No. _____

In the
Supreme Court of the United States

CARE ALTERNATIVES,

Petitioner,

v.

UNITED STATES OF AMERICA; STATE OF NEW JERSEY EX. REL. VICTORIA DRUDING; BARBARA BAIN; LINDA COLEMAN; RONNI O'BRIEN,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Each year, millions of terminally ill Americans make the difficult decision to forgo curative treatment in favor of hospice care, which provides a humane alternative to continued costly and often painful medical interventions. A hospice submitting a Medicare claim must obtain certifications from both the patient's attending physician and a medical director at the hospice that the patient is "terminally ill"—meaning that, in the physicians' "clinical judgment," the patient has a life expectancy of six months or less. Because predicting life expectancy is a notoriously inexact science, the federal government has long reassured hospices and physicians that such opinions will not be lightly second-guessed. In the decision below, however, the Third Circuit held that a Medicare claim for hospice care can be "false" under the False Claims Act based on nothing more than an expert's after-the-fact opinion that a given patient was *not* terminally ill—even when the certifying physician's prognosis had a reasonable basis and was honestly held. In so holding, the Third Circuit expressly rejected the contrary view of the Eleventh Circuit, creating a sharp and acknowledged circuit split while exacerbating continuing confusion in the lower courts regarding when a physician's clinical judgment can be deemed false under the False Claims Act.

The question presented is:

Whether a physician's honestly held clinical judgment regarding hospice certification can be "false" under the False Claims Act based solely on a reasonable difference of opinion among physicians.

CORPORATE DISCLOSURE STATEMENT

Petitioner Care Alternatives, d/b/a Ascend Hospice, is wholly owned by Care Alternatives Hospice Services, LLC. No public company owns 10% or more of Care Alternatives.

STATEMENT OF RELATED CASES

Petitioner is not aware of any proceedings in state or federal trial or appellate courts, including proceedings in this Court, that are directly related to this case.

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PETITION FOR WRIT OF CERTIORARI

Hospice care provides a humane alternative to always costly and often painful medical intervention for millions of Americans facing terminal illnesses each year. The Medicare hospice benefit covers palliative care, which is designed to reduce physical pain, increase emotional comfort, and ensure quality and dignity of life in a person's final days. Because predicting life expectancy is notoriously difficult, Congress has deferred hospice eligibility decisions to the subjective, clinical judgment of qualified physicians. A patient is eligible for Medicare coverage for hospice care when both an attending physician and a hospice medical director independently certify, "based on [their] clinical judgment," that the individual is "terminally ill," meaning "the individual's life expectancy is 6 months or less." 42 U.S.C. §1395f(a)(7)(A)(i); *id.* §1395x(dd)(3)(A). CMS recognizes that prognostication about life expectancy is not an "exact science" and has therefore reassured physicians and hospices that they "need not be concerned" about incurring liability based on their good-faith opinions. DHHS & CMS, *Hospice Care Enhances Dignity And Peace As Life Nears Its End*, CMSPub. 60AB, Transmittal AB-03-040, at 2 (Mar. 28, 2003), https://bit.ly/2DB9JtY ("2003 CMS Hospice Bulletin"). Indeed, CMS has gone so far as to reassure the regulated community that "[t]here is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill." *Id.*

The Third Circuit's decision in this case renders those explicit promises illusory, while creating a square split with the Eleventh Circuit on an issue of

critical importance to the millions of Americans who require hospice care annually and the thousands of hospices and physicians who provide that care. The Third Circuit here concluded that all that is needed to allow a jury to second-guess a physician's clinical judgment and render it "false" for FCA purposes is to find a different medical expert with a different opinion about a patient's life expectancy based on an after-the-fact review of the medical records. In the Third Circuit's view, "a physician's expert testimony challenging a hospice certification creates a triable issue of fact for the jury regarding falsity." App.22. In so holding, the Third Circuit expressly "depart[ed] from" and "disagree[d]" with a contrary decision by the Eleventh Circuit addressing nearly identical facts. App.18, 20-21; *see United States v. AseraCare, Inc.*, 938 F.3d 1278 (11th Cir. 2019). There, the Eleventh Circuit correctly held that "a clinical judgment of terminal illness warranting hospice benefits under Medicare cannot be deemed false, for purposes of the False Claims Act, when there is only a reasonable disagreement between medical experts as to the accuracy of that conclusion." *AseraCare*, 938 F.3d at 1281.

Certiorari is necessary to resolve this square circuit split. The Third Circuit's decision opens up hospices and physicians to crushing financial liability and reputational harm, notwithstanding near-universal acknowledgment that determinations about life expectancy are notoriously difficult and inexact. It equates a difference of opinion into prima facie evidence that one of the opinions is false. And it creates the untenable prospect that hospices in New Jersey will face treble damages for the same difficult

medical judgments that cannot be second-guessed in Florida. Moreover, granting certiorari here will not only resolve this stark and acknowledged circuit conflict, but provide the lower courts with much-needed guidance on when an opinion, as opposed to a statement of fact, can be "false" for FCA purposes.

OPINIONS BELOW

The opinion of the Third Circuit is reported at 952 F.3d 89 and reproduced at App.1-23. The opinion of the district court is reported at 346 F.Supp.3d 669 and reproduced at App.26-65.

JURISDICTION

The Third Circuit issued its opinion on March 4, 2020, and denied a timely petition for rehearing on May 6, 2020. On March 19, 2020, this Court extended the deadline to file any petition for a writ of certiorari due on or after that date to 150 days. This Court has jurisdiction under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS INVOLVED

Pertinent provisions of the False Claims Act, 31 U.S.C. §§3729-3733, are reproduced at App.66. Pertinent provisions of 42 U.S.C. §1395f are reproduced at App.66-67. Pertinent provisions of 42 C.F.R. §418.22 are reproduced at App.67-69.

STATEMENT OF THE CASE

A. The Medicare Hospice Benefit

In 1982, Congress created the Medicare Hospice Benefit, an amendment to the Social Security Act that authorized Medicare beneficiaries to receive coverage for hospice care. *See* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §122,

96 Stat. 324, 356-63. "Hospice care" is defined as "a comprehensive set of services ... identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members." 42 C.F.R. §418.3. According to CMS, "[t]he goal of hospice care is to help terminally ill individuals continue life with minimal disruption in normal activities while remaining primarily in the home environment," and to make those individuals "as physically and emotionally comfortable as possible." 48 Fed. Reg. 56,008, 56,008 (Dec. 16, 1983).

An individual's decision to elect hospice care automatically waives eligibility to receive Medicare coverage for most curative care. 42 U.S.C. §1395d(d)(2)(A)(ii). From that point forward, the "focus" of the individual's treatment "change[s] ... from curative care to palliative care." 85 Fed. Reg. 20,949, 20,950 (Apr. 5, 2020); *see* 42 C.F.R. §418.3.

Congress and CMS have made physicians the gatekeepers of Medicare eligibility for hospice care. Coverage is limited to the terminally ill, and physicians have been assigned the difficult task of prognosticating life expectancy. The Social Security Act provides that, "at the beginning" of the first 90-day period in which an individual is to receive hospice care, that individual's "attending physician" and the hospice's "medical director" must "each certify in writing ... that the individual is terminally ill ... based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." 42 U.S.C. §1395f(a)(7)(A)(i); 42 C.F.R. §418.22(c)(1). The Act further provides that

"[a]n individual is considered to be 'terminally ill' if the individual has a medical prognosis that the individual's life expectancy is 6 months or less." 42 U.S.C. §1395x(dd)(3)(A); 42 C.F.R. §418.3. A CMS regulation also provides that "[c]linical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the [patient's] medical record with the written certification." 42 C.F.R. §418.22(b)(2); *see also id.* §418.22(b)(3) (requiring certification to include a "brief narrative explanation of the clinical findings that support[] a life expectancy of 6 months or less").

Congress recognized that prognoses of life expectancy are inherently inexact, so it neither eliminated the hospice benefit if a patient outlives her prognosis nor set a limit on how long a Medicare beneficiary may receive hospice care. Individuals remain eligible so long as one of their original certifying physicians "recertifies at the beginning" of each "subsequent 90- or 60-day period ... that the individual is terminally ill based on [the physician's] clinical judgment." 42 U.S.C. §1395f(a)(7)(A)(ii); 42 C.F.R. §418.21; *id.* §418.22(c)(2). Individuals who "originally qualify for" the hospice benefit "but stabilize or improve while receiving hospice care … remain eligible" for the benefit provided there is "a reasonable expectation of continued decline for a life expectancy of less than 6 months." 75 Fed. Reg. 70,372, 70,448 (Nov. 17, 2010).

Further underscoring the difficulty of terminal-illness prognoses, CMS has expressly declined to specify any "clinical benchmarks ... that must be met in order to certify terminal illness." 73 Fed. Reg.

32,088, 32,138 (June 5, 2008). Instead, CMS has expressly "recognized the challenges in prognostication," and that "making a prognosis is not an exact science." 79 Fed. Reg. 50,452, 50,470 (Aug. 22, 2014). CMS therefore "expect[s] that hospices will use their expert clinical judgment in determining eligibility for hospice services," which means certifying physicians must "evaluate the full clinical picture" and "uniqueness of every Medicare beneficiary," and "use the full range of tools available ... to make responsible and thoughtful determinations regarding terminally ill eligibility." *Id.* at 50,471.

CMS well understood that hospices and physicians are in a difficult position when it comes to Medicare: in order for a patient to receive coverage, the physicians must certify that they believe their patients do not have long to live—a sensitive matter of grave uncertainty that is easily subject to second-guessing, especially with the benefit of hindsight. To ensure that the difficulties inherent in making this judgment do not deter physicians from authorizing end-of-life care in lieu of painful and costly medical intervention, CMS went out of its way to stress that "[t]he Medicare program recognizes that terminal illnesses do not have entirely predictable courses" and that "prognoses can be uncertain and may change," and therefore "*physicians need not be concerned*" about incurring liability based on their good-faith clinical judgments. 2003 CMS Hospice Bulletin at 2 (emphasis added). To the contrary, CMS emphasized, "*[t]here is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill*." *Id.* (emphasis added). In fact, CMS has expressly "urged" physicians "to recommend

hospice care to [Medicare] beneficiaries whom they determine may benefit from it." *Id.* at 1.

B. The False Claims Act

The FCA "imposes significant penalties on those who defraud the Government." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S.Ct. 1989, 1995 (2016). The FCA makes liable "any person who ... knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" to the government, or who "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. §§3729(a)(1)(A)-(B).

The government may bring FCA actions directly. *Id.* §3730(a). Or, as here, "a private person, known as a relator, may bring a *qui tam* civil action" in the government's name. *Cochise Consultancy, Inc. v. United States ex rel. Hunt*, 139 S.Ct. 1507, 1510 (2019). In such cases, the government may "intervene in the action" after investigating the relator's allegations. *Id.* If, as here, the government declines to intervene, the relator may still "pursue the action." *Id.* The relator is entitled to "a share," generally between 15 and 30 percent, "of any proceeds from the action." *Id.*

Liability under the FCA is "essentially punitive in nature." *Vt. Agency of Nat. Res. v. United States ex rel. Stevens*, 529 U.S. 765, 784 (2000). Defendants are subject to treble damages plus civil penalties of over $23,000 per false claim. *See* 31 U.S.C. §3729(a); 85 Fed. Reg. 37,004, 37,006 (June 19, 2020).

C. Facts and Procedural History

Petitioner provides hospice care to terminally ill patients throughout New Jersey. App.3. Petitioner employs interdisciplinary teams, which include "registered nurses, chaplains, social workers, home health aides, and therapists working alongside independent physicians who serve as hospice medical directors." App.3. These teams evaluate patient care plans and discuss patients who are evaluated for certification or recertification. App.3.

Respondents are four of petitioner's former employees; none is a physician. *See* App.33-34. This case began in 2008 when respondents filed a *qui tam* action alleging that petitioner submitted false reimbursement claims between 2006 and 2007 for hospice care provided to patients who "were not actually eligible for hospice care coverage under Medicare." App.29, 37. In 2015, after investigating these allegations for *over seven years*, the government declined to intervene. App.38.

Respondents' case then floundered. The district court dismissed various claims alleging kickbacks, document alteration, and other violations of state and federal law, all of which respondents abandoned. App.38-39. At summary judgment, the only claim left was an FCA claim alleging "inappropriate patient admission and recertifications for hospice care." App.38. On the critical element of "falsity," however, respondents' evidence was threadbare. Respondents did not "accuse[] a single physician of certifying any patient whom that physician believed was not hospice eligible." App.62. "Nor [was] there evidence of

alteration or falsification of any identified patient's record." App.63.

Instead, "[t]he only ... evidence of falsity" was an "expert report" filed by respondents' paid expert, Dr. Jayes. App.64. Dr. Jayes reviewed medical records concerning 47 patients who were certified (and in most cases re-certified) as eligible for hospice care based on the clinical judgments of both their attending physicians and hospice medical directors. App.48. Dr. Jayes filed his report in August 2017, more than ten years after the actual certifications. App.48. After reviewing the cold medical files for those 47 patients, Dr. Jayes concluded that 26 of them were fully eligible for hospice care at all times, and that 16 others were eligible at some juncture (either certification or re-certification). App.49. But Dr. Jayes concluded that 35% of all terminal-illness certifications and re-certifications that he reviewed were not adequately supported by the underlying medical records. App.49. At the same time, Dr. Jayes "testified that reasonable physicians could differ with his assessment." App.64-65.

The district court held that "Dr. Jayes' expert report is plainly insufficient to establish a genuine dispute of material fact as to falsity," and thus granted petitioner summary judgment. App.65. In so holding, the district court "adopt[ed] the reasoning" of two district courts in other jurisdictions, App.61, both of which had held on substantially identical facts that "a 'mere difference of opinion between physicians, *without more*, is not enough to show falsity'" in an FCA case involving hospice claims. App.58 (quoting *United States v. AseraCare Inc.*, 176 F.Supp.3d 1282, 1283

(N.D. Ala. 2016)); *see United States v. Vista Hospice Care, Inc.*, 2016 WL 3449833, at *17 (N.D. Tex. June 20, 2016) (same). The district court also drew support from decisions by courts of appeals holding that "falsity" under the FCA requires proof of "objective falsity," meaning that when it comes to opinions, an opinion cannot be deemed "false" if it has a reasonable basis and is honestly held. App.56-57 (citing, *inter alia*, *United States ex rel. Riley v. St. Luke's Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004)).

Respondents appealed. Before the Third Circuit, the United States submitted an *amicus* brief supporting them and arguing that "expert testimony may be sufficient to establish the falsity of claims premised on medical judgments." Br. of United States 1, *United States ex rel. Druding v. Care Alternatives, Inc.*, No. 18-3298 (3d Cir. Feb. 28, 2019). The government's arguments to the Third Circuit mirrored arguments it had presented unsuccessfully to the Eleventh Circuit in *AseraCare*. *See* Br. for Appellant 18, *United States v. AseraCare*, No. 16-13004 (11th Cir. Aug. 31, 2016) (contending that "whether a patient's medical records support a prognosis of terminal illness is a question of fact which a jury can … determine based on an examination of each patient's medical records and expert medical testimony about the conclusions to be drawn from those records").

The Third Circuit reversed, holding that "a physician's expert testimony challenging a hospice certification creates a triable issue of fact for the jury regarding falsity" under the FCA, and concluding that "Dr. Jayes's expert report has done just that." App.22.

In construing "the meaning of 'false' under the [FCA]," App.10, the court acknowledged that a physician's clinical judgment is a statement of opinion, App.10-11, 20-21, but it held that because "medical opinions can be false," it "therefore" followed that "a difference of medical opinion is enough evidence to create a triable dispute of fact regarding FCA falsity"—even if the certifying physician's initial judgment was honestly held and reasonable. App.20-21; *see also* App.11-13. The Third Circuit pointed to CMS' requirement that a terminal-illness certification be accompanied by documentation that "support[s] the medical prognosis," 42 C.F.R. §418.22(b)(2), and it held that a hospice could fail that requirement—rendering an associated claim unsupported and "false" under the FCA—if a jury found the certifying physician's prognosis to be less persuasive than a plaintiff's expert's after-the-fact reexamination of the same medical records, again regardless of whether the certifying physician's clinical judgment was reasonable and honestly held. App.15-16, 20, 22.

The Third Circuit acknowledged that the Eleventh Circuit had reached exactly the opposite holding on "nearly identical" facts. *See* App.17-22 & 17 n.3. But the Third Circuit explained at length that it "disagree[d]" with *AseraCare* and was therefore "departing from [its] sister circuit" and "reaching the opposite determination." App.21, 18. The Third Circuit also pointed to other court of appeals decisions that it construed as supporting its conclusion that a difference of opinion among experts is sufficient to create a triable issue of falsity when it comes to medical opinions. App.15-17 (citing, *inter alia*, *United*

States ex rel. Polukoff v. St. Mark's Hosp., 895 F.3d 730, 743, 745-46 (10th Cir. 2018)).

Petitioner sought rehearing *en banc*, which the Third Circuit denied. App.24-25.

REASONS FOR GRANTING THE PETITION

The Third Circuit's decision here creates an acknowledged circuit split over whether a Medicare claim for reimbursement for hospice care can be "false" under the FCA based on nothing more than a reasonable disagreement among physicians as to whether a patient was terminally ill when certified. The Third and Eleventh Circuits have now confronted the same question on materially identical facts: whether "'[a] reasonable difference of opinion among physicians reviewing medical documentation *ex post* is ... sufficient on its own to suggest that those judgments ... are false under the FCA.'" App.20-21 (quoting *AseraCare*, 938 F.3d at 1297). The Eleventh Circuit said no, and the Third Circuit said yes, allowing a physician's difficult decision about the inexact science of life expectancy to be second-guessed by a jury based on nothing more than a differing opinion of a competing expert. The Third Circuit reached that conclusion even though it had the benefit of the Eleventh Circuit's earlier decision in *AseraCare.* The Third Circuit acknowledged the Eleventh Circuit decision and reasoning and simply disagreed. The circuit split is not just stark but outcome-determinative: if petitioner were a hospice in Florida rather than New Jersey, this case would be over. Instead, petitioner continues to face treble damages and reputational harm based on a paid expert's *post*

hoc second-guessing of good-faith medical judgments regarding end-of-life prognoses.

The Third Circuit's decision not only creates a square circuit split, but is squarely wrong in multiple respects. A mere difference of opinion is not enough to render a good-faith and reasonable opinion "false" for FCA purposes. Two physicians may have radically different opinions about the proper course of treatment or the patient's life expectancy without either opinion being false. That is particularly true of a matter as fraught with uncertainty and in need of expert judgment as life expectancy. Under the common law and this Court's precedents, it follows that a terminal-illness certification can be "false" only if the certifying physician(s) did not honestly believe it, if it was so devoid of support that no reasonable physician could have adopted it, or it depended on an embedded fact that the physician knew to be false. An opposing expert's mere disagreement with the certifying physician's reasonable judgment based on a *post hoc* review of the cold file does not establish any of those grounds. The Third Circuit's contrary view not only misreads this Court's decisions but undermines the governing statutory and regulatory framework, which asks for an informed clinical opinion, rather than a certification of objective facts, precisely because reasonable experts can disagree about life expectancy. Under those circumstances, finding an expert with a different opinion is easy and cannot be enough to render another opinion false. In fact, CMS promised physicians that they could make these difficult judgments with "no risk" of liability years later based on Monday morning quarterbacking

by opposing experts and lay juries. The Third Circuit has rendered that critical promise illusory.

The question presented is exceptionally important and warrants review in this case. Every year, millions of families make the difficult decision to forgo costly and sometimes painful medical intervention in favor of hospice care. The vast majority of those decisions are backed by assessments by both attending physicians and hospice medical directors of life expectancy that open the door for Medicare coverage and makes hospice care a realistic possibility. CMS itself acknowledges that those assessments are an inexact science and that physicians and hospices should not be chilled by the prospect of *post hoc* second-guessing and liability. Yet by exposing hospices to FCA treble damages and reputational harm based on retrospective disagreements over physicians' good-faith clinical judgments, the Third Circuit's decision creates just that prospect, all while erecting barriers to affordable hospice care for individuals whose physicians will be deterred from providing certifications given the risk of liability in the inevitable event that some patients outlive their prognoses. The stakes are high. The stark split in this context affects millions of individuals and alone warrants the Court's intervention, but certiorari also would allow the Court to provide much-needed guidance to the courts of appeals regarding the circumstances under which opinions, such as a physician's clinical judgment about treatment, can be "false" under the FCA. The decision below creates a dangerous precedent for converting differences of opinions into treble damages claims under the FCA. This Court should grant certiorari.

I. The Decision Below Creates A Circuit Split Regarding FCA Liability For Medicare Hospice Claims, While Exacerbating Broader Disarray Regarding When Opinions Can Be "False" Under The FCA.

A. The decision below creates a square and acknowledged circuit split with the Eleventh Circuit's *AseraCare* decision over whether physicians' good-faith clinical judgments supporting hospice care certifications can be "false" under the FCA. This indisputable circuit split alone justifies certiorari.

This case and *AseraCare* are on all fours. Like petitioner, AseraCare is a hospice that "bill[s] Medicare for end-of-life care provided to elderly patients." *AseraCare*, 938 F.3d at 1281. Like petitioner, AseraCare was accused of violating the FCA because it "certified patients as eligible for Medicare's hospice benefit, and billed Medicare accordingly, on the basis of erroneous clinical judgments that those patients were terminally ill." *Id.* As to "falsity" under the FCA, the case against AseraCare—like the case against petitioner—boiled down to "the opinion of [plaintiffs'] expert witness," who opined based on a review of cold records "that the patients at issue were not, in fact, terminally ill at the time of certification." *Id.* Like respondents' expert in this case, the opposing expert in *AseraCare* "never testified that ... no reasonable doctor could have concluded that the identified patients were terminally ill at the time of certification. Instead, he only testified that, in his opinion, the patients were not terminally ill." *Id.* at 1287. And the evidence before the Eleventh Circuit—like the evidence here—never

suggested that "AseraCare's physicians had lied about their clinical judgment." *Id.* at 1300.

Unlike the Third Circuit here, however, the Eleventh Circuit held that "a clinical judgment of terminal illness warranting hospice benefits under Medicare cannot be deemed false, for purposes of the False Claims Act, when there is only a reasonable disagreement between medical experts as to the accuracy of that conclusion, with no other evidence to prove the falsity of the assessment." *Id.* at 1281. In reaching that determination, the Eleventh Circuit recognized that a physician's terminal-illness prognosis is a statement of opinion, not of fact. *Id.* at 1296-97. As such, the Eleventh Circuit held that "[a] properly formed and sincerely held clinical judgment is not untrue even if a different physician later contends that the judgment is wrong." *Id.* at 1297. Moreover, the Eleventh Circuit explained that "physicians applying their clinical judgment about a patient's projected life expectancy could disagree, and *neither* physician … be wrong." *Id.* at 1296 (emphasis added). The Eleventh Circuit thus held that "a reasonable difference of opinion among physicians reviewing medical documentation *ex post* is not sufficient on its own to suggest that those judgments—or any claims based on them—are false under the FCA." *Id.* at 1297.

The Eleventh Circuit likewise concluded that the regulatory requirement under 42 C.F.R. §418.22(b)(2), that a terminal-illness certification include "documentation that support[s]" it, does not change the fundamental nature of the certification as a clinical opinion about life expectancy. As the Eleventh

Circuit explained, "[t]he language of the statute and implementing regulations makes plain that the clinical judgment of the patient's attending physician (or the provider's medical director, as the case may be) lies at the center of the eligibility inquiry," and the regulatory framework does not "state or imply that the patient's medical records must unequivocally demonstrate to an unaffiliated physician, reviewing the records after the fact, that the patient was likely to die within six months of the time the certifying physician's clinical judgment was made." *Id.* at 1293-94. To the contrary, "[a]ll the legal framework asks is that physicians exercise their best judgment in light of the facts at hand and that they document their rationale." *Id.* at 1296. Hence, the Eleventh Circuit concluded that it "would read more into the legal framework than its language allows" to hold "that the supporting documentation must, standing alone, prove the validity of the physician's initial clinical judgment" to the satisfaction of a lay jury on after-the-fact review. *Id.* at 1294.

In its decision below, the Third Circuit expressly parted company with the Eleventh Circuit. The Third Circuit repeatedly indicated that it was "disagree[ing]" with *AseraCare*, "departing from [its] sister circuit," and "reaching the opposite determination." App.18, 21. In direct contradiction of the Eleventh Circuit's interpretation of "false" under the FCA, the Third Circuit held that a "difference of medical opinion is enough evidence to create a triable dispute of fact regarding FCA falsity"—regardless of whether the certifying physician's clinical judgment was honestly held and had a reasonable basis. App.20-21; *see also* App.11-13. And the Third Circuit

explicitly rejected the Eleventh Circuit's treatment of 42 C.F.R. §418.22(b)(2) and its "supporting documentation" requirement, holding instead that contemporaneous documentation supporting the certifying physician's prognosis does not suffice to prevent a plaintiff's expert's contrary, after-the-fact conclusion from creating a triable issue for the jury. App.20; *see also* App.15. The Eleventh Circuit rejected that view as not "consistent with the text or design of the law," for "the law is designed to give physicians meaningful latitude to make informed judgments without fear that those judgments will be second-guessed after the fact by laymen in a liability proceeding." *AseraCare*, 938 F.3d at 1294-95.[1]

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[1] This stark conflict cannot be minimized by pointing to the statement in the background section of the Third Circuit opinion describing Dr. Jayes as testifying that "any reasonable physician would have reached the conclusion he reached." App.7. To the extent that remark suggests Dr. Jayes testified that no reasonable physician could have disagreed with him, it simply misstates the record; as the district court found, Dr. Jayes "testified that reasonable physicians could differ with his assessment." App.64-65. Regardless, that (mis)interpretation of the record played no role in the Third Circuit's analysis, and the court never suggested that its holding turned on its characterization of Dr. Jayes's testimony. Rather, the Third Circuit unambiguously held that a physician's terminal-illness prognosis can be deemed "false" any time a different physician disagrees with it, even if both views are reasonable. App.11-13, 20-21. The Third Circuit even quoted the Eleventh Circuit's holding that "'[a] reasonable difference of opinion among physicians reviewing medical documentation *ex post* is not sufficient on its own to suggest that those judgments ... are false under the FCA,'" and immediately said that it "disagree[d]" and was "reaching the opposite determination." App.20-21 (quoting *AseraCare*, 938 F.3d at 1297).

The circuit split is thus stark and outcome-determinative. If petitioner had been sued in the Eleventh Circuit, this case would be over.[2] And had AseraCare been sued in the Third Circuit, it would—like petitioner—continue to face treble damages and substantial reputational harm, with its fate dependent on whether it could convince a lay jury that its physicians' honest and reasonable terminal-illness prognoses were more compelling than a paid expert's Monday morning quarterbacking many years later. That stark and acknowledged conflict fully merits this Court's review.

B. The Third Circuit's decision also exacerbates the broader disarray among the courts of appeals regarding when an opinion, including physicians' clinical judgments, can be "false" under the FCA. For example, in splitting with the Eleventh Circuit over

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[2] This case would also be over in the many district courts that have found a mere disagreement among physicians over life expectancy insufficient to get an FCA claim against a hospice-care provider to the jury. *See Vista Hospice Care*, 2016 WL 3449833, at *17 ("Because a physician must use his or her clinical judgment to determine hospice eligibility, an FCA claim about the exercise of that judgment must be predicated on the presence of an objectively verifiable fact at odds with the exercise of that judgment, not a matter of questioning subjective clinical analysis."); *United States ex rel. Geschrey v. Generations Healthcare, LLC*, 922 F.Supp.2d 695, 703 (N.D. Ill. 2012) (dismissing FCA claims because "[r]elators have not alleged facts demonstrating that the certifying physician did not or could not have believed, based on his or her clinical judgment, that the patient was eligible for hospice care"); *United States ex rel. Fowler v. Evercare Hospice, Inc.*, 2015 WL 5568614, at *9 (D. Colo. Sept. 21, 2015) (noting that, if complaint had been "based entirely on disagreements with [the provider's] certifying physicians," the complaint "would be insufficient to state a claim").

FCA "falsity" in the context of hospice claims, the Third Circuit invoked the Tenth Circuit's decision in *Polukoff*, 895 F.3d at 743, 745-46. App.15-16. In *Polukoff*, the Tenth Circuit considered when "a doctor's certification ... that a procedure is 'reasonable and necessary'" can qualify as "false" under the FCA. 895 F.3d at 743. The "reasonable and necessary" certification at issue in *Polukoff*, which is a common requirement for Medicare reimbursement, *see* 42 U.S.C. §1395y(a)(1), involves a statement of opinion about a physician's clinical judgment—namely, that the procedure in question "'meets, but does not exceed, the patient's medical need,'" and is "'[a]t least as beneficial as an existing and available medically appropriate alternative.'" *Polukoff*, 895 F.3d at 743 (quoting CMS, *Medicare Program Integrity Manual* §13.5.1). Just as physicians can reasonably disagree about life expectancy, they can reasonably disagree about the proper course of treatment. Like the Third Circuit below, the Tenth Circuit held that disagreements about this sort of clinical judgment are sufficient to create a triable issue of falsity. In the Tenth Circuit's view, a clinical opinion about necessity "is 'false' under the FCA if the procedure was *not* reasonable and necessary under the government's definition of the phrase." *Id.* (emphasis added). While the Third Circuit viewed *Polukoff* as on-point and supporting its holding, *see* App.15-16, the Eleventh Circuit found *Polukoff* distinguishable. *See AseraCare*, 938 F.3d at 1300 n.15.

By contrast, the Fifth Circuit has held—contrary to *Polukoff* and the decision below—that when a physician offers a "scientific judgment" that a given procedure is "medically necessary," the physician's

opinion can be deemed "false" under the FCA only if it is "a lie ... *but not*" if it is "an error." *Riley*, 355 F.3d at 376 (emphasis added). The district court in this case cited *Riley* with approval, *see* App.57, and the Third Circuit criticized that reliance as improper, *see* App.8-9, underscoring that the Fifth Circuit's holding as to when clinical judgments can be "false" is incompatible with the Third Circuit's.

The Sixth Circuit has adopted a position similar to the Fifth Circuit's in *Riley*, holding that "opinions—when given honestly—are almost never false," and citing with approval the *AseraCare* district court decision for the proposition that "good-faith medical diagnoses by a doctor cannot be false." *United States v. Paulus*, 894 F.3d 267, 275 (6th Cir. 2018) (citing *AseraCare*, 176 F.Supp.3d at 1282). The Ninth Circuit recently acknowledged this confusion among the circuits about when opinions, including medical opinions reflecting clinical judgments, can be deemed false for FCA purposes. *See Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1118-19 (9th Cir. 2020) (discussing tension between *AseraCare*, *Polukoff*, *Riley*, and Third Circuit's decision in this case).

In short, the decision below underscores that while the lower courts have little difficulty understanding when statements of facts are "false" for FCA purposes, the courts of appeals are in open disarray over when opinions, such as a physician's clinical judgment about life expectancy or the necessity of treatment, can be deemed "false" under the FCA. By granting certiorari here and resolving that question in the specific context of terminal-illness

certifications for hospice care—where the Third and Eleventh Circuits are indisputably split—this Court would provide much-needed guidance to the lower courts on that important broader question.

II. The Decision Below Is Wrong.

The Third Circuit's analysis is wrong at every turn. The FCA does not recognize any theory of liability that would permit a physician's honest and reasonable prognosis to be deemed "false or fraudulent" based on nothing more than a plaintiff's expert's after-the-fact disagreement with that prognosis. An opinion that requires a degree of expert clinical judgment is not false just because another expert has a different opinion. Reasonable physicians can and do disagree in their opinions about proper treatment and life expectancy. Finding an expert with a different opinion is neither difficult nor sufficient to show that a contrary opinion is false. Moreover, a predictive opinion about the course of future events that turns out to be wrong is not thereby false. *See Omnicare, Inc. v. Laborers Dist. Council Constr. Indus. Pension Fund*, 575 U.S. 175, 185-86 (2015). Nor do CMS' regulations render a hospice claim ineligible for payment—and thus "false" under the FCA—merely because a different physician later takes a different view of the supporting documentation and disagrees with a certifying physician's reasonable terminal-illness prognosis based on a contemporary analysis of a variety of factors going well beyond the supporting documentation or any paper record. To the contrary, CMS' regulatory guidance underscores that determining life expectancy and when a disease is

terminal is an inexact science that cannot be lightly second-guessed without chilling physicians making sensitive judgments about when palliative care is the best option.

A. The FCA does "not define what makes a claim 'false' or 'fraudulent,'" but this Court has held that the statute "incorporates the common-law meaning of fraud." *Escobar*, 136 S.Ct. at 1999. As such, there are two ways that a claim can be false or fraudulent: first, if the claim "contain[s] express falsehoods," meaning untrue statements of fact; or second, if the claim contains "misleading omissions." *Id.* Identifying express falsehoods and misleading omissions is relatively straightforward when it comes to certifications of fact. If a claim requires certification that goods were made in America or that a gauge reads higher than 80, courts can readily find a claim "false" when the goods were made elsewhere or the gauge reading was actually in the seventies (or where the goods were made in South America or the gauge read over 80 only because it was broken and stuck on 82). Courts have had greater difficulty when the certification requires a certification of opinion, such as life expectancy. But even in that context, it should be clear that an opinion does not become false merely because someone else holds a different opinion or a predictive opinion turns out to be wrong after the fact. Instead, in a context like this, where coverage depends on the opinion of certifying physicians about a patient's life expectancy, simply finding an expert with a different opinion is not enough to render a good-faith and reasonable opinion "false" for FCA purposes.

A physician's terminal-illness certification is, at bottom, an *opinion* about life expectancy. Congress recognized as much when it specified that terminal-illness certifications must be "based on the physician's or medical director's *clinical judgment* regarding the normal course of [a patient's] illness." 42 U.S.C. §1395f(a)(7)(A)(i)-(ii) (emphasis added). CMS has likewise repeatedly emphasized that predicting life expectancy "is not an exact science," 79 Fed. Reg. at 50,470, and that "certifying physicians" must therefore rely on their "clinical experience, competence and judgment to make the determination that an individual is terminally ill," 78 Fed. Reg. 48,234, 48,247 (Aug. 7, 2013), all without the benefit of any "specific ... clinical benchmarks," 73 Fed. Reg. at 32,138. A terminal-illness certification is therefore a textbook statement of opinion. *See, e.g.*, Restatement (Second) of Torts §538A (Am. Law. Inst. 1977) (defining statement of opinion as a statement of "the belief of the maker, without certainty, as to the existence of a fact," or of "his judgment as to quality, value, authenticity, or other matters of judgment"); *Omnicare*, 575 U.S. at 183 (explaining that "a statement of fact ... expresses certainty about a thing, whereas a statement of opinion ... does not"); *id.* at 186 (noting that "inherently subjective and uncertain assessments" are statements of opinion).

It follows that a reasonable disagreement among experts cannot alone render a physician's good-faith prognosis "false or fraudulent" under *either* an "express falsehoods" theory *or* an "omissions" theory. *Escobar*, 136 S.Ct. at 1999. As to the former, an opinion statement can qualify as an express falsehood only if the speaker does not "actually hold[] the stated

belief," or if the opinion "contain[s] embedded statements of fact" that are untrue. *Omnicare*, 575 U.S. at 184-85. Plainly, a third-party's mere disagreement with an opinion does not establish either of those grounds. As this Court has explained, "a sincere statement of pure opinion is not an 'untrue statement of material fact,' regardless whether [a plaintiff] can ultimately prove the belief wrong." *Id.* at 186. In other words, the prohibition against express falsehoods "does not allow [plaintiffs] to second-guess inherently subjective and uncertain assessments" or "to Monday morning quarterback [a speaker's] opinions." *Id.* Yet that is exactly what the Third Circuit's decision permits.

Nor can a reasonable disagreement among physicians, without more, render a terminal-illness certification false or fraudulent under an "omissions" theory. As Justice Scalia explained in his concurring opinion in *Omnicare*, the common law allowed omissions-based liability for honestly held opinion statements only in two circumstances: first, if the "speaker's judgment ... 'var[ies] so far from the truth that no reasonable man in his position could have such an opinion,'" and second, if the speaker is an expert and he "subjectively believes he lacks a reasonable basis" for his opinion or is "actually aware ... that the listener will understand [his] expression of opinion to have a specific basis that it does not have." *Id.* at 198, 201-02 (Scalia, J., concurring in part and concurring in the judgment); *cf. AseraCare*, 938 F.3d at 1297 (listing similar ways to prove a terminal-illness prognosis "false" under the FCA). Again, however, one expert's mere disagreement with another expert's reasonable opinion is not evidence of *either* scenario.

Hence, under the common law meaning of fraud—which the FCA incorporates, *Escobar*, 136 S. Ct. at 1999 & n.2—it takes more than a differing opinion from another expert to create a triable issue about whether a physician's opinion is false under either an express falsehood or fraudulent omission theory of falsity.[3]

It could hardly be otherwise. The very fact that the government requires a certification of opinion rather than a statement of fact implicitly recognizes that the government has not identified an objective criterion for eligibility and some judgment is required. Where the government wants to pay only for goods manufactured in the United States or for a particular procedure only after a less costly procedure has been exhausted, it can specify as much. But where the government asks instead for a predictive opinion about something as inherently difficult to predict as life expectancy, that is an indication that there is room for reasonable differences of opinion. In that context, merely finding an expert with a different reasonable opinion does not even begin to show that another reasonable opinion is "false." It just underscores that the matter is open for reasonable debate. Likewise, when it comes to predictive opinions, an opinion that

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[3] While the FCA plainly adopts the common-law standard, and *Omnicare* adopted a slightly less demanding test for omission falsity, the Third Circuit's conclusion conflicts with *Omnicare*. Under *Omnicare*, a plaintiff attacking an opinion statement on an omissions theory "cannot state a claim by alleging only that an opinion was wrong; the [plaintiff] must as well call into question the [speaker's] basis for offering the opinion." 575 U.S. at 194. Merely finding a different expert with a different opinion about the same medical files does not satisfy that standard.

turns out to be wrong in hindsight (for example, when a patient lives for a year) does not thereby become "false," even if it makes a different opinion appear more reasonable in hindsight. Thus, the ease with which one can identify an expert with a different opinion only underscores why the government asked for an opinion in the first place. It does not begin to show that the opinion actually offered in real-time based on all the available information about the patient was false. And leaving the determination of "falsity" to a battle of experts is an invitation for hindsight bias and penalizing predictive judgments that turn out to be wrong without ever having been "false."

B. The Third Circuit's misreading of CMS' regulations compounded its misinterpretation of the FCA and contributed to its erroneous conclusion that an after-the-fact disagreement with a certifying physician's honest and reasonable prognosis suffices to render an opinion about life expectancy false under the FCA. Congress made clear that a patient's eligibility to receive Medicare coverage for hospice care—and a hospice's eligibility to receive "payment" for providing such care—depends, above all, on the "clinical judgment" of a physician (or physician*s* in the case of the initial certification decision) about the patient's life expectancy. 42 U.S.C. §1395f(a)(7)(A)(i)-(ii). Nothing in CMS' regulations changes that touchstone. To the contrary, CMS echoed that "[c]ertification will be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." 42 C.F.R. §418.22(b). As the Eleventh Circuit rightly put it, "[t]he language of the statute and implementing

regulations makes plain that the clinical judgment of the patient's attending physician (or the provider's medical director, as the case may be) lies at the center of the eligibility inquiry." *AseraCare*, 938 F.3d at 1293. So long as that clinical judgment has a reasonable basis and is honestly held, it cannot be deemed "false or fraudulent" for FCA purposes merely because it turns out to be unduly pessimistic or is contradicted by the contrary after-the-fact judgment of a different physician.

In rejecting that view, the Third Circuit seized on 42 C.F.R. §418.22(b)(2), a CMS regulation declaring that "[c]linical information and other documentation that *support* the medical prognosis must accompany the certification and must be filed in the medical record with the written certification." 42 C.F.R. §418.22(b)(2) (emphasis added); *see* App.15, 20. But while that provision might be a basis for declining a certification that lacked any supporting documentation, it in no way suggests that a claim for hospice coverage can be deemed inadequate, let alone false, just because a different physician later reviews the supporting documentation actually submitted and comes to a different conclusion about life expectancy. So long as the certifying physician's original prognosis reflected a reasonable interpretation of the patient's medical records—as was the case here—it follows that the patient's medical records *did* "support" that prognosis, which is all §418.22(b)(2) requires. Again, as the Eleventh Circuit correctly held, CMS' regulations do not "state or imply that the patient's medical records must unequivocally demonstrate to an unaffiliated physician, reviewing the records after the fact, that the patient was likely to die within six

months of the time the certifying physician's clinical judgment was made." *AseraCare*, 938 F.3d at 1294. Indeed, "Congress said nothing to indicate that the medical documentation presented with a claim must prove the veracity of the clinical judgment on an after-the-fact review. And CMS's own choice of the word 'support'—instead of, for example, 'demonstrate' or 'prove'—does not imply the level of certitude" the Third Circuit "attribute[d] to it." *Id.*

The Third Circuit's reading of §418.22(b)(2) not only is incompatible with the regulatory and statutory text, but also flies in the face of CMS' longstanding reassurance to physicians and hospices that they "need not be concerned" about incurring liability based on their good-faith clinical judgments—and in fact, that "*[t]here is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill.*" 2003 CMS Hospice Bulletin at 2 (emphasis added). Those assurances reflect CMS' repeated recognition "that terminal illnesses do not have entirely predictable courses," and that "prognoses can be uncertain and may change." *Id.* CMS has specifically "recognized the challenges in prognostication," and acknowledged that "making a prognosis is not an exact science." 79 Fed. Reg. at 50,470. Thus, CMS has said that its "expectation" is simply "that the certifying physicians will use their best clinical judgment ... to make responsible and thoughtful determinations regarding terminally ill eligibility." *Id.* at 50,470-71.

In direct contradiction to CMS' longstanding guidance, physicians and hospice providers within the Third Circuit now face a nearly impossible task: to

certify a patient as terminally ill and protect themselves from the risk of punishing liability, they must make certain that *no other expert* on an after-the-fact review could disagree with their good-faith medical prognosis. No such certitude can be expected of medical providers, particularly in the end-of-life context. Given the inherent limits on the certainty of terminal-illness prognoses, and especially in light of CMS' and Congress' considered views, the Third Circuit plainly misconstrued the legal framework governing Medicare hospice coverage. By contrast, the Eleventh Circuit was entirely correct to hold that "[a]ll the legal framework asks is that physicians exercise their best judgment in light of the facts at hand and that they document their rationale," for "the law is designed to give physicians meaningful latitude to make informed judgments without fear that those judgments will be second-guessed after the fact by laymen in a liability proceeding." *AseraCare*, 938 F.3d at 1295-96.

Finally, there is no plausible policy rationale for the Third Circuit's deviation from text and invitation for second-guessing. The Third Circuit's decision cannot help but chill the provision of hospice care, as CMS itself seemed to recognize in trying to reassure physicians that they would not risk liability for making difficult judgment calls. The decision to opt out of additional medical intervention is difficult enough for families and physicians without creating an artificial reluctance of physicians and hospices to open themselves up to after-the-fact second-guessing fueled by the lure of treble damages. Nor will the decision even protect the public fisc. Unlike most contexts where a low bar for FCA liability promises to

save the federal government money, making hospice-care certifications unduly risky can have the opposite effect. A Medicare beneficiary's decision to elect hospice care automatically waives his or her eligibility to receive coverage for most curative care, which can be both costly and painful. 42 U.S.C. §1395d(d)(2)(A)(ii).

To the extent Congress and CMS think there is a problem with placing such emphasis on a physician's subjective clinical judgment, the answer is to add objective admission criteria that give concrete guidance to the regulated community and incidentally lend themselves to FCA liability in cases of abuse. As the Eleventh Circuit observed, the government easily "could have imposed a more rigid set of criteria for eligibility determinations that would have minimized the role of clinical judgment." *AseraCare*, 938 F.3d at 1301. In reality, however, Congress and CMS have studied the issue exhaustively and concluded that this is an area where objective criteria are of limited utility given the difficulties of ascertaining life expectancy and the need for clinical judgment. Those decisions "to craft the hospice eligibility requirements" in a way that puts physicians' clinical judgments and opinions front and center must be given effect. *Id.*

Of course, the lack of policy support for the Third Circuit's judgment is just a symptom of the real problem. *Cf. Escobar*, 136 S.Ct. at 2002 (observing that "policy arguments cannot supersede the clear" meaning of the FCA); *Omnicare*, 575 U.S. at 193 ("Congress gets to make policy, not the courts."). What ultimately matters is that the Third Circuit's interpretation of the FCA and the Medicare hospice

framework "is not consistent with the text or design of the law," *AseraCare*, 938 F.3d at 1294, underscoring the need for certiorari.

III. The Question Presented Is Exceptionally Important And This Case Is An Ideal Vehicle To Resolve It.

This case implicates an exceptionally important and recurring national issue. More than 1.5 million individuals elected to receive hospice care in fiscal year 2018 alone, a threefold increase from the year 2000. 84 Fed. Reg. 38,484, 38,487 (Aug. 6, 2019). Those beneficiaries were cared for by over 4,500 hospices across the country. *Id.* at 38,497. And as CMS has explained, "Medicare is the largest payer of hospice services," and "Medicare-certified providers predominate in hospice." *Id.* at 38,522. Indeed, Medicare hospice claims totaled $18.7 *billion* in 2018, a nearly seven-fold increase from the year 2000, *id.* at 38,487. CMS expects those figures to continue growing significantly in the years to come—including an 8.5% *annual* increase in hospice expenditures. That continued rise in expected expenditures does not reflect a view that hospice stays are being unnecessarily chosen or extended, but rather is attributable to an increase in the overall number of Medicare beneficiaries, greater awareness of the availability and advantages of hospice care, and a shift in patient preferences toward home- and community-based treatment at the end of life. *Id.* In short, there is a long-term trend that recognizes the benefits of palliative care over often painful and often costly medical intervention.

By exposing hospices to a severe and unjustified risk of FCA financial and reputational liability for submitting purportedly "false" Medicare claims—*notwithstanding* the good-faith, reasonable clinical judgments that underlie determinations that a condition is likely terminal—the decision below creates powerful incentives for physicians and hospices to err on the side of additional medical intervention. And by deterring physicians and hospices from providing honestly held clinical judgments regarding terminal prognoses due to liability concerns, the decision will inevitably make the hospice benefit harder to obtain for individuals who would otherwise benefit from dignified, affordable end-of-life care rather than continued medical intervention that can be both painful and costly (to the patient and to the public fisc). The decision likewise creates powerful incentives for plaintiffs to pursue lucrative FCA settlements by filing after-the-fact attacks on physicians' clinical judgments. Those judgments lend themselves to second-guessing both because a subset of patients will inevitably outlive their prognoses and because the discretionary nature of the judgment makes it easy to find an expert with a different opinion. If permitted to stand, the Third Circuit's decision will not only encourage this burgeoning cottage industry but also deter palliative care and redirect efforts from patient care to papering the file to minimize the risks of second-guessing.

This case is an ideal vehicle to address the question presented. The issue is cleanly presented; indeed, it was the only issue before the Third Circuit, and if resolved favorably for petitioner, it would fully dispose of respondents' suit. Additionally, further

percolation is unnecessary. Not only was the issue thoroughly briefed and addressed in both the Third and Eleventh Circuits, but the federal government submitted briefs in both *AseraCare* (as a party/plaintiff) and here (as *amicus* supporting plaintiffs). The Eleventh Circuit found the government's arguments for more expansive FCA liability unpersuasive, while the Third Circuit sided with the civil division. But given that the Eleventh Circuit had the full benefit of the government's views and disagreed, and the Third Circuit had the full benefit of the Eleventh Circuit's views and disagreed, further percolation will do nothing to eliminate the conflict. A subsequent court of appeals can disagree with the Eleventh Circuit or with the Third Circuit and the government, but it cannot make the circuit split go away. Nor is there any justification for delaying review. This lawsuit would be at an end in the Eleventh Circuit, and there is no reason to treat patients and physicians in Florida radically different from patients and physicians in New Jersey. In the context of a nationwide program like Medicare, there should be a uniform answer.

Finally, both the courts and companies that partner with the government could benefit from additional guidance about when opinions are actionably false under the FCA. FCA litigation is among the fastest growing areas of litigation, fueled by the possibilities for treble damages and civil penalties. *See, e.g.*, American Bar Association, *Deputy AG Rod Rosenstein to Speak at ABA Conference on Civil False Claims Act and Qui Tam Enforcement* (June 6, 2018), https://bit.ly/34x7HXf. The hospice context is only one of many where eligibility for

Medicare or other government funds turns on a determination that rests on clinical judgment or an opinion. If such opinions become "false" for FCA purposes just because a jury finds someone with a different opinion more persuasive, the already ample opportunities for FCA litigation will be expanded considerably. Such an expansion seems entirely unjustified as the government's reliance on opinions, rather than objectively verifiable facts, generally reflects the need for judgment and the possibility for reasonable differences of opinion. But if such an expansion is to occur, it should come from this Court and be applied uniformly, not expansively in the Third and Tenth Circuits, but more narrowly in the Eleventh, Fifth, and Sixth Circuits.

In short, the circuits are clearly split in the hospice context, and the stakes are high both in that multi-billion-dollar context and more generally. This Court should intervene to resolve the split and provide much-needed uniformity and guidance.

CONCLUSION

The Court should grant the petition.

Respectfully submitted,

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