No. 18-10500

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

ANGELA RUCKH, Relator
Plaintiff-Appellant,

v.

SALUS REHABILITATION, LLC, d/b/a Lavie Rehab; 207 MARSHALL DRIVE OPERATIONS, LLC, d/b/a Marshall Health and Rehabilitation Center; SEA CREST HEALTH MANAGEMENT, LLC; 803 OAK STREET OPERATIONS, LLC, d/b/a Governor's Creek Health and Rehabilitation Center; CMC II, LLC,
Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA

BRIEF FOR THE UNITED STATES OF AMERICA AS AMICUS CURIAE SUPPORTING APPELLANT

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Eleventh Circuit Rule 26.1, I hereby certify that the Certificate of Interested Persons contained in the Appellant's Opening Brief is complete, other than the following additions:

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Von Hoene, Kathleen M., Office of the Florida Attorney General.

Watson, Jason A., Consulate Health Care.

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As far as the undersigned is aware, no publicly traded corporation has an interest in the outcome of this appeal.

Dated: July 20, 2018

/s/ Benjamin M. Shultz
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INTEREST OF THE UNITED STATES

The False Claims Act (FCA), 31 U.S.C. § 3729 *et seq.*, is the federal government's primary tool to combat fraud and recover losses due to fraud in federal programs. Accordingly, the United States has a substantial interest in ensuring the proper interpretation of the FCA. The United States submits this amicus brief because the district court committed fundamental errors that threaten important government interests in remedying and deterring fraud.

The district court overturned a jury verdict after concluding that defendants' fraud was not material. But the court fundamentally misunderstood the materiality inquiry. The ultimate question is not whether years after the fact, upon learning of fraud allegations, the government elected to take enforcement actions that might have put defendants out of business. Rather, as the Supreme Court has explained, a defendant's falsehood is material where it would have a natural tendency to influence, or was capable of influencing, the government's behavior at the time of the transaction in question—which, in a fraudulent billing case, would be the time the government made payment. And when judged against that standard, a jury could easily conclude from the evidence in this case that defendants' fraud was material.

The district court also concluded that two defendants had not "caused" the submission of any false claims within the FCA's meaning. But the court applied an incorrect understanding of "cause." The FCA's terms generally incorporate common-law understandings, and thus the relevant standard is proximate cause.

STATEMENT OF THE ISSUES

The United States will address the following issues as amicus curiae:

1. Whether the district court erred in overruling the jury's conclusion that defendants' violations of various requirements for reimbursement under Medicare and Medicaid were material.

2. Whether the district court erred in overruling the jury's conclusion that two management entities "caused" the submission of false claims by adopting policies and practices that were likely or intended to induce facilities to submit false claims.

STATEMENT OF THE CASE

I. STATUTORY BACKGROUND

1. The FCA is "the Government's primary litigative tool for combatting fraud." S. Rep. No. 99-345, at 2 (1986). The FCA addresses a wide variety of fraudulent schemes, and it was drafted "expansively . . . to reach all types of fraud, without qualification, that might result in financial loss to the Government." *Cook County. v. United States ex rel. Chandler*, 538 U.S. 119, 129 (2003) (quotation marks omitted).

An FCA violation can occur when a person "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1)(A). A violation may also occur when a person "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." *Id.* § 3729(a)(1)(B). The FCA's "reverse" false-claims provision

imposes liability for someone who "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government." *Id.* § 3729(a)(1)(G). The term "material" is statutorily defined as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." *Id.* § 3729(b)(4).

Suits to collect statutory damages and penalties may be brought either by the Attorney General, or a private person (known as a *qui tam* relator) in the name of the United States. 31 U.S.C. § 3730(a), (b)(1); *see also Vermont Agency of Nat. Res. v. United States ex rel. Stevens*, 529 U.S. 765, 769-78 (2000). If a *qui tam* action is filed, the government may intervene and take over the case "within 60 days after it receives both the complaint and the material evidence and information," 31 U.S.C. § 3730(b)(2), or at a later date upon a showing of "good cause," *id.* §§ 3730(b)(3), (4), (c)(3). If the government declines to intervene, the relator conducts the litigation. *Id.* § 3730(c)(3). Monetary awards in *qui tam* suits are divided between the government and the relator. *Id.* § 3730(d).

2. This case involves Medicare and Medicaid. Medicare provides federally funded health insurance to eligible elderly and disabled persons. *See* 42 U.S.C. § 1395 *et seq.* Through its Part A, Medicare covers certain skilled nursing and rehabilitation care. *Id.* § 1395d(a)(2)(A); 42 C.F.R. § 409.61(b), (c). Facilities providing such care receive a daily rate for each Medicare patient they treat. *See* 42 C.F.R. § 413.335.

The daily rate varies among patients, with the exact amount depending on each patient's Resource Utilization Group (RUG) score. RUG scores measure the amount of resources a patient is expected to use, so patients with "high" RUG scores (those expected to use lots of resources) translate into higher daily rates for the facility than patients with "low" RUG scores. *See generally* 63 Fed. Reg. 26252, 26261-65 (May 12, 1998). These differences can be significant. In Fiscal Year 2009, for example, the base daily rate for rural facilities was $650.86 for the highest RUG score and $167.44 for the lowest, with numerous other possibilities in between. *See* 73 Fed. Reg. 46416, 46425 (Aug. 8, 2008).[1]

To compute a patient's RUG score, a facility assesses the patient's condition at predetermined intervals (*e.g.*, the patient's 14th day, 30th day, 60th day). 42 C.F.R. § 413.343(a)-(b). These assessments tabulate the amount of therapy, and certain other kinds of assistance, that the patient received in the days preceding the assessment date. *See id.* § 413.337(c); *id.* § 483.20(b)(1); RX2973 (resident assessment instrument manual).[2] After the patient's RUG score is computed, the facility must certify its accuracy, then submits it to Medicare to receive reimbursement. *See* Tr.321-22 (Lowrie-Morris); RX3021.

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[1] Urban rates were similar. *See* 73 Fed. Reg. at 46424-25. Base daily rates exclude local wage index adjustments and special add-ons in AIDS cases. *See id.* at 46424.

[2] Citations to relator's trial exhibits are abbreviated "RX[#]." Citations to the trial transcript are abbreviated "Tr.[page]." Citations to the district court's numbered docket entries are abbreviated "DE[#]."

Medicaid is a joint federal and state program that covers certain health costs for beneficiaries. *See* 42 U.S.C. § 1396 *et seq.* Like Medicare, Medicaid reimburses for skilled nursing care in Florida, but unlike with Medicare Part A, Florida facilities receive a flat daily amount regardless of the actual services required or used by an individual patient. Tr.361 (Lowrie-Morris).

This fee structure has the potential to lead to facilities minimizing the care provided to Medicaid recipients. Florida law, however, includes various provisions designed to ensure that facilities are providing appropriate care. One of these, articulated in a mandatory handbook, requires that facilities develop a "comprehensive plan of care" for all eligible Medicaid patients. *See* RX2972 at 49-50 (handbook); Fla. Admin. Code r. 59G-4.200 (2006) (requiring compliance with state handbook). Florida law also states that when nursing homes submit a Medicaid claim, they must ensure services have been provided "in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies." RX3031 at 192 (Provider General Handbook); Fla. Stat. § 409.908 (providers must be reimbursed in accordance with agency rules and the "policy manuals and handbooks incorporated by reference therein"); Fla. Admin. Code r. 59G-5.020 (2009) (requiring compliance with Provider General Handbook).

II. FACTUAL AND PROCEDURAL BACKGROUND

1. Relator Angela Ruckh brought this *qui tam* action under the FCA against two Florida skilled nursing facilities, two related entities (together, "the management

entity") that provided management services at those facilities and 51 others in Florida, and an affiliated company that provided rehabilitation services. DE63 at 1-2, 6-8; DE452 at 3. Relator previously worked at the two defendant facilities. DE63 at 6.

At trial, relator principally contended that defendants had been involved in three categories of fraud that go to the heart of the appropriateness of the payments made to defendants. First, she maintained that the facilities fraudulently reported higher RUG scores to Medicare than the actual scores dictated by patients' treatments—a practice known as "upcoding." Tr.233-34. Second, relator contended that the facilities would temporarily and artificially increase the treatment provided to Medicare patients during assessment periods, thereby inflating the patients' assigned RUG scores—a practice informally known as "ramping up." Tr. 233-34. Third, relator argued that the facilities failed to maintain the comprehensive care plans required for Medicaid patients, yet continued to bill Medicaid. DE63 at 3-4.

Over the course of a month-long trial, relator presented evidence supporting these contentions. *See, e.g.*, Tr.494, 563 (Ruckh) (upcoding); Tr.603-05 (Ruckh) (ramping up); Tr.696, 804-06 (Ruckh) (missing care plans); Tr.2127-28 (Bradley) (upcoding, ramping up, and missing care plans). An accountant testified that the amount paid in Medicare reimbursement would have been much lower if the reported RUG scores for various patients had not been falsely inflated. Tr.2451, 2472-73, 2497 (Vianello); RX1816BR; *see also* Tr.340-42 (Lowrie-Morris) (explaining how Medicare reimbursements vary based on reported RUG scores). And several witnesses testified

that completing a care plan is a "condition of payment" for Florida Medicaid. *See* Tr.376 (Lowrie-Morris) (Florida Medicaid will "automatically deny payment" if it knows at the time of claim submission that a care plan is missing); Tr.421 (Ruckh) (care plan is "necessary to be paid" by Florida Medicaid); Tr.4133 (Pelovitz) (defense expert, who acknowledged a care plan "need[s] to be in place" for Medicaid to pay). Testimony and exhibits also emphasized that the care plan requirement was important to counteract facilities' incentive to underprovide care to Medicaid recipients. *See, e.g.*, Tr.351-52 (Lowrie-Morris).

Defendants presented some materiality evidence of their own. In particular, they introduced evidence suggesting that state surveyors at some point learned about some of the care plan problems, yet Florida did not shut down the facilities or prospectively remove them from the Medicaid program. Tr.4129-30 (Pelovitz). Defendants' witnesses also testified—and the jury was entitled to believe—that these surveyors were interested in patient care, rather than proper billing (which is the purview of auditors). Tr.3317-23 (Dressel); Tr.4131-33 (Pelovitz). Defendants' evidence did not dispute the well-established proposition that the amount Medicare Part A pays for a given patient depends on the specific RUG code submitted. On the contrary, one defense witnesses expressly acknowledged that upcoding "would definitely influence payments." Tr.2975 (Juliano).

Relator also presented evidence linking the management entity to the facilities' conduct. Multiple witnesses testified that the management entity pressured nursing

home employees to achieve certain RUG targets, such as a certain percentage of patients billed with specified high RUG codes; although these targets were set without considering patients' actual medical needs, the management entity threatened facility employees with termination if they failed to reach these targets. *E.g.*, Tr.506-10 (Ruckh) (discussing weekly meetings at which staff were told they had "no choice" but to meet the targets, or else they would "hit the unemployment line"); Tr.510 (Ruckh) (explaining that because of these meetings, assessments "would be highly upcoded"); Tr.1489-90 (Rousey) (explaining that the RUG targets were not based on patients' actual therapy needs); Tr.3043, 3047-49, 3054-55, 3059-60, 3062 (Juliano) (discussing creation of RUG targets); RX217 (RUG targets); RX463 (same). Relator testified that an executive "expected" employees would engage in upcoding to meet the targets, and that an executive praised an employee for engaging in upcoding and ramping-up. Tr.517-18, 601 (Ruckh).

Relator also presented evidence that the management entity adopted policies that encouraged improper coding. These included: defaulting Medicare patients (but not Medicaid patients, for whom RUG codes are irrelevant) to receive exactly the minimum amount of therapy needed to qualify for the highest RUG score, *see* Tr.489-92 (Ruckh); making it administratively very difficult to assign certain lower RUG scores, *see* Tr.793-99 (Ruckh); and providing directions to facilities (in a presentation called "RUG Enhancement") to have a "mind set" where everyone will be in the

ultra-high therapy category so long as they can physically "tolerate" that amount of therapy, RX162; RX1899.

2. The jury found the management entity liable for causing the presentment of 123 false Medicare claims, for causing false records to be used material to the submission of 110 Medicare and 26 Medicaid claims, and for causing the false retention of overpayments on 21 Medicare claims. DE430 at 2, 4, 6. The two facility defendants were found liable for submitting 44 false Medicare claims and for retaining 34 Medicare overpayments. DE430 at 2, 4, 6; DE431 at 3. The affiliated rehabilitation company was found liable for 88 false claims (and associated statutory penalties) but no damages. DE431 at 3.

Defendants thereafter sought judgment as a matter of law under Rule 50(b), which the district court granted. DE468. The court described relator as arguing that the Medicaid claims were only fraudulent because of the care plan problem, and that the Medicare claims were only fraudulent because of "a handful of paperwork defects." DE468 at 1-2. The court then relied on *Universal Health Services, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016), to conclude that relator's claims failed on the "materiality" element. In the court's view, relator failed to present "evidence of how government has behaved in comparable circumstances," which the court described as evidence that "record-keeping deficiencies" would lead to "sudden and indefinite discontinuation of payment" to a large nursing home chain servicing numerous residents. DE468 at 10-11; *see also id.* at 12-13 (stating relator had to

exclude the possibility the government would choose an intermediate remedy such as an administrative sanction or price adjustment); *id.* at 17-18 (hypothesizing the government would not risk bankrupting numerous nursing homes, "unless every administrative and other remedy was exhausted and until" a satisfactory alternative provider was ready to serve all affected patients). The court expressly rejected any approach to materiality focused on the individual claims. DE468 at 18-20.

The district court also asserted that the scienter element was lacking for the same reason that materiality was lacking. DE468 at 10. And without citing any case law or defining the term "cause," the court concluded there was no evidence the management entity had "caused" the submission of any false claims. DE468 at 20-21; *see also id.* (asserting relator had not identified a person or group who "hatch[ed], direct[ed], and implement[ed]" a widespread scheme to defraud, and that relator failed to connect corporate practices "to any particular claim" actually submitted).

SUMMARY OF ARGUMENT

This case involves Medicare and Medicaid fraud. On the Medicare side, relator contended that defendants misrepresented the treatment they provided, and also artificially inflated their treatments at key times, so they could bill the government at higher rates than otherwise would have applied. On the Medicaid side, relator argued that defendants billed for services despite violating an important and required condition intended to ensure that patients receive the appropriate amount of care. The jury accepted these allegations and returned a verdict for the relator, but the

district court subsequently concluded that any fraud was not material as a matter of law.

That conclusion was erroneous, and it reflects a serious misunderstanding of both the proper test for materiality, and the scope of the misconduct relator asserted. Under the Supreme Court's *Escobar* decision, the materiality inquiry is meant to shed light on the government's decision-making at the time of the relevant transaction—not at some later date after the transaction is over. Thus, in a false billing case, a false representation will be material if it would likely have a tendency to affect the government's payment of the bill.

Judged by that standard, a jury could easily conclude that the undisclosed violations of important requirements for reimbursement under Medicare and Medicaid proven here were material. For the upcoded and ramped-up Medicare claims, materiality was plain: overwhelming evidence demonstrated that Medicare's payment amount turns on the specific RUG code submitted. And as to the Medicaid claims, although there was no direct testimony from a Florida Medicaid official, the jury's conclusion was also reasonable: evidence showed the care plan requirement was both a condition of payment in Florida and important to ensuring that Medicaid recipients received proper treatment.

The district court also erred in overruling the jury's conclusion that the management entity "caused" the submission of false claims by adopting policies and practices that were likely or intended to induce facilities that they managed to submit

false claims. *Escobar* recognized that absent a contrary indication, FCA terms normally incorporate common-law understandings. And as several Circuits have already recognized, that means that an entity "causes" the submission of false claims whenever it is a proximate cause of such submissions—a test the jury could reasonably conclude was met here.

ARGUMENT

I. THE DISTRICT COURT ERRED IN OVERRULING THE JURY'S CONCLUSION THAT DEFENDANTS' VIOLATIONS OF VARIOUS REQUIREMENTS FOR REIMBURSEMENT UNDER MEDICARE AND MEDICAID WERE MATERIAL.

A. Materiality Is Evaluated With Reference To The Time Of The Relevant Transaction

1. The FCA imposes civil liability on any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a)(1)(A), or who "knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim." *Id.* § 3729(a)(1)(B). Similarly, the FCA's "reverse" false claims provision imposes liability on any person who "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government . . . ." *Id.* § 3729(a)(1)(G). These provisions all have a "materiality" requirement—either expressly in the statutory text, or implicitly via common-law understandings about fraud. *See Universal Health Services, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2002 (2016).

Since 2009, the FCA has defined the term "material" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4). This codified the longstanding and pre-existing common-law meaning of "material." *See Escobar*, 136 S. Ct. at 2002 (citing *Neder v. United States*, 527 U.S. 1, 16 (1999), and *Kungys v. United States*, 485 U.S. 759, 770 (1988), as cases that illustrate a "materiality" requirement equivalent to the FCA's); S. Rep. No. 111-10, at 12 & n.6 (2009) (FCA's 2009 amendments codified the "materiality" definition from *Neder*, which had applied the definition in *Kungys*); *Marsteller ex rel. United States v. Tilton*, 880 F.3d 1302, 1313 (11th Cir. 2018) (explaining that the statutory definition of materiality has common-law antecedents).

Under both the FCA's definition and the relevant common law, materiality is ultimately concerned with how a misrepresentation or omission is likely to affect the government *at the time of the relevant transaction*—which in a false billing case would be when an individual false bill is submitted. Thus, typically the materiality inquiry will focus on contemporaneous evidence bearing upon the government's payment decision. The government's subsequent actions once it learns the truth (which could be many years later) may also have probative value, but the ultimate inquiry should nevertheless focus on how the government would have responded at the time of the relevant transaction.

Indeed, the Supreme Court in *Escobar* relied heavily on how various common-law and other authorities have traditionally understood materiality requirements. *See*

Escobar, 136 S. Ct. at 2002-03. Those same authorities make clear that the key question is how the government would have acted at the time of the transaction at issue—such as paying the specific claim in a case of billing fraud, or entering into an agreement in a case of fraudulent inducement. The Restatement (Second) of Torts, for example, clarifies that materiality looks at a representation's importance when the recipient is "determining his choice of action *in the transaction in question*." Restatement (Second) of Torts § 538(2)(a) (1977) (emphasis added). Williston on Contracts is to the same effect. *See* 26 Williston on Contracts § 69:12 (4th ed. 2003) (explaining that "a misrepresentation is material if it concerns a matter to which a reasonable person would attach importance in determining his or her choice of action *with respect to the transaction involved*" (emphasis added)). And in *Kungys* (whose definition of materiality applies to the FCA, as noted above, *see supra* p.13), the Supreme Court examined whether a particular misrepresentation had a natural tendency to influence the specific transaction at issue. *Kungys*, 485 U.S. at 771-72.

Moreover, *Escobar* approvingly cited *United States ex rel. Marcus v. Hess*, 317 U.S. 537 (1943), in which companies had fraudulently induced government entities to enter into contracts with them. *Escobar* described that fraud as material because government "money would never have been placed in the joint fund for payment" had the government known the truth. *Escobar*, 136 S. Ct. at 2003. That description of *Hess* confirms that the materiality inquiry focuses on the initial transaction in question, and thus subsequent events are relevant only insofar as they shed light on that inquiry.

If the district court's theory were correct, the focus in *Hess* should have instead been whether the government made sufficiently vigorous attempts to claw back the money years later, once it learned that it had been defrauded.

This Court's recent *Marsteller* decision also illustrates the district court's error. In considering an FCA claim about misleading payment requests, this Court understood *Escobar* to require an inquiry into "whether the Government would have attached importance to the violation in determining *whether to pay the claim*." 880 F.3d at 1313 (emphasis added). This Court thus properly focused on the specific transaction at issue (payment of the claim), rather than later government attempts to recover money already paid.

Legislative history further demonstrates that materiality is judged with respect to the specific transaction at issue. The Senate Report accompanying the 2009 FCA amendments specifically indicated that Congress was codifying the materiality definition used in certain prior cases, including *United States v. Bourseau*, 531 F.3d 1159, 1171 (9th Cir. 2008); *United States ex rel. Bahrani v. Conagra, Inc.*, 465 F.3d 1189, 1204 (10th Cir. 2006); *United States ex rel. A+ Homecare, Inc. v. Medshares Mgmt. Grp., Inc.*, 400 F.3d 428, 446 (6th Cir. 2005); and *United States ex rel. Harrison v. Westinghouse Savannah River Co.*, 352 F.3d 908, 916-17 (4th Cir. 2003). *See* S. Rep. No. 111-10, at 12 & n.6. All four of those cases recognized that materiality depends upon the actual or likely effect of misrepresentations or omissions with respect to the transaction at issue, as distinguished from when they are subsequently discovered.

2. Without fully addressing these principles, the district court justified its rule simply by citing *Escobar's* statement that "if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated," or it "regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, and has signaled no change in position," this would be "strong evidence" that the requirements are not material. *Escobar*, 136 S. Ct. at 2003-04; *see* DE468 at 8. But those statements actually underscore the district court's error because they focus on the government's payment of a specific claim despite contemporaneous knowledge of a violation, rather than the government's enforcement attempts years after it initially paid a claim. This part of *Escobar* thus confirms that materiality is ultimately concerned with the specific transaction at issue; post-payment actions may be relevant to the materiality inquiry, but are not dispositive.

The district court also failed to appreciate that evidence of the government's actions after it knows of a defendant's fraud may be less probative for a jury than other evidence demonstrating that the defendant's conduct would have been material to the government's payment decision at the time of the transaction. In some payment schemes, it is more difficult to take action after a transaction is completed than it is to simply deny payment upon claim submission, and the government may have good reasons (having nothing to do with materiality) for electing not to pursue recoupment or other enforcement proceedings. For example, there are often

substantial costs associated with recoupment or enforcement; there may be significant collateral effects on third parties (such as patients in a nursing home); or the government may no longer have available alternatives to protect its interests, such as finding alternate suppliers. And ironically, some of these concerns may be particularly present in cases with the most egregious behavior—as the district court's opinion implicitly recognized, *see* DE468 at 18-19 (discussing why recoupment can be difficult when fraud is massive and widespread)—which further illustrates the problems with that court's approach.

Finally, the district court erroneously justified its approach by noting that relator accused defendants of widespread fraud, and used statistical techniques in her presentation. DE468 at 18. Those facts are irrelevant. Materiality has a long-understood meaning at common law and a statutory definition. Neither depends in any way on the number of alleged FCA violations, or the particular mode of proof offered by a plaintiff. In espousing a rule that some fraudulent schemes are effectively "too big to be material," the district court fundamentally erred.

B. A Jury Could Reasonably Conclude That Defendants' Undisclosed Violations Of Medicare And Medicaid Reimbursement Requirements Were Material.

In evaluating a Rule 50(b) motion, a court must view the evidence, including any logical inferences from it and any credibility assessments, in the light most favorable to the verdict. *See, e.g.*, *Lipphardt v. Durango Steakhouse of Brandon, Inc.*, 267 F.3d 1183, 1186 (11th Cir. 2001). The relevant question is not what a court would

have concluded were it the factfinder, but only whether a reasonable jury could have reached its verdict. *Id.* Applying that standard, and the correct understanding of materiality, demonstrates that the district court erred in setting aside the verdict on materiality grounds.[3]

1. For the upcoded and ramped-up claims submitted to Medicare, materiality is obvious. Indeed, it is difficult to see how any reasonable jury could have concluded otherwise.

For the upcoded claims, relator's theory was that defendants submitted a RUG code that was higher than the true RUG code for each patient at issue. Under the governing regulations, this meant the facility necessarily received more money from Medicare when the claim was paid than it would have received if the true RUG code had been used. *See, e.g.*, 73 Fed. Reg. at 46425. One of defendants' witnesses (a management company executive) even acknowledged this fact—she readily conceded that upcoding "would definitely influence payments." Tr.2975 (Juliano). Accordingly, even assuming that the federal government later acquired actual knowledge of the upcoding, yet declined to recoup money it had long ago paid, the jury was not required to infer (nor is it clear how it could have inferred) that defendants' upcoding of particular RUG codes did not result in Medicare paying more than it otherwise

[3] The district court's scienter analysis suffered from the same basic flaws as its materiality analysis. The court's scienter ruling should thus be reversed for the same reasons.

would have absent defendants' misconduct. Upcoding is a classic and well-understood form of healthcare fraud, at the very core of what the FCA prohibits, and the district court erred in deeming it immaterial.

Similar analysis applies to the ramped-up claims. Under relator's theory (which the district court's opinion did not dispute and this brief therefore assumes to be correct), ramped-up claims were false because they involved submission of a higher RUG code than would have been submitted absent ramping. Thus just like with upcoded claims, a jury would have no difficulty finding that ramping was material because it would lead to the government paying a higher amount when it processed each ramped-up claim.

2. A jury could also reasonably conclude that the care plan problems were material to Florida Medicaid at the time defendants submitted claims for affected patients.

As *Escobar* illustrates, the materiality inquiry is holistic, and no one factor is typically dispositive. For example, while a misrepresentation will not automatically be deemed material as a matter of law solely because the government designated compliance with a particular requirement as a condition of payment, such designations are highly relevant for a factfinder. *Escobar*, 136 S. Ct. at 2003. And *Escobar* identified at least three other factors a factfinder might examine when evaluating materiality: whether the violation goes to the "essence of the bargain," *id.* at 2003 n.5; whether the violation is significant or "minor or insubstantial," *id.* at 2003;

and whether the government refused to make payment in this case or others when it had knowledge of similar violations, *id.* at 2003-04. Other factors may also be relevant.

Ultimately, because materiality depends on a holistic assessment, in many cases it is likely to be a determination for a jury. *Cf.* Restatement (Second) of Torts § 538 cmt. e (recognizing that a misrepresentation's materiality will often depend on a jury determination of what is reasonable). And in *Escobar*'s wake, several circuits have expressly recognized that the holistic nature of the materiality inquiry can render it inappropriate for resolution as a matter of law, particularly when factors point in different directions. *See United States ex rel. Prather v. Brookdale Senior Living Cmtys., Inc.*, 892 F.3d 822, 831-37 (6th Cir. 2018); *United States ex rel. Campie v. Gilead Sciences, Inc.*, 862 F.3d 890, 904-06 (9th Cir. 2017), *petition for cert. filed*, No. 17-936 (Jan. 3, 2018); *United States ex rel. Escobar v. Universal Health Servs., Inc.*, 842 F.3d 103, 109-12 (1st Cir. 2016). *Accord United States ex rel. Harman v. Trinity Indus., Inc.*, 872 F.3d 645, 660-65 (5th Cir. 2017) (describing the Ninth Circuit's *Campie* and First Circuit's *Escobar* decisions as "well-considered," and agreeing that a single factor is not normally outcome-determinative as a matter of law). Here, relator presented several pieces of evidence that the jury reasonably could have relied on in concluding that false representations about care plans had a natural tendency to influence Florida Medicaid's payment decisions.

First, relator presented evidence that the Florida government treated having a care plan as a "condition of payment" for Florida Medicaid, and there was expert testimony that payment would automatically be denied if the agency knew a patient lacked a care plan. *See* Tr.376 (Lowrie-Morris); Tr.421 (Ruckh); Tr.4133 (Pelovitz); RX3031 at 192; RX2972 at 49-50. Given *Escobar*'s recognition that a government decision to identify something "as a condition of payment is relevant" to evaluating materiality, 136 S. Ct. at 2003, this evidence alone would have been sufficient to support the verdict on materiality. And that conclusion is fully consistent with *Escobar*'s separate clarification that a plaintiff is not entitled to a directed verdict on materiality simply upon showing that a requirement is a condition of payment. *See id.* at 2004 (rejecting view that a condition of payment is "always" material).

Second, relator introduced evidence that the care plan requirement is integral to Florida Medicaid because it helps counteract facilities' incentive to underprovide care for Medicaid recipients (for whom Florida pays a flat fee regardless of service level), and therefore goes to the "essence of the bargain." *See* RX1970 at 6 (nonbinding recommended practices published by HHS's Office of Inspector General, which explain that care plans are "essential to reducing risk," and note that missing or inadequate plans "jeopardize residents' well-being and risk the provision of inadequate care"); Tr.351-52 (Lowrie-Morris). Indeed, this case illustrated the point rather starkly, as there was evidence that defendants brazenly ignored the needs of Medicaid patients. For example, one email sent among executives from the rehabilitation

company, with the instruction to "please delete this!!!," indicated that some therapists were told not to provide *any* treatment for Medicaid patients unless an executive first approved it after accounting for "how much it will cost." RX450 at 1, 11-12; *see also id.* at 18 (requiring that therapists "verbally" indicate their belief that additional therapy was needed for a patient, at which point a supervisor checked the patient's "payor source"; a jury could infer executives wanted this done "verbally" to avoid documenting their neglect of Medicaid patients); Tr.540 (Ruckh) (therapists would refuse to provide needed therapy to Medicaid patients because doing so yielded no additional funds).

Under *Escobar*, proof of materiality can include evidence that the misrepresentation or omission concerned an issue "to which a reasonable person would attach importance in determining his or her choice of action," including if a matter went to the "essence of the bargain." *Escobar*, 136 S. Ct. at 2003 & n.5 (internal quotation marks omitted). A reasonable jury could thus determine, based on the above-mentioned evidence, that comprehensive care plans were important to Florida Medicaid and that the failure to have required plans was material.

The jury's findings are not fatally undermined by the evidence suggesting that state surveyors had sometimes found issues with care plans at defendants' facilities, and yet Florida Medicaid had neither clawed back its previous payments nor cut the facilities off from future Medicaid reimbursement. After-the-fact government action of this sort could be considered by a factfinder for whatever light it sheds on a

requirement's importance at the time of the relevant transactions.[4] But the factfinder also had to weigh this evidence against relator's countervailing evidence of what Florida Medicaid would have done at the time payments were made if it had known the truth. Indeed, even if defendants' evidence tended to show the government has paid "a particular claim in full despite its actual knowledge that certain requirements were violated," *Escobar*, 136 S. Ct. at 1995, and even if the jury credited that evidence, the Supreme Court made clear in *Escobar* that this would merely constitute "very strong *evidence* that those requirements are not material." *Id.* (emphasis added). *Escobar* confirms that such evidence is not dispositive as a matter of law. In any event, the jury was entitled to give relator's evidence greater weight, and the district court erred in reversing that determination under the very deferential Rule 50(b) standard.

II. THE DISTRICT COURT ERRED IN OVERRULING THE JURY'S CONCLUSION THAT THE MANAGEMENT ENTITY CAUSED THE SUBMISSION OF FALSE CLAIMS.

In addition to establishing liability for one who directly makes misrepresentations or omissions to the government, the FCA imposes liability on an individual who "causes" the presentment of a false claim, or who "causes" a false record to be made or used material to a false claim or an obligation to pay the

[4] The factfinder would also, of course, be entitled to weigh testimony that these surveyors—unlike auditors—were only interested in patient care and did not examine billing propriety. *See* Tr.3317-23 (Dressel); Tr.4131–33 (Pelovitz). The factfinder would similarly be entitled to consider any reasons why post-payment government behavior might differ from government behavior at the time payment was made.

government, 31 U.S.C. § 3729(a)(1)(A), (B), (G). The district court concluded there was insufficient evidence that the management entity "caused" the submission of any false claims. DE468 at 20-21. But the district court appeared to apply a causation standard more stringent than the traditional "proximate cause" test applicable under the common law and the FCA.

Although the FCA does not specifically define the term "cause," the Supreme Court has recognized that the statute normally incorporates "the well-settled meaning of the common-law terms it uses." *Escobar*, 136 S. Ct. at 1999. Here, that leads to the common-sense conclusion that a defendant "causes" the submission of a false claim (or the use of a fraudulent record, or the avoidance of an obligation) whenever it is a "proximate cause" of the claim's submission. *See Paroline v. United States*, 134 S. Ct. 1710, 1720 (2014) ("Proximate cause is a standard aspect of causation in . . . the law of torts."). Indeed, several circuits have already recognized as much. *See United States ex rel. Sikkenga v. Regence Bluecross Blueshield of Utah*, 472 F.3d 702, 714-15 (10th Cir. 2006); *United States ex rel. Schmidt v. Zimmer, Inc.*, 386 F.3d 235, 244-45 (3d Cir. 2004) (applying "ordinary causation principles from negligence law" to determine when a party "causes" the submission of a false claim); *United States ex rel. Hutcheson v. Blackstone Med., Inc.*, 647 F.3d 377, 391-92 (1st Cir. 2011) (recognizing that the term "causes" in the FCA is informed by tort-law principles of causation). *Accord United States v. Luce*, 873 F.3d 999, 1013-14 & n.12 (7th Cir. 2017).

Under traditional understandings of causation, a defendant "proximately cause[s]" a result when its actions are a cause in fact and the result is foreseeable. *See Paroline*, 134 S. Ct. at 1719. There may also be some sort of "direct relation" requirement, which this Court has articulated as the idea that the defendant's behavior "must be a 'substantial' or 'significant contributing cause.'" *U.S. Commodity Futures Trading Comm'n v. Southern Tr. Metals, Inc.*, __ F.3d __, 2018 WL 3384266, at *10-11 (11th Cir. July 12, 2018); *see also* Restatement (Second) of Torts § 431.

A full discussion of how that standard applies here is beyond the scope of this amicus brief. But for illustrative purposes we observe that there is ample evidence supporting the jury's conclusion that the management entity caused numerous false claims to be submitted. As discussed above, *see supra* pp.7-9, there was evidence that employees of the management entity (1) put significant pressure on facility employees to meet RUG budgets that had nothing to do with patients' underlying medical conditions, including by threatening termination, *see, e.g.*, Tr.506-10 (Ruckh); Tr.1489-90 (Rousey); (2) adopted other specific policies that were very likely to lead to the submission of false RUG codes (such as defaulting Medicare patients to receive exactly the minimum amount of therapy needed to qualify for the highest RUG score, Tr.489-92 (Ruckh), making it administratively very difficult to assign certain lower RUG scores, Tr.793-99 (Ruckh), and training facilities to have a "mind set" where everyone will be in the ultra high therapy category so long as they can physically "tolerate" that amount of therapy, RX162; RX1899); and (3) expected that facility

employees would engage in upcoding as a result of these pressures, and then praised them when they did exactly that, Tr.517-18, 601 (Ruckh). If (as the jury in this case apparently found), the management entity directed improper practices in this manner, it can properly be held liable even if it did not instruct subordinates to submit any *particular* false claim.

Moreover, the whole point of these practices by the management entity was to obtain more money from Medicare. The jury thus reasonably concluded that the submission of false claims (and the creation of false records material to false claims) by facility employees was foreseeable, that it would not have occurred absent the management entity's pressure, and that this pressure was a substantial cause of the facility employees' behavior. *Cf. Bridge v. Phoenix Bond & Indem. Co.*, 553 U.S. 639, 656-57 (2008) (recognizing that someone who makes fraudulent misrepresentations to a third party, for the purpose of ultimately injuring the plaintiff, has proximately caused the plaintiff's injuries); *United States ex rel. Rost v. Pfizer, Inc.*, 507 F.3d 720, 732-33 & n.9 (1st Cir. 2007) (pharmaceutical company can "cause" the presentment of false Medicare claims if its marketing practices result in physicians prescribing its drug to Medicare patients).

CONCLUSION

For the foregoing reasons, the district court erred in it analysis of materiality and causation.

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CERTIFICATE OF COMPLIANCE WITH
FEDERAL RULE OF APPELLATE PROCEDURE 32(G)

I hereby certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5)–(6) because it has been prepared in 14-point Garamond, a proportionally spaced font.

I further certify that this brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(4)-(5) because it contains 6484 words, excluding the parts of the brief exempted under Rule 32(a)(7)(B)(iii), according to the count of Microsoft Word.

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CERTIFICATE OF SERVICE

I hereby certify that on July 20, 2018, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Eleventh Circuit by using the appellate CM/ECF system. Service on all participants will be made via the CM/ECF system, except that the State of Florida will be served via:

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