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 PETER E. CLAY

WILLIAM F. JUNG
PAUL M. SISCO
JUNG & SISCO, P.A.
101 E. Kennedy Blvd., Suite 3920
Tampa, FL 33602
(813) 225-1988

LAWRENCE S. ROBBINS
MARK T. STANCIL
DONALD BURKE
DANIEL N. LERMAN
ROBBINS, RUSSELL, ENGLERT, ORSECK,
UNTEREINER & SAUBER LLP
1801 K Street NW, Suite 411-L
Washington, DC 20006
(202) 775-4500
lrobbins@robbinsrussell.com

September 19, 2014

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

In compliance with Federal Rule of Appellate Procedure 26.1 and Eleventh 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. ("WellCare"), none of the entities listed below is publicly traded. WellCare 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.

Adams, Natalie H., Counsel for United States of America

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

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

Burke, Donald, Counsel for Peter E. Clay

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

Carroll, Catherine M.A., Counsel for Todd S. Farha

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

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

Kale, William L., Defendant-Appellant

Kehoe, Gregory W., Counsel for WellCare Health Plans, Inc.

Krigsman, Cherie L., Counsel for United States of America

Lamken, Jeffrey A., Counsel for Paul L. Behrens

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

Lauro, John F., Counsel for Paul L. Behrens

Matthews, Michael P., Counsel for Paul L. Behrens

McCullough, J. Bradford, Counsel for William L. Kale

Michelich, John A., Counsel for United States of America

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

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

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

Moylan, Daniel P., Counsel for WellCare Health Plans, Inc.

Nathans, Larry Allen, Counsel for William L. Kale

Neiman, Peter G., Counsel for Todd S. Farha

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

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

Olympic Health Management Systems, Inc., Indirect wholly-owned subsidiary of Well Care

O'Neill, Robert E., Counsel for the United States of America

Pattillo Jr., Michael G., Counsel for Paul L. Behrens

Pizzo, Mark A., United States Magistrate Judge

Raleigh, Lisa M., Counsel for Florida Agency for Health Care Administration

Reed, Stanley J., Counsel for William L. Kale

Rhodes, David P., Counsel for United States of America

Robbins, Lawrence S., Counsel for Peter E. Clay

Saltzburg, Stephen A., *Amicus Curiae*

Schoenfeld, Alan E., Counsel for Todd. S. Farha

Sisco, Paul M., Counsel for Peter E. Clay

Sonnett, Neal R., *Amicus Curiae*

Stancil, Mark T., Counsel for Peter E. Clay

Sterling Life Insurance Company, Indirect wholly-owned subsidiary of WellCare

Stith, Kate, *Amicus Curiae*

Totaro, Martin V., Counsel for Paul L. Behrens

Walker, Lucas M., Counsel for Paul L. Behrens

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

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

Titus, Jr., Douglas J., Counsel for Todd S. Farha

Totaro, Martin V., Counsel for Paul L. Behrens

United States of America, Plaintiff-Appellee

Trezevant, Jay G., Counsel for United States of America

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

Vaughan, Laura L., Counsel for Todd S. Farha

Walker, Lucas M., Counsel for Paul L. Behrens

Waxman, Seth P., Counsel for Todd S. Farha

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

Weinberg, Jr., Morris, Counsel for Thaddeus Bereday

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

Wisotsky, Steven, *Amicus Curiae*

/s/ Lawrence S. Robbins
LAWRENCE S. ROBBINS
September 19, 2014

STATEMENT REGARDING ORAL ARGUMENT

Peter Clay requests oral argument. This appeal presents significant legal questions about errors committed over the course of a three-month criminal trial. Clay believes that oral argument will assist the Court in understanding the legal issues, as well as the regulatory and factual context in which they arise.

TABLE OF CONTENTS

Page

TABLE OF CONTENTS—Cont'd

Page

TABLE OF AUTHORITIES

Page(s)

Cases

TABLE OF AUTHORITIES—Cont'd

Page(s)

TABLE OF AUTHORITIES—Cont'd

Page(s)

Statutes

TABLE OF AUTHORITIES—Cont'd

Page(s)

Miscellaneous

STATEMENT REGARDING ADOPTION OF BRIEFS

Peter Clay adopts the following portions of other briefs filed in this case:

- Brief for Defendant-Appellant Paul L. Behrens
  - "Statement Of The Case" (pp. 6-44)
  - "Defendants' Convictions Should Be Reversed For Lack Of Falsity Under *Whiteside*" (pp. 48-81)
  - "The Government's Use Of WellCare's Financial Restatement Constitutes Prejudicial Error" (pp. 81-97)
  - "The Willful Blindness Instruction Was Error" (pp. 102-03)
- Brief for Defendant-Appellant Todd S. Farha
  - "The Admission And Use Of The Wealth Evidence Was Reversible Error" (pp. 33-45)

PRELIMINARY STATEMENT

Peter Clay joined WellCare in 2005, long after the company had begun using payments to its Harmony subsidiary for 80/20 purposes.[1] He worked on only two of the submissions to AHCA at issue in this case: the 80/20 submissions for calendar year ("CY") 2005; and the submission of so-called "encounter data"—WellCare's individual claims for behavioral health services—provided in February 2007.

Notwithstanding Clay's brief tenure at the company, and his even more limited participation in the challenged submissions, the government charged Clay, along with his codefendants, with nine counts alleging a wide-ranging scheme to defraud AHCA. The jury, however, did not convict Clay on a single one of those counts. Instead, Clay was convicted only on Counts 10 and 11, which charged him with making false statements to investigating agents, in violation of 18 U.S.C. § 1001, during an informal interview on the day they raided WellCare's offices. That interview was a classic (albeit fruitless) "perjury trap": Having surreptitiously gathered hundreds of hours of audio and video tapes of WellCare's internal meetings, the agents came to the interview with scripted questions designed to see if Clay would contradict his previously taped statements.

[1] This brief focuses solely on Clay's counts of convictions. It assumes familiarity with the terminology in the Brief for Defendant-Appellant Paul L. Behrens (the "Behrens Brief") and is intended to be read only after reading that brief.

The agents were surely disappointed. Clay freely volunteered that WellCare had used the Harmony payments for 80/20 reporting purposes and that there was an ongoing debate between WellCare and AHCA about expense-reporting issues. Clay thus *disclosed* to the agents what prosecutors would later allege to be the core of Defendants' scheme to defraud. At the same time, however, Clay rejected the *legal* conclusions that the government attached to WellCare's reporting practices—namely, that the 80/20 expenditures were "over-reported" and that the encounter pricing data were "inflated."

Nonetheless, the government charged those two utterances—statements about the legal implications of WellCare's reporting—as criminal false statements. Count 10 accused Clay of lying when he told the two investigators that WellCare had not "over-reported" behavioral health expenditures in order to reduce rebates owed to AHCA. Count 11 alleged that Clay lied when he stated that WellCare had not "inflated" the costs associated with encounter data. The jury convicted Clay on both counts.

Those convictions were flawed on numerous grounds. First, neither of Clay's statements was false under *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002). Both statements implicated an interpretive question of law (*i.e.*, according to what legal standards were the Plans' expenses "over-reported" and their encounter data pricing "inflated"?). Under *Whiteside*, the statements could be

criminal falsehoods only if they were false under *every* reasonable understanding of the law. See *id.* at 1351. But both statements were consistent with reasonable understandings of the governing law.

Moreover, the government failed to prove Section 1001's willfulness element. As the jury was instructed, and as the United States has recently acknowledged, that element required proof that Clay understood that his conduct constituted a criminal offense. The government introduced no proof—literally none—on this score.

Finally, the government failed to prove materiality. Given Clay's disclosure of the core features of the alleged fraud, it is hard to see how the government *could* have shown that Clay's conclusory statements were material. In any event, the government did not do so.

There were also serious evidentiary and instructional errors that warrant at least a new trial. As to Count 10, the district court erred by allowing the contents of WellCare's restatement to be presented to the jury. As to Count 11, the district court erred by directing the jury to the wrong benchmark—the "80/20 templates," instead of the separate template that actually governed the encounter submissions—in evaluating Clay's *Whiteside* defense.

JURISDICTIONAL STATEMENT

Clay appeals from a final judgment of conviction entered on May 19, 2014, in the United States District Court for the Middle District of Florida. A895.[2] Notice of appeal was timely filed on May 28, 2014. A901. This Court has jurisdiction under 28 U.S.C. § 1291.

ISSUES PRESENTED FOR REVIEW

1. Whether Clay's convictions should be reversed because—

(a) the government failed to prove that either charged statement was false within the meaning of *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002);

(b) the government failed to prove that Clay knew that his conduct was unlawful; and

(c) Clay's disclosure to the agents of the core mechanism of the alleged scheme to defraud negated the element of materiality.

2. Whether a new trial is warranted due to—

(a) the erroneous presentation of WellCare's financial restatement, which prejudiced the defense to Count 10; and

(b) an erroneous jury instruction directing the jury to the wrong source of law in evaluating the falsity of the statement charged in Count 11.

---

[2] Record materials cited in this brief with the "A___" convention are included in Defendants' Joint Appendix. Citations refer to the district court docket number, prefaced by "A." Trial-court briefs cited herein are not included in the Appendix and are referenced by their district court docket numbers ("Dkt.")

STATEMENT OF THE CASE

A. Factual Background

Peter Clay joined WellCare as Vice President of Medical Economics on April 25, 2005, well after WellCare had formed Harmony, and after the WellCare Plans (Staywell and HealthEase) had filed their first 80/20 submissions treating Harmony subcapitation payments as an allowable expenditure. A751 (18:4-10); A562 (63:9-11); A699 (GX-0319.0001); A699 (GX-1062.0001).[3] During his brief tenure at WellCare, Clay worked on only a single year's 80/20 submissions, CY2005. The government's primary witness, Greg West, confirmed that Clay played no role at all in the CY2006 filings. See A491 (10:19-20); A507 (87:14-24); A537 (103:17-104:1).

The jury ultimately rejected the bulk of the government's case against Clay, acquitting or hanging on Counts 1-9 of the indictment, which charged a conspiracy to defraud AHCA and healthcare fraud and healthcare false-statement offenses based on the Plans' submissions to AHCA. Thus, unlike his codefendants, Clay was not convicted of any offense charging execution of a scheme to defraud AHCA. Clay was instead convicted only on Counts 10 and 11, which charged that

[3] Trial exhibits are included in Defendants' Joint Appendix following the district court docket numbers for the parties' final trial exhibit lists. Accordingly, all government exhibits ("GX") follow Dkt. 699; all defense exhibits ("D_") follow Dkt. 700.

he made false statements, in violation of 18 U.S.C. § 1001, to federal investigators who interviewed him as they served a search warrant on WellCare's offices.

1. Clay's Interview With Federal Agents

When federal law enforcement raided WellCare's offices on October 24, 2007, two agents interviewed Clay. HHS Agent Blair Johnston, one of those agents, testified at trial. He explained that Clay had voluntarily agreed to an unsworn, uncounseled interview and had answered every question put to him. A752 (58:19-23, 70:15-17).

During this wide-ranging interview, Clay disclosed WellCare's use of Harmony for 80/20 purposes. In particular, he volunteered that, in WellCare's view, "Harmony's charge to Staywell and HealthEase at 80 percent or higher under a fixed price contract is enough to meet the 80 percent rule on the 80/20 report." A752 (80:18-21). And when asked whether WellCare's submissions had included non-allowable administrative or outpatient expenses, Clay freely acknowledged that, in his view, "there ha[d] been an ongoing debate between WellCare and AHCA over the definition of an allowable expense." *Id.* at 83:11-13. Thus, Clay affirmatively disclosed that WellCare included payments to Harmony in calculating the Plans' behavioral health expenditures, and alerted the agents to an ongoing debate between WellCare and AHCA over the proper interpretation of the 80/20 Statute.

Clay also made the two statements on which he was convicted. When asked whether the WellCare Plans had "over-reported" their expenditures to reduce their 80/20 refunds, Clay answered that, to his knowledge, they had not. A752 (61:3-11). The government would later allege, in Count 10 of the indictment, that this statement was false because Clay knew that the Plans' CY2005 expenditures had been over-reported. A1 at 21. And when the agents asked whether the Plans had purposely "inflated" the costs associated with their behavioral health encounter data, Clay again answered, "not to his knowledge." A752 (61:23-62:4). Count 11 of the indictment would later allege that this statement was false because Clay knew that the Plans had purposely inflated those costs in a February 2007 submission of encounter data to AHCA. A1 at 22.

2. Clay's Continuing Cooperation With Investigators

In the months following the government's raid, Clay met at least eight times with lawyers conducting an internal investigation for WellCare's Special Committee. A562 (67:5-10). The government later offered some of Clay's statements through the testimony of Davis Polk & Wardwell attorney Thomas Ogden.

During these meetings, Clay again disclosed WellCare's use of Harmony when reporting expenditures under the 80/20 Statute. A562 (49:2-5). Clay also acknowledged that, in his first several months at WellCare, he had developed

concerns over the way the company was using Harmony to meet its 80/20 obligations. *Ibid.* But Clay explained that two of his superiors at WellCare—Thad Bereday, the company's general counsel, and Marc Ryan, its vice president for government relations—had assured him that WellCare's use of Harmony was appropriate and legal. *Id.* at 49:8-10.[4] They told him that Harmony functioned like other, concededly proper, third-party behavioral health organizations. *Id.* 49:10-12.[5]

3. The Plans' Underlying Submissions

As noted above, the false statements charged in Counts 10 and 11 pertained to two sets of submissions the WellCare Plans had made to AHCA.

a. Count 10 pertained to the Plans' CY2005 80/20 expenditure submissions, which were submitted in June 2006.[6] In April 2006, AHCA sent each Plan a

[4] In offering these assurances to Clay, Bereday and Ryan echoed advice WellCare itself had received from expert outside counsel. See Behrens Br. at 39-40, 63-64.

[5] In addition to Ogden's testimony, the government introduced tape-recorded statements in which Clay, despite having been assured by counsel that the Plans' 80/20 approach was *legally* permissible, expressed concerns that AHCA might nonetheless disagree with that approach because it resulted in what he regarded as "huge" (A531 (81:3)) profit at the Harmony level that was "hid[den]" from AHCA (*id.* at 84:5). See also *id.* at 108:25 (likening the prospect of submitting data showing high Harmony profits to "opening the Kimono"). In the same recorded conversation, Clay insisted that WellCare provide a "defensible" response to the AHCA data request under discussion. A532 (27:16).

[6] There were no changes relevant to the Plans' 80/20 obligations between the contracts in force at the time of the CY2005 submissions (the 2004-2006 contracts)

template and accompanying cover letter for the CY2005 80/20 calculation. See, *e.g.*, A699 (GX-0500); A699 (GX-0501). The 80/20 template and cover letter were identical in all relevant respects to the documents sent by AHCA for the Plans' CY2006 reports (discussed in the Behrens Brief). See Behrens Br. at 23-27.[7]

The Plans included two basic categories of expenditures in their CY2005 80/20 reports. For two administrative areas of the State, the Plans included the outpatient portion of the subcapitation paid to Harmony. For other areas, the Plans reported outpatient fee-for-service claims—*i.e.*, amounts paid to clinicians for behavioral health services. The Plans included the fee-for-service component in their reported expenses because HealthEase and Staywell had only recently begun to offer outpatient services in these areas, and the Plans' contracts with Harmony had not yet been amended so that the subcapitation rates would reflect this added responsibility (and these additional costs). See A541 (9:10-13, 10:21-11:2, 17:11-18:11). Significantly, however, after including these two categories of expenditures, the Plans then *reduced* their expenditure totals by approximately $5.4 million. That reduction represented the difference between the outpatient behavioral health premium AHCA reported on the CY2005 80/20 templates as

---

and the 2006-2009 contracts that are cited in the Behrens Brief. See Behrens Br. at 10-12.

[7] Unlike the CY2006 cover letter, the CY2005 letter did not list certain "additional procedure codes." A699 (GX-0600); see also Behrens Br. at 26-27. That distinction is not material to the issues raised here.

having been paid to the Plans, and the premium that Greg West had anticipated based on rates AHCA published on its website. See A533 (100:5-101:14); A757 (110:24-111:3); see also Behrens Br. at 25-26. By reducing their reported expenditures, the Plans resolved this premium difference in AHCA's favor—that is, in a way that increased the payback the Plans made to AHCA.

b. Count 11 pertained to the Plans' submission of "encounter data" to AHCA in February 2007. Unlike the Plans' annual 80/20 submissions, which reported *aggregate* expenditure amounts for the provision of behavioral health over the course of a year, encounter data refers to data files documenting *individual* services provided to Medicaid recipients. See A465 (106:5-14); A531 (34:7-35:18).

Under their contracts with AHCA, the Plans were required to maintain encounter data and submit it to AHCA when requested. A699 (GX-3305.0224). To guide the Plans' submissions, the contracts included a template (the "Encounter Template") directing that each encounter data entry include, *e.g.*, the date of the service, identification codes for the recipient of the services and the provider, and codes designating the procedures performed. A699 (GX-3305.0299). The Encounter Template also included an "[o]ptional" field for "Amount Paid," which was broadly defined as the "[c]osts associated with the claim." *Ibid.*

In January 2007, AHCA sent the Plans a request for behavioral health encounter data, noting that the requested data would be used to facilitate AHCA's rate-setting for future premiums. See A699 (GX-0855.1a.0001). AHCA's request enclosed a copy of the Encounter Template that was identical to the one contained in the Plans' Medicaid Contracts. A699 (GX-0855.1a.0002).

In response, WellCare decided to include the optional field for "Amount Paid." See A757 (27:2-6). But the process of allocating costs to individual claims—"pricing" the encounters, in industry parlance—posed a challenge for WellCare. AHCA's requests were explicitly directed to the Plans. See A699 (GX-0855.1a.0001). But because the Plans had sub-contracted with Harmony and paid Harmony a fixed per-month subcapitation, the Plans' expenditures were for *all* covered services in the aggregate; there was no incremental cost to the Plans for each individual claim funded by the Harmony subcapitation. To carry out the Encounter Template's instruction, therefore, the Plans needed a way to allocate the Harmony subcapitation to the individual services provided to their enrollees through Harmony.

AHCA offered instructions to WellCare in approaching this task. In October 2006, and again in January 2007, WellCare employee Robert Butler—the Company's Director of Medicaid Policy Analytics, and formerly the Bureau Chief

of AHCA's Medicaid Program Analysis—sent his colleagues an e-mail recounting a conversation he had had with AHCA official Ralph Quinn:

> Good news from AHCA regarding encounter pricing of our mental health encounters.
>
> Per Ralph Quinn, he recommends (not just condones) unbundling our payments and determining/allocating to the encounters submitted based upon the actual costs to us. He is interested in seeing what the actual costs are to us of providing the services – and this would accomplish that goal. I think we could do this for all cap and bundled rates that are not paid FFS [fee-for-service].
>
> He also recommended pricing our encounters from Harmony with this same methodology. He may consider adding a field to the minimum data set that denotes an entity as a related party, but was clear that he thinks the encounters should be priced.

A699 (GX-0848); A699 (GX-0853).

Butler later explained Quinn's message at a January 16, 2007, internal WellCare meeting, which Clay attended. Butler stated that he had "cleared with the state" a "pricing methodology" that would base the Plans' encounter prices on the subcapitations they had paid to Harmony. A531 (57:6-7). Butler emphasized that AHCA "want[ed] to know *what we pay* for services"—that is, *the Plans'* costs associated with the claims, not just the amount paid out by Harmony. *Id.* at 57:7-8 (emphasis added). He explained that "the state is okay with us allocating, the cap payments onto those claims … because that is what we paid out." *Id.* at 57:16-19. And Butler added that, when he disclosed to Quinn that Harmony was a related entity, Quinn responded: "[Y]eah, price them." A532 (28:1).

Adopting the methodology Quinn had suggested, the Plans allocated their subcapitation payments to the individual services funded by those payments, based on the relative cost of each underlying service provided to patients. A532 (42:15-43:8).[8]

4. The Charges And Proceedings Below

As noted above, Clay was not convicted on any of the charges alleging conspiracy, healthcare false statements, and healthcare fraud (Counts 1-9). Clay was convicted only on Counts 10 and 11, which alleged that he made false statements to the federal agents during the interview on the day of the government's raid, in violation of 18 U.S.C. § 1001(a)(2). Count 10 covered Clay's statement that, to his knowledge, the Plans had not "over-reported" their expenditures to reduce the refunds paid to AHCA. Count 11 covered Clay's statement that, as far as he knew, the Plans had not purposely "inflated" the costs associated with encounter data submissions to AHCA.

[8] Determining the relative cost of each service posed its own challenges, because Harmony itself paid some downstream providers on a capitated basis. WellCare therefore used the prices set forth in Florida's Medicaid fee schedule as a proxy for the cost of each service provided. See A532 (42:15-20). To arrive at the costs "associated with each claim," WellCare then took the total amount that the Plans paid Harmony and allocated those aggregate costs to each service in proportion to either the fee-for-service or Medicaid fee-schedule price for that service (depending on whether Harmony paid the provider on a fee-for-service or capitated basis, respectively). *Id.* at 42:22-25; A649 (80:10-14).

The district court imposed a sentence of five years' probation, within the Guidelines range, and a fine of $10,000. A903 (109:8-110:3).[9]

B. Standards Of Review

This Court reviews de novo challenges to the sufficiency of the evidence, reversing if the government failed to introduce evidence from which a reasonable jury could find the defendant guilty beyond a reasonable doubt. See, *e.g.*, *United States v. Walker*, 490 F.3d 1282, 1296 (11th Cir. 2007).

Challenges to the admission of evidence receive abuse-of-discretion review. See, *e.g.*, *United States v. Dudley*, 102 F.3d 1184, 1186 (11th Cir. 1997).

Jury instructions are reviewed "*de novo* to determine whether the instructions misstated the law or misled the jury to the prejudice of the objecting party." *United States v. House*, 684 F.3d 1173, 1196 (11th Cir. 2012).

SUMMARY OF ARGUMENT

I. Both counts of conviction should be reversed because the government did not prove violations of Section 1001.

A. The government failed to show that either of the two charged statements was false. Because the truth or falsity of the statements depended on interpretive

[9] Finding that Clay's statements to the agents had been made after the alleged conspiracy had terminated, the district court concluded that Clay's offenses did not cause, and were not intended to cause, any pecuniary loss. A824 (63:16-19). The district court's calculation under the Sentencing Guidelines therefore produced an advisory range of zero to six months' imprisonment. A903 (99:13-22). The government has not appealed the loss finding or sentence with respect to Clay.

questions of law, under *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002), the charged statements could be criminal falsehoods only if they were false under *every* reasonable understanding of the law. See *id.* at 1351. They were not.

1. To prove falsity on Count 10, the government had to show that the expenditures reported in the Plans' CY2005 80/20 submissions were, in fact, "over-reported" under every reasonable understanding of the governing law. The government failed to do so. As the Behrens Brief explains, it was reasonable for the Plans to include the Harmony subcapitation payments as reportable expenditures. And given the Plans' decision to *reduce* their reported expenditures for CY2005 by roughly $5.4 million, the government had to prove that any *remaining* portion of the reported expenses, even if (arguendo) disallowable, *outweighed* this $5.4 million reduction. Without any such proof, the government failed to show that the Plans "over-reported" their total expenses in CY2005, and thus failed to prove that Clay's statement was false.

2. The government likewise failed to prove falsity on Count 11. The statement charged in that count was criminally false only if WellCare's encounter data pricing was "inflated" under every reasonable understanding of the governing law. The benchmark for pricing encounters was the Encounter Template, which instructed the Plans to report "costs associated with" claims. The Plans complied with that instruction by allocating the subcapitation payments they paid to

Harmony across the services funded by those payments. No statute, regulation, or contractual provision precluded that approach. To the contrary, in addition to the plain language of the Encounter Template, both AHCA's specific requests to the Plans and the uniform testimony of the witnesses supported the Plans' pricing methodology.

B. Section 1001 requires proof that the defendant acted "knowingly and willfully." As the district court correctly instructed the jury (at the government's urging), to prove willfulness the government had to show that Clay knew that his conduct was unlawful.

But the government offered no proof that Clay knew that making false statements in an unsworn, informal interview like this would be a crime. Clay's convictions thus rest on a conclusive *presumption* that all persons know that lying to federal law enforcement officers is a crime, regardless of the context. Such a presumption would read the willfulness element out of the statute. It would also blink reality: Far from being obvious to any layperson, the broad sweep of Section 1001 is highly counterintuitive—particularly as applied here. As this case demonstrates, interviews with law enforcement agents often occur in informal circumstances that do not alert the defendant that a false answer is criminal. The Model Penal Code and the criminal codes of at least 12 States do not generally criminalize unsworn false oral statements to law enforcement officers,

undermining any suggestion that knowledge of Section 1001's criminal prohibition is pervasive.

And that is especially true here, where Clay disclosed to the agents the *core mechanic* of the fraud alleged by the government. To be sure, Clay resisted the government's legal labels—refusing to concede that the CY2005 80/20 submissions were "over-reported" or that the February 2007 encounter data pricing was "inflated." But in the context of a much longer interview in which Clay also disclosed to the agents what the prosecution would later allege to be the gravamen of a fraud, it defies common sense to presume that a layperson must know that a denial of "over-reporting" or "inflating" would be a crime.

C. To prove materiality under Section 1001, the government had to show that Clay's statements could influence a government function. Materiality requires *proof*, which must be measured in context. Here, the context shows that Clay's statements could have had no such effect, and the government made no showing that Clay's statements could have influenced the investigation. That failure is unsurprising, because Clay's interview *disclosed* the core allegations upon which the government would later frame this case.

II. If the counts of conviction are not dismissed outright, evidentiary and instructional errors warrant a new trial.

A. The district court erroneously allowed the government to present the contents of WellCare's financial restatement through its expert. That evidence—which conveyed the false impression that WellCare (and its outside auditors) had conceded the falsity of the 80/20 submissions after an impartial evaluation—severely prejudiced Clay's defense on Count 10.

B. The district court also erred by instructing the jury that Clay's *Whiteside* defense to Count 11 should be assessed against AHCA's 80/20 Template. The 80/20 Templates applied *only* to the reporting of 80/20 expenses. But Count 11 charged that Clay had falsely denied inflation of costs in WellCare's *encounter data* submissions, which were governed by the Encounter Template—a distinct document with its own set of requirements. Had the jury not been directed to the wrong template, it could readily have found (and almost surely would have found) that WellCare's encounter reporting was accurate, and thus that Clay's statement in Count 11 was true.

ARGUMENT

I. Both Counts Of Conviction Should Be Reversed Because The Government Did Not Prove Violations Of Section 1001

This Court has held that Section 1001 contains five elements: "(1) a statement, (2) falsity, (3) materiality, (4) specific intent, and (5) agency jurisdiction." *United States v. Lawson*, 809 F.2d 1514, 1517 (11th Cir. 1987). In addition, because Section 1001 prohibits making false statements "knowingly and

willfully," the government must show that the defendant knew that his conduct was unlawful. See pp. 30-32, *infra*.

In this case, the government fell short on at least three elements. First, neither of the charged statements was false under *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002). Second, the government introduced no evidence at all—none—that Clay knew that his conduct was unlawful. Finally, the government failed to prove that Clay's statements were material.

A. The Government Failed To Prove Falsity

Whiteside held that, where the truth of a statement turns "on an interpretive question of law, the government bears the burden of proving beyond a reasonable doubt that the defendant's statement [was] not true under a reasonable interpretation of the law." 285 F.3d at 1351. In other words, the government must prove that there is *no* reasonable understanding of the law under which the defendant's statement would be true.

Both Count 10 and Count 11 presented paradigmatic interpretive questions of law within the meaning of *Whiteside*. On Count 10, to prove that Clay's denial of "over-report[ing]" was false, the government had to prove that the expenditures reported in the Plans' CY2005 submissions exceeded the amounts that the Plans were legally obligated to report. On Count 11, to prove that Clay had falsely denied that WellCare's encounter data pricing was "inflated," the government had

to prove that, under every reasonable interpretation of the encounter materials, the pricing should have been lower. The government's proof fell short on both counts.

1. Clay's Denial Of Over-Reporting Of 80/20 Expenditures Was Not False

The government failed to show that the Plans had "over-reported" their expenditures in their CY2005 80/20 submissions, for the same reasons set forth in the Behrens Brief with respect to the CY2006 submissions. See Behrens Br. at 48-81. Indeed, the government acknowledged below that, if the *Whiteside* challenge with respect to the CY2006 submissions is valid, then so too is Clay's *Whiteside* challenge to Count 10. See Dkt. 857 at 52 (noting that "Clay's argument under *Whiteside* is not uniquely different from those of his co-defendants").

Neither of the two components of the CY2005 80/20 submissions was "over-reported." As the Behrens Brief explains (at 48-81), the Plans' inclusion of the Harmony subcapitation was not false within the meaning of *Whiteside*. Those arguments apply equally to CY2005. As a matter of law, the inclusion of the Harmony subcapitation could not be the source of any "over-report[ing]."

That leaves only the fee-for-service component of the CY2005 80/20 submission. Here, the government contended that the Plans impermissibly counted certain fee-for-service expenses that had not been billed under specific procedure codes identified by AHCA in the cover letter accompanying the CY2005 80/20 templates. As the Behrens Brief explains, however, the Plans were not

unreasonable in construing the governing legal materials to impose no such "codes only" limitation. See Behrens Br. at 70-72. As a result, any failure to comply with the government's "codes only" limitation could not, as a matter of law, constitute "over-report[ing]."

But for CY2005, there is a second dispositive reason why the government's proof fell short: In that year, the Plans *reduced* their reported expenditures by approximately $5.4 million as a result of a premium discrepancy that AHCA chose not to disclose to all of the plans in the industry. See A533 (100:5-101:14); A757 (110:24-111:3); see also Behrens Br. at 25-26. Thus, to prove that the Plans "over-reported" their CY2005 expenses, the government had to show that the amount of any excess in the fee-for-service component (due to the "codes only" limitation, or anything else) *outweighed this $5.4 million reduction*. It failed to do so. And without such evidence, the jury could not permissibly find that the Plans' total expenditure amounts—the only thing Clay discussed in his interview with the agents—were "over-reported."[10]

[10] In addition, if this Court agrees that it was permissible under *Whiteside* to use the Harmony subcapitation for 80/20 purposes, Clay would be entitled, at the very least, to a new trial on Count 10. There is a substantial risk that the jury convicted on Count 10 based on the legally erroneous theory that the subcapitation component, standing alone, constituted an "over-reporting" of expenses. See *Yates v. United States*, 354 U.S. 298, 311-12, 77 S. Ct. 1064, 1173 (1957).

2. Clay's Denial Of "Inflated" Encounter Pricing Was Not False

To prove falsity under Count 11, the government had to show that the costs included in the February 2007 encounter submission were in fact "inflated" under every reasonable interpretation of the law governing encounter pricing. "Inflated" is a *relative* term: Encounter pricing cannot be "inflated" except in comparison to how the encounters were *supposed* to be priced. Here, the benchmark for encounter pricing was contained in the Encounter Template, which defined the "[a]mount [p]aid" for each encounter as the "[c]osts *associated with* the claim." A699 (GX-0855.1a.0002) (emphasis added).

The question under *Whiteside* is whether AHCA's request for the costs "associated with" the claim required WellCare to report the Plans' costs (*i.e.*, what the Plans paid Harmony), or just the amount that Harmony paid directly to physicians. "[T]he words 'associated with' are extremely broad; they are not words of limitation." *Constellation Power Source, Inc. v. Select Energy, Inc.*, 467 F. Supp. 2d 187, 206 (D. Conn. 2006). And AHCA's request for encounter pricing was addressed to the Plans, not to Harmony. The Plans thus reasonably understood that, in order to report the costs "associated with" each claim, they were required to include *all* the Plans' costs connected to each encounter—costs covering the full panoply of behavioral health services offered by Harmony and paid for by the Plans. So that is exactly what the company did: It took the subcapitation that the

Plans paid to Harmony and allocated those expenses across all encounters based on the relative cost of each service. See p. 13, *supra*. Accordingly, the Encounter Template's plain meaning confirms that WellCare's encounter pricing was not "inflated."

There was much more evidence to the same effect. Indeed, AHCA specifically *requested* the Plans to report their own costs, including their subcapitation payments to Harmony. In October 2006, and then again in January 2007, WellCare employee Robert Butler memorialized this request from AHCA in emails to his colleagues. Butler recounted that AHCA official Ralph Quinn had "recommend[ed] (not just condone[d]) unbundling our payments and determining/allocating to the encounters submitted based upon the actual costs to us." A699 (GX-0848); A699 (GX-0853). Butler explained that, by allocating capitation payments over the services they funded, this approach would report to AHCA what Butler called "the actual costs … to us of providing the services," which is what Quinn was "interested in seeing." *Ibid.* And Butler made clear that Quinn "recommended pricing our encounters from Harmony with this same methodology." *Ibid.*

At the January 16, 2007, meeting on WellCare's encounter data options, which Clay attended, Butler reaffirmed that he had "cleared with the state" WellCare's encounter "pricing methodology." A531 (57:6-7). Butler explained

that AHCA "want[ed] to know *what we pay* for services"—that is, *the Plans'* costs "associated" with the claims, not just the amount paid out by Harmony. *Id.* at 57:7-8 (emphasis added). He noted that "the state is okay with us allocating, the cap payments onto those claims … because that is what we paid out." *Id.* at 57:16-19. And Butler was clear that Quinn had recommended this approach even after he was informed that Harmony was a related entity. A532 (27:23-28:3).[11]

AHCA's specific request confirmed that AHCA did not seek merely the costs billed by the physician (or paid out by Harmony), but instead the "actual costs" of the Plans. And it made clear that, to determine those "actual costs," the Plans should "allocate[]" or "unbundl[e]" their costs not only when Harmony paid a capitation to downstream providers (by allocating the capitation across all services provided by the clinician) but should also account for the capitations paid by the Plans to Harmony (which covered case management, utilization review, and other services). That is precisely the approach WellCare employed.

The testimony of defense expert Dr. Henry Miller—the only expert who testified about the pricing issue—also supported the reasonableness of the

[11] In the cover letter sent with its February 9, 2007, submission, WellCare again informed AHCA that "[m]ental health encounters have been priced based upon *the plans'* arrangements for behavioral health services, including those paid on a capitated basis." A700 (D_2188) (emphasis added). Government witness Imtiaz Sattaur, who signed the cover letter, explained that this statement disclosed to AHCA that the encounters had "been paid based upon the capitated amount of monies that have been sent over from the Florida health plan into the Harmony Behavioral Health company." A588 (12:23-13:1).

encounter submission. As he explained, reporting only the amounts Harmony paid out would capture "just what the physician or other provider received," rather than "all of the costs associated with the claim," as AHCA had requested. A649 (84:17-20). The true costs "associated" with the claim were "the costs that *Staywell and HealthEase* incur to provide behavioral health services"—*i.e.*, "the amount that they pay to Harmony." *Id.* at 79:12-14 (emphasis added). Harmony provided—and the Plans paid for—services "associated with" those provided by the physician, including review, case management, and quality-improvement, all of which was "part of the cost of the encounter itself." *Id.* at 79:19-23. Accordingly, Miller testified that WellCare's encounter pricing was not only "reasonable" (*id.* at 89:4) and "submitted appropriately" (*id.* at 82:21), but was in fact "the way it's done throughout the industry" (A663 (24:15-16)).

The government's own witnesses agreed. Michael Turrell, WellCare's former Vice President of Corporate Compliance and Regulatory Affairs, testified that, if the encounter prices included only what Harmony paid to physicians (rather than what the Plans paid Harmony), that amount would *not* "reflect the total costs that the [Plans] incur for the provision of those services," because the Plans incur "additional costs" to provide those services. A559 (125:2-9). And Greg West acknowledged "at least two alternative" methods to price encounters, including the

one adopted by WellCare—*i.e.*, "look[ing] at pricing encounter data from the HMO level, what Staywell and HealthEase pay to Harmony." A756 (35:14-21).

Significantly, the government's expert, Harvey Kelly, did not even *address* WellCare's encounter submission—much less opine that WellCare's encounter pricing was clearly contrary to law or objectively unreasonable. In *Whiteside*, the court reasoned that disagreement among experts on the validity of a legal interpretation "lends credence to defendants' argument that their interpretation was not unreasonable." *Whiteside*, 285 F.3d at 1352-53. Here, witnesses for both sides *agreed* that WellCare's interpretation of "costs associated with the claim" was reasonable.

The government, moreover, failed to identify any "regulation, administrative ruling, or judicial decision" that "clearly" precludes the Plans' approach. *Whiteside*, 285 F.3d at 1352. To the contrary, every witness to address the issue testified that there were no written directions on pricing encounters (apart from the plain language of the Encounter Template). For example, West acknowledged that there was "no one method for valuing or pricing encounter data" and that AHCA never identified "a particular method to calculate or price encounter data." A541 (129:9-16). Defense expert Miller testified that AHCA did not "set forth a specific methodology for pricing encounter data." A649 (73:9-11). And AHCA's own David Starn agreed that "AHCA never defined with specificity how the industry

should provide [encounter] information." A585 (76:5-7). With *no law* governing encounter pricing, there could not be any law "clearly" barring WellCare's approach. *Whiteside*, 285 F.3d at 1352.

In the face of all the evidence confirming that the encounter pricing was not "inflated," the government has invoked two pieces of (supposedly) contradictory proof. First, the government cited Clay's use of the word "inflated" in discussing encounter pricing during a videotaped meeting on January 29, 2007. But even if the government were interpreting that remark correctly, it would not make a difference. For *Whiteside* purposes, what Clay *said* or *believed* about encounter pricing is beside the point. *Whiteside* sets an *objective* standard—it asks whether Clay's statement to the interviewing agents was false under every *objectively* reasonable reading of the underlying legal standard. See 285 F.3d at 1353; see also Behrens Br. at 75-77. Thus, whatever Clay subjectively believed, AHCA asked for all costs "associated with the claim." As shown above, that is just what the company submitted. Even if Clay subjectively thought the encounter pricing was "inflated," his belief would not change the fact that the encounter submissions were consistent with an *objectively* reasonable understanding of the legal requirements.

In any event, the context belies the government's characterization of Clay's comment. AHCA had informed WellCare that the February 2007 encounter data

would be used as one input in a rate-setting analysis for premium rates in future years. A699 (GX-0855.1a.0001). Clay therefore asked his subordinates to prepare charts summarizing the planned encounter submissions, and in the course of reviewing one such chart Clay observed that, "now it's just a matter of how inflated a unit cost number we're going to be submitting here." A532 (68:5-6). A few moments later, Clay emphasized that his subordinate should answer what he called "the next step, which is how that unit cost compares to the state Medicaid fee schedule. How different is that unit cost[?]" *Id.* at 68:23-25.

In other words, Clay wanted to see how the encounter costs WellCare planned to report compared to the prices for equivalent services set forth in Florida's Medicaid fee schedule, which established reimbursement rates for the State's fee-for-service Medicaid program. Clay understood that the Medicaid rates—although not the legal standard for WellCare's encounter pricing—would nevertheless influence AHCA's negotiating position because they would reflect "what the state is going to think is a reasonable dollars [per] encounter." A532 (70:23-24). Clay therefore wanted to know the percentage difference—the "inflat[ion]"—between WellCare's prices and the State's fee schedule. That is the sense in which he used the word "inflated."

Clay's interview with the agents, however, took place in a very different context. Anyone in Clay's shoes would have understood the agents' questions to

be asking whether the encounter costs were "inflated" compared to what *the law* required. And so, when Clay denied that WellCare had "inflated" its encounter pricing in the interview with law enforcement agents, he was clearly referring to whether the pricing was "inflated" compared to the relevant *legal* standard. Because no one contends that the Medicaid fee schedule—the obvious benchmark for "inflat[ion]" in Clay's recorded statement—was the established legal standard governing the submission of encounter data, there was no conflict between what Clay told the agents and what he said on the tape.

Second, the government suggested below that, because AHCA's contract with the Plans required the plans to report "enrollee service level encounter data" for all covered services, the contract precluded the Plans from reporting their actual costs. A699 (GX-3305.0224) (AHCA contract); see Dkt. 772 at 23. But that contractual provision states only *what* is to be priced, not *how* the pricing should work. The contract's reference to "enrollee service level encounter data" simply means that the Plans (having decided to report pricing data) were required to submit an itemization of the costs associated with specific services provided to individual enrollees. That is exactly what the Plans provided to AHCA. The term "enrollee service level encounter data" says nothing about *how* to allocate costs to those enrollee-level services.

B. The Government Failed To Prove Willfulness

The convictions should also be reversed because the government failed to prove willfulness—that Clay knew that his conduct was unlawful. The government introduced literally no evidence on this point. And there is no legal basis to presume—in the absence of such evidence—that Clay must have understood that his conduct violated the law.

1. Section 1001's Willfulness Element Requires Proof That The Defendant Knew That Making False Statements Would Be A Crime

Section 1001 criminalizes false statements that are made "knowingly and willfully." Tracking this Circuit's pattern instructions, the jury instructions defined "willfully" to require a "bad purpose to disobey or disregard the law." A673 at 12; see also 11th Cir. Pattern Jury Instructions (Crim. Cases) § 9.1A (2010). That formulation requires a showing that the defendant acted "with knowledge that his conduct was unlawful." *Bryan v. United States*, 524 U.S. 184, 192, 118 S. Ct. 1939, 1945 (1998) (quoting *Ratzlaf v. United States*, 510 U.S. 135, 137, 114 S. Ct. 655, 657 (1994)). Because the government did not object to that instruction (and in fact proposed it, see A408 at 32), it is law of the case, and the sufficiency of the evidence must be measured against it. See *United States v. Yates*, 733 F.3d 1059, 1063 n.4 (11th Cir. 2013), *cert. granted in irrelevant part*, 134 S. Ct. 1935 (2014); *United States v. Spletzer*, 535 F.2d 950, 954 (5th Cir. 1976).

The district court's instruction was also absolutely correct. Although the Fifth Circuit, in pre-Eleventh Circuit precedent, had construed Section 1001's willfulness element to require proof only that "the defendant acted 'deliberately and with knowledge,'" *United States v. Smith*, 523 F.2d 771, 774 (5th Cir. 1975), the United States has since disavowed that rule. In two recent briefs filed in the Supreme Court (one in a case arising out of the Fifth Circuit itself), the Solicitor General instead endorsed the Third Circuit's contrary holding in *United States v. Starnes*, 583 F.3d 196, 211 (2009), that Section 1001's "willfully" element requires proof that the defendant had "knowledge of the general unlawfulness of the conduct at issue." See Br. in Opp., *Ajoku v. United States*, 2014 WL 1571930 (No. 13-7264); Br. in Opp., *Russell v. United States*, 2014 WL 1571932 (No. 13-7357).

As the government acknowledged to the Supreme Court, as a general matter, "in order to establish a 'willful' violation of a statute, the Government must prove that the defendant acted with knowledge that his conduct was unlawful." *Bryan*, 524 U.S. at 191-92, 118 S. Ct. at 1945. The statutory context, moreover, confirms that the general criminal-law interpretation of "willfully" applies to Section 1001. Interpreting "willfully" to mean nothing more than "deliberately and with knowledge" would deprive that term of independent effect, because Section 1001 separately requires that the defendant act "knowingly," and it is difficult to conceive of a circumstance in which a defendant could "knowingly" make a false

statement without also making that statement "deliberately." See *Ratzlaf*, 510 U.S. at 140, 114 S. Ct. at 659 (cautioning against an interpretation of a criminal statute that would treat its "'willfulness' requirement essentially as surplusage").

It is widely acknowledged that Section 1001 "prosecutions can pose a risk of abuse and injustice." *United States v. Moore*, 612 F.3d 698, 703 (D.C. Cir. 2010) (Kavanaugh, J., concurring). The statute "applies to virtually any statement an individual makes to virtually any federal government official," *ibid.*, and its broad language, if not cabined by a careful application of the elements, may give prosecutors too wide a berth. See, *e.g.*, *Brogan v. United States*, 522 U.S. 398, 409, 118 S. Ct. 805, 812 (1998) (Ginsburg, J., concurring in the judgment) (noting that Section 1001 "arms Government agents with authority not simply to apprehend lawbreakers, but to generate felonies" by asking questions calculated to elicit false denials); *United States v. Yermian*, 468 U.S. 63, 81, 104 S. Ct. 2936, 2946 (1984) (Rehnquist, J., dissenting) (warning that Section 1001 risks "criminaliz[ing] … even the most casual false statements"). By respecting Congress's judgment that liability under Section 1001 should extend only to defendants who know that their conduct is unlawful, however, courts "can mitigate the risk of abuse and unfair lack of notice." *Moore*, 612 F.3d at 703 (Kavanaugh, J., concurring).

2. The Government Offered No Evidence That Clay Knew That His Conduct Was Unlawful

The government presented no proof at all that Clay knew that his conduct would be criminal. Absent from the record are *any* of the indicia courts applying the *Starnes* "knowledge of unlawfulness" standard have invoked as demonstrating willfulness. For example, Clay was not warned by the interviewing agents that making false statements would be a crime. See *United States v. Brandt*, 546 F.3d 912, 916 (7th Cir. 2008) (upholding conviction based on "repeated warnings that lying to federal agents was a crime"). Nor did Clay sign a certification acknowledging that making a false statement would be unlawful. Cf. *United States v. Awad*, 551 F.3d 930, 940 (9th Cir. 2009) (finding instructional error regarding willfulness element of healthcare fraud statute harmless where certification warned of criminal liability). And there were no other indications that Clay understood that making a false statement under these circumstances would be a criminal offense. See *United States v. Moyer*, 674 F.3d 192, 214 (3d Cir. 2012) (defendant's training as "certified law enforcement officer" justified jury's finding that he knew that making false statements is unlawful); *Starnes*, 583 F.3d at 212 (defendant's background and extensive training supported jury's conclusion that defendant knew that his false statements were unlawful).

Accordingly, Clay's statements were "willful" only if all persons are conclusively presumed—without *any* case-specific evidence—to know that making

a false statement to any federal law enforcement officer is a criminal offense. But substituting a presumption for actual proof would read the willfulness element out from Section 1001. That is deeply wrong in any context, but especially for the element of willfulness, where Congress's very purpose was to *depart* from the "background presumption that every citizen knows the law." *Bryan*, 524 U.S. at 193, 118 S. Ct. at 1146.

Moreover, such a presumption would defy reality. Interviews with federal law enforcement agents often occur "under extremely informal circumstances which do not sufficiently alert the person interviewed to the danger that false statements may lead to a felony conviction." *Brogan*, 522 U.S. at 410-11, 118 S. Ct. at 813 (Ginsburg, J., concurring in the judgment) (quoting *United States v. Ehrlichman*, 379 F. Supp. 291, 292 (D.D.C. 1974)). Although *lawyers* may be familiar with the existence and scope of Section 1001, a layperson like Clay is unlikely to understand that it is illegal to mischaracterize a legal conclusion such as "over-report[ing]" or "inflat[ion]" during an impromptu, unsworn, uncounseled interview initiated by federal law enforcement agents.[12]

[12] A number of courts once held that Section 1001 was categorically inapplicable to unsworn interviews with federal law enforcement agents. See *Friedman v. United States*, 374 F.2d 363, 366-67 (8th Cir. 1967); *Ehrlichman*, 379 F. Supp. at 411; *United States v. Davey*, 155 F. Supp. 175, 177 (S.D.N.Y. 1957); *United States v. Stark*, 131 F. Supp. 190, 206 (D. Md. 1955); *United States v. Levin*, 133 F. Supp. 88, 90 (D. Colo. 1953). The Supreme Court ultimately rejected that limitation. See *United States v. Rodgers*, 466 U.S. 475, 479-84, 104 S. Ct. 1942, 1946-49

Tellingly, the Model Penal Code—which the Supreme Court has frequently cited as an exemplar of general American criminal law principles, *e.g.*, *Burrage v. United States*, 134 S. Ct. 881, 887 (2014); *Begay v. United States*, 553 U.S. 137, 145, 128 S. Ct. 1581, 1586 (2008)—does not generally criminalize false oral statements made during unsworn interviews with law enforcement agents. Instead, the Code defines a *misdemeanor* offense called "unsworn falsification to authorities," which is limited to the making of *written* false statements (including misleading written applications for government benefits and the submission of false or forged documents). Model Penal Code § 241.3(1). The Code's separate prohibition on false reports to law enforcement (also a misdemeanor offense) is limited to statements that falsely incriminate another, *id.* § 241.5(1), and fictitious reports of crimes, *id.* § 241.5(2). Neither offense reaches false oral statements that merely deny criminal responsibility. The criminal codes of at least 12 States likewise limit their false-statement offenses to false written submissions (and, in some cases, recorded and electronic statements). See Ala. Code § 13A-10-109(a); Alaska Stat. Ann. § 11.56.210(a) (West); Haw. Rev. Stat. § 710-1063(a)(1), (2) (West); Ky. Rev. Stat. Ann. § 523.100 (West); Me. Rev. Stat. tit. 17-A, § 453; Mont. Code Ann. § 45-7-203; N.Y. Penal Law § 210.45 (McKinney); N.H. Rev.

(1984). Nonetheless, the fact that a series of decisions found it *unthinkable* that Congress intended to criminalize lies made during unsworn interviews powerfully undermines any contention that a layperson can be *presumed* to know of this criminal prohibition.

Stat. Ann. § 641:3; N.J. Stat. Ann. § 2C:28-3 (West); Or. Rev. Stat. Ann. § 162.085 (West); 18 Pa. Cons. Stat. Ann. § 4904 (West); Utah Code Ann. § 76-8-504 (West).[13] The fact that so many American jurisdictions do not criminalize false statements made during unsworn interviews like the one here confirms that Section 1001's broad scope is not so intuitively obvious that a layperson can be presumed to know of it in the absence of any evidence.

Finally, presuming knowledge of unlawfulness would be particularly inappropriate on the facts of this case. The statements charged in Counts 10 and 11 were, at bottom, characterizations about ultimate legal conclusions. Clay denied any knowledge of over-reporting of expenditures under the 80/20 Statute or inflation of encounter pricing, but he did not conceal the underlying methodology WellCare used to prepare its 80/20 submissions. To the contrary, Clay disclosed that, in WellCare's view, "Harmony's charge to Staywell and HealthEase at 80 percent or higher under a fixed price contract is enough to meet the 80 percent rule on the 80/20 report." A752 (80:18-21). The government alleged that this was Defendants' core act of criminality, and contended that it was *concealed* from AHCA. See, *e.g.*, A677 (51:22-52:1); A761 (141:23-25, 145:8-16). But Clay expressly *told* the agents about the Plans' use of the Harmony subcapitation in their

[13] Kentucky and Maine have criminalized false statements to law enforcement officers in certain additional circumstances, but only if the defendant was warned that providing false information would be a crime. See Ky. Rev. Stat. Ann. § 523.110 (West); Me. Rev. Stat. tit. 17-A, § 453(1)(C).

80/20 expenditure calculations. Moreover, when he was asked whether WellCare had included non-allowable expenses in the 80/20 submissions, Clay did not conceal any potential disagreement between the Plans' reports and what he believed to be AHCA's interpretation of the Plans' 80/20 obligations. He instead related his understanding that "there ha[d] been an ongoing debate between WellCare and AHCA over the definition of an allowable expense." A752 (83:11-13).

Thus, anyone listening to Clay's interview would have heard more than just the isolated statements charged in Counts 10 and 11. They would also have been apprised (i) that the Plans had treated the Harmony subcapitation payments as an allowable expense, and (ii) that there was an ongoing debate between WellCare and AHCA regarding expense-reporting issues. Under these unique circumstances, it would defy common sense to presume that Clay must have known that the statements charged in Counts 10 and 11—even if they were false in some technical sense—would constitute criminal falsehoods, when in the same breath Clay disclosed to the agents the core mechanic of the fraud alleged by the government.

C. Clay's Disclosures To The Interviewing Agents Negate Materiality

To prove materiality under Section 1001, the government had to show that Clay's statements had "a natural tendency to influence, or [were] capable of affecting or influencing, a governmental function." *United States v. Diaz*, 690 F.2d

1352, 1357 (11th Cir. 1982) (internal quotation marks omitted). But the government introduced no proof that Clay's conclusory denials of "over-report[ing]" and "inflat[ion]"—even if assumed to be false under *Whiteside*—could conceivably have affected the government's investigation.

Materiality must be analyzed in context. A portion of a statement that in isolation might appear to be material may be completely immaterial when considered along with other portions of the statement. See, *e.g.*, *Weinstock v. United States*, 231 F.2d 699, 702 (D.C. Cir. 1956) (holding that, if the allegedly false statement "had stood alone it might well have been material," but that "in context, as merely part of the long affidavit, it was immaterial, wholly without weight or influence in any decision"); *United States v. Rigas*, 490 F.3d 208, 231 (2d Cir. 2007) (observing in bank fraud case that "[a]nalysis of the misrepresentations must be in the context in which they were made," and holding proof of materiality insufficient).

That is precisely the case here. The government did not prove how Clay's denial of "over-report[ing]" had any capacity to affect the government's investigation when, in the same interview, Clay disclosed to the agents that the Plans had included the Harmony subcapitation as an allowable expense and alerted them to the ongoing debate between WellCare and AHCA over reportable expenses. See pp. 36-37, *supra*.

The same is true of Clay's statements that WellCare had not "inflated" the prices for its encounter data submission. The only sense in which the Plans' encounter pricing was even arguably "inflated" was that the Plans chose (at AHCA's request) to allocate the Harmony subcapitation over all the services it funded. See pp. 22-27, *supra*. The government contended that the purpose of such "inflation" was to conceal the Plans' inclusion of the Harmony subcapitation in their 80/20 submissions. See, *e.g.*, A453 (54:7-11); A677 (101:10-11). But Clay didn't conceal WellCare's reporting methodology from the interviewing agents—he *disclosed* it.

In the end, Clay disclosed to the agents the core facts upon which the government would build its case. To the extent that the statements charged in Counts 10 and 11 were false at all, it was in the most technical possible sense: despite disclosing the underlying facts, Clay declined to admit the *legal* conclusions that the government attached to WellCare's reporting practices. There was no evidence that these conclusory denials could have affected the government's investigation.

More broadly, however capacious the standard for materiality may be, the government cannot substitute speculation for evidence of the likely effect of the defendant's statement. See *United States v. Beer*, 518 F.2d 168, 172 (5th Cir. 1975) ("[W]e are constrained to require a reasonable *showing* of the potential

effects of the statement.") (emphasis added); *ibid.* ("The materiality of a statement rests upon a factual evidentiary showing … ."); cf. *United States v. House*, 684 F.3d 1173, 1204 (11th Cir. 2012) (affirming conviction based on record evidence demonstrating how falsified reports were used); *United States v. Gafyczk*, 847 F.2d 685, 691 (11th Cir. 1988) (relying on testimony demonstrating how falsified forms were used). Yet speculation is all the government offered the jury on materiality.

The government presented the testimony of one of the agents who participated in Clay's interview, Blair Johnston, but Johnston did not explain how the charged statements could have influenced the government's investigation. For example, Johnston testified that he prepared a memorandum recording the interview, A752 (59:15-18), but he did not say how that memorandum was used, or even how such memoranda are typically used. Johnston said nothing about what investigators did in response to Clay's statements, or what they might have done.

And it is far from clear that Johnston *could* have offered testimony regarding the potential impact of Clay's statement. Johnston was brought in from outside Florida to assist with the government's raid on WellCare's facilities, and had no involvement in the investigation prior to the day of the raid—or thereafter. See A752 (51:16-20, 53:1-10). He had received only a short background briefing on the subject of the government's investigation, *id.* at 57:13-23, and he acknowledged that the interview of Clay followed a script prepared by someone

else, *id.* at 58:2-9. Indeed, Johnston was not even responsible for *asking* the scripted questions; he acted merely as the interview scrivener. *Id.* at 59:6-9.

In short, the government simply punted on the materiality element, just as it did on willfulness. For that independent reason, Clay's convictions should be dismissed.

II. In The Alternative, A New Trial Is Warranted On Both Counts Of Conviction

If the convictions are not reversed outright, the case should be remanded for a new trial because of errors that prejudiced Clay's defense on both counts of conviction.[14]

A. The Government Use Of WellCare's Financial Restatement Was Prejudicial Error With Respect To Count 10

The government introduced the fact and contents of WellCare's financial restatement through its expert, Harvey Kelly, and then repeatedly urged the jury to consider the restatement as substantive evidence of Defendants' guilt. The Behrens Brief sets forth the multiple reasons why this use of the restatement was legally erroneous and highly prejudicial. See Behrens Br. at 81-97. Here, we explain how the prejudice of the restatement evidence applies just as readily to

[14] In addition to the new-trial arguments set forth in the text, Clay joins the argument in the Brief for Defendant-Appellant Todd S. Farha (at 33-45) that the erroneous admission of wealth evidence warrants a new trial for Clay, and the Behrens Brief's argument (at 102-03) that the district court's willful blindness instruction was error.

Clay's conviction on Count 10 as it does to those of his codefendants, whose convictions were based directly on the Plans' submissions to AHCA.

Clay's basic defense to Count 10 was (i) that the CY2005 submissions were consistent with a reasonable understanding of the governing legal requirements; and (ii) that, in any event, he believed in good faith that there was no "over-report[ing]." The restatement evidence gutted both defenses. Unaware that WellCare had issued the restatement in a desperate effort to avoid indictment, the jury was almost certain to infer that WellCare had abandoned its prior reporting methodology—and acknowledged over-reporting to the tune of *$35 million*—precisely because those prior reports were unreasonable, rather than because WellCare had been compelled to adopt AHCA's newly announced position that payments to Harmony could not be counted for 80/20 purposes. That inference also undercut Clay's defense on scienter, since if a jury has concluded that a belief is unreasonable it is much less likely to conclude that it was held in subjective good faith. See *Cheek v. United States*, 498 U.S. 192, 203-04, 111 S. Ct. 604, 611 (1991); *United States v. Lankford*, 955 F.2d 1545, 1550-51 (11th Cir. 1992).

In light of the abundant prejudice associated with the government's use of the restatement, Count 10 should at a minimum be remanded for a new trial.

B. The District Court's Instruction On The *Whiteside* Defense Prejudiced Clay's Defense On Count 11 By Directing The Jury To The Wrong Source Of Law

This Court will reverse a conviction if a jury instruction "misstated the law or misled the jury to the prejudice of the objecting party." *House*, 684 F.3d at 1196 (internal quotation marks omitted). With respect to Count 11, the instruction on the *Whiteside* defense did just that. The instruction stated:

> The False Statements, Health Care Fraud and Conspiracy Counts allege that the Defendants made materially false or fraudulent statements or representations to the Florida Medicaid Program. To prove that a statement or representation was false or fraudulent, the government must prove beyond a reasonable doubt that it was not true under any reasonable interpretation *of the 80/20 templates* ("Financial Worksheets for Behavioral Health Care"). If you conclude that the statement charged in a particular count was true under any reasonable interpretation *of the 80/20 templates*, then you must find the Defendants not guilty on that count. It does not matter whether any Defendant actually believed that the statement was true, so long as it was true under a reasonable interpretation of those provisions.
>
> This instruction also applies to Counts Ten and Eleven and statements made to federal agents.

A673 at 25 (emphasis added).

The problem with the instruction was that it tied the *Whiteside* defense on Count 11 to the "80/20 templates." But the 80/20 Templates pertained only to WellCare's *expenditure* reports (the basis of Count 10); WellCare's *encounter data submissions* (the basis of Count 11) were governed by the Encounter Template. Compare A699 (GX-0501.0001), with A699 (GX-0855.1a). With respect to Count 11, the *Whiteside* instruction was thus erroneous in two related respects.

First, the instruction failed to direct the jury to the correct source of law for encounter pricing. Pricing was governed by the Encounter Template, which was taken directly from the Plans' contracts with AHCA and directed the Plans to report the "costs associated with" each claim. Clay's core defense to Count 11 was that the encounter submissions were not "inflated" when evaluated according to that crucial phrase, but the instruction omitted any mention of the Encounter Template. As a result, the jury was effectively told not to consider Clay's defense to Count 11. That is unquestionably reversible error. See *United States v. Kottwitz*, 614 F.3d 1241, 1271 (11th Cir. 2010) (per curiam), *vacated in part on other grounds*, 627 F.3d 1383 (11th Cir. 2010) (per curiam).[15]

Worse still, the instruction directed the jury to the *wrong* source of law: It invited the jury to convict Clay on Count 11 if it determined that WellCare's encounter submissions were inconsistent with "the 80/20 templates"—*even if* the encounter submissions reasonably reported the "costs associated with the claim" as prescribed by the Encounter Template. The instruction therefore affirmatively "misled the jury." *House*, 684 F.3d at 1196. And given the erroneous path to

[15] Defendants had requested (and were denied) a broader instruction that would have encompassed the requirements for encounter data. See A657-1 at 37 (requiring proof of falsity under any reasonable interpretation "of the governing legal requirements"). Clay also specifically objected that the encounter submissions were not governed by the 80/20 Templates, and offered to provide a substitute instruction. The district court overruled the objection. A664 (108:16-23).

conviction offered by the instruction, as well as the confusion it surely caused with respect to Count 11, the government cannot possibly show that the error did not "contribute to the verdict obtained." *Id.* at 1197 (internal quotation marks omitted). Thus, if this Court does not reverse Clay's conviction on Count 11 and order outright dismissal, it should remand for a new trial with a correct *Whiteside* instruction.

CONCLUSION

The judgment of conviction should be reversed.

Respectfully submitted.

/s/ Lawrence S. Robbins

WILLIAM F. JUNG
PAUL M. SISCO
JUNG & SISCO, P.A.
101 E. Kennedy Blvd., Suite 3920
Tampa, FL 33602
(813) 225-1988

LAWRENCE S. ROBBINS
MARK T. STANCIL
DONALD BURKE
DANIEL N. LERMAN
ROBBINS, RUSSELL, ENGLERT, ORSECK, UNTEREINER & SAUBER LLP
1801 K Street NW, Suite 411-L
Washington, DC 20006
(202) 775-4500
lrobbins@robbinsrussell.com

September 19, 2014

CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), the undersigned hereby certifies that this brief complies with the type-volume limitation of Appellate Rule 32(a)(7)(B)(i) and this Court's order dated June 26, 2014.

1. Exclusive of the exempted portions of the brief, as provided in Appellate Rule 32(a)(7)(B) and Eleventh Circuit Rule 32-4, the brief contains 10,410 words.

2. The brief has been prepared in proportionally spaced typeface using Microsoft Word 2010 in 14 point Times New Roman font. As permitted by Appellate Rule 32(a)(7)(B), the undersigned has relied upon the word count feature of this word processing system in preparing this certificate.

/s/ Lawrence S. Robbins
LAWRENCE S. ROBBINS
September 19, 2014

CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of September, 2014, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eleventh Circuit using the appellate CM/ECF system. Counsel for all parties to the case are registered CM/ECF users and 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 FedEx for delivery within three days.

/s/ Lawrence S. Robbins
LAWRENCE S. ROBBINS