No. 14-12373

UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

UNITED STATES OF AMERICA,

Appellee,

v.

PETER E. CLAY, TODD S. FARHA, PAUL L. BEHRENS, AND WILLIAM L. KALE,

Defendants-Appellants.

On Appeal from the United States District Court
for the Middle District of Florida, No. 8:11-cr-00115-JSM-MAP
Before the Honorable James S. Moody, Jr.

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United States v. Clay, et al.
No. 14-12373

AMENDED CERTIFICATE OF INTERESTED PERSONS

The Certificate of Interested Persons in Paul Behrens's opening brief is complete, except that the following additional person has an interest in the outcome of this case:

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STATEMENT REGARDING ADOPTION OF BRIEFS

Pursuant to Federal Rule of Appellate Procedure 28(i) and Eleventh Circuit Rule 28-1(f), Paul Behrens adopts by reference Parts III and IV of the Reply Brief for Defendant-Appellant Todd S. Farha.

INTRODUCTION

The prosecution spends much of its brief addressing everything but the question of law on which this case turns—the reasonableness of the Plans' reported expenditures for *CY2006* under the governing legal requirements. This Court's decision in *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002), holds that if the defendant's allegedly false statement is true under a "reasonable interpretation of the law," the government cannot meet its burden of establishing "the *actus reus* of the offense—actual falsity as a matter of law." *Id.* at 1351, 1353. Here, the allegedly false expenditure figures the Plans reported on the 80/20 forms for CY2006 were true under a reasonable interpretation of governing legal requirements. *Whiteside* therefore requires reversal.

Under the Plans' Contracts with AHCA and the template, the Plans were to report the sums the Plans paid for the provision of relevant behavioral-health services. As was common in the industry, the Plans contracted with an accredited behavioral health organization (a "BHO") to provide all those services for a market-rate, per-member, per-month capitation. In the 80/20 submission, they reported the amounts they paid the BHO for the provision of the relevant services.

The prosecution's theory is that the Plans should not have reported their *own* expenditures, but instead should have reported certain costs that *the BHO* (Harmony) incurred. But after nine years of investigation, and four years after the Indict-

ment, the government still has identified no statute, regulation, court decision, contract provision, template, or other document requiring that result or rendering the Plans' contrary construction objectively unreasonable. To the contrary, the governing legal documents called for the *Plans'* expenditures, not those of some other entity. The prosecution's own witnesses (including experienced healthcare lawyers) confirmed that reporting payments to Harmony was reasonable. Indeed, AHCA openly allowed other companies subject to 80/20 to count capitation payments to their subcontractors, including affiliates. Aware of the practice, AHCA considered prohibiting plans from counting payments to BHOs. But it never did.

The prosecution's response is that only payments to "providers" count for 80/20 purposes—or that only payments to unaffiliated, third-party providers count. But the governing Contracts make clear that a BHO is a "provider," referring to plan agreements with BHOs as "behavioral health *provider* contracts." The government simply refuses to address the meaning of that plain text. Nor does the government address the testimony of its own witnesses, who agreed that BHOs like Harmony are providers. And the government likewise identifies nothing that prohibited the Plans from counting payments to affiliates (at rates that had been submitted to Florida regulators for review). The prosecution's theories do not come close to proving the Plans' approach erroneous, much less so clearly incorrect as to represent an objectively unreasonable interpretation. The prosecution also accuses

the Plans of "slicing and dicing" their numbers. But it nowhere identifies any step in the CY2006 calculation that was impermissible. To the contrary, each step was not only reasonable but—under the government's theory—*required*.

Lacking a basis to challenge the Plans' actual CY2006 submissions, the prosecution changes the subject. It dwells on 80/20 submissions for years before CY2006. But the jury *rejected* the government's case for those earlier years. The government cannot render the CY2006 submissions false by attempting to retry its unsuccessful case about submissions in earlier years.

The prosecution's contention that *Whiteside* should be resolved by juries fares no better. The Court in *Whiteside* resolved the issue "as a matter of law." 285 F.3d at 1353. The scope of legal obligations and the objective reasonableness of a legal interpretation are questions for judges, not juries.

Ultimately, the government devotes the bulk of its argument to urging that *Whiteside* does not apply here. But it is hard to imagine a case more similar to *Whiteside*. Here, as in *Whiteside*, the government alleged that the defendants reported false expenditures on a government healthcare expenditure form. Here, as in *Whiteside*, falsity turned not on an issue of fact (*i.e.*, whether expenses actually were incurred), but on whether reporting particular expenses was legally permissible. And here, as in *Whiteside*, "no . . . regulation, administrative ruling, or judicial decision" (or anything else) mandated the government's interpretation. 285 F.3d at

1352. Indeed, the objective reasonableness of Defendants' construction is clearer here than in *Whiteside*. In *Whiteside*, the defendants were warned their submissions might constitute fraud. Here, WellCare's outside counsel—including the former head of AHCA's Medicaid division—advised Defendants and testified that reporting payments to Harmony *was reasonable*.

At its core, the government's position is that Defendants can be convicted of committing healthcare fraud by submitting "false and fraudulent . . . expenditure information," A1 ¶32, even if the expenditure information was *true* under an objectively reasonable interpretation of the law. That defies both reason and precedent. Defendants' convictions should be reversed.

I. DEFENDANTS' CONVICTIONS SHOULD BE REVERSED UNDER *WHITESIDE* (ALL DEFENDANTS)

The allegedly false statements at issue here were true under a reasonable interpretation of legal requirements. Behrens Br. 55-76. As a result, the government has "failed to meet its burden of proving the *actus reus* of the offense—actual falsity as a matter of law." *Whiteside*, 285 F.3d at 1353.

A. The CY2006 80/20 Submissions Were True Under a Reasonable Interpretation of the Law

1. *Reporting Payments to Harmony Reflected a Reasonable Interpretation of the Law*

When the 80/20 Statute was enacted, capitation arrangements—paying subcontractors a monthly, per-patient fee regardless of services utilized—were com-

mon. Managed-care plans in Florida regularly contracted with BHOs to provide behavioral-health services. *See* A584(92:13-21) (Clarke) ("more frequently than not"); A465(99:7-10) (Barr-Platt) ("most" plans). As AHCA staff observed in 2002, that raised an interpretive question in connection with calculating 80/20 expenditures: Because "HMO's capitate the BHO's and the BHO's subcapitate" clinics, the staff asked, who does AHCA "want the 80/20 [expenditures] from"? A51-1 at 2.

The Statute, as well as AHCA's contracts and templates, provided the answer: The Plans were to report *their own* expenditures, not the BHO's. Behrens Br. 12-14, 58-61. The Statute referred to the amount "the managed care plan expends." Fla. Stat. §409.912(4)(b). The Contracts between the Plans and AHCA required the Plans to report the amount "the Health Plan expend[ed]"—*i.e.*, the amount the Plans "paid directly or indirectly to providers solely for the provision of community behavioral health services, not including administrative expenses or overhead of the plan." A699(GX-3305 at .0166-67). Accordingly, when completing templates addressed to the Plans that asked the Plans to report *their* "expenditure[s] . . . for the provision of community mental health services and targeted case management services," A699(GX-0601), each Plan reported the portion of the capitation it paid their BHO, Harmony, for those services.

That was objectively reasonable. As government witness Carol Barr-Platt testified, it is "common sense" that, "if a plan hires or subcontracts with a BHO, then the expenses paid to the BHO would be the expenses of the plan." A474(47:25-48:21); Behrens Br. 56-57, 61-62. Consistent with that, WellCare outside counsel Gary Clarke—previously head of AHCA's Medicaid Division—had advised the Plans that reporting their payments to an affiliated BHO (Harmony) for the relevant services was a reasonable option, A584(25:2-7); A760(22:19-22), and that other plans likewise reported their capitations to subcontractors, including affiliated BHOs, Behrens Br. 17. The approach, he reported, appeared "acceptable . . . to AHCA." A584(95:10-23). AHCA considered "prohibit[ing] the inclusion of those BHO expenses in the 80/20 calculation," but chose not to. A474(52:19-53:11) (Barr-Platt); Behrens Br. 66. "AHCA was certainly aware that companies like Harmony were routinely used" and "could have tried to include language . . . that prohibited payments to companies like Harmony from being used in connection with the 80/20 calculation," but it "never did." A584(109:25-110:11) (Clarke).

The government ignores that. It also ignores its own witnesses' testimony that reporting the Plans' payments to Harmony was "reasonable" and that nothing in the 80/20 Statute, the Contracts, or any regulation precluded it:

- Gary Clarke agreed that counting payments to Harmony was "reasonable," as "nothing" in the Statute "prohibits it" and it was "one reasonable interpretation of the Contracts."

- WellCare outside counsel Frank Rainer agreed it was a "reasonable interpretation of th[e] statute" and "of the contract" to "include BHO expenses."

- WellCare attorney Michael Turrell testified that nothing in the Statute precluded "using the expenses for a BHO in connection with the 80/20 calculation," and that "the WellCare HMOs were always in compliance with the contract."

- The government's expert conceded that no contractual or statutory provision "prohibits payments to a BHO from being included in the 80/20 calculation."

Behrens Br. 63-65 (quoting testimony); A559(89:25-90:3) (Turrell).[1] That testimony "lends credence" to the objective reasonableness of Defendants' construction. *Whiteside*, 285 F.3d at 1352-53. And even after the raid on WellCare, AHCA's auditor identified "using the subcapitation . . . paid to behavioral health organizations"—including "a related party"—as "reasonable . . . for the calculations submitted in the 80/20 report." A650(13:14-15:23) (Miller).[2]

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[1] The government asserts (at 85) that Turrell "had no knowledge" about the 80/20 calculations. That is false. *See* Farha Reply 9-10.

[2] The prosecution's claim (at 71) that one would have to "win the lottery" for the capitation to match "actual claims" ignores the nature of capitated arrangements. In a capitated arrangement, there are no claims or payments on claims. A505(122:8-14) (West); A649(69:14-22) (Miller). Instead, the HMO pays the provider a flat sum for each covered member—regardless of the actual services used. A534(75:10-23) (West). The HMO's expenditure is that flat fee—not the sums the provider could have charged if it billed for individual services. The capitation may approximate the provider's anticipated costs, but has "no relationship to

As WellCare actuary Todd Whitney testified (again, as a government witness), "what [the Plan] paid" a BHO is the Plan's "Behavioral health expense" because "[t]hat's typically how it's counted." Behrens Br. 64-65. And when Behrens instructed Jian Yu—the actuary responsible for the Plans' CY2006 calculation—to do what "made the most statistical sense," *id.* at 27, 31 n.17, "Yu made a judgment as an actuary that this . . . calculation was true and correct," A757(127:18-24) (West). She told Behrens it was "actuarially sound" and that "her recommendation as an actuary was to go ahead and submit this to AHCA." A757(120:14-17, 126:5-24) (West). Neither Yu nor West ever expressed any concern to Behrens. Behrens Br. 30-31. The government ignores that too.

In *Whiteside*, "[o]ne of the government's witnesses . . . testified that the regulations do not answer the specific question" at issue there. 285 F.3d at 1352. Here, there was no regulation of any sort, and *multiple* government witnesses confirmed that reporting the Plans' payments to Harmony was reasonable under the governing legal authorities. As in *Whiteside*, Defendants are entitled to acquittal as a matter of law.

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current actual costs." A533(72:15-73:1) (West). The government's expert agreed that, where providers receive capitation payments, that payment is reportable, "regardless of codes" or individual services. A634(115:19-116:9) (Kelly).

2. *The Prosecution's "Provider" Arguments Fail*

The government does not dispute that the Plans contracted with Harmony—a bona fide, accredited BHO that operated no differently than any other BHO—"for the provision of" behavioral-health services.[3] Nor does the government dispute that the amounts the Plans paid Harmony were the Plans' expenditures "for the provision of community mental health services and targeted case management services." A699(GX-0601). Instead, it objects that the Plans "were *not* asked to report amounts paid merely 'for the provision of . . . services,'" but rather were directed by the 80/20 templates "to report amounts paid 'to *behavioral health providers*' for those services." Gov't Br. 80-81 (emphasis added); *see id.* at 70, 74, 76, 80-82, 88. Harmony, it contends, "was no provider." *Id.* at 81.

The Contracts foreclose that argument—and certainly foreclose any claim that Defendants' construction is objectively unreasonable. Just three pages before defining the Plans' 80/20 reporting obligations, the Contracts describe "subcontracts with a Managed Behavioral Health Organization (MBHO) for the provision of Behavioral Health Services" as "Behavioral Health *Provider* Contracts." A699(GX-3305 at .0164) (emphasis added). The Contracts thus make clear that

[3] *See* Behrens Br. 3, 15-19, 22, 56-60 & n.30. AHCA itself recognized that the "Plans entered into a contract with Harmony . . . to provide the full range of behavioral health services required under the Medicaid contract [with AHCA]." A700(D_0159); *see* A699(GX-3305 at .0050) (defining "Managed Behavioral Health Organization" as "a behavioral health-care delivery system managing quality, utilization and cost of services").

BHOs like Harmony *are* "behavioral health providers." Gov't Br. 81; *see* Behrens Br. 59-60. That contractual definition conforms with the views of the "major accrediting agency in the U.S.," which "considers behavioral health organizations to be providers," A661(108:15-23) (Miller), as well as the government's concession below that it was reasonable to treat *another* BHO—CompCare—as a provider for 80/20 purposes, Behrens Br. 73-74. The government nowhere addresses the Contracts' clear and unequivocal language.

Instead, the government asks the Court to ignore the Contracts (and the 80/20 Statute) and to focus solely on the templates. The Plans, it says, answered a "question asked by [the 80/20] templates" and "did not have to interpret [the] statute, or their contracts." Gov't Br. 73-74, 76. That "templates only" theory makes no sense. The Statute and Contracts created the reporting and refund obligations; the Plans were to complete the templates to fulfill those obligations.[4] The Indictment thus specified that the templates were "to be completed *in accordance with* the reporting and refund requirement . . . of the Medicaid HMO *contracts*." A1 ¶15 (emphasis added). The prosecution recognized below that any reasonable interpretation "must address the entire Reporting Obligation, *including AHCA's contracts* with the HMOs," *see* Dkt. 441 at 20 (emphasis added), and that "the only

[4] A699(GX-0601 at .0001) (template to be completed "[p]ursuant to" 80/20 Statute); A699(GX-3305 at .0166) (contract requirement that Plans report expenditures "using the spreadsheet template").

reasonable interpretation of the 80/20 requirements" derived from "the *language of the contracts* and related documents," Dkt. 772 at 31 (emphasis added). The government never acknowledges, much less explains, its about-face on appeal.

The government's "templates only" theory is particularly baffling because the templates themselves never mention providers. A699(GX-0601). Neither do the accompanying cover letters. A699(GX-0600). The only place a "providers" limitation appears is *in the Contracts*. *See* A699(GX-3305.0167). The government cannot explain why it is unreasonable to consult the Contracts on the meaning of a "provider" limitation found only in the Contracts. Indeed, if one were to credit the government's "templates only" theory, the "provider" limit on which the prosecution stakes its case would disappear.

The government also points the Court (at 81) to a definition in Florida's *Medicaid Handbooks*. But the Contracts recite that they control over any inconsistent Handbook provision. A699(GX-3305 at .0061). Moreover, the Handbooks do not purport to govern 80/20 reporting. Indeed, they predate the Statute, *see* X3352-E1 at ii (Handbook dated April 2002), and their definition of a "provider" as an entity that "bills Medicaid for services," Gov't Br. 81 (quoting X3352-E1 at ii), does not fit the managed-care regime the 80/20 Statute addresses. *See* A534(69:2-24) (West); Behrens Br. 11 n.4. Under that system, no provider "bills Medicaid" (*i.e.*, AHCA), ever. Applying the Handbook definition of "provider" to

80/20 reporting thus would lead to the absurd result that *no* payments made by an HMO, even to individual doctors, would qualify as a payment to a provider.

Once again, the government's own witnesses testified that Harmony is a provider, "lend[ing] credence" that such an "interpretation was not unreasonable." *Whiteside*, 285 F.3d at 1252-53. Gary Clarke testified that Harmony was "a type of behavioral health provider." A584(91:15-18). Frank Rainer, another veteran Florida healthcare lawyer, testified that he "wasn't concerned about Harmony being a provider" for 80/20 purposes. A562(94:8-12). Carol Barr-Platt, an AHCA employee, testified that a BHO "is basically the provider," qualifying only that "they don't provide direct services." A465(86:3-8).[5] The government's claim (at 82) that the only evidence that BHOs are providers "came from defense expert Miller" is thus false. The evidence came from the Contracts' plain text, and was supported by government witnesses.

The government (at 81-82) musters snippets of testimony suggesting that some witnesses may have thought that, in other contexts, Harmony was not a provider. But that cannot defeat the undisputed meaning of the Contracts. Much of the cited testimony, moreover, addresses a different issue.[6] And any dispute

[5] *See also* A662(83:6-18) (quoting GX-3414) (WellCare e-mail to AHCA describing Harmony as the Plans' "downstream provider").

[6] The government recites testimony that Harmony was not a "provider of *direct* services." Gov't Br. 81-82 (quoting A465 (86-87) (Barr-Platt)) (emphasis added).

among government witnesses—with *two* veteran healthcare lawyers siding with Defendants and their expert—compares favorably with *Whiteside*, where just one government witness sided with the defense. 285 F.3d at 1352. In *Whiteside*, the Court nonetheless invoked that "disagree[ment]" and the existence of "contradictory evidence" as support for its conclusion that "reasonable people could differ" on the proper characterization of the reported expenses and that, as a result, the government could not show falsity as a matter of law. *Id.* at 1352-53. That failure is even clearer here, where the Contracts and multiple government witnesses supported Defendants' interpretation.

3. *The Prosecution's "Affiliates" Argument Fails*

The prosecution suggests (at 83-84) that, even if payments to *third-party* BHOs could count, payments to *affiliated* BHOs like Harmony cannot. But it cites no AHCA rule, guidance, or policy distinguishing between affiliated and unaffiliated BHOs. The government cites *United States v. Gupta*, 463 F.3d 1182, 1193 (11th Cir. 2006), for the notion that "no reasonable interpretation" would allow a defendant "to be on both sides of a transaction." But *Gupta* involved a rule governing related-party transactions "*defined by federal regulation*." Gov't Br. 77 (emphasis added). AHCA had no rule barring related-party transactions or defin-

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But it offers no response to the arguments in Behrens's opening brief (at 66-75) debunking the "direct provider" theory. It also ignores the Contracts' "directly or indirectly" language, and its own witnesses' interpretation of it. Behrens Br. 59-61.

ing their treatment for 80/20 purposes. Nothing in *Gupta* supports conjuring such a rule from thin air.

Moreover, there was ample evidence that AHCA openly accepted payments to affiliates for 80/20 purposes. *See* Behrens Br. 64-66. Without citation, the government asserts (at 87) that the "evidence supporting capitation fees as qualifying 80/20 expenses always concerned an HMO's capitation to its [third-party] providers, not an HMO's 'capitation' to a sister subsidiary." Untrue. Clarke testified that United Health Plans had subcapitated approximately 80% of its premium to its BHO affiliate (United Behavioral Health Plan), and reported that amount "in connection with the 80/20 calculation." A584(94:17-95:5); A564(65:14-69:22). He testified that Florida Health Partners likewise counted the entirety of its capitation to related entities; that AHCA knew; and that it seemed to be acceptable to AHCA. A584(95:10-23) (Clarke); Behrens Br. 65.[7] And Clarke testified that reporting "payments *to Harmony*" was a reasonable interpretation of the law. A760(22:19-22) (emphasis added); Farha Reply 7-9. That testimony plainly did not concern payments to unrelated third parties.

The government hypothesizes (at 78) about the Plans paying Harmony $80, but Harmony paying only $1 for healthcare. That is not what happened, and a pro-

[7] When AHCA belatedly objected to Florida Health Partners' methodology—after the raid on WellCare—AHCA folded and settled for nothing. Behrens Br. 65 n.31.

hibition on affiliate or BHO payments is not necessary to prevent such abuse. A plan and BHO that spent only $1 on care would necessarily fail to provide the "full range of Behavioral Health Services" required by the Contracts. A699 (GX-3305 at .0137). Here, Harmony exceeded requirements. Behrens Br. 22. Inflated fee arrangements would also be rejected by AHCA and Florida's Office of Insurance Regulation, to which all contracts and rates had to be submitted. *See* Behrens Br. 19-20, 74 & n.39. Neither objected to Harmony's rates. The prosecution, moreover, expressly disclaimed *any* argument that the Plans paid Harmony too much; its expert declined to address the issue; and the only evidence showed that the sub-capitation payments were "reasonable," "market" rates. Behrens Br. 19-20, 41, 74 n.39; *see* A534 (26:12-27:9) (quoting D_1648) (Harmony "pricing . . . will be competitive in the marketplace").[8]

The prosecution may prefer a blanket exclusion of payments to BHOs or affiliates. But Florida relied on other measures—reviewing rates and monitoring

[8] In a footnote, the government objects that West "set the rates himself." Gov't Br. 72 n.18. That's not true; West at most updated rates originally set by WellCare's independent consultant, and his results were reviewed by "experienced and competent actuaries." A541 (116:22-117:25). Besides, the prosecution never says the rates—which were accepted by the State—were wrong, unreasonable, or inflated. Behrens Br. 19-20. The government also asserts (at 12) that WellCare reaped "significant profits" in one area of Florida early on, but once one corrects for AHCA's error in reporting the premium and "you actually . . . match the expenses in the premium" to Plan expenditures, "that profit isn't there." A662 (29:3-31:15) (Miller); Behrens Br. 25.

contract compliance. A federal criminal prosecution is no place to create *post hoc* regulatory limits that AHCA itself declined to establish.

The government ignores, moreover, the 80/20 Statute's *express* purpose, which was to "ensure unimpaired access to behavioral health services by Medicaid recipients." Fla. Stat. § 409.912(4)(b). BHOs play a critical role in achieving that goal. They act as "the hub of all services for behavioral health," A465 (86:7-15) (Barr-Platt), offering case management and coordination of care that leads to "better care" for Medicaid patients, A563 (67:22-68:11) (Rainer); Behrens Br. 15. A specialized organization is particularly valuable for behavioral health, where mental health issues may prevent patients from accessing care for themselves. Harmony excelled at that task, employing clinicians and around-the-clock "intensive case managers" who had "direct contact" with patients. A487 (42:19-43:10, 46:23-47:24) (Barr-Platt). Giving plans credit for payments to BHOs is entirely consonant with the statutory design.

4. *The Plans' CY2006 80/20 Submissions Followed Their Reasonable Interpretation*

Apart from its view that the Plans could not report payments to Harmony, the government offers no serious objection to the Plans' CY2006 80/20 submissions (nor does it dispute the facts regarding the underlying calculations). Instead, the government devotes pages to submissions for years for which Defendants were *not* convicted. The only counts for which Behrens, Farha, and Kale were convict-

ed of healthcare fraud (and Behrens of false statements) charged the submission of false expenditure information *for CY2006*. A1 ¶¶28, 32.[9] If the information reported *for that year* was true under a reasonable interpretation, the convictions cannot stand, regardless of whether the government disagrees with other calculations for years for which the jury declined to convict.[10]

The prosecution asserts (at 83) that, even if the Plans could report payments to Harmony, their 80/20 submissions "were not true even under *that* interpretation." The government does *not* argue that the Plans fabricated expenses. Its star witness testified without contradiction that there were "no fake numbers in this calculation," that all reported expenditures were "real dollars going to Harmony," and that "all the numbers" used were "accurate and correct." A757(124:15-16)

[9] Clay was convicted of making a false statement to FBI agents after the fact when asked about the CY2005 submissions. Those submissions are discussed in Clay's opening brief (at 8-10, 20-21) and reply (at 9-10), which explain how the analysis applicable to the CY2006 submissions extends with equal force to the CY2005 submissions.

[10] For each of those years, moreover, West explained each submission in detail and described how they were fully documented, based on real numbers, and available for audit by AHCA. *See, e.g.*, A534(74:17-75:3, 89:9-90:7, 99:7-100:1) (CY2003); A751(19:12-20:8, 47:20-23) (CY2004); A541(15:13-16:2, 50:11-51:10, 53:16-55:22, 56:20-58:6) (CY2005).

(West); A757(127:18-24) (West); A533(68:3-8) (West); A541(12:24-13:12) (West) (no "bogus numbers").[11]

Instead, the government baldly declares (at 83) that the Plans "sliced and diced those numbers." If the government means to argue (as it did below) that the Plans "did not simply claim the *exact dollar amount* they paid to Harmony," Dkt. 772 at 30 (emphasis altered), the answer is "of course not." The Plans could not report their *total* capitation to Harmony because it covered both "inpatient" services (which do not count toward 80/20) and "outpatient" or CMH/TCM services (which do). Behrens Br. 77. Behrens's opening brief discusses in detail (at 28-30, 77-78) the two steps the Plans undertook to limit their reported expenditures for CY2006. The government identifies no fault with either.

First, Greg West and actuary Jian Yu limited the Plans' expenditures to the portion of the Harmony capitation attributable to outpatient (CMH/TCM) services. Behrens Br. 28-29, 77. That was proper. Indeed, the government insists (at 74) that the Plans were permitted to report *only* expenditures "for the provision of . . . TCM and CMH" (*i.e.*, outpatient) services.[12]

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[11] The government's expert agreed that it is "accurate" that the Plans "reported based on the outpatient allocation to Harmony"; he just chose in his calculations to count only "what Harmony paid to direct providers." A634(59:21-60:4) (Kelly).

[12] West also explained without contradiction that there were multiple reasonable ways to allocate between inpatient and outpatient, and that the allocation he used was "reasonable." A751(24:20-25:1, 37:2-12, 40:4-7); A757(109:25-110:5,

Second, Yu and West reduced the outpatient (CMH/TCM) portion so that it reflected "only costs covered by the AHCA specified procedure codes." A699 (GX-0619-03-A at .00002 (cell G-7)); Behrens Br. 29-30. The government concedes as much.[13] Again, that is what the government claims the Plans were *required* to do—it insists the Plans could report only expenditures for services "under the specifically listed codes" in AHCA's cover letters. Gov't Br. 74.[14] Rather than dispute any of that, the government rests on the epithet of "slicing and dicing." But slogans cannot substitute for evidence.

123:17-21); Behrens Br. 28 & n.15. The government offers nothing to the contrary. While the government states (at 20) that "West knew" the inpatient portion should be larger than outpatient, it omits his immediate clarification that that "opinion" was "based on total services and not just mental health," and that he "later learned that mental looked a little different." A492 (9:12-14). Besides, the government offered no contrary evidence of what the allocation *should* have been, and thus "failed to establish as a matter of *fact* that the [expenditures] claimed were actually in excess of what was clearly allowed." *Whiteside*, 285 F.3d at 1352 (citing *United States v. Calhoon*, 97 F.3d 518, 526 (11th Cir. 1996)).

[13] Gov't Br. 36 (West and Yu "figure[d] out what percentage of WellCare's actual outpatient behavioral-healthcare claims were 80/20 claims" and then "appl[ied] that percentage to" the Plans' subcapitation payments to Harmony).

[14] The government asserts (at 36) that West was directed to "break" the numbers. But West was merely asked to "break the capitation" paid to Harmony into the "portion" that is "allowed on the AHCA letter" and the portion that is not. A505 (90:14-21) (West). Breaking capitations into their components, so they can be allocated to different services, is a "common" process done "all the time" in medical economics. A648 (44:6-45:3, 78:21-79:5) (Miller); A534 (75:24-77:16) (West).

In any event, those two steps *reduced* the Plans' reported expenditures, which could only *increase* the payback to AHCA. Fraud requires an effort to deprive another of property. Behrens Br. 78-79. The government's argument that the Plans' methodology resulted in a *greater* payment to AHCA could never amount to fraud.

B. The Government's Efforts To Evade *Whiteside* Lack Merit

The government raises a litany of arguments designed to evade *Whiteside* altogether. None succeeds.

1. *The Government Was Required To Prove that the CY2006 Submissions Were False*

The government urges (at 89) that *Whiteside* does not extend to the healthcare-fraud charges because § 1347 "does not require any misrepresentation." The government thus claims that, although the Indictment charges Defendants with committing healthcare fraud through "[s]ubmission[s] of false and fraudulent . . . expenditure information," A1 ¶32, they can be guilty even if the submissions were *true*. That argument fails.

First, § 1347 *does* require misrepresentation. In *United States v. Medina*, 485 F.3d 1291 (11th Cir. 2007), *cert. denied*, 558 U.S. 816 (2009), this Court held that, "in a health care fraud case, the defendant must be shown to have known that the claims submitted *were, in fact, false*." *Id.* at 1297 (emphasis added).

The government says *Medina* does not apply because it was only "a section 1347(a)*(2)* case" (which requires false pretenses), while this prosecution was also charged under § 1347(a)*(1)* (which prohibits defrauding healthcare programs). Gov't Br. 101 (emphasis added). That is incorrect. Like this case, *Medina* was brought under *both* (a)(1) *and* (a)(2). *Medina*'s jury instructions make that clear:

> There are two means by which the health care fraud statute may be violated: that is, 1) by *a scheme or artifice to defraud* a health care benefit program *or* 2) by a *scheme to make materially false representations or promises* in order to receive money/or property from a health care benefit program. *The indictment in this case charges that the Defendants did both*.

Dkt. 170 at 15-16, in No. 1:05-cr-20144-PCH (S.D. Fla.) (emphasis added).

Medina's holding also applied to both (a)(1) and (a)(2). The Court stated that it was addressing "health care fraud under 18 U.S.C. § 1347" and quoted *both* subsections as the "pertinent part" of the statute. 485 F.3d at 1297. It never limited its holding to (a)(2). Later decisions reaffirming *Medina* do the same. *United States v. Sosa*, 777 F.3d 1279, 1292 (11th Cir. 2015); *United States v. Vernon*, 723 F.3d 1234, 1273 (11th Cir. 2013).[15]

[15] The government (at 60) invokes *Loughrin v. United States*, 134 S. Ct. 2384 (2014), a bank-fraud case. But *Sosa* reaffirmed *Medina* after *Loughrin*. *See* 777 F.3d at 1292. And the distinction between the two statutes makes sense. In the bank-fraud context, one might pass bad checks without making a false statement. *Loughrin*, 134 S. Ct. at 2390 n.4; *Williams v. United States*, 458 U.S. 279, 284, 102 S. Ct. 3088, 3091 (1982) ("check-kiting" does not involve false statement). But it is virtually impossible to imagine a healthcare-fraud case without a false statement.

Second, the charges here explicitly require a false statement. Section 1347 always requires an "execut[ion]" of the alleged scheme. 18 U.S.C. § 1347(a). The Indictment charges only a single "execution" for each count of conviction: the April 2007 "[s]ubmission of false and fraudulent . . . expenditure information" for Staywell (Count 8) and HealthEase (Count 9) for CY2006, A1 ¶32—the same 80/20 submission charged in the healthcare false statements counts for which Behrens was convicted, A1 ¶28. The government cannot charge defendants with executing a fraud by submitting "false and fraudulent" statements and then claim it was not required to prove those statements' falsity. *See United States v. Lander*, 668 F.3d 1289, 1295-96 (11th Cir. 2012) (per curiam).[16]

The government's theory also contravenes the jury instructions. The jury was instructed—without government objection—that Defendants were charged with "execut[ing] a scheme to defraud the Florida Medicaid program *by making submissions of false and fraudulent behavioral health expenditure information*."

[16] Citing nothing, the government asserts (at 58-59) that an "execution" under § 1347 can be "*any* action affecting" a healthcare-benefit program—*i.e.*, any act in furtherance of the scheme. That is not the law. *See United States v. Hickman*, 331 F.3d 439, 446 (5th Cir. 2003) (explaining that, like the bank-fraud statute, but unlike mail and wire fraud, § 1347 "punishes executions or attempted executions of schemes to defraud, and not simply acts in furtherance of the scheme"); *accord United States v. De La Mata*, 266 F.3d 1275, 1287 (11th Cir. 2001) (addressing bank-fraud statute). Moreover, regardless of what *can* be an execution, the Indictment here charged only false statements as executions, and the prosecution must prove the executions it alleged.

A673(21) (emphasis added); A679(23:13-18). The jury was required to find that Defendants "executed, or attempted to execute," the scheme "*by means of false or fraudulent pretenses and representations*." A673(21) (emphasis added); A679(23:21-24:2). *Medina* therefore cannot be distinguished on "the required proof in *that* case." Gov't Br. 101. Falsity was "required proof" in *this* case too. *See United States v. Spletzer*, 535 F.2d 950, 954 (5th Cir. 1976) (element charged to jury "became a necessary element for conviction pursuant to the 'law of the case' doctrine"); *United States v. Yates*, 733 F.3d 1059, 1063 n.4 (11th Cir. 2013) (same), *rev'd on other grounds*, 134 S. Ct. 1074 (2015). The government conceded as much in post-trial motions, urging that "Defendants are guilty not because they failed to make additional disclosures to AHCA, but *because their statements (the expenditure information) were false*." Dkt. 772 at 37 (emphasis added).[17]

[17] The government's claims about alleged efforts to conceal the Plans' methodology are misplaced. For fraud, the government needed to prove a scheme to deprive AHCA of property, not information. Moreover, for fraud and false statements alike, alleged concealment would not make the submissions *false,* particularly where the government did not charge concealment, *see* A1 ¶¶28, 32, and the 80/20 templates did not even ask for the Plans' methodology, A699(GX-0601). *See also* Farha Reply 8 n.3, 14-15 n.9. For the same reasons, the government's claims about later encounter data submissions (at 47, 61) have no bearing on whether the CY2006 *80/20* submissions were true under a reasonable interpretation of the law. Moreover, as Clay's Brief (at 11-13, 23-24) and Reply (at 10-11 n.2) explain, the Plans priced encounters based on the Plans' costs using a methodology "recommended" by AHCA and "cleared with the state."

Third, absent falsity, there could not have been any fraud here. Defendants were accused of defrauding AHCA by improperly reducing the Plans' 80/20 refunds. A1 ¶26(a). But if the reported expenditure information was *true*, then AHCA received the refund to which it was entitled, precluding any harm to AHCA's property rights. *See* Behrens Br. 79. There is also no dispute that patients received all of the care (and more) that AHCA bargained for. *Id.* at 22. It is not fraud to provide the promised services at the promised price. *See United States v. Regent Office Supply Co.*, 421 F.2d 1174, 1180 (2d Cir. 1970).

Fourth, the fraud-without-falsity theory defies *Whiteside*. The defendants there were convicted not only for making false statements in cost reports, but also "for conspiracy *to defraud* the government *by making false statements* in those cost reports." 285 F.3d at 1345 (emphasis added). This Court reversed the conspiracy-to-defraud convictions "[i]n light of [its] decision reversing defendants' convictions for filing false statements." *Id.* at 1351 n.1. Likewise here, Defendants were convicted of executing healthcare fraud by submitting "false and fraudulent . . . expenditure information" in their 80/20 reports. A1 ¶32. If that information was not false, Defendants cannot be convicted for executing a scheme "to defraud the government by making false statements in those cost reports." 285 F.3d at 1345.[18]

[18] There is no conflict with *United States v. Svete*, 556 F.3d 1157 (11th Cir. 2009) (en banc). *See* Gov't Br. 90. *Svete* addressed whether a fraudulent "scheme [must] be capable of deceiving a reasonably prudent person"; the defendants claimed they

Finally, invoking attempt, the government contends that creating the 80/20 reports was a "substantial step" toward healthcare fraud, even if the "reports were true." Gov't Br. 91. To constitute a substantial step, however, "the defendant's *objective* acts, *without reliance on the accompanying mens rea*, must mark the defendant's conduct *as criminal*." *United States v. Carothers*, 121 F.3d 659, 661 (11th Cir. 1997) (emphasis added). Preparing a true cost report cannot mark conduct as criminal. Conduct that "is not criminal may not be turned into a crime after the fact by characterizing [the] acts as an attempt." 2 LaFave, *Substantive Criminal Law* § 11.5(a)(3) (2d ed.).

2. *This Court, Not the Jury, Decides the Legal Question of Objective Reasonableness*

The government urges that *the jury* must decide, subject only to sufficiency review, whether an interpretation of the law is objectively reasonable. Gov't Br. 72, 78, 80-83. That defies *Whiteside*. *Whiteside* nowhere characterized the issue as "sufficiency-of-the-evidence" or "factual sufficiency." Gov't Br. 64, 68. Nor did the Court suggest it would defer to the jury if the jury reasonably could have preferred a particular interpretation. The Court acknowledged that "reasonable people could differ as to whether the debt interest was capital-related"; "that the

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were innocent, *not* because their statements were *true*, but because the statements were *so patently false* that no reasonable person could believe them. 556 F.3d at 1159-60. *Svete* has no relevance where, as here, defendants claim they cannot be convicted for statements that are *true* under a reasonable interpretation of the law.

experts disagreed" over the correct interpretation; and that both "'competing interpretations'" were "'reasonable.'" 285 F.3d at 1352-53. But the Court independently concluded that "the defendants' . . . interpretation was not unreasonable," and therefore held the government had failed to prove falsity "as a matter of law." *Id.*

Other courts agree that, where there is a "genuine and material dispute as to the reasonableness of a defendant's asserted understanding of applicable law, the judge, and not the jury, must resolve the dispute." *United States v. Prigmore*, 243 F.3d 1, 18 (1st Cir. 2001); *see United States v. Race*, 632 F.2d 1114, 1120 (4th Cir. 1980). Questions of "'construction'" of written instruments—such as the Contracts here—are "'questions of law for the judge, not questions of fact for the jury.'" *Markman v. Westview Instruments, Inc.*, 517 U.S. 370, 387, 116 S. Ct. 1384, 1394 (1996). And "[c]haracterizing a particular belief" about lawfulness "as not objectively reasonable transforms the inquiry into a legal one" for the court to decide. *Cheek v. United States*, 498 U.S. 192, 203, 111 S. Ct. 604, 611 (1991).

Consequently, whether it is objectively reasonable to construe the 80/20 requirements as allowing the Plans to report payments to their BHO is an issue of law for the Court. *See Safeco Ins. Co. of Am. v. Burr*, 551 U.S. 47, 69-70, 127 S. Ct. 2201, 2204 (2007) (holding as a matter of law that defendant's "reading of the statute . . . was not objectively unreasonable"). A court that delegates legal ques-

tions to the jury—for example, by allowing a jury to decide which expenses were legally required on a government-issued form—"abdicate[s] its responsibility." *United States v. Lake*, 472 F.3d 1247, 1263 (10th Cir. 2007). The district court made precisely that mistake here. Behrens Br. 80-81. That error was exacerbated when the district court declined to instruct the jury on the Statute and Contracts, referring the jury to the template alone. *See id.* at 80. That left the jury to make its own determination about controlling sources of law—an issue jurors, unlike courts, lack competence to decide.

The government attempts to conflate *Whiteside* with *United States v. Bell*, 623 F.2d 1132 (5th Cir. 1980), inventing a previously unheard-of "*Bell/Whiteside* ambiguity analysis." Gov't Br. 70; *see id.* at 68-69, 78-79. *Whiteside* did not cite *Bell* or any decision applying *Bell*. No case applying *Bell* has cited *Whiteside*, and vice versa. *Whiteside* controls where, as here, falsity turns on an interpretive question of law; *Bell* controls where falsity turns on what a particular question meant as a matter of common English, not law. Defendants thus invoke *Whiteside*, not *Bell*.

In any event, even under the *Bell* line of cases, the government as a matter of law cannot prove falsity if an allegedly false statement is true under a reasonable interpretation: Where "'men of ordinary intellect' might disagree over the meaning of particular questions," the court must "take [the] question away from [the] jury." *United States v. Manapat*, 928 F.2d 1097, 1099, 1100 (11th Cir. 1991) (cit-

ing *United States v. Yasak*, 884 F.2d 996 (7th Cir. 1989)); *see Bell*, 623 F.2d at 1137 (ordering acquittal even though "Bell may very well have known what the government now says it was seeking").[19]

3. Whiteside *Is Not a* Mens Rea *Case*

The government tries to convert *Whiteside* into a *mens rea* case. It urges that "the *Whiteside* defense of 'objective reasonableness' is simply a way of casting reasonable doubt on evidence of *knowing* falsehood," and can be overcome whenever the jury "find[s] a '*knowingly* false' statement." Gov't Br. 67 n.15 (emphasis added); *see id.* at 78-79 & n.22. But *Whiteside* concerned "the *actus reus* of the offense—actual falsity"—not *mens rea* or knowing falsity. 285 F.3d at 1353; *see also* Clay Reply 5-7.

It is thus irrelevant whether a jury could have inferred that anyone *thought* the Plans' reporting was improper. Gov't Br. 63. *Whiteside* itself reversed the convictions despite evidence that the defendants:

- were advised that their reporting "might be fraud";

[19] The government invokes "arguable ambiguity," Gov't Br. 69, 78, but that describes cases where the defendant's proffered interpretation is *unreasonable—i.e.*, "contrived hypertechnical or lame." *Bell*, 623 F.2d at 1136; *Manapat*, 928 F.2d at 1099. In such cases, the jury may decide the defendant's actual understanding. *Id.* But where the construction is *reasonable*—where reasonable people "might disagree over [a question's] meaning"—the Court refers to the question as "fundamentally ambiguous." *Manapat*, 928 F.2d at 1100. In such a case, the Court "cannot allow [the jury] to criminally convict a defendant based on [its] guess as to what the defendant was thinking at the time the response was made." *Id.* at 1101.

- disregarded advice to "flag [their methodology] for the auditor";
- falsified documents; and
- sought "to divert the [fiscal intermediary's] attention from the interest issue."

285 F.3d at 1348-50. Those aspects of *Whiteside* are discussed prominently in Behrens's opening brief (at 75-77). The government offers no answer.

4. *The Plans' 80/20 Reporting Turns on "Interpretive Questions of Law" Governed by Statute and Contract*

Finally, the prosecution argues (at 73-76) that this case involves no "'interpretative question of law'" to which *Whiteside* could apply. According to the prosecution (at 73-74), Defendants falsely answered a question "asked by [the 80/20] templates," whereas *Whiteside* involved "a question 'asked' by a federal regulation." Defendants, the prosecution insists (at 76), "did not have to interpret [the 80/20] statute, or their contracts," to complete the templates.

The government's premise is false. *Whiteside* did not involve "a question 'asked' by a federal regulation." It involved expenditure information reported on Medicare cost report forms and "schedules known as worksheets 'A-6' and 'A-8' in the cost reports." 285 F.3d at 1346-47. The "question" to which the defendants were responding was "asked" by the forms. The regulation itself asked no questions; it merely gave a definition of capital-related interest expense. *Id.* But it was

necessary to interpret the regulation because it defined the defendants' reporting obligation. *Id.* at 1352.

The same logic applies here. The only difference is that AHCA did not issue a regulation. Instead, Defendants' reporting obligation was defined by the Contracts and the Statute, as the government conceded below. *See* pp. 10-11, *supra*; Behrens Br. 55-61. The absence of a regulation hardly renders *Whiteside* irrelevant. Indeed, *Whiteside* relied on *United States v. Race*, 632 F.2d 1114, 1120 (4th Cir. 1980), which (like this case) involved "a reasonable construction of the enabling language of [a] contract," and on *United States v. Anderson*, 579 F.2d 455, 459-60 (8th Cir. 1978), which involved certifications on reimbursement invoices the defendants submitted—not regulations.

II. THE GOVERNMENT'S USE OF WELLCARE'S FINANCIAL RESTATEMENT CONSTITUTES PREJUDICIAL ERROR (ALL DEFENDANTS)

The district court permitted the government to present the contents of WellCare's financial restatement through the testimony of its expert witness, Harvey Kelly. As explained in Behrens's opening brief (at 81-97), that violated Federal Rule of Evidence 703. The restatement did not form the "basis" for Kelly's opinions. And the district court did not even undertake Rule 703's demanding balancing test, which—unlike Rule 403—is weighted *against* admissibility. The jury thus heard what amounted to WellCare's extrajudicial confession—introduced

through a witness who, because he had no personal knowledge, could not be cross-examined about the coercive conditions under which the restatement was prepared.

The government says remarkably little in defense of the court's ruling, and what it does say is evasive. The government primarily seeks affirmance on the alternative ground that the district court *could have* admitted the restatement into evidence in its own right. But that contention lacks merit, as does the government's half-hearted harmless-error argument.[20]

A. The Government's Defense of the District Court's Ruling Is Unpersuasive

The government first contends (at 137-38) that Kelly was entitled to rely on the restatement to inform his opinions. No one suggested otherwise. An accounting expert may look to publicly filed financial statements in reaching an opinion.

[20] The government suggests in passing (at 143) that this issue may be disregarded because the restatement itself was not admitted. That is a non sequitur: Rule 703 *never* authorizes the admission of evidence as substantive proof; it limits the circumstances in which inadmissible evidence is nonetheless *disclosed* to the jury as a basis of an expert's opinion. There is no dispute that Kelly presented to the jury the restatement's contents, including its hearsay conclusion that WellCare had identified "accounting errors" arising from non-compliance with the 80/20 refund obligations, A632(52:23-53:25), and its revised figures purporting to show that WellCare had understated its 80/20 refund obligations by $35 million, *see* A632(55:10-19, 76:13-79:9); A798-1 at 73. Nor is there any basis for the government's suggestions (at 136, 138, 139, 148) that Kelly invoked Deloitte & Touche work papers, rather than the restatement itself. As Kelly testified, he consulted those work papers to determine what portion of *the restatement's* income adjustments was attributable to the 80/20 submissions at issue here. A632(55:10-19). Those numbers were presented to the jury as *the restatement's* conclusions, *see* A798-1 at 73 (demonstrative exhibit displayed to jury), and there can be no question that Defendants objected to any use of the restatement.

The problem is that Kelly did not *in fact* "base" his opinion on the restatement, as Rule 703 requires. Moreover, even had he done so, Rule 703 still required the government to establish that the evidence's "probative value in helping the jury evaluate the opinion substantially outweigh[ed] [its] prejudicial effect," and the district court never made that finding.

1. The government does not meaningfully dispute that Kelly used the restatement, at most, to "double check" findings he had already reached independently. Behrens Br. 90-91. Indeed, the government acknowledges Kelly's concession that the restatement was "just another measuring point to compare the results and—determine the reasonableness of [his] conclusion." Gov't Br. 142 (quoting D632/76). Rule 703 prohibits such purely corroborative materials from being disclosed to the jury. *See* Behrens Br. 89-93. Such testimony could be "relevant only as inadmissible hearsay to bolster the expert witness's testimony." 6 Fishman *et al.*, *Jones on Evidence* § 42:11 (7th ed. 2013).

Nor does it matter that Kelly made some of his concessions to the court. *See* Gov't Br. 141-42. For one thing, the government mischaracterizes the record: Kelly's statement that he used the restatement's numbers to "double-check" his own was delivered *to the jury*. *See* A636 (66:19). So was his statement that the restatement was "consistent" with his own calculations. A636 (67:5-6). For another, whether the jury should receive such otherwise inadmissible evidence is for the

court to decide under Rule 104. Once the court learned that Kelly had used the restatement evidence solely as corroboration of, and not as the basis for, his opinion, the evidence should never have been presented to the jury. 2 Broun, *McCormick on Evidence* §324.3 (7th ed.) (disclosure under Rule 703 permitted only for "limited purpose of informing the jury of the basis of the expert's opinion").[21]

2. As for Rule 703's additional requirement that the probative value of evidence "substantially outweigh" its prejudicial effect, the government does not deny that the district court abdicated its gatekeeping role—a per se abuse of discretion. *See McClain v. Metabolife Int'l, Inc.*, 401 F.3d 1233, 1238 (11th Cir. 2005); *Dodge v. Cotter Corp.*, 328 F.3d 1212, 1223 (10th Cir. 2003). Instead, the government contends (at 145-46) that the restatement evidence *would have* satisfied Rule 703's balancing test had the district court conducted that inquiry. But that argument misrepresents the rationale for the restatement evidence's introduction and ignores the coercive conditions under which the restatement was issued.

a. The government begins by misrepresenting the purpose for which it offered the restatement. It contends (at 145 & n.46) that Kelly used the restate-

[21] The government argues (at 140) that, even if the restatement evidence only corroborated Kelly's testimony, "an expert's opinion should not be suspect merely because it is corroborated." Of course an expert's "opinion" may be strengthened by corroborative evidence. But the question here is whether such allegedly corroborative evidence, if otherwise inadmissible, may be *disclosed to the jury* along with the expert's opinion. Rule 703 permits such disclosure only where the evidence is the "basis" of the expert's opinion. Here, it was not.

ment merely to show how the alleged fraud contributed to WellCare's bottom line, and not as evidence that the Plans over-reported their 80/20 expenditures, as charged in the Indictment.

In fact, Kelly deployed the restatement as substantive evidence that Defendants' 80/20 submissions were false. He told the jury, point blank, that WellCare filed the restatement "to correct for prior year misreportings of required AHCA refunds," A632(51:16-18), and he quoted from the restatement in telling the jury that WellCare's Board had "recommended . . . that [the company's] previously issued consolidated financial statements . . . be restated" in light of "accounting errors" arising from non-compliance with the 80/20 refund obligations. A632(52:23-53:25). He then testified that the revised figures proved that WellCare had understated its 80/20 refund obligations by $35 million. *See* A632(55:10-19, 76:13-79:9); A798-1 at 73 (demonstrative exhibit displayed to jury).

That was exactly the purpose the government identified when, midway through trial, it abandoned its pre-trial concession that the restatement should be excluded as inadmissible hearsay. The government trumpeted the restatement as proof that "WellCare's expenditure reports to AHCA in connection with the 80/20 reporting obligation were materially false." A568 at 1; *see id.* at 9 (proposing to offer the restatement as proof the "reports were false when submitted"). And the

government's summation only reinforces this point.[22] The government repeatedly invoked the credibility of WellCare's outside auditors, Deloitte & Touche, and urged the jury to accept the restatement as what "real financial analysis establishes of what's occurred here." A761(132:2-6); Behrens Br. 86-87 (additional examples). The government openly used the restatement as substantive evidence that the Plans' submissions were false.

b. The government claims (at 146) that "[n]o evidence exists supporting th[e] significant accusation" that WellCare prepared the restatement at the behest of AHCA and the government while under an existential threat of criminal prosecution. In fact, abundant evidence to that effect was presented to the district court (but kept from the jury). *See* Behrens Br. 82-83. Notes taken by an FBI agent who met with the company's lawyers in February 2008 show that WellCare promised to "cooperate fully" precisely because it "want[ed] to avoid an indictment" that "would end" the company. A56-2 at 58. And the government itself has insisted that, if WellCare had not been permitted to enter into a deferred prosecution agreement, it could have been prosecuted criminally and excluded from doing business with the federal government, causing the company to become "worthless." A903 at 19.

[22] Defendants invoke the summation to show the purpose and prejudicial effect of the restatement's admission, not (as the government supposes, Gov't Br. 147-48) to support an independent claim of prosecutorial misconduct.

Unsurprisingly under the circumstances, AHCA dictated the content of WellCare's financial restatement. It was an AHCA employee who, during the negotiations that precipitated the restatement, declared that "payment[s] to an internal subsidiary such as Harmony cannot be counted" and that only payments to "downstream direct services provider[s]" can be—the first time anyone at AHCA had suggested such a standard. A572-5 at 3; Behrens Br. 69 & n.33. It was only after those "discussions with AHCA" that the Special Committee declared that the Plans' 80/20 reporting had been erroneous and that the Plans owed AHCA another $35 million. A572-1 at 5.[23]

Far from constituting "pure speculation," Gov't Br. 145, overwhelming evidence demonstrates that the restatement's contents—including its assertion that payments to Harmony could not qualify as 80/20 expenditures—were dictated by the government while WellCare was under threat of potentially catastrophic criminal prosecution. Under these circumstances—which, again, the district court never considered because it performed no Rule 703 balancing at all—the restatement had almost no *legitimate* probative value. And because Defendants could not cross-

[23] The prosecution likewise directly influenced the restatement's contents. WellCare relied on assurances "by the U.S. Attorney's Office that the amounts reported by AHCA are accurate." Dkt. 572-2 at 2; A572-4. But the prosecution and AHCA knew AHCA had placed *inflated* premiums on the Plans' templates for 2002-2004, and never told WellCare. There is no dispute that, as a result of the premium error, the restatement estimates were millions of dollars too high. *See* A588(123:24-125:13); Behrens Br. 25-26.

examine the proffering witness about the restatement's fundamentally misleading nature, the evidence was especially prejudicial.

B. The Government's Alternative Grounds for Affirmance Lack Merit

Unable to defend the district court's decision on its own terms, the government contends that the restatement evidence was not "otherwise inadmissible," and thus the district court's failure to consider the Rule 703 factors may be excused. These theories are meritless.

1. Invoking waiver, the government first claims (at 144) that Defendants stipulated to the restatement's authenticity and admissibility as a business or public record. That argument—never advanced below—rests on a misleading account of the procedural history.

Before trial, Defendants moved *in limine* to exclude all references to WellCare's restatement. Dkt. 294 at 21-24. In response, the government acknowledged that the restatement was inadmissible hearsay and disclaimed any intent to introduce it as substantive evidence. A347 at 11-12. The court entered an order precluding the government from "us[ing] the restated documents in its case in chief." A354 at 3.

The government now claims that this ruling was superseded when the parties exchanged case-in-chief exhibit lists shortly before trial. The government's list—which stretched over 100 pages and listed more than 2,500 documents—included,

among sixteen 10-Qs and 10-Ks, WellCare's SEC Form 10-K for the quarter ending December 31, 2007, as Item No. 2,319. The parties entered into a general stipulation that (subject to certain categorical exceptions) the listed documents satisfied the requirements of authentication and qualified as business records under Rule 803(6) or as public records under Rule 803(8). At the time, however, the government had already affirmatively conceded that the restatement was inadmissible and disclaimed any intent to offer it as substantive evidence, and the court had held the restatement inadmissible. (The government obscures that chronology by flipping its discussion of the exclusion order and the stipulation, Gov't Br. 119-20.) Defendants thus had no reason to suppose that the government's burying of this document on a massive list would somehow undo the government's prior concession or the court's order.

When the shoe was on the other foot, the government urged that the list could have no such effect. Responding to Defendants' motion to admit internal AHCA legal memoranda, the government explained that it had failed to except those materials from the exhibit-list stipulation because they had previously been excluded by the court: "We thought those were out. *If I had, for a moment thought that those were in, we would have excepted them.*" A662 (118:11-17) (emphasis added). The district court agreed, noting that it was "certainly understandable that the government didn't think they had to exclude this from their stipulation

since I had already ruled it would not come in." A663(81:12-14). Having prevailed on that argument, the government cannot now switch sides and invoke the exhibit list to justify admission of previously excluded evidence. *See, e.g.*, *Davis v. Wakelee*, 156 U.S. 680, 689, 15 S. Ct. 555, 558 (1895) ("[W]here a party assumes a certain position in a legal proceeding, and succeeds in maintaining that position, he may not thereafter, simply because his interests have changed, assume a contrary position . . . .").

In short, no one—not Defendants, not the government, and not the district court—understood the pre-trial stipulation as an agreement that the restatement would be admitted.[24] In any event, because "[c]laims of waiver may be waived in turn," *E.E.O.C. v. Indiana Bell Tel. Co.*, 256 F.3d 516, 526 (7th Cir. 2001), the government forfeited this waiver argument when it failed to raise it at trial when seeking the evidence's introduction. *See Ochran v. United States*, 117 F.3d 495, 503 (11th Cir. 1997). If more were needed, the district court addressed the parties' arguments on the merits, without considering the stipulation (much less the court's

[24] The government's reliance on Rule 803(8)'s public-record exception fails for the same reasons. And the restatement could not qualify as an admissible public record in any event. Rule 803(8) allows admission, under specified circumstances, of "record[s] or statement[s] of a public office." It does not cover documents, like WellCare's restatement, that are *submitted to* a public office by a private party. *See Ake v. GMC*, 942 F. Supp. 869, 878 (W.D.N.Y. 1996). Such filings are addressed by Rule 803(9), which encompasses a narrow category of documents—"record[s] of a birth, death, or marriage, if reported to a public office in accordance with a legal duty"—that excludes WellCare's restatement.

earlier refusal to admit evidence against the government under the stipulation). *See, e.g.*, *United States v. Montgomery*, 620 F.2d 753, 757 (10th Cir. 1980) (district court can relieve a party from a stipulation agreed to as a result of inadvertence).

2. The government's contention that the restatement was an admissible business record under Rule 803(6) is a non-starter. Rule 803(6) "requires the testimony of a custodian or other qualified witness who can explain the record-keeping procedure utilized" by the company and show that each requirement of the business-record exception has been met. *United States v. Garnett*, 122 F.3d 1016, 1018-19 (11th Cir. 1997). "Without such a witness the writing *must* be excluded." *Belber v. Lipson*, 905 F.2d 549, 552 (1st Cir. 1990) (emphasis added); *see also Noble v. Alabama Dep't of Envtl. Mgmt.*, 872 F.2d 361, 367 (11th Cir. 1989) (reversing where custodian "did not testify that he had personal knowledge of the circumstances under which the [documents] were prepared").

Here, the government offered *no* testimony from a custodian or other qualified witness regarding the circumstances of the restatement's creation. That failure is no mere technicality. Without such testimony, the proponent is "rendered immune to cross-examination, thus eliminating the possibility that the defense might be able to keep his testimony from the jury altogether by showing that a condition essential to admissibility under rule 803(6) could not be met." *United States v. Davis*, 571 F.2d 1354, 1359-60 (5th Cir. 1978). Precisely that happened.

The government asserts (at 125-26) that the restatement was admissible as a business record because it was "certified." But the certification was from the *SEC's* records custodian, not from someone with personal knowledge of the conditions under which the restatement was prepared. *See* A632(8:25) (government referring to restatement as a "certified copy that we got from the SEC"). That certification authenticated the restatement only as what it purported to be—namely, a copy of the Form 10-K that WellCare filed with the SEC. *See* Fed. R. Evid. 902(4) (setting forth requirements for self-authentication of "a copy of a document that was recorded or filed in a public office as authorized by law"). But it could not make the restatement admissible under Rule 803(6), which permits a certification to substitute for testimony only when it shows that a document meets the prerequisites for admission as a business record. *See* Fed. R. Evid. 803(6)(D). Filing a document with the SEC does not lay the required foundation.

Even if the government had sought to comply with Rule 803(6), the restatement could not have qualified as a business record. The restatement was prepared under highly coercive circumstances, as WellCare faced a threat of criminal prosecution that company officials believed could "end" WellCare. *See* pp. 35-36, *supra*. It was by no means prepared in the "regular practice" of a "regularly conducted activity." Fed. R. Evid. 803(6)(B), (C); *cf. United States v. Casoni*, 950

F.2d 893, 910-13 (3d Cir. 1991) (attorney's proffer memorandum, intended to secure immunity for client, did not qualify as business record).

3. The government suggests (at 144) that the restatement was admissible under Rule 807's residual exception to the hearsay rule. But Rule 807 permits evidence to be admitted only "if, *before the trial or hearing*, the proponent gives an adverse party reasonable notice of the intent to offer the statement and its particulars." Fed. R. Evid. 807(b) (emphasis added). Here, the government did just the opposite—it conceded before trial that the restatement was inadmissible hearsay and agreed that it would not seek to introduce that evidence; the district court so ruled. Not until six weeks into trial did the government reverse course. Accordingly, Rule 807's residual exception cannot apply. *See, e.g.*, *Davis*, 571 F.2d at 1360 n.11 (rejecting exception where "the Government made no attempt to invoke [it] by giving the defense the required advance notice of the hearsay evidence to be offered at trial").

Rule 807, moreover, authorizes the admission of hearsay only when rigorous requirements are met, including proof that (1) "the statement has equivalent circumstantial guarantees of trustworthiness," (2) "it is more probative on the point for which it is offered than any other evidence that the proponent can obtain through reasonable efforts," and (3) "admitting it will best serve the purposes of" the Federal Rules "and the interests of justice." That demanding test is rarely met,

reflecting Congress's intent that "the residual hearsay exception . . . be used only in exceptional circumstances." *United States v. Jayyousi*, 657 F.3d 1085, 1113 (11th Cir. 2011). The government cannot show, and has never attempted to show, that those elements are satisfied here. The restatement lacked "circumstantial guarantees of trustworthiness" for the same reasons that it could not qualify as a business record: It was prepared under highly coercive circumstances, and its contents were apparently dictated by AHCA. *See* pp. 35-36, *supra*. And because the restatement was not more probative than other evidence the government could obtain through reasonable efforts, it could not satisfy Rule 807's "built-in requirement of necessity." *United States v. Mathis*, 559 F.2d 294, 299 (5th Cir. 1977). The government recognized as much in its pretrial pleading concerning the restatement, where it reserved the right to "call witnesses to testify to the information in the restatements, or to testify regarding information learned while compiling the restatements." A347 at 11. Had the government called those witnesses, Defendants could have cross-examined them regarding the circumstances of the restatement's preparation. Admitting the restatement, however, placed its conclusions "before the jury without subjecting them to scrutiny of cross-examination," which is precisely what the hearsay rule forbids. *United States v. Scrima*, 819 F.2d 996, 1001 (11th Cir. 1987).

C. Introduction of the Restatement's Contents Was Not Harmless

In one conclusory sentence, the government contends (at 147) that disclosure of the restatement's contents was harmless. The government appears to rely on the mistaken premise that the restatement evidence went only to motive.[25] But as explained above, the government repeatedly deployed the restatement as evidence that the WellCare Plans' 80/20 submissions were *false*—the central issue at trial. *See* pp. 33-35, *supra*. The evidence could not have been more prejudicial on that score: The government presented it as a confession by Defendants' alleged coconspirator, a confession reinforced by WellCare's documented willingness to repay *$35 million* as a result of the alleged errors recounted in the restatement. The prejudice is obvious, and the claim of harmlessness without merit.

III. COUNTS 4 AND 5 FAIL TO STATE AN OFFENSE FOR FALSE STATEMENTS (BEHRENS ONLY)

The government nowhere denies that Counts 4 and 5 of the Indictment do not, by themselves, state a healthcare false-statements offense under 18 U.S.C. § 1035. Behrens Br. 100-02. The government argues that the Counts are sufficient if the Indictment is considered "as a whole," Gov't Br. 164, including allegations in separate fraud counts, *id.* at 166-67. But Counts 4 and 5 do not incorporate or

[25] The government is wrong in asserting (at 144 n.45) that the district court "ruled that the restatement was relevant evidence of profit motive." The cited transcript, "D588/145," is wholly unsupportive. And the government surely never used the restatement for that purpose.

even refer to those fraud counts. *See* A1 ¶28. Consequently, *United States v. Schmitz*, 634 F.3d 1247 (11th Cir. 2011), forecloses the government's argument. Under *Schmitz*, "each count of an indictment must be regarded as if it were a separate indictment and must stand on its own content without dependence for its validity on the allegations of any other count not expressly incorporated." *Id.* at 1261 (quotation marks omitted).

The government tries to distinguish *Schmitz*, arguing (at 164) that "factual allegations in one count can inform or provide meaning to the factual allegations in another count" even when not expressly incorporated. 634 F.3d at 1262 n.10. But that does not help the government. As in *Schmitz*, "[w]e are not dealing in this case with factual allegations in one count that simply inform or provide meaning to factual allegations in a separate count." *Id.* Rather, there are virtually "no factual allegations at all" in the false statements counts. *Id.* The government acknowledges that the challenged counts in *Schmitz* were "too spare" because they did not address basic questions like, "What was the purpose of the scheme? How did Schmitz join it? What steps did she or others take to execute it? How did she steal her own salary?" Gov't Br. 165. But Counts 4 and 5 here are no different. They allege only that, in April 2007, Defendants made submissions of "CMH and TCM behavioral health care services expenditure information" for Staywell and HealthEase that were "materially false, fictitious, and fraudulent." A1 ¶28. There

is no indication *what* in the submitted information was false, or *why* it was false. Nor is there anything "relating the charges to Behrens's own conduct"—what "steps . . . [he] or others t[oo]k to execute it." Gov't Br. 165. As in *Schmitz*, the Court cannot "overlook the complete absence of factual allegations in the [false-statements] counts" on the basis that unincorporated counts "adequately describe [the alleged] fraudulent scheme." 634 F.3d at 1261.

The government urges (at 167) that, before trial, it gave Behrens "additional notice regarding the false-statements counts." But "[t]he only way to remedy the defects in the indictment would be to rewrite it, and that [this Court] may not do" on appeal. *United States v. Lang*, 732 F.3d 1246, 1249 (11th Cir. 2013). The government never cites its "additional notice," which was just a letter attaching the Plans' 80/20 submissions. *See* Dkt. 409, attachments. It provides no explanation why the submissions were false, why Behrens was charged, or his role. Dkt. 409, attachment 1 at 2.[26]

Because the Indictment failed to provide basic facts explaining what rendered the Plans' expenditure information false, the government has repeatedly changed its theory of falsity. To obtain favorable evidentiary rulings pretrial, the

[26] The government's suggestion (at 168) that Behrens failed to renew his motion to dismiss after receiving the "additional notice" is baseless. Behrens renewed the motion three times. Dkt. 614 at 1 n.1; Dkt. 669 at 2; Dkt. 731 at 1 n.1; *see* Fed. R. Crim. P. 12(b)(3)(B) (2013) ("at any time while the case is pending, the court may hear a claim that the indictment . . . fails . . . to state an offense").

government represented that whether "it would be 'reasonable' to report the subcapitated expense paid to Harmony is a non-issue." Dkt. 324 at 14. Now, the government argues that "the Harmony method of reporting" rendered the Plans' reporting false. *See, e.g.*, Gov't Br. 62. Clearly, the Indictment did not "sufficiently apprise the defendant of what he must be prepared to meet." *United States v. Bobo*, 344 F.3d 1076, 1083 (11th Cir. 2003).

IV. THE WILLFUL BLINDNESS INSTRUCTION WAS ERROR (BEHRENS & CLAY)

The district court instructed the jury that a defendant could be guilty of a false-statements charge if he "was aware of a high probability that the fact existed and took deliberate action to avoid learning of the fact." A679(16:3-6). But there was no *evidence* to support a willful blindness theory here. The district court gave that instruction on the theory that the jury could find that Defendants "deliberately avoided suing AHCA to find out the correct construction," or "disclos[ing] their subcapitation" methodology to AHCA "more clearly" to prompt action by AHCA. A664(75:2-4, 76:19-24). But that is not willful blindness. Behrens Br. 103.

On appeal, the government nowhere denies the trial evidence failed to support a willful-blindness theory. That argument is thus waived. The government argues (at 171 n.48) only that "the absence of evidence of willful blindness is per se harmless." But there is a circuit split on that issue. Behrens Br. 103. The issue is thus ripe for further review.

CONCLUSION

Defendants' convictions on Counts 8 and 9, and Behrens's convictions on Counts 4 and 5, should be reversed. At the very least, Defendants are entitled to a new trial.

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and with this Court's Order of February 10, 2015 because:

   - This reply brief contains 11,467 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), and

   - all four Appellants' reply briefs in this case contain a total of 27,568 words, excluding the parts exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman 14-point font.

April 17, 2015 /s/ Jeffrey A. Lamken

CERTIFICATE OF SERVICE

I certify that today, April 17, 2015, I electronically filed the foregoing Reply Brief for Defendant-Appellant Paul L. Behrens with the Clerk of the Court using the appellate CM/ECF system. Counsel of record for all parties will be served by the appellate CM/ECF system.

I further certify that today, April 17, 2015, I caused seven paper copies of the foregoing to be dispatched to the clerk by Federal Express for delivery within three days.

April 17, 2015 /s/ Jeffrey A. Lamken