

“DUELING” EXPERTS AND THE FALSE CLAIMS ACT: WEAPONIZING LEGAL FALSITY TO COMBAT HOSPICE FRAUD

Abstract: In 2020, in *United States ex rel. Druding v. Care Alternatives*, the United States Court of Appeals for the Third Circuit advanced a broad interpretation of “falsity” under the federal False Claims Act (FCA) to allow conflicting medical opinions on a patient’s medical prognosis as evidence of false certification for hospice eligibility. In doing so, the court rejected a blanket rule that clinical judgments are immune from legal challenge and dismissed an “objective falsehood” requirement because it inappropriately conflated elements of the statute. The holding has important implications in industries with high risk for fraud, particularly the for-profit hospice industry that contracts with Medicare. This Comment argues that the Third Circuit’s liberalization of the falsity element aligns with congressional intent to create broad FCA liability for any attempt to defraud the government. Moreover, the Third Circuit’s approach incentivizes entities that receive federal funding to strengthen internal oversight and compliance programs.

INTRODUCTION

The federal False Claims Act (FCA), which Congress passed more than 150 years ago, functions as the government’s primary anti-fraud weapon and facilitates billions of dollars in recoupments every year.¹ From healthcare and

¹ See False Claims Act, 31 U.S.C. § 3729(a)–(b) (subjecting a person to liability for submitting a false claim for reimbursement to the government and requiring no evidence “of specific intent to defraud” the government); 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, 20–21 (2016) (noting that Congress has traditionally intended the statute, enacted in 1863, as a device to fight fraudulent claims submitted to the government); Isaac D. Buck, *A Farewell to Falsity: Shifting Standards in Medicare Fraud Enforcement*, 49 SETON HALL L. REV. 1, 5 (2018) (characterizing the FCA as the federal government’s favored mechanism for controlling fraud); *Justice News: Deputy Associate Attorney General Stephen Cox Provides Keynote Remarks at the 2020 Advanced Forum on False Claims and Qui Tam Enforcement*, OFF. OF PUB. AFFS., U.S. DEP’T OF JUST. (Jan. 27, 2020), <https://www.justice.gov/opa/speech/deputy-associate-attorney-general-stephen-cox-provides-keynote-remarks-2020-advanced> [<https://perma.cc/ZAM4-U6L9>] [hereinafter *Stephen Cox Keynote Remarks*] (stating that the Department of Justice (D.O.J.) prioritizes FCA enforcement actions); *Justice News: Justice Department’s False Claims Act Settlements and Judgments Exceed \$5.6 Billion in Fiscal Year 2021*, OFF. OF PUB. AFFS., U.S. DEP’T OF JUST. (Feb. 1, 2022), <https://www.justice.gov/opa/pr/justice-department-s-false-claims-act-settlements-and-judgments-exceed-56-billion-fiscal-year> [<https://perma.cc/V323-V3A3>] [hereinafter *Justice News: False Claims Act Settlements*] (stating that FCA enforcement actions resulted in more than \$5.6 billion in financial recovery for the fiscal year ending in September 2021, adding to the more than \$70 billion in FCA-related recoveries since 1986 (citing an announcement by Brian M. Boyton, Acting Assistant Attorney General of the Justice Department’s Civil Division)).

education to government contracting and housing, the FCA creates broad liability for any entity that submits a “false” claim to obtain federal funds.² Over the past few decades, congressional amendments expanded enforcement procedures and whistleblower provisions, leading to an increase in FCA actions.³ More recently, the FCA has gained prominence during the COVID-19 pandemic, as the government scrutinizes applications for federal aid packages from businesses and individuals.⁴

² See Buck, *supra* note 1, at 5 (noting that the FCA has historically been used most often in the context of healthcare fraud, but it has also been employed in various other contexts); Stephen Cox *Keynote Remarks*, *supra* note 1 (explaining that the FCA applies to fraud involving government contracts and financial matters, such as grants); Lonie Kim, *Am I Liable? The Problem of Defining Falsity Under the False Claims Act*, 39 AM. J.L. & MED. 160, 161 (2013) (explaining how claims billed to the federal healthcare programs, Medicare and Medicaid, may be “false” under the FCA when the provider bills for services that the provider did not actually render or certifies compliance with conditions for reimbursement that the provider did not actually meet).

³ See EDWARD T. ELLIS & GREGORY C. KEATING, *WHISTLEBLOWING AND RETALIATION: A GUIDE FOR HUMAN RESOURCES PROFESSIONALS AND COUNSEL* 2–3 (6th ed. 2016) (explaining that substantial revisions to the FCA in 1986, more than one hundred years after its passage, created robust whistleblower incentives and protections). In 2006, Congress encouraged states to draft similar laws addressing false claims in the Deficit Reduction Act. Deficit Reduction Act of 2005, Pub. L. No. 109-171, tit. VI, ch. 3, § 6031(a), 120 Stat. 4, 72–73 (codified as amended at 42 U.S.C. § 1396h); see ELLIS & KEATING, *supra*, at 2, 202 (noting that an increase in fraud against the federal government during the Reagan Administration drove the expansion of the FCA in 1980s). In 2009, Congress passed the Fraud Enforcement and Recovery Act (FERA) to include more sources of federal funding under the FCA’s purview and to expand access to enforcement actions by, for example, instituting a longer statute of limitations. Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, 123 Stat. 1617 (codified as amended in scattered sections of 18 U.S.C. and 31 U.S.C.); ELLIS & KEATING, *supra*, at 3. FERA was designed to expand monitoring and oversight efforts related to government funds by increasing the “net of liability,” as well as giving the D.O.J. greater latitude in its discussions with relators. See Roger S. Goldman, Katherine A. Lauer, Abid R. Qureshi & Anne W. Robinson, *Significant False Claims Act Amendments Enacted as Part of the Fraud Enforcement and Recovery Act of 2009*, 39 LAWYER’S BRIEF 1 (July 29, 2009), <https://www.lw.com/thoughtLeadership/significant-fca-amendments-part-of-FERA> [<https://perma.cc/WY5Y-ZP7C>] (discussing the impact of FERA); *Relator*, BLACK’S LAW DICTIONARY (11th ed. 2019) (defining “relator” as the “real party in interest” involved in actions (“*ex rel.*”) where the government may intervene and proceed on behalf of the private party, as well as the “informer” who provides “information on which a civil or criminal case is based”). Lastly, in 2010, Congress passed the Dodd-Frank Act, which amended the whistleblower provisions of the FCA to increase protections for whistleblowers against retaliation. Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, § 2, 124 Stat. 1376, 1386–90 (codified as amended at 12 U.S.C. § 5301); see ELLIS & KEATING, *supra*, at 3 (detailing the impact of the Dodd-Frank Act on whistleblower protections).

⁴ See Coronavirus Aid, Relief, and Economic Security Act, 15 U.S.C. §§ 9001–9141 (Supp. 2020); Michael Kendall, Tai Park, Kevin Bolan & Karen Eisenstadt, *Managing FCA Risk Stemming from Virus Relief Funds*, LAW360 (Apr. 28, 2020), <https://www-law360-com.proxy.bc.edu/articles/1262983/print?section=aerospace> [<https://perma.cc/NFV6-WB7A>] (discussing the impact of the Coronavirus Aid, Relief, and Economic Security Act (CARES), which disbursed billions of dollars in federal aid to various industries and individuals, exposing applicants to FCA liability for tendering false or fraudulent applications). Due to the substantial amount of approved relief funds under the CARES Act, the government is expected to conduct more thorough investigations of the distributed aid and has appointed a “special inspector general” to monitor funds. See Kendall et al., *supra* (likening the oversight of CARES Act funding to Congress’ appointment of a “special inspector gen-

At the center of current and past scrutiny is the healthcare industry, which accounts for the vast majority of FCA enforcement actions and recoveries.⁵ Healthcare providers contract with Medicare and Medicaid, two of the government's largest programs, to fund medical treatment for the elderly, poor, and disabled populations.⁶ In this context, whistleblowers and prosecutors enlist the FCA to penalize medical and pharmaceutical entities that submit false claims for Medicare and Medicaid reimbursement.⁷

In recent years, the aging baby boomer population has driven the growth of the for-profit hospice industry, which bills the Medicare Hospice Benefit

eral" to oversee and identify fraud in the Troubled Asset Relief Program (TARP), 12 U.S.C. §§ 5211–5241, enacted during the recession in 2009); see also Ellen Murphy, Mark Mermelstein & Andrea Mazingo, *Health Providers Should Beware FCA Risks of Covid-19 Aid*, LAW360 (Aug. 6, 2020), <https://www-law360-com.proxy.bc.edu/articles/1298547/print?section=banking> [<https://perma.cc/943Y-5K4T>] (noting that the D.O.J. pursues FCA enforcement actions to recover money after most financial relief legislation); *2021 Year-End False Claims Act Update*, GIBSON DUNN (Feb. 3, 2022), <https://www.gibsondunn.com/2021-year-end-false-claims-act-update/> [<https://perma.cc/SDN9-QKG4>] (stating that COVID-19 aid packages remain a main target for the government's FCA enforcement actions and that "the government has repeatedly indicated its intent to rely heavily on the FCA to police any fraud associated with pandemic relief funds" such as the Paycheck Protection Program).

⁵ See Buck, *supra* note 1, at 6–7 (noting that healthcare claims have produced \$20 billion of the \$31 billion in FCA collections since 2009); *Stephen Cox Keynote Remarks*, *supra* note 1 (noting that, of the total \$3 billion in FCA recoupment in the 2019 fiscal year, the government received \$2.6 billion in healthcare actions, marking a decade of healthcare fraud recoveries of more than \$2 billion per year). In the 2021 fiscal year, enforcement actions related to healthcare accounted for more than \$5 billion of the \$5.6 billion in recoveries. See *Justice News: False Claims Act Settlements*, *supra* note 1 (stating that recoveries come from various sources in the healthcare industry: "hospitals, pharmacies, hospice organizations, laboratories and physicians").

⁶ See Kim, *supra* note 2, at 161 (explaining that the expansion of Medicare and Medicaid, as federal programs that receive funding from the government, has contributed to the rise in FCA cases in the healthcare industry); *Medicare*, CONG. BUDGET OFF., <https://www.cbo.gov/topics/health-care/medicare> [<https://perma.cc/8VEK-FF4S>] (stating that Medicare, which furnishes government-subsidized medical coverage to the aging and qualified disabled populations, ranks second in federal spending). President Biden's 2022 budget proposed close to \$1 trillion allocated to Medicare. See Eric Zimmerman et al., *President's Fiscal Year 2022 Budget: What You Need to Know*, MCDERMOTT+ CONSULTING (June 4, 2021), <https://www.mcdermottplus.com/insights/presidents-fiscal-year-2022-budget-what-you-need-to-know/> [<https://perma.cc/Z7AX-EZSZ>] (providing an overview of President Biden's \$6 trillion proposed Fiscal Year 2022 Budget, which was published on May 28, 2021).

⁷ See *The False Claims Act*, CIV. DIV., U.S. DEP'T OF JUST., <https://www.justice.gov/civil/false-claims-act> [<https://perma.cc/PV3J-766C>] (Feb. 2, 2022) (stating that the FCA allows both government prosecutors and private citizens to bring legal action against an entity for allegedly fraudulent activity); *2021 Year-End False Claims Act Update*, *supra* note 4 (noting that the government and private citizens filed an "unprecedented" number of 922 FCA actions in 2020). The robust anti-retaliation and bounty provisions for whistleblowers make the FCA "an increasingly popular vehicle for employees who allege that their employer has committed fraud on the government." ELLIS & KEATING, *supra* note 3, at 201. See generally Isaac D. Buck, *The Cost of High Prices: Embedding an Ethic of Expense into the Standard of Care*, 58 B.C. L. REV. 101, 143–44 (2017) (explaining that Medicare struggles to regulate overtreatment and costs, and that the FCA may even fall short in adequately prosecuting fraud).

(MHB) to finance end-of-life comfort care for beneficiaries.⁸ As a result, hospice providers obtain more federal funding and face increasing FCA liability.⁹ Courts, in turn, must now review the FCA statute to determine what constitutes a false claim in the hospice care setting.¹⁰ Conflicting interpretations of the falsity element create broader implications for the healthcare industry generally, as well as other industries that receive large amounts of money from the government.¹¹

⁸ See *United States ex rel. Druding v. Care Alts.*, 952 F.3d 89, 92 (3d Cir. 2020) (defining the Medicare Hospice Benefit (MHB) as the arm of the Medicare program that provides federal funding to hospice providers that care for eligible Medicare beneficiaries), *cert. denied*, 141 S. Ct. 1371 (2021); Barger, *supra* note 1, at 9 (describing for-profit hospice facilities as those with private owners “seeking a profitable return on their capital” (citing Peter Waldman, *Aunt Midge Not Dying in Hospice Reveals \$14 Billion U.S. Market*, BLOOMBERG (Dec. 6, 2011), <https://www.bloomberg.com/news/articles/2011-12-06/hospice-care-revealed-as-14-billion-u-s-market> [<https://perma.cc/6K6H-S5ZT>])); Buck, *supra* note 1, at 9–11 (noting that the growth of the hospice industry has created formidable risk of FCA violations). There are more than four thousand hospice facilities in the United States as of 2014 authorized to treat Medicare patients, compared to one thousand in 1992, with more than half operating as for-profit businesses. Buck, *supra* note 1, at 11; see also Andrea Lambert South, *Hospice and the False Claims Act: Paradoxes in End-of-Life Care*, 29 ELDER L.J. 127, 129 (2021) (noting that there are more for-profit hospice facilities than non-profit facilities in today’s healthcare marketplace).

⁹ See Barger, *supra* note 1, at 9 (noting that Medicare remuneration of hospice claims during the last ten years has increased more than four hundred percent, with most Medicare reimbursement going to for-profit companies). At least one observer has identified hospice care as a particularly concerning arena for healthcare fraud because societal tolerance of hospice care has expanded, leading to more beneficiaries electing MHB. See Buck, *supra* note 1, at 9–10 (explaining that more Americans have come to regard hospice care as preferable to extending a loved one’s pain or suffering). Medicare started funding hospice services after “a resurgence of interest in end-of-life care” in the early 1980s, leading to an environment today in which almost half of the largest U.S. hospice care providers have faced FCA allegations and lawsuits. Peter Whoriskey & Dan Keating, *Hospice Firms Draining Billions from Medicare*, WASH. POST (Dec. 26, 2013), https://www.washingtonpost.com/business/economy/medicare-rules-create-a-booming-business-in-hospice-care-for-people-who-arent-dying/2013/12/26/4ff75bbe-68c9-11e3-ae56-22de072140a2_story.html [<https://perma.cc/2YX7-N8C4>].

¹⁰ Compare *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1296–97 (11th Cir. 2019) (adopting an objective analysis of falsity, such that a reasonable disagreement among medical experts on the issue of hospice eligibility alone did not prove falsity) with *Druding*, 952 F.3d at 95 (rejecting an objective falsity standard).

¹¹ See *AseraCare*, 938 F.3d at 1292 (lamenting the lack of precedent on the FCA and MHB); *Winter ex rel. United States v. Gardens Reg’l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1118 (9th Cir. 2020) (detailing the prior circuit decisions with various approaches to the falsity element of the FCA within the hospice care setting), *cert. denied sub nom.*, *RollinsNelson LTC Corp. v. United States ex rel. Winters*, 141 S. Ct. 1380 (2021). See generally *US Supreme Court Asked to Resolve Circuit Split Over the Scope of the False Claims Act*, CLIFFORD CHANCE 1 (Nov. 2020), <https://www.cliffordchance.com/content/dam/cliffordchance/briefings/2020/11/US-supreme-court-asked-to-resolve-circuit-split-over-the-scope-of-the-false-claims-act.pdf> [<https://perma.cc/MFK7-H3M4>] (discussing the implications of the circuit split). Commentators note that the Third Circuit’s approach means that “companies submitting claims to the federal government face a much higher risk of FCA claims based on a difference of professional opinion rather than objective falsity.” *US Supreme Court Asked to Resolve Circuit Split Over the Scope of the False Claims Act*, *supra*, at 1. Furthermore, this liberal approach implicates other major industries that submit claims to the government, such as government contractors and technology companies, and urges scrutiny of compliance programs. See *id.* at 4 (explaining how changes to FCA jurisprudence impact other industries); see also Michael DeBernardis & Philip

Part I of this Comment details the elements of the FCA and the MHB, then provides the background of FCA jurisprudence at the time that the Third Circuit considered the falsity element in *United States ex rel. Druding v. Care Alternatives* in 2020.¹² Next, Part II examines and discusses the opinions of five federal appellate courts that have analyzed the falsity element in a healthcare context: the United States Courts of Appeals for the Third, Sixth, Ninth, Tenth, and Eleventh Circuits.¹³ Finally, Part III argues that the Third Circuit adopted the superior framework because the Eleventh Circuit's objective falsehood standard affords too much deference to hospice providers at a time when the booming for-profit hospice industry is brimming with potential for fraud.¹⁴

I. PROSECUTING HEALTHCARE FRAUD UNDER THE FCA

The False Claims Act (FCA) targets individuals and companies that “knowingly” defraud the United States government with any type of “false or fraudulent claim” for federal reimbursement.¹⁵ The healthcare industry faces the majority of FCA actions and violations can be extremely costly to those convicted.¹⁶ Section A of this Part discusses the elements of the FCA in the

Giordano, *FCA Compliance in an Era of Unprecedented Government Stimulus*, CORP. COMPLIANCE INSIGHTS (Jan. 28, 2021), <https://www.corporatecomplianceinsights.com/false-claims-act-compliance-government-stimulus/> [<https://perma.cc/KJ8J-GDN2>] (stating that compliance programs are crucial to avert FCA liability and fines); Michael Volkov, *Healthcare Compliance Programs to Avoid a False Claims Act Case*, VOLKOV LAW BLOG: CORRUPTION, CRIME & COMPLIANCE (May 27, 2015), <https://blog.volkovlaw.com/2015/05/healthcare-compliance-programs-to-avoid-a-false-claims-act-case/> [<https://perma.cc/S8NQ-TGMB>] (urging companies to improve compliance efforts to manage FCA risks).

¹² 952 F.3d at 89; *see infra* notes 15–51 and accompanying text.

¹³ *See infra* notes 52–76 and accompanying text.

¹⁴ *See infra* notes 77–88 and accompanying text.

¹⁵ *See* 31 U.S.C. § 3729(a)(1)(A) (applying liability to a person who “knowingly” submits “a false or fraudulent claim for payment or approval” to the U.S. government); ELLIS & KEATING, *supra* note 3, at 201 (stating that the FCA “generally prohibits making false or fraudulent claims to get the federal government to pay for goods or services”). The statute also makes it illegal for a person to knowingly make “a false record or statement material to a false or fraudulent claim.” § 3729(a)(1)(B).

¹⁶ *See* § 3729(a)(1) (imposing civil penalties plus treble damages for the government's loss *per* claim); *see also A Roadmap for New Physicians: Fraud & Abuse Laws*, OFF. OF THE INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUM. SERVS., <https://oig.hhs.gov/compliance/physician-education/01laws.asp> [<https://perma.cc/9MG4-WZK7>] (noting that fines accumulate rapidly when each line billed for reimbursement can constitute a separate false claim). The Department of Justice adjusts the cost of FCA violations for inflation—as of December 2021, FCA fines span between \$11,803 to \$23,607 per claim. *2021 Year-End False Claims Act Update*, *supra* note 4. Claims submitted to Medicare, one of the largest federally funded programs, are common targets for FCA liability. *See* Ashleigh Garrison, *Medicare's Most Indefensible Fraud Hotspot: Hospice Care*, CNBC, <https://www.cnbc.com/2018/08/02/medicare-most-despicable-indefensible-fraud-hotspot-hospice-care.html> [<https://perma.cc/VU8W-SQ3X>] (Aug. 3, 2018) (noting the rise in fraud cases as both the quantity of hospice providers in the United States and the population of Medicare beneficiaries partaking in the Medicare Hospice Benefit (MHB) have grown). Medicare pays more than six hundred billion dollars annually to provide healthcare services for beneficiaries. *Id.*; *Medicare*, *supra* note 6 (stating that Medicare, which furnishes gov-

context of healthcare fraud and reimbursement claims submitted to the Medicare Hospice Benefit (MHB).¹⁷ Section B discusses United States Supreme Court jurisprudence on the FCA, providing the legal background of *United States ex rel. Druding v. Care Alternatives* in 2020.¹⁸ Section C provides the factual and procedural background of *Druding*.¹⁹

A. The False Claims Act and the Medicare Hospice Benefit

The FCA imposes severe civil penalties on those who commit fraud against the government.²⁰ Though the government may initiate cases against perpetrators, FCA actions often start through the statute's powerful qui tam provision.²¹ The provision incentivizes private citizens (referred to as "relators") to blow the whistle on suspected fraudulent activity by offering a cut of the government's recoupment.²² To prevail on an FCA enforcement action, the government or whistleblower must prove four prima facie elements: "materiality," "knowledge," "causation," and "falsity."²³ Notably, the FCA statute does not define "falsity."²⁴

ernment-subsidized medical coverage to the aging and qualified disabled populations, ranks second in federal spending).

¹⁷ See *infra* notes 20–33 and accompanying text.

¹⁸ 952 F.3d 89 (3d Cir. 2020); see *infra* notes 34–43 and accompanying text.

¹⁹ See *infra* notes 44–51 and accompanying text.

²⁰ See § 3729(a) (imposing set civil penalties per claim plus treble damages).

²¹ See § 3730(a) (tasking the Attorney General with investigating fraud and initiating civil actions against suspected perpetrators); § 3730(b)–(d) (providing a unique procedural pathway and incentive scheme for private citizens to initiate an action against a provider or corporate entity that is allegedly submitting false claims to the government); *Qui Tam Action*, BLACK'S LAW DICTIONARY, *supra* note 3 (defining "qui tam action" as a statutory action in which a private citizen may sue another party to obtain damages that will be shared with the government).

²² See Barger, *supra* note 1, at 19, 21–23 (noting that the qui tam provision incentivizes private individuals, called relators, to investigate fraud and initiate legal proceedings); § 3730(b) (providing that qui tam actions are filed under seal so that the government can review the case and choose whether to intervene and prosecute the action before the defendant receives the complaint or the complaint becomes public record). If the government chooses not to intervene, the relator may proceed with the action against the defendant. § 3730(b)(4)(B). Individuals who prosecute the case without the government's assistance are entitled to a higher percentage of the damage award. See § 3730(d) (providing that relators may receive between fifteen to twenty-five percent if the government intervenes to prosecute, and between twenty-five to thirty percent if the relator prosecutes the case without government assistance).

²³ See Michael E. Paulhus, King & Spalding LLP, Presentation at the American Health Lawyers Association Fundamentals of Health Law Seminar: The False Claims Act: A Powerful Enforcement Tool (Nov. 13, 2014), <https://silo.tips/download/ahla-the-false-claims-act-a-powerful-enforcement-tool-michael-e-paulhus-king-spa> [<https://perma.cc/6B5E-GMRP>] (listing the FCA elements). For a statement to be "material," it must affect the government's decision to pay the claim. See § 3729(b)(4) (defining material as "having a natural tendency to influence . . . the payment or receipt of money"). To satisfy the scienter requirement, the FCA does not require "specific intent to defraud," but merely "knowledge." See § 3729(b)(1)(A)–(B) (defining "knowingly" as one who, concerning the falsity of information, "has actual knowledge," "acts in deliberate ignorance," or "reckless[ly] disregard[s]" the verity of the claim); *Scienter*, BLACK'S LAW DICTIONARY, *supra* note 3 (defining "scienter" as a per-

Within the healthcare industry, FCA enforcement actions fall into two main categories: (1) actions against pharmaceutical companies; and (2) actions against healthcare providers.²⁵ This Comment focuses on the second category of actions against providers who submit “false” claims to the government for reimbursement of medical services, such as hospice care.²⁶ By definition, hospice facilities provide palliative care that aims to maximize the physical comfort and emotional well-being of terminally ill patients.²⁷

Facilities providing hospice care are eligible for reimbursement through the MHB, and the Centers for Medicare & Medicaid Services (CMS) has promulgated regulations for hospice facilities to qualify for such payment.²⁸ Admitting physicians must sign a certification of terminal illness (COTI) for each incoming patient, confirming that the patient is expected to survive for less than six months and thus is eligible for hospice care.²⁹ CMS acknowledges that diagnosing a terminal illness with a six-month survival rate involves phy-

son’s “degree of knowledge” or mental state that establishes culpability for his or her actions, and more specifically, as an intent to “deceive, manipulate, or defraud” in some contexts).

²⁴ See § 3729(b) (providing no definition for “falsity” within the statute); *Universal Health Servs. v. United States ex rel. Escobar*, 579 U.S. 176, 187 (2016) (noting that the statute does not provide definitions for the terms “‘false’ or ‘fraudulent’” within the meaning of the FCA).

²⁵ See Buck, *supra* note 1, at 7 (listing two categories of FCA claims for healthcare fraud).

²⁶ See Kim, *supra* note 2, at 161 (explaining how claims billed to Medicare and Medicaid may be false under the FCA when the provider bills for services that the provider did not actually render or when the provider certifies compliance with conditions for reimbursement that the provider did not actually meet); Barger, *supra* note 1, at 12 (detailing the rise of FCA actions from healthcare professionals seeking to fight “rampant” issues with fraudulent Medicare billing in hospice facilities); Whoriskey & Keating, *supra* note 9 (explaining that almost half of the “largest hospice [care providers] in the United States” faced FCA actions during the hospice boom).

²⁷ See *United States ex rel. Druding v. Care Alts.*, 952 F.3d 89, 92 (3d Cir. 2020) (defining palliative care as “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering” (quoting 42 C.F.R. § 418.3 (2019)), *cert. denied*, 141 S. Ct. 1371 (2021). Terminal illness is “a medical prognosis that the individual’s life expectancy is six months or less, if the illness runs its normal course.” *Id.* (first citing 42 U.S.C. § 1395x(dd)(3)(a); and then citing 42 C.F.R. § 418.3 (2019)). The MHB, which covers all palliative services at no cost to a qualified patient, is only available to those terminally ill Medicare beneficiaries who choose not to undergo any curative care designed to treat their conditions and instead decide that hospice care is the preferable course of action. See Barger, *supra* note 1, at 13–14 (explaining that palliative care includes a wide range of inpatient and outpatient medical services, such as “skilled nursing services, medication for pain and symptom control, physical and occupational therapy, counseling” (citing 42 C.F.R. § 418.202 (2015))).

²⁸ See *Druding*, 952 F.3d at 92 (defining the MHB as the arm of the Medicare program that provides federal funding to hospice providers that care for eligible Medicare beneficiaries); *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1282 (11th Cir. 2019) (explaining that the regulations require a claim to meet specified requirements to be eligible for payment, namely that supporting clinical documentation is filed to bolster the diagnosis of terminal illness).

²⁹ See Barger, *supra* note 1, at 28 (describing the hospice certification process). Once a patient initiates hospice care, each additional sixty- or ninety-day stay requires re-certification. *Druding*, 952 F.3d at 92 (citing 42 U.S.C. § 1395f(a)(7)(A)(ii) (2005)).

sician discretion, but nevertheless requires adequate clinical documentation to corroborate the certification.³⁰

A hospice provider may violate the FCA by submitting claims to Medicare for reimbursement of a patient's hospice care costs when the patient is not actually eligible for such services.³¹ In this scenario, the government or relator must show that the hospice provider falsified the patient's COTI, such that the patient's clinical documentation did not in fact support a diagnosis of terminal illness.³² The MHB reimbursement scheme may incentivize for-profit hospice providers to admit more patients or to prolong existing patients' stays, thus motivating providers to falsify COTIs.³³

B. Supreme Court Guidance: What Proves FCA Falsity?

When the government or whistleblowers initiate FCA enforcement actions against hospice facilities, courts must determine what evidence establishes "falsity" under the FCA.³⁴ Though Congress passed the FCA in 1863, the

³⁰ *Druding*, 952 F.3d at 93. At least one physician must sign the certification and include clinical documentation that substantiates the diagnosis of terminal illness. *See id.* (quoting 42 C.F.R. § 418.22(b)(2) (2011)); Barger, *supra* note 1, at 29 (noting that CMS included the documentation requirement to discourage providers from certifying unqualified patients).

³¹ *See South*, *supra* note 8, at 128 (noting that FCA jurisprudence from the last decade documents employee whistleblowers alleging false certifications for both admission to the facility and for continued hospice care once admitted); *AseraCare*, 938 F.3d at 1284 (explaining that the "'false certification' theory" assigns FCA liability when the defendant expressly or impliedly indicates that they have met the conditions for payment when they actually have not).

³² *See Buck*, *supra* note 1, at 13 (discussing false certifications for admission). Studies have shown increasing numbers of hospice facilities discharging patients alive, calling into question such patients' status as terminally ill. *See Whoriskey & Keating*, *supra* note 9 (reporting that an Alabama location of AseraCare discharged seventy-eight percent of its patients alive).

³³ *See Barger*, *supra* note 1, at 14 (explaining that hospice care is reimbursed at a set daily rate, which Medicare pays directly to the hospice facility for each qualified patient). Importantly, hospice facilities receive this per diem rate independent of the actual services provided on a day-to-day basis, and facilities do not have to submit line-item charges for each patient. *Id.* A study of more than one million patient records in California showed that "[t]he proportion of patients who were discharged alive from hospice care rose about 50 percent between 2002 and 2012," and that "[t]he average length of a stay in hospice care also jumped substantially over that time, in California and nationally." *See Whoriskey & Keating*, *supra* note 9 (noting that profits per patient also increased more than five times the rate from 2002). Commentators note that for-profit entities profit from admitting more patients and the "financial incentive" translates to noticeable figures: for example, although "the average nonprofit serves a patient for 69 days, the average for-profit hospice serves a patient for an average of 102 days." *Id.*; *see also* JOANNE M. CHIEDI, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUM. SERVS., DOC. NO. OEI-02-16-00570, VULNERABILITIES IN THE MEDICARE HOSPICE PROGRAM AFFECT QUALITY CARE AND PROGRAM INTEGRITY: AN OIG PORTFOLIO, at portfolio in brief (2018), <https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf> [<https://perma.cc/9DWW-EV3G>] (finding that fraudulent hospice billing practices cost Medicare "hundreds of millions of dollars" and negatively impact the MHB and its patients).

³⁴ *See Druding*, 952 F.3d at 91 (stating that the enforcement action presented the Third Circuit with a question of first impression: whether conflicting clinical judgments could establish the falsity element of the FCA).

Supreme Court first analyzed the statute's falsity element in 2016 in *Universal Health Services v. United States ex rel. Escobar*.³⁵ Noting that the statute does not define "false" or "fraudulent," the Court looked to the common law definitions to adopt a broad reading of the terms.³⁶ Courts have traditionally recognized two types of falsity: "factual" and "legal."³⁷ Factual falsity refers to a claim that contains untrue facts, such as a claim that bills for a service or medication that a patient never received.³⁸ Legal falsity occurs when a facility submits a claim for government reimbursement without meeting the statutory or regulatory requirements to receive federal funds.³⁹

Under the umbrella of legal falsity, courts acknowledge two theories of liability: "express [false] certification" and "implied [false] certification."⁴⁰ Although federal circuit courts have been reluctant to adopt the implied false certification theory, the Supreme Court unanimously validated it as a basis for liability in *Escobar* and thus broadened the scope of the FCA.⁴¹ As a result, FCA liability may attach to providers who expressly falsify compliance with the "statutory, regulatory, or contractual requirements" for payment and to providers who

³⁵ See Barger, *supra* note 1, at 20–21 (discussing the history of the FCA since its passage to contest fraud during the Civil War in 1863); *Universal Health Serv. v. United States ex rel. Escobar*, 579 U.S. 176, 187 (2016) (holding that the FCA's "false" element includes both "express falsehoods" and "fraudulent misrepresentations").

³⁶ See *Escobar*, 579 U.S. at 187 (consulting common law because Congress did not provide the definition of "false" in the language of the FCA and concluding that "misrepresentations by omission" could qualify as "fraudulent"); *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 741 (10th Cir. 2018) (noting that the Supreme Court has espoused a "more expansive view" of the term "false" by drawing from common law interpretations).

³⁷ See *Polukoff*, 895 F.3d at 741 (explaining that precedent from the United States Court of Appeals for the Tenth Circuit views "false" as encompassing both factual falsity and legal falsity); *Druding*, 953 F.3d at 96 (noting that precedent from the United States Court of Appeals for the Third Circuit similarly allows plaintiffs to demonstrate that a claim is either factually or legally false).

³⁸ See Kim, *supra* note 2, at 167 (stating that factually false claims also "may involve . . . incorrect descriptions of such goods or services" (citing *United States ex rel. Hutcheson v. Blackstone Med. Inc.*, 647 F.3d 377, 382 (1st Cir. 2011))).

³⁹ See *id.* (noting that legally false claims involve facilities that falsely certify compliance with conditions for reimbursement).

⁴⁰ See *id.* (explaining that "express certification" occurs when a provider explicitly verifies it met the conditions for payment when in fact it did not, whereas "implied certification" occurs when a provider indicates that its claim is compliant simply by sending the claim for payment).

⁴¹ See 579 U.S. at 186 (explaining that the Court granted certiorari to provide guidance to the federal appellate courts on whether the implied false certification theory applies to FCA claims); Harold B. Hilborn, *Supreme Court Holds Implied Certifications Create False Claims Act Liability*, NAT'L L. REV. (Sept. 1, 2016), <https://www.natlawreview.com/article/supreme-court-holds-implied-certifications-create-false-claims-act-liability> [<https://perma.cc/63SZ-2YBS>] (noting that the unanimous decision addressed a circuit split). According to the implied false certification theory, FCA liability arises "when the defendant submits a claim for payment that makes specific representations about the goods or services provided, but knowingly fails to disclose the defendant's noncompliance with a statutory, regulatory, or contractual requirement." See *Escobar*, 579 U.S. at 181 (stating that a provider's failure to disclose its noncompliance violates the FCA "if the omission renders those representations misleading").

imply compliance simply by tendering a claim.⁴² In other words, a provider who is not in fact complying with material requirements submits a false claim because that failure to disclose noncompliance is a misleading representation.⁴³

C. The Factual and Procedural History of United States ex rel. Druding v. Care Alternatives

In 2020, in *United States ex rel. Druding v. Care Alternatives*, four private citizens filed suit through the FCA's qui tam provision against their former employer, Care Alternatives, a hospice care provider in New Jersey.⁴⁴ The relators invoked the implied false certification theory: alleging that Care Alternatives certified ineligible patients for hospice admission, the relators accused the facility of noncompliance with regulatory requirements for MHB reimbursement.⁴⁵ As a result, Care Alternatives' claims to MHB for payment misrepres-

⁴² See *Escobar*, 579 U.S. at 187, 190 (holding that claims with either "express falsehoods" or "misrepresentations by omission" fit the falsity requirement within the FCA context under the implied certification theory due to "failure to disclose noncompliance with material statutory, regulatory, or contractual requirements"); Kim, *supra* note 2, at 167. Applying the implied certification theory, the *Escobar* Court held that a Massachusetts mental health clinic faced FCA liability through billing Medicaid for mental health and other counseling services that its staff members were not licensed to provide. 579 U.S. at 189–90 (explaining that the clinic implied that it was compliant with the staff licensing requirements by submitting the claims and holding that such "misrepresentation[] by omission" was actionable under the FCA).

⁴³ See *id.* at 189–90 (explaining that a provider generally implies eligibility to receive federal funds when it submits a claim to the government program). The Court held that "half-truths," which it defined as representations that contain true elements but omit material information, may qualify as misrepresentations under the FCA. *Id.* at 190. Accordingly, the Supreme Court has interpreted "false" to include omissions that create misleading representations on claims for federal reimbursement. See *id.* at 187 (adopting a broader interpretation of "false" in keeping with the common law, which acknowledged falsehoods other than express factual inaccuracies). The decision widened the scope of the FCA because providers may create actionable half-truths if they violate requirements for payment, and then fail to disclose such violations when submitting a claim. See Hilborn, *supra* note 41 (discussing the practical effects of the Supreme Court's decision in *Escobar* for healthcare providers).

⁴⁴ See 952 F.3d 89, 91–92 (3d Cir. 2020) (stating that relators Victoria Druding, Linda Coleman, Barbara Bain, and Ronni O'Brien had served as members of "a team of clinicians known as 'interdisciplinary teams,' ('IDTs') at Care Alternatives), *cert. denied*, 141 S. Ct. 1371 (2021). IDTs, composed of various medical professionals, caregivers, and other support staff, review patient medical records, clinical status, and disease progression to determine whether a patient qualifies or continues to qualify for hospice care under the MHB. *Id.* at 92. The government declined to engage in the action and the plaintiffs moved forward with the suit on behalf of the United States. See *id.* at 93 (noting that the government spent seven years reviewing the original complaint). After reading the complaint and associated documents, the government may decline to intervene for several reasons, including limited resources or evidence, as well as reduced probability for damage payment. See *Declined vs. Intervened False Claims Act Cases*, BERGER MONTAGUE, <https://bergermontague.com/declined-vs-intervened-false-claims-act-cases/> [<https://perma.cc/4MHC-6XGS>] (explaining that the government proceeds with only about twenty percent of FCA cases).

⁴⁵ See *Druding*, 952 F.3d at 92–94 (explaining that the relators accused Care Alternatives of violating the FCA by certifying and admitting ineligible patients for hospice care between 2006 and 2007, as well as inflating the number of eligible patients through employee coercion).

sented its compliance and were therefore “false” under the FCA.⁴⁶ To show that Care Alternatives was falsifying certifications for ineligible patients, the relators presented medical expert testimony asserting that clinical documentation did not actually corroborate a diagnosis of terminal illness in thirty-five percent of the patient records reviewed.⁴⁷

In contrast, Care Alternatives’ medical expert testified that a “reasonable physician” could have certified all of the disputed patients.⁴⁸ Care Alternatives moved for summary judgment, arguing that the relators failed their burden of establishing falsity.⁴⁹ The United States District Court for the District of New Jersey granted the defendant’s motion, relying on the idea that the “dueling” expert opinions as to the clinical certifications did not show any objective or express falsehood sufficient to satisfy the falsity requirement.⁵⁰ The United States Court of Appeals for the Third Circuit reversed on appeal, holding that the conflicting medical expert testimony was sufficient evidence of falsity for the case to proceed.⁵¹

II. THE CIRCUIT SPLIT ON THE FCA’S FALSITY ELEMENT

Since 2016, when the Supreme Court adopted a broad interpretation of falsity in *Universal Health Services v. United States ex rel. Escobar*, federal circuit

⁴⁶ *Id.* at 93. The relators argued that Care Alternatives had implied compliance with Medicare’s “regulatory requirements” for payment, which require a doctor to “certif[y] the patient [as] terminally ill” and provide sufficient “[c]linical . . . documentation [to] support” the diagnosis. *See id.* at 97 (alteration in original) (quoting 42 C.F.R. §§ 418.20, 418.22(b)(2) (2019)) (explaining that the relators’ claim invoked legal falsity by alleging that Care Alternatives did not comply with federal regulations).

⁴⁷ *See id.* at 94 (describing the conflicting testimony from each party). The relators presented medical expert testimony that the defendant incorrectly certified thirty-five percent of patients for hospice care during a review of selected medical records for the years in question. *See id.* at 91, 94 (noting that the relators’ expert, Dr. Jayes, testified that thirty-five percent of the forty-seven patients selected for review were ineligible, and asserted that “any reasonable physician” would agree with his conclusion).

⁴⁸ *See id.* at 94 (noting that the defendant’s expert, Dr. Hughes, testified that a reasonable physician could conclude that each patient had less than six months to live).

⁴⁹ *Id.*

⁵⁰ *See id.* (explaining that the District Court adopted a stringent standard for the FCA element of falsity by requiring a plaintiff to submit proof that the physician’s certification of hospice eligibility was factually inaccurate and thus constituted an “objective falsehood”); *Druding v. Care Alts., Inc.*, 346 F. Supp. 3d 669, 671–72 (D.N.J. 2018) (granting summary judgment to Care Alternatives), *rev’d*, *Druding*, 952 F.3d at 89. Despite declining to intervene in the case, the government submitted a “statement of interest” in which it argued that the court should not adopt the “objective falsehood” standard. *Druding*, 952 F.3d at 94. The District Court, however, concluded that subjective clinical judgments could not satisfy the falsity requirement if the only evidence of falsity was a reasonable difference of opinion among professionals. *See id.* (citing *United States ex rel. Riley v. St. Luke’s Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004)).

⁵¹ *See Druding*, 952 F.3d at 95–96 (rejecting the lower court’s ruling because it applied a test in conflict with the court’s prior precedent). The Third Circuit held that the implied certification theory allowed differing medical expert opinions about a patient’s terminal diagnosis to show that the clinical documentation did not corroborate the certification. *Id.* at 97.

courts have advanced varying analyses of the implied false certification theory.⁵² Section A of this Part details the majority approach of the United States Courts of Appeals for the Third, Tenth, and Ninth Circuits, which allows conflicting medical testimony to support the implied false certification theory of legal falsity.⁵³ Section B discusses the United States Court of Appeals for the Eleventh Circuit's contrasting approach in adopting an objective falsehood standard.⁵⁴

A. Third Circuit Adopts the Majority Approach: Conflicting Medical Expert Testimony Is Sufficient Evidence to Support FCA Falsity

Among the federal circuit courts that have recently confronted healthcare fraud through the lens of the False Claims Act, the majority approach allows scrutiny of physicians' clinical judgments through medical expert testimony as evidence of falsity.⁵⁵ Courts have relied on the implied false certification theory to determine that providers face liability when the patient's medical documentation is contrary to the physician's medical conclusion.⁵⁶ The resulting claim for payment is "false" because the provider, by failing to produce clinical documentation supporting the diagnosis, is not complying with the requirements for federal reimbursement.⁵⁷ In order to show that a patient's record does not support the diagnosis, however, courts must scrutinize the subjective judgments of medical professionals—a task that the majority approach deems acceptable.⁵⁸

⁵² See 579 U.S. 176, 186–87 (2016) (holding that the FCA's "false" element included both "express falsehoods" and claims containing "misleading omissions or "misrepresentations"). Compare *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1296–97 (11th Cir. 2019) (adopting an "objective falsity" standard that requires a showing of "something more than the mere difference of reasonable opinion concerning the prognosis of a patient's likely longevity"), with *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 742 (10th Cir. 2018) (holding that clinical judgments may be "false" under the False Claims Act), and *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1112–13 (9th Cir. 2020) (same), *cert. denied sub nom.*, *RollinsNelson LTC Corp. v. United States ex rel. Winters*, 141 S. Ct. 1380 (2021), and *Druding*, 952 F.3d at 91 (same).

⁵³ See *infra* notes 55–71 and accompanying text.

⁵⁴ See *infra* notes 72–76 and accompanying text.

⁵⁵ See *infra* notes 56–71 (detailing the majority approach, which allows courts to scrutinize medical opinions instead of applying a blanket rule that all "subjective" opinions cannot be false).

⁵⁶ See *Winter*, 953 F.3d at 1113 (holding "that a false certification of medical necessity can give rise to FCA liability"); *United States v. Paulus*, 894 F.3d 267, 275–76 (6th Cir. 2018) (explaining that liability attaches to medical opinions when the speaker does not genuinely believe the statement or knows that the statement conflicts with other verifiable facts).

⁵⁷ See *Druding*, 952 F.3d at 97 (explaining that relators can prove legal falsity by establishing that the hospice facility did not comply with one or both regulatory obligations: (1) that the medical provider signed the patient's COTI; and (2) that the COTI is bolstered by sufficient clinical documentation regarding the diagnosis (citing 42 C.F.R. §§ 418.20, 418.22(b)(2) (2019))).

⁵⁸ See *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 734 (10th Cir. 2018) (holding that medical judgments are subject to scrutiny and may be proven "false"); *Winter*, 953 F.3d at 1113 (same); *Druding*, 952 F.3d at 91 (same); *Paulus*, 894 F.3d at 275 (concluding that medical "opinions are not, and have never been, completely insulated from scrutiny").

For example, in 2018, in *United States ex rel. Polukoff v. St. Mark's Hospital*, the Tenth Circuit rejected the argument that the defendant-physician's clinical judgment, as an opinion, could not be "false" so as to render him liable under the FCA.⁵⁹ The relator, another physician, claimed that the defendant made false representations about the medical necessity of cardiac procedures when submitting claims to Medicare for reimbursement.⁶⁰ The Tenth Circuit concluded that the relator's evidence of the defendant's willful violations of industry and hospital guidelines, and subsequent certification of medical necessity to obtain Medicare reimbursement, was sufficient evidence of "falsity" under the FCA.⁶¹

Similarly, in 2020, in *Winter ex rel. United States v. Gardens Regional Hospital and Medical Center, Inc.*, the Ninth Circuit held that evidence of untrue or misleading physician opinions could support the falsity element for an

⁵⁹ See 895 F.3d at 734 (holding that the medical opinions of the defendant doctor, Dr. Sorensen, may be proven "false" to support an FCA claim). In this case, a qui tam relator, another physician named Dr. Polukoff, brought an FCA action against Dr. Sorensen and the hospitals where he operated, alleging that "Dr. Sorensen performed thousands of unnecessary heart surgeries" and submitted claims to Medicare for payment. See *id.* at 734, 738 (explaining that the hospitals were charged with complicity for submitting claims to Medicare "despite clear compliance red flags" regarding the high number of procedures Dr. Sorensen performed (quoting Amended Complaint for Damages and Other Relief Under the False Claims Act (31 U.S.C. § 3730), ¶ 3, *Polukoff*, 895 F.3d at 730 (No. 2:16CV00304), 2015 WL 13466153, ¶ 3)). Dr. Sorensen had built a reputation for performing numerous "PFO closures," a surgery to address a heart condition known as patent foramen ovale (PFO). See *id.* at 736–37 (noting that the Cleveland Clinic had conducted thirty-seven such procedures during the same year in which Dr. Sorensen had completed 861). PFO causes reverse blood flow through a hole between two chambers located at the top of the heart, and in rare situations, can result in stroke. *Id.* at 736. American Heart Association and American Stroke Association guidelines generally recommend against PFO hole closures unless patients have a prior medical history of stroke. *Id.*

⁶⁰ *Id.* at 734. The relator referred to industry guidelines, hospital guidelines, and a hospital audit of Dr. Sorensen's medical notes as evidence that he performed and billed Medicare for surgical procedures that were not medically necessary. See *id.* at 737–38 (noting that although the hospital's procedures conformed to those of the American Heart Association and American Stroke Association, Dr. Sorensen wrote in his patients' charts that he understood the standard of care but preferred his own approach to using PFO as a strategy to prevent recurrent strokes before they occurred—a preventative measure not supported as medically necessary). As such, Dr. Polukoff based his FCA claim on Dr. Sorensen's misrepresentation of the medical necessity of the procedures. *Id.* at 739; see *Druding*, 952 F.3d at 97 ("[T]he Tenth Circuit emphasized that liability is not premised on factual falsity alone, but a certification is false simply 'if the procedure was not reasonable and necessary under the government's definition of the phrase.'" (quoting *Polukoff*, 895 F.3d. at 742–43)).

⁶¹ See *Polukoff*, 895 F.3d at 743 (explaining that Dr. Polukoff, the relator, presented sufficient evidence to survive Dr. Sorensen's motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) because Dr. Sorensen knew the PFO closures were not medically necessary but certified them as such to Medicare to collect reimbursement). The Tenth Circuit rejected the lower court's reasoning and instead identified three grounds upon which a medical judgment could support the falsity element of the FCA: (1) courts should interpret the FCA more broadly to enable successful prosecutions of all forms of fraud against the government; (2) expert opinions are not immune from liability simply because they are opinions; and (3) unnecessary medical treatments may reveal the falsity of the underlying medical judgments. See *id.* at 742 (listing case law from other circuits in support of allowing scrutiny of medical judgments).

FCA claim.⁶² The relator presented her own clinical opinion as evidence that the hospital certified patients for inpatient hospitalization and billed Medicare, despite the medical records showing no basis for admission and violating the hospital's admission criteria.⁶³ The court advocated for a broad reading of the statute, noting that the statutory language of the FCA applies to all false claims with no exceptions or qualifications.⁶⁴

The Third Circuit adopted the same approach in *United States ex rel. Druding v. Care Alternatives* in 2020.⁶⁵ The court held that conflicting testimony between the relators' expert and Care Alternatives' expert was sufficient evidence to merit a trial on the issue of falsity.⁶⁶ In doing so, the court relied on the Tenth Circuit's reasoning that the relators may show falsity through evidence that a physician's clinical judgment misrepresented the patient's eligibility for a procedure or for admission to a certain level of medical care.⁶⁷ Here, the relators' medical expert testified that clinical documentation did not corroborate a diagnosis of terminal illness required for hospice eligibility.⁶⁸ The court held that a jury could rely on such testimony to determine the issue of legal falsity, namely whether the certifications of terminal illness (COTIs) mis-

⁶² See 953 F.3d at 1112–13 (holding that the court should evaluate a physician's medical opinion just like it would examine any other statements). Reversing the lower court's dismissal of the claims, the court stated that "an opinion can establish falsity." *Id.* at 1120–21 (first citing *Paulus*, 894 F.3d at 270, 277; and then citing *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1300 (11th Cir. 2019)).

⁶³ See *id.* at 1112–13 (explaining that the relator, a former director of care management at the hospital, alleged that the defendant facility admitted patients who did not qualify for inpatient care).

⁶⁴ See *id.* at 1117 (explaining that the FCA language does not specify different types of falsity or provide an "exception" for medical opinions). The court further explained that Congress did not limit the FCA by adding any objective falsehood requirement, so adopting such a standard would effectively "rewrite the statute." *Id.* at 1113.

⁶⁵ See 952 F.3d at 95 (holding that expert testimony challenging the accuracy of a hospice provider's medical opinion can serve as evidence to support the falsity element of a *prima facie* FCA claim). The Third Circuit rejected the lower court's conclusion that medical opinions could never be false. *Id.* at 98.

⁶⁶ See *id.* at 91 (holding that the relators' claim should survive summary judgment because dueling medical testimony was a triable issue of fact to submit to the jury for consideration).

⁶⁷ See *id.* at 97–98 (citing *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 742–43 (10th Cir. 2018)) (discussing the Tenth Circuit's adoption of legal falsity as the proper standard for FCA falsity). The court explained that courts, in analyzing the falsity element, should ask whether a claim is eligible for reimbursement in the sense that it complies with Medicare's regulatory requirements. See *id.* at 97 (explaining that the relevant analysis for implied false certification differs from the express false certification theory, which requires a court to find explicit and affirmative misrepresentations from the provider about diagnoses or medical services).

⁶⁸ *Id.* at 94; see also *supra* note 47 and accompanying text (detailing the relators' medical expert testimony). On the other hand, Care Alternatives produced medical expert testimony that a reasonable physician could have made the same diagnosis and therefore argued that the COTIs were not false certifications. *Druding*, 952 F.3d at 94; see also *supra* note 48 and accompanying text (detailing Care Alternatives' medical expert testimony).

represented hospice care eligibility and thus violated the regulatory requirements for submitting claims to Medicare.⁶⁹

The Third Circuit also relied on the Sixth Circuit's 2016 decision in *United States v. Paulus*, in which the court held that expert testimony showing a pattern of misrepresentations could support falsity in a criminal healthcare fraud charge.⁷⁰ The *Druding* court noted that a "bright-line rule" exempting medical opinions from judicial scrutiny would fail to punish those physicians whose false opinions result in medically unnecessary services or even harm to patients.⁷¹

*B. The Eleventh Circuit Rejects the Majority Approach:
Conflicting Medical Expert Testimony, Without
More, Is Insufficient to State a Claim*

The Eleventh Circuit departed from its sister circuits in its 2019 decision in *United States v. AseraCare, Inc.*⁷² The government prosecuted AseraCare, Inc. on behalf of the whistleblowers, who alleged that the facility submitted false claims to Medicare to finance hospice care for ineligible patients in violation of the

⁶⁹ See *Druding*, 952 F.3d at 97 (explaining that such disagreement could show violations of the regulatory requirements for Medicare reimbursement of hospice care services, which would support the relators' theory of legal falsity).

⁷⁰ See *id.* at 98 (discussing the Sixth Circuit's reasoning that medical opinions could be false "when they are not honestly held by their maker" (quoting *United States v. Paulus*, 894 F.3d 267, 275 (6th Cir. 2018))); *Paulus*, 894 F.3d at 275 (noting that the complaint alleged that the physician, Dr. Paulus, lied about the image produced by an angiogram to defraud insurance companies). The court allowed the government to present testimony from nine medical experts to show that Dr. Paulus had "repeatedly and systematically" misrepresented what he saw on the angiogram machine in order to recommend "unnecessary procedures" to his patients and then bill insurance companies for reimbursement. See *Paulus*, 894 F.3d. at 273, 276 (noting that a jury convicted Dr. Paulus of committing healthcare fraud and making false statements after a twenty-seven-day jury trial). Dr. Paulus had a reputation as the nation's highest biller to Medicare for angiogram procedures, which are used to detect stenosis, or narrowing, of the cardiac arteries. See *id.* at 271–73 (noting that Dr. Paulus received more than \$2.5 million in compensation due to his high number of cardiac procedures).

⁷¹ *Druding*, 952 F.3d at 98 (citing *Paulus*, 894 F.3d. at 276). The *Druding* court cited the Sixth Circuit's conclusion that "a good faith medical opinion is not punishable," but acknowledged that there are cases in which it can be shown that the physician did not act in good faith. *Id.* (citing *Paulus*, 894 F.3d at 276). The Third Circuit further relied on the Sixth Circuit's reasoning that, although they are rarely "false," genuine medical opinions are nevertheless subject to review. See *id.* (quoting *Paulus*, 894 F.3d. at 275) (concluding that medical judgments are subject to scrutiny).

⁷² See 938 F.3d 1278, 1281 (11th Cir. 2019) (holding that evidence of conflicting medical expert testimony, without more, was insufficient to prove that the hospice certification was false). The lower court "granted summary judgment to AseraCare on the issue of falsity." *Id.*; *United States v. AseraCare, Inc.*, 176 F. Supp. 3d 1282, 1284 (N.D. Ala. 2016) (holding that the "[g]overnment's proof on the falsity element"—a single medical expert's opinion—necessarily "fail[ed] as a matter of law"), *vacated and remanded by AseraCare*, 938 F.3d at 1278. The district court began its opinion emphatically with a quote from French mathematician and philosopher Blaise Pascal: "Contradiction is not a sign of falsity, nor the lack of contradiction the sign of truth." *AseraCare*, 176 F. Supp. 3d. at 1283.

FCA.⁷³ On the issue of falsity, the government presented expert witness testimony that the reviewed patient records did not support the COTI that AseraCare had issued for each patient.⁷⁴ The Eleventh Circuit reached the opposite conclusion of the Third Circuit, holding that the government or relator must show an objective falsehood beyond a reasonable disagreement regarding a patient's diagnosis of terminal illness in order to prevail on the issue of falsity.⁷⁵ The court adopted this objective falsehood standard to limit the reach of the FCA.⁷⁶

III. THE THIRD CIRCUIT'S APPROACH STRENGTHENS THE FCA AND ENCOURAGES OVERSIGHT OF THE FOR-PROFIT HOSPICE INDUSTRY

In February 2021, in *Care Alternatives v. United States*, the United States Supreme Court denied Care Alternatives' petition for writ of certiorari, effectively declining to comment on the circuit split regarding medical expert testimony and clinical opinions under the FCA.⁷⁷ Part III of this Comment concludes that the Third Circuit's approach to the falsity element is preferable to the Eleventh Circuit's approach for two reasons.⁷⁸ This Part first argues that a

⁷³ See *AseraCare*, 938 F.3d at 1281 (describing the complaint, in which the government alleged that AseraCare had relied on "erroneous" medical opinions to certify patient eligibility and submit claims to Medicare for hospice services); see also *supra* note 32 (recounting a study showing that an Alabama branch of AseraCare discharged the vast majority of patients admitted to the hospice facility alive). AseraCare is one of the largest for-profit hospice providers in the country. See Whoriskey & Keating, *supra* note 9 (describing recent FCA actions against the largest for-profit hospice companies).

⁷⁴ See *AseraCare*, 938 F.3d at 1281, 1284–85 (explaining that the government's main expert, Dr. Liao, conducted a review of 223 sample patients and found that 123 were ineligible for hospice care, in his medical opinion). The government also presented evidence of approximately two thousand patients who had received hospice treatment at AseraCare facilities for more than a year, despite the fact that terminally ill patients by definition will not stay for longer than six months. See *id.* (describing additional government evidence offered to show that the physician certification practices at AseraCare failed to take into account the patient's complete medical records).

⁷⁵ See *id.* at 1296–97 (holding that a valid FCA claim must allege that the provider's medical opinion contains an objective falsehood); *Druding*, 952 F.3d at 99 (explaining that "the Eleventh Circuit limited the relevant inquiry" to factual falsity—that is, whether the doctor's opinion that the patient was terminally ill was correct (citing *AseraCare*, 938 F.3d at 1294, 1296)). The court concluded that Dr. Liao's testimony alone was insufficient to prove that AseraCare had falsely certified hospice patients and thus submitted false claims for Medicare reimbursement. See *AseraCare*, 938 F.3d at 1297 (noting that the court adopted a legal standard requiring the government to prove an "objective falsehood" through "facts and circumstances surrounding the patient's certification that are inconsistent with the proper exercise of a physician's clinical judgment").

⁷⁶ See *AseraCare*, 938 F.3d at 1301 (claiming that the government should not rely primarily on the FCA to investigate suspect claims for hospice care). The court also reasoned that courts should give medical opinions "deference," allowing physicians room to evaluate patients. See *id.* at 1295 (stating the Centers for Medicare & Medicaid Services rules for certification are intentionally vague in deference to the physician decision-making process). See generally Buck, *supra* note 7 at 145–46 n.271 (explaining that *AseraCare* dealt a blow to the government's FCA enforcement actions that rely on medical necessity and clinical judgments to show falsity).

⁷⁷ 141 S. Ct. 1371, 1371 (2021).

⁷⁸ See *infra* notes 79–88 and accompanying text. Compare *Druding*, 952 F.3d at 97 (holding that conflicting medical judgments may support falsity under the False Claims Act), with *AseraCare*, 938

more liberal reading of falsity reinforces congressional intent to deploy the False Claims Act as a broad fraud-fighting weapon, and the other elements of the statute adequately limit liability for genuine differences of opinion among medical professionals.⁷⁹ Second, this Part argues that the Third Circuit's majority approach eases the burden for showing falsity, which should encourage healthcare providers to develop and maintain robust compliance programs.⁸⁰

Congressional action over the last few decades has exclusively tended to strengthen the FCA by extending the statute of limitations for enforcement actions and expanding whistleblower provisions.⁸¹ The Supreme Court recognized this intention in 2016 in *Universal Health Services, Inc. v. Escobar*, instructing courts to interpret broadly what it means for claims to be false under the FCA.⁸² Though the Eleventh Circuit cautioned that a broad interpretation

F.3d at 1296–97, 1302 (adopting an objective falsehood standard, such that a reasonable disagreement among medical experts on the issue of hospice eligibility, “without more,” cannot prove falsity).

⁷⁹ See *infra* notes 81–84 and accompanying text; see also *Druding*, 952 F.3d at 98–100 (concluding that limiting the basis for FCA liability to factual falsity, instead of legal falsity, is inconsistent with Congress's broad intentions for the FCA and the Supreme Court's instructions to interpret the falsity element more liberally); *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1116 (9th Cir. 2020) (noting that Congress intended for the FCA “to reach all types of fraud, without qualification, that might result in financial loss to the Government” (quoting *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968))), *cert. denied sub nom.*, *RollinsNelson LTC Corp. v. United States ex rel. Winters*, 141 S. Ct. 1380 (2021). The *Winter* court also pointed out that the Supreme Court has repeatedly advised against a “rigid, restrictive” interpretation of the FCA. *Winter*, 953 F.3d at 1116 (quoting *Neifert-White Co.*, 390 U.S. at 232).

⁸⁰ See *infra* notes 85–88 and accompanying text; see also Hilborn, *supra* note 41 (explaining that the practical effect of FCA cases is to enable more plaintiffs to survive dismissal or summary judgment); DeBernardis & Giordano, *supra* note 11 (stating that compliance programs are crucial to avert FCA liability and fines); Volkov, *supra* note 11 (urging companies to “reexamine and enhance their compliance programs” to manage FCA risks).

⁸¹ See Paulhus, *supra* note 23 (noting that congressional amendments have resulted in more FCA actions). In 2009, Congress passed the Fraud Enforcement and Recovery Act (FERA) to expand use of the FCA, signaling its intention to continue and increase anti-fraud efforts through the FCA. Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, 123 Stat. 1617 (codified as amended in scattered sections of 18 U.S.C. and 31 U.S.C.); see Goldman et al., *supra* note 3 (describing the goals of FERA to expand monitoring and oversight efforts related to government funds). For example, FERA broadens the “net of liability” and the statute of limitations, and gives the D.O.J. greater latitude in its discussions with relators. See Goldman et al., *supra* note 3 (listing the three major effects of FERA on the FCA). The legislative trend continues today, as Senator Chuck Grassley, who spearheaded the original 1986 amendments, recently introduced the False Claims Amendments Act of 2021 in the Senate. See S. 2428, 117th Cong. (2021) (placing the bill on the Senate Legislative Calendar on Nov. 16, 2021); *2021 Year-End False Claims Act Update*, *supra* note 4 (discussing the Act, which contains four main changes: first, lowering the burden of proof for a plaintiff (either the government or whistleblower) to prove materiality; second, allowing relators to explain their cases to the D.O.J. before it dismisses the qui tam actions; third, shifting discovery costs to the defendant under certain circumstances; and fourth, extending anti-retaliation measures for whistleblowers who experience adverse action after they have left their previous jobs).

⁸² See 579 U.S. 176, 187 (2016) (stating that the FCA encompasses not only express falsehoods but also “claims that make fraudulent misrepresentations,” including “misleading omissions”); *Winter*,

would subject healthcare providers to endless scrutiny, the majority approach adequately limits liability through the knowledge and materiality elements.⁸³ The Third Circuit's approach therefore holds providers accountable, while restricting liability through proof that the provider *knowingly* submitted a false claim and that the noncompliance involved regulations material to the claim.⁸⁴

In addition, allowing conflicting medical expert testimony to support the falsity element will likely allow the government and relators to survive pretrial motions for dismissal or summary judgment, and therefore expose providers to discovery proceedings and scrutiny of the providers' regulatory and statutory compliance.⁸⁵ In the hospice industry, providers will have an incentive to compile extensive clinical documentation that supports a physician's certification of terminal illness.⁸⁶ Indeed, robust compliance programs improve a facility's operations generally, as well as reduce the risk of substantial litigation costs or hefty FCA penalties.⁸⁷ As a result, the Third Circuit's majority approach creates greater oversight and accountability for healthcare providers, particularly in the for-profit hospice industry that has seen a concerning rise of fraud and FCA actions during its recent growth.⁸⁸

953 F.3d at 1116 (explaining that the Supreme Court has frequently advised against a constrained interpretation of the FCA).

⁸³ See *AseraCare*, 938 F.3d at 1295 (stating that physicians should have discretion to make clinical decisions without worrying that laypeople will later scrutinize their decisions in court). The Eleventh Circuit split with its sister circuits largely on the issue of whether expanding the scope of the FCA would target well-intentioned physicians with crippling FCA liability; however, the majority approach protects honestly-held and genuine medical opinions from punishment. See *Druding*, 952 F.3d at 96 (explaining that the Supreme Court has instructed courts to consider the scienter, or knowledge, element to ensure that hospice providers are protected from endless liability whenever a relator could produce a witness to disagree with a provider's medical judgments regarding certification).

⁸⁴ See *Winter*, 953 F.3d at 1118 (noting that falsity does not alone prove liability because the plaintiff needs to establish the remaining prima facie elements to prevail on an FCA claim); *Escobar*, 579 U.S. at 196 (noting that the materiality requirement prevents the FCA from "adopt[ing] such an extraordinarily expansive view of liability").

⁸⁵ See *Hilborn*, *supra* note 41 (noting that healthcare providers should anticipate facing "more protracted and costly" litigation, involving a "rigorous, fact-intensive inquiry" at the trial court level); *Druding*, 952 F.3d at 91 (vacating the lower court's grant of summary judgment and remanding for further proceedings); *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 734 (10th Cir. 2018) (reversing the lower court's dismissal and remanding for further proceedings); *Winter*, 953 F.3d at 1113 (same).

⁸⁶ See *Druding*, 952 F.3d at 97 (explaining that the implied false certification theory of liability requires a relator to show that the hospice provider's COTI did not comply with Medicare regulations); 42 C.F.R. §§ 418.20, 418.22(b)(2) (2020) (requiring clinical documentation to support physician's diagnosis); DeBernardis & Giordano, *supra* note 11 (noting the importance of record-keeping to explain "how and why decisions were made" during future audits and investigations).

⁸⁷ See, e.g., Murphy et al., *supra* note 4 (explaining that adequate documentation of decision-making maintains "valuable evidence" so as to assert a good faith defense to FCA actions).

⁸⁸ See *Garrison*, *supra* note 16 (documenting a rise in Medicare spending on hospice care as both the amount of hospice providers in the United States has risen and the number of Medicare beneficiaries partaking in the Medicare Hospice Benefit has grown by more than fifty percent between 2006 and 2016); Chiedi, *supra* note 33 (finding that fraudulent hospice billing practices are extremely costly to

CONCLUSION

In 2020, in *United States ex rel. Druding v. Care Alternatives*, the United States Court of Appeals for the Third Circuit embraced a broader reading of the FCA by allowing dueling medical expert testimony to support the falsity element. The court's approach enables the government and relators to use the FCA to its full potential, in keeping with congressional intent, to recoup taxpayer dollars and punish fraudulent behavior in the industries that benefit from federal funding. The hospice industry, and healthcare in general, requires oversight to ensure that for-profit owners are not falsifying certifications to increase financial gain at the expense of the government. In contrast to the approach the United States Court of Appeals for the Eleventh Circuit adopted in 2019 in *United States v. AseraCare, Inc.*, the majority approach better ensures that such providers develop compliance and regulatory programs that combat fraudulent activity and avoid FCA liability.

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Medicare and negatively impact the MHB and its patients); Barger, *supra* note 1, at 12 (detailing the recent rise of FCA actions from healthcare professionals seeking to address Medicare fraud in for-profit hospice facilities); Whoriskey & Keating, *supra* note 9 (explaining that almost half of the largest United States hospice care providers have faced FCA allegations and lawsuits).