No. 14-12373

UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

UNITED STATES OF AMERICA,
Appellee/Cross-Appellant,

v.

PETER E. CLAY,
Defendant-Appellant,

AND

TODD S. FARHA, PAUL L. BEHRENS, AND WILLIAM L. KALE,
Defendants-Appellants/Cross-Appellees.

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.

BRIEF FOR DEFENDANT-APPELLANT PAUL L. BEHRENS

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

In compliance with Federal Rule of Appellate Procedure 26.1 and 11th Circuit Rule 26.1, the undersigned hereby certifies that the persons and entities listed below have an interest in the outcome of this case. Other than WellCare Health Plans, Inc., none of the entities listed below is publicly traded. WellCare Health Plans, Inc., is a publicly traded company, and its stock ticker is WCG. There is no parent corporation or publicly held corporation that owns 10% or more of its stock.

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America's 1st Choice California Holdings, LLC, Indirect wholly-owned subsidiary of WellCare[1]

Behrens, Paul L., Defendant-Appellant

Bentley, Arthur Lee, III, Counsel for United States of America

Bereday, Thaddeus, Defendant

Berman, Douglas A., *Amicus Curiae*

Berman, Nathan M., Counsel for Thaddeus Bereday

Boss, Barrett L., Counsel for Todd S. Farha

Bowers, John J., Counsel for United States of America

[1] "WellCare" refers to WellCare Health Plans, Inc. (WCG).

Burke, Donald, Counsel for Peter E. Clay

Califano, Michael G., Counsel for Paul L. Behrens

Clay, Peter E., Defendant-Appellant

Cleary, Lauri E., Counsel for William L. Kale

Comprehensive Health Management, Inc., Indirect wholly-owned subsidiary of WellCare

Comprehensive Reinsurance, Ltd., Indirect wholly-owned subsidiary of WellCare

Cooper, Todd J., Counsel for Paul L. Behrens

Daniel, Stephanie A., Counsel for Florida Agency for Health Care Administration

Donahue, Patrick M., Counsel for William L. Kale

Easy Choice Health Plan, Inc., Indirect wholly-owned subsidiary of WellCare

Exactus Pharmacy Solutions, Inc., Indirect wholly-owned subsidiary of WellCare

Farha, Todd S., Defendant-Appellant

Fernandez, Jr., Jack E., Counsel for Thaddeus Bereday

Fisher, Jeffrey L., *Amicus Curiae*

Florida Agency for Health Care Administration, Victim

Florida Healthy Kids Corp.[2]

Fugate, Lee, Counsel for Thaddeus Bereday

Garinther, Geoffrey R., Counsel for WellCare Health Plans, Inc.

George, Peter E., Counsel for Todd S. Farha

Green, Bruce, *Amicus Curiae*

Harmony Behavioral Health IPA, Inc., Indirect wholly-owned subsidiary of WellCare

Harmony Behavioral Health, Inc., Indirect wholly-owned subsidiary of WellCare

Harmony Health Management, Inc., Indirect wholly-owned subsidiary of WellCare

Harmony Health Plan of Illinois, Inc., Indirect wholly-owned subsidiary of WellCare

Harmony Health Systems, Inc., Indirect wholly-owned subsidiary of WellCare

Hasbun, Marcos E., Counsel for Thaddeus Bereday

Hoppmann, Karin B., Counsel for United States of America

Jung, William F., Counsel for Peter E. Clay

[2] The government's Certificate of Interested Persons (filed July 11, 2014) identifies Florida Healthy Kids Corp. as a "victim." There was no claim or finding below that Florida Healthy Kids Corp. was a victim of any crime charged in this case.

Kale, William L., Defendant-Appellant

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Lerman, Daniel N., Counsel for Peter E. Clay

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Miller, Gregory R., *Amicus Curiae* and Counsel for *Amici Curiae* Professors and Practitioners

Missouri Care, Incorporated, Indirect wholly-owned subsidiary of WellCare

Moody Jr., James S., United States District Court Judge

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Nathans, Larry Allen, Counsel for William L. Kale

Neiman, Peter Erik, Counsel for Todd S. Farha

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The WellCare Community Foundation, Indirect wholly-owned subsidiary of WellCare

The WellCare Management Group, Inc., Indirect wholly-owned subsidiary of WellCare

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Valiente, Lauren L., Counsel for Paul L. Behrens

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WCG Health Management, Inc., Direct wholly-owned subsidiary of WellCare

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WellCare Health Insurance Company of Kentucky, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare Health Insurance of Arizona, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare Health Insurance of New York, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare Health Plans, Inc., (NYSE ticker symbol: WCG), Petitioner and Movant below

Well Care Health Plans of California, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare Health Plans of New Jersey, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare Health Plans of Tennessee, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of Connecticut, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of Florida, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of Georgia, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of Kansas, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of Louisiana, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of Nevada, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of New York, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of Ohio, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of South Carolina, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare of Texas, Inc., Indirect wholly-owned subsidiary of WellCare

WellCare Pharmacy Benefits Management, Inc., Indirect wholly-owned subsidiary of Well Care

WellCare Prescription Insurance, Inc., Indirect wholly-owned subsidiary of WellCare

Windsor Health Group, Inc., Indirect wholly-owned subsidiary of WellCare

Windsor Health Plan, Inc., Indirect wholly-owned subsidiary of WellCare

Windsor Management Services, Inc., Indirect wholly-owned subsidiary of WellCare

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STATEMENT REGARDING ORAL ARGUMENT

Paul Behrens requests oral argument because it will assist the Court's understanding of the significant legal questions and extensive factual record arising from a more than three-month-long criminal jury trial.

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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 hereby adopts by reference Arguments III (The District Court's Erroneous Jury Instruction Requires a New Trial on the Healthcare Fraud Counts) and IV (The Admission and Use of the Wealth Evidence Was Reversible Error) of the Brief for Defendant-Appellant Todd S. Farha.

INTRODUCTION

Defendants—four former executives of WellCare Health Plans, Inc.—were charged with defrauding Florida's Medicaid program (administered by Florida's Agency for Health Care Administration or "AHCA"). The prosecution had no quarrel with the quality of the services that WellCare's two health plans (the "Plans") provided or with the rates the Plans charged. Instead, the prosecution urged that Defendants caused the Plans to violate a contractual provision that required the Plans to expend 80% of the premium they received from AHCA for the provision of certain services, or refund the difference to AHCA. But the prosecution did not establish a breach of contract, much less a criminal fraud.

The contractual refund obligation—on which the entire prosecution rested—related to outpatient behavioral-health (*i.e.*, mental-health) services. The contracts expressly authorized the Plans to provide those services by subcontracting with specialty organizations called behavioral-health organizations ("BHOs"). After paying a third-party BHO for a time, WellCare created its own BHO—"Harmony"—building up a substantial staff, creating a network of downstream providers (*e.g.*, psychiatrists), and obtaining accreditation. The Plans paid Harmony for providing behavioral healthcare services at market rates. And the Plans disclosed all of that—their affiliation with Harmony, their intent to hire Harmony to provide behavioral health services, and the rates they would pay

Harmony—to AHCA and Florida's Office of Insurance Regulation. Neither agency objected.

Under a provision of their contracts with AHCA—the "80/20" provision—the Plans were required to report their prior year's expenditures for the provision of behavioral health services and refund any difference between those expenses and 80% of the AHCA premium. Before it created Harmony, WellCare had included payments to a third-party BHO for outpatient behavioral services in its 80/20 calculations. Outside counsel advised WellCare that other healthcare plans included payments to affiliated entities when calculating their 80/20 obligations, and AHCA had not objected. The Plans took the same approach, including their payments to Harmony for the relevant services as their 80/20 expenditures.

According to the prosecution, that was fraud. When trial began, the prosecution's theory was that Harmony was a sham—a "shell game" to inflate the Plans' expenses. A453 (9:18-22, 31:11-14) (opening).[1] But the trial evidence showed that Harmony was no shell. By summation, the prosecution urged that "nobody is suggesting that [Harmony] was a shell, because it wasn't," and acknowledged that

[1] Record materials cited in this brief are included in Defendants' Joint Appendix. Citations are to the district court docket number, prefaced by "A." Trial exhibits appear in the Appendix following the final trial exhibit lists. Accordingly, government exhibits ("GX") follow Dkt. 699; defense exhibits ("D_") follow Dkt. 700. Trial-court motions and memoranda are not included in the Appendix and are referenced by their district court docket numbers ("Dkt.").

Harmony was a "good entity" that did "good work." A677 (40:11-16) (closing). The prosecution instead claimed that—although Harmony was a bona fide BHO—the Plans' payments to Harmony could not count as the Plans' 80/20 expenditures. The prosecution claimed instead that the Plans could count only what *Harmony* paid its network of downstream "direct" providers.

After a three-month trial and deliberations spanning nearly a month, the jury rejected most of the prosecution's case. But it convicted WellCare CFO Paul Behrens on false-statement and healthcare-fraud counts as to one of the five years covered by the charges, calendar year ("CY") 2006, while convicting WellCare CEO Todd Farha and Dr. William Kale, a Harmony Vice President, of healthcare fraud but not false statements for CY2006. WellCare Vice President Peter Clay was not convicted on any of those counts. He was convicted of making two false statements in an unsworn interview with federal agents during the government's after-the-fact investigation.

The convictions cannot stand. For each count of conviction, the prosecution had to prove that the expenses the Plans reported to AHCA were false. Which expenses the Plans were required to report is a question of law. As this Court held in *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002), "[w]here the truth or falsity of a statement centers on an interpretive question of law, the government bears the burden of proving beyond a reasonable doubt that the defendant's

statement is not true under a reasonable interpretation of the law." *Id.* at 1351. The government thus was required to establish that it was *objectively unreasonable* to interpret the relevant law to permit the Plans to report their payments to Harmony (rather than Harmony's payments to downstream "direct" providers).

But the government could not find *any* support for its interpretation of the 80/20 requirements in *any* legally binding authority. The Plans' contracts with AHCA (and the Florida statute they implemented) keyed the Plans' reporting and refund obligations to the Plans' own expenses, not those of a subcontractor like Harmony. Nor did AHCA issue regulations on the issue. The reporting template AHCA sent to the Plans requested *their* expenses, and made no reference to the expenses of a subcontracted BHO or expenditures to "direct providers." The accompanying cover letters were to the same effect. Multiple prosecution witnesses, including seasoned Florida healthcare lawyers, agreed that reporting the Plans' own payments to Harmony, rather than Harmony's payments to others, was consistent with a reasonable construction of legal requirements. Indeed, the prosecution's "direct provider" limit was first articulated a year *after* the last of the allegedly false 80/20 submissions. Defendants are entitled to judgments of acquittal.

At the very least, a new trial is required. The district court erroneously permitted the government to introduce—through its expert witness—the contents

of WellCare's restated financial statement. That hearsay document was touted as a confession, by Defendants' former employer and alleged coconspirator, that the Plans' 80/20 submissions were false. Its admission violated Federal Rule of Evidence 703. Worse yet, because the restatement was presented through a witness with no knowledge of its preparation, Defendants were denied any chance to show the jury what the restatement really was—an accommodation the government extracted from WellCare under a threat of indictment. The government exacerbated the evidence's potentially devastating effect by emphasizing it time and again in summation as substantive evidence of Defendants' guilt.

STATEMENT OF JURISDICTION

The district court had jurisdiction under 18 U.S.C. § 3231. This Court has jurisdiction under 28 U.S.C. § 1291. On May 29, 2014, Behrens filed a timely notice of appeal from a final judgment of conviction entered on May 19, 2014. A910.

STATEMENT OF THE ISSUES

1. Whether Defendants' convictions for healthcare fraud and false statements should be reversed because the government failed to establish that the submissions of expenditure information on which those convictions are based were false under any reasonable interpretation of the law, as required under *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002).

2. Whether Defendants are entitled to a new trial because the government was improperly permitted to introduce the contents of WellCare's financial restatement through its expert witness, in violation of Federal Rule of Evidence 703.

3. Whether Counts 4 and 5 of the Indictment should be dismissed, and Behrens' convictions on those counts vacated, because they fail to provide a "definite written statement of the essential facts constituting the offense charged," as required by Federal Rule of Criminal Procedure 7(c)(1).

4. Whether the district court erred in giving the jury an instruction on willful blindness.

5. In the event the government cross-appeals Behrens', Farha's, and Kale's sentences: Whether those sentences should be vacated because the district court erred in (a) denying Defendants a credit against intended loss for services rendered, (b) misidentifying intended loss, and (c) applying a two-level enhancement for sophisticated means.

Behrens also adopts the Statement of Issues II and III in the brief of Todd Farha (at 4-5), consistent with the Statement Regarding Adoption of Briefs above.

STATEMENT OF THE CASE

This appeal arises from a multi-defendant criminal prosecution involving the submission of expenditure reports to a state Medicaid program.

Course of Proceedings Below

The indictment charged Paul Behrens, Todd Farha, William Kale, and Peter Clay with one count of conspiracy, 18 U.S.C. § 371, four counts of making false statements to AHCA in the 80/20 submissions for CY2005 and 2006, 18 U.S.C. § 1035, and four counts of healthcare fraud for CY2005 and 2006, 18 U.S.C. § 1347. Defendant Peter Clay was also charged with two counts of making false statements to federal investigators, 18 U.S.C. § 1001.

On June 13, 2013, the jury convicted Behrens on the healthcare false-statement and healthcare-fraud counts relating to CY2006 (Counts 4 and 5, 8 and 9); convicted Farha and Kale on the healthcare-fraud counts relating to CY2006 (Counts 8 and 9); and convicted Clay on the § 1001 false-statement counts (Counts 10 and 11). The jury either acquitted or hung on the remaining counts. *See* A705, A706, A707, A708. On September 25, 2013, and October 7, 2013, the district court denied Defendants' motions for judgment of acquittal under Federal Rule of Criminal Procedure 29(c) and Kale's motion for a new trial under Rule 33(a). *See* Dkts. 782, 783; A785. On May 19, 2014, the court sentenced Farha to three years' imprisonment and a $50,000 fine, Behrens to two years, Kale to one year and one day, and Clay to five years' probation and a $10,000 fine. It dismissed all hung counts. *See* A884 (Farha); A887 (Behrens); A890 (Kale); A895 (Clay). Defendants Farha, Behrens, and Kale are on release pending appeal. A903 (94:19-22).

Statement of Facts

I. BACKGROUND

A. Florida's Medicaid Program

For years, Florida's Medicaid program operated on a fee-for-service basis, paying doctors a specified fee for each covered service. In the 1990s, the Florida legislature directed AHCA to transition to managed care. A760 (81:5-82:5) (Clarke). Under that system, AHCA contracts with managed-care plans (including health-maintenance organizations or "HMOs") "for the provision of services to recipients." Fla. Stat. § 409.912(3). AHCA pays plans a monthly premium (called a "capitation") for each covered Medicaid recipient. In return, the plans ensure that recipients receive a specified level of services. *See id.* § 409.912.

The capitation is based on the estimated cost of providing the covered services. A492 (33:2-35:24) (West). Because the capitation was set at 92% of AHCA's fee-for-service costs, paying healthcare plans a capitation saved AHCA substantial sums compared to the fee-for-service approach. A198-3 at 15; A584 (69:8-16) (Clarke); *see also* A661 (97:7-17) (Miller).

An HMO receives the same capitation regardless of how many or few services its members use. *See* 42 C.F.R. § 438.2 (2007); A465 (79:23-80:14) (Barr-Platt). If the cost of furnishing services is less than the capitation, the HMO

profits. A465 (80:15-81:4) (Barr-Platt). If the cost is greater, the HMO bears the loss. *Id.*

That model gives HMOs incentives to maintain members' health by providing preventive care that avoids costly procedures later on. *See* 1993 Fla. Laws, ch. 93-129, § 50; A751 (64:16-65:11) (West). HMOs do so by "coordinating the care and providing assistance to the patient," using case managers and a network of providers. A647 (28:19-23) (Miller). The HMO and its case managers ensure a "continuum of care," where "once patients are identified as sick or ailing . . . somebody follows up their care and makes sure that they have continuing services." A584 (76:2-9) (Clarke). HMOs also integrate Medicaid recipients into mainstream healthcare, giving them access to high-quality private physicians, many of whom would not otherwise accept Medicaid patients. A647 (23:1-24:6) (Miller); A584 (58:25-65:8) (Clarke).

B. The 80/20 Statute

Florida Medicaid covers two kinds of healthcare services—medical (physical injuries and illness) and behavioral (mental health and substance abuse). In 2002, the Florida Legislature enacted an amendment to Florida's managed-care law, referred to here as the "80/20 Statute." Under the 80/20 Statute, AHCA's Medicaid contracts must require each healthcare plan to spend 80% of its

behavioral-health premium "for the provision of behavioral health care services" or refund the difference to AHCA:

> [A]ll contracts issued pursuant to this paragraph must require *80 percent of the capitation paid to the managed care plan* . . . to be expended *for the provision of behavioral health care services*. If the managed care plan expends less than 80 percent of the capitation . . . for the provision of behavioral health care services, the difference shall be returned to the agency.

Fla. Stat. § 409.912(4)(b) (emphasis added). Thus, if a plan received $100 for behavioral-health services and spent only $75 for the provision of those services, it would have to refund $5 to AHCA.

C. The WellCare Plans' Medicaid Contracts

WellCare had two HMOs, HealthEase and Staywell (the "Plans"), that contracted with AHCA to provide healthcare to Florida Medicaid recipients (the "Contracts").[2] The Contracts covered a range of medical and behavioral services.[3] This case concerns "community mental health" ("CMH") and "targeted case management" ("TCM") behavioral-health services, also known as "outpatient" or "community" behavioral services. *See* A699 (GX-3305 at .0141, .0148-.0149).

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[2] HealthEase's and Staywell's Contracts were substantially similar in relevant respects. *See* A466 (26:19-27:4) (Barr-Platt). While the Contracts were revised for each contracting period (2002-2004, 2004-2006, and 2006-2009), for simplicity, we cite the HealthEase Contract for 2006-2009, which governed at the time of the CY2006 submissions for which Farha, Behrens, and Kale were convicted.

[3] Negotiated on an arms-length basis, the Contracts disclaimed any principal-agency relationship that might give rise to a fiduciary relationship. *See* A699 (GX-3305 at .0018); A559 (90:18-22) (Turrell).

The Contracts obligated each Plan to provide listed "services as described in the [CMH] and [TCM] Handbook[s]." A699 (GX-3305 at .0137); *see* A699 (GX-3305 at .0140-.0152) (describing therapy, coordination, and related services).[4] The Contracts also addressed the 80/20 requirement:

> In accordance with Section 409.912, F.S., *eighty percent (80%) of the Capitation Rate paid to the Health Plan by the Agency* shall be *expended for the provision of community behavioral health services*. In the event the Health Plan expends less than eighty percent (80%) of the Capitation Rate, the Health Plan shall return the difference to the Agency no later than May 1 of each year.

A699 (GX-3305 at .0166) (emphasis added). The provision also directed "Health Plans" to report their expenditures each year using a "spreadsheet template" to be provided by AHCA. *Id.*; *see also* A699 (GX-3305 at .0237).

"For reporting purposes," the Contracts defined "'community behavioral health services' . . . as those services that the Health Plan is required to provide as

[4] The Handbooks are AHCA's Community Behavioral Health Coverage and Limitations Handbook and Mental Health Targeted Case Management Handbook. Developed for use by clinics (community mental health centers) when seeking reimbursement from AHCA on a fee-for-service basis (not for managed care), the Handbooks provide a list of covered Medicaid services. A699 (GX-3305 at .0137); A465 (113:4-16) (Barr-Platt); A466 (9:8-14) (Barr-Platt); A488 (103:19-104:8) (Hammond). In an appendix, the Handbooks provide codes (often called "H" and "T" codes) that community mental health centers use when submitting bills. A465 (121:17-122:4) (Barr-Platt); A473 (34:1-35:4) (Barr-Platt). Private physicians use a different coding system called "CPT." A473 (33:16-22) (Barr-Platt); A466 (91:9-25) (Barr-Platt). The same or similar service thus may have both an H or T code (when performed by community mental health centers) and a CPT code (when performed by private practitioners). A474 (30:25-31:12, 105:10-13) (Barr-Platt).

listed in the [CMH and TCM Handbooks]." A699 (GX-3305 at .0167). They continued:

> "[E]xpended" means the total amount, in dollars, paid *directly or indirectly* to *community behavioral health services providers* solely for the provision of community behavioral health services, not including *administrative expenses or overhead of the plan*.

Id. (emphasis added).[5]

D. AHCA's Failure To Regulate

To set binding policy under the 80/20 Statute, AHCA would have had to engage in notice-and-comment rulemaking. *See* Fla. Stat. §§120.54(1)(a), 120.52(16); p. 72 & n.37, *infra*. It never did so. *See* A563 (51:9-17, 56:17-57:3) (Rainer).[6] AHCA never issued a rule or regulation defining which payments

[5] The 80/20 Statute appears on its face to apply to *all* behavioral-health services. *See* Fla. Stat. §409.912(4)(b). Beginning in 2004, AHCA's Contracts with the Plans applied the 80/20 provision only to *outpatient* (CMH and TCM) services. *See, e.g.*, A699 (GX-3305 at .0167).

[6] AHCA was deeply divided on the 80/20 Statute's implementation. Some wanted it to channel behavioral-health services to the community mental health centers that had provided those services to Medicaid patients before the switch to managed care. *See* A700 (D_1858) (Clarke memorandum explaining that that position would leave healthcare system "frozen into place under the prior community mental health center-only model"); A584 (64:14-67:1) (Clarke); A563 (46:18-50:20) (Rainer). Others preferred to create incentives for healthcare plans to contract with private physicians. *See* A564 (45:21-47:9, 52:16-53:9) (Clarke). Issuing regulations would have required the agency to resolve that internal dispute. It would have given the industry an opportunity to comment. And it would have made AHCA's judgment subject to legislative oversight. *See* Fla. Stat. §120.545 (Florida APA provides "legislative check" that ensures "[t]he rule is consistent with expressed legislative intent").

qualify as expenditures "for the provision of behavioral health care services" or appropriate methodologies for calculating expenditures. *See* A473 (61:2-12) (Barr-Platt); A563 (59:15-20) (Rainer).[7]

That was regrettably typical. The Florida Legislature has repeatedly criticized AHCA for disregarding rulemaking requirements. *See* A204-1 (Joint Administrative Procedures Committee letter to AHCA); A204-2 (Joint Administrative Procedures Committee Report on Unadopted Rules). And AHCA has been chastised for imposing unpromulgated policies without fair notice. *Rodriguez v. AHCA*, DOAH Case No. 03-2300MPI, at 40-45 (Nov. 26, 2003, adopted May 4, 2004).

Rather than issue binding prospective rules, individual AHCA officials occasionally sent letters. *See, e.g.*, A563 (55:12-56:5) (Rainer); A584 (80:18-23) (Clarke). At trial, the prosecution characterized certain letters as agency "guidance." *See, e.g.*, A453 (53:6) (opening); A466 (13:13-15) (questioning Barr-Platt); A677 (96:18) (closing). But its witnesses testified that the result of those commu-

[7] AHCA's failure to engage in rulemaking contrasts sharply with the later federal implementation of the Affordable Care Act's health insurance payback requirement, which produced detailed regulations regarding which expenses count and which do not. *See* 42 C.F.R. § 422.2400-.2480; http://www.cms.gov/cciio/resources/Regulations-and-Guidance/index.html#Medical%20Loss%Ratio.

nications was a "quagmire." A563 (43:21) (Rainer).[8] And government witnesses agreed that, because the letters were mere "transmittals" that cannot substitute for regulation, they lack the force of law and could not alter obligations under the 80/20 Statute or Contracts; the industry thus was "not required to follow" them and could even "ignore" them. A563 (78:15-19, 86:21-87:11, 105:12-23) (Rainer); *see* A563 (112:17-21) (Rainer) (regardless of agency "letters" or "talk," "it would still be reasonable for the regulated entity to provide information in accordance with the statute").

The absence of regulations left plans free to choose among various reasonable methodologies for calculating expenditures for 80/20 purposes. A760 (26:14-25) (Clarke). A 2011 report commissioned by AHCA identified at least five reasonable methods used by various plans to calculate reportable expenditures under the 80/20 Statute. *See* A660-4 at 14-15; A650 (14:9-16:20) (Miller).

[8] *See* A563 (44:9-19) (Rainer) ("AHCA didn't speak with one voice," its statements were "spotty and muddy"); A584 (84:5-14) (Clarke) ("[D]ozens of Medicaid providers" had "problems because the agency's audit staff determined the policy was one way and bureaucrats had told the providers to do something different."). As WellCare's former outside counsel Gary Clarke observed, AHCA's failure to regulate "le[d] us to the pickle we're in today," *i.e.*, "this particular" criminal prosecution. A584 (83:5-84:19).

II. WELLCARE'S CREATION, DISCLOSURE, AND UTILIZATION OF HARMONY

A. Behavioral-Health Organizations

A behavioral-health organization ("BHO") is "a specialized managed care company that focuses on providing services to people who have behavioral health problems." A647 (34:21-24) (Miller). It serves as "the hub of all services for behavioral health." A465 (86:7-15) (Barr-Platt). BHOs utilize networks of physicians (downstream providers) and "work directly with patients," providing case-management services and coordinating care. A647 (39:9-15) (Miller); A661 (109:10-20) (Miller).

Healthcare plans often subcontract with BHOs because behavioral-health issues are "complex" and "outside the normal flow of medical care" that plans deal with, whereas BHOs specialize in those issues. A647 (34:24-35:7) (Miller). BHOs can "get specialization by concentrating in a narrow area" and "really increas[e] the expertise and the ability of the health plan to react to mental health issues." A564 (57:7-10) (Clarke). By covering both hospital and outpatient behavioral healthcare, BHOs allow patients to obtain all of their services from "the same network" while facilitating communication among providers so that "efforts can be coordinated most effectively." A647 (36:21-37:12) (Miller); *see* A563 (67:12-68:20) (Rainer) (BHOs provide "better" care, although they cost more).

B. WellCare Decides To Form a BHO

The Contracts expressly authorized the Plans to enter into "subcontracts with a Managed Behavioral Health Organization (MBHO) for the provision of Behavioral Health Services." A699 (GX-3305 at .0164). In some parts of Florida, the Plans developed their own network of psychiatrists and other behavioral-health providers. In certain areas, HealthEase initially subcontracted with a third-party BHO called CompCare, which provided both inpatient and outpatient behavioral-health services for a fixed per-patient, per-month "subcapitation" payment. *See* A490 (19:6-20:1, 54:24-55:17, 56:21-57:23) (Whitney).

In 2003, WellCare considered forming its own BHO. Doing so would not only allow WellCare to capture for itself the business it had been giving to CompCare, A584 (92:18-25) (Clarke), but also permit WellCare's BHO to sell behavioral-health services to other plans, A564 (57:5-20) (Clarke); A589 (51:10-23) (Sattaur).[9] WellCare also believed that an affiliated BHO would benefit the

[9] Contemporaneous documents reflect those and other reasons for WellCare to create its own BHO. Unlike a behavioral-health division within WellCare, a separate BHO affiliate could be a "vehicle for expansion and diversification" of business, A699 (GX-1048 at .0003), obtaining accreditation and permitting WellCare to offer BHO plans "into commercial markets and into employee assistance plans," A564 (57:12-20) (Clarke); *see* A489 (89:2-4) (Hammond). By consolidating all behavioral health services within one entity, having a BHO would make things "[s]impler for [80/20] accounting purposes." A564 (57:22-58:9) (Clarke). And an affiliated BHO could be a tool for "[c]ost [e]ffective [p]urchasing of [h]ealthcare." A699 (GX-1048 at .0003).

Plans financially under the 80/20 Statute. The company's outside counsel Gary Clarke—formerly the head of AHCA's Medicaid Division—had advised the Plans that another HMO was using its affiliated BHO for 80/20 reporting. A584 (94:17-95:9) (Clarke); *see also* A700 (D_1165). Clarke also advised them that a prepaid mental health plan, which was likewise subject to the 80/20 Statute, had "subcapitated to related entities" (affiliated clinics) and included those payments in its 80/20 calculation, an approach that appeared "acceptable . . . to AHCA." A584 (95:10-23) (Clarke); *see* A473 (68:14-23) (Barr-Platt). Indeed, AHCA was informed that the prepaid mental health plan was doing so, and raised no objection. A699 (GX-1245 at .0002).

C. Harmony's Creation, Operation, and Disclosure to AHCA

Acting on Clarke's advice, WellCare formed a BHO called Harmony Behavioral Health, Inc. ("Harmony") in 2003. A462 (59:19-62:5) (Ortega); A699 (GX-2005).[10] That was a complex undertaking: WellCare had to build up a large staff, obtain accreditation, and prepare extensive contracts defining Harmony's obligations to the Plans and their members. In late 2003, Farha expressed dismay to WellCare general counsel Thad Bereday, and outside counsel Gary Clarke, about the rate of progress, stating that the delay in creating Harmony was "costing [WellCare] 400K/Month." A699 (GX-1024 at .0001); *see* A699 (GX-1023).

[10] Harmony was initially called WellCare Behavioral Health ("WCBH").

When Bereday said "We need more lawyers," Farha directed him to bring in the law firm Greenberg Traurig: "OUTSOURCE: Get it done, GT/ OTher/ Spend $$." *Id.* WellCare did so, and Harmony was created before year's end.

Although many Harmony employees had been part of WellCare's behavioral-health department, Harmony expanded and operated as a full-fledged BHO. *See* A489 (72:10-76:2) (Hammond). Harmony obtained certification from an exacting, national healthcare-accreditation organization (URAC), and employed an extensive staff of clinicians and case managers. A488 (81:9-19) (Hammond); A489 (72:15-17) (Hammond); A473 (35:24-36:10, 77:6-15) (Barr-Platt); A474 (7:25-8:11, 11:2-9) (Barr-Platt). It established a network of private practitioners, coordinated patients' care, and provided case management. A473 (30:3-14, 78:4-20) (Barr-Platt); A474 (9:8-17) (Barr-Platt); A489 (44:2-6) (Hammond).

Assisted by Greenberg Traurig, each Plan executed "a separate contract with Harmony to provide . . . behavioral health services." A465 (86:19-21) (Barr-Platt); A563 (90:19-91:14) (Rainer). Under the subcontracts, Harmony was responsible for providing all inpatient and outpatient behavioral-health services covered by the Plans' Contracts with AHCA. *See* A699 (GX-1062 at .0002-.0005); *see also* A487 (49:25-50:3) (Barr-Platt).

In return, each Plan paid Harmony a subcapitation. *See* A533 (70:20-72:23) (West). WellCare retained an independent consultant to develop the subcapitation

rates, A647 (54:20-55:9) (Miller), which were initially set at 85% of the behavioral-health premiums the Plans were then receiving from AHCA, A649 (36:10-14) (Miller); A541 (112:25-113:3) (West). At trial, defense expert Dr. Henry Miller, a leading healthcare economist, explained that the rates the Plans paid Harmony were "reasonable," "appropriate," and "right in the middle of what would be an acceptable market rate." A647 (47:19-21, 55:3-13) (Miller). No witness testified to the contrary.

WellCare disclosed Harmony's existence, operations, and arrangements with the Plans to AHCA. *See* A473 (29:17-30:14) (Barr-Platt). AHCA had authority to reject the Plans' subcontracts with Harmony, but did not. A699 (GX-3305 at .0318); A466 (117:18-118:10) (Barr-Platt). The Plans submitted the Harmony subcontracts and rates to Florida's Office of Insurance Regulation, which had authority to reject the rates. A760 (31:11-32:11) (Clarke); *see* A541 (119:19-120:11) (West); A700 (D_1709); A700 (D_0321 at .3). The Office never "object[ed] to the rates between HealthEase and Staywell and Harmony." A760 (32:8-11) (Clarke); *see* A541 (119:19-120:11) (West). In 2006, the Office again accepted the rates paid to Harmony when they were adjusted to account for the Plans' (and Har-

mony's) provision of outpatient services in new areas of the State. A541 (118:11-120:11) (West).[11]

D. AHCA-WellCare Interactions

From early on, AHCA recognized that HMOs were subcontracting with BHOs. There was discussion as far back as 2002 within AHCA about whose expenditures counted for 80/20 reporting purposes—the HMO's or the BHO's. A51-1 at 2 ("HMO's capitate the BHO's," AHCA staffers observed, and "the BHO's sub-capitate the community mental health centers who perform the mentioned services"; "Who do we want the 80/20 from[?]"). There were also discussions within AHCA over whether AHCA should "expressly prohibit the inclusion of those BHO expenses in the 80/20 calculation." A474 (52:19-53:11) (Barr-Platt). But AHCA neither amended its contracts to include the discussed prohibition, nor did it raise the issue with the industry.

At least one AHCA official, moreover, was aware that the Plans included payments to Harmony in their 80/20 calculations—because WellCare told him. In early 2005, Greg West—an analyst in WellCare's Medical Economics department responsible for performing the Plans' 80/20 calculations—and his boss Keith Sanders spoke with Jack Shi, an AHCA analyst. Shi was in AHCA's Medicaid

[11] AHCA divided the State into eleven administrative units called "Areas." Managed-care behavioral health services were initially offered in two Areas and gradually expanded to others.

Division, the only part of AHCA with policy and rulemaking authority. A465 (76:4-16) (Barr-Platt). West testified that, when Shi brought up the Plans' 80/20 submissions, Sanders responded, "We use Harmony for that calculation." A533 (26:9-18, 28:18-29:1, 30:14-18). Sanders followed up by sending Shi a schematic illustrating the "flow of medical costs," including the "capitated amount" paid "to Harmony." A584 (103:23-104:5) (Clarke) (quoting A699 (GX-3415.1 at .0001)); *see* A699 (GX-3415.1a). West understood that Shi knew the Plans' 80/20 calculations included their payments to Harmony. A751 (57:2-10, 58:4-7) (West).

At the same time, the government presented evidence that, in other contexts, the Plans did not apprise AHCA of that fact. For example, in April 2005, AHCA asked WellCare to explain the difference between AHCA's estimate of the Plans' ratio of expenses to premium and the ratio the Plans reported in their CY2004 80/20 submissions. A699 (GX-1215.01). A draft response included a description of the Plans' reporting of payments to Harmony. A699 (GX-1255.01-A). The final version, drafted by counsel, did not contain that language. A699 (GX-1270a at .0001); *see* A560 (97:8-10) (Turrell).[12] The prosecution also pointed out that,

[12] Instead, the final letter explained that there appeared to be a "difference in the interpretation of the statute in question" and referred AHCA to a letter from the Florida Association of Health Plans ("FAHP") to a senior AHCA official. A699 (GX-1270a at .0001). The FAHP letter stated in relevant part that—for prepaid mental health plans—"payment of 80 percent of the premium dollar in a sub-

acting through FAHP, WellCare and other health plans engaged in negotiations with AHCA related to 80/20 implementation. *See, e.g.*, A699 (GX-1245) (May 19, 2005 letter from FAHP to AHCA Deputy Secretary); A699 (GX-1275 at .0002) (letter from HealthEase telling AHCA that "Florida Association of Health Plan[s] has taken the lead on this issue"). Although those negotiations focused primarily on the services that should count, one WellCare executive believed that—while the expenditure reporting was proper—WellCare should have, as a business and customer-relations matter, expressly raised with its negotiating counterparts at AHCA that the Plans included subcapitation payments to Harmony in their 80/20 reporting. A588 (37:4-38:5, 94:4-95:6) (Sattaur); *see* Farha Br. 11.

E. Harmony Exceeds Requirements

Harmony excelled at providing behavioral healthcare. As AHCA employee and government witness Carol Barr-Platt testified, a 2007 audit by AHCA concluded that Harmony was "exceed[ing] the contract standards in ensuring the provision of behavioral health services to their members." A487 (105:02-111:10).

III. THE WELLCARE PLANS' 80/20 SUBMISSIONS FOR CY2006

Each year, the Plans reported their expenditures for outpatient behavioral-health services to AHCA. The trial addressed five reporting periods—July-

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capitated form to subcontracted providers," including related ones, "is considered [by AHCA] to meet the intent of the law." A699 (GX-1245 at .0002).

December 2002, CY2003, CY2004, CY2005, and CY2006. The government devoted the vast majority of its evidence to the earlier submissions. As to July-December 2002 and most of CY2003, the government took issue with the Plans' inclusion of "gray areas" in calculating outpatient expenditures. *See, e.g.*, A677 (42:15-45:24) (closing). For CY2004 and CY2005, the government challenged the inclusion of payments to Harmony and how the Plans excluded certain sums from those expenses (often necessitated by AHCA's provision of faulty premium data). *See* pp. 25-26, *infra*. The jury was not convinced, declining to convict any Defendant for the alleged conspiracy covering those years or for the healthcare false-statement and fraud charges based on the Plans' CY2005 submissions. The CY2006 submissions were the only ones for which Behrens, Farha, and Kale were convicted. Accordingly, we discuss only the CY2006 calculation.[13]

A. AHCA's CY2006 Template and Cover Letter

In early 2007, AHCA sent each Plan a "template" for calculating and reporting 80/20 expenditures for the preceding year. The template was accompanied by a cover letter addressed to the Plan.

The Template. Citing the 80/20 Statute, the CY2006 template stated that plans providing "behavioral health services must expend at least eighty (80)

[13] 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 separate brief.

percent of the capitation paid by the Agency on those services" or "return the difference to the Agency." A699 (GX-0601 at .0001). Paraphrasing the Contracts, the template defined reportable "behavioral health services" as "community mental health and targeted case management services only"—*i.e.*, outpatient behavioral services. *Id.*

The template then provided a "simple calculation" that would "determine the loss ratio and the amount your plan must refund the Agency." A699 (GX-0601 at .0001). The template listed the premium that, according to AHCA, the Plan had been paid for outpatient behavioral-health services during the previous year. *Id.*; *see* A533 (126:12-15) (West). Below the stated premium were two lines on which the Plan was to report amounts spent for the provision of "community mental health" and "targeted case management" services, followed by a line for the total. A699 (GX-0601 at .0001). The next lines showed (1) the loss ratio, *i.e.*, total expenditures identified by the Plan divided by the capitation paid by AHCA; (2) the difference between that loss ratio and 80% of the AHCA-reported premium; and (3) any payment owed to AHCA (if the Plan spent less than 80% of the premium). Finally, the template required the Plan's CEO or President to certify that the "expenditure information reported for the provision of community mental health services and targeted case management services" was "true and correct to the best of [his] knowledge and belief." A699 (GX-0601 at .0002).

AHCA's Premium Error. AHCA paid the plans a single, comprehensive monthly premium covering all services (medical and behavioral, inpatient and out-patient). Accordingly, the Plans relied on AHCA to identify, on the template, the portion of the premium paid for outpatient behavioral-health services. *See* A533 (88:21-89:6) (West). For each of the first three reporting periods (July-December 2002, CY2003, and CY2004), the outpatient behavioral-health premium AHCA reported on the template was too high. Unbeknownst to the industry, that figure included not only the premium for outpatient services, but also for some inpatient services. A647 (101:1-25) (Miller). That error caused healthcare plans to *overpay* refunds to AHCA. A648 (9:17-23) (Miller). But the Plans did not detect the error because the AHCA-provided rate tables they used to estimate and verify the outpatient premium, A533 (89:2-21) (West); A751 (123:5-25, 124:23-125:9, 126:6-127:1) (West), incorporated the same error; as a result, the Plans' expected premium approximated AHCA's erroneous reported premium, *see* A647 (101:1-25, 102:14-103:5) (Miller). AHCA eventually discovered its error and calculated the refunds it owed for overpayments. A647 (102:1-7) (Miller); A358-29. But AHCA neither sent any refunds nor disclosed its error. A648 (9:11-23) (Miller).

For CY2005 and CY2006, AHCA fixed the error internally and reported the correct premium on the templates. A648 (9:4-13) (Miller). It did not, however, correct the published rate tables that healthcare plans used to estimate expected

premiums. A663 (8:14-23) (Miller). As a result, when the templates arrived, healthcare plans were surprised to see premium figures many millions of dollars lower than anticipated. *Id.*; A541 (28:10-31:15) (West); A757 (103:16-104:6) (West). AHCA never responded to industry inquiries about its premium calculations. *See* A699 (GX-1245 at .0002); A560 (61:17-25, 107:13-23) (Turrell). No one outside AHCA knew what caused the discrepancy. A648 (9:11-13) (Miller); A757 (104:3-11, 111:8-10) (West); A541 (26:13-31:15) (West). For a plan seeking to follow matching principles—*i.e.*, reporting expenses for the same services included in AHCA's reported premium—the unexplained discrepancy created substantial confusion. *See* A541 (28:10-13, 39:24-40:5) (West).

The Cover Letter. The letter accompanying the CY2006 template advised that, under the 80/20 Statute, 80% of the behavioral-health capitation must "be expended for the provision of behavioral health care services." A699 (GX-600). It then stated that the "Agency has determined that," for 80/20 reporting purposes, "'behavioral health care services'" are defined as "community mental health" and "targeted case management." *Id.* Unlike the letters for CY2002-CY2004 (the letters changed each year) the CY2006 letter followed those terms with parenthetical lists of procedure codes used by community mental health centers for billing certain services, along with some additional codes used by private practitioners. *Id.*; *see* p. 11, n.4, *supra*. At trial, the government took the position that only

services recorded under the listed codes counted towards the Plans' 80/20 obligations. *See* p. 62, *infra*.

B. The Plans' 80/20 Calculations for CY2006

To explain how the Plans performed their CY2006 80/20 calculations, the government called Greg West, the WellCare financial analyst responsible for the calculations.[14] For the CY2006 calculations, West worked directly under actuary Jian Yu, director of WellCare's Medical Economics department. A757 (91:19-92:18, 101:1-3). Although interpretation of the 80/20 Statute and the Contracts were matters for WellCare's legal department, A559 (41:22-42:4) (Turrell); A536 (111:15-112:15) (West), WellCare Chief Financial Officer Paul Behrens—who had joined WellCare after 20 years as an auditor at Ernst & Young—had "ultimate responsibility" for the financial calculations, A491 (62:15-21) (West); A604 (49:24-50:4) (Haber). West testified that Behrens respected West's abilities, and had confidence that Yu would review the Plans' 80/20 calculations consistent with regulatory requirements. A536 (39:13-40:5); A757 (125:20-126:10). Because Yu was an actuary, she provided a higher level of training and analysis. A757 (100:5-25, 115:25-116:19) (West). West testified that Yu rolled up her sleeves and "d[id] the work" to understand the mechanics of the calculation. A757 (114:23-116:9).

[14] West testified under a cooperation agreement after pleading guilty. Although the government identified more than ten WellCare employees as co-conspirators, West was the only person to plead guilty.

West testified that the Plans accurately reported the amounts they paid Harmony for the relevant behavioral-health services. Because the Plans paid Harmony a comprehensive subcapitation covering *all* behavioral-health services—outpatient and inpatient—the Plans could not report *everything* they had paid Harmony. Instead, West and Yu conducted a two-step calculation to isolate the portion of the subcapitation that was for the relevant services.

The first step isolated the portion of the Plans' payments attributable to outpatient services (*i.e.*, CMH and TCM). To do that, Yu and West took the total subcapitation paid to Harmony and subtracted the portion attributable to inpatient services. *See* A504 (70:14-17) (West); A757 (98:10-24, 123:17-21) (West); A649 (49:10-18) (Miller). They identified the inpatient portion as $4.68 per-member per-month, a figure West had previously used and characterized as "reasonable." A757 (109:25-110:5, 123:17-21).[15] Removing inpatient left only the portion paid for outpatient. *See* A504 (70:14-17) (West) (they removed inpatient "so the

[15] West testified that there was no single acceptable methodology for allocating the subcapitation between outpatient and inpatient services, because the patient mix between outpatient and inpatient changed constantly. A751 (37:2-12). West testified that a number of allocations were possible, with reasonable inpatient components ranging at least from $3.50 to $4.91. A751 (24:13-14); A541 (15:13-16:2). Ultimately, West "locked into 4.68" as a "reasonable" inpatient allocation and used that figure for the CY2006 80/20 calculation. A504 (51:17-20); A757 (109:25-110:5). West repeatedly confirmed that estimate was reasonable, A751 (25:12-26:1, 40:4-7), and the government presented no contrary evidence.

remainder of the capitation would be outpatient"); A757 (123:17-21) (West) ("left with outpatient"); A649 (49:10-18) (Miller) (similar).

The second step reduced the outpatient amount further to reflect only the codes listed in AHCA's CY2006 cover letter. As explained above (at 25-26), AHCA's undisclosed errors caused the premium it reported on the CY2006 template to be $5.9 million *less* than the Plans had expected—around a "14 or 15 percent" difference. A757 (103:16-104:2) (West). Yu suspected the premium on the template was lower because it reflected only the "codes on the letter" rather than all outpatient services. *See* A504 (72:9-18) (West); A757 (117:2-119:9) (West). An analysis of claims data corroborated Yu's intuition, showing that around 15% of Harmony's payments for outpatient claims did not use the codes in the letter.[16] Yu and West thus concluded that the premium difference was "a result of the differences in codes on the letter." A757 (118:17-24) (West). Because AHCA's reported *premium* appeared to reflect only certain outpatient codes, Yu believed the Plans' reported *expenditures* should likewise reflect only those codes. A757 (119:10-15) (West). That followed the generally accepted principle in medical economics and accounting that revenues should match corresponding

[16] Yu directed West to compare Harmony's payments for outpatient claims that used the codes in the cover letter against its payments for all outpatient claims. A757 (118:1-6) (West). West's analysis showed that approximately 85% used the codes in the letter and 15% did not. A757 (118:17-24, 120:1-4) (West); A663 (8:6-13) (Miller).

expenses. A533 (130:6-9) (West); A534 (57:19-58:9) (West); A649 (21:9-21) (Miller).

Accordingly, Yu instructed West "to reduce the capitation that's paid [to Harmony] for outpatient so that capitation only reflects those—the codes in the letter." A757 (119:10-14) (West). West did so, reducing the outpatient portion by 15%. A757 (119:15-24). He annotated his spreadsheet to note that the 15% reduction ensured that the Plans' reported expenses included "*only costs covered by the AHCA specified procedure codes*." A699 (GX-0619-03-A at .0002) (Summary tab, cell G7 cmt.) (emphasis added); A662 (100:6-10) (Miller). Making that adjustment reduced the Plans' reported expenditures and thus *increased* the refund to AHCA. A757 (120:5-7) (West).

West testified that there were "no fake numbers in this calculation." A757 (124:8-16). To the contrary, "all the numbers [West] presented to Ms. Yu [were] accurate and correct," and ultimately "Ms. Yu made a judgment as an actuary that this . . . calculation was true and correct." A757 (127:18-24) (West).

Yu and West presented their calculation to Behrens. West "felt free to . . . speak with Mr. Behrens" if he "had a concern about a policy decision or business judgment." A536 (39:13-16). But West "never told Mr. Behrens" he had concerns about the Plans' 80/20 reporting or that he believed "it was improper to include Harmony expenses in the 80/20 calculation." A533 (120:11-17). West testified he

"never had any conversations with Mr. Behrens about illegal options," and that Behrens never asked him to "do an illegal calculation," A541 (97:15-17, 98:7-9).[17]

Behrens asked Yu about her methodology for addressing the premium difference, as it differed slightly from CY2005. A757 (126:11-16) (West).[18] Yu explained that she believed her approach was "actuarially sound." A757 (120:14-17, 126:15-24) (West). She was "comfortable with this analysis"; she believed the "capitation calculation was true and correct"; and "her recommendation as an actuary was to go ahead and submit this to AHCA." A757 (126:5-10, 127:21-24) (West). Others concurred.[19] Satisfied with the calculation's accuracy, Behrens approved Yu's approach. A757 (120:18-20) (West).

C. The Plans' Submissions

Using AHCA's templates, the Plans reported the expenditures calculated by Yu and West and the resulting loss ratios and refunds. HealthEase reported a loss

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[17] Similarly, Yu told counsel from WellCare's Special Committee that Behrens "did not tell her to use one method or the other" but rather said "to use the method that made the most statistical sense." A876-5 at 5.

[18] As described in Clay's brief (at 9-10), the Plans encountered a similar discrepancy between reported and expected premiums for CY2005. To reconcile the difference, WellCare effectively "refund[ed]" the premium difference to AHCA by reducing the Plans' reported expenses by the dollar amount of the difference. A541 (51:11-17, 53:16-54:5) (West).

[19] Sabrina Gibson, another WellCare actuary, agreed the approach was "appropriate." A536 (62:13-23) (West). Harmony Finance Director Kerri Fritsch likewise "agreed with the approach." A536 (7:19-21, 64:6-9) (West). No one told Behrens they disagreed.

ratio of 75.85%, refunding AHCA about $803,000. A699 (GX-0603). Staywell reported a loss ratio of 78.32%, refunding about $306,000. A699 (GX-0604).[20]

Imtiaz Sattaur, the Plans' President, signed the certification on each template "that the expenditure information reported for the provision of community mental health services and targeted case management services" was "true and correct" to the best of his knowledge. A699 (GX-0603 at .0002); A699 (GX-0604 at .0002). Called by the government at trial, Sattaur testified that he knew the reported expenditures reflected the amounts the Plans paid Harmony "less the inpatient dollars," A588 (6:10-8:20), and believed the submission was lawful, A589 (29:9-14).

IV. PROCEEDINGS BELOW

A. The Raid and Indictment

In October 2007, the government conducted a highly publicized, 200-officer raid of WellCare's headquarters. A462 (48:22-49:11, 68:24-69:16) (Ortega). The raid was based on information provided by Sean Hellein, a WellCare employee who had surreptitiously taped conversations for months in hopes of reaping a large

[20] Because the Harmony subcapitation was not divided between CMH and TCM, the Plans filled in only the total expenditures line, rather than the separate lines for those two subcategories. A footnote explained that because "Community Mental Health and Targeted Case Management Expenses are contracted on a comprehensive basis; amounts are not broken out by vendor contracts." A699 (GX-0603); A699 (GX-0604). That footnote was drafted by Gary Clarke, WellCare's outside counsel, in 2004 and appeared on all of the Plans' submissions thereafter. A533 (132:19-134:3) (West).

whistleblower reward. *See, e.g.*, A541 (64:5-67:25) (West).[21]

WellCare quickly shifted into damage-control mode, forming a Special Committee to investigate. A294-3 at 2. WellCare forced out Defendants Farha and Behrens and announced that it was "cooperating with the U.S. Department of Justice, the U.S. Federal Bureau of Investigation," and other agencies. *Id.* Within a few months, WellCare was meeting with the U.S. Attorney's Office to seek leniency for the company, urging "[p]rosecution" of former "top-level management" instead. *See* A294-4 at 14, 15, 29, 32.

It was during that post-raid period that an AHCA employee first told WellCare that the Plans' subcapitation payments to Harmony were not reportable 80/20 expenses, and that the Plans instead could report only Harmony's payments to downstream "direct" service providers. A572-5 at 3; A650 (7:17-8:25) (Miller).[22] Based on that directive, WellCare recalculated refund amounts for CY2002-CY2006, and restated its financials. *See* A841-5.

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[21] Hellein so incessantly questioned West—who admitted "speculat[ing]," "embellish[ing]" and "exaggerat[ing]" on the tapes—that West would give him "any answer . . . just to shut him up." A541 (98:22-99:6) (West); A533 (21:4-22:25, 24:16-25:9) (West).

[22] Still later, internal communications showed that "AHCA still needed to decide what claims expenses" should count, A358-8, and that AHCA believed it had allowed "all provider types" in 2006 but was "re-evaluating" that position, A876-8; *see* Dkt. 660 (offer of proof).

In 2011, Defendants were indicted. A1 ¶¶20-24.[23] The Indictment charged that the Plans had "falsely and fraudulently includ[ed]" expenditures that were "made for services other than CMH and TCM services," and "us[ed] a wholly-owned entity named HARMONY to . . . falsely and fraudulently increase the expenditures reported to AHCA." *Id.* ¶26(a)(i)-(ii).

Along with a conspiracy count, the indictment charged Defendants with causing Staywell and HealthEase to submit false expenditure information on the 80/20 templates for CY2005 (Counts 2-3) and CY2006 (Counts 4-5), in violation of 18 U.S.C. §1035. A1 ¶28. The Indictment also charged Defendants with healthcare fraud for CY2005 (Counts 6-7) and CY2006 (Counts 8-9), in violation of 18 U.S.C. §1347. *Id.* ¶¶29-32. The only "Execution of the Scheme" charged in those counts was the same 80/20 submissions identified in the false-statement counts. *Id.* ¶32. Clay was also charged with making false statements to the FBI during the raid, in violation of 18 U.S.C. §1001 (Counts 10-11). *Id.* ¶¶32-36.

B. The *Whiteside* Defense and the Government's Theory of Falsity

From the outset, Defendants urged that the Plans' 80/20 submissions were not false under *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002).

[23] Another defendant, WellCare General Counsel Thad Bereday, was severed before trial because of health issues. Dkt. 424. His trial is scheduled for November 2014.

Whiteside holds that, "where the truth or falsity of a statement centers on an interpretive question of law, the government bears the burden of proving beyond a reasonable doubt that the defendant's statement is not true under a reasonable interpretation of the law." *Id.* at 1351. Moving to dismiss the Indictment, Defendants argued that the Plans' 80/20 submissions were truthful because they reported, as the Plans' expenditures "for the provision of behavioral health care services," the subcapitation payments the Plans had paid Harmony "to provide all the required services under the Medicaid Contract for the provision of behavioral health care." Dkt. 203 at 2. Defendants explained that the government appeared to take the position that the Plans were required to report "*only . . . their subcontractor BHOs*'" expenditures for the relevant services, "rather than the HMOs' own actual expenditures." *Id.* at 8 (emphasis added).

The prosecution did not (at that time) dispute that the Plans could report the subcapitation paid to Harmony. It instead urged that, rather than "openly and honestly submit[ting] true and accurate information using that approach," the Plans had "submitted bogus expenditure information." Dkt. 239 at 5; *see* Dkt. 300 at 9 n.3 ("made up the numbers . . . from wholecloth"; "fabricated data"). The prosecution insisted that this case "is emphatically *not*" a "disagreement" over "how to

calculate expenditure information." Dkt. 239 at 2.[24] At trial, however, the prosecution argued that the Plans could not report their payments to Harmony for provision of the relevant services. Instead, it contended, the Plans had to report the amounts Harmony paid to downstream "direct providers" for services recorded using the procedure codes in AHCA's cover letters. *See, e.g.*, A677 (45:14-18) (closing); A634 (59:25-60:4) (Kelly); Dkt. 772 at 31-33.

C. The Government's Key Witnesses at Trial

1. *Greg West*

Greg West was the government's star witness. His testimony spanned three weeks and 23 volumes of transcripts. As discussed above (at 27-31), West carefully described the methodology used in the Plans' 80/20 submissions for CY2006. West repeatedly confirmed that he "never intentionally came up with bogus numbers," A541 (13:10-12), and was "never told to make up numbers," A534 (58:17-19). Rather, the numbers used in the Plans' reporting were for "real claims paid," A541 (14:23-25), and the Plans' subcapitation payments to Harmony were "true costs," A533 (67:4-24).

[24] The Court denied Defendants' motions for a bill of particulars explaining how the Plans deviated from the required methodology, including any purported expenditures that were unlawfully included. Dkts. 50, 55, 58, 63; A82. As a result, the government was never required to articulate its theory of falsity.

West did testify that he modeled multiple scenarios, resulting in different paybacks, for various reporting periods. But he explained that modeling different scenarios is something "folks in medical economics do all the time." A751 (35:19-36:3); *see also* A649 (24:4-14, 26:2-11, 29:7-17) (Miller). For CY2006, West's spreadsheets identified four "Alternate Medical Cost Methods." A699 (GX-0619-03-A at .0002) (Summary tab). One of them, titled "Prem[ium] from AHCA Using AHCA Proc[edure] Codes & Outside Cap," showed a payback to AHCA of $12 million. *Id.* West testified that that column represented Harmony's "outside capitation paid to downstream providers" and fee-for-service claims for the "codes from the letter." A505 (91:4-8). That is, the column "tested what the payback would be if we didn't have Harmony." A757 (108:12-21) (West). The Plans instead reported their payments to Harmony for those services and refunded $1.1 million to AHCA. A757 (108:22-25) (West); A699 (GX-0603); A699 (GX-0604).[25]

West testified that he pled guilty based on his "underst[anding] that you couldn't" include "the real dollars going to Harmony" "in the 80/20." A533 (68:5-8). Consistent with that, he testified that the Plans' 80/20 submissions were

[25] At sentencing, Defendants demonstrated that—even if payments to Harmony were disregarded—the Plans at most would have owed AHCA an additional $113,590 for CY2006. A808-1 at 49 (Dobson Decl.).

"false." A501 (77:16-78:10); A502 (71:16-75:8); A505 (114:4-115:25). But West conceded that he "did not have the full picture." A533 (68:17-20). He had never read the 80/20 Statute or the Plans' Contracts until cross-examination. A533 (11:2-4, 12:1-13, 12:17-13:7, 14:7-16:3). Nor had he ever discussed the proper interpretation of the Contracts' reporting provisions with anyone at WellCare or AHCA. A534 (48:23-49:3). Even the prosecution objected to West's "competence" to testify about "questions on the contract." A751 (122:22-23). West ultimately agreed that he was not in a position to know WellCare's legal obligations with respect to 80/20 reporting. *See* A533 (18:10-20:15).

2. *Carol Barr-Platt*

The government also called Carol Barr-Platt, a low-level AHCA employee, to testify about the 80/20 reporting requirements. Barr-Platt admitted that she had no role in drafting AHCA's Medicaid contracts or establishing AHCA policy. A473 (51:6-52:4). But she offered her view that the Plans could not report payments to a BHO. A465 (102:9-21). She theorized that, although a BHO like Harmony "is basically the provider," payments to BHOs do not count for 80/20 purposes because BHOs "don't provide *direct* services." A465 (86:3-87:1) (emphasis added). Barr-Platt offered no authority for limiting reportable expenses to "direct services," a term that does not appear in the relevant portions of the Statute, Contracts, templates, or cover letters. When confronted with the Contracts' lan-

guage referring to "dollars paid directly *or indirectly* to behavioral healthcare providers," she confessed that she was "confused or uncertain" about the Contracts' meaning and "really d[id]n't" know "how a managed care plan can pay a provider indirectly." A474 (79:20-81:7, 82:15-83:5). She agreed that "somebody reading this contract may have different reasonable interpretations," and that such interpretations "came up." A474 (83:6-8).

While Barr-Platt testified that the meaning of the 80/20 provision "was clarified to [her] by the Agency," she was not aware of the Agency "ever clarify[ing] that language to the healthcare industry." A474 (87:15-20, 88:16-18). Indeed, Barr-Platt recounted "numerous conversations over a very long period of time with multiple people" within AHCA about "expressly prohibit[ing] the inclusion of those BHO expenses in the 80/20 calculation," but such language was never included in AHCA's contracts, or anywhere else. A474 (52:19-53:11).

3. *Gary Clarke and Frank Rainer*

The government also called Gary Clarke and Frank Rainer, WellCare's former outside counsel. Clarke and Rainer—experts on healthcare law and compliance—testified that the Plans' reporting was consistent with a reasonable interpretation of legal requirements.

Clarke, former Director of AHCA's Medicaid Division, testified that he had advised WellCare regarding Harmony's creation and use. *See* pp. 16-17, *supra*.

Clarke testified that "nothing in the 80/20 amendment" or in the Contract "prohibit[ed] the WellCare HMOs from using payments to Harmony" in "connection with the 80/20 reporting." A584 (99:15-19, 109:12-15). Clarke confirmed that "one reasonable interpretation" of the Plans' "contract is that you could include payments to Harmony." A760 (22:19-22).

Rainer agreed. He testified that "one reasonable interpretation" of the 80/20 Statute and Contracts is "you could include BHO expenses" in 80/20 calculations, that "AHCA never promulgated any kind of policy statement that said you couldn't," and that the Statute in fact "contemplates" such arrangements. A563 (59:9-21, 76:13-19).

Clarke acknowledged that his firm could not give WellCare a "clean opinion" that it would face no regulatory issues if the Plans used the Harmony subcapitation for 80/20 reporting; in his view, there were simply "too many unsolved issues" concerning the "new statute and contract amendment" to provide such assurance. A564 (103:21-104:7).

4. *Harvey Kelly*

The government called Harvey Kelly, a forensic accountant with no medical economics experience, as an expert witness. Kelly opined that "WellCare engaged in a results-oriented approach in calculating the amounts of expenditures reported in its certified 80/20 annual refund filing submitted to AHCA." A590 (110:24-

111:1). He claimed to have found "inconsistencies across the filing periods of the WellCare methodologies." A590 (108:23-25). He did not, however, explain why such changes would be suspect given the circumstances (which included AHCA's handling of undisclosed errors in premium information) or how those purported inconsistencies made the information false.

Kelly compared the Plans' 80/20 submissions to what he considered "the actual expenditure information that was in the claims files and so forth." A590 (108:10-14). For his calculations, Kelly accepted the prosecution's position that only the amounts Harmony paid to "direct providers" could be counted in the Plans' 80/20 calculation (and thus ignored the Plans' payments to Harmony, and even payments to unaffiliated BHO CompCare). A634 (59:25-60:4). He testified that, accepting that assumption, the Plans' CY2006 expenditures were overstated by $8,994,000. A632 (73:23-24). Kelly conceded that nothing in the Contracts or AHCA's cover letters "prohibits payments to a BHO from being included in the 80/20 calculation." A633 (114:12-21, 116:24-117:1). Asked whether the subcapitation the Plans paid Harmony was a "fair" or "reasonable" rate, Kelly "d[id]n't recall questioning whether [those] were fair rates," and "d[id]n't have a view one way or another." A633 (31:5-32:11).

D. The Defense Case

Defendants called Dr. Henry Miller, a leading healthcare economist and longtime consultant to the Centers for Medicare and Medicaid Services. Miller testified that the Plans' decision to report payments to Harmony as 80/20 expenses "accord[ed] with the . . . statute" and "with the contractual requirements." A649 (33:4-34:25); *see* A649 (68:5-24) ("reasonable approach"). He also testified that reporting subcapitation payments to a BHO was consistent with industry practice. A647 (22:8-23). The Plans' reported expenses, he concluded, were "true, . . . accurate, and . . . appropriate to include in the 80/20 calculation." A647 (22:16-23).

E. The Jury's Deliberations and Verdict

Trial lasted nearly three months. The district court submitted the case to the jury on May 14, 2013. On May 22, the jury reported that it was divided on all 38 counts. The next day, over Defendants' objection, the court issued an *Allen* charge and, again over Defendants' objection, permitted the jury to suspend its deliberations for 10 days for a juror's vacation. After that break, the jury returned a verdict.

The jury hung on the conspiracy charge (Count 1). With respect to the counts based on the Plans' CY2005 submissions, the jury acquitted all Defendants of making false statements (Counts 2-3) and either acquitted or hung on healthcare fraud (Counts 6-7). The jury found Farha, Behrens, and Kale guilty of healthcare

fraud in connection with the CY2006 submissions (Counts 8-9), but reached no verdict for Clay. On the false-statement charges relating to the CY2006 submissions (Counts 4-5), the jury found Farha not guilty, reached no verdict for Kale or Clay, but convicted Behrens. It convicted Clay on the separate false-statement charges (Counts 10-11).

F. Sentencing and Release Pending Appeal

At sentencing, the district court recognized that this was not a "typical fraud" where the government gets billed for false patients or services. A903 (89:2-9). The court found that even the intended loss the government alleged for CY2006, about $11 million, was dwarfed by the billions in premiums AHCA paid WellCare, and in any event, "it's not a number that went directly into the pockets of these individuals." A903 (90:3-91:2). The court found the conduct here to be "a complete aberration from the entire lives and careers of these individual defendants." A903 (89:10-11). And it found "no risk of reoffending." A903 (89:20).

Following briefing, argument, and full consideration of the Advisory Guidelines factors, the court granted Farha, Behrens, and Kale substantial downward variances from the Guidelines ranges, imposing sentences of three years', two years', and one year's imprisonment respectively, while sentencing Clay to five years' probation (within the Guidelines range of zero to six months' imprisonment).

A903 (91:11-16, 109:8-17); *see* p. 7, *supra*. Over the government's objection, the court granted Farha, Behrens, and Kale release pending appeal. A903 (94:19-22).

Standards of Review

Whether the statements at issue here were true under a reasonable interpretation of the law is a question of law reviewed de novo. *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002); *United States v. Gupta*, 463 F.3d 1182, 1191 (11th Cir. 2006). To the extent factual issues are implicated, sufficiency of the evidence is reviewed de novo; this Court must reverse where "the jury could not have found the defendant guilty under any reasonable construction of the evidence." *United States v. Jimenez*, 705 F.3d 1305, 1308 (11th Cir. 2013).

Challenges to the admission or exclusion of evidence are reviewed for abuse of discretion. *United States v. Dudley*, 102 F.3d 1184, 1186 (11th Cir. 1997).

The sufficiency of an indictment is reviewed de novo. *United States v. Schmitz*, 634 F.3d 1247, 1259 (11th Cir. 2011).

This Court reviews the decision to give a jury instruction for abuse of discretion. *See United States v. Steed*, 548 F.3d 961, 977 (11th Cir. 2008).

SUMMARY OF ARGUMENT

I. Defendants' convictions should be reversed for failure to establish falsity. Whether the expenditure information reported on the Plans' CY2006 80/20 submissions was true or false turned on a question of law: could the Plans report

their payments to Harmony for the relevant behavioral health services, or (as the government contended) could they report only the payments Harmony made to downstream direct service providers? Where, as here, "the truth or falsity of a statement centers on an interpretive question of law, the government bears the burden of proving beyond a reasonable doubt that the defendant's statement is not true under a reasonable interpretation of the law." *United States v. Whiteside*, 285 F.3d 1345, 1351 (11th Cir. 2002).

The government failed to carry that burden. The 80/20 Statute, the Plans' Medicaid Contracts, the 80/20 templates, and AHCA's cover letters are all reasonably interpreted as allowing the Plans to report the amounts they paid their BHO subcontractor, Harmony, for the provision of the relevant behavioral health services. Those sources all ask for the *Plans'* expenses, not Harmony's. The Contracts expressly permitted the Plans to subcontract with a BHO for the provision of those services, and nothing excluded payments to a BHO from the 80/20 calculation. The government argued that AHCA's cover letters limited reportable expenses to a subset of CMH and TCM services represented by particular procedure codes. But the Plans complied with that limitation too, as they reduced their reported expenses to reflect only the codes in AHCA's letters.

The government's contrary arguments fail. Its theory that the Plans could report only the amounts paid to direct providers is not supported—much less

compelled—by the Contracts, the cover letters, or anything else. The government's supposed evidence of subjective intent is irrelevant under *Whiteside*, which concerns *actus reus*, not *mens rea*. And its claim that the Plans' submissions did not actually follow their interpretation of the 80/20 requirement is refuted by the unchallenged testimony of the government's own star witness.

II. The district court erred by allowing the government to present the contents of WellCare's financial restatement to the jury through the testimony of its expert witness, Harvey Kelly. The jury heard from Kelly that WellCare had revised its financial statements and returned roughly $35 million to AHCA based on errors in the Plans' 80/20 calculations—even though Kelly had no personal knowledge of the restatement's preparation. In fact, WellCare issued its restatement to avoid prosecution. And the government dictated the standard used in performing the restatement. But Defendants were precluded from presenting that critical context to the jury. The jury was thus left with the misleading impression that WellCare (and its auditors) restated the company's financial statement only after a careful and impartial evaluation that confirmed the government's view of the Plans' reporting obligations.

That evidence should never have been presented to the jury. Federal Rule of Evidence 703 permits the introduction of otherwise-inadmissible material only when the expert "base[d]" his opinion on it, its introduction would not curtail a

party's right to cross-examination, and its probative value substantially outweighs its prejudicial effect. Here, Kelly did not "base" his opinion on the restatement. He merely purported to have used the restatement to "double-check" his own findings. Kelly, moreover, used the restatement to bolster his own conclusions by invoking the views of the restatement's authors, who could not be cross-examined. And the district court failed to undertake the balancing inquiry required by Rule 703, which could not have been satisfied in any event. A new trial is warranted.

III. Although Counts 4 and 5 of the Indictment accuse Paul Behrens of making false statements relating to healthcare matters in violation of 18 U.S.C. § 1035, those Counts are devoid of facts. Those Counts merely parrot § 1035 without alleging the "essential facts constituting the offense charged." Fed. R. Crim. P. 7(c)(1). The district court refused to dismiss because it thought Counts 4 and 5 sufficient if the Indictment is "read as a whole." But this Court's cases foreclose that reasoning where, as here, the counts at issue do not incorporate any other part of the Indictment.

IV. The district court erred in issuing a willful blindness instruction. This issue is raised to preserve it for further review.

V. The government has filed a notice of cross-appeal. If the government were to cross-appeal to seek resentencing, Defendants would challenge the district court's failure to reduce its intended-loss calculation by the fair market value of the

services Defendants rendered to AHCA. Defendants would also challenge the district court's imposition of a sophisticated-means enhancement.

ARGUMENT

I. DEFENDANTS' CONVICTIONS SHOULD BE REVERSED FOR LACK OF FALSITY UNDER *WHITESIDE* (ALL DEFENDANTS)

The central question before the jury on the counts of conviction was whether the Plans' reported outpatient behavioral health expenditures for CY2006 were false. *See* A1 ¶32 (Counts 8 and 9), ¶28 (Counts 4 and 5). The government's star witness, Greg West—the WellCare analyst who performed the Plans' 80/20 calculations—carefully explained how he and WellCare actuary Jian Yu calculated the figures for CY2006. He repeatedly confirmed that those figures accurately reflected the sums the Plans paid Harmony, their BHO subcontractor, for providing the services that, according to the prosecution, fall within the 80/20 reporting requirements. *See* pp. 27-31, 36, *supra*.

To prove the submissions false, the government thus was required to prove that the Plans were not permitted to report their own expenses for the provision of the relevant services—the amounts they paid Harmony for those services—but instead could report only the amounts Harmony paid downstream direct providers. As West agreed, the government's "whole case is about whether or not you can use Harmony for those calculations." A533 (47:25-48:5).

Where, as here, "the truth or falsity of a statement centers on an interpretive

question of law, the government bears the burden of proving beyond a reasonable doubt that the defendant's statement is not true under a reasonable interpretation of the law." *United States v. Whiteside*, 285 F.3d 1345, 1351 (11th Cir. 2002). In other words, the government must "negate any reasonable interpretations that would make the defendant's statement correct." *Id.* (citing *United States v. Migliaccio*, 34 F.3d 1517, 1525 (10th Cir. 1994)). If the statement is true under any objectively reasonable construction of the law, the government cannot meet its burden of proving falsity beyond a reasonable doubt. *Id.*

That principle controls this case. Reporting the Plans' payments to a BHO for the relevant services, rather than the BHO's payments to downstream "direct" providers, reflected a reasonable interpretation of the law. The 80/20 Statute, the Contracts, and AHCA's reporting template all explicitly linked the 80/20 calculation to the expenses of the *Plans*, not the expenses of their subcontracted BHO. The Plans' expense for the provision of the relevant behavioral health services is the amount they paid Harmony for them. Nothing in the Statute, Contracts, or any other relevant authority supports the government's claim that the Plans instead could report only payments the BHO made to downstream, "direct" service providers. Indeed, the government called three experienced healthcare lawyers as witnesses, and they all testified that reporting the Plans' payments to Harmony was a reasonable interpretation of the Statute and Contracts—as they had

advised WellCare and Defendants.

Just as in *Whiteside*, "'competing interpretations of the applicable law [are] far too reasonable to justify these convictions.'" 285 F.3d at 1353 (quoting *United States v. Mallas*, 762 F.2d 361, 363 (4th Cir. 1985)). "As such, the government failed to meet its burden of proving the *actus reus* of the offense—actual falsity as a matter of law." *Id.* The district court accordingly should have entered judgments of acquittal on Counts 4, 5, 8, and 9.

A. *Whiteside* Forecloses Criminal Liability for Statements That Are True Under a Reasonable Interpretation of the Law

The defendants in *Whiteside* were convicted of making false statements in Medicare cost reports, as well as conspiracy to defraud the government based on those reports. 285 F.3d at 1345. The cost reports required the defendants to allocate interest payments between "administrative and general" costs and "capital related" costs. *Id.* at 1346, 1347. The two categories were reimbursed differently, with capital costs being "more financially beneficial to" the defendants. *Id.* The reports were filed with a fiscal intermediary, the government-designated entity that "administer[ed] the Medicare program and distribute[d] Medicare funds based upon the claims included by the providers in their cost reports." *Id.* at 1347.

The defendants' cost reports classified their loan interest as 100% capital-related. 285 F.3d at 1351. They were convicted on the theory that their "classification of the interest expense based on how the debt was being used at the time of

the *filing of the cost report* rather than how the funds were used at the time of the *loan origination* was inconsistent with the Medicare regulations." *Id.* (emphasis added). This Court reversed, finding that "the government failed to meet its burden of proving the *actus reus* of the offense—actual falsity as a matter of law." *Id.* at 1353. The government could not meet that burden, the Court ruled, because "no Medicare regulation, administrative ruling, or judicial decision" dictated how providers should characterize loans whose use changed over time. *Id.* at 1352; *see id.* (quoting *United States v. Harris*, 942 F.2d 1125, 1132 (7th Cir. 1991) (reversing conviction because the " 'usual sources of authority [we]re silent' on the statement at issue")).

Treating the question of falsity as a question of law, the Court focused on the regulatory and administrative authority that defined the defendants' reporting obligations. The government relied on a regulation defining "capital-related interest expense" as "the cost incurred for funds borrowed for capital purposes," arguing that it required "interest expense to be reported in accordance with the original use of the loan." 285 F.3d at 1352. This Court concluded that the regulation was not "pellucid" on the relevant point, because it did not "explain how to define the underlying debt." *Id.* The government likewise found no support from the relevant administrative authority—an administrative bulletin "officially endorsed" by the regulator and "applied in a capital reimbursement review pro-

ceeding" that produced a binding administrative ruling. *Id.* And "[o]ne of the government's witnesses . . . testified that the regulations do not answer the specific question of whether the character of interest can change from capital to operating, and in fact 'can be interpreted in different ways.'" *Id.*

In short, no controlling authority "clearly answer[ed] the dilemma the defendants faced"; government witnesses testified that "reasonable people could differ as to whether the debt interest was capital-related"; and "the experts disagreed as to the validity of the theory of capital reimbursement suggested by the government." 285 F.3d at 1352. This Court thus ordered judgments of acquittal. *Id.* at 1353. The Court did so even though the government's agent, the fiscal intermediary, had previously rejected defendants' characterization of the loan interest as 100% capital-related, and even though the defendants were advised to (but did not) "flag" their disagreement on the form's "protest line." *See id.* at 1348, 1352; *see also id.* at 1347-48 (noting fiscal intermediary's adjustments in prior years).

Nor did it matter that the defendants' own consultant had warned them that "claiming the interest as 100% capital-related might be fraud." 285 F.3d at 1348. The question was not the defendants' *mens rea* or subjective belief; it was whether the government had proved "the *actus reus* of the offense—actual falsity as a matter of law." *Id.* at 1353. Where "the truth or falsity of a statement centers on

an interpretive question of law," the Court declared, "the government bears the burden of proving beyond a reasonable doubt that the defendant's statement is not true under a reasonable interpretation of the law." *Id.* at 1351. It concluded that the "'competing interpretations of the applicable law [were] far too reasonable to justify these convictions.'" *Id.* at 1353 (quoting *Mallas*, 762 F.2d at 363).

Whiteside follows from a long line of precedent holding that a criminal conviction cannot be based on a statement that is true under a reasonable interpretation of the law. *See* 285 F.3d at 1351-52 (collecting cases). That principle protects participants in regulated industries from improper criminalization of routine contractual and regulatory disagreements. It ensures that criminal liability is not imposed under vague and undefined standards, *see United States v. Levin*, 973 F.2d 463, 467 (6th Cir. 1992), or where "a regulated party is not 'on notice' of the agency's ultimate interpretation of the regulations," *Gen. Elec. Co. v. EPA*, 53 F.3d 1324, 1333-34 (D.C. Cir. 1995) (regulated entity "may not be punished" where "the regulations and other policy statements are unclear, where the petitioner's interpretation is reasonable, and where the agency itself struggles to provide a definitive reading of the regulatory requirements").

Where the meaning of contractual or other requirements is subject to reasonable dispute, the proper forum for resolving the dispute is a civil or administrative proceeding. *See United States v. Goyal*, 629 F.3d 912, 922 (9th Cir. 2010)

(Kozinski, C.J., concurring) ("Civil law often covers conduct that falls in a gray area of arguable legality. But criminal law should clearly separate conduct that is criminal from conduct that is legal.").[26] Where a regulatory submission is true under a reasonable interpretation of the governing law, *Whiteside* bars criminal prosecution based on purported falsity—even if the regulator arrives at a different view about the law's meaning and the defendant has not called out the disagreement to the regulator.

Those protections are particularly important where, as here, companies must operate without the benefit of rules or regulations. In *Whiteside*, the applicable regulation was ambiguous. Here, AHCA defaulted entirely on its statutory duty, failing to promulgate *any* regulations implementing the 80/20 Statute. *See* pp. 12-14, *supra*. It never issued regulations regarding which expenditures were reportable, much less a rule as to what the Statute required when plans subcontract with BHOs. Defendants, in consultation with WellCare's counsel, adopted one reasonable view of the governing legal requirements: that the Plans could report their market-rate payments to Harmony for the provision of the relevant services. This

[26] *See also* Matthew, *The Moral Hazard Problem With Privatization of Public Enforcement: The Case of Pharmaceutical Fraud*, 40 U. Mich. J.L. Reform 281, 330 (2007) (discussing *Whiteside* and concluding that "[c]ourts appear appropriately unwilling to classify as fraud misinterpretations of vague, ambiguous, or contradictory regulatory schemes").

prosecution reduces to little more than an effort to criminalize a disagreement over contractual requirements.

B. Defendants' CY2006 80/20 Submissions Were True Under a Reasonable Interpretation of Governing Law

For CY2006, the Plans contracted with Harmony to provide behavioral health services to their members. That was a common way for a healthcare plan to provide behavioral services. Many other plans provided behavioral health services by subcontracting with a BHO. And before WellCare formed its own BHO, one of the Plans had done so by contracting with the unaffiliated BHO CompCare. *See* p. 16, *supra*.

When the 80/20 template requested the Plans' expenditures "for the provision of" CMH and TCM (*i.e.*, "community" or "outpatient") services, the Plans reported the portion of their total subcapitation payment to Harmony for the very services that, according to the prosecution, count as CMH and TCM. Reporting that amount as the Plans' expenditures was fully consistent with—and truthful under an objectively reasonable construction of—all the materials that arguably bear on the Plans' 80/20 obligations: the 80/20 Statute, the Contracts, the template, and the cover letters. The government's own witnesses confirmed as much.

1. *The 80/20 Statute*

The 80/20 Statute imposes one legal requirement: AHCA's Medicaid contracts "must require 80 percent of the capitation paid to the managed care plan

. . . to be expended *for the provision of behavioral health care services*." Fla. Stat. § 409.912(4)(b) (emphasis added). If "*the managed care plan expends* less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency." *Id.* (emphasis added). The 80/20 Statute thus explicitly prescribes *whose* expenses count (the managed care plan's, not a subcontractor like a BHO's) and *which* expenses count (those "for the provision of behavioral health care services").

As a matter of common sense, the amount a plan pays a BHO for providing behavioral health services to plan members *is* the plan's expenditure "for the provision of" those services. The employee the government presented as the face of AHCA, Carol Barr-Platt, thus agreed that, "[j]ust in commonsense understanding ," "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).[27]

The legislature's use of the phrase "for the provision of" elsewhere in the Statute confirms that understanding. *See Taniguchi v. Kan Pac. Saipan, Ltd.*, 132 S. Ct. 1997, 2004-05 (2012) ("[I]dentical words used in different parts of the same act are intended to have the same meaning." (quotation marks omitted)); *Goldstein*

[27] In ordinary usage, "provision" means "the act or process of providing." *Webster's Third New Int'l Dictionary* 1827 (2002). The Plans' "process of providing" behavioral health services was to subcontract with and pay a BHO. The amount the Plans paid the BHO for those services thus was the amount the Plans expended for the "provision" of behavioral health care services. Fla. Stat. § 409.912(4)(b).

v. Acme Concrete Corp., 103 So. 2d 202, 204 (Fla. 1958). AHCA is authorized to contract with "health maintenance organizations" and pay them a monthly capitation "for the provision of [healthcare] services to [Medicaid] recipients." Fla. Stat. §409.912(3).[28] If that capitation is "for the provision of [healthcare] services," then logically an HMO's contractual payment to a BHO for the behavioral health subset of those services is "for the provision of behavioral healthcare services." And expenditures "for the provision of behavioral health care services" are what count toward the 80/20 requirement. *See id.* §409.912(4)(b). The Plans' expenditures under their BHO subcontracts—their subcapitation payments to Harmony for providing the relevant services—thus were the Plans' expenditures "for the provision of behavioral health care services." Fla. Stat. § 409.912(4)(b). At the very least, that is a reasonable interpretation.[29]

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[28] *See also* Fla. Stat. §409.912(22), (23) (referring to a "health maintenance organization . . . under contract with the agency for the provision of health care services to Medicaid recipients").

[29] That construction also flows from the statutory goal of providing "a case-managed continuum of care." Fla. Stat. §409.912. Under managed care, the provision of healthcare involves more than paying individual doctors for individual services. Plans instead must coordinate patient care among providers, taking a broader perspective than individual doctors can provide. *See* pp. 9, 15, *supra*. That is critical in the behavioral health context, where the patient's condition may prevent him from managing his own care. When an HMO hires a BHO, the BHO coordinates care among multiple providers and ensures the patient utilizes the care being offered. A465 (86:7-15) (Barr-Platt). That is as much a part of "the provision of behavioral health care services" as is a visit with a psychiatrist. Denying HMOs credit for their payments to BHOs for those services would

2. *The Plans' Medicaid Contracts*

Tracking the Statute, the Contracts provide that "eighty percent (80%) of the Capitation Rate paid to the Health Plan by the Agency shall be expended for the provision of community behavioral health services," and that if "the Health Plan expends less than eighty percent (80%) of the Capitation Rate, the Health Plan shall return the difference to the Agency." A699 (GX-3305 at .0166). Thus, like the Statute, the Contracts make clear that it is the *Plan's* expenditures that matter (not those of a subcontractor like a BHO), and that the expenses that count are those the Plan pays "for the provision of" the relevant services. The Contracts reaffirm that focus on the Plan's expenditures by stating that the "administrative expenses or overhead of *the plan*"—not of the plan's subcontractors—must be excluded from the 80/20 calculation. A699 (GX-3305 at .0167) (emphasis added).

As with the Statute, the language and structure of the Contracts confirm that a Plan's payments to a BHO are expenditures "for the provision of" the services a BHO is responsible for providing. The Contracts use the phrase "for the provision of" in describing a Plan's subcontract with a BHO: A Plan, they state, may "sub-contract[ ] with a Managed Behavioral Health Organization . . . for the provision of Behavioral Health Services." A699 (GX-3305 at .0164). Logically, if a Plan's

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discourage the use of BHOs and undermine the "continuum of care" the Statute seeks to promote.

subcontract with a BHO is "for the provision of" behavioral health services, so too are the Plan's payments under that subcontract. The express authorization to subcontract with BHOs, moreover, would make little sense if the Contracts simultaneously excluded payments to BHOs from the 80/20 calculation. As a practical matter, no Plan would subcontract with a BHO to assume the Plan's obligations "for the provision of" behavioral health services to its members if the Plan's payments to the BHO did not count for 80/20 purposes.

The Contracts impose two additional restrictions beyond the Statute's 80/20 directive, and the Plans' CY2006 filings complied with both. *First*, only expenses for the provision of "community" (that is, CMH and TCM or "outpatient") behavioral services count. A699 (GX-3305 at .0167). The Plans met that requirement because they reported only payments to Harmony properly allocable to outpatient services. *See* pp. 28-30, *supra*. *Second*, the Contracts require that reported payments be made "directly or indirectly" to "community behavioral health services providers." A699 (GX-3305 at .0167). Under a reasonable construction of the Contracts, they were.

In ordinary meaning, a BHO like Harmony is a "community behavioral health services provider," because community behavioral health is one of the services it is paid to provide. "National authorities recognize [BHOs] as providers," A648 (64:1-8) (Miller), and "[t]he major accrediting agency in the U.S. . . .

considers behavioral health organizations to be providers," A661 (108:15-23) (Miller); A465 (86:3-87:1) (Barr-Platt) (conceding that "an MBHO is basically the provider" while disputing only whether it provides "direct" services). And the Contracts themselves adopt that meaning. Just two pages before their 80/20 provision, the Contracts contain a section addressing "Behavioral Health *Provider* Contracts." A699 (GX-3305 at .0164) (emphasis added). The first category of "Behavioral Health Provider" contracts is "subcontracts with a *Managed Behavioral Health Organization (MBHO)* for the provision of Behavioral Health Services." *Id.* (emphasis added). It would make no sense to address contracts with BHOs in a section titled "Behavioral Health *Provider* Contracts" if BHOs were not behavioral health providers. The Plans' payments to Harmony thus were payments made "directly" to a provider. A699 (GX-3305 at .0167).[30]

The Contracts, moreover, also permitted the Plans to include payments made "*indirectly* to community behavioral health services providers." A699 (GX-3305 at .0167) (emphasis added). The Plans paid Harmony, which in turn built a network of third-party direct providers—doctors and other health professionals—and

[30] Additionally, the Contract defines "Provider" as "[a] person or entity that is eligible to provide Medicaid services and has a contractual agreement with the Health Plan to provide Medicaid services." A699 (GX-3305 at .0053). Harmony, a URAC-certified BHO, was authorized to and did provide Medicaid services under its contracts with the Plans. *See* pp. 17-20, 22, *supra*.

paid those providers for serving the Plans' members. *See* pp. 17-20, *supra*. The Plans' payments to Harmony were "indirect" payments to those providers, as multiple government witnesses agreed. A760 (14:16-24) (Clarke) ("An indirect payment might be through an entity such as Harmony."); A490 (56:21-57:1) (Whitney) (the Plans "could have paid the providers indirectly using CompCare [a BHO]").

3. *The Templates*

The 80/20 templates AHCA sent the Plans each year reinforce Defendants' construction. The templates are addressed to the Plans—HealthEase and Staywell—and request that the Plans report *their own* expenditures for the provision of CMH and TCM services, not the expenditures of their subcontractors (like Harmony) to direct service providers. *See* A699 (GX-0603 at .0001) (requesting expenses of "managed care entities" receiving capitation from AHCA); A699 (GX-0604 at .0001) (same).

Moreover, the templates' certification tracks the language of the Statute and Contracts. The CEO or President of the "Health Plan" (not Harmony) must "swear or affirm that the expenditure information reported *for the provision of* community mental health services and targeted case management services is true and correct to the best of [his] knowledge and belief." A699 (GX-0603 at .0002) (emphasis added); A699 (GX-0604 at .0002). That is precisely what the Plans reported—the

sums they paid Harmony "for the provision of" the relevant services. The templates require no more.

4. *The Cover Letters*

The AHCA cover letters that accompanied the templates, like everything else, were addressed to the Plans—not to Harmony. Although the Plans' contractual obligations to provide behavioral health services remained constant over the relevant years, the cover letters changed from year to year. *Compare* A699 (GX-0400) *with* A699 (GX-0500) *and* A699 (GX-0600). The cover letters for CY2006 (like those for prior years) identified the relevant services as "community mental health" and "targeted case management" (*i.e.*, outpatient services). A699 (GX-0600). Unlike some earlier letters, however, the CY2006 cover letters also included, after "community mental health" and "targeted case management," parentheticals containing a number of procedure codes. *Id.* The prosecution has taken the view that, by listing (in parentheses) a subset of the procedure codes associated with CMH and TCM services, the CY2006 letters restricted reportable expenses to expenditures corresponding to those codes. *See* A631 (98:1-6) (Kelly) (letter listed "the allowable codes"); A632 (118:13) (Kelly) (expenditures excluded if they "did not meet the codes" in letters); A633 (9:5-7) (Kelly); A677 (41:23-42:14) (closing) ("codes that qualify"); Dkt. 772 at 22 & n.18.

The Court need not determine whether the prosecution's interpretation of the letters as limiting reportable expenses to the listed codes was the only reasonable interpretation, *see* pp. 70-72, *infra*, because for CY2006 the Plans did limit their reported expenditures to reflect those codes. The government's star witness, Greg West, testified without contradiction that, in response to the premium discrepancy, he and Jian Yu reduced the Plans' reported subcapitation payments to Harmony to ensure they "only reflect[ed] . . . the codes in the letter." A757 (119:10-14). And West's spreadsheet confirms their effort to report "only costs covered by AHCA specified procedure codes." A699 (GX-0619-03-A at .0002) ("Summary" tab, cell G7 cmt.); A662 (100:6-10) (Miller); *see* p. 30, *supra*.

5. *The Government's Own Witnesses*

In *Whiteside*, this Court found it significant that "[o]ne of the government's witnesses . . . testified that the regulations do not answer the specific question" of interpretation at issue. 285 F.3d at 1352. Here, multiple government witnesses testified that reporting the Plans' subcapitation payments to Harmony was consistent with a reasonable interpretation of the Statute and Contracts. And no witness could point to anything prohibiting that approach.

Gary Clarke—one of WellCare's outside counsel and former head of AHCA's Medicaid Division—testified that, when WellCare was considering whether to form a BHO, he advised that another HMO was using payments to an

affiliated BHO for 80/20 reporting. A584 (94:17-95:9). He identified it as one "reasonable" option among many. *See* pp. 17, 39-40, *supra*. And he confirmed that approach's legality at trial. "[T]here is nothing in the 80/20 amendment itself," he testified, "that prohibits the WellCare HMOs from including those payments to Harmony in connection with the 80/20 reporting." A584 (99:15-19). Clarke likewise testified that "one reasonable interpretation" of the Contracts "is that you could include payments to Harmony." A760 (22:19-22).

Frank Rainer, another of WellCare's outside counsel, agreed that "one reasonable interpretation of that statute is you could include BHO expenses." A563 (59:9-12). He stated that it was "one reasonable interpretation of the contract" as well. A563 (76:13-19). Michael Turrell, a WellCare attorney, similarly testified that nothing in the Statute precludes plans from "using the expenses for a BHO in connection with the 80/20 calculation." A559 (71:19-22); *see also* Farha Br. 11 (experienced healthcare professional Imtiaz Sattaur). Even the government's expert conceded that no contractual provision "prohibits payments to a BHO from being included in the 80/20 calculation." A633 (114:12-21) (Kelly).

That was the industry's understanding as well. WellCare actuary Todd Whitney explained that, when HealthEase subcapitated to a BHO named CompCare to provide behavioral health services to its members, "[t]he amount of HealthEase['s] Behavioral health expense" was "what it paid CompCare." A490

(56:21-58:1). That was true even though CompCare would use some of that money for its "administrative expenses" and may "take a profit from that as well." A490 (57:13-23). The entire "capitation amount to CompCare would be included in medical expense. That's typically how it's counted." A490 (104:24-105:1).

In a closely analogous context, AHCA itself recognized that payments to affiliated entities count for 80/20 purposes. Government witnesses agreed that AHCA permitted prepaid mental health plans—which are subject to the same 80/20 Statute as HMOs—to report subcapitation payments they made to related entities. *See* A473 (68:11-69:4) (Barr-Platt) ("all of those subcontract costs get included in the 80/20 calculation"). As Clarke explained at trial (and advised Defendants a decade ago), prepaid mental health plan Florida Health Partners "subcapitated to related entities" for outpatient services; it included that subcapitation in its 80/20 calculation; and that approach "seemed to be" acceptable to AHCA. A584 (95:10-23). Given AHCA's acceptance of that approach from other entities subject to the 80/20 Statute, the Plans' interpretation of the Statute was at least reasonable. As Clarke explained, "What's good for the goose is good for the gander." *Id.* at 95:24-96:1.[31] After the raid on WellCare, an AHCA-commissioned

[31] After the raid on WellCare, AHCA challenged Florida Health Partners' methodology, demanding a payback. A650 (18:19-24) (Miller). But AHCA ultimately accepted Florida Health Partners' methodology and "did not require a payback from them." A650 (15:7-13, 18:25-19:1) (Miller).

report identified reporting subcapitation payments to an affiliated entity as one of five reasonable methods plans had used for 80/20 purposes. *See* A660-4 at 14-15; *see* A650 (15:7-13, 15:21-23) (Miller).

AHCA's Carol Barr-Platt testified that there were "numerous conversations over a very long period of time with multiple people" within AHCA about whether to amend the Contracts "to expressly prohibit the inclusion of those BHO expenses in the 80/20 calculation." A474 (52:19-53:11). But no such language was ever included in the Contracts—or anywhere else. *Id.* That confirms that it was at least reasonable to read the Contracts as permitting inclusion of such payments.

C. The Government's Contrary Arguments Fail

The government's contrary contentions are legally and factually unfounded.

1. *The Government's "Direct Providers" Interpretation Is Unsupported*

The government has urged that the Plans were required to report, not what they paid Harmony for the relevant services, but what *Harmony* paid to downstream *direct providers*. *See* Dkt. 772 at 31-33.[32] That, the government argued, is "the only reasonable interpretation of the 80/20 requirements that

[32] Thus, the government's expert—who purported to compare the Plans' reported expenditures to their "actual" expenditures, Dkt. 772 at 32; *see* A590 (108:10-14) (Kelly)—ignored the Plans' payments to Harmony and counted only "the amounts *Harmony* paid to *direct* providers" for services recorded using the codes in AHCA's cover letters. A634 (59:25-60:24) (Kelly) (emphasis added); *see* A631 (53:7-15) (Kelly) ("monies paid to third-party providers").

existed." *Id.* at 31. In post-trial motions, the government asserted that its "direct providers" interpretation was based on "the language of the contracts and related documents between AHCA and the HMOs." *Id.* But the government never could explain *how* the Contracts and "related documents" (presumably the templates and cover letters) support that construction, much less negate any other reasonable construction.

a. At trial, the government called AHCA employee Carol Barr-Platt to testify that the Contracts supported its position. Barr-Platt offered her personal belief that only amounts paid for "the provision of *direct services* to a member" count for 80/20 purposes, and that payments to BHOs do not count. A465 (102:9-21) (emphasis added); A473 (57:4-9). But she pointed to no authority—contractual or otherwise—for that position. She confessed that she was "confused or uncertain" about the Contracts' meaning, and could not reconcile her view with the Contracts' language referring to "dollars paid directly *or indirectly* to behavioral healthcare providers." A474 (79:20-80:7, 82:15-83:5) (emphasis added). Barr-Platt also conceded that BHOs do provide "direct" services to patients, such as targeted case management, undermining her "BHOs are not direct providers" theory. *Contrast* A473 (118:3-20) (Harmony is not a "direct provider") *with* A487 (42:19-43:10, 46:19-47:24) (conceding that Harmony provided targeted case management services directly to patients). And she admitted that "somebody

reading this contract may have different reasonable interpretations." A474 (83:6-8).

Barr-Platt and the government could find no support for their "direct provider" theory in the Contracts because the Contracts defy that construction. The Contracts' 80/20 provision *disclaims* a "direct" restriction, stating that the Plans may count amounts "paid directly *or indirectly*" to behavioral health providers. A699 (GX-3305 at .0167) (emphasis added). More important, where the Contracts elsewhere seek to impose a "direct provider" limitation, they use a specifically defined term—"*Direct* Service Behavioral Health Care Provider." A699 (GX-3305 at .0046) (emphasis added). AHCA conspicuously did not use that term in the Contracts' 80/20 provision (or the templates or cover letters). Instead, it used "community behavioral health services provider," which comfortably includes BHOs like Harmony. *See* pp. 59-60, *supra*.

That was not because AHCA overlooked the issue. AHCA staffers observed in 2002 that "HMO's capitate the BHO's and the BHO's sub-capitate the community mental health centers who perform the mentioned services," and asked, "Who do we want the 80/20 from[?]" A51-1 at 2. AHCA answered that question by obligating "the Health Plan" to calculate its expenditures and return any difference to the agency. A699 (GX-3305 at .0166); pp. 58, 61, 62, *supra*. It thus does not matter that, according to Barr-Platt, the Contracts' meaning "was clarified to

[her] by the Agency." A474 (87:15-20). She admitted that she was not aware of the Agency "ever clarify[ing] that language to the healthcare industry." A474 (88:16-18). AHCA considered amending the Contracts to exclude payments to BHOs from the 80/20 calculations but never did so. *See* p. 66, *supra*.

As a result, the first time anyone at AHCA articulated a "direct providers" interpretation was in 2008—well after the raid on WellCare—when counsel for WellCare's Special Committee asked how to calculate 80/20 expenditures (apparently the answer was not clear to them, either). A650 (7:17-8:8) (Miller); A572-5 at 3.[33] Failure to follow an unsupported, *post hoc* edict years before its articulation is not a crime.[34]

b. Nor can the government find support for its "direct providers"

[33] AHCA employee Elfie Stamm responded that only payments to downstream direct services providers could be included. A650 (7:24-8:8); *see* A572-5 at 3 ("[a] payment to an internal subsidiary such as Harmony cannot be counted," referring instead to "the amount of capitation paid to a downstream direct services provider"). For that, she cited only the Contract provision requiring plans to report the amount "paid directly or indirectly to community behavioral health services providers." A572-5 at 3. *But see* pp. 59-61, *supra* (discussing that provision).

[34] The prosecution's interpretation also creates absurd results. Applying that interpretation at trial, government expert Harvey Kelly—ignoring HealthEase's 2002 payments to a third-party BHO called CompCare—concluded that HealthEase had only *$142* in qualifying expenditures for July-December 2002—when HealthEase had approximately *40,000 members*. A631 (17:21-18:6); A632 (87:24-88:2); A632 (89:9-13); A648 (72:2-4) (Miller). In fact, HealthEase spent vastly more on outpatient behavioral healthcare services over that period. A648 (41:15-21, 72:2-8) (Miller).

limitation in AHCA's CY2006 cover letter. The term "direct providers" does not appear in the cover letter. Other than echoing the Statute's text, the CY2006 cover letter states only that AHCA has "determined" that, "for this purpose," "'behavioral health care services' are defined as community mental health," "targeted case management," and certain "additional procedure codes." A699 (GX-0600). After using the phrases "community behavioral health," "targeted case management," and "additional procedure codes," the letters listed certain procedure codes. Nothing about that language addresses whether a Plan can report only payments a BHO makes to "direct providers" of those services, or may instead report its own payments to the BHO for the provision of those same services.

At trial, the government urged another limitation—that the letters precluded the Plans from reporting expenditures unless they were billed or identified using one of the listed codes. *See* p. 62, *supra*. That has no relevance for CY2006; responding to the premium difference, the Plans adjusted their reported expenditures to reflect only the listed codes. *See* pp. 29-30, *supra*. But it hardly represents the only reasonable construction of the letters in any event. The cover letters tell the Plans to "[r]eport expenditures for behavioral health *services that cover* targeted case management and community mental health services only." A699 (GX-0600) (emphasis added). It is thus reasonable to conclude that it is the *ser-*

vice, not the code, that matters. That makes sense: Multiple codes from different coding systems often cover the same service. *See* p. 11 n.4, *supra*. And the Contracts allow the Plans to "substitut[e]" "additional services" and "different or alternative" services for the ones listed in the TCM and CMH Handbooks, provided "the net effect" is equivalent. A699 (GX-3305 at .0137). The cover letters do not compel the illogical result that the Plans should receive no credit for otherwise identical services, or their equivalents, simply because of the code used to identify them.[35]

Indeed, it would make no sense to construe the cover letters—which were sent after the Plans had already performed for the year in question—as imposing any limitation not in the Statute or Contract. It is black-letter contract law that an after-the-fact letter by one contracting party cannot alter the terms of a contract.[36]

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[35] That construction would be particularly improper given that the CY2005 cover letter listed only the "H" and "T" codes used by community mental health centers, but not CPT codes used by private practitioners. A699 (GX-0500). AHCA could not decree that only services performed by community mental health centers count; the Contract says the opposite. A699 (GX-3305 at .0141) (contract "not intended to suggest that" services "must be provided by State funded 'community mental health centers' "). And the construction would be absurd, given that the CPT codes added by the CY2006 letter include (for example) the code for ten-minute physician visits, but not five- or fifteen-minute visits. *See* A808-1 ¶25 (Dobson Decl.). The government has never explained why it makes sense to read the cover letter as saying ten-minute visits count, but five- and fifteen-minute visits do not.

[36] "The unilateral modification of a contract is unenforceable." *Dows v. Nike, Inc.*, 846 So. 2d 595, 603 (Fla. Dist. Ct. App. 2003). Government witness Barr-Platt confirmed that AHCA's letters "cannot modify the contract." A474 (58:4-6).

Any effort to alter the Plans' reporting and refund obligations by letter would also contravene Florida statutory law.[37] It is at least reasonable to construe the cover letters consistent with the Contract rather than reading them as attempting to impose alterations they had no power to effect. And such an effort to change obligations by letter could not create a property interest sufficient to support a criminal fraud prosecution.[38]

c. The government also relied on West's spreadsheets, urging that "West annually calculated for management the expenditure amounts that *should have been reported* following AHCA's guidance and instructions" and, for CY2006, "created an internal worksheet that revealed the HMOs owed a combined refund to AHCA of more than $12 million." Dkt. 772 at 32. But West's worksheets con-

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And the Contracts themselves precluded AHCA from modifying the terms without the Plans' written consent. A699 (GX-3305 at .0026).

[37] Under Florida law, any "agency statement of general applicability that implements, interprets, or prescribes law or policy"—including "any form which imposes any requirement or solicits any information not specifically required by statute or by an existing rule"—must be adopted through notice-and-comment rulemaking. Fla. Stat. §120.52(16). "An unpromulgated agency rule constitutes an invalid exercise of delegated legislative authority and, therefore, is unenforceable." *Fla. Dep't of Revenue v. Vanjaria Enters., Inc.*, 675 So. 2d 252, 255 (Fla. Dist. Ct. App. 1996).

[38] As noted below (at 79), fraud cannot be established unless the defendant sought to wrong someone "in his property." Under Florida law, a property interest may be created only by "statute, ordinance or contract"—not post-hoc letters. *Metropolitan Dade County v. Sokolowski*, 439 So. 2d 932, 934 (Fla. Dist. Ct. App. 1983) (citing *Bishop v. Wood*, 426 U.S. 341, 96 S. Ct. 2074 (1976)).

tained multiple calculations, including the calculation the Plans actually used. The government simply begs the question of what "should have been reported."

One column on West's spreadsheet reflects his estimate of the payback if the Plans reported only Harmony's payments to other providers, which *West* may have thought was the proper method. A757 (108:12-21) (West); *see* A699 (GX-0619-03-A at .0002). But West testified that he was in no position to know what the Plans' legal obligations were; that was handled by others, including WellCare's legal department. A533 (18:10-20:15). West never discussed the proper interpretation of the Contracts' reporting provisions with anyone (and in fact never read the Contracts or the 80/20 Statute until his cross-examination). A534 (48:23-49:3); A533 (11:2-4, 11:22-25, 12:1-13, 14:7-16:13). Indeed, the government objected to West's "competence" to testify "as to questions on the contract." A751 (122:22-23). West's putative views on what he thought the Plans owed are just that—one man's (less-than-fully-informed) thoughts about the reporting requirements. They hardly "negate" any other "reasonable interpretations that would make the defendant's statement correct." *Whiteside*, 285 F.3d at 1351.

d. The government's "direct providers" theory contradicts even its own representations. When addressing loss for sentencing purposes, the prosecution agreed that HealthEase should receive credit for the amounts it paid another BHO, CompCare, for outpatient services in 2002 (before Harmony's creation). Dkt. 819

at 27 & n.22 (explaining that WellCare's reporting of the outpatient portion of its subcapitation to CompCare was the "most reasonable" existing 80/20 expense figure); *see also* pp. 64-65, *supra* (Whitney). The only possible distinction between Harmony and CompCare is that Harmony and the Plans were related, while CompCare was not. The government, however, has identified *nothing* in the 80/20 Statute and Contracts, or even cover letters or witness testimony, stating that the Plans had to treat payments to related entities differently from payments to unrelated entities. *Cf. United States ex rel. Williams v. Renal Care Grp., Inc.*, 696 F.3d 518, 528 (6th Cir. 2012) (it is not "inherently improper" to create and operate a related company "for the sole purpose of increasing its profit margins" by "receiv[ing] . . . higher [Medicare reimbursement] payments"). Payments to both kinds of entities were subject to review by AHCA and Florida's Office of Insurance Regulation, neither of which objected to the rates the Plans paid to Harmony or CompCare. *See* pp. 19-20, *supra*. And the government has disavowed any claim that the rates paid to Harmony were excessive.[39] The Plans were entitled to report those authorized payments in their 80/20 submissions, regardless of

[39] In the government's words: "The case does not concern whether WellCare overpaid Harmony"; "[a]ny discussion that makes that point is not only irrelevant but will also confuse the jury and waste time." Dkt. 348 at 20-21. And the only witness to testify on the issue, a leading healthcare economist, explained that the subcapitation the Plans paid Harmony was a "reasonable," "appropriate," "market rate." A647 (47:19-21, 55:3-13) (Miller).

corporate kinship. Nothing renders that construction unreasonable.

2. *Evidence of Subjective Intent Is Irrelevant*

The government sought to establish falsity by pointing to supposed evidence of subjective intent. A824 (50:19-51:7); Dkt. 324 at 3. Among other things, it relied on alleged inconsistencies in Defendants' 80/20 methodology over the years (though there were changed circumstances), alleged payback targets, and taped conversations. *See, e.g.*, Dkt. 772 at 30.

That putative *mens rea* evidence, *see, e.g.*, Farha Br. 19-25; *Safeco Ins. Co. of Am. v. Burr*, 551 U.S. 47, 70, 127 S. Ct. 2201, 2216 (2007),[40] is legally irrelevant. *Whiteside* addresses *actus reus*, not *mens rea*. *See* 285 F.3d at 1352; *see also United States v. Gupta*, 463 F.3d 1182, 1192 (11th Cir. 2006) ("In *Whiteside*, we reversed on the basis that the government could not prove the *actus reus* of the offenses . . . ."). Bad intent cannot make a true answer false. *Cf. United States v. Wu*, 711 F.3d 1, 18 (1st Cir. 2013) ("But even where the evidence is sufficient to

[40] Both the healthcare-fraud and false-statement charges require proof that the violations were committed "willfully." 18 U.S.C. §§ 1035(a), 1347(a). But a defendant does not act "willfully" where his conduct would be lawful under an interpretation of governing law that is "not objectively unreasonable," regardless of his subjective intent. *Safeco*, 551 U.S. at 70 n.20, 127 S. Ct. at 2216; *see Levine v. World Fin. Network Nat'l Bank*, 554 F.3d 1314, 1318-19 (11th Cir. 2009). That rule, announced in the civil context, applies with no less force in criminal cases. *See Safeco*, 551 U.S. at 68 n.18, 127 S. Ct. at 2215. For the reasons above, the Plans' statements were true, and thus lawful, under an objectively reasonable construction of the law.

show the necessary *mens rea*, the government still must always 'meet its burden of proving the *actus reus* of the offense.'" (quoting *Whiteside*, 285 F.3d at 1353)). Alleged *mens rea* matters only if the government has proven falsity. It "makes no difference what the defendants thought if [the statements] were authorized under a reasonable interpretation of the contract; their thought in that regard becomes important if, but only if, the billing was false—that is, only if it was not a reasonable construction of the contract." *United States v. Race*, 632 F.2d 1114, 1120 (4th Cir. 1980), *abrogated in part*, *United States v. Sarwari*, 669 F.3d 401, 407 n.3 (4th Cir. 2012); *see Whiteside*, 285 F.3d at 1352 (citing *Race* with approval).

Whiteside makes that clear. There, the government presented extensive evidence of bad intent:

- The government's agent, the fiscal intermediary, had repeatedly rejected the defendants' characterization of the loan in prior years, 285 F.3d at 1348;
- The defendants' consultant had informed them that "claiming the interest as 100% capital-related might be fraud," *id.*;
- The defendants had been told they should highlight their disagreement with the government by putting it "on the protest line to flag it for the auditor," but did not do so, *id.*;
- The work papers sent to the fiscal intermediary relating to the cost classification were falsified, *id.* at 1349; and
- The defendants "discussed ways to divert the fiscal intermediary's attention from the interest issue," *id.* at 1350.

The Court found all of that irrelevant. Because the cost report at issue was true

under an objectively reasonable construction of the law, it was not "false" and the defendants were entitled to acquittal. *See id.* at 1352-53. The same is true here.

3. *The Plans' Reduction of Reported Expenditures Cannot Sustain the Convictions*

The government has also urged that it does not matter whether the Plans could reasonably report payments to Harmony for the relevant services because "*that is not what happened in this case*." Dkt. 772 at 30. The Plans, the prosecution complains, "did not simply claim the *exact dollar amount they paid to Harmony* as their expenditures on the 80/20 worksheets." *Id.* (emphasis altered).

a. That is a red herring. The Plans did not report "exactly" what they paid Harmony for good reason: They paid Harmony a *comprehensive* rate covering both inpatient and outpatient behavioral health services, but only expenditures for *outpatient* services (CMH and TCM) count toward the 80/20 calculation. It thus was necessary to allocate the total subcapitation to Harmony between inpatient and outpatient and report only the outpatient component. That is precisely what the Plans did, as Greg West repeatedly testified. *See* pp. 28-29, *supra*. Given that the Indictment alleges—and the government has urged—that it would have been improper to include "expenditures made for services other than CMH and TCM services," A1 ¶26(a)(i), the government cannot criticize the Plans for reporting only the amount the Plans paid Harmony for CMH and TCM services, rather than the "exact dollar amount they paid Harmony" for *all* services.

The government has complained that, in addition to isolating the CMH and TCM portion of the subcapitation, the Plans "adjusted downward the expenditure amounts paid from the HMOs to [Harmony] by approximately 15%." Dkt. 772 at 25. But the government ignores its star witness's unrebutted explanation—that it was a bona fide effort to restrict reported expenditures to cover the codes in AHCA's cover letter (so the reported services would match with the ones included in AHCA's reported premium). *See* pp. 29-30, *supra*. The government itself argued that the Plans could report only expenditures corresponding to codes in AHCA's cover letters. *See* pp. 62, 70-71, *supra*. Having taken that position, the government cannot credibly claim Defendants are criminally liable for reducing reported expenditures to ensure they reflect "only costs covered by the AHCA specified procedure codes." A699 (GX-0619-03-A at .0002) ("Summary" tab, cell G-7) (West spreadsheet comment explaining 15% reduction).

b. The government's reliance on the Plans' *reduction* of their reported expenditures—*increasing* their payment to AHCA—fails for additional reasons. It defies common sense to say that Defendants *defrauded* AHCA by paying it back *more* than they should have. It also defies the Indictment, which charges that Defendants sought "to falsely and fraudulently *increase* the expenditures reported to AHCA" and thereby "*reduce* [the Plans'] annual contractual refund obligations." A1 ¶26(a), (a)(ii) (emphasis added). The government cannot now defend the

convictions by claiming the opposite—that the Plans *reduced* the expenditures reported to AHCA and thereby *increased* the Plans' refunds to AHCA. *See United States v. Lander*, 668 F.3d 1289, 1296 (11th Cir. 2012) (per curiam).[41]

Nor can the government's theory be reconciled with the healthcare-fraud statute, which requires execution of a scheme to "defraud" or to "obtain, by means of false or fraudulent pretenses, representations, or promises, . . . money or property," 18 U.S.C. §1347(a)—terms that refer to "wronging one in his property," *McNally v. United States*, 483 U.S. 350, 358, 107 S. Ct. 2875, 2877 (1987), *superseded in part by statute*, 18 U.S.C. §1346; *Cleveland v. United States*, 531 U.S. 12, 15, 26, 121 S. Ct. 265, 368, 374 (2000); *United States v. Bobo*, 344 F.3d 1076, 1084 (11th Cir. 2003). The government seems to suggest that the sole "execution" alleged here, the submission of allegedly false 80/20 reports for CY2006, A1 ¶32, involved increasing the payments to AHCA for that year. But paying AHCA *more* than required could not *deprive* the agency of a property interest.

* * * * *

[41] The same rationale applies to Behrens's false-statements convictions in the event Counts 4 and 5 of the Indictment are held sufficient. *See* pp. 97-102, *infra* (explaining that those counts are legally insufficient). As the district court recognized, those counts could be sustained only by reading into them allegations from elsewhere in the Indictment. That would necessarily include the allegation that the Plans used Harmony to fraudulently *increase* their reported expenditures.

Despite repeated motions, the district court refused to engage the relevant documents and determine the reasonableness of any construction of the Plans' obligations. Instead, the court adhered to its view that, "[i]f the case survives dismissal, it is for the jury to decide whether the expenditure information was consistent with a reasonable interpretation of the refund provisions." A244 at 2; A252 at 3 (disagreeing with Defendants' argument that reporting the subcapitation to Harmony is "not criminal as a matter of law" and holding: "It is a question of fact, not law, whether the information reported to AHCA was knowingly false"); *see* Dkt. 228 (endorsed order denying motion to dismiss); Dkts. 625, 782, 783 (endorsed orders denying Rule 29 motions). The Court then erroneously instructed the jury to decide whether the Plans' CY2006 submissions were consistent with a reasonable construction of the CY2006 *template*, leaving the rules of construction and questions about controlling legal authority to lawyer argument. A679 (27:1-4); A664 (101:14-20, 125:13-25).

That was error. Whether the Plans' payments to Harmony for the relevant services could reasonably be considered the Plans' "expenditures for the provision of" those services was a question of law for the court—not, as the district court ruled, a question of fact for the jury. *See Whiteside*, 285 F.3d at 1352; *Race*, 632 F.2d at 1120 ("The meaning of a clause, couched as this one was in language of common use and understanding, was purely a matter of law for the court, which

should have granted the defendants' motion to dismiss any charge based on the defendants' billing for per diem under the contract."). The district court should have granted Defendants judgment as a matter of law.

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

Seeking to show that the Plans' 80/20 submissions were criminally false under *Whiteside* and were submitted in subjective bad faith, the government introduced (over defense objections) the contents of WellCare's financial restatement. That restatement had been extracted from WellCare under highly coercive conditions. WellCare restated its financials to avoid indictment by parroting the post-raid position the government dictated. But the jury never learned this, because the government was permitted—in violation of Federal Rule of Evidence 703—to present the restatement through an expert witness who had no personal knowledge of its creation. That left the prosecution free to present the restatement to the jury as WellCare's admission that, following a careful and impartial determination, WellCare had confirmed the government's interpretation of the Plans' reporting obligations; that the Plans' 80/20 submissions were false; and that, as a result, the Plans had underpaid AHCA by more than $35 million. The district court thus permitted the government to invoke WellCare's imprimatur and the prestige of its auditors to bolster its side of the core legal dispute in this case, while precluding cross-examination that would have demonstrated the restatement's unreliability. It

is difficult to imagine a more prejudicial use of evidence that never should have been admitted.

A. The Restatement and Its Presentation to the Jury

1. WellCare issued the restatement only after 200 agents raided its headquarters and the company initiated a Special Committee investigation. Within a week after the raid, WellCare announced that it was "cooperating with the U.S. Department of Justice, the U.S. Federal Bureau of Investigation," and other agencies. A294-3 at 2. That cooperation—which WellCare touted as "immediate and extensive" and "aggressive and comprehensive," A294-4 at 14, 29—reflected WellCare's well-founded fear of criminal prosecution. A56-2 at 58 (notes of FBI Agent Ortega). According to the government, WellCare also faced pressure from AHCA, which allegedly "threatened to stop letting [WellCare] do business in Florida." A640 (47:4-5) (proffer). In August 2008, after extensive negotiations with the U.S. Attorney's Office, the Florida Attorney General's Office, and other agencies, WellCare agreed to pay AHCA $35.2 million. A640 (47:6-8).

In the course of those negotiations, AHCA officials apparently dictated the content of WellCare's financial restatement. Counsel for WellCare's Special Committee asked AHCA to give its view—*i.e.*, its view in 2008, after the raid and after the reporting periods at issue—regarding permissible 80/20 expenditures. In response, an AHCA employee stated for the first time that "payment[s] to an

internal subsidiary such as Harmony cannot be counted," and that only payments to "downstream direct services providers" can be. A572-5 at 3; p. 69 & n.33, *supra*. It was only after those "discussions with AHCA" that the Special Committee declared that the Plans' prior 80/20 reporting had been erroneous and that the Plans owed AHCA another $35 million. A572-1 at 5. WellCare restated its financials accordingly. *See* A841-5 (restatement).

After WellCare filed the restatement, the government agreed to defer prosecution of WellCare if the company would "accept and acknowledge responsibility for certain past conduct." A294-5 at 4. That agreement prohibited WellCare from contradicting the government's account of the facts, *id.* at 6, an obligation WellCare would have risked breaching had it not restated its financials consistent with the government's views.

2. When Defendants moved *in limine* to exclude all references to WellCare's restatement, the government conceded that the restatement was inadmissible hearsay and disclaimed any intent to introduce it as substantive evidence. A347 at 11-12. The district court accordingly held the restatement inadmissible. A354 at 3. Mid-trial, however, the government reversed course. It argued that, by denying the falsity of their 80/20 submissions, Defendants had made the restatement relevant as evidence of the submissions' objective falsity. The prosecution thus sought to use WellCare's restatement to convince the jury that Defendants'

interpretation of their reporting requirements was objectively wrong. And, contradicting its earlier concession, the government now contended that the restatement was admissible as a business record made in the ordinary course of business. A568. Rather than offer the restatement through a witness with knowledge of its preparation who could authenticate it as a business record, the government sought to shield the restatement from cross-examination by presenting it through expert witness Harvey Kelly, on the theory that Kelly had relied on the restatement in preparing his opinion.

Abandoning its pre-trial decision—and denying Defendants' request for a continuance to address this new evidence—the district court preliminarily concluded that the restatement was admissible as a business record. *See* A588 (138:14-15); A632 (13:3-5). When the court learned that the restatement contained not only financial figures but also "all kinds of verbal language," it reversed course again and said the restatement itself must stay out of evidence "for now," but it permitted the prosecution to present the restatement's content through Kelly's testimony. A632 (27:2-4, 28:8-11).

Only after announcing that conclusion did the court hear from Kelly. During *voir dire*, Kelly did not testify that he "based" his opinion on the restatement in any way. To the contrary, he acknowledged that he had independently calculated the Plans' rebate obligations first, and consulted WellCare's restatement only after-

ward. A632 (33:3-10). Kelly called the restated figures "consistent" with his own "ultimate conclusion," despite a $5-million net discrepancy between the restated figures and the underpayment he had calculated. A632 (33:11-24, 34:3-8). Kelly later acknowledged that he made no attempt to reconcile the numbers, *see* A632 (77:25-78:6, 88:15-16), and that he used the restatement only as "sort of a double-check," A636 (66:19-20).[42]

Defendants objected that Kelly had not relied on the restatement in forming his opinion, as Rule 703 requires, and that the restatement's probative value did not substantially outweigh its prejudicial effect, as Rule 703 also requires. The district court nonetheless permitted Kelly to testify regarding the restatement's contents. A632 (37:24-25).

Kelly was then off to the races. Before the jury, Kelly characterized WellCare's restatement as the company's confession, a filing designed "to correct for prior year misreportings of required AHCA refunds." A632 (51:16-18). Quoting from the restatement, Kelly testified that WellCare's Board had "recommended . . . that [the company's] previously issued consolidated financial statements . . . be re-stated" in light of "accounting errors" arising from non-compliance with the 80/20

[42] In fact, Kelly's results diverged wildly from the restatement. For example, Kelly calculated $142 in expenses for HealthEase during half of 2002, while the figures in the restatement yielded $435,000 for the same period. A632 (87:24-88:16) (Kelly). For 2003, Kelly calculated $23,000 in fee-for-service expenses, A632 (90:19-91:10), while the restatement found about $1.3 million, *see* A572-4 at 5.

refund obligations. A632 (52:23-53:25). Kelly told the jury he had reviewed the revised income figures in the restatement, as well as the accounting underlying the restatement, A632 (54:17-24), and that the revised figures showed WellCare had understated its 80/20 rebate obligations by $35 million. *See* A632 (55:10-19, 76:13-79:9); A798-1 at 73 (demonstrative exhibit displayed to jury). And Kelly professed that the restated figures, though different from his, confirmed his own findings. A632 (76:13-79:9); A636 (66:11-67:7).

On cross-examination, defense counsel questioned Kelly about the coercive circumstances under which WellCare prepared the restatement. Having had no role in that process, however, Kelly responded that he was unfamiliar with those circumstances. He knew nothing—and thus could not tell the jury—about "the particulars" of the government's investigation, A632 (80:19-20), any potential prosecution of WellCare or the government's reasons for not prosecuting, A632 (81:16-17, 87:10-11), or any communications between AHCA and the Special Committee's counsel regarding reportable 80/20 expenditures, A634 (75:21).

In summation, the government emphasized the restatement at every turn, urging the jury to accept it as objective corroboration of the government's conception of the Plans' 80/20 obligations. The government repeatedly invoked the credibility of WellCare and its outside auditor, Deloitte & Touche, to vouch for the government's theory of the case. The data undergirding its theory, the government

urged, was examined "start to finish, piece by piece, item by item, claim by claim" in a "true audit[ ]," undertaken not merely by the government's expert, A761 (130:20-24), but also by "Deloitte & Touche, the big four accounting firm," A761 (130:24-25). "One of the biggest accounting firms in the world," the government declared, "audited WellCare's restatement after the search." A761 (130:25-131:1).

The government pounded the point home:

- "[I]f you recall, that restatement . . . 35 million, that's what the WellCare investigation found following the search." A761 (131:11-14).
- "[T]hey restated their financials and that was audited by Deloitte & Touche, big four accounting firm." A761 (131:14-16).
- "That's significant, members of the jury. And that's Deloitte & Touche. And they agree with [the government's expert]." A761 (132:2-4).
- "That's what real financial analysis establishes of what's occurred here." A761 (132:2-6).

The government also cited the restatement as a reason to discount Defendants' expert, Dr. Henry Miller, arguing: The restatement "found numbers very similar to what Harvey Kelly [found]. So, you have Greg West calculating numbers, Harvey Kelly calculating numbers, and Deloitte & Touche auditing numbers calculated by WellCare all about the same. The only outlier is Dr. Miller." A761 (10:15-19).

The government's message was unmistakable: WellCare—seconded by one of the world's most prestigious accounting firms—had concluded that the Plans'

80/20 submissions were false, and had therefore decided to pay back over $35 million to AHCA. "That's evidence," the government declared. A761 (132:5). And without cross-examination to illuminate the coercive circumstances surrounding the restatement's creation, Defendants could not rebut the misimpression that WellCare had reached this conclusion only after careful and impartial investigation.

B. Admitting the Restatement's Contents Was Error

The district court erred in permitting the prosecution to introduce the restatement's contents through Kelly's testimony.[43] Federal Rule of Evidence 703 permits an expert to present evidence that is otherwise inadmissible only when the expert "base[d]" an opinion on that evidence, introducing the evidence will not

[43] Although the district court was at one point prepared to allow the restatement into evidence as a business record, that theory provides no basis for the restatement's admission. 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 of the requirements of the business-record exception has been met. *United States v. Garnett*, 122 F.3d 1016, 1018-19 (11th Cir. 1997) (per curiam). "Without such a witness the writing must be excluded." *Belber v. Lipson*, 905 F.2d 549, 552 (1st Cir. 1990); *see also Noble v. Alabama Dep't of Envtl. Mgmt.*, 872 F.2d 361, 367 (11th Cir. 1989) (reversing admission of putative business record where custodian "did not testify that he had personal knowledge of the circumstances under which the [documents] were prepared"). Here, the government elicited no testimony from any custodian or other qualified witness regarding the restatement's creation. Nor could the required foundation have been laid. Far from being prepared in the "regular practice" of a "regularly conducted activity," Fed. R. Evid. 803(6)(B), (C), the restatement resulted from pressure WellCare faced while under the threat of criminal prosecution.

curtail a party's right to cross-examination, and the evidence's "probative value in helping the jury evaluate the opinion substantially outweighs [its] prejudicial effect." The government's use of the restatement violated all of these requirements.

1. Rule 703 "does not permit an expert witness to circumvent the rules of hearsay by testifying that other experts, not present in the courtroom, corroborate his views." *United States v. Grey Bear*, 883 F.2d 1382, 1392-93 (8th Cir. 1989) (expert witness could not testify that two other pathologists agreed with his opinion); 6 Fishman *et al.*, *Jones on Evidence* § 42:11 (7th ed. 2013) (Rule 703 does not permit an expert "to testify that other experts have the same opinion as he does"). Such corroborative-type testimony violates Rule 703 in two respects.

First, Rule 703 is limited to evidence on which an expert "base[d]" an opinion. Although corroboration provided by another's analysis "might reinforce the expert's confidence in the opinion," it "is not the *basis* of the expert's opinion." *Kim v. Nazarian*, 576 N.E.2d 427, 434 (Ill. 1991) (applying Rule 703); *see also C.S.I. Chem. Sales, Inc. v. Mapco Gas Prods., Inc.*, 557 N.W.2d 528, 531 (Iowa Ct. App. 1996) (applying materially identical state rule); *State v. Connor*, 937 A.2d 928, 932 (N.H. 2007) (materially identical state rule did not permit disclosure of

non-testifying expert's opinion, where testifying expert's "opinion was formed independent of [non-testifying expert's] verification, not based upon it").[44]

That principle follows directly from the premise justifying disclosure of otherwise inadmissible evidence under Rule 703—*i.e.*, that such evidence is admitted not for its truth, but for the "limited purpose of informing the jury of the basis of the expert's opinion." 2 Broun, *McCormick on Evidence* § 324.3 (7th ed.). When an expert seeks "to testify that other experts have the same opinion as he does"—thus providing "corroborative" testimony—that "testimony is relevant only as inadmissible hearsay to bolster the expert witness's testimony." *Jones on Evidence*, *supra*, § 42:11. And because such evidence does not help explain the process by which the expert arrived at his opinion, it can *only* be "misuse[d] . . . for substantive purposes." Fed. R. Evid. 703, Advisory Committee Note to 2000 amendment.

Here, Kelly's testimony confirms that he did not "base" his opinion on the restatement, but used it only as corroboration. Kelly did not say he used the re-

[44] The accounting judgments underlying the restatement are just the "sorts of technical and specialized expertise the use of which is governed by Rule 702 and *Daubert*." *City of Tuscaloosa v. Harcros Chems., Inc.*, 158 F.3d 548, 563 n.17 (11th Cir. 1998). Kelly's recitation of the restatement's conclusion was thus equivalent to testimony relating a non-testifying expert's opinion. But even if it were not, introducing the restatement would have been improper because Rule 703 permits the presentation only of evidence on which an expert's opinion is "base[d]" and excludes any evidence that serves merely to corroborate an expert's findings—whether or not that evidence is itself an expert opinion.

statement in forming his opinion; indeed, he acknowledged that he consulted the restatement only *after* reaching his own conclusions. A632 (33:3-10). Moreover, Kelly's failure to investigate multi-million-dollar discrepancies between the restatement's conclusion and his own calculation, *see* p. 85 n.42, *supra*, would be inexplicable if Kelly had actually "base[d]" his opinion on the restatement. Rather, as Kelly acknowledged, he consulted the restatement—at most—to "sort of . . . double-check" his own findings. A636 (66:19). That epitomizes corroboration.[45]

Second, Rule 703 does not permit a party to use an expert witness "as a screen against cross-examination." *In re James Wilson Assocs.*, 965 F.2d 160, 173 (7th Cir. 1992). When one expert testifies that other, non-testifying experts have reached the same conclusion, the opposing party is "[e]ssentially . . . subjected to the testimony of a witness whom he may not cross-examine." *United States v. Tran Trong Cuong*, 18 F.3d 1132, 1143 (4th Cir. 1994). That is precisely what

[45] The district court suggested that the discrepancies between Kelly's analysis and the restatement went only to the "weight" of the restatement evidence, rather than its admissibility, and could be raised on cross-examination. A632 (37:13-14). That reasoning fundamentally misunderstands the district court's gatekeeping role under Rule 703. While Defendants' cross-examination showed that Kelly never relied on the restatement in formulating his opinion, that was too little, too late. It cannot be assumed the jury would discount Kelly's testimony because (unbeknownst to them) it violated Rule 703. Contrary to the district court's understanding, the discrepancies between Kelly's conclusions and the restatement's findings went to admissibility, not weight, because they confirmed that Kelly did not base his opinion on the restatement. As a result, Rule 703 did not permit the restatement's introduction.

occurred here. Kelly bolstered his own testimony by telling the jury that other experts—the auditors and experts hired by WellCare's Special Committee—agreed with him on disputed questions about what expenditures could be included in the Plans' 80/20 submissions. In substance, WellCare's Special Committee and new management became uncalled government witnesses, and Deloitte & Touche an uncalled expert who could not be cross-examined.

Courts have rejected similar attempts to evade cross-examination. In *Mike's Train House, Inc. v. Lionel, L.L.C.*, 472 F.3d 398 (6th Cir. 2006), the plaintiff's expert opined on the degree of similarity he perceived between model train designs prepared by the plaintiff and designs prepared by the defendant. *Id.* at 406. The expert testified not only that he had found copying in 67% of the drawings he had examined, but also that another, non-testifying expert had examined a larger set of drawings and found copying in 61% percent. *Id.* Like the government in this case, the plaintiff argued that its expert "could properly testify about the similarity of his and [the non-testifying expert's] conclusions." *Id.* at 409. The Sixth Circuit rejected that view, holding that Rule 703 does not "allow an expert to testify about the conclusions of other experts." *Id.*; *see also Tran Trong Cuong*, 18 F.3d at 1143 (error to allow expert "to bolster his opinion evidence by testifying that his conclusions . . . were 'essentially the same' as those" reached by another, non-testifying doctor); *Hutchinson v. Groskin*, 927 F.2d 722, 725 (2d Cir. 1991) (letters

from non-testifying physicians impermissibly bolstered opinions of defense experts). The same conclusion follows here. Because the restatement was in effect the opinion of a non-testifying expert whom Defendants could not cross-examine, it should not have been presented to the jury.

2. The restatement's introduction was also erroneous because the district court never balanced its probative value against its prejudicial effect as required by Rule 703, even though Defendants objected on that ground. *See* A632 (6:12-21). The court abused its discretion by failing to perform that mandatory gatekeeping role. *See McClain v. Metabolife Int'l, Inc.*, 401 F.3d 1233, 1238 (11th Cir. 2005) (district court "abuses its discretion by failing to act as a gatekeeper" in admitting expert testimony); *Dodge v. Cotter Corp.*, 328 F.3d 1212, 1223 (10th Cir. 2003) (district court "has no discretion to avoid performing the gatekeeper function" in admitting expert testimony).

Had the district court performed the required inquiry, the government could not possibly have shown that the restatement's probative value "substantially outweigh[ed]" its prejudicial effect. Rule 703 reverses the usual balancing test under Rule 403 and "provides a presumption *against* disclosure to the jury of information used as the basis of an expert's opinion and not admissible for any substantive purpose." Fed. R. Evid. 703, Advisory Committee Note to 2000 amendment (em-

phasis added). The prosecution did not, and could not, overcome that presumption here.

As presented to the jury, the restatement was fundamentally misleading. The restatement stemmed from WellCare's desperate attempt to avoid prosecution. And, from all appearances, the contents of the restatement—including its position that payments to Harmony could not qualify as 80/20 expenditures—were dictated by AHCA. *See* pp. 33, 82-83, *supra*. Consequently, the restatement had virtually no *legitimate* probative value. It simply parroted the government's view of the Plans' reporting requirements. It did not offer independent evidence that the prosecution's understanding was correct or that other approaches (such as the Plans' for the years in question) were unreasonable.

But Defendants had no way to convey this critical information to the jury, because the restatement's conclusions were presented through the testimony of an expert who had no knowledge of its preparation. The jury was thus left with the misimpression—which the government repeatedly drove home in closing—that WellCare and its prestigious auditor had disavowed the company's prior 80/20 submissions after a careful and impartial investigation. The restatement was thus considerably more prejudicial than probative, and the district court abused its discretion in admitting it.

In an ordinary case, it would be unthinkable to admit the extrajudicial confession of an alleged co-conspirator without affording the defense an opportunity to show the jury that the confessor faced draconian sanctions and that the authorities dictated the confession. Doing so would plainly violate the Confrontation Clause—let alone the rules of evidence—even if the confession was laundered through an expert who allegedly used it to "confirm" an opinion reached through some other means. The prejudice to Defendants was no less extreme here simply because the confession was made through WellCare's accountants.

C. Introduction of the Restatement's Contents Requires a New Trial

Erroneous introduction of evidence is reversible if "there is a reasonable likelihood that [it] affected the defendant's substantial rights." *United States v. Hands*, 184 F.3d 1322, 1329, *corrected*, 194 F.3d 1186 (11th Cir. 1999). "[T]he government has the burden of establishing that the error was harmless." *United States v. Sweat*, 555 F.3d 1364, 1367 (11th Cir. 2009) (per curiam).

That standard is "difficult for the government to meet," *United States v. Mathenia*, 409 F.3d 1289, 1292 (11th Cir. 2005) (per curiam), and the government has no hope of doing so here. As presented to the jury, without cross-examination, the restatement appeared to be an impartial confession by Defendants' former employer that the 80/20 submissions were false. The jury was left with the mistaken, and highly prejudicial, impression that WellCare and its auditors inde-

pendently concluded that the company had overreported its 80/20 expenditures. That torpedoed Defendants' core position that WellCare's submissions were consistent with an objectively reasonable interpretation of the governing law. It also undercut their defense that they did not subjectively believe the submissions were false. After all, "the more unreasonable the asserted beliefs or misunderstandings are, the more likely the jury will consider them to be nothing more than simple disagreement with known legal duties . . . and will find that the government has carried its burden of proving knowledge." *Cheek v. United States*, 498 U.S. 192, 203-04, 111 S. Ct. 604, 611-12 (1991); *see also United States v. Lankford*, 955 F.2d 1545, 1550-51 (11th Cir. 1992) ("[E]vidence of a belief's reasonableness tends . . . to support a finding that the defendant's belief was held in good faith."). The prosecution amplified that prejudice in summation by repeatedly inviting the jury to treat the restatement's conclusions as evidence of guilt. *See United States v. Marshall*, 173 F.3d 1312, 1318 (11th Cir. 1999); *United States v. Alvarado-Valdez*, 521 F.3d 337, 342 (5th Cir. 2008).

Defendants made a strong case that the 80/20 submissions were reasonable: Government witness after government witness acknowledged that the submissions were consistent with a reasonable understanding of the law. *See* pp. 63-66, *supra*. Had the restatement not been erroneously presented to the jury, it is highly likely

the jury would have accepted that consensus. In light of this clear prejudice, a new trial is warranted.

III. COUNTS 4 AND 5 FAIL TO STATE A HEALTHCARE FALSE-STATEMENTS OFFENSE (BEHRENS ONLY)

Counts 4 and 5 of the Indictment accuse Paul Behrens of making false statements relating to healthcare matters in violation of 18 U.S.C. § 1035. A1 ¶28. But those Counts are devoid of facts. They neither re-allege nor incorporate by reference any allegations elsewhere in the Indictment. They only allege that, in April 2007, Behrens made submissions of "CMH and TCM behavioral health care services expenditure information" for Staywell (Count 4) and HealthEase (Count 5), and that those submissions were "materially false, fictitious, and fraudulent." *Id.* That tracks the language of § 1035. But it fails to allege the "essential facts" establishing a crime. Fed. R. Crim. P. 7(c)(1).

A. The District Court's Refusal To Dismiss Defies Precedent

Under Rule 7, a criminal indictment must contain "a plain, concise, and definite written statement of the essential facts constituting the offense charged." Fed. R. Crim. P. 7(c)(1). "For an indictment to be valid, it must . . . 'sufficiently apprise the defendant of what he must be prepared to meet.'" *United States v. Bobo*, 344 F.3d 1076, 1083 (11th Cir. 2003) (punctuation omitted). "When the indictment uses generic terms, it must state the offense with particularity." *Id.*

In *United States v. Schmitz*, 634 F.3d 1247 (11th Cir. 2011), for example, the indictment included four counts of theft from a federally funded program in violation of 18 U.S.C. § 666(a)(1)(A). *Id.* at 1260. Those "federal-funds" counts alleged that Schmitz had "'embezzle[d], st[olen], *obtain[ed] by fraud* and without authority convert[ed] to her own use, and intentionally misappli[ed]' the salary she received [from the program] over four years." *Id.* at 1257 (emphasis added). Four other counts charged mail fraud and described a "scheme to defraud" the same federally funded program of the same salary. *Id.* at 1256-57.

This Court held that "the allegations of fraud in the federal-funds counts are insufficient because they provide absolutely no factual detail regarding the scheme to defraud." 634 F.3d at 1261. Although the indictment "track[ed]" the statute, "the federal-funds counts allege[d] no facts or circumstances that inform[ed] [the defendant] of these specific charges." *Id.* The Court rejected the government's contention that the federal-funds counts were sufficient "if the indictment is considered as a whole, and given a common-sense construction." *Id.* "[E]ach count of an indictment," the Court explained, "must be regarded as if it were a separate indictment and must stand on its own content without dependence for its own validity on the allegations of any other count not expressly incorporated." *Id.* For facts alleged elsewhere to be read into the charge, "such incorporation must be express," and the government had not done that. *Id.* at 1262. Because the federal-

funds counts by themselves failed to sufficiently allege that Schmitz sought to obtain her salary by fraud, the court vacated Schmitz's convictions on those counts. *Id.* at 1263-64.

Counts 4 and 5 here suffer the same defect. They identify two "[s]ubmission[s] of . . . CMH and TCM behavioral health care services expenditure information" to the AHCA, and assert conclusorily that those submissions were "materially false, fictitious, and fraudulent." A1 ¶28. But neither Count re-alleges or incorporates by reference any other allegations in the Indictment. That stands in stark contrast to the other counts, which incorporate dozens of paragraphs of additional allegations. *See*, *e.g.*, A1 ¶¶29, 31, 33, 35.

The district court recognized the defect. Because "beauty is in the eye of the beholder," it warned, the Indictment's adequacy "may depend on what panel you draw in the Eleventh Circuit." A253 (11:18-20). The court told prosecutors it "d[id not] know why [Counts 4 and 5] didn't incorporate by reference some of [the Indictment's] other paragraphs." A253 (11:20-22). But the district court refused to dismiss because, "if you read *the indictment as a whole*, that's specific enough to describe the charge." A253 (11:16-18) (emphasis added); *see also* A253 (11:25-12:3) ("taking it as a whole, it's sufficient").

That cannot be reconciled with *Schmitz*. Like the counts in *Schmitz*, Counts 4 and 5 do not re-allege or incorporate other paragraphs in the Indictment. As a

result, like the counts in *Schmitz*, each "must stand on its own content without dependence for its own validity on the allegations of any other count." 634 F.3d at 1261; *see United States v. Lang*, 732 F.3d 1246, 1249 (11th Cir. 2013) ("Allegations in one count of an indictment are not automatically incorporated into another; express incorporation is required."). The district court adopted precisely the approach that *Schmitz* rejected—finding adequacy by viewing the "indictment as a whole" even absent express incorporation.

B. Counts 4 and 5 Do Not Allege the Facts Essential to the False-Statements Charges

The alleged falsity of the expenditure submissions charged in Counts 4 and 5 turned on the interpretation of legal requirements and potentially extensive calculations in a complex and unsettled regulatory environment. At trial, the government spent more than three weeks walking through the calculations in West's spreadsheets. In those circumstances, a "definite" statement of the "essential facts constituting the offense charged," Fed. R. Crim. P. 7(c)(1), must include at least *some* indication as to "the specific manner in which the item is alleged to be false," *United States v. McGough*, 510 F.2d 598, 603 (5th Cir. 1975). The government could not indict a public company for filing false financial reports with the SEC (likely involving interpretations of the securities laws) simply by pointing to the bottom line on the company's Form 10-K and claiming it was "false." Without any hint about *which* of the myriad data points and determina-

tions that go into such calculations is improper, such an allegation utterly fails to "inform the accused of the specific offense . . . with which he is charged." *Bobo*, 344 F.3d at 1083.

Yet the prosecution did just that here. Beyond tracking § 1035(a)(2)'s prohibition on false statements, Counts 4 and 5 allege only that "CMH and TCM behavioral health care services expenditure information" submitted for the Plans in April 2007 was "false." A1 ¶ 28. The Counts never describe the Florida Medicaid Program, the purpose of the filings, the 80/20 Statute, the Contracts, templates, or cover letters. They do not identify which (if any) of the data points incorporated into the calculation rendered it false. They do not identify which (if any) methodological choice in performing the calculation was at issue. The government simply labeled the result "false" and left Defendants to guess at everything else.

The ensuing proceedings illustrated precisely the evils Rule 7's definiteness requirement is designed to prevent. Having declined to offer any facts other than an assertion of falsity, the government's theory of falsity gyrated throughout the case, and thus remained a moving target. Having refused to provide the necessary facts in Counts 4 and 5—or in the requested bill of particulars, *see* Dkt. 50; A82—the government does not get another bite at the apple. "The only way to remedy the defects in the indictment would be to rewrite it, and that [this Court] may not

do." *Lang*, 732 F.3d at 1249. Counts 4 and 5 of the Indictment should be dismissed.

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

Over objection, the district court instructed the jury on willful blindness, stating that the jury could find a defendant acted "knowingly" for any charged offense 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); *see* A664 (70:3-17, 74:22-78:4, 78:24-79:10, 80:13-84:10); Dkt. 668 at 1-5; A678 (114:9-117:2); A761 (116:18-117:3). A willful blindness instruction, however, should be given only in "rare cases where . . . there are facts that point in the direction of deliberate ignorance." *United States v. Rivera*, 944 F.2d 1563, 1570 (11th Cir. 1991) (quotation marks omitted). Such instructions create a "danger" that "juries will convict on a basis akin to a standard of negligence: that the defendant *should* have known that the conduct was illegal." *Id.* Here, the issuance of an unwarranted willful blindness instruction did just that.[46]

There was no evidence Defendants: (1) were aware of a high probability their calculations were false; and (2) took deliberate steps to avoid learning they

[46] The instructional error for the fraud count was worse still—it improperly reduced the *mens rea* required to deliberate indifference, which is even lower than willful blindness. *See* Farha Br. 25-33; *Global-Tech Appliances, Inc. v. SEB S.A.*, 131 S. Ct. 2060, 2068 (2011). The willful-blindness error thus affects only the false-statements counts.

were false. *Global-Tech Appliances, Inc. v. SEB S.A.*, 131 S. Ct. 2060, 2070 (2011); *Rivera*, 944 F.2d at 1570-71. The district court believed the instruction was proper if Defendants "deliberately avoided *suing AHCA* to find out the correct construction," or "disclos[ing] their subcapitation" methodology to AHCA "more clearly" so as to prompt an audit or lawsuit. A664 (75:2-4, 76:19-24) (emphasis added). But that is not willful blindness—*i.e.*, averting one's eyes to what is otherwise obvious. *United States v. Hilliard*, 31 F.3d 1509, 1516 (10th Cir. 1994) (reversing conviction where district court gave willful blindness instruction based on failure to seek "legal advice or dialogue" with agency, which "is too close to premising criminal liability upon a reckless disregard for the truth or a negligent failure to inquire"). We acknowledge that this Court has held that a willful-blindness instruction is *per se* harmless if there is sufficient evidence to support a finding of actual knowledge. *United States v. Stone*, 9 F.3d 934, 938-39 (11th Cir. 1993). This Court, however, has recognized that there is a circuit split on that question. *See id.* at 939-40. We therefore assert the argument to preserve it for further review.

V. DEFENDANTS FARHA, BEHRENS, AND KALE PRESERVE THEIR SENTENCING OBJECTIONS IN THE EVENT OF CROSS-APPEAL

The government has filed a notice of cross-appeal, presumably to raise issues about three Defendants' sentences. A930. To the extent the government

seeks resentencing, those Defendants would present the following grounds for this Court's review.

First, the district court erred in its intended-loss calculation. Like actual loss, the calculation of intended loss must "be reduced by" the fair market value of "services rendered, by the defendant or other persons acting jointly with the defendant, to the victim before the offense was detected." U.S.S.G. §2B1.1, cmt. n.3(E)(i). Thus, "'loss' for purposes of §2B1.1(b)(1)" "equals actual loss (or intended loss) minus credits against loss." *United States v. Crowe*, 735 F.3d 1229, 1237 (10th Cir. 2013); *United States v. Brownell*, 495 F.3d 459, 463-64 (7th Cir. 2007). Here, the Plans provided, and Defendants intended the Plans to provide, a wealth of services that count for 80/20 purposes under the Contracts. Defendants are entitled to credit for the fair market value of those services the Plans actually provided. *See* Dkt. 808-1 ¶¶4-5, 8-9 (Dobson Decl.).[47] Moreover, the intended

[47] In *United States v. Massam*, 751 F.3d 1229 (11th Cir. 2014), this Court held that a "credit against loss based on money returned is not available for intended loss *alone*." *Id.* at 1233 (emphasis added); *see id.* ("[A] credit against loss requires a 'victim,' which requires an actual loss, which does not exist when there is *only* intended loss." (emphasis added)). Here, the government argued that there was a victim—AHCA—and that it suffered actual loss. *See* Dkt. 798 at 13 ("[A] conservative estimate of the *actual loss to AHCA* . . . from the defendants' criminal scheme is $23,638,803.") (emphasis added). *Massam* thus does not apply. Moreover, Defendants respectfully submit that *Massam* was incorrectly decided, and—should the government cross-appeal, and should this Court affirm the district court's loss calculation—preserve their right to seek *en banc* review.

loss here would at most be the difference between what Defendants believed *AHCA was entitled to* and the amount the Plans actually refunded, A824 (26:6-27:7, 40:1-5)—not, as the district court supposed, the difference between what Defendants supposedly thought "AHCA expected" and the amount the Plans refunded, A824 (62:25-63:3); *id.* ("what AHCA thought was the correct number").

Second, the enhancement for sophisticated means was unwarranted. The Sentencing Commission has defined "sophisticated means" as "especially complex or especially intricate offense conduct pertaining to the execution or concealment of an offense." U.S.S.G. §2B1.1(b)(9)(C), cmt. n.8(B). The fraud alleged here—while occurring in a complex regulatory context—was simple. Under the government's theory, it involved nothing more than reporting "bogus" numbers—"one of the cleanest, easiest, most straightforward examples of fraud you'll find." A677 (22:20-21, 47:14-22) (government closing); *see id.* at 59:12-60:5 (equating West's conduct in performing the challenged calculations with that of a "monkey . . . pushing buttons").

The district court imposed the sophisticated-means enhancement on the theory that "[t]he use of Harmony to try to hide the refund due to AHCA was tantamount to a shell company," "[e]ven though [Harmony] was a real company." A903 (37:22-38:16); *see* U.S.S.G. §2B1.1(b)(9), cmt. n.8(B) (use of a sham entity can be evidence of sophisticated means). But "a real company" does not become

tantamount to a sham simply because an affiliate allegedly reported a false figure. Under that theory, *any* fraud by an affiliated company would be "sophisticated," regardless of the fraud's complexity. Other fraud cases—the benchmark for determining whether conduct was "especially complex," *see United States v. Mendez*, 420 F. App'x 933, 938 (11th Cir. 2011)—confirm that the conduct alleged here was hardly sophisticated. "In each case in which [the Eleventh Circuit] ha[s] upheld the application of a sophisticated-means enhancement, the defendant used false identities, fraudulent accounts, or fictitious entities to conceal his participation in the scheme or to execute and conceal the fraudulent transactions." *Id.* (collecting cases). None of that occurred here.

CONCLUSION

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

September 19, 2014

Respectfully submitted,

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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 June 26, 2014 because:

   - this brief contains 24,525 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), and

   - all four Appellants' initial briefs in this case contain a total of 53,531 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.

September 19, 2014 /s/ Jeffrey A. Lamken

CERTIFICATE OF SERVICE

I certify that today, September 19, 2014, I electronically filed the foregoing 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, September 19, 2014, I caused seven paper copies of the foregoing to be dispatched to the clerk by Federal Express for delivery within three days.

September 19, 2014 /s/ Jeffrey A. Lamken

ADDENDUM OF RELEVANT STATUTES AND RULES

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1. Section 1035 of Title 18, United States Code (2006), provided:

> (a) Whoever, in any matter involving a health care benefit program, knowingly and willfully—
>
> (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or
>
> (2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry,
>
> in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.
>
> (b) As used in this section, the term "health care benefit program" has the meaning given such term in section 24(b) of this title.

2. Section 1347 of Title 18, United States Code (2006), provided:

> Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—
>
> (1) to defraud any health care benefit program; or
>
> (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,
>
> in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be

fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

3. Federal Rule of Evidence 703 provides:

An expert may base an opinion on facts or data in the case that the expert has been made aware of or personally observed. If experts in the particular field would reasonably rely on those kinds of facts or data in forming an opinion on the subject, they need not be admissible for the opinion to be admitted. But if the facts or data would otherwise be inadmissible, the proponent of the opinion may disclose them to the jury only if their probative value in helping the jury evaluate the opinion substantially outweighs their prejudicial effect.

4. Section 409.912(4)(b), Florida Statutes, provides in relevant part:

(4) The agency may contract with:

* * *

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such entity must be licensed under chapter 624, chapter 636, or chapter 641, or authorized under paragraph (c) or paragraph (d), and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Families shall approve provisions of procurements related to children in the department's care or custody before enrolling such children in a prepaid behavioral health plan. Any

contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities that hold a limited mental health license. Except as provided in subparagraph 5., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211, a provider service network authorized under paragraph (d), or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and are subject to this paragraph. Each entity must offer a sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph must require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations and capitated provider service networks, to be expended for the provision of behavioral health care services. If the managed care plan expends less than 80 percent of the capitation paid for the provision of behavioral health care services, the difference shall be returned to the agency. The agency shall provide the plan with a certification letter indicating the amount of capitation paid during each calendar year for behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.