

16-13004

**IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

UNITED STATES OF AMERICA *ex rel.* PARADIES, *et al.*,

Plaintiffs-Appellants,

v.

GGNSC ADMINISTRATIVE SERVICES, *et al.*,

Defendants-Appellees.

**ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA, SOUTHERN DIVISION,
CASE NO. 2:12-cv-245-KOB**

AMENDED BRIEF FOR AMICI CURIAE AARP
AND AARP FOUNDATION IN SUPPORT OF NEITHER PARTY

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United States v. GGNSC Administrative Services, No. 16-13004

**CERTIFICATE OF INTERESTED PERSONS AND CORPORATE
DISCLOSURE STATEMENT**

Pursuant to 11th Circuit Rules 26.1, 28-1(b), and 29-2, Amici Curiae AARP and AARP Foundation through the undersigned counsel of record certify that, in addition to the individuals and entities identified in the Appellants' and Appellees' opening briefs, the following listed individuals and entities have an interest in the outcome of this case:

AARP (Amicus Curiae)

AARP Foundation (Amicus Curiae)

Bagby, Kelly (counsel for Amici Curiae)

Gyamfi, Maame (counsel for Amici Curiae)

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The Internal Revenue Service has determined that AARP is organized and operated exclusively for the promotion of social welfare pursuant to Section 501(c)(4) of the Internal Revenue Code and is exempt from income tax. The Internal Revenue Service has determined that AARP Foundation is organized and operated exclusively for charitable purposes pursuant to Section 501(c)(3) of the Internal Revenue Code and is exempt from income tax. AARP and AARP Foundation are also organized and operated as nonprofit corporations under the District of Columbia Nonprofit Corporation Act.

Other legal entities related to AARP and AARP Foundation include AARP Services, Inc., and Legal Counsel for the Elderly. Neither AARP nor AARP Foundation has a parent corporation, nor has either issued shares or securities.

Dated: October 20, 2016

/s/Maame Gyamfi

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STATEMENT OF INTEREST

AARP is a nonprofit, nonpartisan organization dedicated to fulfilling the needs and representing the interests of people age fifty and older. AARP fights to protect older people's health, financial security, and well-being.¹ AARP's charitable affiliate, AARP Foundation, creates and advances effective solutions that help low-income individuals fifty and older secure the essentials. Among other things, AARP and AARP Foundation work to combat fraud, waste and abuse in federal health care programs by participating as amicus curiae in state and federal courts. *E.g., Universal Health Services, Inc. v. United States ex rel. Escobar*, 136 S.Ct. 1989 (2016). In addition to our fraud enforcement litigation, AARP and AARP Foundation work to ensure that people have access to necessary long-term services and supports.

AARP and AARP Foundation submit this brief to illuminate the importance of the Medicare hospice benefit. We are not advocating on behalf of either party, but rather request that the Court narrowly tailor whatever decision it makes to ensure that eligible patients and their families continue to have access to vital hospice services.

¹ Pursuant to Fed. R. App. P. 29, amici certify that all parties have consented to the filing of this brief. No party or party's counsel authored this brief in whole or in part; and no person other than amici contributed money intended to fund the brief's preparation or submission.

This case presents two legal questions: whether the district court erred in granting summary judgment in favor of AseraCare, and whether the district court erred in granting AseraCare a new trial. The court below separated the trial into two “phases.” Dkt. 298. Phase One was to determine whether the reimbursement claims submitted by AseraCare were “false” under the False Claims Act (“FCA”). Dkt. 288. At Phase Two (which did not occur) the jury would decide whether AseraCare knew that the claims they submitted were false, as well as the remaining elements of liability and damages. *Id.* The government argued that this bifurcation would limit its ability to prove falsity, as they argued that knowledge and falsity are inextricably linked. Dkt. 295. In the absence of evidence about knowledge, the case turned on whether a physician’s clinical judgment was supported by the clinical record about the prognosis of each patient under review. If the Government had been able to present its case looking at both falsity and knowledge at the same time, the danger of making a legal finding that a false claim could be based simply upon the establishment of a difference of clinical judgment about a patient’s life expectancy would have been minimized.

As we argue below, hospice is an integral service to those nearing the end of their life. A holding in this case that allows for FCA liability to attach to a legitimate physician’s certification after review of the clinical record could force hospice providers to wait until the last few days of a patient’s life to admit her or

him to hospice. This late admission would negate the beneficial services provided by hospice. Likewise, a decision that inhibits whistleblowers from uncovering fraud would grant disreputable providers a blank check reimbursable by Medicare. A narrow ruling would ensure continued access to important hospice services provided to those at the end of life.

SUMMARY OF ARGUMENT

Rooting out fraud, waste and abuse is vital to the long-term viability of the Medicare program. AARP and AARP Foundation strongly support government enforcement of the FCA and the whistleblowers who bring fraud allegations to light. We submit this brief to assist the Court by highlighting the essential role that hospice services play and to underscore the need for patients and families to be able to secure hospice services at the earliest point at which eligibility for the services is identified. Moreover, we describe the vital role that hospice services play in ameliorating suffering and improving the quality of care provided to a dying person. Further, we explain the dramatic impact that hospice providers have supporting family caregivers with the day-to-day grief counseling and bereavement benefits included within hospice services. Finally, we identify the ways in which hospice services have changed over the years in both the kinds of hospice providers that exist and the sorts of chronic illnesses that bring patients into hospice services. Although these changes have caused the hospice industry to

serve a wider group of people, the expansion has also challenged the capacity and availability of hospice care.

ARGUMENT

I. HOSPICE CARE IMPROVES THE BENEFICIARY’S END-OF- LIFE QUALITY OF CARE AND PROVIDES IMMEASURABLE SUPPORT FOR FAMILIES AND CAREGIVERS.

Hospice is an integral part of limiting suffering at the end of life. It provides “comprehensive, interdisciplinary, team-based palliative care, mostly in a place the patient calls home, for dying patients with an identifiably short prognosis.” Diane E. Meier, *Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care*, 89 *Milbank Q.* 343, 345 (2011). This care “focuses on achieving the best-possible quality of life for patients and their family caregivers, based on patient and family needs and goals and independent of prognosis.” *Id.* at 344. Hospice services are designed to address the weaknesses in the medical treatments that too often plague those nearing the end of life and their families. *Id.* at 348-49.

To be eligible for hospice care, a Medicare beneficiary must be entitled to benefits under Medicare Part A and be certified as having a terminal illness with a life expectancy of six months or less if the disease runs its normal course. Off. of Inspector Gen., Dep’t of Health & Human Servs., OEI-02-10-00492, *Hospice Should Improve Their Election Statements and Certifications of Terminal Illness 2*

(2016). Beneficiaries who elect hospice care are entitled to receive that level of care for two 90-day periods, followed by an unlimited number of 60-day periods. *Id.* at 2-3. Central to the facts of this case is the requirement that at least one physician must certify that the beneficiary is terminally ill at the beginning of each election period. *Id.* at 4. The certification of terminal illness must be based on the physician's clinical judgment regarding the normal course of the patient's illness and must be supported by clinical information from the patient's medical record. *Id.*

A. Hospice Improves Care and Decreases Pain.

When people die in hospitals, intensive care units and nursing facilities, they all too often “receive poor-quality medical care, characterized by untreated symptoms, unmet psychosocial and personal care needs, a great burden for the caregiver, and low patient and family satisfaction.” Meier, *supra* at 346. By contrast, a recent study demonstrated that a greater use of hospice care in the last six months of life is associated with improved patient experience, including satisfaction and pain control, as well as improved clinical outcomes of care. Ruth Kleinpell et al., *Exploring the Association of Hospice Care on Patient Experience and Outcomes of Care*, *BMJ Supportive & Palliative Care* (2016).

For people with dementia who are placed into nursing facilities at the end of their lives, the care provided compares even less favorably to hospice care. *See*

Joan M. Teno, *Does Hospice Improve Quality of Care for Persons Dying from Dementia?*, 59 J. Am. Geriatrics Soc’y 1531, 1531 (2011). Persistent and unresolved severe pain is an important concern for these nursing facility residents. *Id.* “Family members of those who died in a nursing home reported higher rates of unmet needs, more concerns with care, and lower ratings of satisfaction with the quality of care than those of persons who died at home with hospice care.” *Id.* Nursing facility residents with dementia often undergo burdensome treatments in the last months of life. *Id.* Hospice care, unlike nursing facility care, has the goal of ensuring effective symptom management and maximization of quality of life. *Id.* Nursing facility residents enrolled in hospice were found to be less likely than those not enrolled in hospice to be hospitalized in the last 30 days of life and more likely to receive regular assessment and treatment of pain. *Id.* Moreover, they experience lower rates of having physical restraints, intravenous feeding, and feeding tubes. *Id.*

B. Hospice Care is Vital For Caregivers

The benefit of hospice extends beyond those nearing the end of life. One of the central benefits of hospice is peace of mind, allowing the dying and his or her loved ones to come to terms with the end of life. Anna-Gene O’Neal, *Good Hospice, Palliative Care Brings Peace of Mind*, The Tennessean (Oct. 8, 2016, 6:01 AM), <http://www.tennessean.com/story/opinion/contributors/2016/10/08/>

good-hospice-palliative-care-brings-peace-mind/91752046/. Hospice allows for quality experiences for family members and caregivers with their dying loved ones.

Hospice provides remarkable clinical benefits to both patient and caregiver mental, physical, and psychosocial states, especially when compared with family members' health outcomes when their loved ones die in intensive care units or in hospitals. Alexi A. Wright et al., *J. of Clinical Oncology, Place of Death: Correlations with Quality of Life of Patient with Cancer and Predictors of Bereaved Caregivers' Mental Health* 5 (2010). In fact, caregivers and family members of loved ones who die in intensive care units or hospitals have a five- to nine-times higher risk of developing post-traumatic stress disorder compared to those with loved ones who passed away in hospice. Diane E. Meier & Otis W. Brawley, *Palliative Care and the Quality of Life*, 29 *J. of Clinical Oncology* 2750, 2751 (2011).

Hospice allows families to spend quality time with their dying loved ones. O'Neal, *supra*. Hospice caregivers aim to “create an environment where everyone involved has the space and time to focus on one another rather than on the consuming demands of caregiving.” *Id.* Common hospice benefits for family members include services aimed to provide comfort and support following the death of the loved one. Leah Eskanazi, *Why Hospice Care Could Benefit Your*

Loved One Sooner Than You Think, PBS Newshour, (Jan. 29, 2015, 6:10 PM), <http://www.pbs.org/newshour/updates/hospice-care-might-benefit-loved-one-sooner-think/>. These benefits include bereavement services, which are covered by the Medicare hospice benefit for up to one year. *Id.* Hospice caretakers provide phone calls, home visits, support groups and written materials about grief to the family. *Id.* In addition, the hospice benefit provides help to home caregivers, providing volunteers to sit with the patient or help with chores in order to assist family caretakers during this time. *Id.* In 2014, 93.8 percent of hospice beneficiaries received their services at home, allowing their family to receive the at-home benefits. Nat'l Hospice & Palliative Care Org., *NHPCO's Facts and Figures: Hospice Care in America* 11 (2015). For 2014, "for each patient death, an average of [two] family members received bereavement support from their hospice." *Id.* at 12.

One 2011 study showed that families of people who received hospice care thought their loved one's passing was more peaceful and less traumatic than those whose relatives did not receive hospice care. Teno, *supra* at 1534. Family members were 51 percent less likely to report that their terminally ill family member did not have his or her needs met if they were in hospice. *Id.* at 1533. Studies show that caregivers of patients who die in hospitals or intensive care units are also more likely to have a major depressive disorder and prolonged grief

disorder. Wright, *supra* at 1, 5. This evidence all points to a substantial emotional, physical, and psychological benefit that hospice gives to caregivers and family members.

II. THERE HAS BEEN SIGNIFICANT GROWTH IN THE PROVISION OF HOSPICE CARE, BUT BENEFICIARIES STILL FACE BARRIERS TO ACCESSING CARE.

A rapidly aging populace and growing consensus on the benefits of hospice has precipitated a substantial increase in the supply and use of hospice in the United States. Over the past ten years, there has been a 47 percent growth in the number of hospice programs and a 74 percent increase in the number of people served by hospice in the United States. Meier, *supra* at 354. According to the National Hospice and Palliative Care Organization, in 2014, an estimated 1.6 to 1.7 million patients received hospice services. Nat'l Hospice & Palliative Care Org., *supra* at 4. More than 80 percent of hospice beneficiaries are over age 65, and more than a third are over age 85. Meier, *supra* at 355. The use of hospice will only grow as the Baby Boomer generation ages, and it is imperative to maintain and expand access to hospice services. See Donald Redfoot et al., AARP Pub. Pol'y Inst., *The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers* (2013).

Despite the growth in the number of people who receive hospice care and hospice providers, some experts argue that many more people are eligible for hospice care but cannot access the services. See Melissa D. Aldridge Carlson et al., *Hospices' Enrollment Policies May Contribute to Underuse of Hospice Care in the United States*, 31 Health Affairs 2690 (2012). "People often wait too long before seeking hospice care. In the United States, the average length of hospice care is less than 60 days with 30 percent of those who elect hospice care dying in seven days or fewer." Eskanazi, *supra*. One barrier is the prognosis requirement of the Medicare benefit. Medicare requires that a physician certify that the patient has a life expectancy of six months or less; however, the majority of hospice patients now have diseases that have unreliable mortality prognoses. Meier, *supra* at 355. Ten years ago, the majority of hospice beneficiaries (53%) died from cancer. *Id.* In 2008, "only 31 percent of the hospice patients had cancer and 69 percent had died from chronic debilitating diseases such as frailty, atherosclerotic and respiratory disease, and dementia, for whom the art and science of predicting prognosis is considerably more uncertain." *Id.* This uncertainty about a patient's prognosis puts a fine point on why hospice providers could be reluctant to accept patients going forward if the government can retroactively establish a false claim simply by finding an expert who holds

a different clinical opinion about a patient's life expectancy than that of the certifying physician.

III. IT IS CRITICAL THAT THERE BE ADEQUATE PROVIDER CAPACITY TO MEET THE NEEDS OF THE BENEFICIARIES WHO NEED IT.

The benefits to patients and caregivers from hospice are worthless if individuals do not have the ability to access hospice. Hospice access is currently beset by systematic barriers preventing patients from receiving much-needed care. Carlson et al., *supra* at 1. Additionally, access to hospice is dependent upon the patient's location. From state to state, the availability of hospice care varies widely. According to 2006 data, for example, only 6.7 percent of all deaths in Alaska involved the provision of hospice care. Meier, *supra*. at 355. In Arizona, on the other hand, 44.7 percent of deaths involved the provision of hospice care. *Id.* Increasing and ensuring access to hospice is incredibly important, considering the rising burden on caregivers and the changing demographics of the United States. While the number hospice patients served has dramatically increased, the number of trained hospice professionals has not kept pace. *Id.* at 356.

The benefits of hospice care to patients and caregivers will become ever more important as the Baby Boomer generation ages. Redfoot, *supra* at 1. Born in the post-war years of 1946 to 1964, Baby Boomers will begin to enter their eighties in the late 2020s. *See id.* at 3. People age 80 or older are most likely to need

long-term services and supports (LTSS). *Id.* at 2. In 2010, seventy percent of people age 80 and older had a disability, and over 50 percent of those age 80 and older had a severe disability. *Id.* In that same year, one in three needed assistance from a caregiver with one or more activities of daily living. *Id.* The supports needed by these individuals are most likely administered by “adult children” caregivers, or those between 45 and 64 years old. *Id.* at 1. In fact, more than 68 percent of Americans believe that they will be able to rely on their family to meet their long-term care needs. However, as the Boomers age, caregiver availability will substantially decrease. *Id.* at 1-2.

Between 1990 and 2010, the ratio between Americans over 80 years of age and those in the caregiver years (45-64) increased as the Baby Boomers entered their caregiving years. *Id.* at 3. As a result, the number of potential caregivers relative to those age 80 and over increased from 6.6 to 7.2. *Id.* But, as the Baby Boomers age, the caregiver ratio will plummet, falling from 7.2 in 2010 to 6.1 in 2020 and 4.1 in 2030. *Id.* at 5. As the younger Baby Boomers enter their 80s, the ratio falls even further, from 4.1 to 2.9 between 2030 and 2050. *Id.* at 6. “By 2050, an estimated 27 million people will need some type of long-term care.” Christine Caffrey et al., National Health Statistics Reports, *Home Health Care and Discharged Hospice Care Patients: United States, 2000 and 2007* 1 (2011). These millions of people will have to rely upon a small and shrinking pool of caregivers.

The burden faced by these caregivers is currently immense, and it will only grow as more people rely upon their adult children or institutional care later in life.

Redfoot et al., *supra* at 2.

Hospice will play an essential role in providing care to the aging population; however, it is important to note the future benefit to caregivers that hospice will also provide. Recently, the role of family caregiver expanded from “coordinating and providing personal care and household chores” to complex medical or nursing tasks, “such as wound care and administering injections.” *Id.* Family caregivers must administer medication with little-to-no training or professional support. *Id.* As more is expected of fewer caregivers, these burdens will only continue to grow, forcing caregivers to juggle increasingly complex medical and nursing care with the “emotional and physical strain, competing demands of work and caregiving, and financial hardships” found in caring for an aging family member. *Id.* at 2. Quality hospice care presents an invaluable tool for the shrinking pool of caregivers in the coming decades. By providing substantial benefits to both patients (*supra* Part II.A) and caregivers (*supra* Part II.B), hospice can relieve the tremendous burden facing family caregivers, especially at the end of a loved one’s life.

CONCLUSION

For the foregoing reasons, AARP and AARP Foundation ask that the Court narrowly tailor any decision about the allegations of fraud, waste and abuse, to protect the access and availability of hospice service provider capacity for Medicare beneficiaries.

Dated: October 20, 2016

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on October 20, 2016, I caused a true and correct copy of the foregoing Amended Brief of Amici Curiae AARP and AARP Foundation in Support of Neither Party to be served via the Court's ECF Filing System. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: October 20, 2016

/s/ Maame Gyamfi
Attorney for *Amici Curiae*

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 3,086 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure.

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in Times New Roman 14-point typeface.

Dated: October 20, 2016

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