
**BATTLE OF THE OPINIONS:
CONFLICTING INTERPRETATIONS OF
FALSE OPINIONS AND THE FALSITY
STANDARD UNDER THE FALSE
CLAIMS ACT**

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Congress has let loose a posse of *ad hoc* deputies to uncover and prosecute frauds against the government . . . [Bad actors] may prefer the dignity of being chased only by the regular troops; if so, they must seek relief from Congress.¹

INTRODUCTION

What most people probably do not realize is that approximately ten percent of all government spending is lost to fraud, which amounts to hundreds of billions of dollars annually.² It should be of no surprise then that public attitudes toward government spending are mixed.³ With the recent COVID-19 pandemic, government spending and the number of fraudulent schemes have both reached unprecedented levels.⁴ This alone is quite alarming from a policy perspective. Furthermore, in combatting this widespread fraud, the government has had to consider an important legal issue, which also happens to be a philosophical concern that permeates life and introduces uncertainty into the legal system.

The distinction between fact and opinion seems quite obvious, but there is more to this dichotomy than meets the eye. Most individuals intuitively understand that facts have an objective basis in reality whereas opinions are

1. *United States ex rel. Milam v. Univ. of Tex. M.D. Anderson Cancer Ctr.*, 961 F.2d 46, 49 (4th Cir. 1992).

2. Joel D. Hesch, *It Takes Time: The Need to Extend the Seal Period for Qui Tam Complaints Filed Under the False Claims Act*, 38 SEATTLE U.L. REV. 901, 901 (2015).

3. *See generally* William G. Jacoby, *Public Attitudes Toward Government Spending*, 38 AM. J. POL. SCI. 336 (1994) (exploring the nature, sources, and consequences of citizens' attitudes toward government spending).

4. *See* Press Release, U.S. Dep't of Just., Justice Department Takes Action Against COVID-19 Fraud (Mar. 26, 2021) [hereinafter COVID-19 Fraud], <http://www.justice.gov/opa/pr/justice-department-takes-action-against-covid-19-fraud> [http://perma.cc/6R6K-YCJW].

merely one's own subjective interpretation of some matter. It follows that facts can be proven or disproven using an objective metric and that facts can reinforce or contradict any given claim. But what about opinions? Can they be "true" or "false" in the same sense? Can the substance of their truth be invalidated by other opinions? Do opinions gain an elevated legal status if they inevitably result in life-or-death consequences for another individual?

The circuit courts have recently grappled with these difficult questions in the context of Medicare-related claims under the False Claims Act ("FCA"), a civil anti-fraud statute.⁵ To prevail on an FCA claim, plaintiffs must prove, *inter alia*, falsity; that is, the defendant made a false claim for government payment.⁶ The FCA, in its current iteration, does not provide guidance on the standard for proving falsity.⁷ Normally, this would not present an issue because "absent other indication, 'Congress intends to incorporate the well-settled meaning of the common-law terms it uses.'"⁸ However, claims for government payment or reimbursement are sometimes based only on a subject matter expert's evaluation. This is particularly true in the medical field, where doctors are required to treat patients using their clinical judgments.⁹ Thus, proving falsity in these cases necessarily entails disproving expert opinion. Given the subjective nature of opinions, common-law developments have not been uniform, and circuit courts have entrenched themselves on different sides of the aisle.¹⁰

On one side are circuit courts that believe that the FCA requires proof of an "objective falsehood."¹¹ This seems to be the traditional interpretation, with many courts at the district and appellate levels dismissing plaintiffs' claims when they failed to establish that a defendant's representation was objectively false.¹² Most recently, the Eleventh Circuit, in *United States v. AseraCare, Inc.*, considered when the hospice provider certifications regarding a patient's "terminally ill" status can be considered false under the FCA.¹³ In its holding, the court determined that claims cannot be false based

5. See JOHN T. BOESE & DOUGLAS W. BARUCH, CIVIL FALSE CLAIMS AND *QUI TAM* ACTIONS 1-5 (5th ed. 2022). See generally 31 U.S.C. §§ 3729-3733 (creating liability for individuals who engage in fraudulent acts against the government).

6. 31 U.S.C. § 3729.

7. See *id.* §§ 3729-3733.

8. *Universal Health Servs., Inc. v. United States*, 579 U.S. 176, 177 (2016) (quoting *Sekhar v. United States*, 570 U.S. 729, 732 (2013)).

9. See *infra* Section I.C.

10. Compare *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1281 (11th Cir. 2019) (holding that an objective falsehood standard is proper), with *United States v. Care Alts.*, 952 F.3d 89, 91 (3d Cir. 2020) (ruling against an objective falsehood standard), *cert. denied*, 141 S. Ct. 1371 (2021).

11. See, e.g., *AseraCare*, 938 F.3d at 1281.

12. See *infra* Section I.D, Appendix A.

13. *AseraCare*, 938 F.3d at 1281.

on “a reasonable disagreement between medical experts.”¹⁴

Approximately six months after the Eleventh Circuit’s ruling, the Third Circuit, in *United States v. Care Alternatives*, explicitly rejected the objective falsity standard in favor of a subjective falsity standard, whereby expert testimony challenging a physician’s judgment can be adequate evidence of falsity.¹⁵ The Ninth Circuit seemingly followed suit in *Winter ex rel. United States v. Gardens Regional Hospital & Medical Center, Inc.* when it proclaimed that a party stating an FCA claim does not need to plead an objective falsehood.¹⁶ The defendants in both cases petitioned the Supreme Court for writs of certiorari; unfortunately, on February 22, 2021, the Court rejected the petitions without comment, leaving the question unaddressed and prolonging the circuit split.¹⁷

This Note explores the aforementioned circuit split and scrutinizes the decisions under various frameworks given the statutory gap regarding falsity under the FCA. In doing so, it will consider relevant common law guidance and regulations and focus on the courts’ adherence to precedent and principles. Few doctrinal analyses on the falsity element of the FCA have been conducted,¹⁸ and to my knowledge, this is the one of the first to propose that (1) the recent disagreement over objective falsity is a nontraditional

14. *Id.*

15. *Care Alts.*, 952 F.3d at 91.

16. *Winter ex rel. United States v. Gardens Reg’l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1113 (9th Cir. 2020), *cert. denied sub nom. RollinsNelson LTC Corp. v. United States ex rel. Winters*, 141 S. Ct. 1380 (2021).

17. *Care Alts.*, 141 S. Ct. 1371; *RollinsNelson*, 141 S. Ct. 1380.

18. Most prior noteworthy analyses have explicated objective falsity through a healthcare lens. *See, e.g.*, Sebastian West, *Proof of Objective Falsehood: Liability Under the False Claims Act for Hospice Providers*, 90 U. CIN. L. REV. 328, 328 (2021) (arguing that when narrowly tailored to hospice-related claims under the FCA, the objective falsity standard adopted by the Eleventh Circuit is the correct interpretation but fails to sufficiently guide the lower courts); Elizabeth A. Caruso, Comment, *Hospice Care’s Adventures in Fraudland: “Battle of the Experts” & Proving Falsity Under the False Claims Act*, 62 B.C. L. REV. E. SUPP. 21, 38–42 (2021) (advocating for objective falsity in hospice certification claims because it aligns with Supreme Court precedent and the Centers for Medicare & Medicaid Services’ intent for the Medicare hospice benefit); Jameson Steffel, *End of Life Uncertainty: Terminal Illness, Medicare Hospice Reimbursement, and the “Falsity” of Physicians’ Clinical Judgments*, 89 U. CIN. L. REV. 779, 780 (2021) (concluding that the Eleventh Circuit’s approach is the correct legal and policy interpretation with regards to Medicare-related false claims); Bryce T. Daniels, *A Tale of Two Falsities: Objective Falsity and Common-Law Falsity in the False Claims Act 2* (Aug. 1, 2021) (unpublished manuscript), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3922788 [<https://perma.cc/QL6J-WAS2>] (claiming that the objective falsity standard should be disfavored because medical opinions, whether construed as opinions or statements of fact, are falsifiable in many contexts). Some articles maintain that there is actually no circuit split over doctors’ FCA liability. *See, e.g.*, Jenna L. Schaffer, Note, *Not Quite What the Doctor Ordered: The Third Circuit Pulls the Plug on Objective Falsity in United States Ex Rel. Druding v. Care Alternatives*, 67 VILL. L. REV. 167, 171 (2022) (suggesting that the Eleventh Circuit’s ruling merely “created the perception of a circuit split—even though a split may not actually exist”); Matthew Gill, *There Is No Circuit Split Over Doctors’ FCA Liability*, LAW360 (May 18, 2020), <http://www.porterwright.com/content/uploads/2020/05/Law360-There-Is-No-Circuit-Split-Over-Doctors-FCA-Liability.pdf> [<http://perma.cc/G866-ATA7>].

three-way circuit split, and (2) the falsity standard needs to be flexible to accommodate various controlling regulations and statutes. This Note then argues that the Ninth Circuit has correctly elucidated the issue: courts should not focus on the objective or subjective falsehood standard but rather on the context and circumstances of each case.

Part I of this Note provides a foundational understanding of the FCA, the healthcare industry, and falsity in common law contexts. This includes the FCA's legislative history, *qui tam* claims, statistics regarding recovery, medical decision-making, Medicare hospice benefit ("MHB"), and history of objective falsity cases. Part II discusses prior Supreme Court and appellate decisions that provide a useful framework to analyze the circuit split. Part III analyzes the three central cases that have contributed to the recent circuit split: *United States v. AseraCare, Inc.*,¹⁹ *United States v. Care Alternatives*,²⁰ and *Winter ex rel. United States v. Gardens Regional Hospital and Medical Center, Inc.*²¹ Part IV recommends that courts analyze falsity under the Tenth Circuit and Supreme Court's common law test defined in *United States ex rel. Polukoff v. St. Mark's Hospital and Omnicare, Inc. v. Laborers District Council Construction Industry Pension Fund*.²² Part IV also argues that FCA-intersecting statutes and regulations have impliedly allowed for both objective and subjective falsity standards to exist. Furthermore, Part IV suggests that the issue may be more efficiently addressed by the legislature than the courts and contextualizes the problem within the broader whistleblower policy debate.

19. *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1278 (11th Cir. 2019).

20. *Care Alts.*, 952 F.3d at 89.

21. *Winter*, 953 F.3d at 1108.

22. *Omnicare, Inc. v. Laborers Dist. Council Constr. Indus. Pension Fund*, 575 U.S. 175, 184–89 (2015); *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 741 (10th Cir. 2018). One report has previously suggested that courts should simply apply the *Omnicare* test. See Robert Salcido, *When Can Opinions be "False" and Result in False Claims Act Liability: Three Circuit Courts Provide Conflicting Guidance*, SALCIDO REP.: FALSE CLAIMS ACT PUB. DISCLOSURE ALERT (Nov. 24, 2020), <http://www.akingump.com/en/news-insights/when-can-opinions-be-false-and-result-in-false-claims-act-liability-three-circuit-courts-provide-conflicting-guidance.html> [<http://perma.cc/URM5-RK3L>].

I. BACKGROUND

A. THE FALSE CLAIMS ACT AND ITS LEGISLATIVE HISTORY

Originally enacted in 1863 at the request of President Abraham Lincoln,²³ the FCA is America's first whistleblower law and currently one of the strongest whistleblower laws in the United States.²⁴ The FCA allowed the federal government to combat widespread fraud committed by defense contractors against the Union Army during the American Civil War.²⁵ In a congressional session statement, Senator Jacob Howard noted that "shells for the use of the Army . . . have been filled not with the proper explosive materials . . . but with saw dust" and that "[a]rms have been supplied which, on examination and use, have turned out to be useless and valueless."²⁶ The original Act contained criminal and civil penalties for wrongdoers.²⁷ But the crucial feature of the Act that allows for its effective implementation is the *qui tam* provision, which enables private citizens to bring suits on behalf of the government; this essentially "empower[s] . . . ordinary citizens to act as private attorneys general."²⁸ Claimants in these *qui tam* actions, known as the "relators," are incentivized by the fact that they receive a portion of the recovered damages.²⁹ Relator is the term found in the FCA statute because the term whistleblower was not in use at the time of statutory enactment.³⁰ Although the two terms are synonymous, courts and parties often prefer to use the term relator.³¹ Congress believed that it was necessary to "set[] a rogue to catch a rogue" due to the resource constraints that the government would have faced if it investigated and inquired into every business dealing involving its contractors.³² Senator Howard declared that this provision was "the safest and most expeditious way I have ever discovered of bringing rouges to justice."³³ Those convicted under the original version of the statute

23. 132 CONG. REC. H22,339 (daily ed. Sept. 9, 1986) (statement of Rep. Berman).

24. *False Claims Act (Qui Tam) Whistleblower FAQ*, NAT'L WHISTLEBLOWER CTR. [hereinafter *Whistleblower FAQ*], <http://www.whistleblowers.org/faq/false-claims-act-qui-tam> [<http://perma.cc/XNA2-T3MB>].

25. See BOESE & BARUCH, *supra* note 5 (describing Congress's motivation in enacting the FCA).

26. CONG. GLOBE, 37th Cong., 3d Sess. 955 (1863) (statement of Sen. Jacob Howard).

27. Pamela H. Bucy, *Private Justice and the Constitution*, 69 TENN. L. REV. 939, 945 (2002) (explaining that the penalties were separated in 1874 and the criminal portion can now be found at 18 U.S.C. § 287).

28. Christopher C. Frieden, *Protecting the Government's Interests: Qui Tam Actions Under The False Claims Act and the Government's Right to Veto Settlements of Those Actions*, 47 EMORY L.J. 1041, 1041 (1998).

29. See Isaac B. Rosenberg, *Raising the Hue . . . and Crying: Do False Claims Act Qui Tam Relators Act Under Color of Federal Law?*, 37 PUB. CONT. L.J. 271, 276-78 (2008).

30. *Whistleblower FAQ*, *supra* note 24.

31. *See id.*

32. See CONG. GLOBE, 37th Cong., 3d Sess. 956 (1863) (statement of Sen. Jacob Howard).

33. *Id.*

were liable for double the government's damages in addition to a \$2,000 penalty for each false claim.³⁴ Relators would have received fifty percent of the total damages.³⁵

Nonetheless, since its inception, the FCA has been amended by Congress several times. Given that the Act was made for the purposes of deterring fraudulent profiteers of war while rewarding those who were upstanding, it was only fitting that the statute would be abused and tested during a subsequent major conflict, World War II.³⁶ Then Attorney General Francis Biddle pursued criminal action against a host of defense contractors using the criminal provision of the FCA.³⁷ Concurrently, groups of petitioners filed civil complaints against the same contractors and undoubtedly attempted to piggyback off the government's work in the hopes of gaining a piece of the settlement.³⁸ This parasitic exploitation of the Act did not go unnoticed, and Congress amended the FCA in 1943.³⁹ The amendment reduced the relator's guarantee of fifty percent of recovered damages to a maximum of ten percent.⁴⁰ The recovery limit for relators was also capped at twenty-five percent in cases in which the United States did not join.⁴¹ Most importantly, Congress removed relators' ability to file suits if "the United States, or any agency, officer or employee thereof" possessed evidence or information of the fraud.⁴² This alteration single-handedly eliminated the majority of *qui tam* FCA cases.⁴³

Approximately forty years later, Congress caught wind of reports of rampant fraud committed by federal contractors.⁴⁴ In 1986, the FCA experienced almost a complete reversal of the strict prohibitions which chilled *qui tam* cases. The "any prior government knowledge" proscription was replaced with the substantially less restrictive "public disclosure of allegations or transactions" qualification.⁴⁵ In addition, recovery for

34. *The False Claims Act: A Primer*, U.S. DEP'T OF JUST. (Apr. 22, 2011) [hereinafter *Primer*], http://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf [http://perma.cc/NRM2-8KWD].

35. CHARLES DOYLE, CONG. RSCH. SERV., R40785, QUI TAM: THE FALSE CLAIMS ACT AND RELATED FEDERAL STATUTES 6 (2021).

36. See James B. Helmer Jr., *False Claims Act: Incentivizing Integrity for 150 Years for Rogues, Privateers, Parasites and Patriots*, 81 U. CIN. L. REV. 1261, 1267 (2013).

37. See *id.*

38. See *id.* at 1267–68.

39. DOYLE, *supra* note 35, at 7–8.

40. False Claims Act of 1943, Pub. L. No. 78-213, 57 Stat. 608, 609 (1943).

41. *Id.*

42. *Id.*

43. See Helmer Jr., *supra* note 36, at 1270.

44. See 131 CONG. REC. 17818 (1985) (statement of Rep. Weiss).

45. Compare False Claims Act of 1943, Pub. L. No. 78-213, 57 Stat. 608, 609 (1943) (creating strict prohibitions), with False Claims Act of 1986, Pub. L. No. 99-562, 100 Stat. 3153, § 3 (1986)

successful relators increased marginally, and liability for perpetrators of fraud increased from double damages to treble damages.⁴⁶

The most recent iteration of the FCA occurred in 2009, when Congress made a somewhat subtle amendment to the statute which limited the scope of claims encompassed by the FCA.⁴⁷ A “material to a false or fraudulent claim” element was added.⁴⁸ In essence, the wording of the prior FCA iteration allowed one of the critical elements to be met if the government simply paid or approved a fraudulent claim. The new requirement, however, adds a materiality aspect; that is, the government’s decision to pay or approve a claim must have been predicated on a falsity.

This current version of the FCA specifically penalizes, among other offenses, (1) knowingly presenting, or causing to be presented, a false or fraudulent claim for payment,⁴⁹ and (2) knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim.⁵⁰ FCA claims are broken down into the following requirements: falsity, causation, knowledge, and materiality.⁵¹ The statute provides functional definitions for knowledge but offers no guidance on the definitions of falsity.⁵²

B. THE FALSE CLAIMS ACT IN THE TWENTY-FIRST CENTURY

The importance of the FCA in combatting fraud in the twenty-first century should not be underestimated. Approximately ten percent of all government spending is lost to fraud.⁵³ During fiscal year 2020, the government spent over \$6 trillion dollars.⁵⁴ Accordingly, the government stands to lose hundreds of millions of dollars each year. Like cases in other areas of law, the majority of FCA cases settle or are dismissed before trial.⁵⁵ Nonetheless, the number of FCA cases and associated monetary payments

(loosening of such restrictions).

46. *Id.* at § 2.

47. DOYLE, *supra* note 35, at 9.

48. Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, 123 Stat. 1617 (2009).

49. 31 U.S.C. § 3729(a)(1)(A).

50. *Id.* § 3729(a)(1)(B).

51. *United States v. Care Alts.*, 952 F.3d 89, 94 (3d Cir. 2020), *cert. denied*, 141 S. Ct. 1371 (2021).

52. *See* 31 U.S.C. § 3729(b)(1). The knowledge requirement includes (1) actual knowledge that the claim or information was false, (2) deliberate ignorance of the truth or falsity of the information, or (3) a reckless disregard of the truth or falsity of the claim or information. *Id.*

53. Hesch, *supra* note 2.

54. Press Release, U.S. Dep’t of the Treasury, Mnuchin and Vought Release Joint Statement on Budget Results for Fiscal Year 2020 (Oct. 16, 2020), <http://home.treasury.gov/news/press-releases/sm1155> [<http://perma.cc/5QX5-PAE3>].

55. *See Strategic Budgeting Can Result in Early Resolution of False Claims Act Cases*, JONES DAY (Aug. 2018) [hereinafter *Strategic Budgeting*], <http://www.jonesday.com/en/insights/2018/08/strategic-budgeting-can-result-in-early-resolution> [<http://perma.cc/3MEP-R6CZ>].

have substantially amplified in recent years. More than 4,000 new cases have opened since 2015.⁵⁶ In 2020 alone, *qui tam* relators and the government filed 922 new FCA suits and subsequently obtained more than \$2 billion dollars in recovery and settlements.⁵⁷ With the onset of the COVID-19 pandemic, the Department of Justice has already begun investigating and prosecuting the spike in COVID-19 recovery-related programs.⁵⁸ Fraud cases are more prevalent now than ever, and the FCA creates a necessary foundation with which to combat these issues.

Although historically used to uncover and deter military-based fraud against the federal government, the FCA in the current era has undergone a drastic shift, not based on the substance of law but rather due to policy shifts in healthcare law. The rapid expansion of the healthcare sector and burgeoning government programs are likely responsible for this shift.⁵⁹ Over eighty percent of fraud cases against the government are now related to healthcare.⁶⁰ Furthermore, healthcare-related FCA cases account for more recovery than FCA recovery from all other sectors combined.⁶¹

C. MEDICAL DECISION-MAKING AND MEDICARE HOSPICE BENEFITS

Given that all three cases contributing to the circuit split concern Medicare-related fraud, a general discussion of fraud within the medical practice area is warranted. Fraud in the medical industry is not novel. In particular, the Federal Bureau of Investigation has noted that health care fraud causes several billions of dollars in losses each year.⁶² Although there are a variety of factors that contribute to the prevalence of health care fraud, the subjectivity inherent in medical decision-making is a prominent one.⁶³

56. *Fraud Statistics - Overview: October 1, 1986–September 30, 2020*, CIV. DIV. U.S. DEP'T OF JUST. (Jan. 14, 2021) [hereinafter *Fraud Statistics*], <http://www.justice.gov/opa/press-release/file/1354316/download> [<http://perma.cc/T74F-E6FG>].

57. *Id.*

58. *See* COVID-19 Fraud, *supra* note 4; Press Release, U.S. Dep't of Just., Eastern District of California Obtains Nation's First Civil Settlement for Fraud on Cares Act Paycheck Protection Program (Jan. 12, 2021), <http://www.justice.gov/usao-edca/pr/eastern-district-california-obtains-nation-s-first-civil-settlement-fraud-cares-act> [<http://perma.cc/H8AB-FEH8>].

59. *See National Health Expenditure Data: Historical*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical> [<http://perma.cc/9J2N-7LP8>]; Nicole Forbes Stowell, Carl Pacini, Nathan Wadlinger, Jaqueline M. Crain & Martina Schmidt, *Investigating Healthcare Fraud: Its Scope, Applicable Laws, and Regulations*, 11 WM. & MARY BUS. L. REV. 479 (2020) (describing the healthcare landscape and prevalence of healthcare fraud).

60. *Fraud Statistics*, *supra* note 56.

61. *Id.*

62. *White-Collar Crime: Health Care Fraud*, FED. BUREAU OF INVESTIGATION, <http://www.fbi.gov/investigate/white-collar-crime/health-care-fraud> [<http://perma.cc/L86N-LDSU>].

63. *See infra* note 72 and accompanying text. Relatedly, it is quite possible that doctors undertreat patients due to fears of FCA liability. However, no literature has studied this specific issue. Nonetheless,

There will almost always be another medical professional who does not agree with the course of action taken. Moreover, the medical industry is unique in that the medical opinions of physicians sometimes lack the objective proof to reinforce their actions and regulations often give deference to medical judgments.⁶⁴

The MHB presents a fitting example of a controlling statutory restriction that specifically grants physicians this deference. Due to the growing number of aging individuals enrolled in Medicare, Congress passed the MHB in 1983.⁶⁵ The MHB allows Medicare beneficiaries to forego traditional curative care in favor of electing interdisciplinary palliative treatment.⁶⁶ However, eligibility is based on a written confirmation of a “terminally ill” prognosis by a physician or medical director.⁶⁷ Terminally ill is defined as “a life expectancy of 6 months or less if the terminal illness runs its normal course.”⁶⁸ This certification must include a written narrative explaining the clinical findings and be accompanied by clinical information and other documentation.⁶⁹ Once these conditions are met, Medicare and Medicaid programs will provide payment to hospice providers for costs incurred under the Social Security Act.⁷⁰ The regulations have directly acknowledged the “uniqueness of every Medicare beneficiary” and that predicting someone’s end-of-life is not an “exact science.”⁷¹ Accordingly,

this theory is not unfounded because there have been instances of lawsuits for the undertreatment of pain, indicating that physicians are capable of undertreating patients in various circumstances. *See, e.g., Doctor Tagged with \$1.5m Verdict in Landmark Elder Abuse Case: Bergman v. Chin*, 3 ANDREWS NURSING HOME LITIG. REP. 3 (2001).

64. *See* Marissa Fritz, *Using Subjective Evidence in FDA Review*, REGUL. REV. (July 15, 2020), <http://www.theregreview.org/2020/07/15/fritz-using-subjective-evidence-fda-review> [http://perma.cc/MQ7X-T2V3].

65. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 122, 96 Stat. 324, 356–63 (codified at 42 C.F.R. pts. 400, 405, 408, 409, 418, 420, 421, 489). Interdisciplinary teams are composed of health professionals from various specialties including physicians, therapists, spiritual counselors, and social workers. 42 C.F.R. § 418.56 (2020).

66. *See* 42 U.S.C. § 1395y(a)(1)(C). It should be noted that Medicare only pays for palliative care services if they are deemed to be “reasonable and necessary.” *Id.* Curative care refers to care focused on improving a patient’s medical condition whereas palliative care provides relief, emotional and spiritual support, and comfort for patients with a terminal diagnosis. *See* James F. Barger, Jr., Symposium, *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, 13 (2016).

67. 42 U.S.C. § 1395f(a)(7)(A); *see also* 42 C.F.R. §§ 418.20(b), 418.22(a) (2021).

68. 42 C.F.R. § 418.22(b)(1) (2021).

69. *Id.* § 418.22(b)(2)–(b)(3).

70. *See* Michael W. Youtt, H. Victor Thomas & Adam Robison, *False Claims Act Actions—The Developing Case Law Regarding If and When Opinions of Medical Necessity Can Be Fraudulent*, 27 HEALTH LAW. 36, 37 (2015).

71. Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice, 79 Fed. Reg. 50452, 50470–71 (Aug. 22, 2014) (to be codified at 42 C.F.R. pts. 405, 418). This shows that regulators have recognized the subjectivity in medical decision-making. *Id.*

certifications may be renewed by the physician for additional sixty- or ninety-day periods.⁷²

Following the MHB's establishment, FCA cases alleging hospice fraud have increased dramatically.⁷³ This includes two of the three circuit split cases.⁷⁴ Predictably, most cases are initiated by whistleblowers in *qui tam* suits, as foreseen by the legislature.⁷⁵ In 2016, the MHB provided hospice care to more than one million individuals, and Medicare reimbursed over \$16 billion for hospice care.⁷⁶ Moreover, unlike FCA litigation in other areas of law, FCA litigation in connection with the MHB demonstrates a unique scenario that has perplexed the courts: stratification of the FCA by a purposefully deferential statute.

D. AN UNDISPUTED ERA OF OBJECTIVE FALSITY

Objective falsity was widely considered to be the standard before the new Third and Ninth Circuit holdings challenged the status quo; a considerable number of courts, including the Third Circuit itself, have previously recognized this standard.⁷⁷ This ostensibly established standard derived from a mix of healthcare- and non-healthcare-related FCA claims,⁷⁸ which likely solidified its acceptance and promulgated its spread across jurisdictions. Some of these cases were decided as early as 2005⁷⁹ and are briefly explained below to illustrate the formerly unified landscape which has been shattered by the circuit split.⁸⁰

In *United States v. Prabhu*, the District of Nevada held:

To establish falsity under the FCA, it is not sufficient to demonstrate that the person's practices could have or should have been better. Instead, plaintiff must demonstrate that an objective gap exists between what the

72. 42 U.S.C. § 1395f(a)(7)(A); *see also* 42 C.F.R. § 418.21 (2021).

73. *See, e.g.*, *United States v. Care Alts.*, 952 F.3d 89 (3d Cir. 2020) (litigating FCA charges based on false hospice care claims), *cert. denied*, 141 S. Ct. 1371 (2021); *United States v. AseraCare, Inc.*, 938 F.3d 1278 (11th Cir. 2019) (same); *United States ex rel. Wall v. Vista Hospice Care, Inc.*, 778 F. Supp. 2d 709 (N.D. Tex. 2011) (same); *United States ex rel. Holloway v. Heartland Hospice, Inc.*, 960 F.3d 836 (6th Cir. 2020) (same); *United States ex rel. Lemon v. Nurses To Go, Inc.*, 924 F.3d 155 (5th Cir. 2019) (same).

74. *See infra* Sections III.A–B.

75. *See Fraud Statistics*, *supra* note 56.

76. OFF. OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUM. SERVS., OEI-02-16-00570, VULNERABILITIES IN THE MEDICARE HOSPICE PROGRAM AFFECT QUALITY CARE AND PROGRAM INTEGRITY: AN OIG PORTFOLIO 3 (2018).

77. *See infra* Appendix A.

78. *See infra* Appendix A.

79. *See United States ex rel. Morton v. A Plus Benefits, Inc.*, 139 F. App'x 980, 982 (10th Cir. 2005).

80. For a more comprehensive list, *see infra* Appendix A.

defendant represented and what the Defendant would have stated had the Defendant told the truth.⁸¹

The government alleged that the physician's claims for pulmonary rehabilitation and simple pulmonary stress tests were false due to insufficient documentation.⁸² The government interpreted the American Medical Association's guidance publication to require specific measurements and a written report for a simple stress test.⁸³ However, the record indicated that Medicare failed to issue specific guidance regarding the precise type of documentation needed to provide care and that there was no physician writing documentation requirement.⁸⁴ In light of these facts, the parties' contentions, and the "general confusion" among the government and its own experts, the court believed that "reasonable persons can disagree regarding the billing requirement[]" and the physician's documentation practices fell within "the range of reasonable medical and scientific judgment."⁸⁵ Furthermore, the government did not establish a concrete violation of a "controlling rule, regulation, or standard" when the physician provided pulmonary rehabilitation services.⁸⁶ As a matter of law, the government failed to establish falsity, and the court granted the motion for summary judgment.⁸⁷

In *United States ex rel. Wilson v. Kellogg Brown & Root, Inc.*, the Fourth Circuit determined that "[an] FCA relator cannot base a fraud claim on nothing more than his own interpretation of an imprecise contractual provision."⁸⁸ The relators claimed that the defendant contractor, their former employer, falsely certified that it would uphold its contractual duties by maintaining military vehicles in "good appearance" when "it would not, and later did not, abide by those terms."⁸⁹ The court outright rejected this assertion because "[i]t is well-established that the FCA requires proof of an objective falsehood."⁹⁰ The court also found no evidence of this claim, as the United States government—the actual party to the contract—never expressed dissatisfaction with the contractor's performance.⁹¹ Relying solely on their interpretation of imprecise maintenance provisions, the relators

81. *United States v. Prabhu*, 442 F. Supp. 2d 1008, 1032–33 (D. Nev. 2006).

82. *Id.* at 1010–11.

83. *Id.* at 1028.

84. *Id.* at 1016–17.

85. *Id.* at 1016–17, 1032.

86. *Id.* at 1032.

87. *Id.* at 1026, 1032.

88. *United States ex rel. Wilson v. Kellogg Brown & Root, Inc.*, 525 F.3d, 370, 378 (4th Cir. 2008).

89. *Id.* at 377.

90. *Id.* (citing *United States ex rel. DRC, Inc. v. Custer Battles, LLC*, 472 F. Supp. 2d 787, 797 (E.D. Va. 2007)).

91. *Id.*

failed to state a valid falsity claim under the FCA.⁹²

In *United States ex rel. Yannacopoulos v. General Dynamics*, the Seventh Circuit decided that “[a] statement may be deemed ‘false’ for purposes of the False Claims Act only if the statement represents ‘an objective falsehood.’”⁹³ The relator contended that amendments to a contract between a company and Greece were “reverse false claims,” false statements used to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.⁹⁴ However, the relator simply relied on his interpretation of the terms of agreement without proof of any evidence.⁹⁵ As a result, the court affirmed the district court’s motion for summary judgment.⁹⁶

In *United States ex rel. Wall v. Vista Hospice Care, Inc.*, the Northern District of Texas ruled that “[a] testifying physician’s disagreement with a certifying physician’s prediction of life expectancy is not enough to show falsity.”⁹⁷ The relator asserted, *inter alia*, that defendant hospice service providers improperly enrolled and sought reimbursement from Medicare and Medicaid for patients who were not eligible for hospice care.⁹⁸ Although the relator presented a medical expert’s testimony that ninety percent of the records were ineligible for certification, it was not sufficiently linked to the corporate scheme to falsify records and thus did not create a triable “fact issue as to falsity.”⁹⁹

II. BUILDING AN ANALYTICAL FRAMEWORK

Important cases have discussed how opinions relate to the FCA, when opinions may be considered false in the context of medical necessity, and the two theories of falsity.¹⁰⁰ The totality of these cases provides an analytical framework with which to analyze the circuit split and are discussed below:

92. *Id.* at 378.

93. *United States ex rel. Yannacopoulos v. Gen. Dynamics*, 652 F.3d 818, 836 (7th Cir. 2011).

94. *Id.* at 835.

95. *See id.* at 836–39.

96. *Id.* at 840.

97. *United States ex rel. Wall v. Vista Hospice Care, Inc.*, No. 3:07-cv-00604-M, 2016 U.S. Dist. LEXIS 80160, at *56 (N.D. Tex. June 20, 2016).

98. *Id.* at *55.

99. *See id.* at *33, *62.

100. *See infra* Sections II.A–C.

A. WHEN OPINIONS CAN BE FALSE

As a prelude to the circuit split, the Supreme Court in *Omnicare, Inc. v. Laborers District Council Construction Industry Pension Fund* addressed the issue of when opinions can be false.¹⁰¹ The case involved Omnicare, the largest pharmacy services provider for nursing home residents in the United States, and its filed registration statement with the Securities and Exchange Commission (“SEC”).¹⁰² The filing included two statements of opinion. First, the company believed that its “contract[ual] arrangements with other healthcare providers, . . . pharmaceutical suppliers and . . . pharmacy practices [were] in compliance with applicable federal and state laws.”¹⁰³ Second, the company believed that its “contracts with pharmaceutical manufacturers [were] legally and economically valid arrangements that [brought] value to the healthcare system and the patients.”¹⁰⁴ The plaintiffs, pension funds that purchased Omnicare stock, alleged that the company’s statements were materially false based on later lawsuit filings from the government stating that the company received payments from drug manufacturers in violation of anti-kickback laws.¹⁰⁵ In addition to claims of materially false representations regarding legal compliance, the complaint maintained that none of the company’s officers and directors possessed reasonable ground to believe that the opinions offered were truthful and complete.¹⁰⁶ In support of this, plaintiffs pointed to the fact that one of Omnicare’s attorneys previously warned of a contract that carried a heightened risk of liability under anti-kickback laws.¹⁰⁷

The district court granted Omnicare’s motion to dismiss on the grounds that the statements about a company’s belief regarding its legal compliance are only actionable if those who made the statements knew they were untrue at the time.¹⁰⁸ The court thus concluded that the plaintiffs’ complaint failed to meet the standard because there were no allegations stating that Omnicare’s officers knew they were violating the law.¹⁰⁹

On appeal, the Sixth Circuit reversed the district court’s holding.¹¹⁰ The court acknowledged that the opinions related to legal compliance, rather than

101. See *Omnicare, Inc. v. Laborers Dist. Council Constr. Indus. Pension Fund*, 575 U.S. 175, 176 (2015).

102. *Id.* at 179.

103. *Id.*

104. *Id.* at 180.

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.* at 181.

109. *Id.*

110. *Id.*

“hard facts.”¹¹¹ Nonetheless, the court proceeded to explain that the plaintiffs simply had to allege that the opinion was objectively false and were not required to contend that an Omnicare employee “disbelieved [the opinion] at the time it was expressed.”¹¹²

After granting certiorari, the Supreme Court addressed the following two issues: (1) when an opinion may constitute a factual misstatement; and (2) when an opinion may be considered misleading by the omission of discrete factual representations.¹¹³ On the first issue, the Court held that sincere statements of pure opinion are not “‘untrue statement[s] of material fact,’ regardless [of] whether an investor can ultimately prove the belief [was] wrong.”¹¹⁴ Relying on common law principles, the Court illustrated two examples that provided exceptions to when statements of pure opinion can be false.¹¹⁵ These exceptions include when (1) the speaker does not actually hold the opinion, or (2) the opinion contains a false, embedded fact.¹¹⁶ On the second issue, the Court ruled that opinions may be misleading when a registration statement omits material facts about the issuer’s inquiry into or knowledge concerning a statement of opinion and if those facts conflict with what a reasonable investor would take from the statement itself.¹¹⁷ The Court does note, however, that an opinion is not necessarily misleading if it omits facts that “cut[] the other way” and analyses into this inquiry should always consider context.¹¹⁸

Thus, the Supreme Court effectively recognized that individuals make false opinions when (1) they do not actually hold the opinion; (2) the opinion contains a false, embedded fact; (3) they are aware of facts that would preclude such an opinion; or (4) they are not aware of any facts that would justify the opinion.¹¹⁹

111. *Id.* (quoting *In re Sofamor Danek Group Inc.*, 123 F.3d 394, 401–02 (6th Cir. 1997)).

112. *Id.* (quoting *Fait v. Regions Fin. Corp.*, 655 F.3d 105, 110 (2d Cir. 2011)).

113. *See id.* at 186–89.

114. *Id.* at 186. To support its contention, the Court viewed the clause as limiting investors’ ability to “second-guess inherently subjective and uncertain assessments. In other words, the provision is not . . . an invitation to Monday morning quarterback an issuer’s opinions.” *Id.*

115. *Id.* at 184–86.

116. *Id.*

117. *Id.* at 189. The Court asserted that this principle is consistent with the common law tort of misrepresentation. *Id.* at 191–92. Undisclosed facts may constitute a misleading opinion when the expression of such opinion involves an “implied assertion” that the speaker is unaware of any contradictory facts and that the speaker understands facts which justify the opinion. *Id.*

118. *Id.* at 189–90.

119. *Id.* at 184–89.

B. OPINIONS ANALYSIS IN THE CONTEXT OF MEDICAL NECESSITY

In *United States v. Paulus*, the Sixth Circuit conducted an *Omnicare*-based analysis in the context of a medical case without explicitly referencing the case.¹²⁰ In *Paulus*, a cardiologist was criminally prosecuted for health care fraud and false statements.¹²¹ Specifically, the cardiologist exaggerated the extent of arterial blockages in his patients in order to perform and bill for medically unnecessary coronary stenting procedures.¹²² The crux of this case depended on the interpretation of angiograms, with the plaintiff using the testimony of nine doctors to testify that the level of blockage differed from what the defendant had reported.¹²³ The defendant responded by pointing out the subjectivity of angiogram interpretation, including data from multiple studies.¹²⁴

During trial at the district court level, the jury convicted the cardiologist of healthcare fraud and making false statements.¹²⁵ However, the court directed a judgment of acquittal and subsequently ordered a new trial.¹²⁶ The court reasoned that the degree of arterial blockage was a matter of “subjective medical opinion,” and thus the cardiologist’s angiogram interpretations “could be neither false nor fraudulent.”¹²⁷

On appeal, the Sixth Circuit reversed because it believed that clinical judgments can trigger FCA liability when an individual (1) asserts an opinion they do not truly believe, or (2) has knowledge of facts that contradict their opinion.¹²⁸ The court reasoned that “[t]he degree of stenosis *is* a fact capable of proof or disproof.”¹²⁹ The court then likened the deliberate inflation of blockages on an angiogram to the telling of a lie, which infers the commission of a fraud when paired with the billing of a more expensive procedure.¹³⁰ In its analysis, the court essentially utilized the first two false opinion definitions described in *Omnicare*: (1) not honestly holding an opinion, and (2) an opinion containing a false, embedded fact.¹³¹

120. See *United States v. Paulus*, 894 F.3d 267, 275 (6th Cir. 2018).

121. *Id.* at 267.

122. *Id.* at 270–71.

123. *Id.* at 273–74. Of note, there were instances in which the defendant reported more than seventy percent blockage when in reality there was no blockage according to expert testimony. *Id.*

124. *Id.* at 272.

125. *Id.* at 270.

126. *Id.* at 274–75.

127. *Id.* at 275.

128. *Id.* at 275–76.

129. *Id.* at 275.

130. *Id.*

131. Compare *id.* (discussing the two ways in which clinical judgments can be false), with *Omnicare, Inc. v. Laborers Dist. Council Constr. Indus. Pension Fund*, 575 U.S. 175, 184–86 (2015) (describing the same two factors with different phrasing).

The court thought it to be clear that angiograms are facts and implied that angiogram interpretations are obviously not facts “capable of confirmation or contradiction.”¹³² Accordingly, the court pivoted to the idea that the cardiologist did not give an opinion but instead misrepresented facts by lying about the results.¹³³ Thus, the court reversed the trial court’s judgment and reinstated the jury’s verdict.¹³⁴

C. FACTUAL VERSUS LEGAL FALSITY

In *United States ex rel. Polukoff v. St. Mark’s Hospital*, the Tenth Circuit identified and distinguished between two types of falsities, factual and legal falsity, prior to conducting a falsity analysis under the FCA.¹³⁵ In this case, a relator, the former co-worker of the defendant, sued the defendant-cardiologist as well as two hospitals under the FCA.¹³⁶ The complaint alleged that the cardiologist performed thousands of medically unnecessary cardiac surgical procedures and fraudulently certified otherwise to receive reimbursement under the Medicare Act.¹³⁷ Central to this claim was the Centers for Medicare and Medicaid Services’ (“CMS”) “reasonable and necessary” requirement for surgeries.¹³⁸ Industry guidelines indicated when performing surgeries would be appropriate for specific types of patients, which the cardiologist allegedly ignored.¹³⁹ Instead, he misrepresented on the certifications that he had performed them in accordance with the guidelines.¹⁴⁰ Thus, this representation was false under the FCA.¹⁴¹

The district court granted the defendants’ motion to dismiss. The court reasoned that “Medicare does not require compliance with an industry standard as a prerequisite to payment. Thus, requesting payment . . . does not amount to a ‘fraudulent scheme.’”¹⁴² Moreover, “because [o]pinions, medical judgments, and conclusions about which reasonable minds may

132. *United States v. Paulus*, 894 F.3d 267, 275 (6th Cir. 2018).

133. *Id.* at 276. The court believed that the cardiologist did not simply misread the angiograms but rather “repeatedly and systematically saw one thing on the angiogram and consciously wrote down another, and then used that misinformation to perform and bill unnecessary procedures. The difficulty of interpreting angiograms has no bearing on the capacity of these statements to be false.” *Id.*

134. *Id.* at 280.

135. *See United States ex rel. Polukoff v. St. Mark’s Hosp.*, 895 F.3d 730, 741 (10th Cir. 2018).

136. *Id.* at 734.

137. *Id.*

138. *Id.* at 735.

139. *Id.* at 736–37.

140. *Id.*

141. *Id.* at 739.

142. *United States ex rel. Polukoff v. St. Mark’s Hosp.*, No. 2:16-cv-00304-JNP-EJF, 2017 U.S. Dist. LEXIS 8167, at *27 (D. Utah Jan. 19, 2017), *rev’d and remanded*, 895 F.3d 730 (10th Cir. 2018).

differ cannot be false for the purposes of an FCA claim,” the relator failed to state a claim under the FCA.¹⁴³

On appeal, the Tenth Circuit reversed and remanded because it fundamentally disagreed with the district court’s narrow interpretation of the FCA’s reach.¹⁴⁴ The court read the FCA broadly so as to encompass “claims for medically unnecessary treatment.”¹⁴⁵ Another reason the court presented was “that an allegedly false statement constitut[ing] the speaker’s opinion does not disqualify it from forming the basis of FCA liability.”¹⁴⁶ To support this reasoning, the court looked to its bifurcated understanding of falsity in a previously decided case.¹⁴⁷ The court held that “false” may indicate factually false or legally false.¹⁴⁸ Factually false claims are express claims that are not based in fact (for example, seeking payment for services that were never provided or submitting incorrect information), whereas legally false claims cover instances where an individual certifies compliance with applicable legal requirements when, in fact, the individual knew there was no compliance.¹⁴⁹ Since the relator’s complaint alleged non-compliance with Medicare regulations, the court’s straightforward, logical analysis of legal falsity was as follows: (1) “[a] Medicare claim is false if it is not reimbursable;” (2) “a Medicare claim is not reimbursable if the services provided were not medically necessary;” and (3) in order for a claim to be medically necessary, “it must meet the government’s definition of ‘reasonable and necessary,’ as found in the Medicare Program Integrity Manual.”¹⁵⁰ The procedures, certified by the cardiologist, did not comport with the government’s definition of the phrase, and thus the certifications were false under the FCA.¹⁵¹

III. ANALYSIS

While most articles have divided the circuit split issue between objective and subjective falsity,¹⁵² further inspection demonstrates that the circuit split is not binary. All three cases in the circuit split look to the statutory language of the FCA.¹⁵³ The Eleventh and Third Circuit

143. *Polukoff*, 895 F.3d at 739 (internal quotation marks omitted).

144. *See id.* at 741.

145. *Id.* at 742.

146. *Id.*

147. *See id.* at 741.

148. *Id.* (citing *United States ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163, 1168 (10th Cir. 2010)).

149. *Id.*

150. *Id.* at 742.

151. *Id.* at 743.

152. *See West, supra* note 18; *Caruso, supra* note 18.

153. *See infra* Sections III.A–C.

interpretations directly conflict, as they arrived at an objective and subjective falsity standard, respectively, after contemplating the same regulations surrounding the MHB.¹⁵⁴ The Ninth Circuit case did not involve the MHB but instead considered the statutory language of Medicare programs and the CMS’s definition of “reasonable and necessary.”¹⁵⁵ Although the Ninth Circuit fundamentally employed the same analysis as the Eleventh Circuit, it explicitly rejected the Eleventh Circuit’s objective falsity standard and implicitly adopted the subjective falsity standard.¹⁵⁶ Thus, three distinct standards have emerged from the case law.

First, this Section will discuss the Eleventh Circuit’s analysis and decision in *United States v. AseraCare, Inc.*, which establishes a higher burden of proof at the summary judgment stage for relators and the government. Second, this Section will examine the Third Circuit’s holding in *United States v. Care Alternatives* and why it chose to critique and explicitly depart from the Eleventh Circuit’s adoption of the objective falsity standard. Third, this Section will consider the Ninth Circuit’s more even-handed analysis in *Winter ex rel. United States v. Gardens Regional Hospital & Medical Center, Inc.* and why it refused to adopt a rigid falsity standard.

A. *UNITED STATES V. ASERACARE, INC.*

In *AseraCare*, the government intervened in a *qui tam* suit filed by three former AseraCare employees against AseraCare, claiming that the hospice provider had a practice of knowingly submitting unsubstantiated Medicare claims in violation of the FCA.¹⁵⁷ These reckless business practices allegedly enabled the provider “to admit, and receive reimbursement for, patients who were not eligible for [MHB],” resulting in the “mispending” of millions of Medicare dollars.¹⁵⁸ The court noted this case as falling under the “false certification” theory of FCA liability (in other words, when there is a false

154. See *infra* Sections III.A–B.

155. See *infra* Section III.C.

156. See *infra* Section III.C.

157. *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1282, 1284 (11th Cir. 2019). The government intervenes in approximately twenty-five percent of FCA claims. *Government Intervention in False Claims Acts*, BUTLER PRATHER LLP, <https://www.butlerwprather.com/practice-areas/government-intervention-in-false-claims-acts> [<https://perma.cc/Y55G-7NH3>]. Generally, the government reviews the information about the claim and initiates an independent investigation of the alleged illegal acts. *Id.* The government then decides whether to intervene, decline intervention, or move to dismiss the relator’s complaint based on the findings of the investigation. *Id.* It should be noted, however, that simply because the government intervenes in a case does not mean that the government automatically agrees with the relator’s claims. *Id.* Rather, the government may have found another basis on which to intervene. *Id.* The government likely intervened in this case due to the scale of the fraud and amount of monetary loss involved. See *infra* notes 161–63 and accompanying text.

158. *AseraCare*, 938 F.3d at 1284.

implication of having complied with a legal requirement).¹⁵⁹

To establish its case, the government first identified over 2,000 hospice patients for whom AseraCare had billed Medicare.¹⁶⁰ The government then narrowed this population to a subset of 223 patients and retained a physician to directly review these patients' medical records and clinical histories.¹⁶¹ Acting as the government's primary expert witness, the physician, relying on his own clinical judgment, opined that 123 out of 223 patients were ineligible for hospice benefits at the time AseraCare received reimbursements from Medicare.¹⁶² Critically, the government's case was substantially weakened when its expert witness conceded that he was unable to affirmatively say whether AseraCare's medical expert, or any other physician, was wrong about the accuracy of the prognoses at issue.¹⁶³ Furthermore, the expert witness (1) never testified that no reasonable doctor could have concluded that the patients were terminally ill at the time of certification, and (2) changed his opinion concerning the eligibility of certain patients over the course of the proceeding.¹⁶⁴

A brief recitation of the procedural posture and history is warranted so as to provide context for the appellate court's analysis. Following discovery and analysis of relevant patient records, AseraCare moved for summary judgment on the grounds that the government failed to adduce evidence of falsity under the FCA.¹⁶⁵ In its motion, AseraCare specifically asked the district court to apply the "reasonable doctor" standard; that is, "the government must show that a reasonable physician applying his or her clinical judgment could not have held the opinion that the patient at issue was terminally ill at the time of certification."¹⁶⁶ Even though the district court found this standard convincing, it declined to apply it and denied the motion.¹⁶⁷ The district court then bifurcated the trial into two phases, one on the falsity element and the second on the remaining FCA elements.¹⁶⁸ This limited the government's ability to rebut AseraCare's expert testimony

159. *Id.* This theory is akin to the Tenth Circuit's legal falsity framework in *Polukoff*. See United States *ex rel.* Polukoff v. St. Mark's Hosp., 895 F.3d 730, 741 (10th Cir. 2018).

160. *AseraCare*, 938 F.3d at 1284.

161. *Id.* at 1284–85.

162. *Id.* at 1285.

163. *Id.* at 1287. The judgment of AseraCare's medical expert expectedly conflicted with the judgment of the government's expert witness. *Id.*

164. *Id.* at 1287–88.

165. *Id.* at 1285.

166. *Id.* at 1286.

167. *Id.* The district court noted that the standard had not been adopted by the Eleventh Circuit, which may have influenced its decision to deny the motion for summary judgment. See *id.* The court also believed that "fact questions remained regarding whether clinical information and other documentation in the relevant medical records supported the certifications of terminal illness." *Id.*

168. *Id.* at 1286–87.

during the first phase.¹⁶⁹ Nonetheless, the dueling expert testimony was a critical component of trial. The government's expert and AseraCare's expert diverged in how they approached analysis of patient life expectancy.¹⁷⁰ The government's expert used a "checkbox approach" to assess terminal illness by comparing patient records to medical guidelines.¹⁷¹ By contrast, AseraCare's expert did not formulaically apply guidance and used a more "holistic" approach.¹⁷² At the trial's conclusion, the district court provided the following jury instruction: "A claim is 'false' if it is an assertion that is untrue when made or used. Claims to Medicare may be false if the provider seeks payment, or reimbursement, for health care that is not reimbursable."¹⁷³ Thus, the jury had to decide which expert was more persuasive, with the less persuasive opinion being deemed a false opinion.¹⁷⁴ In its answers to special interrogatories, the jury found that AseraCare had submitted false claims for 104 of the 123 patients at issue.¹⁷⁵

Following this partial verdict, AseraCare moved for judgment as a matter of law, contending that the district court articulated an incorrect legal standard in its instruction.¹⁷⁶ The court agreed that it had committed reversible error in its instruction and ordered a new trial.¹⁷⁷ The court believed it should have advised the jury of two "key points of law," which were not previously acknowledged: (1) "the FCA's falsity element requires proof of an objective falsehood"; and (2) "a mere difference of opinion between physicians, without more, is not enough to show falsity."¹⁷⁸ The court then considered summary judgment *sua sponte* and concluded that the government could not prove the falsity element as a matter of law because the government "presented no evidence of an objective falsehood for any of the patients at issue."¹⁷⁹ Summary judgment was granted in AseraCare's favor, and the government appealed.¹⁸⁰

On appeal, the government's core argument was that competing expert testimony regarding patients' medical records supporting a terminal illness

169. *Id.* at 1288.

170. *See id.*

171. *Id.*

172. *Id.*

173. *Id.* at 1289.

174. *Id.* at 1288–89.

175. *Id.* at 1289.

176. *Id.* at 1290.

177. *Id.*

178. *Id.* (emphasis omitted). The court noted that "AseraCare had advocated for this legal standard since the start of trial, but only after hearing all the evidence had the court become 'convinced' that 'a difference of opinion is not enough.'" *Id.*

179. *Id.*

180. *Id.*

prognoses was enough to raise a factual question for the jury.¹⁸¹ In contrast, AseraCare contended that the determinative inquiry was whether the certifying physician exercised genuine clinical judgment.¹⁸² If so, the accuracy of such judgment cannot be false as a factual matter.¹⁸³ The Eleventh Circuit immediately recognized that “the standard for falsity [was] in the context of the Medicare hospice benefit, where the controlling condition of reimbursement is a matter of clinical judgment.”¹⁸⁴ Accordingly, the Eleventh Circuit was tasked with considering how the FCA intersects the scope of hospice eligibility requirements.¹⁸⁵

The Eleventh Circuit initially evaluated whether the falsity claim was a legal or factual falsity.¹⁸⁶ The court concluded that the case concerned a legal falsity claim because “[t]here is no allegation that the hospice services AseraCare provided were not rendered as claimed.”¹⁸⁷ Then, the court identified the following two “representations,” which may form the legal basis for an FCA claim: (1) the “representation by a physician to AseraCare that the patient is terminally ill in the physician’s clinical judgment”; and (2) the “representation by AseraCare to Medicare that such clinical judgment has been obtained and that the patient is therefore eligible.”¹⁸⁸ The court found that the government’s allegations only referred to the first representation.¹⁸⁹ The first representation, however, made it such that the government’s FCA case rested entirely on the question of when a “physician’s clinical judgment regarding a patient’s prognosis [can] be deemed ‘false.’ ”¹⁹⁰

To answer this question, the court heavily relied on applicable regulations and the text of the MHB statute due to the “dearth of controlling case law.”¹⁹¹ The court looked to the plain meaning of the entire statute and regulations instead of focusing on specific words.¹⁹² The general requirements were that (1) hospice providers must submit a certification claim for patients, (2) the certification must be in writing, (3) the certification must be based on clinical judgment, (4) clinical information and other documentation supporting the prognoses must accompany the

181. *Id.* at 1291.

182. *Id.* at 1291–92.

183. *Id.* at 1292.

184. *Id.* at 1291.

185. *Id.*

186. *See id.*

187. *Id.*

188. *Id.* at 1295–96.

189. *Id.* at 1296.

190. *Id.*

191. *Id.* at 1292–95.

192. *Id.* at 1292.

certification, and (5) the reimbursement must be for “reasonable and necessary” payments for managing terminally ill patients.¹⁹³ The court subsequently pointed out that several requirements allow for a certain degree of subjectivity.¹⁹⁴ For example, submission of claims must be individually tailored to each patient’s clinical circumstances.¹⁹⁵ Check boxes and standard language used for all patients are prohibited.¹⁹⁶ Furthermore, the subjective and objective medical findings of each patient should be considered.¹⁹⁷ The court believed that this built-in flexibility was fully intended by Congress and that Congress would have used different language if it wanted a more rigid and objective standard.¹⁹⁸ Thus, the court’s role was not to establish a more objective standard against the implied language of the statute and regulations.¹⁹⁹

Although the court emphasized that the regulations intended for MHB eligibility were to simply be predicated on the procurement of a physician’s clinical judgment, the government sought to elevate the standard such that the underlying information must support, “as a factual matter,” the certification.²⁰⁰ The court disagreed with this framing of the eligibility requirements, stating that it is not consistent with the text or design of the law.²⁰¹ The relevant regulations merely require that clinical information and other documentation supporting the medical prognosis accompany the certification and be filed in the medical record.²⁰² The court therefore determined that supporting documentation does not have to, standing alone, prove the validity of a physician’s initial clinical judgment.²⁰³ As long as the physician’s interpretation is reasonable, certification requirements are met.²⁰⁴

The Eleventh Circuit ultimately concurred with the district court’s holding that a mere difference of medical opinion alone is insufficient to establish falsity under the FCA; however, it also ruled that the district court had gone too far in *sua sponte* granting summary judgment.²⁰⁵ The court

193. *Id.* at 1292–93.

194. *Id.* at 1293. The court noted regulations stating that “[p]redicting life expectancy is not an exact science.” *Id.*

195. *Id.*

196. *Id.*

197. *Id.*

198. *Id.* at 1294.

199. *See id.* at 1294–95.

200. *Id.* at 1294.

201. *Id.* at 1295.

202. *Id.* at 1294.

203. *Id.*

204. *See id.*

205. *Id.* at 1297, 1302–05.

recognized that reasonable doctors may disagree on a patient's condition and that neither one could be wrong.²⁰⁶ As a result, "[a] properly formed and sincerely held clinical judgment is not untrue even if a different physician later contends that the judgment is wrong."²⁰⁷ To reach this conclusion, the court relied on and cited to the Supreme Court's decision in *Omnicare*.²⁰⁸ Adhering to *Omnicare*'s general principles, the court acknowledged that opinions regarding terminal illness can be deemed objectively false in various circumstances.²⁰⁹ The court finally deferred to the legislature or CMS after the government expressed concerns that an objective falsity standard "will likely prove more challenging for an FCA plaintiff."²¹⁰

B. *UNITED STATES V. CARE ALTERNATIVES*

Like the *AseraCare* case, *Care Alternatives* involved *qui tam* relators who were former employees of a hospice provider, Care Alternatives.²¹¹ The relators alleged that Care Alternatives admitted ineligible MHB patients and directed its employees to alter the patients' certifications to reflect eligibility.²¹² During discovery, both sides produced extensive evidence, which included dueling expert opinions.²¹³ The relators' expert examined nearly fifty patient records and opined that thirty-five percent of patients' records did not support a certification of need for hospice care.²¹⁴ The expert went even further and testified that "any reasonable physician would have reached the conclusion he reached."²¹⁵ Care Alternatives' expert disagreed and believed that a reasonable physician would have found all of the patients to be hospice-eligible.²¹⁶

At the district court level, Care Alternatives moved for summary

206. *Id.* at 1296.

207. *Id.* at 1297.

208. *See id.*

209. *Id.* For example, the court noted that a physician's opinion can be false when the "physician fails to review a patient's medical records or otherwise familiarize himself with the patient's condition." *Id.* An opinion can also be false when "a physician did not, in fact, subjectively believe that his patient was terminally ill at the time of certification." *Id.* Moreover, a physician's opinion can be false "when expert evidence proves that no reasonable physician could have concluded that a patient was terminally ill given the relevant medical records." *Id.* These are essentially the same factors that the *Omnicare* decision identified. *See Omnicare, Inc. v. Laborers Dist. Council Constr. Indus. Pension Fund*, 575 U.S. 175, 184–89 (2015). The court, however, maintained that in each of the above examples, the "flaw . . . can be demonstrated through verifiable facts." *AseraCare*, 938 F.3d at 1297.

210. *AseraCare*, 938 F.3d at 1301.

211. *United States v. Care Alts.*, 952 F.3d 89, 91 (3d Cir. 2020), *cert. denied*, 141 S. Ct. 1371 (2021). The government declined to intervene. *Id.* at 93. It is unclear why it pursued this option.

212. *Id.* at 91.

213. *Id.* at 94.

214. *Id.*

215. *Id.*

216. *Id.*

judgment based on the finding that the relators could not satisfy the four elements of the FCA claim.²¹⁷ In particular, Care Alternatives claimed that relators had not produced sufficient evidence of falsity.²¹⁸ The court granted Care Alternatives' motion "based solely on failure to show falsity."²¹⁹ To reach its conclusion, the court looked to the holding in *AseraCare*, finding that a "mere difference of opinion between physicians, without more, is not enough to show falsity."²²⁰ The relators appealed.²²¹ Thus, the question before the appellate court was whether a reimbursement claim may be considered false under the FCA simply on the basis of conflicting medical expert testimony.²²²

In reviewing the appeal, the Third Circuit began its analysis by discussing the MHB.²²³ For the most part, the court agreed with the Eleventh Circuit's interpretation in *AseraCare* of the certification requirements for Medicare reimbursement of terminally ill patients.²²⁴ Similar to the *AseraCare* court, the Third Circuit even noted that "making a prognosis is not an exact science."²²⁵ However, departing from the Eleventh Circuit's reading, the court emphasized that this "inexactitude does not negate the fact that there must be a clinical basis for a certification."²²⁶

Where the Third Circuit truly departed from the Eleventh Circuit was in its common law analysis of the terms "false" or "fraudulent" under the FCA.²²⁷ Due to the lack of statutory guidance on the meaning of falsity, the court identified, from its prior cases and the Tenth Circuit's rationale in *Polukoff*,²²⁸ the following two ways in which a claim may be false: (1) "factually, when the facts contained within the claim are untrue"; and (2) "legally, when the claimant . . . falsely certifies that it has complied with a statute or regulation the compliance with which is a condition for government payment."²²⁹ As applied to the case before the court, Care Alternatives allegedly made incorrect certifications, which qualified the

217. *Id.*

218. *Id.* Of note, the government submitted a statement of interest urging the district court to reject the objective falsehood standard. *Id.*

219. *Id.*

220. *Id.* (emphasis omitted) (quoting *Druding v Care Alts., Inc.*, 346 F. Supp. 3d 669, 685 (D.N.J. 2018)).

221. *Id.*

222. *Id.* at 95.

223. *See id.* at 92.

224. *See id.*

225. *Id.* at 93.

226. *Id.* (internal quotation marks omitted).

227. *See id.* at 95.

228. *Id.* at 98.

229. *Id.* at 96 (quoting *Druding v Care Alts., Inc.*, 346 F. Supp. 3d 669, 682 (D.N.J. 2018)).

claim under the legal falsity theory.²³⁰ The court reasoned that the objective falsity standard is at odds with the concept of legal falsity, which is the appropriate standard, and by adopting the prior standard, the district court limited its analysis to factual falsity.²³¹ The court further held that the district court's objective falsity standard conflated the knowledge and falsity elements of an FCA claim.²³² Thus, by rejecting the objective falsity standard, the court sought to separate the knowledge and falsity analyses to comply with the text of the statute.²³³ Under a legal falsity standard, disagreement between experts as to a physician's certification may be evidence of falsity under the FCA.²³⁴

The Third Circuit also considered and rejected the district court's bright-line rule that a doctor's clinical judgment cannot be "false."²³⁵ In doing so, the court acutely relied on the *Paulus* opinion.²³⁶ Underlying the district court's decision was the premise that medical opinions are subjective and cannot be false.²³⁷ The Third Circuit sided with the Sixth Circuit's emphasis on the fact that medical "opinions are not, and have never been, completely insulated from scrutiny."²³⁸ The *Paulus* holding suggested that good faith medical opinions are not punishable but dishonest medical opinions may trigger liability for fraud.²³⁹ Consequently, in line with its legal falsity analysis, the court believed that whether an individual acted in good faith or misrepresented a fact, thereby committing fraud, was "exclusively" a question for the jury.²⁴⁰

The Third Circuit then went on to explain why it chose to depart from the Eleventh Circuit's standard. The first issue that the court highlighted was how the Eleventh Circuit framed the falsity question.²⁴¹ The court interpreted its sibling court as having construed the clinical information and documentation requirement of the MHB in an overly narrow fashion when it concluded that the supporting documentation requirement is only designed

230. *Id.* at 97.

231. *See id.*

232. *Id.* at 96. The Third Circuit believed that the district court incorporated the knowledge element into its analysis by finding that the relators "could not prove falsity because they had not produced evidence that any physician lied and received a kickback to certify any patient as hospice eligible" or "certif[ied] any patient whom that physician believed was not hospice eligible." *Id.*

233. *Id.*

234. *Id.* at 97.

235. *Id.* at 98.

236. *See id.*

237. *Id.* at 94.

238. *Id.* (quoting *United States v. Paulus*, 894 F.3d 267, 275 (6th Cir. 2018)).

239. *Id.* (citing *Paulus*, 894 F.3d at 275–76).

240. *Id.*

241. *Id.* at 98–100.

to address the mandate that there be a medical basis for certification instead of considering “whether the clinical information and other documentation accompanying a certification of terminal illness support[s] . . . the physician’s certification.”²⁴² Therefore, this limited the inquiry to whether there was sufficient evidence of “the accuracy of the physician’s clinical judgment regarding terminality,” which the court understood to exclude legal falsity and only include factual falsity.²⁴³ The court posited that under the legal falsity theory, conflicting medical opinion is relevant evidence of the clinical information and documentation requirements.²⁴⁴ Furthermore, the court characterized the *AseraCare* court as coming to the conclusion that clinical judgments cannot be untrue, which it fundamentally disagreed with based on its interpretation of common-law definitions.²⁴⁵

Ultimately, the Third Circuit had a drastically different breakdown of the falsity issue as compared to the Eleventh Circuit because it based its entire analysis upon the distinction between what it understood to be factual and legal falsity.

C. *WINTER EX REL. UNITED STATES V. GARDENS REGIONAL HOSPITAL AND MEDICAL CENTER, INC.*

In *Winter*, the relator, a registered nurse and former director at Gardens Regional Hospital (“Gardens”), filed a *qui tam* FCA suit against her former employer.²⁴⁶ The procedural history of this case is relatively simple compared to those of the aforementioned cases. The relator alleged in a complaint that Gardens submitted Medicare claims falsely certifying that patients’ hospitalizations were medically necessary.²⁴⁷ In support of this claim, the relator pointed to her own after-the-fact review of admission records.²⁴⁸ Gardens moved to dismiss the complaint for failure to state a claim, which was subsequently granted by the district court.²⁴⁹ The district court asserted that to prevail on an FCA claim, plaintiffs must show that a defendant knowingly made an objectively false representation. Thus, a statement that implicates a doctor’s clinical judgment can never state an FCA claim because subjective medical opinions cannot be proven to be

242. *Id.* at 99. (alteration in original) (quoting *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1294 (11th Cir. 2019)).

243. *Id.* (quoting *AseraCare*, 938 F.3d at 1296).

244. *Id.* at 100.

245. *Id.*

246. *Winter ex rel. United States v. Gardens Reg’l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1112, 1114 (9th Cir. 2020), *cert. denied sub nom. RollinsNelson LTC Corp. v. United States ex rel. Winters*, 141 S. Ct. 1380 (2021).

247. *Id.*

248. *Id.* at 1112–13, 1120.

249. *Id.* at 1116.

objectively false.²⁵⁰ The relator appealed.²⁵¹

The Ninth Circuit started its analysis by reviewing the medical necessity requirement and the FCA.²⁵² Medicare reimburses providers for inpatient hospitalization only if the expenses incurred are “reasonable and necessary.”²⁵³ CMS administers the Medicare program and has defined a reasonable and necessary service as one that “meets, but does not exceed, the patient’s medical need, and is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition.”²⁵⁴ Similar to the MHB, the Medicare program allows doctors to form their own clinical judgment based on complex medical factors.²⁵⁵ However, the language specifically provides that factors must be documented in the medical record and the regulations consider medical necessity a question of fact.²⁵⁶ Thus, a physician’s certification has no presumptive weight in determining medical necessity and must be evaluated in the context of medical evidence.²⁵⁷ The court subsequently reasoned that the relator’s allegations fall under the “false certification” theory of FCA liability.²⁵⁸ Since medical necessity is a condition of payment, every Medicare claim includes an express or implied certification of necessary treatment.²⁵⁹ Accordingly, claims for unnecessary treatment are false claims.²⁶⁰ The court stated that many other circuits, including the Tenth in *Polukoff* and Third in *Care Alternatives*, reached the same conclusion regarding the scope of FCA claims.²⁶¹

The Ninth Circuit then proceeded to analyze the application of opinions to the FCA by interpreting the language of the statute.²⁶² The court interpreted the FCA broadly, citing congressional intent and the Supreme Court’s refusal to “accept a rigid, restrictive reading” of the FCA.²⁶³ Due to the lack of statutory guidance on what constitutes a false or fraudulent claim, the court looked to common-law definitions.²⁶⁴ In doing so, the court referred

250. *Id.* at 1113.

251. *Id.*

252. *See id.* at 1113–14.

253. *Id.* at 1113 (quoting 42 U.S.C. § 1395y(a)(1)(A)).

254. *Id.* (internal quotation marks omitted).

255. *Id.*

256. *Id.*

257. *Id.*

258. *Id.*

259. *Id.*

260. *Id.*

261. *Id.* at 1118.

262. *See id.* at 1116–18.

263. *Id.* at 1116 (quoting *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968)).

264. *Id.* at 1117. The court noted, however, that Congress actually intended for the FCA to be broader than the common law based on the knowledge requirement. *See id.*

to treatises and a number of cases, including *Paulus* and *Omnicare*, that a subjective opinion may be fraudulent if (1) it is “not honestly held,” (2) it implies the existence of nonexistent facts, (3) the speaker knows facts that would preclude such an opinion, and (4) the speaker does not know facts that justify it.²⁶⁵ The court additionally explained that the “knowing presentation of what is known to be false” does not mean “scientifically untrue.”²⁶⁶ Although a scientifically untrue statement is false, it may not be actionable if it was not made with the requisite intent.²⁶⁷ Likewise, an opinion with no basis in fact can be fraudulent if expressed with knowledge.²⁶⁸

The court considered and outright rejected the request from Gardens and amici curiae for the court to hold that the FCA requires plaintiffs to plead an objective falsehood.²⁶⁹ The court stated that the plain language of the FCA “does not distinguish between ‘objective’ and ‘subjective’ falsity or carve out an exception for clinical judgments and opinions.”²⁷⁰ The court further noted that policy arguments cannot supersede the “clear” statutory text and it could not engraft that requirement onto the statute.²⁷¹ The court therefore held that the FCA does not require plaintiffs to plead an objective falsehood.²⁷²

Interestingly, the court claimed that the Eleventh Circuit’s decision in *AseraCare* was not “directly to the contrary.”²⁷³ First, the court noted that the Eleventh Circuit, notwithstanding the language about objective falsehoods, did not consider all subjective statements to be incapable of falsity.²⁷⁴ Second, the court believed that the Eleventh Circuit narrowly confined the objective falsity standard to the MHB, which granted deference to physician judgment.²⁷⁵ In the court’s view, its sister circuit did not necessarily apply the standard to a physician’s certification of medical necessity by (1) explicitly distinguishing *Polukoff*, and (2) explaining that the less-deferential medical necessity requirement remained an important safeguard to its reading of the MHB eligibility framework.²⁷⁶

Given that litigation was at the motion to dismiss stage, the court ruled

265. *Id.*

266. *Id.* (internal quotation marks omitted).

267. *Id.*

268. *Id.*

269. *Id.*

270. *Id.*

271. *Id.* at 1113, 1117.

272. *Id.* at 1119.

273. *Id.* at 1118.

274. *Id.* at 1118–19.

275. *Id.* at 1119.

276. *Id.*

that the relator's complaint plausibly alleged false certifications of medical necessity.²⁷⁷ The relator (1) showed correlations between the spike in admissions and timing of the scheme; (2) presented both irregular admission trends and admission statistics; (3) alleged a specific number of false claims, each in great detail; and (4) set forth anecdotal evidence which supported both an inference of knowledge and falsity.²⁷⁸ The court also plainly dismissed Gardens' argument and the district court's characterization of the relator's allegation as simply being her own competing opinion.²⁷⁹ First, according to the court, opinions can establish falsity.²⁸⁰ Second, the court believed that even if the relator's own evaluations of the medical record were discounted, there were enough facts alleged to suffice the plausibility of fraud.²⁸¹

In sum, while the Ninth Circuit disagreed with the Eleventh Circuit about the objective falsehood standard, it applied the same common law rule regarding when an opinion can be false for the purposes of an FCA claim.

IV. DISCUSSION

AseraCare, *Care Alternatives*, and *Winter* highlight a growing tension between the different approaches and standards within the falsity element of the FCA. The hospice context has been the battleground between the Third and Eleventh Circuits, which have attempted to solve the issue of whether dueling expert testimonies, without more, create a triable issue of fact for the jury.²⁸² Nonetheless, it is quite evident that the imposition of a rigid falsity standard lends itself to application in FCA claims which have no basis in hospice care certifications, as seen in *Winter*.²⁸³ Furthermore, how courts analyze false opinions according to laws and regulations as well as the intent behind them is of great importance because it forms the conceptual foundation for constructing a proper framework and reaching the most legally sound conclusion. The following questions naturally follow: How should courts analyze false opinions and the falsity standard? And is the objective or subjective falsity standard the more appropriate reading of the FCA statute?

Section IV.A argues that *Polukoff* and *Omnicare* provide a comprehensive framework for the courts to categorize types of FCA claims

277. *Id.* at 1119, 1121.

278. *Id.* at 1120.

279. *Id.*

280. *Id.*

281. *Id.*

282. *See supra* Sections III.A–B.

283. *See supra* Section III.C.

and, if the alleged conduct includes opinions, whether the opinion is false. Section IV.B argues that, given the reach of the FCA, objective and subjective falsity standards are appropriate depending on the applicable regulations. Section IV.C suggests that, as a practical matter based on policy concerns, Congress amend the FCA to create special definitions and provisions for professional medical judgment. Finally, Section IV.D addresses the competing policy trade-off of over-incentivization to file false claims and contextualizes the arguments made in this Note to the broader whistleblower policy debate.

A. THE *POLUKOFF-OMNICARE* COMMON LAW TEST

Unlike the *Care Alternatives* court's factual and legal falsity breakdown, the *AseraCare* and *Winter* courts utilized the *Polukoff-Omnicare* common law framework to reach their conclusions; this is the proper way to analyze the falsity element of the FCA. First, the *Polukoff-Omnicare* framework fully encompasses all types of FCA claims. The *Polukoff* court divides FCA claims into factual and legal claims.²⁸⁴ The *Omnicare* decision sets out the four different ways in which an opinion may be false: (1) the actor does not actually hold the opinion; (2) the opinion contains a false, embedded fact; (3) the actor is aware of facts that would preclude such an opinion; or (4) the actor is not aware of any facts that would justify the opinion.²⁸⁵ The first step in any FCA claim determination should be the *Polukoff* analysis. Courts can properly distinguish the entire universe of FCA claims into two categories and decide where the claim before them fits. Moreover, if legal claims are not implicated, the standard automatically defaults to an objective falsehood standard.²⁸⁶ Courts should subsequently consider whether a legal, FCA claim fits into one of the four *Omnicare* false opinion types. Regardless of whether courts adopt an objective or subjective falsehood standard, the *Omnicare* framework remains pertinent because it defines the totality of false opinions. Adhering to this analytical procedure will not only ensure that common law precedent has been properly followed but also unofficially standardize the framework across circuits. As discussed above, the Eleventh and Ninth Circuits identically and correctly applied this framework.²⁸⁷

Second, while the Third Circuit correctly relied on *Paulus* to identify that opinions can be false, it fully ignored when opinions can be false

284. See *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 741 (10th Cir. 2018).

285. See *Omnicare, Inc. v. Laborers Dist. Council Const. Indus. Pension Fund*, 575 U.S. 175, 184–89 (2015).

286. See *infra* Section IV.B.

287. See *supra* Sections III.A, III.C.

according to the common law; it would not have made this fatal error if it used the *Omnicare* framework. The *Paulus* court specifically stated 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.*”²⁸⁸ The “when” conjunctions in the statement are critical to understanding the common law reasoning behind false opinions. However, the Third Circuit seemingly disregarded the dependent clauses, so that it could adduce some misconstrued holding from another circuit to support its conclusion regarding subjective falsity. In a similarly reductive fashion, the Third Circuit mischaracterized the Eleventh Circuit’s holding in *AseraCare* to state that clinical judgments are never false.²⁸⁹ The primary reason the government was unable to successfully make its case in *AseraCare* was that, in lieu of available evidence, it solely used an expert witness who was unable to claim that no reasonable physician could have reached the contested conclusions.²⁹⁰ The Third Circuit, however, conflated the lack of evidence with the Eleventh Circuit’s framing of the issue. In reality, the Eleventh Circuit noted that opinions can be false, as it directly followed and cited to the *Omnicare* decision.²⁹¹ The Third Circuit invoked the common law but never identified any evidence to suggest a false opinion under the *Omnicare* categories. The Third Circuit completely discounted the Supreme Court’s principle that, as a general rule, sincere statements of pure opinion are not “untrue statement[s] of material fact” even if the speakers are ultimately wrong.²⁹² Thus, if the certifying physicians in *Care Alternatives* truly believed that their patients were terminally ill, the Third Circuit, without conducting a proper *Omnicare*-based analysis, would have controverted existing Supreme Court precedent.

Third, the Third Circuit’s entire analysis is based on its understanding of factual and legal falsity, but the court fundamentally misconstrued the relationship between objective falsity and the factual/legal falsity distinction in the *Polukoff* holding. The *Polukoff* decision indicated that factual falsity refers to express claims which are entirely based on fact, whereas legal falsity refers to any claim where legal requirements were not met.²⁹³ Accordingly, a subset of legal falsity claims includes claims where the legal requirement was not met due to negligent, reckless, or deceitful conduct,

288. *United States v. Paulus*, 894 F.3d 267, 275 (6th Cir. 2018) (emphasis added).

289. *United States v. Care Alts.*, 952 F.3d 89, 100 (3d Cir. 2020), *cert. denied*, 141 S. Ct. 1371 (2021).

290. *United States v. AseraCare, Inc.*, 938 F.3d 1278, 1287 (11th Cir. 2019).

291. *Id.* at 1297.

292. *Omnicare, Inc. v. Laborers Dist. Council Const. Indus. Pension Fund*, 575 U.S. 175, 186 (2015).

293. *United States ex rel. Polukoff v. St. Mark’s Hosp.*, 895 F.3d 730, 741 (10th Cir. 2018).

which implicates some extent of knowledge or lack thereof (in other words, implied claims).²⁹⁴ The *Polukoff* court simply demarcated the types of FCA claims which could reasonably be brought by plaintiffs. The Third Circuit, however, proclaimed that objective falsity is incompatible with legal falsity.²⁹⁵ The underlying assumption with this assertion is that objective facts may only be employed to challenge facts and not opinions. On a theoretical level, this line of logic is problematic because facts are objectively more concrete than opinions. Accordingly, as a matter of law, facts take precedence over opinions in the hierarchy of proof. Although “pure” opinions cannot be rebutted with facts,²⁹⁶ not all opinions are “pure,” especially those of medical professionals. Generally, professional opinions have some foundation in fact, which essentially places them on a spectrum between fact and opinion. This hybridization makes professional opinions susceptible to dispute by both facts and opinions. Thus, relegating the objective falsity standard to factual claims of falsity severely misses the extent of the standard’s applicability. On a practical level, the Supreme Court in *Omnicare* codified these observations into common law.²⁹⁷ For example, an opinion which contains a false, embedded fact is considered a false opinion.²⁹⁸ False opinions naturally fall under the Third Circuit’s legal falsity umbrella. The Supreme Court stated that if the embedded fact is proven to be false, the opinion is also false.²⁹⁹ This type of false opinion clearly allows for rebuttal with a contradictory factual finding, so an objective falsity standard is not necessarily improper when applied to legal falsity claims.

Finally, the Third Circuit improperly accused the Eleventh Circuit of wrongfully conflating the FCA’s knowledge and falsity elements; in fact, the Third Circuit was the court that conflated these elements. In *AseraCare* and *Winter*, the Eleventh and Ninth Circuits acknowledged that some evidence applies to proving both knowledge and falsity.³⁰⁰ This necessarily makes it difficult to analyze these elements separately. Even the district court in *Care Alternatives* realized this when it rejected the relators’ claim because they failed to establish evidence of the physicians’ underlying knowledge (such that any physician lied or actually believed that the certified patients were not hospice-eligible).³⁰¹ The Third Circuit made clear that “in our Court,

294. *Id.*

295. *United States v. Care Alts.*, 952 F.3d 89, 97 (3d Cir. 2020), *cert. denied*, 141 S. Ct. 1371 (2021).

296. *See Omnicare*, 575 U.S. at 186.

297. *See id.* at 184–89.

298. *Id.* at 185–86.

299. *Id.*

300. *See United States v. AseraCare, Inc.*, 938 F.3d 1278, 1302–05 (11th Cir. 2019); *Winter ex rel. United States v. Gardens Reg’l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1120 (9th Cir. 2020), *cert. denied sub nom. RollinsNelson LTC Corp. v. United States ex rel. Winters*, 141 S. Ct. 1380 (2021).

301. *United States v. Care Alts.*, 952 F.3d 89, 96 (3d Cir. 2020), *cert. denied*, 141 S. Ct. 1371 (2021).

findings of falsity and scienter must be independent from one another for purposes of FCA liability.”³⁰² This is a misunderstanding of what common law principles apply. The fundamental distinction between an honest opinion and an opinion made in bad faith is the prerequisite knowledge used in forming the opinion. Therefore, when determining whether an opinion is false, the common law specifically looks to the speaker’s intent, which necessarily implies a knowledge requirement. The Third Circuit clearly subverted *Omnicare* by ruling that an after-the-fact reasonable disagreement between physicians can show falsity. Furthermore, as a practical concern, the Third Circuit’s falsity and knowledge separation could substantially increase the risk that the juror’s perception becomes tainted. The district court in *AseraCare* bifurcated its trial because it feared that evidence related to the knowledge element, particularly AseraCare’s flawed admissions policies and certification procedures to determine if a patient was terminally ill, would be inferred by the jury to satisfy the falsity element.³⁰³ This did, in fact, confuse the jury’s analysis of the threshold falsity question.³⁰⁴ Conceptually, general corporate practices have no bearing on whether a particular hospice claim is false if the medical evidence points to the fact that the patient was terminally ill. Accordingly, the Third Circuit’s interpretation of the knowledge and falsity elements potentially writes the falsity element out of the FCA statute by allowing evidence of knowledge to cloud a jury’s perception of falsity.

B. COURTS MAY REASONABLY REACH DIFFERENT FALSITY STANDARDS

The objective and subjective falsehood standards are not necessarily diametrically opposed in the broad legal sense. In remaining true to Congress’s intent, courts have used the FCA “to reach all types of fraud, without qualification, that might result in financial loss to the Government.”³⁰⁵ In doing so, the FCA has been interpreted alongside other applicable laws and regulations since its inception. Prior to the recent medical FCA cases, this was not an issue because fraud was never predicated solely on subjective professional opinions without a tangible associated fact.³⁰⁶ In *Polukoff* terms, the entire realm of FCA claims were factual claims and non-opinion legal claims. Due to the factual basis for these types of claims, courts had to adopt an objective falsehood standard, which slowly resulted in uniformity among jurisdictions. However, as noted by the *Winter*

302. *Id.* at 100.

303. *See AseraCare*, 938 F.3d at 1287.

304. *Id.*

305. *Winter*, 953 F.3d at 1116 (quoting *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968)).

306. *See supra* Section I.D.

court, the Supreme Court “ ‘has consistently refused to accept a rigid, restrictive reading’ of the FCA.”³⁰⁷ The same reasoning can be extrapolated to the falsity standard to the extent that it is an element of an FCA claim. Interactions between the FCA and applicable laws and regulations thus do not inherently allow for a universal falsity standard but rather the possibility of different falsity standards to be adopted in specific circumstances. This flexibility in the legal interpretation of falsity is also the better policy approach that allows for a more robust legal system.

The objective falsehood standard is an appropriate legal interpretation based on CMS’s guidelines and the MHB’s purposeful deference to physician judgment. The MHB and CMS’s guidelines for hospice eligibility repeatedly reference the subjectivity involved in determining terminal illness.³⁰⁸ First, as a general matter, Congress has not amended the hospice eligibility criteria.³⁰⁹ Second, the MHB specifically prohibits the use of check boxes and requires a narrative explanation of the diagnosis.³¹⁰ Third, the MHB allows for unlimited recertifications.³¹¹ Fourth, the MHB requires physicians to consider subjective and objective medical findings.³¹² Finally, the MHB explicitly declared that predicting life expectancy is not an exact science.³¹³ Taken in totality, these factors show the imprecise nature and complexity of hospice certifications. Thus, based on the lack of any statistical or medical measurement for longevity, medical professionals have been afforded the utmost deference by Congress. If courts were to adopt a subjective falsity standard with regards to hospice care, FCA trials would devolve into a meaningless battle of expert opinions, neither of which may be false. This is exactly what happened at the district level in *AseraCare*.³¹⁴ The objective falsity standard is more sensible and provides a safeguard to trivial FCA claims based on falsity. Congress’s intention was not to allow “rogues” to take a doctor to court based on their certification that a patient had six more months to live simply because they found another doctor who believed the same patient had a remaining life expectancy of six and a half months. By adopting an objective standard, juries are not forced to become a “third doctor” who simply evaluates purely medical judgments.

At the same time, the subjective falsehood standard is an appropriate legal interpretation based on Medicare regulations and CMS’s definition of

307. *Winter*, 953 F.3d at 1116 (quoting *Neifert-White*, 390 U.S. at 232).

308. *See AseraCare*, 938 F.3d at 1293, 1295, 1304.

309. *See id.* at 1295.

310. *Id.* at 1293.

311. *Id.* at 1283.

312. *Id.* at 1293.

313. *Id.*

314. *Id.* at 1287.

“reasonable and necessary.” Medicare reimbursements for inpatient hospitalizations are contingent on the provided services being reasonable and necessary, as defined by the CMS.³¹⁵ Similar to the MHB, Medicare regulations demand that doctors evaluate complex medical factors to form their clinical judgment. In contrast to the MHB, however, Medicare regulations do not give physicians “unfettered discretion.”³¹⁶ The regulations explicitly defer to the accepted standards of medical practice but provide no presumptive weight to a physician’s certification.³¹⁷ Expert opinions must be analyzed in the context of medical evidence.³¹⁸ An objective falsehood standard is not necessarily incompatible with Medicare hospitalization claims but would be redundant. Since the Medicare program already requires medical evidence for initial certifications, facts are presumably available in every case. The focal point of these cases surrounds the interpretation of these facts. Therefore, medical expert testimony offers more value than just competing medical theory. Testimony effectively provides valuable, logical medical inferences and contextualizes the interpretation of medical data, which is substantially less subjective than end-of-life determinations. Due to the fact that judgments are less rooted in medical theory and more rooted in medical practice, juries are able to make more substantiated findings, as they did so in *Paulus* and *Polukoff*. Accordingly, the subjective falsity standard is the more appropriate standard under these circumstances.

C. LEGISLATIVE ACTION FOR THE FCA

Given that rejections of the objective falsity standard have occurred exclusively in medical-related FCA claims, the unique challenges associated with the medical realm may be more efficiently handled through legislation. Judicial interpretations of falsity have been effective in filling the statutory gap in the FCA until the current circuit split, where false opinions in the medical context have divided the common law landscape. The crux of the issue is that the medical sector is quite anomalous when compared to other areas of practice, but courts cannot simply apply a medical-specific standard.³¹⁹ As a general matter, courts do not derogate legal standards based on the field of application (for instance, the financial sector does not receive a different legal standard from the technology sector simply because the

315. *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1113 (9th Cir. 2020), *cert. denied sub nom. RollinsNelson LTC Corp. v. United States ex rel. Winters*, 141 S. Ct. 1380 (2021).

316. *Id.* at 1114.

317. *Id.*

318. *Id.*

319. See Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, 1996 U. CHI. LEGAL F. 207, 207–08 (1996).

fields are different).³²⁰ Common law seeks to prescribe a set of legal rules and principles that can be consistently applied.³²¹ Absent some countervailing statute or regulation, the common law is standardized across all fields.³²² The countervailing statute in *AseraCare* and *Care Alternatives* was the MHB. The countervailing regulation in *Winter* was Medicare. However, the plain language of the MHB statute and Medicare regulations grants different degrees of deference to doctors. As a result, it is unclear how courts can adopt one standard without subverting congressional deference to doctors. If courts adopt a bright-line objective falsity standard, they will comply with the MHB and protect medical professionals from frivolous FCA suits but impose a higher standard of proof for plaintiffs, which will prevent valid suits involving false Medicare certifications from getting through trial. On the other hand, if courts adopt a subjective falsity standard, false Medicare certification claims could be handled appropriately through FCA litigation while frivolous claims will be brought against physicians who genuinely certify hospice care, which neither the FCA nor the MHB protects against. As a result, while the Supreme Court can attempt to resolve the circuit split in the future, the resolution may not be desirable as the adopted standard may lack the nuance needed to accommodate both medical laws and regulations.

From a policy perspective, it is also in Congress's interest to clarify how and when physicians should be held accountable for their clinical opinions. The legislative branch, beholden to the people, creates laws while the judiciary promotes fairness and justice through the interpretation of such laws. Congress originally wrote the MHB and authorized Medicare programs after appreciating the host of factors that go into complex medical decision-making. The objective was to strike a balance between accountability and scrutiny within different medical settings. It is simply not the courts' job to engage in judicial policymaking that overrides congressional intent. Courts cannot require stricter or looser scrutiny of physician judgments as they see fit and would effectively be doing so by adopting a bright-line standard. Moreover, the majority of FCA claims for the past several years have been from the medical field.³²³ Based on this consistent trend and America's aging population, the composition of FCA claims for the foreseeable future will remain dominated by healthcare-related claims. Thus, it is imperative that Congress provide explicit, meaningful

320. *Id.*

321. *Id.*

322. *Id.*

323. See *Fraud Statistics*, *supra* note 56 (showing that fraud cases in the Department of Health and Human Services have drastically increased from 1986 to 2020 and now comprise the vast majority of all fraud cases).

guidance on this issue.

D. POLICY CONSIDERATIONS FOR THE FCA

Although this Note primarily focuses on the fraud deterrence aspect of the FCA, a comprehensive discussion would not be complete without addressing the competing policy tradeoff—over-incentivization of whistleblowers to file false or frivolous FCA claims. In 2020, the relator share awards totaled over \$300 million with only 672 *qui tam* claims filed.³²⁴ Although the potential for monetary gain differs for each case, it can be extrapolated from this data that whistleblowers can win hundreds of thousands, if not millions, of dollars if they prevail on a claim. This is a powerful incentive for unscrupulous individuals hoping to profit from this well-intentioned statute. A legal falsity standard certainly eases their ability to do so. However, the hurdles that would have to be overcome by such individuals virtually eliminate the risk of undeserving payouts. First, after the filing of a *qui tam* complaint, the government is required to investigate the allegations and can move to dismiss if the findings show that the relator has no grounds for the complaint.³²⁵ Even if the government does not move to dismiss, approximately 52% of FCA cases are resolved at this stage by agreed dismissal or settlement.³²⁶ Second, at the motion-to-dismiss stage, the complaint may fail as a matter of law due to lack of specificity. Third, at the summary judgment stage, the relator must show a genuine dispute of material fact. In the event that a legal falsity standard is applied, the relator may not have any issues convincing the court. Nonetheless, nearly 80% of FCA cases were resolved before the summary judgment stage.³²⁷ Thus, it is statistically unlikely for a relator, much less a dishonest one, to even reach this stage. Finally, the relator must prevail at trial. But more than 99% of FCA cases settle or are dismissed before reaching trial due to the high stakes nature of FCA litigation.³²⁸ Consequently, the systemic barriers and costly litigation process should sufficiently dissuade fraudulent rogues and assuage any concerns regarding overburdening of the judicial system.

In addition, while the extracted case law from the described cases does not provide an exactly useful model for FCA litigation in non-medical practice areas, the proposed non-duality falsity standard concept can be

324. *Id.* (presenting the number of *qui tam* claims filed in column two and the total relator share awards in the last column).

325. *Primer*, *supra* note 34 (describing the government investigation process under the *qui tam* provisions section).

326. *Strategic Budgeting*, *supra* note 55.

327. *Id.*

328. *Id.*; see Pamela H. Bucy, *Games and Stories: Game Theory and the Civil False Claims Act*, 31 FLA. ST. U.L. REV. 603, 608 (2004).

utilized to address the broader whistleblower policy debate. Whistleblower laws typically attempt to strike a balance between protecting the rights of whistleblowers and respecting an employer's rights to remove personnel.³²⁹ Lawmakers must therefore decide who whistleblowers can report information to while still receiving sufficient protections from employer retaliation.³³⁰ This has been the subject of scholarly debate and criticism for years, which still rages on today.³³¹ In January 2021, the Anti-Money Laundering Act was enacted, which expanded the recipient list for employees of financial services institutions.³³² However, the Act still imposes a rigid report recipient requirement.³³³ Similar to how a rigid falsity standard fails to account for the plethora of intersecting laws and regulations, an unduly restrictive recipient list likely cannot match the diversity of situations that whistleblowers find themselves in. It is evident that the issue of rigid standards permeates the whistleblower legal arena. Moving forward, open-ended or flexible standards may provide the nuance necessary to usher in a new era of comprehensive whistleblower reforms.

CONCLUSION

AseraCare, *Care Alternatives*, and *Winter* are the first cases to adopt the objective or subjective falsehood standard for FCA claims in the context of medical certifications based on "false opinions." The specific question at issue is whether dueling expert opinion, without more, creates a triable issue of fact for the jury. The objective falsity standard posits that conflicting opinions are not enough whereas the subjective falsity standard believes contradictory judgments are sufficient. The practical result of courts adopting the subjective standard is that relators and the government are more likely to survive the pleading and summary judgment stage by simply providing dueling expert opinion. An objective falsity standard makes it more difficult for plaintiffs to prevail on an FCA claim. The Eleventh Circuit in *AseraCare* adopted the objective standard after analyzing the plain language of the FCA and MHB. The Third Circuit in *Care Alternatives*

329. Philip Berkowitz, *The Anti-Money Laundering Act (AMLA): Defending Whistleblower Claims in the Financial Services Industry*, A.B.A. (Apr. 28, 2021), http://www.americanbar.org/groups/business_law/publications/blt/2021/05/amla [<http://perma.cc/8EYV-YRQE>].

330. *See id.*

331. *See, e.g.,* Elletta Sangrey Callahan & Terry Morehead Dworkin, *The State of State Whistleblower Protection*, 38 AM. BUS. L.J. 99, 100 (2000) (describing the competing incentive and protection approaches of various federal whistleblower laws); Thomas M. Devine, *The Whistleblower Protection Act of 1989: Foundation for the Modern Law of Employment Dissent*, 51 ADMIN. L. REV. 531, 532–35 (1999) (discussing the relative effectiveness of the Whistleblower Protection Act of 1989 over the Civil Service Reform Act of 1978).

332. Berkowitz, *supra* note 329; 31 U.S.C. § 5323.

333. *See* 31 U.S.C. § 5323(g)(1) (allowing whistleblowers to only report compliance violations to their employer, the attorney general, secretary of treasury, regulators, and members of Congress).

arrived at the subjective standard after analyzing the same statutes. The Ninth Circuit in *Winter* implicitly agreed with the subjective standard after it considered the FCA and Medicare regulations. Superficially, there is a clear circuit split over the falsity standard. The two standards are at odds, but each one is applicable in different medical settings based on Congress's intent and the plain meaning of the governing statutes and regulations. More importantly, however, is not what standard each circuit adopted but how the courts arrived at their conclusions.

While there are countless examples of FCA certifications requiring a medical opinion or exercise of discretion, the above trifecta of cases perfectly contrasts how courts should and should not invoke common law. The Eleventh and Ninth Circuits, while reaching different conclusions, employed the same common law framework and principles in their analyses. They primarily relied on (1) the Tenth Circuit's *Polukoff* holding to distinguish factual and legal falsity, and (2) the Supreme Court's *Omnicare* decision discussing when opinions may be deemed false. Conversely, the Third Circuit stated that it looked to common law for guidance while (1) misconstruing case law, (2) ignoring common law precedent, and (3) failing to apply common law in its lackluster analysis. Unlike the Third Circuit, courts should utilize the *Polukoff-Omnicare* framework because it categorically constricts the universe of FCA claims into a logical, comprehensive framework with which to analyze false opinions.

The Supreme Court missed an opportunity to at least resolve the analytical differences between the circuits when it denied certiorari for *Care Alternatives* and *Winter*. As a matter of policy, the decision to adopt or reject a rigid falsity standard will have wide-ranging consequences, and it should be up to the legislature to insulate or scrutinize physicians for their certifications. Aside from adjudging these exercises of discretion as true or false, the Supreme Court has the responsibility of correcting circuits when they falter in their representation of common law principles. *Omnicare* is arguably the most relevant common law precedent in terms of providing an analytical framework for determining false opinions. Thus, the Third Circuit's disregard of *Omnicare* sets an extremely disruptive example for other courts. Moving forward, the Supreme Court should announce that courts must abide by *Omnicare* when engaging in an FCA analysis involving opinions.

APPENDIX: COURTS ADOPTING OR REJECTING OBJECTIVE
FALSITY

<i>Court^a</i>	<i>Case Name</i>	<i>Year</i>	<i>Type of Legal Claim</i>
<i>Adopting Courts</i>			
Tenth Circuit	United States <i>ex rel.</i> Morton v. A Plus Benefits, Inc. ^b	2005	Medicaid
District of Nevada	United States v. Prabhu ^c	2006	Medicare
Fourth Circuit	United States <i>ex rel.</i> Wilson v. Kellogg Brown & Root, Inc. ^d	2008	Contract
Seventh Circuit	United States <i>ex rel.</i> Yannacopoulos v. General Dynamics ^e	2011	Contract
Third Circuit	United States <i>ex rel.</i> Hill v. University of Medicine & Dentistry of New Jersey ^f	2011	Research Grant
Third Circuit	United States <i>ex rel.</i> Thomas v. Siemens AG ^g	2014	Contract
Northern District of Texas	United States <i>ex rel.</i> Wall v. Vista Hospice Care, Inc. ^h	2016	Medicare/Medicaid
Eleventh Circuit	United States v. AseraCare, Inc. ⁱ	2019	Medicare
<i>Rejecting Courts</i>			
Third Circuit	United States v. Care Alternatives ^j	2020	Medicare/Medicaid
Ninth Circuit	Winter <i>ex rel.</i> United States v. Gardens Regional Hospital & Medical Center, Inc. ^k	2020	Medicare

Notes: This list merely demonstrates the uniformity of the legal landscape prior to the Third and Ninth Circuit decisions in 2020 and is not intended to show every single jurisdiction that has ruled on the issue. ^aOf note, the Third Circuit originally adopted the objective falsity standard in 2011, reaffirmed the standard in 2014, and rejected the standard in 2020. This is quite peculiar, as it is the only Circuit that has switched its opinion on the issue. The Tenth Circuit adopted the objective falsity standard in 2005 but moved away from that decision in *United States ex rel. Polukoff v. St. Mark's Hospital*. However, the Tenth Circuit has not explicitly embraced a subjective falsity standard. *Sources:* ^b*United States ex rel. Morton v. A Plus Benefits, Inc.*, 139 F. App'x 980 (10th Cir. 2005). ^c*United States v. Prabhu*, 442 F. Supp. 2d 1008 (D. Nev. 2006). ^d*United States ex rel. Wilson v. Kellogg Brown & Root, Inc.*, 525 F.3d 370 (4th Cir. 2008). ^e*United States ex rel. Yannacopoulos v. Gen. Dynamics*, 652 F.3d 818 (7th Cir. 2011). ^f*United States ex rel. Hill v. Univ. of Med. & Dentistry of New Jersey*, 448 F. App'x 314 (3d Cir. 2011). ^g*United States ex rel. Thomas v. Siemens AG*, 593 F. App'x 139 (3d Cir. 2014). ^h*United States ex rel. Wall v. Vista Hospice Care, Inc.*, No. 3:07-cv-00604-M, 2016 U.S. Dist. LEXIS 80160 (N.D. Tex. June 20, 2016). ⁱ*United States v. AseraCare, Inc.*, 938 F.3d 1278 (11th Cir. 2019). ^j*United States v. Care Alts.*, 952 F.3d 89 (3d Cir. 2020), *cert. denied*, 141 S. Ct. 1371 (2021). ^k*Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108 (9th Cir. 2020), *cert. denied sub nom. RollinsNelson LTC Corp. v. United States ex rel. Winters*, 141 S. Ct. 1380 (2021).

