IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
ASHEVILLE DIVISION
CASE NO. 1:21-CV-219-MR-WCM

THE UNITED STATES OF AMERICA, the STATE OF NORTH CAROLINA and the STATE OF TENNESSEE, *ex rel*. ALANA SULLIVAN and J. BRITTON TABOR,

Plaintiffs,

v.

MURPHY MEDICAL CENTER, INC. d/b/a ERLANGER WESTERN CAROLINA HOSPITAL and CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY d/b/a ERLANGER HEALTH SYSTEM, d/b/a ERLANGER MEDICAL CENTER,

Defendants.

THE UNITED STATES' COMPLAINT IN INTERVENTION

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The United States of America (the "United States" or the "Government") brings this civil action against Murphy Medical Center, Inc. d/b/a Erlanger Western Carolina Hospital and Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System and Erlanger Medical Center to recover damages from false claims, payment by mistake, and unjust enrichment.

I. Introduction

1. This is a civil action brought by the United States against the Defendants under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, and federal common law, to recover treble damages sustained by, and civil penalties and restitution owed to, the United States based on Defendants' knowing payment of compensation exceeding fair market value to employed physicians to secure their referrals.

2. As set forth below, from 2014 through at least 2021, Defendants knowingly submitted or caused the submission of claims for payment to the Medicare Program for hospital services that were referred by physicians with whom they had financial relationships which did not satisfy the requirements of any applicable exception of the physician self-referral law, 42 U.S.C. § 1395nn

(commonly referred to as the "Stark Law"). In so doing, they violated the FCA, were paid by mistake, and were unjustly enriched.

II. Parties

3. Plaintiff, the United States, brings this action on behalf of the United States Department of Health and Human Services ("HHS") and its component the Centers for Medicare & Medicaid Services ("CMS"), which administers the Medicare Program and promulgates regulations implementing the Stark Law.

4. Defendant Chattanooga-Hamilton County Hospital Authority is a public, tax-exempt organization that owned, controlled, and operated several hospitals in Chattanooga and the Sequatchie Valley in Tennessee in the period from 2014 through 2021. During the relevant time period, a Board of Trustees operated and controlled the Chattanooga-Hamilton County Hospital Authority, which did business as Erlanger Medical Center and Erlanger Health System.

5. Defendant Murphy Medical Center, Inc. is a non-profit corporation organized under the laws of the State of North Carolina that is located in Cherokee County, North Carolina. On April 1, 2018, the Chattanooga-Hamilton County Hospital Authority became the sole member of Murphy Medical Center, Inc., which became part of Erlanger Health System and began doing business as Erlanger Western Carolina Hospital.

6. In this Complaint, Defendant Chattanooga-Hamilton County Hospital Authority will be referred to as "Erlanger Health System." Defendant Murphy Medical Center, Inc. will be referred to as "Erlanger Western Carolina Hospital." The Defendants will be referred to collectively as "Defendants" or "Erlanger."

7. In the period from 2014 through 2021, Erlanger received substantial revenue from federal health care programs. Charges to the Medicare program represented approximately 30 percent of Erlanger's patient service charges during that period.

8. During the relevant time period, Erlanger Health System was the primary site of graduate medical education training at the University of Tennessee College of Medicine ("UTCOM"). Physicians employed by Erlanger Health System supervised UTCOM's graduate medical education students, or residents. Academic salaries to Erlanger physicians for supervising UTCOM residents were paid by Erlanger or were paid by UTCOM with Erlanger's funds.

9. During the relevant time period, the Board of Trustees, CEO, and other officers of Erlanger Health System controlled the hospitals in the Erlanger system, including Erlanger Western Carolina Hospital. Erlanger Western Carolina Hospital's financial statements were blended in the combined financials statements of Erlanger Health System. Physicians employed by Erlanger Health System

provided services at Erlanger Western Carolina Hospital and referred patients for services at Erlanger Western Carolina Hospital. Erlanger Health System controlled physician hiring and compensation decisions for the system, including Erlanger Western Carolina Hospital. Erlanger Health System's central billing department submitted claims to federal health care programs for the hospitals in the system, including Erlanger Western Carolina Hospital.

10. Relator Alana Sullivan was hired by Erlanger Health System in January 2006 to serve as its Chief Compliance Officer. She served as Chief Compliance Officer for the hospitals in the system, including Erlanger Western Carolina Hospital. In October 2019, Erlanger Health System eliminated the role of Chief Compliance Officer and terminated Ms. Sullivan's employment.

11. Relator J. Britton Tabor began working at Erlanger in 1986 and served as Chief Financial Officer for Erlanger Health System, including all the hospitals in the system, from 2006 to April 2021.

III. Jurisdiction and Venue

12. This action arises under the FCA, 31 U.S.C. §§ 3729-3733, and under common law theories of payment by mistake of fact and unjust enrichment. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331, 1345, because this action is brought by the United States as a Plaintiff pursuant to the FCA, and

supplemental jurisdiction to entertain common law and equitable claims under 28 U.S.C. § 1367(a).

13. This Court has personal jurisdiction over the Defendants pursuant to 31 U.S.C. § 3732(a) and because the Defendants can be found, reside, or transact business in the Western District of North Carolina.

14. Venue is proper in the Western District of North Carolina under 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and (c) because the Defendants can be found, reside, or transact business in this judicial district.

15. The claims against the Defendants relate back to the original filing date of the Relators' complaint pursuant to 31 U.S.C. § 3731(c) and are timely brought due to the dates of the alleged violations and the time frame in which an official of the United States with responsibility to act under the circumstances knew the essential elements of the causes of action.

IV. Background

A. The Medicare Program

16. Congress established Medicare in 1965 to provide health insurance coverage for people aged sixty-five or older and for people with certain disabilities or afflictions. *See* 42 U.S.C. §§ 426, 426a. Individuals who receive health insurance coverage under Medicare are referred to as Medicare "beneficiaries."

17. Part A of the Medicare Program provides coverage for institutional health care, including inpatient hospital services. *See* 42 U.S.C. §§ 1395c, 1395d. Part B of Medicare provides coverage for outpatient care, including physician services. *See* 42 U.S.C. § 1395k.

18. Medicare is funded by the federal government and administered by CMS, which is part of HHS.

19. CMS contracts with Medicare Administrative Contractors ("MACs") to administer Medicare Parts A and B. *See* 42 U.S.C. §§ 1395h, 1395kk-1. MACs generally act as CMS's agents in reviewing and paying claims submitted by healthcare providers for reimbursement for Part A and Part B covered health care services for Medicare beneficiaries. *See* 42 C.F.R. §§ 421.3, 421.5(b), 421.100.

20. Health care providers, including hospitals and physicians, must be enrolled in Medicare to be reimbursed by the Medicare Program. *See* 42 C.F.R. § 424.505. To enroll in Medicare and receive a Medicare billing number, a hospital must complete a CMS-855A Medicare Enrollment Application. By signing the Medicare Enrollment Application, a hospital attests to reading, understanding, and agreeing to comply with the requirements that the hospital must meet and maintain in order to bill the Medicare Program. Those requirements include an agreement to "abide by the Medicare laws, regulations and program instructions that apply to me"

and an understanding that "payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (Section 1877 of the Social Security Act))."

21. The CMS-855A Medicare Enrollment Application also explains the penalties for falsifying information in the application, including potential civil liability under the False Claims Act, 31 U.S.C. § 3729.

22. The Medicare enrollment regulations further require providers to certify compliance with the requirements of the Medicare statute and regulations. *See* 42 C.F.R. § 424.516(a)(1).

23. When a Medicare-enrolled physician provides health care services to a Medicare beneficiary in a hospital setting, whether to hospital inpatients or outpatients, the physician (or the hospital or other entity to which the physician has assigned billing rights) may bill Medicare for the "professional" services that the physician performed, such as a surgery or interpretation of test results, using the ASC X12 837 professional claim format or the CMS-1500 Claim Form. In addition, the hospital may submit a separate claim, using the ASC X12 837 institutional claim

format or the CMS-1450 Claim Form, to Medicare for the "facility" component of services rendered by the hospital, such as the furnishing of the hospital room, equipment, nursing care, and medications.

24. CMS also requires hospitals to submit annually a CMS-2552 Hospital Cost Report. A cost report is the final claim that a hospital submits to Medicare for items and services rendered to Medicare beneficiaries during the year covered by the report.

25. At the end of the hospital's fiscal year, the hospital must file its cost report with the MAC, stating the amount of Part A reimbursement the hospital believes it is due for the year, or the amount of excess reimbursement it has received through the year that is owed back to Medicare. *See* 42 U.S.C. § 1395g(a); 42 C.F.R. §§ 413.20, 405.1801(b)(1). Medicare relies on the hospital's cost report to determine whether the hospital is entitled to more reimbursement than it already received or whether the provider has been overpaid and must reimburse Medicare. *See* 42 C.F.R. §§ 405.1803, 413.60, 413.64.

26. On the hospital cost report, the Medicare Part A services billed by the hospital during the course of the fiscal year are added to any Medicare Part A add-on payments due to the provider. This total is the amount that Medicare owes the hospital for services rendered to beneficiaries during the fiscal year. From this sum,

interim payments made to the hospital on claims the hospital submitted during the year are subtracted to determine the amount due to or from the hospital.

27. Every hospital cost report contains a certification that must be signed by the chief financial officer or administrator of the hospital.

28. The chief financial officer or administrator must certify, in pertinent part, that "to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted." The officer or administrator must further certify that "I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations."

29. The certification section of the cost report also contains the following warning: "MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND

ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT."

30. Thus, a hospital must certify in its cost report that (1) the report is true and correct, meaning the provider is entitled to reimbursement for the reported costs; (2) the report is complete, meaning the report is based on all information known to the provider; and (3) the services reflected in the cost report were billed in compliance with applicable laws and regulations, including the Stark Law.

31. A hospital is required to disclose to the MAC all known errors and omissions in its claims for Medicare Part A reimbursement, including in its cost reports.

32. Medicare, through the MACs, has the right to audit a hospital's cost reports and financial representations to ensure their accuracy. This right includes the right to make retroactive adjustments to hospital cost reports previously submitted by a provider if any overpayments have been made. *See* 42 C.F.R. § 413.64.

33. During the relevant time period, Cahaba GBA and Palmetto GBA were the MACs for Erlanger Health System and Erlanger Western Carolina Hospital.

B. The Stark Law

34. The Stark Law, 42 U.S.C. § 1395nn, was enacted to combat the potential that financial self-interest would affect a physician's medical decision-making regarding whether health care services were necessary, which services were preferable, and who should provide them to his or her patients. The statute's prohibitions are intended to prevent a patient from being referred for health services that are not needed, more expensive, lower quality, or less convenient because the patient's physician may improve his or her own financial situation through those referrals. *See* Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492, 77493, 77506 (Dec. 2, 2020).

35. The Stark Law is a strict liability statute.

36. The Stark Law prohibits an entity, such as a hospital, from submitting claims to Medicare for payment for "designated health services" that are "referred" to the entity by a physician with whom the entity has a "financial relationship" that does not quality for an exception to the prohibition. 42 U.S.C. § 1395nn(a)(1).

37. "Designated health services," or "DHS," include inpatient and outpatient hospital services. 42 U.S.C. § 1395nn(h)(6)(K). Inpatient hospital services include bed and board, equipment, nursing care, and medications. *See* 42 C.F.R. § 409.10(a).

38. A "referral" is a physician's request for a designated health service. 42 U.S.C. § 1395nn(h)(5)(A). Services that the physician personally performs do not count as referrals. *See* 42 C.F.R. § 411.351. However, in the context of hospital services, there is a "referral" of any hospital service or facility fee billed by the hospital in connection with the physician's personally performed service. *See* Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships, 66 Fed. Reg. 856, 941 (Jan. 4, 2001).

39. A "financial relationship" includes a "compensation arrangement," which means any arrangement involving any "remuneration" paid to a referring physician "directly or indirectly, overtly or covertly, in cash or kind." *See* 42 U.S.C. § 1395nn(h)(a)(1); 42 C.F.R. § 411.351.

40. A direct compensation arrangement exists "if remuneration passes between the referring physician … and the entity furnishing DHS without any intervening persons or entities." 42 C.F.R. § 411.354(c)(1)(i).

41. The Stark Law and its implementing regulations contain exceptions to the Stark Law's prohibition for certain financial arrangements. To fit an exception, an arrangement must squarely meet all the conditions set forth in the exception. It is the actual relationship between the parties, and not merely the paperwork, that

must fit in an exception. *See, e.g.,* Medicare Program; Revisions to Payment Policies, 80 Fed. Reg. 70886, 71317 (Nov. 16, 2015); HHS-OIG Supplemental Compliance Guidance for Hospitals, 70 Fed. Reg. 4858, 4863 (Jan. 31, 2005).

42. To qualify for the bona fide employment relationships exception, a compensation arrangement must meet all of the following requirements:

> (A) the employment is for identifiable services,
>
> (B) the amount of the remuneration under the employment—
>
> > (i) is consistent with the fair market value of the services, and
> >
> > (ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,
>
> (C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer, and
>
> (D) the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

42 U.S.C. § 1395nn(e)(2); *see also* 42 C.F.R. § 411.357(c).

43. Fair market value is a significant concept in the Stark Law legal framework. "Compensation for personal services above the fair market value of those services can suggest that the compensation is really for referrals." *See United*

States ex rel. Bookwalter v. UPMC, 946 F.3d 162, 171-72 (3d Cir. 2019) ("Anyone would wonder why the hospital would pay so much if it was not taking into account the doctor's referrals for other services.").

44. The Stark Law's exceptions operate as affirmative defenses to alleged violations of the statute. Once it has been shown that a party submitting Medicare claims has a financial relationship with a referring physician, the defendant bears the burden of demonstrating that the relationship meets all the requirements of a statutory or regulatory exception. *See, e.g., United States ex rel. Drakeford v. Tuomey*, 792 F.3d 364, 374 (4th Cir. 2015).

45. The Stark Law prohibits Medicare from paying for any DHS claims referred in violation of the Stark Law. 42 U.S.C. § 1395nn(g)(1). The Stark Law demands repayment from any Medicare provider that received payment for such claims. 42 U.S.C. § 1395nn(g)(2). A knowing violation of the Stark Law may also subject the billing provider to civil monetary penalties or exclusion from participation in federal health care programs. 42 U.S.C. §§ 1395nn(g)(3), 1320a-7a(a). In addition, Medicare providers who knowingly submit claims to Medicare in violation of the Stark Law may be liable under the False Claims Act. *See, e.g., Tuomey*, 792 F.3d at 376, 383-84.

46. The fact that a claim is submitted to Medicare in violation of the Stark Law is material to Medicare's payment decision. *See, e.g., United States ex rel. Longo v. Wheeling Hospital, Inc.*, No. 5:19-CV-192, 2019 WL 4478843, at *8 (N.D.W. Va. Sept. 18, 2019) ("Congress did not merely label the Stark Law a condition of payment, but imposed it as a mandatory condition, which is the strongest possible indication of materiality.").

C. The False Claims Act

47. The False Claims Act provides, in pertinent part, that any person who:

> (a)(1)(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; or
>
> (a)(1) (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

is liable to the United States for three times the amount of damages which the Government sustains, plus a civil penalty per violation. 31 U.S.C. § 3729(a)(1)(A)-(B).

48. The terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard

of the truth or falsity of the information. 31 U.S.C. § 3729(b)(1). No proof of specific intent to defraud is required. *Id.*

49. The term "material" means "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

V. Defendants Knowingly Billed Medicare for Hospital Services Referred by Physicians in Violation of the Stark Law from 2014 to at Least 2021

50. In 2005, Erlanger Health System agreed to pay the United States $40 million to resolve allegations that it knowingly submitted false claims to Medicare. *See* Press Release, U.S. Attorney Eastern District of Tennessee, Erlanger Will Pay $40 Million to Resolve Chattanooga Federal Health Care Fraud Investigation (Oct. 24, 2005). The settlement resolved allegations by the Government that Erlanger Health System submitted or caused the submission of claims to Medicare that were false because they violated the Stark Law.

51. As part of that settlement, Erlanger Health System entered into a Corporate Integrity Agreement ("CIA") with the Department of Health and Human Services' Office of Inspector General ("HHS-OIG") that was in effect from October 2005 through October 2010. Under the terms of the CIA, Erlanger Health System

was required to put in place controls to ensure that its financial relationships with employed physicians did not violate the Stark Law.

52. The CIA expired in October 2010. Beginning in 2013, Erlanger Health System implemented a strategy to increase profits by employing more physicians, particularly specialists who practiced at competing hospitals whose patients would require revenue-generating hospital stays. Once hired, Erlanger expected its physicians to treat their patients at Erlanger's hospitals and refer them to other providers employed by Erlanger, thus generating downstream revenue for Erlanger.

53. To facilitate the hiring and retention of physicians who would generate significant downstream revenue, Erlanger relaxed or eliminated the oversight and controls on physician compensation that had been in place under the CIA. Among other changes, beginning in 2013, Erlanger's CEO at times signed physician compensation contracts before any review by the Chief Compliance Officer, who was no longer given a vote on whether to approve physician compensation arrangements.

54. To attract revenue-generating physicians and incentivize their productivity, Erlanger changed its compensation model to include large salaries for medical director and academic positions. Erlanger then paid these salaries to its

employed physicians without regard to whether the work required by these positions was actually performed. Erlanger likewise added uncapped payments for covering on-call shifts and productivity bonuses to its physician compensation packages. As a result of reducing its compliance controls and offering generous compensation packages, Erlanger paid certain physicians amounts that were two to three times the median salary for their specialties.

55. During the years at issue in this case, Erlanger knew that compensation paid to employed physicians must be consistent with fair market value to qualify for an exception to the Stark Law. Erlanger also knew that the compensation it was paying to employed physicians exceeded fair market value.

56. Among other facts supporting knowledge, Erlanger knew that it was paying employed physicians significantly more than it was collecting for their services, and that the employed physicians were only profitable when their downstream revenue was considered. Both of these metrics are directly relevant to determining whether physician compensation is consistent with fair market value. Nonetheless, Erlanger dismissed these indicators that the physician salaries were above fair market value and therefore did not fit within any exception to the Stark Law.

57. In addition, several health care compensation and billing consultants put Erlanger on notice that it was paying bonuses based on productivity measures that overstated the work the physicians were personally performing, and paying medical director and academic salaries that were unsupported. Medical staff and others also informed Erlanger of quality of care failures by a cardiothoracic surgeon, thus alerting Erlanger to the risk that it was paying the surgeon more than the fair market value of the work that he performed. Erlanger ignored these warnings and increased his compensation.

58. Moreover, the compensation that Erlanger actually paid to physicians at times significantly exceeded the amounts that Erlanger's internal analysts and outside compensation consultants concluded were consistent with fair market value. Erlanger administrators also resisted efforts by the Chief Compliance Officer to engage an outside consultant to review the actual compensation that Erlanger was paying. When Erlanger eventually performed an analysis of 2018-2019 physician compensation, it identified compensation to multiple physicians that exceeded fair market value metrics.

A. Erlanger knew compensation to employed physicians must be consistent with fair market value to qualify for an exception to the Stark Law prohibition.

59. The Stark Law is a prominent statute in the hospital industry. In 1998, HHS-OIG issued Compliance Program Guidance for Hospitals that identified compliance with the Stark Law as a special area of OIG concern. The Compliance Guidance recommended that hospitals put policies and procedures in place to ensure compliance with the Stark Law and to prevent hospitals from submitting or causing the submission of claims to federal health care programs for patients who were referred to the hospital pursuant to financial arrangements that violate the Stark Law. *See* Compliance Program Guidance for Hospitals, 65 Fed. Reg. 8987, 8990, 8992 (Feb. 23, 1998).

60. In 2005, as noted above, Erlanger Health System agreed to pay the United States $40 million to resolve allegations that it knowingly submitted false claims to Medicare for hospital services that were referred by physicians with whom it had financial relationships that violated the Stark Law and entered into a five-year CIA with HHS-OIG.

61. The CIA required Erlanger Health System to appoint a Compliance Officer who was not subordinate to the General Counsel and was responsible for developing and implementing policies and procedures to ensure compliance with

federal health care program requirements. In particular, the CIA required that Erlanger Health System implement processes and procedures to ensure that financial arrangements with physicians complied with the Stark Law and that physicians were performing all of the services for which they were paid.

62. In January 2006, Erlanger Health System hired Relator Sullivan as Chief Compliance Officer. Ms. Sullivan led the Compliance Department, which was separate from and independent of the Legal Department and reported directly to Erlanger's CEO. In the company's Code of Conduct, Erlanger instructed its physicians and other employees to bring compliance concerns to the Chief Compliance Officer.

63. As Chief Compliance Officer during the period that the CIA was in effect, from 2005 to 2010, Ms. Sullivan played a central role in reviewing Erlanger Health System's financial arrangements with physicians. Before Erlanger Health System signed an employment contract with a physician, Ms. Sullivan received and reviewed the proposed contract along with (1) documentation of the need to hire the physician and (2) a written assessment of the fair market value of the proposed compensation. During the period that the CIA was in effect, Erlanger Health System would not sign an employment contract with a physician unless any concerns that Ms. Sullivan raised had been addressed.

64. Many of the physicians employed by Erlanger Health System during that period were pediatric specialists who worked in Erlanger's Children's Hospital in Chattanooga, Tennessee. Erlanger's Children's Hospital was the region's only Children's Hospital; therefore, Erlanger Health System did not compete with other area hospitals for pediatric referrals. There were large private medical practices in the area that employed physicians in specialties such as cardiology, orthopedics, and neurology who treated their patients at several area hospitals, including Erlanger's.

65. During the years that the CIA was in effect, physicians employed by Erlanger Health System were primarily (or entirely) compensated through a fixed base salary. To the extent that Erlanger offered a "productivity incentive" to employed physicians during this time period, the productivity incentive that a physician could earn was not a significant portion of their total compensation.

66. Work relative value units, or wRVUs, are a commonly-used measure of physician productivity. The amount that Medicare pays for physician services is based in part on wRVUs. A certain number of wRVUs are assigned to each Current Procedural Terminology ("CPT") code used to bill medical procedures and services. A higher number of wRVUs are assigned to CPT codes for services that require greater resources. Thus, two wRVUs may be assigned to the CPT code for a doctor

visit for a patient with moderately complex medical issues while three wRVUs may be assigned to a visit with a patient with highly complex medical issues.

67. Pursuant to the procedures that Erlanger Health System put in place in order to comply with the CIA, if an employed physician's billing resulted in high wRVUs, Erlanger Health System evaluated whether the physician was personally performing the billed services, whether the wRVUs were accurate, and whether any productivity incentive amount payable per wRVU was reasonable.

68. The allegations in the present case arose out of events that occurred from 2014 through at least 2021. Throughout that time period, Erlanger administrators and executives knew that the compensation Erlanger paid to employed physicians must be consistent with fair market value to comply with the Stark Law. Erlanger Health System's internal fair market value policy dated September 18, 2013, stated that the "compensation under all Erlanger Health System ("Erlanger") transactions must be consistent with fair market value (FMV) and commercially reasonable." The policy defined fair market value in the context of physician employment agreements to mean "the total compensation that would be determined in an arms' length transaction, consistent with the total compensation that would be included in such an agreement as the result of bona fide bargaining

between well-informed parties who are not otherwise in a position to generate business for the other party, at the time of the agreement."

69. During the relevant time period, Erlanger also knew the measurements that are commonly used to determine the fair market value of physician compensation. Erlanger knew that (1) the total cash compensation paid to a physician, (2) the average amount paid to a physician for each wRVU, and (3) the ratio of the physician's compensation to the amount collected for the physician's work, were all used to evaluate whether the compensation was consistent with fair market value.

70. Erlanger also knew that physician compensation likely exceeds fair market value when it is greater than the amount that 75 percent of comparable physicians are paid, when considering the metrics of total compensation, compensation per wRVU, and compensation compared to collections.

71. During the relevant time period, Erlanger also knew that it must be able to demonstrate that physicians were actually providing the level of services for which they were being paid in order for the compensation to be considered fair market value. Erlanger likewise knew that it should not compensate physicians for wRVUs associated with work that the physician did not personally perform.

B. Beginning in 2014, Erlanger employed more physicians to secure their downstream revenue.

72. Erlanger Health System's CIA with HHS-OIG ended in October 2010. From 2011 to 2013, Erlanger Health System lost nearly $32 million. In fiscal year 2013, it had only 65 days of cash on hand, which put the hospital in technical default on its bonds. Unless the hospital's financial situation improved, it would be unable to issue more debt for at least two years.

73. To turn around the hospital's negative financial situation, Erlanger Health System hired Kevin Spiegel to serve as CEO beginning in April 2013. The Board of Erlanger Health System expected Mr. Spiegel to make money and improve the hospital's bottom line. Mr. Spiegel's goals were to grow Erlanger's net revenue to $1.2 billion and maintain a top 10 position in Modern Healthcare's ranking of public hospitals, which was based in part on revenues.

74. Erlanger CEO Spiegel implemented several strategies to capture more revenue for the system, including employing more physicians, particularly physicians whose patients would require inpatient hospital stays and generate additional "downstream revenue." Downstream revenue refers to the facility fees, laboratory tests, and other hospital charges ancillary to the physician's services. By hiring a physician, Erlanger captured the revenue from the services the physician

personally performed and the downstream revenue because employed physicians were expected to treat their patients at Erlanger's facilities and to refer their patients to other medical providers employed by Erlanger.

75. The downstream revenue from a surgery, for example, often exceeded the amount Erlanger collected for the professional services that the surgeon personally performed. For instance, Erlanger collected approximately $2,215 from Medicare for a coronary artery bypass surgery that Erlanger cardiothoracic surgeon Larry Shears performed on beneficiary M.N. on March 8, 2018.[1] M.N. was in the hospital for a week after the surgery until she died on March 15, 2018. Erlanger collected approximately $109,890 from Medicare for M.N.'s hospital stay, which included reimbursement for the use of Extra Corporeal Membrane Oxygenation, which is addressed further *infra* Section V.G.

76. CEO Spiegel frequently told Erlanger physicians to refer their patients to Erlanger specialists and to keep their patients within the Erlanger Health System or they would be replaced by physicians who did.

[1] To protect patient privacy, patient identifiers are omitted from this complaint and its exhibits. The United States will provide counsel for the Defendants with the names and identification numbers of the patients under separate cover.

77. As part of the strategy to boost revenues, Erlanger hired specialists who had practiced at competing hospitals, and by requiring them to practice only at Erlanger, Erlanger secured their patients and their downstream revenue.

78. Erlanger tracked referrals outside of its system and enforced the referral requirement. Referral outside of the system by Erlanger employees was referred to as "leakage." At the request of CEO Spiegel, Erlanger's Chief Information Officer prepared "leakage reports" that identified the physicians who were referring outside of Erlanger. Erlanger's CEO requested the reports to enable him or other members of management to speak to the physicians identified in the report about the need to reduce their leakage. At times, Spiegel threatened physicians with adverse action, such as reduced funding to their department, if they did not increase their internal referrals.

79. As a result of CEO Spiegel's efforts, the approximate number of physicians employed by Erlanger Health System grew from 140 in 2014 to 180 in 2016 to 380 in 2018.

80. By July 2018, Erlanger's strategy of employing more physicians to secure their downstream referrals had improved Erlanger's financial situation. On July 14, 2018, Modern Healthcare published an article titled "Docs don't drain hospital finances, systems say." The article states that, "Joe Winick, Erlanger's lead

executive responsible for planning, business development and analytics, said that [Erlanger Health] system's finances improved as a result of hiring more physicians because most of the new doctors add revenue through increased referrals, especially if they're local and bring an existing patient base with them."

81. Enforcement of the referral requirement continued when Dr. William Jackson became CEO in September 2019. During Dr. Jackson's tenure as CEO from September 2019 through 2021, a leakage committee was formed, which was chaired by Meridith O'Keefe, the head of Erlanger's physician services group. Leakage reports were prepared during Dr. Jackson's tenure as CEO and used to identify physicians who were instructed to stop referring outside of Erlanger.

C. Erlanger relaxed or eliminated physician compensation oversight and controls in order to recruit and retain physicians with valuable downstream revenue.

82. Erlanger CEO Spiegel viewed the oversight and controls on physician compensation that were in place under the CIA as barriers to increasing Erlanger's revenues through employed physicians. Over several years following the end of the CIA, Erlanger relaxed or eliminated its compliance controls in order to facilitate the hiring and retention of revenue-generating physicians.

83. After Mr. Spiegel became CEO in April 2013, the Compliance Department, which had functioned effectively to ensure Erlanger's compliance with

the Stark Law, was sidelined. The Chief Compliance Officer was made a non-voting member of a physician contracting committee that Mr. Spiegel formed to review physician contracts. At times, the committee reviewed contracts without a final fair market value assessment of the contract terms. Moreover, the CEO could enter into contracts that the committee did not recommend and could override the Chief Compliance Officer's objection to a contract.

84. During this period, Erlanger CEO Spiegel signed many physician contracts despite the objections of the committee or the Chief Compliance Officer and sometimes before any review by the Chief Compliance Officer at all.

85. In the summer of 2019, Erlanger instructed its physicians to no longer bring compliance concerns to the Chief Compliance Officer. In October 2019, Erlanger Health System eliminated the role of Chief Compliance Officer and terminated Ms. Sullivan's employment.

D. Erlanger changed its compensation model to attract revenue-generating physicians and incentivize their productivity.

86. Beginning under Mr. Spiegel's leadership and continuing under Dr. Jackson, Erlanger's compensation model shifted from the primarily base clinical compensation model used during the years that the CIA was in effect to a model in which large additional payments were made to revenue-generating physicians.

These payments were made in the form of medical director and academic salaries that were paid without regard to whether they were earned; uncapped payments for covering excess on-call shifts; sign-on, retention, and program bonuses; and uncapped productivity incentives.

87. For example, Erlanger provided additional compensation to revenue-generating physicians that was described as medical director or academic salaries. These "salaries" were paid to the physicians without requiring them to document any time actually spent on medical director or academic duties or otherwise ensuring that the physicians were in fact performing separate and independent administrative or academic work.

88. From May 2018 until September 2021, Erlanger paid Dr. Harish Manyam, an electrophysiologist, an annual clinical salary of $816,701, a medical director salary of $101,080, an academic salary of $59,322, and a productivity incentive based on wRVUs. The medical director and academic salaries that Erlanger paid Dr. Manyam during that period were near the 90th percentile of comparable salaries in Dr. Manyam's specialty.

89. Dr. Manyam's employment contract in effect from May 2018 until September 2021 required him to "provide documentation of his Medical Director activities on a monthly basis." The United States does not believe timesheets or

documentation exists to support Dr. Manyam's performance of medical director duties for the period prior to September 2021.

90. In addition, when Erlanger paid Dr. Manyam's $59,322 academic salary in the period prior to September 2021, UTCOM considered Dr. Manyam's academic position to be "a volunteer faculty appointment" that "will not involve salary." Dr. Manyam did not keep academic time records and UTCOM did not evaluate his performance of any academic duties.

91. Premium payments for excess on-call coverage was another means for Erlanger to provide high compensation to revenue-generating physicians. For example, under a December 31, 2014, contract with neurosurgeon Peter Boehm, Jr., Erlanger agreed to pay Dr. Boehm a base salary of $654,735, a productivity incentive based on wRVUs, and payments for excess call coverage ranging from $400 to $1000 per 24-hour shift. Dr. Boehm's contract conditioned Erlanger's payment for excess call coverage on the furnishing of written time records, signed and certified as accurate by Dr. Boehm, that documented the call coverage shifts worked by Dr. Boehm.

92. In 2016, Erlanger paid Dr. Boehm over $500,000 in excess call payments. The United States does not believe documentation certified by Dr. Boehm showing the call coverage shifts that Dr. Boehm worked in 2016 exists.

93. Erlanger similarly paid neurosurgeon Daniel Kueter over $500,000 in excess call payments in 2016. Erlanger made these payments to Dr. Kueter even though Erlanger has not produced any certified written time records as required by Erlanger's compensation contracts with Dr. Kueter that were in effect from December 31, 2014 through 2016.

94. Sign-on, retention, and program bonuses were another vehicle for providing additional compensation to revenue-generating physicians. For example, when Erlanger and cardiothoracic surgeon Larry Shears signed an employment contract in June 2016, Erlanger agreed to pay Dr. Shears a base clinical salary of $1,070,000, excess on-call coverage payments, a sign-on bonus of $150,000, a retention bonus of $100,000 (payable in the fourth year of the contract), and a program incentive of up to $150,000 per year. The payout of the program incentive was based on Dr. Shears achieving goals for Erlanger's Structural Heart and Cardiovascular Surgical Program that had not been set at the time the contract was signed.

95. In addition, productivity incentives were commonly used under CEOs Spiegel and Jackson's leadership to provide additional compensation to employed physicians. Productivity incentives paid physicians premium rates per wRVU as the services that they billed increased, so the more services they billed,

the more they were paid. The productivity bonus at times accounted for a significant portion of the physicians' total compensation.

96. For example, under a compensation contract in effect from August 2016 through 2018, Erlanger paid orthopedic surgeon Mark Freeman a clinical base salary of $485,377, a medical director salary of $45,674, an academic salary (paid by UTCOM with Erlanger funds) of $82,225, and a productivity incentive of approximately $375,000. The productivity incentive payments that Dr. Freeman received in 2017 and 2018 were 35 to 45 percent of the total compensation he received directly from Erlanger, which was $827,822 in 2017 and $1,037,403 in 2018.

97. The productivity incentive that Erlanger paid Dr. Freeman under this agreement was based on Dr. Freeman's billing and associated wRVUs. The per wRVU rates that Erlanger paid when Dr. Freeman's wRVUs exceeded the productivity incentive thresholds were significantly higher than the per wRVU rate reflected in Dr. Freeman's base compensation. The per wRVU rate reflected in Dr. Freeman's base clinical salary was $59.42 (or $485,377 divided by 8,169 wRVUs). Once Dr. Freeman generated 8,170 wRVUs, he was paid $91.29 for each wRVU from 8,170 to 9,506. He was paid an even higher amount, $95.86, for each wRVU in excess of 9,506.

98. In a November 3, 2016, fair market value assessment Erlanger identified $76.43 as the applicable 75th percentile per wRVU rate, meaning 75 percent of comparable physicians were paid below $76.43 per wRVU, according to physician salary survey data. Thus, both productivity incentive rates Erlanger paid Dr. Freeman were significantly higher than this 75th percentile rate. For comparison, the Medicare payment rate per wRVU was $35.83 at the time.

E. The Erlanger physicians who generated valuable downstream revenue were among the highest paid in the nation.

99. The compensation packages that Erlanger began offering to physicians with valuable downstream revenue under CEO Spiegel's leadership resulted in very high compensation to those physicians. Erlanger's physicians with profitable referrals were among the most highly compensated in the nation in their specialties.

100. For example, in 2016, Erlanger paid neurosurgeons Daniel Kueter and Peter Boehm, Jr. approximately twice the comparable median salary for physicians in their specialty, according to salary survey data. In 2017, Erlanger paid orthopedic surgeon Jesse Doty over 3.5 times the comparable median salary for physicians in his specialty. In 2018, Erlanger paid orthopedic surgeon Mark Freeman nearly twice the comparable median salary for physicians in his specialty. In 2019, Erlanger paid electrophysiologist Dr. Manyam over three times the comparable median salary for

physicians in Dr. Manyam's specialty. In 2020, Erlanger paid oncologist Stephen DePasquale nearly three times the comparable median salary for physicians in Dr. DePasquale's specialty.

F. Erlanger dismissed concerns that it was paying employed physicians significantly more than it was collecting for their physician services due to the profitable downstream revenue.

101. Erlanger dismissed concerns that it was paying its employed physicians significantly more than it was collecting for their services. An income statement for all of the employed physician practices for fiscal year 2018 showed over $100 million in losses from employed physicians' salaries, benefits, and expenses compared to the revenue generated by the physicians' work (excluding their referrals).

102. When Chief Financial Officer Tabor raised concerns that employed physicians were paid more than the hospital collected for their professional services, CEO Spiegel referred to the downstream revenue generated by the employed physicians, which bridged the wide gap between employed physician salaries and collections.

103. There was a correlation between the generous compensation packages that some physicians received from Erlanger and the value of their referrals. In 2018, for example, Erlanger paid orthopedic surgeon Freeman, $1,037,403 (primarily in

clinical and medical director salaries and productivity bonus), but only collected approximately $750,000 for physician services billed by Dr. Freeman. Based on these numbers alone, Erlanger lost more than a quarter of a million dollars on Dr. Freeman's practice in 2018. However, in 2018, Dr. Freeman referred 495 patient days at Erlanger hospitals for which Erlanger projected it would receive $5,904,809.

104. As another example, in 2018, Erlanger paid $1,636,962 to electrophysiologist Harish Manyam. Erlanger collected less than $1,250,000 for physician services billed by Dr. Manyam. However, Erlanger profited from Dr. Manyam's referrals, which included 291 inpatient hospital days, for which Erlanger projected to receive $7,727,735 in payments in 2018.

G. Erlanger disregarded overutilization and quality of care concerns bearing on the fair market value of its compensation to a cardiothoracic surgeon.

105. Erlanger was alerted to the risk that it was paying cardiothoracic surgeon Larry Shears more than fair market value in light of significant concerns regarding the quality and medical necessity of services provided by Dr. Shears. Erlanger ignored these concerns because Dr. Shears generated so much revenue.

106. In 2016, Erlanger recruited Dr. Shears from a hospital in Pennsylvania to be the medical director of Erlanger's Cardiovascular Surgery Department. In its initial contract with Dr. Shears, signed June 17, 2016, Erlanger agreed to pay

Dr. Shears a base compensation of $1,070,000, plus excess call pay, sign-on and program incentive bonuses totaling $300,000, and a $100,000 retention bonus payable at the beginning of the fourth year of his contract.

107. By early 2018, Erlanger had received numerous complaints about Dr. Shears and the Cardiovascular Surgery Department from medical staff and patients. Concerns included misuse of Extra Corporeal Membrane Oxygenation, or ECMO, an expensive form of life support in which pumps and oxygenators take over heart and lung function. Dr. Shears' use of ECMO prolonged patients' hospital stays and increased the hospital fees generated by Dr. Shears. Dr. Jackson and others in Erlanger's management knew about the medical staff's concerns that Dr. Shears' Department misused ECMO on patients who were dying or had a low likelihood of survival.

108. By 2018, Erlanger was also aware of a significant number of deaths in a six month period following surgeries performed by Dr. Shears and others in the Cardiovascular Surgery Department.

109. Complaints and concerns about Dr. Shears' performance as a surgeon continued to be raised to Erlanger's management in 2019. In April or May 2019, for example, the medical director of Erlanger's Neurology Group reported to Dr. Jackson, who was then Erlanger's Chief Medical Officer, his concern that

Dr. Shears and the Cardiovascular Surgery Department were covering up neurological complications resulting from cardiac procedures by not alerting neurology when patients experienced stroke symptoms. Dr. Jackson, who later became Erlanger's CEO, did not take any action in response to this concern and the neurologist was reprimanded by Erlanger because he had first reported his concerns about Dr. Shears to the Chief Compliance Officer.

110. Many of the medical staff officers (physicians elected by the medical staff with quality of care responsibilities) believed that Dr. Shears should have been terminated. Instead of terminating Dr. Shears, however, Erlanger increased his compensation. On July 16, 2018, CEO Spiegel signed a contract with Dr. Shears that increased his retention bonus from $100,000 to $250,000 and made it payable immediately. Less than a year later, on May 30, 2019, CEO Spiegel signed another contract with Dr. Shears that increased his base salary from $1,070,000 to $1,195,000.

111. Spiegel and Jackson disregarded quality of care concerns about Dr. Shears and the risk that Erlanger's payments to Dr. Shears exceeded fair market value because Dr. Shears generated significant revenue for Erlanger. In 2018, Dr. Shears' procedures generated 4,567 hospital days for which Erlanger projected

to receive $21,260,600, the highest projected downstream revenue of all Erlanger's employed physicians in 2018.

H. Erlanger ignored warnings that its compensation to physicians exceeded the level of service those physicians were personally providing.

112. Erlanger knew that it was paying productivity bonuses based on productivity measures that overstated the work the physicians were personally performing.

113. Erlanger paid some physicians based on wRVUs that were two or three times the median wRVUs for comparable physicians. In 2017, for example, Erlanger paid orthopedic surgeon Jesse Doty based on wRVUs that were nearly three times the comparable median wRVUs for orthopedics. In 2019, Erlanger paid electrophysiologist Harish Manyam based on wRVUs that were nearly three times the comparable median wRVUs. Similarly, in 2019, Erlanger paid oncologist Stephen DePasquale based on wRVUs that were more than twice the median wRVUs for his specialty.

114. An outside consultant, Pershing Yoakley & Associates ("PYA"), notified Erlanger that the exceptionally high wRVUs claimed by Drs. Doty, Manyam, DePasquale, and others were not accurate. In June 2017, PYA reviewed the accuracy of Erlanger's billing for evaluating or managing patients' health,

referred to as E/M coding, in the period from July to September 2016. The review examined 11 physicians with high wRVUs. In a March 13, 2018 report, PYA informed Erlanger that the overall accuracy rate of E/M coding by the 11 physicians was only 57.3 percent.

115. In September 2017, PYA conducted a second review of E/M billing in July 2017 by the same 11 physicians. In a March 13, 2018, report, PYA informed Erlanger that the overall accuracy rate of E/M coding by the 11 physicians in the second review was only 55.2 percent, worse than the initial review. PYA described all 11 physicians as either "High Risk" or "Medium Risk" of inaccurate E/M coding. PYA further informed Erlanger that wRVUs were inflated for all 11 physicians as a result of the overbilling.

116. Orthopedic surgeon Jesse Doty was among the 11 physicians whose 2016 and 2017 E/M coding was reviewed by PYA. In its March 13, 2018, report of the second review, PYA identified Dr. Doty as a physician with a "Medium Risk" of inaccurate E/M coding. Of the 50 E/M codes reviewed for Dr. Doty, 46 percent were "over-coded," meaning Dr. Doty reported a higher, more expensive E/M code than was supported by the medical records. PYA's March 13, 2018, report also informed Erlanger that Dr. Doty's wRVUs were inaccurate. As a result of Dr. Doty's

inaccurate billing, the reported wRVUs associated with the billed services were 31 percent higher than they should have been.

117. In October 2018, PYA conducted a third review of E/M billing in the period from March to September 2018 for the same 11 physicians and 5 additional physicians with high wRVUs. PYA described 8 of the 16 physicians as "High Risk" or "Medium Risk" of inaccurate E/M coding. PYA also informed Erlanger that wRVUs were inflated as a result of the inaccurate billing.

118. Doctors Harish Manyam, Larry Shears, and Stephen DePasquale were among the 5 additional physicians whose E/M coding was evaluated in the third review. In its January 22, 2019, report, PYA identified Drs. DePasquale and Shears as "High Risk" of inaccurate billing and Dr. Manyam as a "Medium Risk" of inaccurate billing.

119. PYA informed Erlanger that 63 percent of the E/M codes reviewed for Dr. Shears were over-coded, inflating the wRVU value by 38 percent; 74 percent of the E/M codes reviewed for Dr. DePasquale were over-coded, inflating the wRVU value by 42 percent; and 22 percent of the E/M codes for Dr. Manyam were over-coded, inflating the wRVUs value by 8 percent. PYA's January 22, 2019, report further noted that many of the E/M services billed by Dr. DePasquale were

performed by residents without documentation that Dr. DePasquale was present during the key or critical portions of the service.

120. PYA's findings were summarized by Erlanger's Compliance Department in a January 23, 2019, report. The report described E/M errors as an area of "High Risk" based on PYA's findings. The report included an action plan pursuant to which a professional coding team would conduct quarterly audits of 30-50 cases for those physicians with low accuracy, including Drs. Shears, DePasquale, and Manyam, until 95 percent accuracy was achieved.

121. The Compliance Department's January 23, 2019, report, or a summary of the report, was provided to the Audit and Compliance Committee of Erlanger's Board of Directors, including CEO Spiegel, who was a member of the Committee. Thus, the Audit and Compliance Committee and CEO Spiegel were informed of both PYA's findings and the Compliance Department's action plan to address the findings.

122. Nonetheless, Erlanger did not implement the action plan. Erlanger did not conduct quarterly audits of the physicians with low coding accuracy. When Erlanger did audit physicians with low accuracy, it reviewed fewer than 30 cases. These reviews continued to find over-coding, in some cases noting that the physicians billed for services that had been performed by other providers.

123. For example, according to the Compliance Department's January 23, 2019, report, Erlanger planned for a professional coding team to review 50 patient accounts per quarter for Dr. DePasquale and Dr. Shears until 95 percent accuracy was achieved. However, PYA only performed one subsequent review of 20 E/M codes billed by those physicians in the 2019-2021 period, and the review did not find 95 percent accuracy. In reporting the results of its subsequent review of Dr. Shears, PYA also informed Erlanger that Dr. Shears billed for services that should have been billed as performed by Physicians' Assistants.

124. According to the January 23, 2019, report, Erlanger also planned to review 30 patient accounts per quarter for Dr. Manyam, and to continue the reviews until Dr. Manyam achieved 95 percent accuracy. In October 2019, PYA reviewed 20 E/M codes billed by Mr. Manyam in June-July 2019 and found 25 percent were over-coded. The next reviews of Dr. Manyam's E/M coding did not occur until 2021. A February 11, 2021, review by Erlanger's billing department of 5 E/M codes billed by Dr. Manyam in January-February 2021 found no inaccuracy; however, an April 13, 2021, review by Erlanger's audit department of 10 codes billed in January 2021 found all 10 codes, or 100 percent, were over-coded.

125. Although Erlanger paid productivity bonuses to physicians based on their reported wRVUs, including Drs. Doty, Manyam, and DePasquale, Erlanger did

not reduce physician compensation based on PYA's findings that physicians' wRVUs were inaccurate and inflated.

I. Erlanger paid compensation significantly higher than the amounts found to be consistent with fair market value in internal and external analyses.

126. In the period from 2014 through 2021, Erlanger or outside consultants prepared fair market value analyses of Erlanger's contracts with highly compensated physicians. However, these analyses only addressed *potential* compensation under the terms in the contracts, rather than the actual compensation that Erlanger paid. Consequently, the compensation found to be consistent with fair market value in these analyses was frequently much lower than the compensation Erlanger actually paid.

127. The contract between Erlanger and neurosurgeon Peter Boehm, Jr., dated December 31, 2014, was evaluated by the Carnahan Group, an outside consultant, in a report dated April 27, 2015. The report concluded that $783,830 in projected clinical compensation to Dr. Boehm would be consistent with fair market value. In 2016, however, Erlanger actually paid Dr. Boehm $1,732,075, which is $948,245, or *120 percent*, more than the projected compensation analyzed by the consultant.

128. Erlanger's employment contract with neurosurgeon Daniel Kueter, dated December 31, 2014, was also evaluated by the Carnahan Group in the April 27, 2015 report. The report concluded that $1,345,309 in projected clinical compensation to Dr. Kueter would be consistent with fair market value. An internal analysis subsequently prepared on August 22, 2016, concluded that a lower amount, $1,212,095, would fall within an acceptable range of fair market value. In 2016, Erlanger Health System actually paid Dr. Kueter $1,958,722, which is $613,413, or 45 percent, more than the projected compensation analyzed in the April 27, 2015, report and $746,627, or 61 percent, more than the amount evaluated in Erlanger's 2016 internal analysis.

129. In addition, in order to avoid unfavorable results, Erlanger's fair market value analyses for highly compensated physicians were at times based on materially lower wRVUs than Erlanger used to calculate the salary increases that it actually provided.

130. On August 24-25, 2016, for example, during salary negotiations with Dr. Doty, Erlanger discussed paying Doty approximately $1.4 million in compensation based on 19,037 wRVUs.

131. On August 29, 2016, Erlanger and Dr. Doty signed a contract in which Erlanger agreed to pay Dr. Doty escalating amounts per wRVU as Dr. Doty's

wRVUs increased. The contract provided that Dr. Doty would receive a per wRVU rate of $61.94 at his base clinical salary, a higher per wRVU rate of $76.09 for each wRVU from 8,073 to 8,923, and an even higher amount, $79.89, for each wRVU in excess of 8,923.

132. Erlanger's September 7, 2016, internal fair market value analysis concluded that Dr. Doty's contract would fall within an acceptable range of fair market value. This conclusion was based on the fact that—according to this analysis—Dr. Doty's clinical compensation rate would be lower than $71.89 per wRVU, the applicable 75th percentile per wRVU rate identified in the analysis. In order to reach this conclusion, Erlanger's analysis assumed that Dr. Doty's "maximum total compensation" (including a $68,949 academic salary) would be $835,907 based on a "highest productivity level of 11,455 wRVUs."

133. In fact, however, under this contract, Erlanger had agreed to pay Dr. Doty $76.09 for each wRVU over 8,072 and $79.89 for each wRVU over 8,923. Therefore, if Erlanger's fair market value analysis had taken into account the 19,037 wRVUs that Erlanger had discussed with Dr. Doty during salary negotiations that took place only a few weeks before the fair market value analysis, the clinical compensation per wRVU rate would have exceeded the 75th percentile. And the per

wRVU rate would have been even higher had Dr. Doty's academic salary (paid by UTCOM with Erlanger funds) been included in this analysis.

134. In 2017, Erlanger paid Dr. Doty $2,143,436, more than twice the "maximum total compensation" that Erlanger concluded was consistent with fair market value in the September 7, 2016, analysis. Dr. Doty's actual 2017 compensation was based on 26,358 wRVUs, which is 14,903 more than the 11,455 wRVUs addressed in the fair market value analysis and 7,321 more than the 19,037 wRVUs discussed in salary negotiations.

135. At times, the fair market value calculations that Erlanger relied on omitted compensation components from the calculation of the compensation rate per wRVU to avoid unfavorable conclusions. For example, in an employment contract with oncologist Stephen DePasquale signed February 21, 2019, Erlanger agreed to pay a $400,000 retention bonus, with $200,000 payable on the effective date and $200,000 payable on the first anniversary of the effective date. Dr. DePasquale's February 2019 contract was evaluated by Integrated Healthcare Strategies, an outside consultant, in a report dated April 2, 2019. The consultant's report concluded that the compensation was consistent with fair market value, but did not include Dr. DePasquale's $400,000 retention bonus in the per wRVU calculation. Had the bonus been included, the per wRVU rate in the analysis would have

exceeded the 75th percentile rate identified as a fair market value benchmark in the report.

J. Erlanger disregarded warnings in fair market value assessments.

136. The fair market value assessments that Erlanger obtained at times warned Erlanger that the lower compensation addressed in the opinions nevertheless raised multiple fair market value concerns.

137. Erlanger knew from some fair market value opinions that the compensation would exceed the 75th or 90th percentile. For example, a June 25, 2018, fair market value assessment of Dr. Manyam's May 2018 contract by consultant Integrated Healthcare Strategies informed Erlanger that projected total compensation to Dr. Manyam of $1,199,215—which was significantly less than the $1,636,962 that Erlanger actually paid Dr. Manyam in 2018—exceeded the 90th percentile of national compensation data.

138. Fair market value opinions also warned Erlanger of the risk that exceptionally high wRVUs were upcoded or resulted from unnecessary services. For example, Integrated Healthcare Strategies' June 25, 2018, fair market value assessment of Dr. Manyam's May 2018 contract and April 2, 2019, fair market value analysis of Dr. DePasquale's February 2019 contract informed Erlanger that the projected wRVUs for Dr. Manyam and Dr. DePasquale—which were less than the

wRVUs those physicians actually reported—nevertheless exceeded the 90th percentile of the national market data. Both opinions advised Erlanger to conduct a "rigorous chart audit, coding audit, medical necessity and quality review" to ensure Dr. Manyam's and Dr. DePasquale's billing and associated wRVUs were "consistent with the documentation and established performance standards." As alleged *supra* Section V.H., Erlanger did not rigorously audit Dr. Manyam's or Dr. DePasquale's billing and the audits that were performed found over-coding and inflated wRVUs.

139. In addition, Integrated Healthcare Strategies' conclusion in its June 25, 2018, report that Dr. Manyam's compensation would be within fair market value is conditioned on Dr. Manyam "document[ing] all time spent in the provision of academic and administrative services" and Erlanger "demonstrat[ing] that the administrative and academic time provided by Dr. Manyam is separate and distinct from each other and from the provision of clinical services." As alleged *supra* Section V.D., the United States does not believe that Erlanger tracked Dr. Manyam's academic or administrative time in the period from May 2018 until September 2021 and therefore Erlanger cannot demonstrate that Dr. Manyam actually performed the separate and independent academic and administrative work for which he was paid.

K. Erlanger resisted the Chief Compliance Officer's efforts to engage an outside consultant to review employed physicians' actual compensation.

140. On multiple occasions during her employment, Erlanger's Chief Compliance Officer, Ms. Sullivan, raised concerns about physician compensation with Dr. Jackson, Ms. O'Keefe, the head of Erlanger's physician services group, and Gerald Webb, the Chairman of the Audit and Compliance Committee of Erlanger's Board.

141. Ms. O'Keefe, a member of Erlanger's Compliance Committee, received a January 31, 2019, Compliance Department plan to retain outside consultant Integrated Healthcare Strategies to review the fair market value of the actual compensation being paid to employed physicians. The Compliance Department identified the fair market value audit as related to Stark Law compliance, a "High" risk area.

142. In 2019, Ms. Sullivan communicated to Ms. O'Keefe and Dr. Jackson her belief that Erlanger needed to engage an outside review of compensation being paid to employed physicians because the fair market value assessments that Erlanger was obtaining for individual physicians were not evaluating the high amounts actually being paid. Ms. Sullivan understood that Ms. O'Keefe did not want an

outside review of actual compensation being paid because Ms. O'Keefe expected the results would not be favorable to Erlanger.

143. In 2019, Ms. Sullivan also spoke on several occasions with Mr. Webb about her concern that Erlanger was paying very high compensation to many employed physicians without assessing whether the compensation was fair market value for the work the physicians were performing. Despite Ms. Sullivan's persistent warnings, in the period from 2019 through 2021, Erlanger did not obtain an outside review of the compensation it was actually paying to employed physicians.

144. In October 2019, Erlanger terminated Ms. Sullivan's employment and eliminated the role of Chief Compliance Officer. At that time, Erlanger required Ms. Sullivan to provide a written disclosure of unresolved compliance issues. In the written disclosure, dated November 18, 2019, Ms. Sullivan identified "FMV and Commercial Reasonableness assessment for Erlanger employed physicians" as among the unaddressed compliance issues, noting that it was apparent to her from conversations with Ms. O'Keefe and Dr. Jackson that they did not want the assessment to be completed.

L. Erlanger knew its physician compensation exceeded fair market value metrics.

145. After Ms. Sullivan was terminated, Erlanger itself performed a fair market value analysis of physician compensation paid in 2018-2019. The internal review, which was completed by January 8, 2021, is described in a report titled "FY21 Physician Compensation Hindsight Review." The report identified "compensation outliers and anomalies" in the 2018-2019 compensation paid to 25 different physicians, including Drs. Manyam, DePasquale, and Freeman. The report identified 15 different physicians whose 2018 and/or 2019 compensation per wRVU exceeded the 75th percentile, including Dr. Freeman in 2018 and Dr. DePasquale in 2019.

146. All of the Erlanger physicians identified in the internal analysis of 2018-2019 compensation whose 2018 compensation per wRVU exceeded the 75th percentile had profitable downstream revenue in 2018.

M. Examples of compensation to employed physicians in excess of fair market value.

147. From 2017 through 2019 and in 2021, Erlanger knowingly paid compensation to electrophysiologist Harish Manyam that exceeded fair market value for numerous reasons, including: (a) Dr. Manyam's total compensation exceeded the 90th percentile in comparable salary survey data for physicians in his specialty

in 2017 through 2019 and in 2021, and in 2019, Dr. Manyam' total compensation was more than three times the comparable median salary; (b) the ratio of Dr. Manyam's compensation to the amount collected for his work exceeded the 75th percentile in 2017 through 2019 and in 2021; (c) Dr. Manyam's compensation rate per wRVU exceeded the 75th percentile in 2021 and the 62.5th percentile in 2017 through 2019; (d) the wRVUs for which he was paid exceeded the 90th percentile in 2017 through 2019 and in 2021, and were nearly three times the comparable median wRVUs in 2019; (e) a consultant's fair market value opinions dated June 25, 2018, and August 13, 2021, warned Erlanger of the risk that his exceptionally high wRVUs were upcoded or resulted from unnecessary services; (f) 2018, 2019, and 2021 reviews of Dr. Manyam's billing informed Erlanger that his wRVUs were inaccurate and inflated; (g) the contract in effect from May 2018 to September 2021 required Dr. Manyam to "provide documentation of his Medical Director activities on a monthly basis," the consultant's June 25, 2018, opinion concluding that Dr. Manyam's compensation was consistent with fair market value was conditioned on him "document[ing] all time spent" providing academic and medical director duties and Erlanger "demonstrat[ing]" that the academic and medical director time provided by him were "separate and distinct from each other and from the provision of clinical services," but Erlanger did not track Dr. Manyam's academic or

administrative time prior to September 2021; and (h) Erlanger knew from its FY21 Physician Compensation Hindsight Review of 2018-2019 paid compensation that there were "compensation outliers and anomalies" with respect to Dr. Manyam.

148. Erlanger knowingly paid compensation to orthopedic surgeon Jesse Doty in 2014 through 2017 that exceeded fair market value for numerous reasons including: (a) the total compensation exceeded the 90th percentile in 2014 through 2017, and in 2017, the total compensation was over 3.5 times the comparable median salary for physicians in his specialty; (b) the ratio of his compensation compared to the amount collected for his work exceeded the 90th percentile in 2014 through 2017; (c) the compensation rate per wRVU exceeded the 90th percentile in 2014 through 2016 and the 75th percentile in 2017; (d) the wRVUs for which he was paid exceeded the 90th percentile in 2016 and 2017 and the 75th percentile in 2015, and were nearly three times the comparable median wRVUs in 2017; (e) a 2017 consultant review of his billing informed Erlanger that his wRVUs were inaccurate and inflated; (f) an internal fair market value analysis dated September 7, 2016, was based on materially lower wRVUs than Erlanger used to calculate his 2016 salary increase; and (g) in 2017, Erlanger paid Dr. Doty more than twice the compensation that Erlanger concluded was consistent with fair market value in the September 7, 2016, fair market value analysis.

149. Erlanger knowingly paid compensation to oncologist Stephen DePasquale in 2019 through 2020 that exceeded fair market value for numerous reasons including: (a) the total compensation exceeded the 90th percentile in 2019 through 2020, and was nearly three times the comparable median salary in 2020; (b) the ratio of his compensation compared to the amount collected for his work exceeded the 90th percentile in 2020 and the 75th percentile in 2019; (c) the compensation rate per wRVU exceeded the 75th percentile in 2019 through 2020; (d) the wRVUs for which he was paid exceeded the 90th percentile in 2019 through 2020, and were more than twice the median wRVUs in 2019; (e) a 2018 consultant's review of Dr. DePasquale's billing informed Erlanger that his wRVUs were inaccurate and inflated; (f) a consultant's fair market value opinion dated April 2, 2019, warned Erlanger of the risk that his exceptionally high wRVUs were upcoded or resulted from unnecessary services; (g) the April 2, 2019, fair market value opinion did not include his $400,000 retention bonus in the calculation of the compensation per wRVU rate, a material omission; and (h) Erlanger knew from its FY21 Physician Compensation Hindsight Review of 2018-2019 paid compensation that Dr. DePasquale's 2019 compensation per wRVU rate exceeded the 75th percentile.

150. Erlanger knowingly paid compensation to orthopedic surgeon Mark Freeman in 2017 through 2018 that exceeded fair market value for numerous reasons including: (a) the total compensation exceeded the 90th percentile in 2018 and was nearly twice the comparable median salary in 2018; (b) the ratio of his compensation compared to the amount collected for his work exceeded the 75th percentile in 2017 through 2018; (c) Erlanger knew from a November 3, 2016, fair market value assessment that the productivity incentive rates that it paid to Dr. Freeman under the compensation contract in effect from August 1, 2016 through 2018 were significantly higher than the 75th percentile per wRVU rate; (d) the paid compensation rate per wRVU exceeded the 75th percentile in 2017 through 2018; and (e) Erlanger knew from its FY21 Physician Compensation Hindsight Review of 2018-2019 paid compensation that Dr. Freeman's 2018 compensation per wRVU exceeded the 75th percentile.

151. Erlanger knowingly paid compensation to neurosurgeon Peter Boehm, Jr. in 2016 that exceeded fair market value for numerous reasons including: (a) the total compensation exceeded the 90th percentile and was nearly twice the comparable median salary for neurosurgeons; (b) the ratio of his compensation compared to collections exceeded the 75th percentile; (c) the compensation rate per wRVU exceeded the 75th percentile; (d) Erlanger paid Dr. Boehm over $500,000 in

excess on-call payments in 2016 without certified written time records as required by its December 31, 2014, compensation contract with Dr. Boehm; and (e) in 2016, Erlanger paid Dr. Boehm more than twice the compensation that Erlanger's consultant concluded was consistent with fair market value in a April 27, 2015, report.

152. Erlanger knowingly paid compensation to neurosurgeon Daniel Kueter in 2016 that exceeded fair market value for numerous reasons including: (a) the total compensation exceeded the 90th percentile and was more than twice the comparable median salary for neurosurgeons; (b) the ratio of his compensation compared to collections exceeded the 75th percentile; (c) the compensation rate per wRVU exceeded the 75th percentile; (d) Erlanger paid Dr. Kueter over $500,000 in excess on-call payments in 2016 without certified written time records as required by its contracts with Dr. Kueter in effect from December 31, 2014, through 2016; and (e) in 2016, Erlanger paid Dr. Kueter over 60 percent more than the amount Erlanger concluded was acceptable in an August 22, 2016, fair market value analysis.

153. The compensation to employed physicians described above are examples of compensation that exceeded fair market value in the period from 2014 through 2021. The evidence set forth by the United States in this complaint supports the conclusion that from 2014 through 2021 Erlanger knowingly engaged in a pattern

and practice of paying compensation to employed physicians that exceeded fair market value. The United States believes that this practice extended to additional physicians and compensation arrangements which the United States has not yet been able to identify. On information and belief, because these additional Erlanger compensation arrangements did not fit within an exception to the Stark Law, they gave rise to additional False Claims Act violations.

VI. Erlanger's Violation of the Stark Law is Material

154. Compliance with the Stark Law is material to Medicare's decision to pay a hospital's claims for payment for hospital services rendered to Medicare beneficiaries.

155. Erlanger's false representations in its Medicare enrollment forms and cost reports— certifying prospectively and retrospectively that its claims complied with the Stark Law—were material to Medicare's decision whether to pay Erlanger's claims and were intended to induce Medicare to pay those claims.

156. The Stark Law expressly states that hospitals may not submit, and Medicare may not pay, claims for designated health services referred in violation of the statute. *See* 42 U.S.C. §§ 1395nn(a)(1), 1395nn(g)(1).

157. The accompanying regulations require the timely refund of any payments received in violation of the Stark Law. *See* 42 C.F.R. § 411.353(d).

158. CMS identifies compliance with the Stark Law as a condition of payment for Medicare claims on its provider enrollment form and elsewhere.

159. Compliance with the Stark Law goes to the essence of Medicare's bargain with participating healthcare providers. The Stark Law plays a key role in ensuring that services are reasonable and necessary, and are not provided merely to enrich the parties in a financial relationship at the expense of federal health care programs and their beneficiaries.

160. For these reasons, the United States routinely pursues cases, like this one, alleging that entities or individuals submitted or caused the submission of claims that were false because they violated the Stark Law.

161. For example, in *United States v. Rogan*, 459 F. Supp. 2d 692 (N.D. Ill. 2006), aff'd, 517 F.3d 449 (7th Cir. 2008), the United States obtained a judgment against a hospital executive who had knowingly caused the hospital to submit false claims resulting from referrals by physicians whose compensation arrangements with the hospital did not satisfy the requirements of any applicable exception to the Stark Law, including because the compensation paid exceeded the fair market value of the physicians' services.

162. In *United States ex rel. Drakeford v. Tuomey Healthcare System, Inc.*, No. 3:05-cv-02858 (D.S.C.), aff'd, 792 F.3d 364 (4th Cir. 2015), the United States

obtained a judgment against a hospital that had compensation arrangements with physicians that failed to satisfy the requirements of any applicable exception to the Stark Law, including because the physicians' compensation exceeded the fair market value of their actual services.

163. In September 2015, the United States settled two cases, *United States ex rel. Payne, et al. v. Adventist Health System/Sunbelt, Inc., et al*., No. 12-cv-856 (W.D.N.C) and *United States ex rel. Dorsey v. Adventist Health System Sunbelt Healthcare Corp., et al*., No. 13-cv-217 (W.D.N.C), involving allegations that a hospital had entered into compensation arrangements with physicians that did not satisfy the requirements of any applicable exception to the Stark Law.

164. In September 2015, the United States settled a case, *United States ex rel. Reilly v. North Broward Hospital District, et al*., No. 10-cv-60590 (S.D. Fla.), involving allegations that a hospital had entered into compensation arrangements with certain physicians that did not satisfy the requirements of any applicable exception to the Stark Law, including because the compensation paid exceeded fair market value.

165. In August 2018, the United States settled four cases, *United States ex rel. David Felten, M.D., Ph.D. v. William Beaumont Hospitals, et al*., No. 2:10-cv-13440 (E.D. Mich.), *United States ex rel. Karen Carbone v. William Beaumont*

Hospital, No. 11-cv-12117 (E.D. Mich.), *United States ex rel. Cathryn Pawlusiak v. Beaumont Health System, et al.*, No. 2:11-cv- 12515 (E.D. Mich.), and *United States ex rel. Karen Houghton v. William Beaumont Hospital*, No. 2:11-cv-14312 (E.D. Mich.), involving allegations that a hospital had entered into compensation arrangements with certain physicians that did not satisfy the requirements of any applicable exception to the Stark Law, including because the compensation paid exceeded fair market value.

166. In January 2020, the United States intervened in a case, *United States ex rel. Thomas Fischer v. Community Health Network, Inc.*, No. 1:14-cv-1215 (S.D. Ind.), involving allegations that a hospital had entered into compensation agreements with certain physicians that did not satisfy the requirements of any applicable exception to the Stark Law, including because the compensation paid exceeded fair market value. The United States settled this case in December 2023.

167. In September 2020, the United States settled a case, *United States of America ex rel. Louis Longo v. Wheeling Hospital, Inc. et al.*, No. 19-cv-192 (N.D.W. Va.), involving allegations that a hospital had entered into compensation agreements with certain physicians that did not satisfy the requirements of any applicable exception to the Stark Law, including because the compensation paid exceeded fair market value.

168. In December 2023, the United States intervened in a case, *United States ex rel. Joseph Nocie v. Steward Health Care System, LLC, et al*., No. 1:18-cv-11160 (D. Mass.), alleging that a hospital had a compensation arrangement with a cardiac surgeon that did not satisfy the requirements of any applicable Stark Law exception, including because the compensation exceeded fair market value.

169. The alleged violations by Erlanger are not minor or insubstantial. Erlanger violated the Stark Law in ways that implicate the core concerns of the statute, including because Erlanger paid physicians in excess of fair market value. Erlanger knowingly paid physicians compensation that exceeded the value of the work those physicians personally performed, resulting in false claims and statements to Medicare.

VII. Erlanger's False Claims and Statements

170. Erlanger submitted claims to Medicare for hospital services provided to Medicare beneficiaries that were referred in violation of the Stark Law by physicians with whom Erlanger had financial arrangements, as described above.

171. At all times relevant to this lawsuit, the Medicare statutory and regulatory rules described above, *see supra* Section IV., applied to Erlanger.

172. During the relevant time period, Erlanger submitted enrollment applications, including the applications identified on Exhibit 1, to revalidate or make changes to its enrollment information.

173. In those enrollment applications, Erlanger certified, among other things, to "abide by the Medicare laws, regulations and program instructions" that applied to it and certified an understanding that "payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with" the Stark Law, among other laws and regulations.

174. During the relevant time period, Erlanger submitted annual Medicare cost reports, as described above, *see supra* Section IV.A., which constituted Erlanger's final claims to Medicare for items and services rendered to Medicare beneficiaries during the year covered by the report.

175. In each cost report, Erlanger certified that the report and statements in the report were "true, correct, [and] complete," and the services identified in the cost report were provided in compliance with applicable laws and regulations, including the Stark Law.

176. Erlanger's certifications of compliance with the Stark Law in its annual cost reports, including the cost reports identified on Exhibit 2, were false because, as explained above, Erlanger did not comply with the Stark Law.

177. Erlanger submitted thousands of Medicare claims for services unlawfully referred in violation of the Stark Law.

178. In submitting these claims, Erlanger made specific representations about the billed services that were rendered materially misleading by Erlanger's knowing failure to disclose the claims' noncompliance with the Stark Law.

179. The allegations below and Exhibit 3 contain specific representative examples of claims for hospital services that were submitted by Erlanger that resulted from referrals by physicians with whom Erlanger had financial relationships that did not meet the requirements for an applicable exception of the Stark Law.

A. Representative Example 1 (Harish Manyam)

180. Erlanger submitted a claim to Medicare and received $33,341.50 in payment for hospital services for beneficiary J.B. on April 10-11, 2019. The claim that Erlanger submitted to Medicare for hospital services for beneficiary J.B. was billed in connection with implantation of a cardiac defibrillator by electrophysiologist Harish Manyam on April 11, 2019. The claim for hospital services for beneficiary J.B. referred by Dr. Manyam violated the Stark Law because Erlanger had a financial relationship with Dr. Manyam that did not satisfy the requirements of an exception under the Stark Law.

B. Representative Example 2 (Harish Manyam)

181. Erlanger submitted a claim to Medicare and received $46.63 in payment for hospital services for beneficiary V.M. on August 13, 2021. The claim that Erlanger submitted to Medicare for hospital services for beneficiary V.M. was billed in connection with an electrocardiogram by Dr. Manyam at Erlanger Western Carolina Hospital on August 13, 2021. The claim for hospital services for beneficiary V.M. referred by Dr. Manyam violated the Stark Law because Erlanger had a financial relationship with Dr. Manyam that did not satisfy the requirements of an exception under the Stark Law.

C. Representative Example 3 (Jesse Doty)

182. Erlanger submitted a claim to Medicare and received $29,603.70 in payment for hospital services for beneficiary C.B. on February 2-10, 2016. The claim that Erlanger submitted to Medicare for hospital services for beneficiary C.B. was billed in connection with wound debridement and skin graft procedures by orthopedic surgeon Jesse Doty on February 2 and 8, 2016. The claim for hospital services for beneficiary C.B. referred by Dr. Doty violated the Stark Law because Erlanger had a financial relationship with Dr. Doty that did not satisfy the requirements of an exception under the Stark Law.

D. Representative Example 4 (Jesse Doty)

183. Erlanger submitted a claim to Medicare and received $18,192.28 in payment for hospital services for beneficiary N.T. on December 14-19, 2017. The claim that Erlanger submitted to Medicare for hospital services for beneficiary N.T. was billed in connection with biopsy procedures by Dr. Doty on December 14, 2017. The claim for hospital services for beneficiary N.T. referred by Dr. Doty violated the Stark Law because Erlanger had a financial relationship with Dr. Doty that did not satisfy the requirements of an exception under the Stark Law.

E. Representative Example 5 (Stephen DePasquale)

184. Erlanger submitted a claim to Medicare and received $10,882.97 in payment for hospital services for beneficiary H.S. on January 24-February 5, 2019. The claim that Erlanger submitted to Medicare for hospital services for beneficiary H.S. was billed in connection with an excision procedure by oncologist Stephen DePasquale on January 24, 2019. The claim for hospital services for beneficiary H.S. referred by Dr. DePasquale violated the Stark Law because Erlanger had a financial relationship with Dr. DePasquale that did not satisfy the requirements of an exception under the Stark Law.

F. Representative Example 6 (Stephen DePasquale)

185. Erlanger submitted a claim to Medicare and received $14,852.77 in payment for hospital services for beneficiary N.C. on May 13-16, 2020. The claim that Erlanger submitted to Medicare for hospital services for beneficiary N.C. was billed in connection with a laparoscopic procedure by Dr. DePasquale on May 12, 2020. The claim for hospital services for beneficiary N.C. referred by Dr. DePasquale violated the Stark Law because Erlanger had a financial relationship with Dr. DePasquale that did not satisfy the requirements of an exception under the Stark Law.

G. Representative Example 7 (Mark Freeman)

186. Erlanger submitted a claim to Medicare and received $20,558.57 in payment for hospital services for beneficiary D.B. on April 17-20, 2017. The claim that Erlanger submitted to Medicare for hospital services for beneficiary D.B. was billed in connection with a hip replacement surgery by orthopedic surgeon Mark Freeman on April 17, 2017. The claim for hospital services for beneficiary D.B. referred by Dr. Freeman violated the Stark Law because Erlanger had a financial relationship with Dr. Freeman that did not satisfy the requirements of an exception under the Stark Law.

H. Representative Example 8 (Mark Freeman)

187. Erlanger submitted a claim to Medicare and received $32,321.94 in payment for hospital services for beneficiary W.H. on December 21-27, 2018. The claim that Erlanger submitted to Medicare for hospital services for beneficiary W.H. was billed in connection with a hip replacement surgery by Dr. Freeman on December 21, 2018. The claim for hospital services for beneficiary W.H. referred by Dr. Freeman violated the Stark Law because Erlanger had a financial relationship with Dr. Freeman that did not satisfy the requirements of an exception under the Stark Law.

I. Representative Example 9 (Peter Boehm, Jr.)

188. Erlanger submitted a claim to Medicare and received $50,759.21 in payment for hospital services for beneficiary J.W. on February 29-March 4, 2016. The claim that Erlanger submitted to Medicare for hospital services for beneficiary J.W. was billed in connection with a spinal fusion by neurosurgeon Peter Boehm, Jr. on February 29, 2026. The claim for hospital services for beneficiary J.B. referred by Dr. Boehm violated the Stark Law because Erlanger had a financial relationship with Dr. Boehm that did not satisfy the requirements of an exception under the Stark Law.

J. Representative Example 10 (Daniel Kueter)

189. Erlanger submitted a claim to Medicare and received $72,070.28 in payment for hospital services for beneficiary D.B. on September 11-21, 2016. The claim that Erlanger submitted to Medicare for hospital services for beneficiary D.B. was billed in connection with a spinal fusion by neurosurgeon Daniel Kueter on September 14, 2016. The claim for hospital services for beneficiary D.B. referred by Dr. Kueter violated the Stark Law because Erlanger had a financial relationship with Dr. Kueter that did not satisfy the requirements of an exception under the Stark Law.

VIII. The United States Suffered Damages

190. Medicare paid Erlanger approximately $27.8 million for claims that Erlanger submitted to Medicare for hospital services referred by the physicians identified in Section V.M. during the time periods in which Erlanger's compensation to those physicians exceeded fair market value.

FIRST CAUSE OF ACTION

False Claims Act: Presenting and Causing False Claims
(31 U.S.C. § 3729(a)(1)(A))

191. The United States incorporates by reference all paragraphs of the complaint set forth above as if fully set forth here.

192. Defendants presented or caused to be presented materially false or fraudulent claims for payment or approval to the United States, including claims to the Medicare Program for reimbursement (specific examples of which are identified in Section VII. and Exhibit 3) of designated health services rendered to patients who were referred to Defendants by employed physicians in violation of the Stark Law.

193. Defendants presented or caused to be presented such claims with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

194. The United States sustained damages because of Defendants' wrongful conduct.

SECOND CAUSE OF ACTION

False Claims Act: False Statements Material to False Claims
(31 U.S.C. § 3729(a)(1)(B))

195. The United States incorporates by reference all paragraphs of the complaint set forth above as if fully set forth here.

196. Defendants made, used, or caused to be made or used false records or statements, i.e., false certifications in enrollment applications and cost reports (specific examples of which are identified in Exhibits 1 and 2).

197. Defendants false certifications were made for the purpose of getting false or fraudulent claims paid by the United States, and payment of the false or fraudulent claims by the United States was a reasonably foreseeable consequence of Defendants' certifications and actions.

198. The false certifications made or caused to be made by Defendants were material to the United States' payment of the false claims.

199. Defendants made or caused such false certifications with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

200. The United States sustained damages because of Defendants' wrongful conduct.

THIRD CAUSE OF ACTION

Unjust Enrichment

201. The United States incorporates by reference all paragraphs of this complaint set out above as if fully set forth here.

202. This is a claim for recovery of monies by which Defendants have been unjustly enriched at the expense of the United States.

203. By obtaining government funds to which they were not entitled, Defendants were unjustly enriched and are liable to pay as restitution such amounts, which are to be determined at trial, to the United States.

FOURTH CAUSE OF ACTION

Payment by Mistake

204. The United States incorporates by reference all paragraphs of this complaint set out above as if fully set forth here.

205. This is a claim for the recovery of monies paid by the United States to Defendants as a result of mistaken understandings of fact.

206. The United States paid Defendants for claims for designated health services referred by physicians who had compensation arrangements with Defendants in violation of the Stark Law, without knowledge of material facts, and under the mistaken belief that Defendants were entitled to receive payment for such claims, which were not eligible for payment. The United States' mistaken belief was material to its decision to pay Defendants for such ineligible claims. Accordingly, Defendants are liable for damages to the United States for the total amount of the payments made in error to Defendants by the United States.

PRAYER FOR RELIEF

The United States requests that judgment be entered in its favor and against the Defendants as follows:

(a) On the First and Second Counts (False Claims Act), for treble the United States' damages, together with civil penalties allowed by law;

(b) On the Third Count (Unjust Enrichment), in the amount that Defendants were unjustly enriched;

(c) On the Fourth Count (Payment by Mistake), in the amount that Defendants illegally obtained and retained; and

(d) For pre- and post-judgment interest, costs, and such other relief as the Court may deem appropriate.

JURY DEMAND

Pursuant to Federal Rule of Civil Procedure 38, the United States requests a trial by jury.

This the 26th day of July, 2024.

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CERTIFICATE OF SERVICE

I hereby certify that on the 26th day of July, 2024, the foregoing pleading was served upon the parties below by electronic mail, pursuant to the parties' consent to service of pleadings in this matter by electronic mail.

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