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INTRODUCTION

During the Civil War, Union soldiers were tricked into paying multiple times for a single horse.[1] Over 150 years later, a cardiologist from Utah spent two days answering questions about the large number of procedures he performed on his patients.[2] These two events are linked by a single thread: the False Claims Act.[3]

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1. *See* 132 CONG. REC. 22,339 (1986) (statement of Rep. Howard Berman); James B. Helmer, Jr., *False Claims Act: Incentivizing Integrity for 150 Years for Rogues, Privateers, Parasites and Patriots*, 81 U. CIN. L. REV. 1261, 1264 (2013).

2. *See* Chris Outcalt, *'He Thought What He was Doing was Good for People,'* ATLANTIC (Aug. 13, 2021), https://www.theatlantic.com/politics/archive/2021/08/health-care-sherman-sorensen-pfo-closures/619649/.

3. *See* Helmer, *supra* note 1, at 1264; United States *ex rel.* Polukoff v. St. Mark's Hosp., 895 F.3d 730, 734 (10th Cir. 2018).

The False Claims Act[4] (FCA) is used to impose liability on individuals who attempt to defraud the United States government.[5] It originated due to widespread defense contracting fraud during the Civil War, but its scope quickly grew. The FCA now governs false claims submitted for Medicare or Medicaid reimbursement.[6] One of the requirements for liability under the FCA is that the submitted claim be "false."[7] However, "false" is not defined in the Act.[8]

Circuit courts have attempted to discern a definition of "false" on their own.[9] Unfortunately, this has resulted in confusion, inconsistency, and a circuit split.[10] If left unresolved, the current FCA circuit split will result in even further confusion in the federal judiciary, as well as legitimate harm to Medicare and Medicaid recipients.[11] Additionally, the split poses risks that extend beyond Medicare and Medicaid recipients.[12]

Part I of this Comment describes the history of this issue and how the current circuit split came about.[13] Part II delves into the myriad of risks the split poses.[14] Lastly, Part III offers proposals for how the split can be resolved, or at the very least, have its risks limited.[15] Recent denials of certiorari by the Supreme Court indicate that those solutions

4. 31 U.S.C. §§ 3729–3733.

5. *See id.*

6. *See infra* Section I.A.

7. *See id.*; *see also* 31 U.S.C. § 3729(a)(1)(A).

8. *See* 31 U.S.C. § 3729(b).

9. *See infra* Section I.B.

10. *See id.*

11. *See infra* Section II.B.1.

12. *See id.*

13. *See infra* Part I.

14. *See infra* Part II.

15. *See infra* Part III.

may be unlikely to come by judicial guidance, so Part III offers judicial, legislative, and administrative frameworks.[16]

I. BACKGROUND AND OVERVIEW OF THE CURRENT FCA CIRCUIT SPLIT

A. *The False Claims Act, Medicare, and Medicaid*

The federal False Claims Act imposes liability on attempts to defraud the United States government.[17] The FCA was passed in 1863, in response to frequent fraudulent activities by government defense contractors during the Civil War.[18] Congress's primary purpose in enacting the FCA was to regulate such fraudulent activities.[19]

To be liable under the FCA, a claim to the federal government for payment or reimbursement must satisfy three elements.[20] The claim must be presented to the United States government, it must be false or fraudulent, and the claimant must have knowledge that the claim is false or fraudulent when the claim is presented to the government.[21] Knowledge is defined in the Act.[22] The definition of claim is

16. *See id.*

17. *See* 31 U.S.C. § 3729(a).

18. *See*, *e.g.*, Helmer, *supra* note 1, at 1264; Patricia Meador & Elizabeth S. Warren, *The False Claims Act: A Civil War Relic Evolves into a Modern Weapon*, 65 TENN. L. REV. 455, 458 (1998).

19. *See* Meador & Warren, *supra* note 18, at 458.

20. *See, e.g.*, Carolyn J. Pashke, *The Qui Tam Provision of the Federal False Claims Act: The Statute in Current Form, Its History and Its Unique Position to Influence the Health Care Industry*, 9 J.L. & HEALTH 163, 168 (1994).

21. *Id.*

22. *See* 31 U.S.C. §§ 3729(b)(1)(A)–(B) ("[T]he terms 'knowing' and 'knowingly'—(A) mean that a person, with respect to information—(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific

also provided in the Act.[23] However, the FCA does not define false, falsity, or fraudulent anywhere in its text.[24]

Since its enactment during the Civil War, the FCA's application has expanded beyond wartime industries.[25] Major contributors to this expansion were 1986 amendments to the Act that encouraged private relators to bring *qui tam* actions against alleged violators.[26] Specifically, these amendments lowered the plaintiff's burden of proof, lowered

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intent to defraud.").

23. *See* 31 U.S.C. §§ 3729(b)(2)(A)–(B) (defining "claim" as "any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—(i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—(I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and (B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property").

24. *See generally* 31 U.S.C. §§ 3729–3733 (omitting any definition of false, falsity, or fraudulent). *See also* Latoya C. Dawkins, *Not So Fast: Proving Implied False Certification Theory Post-*Escobar, 42 SETON HALL LEGIS. J. 163, 164 (2017) ("[C]ircuit court precedent and the definitions of 'falsity' and 'materiality' have become particularly relevant in FCA jurisprudence. False claims cases can take on many different forms.").

25. *See, e.g.*, Meador & Warren, *supra* note 18, at 460–61 (stating that after Congress amended the Act, "the government increased its use of the Act to fight government fraud," and "[t]oday, the False Claims Act is being used aggressively to attack the perceived health care fraud crisis"); Pashke, *supra* note 20, at 172 ("[T]he [FCA's] *qui tam* provision evolved from a broad cause of action allowing virtually anybody to bring a claim . . . .").

26. *See* Pashke, *supra* note 20, at 164 (stating that "[t]he statute, in its current form, was amended in 1986" when "Congress loosened restrictions on the use of the statute," and "the 1986 amendments create incentives and give relators power to bring *qui tam* actions in response to fraud in other areas of Government spending").

the standards for demonstrating knowledge and intent, and increased damages.[27] One result of the FCA's expansion following these amendments was incentivizing relators to bring claims in the context of Medicare and Medicaid.[28]

Medicare and Medicaid are the two federal health insurance programs in the United States.[29] In 1965, Congress created these two programs as Title XVIII and Title XIX of the Social Security Act.[30] While the eligibility and coverage requirements of these two programs changed slightly in the decades that followed, the basic principles remained the same.[31] Medicare is available for elderly and disabled individuals, and Medicaid is available for low-income individuals.[32]

In 1986, the *qui tam* FCA amendments incentivized a number of Medicare and Medicaid fraud claims to be brought by relators against health care providers.[33] These claims allege that the providers fraudulently submitted reimbursement claims to Medicare or Medicaid in violation of the three aforementioned FCA elements.[34]

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27. David J. Ryan, *The False Claims Act: An Old Weapon with New Firepower is Aimed at Health Care Fraud*, 4 ANNALS HEALTH L. 127, 129 (1995).

28. *See* Pashke, *supra* note 20, at 164–65.

29. *See generally* Earl Dirk Hoffman, Jr. et al., *Overview of the Medicare and Medicaid Programs*, 21 HEALTH CARE FIN. REV. 1, 1 (2000) (discussing the history and scope of the Medicare and Medicaid programs).

30. *Id.*

31. *See generally CMS' Program History*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/About-CMS/Agency-Information/History (Dec. 1, 2021, 7:02 PM) (stating that since the inception of these programs, more people have become eligible and more benefits have been offered).

32. *See, e.g.*, *id.*; *see also* Hoffman et al., *supra* note 29, at 1–2.

33. *See* Pashke, *supra* note 20, at 173.

34. *See id.* at 168.

The FCA is just one of several avenues for health care fraudsters generally—and Medicare and Medicaid fraudsters specifically—to be held accountable.[35] However, FCA claims are frequently brought.[36] The trouble with FCA claims related to Medicare and Medicaid is the Act's lack of a unified definition of what constitutes a "false claim." The lack of legislative guidance on this definition has left courts across the country to attempt to discern a workable definition on their own.[37] This has resulted in different jurisdictions developing starkly different approaches, and this has created a circuit split on the definition of falsity in the context of FCA Medicare and Medicaid cases.[38]

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35. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE FRAUD & ABUSE: PREVENT, DETECT, REPORT 8–11 (2021), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf (describing a number of civil and criminal health care fraud statutes in addition to the FCA); *see also* 42 U.S.C. § 1320a-7b (imposing criminal penalties for acts involving federal health care programs).

36. *See* Robert Salcido, *The Government's Increasing Use of the False Claims Act Against the Health Care Industry*, 24 J. LEGAL MED. 457, 462–63 (2003) ("As a result of the 1986 amendments, the application of the FCA to Medicare and Medicaid claims has escalated dramatically. From the time of the 1986 amendments to September 2000, 1,603 health-related *qui tam* actions have been filed. The number of *qui tam* cases in the health care sector rose steadily over the 1992–1998 period from only 18 in 1992 (15% of the total number of all *qui tam* actions filed) to 94 in 1995 (34%) and 288 in 1998 (61%) and now consistently represents more than half of all *qui tam* actions filed.") (citations omitted).

37. *See infra* Section I.B.

38. *Id.* This Comment focuses on this particular criticism of the FCA, but that is not to say it is the only criticism of the Act. These criticisms vary and exist both among legal scholars and the general public. *See, e.g.*, Jacob T. Elberg, *Health Care Fraud Means Never Having to Say You're Sorry*, 96 WASH. L. REV. 371, 400 (2021) (arguing that the FCA as applied is not the best way to deter health care fraud); Thomas L. Carson et al., *Whistle-Blowing for Profit: An Ethical Analysis of the Federal False Claims Act*, 77 J. BUS. ETHICS 361, 365–67 (2008) (discussing and responding to moral objections that have been posed with regard to the

B. *The Current Circuit Split*

The current circuit split is comprised of recent health care fraud decisions from at least five circuits.[39] This subsection outlines those cases chronologically.

1. Sixth Circuit

The first case leading to the current circuit split occurred in the Sixth Circuit in 2018.[40] There, the Sixth Circuit held that the exaggeration of verifiable facts in order to justify unnecessary diagnostic procedures can constitute Medicare fraud.[41]

The defendant in *United States v. Paulus* was a Kentucky cardiologist who submitted an inordinately high volume of claims for angiograms to both Medicare, Medicaid, and various private insurers.[42] The United States

FCA).

39. *See* United States v. Paulus, 894 F.3d 267 (6th Cir. 2018); United States *ex rel.* Polukoff v. St. Mark's Hosp., 895 F.3d 730 (10th Cir. 2018); United States v. AseraCare, Inc., 938 F.3d 1278 (11th Cir. 2019); 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); United States *ex rel.* Druding v. Care Alts., 952 F.3d 89 (3d Cir. 2020), *cert. denied sub nom*. Care Alts. v. United States, 141 S. Ct. 1371 (2021).

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

41. *See id.* at 270.

42. *Id.* at 272. Angiograms are specialized X-rays that provide an approximation of the extent to which a patient's arteries are blocked. *Id.* at 270. *See also Coronary Angiogram*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/coronary-angiogram/about/pac-20384904 (last visited Apr. 8, 2022) ("A coronary angiogram is a procedure that uses X-ray imaging to see your heart's blood vessels. The test is generally done to see if there's a restriction in blood going to the heart."); *Angiogram*, CLEVELAND CLINIC, https://my.clevelandclinic.org/health/treatments/4977-angiography (last reviewed Aug. 5, 2022) (explaining that an angiogram helps physicians determine the source and extent of blocked, damaged, or abnormal blood vessels).

Department of Health and Human Services conducted an audit of the cardiologist's angiograms after an anonymous tip stated that they were not medical necessary.[43]

The medical necessity of angiograms was determined based on the degree of stenosis (i.e., accumulation of fatty plaque and cholesterol inside an artery wall) present in the patient.[44] Although the court acknowledged that there is some level of "inter-observer variability" that would lead different cardiologists to reach different conclusions on the medical necessity of an angiogram, that variability was limited within a certain reasonable standard of error.[45] In other words, a physician's decision to perform an angiogram may be based on an evaluation of stenosis that is so far outside the reasonable variability that the decision could be considered fraudulent.[46] For that reason, the Sixth Circuit upheld the jury's decision to convict the cardiologist of making a false statement to commit health care fraud.[47]

2. Tenth Circuit

Following *Paulus*, the Tenth Circuit held in 2018 that an FCA complaint alleging Medicare fraud can survive if it asserts that the doctor submitting the claim went outside the

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43. *Paulus,* 894 F.3d at 272–73.

44. *Id.* at 270–71.

45. *Id.* at 271–72.

46. *Id.* at 275 ("The degree of stenosis *is* a fact capable of proof or disproof. A doctor who deliberately inflates the blockage he sees on an angiogram has told a lie; if he does so to bill a more expensive procedure, then he has also committed fraud.").

47. *Id.* at 277. Dr. Paulus was charged with violating 18 U.S.C. § 1035 and 18 U.S.C. § 1347, neither of which are parts of the FCA itself. *See id.* Rather, these laws are separate statutes that penalize making false statements relating to health care matters and knowingly engaging in health care fraud, respectively. *See id.* While Dr. Paulus was not accused of violating the FCA specifically, this case is pertinent because it was the first in a rapid succession of conflicting circuit court cases dealing with the question of falsity in the context of Medicare and Medicaid claims.

standard of care for a particular course of treatment.[48] There, a physician was accused of performing unnecessary procedures that were outside the general standard of care for treating a particular condition.[49]

Similar to the defendant in *Paulus*, the defendant in *United States ex rel. Polukoff v. St. Mark's Hospital* was a cardiologist who submitted claims to Medicaid and Medicare for an inordinately high number of patent foramen ovale ("PFO") closures.[50] A PFO closure is a procedure generally considered for stroke patients.[51]

In this case, it was alleged that the defendant cardiologist had performed many PFO closures in order to treat patients with migraines.[52] An FCA complaint was filed against the cardiologist, but the trial court dismissed it.[53] The trial court determined that although PFO closures were outside the normal standard of care for migraine patients, "opinions, medical judgments, and 'conclusions about which reasonable minds may differ cannot be false' for the purposes of an FCA claim, [so] Dr. Sorensen's representations to the government could not be false absent 'a regulation that clarifies the conditions under which it will or will not pay for a PFO closure.'"[54]

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48. United States *ex rel.* Polukoff v. St. Mark's Hosp., 895 F.3d 730, 742–43 (10th Cir. 2018).

49. *Id.* at 743.

50. *Id.* at 737. A PFO closure is a procedure meant to fix a hole between the two upper chambers of the heart, which can cause blood to flow in the wrong direction. *Id.* at 736; *see also* Fareed Moses S. Collado et al., *Patent Foramen Ovale Closure for Stroke Prevention and Other Disorders*, 7 J. AM. HEART ASS'N 1, 1 (2018).

51. *Polukoff*, 895 F.3d at 736–37.

52. *Id.* at 737.

53. *Id.* at 739.

54. United States *ex rel.* Polukoff v. St. Mark's Hosp., 895 F.3d 730, 739 (10th Cir. 2018) (quoting United States *ex rel.* Morton v. A Plus Benefits, Inc., 139 F. App'x 980, 983 (10th Cir. 2005)).

However, the Tenth Circuit reversed the dismissal, finding that Medicare and Medicaid claims that act "with reckless disregard" as to whether procedures are medically necessary can constitute the submission of a knowingly false claim.[55] The court held that, at a minimum, performing PFO closures in such a way that was outside the medically accepted standard of care for a particular condition could meet that standard.[56] Thus, the relator's amended FCA complaint was sufficient.[57] The court's reasoning applied regardless of whether the physician in question held a genuine belief or opinion that the procedures would cure the patients' symptoms.[58]

3. Eleventh Circuit

In 2019, in a dispute concerning certifications of patients' eligibility for hospice care, the Eleventh Circuit implemented its own standard on this issue.[59] This standard is the "objective falsity" standard.[60] Under the objective falsity standard, claims cannot be "deemed false" under the FCA based solely on "a reasonable disagreement between medical experts."[61]

In the Eleventh Circuit's case, *United States v. AseraCare, Inc.*, three former employees of the defendant hospice provider alleged that the defendant had submitted fraudulent Medicare claims for hospice care.[62] The allegations stated that the provider was not entitled to

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55. *Id.* at 744.

56. *Id.*

57. *Id.*

58. *See id.* at 742 (noting there is no "bright-line rule that a medical judgment can never serve as the basis for an FCA claim").

59. United States v. AseraCare, Inc., 938 F.3d 1278, 1298 (11th Cir. 2019).

60. *See id.*

61. *Id.* at 1281.

62. *Id.* at 1282.

receive funds for those claims because it failed to satisfy the requirements of the Medicare hospice benefit.[63] Based on the specificity of the eligibility standards for the Medicare hospice benefit, the government pursued the claim on a theory that, "FCA liability may arise where a defendant falsely asserts or implies that it has complied with a statutory or regulatory requirement when, in actuality, it has not so complied."[64]

However, when the case went to trial in the Northern District of Alabama, the testimony of the defendant's expert witnesses contrasted with the testimony of the government's witnesses.[65] Specifically, AseraCare's witnesses described a "whole patient" approach to decision making that led to the providers deciding to certify patients for hospice care, as opposed to strict adherence to the Local Coverage Determinations.[66] In opposition, the government's witness "never testified that, in his opinion, no reasonable doctor could have concluded that the identified patients were [eligible for hospice care]."[67] In light of the inconsistency in the litigants' battle of the experts, the district court ended up granting post-verdict summary judgment to the defendant.[68]

On appeal, the Eleventh Circuit held that disagreement between experts as to a medical provider's clinical judgment was not enough on its own to subject the provider to FCA

63. *Id.* In order to be eligible for the Medicare hospice benefit, providers must certify that the patient is "terminally ill," and the certification must be accompanied by "'clinical information and other documentation that support the medical prognosis,' and such support 'must be filed in the medical record with the written certification.'" *Id.* (quoting 42 C.F.R. § 418.22(b)(2)).

64. *Id.* at 1284.

65. *Id.* at 1287–89.

66. *Id.* at 1288.

67. *Id.* at 1287.

68. *Id.* at 1302.

liability.[69] This is because under the Eleventh Circuit's approach, for liability to be invoked, the FCA requires proof of an "objective falsehood" underlying a physician's clinical judgment regarding a claim for payment.[70] The Eleventh Circuit ordered the case to be remanded and reconsidered "in light of all the relevant evidence."[71]

4. Ninth Circuit

The Ninth Circuit's entrance into this analysis came after a health care management company and hospital in California were accused of falsely certifying inpatient hospitalizations as medically necessary.[72] There, the relator was the former director of care management for the hospital.[73] The relator accused the hospital of submitting Medicare claims for patients while knowing that their admissions were not medically necessary.[74] The district court dismissed the complaint on the grounds that "subjective medical opinions . . . cannot be proven to be objectively false."[75] On appeal, that decision was reversed.[76] The Ninth Circuit held that a certification of medical necessity can be subject to FCA liability if the certifying physician knew the opinion to be false, or if the certification was rendered "in reckless disregard of its truth or falsity."[77]

In reversing the district court's dismissal, the Ninth Circuit came down conclusively against the Eleventh

69. *See id.* at 1302–03.

70. *See id.* at 1296–97.

71. *Id.* at 1305.

72. 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).

73. *Id.* at 1112.

74. *Id.* at 1112–13.

75. *Id.* at 1113.

76. *Id.*

77. *Id.*

Circuit's previously announced "objective falsehood" approach.[78] The court concluded that "the FCA does not require a plaintiff to plead an 'objective falsehood'" because a "physician's certification . . . can be false or fraudulent for the same reasons any opinion can be false or fraudulent," including "if the opinion is not honestly held."[79]

However, even though the language in the Ninth Circuit's decision was clearly opposed to the objective falsehood standard, the court insisted that its decision did not contradict the Eleventh Circuit's earlier decision.[80] The court's purported basis for this distinction was that the Eleventh Circuit's decision regarded reasonable disagreement between physicians, as opposed to whether a medical opinion could ever be false, and that the Eleventh Circuit's "'objective falsehood' requirement did not necessarily apply to a physician's certification of medical necessity."[81] Still, the Ninth Circuit concluded that "a plaintiff need not plead an 'objective falsehood' to state a claim under the FCA."[82]

The RollinsNelson LTC Corporation[83] petitioned the Supreme Court for review of this case.[84] The Court denied

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78. *See id.* at 1119. The litigants did not address the merits of the Eleventh Circuit's *AseraCare* decision in their briefs, as the submissions were all filed before that decision was issued. *See* Reply Brief for Appellant, Winter *ex rel.* United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc., 953 F.3d 1108 (9th Cir. 2020) (No. 2:14-cv-08850-JFW-E), 2018 WL 4778166.

79. *Winter*, 953 F.3d at 1119.

80. *Id.* at 1118.

81. *Id.* at 1119. In doing so, the Eleventh Circuit "explicitly distinguish[ed] *Polukoff*." *Id.* (citing United States v. AseraCare, Inc., 938 F.3d 1278, 1300 n.15 (11th Cir. 2019)).

82. *Id.* at 1122.

83. RollinsNelson was the defendant corporation that oversaw operations at Gardens Regional Hospital, where the allegedly false certifications took place. *Id.* at 1115.

84. *See* Petition for Writ of Certiorari, *Winters*, 141 S. Ct. 1380 (No.

certiorari without comment on February 22, 2021.[85]

5. Third Circuit

Lastly, the Third Circuit weighed in on this issue in 2020, in another case involving eligibility for hospice care.[86] In *United States ex rel. Druding v. Care Alternatives*, the Third Circuit adjudicated a dispute involving conflicting expert medical opinions as to whether patients were eligible for hospice care claims that the defendant submitted on their behalf.[87]

The relators were former employees of the hospice care provider, Care Alternatives, and they alleged that Care Alternatives had "admitted ineligible patients and directed its employees to alter Medicare certifications to increase the number of eligible patients."[88] During discovery, the parties' respective expert witnesses disagreed as to whether a physician could reasonably certify that the patients in question were eligible for the Medicare hospice benefit.[89] Based on the dispute between expert witnesses, the district court found that there was no sufficient proof of falsity in Care Alternatives' claims, and granted summary judgment to Care Alternatives.[90]

The Third Circuit reversed and remanded, holding that

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85. RollinsNelson LTC Corp. v. United States *ex rel.* Winters, 141 S. Ct. 1380, 1380 (2021).

86. United States *ex rel.* Druding v. Care Alts., 952 F.3d 89, 91 (3d Cir. 2020), *cert. denied sub nom.* Care Alts. v. United States, 141 S. Ct. 1371 (2021).

87. *Id.*

88. *Id.* at 92. The Medicare hospice care eligibility standards required patients to be certified as "terminally ill" by a physician within ninety days of arriving in hospice care, and re-certified every sixty days the patient remained in hospice care. *Id.*

89. *Id.* at 94.

90. *Id.*

"medical opinions may be 'false' and an expert's testimony challenging a physician's medical opinion can be appropriate evidence for the jury to consider on the question of falsity."[91] Thus, "a difference of medical opinion is enough evidence to create a triable dispute of fact regarding FCA falsity."[92]

In making this ruling, the Third Circuit rejected the Eleventh Circuit's objective falsity standard.[93] Specifically, the court said that such a standard improperly conflates the FCA elements of falsity and scienter.[94]

Care Alternatives petitioned the Supreme Court for a writ of certiorari.[95] However, as with the Ninth Circuit's case, the Supreme Court denied certiorari without comment on February 22, 2021.[96]

II. RISKS POSED BY THE SPLIT

A. *The FCA Circuit Cases Constitute a Circuit Split*

Before discussing the impact of this split and possible resolutions to it, it is necessary to first prove that this is, in fact, a circuit split. This is because there has been some debate as to whether these cases constitute a genuine circuit split. The Eleventh Circuit stated its decision did not conflict

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91. *Id.* at 98.

92. *Id.* at 100.

93. *See id.* The Third Circuit was specifically reviewing the District Court of the District of New Jersey's adoption of the objective falsehood standard. *Id.* at 91. Nevertheless, the court's position in relation to the Eleventh Circuit was clear: "[R]egarding FCA falsity, we reject the objective falsehood standard." *Id.* at 100.

94. *Id.* The court made explicit that scienter, or knowing intent, must be found independently from the existence of falsity. *See id.*

95. *See* Petition for Writ of Certiorari, *Care Alts.*, 141 S. Ct. 1371 (2021).

96. *See id.*

with the Tenth Circuit's decision.[97] Following that same logic, the Ninth Circuit stated its decision did not conflict with either of those cases.[98]

These self-assessments by the circuits must be read with a critical eye. It is within any given circuit panel's interest to claim its reasoning and holding does not conflict with that of another circuit, as doing so lowers the likelihood of getting reversed or abrogated by the Supreme Court.[99] Due to this interest, observers should take care to look beyond the labels proffered by the circuits themselves in order to determine whether circuit splits exist.[100]

In this instance, the Eleventh Circuit's opinion is directly contradictory to those from the Ninth and Third.[101] The

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97. *See* United States v. AseraCare, Inc., 938 F.3d 1278, 1300 n.15 (11th Cir. 2019) (identifying factual differences between its own case and that from the Tenth Circuit).

98. Winter *ex rel.* United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc., 953 F.3d 1108, 1119 (9th Cir. 2020), *cert. denied sub nom.* RollinsNelson LTC Corp. v. United States *ex rel.* Winters, 141 S. Ct. 1380 (2021), ("[F]or the same reason that the Eleventh Circuit recognized *AseraCare* did not conflict with *Polukoff*, we believe our decision does not conflict with *AseraCare*.").

99. *See* Aaron-Andrew P. Bruhl, *Measuring Circuit Splits: A Cautionary Note*, 4 J.L. 361, 375 (2014) (noting that in general, petitioners for Supreme Court review have an incentive to claim a conflict between circuits wherever possible, whereas respondents have an incentive to claim the opposite).

100. *See* Arthur H. Hellman, *Never the Same River Twice: The Empirics and Epistemology of Intercircuit Conflicts*, 63 U. PITT. L. REV. 81, 87 (2001) (noting that some appellate opinions are written in ways that deliberately minimize the appearance of intercircuit conflict, thus making the phenomenon of intercircuit conflict more widespread than it seems).

101. *Compare* United States v. AseraCare, Inc., 938 F.3d 1278, 1296–97 (11th Cir. 2019) ("[T]he claim cannot be 'false'—and thus cannot trigger FCA liability—if the underlying clinical judgment does not reflect an objective falsehood."), *with* Winter *ex rel.* United States v. Garden Reg'l Hospital, 953 F.3d 1108, 1119 (9th Cir. 2020), *cert. denied sub nom.* RollinsNelson LTC Corp. v. United States *ex rel.* Winters, 141 S. Ct. 1380

Eleventh Circuit implemented an objective falsity framework, while the Ninth and Third circuits emphatically rejected that framework. This represents two fundamentally opposite approaches that cannot be congruent with one another.

The decisions from the Sixth and Tenth circuits focused on doctors' opinions of medical necessity. The Sixth Circuit held that a doctor's opinion of medical necessity can be false in certain circumstances, such as when the doctor knows of facts that are incompatible with that opinion.[102] The Tenth Circuit went on to state that a medical judgment can lead to FCA liability if it resulted in claims that were not reasonable and necessary.[103] Both of these decisions, however, are in tension with the Eleventh Circuit's assertion that an after-the-fact review of a sincerely held medical judgment is insufficient to render that judgment false.[104] Based on the variety of approaches the circuits are taking in defining medical falsity, it is clear that there is no unified, cohesive definition. The circuit-level discrepancies in approaches, reasoning, and results demonstrate that there is substantial confusion and inconsistency between the circuits on the definition of medical falsity. This split will only deepen if left alone.

B. *Risks of Leaving the FCA Split Unresolved*

The circuit split presents a crossroads for many medical professionals. Without resolution of this split, many medical

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(2021) ("[W]e hold that the FCA does not require a plaintiff to plead an 'objective falsehood.'"), *and* United States *ex rel.* Druding v. Care Alts., 952 F.3d 89, 100 (3d Cir. 2020), *cert. denied sub nom.* Care Alts. v. United States, 141 S. Ct. 1371 (2021). ("[R]egarding FCA falsity, we reject the objective falsehood standard.").

102. *See* United States v. Paulus, 849 F.3d 267, 275 (6th Cir. 2018).

103. *See* United States *ex rel.* Polukoff v. St. Mark's Hosp., 895 F.3d 730, 743 (10th Cir. 2018).

104. *See AseraCare*, 938 F.3d at 1297.

practitioners are left in a position where they cannot know whether their treatment decisions for patients will subject themselves to liability.[105] This can result in nationwide occurrences of medical providers being less willing to work with patients who rely on Medicare or Medicaid out of fear that a treatment decision will subject the provider to FCA liability.[106]

Further, this may result in medical providers who do take on Medicare or Medicaid patients being overly conservative in their treatment out of that same fear. The phenomenon of overly conservative treatment decisions by physicians due to fear of liability is called "defensive medicine," and its existence and implications have been well documented.[107] While defensive medicine is frequently

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105. *See Polukoff*, 895 F.3d at 742 (stating a defendant physician's genuine belief or opinion that certain procedures are medically necessary may not be enough to defeat FCA liability if the Medicare or Medicaid claims for those procedures are challenged).

106. Health care providers' refusal to accept Medicare and Medicaid patients is a barrier such patients already have to deal with. *See, e.g.*, Kayla Holgash & Martha Heberlein, *Physician Acceptance of New Medicaid Patients*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N 6 (Jan. 24, 2019) https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf ("Providers [are] less likely to accept new patients insured by Medicaid (70.8 percent) than those with Medicare (85.3 percent) or private insurance (90.0 percent)."). The current split risks exacerbating this disparity by increasing providers' uncertainty surrounding liability risk when treating Medicare and Medicaid recipients, thus decreasing providers' likelihood to treat such patients. Limited treatment options are also a current risk faced by some Medicare and Medicaid recipients. *See* Sonal Sekhar M. & Vyas N., *Defensive Medicine: A Bane to Healthcare*, 3 ANNALS MED. & HEALTH SCIS. RSCH. 295, 295 (2013) ("[P]atients with private insurance stay in hospitals longer and receive many procedures compared to patients with Medicaid coverage . . . .").

107. *See* Frank A. Sloan & John H. Shadle, *Is There Empirical Evidence for "Defensive Medicine"? A Reassessment*, 28 J. HEALTH ECON. 481, 481 (2009) ("Traditionally, defensive medicine has been defined in policy contexts as the provision of care that is not beneficial, or at most slightly beneficial, to patients, but is ordered to avoid lawsuits."); Daniel Kessler

discussed as a reaction to malpractice liability, it has also been seen as a reaction to the threat of *qui tam* litigation.[108]

These potential results of the FCA split represent unnecessary limitations on the nation's health care system. They also present dangerous implications for patients. The patients most directly affected by this split will be those who receive Medicare or Medicaid benefits. These patients rely on those federal programs for their health care and already face more severe health risks than the general population.[109]

It is also important to resolve this split because the split presents risks for individuals beyond current Medicare and Medicaid recipients.[110] The confusion resulting from the split may impact coverage decisions by private health insurers, adjudications of medical malpractice claims, and several other areas of the law.[111] Effective resolution of the split may reduce all those risks while maintaining liability for bad apples who intentionally commit Medicare or Medicaid fraud.[112]

& Mark McClellan, *Do Doctors Practice Defensive Medicine?* 111 Q. J. ECON. 353, 358 (1996) ("[P]revious empirical literature is consistent with the hypothesis that providers practice defensive medicine . . . ."); Tara F. Bishop et al., *Physicians' Views on Defensive Medicine: A National Survey*, 170 JAMA INTERN. MED. 1081, 1082 (2010) ("[I]t is estimated that as much as $60 billion are spent annually on defensive medicine. Even if the true cost of defensive practices was only a fraction of this amount, it would still represent a significant source of cost savings.") (footnote omitted).

108. *See* Pashke, *supra* note 20, at 184–85 (arguing that *qui tam* actions may place too much pressure on medical providers and create a "disincentive for treating Medicare/Medicaid patients.").

109. *See* Drew Altman & William H. Frist, *Medicare and Medicaid at 50 Years: Perspectives of Beneficiaries, Health Care Professionals and Institutions, and Policy Makers*, 314 J. AM. MED. ASS'N, 384, 392 (2015) ("Together, [Medicare and Medicaid] serve more than a hundred million of the nation's most vulnerable people . . . .").

110. *See infra* Section II.B.2.

111. *See id.*

112. *See infra* Section II.C.

1. Implications for Medicare and Medicaid Recipients

The most immediately apparent individuals impacted by the split are those who receive Medicare or Medicaid benefits. Medicare and Medicaid recipients tend to face higher health risks than the general population, so limiting the treatment options for this specific group of patients is particularly dangerous.[113]

i. Medicare Recipients

Medicare is only available for individuals who are over the age of 65 or have disabilities.[114] Both of these groups require a greater degree of medical care than the general population.[115]

Individuals over the age of 65 experience a greater frequency of chronic diseases, physical disabilities, mental illnesses, and other co-morbidities, all of which require medical care.[116] In the United States, this population is becoming an increasingly large portion of the country.[117]

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113. *See supra* note 106 and accompanying text.

114. Altman & Frist, *supra* note 109, at 386.

115. *See, e.g.*, Monique M. Williams, *Invisible, Unequal, And Forgotten: Health Disparities in the Elderly*, 21 NOTRE DAME J.L. ETHICS & PUB. POL'Y 441, 477 (2007) (discussing the institutional and individual ageism that is present in the American health care system); Charles E. Drum et al., *Recognizing and Responding to the Health Disparities of People with Disabilities*, 3 CAL. J. HEALTH PROMOTION 29, 38 (2005) ("Available data indicate that having a disability puts one at substantially higher risk for experiencing poorer health status than the general population. Disparities appear related to both differences in access to medical care and to health promotion services."); Gloria L. Krahn et al., *Persons with Disabilities as an Unrecognized Health Disparity Population*, 105 AM. J. PUB. HEALTH, S198, S201 (2015) ("As a group, people with disabilities fare far worse than their nondisabled counterparts across a broad range of health indicators.").

116. Saurabh Ram Bihar Lal Shrivastava et al., *Health-Care of Elderly: Determinants, Needs and Services*, 4 INT'L J. PREVENTATIVE MED. 1224, 1224 (2013).

117. Williams, *supra* note 115, at 442 ("Older adults compose the most

Since this category of Medicare recipients has a greater demand for health care services than the general public and is a growing population, it stands to reason that it is not a population for which the availability of medical care should be subjected to external limitations. However, if the unresolved split results in the aforementioned fear and conservatism by doctors with regard to Medicare patients, then the split will constitute such a limitation on treatment for this population.

Medicare recipients who are eligible based on disability face a similar predicament. Individuals with disabilities have higher rates of unmet health needs than individuals without disabilities.[118] They experience a higher than average rate of chronic diseases and conditions, and they experience those diseases and conditions at earlier ages than average.[119] The higher prevalence and earlier occurrence of chronic diseases and conditions necessitates a higher demand for medical care.[120] Therefore, both categories of Medicare recipients constitute populations with increased need for medical care.

Due to the greater need for medical care of Medicare eligible individuals, these individuals inherently have much to lose by increasing providers' reluctancy to treat them. For that reason, it is imperative to address the current FCA split and clear up the definition of falsity in the context of Medicare claims. Doing so will limit the restrictions that the split places on the health care of Medicare recipients.

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rapidly growing subset of the United States population . . . .").

118. Drum, *supra* note 115, at 36.

119. Krahn, *supra* note 115, at S204.

120. *See* Gerard Anderson & Jane Horvath, *The Growing Burden of Chronic Disease in America*, 119 PUB. HEALTH REPS. 263, 264 (2004) ("[A]lmost four in five health care dollars (78%) are spent on behalf of people with chronic conditions.").

ii. Medicaid Recipients

The same is generally true for Medicaid recipients. Medicaid is primarily available for low-income individuals.[121] Additionally, Medicaid may be available for certain individuals who meet state-defined "medically needy" criteria.[122] Under either eligibility standard, Medicaid recipients face higher health risks than the general population.

For the latter category, eligible recipients are required to have "significant health needs."[123] This means that individuals who receive Medicaid under a "medically needy" designation necessarily have a heightened health risk. While states are empowered to define their own criteria for "medically needy" and "significant health needs," it is axiomatic that eligible individuals would require a high degree of health care.[124] That high degree of need means that medically needy individuals receiving Medicaid would be

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121. *See Eligibility*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/eligibility/index.html (last visited Apr. 8, 2022) ("To participate in Medicaid, federal law requires states to cover certain groups of individuals. Low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups.").

122. *Id.* ("States have the option to establish a 'medically needy program' for individuals with significant health needs whose income is too high to otherwise qualify for Medicaid under other eligibility groups.").

123. *Id.*

124. States are empowered to create their own criteria for the medically needy eligibility, but the connective tissue between these criteria are that they all require some high degree of need for medical care. *Compare Medicaid Spend-Down in New York State*, MEDICARE RIGHTS CTR., https://www.medicarerights.org/fliers/Medicaid/Medicaid-Spend-Down-(NY).pdf?nrd=1 (last visited Apr. 8, 2022) (requiring recipients of this program to be 65 years old or disabled and have "high health care costs") *with* 1 TEX. ADMIN. CODE § 366.807 (2014) (limiting eligibility for the medically needy program to pregnant women or individuals under 19 years of age who satisfy income requirements).

more adversely affected than the general population by their health care providers denying treatment or being overly cautious with treatment out of fear of FCA liability.

This greater impact would also be felt by the primary category of Medicaid recipients, low-income individuals. As with Medicare recipients and medically needy Medicaid recipients, this group of federally funded health care recipients also generally faces higher health risks than the population at large.[125] Therefore, this group fits the same pattern as the preceding two groups and will also face greater risks than the general population if the circuit split is not resolved.

2. Implications Beyond Medicare and Medicaid Recipients

While the circuit split has a clear and direct impact on Medicare and Medicaid recipients, the risks also extend beyond those two groups. Thus, resolution of the split, or the lack thereof, may have implications beyond the impact felt by Medicare and Medicaid recipients. These implications include effects on private insurers, the potential conflation of FCA liability with medical malpractice liability, and influence on other areas of law.

i. Risk of Private Insurers Following the Government's Example

Leaving the split unresolved produces a risk that private

125. *See generally* David Orentlicher, *Healthcare, Health, and Income*, 46 J.L. MED. & ETHICS 567, 568–69 (2018) (describing multiple studies that have revealed that higher incomes result in better health, and vice versa, both in the United States and globally). This inverse relationship between income and health care outcomes is not a uniquely American phenomenon. *See id.*; *see also* James Macinko et al., *The Impact of Primary Healthcare on Population Health in Low- and Middle-Income Countries*, 32 J. AMBULATORY CARE MGMT. 150, 151 (2009) ("[T]here is considerable debate about how effective [primary health care] has been in improving population health in low- and middle-income countries.") (citation omitted).

health insurers may follow the government's example and begin denying claims simply based on "difference of medical opinion" or some other standard. This would create a system where insurers could deny claims practically at will. Ultimately, the harm from this will fall on either patients or practitioners. In the former outcome, patients will be forced to either forego necessary medical treatment or take on substantial personal costs. In the latter, practitioners and health care providers can face near-arbitrary refusal by insurers to pay for medically justifiable treatment.

Some health care professionals already believe that health insurers' propensity to deny claims at will does little to improve health care quality.[126] Further, such denials may constitute the usurpation of the role of a physician or even unlicensed practice of medicine.[127] This perception is only exacerbated by case law that provides tremendous discretion to administrators of health plans, allowing those administers to deny claims so long as such denial can be explained away as reasonable.[128]

With all these factors providing cover for insurers to deny claims, the average consumer of health care services has reason to fear private insurers obtaining even more grounds for denial. Unresolved federal jurisprudence about the definition of falsity in the context of medical claims provides the potential for the actualization of this fear. For example, if the split remains unresolved nationally, private insurers may take inspiration from the Third Circuit.[129] That

126. *See* William E. Bennett, *Insurance Denials of Care Amount to Unlicensed Medical Practice*, 26 J. MANAGED CARE & SPEC. PHARM. 822, 823 (2020) (providing a physician's critique of the practice of claim denial by health insurers).

127. *See id.*

128. *See* Carr v. The Gates Health Care Plan, 195 F.3d 292, 294–95 (7th Cir. 1999), *cert. denied*, 529 U.S. 1068 (2000).

129. *See* United States *ex rel.* Druding v. Care Alts., 952 F.3d 89 (3d Cir. 2020), *cert. denied sub nom.* Care Alts. v. United States, 141 S. Ct.

court stated that Medicare and Medicaid claims may be considered false so long as expert testimony is provided to challenge the treating physician's medical opinion.[130] Such a framework, if adopted by private insurers, could enable them to simply retain physicians to oppose the opinions of physicians submitting claims. This move away from "objective falsity" would open the door for insurers to engage in more creative and subjective denials.

The risks associated with insurers' broad ability to deny have been documented in both medical[131] and legal academic literature.[132] They are apparent to nearly anyone who interacts with the American health care system.[133] At worst, such denials can result in death.[134] More frequently, they

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1371 (2021).

130. *Id.* at 98 ("[M]edical opinions may be 'false' and an expert's testimony challenging a physician's medical opinion can be appropriate evidence for the jury to consider the question of falsity.").

131. *See* Bennett, *supra* note 126, at 823 (primarily discussing the denial-heavy practices of private health insurers, but noting, "we should not be fooled into thinking that public payers such as Medicaid or Medicare behave any differently").

132. *See, e.g.*, E. Daniel Robinson, Note, *Embracing Equity: A New Remedy for Wrongful Health Insurance Denials*, 90 MINN. L. REV. 1447, 1447–48 (2006) (discussing the harms of wrongful health care denials in the context of ERISA claims).

133. *See generally* DANIEL SKINNER, MEDICAL NECESSITY: HEALTH CARE ACCESS AND THE POLITICS OF DECISION MAKING 3–4 (2019) ("The actors within medical necessity debates include patients and physicians . . . but also the pharmaceutical, hospital, and insurance industries, physicians' groups, the American Association of Retired Persons (AARP), marijuana supporters and opponents, mental health and disability rights advocates, various governmental and nongovernmental actors, and pressure groups on both the federal and state levels. . . . with daily medical necessity debates collectively amounting to a persistent uncertainty about the basic mechanisms and aims of medical decision making.").

134. *See* Robinson, *supra* note 132, at 1447 (discussing the factual background of *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003), wherein Carmine Cicio was diagnosed with blood cancer and her insurance provider unilaterally denied authorization for a stem cell transplant until the

lead to inefficiencies for physician offices and frustration for patients.[135] Denial-heavy practices by insurers have not been demonstrated to improve care quality for patients.[136] Further, these practices may actually increase the overall economic cost of health care rather than decrease it, creating financial harm to patients beyond the health harm of withholding treatment.[137]

In light of these risks, it would be prudent to resolve the FCA split before private insurers, or even the Centers for Medicare and Medicaid Services, use it to broaden their repertoire of reasons for claim denial.

ii. Risk of Conflating FCA Liability with Medical Malpractice

Confusion resulting from this split may not necessarily be limited to decisions on insurance claims. Rather, the current split also has the potential to inadvertently conflate the standards of FCA liability with those of medical malpractice. Traditionally, these have been different causes of action with different standards and jurisprudence.[138] The

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cancer had progressed to such an extent that the treatment would no longer be effective).

135. *See, e.g.*, Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, U. PA. L. REV. 1637, 1711 (1992) ("Health insurance coverage disputes are subject to a complex interplay among courts, insurers, and patients. . . . Two forms of market failure result: pricing purchasers out of the market altogether, or forcing them to buy more expensive insurance products than they desire."). *See also* Marina Evrim Johnson & Nagen Nagarur, *Multi-Stage Methodology to Detect Health Insurance Claim Fraud*, 19 HEALTH CARE MGMT. SCI. 249, 249 (2016) ("[I]nsurance claim denials are also a significant part of total healthcare spending. They bring a lot of unnecessary administrative cost because most of the providers and patients appeal the claim denials.").

136. Bennett, *supra* note 126, at 823–24.

137. *See id.* at 823 (denials create delays in treatment and care, which in turn create unnecessary costs, "most of which is born by hospitals and passed on to health care consumers.").

138. *See generally* Patrick A. Scheiderer, *Medical Malpractice as a*

FCA requires a submission of a false claim to the federal government in order to invoke liability.[139] Medical malpractice, conversely, is a common law claim arising from a violation of the standard of care in a physician-patient relationship.[140] While these two concepts do both relate to some sort of malfeasance by a health care professional, they are still distinct from one another.

Medical malpractice is a common law doctrine that far predates the FCA.[141] However, the current split blurs the line between these two separate actions. To understand this, one need only look as far as the Tenth Circuit's 2018 decision in *Polukoff*.[142] That court's reasoning rested on the notion that since the disputed treatment was outside the typical standard of care, it could count as a false claim for the purpose of FCA liability.[143] This was an example of a court trying to discern the definition of medical falsity under the

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Basis For a False Claims Action?, 33 IND. L. REV. 1077 (2000) (discussing the legal and historical distinctions between FCA liability and medical malpractice and concluding that medical malpractice should not be a potential basis for FCA liability).

139. 31 U.S.C. § 3729(a)(1)(A).

140. 3 MODERN TORT LAW: LIABILITY AND LITIGATION 2d *Elements of Medical Malpractice Claim* § 24:1, Westlaw (database updated June 2021).

141. *See* McCullum v. Tepe, 693 F.3d 696, 702 (6th Cir. 2012) ("In England, '*mala praxis* [was] a great misdemesnor [sic] and offence at common law, whether it be for curiosity and experiment or by neglect; because it breaks the trust which the party had placed in his physician, and tends to the patient's destruction.' 4 William Blackstone, Commentaries, *122; *see also Dr. Groenvelt's Case,* (1697) 91 Eng. Rep. 1038 (K.B.) (discussing the case a of doctor imprisoned for malpractice); Andrew A. Sandor, *The History of Professional Liability Suits in the United States,* 163 J. Am. Med. Ass'n 459, 459 (1957) (citing English civil medical-malpractice cases decided as early as 1374. . . . The first reported American medical-malpractice case appears to be *Cross v. Guthery,* 2 Root 90, 1794 WL 198 (Conn.Super.1794).") (footnote omitted).

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

143. *See id.* at 744.

False Claims Act, and it resulted in the court simply resorting to a medical malpractice framework.

Without addressing and resolving this split, these two standards may conflate further and eventually blur the lines between FCA claims and malpractice claims. This would result in increased confusion for doctors, patients, malpractice insurers, and courts. Such confusion would have negative consequences.[144] In light of these implications, the FCA split should be addressed before the line between FCA liability and medical malpractice blurs entirely.

iii. Implications on Other Areas of the Law

Finally, resolution of this split, or lack thereof, can have implications across a range of legal areas beyond Medicare and Medicaid fraud. These include all areas of law where the veracity of a medical opinion may be at issue, such as personal injury litigation, social security disability claims, worker's compensation, etc.[145] Dealing with conflicting medical opinions is by no means a modern development in the legal system.[146] Rather, conflicting opinions of medical

144. Scheiderer, *supra* note 138, at 1098–99 ("The FCA should not be used to help ensure that individuals who are provided government-funded health care receive quality health care. Particularly, it should not be used as an additional punishment of doctors who commit medical malpractice, above and beyond the penalties accessed by a victim's normal civil malpractice claim . . . In addition, a doctor should not be subjected to false claims liability based on a mere mistake, negligence or lack of insight. Such mistakes, negligence or lack of insight do not reach the level of immoral wrongdoings that the FCA sought to punish. . . . For the above reasons, it is inconceivable that medical malpractice could serve as a basis for a false claims cause of action under the FCA. Not only is such an application of the FCA unreasonable and illogical, it is not what Congress intended.").

145. *See* Jerome Schofferman, *Opinions and Testimony of Expert Witnesses and Independent Medical Evaluators*, 8 J. PAIN MED. 376, 376 (2007) ("The practice of medicine has expanded from clinical care and research to include medical-legal work such as expert witness testimony and independent medical evaluations.").

146. *See, e.g.*, ALEXANDER WILLIAM MACDOUGALL, THE MAYBRICK

professionals have been the focus of judicial decisions for generations.[147]

The areas of law that deal with these issues are vast and diverse.[148] These issues are not limited to civil litigation; they come up in criminal cases as well.[149] These issues arise so frequently that they have resulted in discussion of the potential ethical quandaries physicians may face when testifying on these issues.[150]

While not every instance of a disputed medical opinion falls within the context of FCA liability for Medicare or Medicaid fraud, all these disputes rest on several of the same central questions: How should a court best give credence to different medical opinions? Should judges be empowered to disagree with physicians on issues of treatment? When can a medical opinion be false?

These questions are unlikely to disappear from any areas of the legal system on their own. Rather, they will continue to come up in expected and unexpected ways, and that will remain true regardless of whether or how the FCA split is resolved. However, resolution of the FCA split may provide a helpful model for how to deal with these questions in the future.

CASE: A TREATISE 128 (1891) ("The only thing before a coroner's jury is a dead body which they have viewed, and the jury are summoned by the coroner to make an inquiry into the circumstances under which that death occurred.").

147. *See id.*

148. *See* Larry W. Myers, *"The Battle of Experts:" A New Approach to an Old Problem in Medical Testimony*, 44 NEB. L. REV. 539, 542–43 (1965) (collecting cases in which a "battle of experts" took place for juries to decide between conflicting medical opinions); *see also* Schofferman, *supra* note 145.

149. *See, e.g.*, Henry Weihofen, *Eliminating the Battle of Experts in Criminal Insanity Cases*, 48 MICH. L. REV. 961 (1950); Leonard B. Steinberg, *The Impartial Expert Medical Witness in a Criminal Proceeding*, 34 TEMP. L. Q. 453 (1961).

150. *See, e.g.*, Schofferman, *supra* note 145, at 377.

To date, the Supreme Court has not taken advantage of the opportunity to provide guidance on these questions. Rather, it has recently denied certiorari on them.[151] Granting certiorari on these questions could lead to a more universal and coherent framework for dealing with the issue of medical falsity under the FCA. Such a framework would not necessarily be limited to *qui tam* FCA claims but could potentially impact a wide array of cases.

C. *A Note on "Bad Apples"*

Before proceeding into a discussion of the possible ways to resolve this split, it is important to note that no matter how this is resolved, there will always be the potential of some number of health care practitioners who try to game the system. It is inevitable that bad actors will try to commit fraud regardless of the status of the current circuit split.[152] Fraud is an unfortunate reality in practically any

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151. *See* 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); United States *ex rel.* Druding v. Care Alts., 952 F.3d 89 (3d Cir. 2020), *cert. denied sub nom.* Care Alts. v. United States, 141 S. Ct. 1371 (2021).

152. *See Quick Facts on Health Care Fraud Offenses*, U.S. SENT'G COMM'N, https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Health_Care_Fraud_FY20.pdf (last visited Apr. 8, 2022) (In the 2020 fiscal year, 64,565 cases of health care fraud were reported to the United States Sentencing Commission.); *Justice Department Recovers Over $2.2 Billion from False Claims Act Cases in Fiscal Year 2020*, U.S. DEP'T JUST. (Jan. 14, 2021), https://www.justice.gov/opa/pr/justice-department-recovers-over-22-billion-false-claims-act-cases-fiscal-year-2020 (describing the billions of dollars recovered by the federal government in the 2020 fiscal year alone due to FCA fraud cases); Geoff Norman, *Identifying the Bad Apples*, 20 ADV. IN HEALTH SCI. EDUC. 299, 302 (2015) (asserting "it is folly to presume that we will ever be able to create an adequate diagnostic test to the ultimately rare disease of unprofessionalism" in the medical field).

industry.[153] The health care industry is no exception.[154] The proclivity for certain actors to engage in fraudulent practices in business generally, and in health care specifically, further underscores the need to clear up the issues created by the FCA split.

An effective resolution to the split must therefore acknowledge that proclivity. Doing so can enable a resolution to ensure that liability still is available in situations where it is truly warranted, such as when "bad doctors" have specific intent to defraud the United States government.

III. RESOLVING THE SPLIT

Having examined the risks the current split poses, this Part now examines two broad categories of resolution to the split. These categories are (1) judicial resolutions and (2) legislative or administrative resolutions. It is outside the scope of this Comment to identify any single proposal as an ideal one. Rather, this Comment has sought to demonstrate the need for effective resolution to the current split. It now provides an overview of possible means by which this can be achieved. Feasible judicial solutions could come from the Supreme Court adopting one of the circuit's approaches or espousing a new standard. Alternatively, possible legislative or administrative resolutions may embrace a framework that is deferential to the opinions of the medical practitioners closest to the case.

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153. *See* Alexander Dyck et al., *How Pervasive is Corporate Fraud?*, REV. OF ACCT. STUD. (2023) (estimating ten percent of large publicly traded firms commit securities fraud every year); Anup Agrawal & Sahiba Chadha, *Corporate Governance and Accounting* Scandals, 48 J.L. & ECON. 371, 372 (2005) (examining the reasoning behind the observation that in corporate America, "[r]evelations about the unreliability of reported earnings continue to mount.").

154. *See, e.g.*, Norman, *supra* note 152, at 302.

A. *Judicial Resolution*

1. Circuit Resolution

The United States Supreme Court does not have the time or resources to adequately deal with every open question of law.[155] For this reason, some commentators promote circuits attempting to resolve splits without guidance from the Supreme Court.[156]

Particularly, Professor Wyatt G. Sassman recently advocated for circuit courts to be less stringent in their application of the "law of the circuit" doctrine.[157] This doctrine, when employed strictly, requires federal appellate panels to abide by precedents of prior panels from the same circuit.[158] At face value, this appears to be a simple application of the principle of *stare decisis*.[159] Professor

155. *See* Wyatt G. Sassman, *How Circuits Can Fix Their Own Splits*, 103 MARQ. L. REV. 1401, 1405 (2020) ("[T]he open secret is that the Supreme Court cannot possibly resolve all of the conflicts generated by the courts of appeal.").

156. *See id.* at 1403; Michael Duvall, *Resolving Intra-Circuit Splits in the Federal Courts of Appeal*, 3 FED. CTS. L. REV. 17 (2009) (discussing advantages and disadvantages to different methods of resolving intra-circuit splits in courts of appeals).

157. Sassman, *supra* note 155, at 1451.

158. *See id.* at 1406 ("The heart of the doctrine is a strict rule that prohibits panels of a federal court of appeals from revisiting prior panel decisions unless there is an intervening change in higher authority, generally meaning a change in the law from the Supreme Court or the court of appeals sitting en banc."); Henry J. Dickman, Note, *Conflicts of Precedent*, 106 VA. L. REV. 1345, 1350 (2020) (identifying the law of the circuit doctrine as the "same general framework" employed by all circuit courts of appeals).

159. *See generally* Henry Paul Monaghan, *Stare Decisis and Constitutional Adjudication*, 88 COLUM. L. REV. 723, 745 (1988) ("The operation of stare decisis . . . is agenda limiting in nature. The Court could not fairly look at [previously decided] issues *res nova*. Regardless of whether the Court thought these issues rightly decided, consciously or unconsciously any challenge would be screened out *in limine*.").

Sassman notes, however, that strict adherence to the decisions of prior panels within a circuit does not lend itself to resolving discrepancies between different circuits when they arise.[160] Rather, such adherence only serves to deepen splits that occur. With this dynamic in mind, Professor Sassman suggests that a relaxation of the law of the circuit doctrine would allow appellate courts to resolve splits without needing Supreme Court guidance.[161] He argues this would result in structural, institutional, and economic benefits for the federal judiciary.[162]

While a relaxation of the law of the circuit doctrine may provide those benefits, it would be unlikely to completely resolve the confusion created by the current FCA split. The current split is spread between several circuits,[163] so resolution between them would take a substantial collective effort. This is unlikely considering that some of the circuits refuse to acknowledge their inconsistency with one another.[164]

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160. *See* Sassman, *supra* note 155, at 1451–52. Sassman's critique of the rigidity of the law of the circuit doctrine is evocative of mainstream commentary, both judicial and academic, about the drawbacks of *stare decisis*. *See, e.g.*, Monell v. Dep't Soc. Servs. New York, 436 U.S. 658, 695 (1978) ("[W]e have never applied *stare decisis* mechanically to prohibit overruling our earlier decisions determining the meaning of statutes."); Roscoe Pound, *What Of Stare Decisis?*, 10 FORDHAM L. REV. 1, 13 (1941) ("American courts have been quite sufficiently inclined to rectify obvious, clearly demonstrated mistakes in the light of reason applied to experience. What needs rectification is a judicial habit of following language extracted from its setting by text writers, of adherence to formulas instead of to the principle of decisions, and the taking of the words for law rather than the judicial action which those words sought to explain.").

161. Sassman, *supra* note 155, at 1454.

162. *Id.*

163. *See supra* Section I.B.

164. *See, e.g.*, Winter *ex rel.* United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc., 953 F.3d 1108, 1118 (9th Cir. 2020), *cert. denied sub nom.* RollinsNelson LTC Corp. v. United States *ex rel.* Winters, 141 S. Ct. 1380

Therefore, it would be imprudent for the Supreme Court to continue to forgo dealing with this split on the belief that the circuits can work it out themselves. Doing so will only exacerbate the problems caused by this split and proliferate future problems.[165]

2. Supreme Court Resolution

While one may hold out hope for the FCA split to be resolved by the circuits themselves, a more realistic judicial solution may be for the Supreme Court to address the split. If the Court does address this split, the primary ways to do so would either be to adopt one of the circuit's approaches or to espouse a new doctrine.

If the Supreme Court took up this question, it would not do so with a blank slate regarding its own jurisprudence. While the Court has yet to define "false" or "fraudulent" with regard to the FCA,[166] and has acknowledged that the text of the statute is silent as to those definitions,[167] it has held that the FCA should be interpreted as "incorporat[ing] the common-law meaning of fraud."[168]

In 2016, the Court stated in *Universal Health Services, Inc. v. United States ex rel. Escobar* that "fraudulent" as used in the FCA is a "paradigmatic example of a term that

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(2021).

165. *See supra* Part II.

166. *See, e.g.*, 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. II.-21, II-27 to II-28 n.38 (2021).

167. *See* Universal Health Servs., Inc. v. United States *ex rel.* Escobar, 579 U.S. 176, 187 (2016) ("Congress did not define what makes a claim 'false' or 'fraudulent.'").

168. *Id.* The Court highlighted that a well settled principle of statutory interpretation is that "absent other indication, 'Congress intends to incorporate the well settled meaning of the common-law terms is uses.'" *Id.* (quoting Sekhar v. United States, 570 U.S. 729, 732 (2013)).

incorporates the common-law meaning of fraud."[169] In support of that proposition, the Court cited a 1999 mail fraud case.[170] In that case, the Court stated, "the well-settled, common-law meaning of 'fraud' require[s] a misrepresentation or concealment of *material* fact."[171]

In *Escobar*, it was undisputed that misrepresentations by omission can constitute falsity.[172] In fact, this was asserted in both the appellant's[173] and respondent's briefs,[174] as well as the amicus curiae brief of the United States.[175] Unfortunately, the Court's acknowledgment that the common law's definition of falsity includes misrepresentations by omission falls short of a cohesive, unified definition of falsity.[176] It implies that certain

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169. *Id.*

170. *See id.* (citing Neder v. United States, 527 U.S. 1, 22 (1999)).

171. *See Neder*, 527 U.S. at 22.

172. *Escobar*, 579 U.S. at 187.

173. *Id.* (citing Brief for Petitioner at 30–31, Universal Health Services, Inc. v. United States *ex rel.* Escobar, 579 U.S. 176 (2016) (No. 15-7)).

174. *Id.* (citing Brief for Respondents at 22–31, *Escobar*, 579 U.S. 176 (No. 15-7)).

175. *Id.* (citing Brief for United States as Amicus Curiae at 16–20, *Escobar*, 579 U.S. 176 (No. 15-7)).

176. The *Escobar* holding was limited to confirming that health care providers submitting Medicare or Medicaid claims that make representations about services provided—while knowing that statutory, regulatory, or contractual requirements were not complied with in the rendering of those services—can constitute a false claim if a misrepresentation about the provider's compliance with those requirements is material to the federal government's payment decision on the claim. *See id.* The Court provided three factors for examining whether a claimant's misrepresentation is material to the government's decision to pay the claim. *See id.* at 194–95. These are (1) "the Government's decision to expressly identify a provision as a condition of payment," (2) "evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement," and (3) "if the Government pays a particular claim in full

misrepresentations may not necessarily be "false" without meeting a certain threshold of severity,[177] but it does not state what that threshold is. It does not answer, for instance, whether that threshold must reach objective falsity.[178] Nor does it state whether it is necessary or sufficient for there to be a difference of medical opinion,[179] exaggeration of fact,[180] reckless disregard with respect to medical necessity,[181] or some other standard. These questions remain unresolved due to the split.

Perhaps the simplest method for the Supreme Court to resolve the split would be to render a decision formally adopting one of the circuits' approaches. This has been advocated for by multiple commentators.[182] However, a fault

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despite its actual knowledge that certain requirements were violated." *Id.* The Court's enumeration of factors to analyze materiality but not falsity may be linked to the fact that the FCA does provide a statutory definition of "material." *See* 31 U.S.C. § 3729(b)(4) ("[T]he term 'material' means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.").

177. *See Escobar*, 579 U.S. at 194 ("Materiality . . . cannot be found where noncompliance is minor or insubstantial.").

178. *Compare* United States v. AseraCare, Inc., 938 F.3d 1278, 1298 (11th Cir. 2019) (implementing the objective falsehood standard), *with* Winter *ex rel.* United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc., 953 F.3d 1108, 1122 (9th Cir. 2020), *cert. denied sub nom.* RollinsNelson LTC Corp. v. United States *ex rel.* Winters, 141 S. Ct. 1380 (2021) (rejecting the objective falsehood standard), *and* United States *ex rel.* Druding v. Care Alts., 952 F.3d 89, 100 (3d Cir. 2020), *cert. denied sub nom.* Care Alts. v. United States, 141 S. Ct. 1371 (2021) (rejecting the objective falsehood standard).

179. *See Druding*, 952 F.3d at 100.

180. *See* United States v. Paulus, 894 F.3d 267, 270 (6th Cir. 2018).

181. *See* United States *ex rel.* Polukoff v. St. Mark's Hosp., 895 F.3d 730, 744 (10th Cir. 2018).

182. *See* Caruso, *supra* note 166, at II-43 (concluding the Supreme Court should have adopted the Eleventh Circuit's objective falsehood standard); Jameson Steffel, *End of Life Uncertainty: Terminal Illness, Medical Hospice Reimbursement, and the "Falsity" of Physicians' Clinical Judgments*, 89 U. CIN. LAW. REV. 779, 805 ("Moving forward, courts

of this approach is the prospect that lower courts may not feel bound by such a ruling. Some circuits have already expressed a view that the current circuit cases are sufficiently distinguishable from one another so that they can exist without tension.[183] If this viewpoint is held now, it will likely continue to be exhibited after the Supreme Court adopts one of the circuit's approaches. Circuit courts would likely continue to claim distinguishable facts and circumstances that warrant them not needing to follow the Supreme Court's ruling.[184] This would do little to rectify the actual confusion and negative impacts created by the split. Therefore, it is worth exploring a new, unified judicial standard to resolve the split.

Under a new standard, the Court may look to other areas of law for inspiration. In particular, the Court can look to the Social Security Administration's foregone treating physician rule.[185] This rule allows an adjudicator to view medical opinions of a provider who has a history of treating a particular patient with greater weight than those of a medical professional without that history.[186] It is only when substantial evidence is inconsistent with the treating

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should follow the AseraCare ruling when determining whether a physician's clinical judgment was false within the hospice setting.").

183. *See* United States v. AseraCare, Inc., 938 F.3d 1278, 1300 n.15 (11th Cir. 2019); Winter *ex rel.* United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc., 953 F.3d 1108, 1119 (9th Cir. 2020), *cert. denied sub nom*. RollinsNelson LTC Corp. v. United States *ex rel.* Winters, 141 S. Ct. 1380 (2021).

184. *See* Hellman, *supra* note 100.

185. *See* 20 C.F.R. § 404.1527(c)(2) ("Generally, we give more weight to medical opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.").

186. *See id.*

physician's opinion that the medically acceptable opinion of a treating physician would not be given controlling weight.[187] Essentially, the rule protects patients' care from interference by independent, or even adversarial, medical evaluators who do not necessarily have the patients' well-beings as their top priority.[188]

In the context of the questions raised by the current FCA

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187. *See* Edward Dale et al., *The Treating Physician Rule in Medicare Cases*, 28 CLEARINGHOUSE REV. 1162, 1163 (1995) (citing then existing Social Security Administration regulations). For an example of this standard in action, see Stacey v. Comm'r Soc. Sec. Admin., 799 Fed. App'x 7 (2d Cir. 2020). There, the Second Circuit held that an administrative law judge's decision to not give controlling weight to medical opinions of a claimant's treating physician was not supported by substantial evidence. *Id.* at 9. The administrative law judge had regarded the opinions of two state psychological experts above the opinions of the claimant's treating psychologist regarding the claimant's vocational capabilities. *Id.* at 8. The Second Circuit reversed that evidence, holding that substantial evidence must be present to disregard the findings of a claimant's treating physician. *Id.* at 9.

188. Such evaluators appear in a variety of contexts where patients' treatment is at stake, and the negative impact for patients is widely documented. *See, e.g.*, Richard J. Thomas & Bryan G. Ascheman, *No-Fault Independent Medical Examinations: Purpose, Timing and Impact*, 24 WM. MITCHELL L. REV. 1045, 1051–52 (1998) (discussing the Minnesota No-Fault Automobile Insurance Act's requirements for car accident victims who seek medical treatment to undergo independent medical exams where insurers can assess the medical necessity of treatment, and noting that such a system is "overly adversarial" and "more often than not, results in a finding adverse to the claimant"); Samuel D. Hodge, Jr. et al., *A Guide to the Independent Medical Examination*, 25 ALB. L.J. SCI. & TECH. 339 (2015) (examining conflicting approaches among a variety of jurisdictions as to the extent to which independent medical examiners owe a duty of care to the examinee); Jerome Schofferman, *Opinions and Testimony of Expert Witnesses and Independent Medical Evaluators*, 8 PAIN MED. 376, 378 (2007) ("[I]n our current [adversarial] system, it is no longer expected that an expert's opinion will be fair and balanced. An expert witness physician is 'not expected to excel in fair and probing analyses of all sides of issues.'") (quoting ROBERT A. KAGAN, *Adversarial Legalism and Civil Justice*, *in* ADVERSARIAL LEGALISM: THE AMERICAN WAY OF LAW 61–81 (2001)).

split, judicial adoption of the treating physician rule can allow judges to give greater weight to treatment decisions rendered by physicians with a history of treating a particular patient. In the circuit cases that led to this split, such an approach could have resulted in more efficient resolutions. Whether it was a physician treating patients' migraines with unorthodox procedures,[189] a cardiologist deciding that an angiogram was necessary for a patient,[190] or a health care provider determining that their patient needed hospice care,[191] the treatment decisions of treating physicians were central in these cases. Therefore, applying a version of the treating physician rule to these disputes may represent a framework for resolution.[192] Deferring to the opinions of treating physicians in instances where the evidence and circumstances do not substantially suggest fraud would enable patients to receive the treatment they need while still allowing for FCA enforcement when fraud is present.

Such a doctrine would not be without criticism. Detractors would inevitably argue that it provides too much deference to treating physicians, which results in a virtually unfettered ability to defraud the federal government. However, a treating physician standard would not require blind adherence to assertions by physicians. Rather, it would defer to treating physicians when there is no substantial evidence of fraud.[193] This represents a workable standard that balances the national interest in pursuing health care

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

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

191. *See* United States v. AseraCare, Inc., 938 F.3d 1278 (11th Cir. 2019); United States *ex rel.* Druding v. Care Alts., 952 F.3d 89 (3d Cir. 2020), *cert. denied sub nom.* Care Alts. v. United States, 141 S. Ct. 1371 (2021).

192. *See generally* Dale et al., *supra* note 187(noting arguments that in Medicare cases, treating physicians' opinions should be accorded even greater weight than in social security disability cases).

193. *See supra* note 187 and accompanying text.

treatment with that of avoiding fraud.

Of course, this would not be a complete panacea for falsity issues raised by Medicare and Medicaid FCA claims. For example, it would not apply to claims arising from physicians without a history of treating the patient in question. Additionally, it may garner criticism since the Social Security Administration formally repealed its version of the treating physician rule in 2017.[194] The rule's conceptual import, however, can be applied to Medicare and Medicaid FCA claims and represent an appropriate framework to navigate the issues arising from the split. A version of the rule's substantial evidence standard would be one method to seek out the appropriate threshold suggested in *Escobar*.

B. *Non-Judicial Resolutions*

The Supreme Court's recent reluctance to grant certiorari on this issue means a judicial resolution to this split may not be seen anytime soon. Further, fear of a judicial activist label may disincline the Court from taking any broad remedial measures on this issue. Therefore, it is prudent to examine other possible ways to resolve the split, or at least limit the harm caused by it. Such possibilities may include legislative or administrative solutions. Social security disability law provides examples of both kinds that may be beneficial if applied to the current split.

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194. *See* Charles Terranova, Comment, *Somebody Call My Doctor: Repeal of the Treating Physician Rule in Social Security Disability Adjudication*, 68 BUFF. L. REV. 931, 957–58 (2020) (noting on January 18, 2017, the Social Security Administration published a final rule repealing its treating physician rule with regard to all claims filed after March 27, 2017). *But see* Dale et al., *supra* note 187, at 1163 ("Advocates have successfully argued that attending doctors' opinions should be accorded ever greater weight in Medicare cases than in social security disability cases.")

1. Legislative Resolution

There are three legislative approaches to resolving the split that may immediately jump out to an observer. These are (1) amending the FCA to define "false" or "fraudulent"; (2) repealing the 1986 amendments that led to a proliferation of Medicare and Medicaid FCA claims;[195] and (3) adopting a national single-payer health care system.[196] However, these three proposals are unlikely to make any significant progress on the issues created by this split. Therefore, for the purposes of this Comment, they can be dismissed relatively summarily.

Regarding the first proposal, while a statutory definition of "false" would lessen the need for judicial interpretation of the term, the history of this issue reveals that the term is inherently challenging—if even possible—to define with clarity.[197] Therefore, this may not be a viable legislative

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195. *See* Salcido, *supra* note 36.

196. No contemporary discussion of issues in the United States health care industry would feel complete without mentioning proposals for single-payer health care. This topic has proliferated the legal, academic, and political discourse of health care reform over the past several years. *See, e.g.*, Edward Lee, *Universal Access to Health Care*, 108 HARV. L. REV. 1323, 1328 (1995) ("For health care, the central moral question is whether universal access to health care is more just than the current market-based distribution of health insurance."); Jean Yi, *More States are Proposing Single-Payer Healthcare. Why Aren't They Succeeding?*, FIVETHIRTYEIGHT (Mar. 9, 2022, 6:00 AM), https://fivethirtyeight.com/features/more-states-are-proposing-single-payer-health-care-why-arent-they-succeeding/. Arguments for and against such a system are well documented in literature across a variety of fields. *Compare* James B. Roche, *Health Care in America: Why We Need Universal Health Care and Why We Need It Now*, 13 ST. THOMAS L. REV. 1013 (2001) (offering moral, economic, and logistical arguments in favor of universal health care), *with* David E. Bloom et al., *The Promise and Peril of Universal Health Care*, 361 SCIENCE, Aug. 24, 2018, at 6 (noting several potential pitfalls in the implementation of a universal health care system).

197. *See, e.g.*, Isaac D. Buck, *A Farewell to Falsity: Shifting Standards in Medicare Fraud Enforcement*, 49 SETON HALL L. REV. 1, 41 (2018). The difficulty in defining falsity—or even truth—is not limited to FCA issues.

solution.

As for the second proposal, the 1986 amendments did nothing to address how falsity is defined or interpreted under the act.[198] Therefore, repealing them would do nothing to assist courts in determining whether a claim is false when challenged under the FCA.[199]

For the third proposal, while it is possible such a reform could improve other areas of health care,[200] it would do little to fix the issues caused by this split. This is because this split already applies to health care claims submitted to the federal government. Health care claims under a national single-payer health care system, would still be claims submitted to the government. False claims under such a system would therefore still be subject to liability under the FCA. The same issues in defining falsity would arise.

A legislative solution that could alleviate some of these issues would be to amend the FCA to incorporate a rule to the same effect as the treating physician rule. This would allow the rule's substantive benefits to enter FCA

See Robert S. Summers, *Formal Legal Truth and Substantive Truth in Judicial Fact-Finding—Their Justified Divergence in Some Particular Cases*, 18 L. & PHILOSOPHY 497, 501–05 (1999) (observing how fact findings in court may diverge from substantive truth); Susan Haack, *Truth, Truths, "Truth," and "Truths" in the Law*, 26 HARV. J.L. & PUB. POL'Y 17, 20 (2003) ("[L]egal claims are subject to indeterminacies of meaning, and, as with partially defined predicates or functions in logic or mathematics, may be definitely correct or definitely incorrect only in some applications. So, they are susceptible to truth-value gaps.").

198. *See* Pashke, *supra* note 20, at 164–65 ("[T]he 1986 amendments create incentives and give relators power to bring qui tam actions in response to fraud in other areas of Government spending [beyond military and defense fraud].").

199. The 1986 amendments did, however, lead to a proliferation of Medicare and Medicaid claims brought under the FCA. *See* Salcido, *supra* note 36. Repealing them may therefore potentially serve as a stopgap to prevent the split from worsening while a proper solution is worked out. This would not in and of itself resolve the split.

200. *See, e.g.*, Roche, *supra* note 196.

jurisprudence without the need for judicial intervention. As discussed above, the treating physician rule was initially a codified rule of the Social Security Administration.[201] It allowed judges to give greater weight to the medical opinions of patients' regular physicians than those of independent examiners.[202]

In the context of Medicare and Medicaid FCA disputes, such a rule could more effectively balance the goals of the FCA with the interest of providing treatment to Medicare and Medicaid patients.[203] In light of the Supreme Court's reluctance to wade into this issue, and the current inconsistent approaches across circuits, it may be unlikely to see the judiciary adopt this rule anytime in the near future. The rule's substantive benefits, however, may be achieved legislatively through amendments to the FCA.[204]

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201. *See supra* note 185 and accompanying text.

202. *See* Terranova, *supra* note 194, at 944 ("While slight variations [of the treating physician rule] developed over time, the rule's core idea remained: the opinion of a claimant's treating source deserves great weight because of her unique perspective on the claimant's conditions.").

203. *See* Dale et al., *supra* note 187.

204. Amending the FCA is not unfamiliar territory for Congress. For instance, the 1986 amendments created a significant change in how the Act is utilized among practitioners. *See* Pashke, *supra* note 20, at 173. Further amendments have been regularly discussed and debated since then. *See, e.g.*, Gregory R. Jones & Kevin M. Coffey, *Senate to Consider Pared Down, But Still Unfavorable, Amendments to FCA*, NAT. L. REV. (Nov. 22, 2021), https://www.natlawreview.com/article/senate-to-consider-pared-down-still-unfavorable-amendments-to-fca; Robert T. Rhoad & Matthew T. Fornataro, *A Gathering Storm: The New False Claims Act Amendments and Their Impact on Healthcare Fraud Enforcement*, 21 HEALTH LAW. 14, 16–20 (2009) (discussing the 2009 Fraud Enforcement and Recovery Act (FERA), which made several procedural and substantive amendments to the FCA); Jeremy E. Gersh, Comment, *Saying What They Mean: The False Claims Act Amendments in the Wake of* Allison Engine, 5 J. BUS. & TECH. L. 125, 134–40 (2010) (same).

2. Administrative Resolution

Alternatively, the problems caused by the split could be alleviated by establishing an administrative framework to deal with Medicare and Medicaid FCA claims. One way this framework could work is by creating an independent commission or legislative agency specifically tasked with adjudicating these kinds of claims. This style of entity is utilized in several areas of the federal government.[205] When utilized effectively, it delegates authority to resolve disputes of a particular nature to adjudicators who have a sufficient level of expertise and experience in the relevant subject matter.[206]

A version of this model is used in social security disability law, a field which, like FCA litigation, frequently deals with disputed medical assessments.[207] Applying the

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205. *See generally Branches of the U.S. Government*, USAGOV, https://www.usa.gov/branches-of-government (last visited Apr. 8, 2022) (listing 20 legislative branch agencies, 66 independent agencies, 42 boards, commissions, and committees, and 14 special federal courts and judicial agencies).

206. For example, the National Labor Relations Board is a federal independent agency that specifically deals with labor disputes, such as claims under the National Labor Relations Act. *See* Samuel Estreicher, *'Depoliticizing' the National Labor Relations Board: Administrative Steps*, 64 EMORY L.J. 1611, 1612 (2015). A similar institution could be created for FCA disputes relating to Medicare and Medicaid claims. Certain legislative agencies already exist in the world of Medicare and Medicaid. *See About MACPAC*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/about-macpac/ (last visited Apr. 8, 2022) ("The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress . . . ."); MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE REPAYMENT POLICY (2022) ("The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency . . . [established] to advise the U.S. Congress on issues affecting the Medicare program.").

207. Administrative law judges ("ALJs") are used to hearing social security disability appeals and render final determinations on behalf of

model to Medicare and Medicaid FCA claims would effectively result in FCA adjudicators who have experience and expertise at the intersection of law and medicine. These adjudicators could fairly weigh the relative merits of the medical necessities of each respective claim. If these claims were guaranteed to be adjudicated by groups specifically designed to evaluate when a health care claim can be considered false, then the risk of judicial inconsistency and inaccuracy on this issue would likely be lowered.[208]

Of course, an administrative solution carries risk. It may

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the Social Security Administration. *See* Gerald Hayes, *Social Security Disability and the Administrative Law Judge*, 17 A.F. L. REV. 73, 75–76 (1975). They specialize in adjudicating disputes pertaining to the existence of a medical disability. *See id.* at 74–75. ALJs also may hear appeals in health insurance cases or hospital insurance benefit cases. *Id.* at 76. All these contexts revolve around questions relating to medical status or rendered treatment. Since these issues inherently involve complex medical determinations, it is appropriate for them to be adjudicated by specialists with expertise at the intersection of health and law.

208. Retroactive evaluation of medical treatment decisions requires a fair extent of understanding of the complexity of health care and medical expertise required to make adequate treatment decisions. The issues associated with judges making rulings based on technical complexities that they are not completely fluent in have been thoroughly debated, particularly in the context of administrative law. *See, e.g.*, Ethyl Corp. v. EPA, 541 F.2d 1, 66 (D.C. Cir. 1976) (Bazelon, C.J., concurring) ("'[I]n cases of great technological complexity, the best way for courts to guard against unreasonable or erroneous administrative decisions is not for the judges themselves to scrutinize the technical merits of each decision. Rather, it is to establish a decision-making process that assures a reasoned decision that can be held up to the scrutiny of the scientific community and the public.' . . . But I doubt judges contribute much to improving the quality of the difficult decisions which must be made in highly technical areas when they take it upon themselves to decide, as did the panel in this case, 'that in assessing the scientific and medical data the Administrator made clear errors of judgment.' The process making a de novo evaluation of the scientific evidence inevitably invites judges of opposing views to make plausible-sounding, but simplistic, judgments of the relative weight to be afforded various pieces of technical data.") (citations omitted).

face criticism for adding additional layers of bureaucracy to an area of the law that already faces a tremendous amount of red tape.[209] There is also a risk that specialized adjudicators would simply devolve into implementing the same practices as those done by conventional private insurers to determine medical necessity, thus replicating some of the harms identified in Part II.[210]

However, these risks pose no greater harm than those currently posed by the split.[211] Therefore, the benefits derived from utilizing focused expertise to resolve FCA Medicare and Medicaid disputes would outweigh the costs.

CONCLUSION

The FCA circuit split is the result of falsity being undefined in the FCA. While the confusion among federal courts on this issue is understandable, the harms to Medicare and Medicaid patients are real. Furthermore, the harm extends beyond those already at-risk groups. Therefore, it is imperative that this issue be addressed. The Supreme Court's recent denials of certiorari make it unlikely that the Court will adopt any of the circuit's approaches or create its own approach any time soon. Thus, there may be a need for a legislative solution that rectifies this issue. This can come by amending the FCA to incorporate either a version of the treating physician rule or by creating an administrative adjudication framework.

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209. For a brief overview of some the existing procedural red tape associated with FCA claims, see Marc S. Raspanti & David M. Laigaie, *Current Practice and Procedure Under the Whistleblower Provisions of the Federal False Claims Act*, 71 TEMP. L. REV. 23, 36–42 (1998).

210. *See supra* Section II.B.2,

211. *See generally supra* Section II.B (identifying risks for Medicare and Medicaid recipients as well as risks beyond that group).