UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF LOUISIANA
SHREVEPORT DIVISION

UNITED STATES OF AMERICA, and the STATES OF LOUISIANA and TEXAS, *ex rel.* MICHAELA DEVOS	)	**CIVIL ACTION NO: 20-cv-01041** **FILED UNDER SEAL**
VERSUS	)	**JUDGE DOUGHTY**
PRIORITY HOSPITAL GROUP, LLC; RIVERSIDE HOSPITAL OF LOUISIANA, INC.; RIVERSIDE HOSPITAL, LLC; POST ACUTE ENTERPRISES, LLC D/B/A MID JEFFERSON EXTENDED CARE HOSPITAL; NEW LIFECARE SPECIALTY HOSPITAL OF NORTH LOUISIANA, LLC D/B/A RUSTON REGIONAL SPECIALTY HOSPITAL; and BENJAMIN NEWSOM	)	**MAGISTRATE JUDGE PEREZ-MONTES** **JURY TRIAL DEMANDED**

UNITED STATES' COMPLAINT IN INTERVENTION

Plaintiff the United States brings this action against defendants Priority Hospital Group, LLC (PHG), three PHG-managed long-term care hospitals (LTCHs),[1] and a physician, Dr. Benjamin Kyle Newsom, to recover damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33, and common law causes of action. The three long-term care hospital defendants collectively will be

[1] Riverside Hospital, LLC and Riverside Hospital of Louisiana, Inc. dba Riverside Hospital; New Lifecare Specialty Hospital of North Louisiana, LLC dba Ruston Regional Specialty Hospital; and Post Acute Enterprises, LLC dba Mid Jefferson Extended Care Hospital.

referred to as the LTCH Defendants. PHG and the LTCH Defendants together will be referred to as the PHG Defendants. The PHG Defendants and Dr. Newsom together will be referred to as the Defendants.

INTRODUCTION

1. LTCHs are specialty hospitals intended for complex patients who need several weeks of inpatient hospital care. Medicare generally pays LTCHs more than standard hospitals because of the extended length of patient stays. To qualify as an LTCH, a hospital must maintain an average length of stay over twenty-five days for certain Medicare patients (Qualifying Patients).

2. Medicare reimburses LTCHs based in part on a patient's length of stay. Medicare's payment increases with the length of stay until the "5/6th date"—the day a patient exceeds 5/6th of the average length of stay for all LTCH patients with similar diagnoses and treatment. After a patient reaches the 5/6th date, Medicare generally pays the same amount whether the patient is discharged immediately or stays longer in the hospital.

3. The PHG Defendants illegally inflated their Medicare payments by holding patients who were ready for discharge until they reached their 5/6th date. If a patient was a Qualifying Patient, they also held the patient long enough to meet the 25-day average length of stay requirement to maintain their LTCH status and be paid at the higher LTCH rate. The PHG Defendants aimed to discharge patients as soon as they reached the 5/6th date and satisfied the 25-day requirement because

longer stays resulted in additional costs to the hospital but no additional reimbursement.

4. The PHG Defendants' goal was to make as much money as possible off each patient regardless of their medical needs. As one executive told her employees: "No one is leaving early. We lose money." Another executive praised employees who discharged patients "on their correct discharge day to maximize our revenue."

5. The PHG Defendants' scheme had a significant impact on when patients left their hospitals—over half of non-Qualifying Patients were discharged within one day of the 5/6th date. Many of these patients could have been discharged earlier and received care at home or in a nursing facility for a fraction of the cost to Medicare.

6. The PHG Defendants knew that holding patients longer than medically necessary resulted in fraudulent claims to Medicare. The Center for Medicare & Medicaid Services explicitly stated in 2017 that it was improper for LTCHs to delay patient discharges until the 5/6th date to maximize payment. *See* 82 Fed. Reg. 19796, 20022-23 (Apr. 28, 2017). When employees raised concerns about PHG's practices to one of its executives, the executive dismissed them, noting PHG would make money even if Medicare denied some medically unnecessary claims.

7. In addition to manipulating patient length of stay, one LTCH Defendant, Riverside Hospital, entered financial arrangements with Dr. Benjamin Newsom that violated the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, and the

physician self-referral law, 42 U.S.C. § 1395nn (commonly referred to as the Stark Law).

8. Riverside engaged Dr. Newsom as a "medical director" under three agreements and paid him over $450,000 between 2017 and 2022. Riverside intended these payments to induce Dr. Newsom to refer and admit patients to Riverside, and Riverside gave Dr. Newsom other gifts, such as a PlayStation 4, "for all of the referrals." Dr. Newsom did, in fact, refer patients to Riverside for whom Medicare paid over $2 million and admit patients for whom Medicare paid over $17 million.

9. Communications between Riverside and Dr. Newsom show they knew these payments and gifts violated the law. For example, after a doctor expressed concern about Dr. Newsom accepting the PlayStation 4, Dr. Newsom texted a Riverside manager, "[W]e had a meeting just now bout the PS4. We will keep it. But we are telling ppl that I bought it for the office. Everyone will still support my ventures and my referral patterns without getting anyone in trouble. Keep it quiet and don't let it get out."

10. The United States brings this suit to recover damages, restitution, and civil penalties from Defendants under the False Claims Act and federal common law related to (i) the PHG Defendants' claims for medically unnecessary care and (ii) claims related to Dr. Newsom's illegal referrals to Riverside, which violated the Anti-Kickback Statute and Stark Law.

JURISDICTION AND VENUE

11. This action arises under the False Claims Act (FCA) and the common law.

12. This Court has subject matter jurisdiction over this action under 28 U.S.C. § 1345 because the United States is the plaintiff. The Court also has subject matter jurisdiction over this action under 28 U.S.C. §§ 1331 and 1367(a).

13. The Court may exercise personal jurisdiction over the defendants under 31 U.S.C. § 3732(a), because acts proscribed by the FCA occurred in this district, and one or more defendants can be found, reside, or transact business in this district.

14. Venue is proper in this district under 28 U.S.C. § 1391(b) and 31 U.S.C. § 3732(a), because a substantial part of the events giving rise to this action occurred in this district and one or more defendants can be found, reside, or transact business in this district.

PARTIES

15. Plaintiff the United States of America brings this action on behalf of the Department of Health and Human Services (HHS), which, through the Centers for Medicare & Medicaid Services (CMS), administers the Health Insurance Program for the Aged and Disabled established by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.* (Medicare).

16. Defendant Priority Hospital Group, L.L.C. (PHG) is a Louisiana limited liability company. PHG's principal place of business is 1000 Chinaberry Drive, Suite 200, Bossier City, Louisiana 71111.

17. During the relevant period, PHG managed three long-term care hospitals in Louisiana and Texas (the LTCH Defendants):

a. Defendant Riverside Hospital of Louisiana, Inc. is a Delaware corporation doing business as Riverside Hospital and is located at 13 Heyman Lane, Alexandria, Louisiana 71303. Defendant Riverside Hospital of Louisiana, Inc.'s sole shareholder is defendant Riverside Hospital, LLC, a Louisiana limited liability company. Riverside Hospital of Louisiana, Inc. and Riverside Hospital, LLC operated day-to-day as a single entity with the same management, and their accounting and financial performance were combined. (Riverside Hospital of Louisiana, Inc. and Riverside Hospital, LLC will be collectively referred to as Riverside.)

b. Defendant Post Acute Enterprises, L.L.C. is a Louisiana limited liability company doing business as Mid Jefferson Extended Care Hospital and is located at 860 S 8th Street, Beaumont, Texas 77701 (Mid-Jefferson). Until 2023, Mid-Jefferson had a second campus at 2600 Highway 365, Nederland, Texas 77627.

c. Defendant New Lifecare Specialty Hospital of North Louisiana, LLC is a Delaware limited liability company that conducted business as

Ruston Regional Specialty Hospital and was located at 1401 Ezell Street, Ruston, Louisiana 71270 (Ruston Regional).

18. Defendant Benjamin Kyle Newsom is a medical doctor residing and practicing in Alexandria, Louisiana. Dr. Newsom has practiced at Riverside since 2017.

19. The relator, Michaela DeVos, filed this case in August 2020 under the FCA's *qui tam* provisions, 31 U.S.C. § 3730(b), alleging violations of the FCA on behalf of herself and the United States. DeVos worked for defendant Riverside and its predecessors for 18 years. She was serving as Riverside's Chief Operating Officer and Nursing Director when she left in 2020.

LEGAL AND REGULATORY BACKGROUND

I. The False Claims Act

20. The FCA provides, in part, that any person who (1) "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;" or (2) "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 damages and penalties. 31 U.S.C. §§ 3729(a)(1)(A)-(B).

21. Under the FCA, a "claim" includes direct requests to the United States for payment as well as reimbursement requests made to the recipients of federal funds under federal benefits programs. 31 U.S.C. § 3729(b)(2)(A).

22. The FCA provides that a person acts "knowingly" with respect to information when a person "(i) has actual knowledge of the information; (ii) acts in

deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information[.]" 31 U.S.C. § 3729(b)(1). Specific intent to defraud is not required. *Id*.

23. The FCA defines "material" to mean "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).

24. A person is liable to the United States under the FCA for three times the damages that the United States sustains because of an act of that person, plus a civil penalty between $14,308 and $28,619 per violation. 31 U.S.C. § 3729(a)(1); 28 C.F.R. § 85.5.

II. The Anti-Kickback Statute

25. The Anti-Kickback Statute (AKS) is a federal criminal statute. It arose out of Congressional concern that kickbacks could corrupt medical decision-making, increase health care costs, and divert funds to high cost, medically unnecessary, poor quality, or potentially harmful goods and services. AKS violations may subject the perpetrator to fines, imprisonment, exclusion from participation in federal health care programs, and civil monetary penalties. 42 U.S.C. §§ 1320a-7(b)(7),1320a-7a(a)(7), 1320a-7b(b).

26. The AKS prohibits any person from:

> knowingly and willfully solicit[ing] or receiv[ing] any remuneration . . .
>
> > (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program[.]

42 U.S.C. § 1320a-7b(b)(1).

27. The AKS also prohibits any person from:

> knowingly and willfully offer[ing] or pay[ing] any remuneration . . . to any person to induce such person—
>
> (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program,
>
> (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program[.]

42 U.S.C. § 1320a-7b(b)(2).

28. AKS remuneration has been broadly defined as anything of value.

29. Although "willfulness" in the AKS requires that a person intend to violate the law, they "need not have actual knowledge of th[e AKS] or specific intent to commit a violation of th[e AKS]." 42 U.S.C. § 1320a-7b(h).

30. "To refer" under the AKS has a broad definition that "includes not only a doctor's recommendation of a provider, but also a doctor's *authorization* of care by a particular provider." *United States v. Cooper*, 38 F.4th 428, 433 (5th Cir. 2022) (quoting *United States v. Patel*, 778 F.3d 607, 612 (7th Cir. 2015) (finding doctor "referred" patient to home health agency when he signed certification forms necessary for patients to receive home health services)) (emphasis in original). "And

the inquiry [whether an arrangement is a referral under the AKS] is a practical one that focuses on substance, not form." *Stop Ill. Health Care Fraud, LLC v. Sayeed*, 957 F.3d 743, 750 (7th Cir. 2020).

31. Medicare is a "Federal health care program" as defined in the AKS. *See* 42 U.S.C. § 1320a-7b(f).

32. Compliance with the AKS is a material condition to payment by Medicare.

33. In 2010, Congress reiterated the centrality of the AKS to federal health care programs' claims payment decisions by amending the AKS to provide that any "claim that includes items or services resulting from a violation of [the AKS] constitutes a false or fraudulent claim for purposes of [the FCA]." 42 U.S.C. § 1320a-7b(g). Thus, Medicare claims resulting from AKS violations are *per se* false or fraudulent under the FCA.

34. In addition to showing that a claim is *per se* false under 42 U.S.C. § 1320a-7b(g), a second and distinct "pathway to FCA liability for an AKS violation [exists] when someone falsely represents compliance with a material requirement that there be no AKS violation in connection with the claim." *United States v. Regeneron Pharms., Inc.*, 128 F.4th 324, 333 (1st Cir. 2025). Even without an express representation of compliance, a party can be liable under the FCA if it "makes specific representations about the goods or services provided" but "fail[s] to disclose noncompliance with material statutory, regulatory, or contractual requirements" in a way that "makes those representations misleading half-truths."

Universal Health Servs., Inc. v. United States, 579 U.S. 176, 190 (2016). This second pathway "require[s] no proof of causation." *Regeneron*, 128 F.4th at 334.

35. The Government regularly enforces the AKS and pursues FCA liability based on underlying violations of the AKS.

36. The AKS and its associated regulations contain "safe harbors" protecting some arrangements unlikely to result in fraud or abuse from the law's reach. *See generally* 42 U.S.C. § 1320a-7b(b); 42 C.F.R. § 1001.952. The safe harbors set forth specific conditions that, if met, assure persons involved that they will not be sanctioned.

37. The AKS safe harbors are affirmative defenses available only where an arrangement precisely meets all the safe harbor requirements.

38. The AKS safe harbor for personal services and management contracts is narrowly tailored to prevent kickbacks disguised as service contracts, which the HHS Office of Inspector General has long warned against. *See* Publication of OIG Special Fraud Alerts, 59 Fed. Reg. 65372, 65375 (Dec. 19, 1994) (incentives from hospitals to physicians can inflate costs to Medicare by inducing physicians "to refer patients to the hospital providing financial incentives rather than to another hospital (or non-acute facility) offering the best or most appropriate care for that patient").

39. To qualify for the personal services and management contracts safe harbor, an agreement under which a physician serves as a hospital's agent must satisfy the following requirements:

i. The agency agreement is set out in writing and signed by the parties.

ii. The agency agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent.

iii. The term of the agreement is not less than 1 year.

iv. The methodology for determining the compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arm's-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs.

v. The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

vi. The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

42 C.F.R. § 1001.952(d)(1).

40. Riverside's arrangements with Dr. Newsom did not satisfy the requirements of this or any other AKS safe harbor.

III. The Stark Law

41. Congress enacted the Stark Law to prevent financial self-interest from affecting physicians' decisions about whether health care services are necessary, which services are preferable, and who should provide them to their patients. The statute is intended to reduce referrals for health services that are unnecessary, more expensive, lower quality, or less convenient that are made because the

physician may financially benefit from those referrals. *See* Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492, 77493, 77506 (Dec. 2, 2020).

42. The Stark Law is a strict liability statute.

43. The Stark Law prohibits physicians from referring an individual for "designated health services" (DHS) to entities with which they have a direct or indirect financial relationship that does not satisfy the requirements of an applicable exception. 42 U.S.C. § 1395nn(a)(1); 42 C.F.R. § 411.353(a). The Stark Law also prohibits entities from submitting claims to Medicare for DHS furnished pursuant to a prohibited referral. 42 U.S.C. § 1395nn(a)(1); 42 C.F.R. §§ 411.353(b)-(c).

44. DHS includes inpatient hospital services, such as bed and board, equipment, nursing care, and medications. 42 U.S.C. § 1395nn(h)(6)(K); 42 C.F.R. § 409.10(a). DHS includes hospital services provided by an LTCH. *See* 42 C.F.R. § 411.351; 42 U.S.C. §§ 1395x(e), 1395x(ccc).

45. Medicare payment is conditioned on compliance with the Stark Law.

46. Medicare is prohibited from paying for any DHS provided in violation of the Stark Law. *See* 42 U.S.C. §§ 1395nn(a)(1), (g)(1). And "[a]n entity that collects payment for a [DHS] that was performed pursuant to a prohibited referral must refund all collected amounts on a timely basis[.]" 42 U.S.C. § 411.353(d).

47. A "referral" under the Stark Law includes a "request or establishment of a plan of care by a physician which includes the provision of the [DHS.]" 42

U.S.C. § 1395nn(h)(5); *see also* 42 C.F.R. § 411.351. This includes a physician's decision to admit a patient to an inpatient hospital. *See* 85 Fed. Reg. at 77571.

48. A "financial relationship" includes a "compensation arrangement," which means any arrangement involving "remuneration" paid to a referring physician "directly or indirectly, overtly or covertly, in cash or kind." *See* 42 U.S.C. §§ 1395nn(a)(2), 1395nn(h)(1); 42 C.F.R. §§ 411.351, 411.354.

49. 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). A physician with an ownership interest in a physician organization "stands in the shoes" of the organization for the purpose of compensation arrangements with an entity furnishing DHS and is deemed to have a direct compensation arrangement with such an entity. 42 C.F.R.§ 411.354(c)(1)(ii).

50. A claim submitted to Medicare in violation of the Stark Law is false within the meaning of the FCA.

51. A Medicare claim accompanied by a false certification of compliance, express or implied, with the Stark Law is also false within the meaning of the FCA.

52. 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).

53. The Stark Law and its associated regulations contain exceptions for certain financial arrangements. An arrangement must satisfy all requirements of

an applicable exception. It is the actual relationship between the parties, and not merely the paperwork, that must satisfy the requirements of an exception. *See* OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4858, 4863 (Jan. 31, 2005).

54. 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 invoking an exception and demonstrating that the relationship satisfies all the applicable statutory or regulatory requirements. *See, e.g., United States ex rel. Drakeford v. Tuomey*, 792 F.3d 364, 374 (4th Cir. 2015).

55. To qualify for the fair market value compensation exception, a compensation arrangement must meet the following requirements, among others:

a. the arrangement must be in writing, signed by the parties, and identify the services covered, compensation provided, and term;

b. the compensation must be set in advance, consistent with fair market value, and not take into account the volume or value of referrals or other business generated by the referring physician;

c. the arrangement must be commercially reasonable even if no referrals were made between the parties; and

d. the arrangement must not violate the AKS.

42 C.F.R. § 411.357(l).

56. To qualify for the personal service arrangement exception, a compensation arrangement must meet the following requirements, among others:

a. the arrangement must be in writing, signed by the parties, and must specify the services covered;

b. the arrangement must cover all services furnished by the physician or cross-reference other agreements;

c. the aggregate services covered by the arrangement must not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement; and

d. the compensation must be set in advance, not exceed fair market value, and not be determined in a manner that takes into account the volume or value of referrals or other business generated between the parties.

42 U.S.C. § 1395nn(e)(3); 42 C.F.R. § 411.357(d)(1).

57. Fair market value and commercial reasonableness are significant concepts in the Stark Law's legal framework.

58. With respect to compensation for services, fair market value is the value that "well-informed parties that are not otherwise in a position to generate business for each other" would pay in an arm's-length transaction. 42 C.F.R. § 411.351; *see also* 85 Fed. Reg. at 77554 ("[W]hen parties to a potential medical director arrangement determine the value of the physician's administrative services, they must not consider that the physician could also refer patients to the entity when not acting as its medical director.").

59. Commercial reasonableness requires that the arrangement further a legitimate business purpose and be sensible, considering the characteristics of the parties. *See* 42 C.F.R. § 411.351. "[A]rrangements that, on their face, appear to further a legitimate business purpose of the parties may not be commercially

reasonable if they merely duplicate other facially legitimate arrangements." 85 Fed. Reg. at 77533 (arrangement that duplicates existing medical director services may not be commercially reasonable).

60. Riverside's arrangements with Dr. Newsom did not satisfy the requirements of the fair market value compensation exception, personal services arrangement exception, or any other exception to the Stark Law.

IV. The Medicare Program

61. 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."

62. Medicare is funded by the federal government and administered by the Centers for Medicare & Medicaid Services (CMS).

63. Medical necessity is a condition of payment for Medicare claims.

64. Medicare is prohibited from paying for services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member[.]" 42 U.S.C. § 1395y(a)(1)(A). "That the services be medically necessary is a condition for payment under the regulations." *United States ex rel. Riley v. St. Luke's Episcopal Hosp.*, 355 F.3d 370, 376 n.6 (5th Cir. 2004).

65. A claim's medical necessity goes to the essence of the bargain between Medicare and providers. *See* 78 Fed. Reg. 50496, 50947-48 (Aug. 19, 2013) ("Medicare is statutorily prohibited . . . from paying for services that are not

reasonable and necessary."). Medicare refuses to pay claims for care that is not medically necessary. *See id.* at 50943 (describing denial of claims where inpatient hospital services are not medically necessary).

66. Medicare Part A covers institutional health care, including inpatient hospital services. *See* 42 U.S.C. §§ 1395c, 1395d.

67. CMS contracts with Medicare Administrative Contractors (MACs) to administer Medicare Part A. *See* 42 U.S.C. §§ 1395h, 1395kk-1. MACs generally act as CMS's agents in reviewing and paying Medicare Part A claims. *See* 42 C.F.R. §§ 421.3, 421.5(b), 421.100.

68. When a Medicare Part A beneficiary receives services in a hospital, the hospital submits a "facility" claim to the MAC using the electronic ASC X12 837 institutional claim format or the paper UB-04 CMS-1450 Claim Form. This claim includes the goods and services provided by the hospital (such as the room, equipment, nursing care, and medications).

69. A hospital claim submitted to Medicare in this manner is a "claim" for the purpose of the FCA.

70. MACs pay Medicare claims with federal funds. *See* 42 U.S.C. § 1395g.

71. Because it is not feasible for CMS to review the records underlying every claim for payment, CMS relies on providers to comply with Medicare requirements and trusts providers to submit truthful and accurate certifications and claims.

72. Thus, CMS conditions payment on provider certifications of compliance with the legal and regulatory requirements cited herein, among others. *See, e.g.,* 42 C.F.R. §§ 424.10, 424.516(a).

73. Providers make these certifications in several places, including their enrollment applications, claim forms, and cost reports.

A. Medicare Enrollment Applications

74. 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.

75. A hospital must complete a CMS-855A Medicare Enrollment Application. A physician must complete a CMS-855I Medicare Enrollment Application.

76. Both the CMS-855A and the CMS-855I require that the provider certify:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to me . . . . I understand 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 [AKS] and [Stark Law]).
> . . .
> I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

77. The Medicare enrollment applications explain the penalties for falsifying information in the application, including potential civil liability under the FCA.

78. An authorized official must sign the "Certification Section" in Section 15 of Form CMS-855A, which "legally and financially binds [the] provider to the laws, regulations, and program instructions of the Medicare program."

79. Physicians must sign the "Certification Section" in Section 15 of Form CMS-855I, and in doing so, they "attest[] to meeting and maintaining the Medicare requirements" excerpted above, among others.

B. Medicare Claim Forms

80. A hospital must certify on the UB-04 CMS-1450 claim form for reimbursement from Medicare Part A that: "The submitter of this form understands that misrepresentation or falsification of essential information as requested by this form, may serve as the basis for civil monetary penalties and assessments[.]"

81. The hospital must also certify that all necessary physician certifications and re-certifications required by Federal regulations are on file.

82. To submit electronic claims, a provider must complete an Electronic Data Interchange (EDI) Enrollment Form (CMS Form 10164) that requires providers agree to "submit claims that are accurate, complete, and truthful," acknowledge claims will be paid from Federal funds, and acknowledge that "anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this

Agreement" may be subject to a fine and/or imprisonment under applicable Federal law.

83. The data fields for electronic claim submission via the ASC X12 837 form are consistent with the UB-04 CMS-1450 data set.

C. Medicare Cost Reports

84. Hospitals must submit a CMS Form 2552 Hospital Cost Report to their MAC each year. The cost report determines a provider's Medicare reimbursable costs for a fiscal year. 42 U.S.C. § 1395g(a); 42 C.F.R. §413.20.

85. The cost report is the provider's final claim for payment from the Medicare program for the services rendered to all program beneficiaries for a fiscal year.

86. The cost report calculates the amount of Part A reimbursement the hospital believes it is due for the year. *See* 42 U.S.C. § 1395g(a); 42 C.F.R. §§ 413.20, 405.1801(b)(1). Medicare relies on the 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.

87. The cost report contains the following warning in capital letters:

> 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.

88. A hospital's chief financial officer or administrator must certify they read the statement above and that "to the best of [their] 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." They must further certify they are "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."

89. Medicare, through the MACs, can audit hospitals' cost reports and financial representations to ensure their accuracy. Medicare has the right to make retroactive adjustments to cost reports if any overpayments have been made. *See* 42 C.F.R. § 413.64.

V. Long-Term Care Hospitals

90. Long-term care hospitals (LTCHs) are intended for complex patients who are expected to require acute hospital care for several weeks.

91. Medicare requires LTCHs have an "average inpatient length of stay [ALOS] (as determined by the [HHS] Secretary) of greater than 25 days" (the "25-day ALOS Qualification"). 42 U.S.C. § 1395ww(d)(1)(B)(iv); 42 C.F.R. § 412.23(e)(2).

92. Since 2015, the 25-day ALOS Qualification only applies to Medicare Part A patients (i) without a psychiatric or rehabilitation principal diagnosis; (ii) who received inpatient hospital care immediately preceding the LTCH stay; and (iii) either (a) spent at least three days in the intensive care unit during the immediately preceding hospital stay, or (b) received ventilator services for at least 96 hours at the LTCH. 42 C.F.R. §§ 412.23(e)(3); 412.522(b).

93. LTCH patients who do not meet these criteria are not included in the calculation to determine whether an LTCH meets the 25-day ALOS Qualification.

94. MACs calculate whether an LTCH meets the 25-day ALOS Qualification on an annual basis. If an LTCH does not qualify and is not able to cure the issue, it reverts to a standard short-term hospital, which results in lower Medicare reimbursement.

95. CMS waived the 25-day ALOS Qualification for annual cost reporting periods that included the COVID-19 public health emergency, which lasted from March 1, 2020 to May 11, 2023.

96. For the purposes of this complaint, patients that were included in calculating whether an LTCH Defendant met the 25-day ALOS Qualification will be called "Qualifying Patients." All other patients will be referred to as "Exempt Patients."

A. Criteria for LTCH Admission and Continued Stay

97. Medicare Part A covers LTCH services when a beneficiary is "formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner" that is made at or before the time of admission. 42 C.F.R. §§ 412.3(a), (c).

98. Federal law requires health care providers, including LTCHs, to ensure services to Medicare beneficiaries are "provided economically and only when, and to the extent, medically necessary" and "supported by evidence of medical necessity." 42 U.S.C. §§ 1320c-5(a)(1), (3).

99. Although inpatient admission in a short-term hospital "is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights," 42 C.F.R. § 412.3(d)(1), LTCHs are intended for patients that have "medically complex conditions [that] require a long hospital stay and programs of care provided by a long-term care hospital." 42 U.S.C. § 1395x(ccc).

100. A physician who orders an inpatient admission must be "knowledgeable about the patient's hospital course, medical plan of care, and current condition." 42 C.F.R. § 412.3(b). The physician cannot delegate the decision. *Id.*

101. A physician's expectation of a patient's need for hospital care "should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event." 42 C.F.R. § 412.3(d)(1)(i).

102. A physician does not have unfettered discretion to decide whether admission is necessary. "The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration." *Id.*

103. "No presumptive weight shall be assigned to the physician's order under § 412.3 or the physician's certification . . . in determining the medical necessity of inpatient hospital services . . . . A physician's order or certification will be evaluated in the context of the evidence in the medical record." 42 C.F.R. § 412.46(b).

104. For hospital stays over 20 days, a physician must certify the reasons for continued hospitalization, the estimated time the patient will remain in the hospital, and the plans for post-hospital care. 42 U.S.C. § 1395f; 42 C.F.R. § 424.13(a).

105. LTCHs must obtain signed and dated acknowledgements from all admitting and attending physicians that Medicare payments are based on their attestations and that "[a]nyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws." 42 C.F.R. § 412.46(a)(2).

106. LTCHs, specifically, must have a documented process that:

> screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria[.]

42 U.S.C. § 1395x(ccc)(4)(A).

107. The Medicare Program Integrity Manual instructs MACs that, for an LTCH claim to be appropriate for Medicare Part A payment, "[r]eview of the medical record must indicate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary." Medicare Program Integrity Manual, Pub. No. 100-08, Ch. 6, § 6.5.2.

108. The manual explains that a reasonable and necessary service must be appropriate in duration, "furnished in a setting appropriate to the patient's medical

needs and condition," and "meet[], but [] not exceed, the patient's medical needs[.]" *Id.*, Ch. 13, § 13.5.4 (in the context of local coverage determinations).

109. Medicare is prohibited from paying for portions of an LTCH stay that exceed what is medically necessary for the patient.

110. Claims submitted by an LTCH to Medicare that include medically unnecessary lengths of stay are false claims under the FCA.

111. LTCHs that submit such claims while certifying compliance with Medicare's laws and regulations have made a false record or statement material to a false claim under the FCA.

B. The LTCH Prospective Payment System

112. Medicare Part A uses the LTCH prospective payment system (PPS) to calculate LTCH reimbursement.[2] The LTCH PPS classifies patients into Medicare severity long-term care diagnosis-related groups (LTC-DRGs) based on their clinical characteristics, including their diagnoses and treatment. 42 C.F.R. § 412.513.

113. Each LTC-DRG is assigned a "weight" reflecting the estimated hospital resources needed to treat a patient assigned to the LTC-DRG. *See* 42 C.F.R. § 412.515. The LTC-DRG weight is multiplied by a base rate (with certain geographic adjustments) to determine the "full DRG payment." *See* 68 Fed. Reg. 34122, 34131 (June 6, 2003) ("For example, cases in an LTC-DRG with a relative

[2] A prospective payment system pays a predetermined, fixed amount per claim based on a classification system intended to estimate the resources needed to treat the patient.

weight of 2 will, on average, cost twice as much as cases in an LTC-DRG with a weight of 1.").

114. However, patients who stay at the LTCH for considerably less than the average patient assigned to the same LTC-DRG do not receive the full DRG payment. Medicare established a lower payment rate for such patients because they receive less than the expected full course of treatment at an LTCH. 42 C.F.R. § 412.529; 82 Fed. Reg. 19796, 20022 (Apr. 28, 2017). These patients are called short stay outliers (SSOs).

115. Medicare adopted lower payment rates for SSOs in part because it believed that many of these patients could have been treated more appropriately in a standard short-term acute hospital and sought to discourage LTCHs from admitting them. *See* 82 Fed. Reg. at 20022.

116. Patients are considered SSOs if their stay does not exceed five-sixth of the geometric ALOS for the LTC-DRG. 42 C.F.R. § 412.529.

117. In other words, for an LTCH to obtain the full DRG payment, a patient must stay in the hospital until they exceed five-sixth of the ALOS for the patient's DRG. If a patient does not meet this threshold length of stay (called the "SSO threshold"), the LTCH receives a lower payment (called an "SSO payment"). *See* 42 C.F.R. § 412.529(b).

118. The first day on which a patient exceeds the SSO threshold is often called the "5/6th date." The LTCH's reimbursement generally does not increase if a

patient stays additional days after their 5/6th date—it receives the full DRG payment whether the patient is discharged on the 5/6th date or a week later.[3]

119. Each year CMS releases a table that includes the weight, ALOS, and SSO threshold for each LTC-DRG.

120. In 2017, CMS observed that LTCHs appeared to be "improperly hold[ing] patients beyond the SSO threshold" in order to obtain the full DRG payment, which "resulted in potentially improper delays in patient discharges other than solely for medical reasons." 82 Fed. Reg. at 20022-3.

121. CMS revised the SSO payment methodology in fiscal year 2018 to reduce LTCHs' financial incentive to delay patient discharges until after the SSO threshold. *See* 82 Fed. Reg. 37990, 38312-13 (Aug. 14, 2017); *see also* 42 C.F.R. §§ 412.529(c)(2)(iv), 412.529(c)(4). Under this methodology, the SSO payment is a combination of the short-term hospital PPS payment and the LTCH PPS payment, with the portion of the payment attributable to the LTCH PPS payment increasing with the patient's length of stay.

122. Although these changes reduced LTCHs' financial incentive to hold patients until the SSO threshold, they did not eliminate the incentive. *See infra* Paragraphs 127 to 130.

[3] In rare instances, a hospital may receive a "high-cost outlier" payment if a patient's stay resulted in outlier costs to the hospital. High cost outlier claims are excluded from the allegations in this complaint.

C. Site Neutral Payments

123. Congress established a lower payment rate for "site neutral" LTCH admissions starting in October 2015. Site neutral admissions are those that do not meet the criteria listed in Paragraph 92, *supra* (*e.g.,* patients who are not ventilated for at least 36 hours and/or do not spend 3 nights in an intensive care unit before admission to the LTCH). *See generally* 42 U.S.C. § 1395ww(m)(6); 42 C.F.R. § 412.522.

124. The site neutral payment rate is the lower of the short-term hospital inpatient PPS rate or the cost of the case. This rate usually is significantly lower than the LTCH PPS standard rate. 42 C.F.R. § 412.522(c)(1).

125. As a transition, Medicare applied a blended payment rate for site neutral discharges between 2015 and 2020. *See* 42 C.F.R. § 412.522(c)(3). This blended rate was comprised of half the site neutral payment rate and half the LTCH PPS standard payment rate. *Id.*

126. Congress waived the application of the site neutral payment rate during the COVID-19 public health emergency. *See* Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, § 3711(b). During this time (March 1, 2020 to May 11, 2023), Medicare paid all LTCH claims at the LTCH PPS standard rate.

D. LTCH PPS Reimbursement Example and Summary Chart

127. DRG 189 (Pulmonary Edema and Respiratory Failure) is a common LTC-DRG. For fiscal year 2022, CMS assigned DRG 189 a weight of 0.9448 and calculated its geometric ALOS at 21.3 days and SSO threshold at 17.8 days.

128. In fiscal year 2022, the full DRG payment for DRG 189 at defendant Riverside would have been approximately $38,500. (The DRG weight (0.9448) multiplied by the LTCH PPS base rate of approximately $45,000 adjusted for geographic factors.)

129. LTCHs received the full DRG payment for a patient assigned to DRG 189 if the patient was discharged after the SSO threshold of 17.8 days. Thus, the patient must have been discharged on day 18 of their stay or later for an LTCH to receive the full DRG payment.

130. The estimated LTCH PPS payment for a Riverside patient assigned to DRG 189 in fiscal year 2022 varied by discharge date. For example:

a. The LTCH would have received a SSO payment of about $13,500 for a patient discharged on day 9 of their stay (or $1,500 per day).

b. The LTCH would have received a full DRG payment of about $38,500 for a patient discharged on day 18 of their stay (or about $2,150 per day). (This is the 5/6th date because it is first date that exceeds the SSO threshold of 17.8 days.)

c. The LTCH also would have received a full DRG payment of about $38,500 for a patient discharged on day 25 (or about $1,550) per day.

131. As illustrated by this example, an LTCH generally maximizes revenue and profit by discharging a patient on the first date that exceeds the SSO threshold (the 5/6th date).

132. When the 5/6th date for a Qualifying Patient is less than 25 days after admission, LTCHs have a competing incentive to keep the patient past the 5/6th date to meet the 25-day ALOS requirement.

133. Figure 1 summarizes payment rates by time period and patient type, along with the impact of discharge timing on payment for each category:

Figure 1.

Time Period	Patient Type	Payment Rate	Discharge Timing Payment Impact
2016-2020	Qualifying (subject to 25-day ALOS Qualification)	LTCH PPS standard	Payment maximized by discharging patients immediately after SSO threshold (5/6th date), but LTCHs must also maintain ALOS over 25 days for this group of patients.
	Exempt	Blended (50% LTCH PPS standard; 50% site neutral)	Payment maximized by discharging patients immediately after SSO threshold (5/6th date).
2020-2023 (COVID-19 Public Health Emergency)	Exempt (25-day ALOS Qualification waived)	LTCH PPS standard	Payment maximized by discharging patients immediately after SSO threshold (5/6th date).

PHG BACKGROUND

134. During the time period relevant to this complaint, PHG was owned and operated by Mark Rice (PHG's President and CEO) and Christopher "Kemp" Wright (PHG's Senior Vice President of Development and Contracting). Douglas Boulware also had an ownership interest in PHG until around 2023.

135. During the time period relevant to this complaint, PHG managed several LTCHs, including the LTCH Defendants.

136. The LTCH Defendants provided long-term hospital services to Medicare Part A beneficiaries and other patients during the relevant time period.

137. From at least 2016 to 2023, the LTCH Defendants submitted claims for hospital services to Medicare Part A through their MACs. The entities that have served as MACs for the LTCH Defendants include Palmetto GBA, Novitas Solutions, and WPS Health Solutions.

138. The MACs paid the LTCH Defendants' Medicare Part A claims with federal funds.

139. During the time period relevant to this complaint, the LTCH Defendants were owned by a small group of investors, including Rice, Wright, and Boulware.

140. The investor group purchased Riverside in 2007. Wright was Riverside's CEO before the purchase, and he returned as Riverside's CEO a few months after the purchase.

141. The investor group purchased Mid-Jefferson in 2011. Rice joined the investor group at this time and became Mid-Jefferson's CEO.

142. Rice hired Wade Lester as Mid-Jefferson's Chief Operating Officer in 2012. Lester was promoted to PHG's Vice President of Operations and Clinical Services in 2017.

143. The investor group purchased Ruston Regional in 2017, and Rice became Ruston Regional's CEO.

144. During the time period relevant to this complaint, Rice, Wright, and Lester (together, the PHG Executives) directed and controlled the operations of the PHG Defendants.

145. During the time period relevant to this complaint, the PHG Executives communicated regularly with the LTCH Defendants through emails, text messages, and phone calls. The PHG Executives also often visited or worked out of the LTCH Defendants' premises.

146. During the time period relevant to this complaint, the PHG Executives served on the governing boards of all the LTCH Defendants. They also served on other committees at the LTCH Defendants, such as the Medical Executive Committees and Utilization Review Committees.

147. PHG acted as the LTCH Defendants' agent in managing the hospitals and communicating with CMS.

148. For example, PHG's Chief Financial Officer certified the LTCH Defendants' cost reports, and Rice and Wright certified their Medicare enrollment applications.

PHG DEFENDANTS' SCHEME TO PROFIT FROM UNNECESSARY CARE

149. The PHG Defendants engaged in a concerted scheme to inflate their Medicare payments by holding hospital patients until their 5/6th date regardless of the medical necessity of their inpatient care. And, if a patient was subject to the 25-day ALOS Qualification, the PHG Defendants held the patient until at least day 25 to maintain their LTCH status, which also resulted in higher reimbursements.

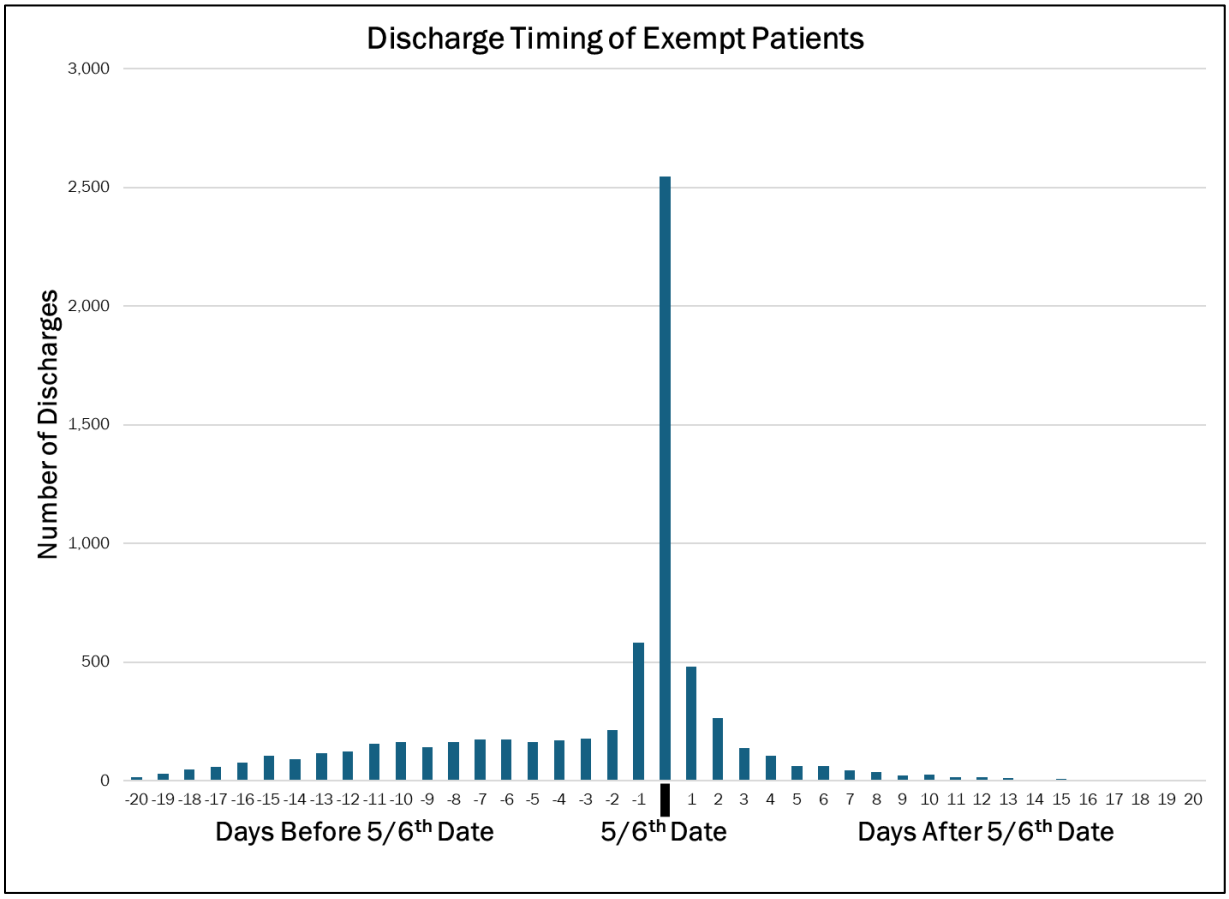
150. This scheme had a marked effect on the discharge timing of Medicare patients at the LTCH Defendants.

151. Between 2016 and the end of the COVID public health emergency in 2023 (the relevant time period for this claim), the LTCH Defendants submitted approximately 9,000 inpatient hospital claims to Medicare Part A. Approximately 6,800 of these stays were exempt from the 25-day ALOS Qualification (Exempt Patients). Approximately 2,200 were included in the 25-day ALOS Qualification (Qualifying Patients).

152. The PHG Defendants aimed to discharge Exempt Patients on their 5/6th date (immediately after they met the SSO threshold) to maximize their Medicare revenue and profit. By discharging Exempt Patients on their 5/6th date, the PHG Defendants received the full DRG payment and did not have to pay the cost of additional days of care.

153. Figure 2 reflects the discharge timing of Exempt Patients at the LTCH Defendants compared to the 5/6th date during the period from 2016 to the end of the COVID public health emergency in 2023. The PHG Defendants' scheme, further detailed in this section, caused a large spike of discharges on the 5/6th date.

Figure 2.[4]



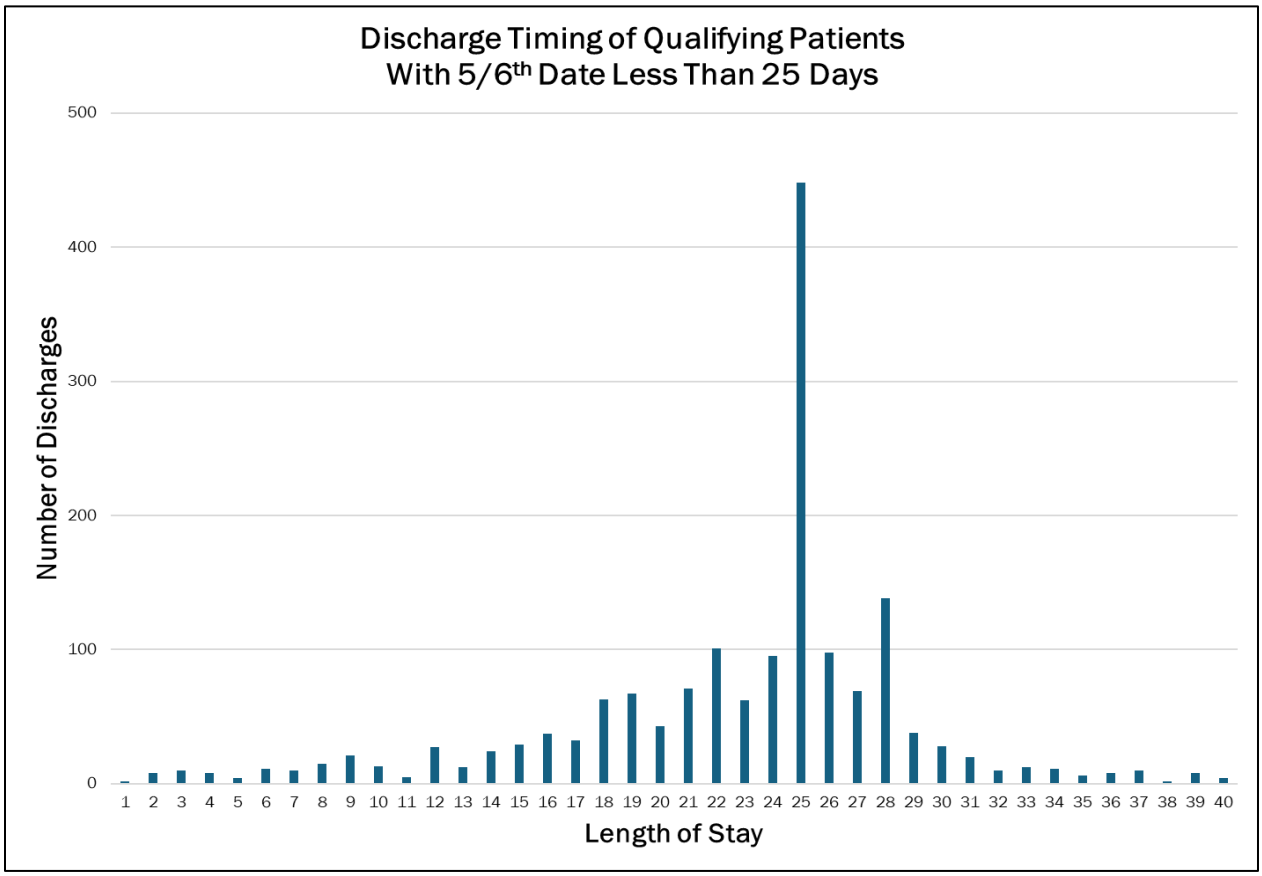
154. To meet the 25-Day ALOS Qualification, the PHG Defendants generally aimed to discharge Qualifying Patients on or after day 25 of their stay.[5] Figure 3 reflects the discharge timing of Qualifying Patients with a 5/6th date less than 25 days into their stay. The PHG Defendants' scheme caused a large spike of

[4] For readability, Figure 2 also excludes approximately one percent of visits with outlier lengths of stay.

[5] The PHG Defendants changed the targeted discharge date for Qualifying Patients from time to time based on the ALOS at the LTCH. *See infra* Paragraphs 176-177 for more details.

discharges on day 25 for those patients who had already met their 5/6th date (*i.e.*, had already reached full DRG payment).

Figure 3.[6]

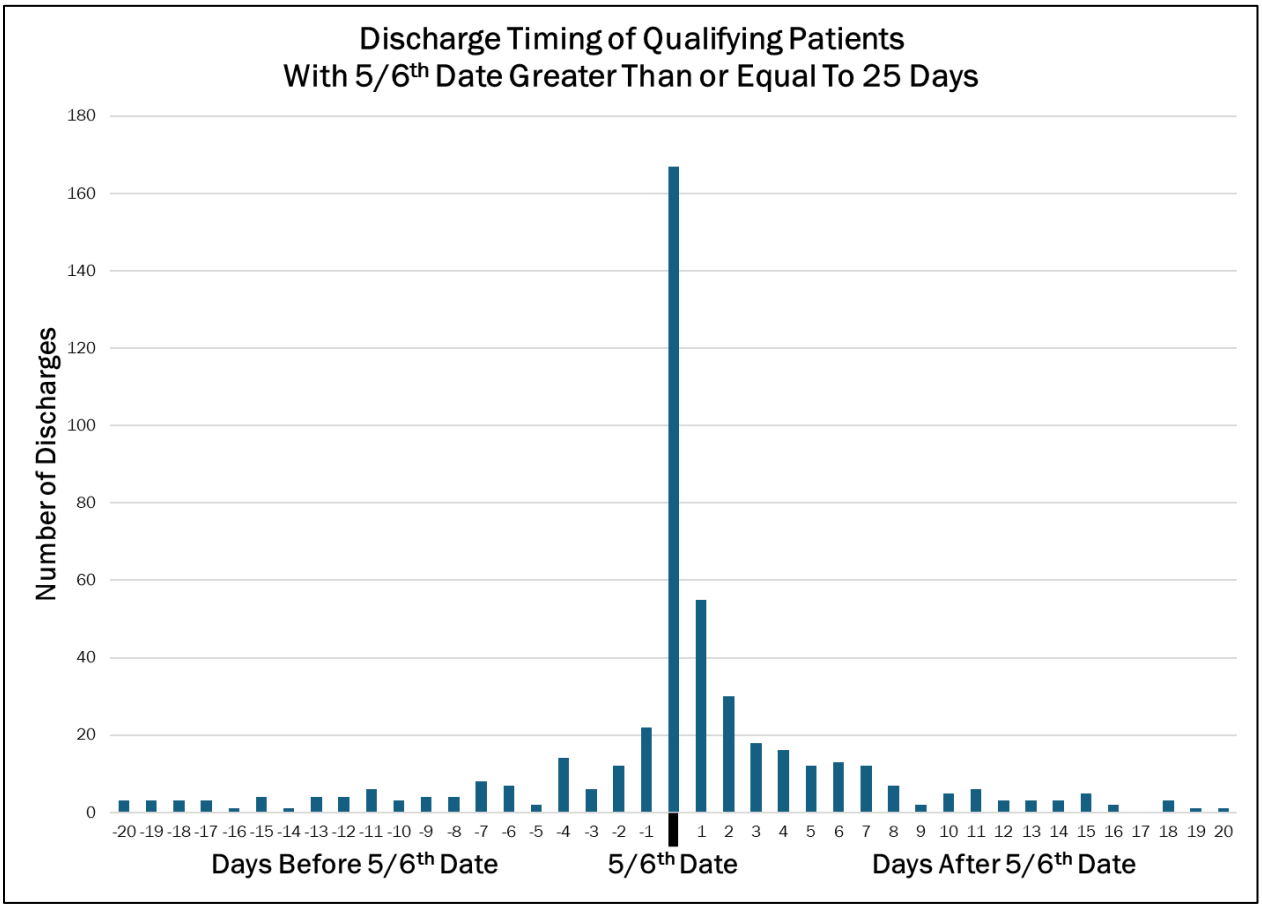


155. However, if a Qualifying Patient had a 5/6th date that was after day 25 of their stay, the PHG Defendants aimed to hold the patient until they met the 5/6th date to maximize revenue. Figure 4 reflects the discharge timing of Qualifying Patients who had not reached their 5/6th date by the 25th day of their stay compared to the 5/6th date. For these patients, the PHG Defendants' scheme caused a spike of

[6] For readability, Figure 3 also excludes approximately one percent of visits with outlier lengths of stay.

discharges on the 5/6th date, when the LTCH Defendants received the maximum Medicare payment and did not have to foot the bill for additional days of care.

Figure 4.[7]



156. Figures 2-4 show large spikes in discharges on the date that was most lucrative for the PHG Defendants.

157. These distributions are consistent with what would be expected if, as alleged, the PHG Defendants were discharging patients with the objectives to

[7] For readability, Figure 4 excludes approximately 6 percent of discharges with outlier lengths of stay.

(1) reach the 5/6th date for all patients, (2) maintain the required 25-day ALOS for Qualifying Patients, and (3) minimize patients' length of stay after the 5/6th date.

158. As detailed below, the PHG Defendants implemented their scheme to profit from medically unnecessary care by (I) closely tracking the most lucrative discharge date for each patient, (II) instructing LTCH staff to discharge patients on the most lucrative date, (III) incentivizing doctors to discharge patients on the most lucrative date, and (IV) admitting low acuity patients and pressuring them to remain at the LTCH until the most lucrative date.

I. The PHG Defendants Closely Tracked the Most Lucrative "Planned Discharge Date" for Each Medicare Patient

159. In March 2016, the PHG Executives met with Riverside and Mid-Jefferson administration to discuss the impact of new Medicare rules that exempted some patients from the 25-Day ALOS Qualification.

160. Lester gave a presentation at this meeting called "Revenue Maximization & Case Management Tools."

161. "Case management" refers to the LTCH staff responsible for planning patient discharges. Each LTCH Defendant had one or more case managers.

162. Lester's presentation detailed how the LTCH Defendants could maximize revenue by discharging Exempt Patients on their "5/6th", which the slide deck defined as the "number of days the patient has to stay to achieve maximum profitability."

163. After the March 2016 meeting, Lester developed a "Case Management Dashboard" to track patient discharge timing.

164. Riverside began using Lester's dashboard in May 2016.

165. Mid-Jefferson began using Lester's dashboard by September 2016.

166. Ruston Regional began using Lester's dashboard by August 2017—two months after it was purchased by the PHG investor group.

167. The dashboard lists each patient and their DRG, 5/6th length of stay (LOS), admission date, and target discharge date.

168. Figure 5 is an excerpt from Riverside's 2016 dashboard with personally identifiable information removed.

Figure 5.

Riverside Case Management Dashboard

Medicare and other DRG Based Payors(eg.. Includes Most Medicare Advantage, Some Case-By-Case Negotiated Contracts)

ALOS for Inhouse Medicare LTCH Patie 24.909 Last Revis

Room #	Patient Name	Track	DRG	DRG Desciption	CMI	5/6th	Total Pmt/Case	Net Rev/PPD	Admit Date	Planned D/C Date	Planned LOS
501	[redacted]	SNLT	301	Peripheral vascular disorders w/o CC/MCC*	0.569	16	$11,965.72	$747.86	7/12/2016	7/28/2016	16
502		SNLT	949	Aftercare w CC/MCC	0.7394	18	$16,065.07	$892.50	7/8/2016	7/26/2016	18
503		LTCH	559	Aftercare, musculoskeletal system & connective tissue w MCC	0.9533	22	$34,231.47	$1,369.26	6/23/2016	7/18/2016	25

169. LTCH staff filled in the dashboard's gray-shaded cells, and the white cells automatically populated based on the entries in the gray cells.

170. The DRG description, case mix index ("CMI"), 5/6th LOS ("5/6th"), and total payment per case ("Total Pmt/Case") auto-completed after an LTCH staff member entered the patient's DRG. The "Planned LOS" auto-completed after the "Planned D/C [discharge] Date" was entered. The net revenue per patient day ("Net Rev/PPD") was populated through a formula that divided the total payment per case by the planned LOS.

171. Although CMS published both an ALOS and a 5/6th LOS for each DRG, Lester only included the 5/6th LOS in the dashboard.

172. He did this because the 5/6th LOS indicated the date of maximum revenue for Medicare patients.

173. Lester taught employees at each LTCH Defendant how to calculate and complete the "Planned D/C Date" column in the dashboard.

174. For Exempt Patients, referred to as SNLT (site neutral long term) in the "Track" column in Figure 5, Lester instructed employees at each LTCH Defendant to fill the "Planned D/C Date" with the date that was the admission date plus the 5/6th LOS (i.e., the 5/6th date).

175. For Qualifying Patients (referred to as LTCH in the "Track" column in Figure 5), Lester instructed employees at each LTCH Defendant to fill the "Planned D/C Date" with the date that was the admission date plus 25 days. But, if a Qualifying Patient had a 5/6th LOS longer than 25 days, the 5/6th date was entered in the Planned D/C Date.

176. The PHG Defendants modified the 25-day target for Qualifying Patients when an LTCH had an ALOS for Qualifying Patients significantly under or over 25 days.

177. For example, when Riverside was concerned about meeting the 25-day requirement in November 2017, Wright emailed Lester that Riverside's "LOS target for LTCH [Qualifying] pts has been 28, which has given us a little breathing room[.]" The smaller spike on day 28 in Figure 3 reflects this guidance.

178. The PHG Defendants also gamed the system by not billing for Qualifying Patients with short stays if it would drop them under the required 25-

day average length of stay. If there were enough "days on [the] avg los" at the end of the year, the PHG Defendants would "go back and bill" for the claims.

179. Lester regularly updated the LTCH Defendants' dashboards and checked that they accurately reflected the most favorable discharge date for the LTCH.

180. When CMS released new 5/6th dates, Lester forwarded the information to employees at each LTCH Defendant and told them to "manually verify the 5/6th length of stay for your inhouse patients" or "take a look at the DRG's you currently have in-house and adjust their planned D/C date."

II. The PHG Defendants Directed Staff to Discharge Medicare Patients on the "Planned Discharge Date"

181. PHG directed and expected the LTCH Defendant employees to discharge patients on the dashboards' Planned D/C Date, specifically targeting the LTCH case managers who were responsible for planning patient discharges.

182. For example, Lester praised Mid-Jefferson case managers in a 2017 email to a broad group of PHG and Mid-Jefferson staff for getting "patients discharged on their correct discharge day to maximize our revenue."

183. Lester also developed a bonus plan for Riverside's case manager in 2018 that required her to discharge 90 percent of patients on the "ideal discharge date" to receive a bonus.

184. The "ideal discharge date" was the "Planned D/C Date" date reflected in the dashboard and calculated per Lester's instructions.

185. To decide whether to award the bonus, Lester asked the case manager to justify why patients "did not meet their length of stay." The case manager's explanations included that she simply "counted days wrong." In another instance, the case manager explained that a doctor had "talked to [a patient's] wife about staying to meet [his] length of stay but she wanted to take patient home to die so she did not see any point of staying in the hospital because he was terminal."

186. Shortly after the PHG owners purchased Ruston Regional in 2017, a Riverside manager educated a Ruston employee on PHG's discharge timing scheme. The Riverside manager described the 5/6th date as "how many days you needed the patient to stay" and explained that "[t]he problem with a short stay is that you don't make the full DRG payment." A few months later the Riverside manager emphasized to the Ruston employee, "with the 5/6, if they leave one day early you lose money…and it can be major[.]"

187. In 2021, Wright and Lester discovered that Ruston Regional had lost almost $200,000 over two months by discharging patients before their 5/6th dates. Wright blamed inadequate attention to 5/6th dates and Ruston Regional's failure to hold case managers "accountable." He suggested that Rice "be made aware so we can immediately stem the losses."

188. Lester followed up with Ruston Regional's administration, flagging the cases that "did not meet their 5/6" and asking "why were they discharged short."

189. Administration at each LTCH Defendant reinforced PHG's discharge timing direction in daily and weekly meetings, using Lester's dashboard to guide discharge planning discussions.

190. Although these discussions often occurred in person, LTCH Defendant staff also texted about holding patients to maximize revenue and maintain LTCH status.

191. Mid-Jefferson's CEO directed her staff via text message:

a. "Make sure on dashboard we are managing to 5/6 on every patient;" and

b. "No one is leaving early. We lose money."

192. For Qualifying Patients who counted toward the 25-day ALOS Qualification, Mid-Jefferson's CEO instructed her staff:

a. "Every other that is possibly a ltac [Qualifying] patient must stay 25 days;" and

b. "Please start holding ltac patients 28 days minimum. We need to build a cushion[.]"

193. Mid-Jefferson's staff assessed how much money Mid-Jefferson would lose before letting a patient leave "early." For example:

a. The CEO asked, "What's the financial hit of early dc [discharge]?" when considering a patient's family request to discharge the patient to her nursing home for a scheduled COVID-19 vaccination.

b. The admissions coordinator told a case manager that discharging another patient early would "loose [sic] 25,000." The case manager replied, "Then no."

c. Another case manager asked how much Mid-Jefferson would lose if she discharged a patient early to make a "trip she already paid for." The admissions coordinator replied, "Every day early is 4,000."

194. Riverside staff regularly texted about patients' expected 5/6th LOS and calculated Medicare's payment per day assuming the patient would be discharged on the 5/6th date.

195. Sometimes a procedure or new diagnosis would change a patient's DRG after they were admitted to the LTCH. When this happened, LTCH Defendant staff would communicate the 5/6th LOS for the new DRG and update Lester's dashboard with a revised "Planned D/C Date." For example:

a. An admissions liaison texted a Riverside group chat that a patient might have to have her leg amputated during her LTCH stay and asked whether that would increase the "LOS and $$." An employee responded, "Yes ma'am[.] We like removing limbs."

b. A Mid-Jefferson employee emailed case managers after a procedure that a patient's "drg and dc date changed. I could not put change on dashboard due to someone being in it . . . . It will add five days to her stay."

c. A Mid-Jefferson employee asked an attending doctor to document a new diagnosis for a patient and informed the doctor, "that will increase his length of stay 3 more days, so discharge will be Wednesday 8/24."

III. The PHG Defendants Incentivized Doctors to Discharge Medicare Patients on the "Planned Discharge Date" and Threatened Those Who Did Not

196. Each LTCH Defendant had a roster of doctors who admitted and attended patients at the LTCH.

197. Many attending doctors rotated their LTCH coverage with other doctors in one- or two-week intervals (*i.e.*, one doctor would admit and care for patients for a week and then another doctor would take over those patients and handle new admissions for the next week).

198. The PHG Defendants conveyed their target discharge dates—the Planned D/C Dates in Lester's dashboard—to attending doctors in various ways.

199. PHG Executives met with the LTCH Defendants' attending doctors and educated them about Medicare's reimbursement rules related to length of stay.

200. Each LTCH Defendant included the target discharge date in or on patient charts.

201. Case managers and other staff at each LTCH Defendant regularly discussed target discharge dates with attending doctors in person.

202. At Ruston Regional, where attending doctors rotated every week, the target discharge date was written on boards in patient rooms.

203. LTCH Defendant employees sometimes conveyed target discharge dates to attending doctors via text. For example:

a. A Riverside employee texted Dr. Newsom, "I got the referral on [Medicare Patient]. We can keep her 14 days." (This patient was discharged after 14 days on the date Riverside believed was her 5/6th date.)

b. When Dr. Newsom asked a nurse why a Medicare patient was not being discharged on the original target discharge date, the nurse responded, "Something about his days changed and it will be around the 15th now." (This patient had received a debridement, which changed his DRG and 5/6th date. The patient was discharged on the new 5/6th date, nine days after his original 5/6th date.)

c. A Riverside nurse texted another attending doctor that the case manager said "we need to hold [Medicare Patient] off until Saturday." The doctor responded, "Did she [the case manager] tell him that," and the nurse replied, "Lol….Not yet. He's ready to go now." (This patient was held in the hospital 5 more days until Saturday and discharged on his 5/6th date.)

d. A Riverside admissions liaison told a doctor that a patient he believed was a Qualifying Patient would have a 28-day length of stay. An hour later, the liaison texted the doctor that the patient was not Qualifying so "her length of stay with us will actually be 18-20 days."

e. A Mid-Jefferson employee updated another attending doctor that a patient "received a Debridement so it extended his DRG. Plan is to

send for rehab when he's met his stay." (This patient had an unplanned discharge 16 days before his 5/6th date due to a hurricane.)

f. Ruston's chief nursing officer texted an attending doctor to hold off discharging a patient because she was going to change the patient's DRG and "get her a few more days."

204. Attending doctors at the LTCHs understood the PHG Defendants were targeting specific discharge dates to maximize payment, and the doctors often deferred to the PHG Defendants' target discharge timing.

205. Communications between the LTCH Defendant staff and attending doctors show their understanding:

a. A month after Dr. Newsom started at Riverside, he texted a nurse about a patient that was slated for discharge, "When is his D.C. Date? Thought it was too early to send him? How does that work?" The nurse responded that the patient had commercial insurance (which does not reimburse based on length of stay) and that Dr. Newsom was thinking of a Medicare patient.

b. A Riverside nurse texted an attending doctor that a patient was "packing her things to leave today. Her antibiotics have been finished since Friday. Shes upset because we are keeping her here for nothing. She is an LTAC patient and she will be leave AMA[8] one day early!!!! Can you please call her maybe? I'm so sorry!!!! Nothing I tell her

[8] AMA is an abbreviation for "against medical advice."

works:-/" The doctor asked what would happen if the patient left early and the nurse replied, "Our payment drastically drops :(" The doctor replied that he would try to call the patient.

c. Mid-Jefferson's CEO texted five attending doctors about plans to close a COVID-19 unit after "those few remaining meet their los[.]" One doctor responded that his patients in the unit could be discharged. The CEO replied, "Just make sure they make length of stay or we lose a lot."

d. Mid-Jefferson's CEO texted another attending doctor, "Ur killing me with these early dc [discharges]."

206. The LTCH Defendants paid most of their attending doctors a monthly stipend through medical director or on-call agreements. Attending doctors also benefited financially when the LTCH Defendants assigned Medicare patients to their service because they could bill Medicare Part B for the professional services they provided to the patients.

207. The PHG Defendants threatened to remove or did remove these financial benefits from attending doctors who did not follow their desired discharge timing.

208. Riverside's CEO texted Dr. Newsom that Lester was "ready to chop a couple [attending doctors]" because "[d]ocs not being team players…with length of stay..etc. [Lester] doesn't play games." She continued, "He looks at financials

strictly … and these two days here two days there kill the budget." Dr. Newsom replied, "He seems kinda strict.. I try to be flexible."

209. Mid-Jefferson's CEO texted admissions staff, "do not give [attending doctor] any patients that are low criteria. He has a bad habit of short stays. Killing us."

210. Pressure from the PHG Defendants caused attending doctors to accept the PHG Defendants' targeted discharge timing.

211. Dr. Newsom asked Riverside staff whether it would "hurt the hospital" to discharge a patient early and suggested he could let the patient leave "against medical advice" instead.

212. Another attending doctor asked the Riverside CEO if he could "discharge bed 10 few days early" because the patient was "crying in the room to go home every day." The doctor noted that the patient was only on 1L of oxygen. The CEO agreed, but said, "not today please. too many going already."

213. As illustrated by Figures 2-4 above, the PHG Defendants' pressure on LTCH staff and attending doctors resulted in patients being discharged on the PHG Defendants' target date.

214. Although the PHG Defendants' pressure to discharge on the target date usually resulted in patients being held longer than necessary at the LTCH, sometimes patients were discharged when they needed additional care.

215. For example, a Mid-Jefferson attending doctor pushed back on discharging a patient with an "open wound" on his 5/6th date but agreed to the

discharge after pressure from LTCH staff. The patient was readmitted to the LTCH ten days later.

216. Other patients who needed care past their target discharge date were sent to acute care hospitals for 9 days, after which they could be sent back to the LTCH for new stay (*i.e.,* a new claim worth tens of thousands of dollars). For example:

a. A Mid-Jefferson employee told a doctor who worked at both Mid-Jefferson and the acute care hospital where the patient was transferred that the patient "can't come back until Friday" because he "has to stay out 9 days."

b. Dr. Newsom told a nurse that "if [a patient] meets her days tomorrow then she needs ER. It will take 2 weeks to fix her."

IV. The PHG Defendants Admitted Low Acuity Patients and Pressured Them to Stay Until the Planned Discharge Date

217. The PHG Defendants often admitted Medicare patients who did not require hospital-level care at the time of admission or who the PHG Defendants knew would not require hospital-level care for their entire stay.

218. The PHG Defendants admitted these low acuity patients because they were more likely to be ready for discharge on the planned discharge date and not require extended stays that would eat into the PHG Defendants' profits.

219. These patients often could have been treated at a lower level of care such as an inpatient rehabilitation facility.

220. This is reflected in texts between a Riverside admissions liaison and the Riverside CEO:

a. The liaison texted the CEO that a referral will be "1,735/day for 22 days" but the patient could "definitely go to rehab."

b. The liaison texted the CEO that she was "stretching" with another patient that "could go to rehab because we aren't doing much for him…but we need patients."

c. The liaison texted the CEO, "please know [another prospective patient] is a stretch.. meaning I know [admitting doctor] will probably say 'why are we taking this patient' he's just coming for therapy because increased falls." The CEO replied, "that's fine – we have majority therapy here now."

221. If a patient went to an inpatient rehabilitation facility instead of an LTCH, Medicare rules would have required that the patient receive significantly more therapy.

222. The PHG Defendants also admitted patients for courses of IV antibiotics scheduled to end before the planned discharge date. The PHG Defendants would hold these patients until the planned discharge date even though their treatment had ended.

223. LTCH Defendant administration and staff often made the decision whether to admit a patient. Attending physicians generally deferred to the LTCH Defendants' decisions.

224. Ruston Regional often did not consult attending doctors before admitting patients.

225. Riverside employees frequently provided attending doctors a few sentences about a prospective patient and asked for their agreement to admit the patient via text message.

226. The attending doctors did not always review this information before agreeing to the admission.

227. Dr. Newsom texted Riverside admissions staff that he would not "say no [to admitting a patient] as long as has a payer source." The staff member responded, "Yes! Medicare is payer!"

228. When Dr. Newsom questioned why Riverside was admitting patients he did not want to accept, a Riverside employee replied, "Well you know we don't have much of a 'criteria'…except for pulse and payment source lol."

229. Mid-Jefferson employees also texted attending doctors with limited information to gain admission approval and provided incorrect guidance about admission criteria.

230. When an attending doctor asked Mid-Jefferson's CEO if a patient was appropriate for the LTCH, the CEO responded, "if it's Medicare we can take even if just for therapy."

231. Patients often complained to LTCH Defendant staff about having to remain in the hospital unnecessarily.

232. The PHG Defendants used several tactics to prevent patients from leaving before their planned discharge date.

233. First, the PHG Defendants required patients or their families agree to the anticipated length of stay before admission.

a. Ruston Regional required patients and their families to sign a statement at admission "approving and understanding length of stay."

b. Riverside and Mid-Jefferson administration regularly confirmed whether patients had agreed to their length of stay.

c. One Riverside employee touted a patient referred by her friend who "agreed to come however long we need" and asked her manager if she could give her friend a gift card in exchange for the referral. The manager agreed.

d. Mid-Jefferson's CEO texted an admissions staff member that a patient "can't come if she won't agree to the los."

234. Second, Riverside attending doctors gave patients "day passes" to leave the hospital for activities such as paying bills, going out to eat, or visiting family. Patients who actually require inpatient hospital care are generally not physically able to leave the hospital because their care needs are so acute.

235. In one example, Dr. Newsom granted a patient three day passes in a row. The patient then offered marijuana (likely obtained on a day pass) to a Riverside employee. After this incident, Dr. Newsom texted the charge nurse, "He needs to go this week." The charge nurse replied that the case manager had told her

that the patient "meets his length of stay on Monday…" (The patient ended up staying six more days until Monday, which was his 5/6th date.)

236. Medicare reimbursed Riverside the full amount for patients who went on day passes even though they were out of the hospital and not incurring costs for significant periods during their stays.

237. Third, the PHG Defendants forced patients who wanted to leave "early" to sign out against medical advice (AMA) and misinformed patients and their families that Medicare would not pay for their stay if they left AMA.

238. Finally, LTCH staff sometimes purchased food or gifts for patients if they agreed to remain in the hospital.

239. Although these tactics often worked, some patients with the means to do so did choose to leave early. For example, after receiving two day passes from Dr. Newsom, a Riverside patient decided to leave AMA two weeks before his target discharge date. The nurse texted Dr. Newsom that the patient, "just walked out of the hospital, got in his old blue ford truck and left." Dr. Newsom responded, "Good for him."

V. The PHG Defendants Acted with Actual Knowledge or Reckless Disregard When They Submitted or Caused the Submission of False Claims for Medically Unnecessary Care

A. The PHG Defendants Knew Their Scheme Resulted in Medically Unnecessary Care

240. The PHG Defendants knew, or acted in reckless disregard or deliberate ignorance of the fact, that their scheme to delay discharges to maximize Medicare reimbursement resulted in medically unnecessary care.

241. When an employee raised concerns that delaying patient discharges resulted in medically unnecessary care to Lester, he responded that the LTCHs would still make money even if Medicare denied some claims.

242. Lester also was personally involved in decisions to admit and hold patients who did not require acute care. For example, Lester approved a patient's admission to Riverside for "comfort measures only," and Dr. Newsom admitted the patient. When Riverside's head nurse texted Dr. Newsom about the fact that patient did not require treatment, he responded, "🤷‍♂️" and directed the nurse to stop ordering labs for the patient. The patient remained at Riverside for 17 days until her "Planned D/C Date" in the dashboard.

243. The PHG Defendants' knowledge that they were providing medically unnecessary care is also illustrated by the fact that they did discharge patients before the "Planned D/C Date" when it was in their financial interest.

244. The PHG Defendants were willing to discharge patients "early" when:

a. The patients' care became too expensive. For example, after a test showed a Mid-Jefferson patient might need surgery, a staff member texted the CEO, "if it end[s] up surgical I'm going to dc home with outpatient workup to avoid surgical cost."

b. They could immediately fill the bed with another patient. For example, a Mid-Jefferson staff member texted the CEO that a family wanted a patient with a new cancer diagnosis to leave early to start cancer treatment. The staff member wrote, "I told them he needs more

> therapy first but if we need a bed next week that's one we could do." The CEO responded, "As of now I don't think we need a bed. If we can fill the bed let him go." The CEO then texted admissions staff that she would allow the cancer patient to "go early . . . but only if y'all fill bed same day."

245. To the extent any PHG Defendant did not actually know their scheme resulted in medically unnecessary care, they acted in deliberate ignorance or reckless disregard of that fact.

246. As reflected in the communications described in Sections I-IV above, PHG Executives and LTCH Defendant staff consistently discussed and targeted planned discharge dates based solely on financial considerations without reference to patients' clinical status. These communications show the PHG Defendants' disregard of the medical necessity of the patients' continued stay.

247. PHG Executives also were informed that Medicare changed its payment system in 2017 because LTCHs were improperly delaying patient discharges to increase their Medicare reimbursement. However, they continued with their scheme to hold patients to maximize Medicare reimbursement.

B. The PHG Defendants Knew Submission of Medically Unnecessary Claims Violated Medicare Laws and Regulations

248. During the time covered by this complaint, each PHG Defendant knew that Medicare prohibits payment for medically unnecessary care.

249. During the time covered by this complaint, each PHG Defendant also knew that the medical necessity of care was material to Medicare's decision to pay claims.

250. PHG Executives Rice, Wright, and Lester each had significant health care experience prior to their work with PHG and were aware of Medicare's medical necessity requirement.

251. Lester, a registered nurse, previously conducted medical necessity reviews for a short-term hospital.

252. The administrators of each LTCH Defendant also had significant health care experience and were aware of Medicare's medical necessity requirement.

253. The LTCH Defendants expressly agreed and certified in their Medicare enrollment applications and cost reports that they would comply with Medicare laws and regulations and that all services for which they sought reimbursement complied with these laws and regulations.

254. A known and intended result of the PHG Defendants' scheme to hold patients in the hospital to maximize reimbursement was to induce Medicare to pay for medically unnecessary hospital services. By submitting claims that included medically unnecessary hospital services, the LTCH Defendants knowingly and falsely implied that they were entitled to full payment from Medicare.

VI. Representative Examples

A. Representative Examples of Medically Unnecessary Claims Caused By the PHG Defendants' Scheme

255. The LTCH Defendants submitted the claims described in this section (the Medically Unnecessary Example Claims) to their MACs. These claims were false because they included medically unnecessary hospital services provided to Medicare Part A beneficiaries.

256. Through the act of submitting the Medically Unnecessary Example Claims, the LTCH Defendants also knowingly and falsely implied that they were entitled to full payment from Medicare.

257. PHG caused the submission of these claims, including by setting company policy and implementing financial incentives designed to induce submission of false claims for medically unnecessary hospital services.

258. The relevant MAC, acting as CMS's agent, paid the Medically Unnecessary Example Claims with federal funds.

259. Medicare would not have reimbursed the Medically Unnecessary Example Claims in whole had it known that they requested payment for medically unnecessary care.

1. Medically Unnecessary Example Claim 1 (Riverside)[9]

260. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient A, a Medicare beneficiary over 90 years old.

[9] The names of the patients used in these examples and exact dates of service will be provided to the PHG Defendants.

261. On the date of Patient' A's admission to Riverside, a Riverside employee texted a physician that a local nursing home had referred Patient A to Riverside because she was "running out of skilled days."[10] The physician accepted Patient A, and Riverside admitted her for "weakness."

262. Patient A was an Exempt Patient who did not count toward Riverside's 25-day ALOS Qualification. Riverside's dashboard reflected a "Planned D/C Date" for Patient A on the 5/6th date (day 17 of her stay), and her chart included a "Note to Physician" that Riverside anticipated discharging the patient on the 5/6th date. On the 5/6th date, Riverside's CEO asked Patient A's attending physician for orders to discharge Patient A. Riverside discharged her the same day.

263. Attending physicians completed twelve progress notes on Patient A during her stay at Riverside. The progress notes generally stated Patient A had "no complaints," "no problems," or "no new problems," and eight notes stated Patient A was "doing well" or "stable." Patient A's attending physician allowed Patient A to leave the hospital with day passes on Christmas Eve and Christmas.

264. Riverside submitted a claim to Medicare Part A for Patient A's hospital stay in 2020, and Medicare paid $13,502.76. This claim was false or fraudulent because, as demonstrated by Riverside's medical records, Patient A's stay at Riverside until her 5/6th date was medically unnecessary. If Patient A had been discharged earlier, Medicare would have paid Riverside less for the claim.

[10] Medicare Part A covers care in a skilled nursing facility for a limited number of days. This period resets if a beneficiary is admitted to a hospital (including an LTCH) for three days.

2. Medically Unnecessary Example Claim 2 (Riverside)

265. The PHG Defendants knowingly submitted or caused to be submitted a false or fraudulent claim to Medicare for Patient B, a 65-year-old Medicare beneficiary. Riverside admitted Patient B from home for "therapy."

266. Patient B was an Exempt Patient who did not count toward Riverside's 25-day ALOS Qualification. Riverside's dashboard reflected a "Planned D/C Date" for Patient B on the 5/6th date. Riverside discharged Patient B on the 5/6th date (day 14 of his stay).

267. Attending physicians' progress notes on Patient B show little change in his status or treatment. For example, a week after Patient B was admitted to Riverside, the attending physician observed he was "[c]linically about the same. No new issues noted. In good spirits. Still going outside to smoke frequently." Patient B's discharge note stated, "The patient's hospitalization here was unremarkable. The patient continued to do well with therapy."

268. Riverside submitted a claim to Medicare Part A for Patient B's hospital stay in 2020, and Medicare paid $18,884.45. This claim was false or fraudulent because, as demonstrated by Riverside's medical records, Patient B's stay at Riverside until his 5/6th date was medically unnecessary. If Patient B had been discharged earlier, Medicare would have paid Riverside less for the claim.

3. Medically Unnecessary Example Claim 3 (Riverside)

269. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient C, an 80-year-old Medicare beneficiary.

Riverside admitted Patient C from home for "aggressive physical therapy, nutrition consultation, and diet evaluation."

270. Patient C was an Exempt Patient who did not count toward Riverside's 25-day ALOS Qualification. Riverside's dashboard reflected a "Planned D/C Date" for Patient C on the 5/6th date. Riverside discharged Patient C on the 5/6th date (day 23 of her stay).

271. Attending physicians' progress notes on Patient C show little change in her status or treatment. Patient C's physical therapy notes show that she walked 125 feet on day 7 of her stay, surpassing her short-term goal and almost achieving her long-term goal. Halfway through her stay, the attending physician observed that Patient C "[c]ontinues to do fairly well." Riverside allowed Patient C to leave the hospital on a day pass a week before she was discharged.

272. Riverside submitted a claim to Medicare Part A for Patient C's hospital stay in 2018, and Medicare paid $23,214.86. This claim was false or fraudulent because, as demonstrated by Riverside's medical records, Patient C's stay at Riverside until her 5/6th date was medically unnecessary. If Patient C had been discharged earlier, Medicare would have paid Riverside less for the claim.

4. Medically Unnecessary Example Claim 4 (Ruston Regional)

273. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient D, a 79-year-old Medicare beneficiary. Ruston Regional admitted Patient D from the nursing home where he lived for "intensified IV antibiotic treatment and wound care" related to a heel wound.

274. Patient D was an Exempt Patient who did not count toward Ruston Regional's 25-day ALOS Qualification. Ruston Regional discharged Patient D on the 5/6th date (day 21 of his stay).

275. The wound care clinic that referred Patient D to Ruston Regional anticipated that he would require IV antibiotics for six to eight weeks. On day 11 of Patient D's stay, the attending physician observed that Patient D "is receiving IV antibiotics and wound care" and his plan is to "1. Continue intravenous antibiotics. 2. Continue wound care." On day 14, the case manager faxed Patient D's information to a swing bed facility and noted, "Expected d/c date [5/6th date]." Patient D was discharged to a swing bed on his 5/6th date even though his physicians determined he needed to continue the same treatment he was receiving at the LTCH (antibiotics and wound care).

276. Ruston Regional submitted a claim to Medicare Part A for Patient D's hospital stay in 2018, and Medicare paid $16,545.64. This claim was false or fraudulent because, as demonstrated by Ruston Regional's medical records, Patient D's stay at Ruston Regional until his 5/6th date was medically unnecessary. If Patient D had been discharged earlier, Medicare would have paid Ruston Regional less for the claim.

5. Medically Unnecessary Example Claim 5 (Ruston Regional)

277. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient E, a 78-year-old Medicare beneficiary. Ruston Regional admitted Patient E from a nursing home where she lived for "IV

antibiotics and more aggressive treatment and possible I&D [incision and drainage]" for a non-healing wound.

278. Patient E was an Exempt Patient who did not count toward Ruston Regional's 25-day ALOS Qualification. Ruston Regional assigned Patient E a DRG with a 5/6th LOS of 29.4. However, Ruston Regional was using outdated 5/6th LOS data, and its dashboard reflects a 5/6th LOS for Patient E of 28 days. Ruston Regional discharged Patient E after 28 days.

279. Patient E's wound was debrided two days after her admission. After the debridement, Patient E had "no problems" or "no complaints" for her remaining 26 days at Ruston Regional. She stopped antibiotics on day 23 of her stay and her doctor stated the same day that she was "okay to D/C [on day 28]." Patient E's discharge summary states, "She has remained stable throughout her hospitalization and will be discharged back to [nursing home]."

280. Ruston Regional submitted a claim to Medicare Part A for Patient E's hospital stay in 2019, and Medicare paid $28,796.22. This claim was false or fraudulent because, as demonstrated by Ruston Regional's medical records, Patient E's stay at Ruston Regional until her discharge date was medically unnecessary. If Patient E had been discharged earlier, Medicare would have paid Ruston Regional less for the claim.

6. Medically Unnecessary Example Claim 6 (Ruston Regional)

281. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient F, a Medicare beneficiary over 90 years old.

Ruston Regional admitted Patient F from a short-term hospital for "continued occupational therapy and physical therapy."

282. Patient F was a Qualifying Patient and counted toward Ruston Regional's 25-day ALOS Qualification. Ruston Regional assigned Patient F a DRG with a 5/6th LOS of 17.8 days. Ruston Regional discharged Patient F after 25 days.

283. Attending physicians' progress notes on Patient F show little change in her status or treatment. Over two weeks before her discharge, the attending physician noted Patient F was "[s]cheduled to discharge in a couple weeks." But three days later, the attending physician noted Patient F "feels great today and would entertain the idea of going home." Despite this, the attending physician continued to observe in his notes that Patient F's scheduled discharge date was not until later in the month. Throughout Patient F's stay, case management notes indicate a scheduled discharge date on day 25.

284. Ruston Regional submitted a claim to Medicare Part A for Patient F's hospital stay in 2019, and Medicare paid $31,348.66. This claim was false or fraudulent because, as demonstrated by Ruston Regional's medical records, Patient F's stay at Ruston Regional for 25 days was medically unnecessary. If Patient F had been discharged earlier, Medicare would have paid Ruston Regional less for the claim.

7. Medically Unnecessary Example Claim 7 (Mid-Jefferson)

285. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient G, a 65-year-old Medicare beneficiary. Mid-Jefferson admitted Patient G from a short-term hospital, where he was treated for

necrosis of his toe and COVID-19. At Mid-Jefferson, Patient G received wound care, IV antibiotics, and therapy.

286. Patient G was an Exempt Patient who did not count toward Mid-Jefferson's 25-day ALOS Qualification. Mid-Jefferson's coder emailed the case manager with Patient G's DRG and "LOS," which was 34 days. Mid-Jefferson's dashboard reflected that Patient G's 5/6th LOS was 34 days and set a "Planned D/C Date" on the 5/6th date. Mid-Jefferson discharged Patient G on his 5/6th date.

287. Patient G's progress notes show little change in his status or treatment. He received one debridement on his finger on day 7 of his stay. Two days later, his attending physician observed that he was "doing clinically well." By day 10, Patient G was "S/P [status post] COVID-19."

288. Mid-Jefferson submitted a claim to Medicare Part A for Patient G's hospital stay in 2021, and Medicare paid $93,563.54. This claim was false or fraudulent because, as demonstrated by Mid-Jefferson's medical records, Patient G's stay at Mid-Jefferson until his 5/6th date was medically unnecessary. If Patient G had been discharged earlier, Medicare would have paid Mid-Jefferson less for the claim.

8. Medically Unnecessary Example Claim 8 (Mid-Jefferson)

289. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient H, a 77-year-old Medicare beneficiary. Mid-Jefferson admitted Patient H from a short-term hospital for pneumonia and chronic obstructive pulmonary disease.

290. Patient H was a Qualifying Patient who counted toward Mid-Jefferson's 25-day ALOS Qualification. Mid-Jefferson assigned Patient H to a DRG with a 5/6th LOS of 17.7 days. Mid-Jefferson discharged Patient H after 25 days.

291. Patient H's progress notes show little change in her status or treatment at Mid-Jefferson. On day 4 of her stay, Patient H's attending physician noted, "likely SNF [skilled nursing facility] soon." Patient H remained at Mid-Jefferson for another 20 days.

292. Mid-Jefferson submitted a claim to Medicare Part A for Patient H's hospital stay, in 2019 and Medicare paid $32,121.36. This claim was false or fraudulent because, as demonstrated by Mid-Jefferson's medical records, Patient H's stay at Mid-Jefferson for 25 days was medically unnecessary. If Patient H had been discharged earlier, Medicare would have paid Mid-Jefferson less for the claim.

9. Medically Unnecessary Example Claim 9 (Mid-Jefferson)

293. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient I, a Medicare beneficiary over 90 years old. Mid-Jefferson admitted Patient I from hospice so she could receive "a higher level of care" for her medical conditions.

294. Patient I was an Exempt Patient who did not count toward Mid-Jefferson's 25-day ALOS Qualification. Mid-Jefferson's census reports show that Patient I's DRG was changed two weeks into her stay to a DRG with a 5/6th LOS of 27.0 days. The same day, Mid-Jefferson's admission coordinator informed the case manager that Patient I's "drg changed and her dc date changed." Mid-Jefferson

discharged Patient I on day 27 of her stay, which it believed was her 5/6th date due to a rounding error in the dashboard.

295. On day 10 of her stay, Patient I's attending doctor observed she was "feeling better. No events." Patient I remained at Mid-Jefferson for another 18 days.

296. Mid-Jefferson submitted a claim to Medicare Part A for Patient I's hospital stay in 2018, and Medicare paid $26,251.71. This claim was false or fraudulent because, as demonstrated by Mid-Jefferson's medical records, Patient I's stay at Mid-Jefferson until her discharge date was medically unnecessary. If Patient I had been discharged earlier, Medicare would have paid Mid-Jefferson less for the claim.

10. Medically Unnecessary Example Claim 10 (Mid-Jefferson)

297. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient J, a 43-year-old Medicare beneficiary. Mid-Jefferson admitted Patient J from a short term hospital for "further management and rehabilitation."

298. Patient J was a Qualifying Patient who counted toward Mid-Jefferson's 25-day ALOS Qualification. Mid-Jefferson assigned Patient J a DRG with a 5/6th LOS of 25.1 days. Mid-Jefferson discharged Patient J after 26 days, on her 5/6th date.

299. Patient J's progress notes show little change in her status or treatment at Mid-Jefferson. On day 2 of her stay, the attending doctor described Patient J as "clinically doing well." On day 8, the attending doctor observed that, "Overall, the patient's clinical status appeared to be stable." From days 18-20, the attending

doctor noted his plan included, "Discharge planning." On day 21, the case manager noted, "Patient discharging [5/6th date]." Patient J's discharge summary describes her 26-day stay at Mid-Jefferson as "not complicated."

300. Mid-Jefferson submitted a claim to Medicare Part A for Patient J's hospital stay in 2019, and Medicare paid $45,714.67. This claim was false or fraudulent because, as demonstrated by Mid-Jefferson's medical records, Patient J's stay at Mid-Jefferson until her 5/6th date was medically unnecessary. If Patient J had been discharged earlier, Medicare would have paid Mid-Jefferson less for the claim

11. Medically Unnecessary Example Claim 11 (Mid-Jefferson)

301. The PHG Defendants knowingly submitted or caused to be submitted a false claim to Medicare for Patient K, a 64-year-old Medicare beneficiary. Mid-Jefferson admitted Patient K from home for wound care.

302. Patient K was an Exempt Patient who did not count toward Mid-Jefferson's 25-day ALOS Qualification. Mid-Jefferson discharged Patient K on the 5/6th date (day 22 of his stay).

303. Patient K's progress notes show little change in his status or treatment at Mid-Jefferson. On day 4 of his stay, Patient K's doctor suggests treating his wound with ointment and defers a debridement procedure. Mid-Jefferson's team conference notes from days 5, 12, and 19 reflect that they anticipate discharging Patient K on his 5/6th date. No explanation is provided for the timing of discharge and no "barriers to discharge" are mentioned in the plan.

304. Mid-Jefferson submitted a claim to Medicare Part A for Patient K's hospital stay in 2017, and Medicare paid $19,482.61. This claim was false or fraudulent because, as demonstrated by Mid-Jefferson's medical records, Patient K's stay at Mid-Jefferson until his 5/6th date was medically unnecessary. If Patient K had been discharged earlier, Medicare would have paid Mid-Jefferson less for the claim.

B. Representative Examples of False Statements or Records PHG Defendants Made, or Caused to Be Made, to Medicare

305. Throughout the relevant time period, the LTCH Defendants falsely certified in their Medicare enrollment applications, claims, cost reports, and other documents that their claims, including the Medically Unnecessary Example Claims, and their actions complied with Medicare laws and regulations, which include Medicare's medical necessity requirement.

306. These false statements were made or caused to be made by PHG, including through its setting of company policy and implementing financial incentives designed to induce submission of false claims for medically unnecessary hospital services.

307. As described in Paragraphs 74-79 *supra*, the LTCH Defendants' Medicare enrollment applications certified, among other things, that they "agree[d] to abide by the [applicable] Medicare laws, regulations, and program instructions."

308. Figure 6 provides specific examples of Medicare enrollment applications that the LTCH Defendants submitted, and that PHG caused them to

submit, which contained false certifications of compliance with Medicare laws, regulations, and program instructions.

Figure 6.

Date	Facility	Signatory
June 2016	Riverside	Boulware
June 2017	Ruston Regional	Wright
December 2018	Mid-Jefferson	Rice
November 2021	Riverside	Boulware
April 2022	Ruston Regional	Rice
April 2022	Mid-Jefferson	Rice
May 2023	Riverside	Rice and Wright

309. Throughout the relevant time period, the LTCH Defendants also submitted annual Medicare cost reports signed by the PHG Chief Financial Officer.

310. As described in Paragraphs 84-89 *supra*, those cost reports certified, among other things, that "the services identified in this cost report were provided in compliance with the laws and regulations regarding the provision of health care services."

311. Figure 7 provides specific examples of Medicare cost reports that the LTCH Defendants submitted, and that PHG caused them to submit, which contained such false certifications of compliance with "the laws and regulations regarding the provision of health care services."

Figure 7.

Date	Facility	Signatory
October 11, 2019	Ruston Regional	PHG CFO
November 22, 2019	Riverside	PHG CFO
January 27, 2020	Mid-Jefferson	PHG CFO
November 30, 2020	Riverside	PHG CFO
December 15, 2020	Ruston Regional	PHG CFO
March 30, 2021	Mid-Jefferson	PHG CFO

312. The LTCH Defendants also completed Electronic Data Interchange (EDI) Enrollment Forms to allow them to submit Medicare claims electronically. These forms required the LTCH Defendants to agree to "submit claims that are accurate, complete, and truthful," acknowledge claims will be paid from Federal funds, and acknowledge that "anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement" may be subject to a fine and/or imprisonment under applicable Federal law.

313. Wright completed an EDI enrollment for Riverside in 2014 and certified that he was an authorized individual to "commit the provider to abide by the laws, regulations and program instructions of Medicare."

PHG and Riverside's Scheme to Pay Dr. Newsom to Induce Referrals

I. Riverside Sought to Increase Referrals from a Local Hospital

314. In May 2017, Riverside's owners were unhappy with the number of patients being admitted to Riverside.

315. Wright, who was Riverside's CEO at the time, led the effort to increase Riverside's census. He targeted referrals from the local short-term hospital, Rapides Regional Medical Center (RRMC).

316. Wright described his efforts to one of Riverside's owners:

> I've developed and made proposals to 4 different groups of physicians in Alexandria in an effort to "cure" our issue with [RRMC]. The latest group consists of 2 hospitalists that work for Teamhealth (the group that handles all of the ICU and

> hospitalist work for RRMC). I believe this will go a long way in resolving our lack of RRMC volume.

317. Wright's "proposals" included (i) Riverside entering "medical director" contracts with the physicians under which Riverside would pay thousands of dollars a month ostensibly in return for the physicians' administrative services to Riverside; (ii) the physicians referring patients to Riverside; and (iii) Riverside assigning some patients who did not already have a doctor (called "unassigned patients") to the physicians' service.

318. The physicians financially benefited from such an arrangement through both the monthly directorship payments from Riverside and the professional fees they could collect from insurers for seeing patients at Riverside (around $65-$70 per visit for a patient insured through Medicare Part B).

319. Rice explained the "possible revenue for a doctor who took a directorship and carried so many patients" in an email to Wright:

> [F]or a group of new doctors who maintain a Medicare census of 10, the monthly proceeds from professional services will be ($67)(10)(30)=$20,100. If we make one of the members the Medical Director and pay $5,000 per month, the total is $300,000+ per year. It can be north of $400,000 if they keep a higher census. If they can bring 8-10 patients per month, plus what we are able to assign to them through the unassigned rotation, it should make good economic sense to them.

II. Riverside Retained Dr. Newsom as Medical Director Assuming He Could "Keep a Minimum of 8 Patients in Riverside"

320. Defendant Dr. Newsom was one of the RRMC hospitalists that Wright approached with a proposal to "cure" the lack of referrals from RRMC.

321. On May 1, 2017, Wright emailed Dr. Newsom and another physician, Dr. Gulati (a nephrologist who also saw patients at RRMC), about "mov[ing] forward with trying to develop an agreement with you[.]" Wright continued:

> Here are my assumptions and proposal . . . .
>
> 1) I would assume you could keep a minimum of 8 patients in Riverside. Assuming an average physician payment per patient of $70, maintaining a census of 8 patients would equate to billable visits of approximately $16,800 per month for your partnership.
>
> 2) The nature of your agreement with Riverside would be a "Physician Administrative Services" agreement in which you agree to be a program director of a specific area. We'll need to discuss this more to determine the areas in which you're most proficient or comfortable . . . . In essence, the agreement provides for about 25 different ways to fulfill time from an hourly perspective. This is necessary to pass muster with CMS. Once I familiarize you with the agreement and time sheet, I don't think you'll find it difficult or burdensome.
>
> 3) The agreement would be a yearly contract with automatic renewal clauses (as well as "exit" clauses). I propose a total monthly payment of $3,000, which represents 20 hours per month of administrative tasks at a rate of $150 per hour.

322. Although Wright's email also stated that "[i]n no way will I ever expect a 'quid pro quo' arrangement,' the AKS does not require the presence of an explicit *quid pro quo*. *See, e.g., United States v. Regeneron Pharms., Inc.*, No. 20-11217, 2020 WL 7130004, at *11 (D. Mass. Dec. 4, 2020).

323. Further, Wright's email noted that Riverside would only "occasionally" ask the doctors to see unassigned patients, indicating that he expected the "minimum of 8 patients" to come primarily from referrals caused by the doctors.

324. Three days later, Wright emailed Dr. Newsom a draft contract to become Riverside's Program Director for Pharmacy and Therapeutics.

325. After realizing his initial proposal for contracting with Dr. Gulati raised clear AKS compliance concerns related to the number of hours he would be required to devote to Riverside work and hourly rate, Wright ultimately gave Dr. Gulati the "Pharmacy and Therapeutics" position and changed Dr. Newsom's program area to "Quality Assurance."

326. Riverside and Dr. Newsom entered into a Program Medical Director Agreement for Quality Management effective July 1, 2017. Wright signed the agreement for Riverside.

327. The agreement called for Riverside to pay Dr. Newsom $150 per hour for approximately 20 hours per month of administrative support to Riverside's "quality management program." The agreement specified that patient care did not count toward Dr. Newsom's contractual services.

328. Although Wright described responsibilities related to referring, admitting, and attending patients in his May 1st "assumptions and proposal" email (described in Paragraph 321), Dr. Newsom's Program Director Agreement does not mention any of these responsibilities.

329. Neither PHG nor Riverside conducted a formal needs analysis related to the services to be provided by Dr. Newsom under the Program Director Agreement.

330. The services that Riverside purported to engage from Dr. Newsom under the Program Director Agreement duplicated services Riverside had contracted from another physician.

331. Specifically, when Riverside entered into the Program Director Agreement for Quality Management with Dr. Newsom, another physician was already contracted as Riverside's Director of Quality Improvement. Riverside paid the other physician $1,500 per month for the Quality Improvement services from at least 2013 to February 2021.

332. Moreover, at the time Riverside entered into the Program Director Agreement with Dr. Newsom, Riverside was paying six other physicians monthly stipends between $1,500 and $5,000 under other medical director agreements.

333. Neither PHG nor Riverside documented any fair market value analysis of Dr. Newsom's payment rate under the Program Director Agreement.

334. Riverside's obligation to pay Dr. Newsom under the Program Director Agreement was conditioned on the completion of monthly time sheets "describing with particularity the time spent and services provided, by date, in the preceding calendar month."

335. Riverside and Dr. Newsom did not track the time Dr. Newsom spent on his program director duties, and Dr. Newsom did not complete any timesheets for his program director work.

336. The only support for the time Dr. Newsom spent on his program director duties are inaccurate time sheets completed by Riverside employees without tracking the time actually spent by Dr. Newsom.

337. Dr. Newsom signed the time sheets without reviewing them.

338. Between July 2017 and at least July 2021, Dr. Newsom's program director timesheets reflect exactly 20 hours each month.

339. Dr. Newsom, however, spent less than 20 hours per month on his program director duties.

340. Riverside paid Dr. Newsom exactly $3,000 each month under the Program Director Agreement from July 2017 to at least July 2021.

341. After the 2017 agreement, Dr. Newsom and Dr. Gulati began to cross-cover for each other at Riverside: Dr. Newsom admitted and saw patients at Riverside for about two weeks and then transferred his remaining patients to Dr. Gulati, who admitted and saw patients for the next two weeks and transferred his remaining patients back to Dr. Newsom.

342. Riverside soon was giving most of its unassigned patients to Dr. Newsom and Dr. Gulati.

343. This was in part because Dr. Newsom and Dr. Gulati were more willing than other attending doctors to hold patients until Riverside's planned discharge date.

III. Riverside Increased Dr. Newsom's Monthly Payments Through a Sham Physician On-Call Agreement

344. Even though Dr. Newsom's Program Director Agreement was not meant to compensate him for patient care, in June 2018, Dr. Newsom texted Amy Grimes (Riverside's Business Development Director): "3000 a month is getting tough for 25 pts."

345. Grimes replied, "The big money is with the billing of them. I know it has to be hard with that many - I can divide some out if you ever need a break. [Lester] will be here tomorrow and I will talk to [h]im."

346. Grimes texted Dr. Newsom a month later, "I just had a call with [Lester]. We will increase each of you to a total of 5000 per month. [H]e wants to talk with you next week about how it will be added or worded in the contract. There are two different ways we could do it."

347. Dr. Newsom and Riverside entered a Physician On-Call Agreement effective August 1, 2018. Lester signed the agreement for Riverside.

348. The parties did not sign the On-Call Agreement until after its effective date.

349. The On-Call Agreement purportedly provided for "physician coverage at the Facility 24 hours a day, 7 days per week" and was meant to "insur[e] that a physician is always available to admit and treat any and all unassigned patients . . . and to treat any and all patients admitted by other physicians who are also included in the 'on call' rotation, and to provide patient care in the event of an emergency to all patients of the hospital."

350. The On-Call Agreement stated that the fees paid by Riverside under the agreement "do not include any payment for the provision of any professional medical services to such patients." (Emphasis in original.)

351. The On-Call Agreement provided Dr. Newsom would receive a flat fee of two thousand dollars per month but, if he provided "services for more or less than an entire 7 day period, the payment amount will be prorated on an hourly basis in the amount of $25.00 per hour."

352. Riverside's obligation to pay Dr. Newsom under the On-Call Agreement was contingent on his submission of monthly time sheets reflecting his on-call hours.

353. Dr. Newsom's work at Riverside did not change after the On-Call Agreement.

354. Riverside never developed an on-call schedule for Dr. Newsom.

355. Neither Riverside nor Dr. Newsom tracked the hours Dr. Newsom was on call.

356. Neither Riverside nor Dr. Newsom completed time sheets for his on-call services.

357. Dr. Gulati entered an identical On-Call Agreement, which also contemplated seven days of call per month. Dr. Newsom's and Dr. Gulati's agreements only covered two weeks a month. Riverside had no other on-call coverage.

358. No other admitting or attending doctors at Riverside were compensated for on-call services.

359. The fact that Riverside did not provide for call coverage spanning the whole month indicates the On-Call Agreement did not have a reasonable and legitimate business purpose.

360. Neither PHG nor Riverside conducted a fair market value analysis related to Dr. Newsom's On-Call Agreement.

361. The On-Call Agreement does not reflect fair market value for the services performed by Dr. Newsom under the agreement.

362. Riverside's medical staff by-laws already required admitting physicians be located within a reasonable distance to the hospital and "provide continuous care" for their patients. It was not commercially reasonable for Riverside to pay Dr. Newsom for services he was already required to provide.

363. Riverside paid Dr. Newsom exactly $2,000 each month under his On-Call Agreement from August 2018 to at least March 2023.

364. Riverside never paid Dr. Newsom for prorated hours more or less than the seven days provided for by the $2,000 flat fee in the On-Call Agreement.

IV. Riverside Again Increased Dr. Newsom's Monthly Payments Through a Sham Rehabilitation Director Agreement

365. Riverside opened an inpatient rehabilitation facility (IRF) unit in 2020, assigning half of its existing 28 beds to the new unit.

366. Medicare requires IRF units have a director of rehabilitation who provides services to the IRF and its patients for at least twenty hours per week. 42 C.F.R. § 412.29(g).

367. Riverside contracted Dr. Newsom and Dr. Gulati to share the rehabilitation director duties.

368. On April 2, 2020, Grimes emailed Dr. Newsom a draft Medical Director Agreement for Rehabilitation.

369. On April 10, 2020, Grimes texted Dr. Newsom, "[I] can start paying y'all june first – the first month can be 'training'" (quotation marks in original).

370. Riverside and Dr. Newsom entered a Medical Director Agreement for Rehabilitation that was dated June 1, 2020, but had an effective date "on the date that the hospital receives state licensure and a patient is first admitted to the hospital." Grimes, who had been promoted to Riverside's CEO in 2019, signed the agreement for Riverside.

371. The Rehabilitation Agreement required Riverside pay Dr. Newsom $5,000 per month for "patient care and administrative services on a part-time basis (a minimum of twenty (20) hours per week) during physician specified rotation." The agreement required substantially all the care and services to be performed on Riverside's premises.

372. The Rehabilitation Agreement contained an exhibit entitled "Master List of Financial Arrangements." However, neither this exhibit nor any exhibit to

Dr. Newsom's other agreements with Riverside included a full list of his arrangements with Riverside.

373. Riverside began paying Dr. Newsom under the Rehabilitation Agreement in June 2020.

374. Riverside accepted its first IRF patient on October 5, 2020.

375. Riverside paid Dr. Newsom at least $15,000 under the Rehabilitation Agreement before Riverside opened its IRF and before the agreement was effective.

376. Riverside's obligation to pay Dr. Newsom under the Rehabilitation Agreement was conditioned on his submission of time sheets.

377. Dr. Newsom did not complete Rehabilitation Director time sheets and did not track the time he spent on his rehabilitation director duties.

378. Riverside employees completed time sheets for Dr. Newsom's Rehabilitation directorship. The employees did not track the time Dr. Newsom spent on his Rehabilitation Director duties.

379. Dr. Newsom signed the time sheets without reviewing them.

380. Above Dr. Newsom's signature, the Rehabilitation Director time sheets state, "By completing and signing this timesheet, Director understands he/she is making a representation which will be included on Medicare and Medicaid cost reports. Any false statement on this time sheet may therefore be a violation of state or federal laws."

381. Between July 2020 and July 2021, all of Dr. Newsom's Rehabilitation Director time sheets except one reflect that he spent 20 hours per month on the directorship. The July 2021 time sheet reflects 22 hours.

382. The hours reflected on Dr. Newsom's Rehabilitation Director time sheets do not meet the 20 hours per week required under the Rehabilitation Agreement and Medicare regulations.

383. Neither PHG nor Riverside conducted a fair market value analysis related to Dr. Newsom's Rehabilitation Director Agreement.

384. The compensation Dr. Newsom received under the Rehabilitation Director Agreement does not reflect fair market value for services he actually provided.

385. Riverside paid Dr. Newsom $5,000 per month for the 20 hours of purported rehabilitation director work reflected on his time sheets, equaling $250 per hour.

386. The $250 hourly rate under the Rehabilitation Director Agreement is significantly more than Dr. Newsom's $150 hourly rate under his Program Director Agreement with Riverside.

387. Although Riverside halved the size of its LTCH when it opened the IRF unit, it did not adjust the number of hours required by Dr. Newsom under his LTCH-related contracts.

V. Summary of Dr. Newsom's Relationship with Riverside

388. From 2017 to 2022, Riverside paid Dr. Newsom a total of $450,000 under the Program Director Agreement, On-Call Agreement, and Rehabilitation Agreement (together, the Director Agreements).

389. Riverside's payments to Dr. Newsom under the Director Agreements were made to him or his limited liability company, Benjamin Newsom, LLC, which is a physician organization as defined in 42 C.F.R. § 411.351.

390. Riverside's payments to Dr. Newsom under the Director Agreements, and its gifts and lunches provided to Dr. Newsom described below, constitute remuneration under the AKS and Stark Law.

391. The Director Agreements created a financial relationship between Dr. Newsom and Riverside under the Stark Law.

392. In addition to the Director Agreement payments, Dr. Newsom received significant professional fees from insurers related to his care at Riverside. Between 2017 and 2023, Dr. Newsom was the attending doctor for over 500 Medicare patients at Riverside. He spent an average of five minutes with each Riverside patient on a typical day and received an average payment per visit from Medicare Part B of $65. In all, Dr. Newsom received over $900,000 in Medicare Part B professional fees for seeing patients at Riverside between 2017 and 2023.

393. Riverside's compensation to Dr. Newsom under the Director Agreements was not consistent with fair market value in arm's-length transactions. For example, Riverside paid Dr. Newsom under the Rehabilitation Agreement for months before it opened the rehabilitation unit.

394. And Dr. Newsom did not actually work the hours required by his Riverside contracts and paid for by Riverside.

395. After the Rehabilitation Agreement, Dr. Newsom was contractually obligated to spend twenty hours per week while he was on his Riverside rotation (approximately two weeks a month) on administrative rehabilitation services and rehabilitation patient care. These services were required to be performed substantially at Riverside. He was also contractually obligated to spend twenty hours per month on administrative services for the LTCH quality management program.

396. On most days he was on rotation, Dr. Newsom spent around two to two and a half hours at Riverside.

397. Dr. Newsom also had significant duties outside of Riverside between 2017 and 2023. These duties included his hospitalist job at RRMC, which required twelve-hour shifts in a week on/week off rotation, and hospice and home health directorships, among other things.

398. The services required under the Director Agreements exceeded those that were reasonable and necessary for Riverside's legitimate (or commercially reasonable) business purposes. For example, Dr. Newsom's Program Director Agreement duplicated that of another Riverside physician.

399. The amounts paid by Riverside under the Director Agreements would not have been commercially reasonable if Dr. Newsom did not refer patients to Riverside.

400. Further, the Director Agreements failed to specify all services that Riverside and Dr. Newsom agreed to as part of their arrangement. For example, the agreements do not mention that Dr. Newsom would refer, admit, and attend patients at Riverside even though Dr. Newsom saw this as the primary reason Riverside was paying him. *See supra* Paragraph 344 (Dr. Newsom text that "3000 a month is getting tough for 25 pts").

VI. Riverside Bought Dr. Newsom Lunches and Gifts in Exchange for Referrals

401. Riverside regularly purchased lunch for Dr. Newsom and his colleagues at RRMC in exchange for referrals.

402. Riverside staff communicated with Dr. Newsom about these lunches via text message. For example:

a. On February 23, 2018, Grimes texted Dr. Newsom, "We have to fill 3-4 beds today!!" Dr. Newsom replied, "I'm trying to find them. I just don't have any on my list[.]" Grimes responded, "I can send lunch if y'all want/need!"

b. On June 27, 2018, a Riverside liaison asked Dr. Newsom when two RRMC patients he referred would be ready for transfer to Riverside. Dr. Newsom texted back, "You tell me what you rather . . . I'm trying to keep y'all afloat over there . . . I need to get the other guys to buy in and push like I do lol." The liaison replied, "Whatever it takes. [Riverside Liaison] can bring lunch everyday if she has to lol."

c. On September 17, 2018, Grimes texted Dr. Newsom, "I'm crossing my fingers you can do a rain dance and find some patients for this way ! . . . I can bring lunch if y'all are busy!!" Dr. Newsom asked Grimes to bring three lunches to the RRMC hospitalist office.

d. On September 18, 2018, Grimes texted Dr. Newsom, "Total Census dropping to 15 today - we can do lunch again if y'all can find some magical refs lol – Lunch every day this week if we can get a few [.]" Dr. Newsom replied that he had been "telling everyone," and he "didn't have any yesterday but will keep looking."

e. On January 23, 2019, a Riverside liaison texted Dr. Newsom, "I need to rally the troops [at RRMC] . . . . I can bring y'all lunch if you have time[.]" Dr. Newsom ordered four lunches from the liaison.

f. On February 12, 2019, Dr. Newsom texted a Riverside liaison, "Can you give me six tacos for lunch today, I want to bring home some [for] my wife."

g. Riverside's liaisons offered Dr. Newsom lunches, and Dr. Newsom accepted lunches at least eight times between June 2019 and February 2020.

h. On December 30, 2020, Dr. Newsom texted a Riverside liaison that he could "hold" a patient "as long as I want" at RRMC to allow Riverside to admit the patient as a new patient, which was financially beneficial

to Riverside. Dr. Newsom then demanded, "Food today" and ordered five lunches from the liaison.

403. Riverside bought Dr. Newsom a Playstation to use in his RRMC hospitalist office.

404. Riverside's CEO told Dr. Newsom that she gave him the Playstation with the intent to induce referrals from him and other RRMC doctors.

405. On August 9, 2019, Grimes and Dr. Newsom exchanged the following text messages:

a. Between 8:44 and 9:02 a.m.:

> **GRIMES**: y'all want lunch today?? i'm double covering at the office but i can run it over or have it delivered!
>
> **DR. NEWSOM**: Nah. I have a hospice meeting for lunch today.
>
> **GRIMES**: ok . . . so just a playstation 4?
>
> **DR. NEWSOM**: With extra controllers!! . . . . You can put a sticker on it . . . . That is just a joke. Please don't waste your money on that.
>
> **GRIMES**: for all of the referrals i'm not joking! haha if it means i get all of the referrals then playstation it is- that's cheaper than 2 lunches basically
>
> **DR. NEWSOM**: Put today's lunch money [in] a jar then
>
> **GRIMES**: deal

b. Between 11:00 and 11:08 a.m.:

> **GRIMES**: i just can't get over how [hospitalist M] was about that
>
> **DR. NEWSOM**: He doesn't like owing ppl stuff. Now he feels obligated for referrals . . . . Keep the receipt just [in] case. If this causes a big problem you might have to return it.

GRIMES: it won't cause problems with me- but if it does with y'all let me know and i'll come get it- did he say anything after we left?

DR. NEWSOM: He was mad at [hospitalist A]. [Hospitalist A] was ecstatic. [Hospitalist M] just doesn't want to feel obligated to give referrals I guess.

GRIMES: glad at least one was happy! i wish he would have been in there when we brought it! lol

DR. NEWSOM: I told him to come. Just lazy

GRIMES: well at least hopefully we have one on our side lol . . . tell [hospitalist A] he can have a new game with each ref

c. Between 3:53 and 5:17 p.m.:

DR. NEWSOM: So we had a meeting just now bout the PS4. We will keep it. But we are telling ppl that I bought it for the office. Everyone will still support my ventures and my referral patterns without getting anyone in trouble. Keep it quiet and don't let it get out

GRIMES: perfect !! . . . as long as you are comfortable and confident with that i am good with it! . . . did [C] know about the play station? [Riverside liaison] and i didn't tell anyone except [Riverside employees] and they won't repeat it

DR. NEWSOM: Not from me. I didn't mention it

GRIMES: ok good deal us either. our little secret

406. Grimes purchased the Playstation from Target on August 9, 2019. The $477 charge is reflected on her business credit card statement.

407. PHG coded the expense in Riverside's financial statements as "community education."

408. PHG also coded the lunches purchased for Dr. Newsom and his colleagues at RRMC as "community education."

VII. PHG and Riverside Intended Payments and Gifts to Dr. Newsom to Induce Referrals, and Dr. Newsom Knew They Were Intended to Induce Referrals

409. PHG and Riverside knowingly and willfully paid Dr. Newsom the purported "medical director" fees, and gave him lunches and gifts, to induce him to refer, and cause referrals, to Riverside.

410. Dr. Newsom knowingly and willfully solicited and received the purported "medical director" payments, lunches, and gifts from Riverside in exchange for referrals.

411. The knowledge of PHG, Riverside, and Dr. Newsom is evidenced by communications among them that discuss PHG's and Riverside's intent to induce referrals through medical director payments, lunches, and gifts.

412. Wright, PHG's Vice President of Operations and Riverside's CEO in 2017, personally negotiated and signed Dr. Newsom's initial Program Director Agreement. Wright's emails with Boulware, Rice, and Dr. Newsom described in Sections I-II above reflect PHG's intent to induce referrals to Riverside and Dr. Newsom's understanding of that intent.

413. Lester, PHG's Director of Hospital Operations and Riverside's CEO from late 2017 to 2018, intended the medical director payments to induce referrals.

414. Lester instructed Riverside employees to use medical director payments to induce referrals. In November 2017, Lester told Grimes to pass out medical director checks "individually and ask for patients with them." Grimes passed Lester's direction on to other Riverside employees, telling them that Lester

wanted them to hand the checks out personally "and ask for patients in return. Makes the doc remember the request a little better :)."

415. Grimes expressly told Dr. Newsom that he could maintain his position at Riverside if he continued to refer patients. Grimes texted Dr. Newsom, "just make sure I see your name in referrals every once in a while and I'll always have a leg to stand on!" Dr. Newsom replied, "Def try. Kinda want a long term gig there. If I stay in hospitalist medicine long term then referrals shouldn't be too hard."

416. The mutual understanding that Riverside was paying Dr. Newsom medical director fees in exchange for referrals is evidenced by other text communications between Grimes and Dr. Newsom. For example, Dr. Newsom threatened Grimes that if she got "rid of" him, it would be "lights out" for Riverside's Medicare referrals from RRMC.

417. In fact, Riverside engaged in a pattern and practice of offering remuneration to physicians with the intent to induce referrals. For example, Grimes told a Riverside liaison she should give free sports tickets to the doctor with the first "good referral." And when liaisons complained about low referral numbers, Grimes responded, "You can promise a gift card or dinner to someone if you have to!"

VIII. PHG and Riverside Knew the Payments and Gifts to Dr. Newsom Violated the Law

418. PHG, Riverside, and Dr. Newsom knowingly and willfully acted to violate the law.

419. The PHG Executives and Grimes received multiple trainings on the AKS and Stark Law.

420. The PHG Executives and Grimes understood the substance of the AKS and Stark Law before they engaged in the conduct described in this complaint.

421. Dr. Newsom received annual training on the AKS and Stark Law for his hospitalist position at RRMC, and he was required to certify compliance with the AKS and Stark Law in his Medicare enrollment application.

422. Dr. Newsom understood the substance of the AKS and Stark Law before he engaged in the conduct described in this complaint.

423. Dr. Newsom's understanding of the AKS and Stark Law is illustrated by his communications with Riverside employees. For example, when a Riverside liaison asked Dr. Newsom whether she could get a gift for one of his colleagues who referred a lot of patients, Dr. Newsom told the liaison not to because the other doctor was "by the book."

424. PHG, Riverside, and Dr. Newsom knew that the AKS and Stark Law were implicated by financial arrangements with referring physicians, such as the Director Agreements.

425. The Director Agreements, which were drafted by PHG or Riverside and signed by Dr. Newsom and the Riverside CEO at the time of the agreement (either Wright, Lester, or Grimes), show that PHG, Riverside, and Dr. Newsom were aware of the AKS and Stark Law restrictions related to physician compensation.

a. Each Director Agreement states that it is intended to comply with the AKS and Stark Law.

b. Each Director Agreement also states, "It is not a purpose of this Agreement to induce the referral of patients."

426. Riverside and Dr. Newsom's attempts to conceal facts surrounding their financial arrangements evidences a knowing violation of the law. For example:

a. Riverside and Dr. Newsom falsified the timesheets required for the Director Agreements.

b. Riverside and Dr. Newsom sought to conceal the source of the Playstation gift.

c. Riverside used a pretextual on-call agreement to conceal Riverside's increase in payments to Dr. Newsom that was related to the number of patients he was referring and admitting to Riverside.

427. Riverside submitted claims to Medicare with actual knowledge, deliberate ignorance, and/or reckless disregard of the fact that they were false or fraudulent as a result of the AKS and Stark Law violations described in this complaint or Riverside's false certifications of compliance with the AKS and Stark Law.

428. PHG and Dr. Newsom caused the submission of claims to Medicare with actual knowledge, deliberate ignorance, and/or reckless disregard of the fact that the claims were false or fraudulent as a result of the AKS violations described in this complaint or Riverside's false certifications of compliance with the AKS and Stark Law.

IX. Payments and Gifts to Dr. Newsom Caused Referrals to Riverside, and Caused Riverside to Submit False Claims to Medicare

429. Dr. Newsom personally referred at least 85 patients from other facilities (usually RRMC) that were admitted at Riverside between 2017 and 2021.

430. Dr. Newsom referred patients to Riverside by ordering that they required an LTCH level-of-care after their short-term hospital stay and/or recommending Riverside.

431. Dr. Newsom acknowledged that he successfully recommended Riverside to patients when he texted Grimes that he would be able to continue referring to Riverside if he remained a hospitalist and when he threatened that referrals would stop if Grimes terminated his relationship with Riverside.

432. Dr. Newsom also referred patients by authorizing their care (or admitting them) at Riverside. Dr. Newsom admitted over 500 patients to Riverside between 2017 and 2023.

433. Dr. Newsom referred patients to Riverside immediately after requests from Riverside administration. For example:

a. In February 2018, Grimes texted Dr. Newsom, "Text all of your buddies… we need 4 more admits for the month [.]" Dr. Newsom responded five minutes later listing five potential RRMC patients and noting that that he "put ltach consults on most of these ppl."

b. In June 2018, Grimes asked Dr. Newsom about "possible refs." Dr. Newsom responded, "I've got you 2-3 personally this week. I'll keep looking though[.]"

434. Dr. Newsom also caused his colleagues at RRMC to refer patients to Riverside.

435. As illustrated by Dr. Newsom's own statements, these referrals were caused by Riverside's illegal remuneration. For example:

a. In 2018, Grimes texted Dr. Newsom "Just got a [RRMC] Medicare ref " Dr. Newsom responded, "Just like the stock market. Just got to ride it out . . . . You do know that if you get rid of me though.. it's lights out lol!"

b. In 2019, Dr. Newsom texted Grimes that one of his colleagues, "refers a lot [to Riverside] for me." Grimes responded that the doctor "has been great! He's the top referring doctor of the year[.]" Dr. Newsom told Grimes that he should "get credit" for the doctor's referrals, and Grimes responded, "I know :) you get credit for all team health."

436. Referrals caused by Dr. Newsom and his RRMC colleagues increased after Dr. Newsom entered into the Director Agreements with Riverside.

437. Claims submitted by Riverside related to Dr. Newsom's referrals were false under the FCA because they included items or services resulting from a violation of the AKS.

438. Claims submitted by Riverside were false under the FCA because the underlying services were furnished pursuant to Dr. Newsom's referrals, which are prohibited by the Stark Law.

X. AKS and Stark Law Compliance Is Material To Medicare's Payment Decision

439. Compliance with the AKS is material to Medicare's decision to pay a hospital's claims for services rendered to Medicare beneficiaries. *See, e.g., United States v. Marlin Med. Solutions LLC*, 579 F. Supp. 3d 876, 890 (W.D. Tex. 2022) (collecting cases finding AKS violations "inherently material" to government's payment decision).

440. The centrality of the AKS to the government's claims payment decision is demonstrated by the fact that Congress has determined that any Medicare claim "that includes items or services resulting from a violation of [the AKS] constitutes a false or fraudulent claim for purposes of [the FCA]." 42 U.S.C. § 1320a-7b(g).

441. Entities submitting claims to Medicare are subject to mandatory exclusion from Medicare by HHS-OIG if criminally convicted of an AKS violation, *see, e.g.,* 42 U.S.C. § 1320a-7(a)(1), and subject to permissive exclusion if HHS-OIG determines that the provider "has committed an act" described in the AKS, 42 U.S.C. § 1320a-7(b)(7).

442. Compliance with the Stark Law also is material to Medicare's decision to pay a hospital's claims for services rendered to Medicare beneficiaries. *See, e.g.*, *United States ex rel. Longo v. Wheeling Hosp., 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.").

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

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

445. CMS identifies compliance with the AKS and Stark Law as a condition of payment for Medicare claims on its provider enrollment forms and other documents.

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

447. Compliance with the AKS and Stark Law goes to the essence of Medicare's bargain with participating health care providers. The AKS and Stark Law play 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.

448. 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 AKS or Stark Law.

449. The alleged violations by Riverside, PHG, and Dr. Newsom are not minor or insubstantial. They violated the AKS and Stark Law in ways that implicate the core concerns of the statutes. In particular, these defendants used financial incentives to skew medical decision making.

450. PHG, Riverside, and Dr. Newsom knew that compliance with the AKS and Stark Law is material to Medicare's decision to pay a claim.

XI. Representative Examples of Claims Referred to Riverside by Dr. Newsom

451. Dr. Newsom made "referrals" to Riverside for inpatient hospital services by sending patients from other facilities—usually RRMC—and admitting patients at Riverside.

452. Figure 8 provides examples of false claims for inpatient LTCH services covered by Medicare Part A, submitted by Riverside, and caused by PHG and Dr. Newsom, that resulted from illegal or prohibited referrals from Dr. Newsom.

Figure 8.

Claim	Referring Physician	Admitting Physician	Admission Date	Medicare Reimbursement
1	Dr. Newsom	Dr. Newsom	08/29/2019	$42,632.12
2	Dr. Newsom	Dr. Newsom	11/06/2019	$24,719.61
3	Dr. Newsom	Dr. Newsom	01/01/2020	$21,251.76
4	Dr. Newsom	Dr. Newsom	01/07/2020	$36,362.34
5	Dr. Newsom	Dr. Newsom	05/09/2020	$23,707.32
6	Dr. Newsom	Dr. Newsom	09/16/2020	$36,571.18
7	Dr. Newsom	Dr. Newsom	11/11/2020	$37,185.29
8	Dr. Newsom	Dr. Newsom	01/22/2021	$34,264.32
9	Dr. Newsom	Dr. Newsom	06/01/2021	$21,650.32
10	Dr. Newsom	Other physician	08/07/2019	$16,888.70
11	Dr. Newsom	Other physician	06/01/2020	$41,588.14
12	Dr. Newsom	Other physician	12/10/2020	$37,185.29
13	Dr. Newsom	Other physician	07/02/2021	$35,827.16
14	Other	Dr. Newsom	06/06/2019	$36,183.62

15	Other	Dr. Newsom	12/27/2019	$24,719.61
16	Other	Dr. Newsom	03/04/2020	$30,724.22
17	Other	Dr. Newsom	05/05/2020	$33,295.98
18	Other	Dr. Newsom	11/21/2020	$34,130.15
19	Other	Dr. Newsom	06/10/2021	$23,033.15
20	Other	Dr. Newsom	02/28/2022	$21,058.08

XII. Representative Examples of False Statements or Records Riverside Made, and PHG and Dr. Newsom Caused to Be Made, To Medicare

453. Throughout the relevant time period, Riverside submitted statements to Medicare related to its compliance with the Stark Law and AKS.

454. These statements were false because, as described in Sections I-XI *supra*, Riverside and Dr. Newsom were violating the AKS and Stark Law.

455. These false statements were caused by PHG and Dr. Newsom.

456. For example, Riverside submitted Medicare enrollment applications that certified, among other things, that Riverside "agree[d] to abide by the [applicable] Medicare laws, regulations, and program instructions," and "underst[ood] 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 and the Stark Law)[.]" *See supra* Paragraphs 74-77.

457. Specific examples of Medicare enrollment applications with false certifications of compliance with the AKS and Stark Law that Riverside submitted, and that PHG and Dr. Newsom caused it to submit, are provided in Paragraph 308 above.

458. Throughout the relevant time period, Riverside also submitted annual Medicare cost reports signed by PHG's CFO that certified, among other things, that "the services identified in this cost report were provided in compliance with" "the laws and regulations regarding the provision of health care services," and that "if services identified in this report were provided or procured through the payment directly or indirectly of a kickback . . . , fines and/or imprisonment may result." *See supra* Paragraphs 84-89.

459. Specific examples of annual Medicare cost reports with false certifications of compliance with the AKS and Stark Law that Riverside submitted, and that PHG and Dr. Newsom caused it to submit, are provided in Paragraph 311 above.

460. Wright also completed an EDI enrollment for Riverside in 2014, with the certifications discussed in Paragraph 82 above, and certified that he was an authorized individual to "commit the provider to abide by the laws, regulations and program instructions of Medicare."

COUNT I
(Against PHG Defendants)
False Claims Act: Presenting or Causing False Claims to Be Presented
31 U.S.C. § 3729(a)(1)(A)

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

462. This cause of action is brought against the PHG Defendants.

463. By virtue of the acts described above, the PHG Defendants presented or caused to be presented materially false or fraudulent claims for payment or

approval to the United States. Specifically, the PHG Defendants submitted or caused to be submitted false claims to Medicare (examples of which are identified in Paragraphs 255 to 304 above) for reimbursement of hospital services that were not reasonable or necessary.

464. The PHG 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.

465. The United States sustained damages in an amount to be determined at trial because of the PHG Defendants' wrongful conduct, and is therefore entitled to treble damages under the FCA, plus a civil penalty for each violation.

COUNT II
(Against PHG Defendants)
False Claims Act: Making or Using False Records or Statements
31 U.S.C. § 3729(a)(1)(B)

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

467. This cause of action is brought against the PHG Defendants.

468. By virtue of the acts described above, the PHG Defendants made, used, or caused to be made or used, false records or statements material to false or fraudulent claims paid or approved by the United States. Specifically, the PHG Defendants made, used, or caused to be made or used false certifications and representations of compliance with Medicare requirements (examples of which are identified in Paragraphs 305 to 311 above), including that all covered services be reasonable and necessary, when submitting the false claims for payment.

469. The PHG Defendants' false certifications and representations were made for the purpose of obtaining payment from the United States for the false or fraudulent claims, and payment of the false or fraudulent claims by the United States was a reasonably foreseeable consequence of the PHG Defendants' certifications and actions.

470. The false records or statements made or caused to be made by the PHG Defendants were material to the United States' payment of the false claims.

471. The PHG Defendants made or caused such false records or statements with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

472. The United States sustained damages in an amount to be determined at trial because of the PHG Defendants' wrongful conduct, and is therefore entitled to treble damages under the FCA, plus a civil penalty for each violation.

COUNT III
(Against PHG, Riverside, and Dr. Newsom)
False Claims Act: Presenting or Causing False Claims To Be Presented
31 U.S.C. § 3729(a)(1)(A)

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

474. This cause of action is brought against PHG, Riverside, and Dr. Newsom (the AKS/Stark Defendants).

475. By virtue of the acts described above, the AKS/Stark Defendants presented or caused to be presented materially false or fraudulent claims for payment or approval to the United States. Specifically, the AKS/Stark Defendants

submitted or caused the submission of false claims (examples of which are identified in Paragraph 452) to Medicare for reimbursement of (i) hospital services rendered to patients that resulted from knowing and willful violations of the AKS, and (ii) designated health services rendered to patients who were referred to Riverside by Dr. Newsom in violation of the Stark Law.

476. The AKS/Stark 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.

477. The United States sustained damages in an amount to be determined at trial because of the AKS/Stark Defendants' wrongful conduct, and is therefore entitled to treble damages under the FCA, plus a civil penalty for each violation.

COUNT IV
(Against PHG, Riverside, and Dr. Newsom)
False Claims Act: Making or Using False Records or Statements
31 U.S.C. § 3729(a)(1)(B)

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

479. This cause of action is brought against the AKS/Stark Defendants.

480. By virtue of the acts described above, the AKS/Stark Defendants made, used, or caused to be made or used, false records or statements material to false or fraudulent claims paid or approved by the United States. Specifically, the AKS/Stark Defendants made, used, or caused to be made or used false certifications and representations (examples of which are identified in Paragraphs 453 to 459) of

compliance with Medicare requirements, including (i) the AKS and (ii) the Stark Law, when submitting the false claims for payment.

481. The AKS/Stark Defendants' false certifications and representations were made for the purpose of obtaining payment from the United States for the false or fraudulent claims, and payment of the false or fraudulent claims by the United States was a reasonably foreseeable consequence of the AKS/Stark Defendants' certifications and actions.

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

483. The AKS/Stark 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.

484. The United States sustained damages in an amount to be determined at trial because of the AKS/Stark Defendants' wrongful conduct, and is therefore entitled to treble damages under the FCA, plus a civil penalty for each violation.

COUNT V
(Against PHG Defendants)
Payment by Mistake

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

486. This is a claim for recovery of monies the United States paid directly or indirectly to the Defendants as a result of mistaken understandings.

487. The United States' mistaken understandings of fact were material to its decision to pay defendants for ineligible Medicare claims for hospital services.

488. The United States, acting in reasonable reliance on the truthfulness of the claims and the truthfulness of associated statements, certification, and representations, paid monies directly or indirectly to defendants to which they were not entitled. Accordingly, the United States is entitled to recoup such monies, in an amount to be determined at trial.

COUNT VI
(Against PHG Defendants)
Unjust Enrichment

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

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

491. By obtaining government funds to which they were not entitled, the Defendants were unjustly enriched and are liable to pay as restitution such amounts, which are to be determined at trial, to 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 Counts I-IV (False Claims Act), for treble the United States' damages, together with civil penalties allowed by law;

(b) On Count V (Payment by Mistake), in the amount mistakenly paid to the Defendants;

(c) On Count VI (Unjust Enrichment), in the amount that the Defendants were unjustly enriched; and

(d) For pre- and post-judgment 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.

Date: January 16, 2026

Respectfully Submitted,

BRETT A. SHUMATE

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