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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA et al. ex rel. KEVIN G. MURPHY, Plaintiffs, v. NEW YORK-PRESBYTERIAN HEALTHCARE SYSTEM, INC., et al., Defendants.	21 Civ. 1762 (NSR)
UNITED STATES OF AMERICA, Plaintiff-Intervenor, v. NEW YORK-PRESBYTERIAN HUDSON VALLEY HOSPITAL, Defendant.	**COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA** JURY TRIAL DEMANDED

Plaintiff the United States of America (the "United States"), by and through its attorney, Jay Clayton, United States Attorney for the Southern District of New York, brings this action against New York-Presbyterian Hudson Valley Hospital ("NYPHV" or "Defendant") alleging as follows:

PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the United States against NYPHV under the False Claims Act, 31 U.S.C. §§ 3729-33 (the "FCA"), and the common law to recover treble damages sustained by, and penalties owed to, the United States based on NYPHV's violations of the Stark Law, 42 U.S.C. § 1395nn, and the Anti-Kickback Statute (the "AKS"), 42 U.S.C. § 1320a-7b(b).

2. NYPHV is a hospital located in Cortlandt Manor, New York. Prior to 2015, NYPHV was known as Hudson Valley Hospital Center ("Hudson Valley"). In 2015, New York Presbyterian Hospital ("NYP") began the process of acquiring Hudson Valley, and, in so doing, assumed control and active-parent status over Hudson Valley, which then became known as NYPHV.

3. Between January 2011 and December 2019 (the "Covered Period"), NYPHV and Hudson Valley improperly paid millions of dollars to a Westchester-based oncology practice (the "Oncology Practice"), often with no justification, to induce the Oncology Practice to refer its patients to Hudson Valley and NYPHV for oncology-related services that were subsequently paid for by Medicare and Medicaid. These payments were purportedly made pursuant to two medical directorship agreements and a management services agreement, which provided that Hudson Valley (and later NYPHV) would pay hundreds of thousands of dollars per year to the Oncology Practice in exchange for, among other things, work on a proposed melanoma center (the "Melanoma Center"), work on a proposed breast cancer center (the "Breast Center"), and the development and management of an intraoperative radiation therapy service line (the "IORT Service Line" and, collectively, with the agreements concerning the Melanoma Center and the Breast Center, the "Agreements").

4. However, the Oncology Practice failed to perform or document the central services identified in the Agreements. In fact, Hudson Valley and NYPHV made payments to the Oncology Practice in instances when the services set forth in the Agreements had not been performed or documented by the Oncology Practice, and in instances when the Agreements were no longer even operative. All the while, Hudson Valley and later NYPHV continued to receive referrals from the Oncology Practice that generated millions of dollars in reimbursements from Medicare and Medicaid.

5. All told, during the Covered Period, Hudson Valley and NYPHV paid, in total, over $4 million in fees to the Oncology Practice in connection with the Agreements—including payments for work that was not performed—to induce the Oncology Practice to refer its patients to Hudson Valley, and later NYPHV, for oncology-related medical services in violation of the AKS and the Stark Law. As a result of this conduct, Hudson Valley and NYPHV submitted false claims for payment to Medicare and Medicaid for services provided to these patients in violation of the FCA.

JURISDICTION AND VENUE

6. This Court has jurisdiction over the claims brought under the FCA pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C. §§ 1331 and 1345, and over the remaining claims pursuant to 28 U.S.C. § 1345.

7. This Court may exercise personal jurisdiction over NYPHV pursuant to 31 U.S.C. § 3732(a), which provides for nationwide service of process.

8. Venue lies in the Southern District of New York pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and 1391(c), because NYPHV does business in this District, and its fraudulent acts occurred in this District.

PARTIES

9. Plaintiff is the United States of America and is suing on its own behalf and on behalf of the United States Department of Health and Human Services and its component agency, the Centers for Medicare & Medicaid Services ("CMS"), which administers and oversees the Medicare and Medicaid programs.

10. Defendant New York Presbyterian Hudson Valley Hospital is a not-for-profit hospital located in Cortlandt Manor, New York, that provides a wide range of inpatient and outpatient services to patients, including oncology-related services.

11. Relator Kevin G. Murphy was NYPHV's Chief Financial Officer from June 2015 through October 2017. On or about February 25, 2021, Relator filed a complaint under the *qui tam* provisions of the FCA alleging, among other things, that Hudson Valley and NYPHV violated the FCA by paying kickbacks to the Oncology Practice in exchange for patient referrals and submitting claims to Medicare and Medicaid for services provided to these patients that resulted from violations of the AKS and the Stark Law.

BACKGROUND

I. Relevant Statutes

A. The False Claims Act

12. The FCA establishes liability for treble damages and civil penalties to the United States for an individual who, or entity that, "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1). "Knowingly" is defined to include "actual knowledge," "act[ing] in deliberate ignorance of the truth or falsity of the [relevant] information," or "act[ing] in reckless disregard of the truth or

falsity of the information." *Id.* § 3729(b)(1). The FCA "require[s] no proof of specific intent to defraud." *Id.*

B. The Anti-Kickback Statute

13. The AKS makes it illegal for individuals or entities to knowingly and willfully "offer[] or pay[] any remuneration (including any kickback, bribe, or rebate) . . . to any person to induce such person . . . to purchase, . . . order, . . . or recommend purchasing . . . or ordering any good . . . 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).

14. As codified in the Patient Protection and Affordable Care Act of 2010 ("PPACA"), Pub. L. No. 111-148, § 6402(f), 124 Stat. 119, codified at 42 U.S.C. § 1320a-7b(g), "a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of [the FCA]." Accordingly, a person or entity violates the FCA when they knowingly submit or cause to be submitted claims to federal healthcare programs that result from violations of the AKS.

15. The AKS arose out of congressional concern that remuneration given to those who can influence healthcare decisions would result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the Medicare and Medicaid programs, among other federal healthcare programs, from these harms, Congress enacted a prohibition against the payment of kickbacks in any form.

16. The AKS defines remuneration to include anything of value, including "cash" or "in-kind" payments. 42 U.S.C. § 1320a-7b(b)(2).

17. The Office of the Inspector General for the United States Department of Health and Human Services has promulgated "safe harbor" regulations that define practices that are not subject to the AKS because such practices are unlikely to result in fraud or abuse. 42 C.F.R. §

1001.952. The safe harbors set forth specific conditions that, if met, assure persons involved of not being sanctioned for the arrangement qualifying for the safe harbor. However, safe harbor protection is an affirmative defense that is afforded to only those arrangements that meet all requirements of the safe harbor.

18. Under the "personal services" safe harbor, a payment made to a doctor or medical practice for services such as serving as a medical director or managing an intraoperative radiology therapy ("IORT") service line is not remuneration for purposes of the AKS if certain requirements are met. These requirements include, among other things, that the agreement is set out in writing, is for not less than one year, is consistent with fair market value, and not determined in a manner that takes into account the volume or value of any referrals for services that may be covered by a federal health care program. 42 C.F.R. § 1001.952(d). In addition, the services contracted for must "not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services." *Id.*

C. The Stark Law

19. The Medicare/Medicaid Self-Referral Statute, 42 U.S.C. § 1395nn, known as the Stark Law, prohibits physicians from referring Medicare or Medicaid patients for "designated health services" to an entity with which the physician has a nonexempt "financial relationship," including a nonexempt "compensation arrangement" in which remuneration of any kind is exchanged. 42 U.S.C. § 1395nn(a)(1)(A). It also prohibits anyone from presenting claims for "designated health services" generated through such a referral, and prohibits the payment of claims generated through such a referral. *Id.* § 1395nn(a)(1)(B), (g)(1).

20. "Designated health services" include, among other things, various services connected with oncological treatments, such as clinical laboratory services, radiology services,

radiation therapy, and inpatient and outpatient hospital services. *Id.* § 1395nn(h)(6); 42 C.F.R. § 411.351.

21. Personal services arrangements are excepted from the definition of "compensation arrangement" if they meet certain criteria. Among other things, the services contracted for must be "set out in writing," "reasonable and necessary for the legitimate business purposes of the arrangement," and the remuneration must "not exceed fair market value" and "not [be] determined in a manner that takes into account the volume or value of any referrals." *Id.* § 1395nn(e)(3).

22. In the absence of a qualifying exception, the Stark Law provides that Medicare will not pay for designated health services billed by a hospital when the designated health services resulted from a prohibited referral under the statute. 42 U.S.C. § 1395nn(g)(1). The regulations implementing the Stark Law also expressly require that any entity collecting payment for a healthcare service "performed under a prohibited referral must refund all collected amounts on a timely basis." 42 C.F.R. § 411.353 (2006). Accordingly, a person or entity violates the FCA when they knowingly submit or cause to be submitted claims to federal healthcare programs that result from a referral prohibited under the Stark Law.

II. Relevant Federal Health Care Programs

23. ***Medicare.*** In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program, to pay for the costs of certain healthcare services. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 426, 426A. HHS is responsible for the administration and supervision of the Medicare program. CMS is an agency of HHS and is directly responsible for the administration of the Medicare program.

24. Medicare has several parts, including Part A (which is primarily for hospital-based charges) and Part B (which is primarily for physician and other ancillary services).

25. To assist in the administration of Medicare Parts A and B, CMS contracts with Medicare Administrative Contractors ("MACs"). *See* 42 U.S.C. §§ 1395h, 1395u. Hospitals and physicians submit claims for payment to MACs, and, in turn, MACs process medical claims for Medicare beneficiaries.

26. Medicare enters into agreements with both hospitals and physicians to establish their eligibility to participate in the Medicare program. Once enrolled in the program, hospitals and physicians are each required under Medicare to submit enrollment applications periodically to "revalidate" their enrollment information. For hospitals, this revalidation is submitted through the CMS 855A form, which contains a "Certification Statement" wherein the hospital agrees to abide by the Medicare laws, regulations, and program instructions that apply to them. Specifically, the Certification provides that the hospital:

> [A]gree[s] to abide by the Medicare laws, regulations and program instructions that apply to [the physician or hospital] . . . [] understand[s] 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), and on the [physician or hospital's] compliance with all applicable conditions of participation in Medicare . . ..

27. As part of the Certification Statement, the hospital further agrees to: "not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare," and to "not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

28. When submitting claims to Part B, either via the hard copy CMS 1500 form or electronically, hospitals are similarly required to certify that they are knowledgeable of Medicare's requirements and that the individual claim complies with applicable laws and regulations, including the Stark Law and Anti-Kickback statute.

29. ***Medicaid.*** Medicaid is a joint federal and state program that provides healthcare benefits to certain groups, primarily the poor and those with disabilities. 42 U.S.C. § 1396 *et seq.*

Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates, and program administration rules in accordance with certain federal statutory and regulatory requirements. The state may directly pay the healthcare providers for services rendered to Medicaid recipients, with the state obtaining the federal share of the Medicaid payment from accounts which draw on the United States Treasury. *See* 42 C.F.R. § 430.0 *et seq.* In addition, private insurers and managed care organizations may offer Medicaid benefits as Medicaid Managed Care Organizations ("MCOs"). MCOs contract with states to provide Medicaid benefits to beneficiaries. Pursuant to those contracts, the MCOs are paid a capitated rate by Medicaid and the MCO, in turn, reimburses providers such as NYPHV for services rendered to their beneficiaries.[1] New York's Medicaid program covers oncology-related services, including the types of oncological services and tests that were referred to, and provided by, NYPHV.

30. The federal portion of each state's Medicaid payments, known as the Federal Medical Assistance Percentage, is based on the state's per capita income compared to the national average. 42 U.S.C. § 1396d(b). Federal funding under Medicaid is provided only when there is a corresponding state expenditure for a covered Medicaid service to a Medicaid recipient. The federal government pays to the state the statutorily established share of the "total amount expended . . . as medical assistance under the State plan." 42 U.S.C. § 1396b(a)(1).

FACTUAL ALLEGATIONS

31. During the Covered Period, Hudson Valley and NYPHV submitted numerous claims to Medicare and Medicaid for oncology-related services, such as diagnostic imaging tests and surgical procedures. Hudson Valley and NYPHV knew or should have known, however, that many of those claims resulted from and were tainted by violations of the AKS and the Stark Law.

[1] Any references in this Complaint to claims for payment submitted to Medicaid, or payments made by Medicaid, should be interpreted to include claims for payment submitted to MCOs, or payments by MCOs.

32. More specifically, Hudson Valley and NYPHV paid the Oncology Practice millions of dollars, in part, to induce the Oncology Practice to refer oncology-related services to Hudson Valley and NYPHV in violation of the AKS. After receiving such remuneration, the Oncology Practice repeatedly referred patients to Hudson Valley and later NYPHV which, in turn, submitted claims for payment to Medicare and Medicaid for services arising from these tainted referrals.

33. In addition, these payments from Hudson Valley and NYPHV to the Oncology Practice also created a compensation arrangement between the parties that did not fall into a qualifying exception from the Stark Law's referral prohibitions. Accordingly, Hudson Valley and NYPHV violated the Stark Law by receiving referrals of Medicare and Medicaid patients from the Oncology Practice. Further, Hudson Valley and NYPHV violated the FCA when they submitted claims arising from those referrals to Medicare and Medicaid.

34. As detailed below, Hudson Valley and NYPHV purportedly paid the Oncology Practice for services provided pursuant to the Agreements. But many payments from Hudson Valley and NYPHV to the Oncology Practice could not be justified by the Agreements. Indeed, during the Covered Period, Hudson Valley and NYPHV together paid the Oncology Practice over $4 million pursuant to the Agreements for work that was either not performed, not performed as called for in the Agreements, or for which NYPHV lacks any time records reflecting the work performed. And, throughout the Covered Period, the Oncology Practice and its physicians referred their patients to Hudson Valley, and later NYPHV, for oncology-related services. Medicare and Medicaid paid Hudson Valley and NYPHV millions of dollars for these services.

I. Hudson Valley Enters Into Agreements With the Oncology Practice and is Later Acquired by New York Presbyterian Hospital System

35. In or around 2010, Hudson Valley sought to expand its oncology department, including its breast surgery practice. As part of those expansion efforts, Hudson Valley recruited

the Oncology Practice to move its operations to Hudson Valley. In July 2011, Hudson Valley entered into an agreement with the Oncology Practice, whereby Hudson Valley agreed to provide space, equipment, and services to the Oncology Practice.

36. Around the same time, Hudson Valley also entered into the three Agreements with the Oncology Practice. One agreement provided, among other things, that one of the Oncology Practice's physician principals ("Physician A") would serve as the Medical Director of the proposed Melanoma Center at the hospital (the "Melanoma Directorship Agreement"). Another agreement provided, among other things, that the Oncology Practice's other physician principal ("Physician B") would serve as the Medical Director of the proposed Breast Center at the hospital (the "Breast Center Directorship Agreement"). Lastly, the third agreement provided, among other things, that the Oncology Practice would develop, manage, market, and integrate the IORT Service Line as part of the hospital's Department of Radiation Oncology (the "IORT Management Services Agreement").

37. Under each Agreement, the Oncology Practice received an annual fee in exchange for services the Oncology Practice and its two physician principals (Physician A and Physician B) or their designees were required to perform. The Breast Center Directorship Agreement and the Melanoma Center Directorship Agreement each stated that the agreements would run for a term of 5 years, beginning in 2011 and ending in 2016. The IORT Management Services Agreement stated that it would run for a term of 4 years, beginning in 2012 and ending in 2016.

38. In 2015, NYP began the process of acquiring Hudson Valley. In so doing, NYP assumed control and active-parent status over Hudson Valley and began to integrate Hudson Valley's clinical services and operations. NYPHV did not renew the Agreements with the Oncology Practice after they expired in 2016.

39. By October 2016 at the latest, NYPHV was, or at minimum should have been, aware that the Oncology Practice was performing only a portion of the work called for under the IORT Management Services Agreement and was not performing the majority of the work being called for under the Melanoma Directorship Agreement. Nevertheless, NYPHV continued paying the Oncology Practice their fees under each of the Agreements for another three years, even though all three Agreements had expired.

II. NYPHV and Hudson Valley Made Payments to the Oncology Practice That Were Not Justified Under the Melanoma Directorship Agreement

40. The Melanoma Directorship Agreement required the hospital to pay the Oncology Practice an annual fee of $185,000. In exchange, pursuant to the terms of the agreement, Physician A or their designee was required to devote at least 50 hours per month to performing their duties as Medical Director of the Melanoma Center, including the primary task of developing and operating the Melanoma Center and establishing standards and indicators for quality measures for the Melanoma Center's programs. Further, the Melanoma Directorship Agreement required Physician A to maintain time records reflecting the services provided and to submit monthly reports to the hospital as a prerequisite to payment.

41. However, the Oncology Practice and Physician A never developed or established the Melanoma Center as envisioned by the Melanoma Directorship Agreement and, accordingly, Physician A failed to perform the primary duties of a Medical Director as contemplated by the Melanoma Directorship Agreement. Further, by 2012 at the latest, Physician A was not providing 50 hours of work per month toward developing or establishing the Melanoma Center, as required by the agreement, and NYPHV has not located any time records from the Covered Period documenting work by Physician A or their designee related to the Melanoma Directorship Agreement.

42. Moreover, as described above, NYPHV did not execute a written extension of the Melanoma Directorship Agreement after it expired on July 5, 2016. Nevertheless, NYPHV continued to pay the Oncology Practice $185,000 per year through 2019, despite the absence of any written agreement.

43. All told, between 2011 and 2019, Hudson Valley and NYPHV together paid the Oncology Practice over $1.6 million to provide the services set forth in the Melanoma Directorship Agreement, including, principally, for the establishment and operation of the Melanoma Center. However, the Melanoma Center was never established as envisioned by the Melanoma Directorship Agreement.

III. NYPHV and Hudson Valley Made Payments to the Oncology Practice That Were Not Justified Under the IORT Management Services Agreement

44. The IORT Management Services Agreement had a duration of approximately four years—beginning on September 3, 2012, and expiring on June 30, 2016—and required the hospital to pay the Oncology Practice an annual fee of $125,000. In exchange, the Oncology Practice was required to devote at least 45 hours per month to providing management services related to the IORT Service Line. Further, the IORT Management Services Agreement required the Oncology Practice to maintain time records reflecting the services provided and to submit such records upon the hospital's request.

45. However, NYPHV has not located any time records from the Covered Period documenting the work performed by the Oncology Practice under the agreement. Moreover, as noted above, by October 2016, NYPHV was, or at minimum should have been, aware that the Oncology Practice was performing only a portion of the work called for under the IORT Management Services Agreement.

46. And, after the IORT Management Services Agreement expired on June 30, 2016, NYPHV did not execute a written extension of the IORT Management Services Agreement. Nevertheless, despite the absence of an agreement and despite the fact that NYPHV knew or should have known that the Oncology Practice was not providing all the work called for by the IORT Management Services Agreement, NYPHV continued to pay the Oncology Practice $125,000 per year through 2019.

47. All told, between 2012 and 2019, Hudson Valley and NYPHV together paid the Oncology Practice over $900,000 for services purportedly provided in connection with the IORT Service Line even though the Oncology Practice, including Physician A and B, failed to provide many of the services for which Hudson Valley and NYPHV made payments.

IV. NYPHV and Hudson Valley Made Payments to the Oncology Practice That Were Not Justified Under the Breast Center Directorship Agreement

48. The Breast Center Directorship Agreement had a duration of five years—beginning on July 5, 2011, and expiring on July 5, 2016—and required the hospital to pay the Oncology Practice an annual fee of $185,000. In exchange, Physician B or their designee was required to devote at least 50 hours per month to performing their duties as Medical Director, including developing and operating the Breast Center and establishing standards and indicators for quality measures for its programs. The Breast Center Directorship Agreement required Physician B to maintain time records reflecting the services provided and to submit monthly reports to the hospital as a prerequisite for payment.

49. However, NYPHV has not located any time records from the Covered Period documenting work by Physician B or their designee related to the Breast Center Directorship Agreement.

50. Further, after the agreement expired in 2016, NYPHV did not execute a written extension of the Breast Center Directorship Agreement. Nevertheless, NYPHV continued to pay the Oncology Practice $185,000 per year through 2019, despite the absence of any written agreement. In total, between 2011 and 2019, Hudson Valley and NYPHV together paid the Oncology Practice over $1.6 million for services provided in connection with the Breast Center Directorship Agreement despite the absence of a written agreement after 2016 and the lack of any time records documenting the work performed by Physician B (or their designee) as required by the Breast Center Directorship Agreement.

* * *

51. Defendant submitted or caused to be submitted claims for payment to Medicare and Medicaid for oncology-related services that resulted from the unlawful payments made to the Oncology Practice. These services included diagnostic imaging tests, surgical procedures and other oncology-related services that are "designated health services" under the Stark Law. Because these claims were tainted by Defendant's unlawful kickbacks and Stark Law violations, they constituted false claims under the FCA. As a result, Defendant wrongfully received millions of dollars from Medicare and Medicaid.

CLAIMS FOR RELIEF

FIRST CLAIM

Violation of the False Claims Act: Presenting False Claims for Payment
(31 U.S.C. § 3729(a)(1)(A))

52. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

53. The United States seeks relief against Defendant under Section 3729(a)(1)(A) of the False Claims Act.

54. Through the acts set forth above, Defendant, acting with actual knowledge or with deliberate ignorance or reckless disregard of the truth, presented, or caused to be presented, false or fraudulent claims for payment or approval to the United States when requesting reimbursements for services or procedures. Specifically, Defendant presented or caused to be presented false claims for payment to Medicare and Medicaid for oncology-related services that were the result of patient referrals by physicians to whom Defendant had paid kickbacks in violation of the AKS and with whom Defendant had a non-exempt compensation arrangement in violation of the Stark Law.

55. If payors such as CMS had known about the improper practices set forth above, they would not have paid the claims.

56. By reason of these false or fraudulent claims that Defendant presented or caused to be presented to Medicare and Medicaid, the United States has been damaged in a substantial amount, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

SECOND CLAIM

Violation of the False Claims Act: Use of False Statements (31 U.S.C. § 3729(a)(1)(B))

57. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

58. The United States seeks relief against Defendant under Section 3729(a)(1)(B) of the False Claims Act.

59. As a result of Defendant's kickbacks to induce the Oncology Practice to refer oncology-related services to the Defendant in violation of the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)(2), and as a result of Defendant's claims for payments for services for which Defendant knew or should have known that payment was prohibited by the Stark Law, 42 U.S.C.

§ 1395nn(g)(1), Defendant made or used false records or statements that were material to false or fraudulent claims for payment submitted to Medicare and Medicaid.

60. If payors such as CMS had known about the improper practices set forth above, they would have not paid the claims.

61. By reason of these false or fraudulent records or statements that Defendant made or used, the United States has been damaged in a substantial amount, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

THIRD CLAIM

Violation of the Stark Law: Presenting Improper Claims (Stark Law, 42 U.S.C. § 1395nn(g)(3))

62. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

63. The United States seeks relief against Defendant under Section 1395nn(g)(3) of the Stark Law.

64. Through the acts set forth above, Defendant presented or caused to be presented bills or claims for services for which they knew or should have known payment was prohibited by the Stark Law, 42 U.S.C. § 1395nn(g)(1). Specifically, Defendant presented or caused to be presented claims for oncology-related services referred by the Oncology Practice, with whom Defendant had a non-exempt financial relationship.

65. The United States is entitled to a civil penalty for each violation.

FOURTH CLAIM

Unjust Enrichment

66. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

67. Through the acts set forth above, Defendant has received Medicare and Medicaid reimbursements to which they were not entitled and therefore Defendant has been unjustly enriched. The circumstances of these payments are such that, in equity and good conscience, Defendant should not retain those payments, the amount of which is to be determined at trial.

FIFTH CLAIM

Payment Under Mistake of Fact

68. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

69. The United States seeks relief against Defendant to recover monies paid under mistake of fact.

70. The United States paid Defendant for claims submitted to Medicare and Medicaid based on the mistaken and erroneous belief that the claims were not the result of patient referrals by physicians to whom Defendant had paid kickbacks in violation of the AKS and with whom Defendant had a non-exempt financial relationship in violation of the Stark Law. If the United States had known that the claims were the result of patient referrals by physicians to whom Defendant had paid kickbacks in violation of the AKS and with whom Defendant had a non-exempt financial relationship in violation of the Stark Law, it would not have paid the claims. In such circumstances, the payments by Medicare and Medicaid to Defendant were by mistake and were not authorized.

71. Because of these payments by mistake, Defendant received monies to which it is not entitled.

72. By reason of the foregoing, the United States was damaged in a substantial amount to be determined at trial.

PRAYER FOR RELIEF

73. WHEREFORE, the United States respectfully requests judgment to be entered in its favor as follows:

(i) On Counts One and Two (FCA violations), a judgment against Defendant for treble damages and civil penalties to the maximum extent allowed by law.

(ii) On Count Three (Stark Law violation), a judgment against Defendant for civil penalties to the maximum extent allowed by law.

(iii) On Counts Four and Five (Unjust Enrichment and Payment Under Mistake of Fact), a judgment against Defendant for damages to the maximum extent allowed by law.

(iv) A judgment against Defendant for costs and such other relief as the Court may deem appropriate.

Dated: December 15, 2025
New York, New York

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Southern District of New York

/s/ Jacob M. Bergman

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