proof of a genuine issue of material fact.¹⁰³ Despite the Third Circuit's statement that courts must interpret statutes to determine violations, the court read words into the statutory text.¹⁰⁴ To certify patients for hospice care, Congress only required that clinical judgments comply with regulations. If Congress wanted more criteria, then it is up to Congress to make those determinations.¹⁰⁵ The mere difference of opinions regarding certification does not make the certifications false—and thus triable—because Congress has not written that into the statute. Furthermore, a litany of FCA lawsuits have previously held “[e]xpressions of opinion, scientific

support the medical prognosis.

98. See *AseraCare III*, 938 F.3d at 1296.

99. *Id.*

100. See *id.* at 1297 (providing that failure to identify facts and circumstances surrounding patient certification that show inconsistencies with proper clinical judgment fail as a matter of law).

101. See *AseraCare III*, 938 F.3d at 1295.

102. Patrick M. Hagan, *Two Circuits Hold the FCA Does Not Require “Objective Falsity,” Creating Confusion on the Appropriate Standard*, 6 PRATT'S GOV'T CONTRACTING L. REP. §63.04 (2020) (stating the Third Circuit's rejection of *AseraCare III* creates unnecessary confusion).

103. *Id.* (arguing the Third Circuit improperly immunized that all medical opinions from liability and thus botched its analysis of the falsity element and confused the rule of law that is likely similar to the Eleventh Circuit's holding).

104. See *Druding II*, 952 F.3d at 95 (providing that questions of statutory interpretation begin with an analysis of the text) (citing *Escobar*, 136 S. Ct. at 1999).

105. See *AseraCare III*, 938 F.3d at 1301 (stating that Congress determines eligibility requirements for certification, and until Congress changes how a physician's clinical judgment governs certification, that clinical judgment is granted deference when making prognoses that lead to certification).

judgments, or statements as to conclusions about which reasonable minds may differ cannot be false.”¹⁰⁶

The Third Circuit held that FCA liability can arise under the implied false certification theory.¹⁰⁷ While both circuits agree that implied false certification leads to liability, the Third Circuit did not discuss how Care Alternative providers failed to follow the statutory and regulatory framework for certification. When the government’s expert reviewed the records, he opined that his prognoses would *not* have resulted in certification.¹⁰⁸ That difference of opinion is presumably proof of a genuine dispute of material fact. That expert, however, could not further testify that Care Alternative’s certifications violated the legal frameworks—crucial to the legally false analysis for compliance with regulations.¹⁰⁹ The government’s expert could not testify to that point because the patient records he reviewed included the requisite clinical information and supporting documentation.¹¹⁰ Had those records lacked the necessary supporting documents, then Care Alternatives would have violated the law, because it falsely certified patients.¹¹¹ In that scenario, those violations would have been elicited by differing experts opining that

106. *United States ex rel. Roby v. Boeing Co.*, 100 F. Supp. 2d 619, 625 (S.D. Ohio 2000) (ultimately denying defendant’s motion for summary judgment because plaintiff’s presented evidence of objective falsehood that defendant supplied United States Army with defective helicopter transmission gears). *See also* *United States ex rel. Riley v. St. Luke’s Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004) (holding “expressions of opinion or scientific judgments about which reasonable minds may differ cannot be ‘false’”); *United States ex rel. Morton v. A Plus Benefits, Inc.*, 139 Fed. Appx. 980, 983-84 (10th Cir. 2005) (granting defendant’s motion to dismiss because expression of opinions regarding an ambiguous term regarding insurance coverage under ERISA did not sufficiently allege FCA liability); *United States ex rel. Hill v. Univ. of Med. & Dentistry*, 448 Fed. Appx. 314, 316 (3rd Cir. 2011) (affirming the district court’s granting of defendant’s motion for summary judgment after three independent review panels confirmed that there was no scientific misconduct and thus relators failed to prove objective falsehood); *United States ex rel. Jones v. Brigham & Women’s Hosp.*, 678 F.3d 72, 87, 90 (1st Cir. 2012) (agreeing that scientific judgments which reasonable minds can differ cannot be false, but vacating the grant of summary judgment because the facts did not amount to scientific judgments); *U.S. v. Prabhu*, 442 F. Supp. 2d 1008, 1036, n. 23 (D. Nev. 2019) (granting defendant’s motion for summary judgment because relator failed to show falsity regarding tests that were reasonable and necessary).

107. *See Druding II*, 952 F.3d at 97 (stating the Third Circuit recognizes both factual falsity and legal falsity for FCA liability).

108. *Id.* at 94.

109. *See id.* (leaving room for this omission of the expert’s testimony, which was pivotal the Third Circuit’s legally false analysis).

110. *See id.* (providing the records satisfied §418.22(b)(2) requirements).

111. That did not happen in this case. Even if the district court did limit its analysis to factual falsity, upon appellate review, it should have been clear that the district court’s analysis was in fact limited to legal falsity. *See Druding II*, 952 F.3d at 97 (stating the district court limited its FCA falsity analysis to factual falsity). This was because the government argued that by having an expert find the certifications to be improper, Care Alternatives must not have complied with the regulations. *See Druding*, 346 F. Supp. 3d at 681 (describing the government’s expert’s testimony). Nowhere did the government argue that Care Alternatives falsified those patient records before Care Alternative physicians certified patients. *See id.* at 680-81 (providing evidence that relators alleged altered patient records so that patients could be certified but failing to link those allegedly altered records to those records reviewed by the government’s expert).

there was insufficient information in the patient record to warrant certification, which would have presented a triable issue.

Furthermore, the Third Circuit inappropriately relied on Sixth Circuit precedent to determine that clinical judgments are not immune from judicial scrutiny.¹¹² Citing *United States v. Paulus*, the Third Circuit adopted that “medical ‘opinions are not, and have never been, completely insulated from scrutiny,’” and that “‘reliability and believability of [differing] expert testimony . . . is exclusively for the jury to decide.’”¹¹³ However, *Paulus* involved criminal liability for healthcare fraud.¹¹⁴ The Third Circuit also ignored the *Paulus* court’s reasoning “that opinions may trigger liability for fraud when they are not honestly held by their maker or when the speaker knows of facts that are fundamentally incompatible with his opinion.”¹¹⁵ Instead of limiting that language to allege liability, the Third Circuit used that language to support the position that differing medical opinions raise genuine disputes of material fact.¹¹⁶ Finally, the Third Circuit failed to note that Dr. Paulus’s conviction was based on his misrepresentation of facts rather than opinions.¹¹⁷

The Third Circuit’s failure to acknowledge these considerations weaken their ruling for two reasons. First, the court ignored important language regarding the scienter element of an FCA claim. The Sixth Circuit arguably combined the falsity and scienter elements, which the Third Circuit explicitly held was improper because the elements are distinct.¹¹⁸ Second, because the Sixth Circuit reinstated the conviction due to misrepresentation of facts rather than a difference of opinions, the Third Circuit selected favorable parts of the Sixth Circuit’s holding. Had

112. See *Druding II*, 952 F.3d at 98 (relying on *United States v. Paulus*, 894 F.3d 267 (6th Cir. 2018)).

113. See *id.* (quoting *Paulus*, 894 F.3d at 275, 277).

114. See *Paulus*, 894 F.3d at 270 (reversing the district court’s judgment of acquittal after defendant Paulus was convicted of healthcare fraud).

115. *Id.* at 275 (citing RESTATEMENT (SECOND) OF TORTS §539(1)(a) (Am. L. Inst. 1977)).

116. See *Druding II*, 952 F.3d at 98. See also *Winter ex rel. United States v. Gardens Reg’l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1118 (9th Cir. 2020) (noting false certification of medical necessity can give rise to FCA liability). In *Winter*, the court held that any patient certification for medically necessity can be false for the same reasons as any opinion can be false, but the FCA does not require a plaintiff to plead an “objective falsehood.” *Id.* at 1119. The “objective falsehood” standard was adopted by lower courts and the Eleventh Circuit because after extensive discovery, the relators needed to present more evidence than what was pleaded to proceed to trial.

117. *Druding II*, 952 F.3d at 98. The court failed to provide that crucial detail in its analysis, and by doing so conflated that the expert testimony going to trial in *Paulus* was in fact expert opinion testimony reviewing medical records, when it was actually expert opinion testimony regarding verifiable facts.

118. See *id.* at 100 (stating scienter and falsity are separate elements of an FCA claim). See also Hagan, *supra* note 103 (arguing that by using *Paulus* and *Ommicare* as authority, the Third Circuit contradicts itself because both of those cases conflate falsity and scienter elements).

the Third Circuit reasoned that the government's expert opinion differed from Care Alternative's expert opinion because of the misrepresentation of facts in the patient records, then the two differing testimonies would present a genuine dispute of material fact.

While the Third Circuit's ruling appeared to be an anomaly in FCA claims,¹¹⁹ the court's belief that medical opinions should not be entirely insulted from judicial scrutiny is persuasive. If we accept that medical opinions can never be scrutinized, maybe individuals who argue hospice certifications that result in unreasonable and unnecessary care for the management of terminal illness can be used to help prove the initial certifications were indeed false.¹²⁰

C. Certifications that Result in Reasonable and Necessary Care

The Eleventh Circuit should have considered how the certifications at issue conformed to the reasonable and necessary regulation. To begin, the government's expert reviewed 233 records, but the Eleventh Circuit failed to acknowledge the factual importance of those records.¹²¹ All of the certification records were for patients receiving hospice care for over a year.¹²² The Eleventh Circuit should have required AseraCare to justify those certifications because the patients twice outlived the regulatory expectation of terminally ill individuals.¹²³

While prognostication is not an exact science,¹²⁴ repeated recertification of hospice status should raise questions. Patients in hospice care for over 365 continuous days require a *minimum* of five recertifications.¹²⁵ That number should raise questions about the correctness of the initial certification, especially because the median length of hospice care ranged from seventeen to eighteen days from 2000

119. See *supra* text accompanying note 78. But see Hagan, *supra* note 103 (arguing that the muddled *Druding II* ruling actually requires the same standard as *AseraCare III* to prove falsity—relator's expert to opine that no reasonable physician could have reached the conclusion at issue).

120. 42 U.S.C. §1395y(a)(1)(C).

121. See *AseraCare III*, 938 F.3d at 1284, 1304 (providing that the district court acknowledged the 233 certifications were for patients receiving treatment for over 365 continuous days, and the Eleventh Circuit stating that the expert's testimony might still not be enough to show falsity because the expert could not link those records to the specific instances of questionable certifications provided by each relator's testimony).

122. *Id.* at 1284.

123. See 42 U.S.C. §1395x(dd)(3)(A) ("individual is considered to be 'terminally ill' if the individual has a medical prognosis that the individual's life expectancy is 6 months or less").

124. See *supra* text accompanying note 11.

125. See 42 U.S.C. §1395f(a)(7)(A) (stating that for the first 90-day period, a physician or medical director certify patient as terminally ill, and for the subsequent 90-, and each subsequent 60-day, period the medical professional recertify at the beginning of the treatment period that the patient is terminally ill based on clinical judgments). The patients were certified five times because 365 days equates to two, 90-day periods and three, 60-day periods.

to 2010.¹²⁶

According to regulations, the initial certification requires a prognosis of terminal illness based on a medical expert's clinical judgment and supporting documents.¹²⁷ Yet, if the patient is on his fifth recertification, does that mean the first clinical judgment, made 300 days ago, was misguided, arbitrary, unreasonable or unnecessary?¹²⁸ If true, the initial certification is potentially proof of an objective falsehood.¹²⁹ Furthermore, if the first certifying physician was the same physician recertifying the patient for the fifth time, then relators could allege that the physician could not hold a subjective belief the patient was terminally ill for the first certification.¹³⁰ The argument being, that by certifying the patient on day 300, the physician believed that she initially certified a patient when no other reasonable physician would have made that same initial certification.¹³¹

To recertify a patient who no other reasonable physician would have recertified is exactly what the Eleventh Circuit described as proof of objective falsehood.¹³² If an expert had testified to that fact, AseraCare's motion for summary judgment may have been denied. Moreover, the ability for an expert to provide such testimony becomes more plausible when viewed against the total number of patients from which the sample was taken. In *AseraCare III*, 2,180 individuals received continuous care for over 365 days. Only 233 patient certifications, however, were subject

126. David G. Stevenson, Ph.D., *Growing Pains for the Medicare Hospice Benefit*, 367: 18 N. ENGL. J. MED. 1683, 1684 (Nov. 1, 2012) (the author importantly notes that this figure represents a sizable minority of beneficiaries who enroll only days before death). Additionally, in the government's complaint filed in 2012, it was alleged that from at least 2007, AseraCare submitted false claims for Medicare reimbursement. See Intervenor Complaint at ¶35, *United States v. AseraCare, Inc.*, 153 F. Supp. 3d 1372 (N.D. Ala. 2015) (Case No. 2:12-cv-0245-KOB).

127. See 42 C.F.R. §418.22(b)(2) ("Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record").

128. Stevenson, *supra* note 127, at 1684 (stating "defining hospice eligibility relative to the 6-month prognosis mark is clinically arbitrary and practically difficult, especially for people with noncancer diagnoses").

129. The objective falsehood would be that the physician did not subjectively believe the patient was terminally ill.

130. The author writes this sentence because the subjective belief of the certifying physician that the patient was not terminally ill is an example of how to prove "objective falsehood" according to the Eleventh Circuit.

131. For some MHB figures see MEDICARE PAYMENT ADVISORY COMMITTEE, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY, 355, at Figure 6.1 (March 2009) [hereinafter MedPAC March 2009 report] (providing that from 2000 to 2005, the median length of hospice stay was just over two weeks but stays for patients in the 90th Percentile rose from approximately 140 days to approximately 215 days). It would appear that even on day 300, the physician would arguably be recertifying a patient who would fall in the 99th Percentile. See also Amanda Jacobowski, *Calculating Death: Implications of the Six-Month Prognosis Certification Requirement for the Medicare Hospice Benefit*, 19 ELDER L. J. 187, 203 (2011) (finding that in 2008, the average length of a hospice stay was 69 days).

132. See *supra* text accompanying note 77.

to expert testimony.¹³³ Although the size of the patient pool provides no concrete indication that any single certification was legally false, it is arguable that relators could have retained several experts to testify that hundreds of those 2,180 initial certifications were false and required unreasonable and unnecessary treatment.¹³⁴

If the above argument had been accepted, then the Eleventh Circuit would have concluded that the initial payment for hospice services during the first 90-day period was neither reasonable nor necessary for the management of terminal illness.¹³⁵ This presents a clear example of legal falsity. Because the relators provided proof of an objective falsehood that patients were not terminally ill, CMS paid for services that were not reasonable and necessary.¹³⁶ That alone warrants FCA liability because the person submitted “a false or fraudulent claim for payment or approval.”¹³⁷ Had the Eleventh Circuit scrutinized these facts, it could have found that AseraCare violated the FCA and determined the government presented a triable issue. More importantly, the court could have provided direction for lower courts to determine additional ways hospice providers can legally falsify certifications and bill CMS. Instead, the court simply ruled that, so long as reasonable doctors exercised clinical judgments when making certifications, there is no falsehood.¹³⁸

The Eleventh Circuit’s ruling may have created a paradox for the government and relators.¹³⁹ Because the government cannot solely rely on expert testimony to show that hospice certifications were false, there becomes an unenforceable legal rule.¹⁴⁰ Consequently, the Eleventh Circuit essentially granted hospice providers immunity from future

133. See *AseraCare III*, 938 F.3d at 1284-85 (stating the government built its case from a universe of approximately 2,180 patients who received hospice care for 365 days and narrowing its sample size to 233 patients).

134. The author writes hundreds because if one expert opined that he would not have certified 123 of the 233 patients records, then a few experts could possibly opine that they would not have certified hundreds of the approximate 2,180 patient records.

135. See 42 U.S.C. §1395y(a)(1)(C) (“no payment made be made under part A [of Medicare] . . . for any expenses incurred for items or services—in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness”).

136. For the AseraCare lawsuit, the Department of Justice (“DOJ”) sought \$67.5 million for fraudulent claims for a total of \$200 million because of the FCA’s treble damages. See Buck, *infra* note 140, at 26-27.

137. 31 U.S.C. §3729(a)(1)(A).

138. See *Aseracare III*, 938 F.3d at 1301 (“[an] FCA claim fails as a matter of law if the plaintiff proves nothing more than a reasonable difference of opinion as to the patient’s prognosis”).

139. Isaac D. Buck, *A Farewell to Falsity Shifting Standards in Medicare Fraud Enforcement*, 49 SETON HALL L. REV. 1, 41 (2018) (arguing that by dismissing medical necessity-based FCA claims due to a mere difference in clinical opinions between doctors, the DOJ could never prove that clinical opinions were not deserving of medically necessary treatment).

140. *Id.* at 41-42.

lawsuits.¹⁴¹ By reasoning clinical opinions for certification are complex and not an exact science, the court's ruling creates a high bar to prove those certification were false and unnecessary. Although the Eleventh Circuit's holding leaves the government and relators a huge legal hurdle to overcome, there might be hope for future claims.

D. The 2011 Amendments to Conditions and Limitations for Payment of Services

Effective January 1, 2011, for each recertification after the patient's 180th day of hospice care, the certifying physician must have a "face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care."¹⁴² The change in eligibility requirements resulted from a March 2009 report issued by the Medicare Payment Advisory Committee (MedPAC).¹⁴³ MedPAC felt that the current MHB payment system incentivized providers to improperly certify patients because of the financial benefits of long-term hospice stays.¹⁴⁴ Before the change, there was little enforcement of regulatory compliance, but with the 2011 changes, providers could only seek repayment for hospice services if they conducted a face-to-face visit and provided a brief narrative for the certification.¹⁴⁵

The 2011 addition is important because the initial AseraCare lawsuit arguably hinged on the reasons why MedPAC recommended changes. AseraCare did not require physicians to conduct face-to-face encounters to recertify patients; instead, physicians could make clinical judgments based on all the clinical information and supporting documentation. Had AseraCare been required to conduct these face-to-face encounters for the third certification period,¹⁴⁶ AseraCare's providers would have had to familiarize themselves with patients' records and provide a brief narrative for why certification was still proper. With those procedures in place and

141. See *Aseracare III*, 938 F.3d at 1301 (Government arguing that the legal standard would create an under-inclusive problem because hospice providers with sloppy or improper certification procedures could evade FCA liability so long as they can assert their physicians' clinical judgments were justifiable). See also Buck, *supra* note 140 at 30 (arguing so long as hospice providers present a reasonable clinical disagreement about certification, they will be immunized from FCA enforcement and liability).

142. 42 U.S.C. §1395f(a)(7)(D)(i)(I); 42 C.F.R. §418.22(b)(3)(v).

143. MedPAC March 2009 report, *supra* note 132, at 350, Recommendation 6-2A.

144. See *id.* at 348-49 (providing that certification requirements and payment reform was imperative because current MHB lacked adequate administrative and other controls to check incentives for long stays and CMS lacked data vital to the effective management of MHB. By reforming the certification process, MHB could have more oversight for regulatory compliance to reduce unnecessary CMS expenditure).

145. 42 C.F.R. §418.22(b).

146. The face-to-face encounter would have occurred prior to the third certification period starting on day 181.

documents recorded, when providers went to recertify the patient for the fourth or fifth time, they still would have had to review the medical records and supply a brief narrative for the certification. If upon reviewing the record the certifying physician found that no reasonable physician would have initially certified the patient, relators could prove a type of objective falsehood described by the Eleventh Circuit.¹⁴⁷ Furthermore, the failure to even record face-to-face encounters or brief narratives for patients in the certification process would give rise to FCA liability under the legally false certification theory.¹⁴⁸ This hypothetical, however, and most hospice FCA actions brought before 2011, will be resolved at the summary judgment stage or likely be moot because of the changed requirements for recertification.

E. Practical Implications

The Eleventh Circuit's ruling may immunize hospice providers from future FCA liability. Lawsuits filed before the 2011 changes will most likely be resolved at the summary judgment stage because of the hardships relators face when attempting to prove objective falsehood.¹⁴⁹ So long as hospice providers can defend a reasonable disagreement about the clinical judgment to certify patients, the providers will not be held liable.¹⁵⁰ In other words, the providers avoid liability because their certifications are reasonable.¹⁵¹ Even if opposing experts disagree and determine the certifications are false, making treatment unnecessary, then hospice providers may still prevail on a motion for summary judgment because the certification would be *reasonable*. This consequence of the Eleventh Circuit's approach has significant financial implications for the government.

Granting hospice providers some level of immunity impedes the government from collecting treble damages after a favorable verdict¹⁵² or future settlement amounts. For example, the government alleged \$67 million in fraudulent claims and sought a total of \$200 million in damages

147. Additionally, by reviewing the record, the physician would have to familiarize herself with the patient record.

148. The hospice providers would be liable for their failure to comply with regulatory requirements. *See* 42 C.F.R. §418.22(b)(3)(v).

149. *See generally* the lower court decisions in *AseraCare I, U.S. ex rel. Wall v. Vista Hospice Care, Inc.* and *Druding v. Care Alternative, Inc.* Also, hospice providers argued that all of their certifications were proper, and to avoid treble damages, they arguably spared no expense to find an expert to testify that no reasonable doctor would conclude that the certifications were medically improper.

150. *See* Buck, *supra* note 140, at 30.

151. *Id.* at 45 (arguing that the if the Eleventh Circuit adopts the district court's holding, it will immunize providers who "administer care that is not medically necessary, but 'reasonable' nonetheless").

152. 31 U.S.C. §3729 (a)(1).

from AseraCare.¹⁵³ In the first trial, the jury returned a verdict for the government, creating upwards of \$200 million in liability for AseraCare.¹⁵⁴ But, the standard changed, and now the government will have to satisfy a more robust burden of proof to recover damages.¹⁵⁵ That standard protects hospice providers from large damages and disincentives providers from settling, as the chances of prevailing on a motion for summary judgment may have increased.¹⁵⁶

Additionally, the *AseraCare III* and *Druding II* cases seem to rely on moot legal standards. The standard may be moot because there is lesser need for relators to prove objective falsehood now.¹⁵⁷ If any reviewing physicians can see that the third or any subsequent certification was improper because of the supporting medical records and narrative or lack thereof, then there is no dispute of material fact. Instead, the hospice provider plainly failed to comply with the statutory and regulatory frameworks and is liable. Certainly, medical judgments still need to be immune from judicial scrutiny,¹⁵⁸ but FCA liability for hospice certification weighs more heavily on regulatory compliance than actual medical opinion.

In sum, the Eleventh Circuit's adoption of the "objective falsehood" standard presents the clearest framework for courts to determine whether hospice certifications complied with regulations. However, the Eleventh

153. See Buck, *supra* note 140 at 26-27.

154. Gabriel Imperato, *An Overview of Pervasive Allegations in Hospice and Home Health Fraud Cases*, 30 HEALTH LAW. 22, 23 (2018).

155. Note that in March 2020, AseraCare settled with the DOJ for \$1 million. Scott R. Grubman, *Hospice Providers Remain Squarely in the Government's Enforcement Crosshairs*, 32 HEALTH LAW 25 (August 2020).

156. For examples of settlements please see e.g. James F. Barger, Jr., *Life, Death, and Medicare Fraud: The Corruption of Hospice and What the Private Public Partnership under the Federal False Claims Act is Doing About It*, 53 AM. CRIM. L. REV. 1, Appendix (Winter 2016) (finding in 2012, Odyssey Healthcare, Inc. settled for \$25 million; in 2012 Harmony Care Hospice, Inc. settled for \$1.29 million; in 2013, Hospice of the Comforter, Inc. settled for \$3 million; in 2014, Serenity Hospice Care, LLC settled for \$581,504.46; in 2014, San Diego Hospice & Palliative Care Corp. settled for \$1 million out of bankruptcy proceeding; in 2015, Good Shepherd Hospice of Mid America settled for \$4 million; in 2015, Compassionate Care Hospice, Inc. settled for \$6.672 million); See also Jacobowski, *supra* note 132, at 205-06 (finding in 2009, SouthernCare settled for \$24.7 million and in 2006 Odyssey HealthCare, Inc. settled for \$12.9 million).

157. The exception here might be that no reasonable physician would have concluded the patient was terminally ill. However, there is a lesser need for proof of objective falsehood because lawsuits can only be brought when patients have outlived their 180-day prognosis. As Jacobowski wrote, in 2008, the average length of stay was 69 days. See Jacobowski, *supra* note 132. By comparison, from 2014-2018, the average length of stay rose from 88.2 days to 89.6 days, yet in 2018, only 14.1% of the 1.55 million MHB patients needed hospice care for more than 180 days. See NHPCO, *Facts and Figures*, *supra* note 5, at Table 1 and Figure 12, p. 12. Given the percentage of individuals receiving care past 180 days combined with the increased statutory requirements, the medical records and brief narratives supporting recertification should objectively show if the initial certification and subsequent recertification were reasonable and necessary.

158. Compare to text accompanying *supra* note 91.

Circuit should have analyzed the certifications against the reasonable and necessary aspects of the MHB. The court should have considered that if a fifth recertification yields support that the initial certification was unreasonable and unnecessary, the initial certification was false. Additionally, the 2011 changes were adopted to reduce the financial incentive for providers to certify patients ineligible for hospice certification. Those changes may be a direct result of why the government would ever intervene. Regardless, the Eleventh Circuit's holding shields hospice providers from future FCA litigation, decreases the government's changes of settling or winning at trial, and may even be a moot legal standard.

V. CONCLUSION

Adjudication of hospice fraud under the FCA is still a developing body of law. Only two circuits have decided the legal standard to resolve motions for summary judgment in such cases, which have produced divergent analyses and conflicting legal standards. Although the Third Circuit holds that physicians' clinical judgments are not immune from judicial scrutiny, the court did not consider how providers legally falsified the hospice certifications but instead ruled that a difference in medical expert testimony creates a triable issue. Conversely, the Eleventh Circuit held that a mere difference of opinions is not evidence of "objective falsehood," and without more, does not create an issue of material fact to survive a motion for summary judgment. The Eleventh Circuit's holding protects the subjective nature of a physicians' clinical judgments and grants physicians deference when they certify a patient. The court emphasized that estimating death is not an exact science, and thus it is inappropriate to require jurors to consider differing expert opinions.

Additionally, proof of objective falsehood acknowledges Congress's authority to require more or less requirements for hospice certification. Congress exercised that authority when in enacted changes in 2011. Now, for the third and all subsequent recertification periods, providers must have face-to-face encounters with patients and provide a brief write-up for why certification is still proper. The 2011 changes will likely modify FCA claims in the future. If providers fail to comply with regulations, their failure can yield proof of an objective falsehood when analyzed against the reasonable and necessary provision. More powerfully, if there is lacking documentation in the medical records, then all subsequent certifications would be false because the physician would have certified a patient without clinical information and other documentation that supports a prognosis of terminal illness. Nonetheless, the Eleventh Circuit's holding effectively grants some immunity to hospice providers

2021]

PROOF OF OBJECTIVE FALSEHOOD

351

against FCA liability and has the potential to greatly reduce the government's ability to collect damages for fraudulent claims. The author believes the future of FCA liability will likely be governed by the Eleventh Circuit's holding, and how courts apply that legal standard to the 2011 changes will present several other issues for determining hospice fraud.