APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS,
THIRD CIRCUIT

UNITED STATES OF AMERICA, EX REL. J. WILLIAM BOOKWALTER, III, M.D.; ROBERT J. SCLABASSI, M.D.; ANNA MITINA

v.

UPMC; UNIVERSITY OF PITTSBURGH PHYSICIANS, D/B/A UPP DEPARTMENT OF NEUROSURGERY

J. WILLIAM BOOKWALTER, III, M.D.; ROBERT J. SCLABASSI, M.D.; ANNA MITINA,

Appellants.

No. 18-1693

Argued: January 10, 2019

(Filed: December 20, 2019)

Before: AMBRO, BIBAS, and FUENTES, Circuit Judges

OPINION OF THE COURT

BIBAS, Circuit Judge.

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Healthcare spending is a huge chunk of the federal budget. Medicare and Medicaid cost roughly a trillion dollars per year. And with trillions of dollars comes the temptation for fraud.

Fraud is a particular danger because doctors and hospitals can make lots of money for one another. When doctors refer patients to hospitals for services, the hospitals make money. There is nothing inherently wrong with that. But when hospitals pay their doctors based on the number or value of their referrals, the doctors have incentives to refer more.

The potential for abuse is obvious and requires scrutiny.

The Stark Act and the False Claims Act work together to ensure this scrutiny and safeguard taxpayer funds against abuse. The Stark Act forbids hospitals to bill Medicare for certain services when the hospital has a financial relationship with the doctor who asked for those services, unless an exception applies. And the False Claims Act gives the government and relators a cause of action with which to sue those who violate the Stark Act.

Here, the relators allege that the defendants have for years been billing Medicare for services referred by their neurosurgeons in violation of the Stark Act. The District Court found that the relators had failed to state a plausible claim and dismissed their suit.

This appeal revolves around two questions: First, do the relators offer enough facts to plausibly allege that the surgeons' pay varies with, or takes into account, their referrals? Second, who bears the burden of pleading Stark Act exceptions under the False Claims Act?

The answer to the first question is *yes*. The relators' complaint alleges enough facts to make out their claim. The relators make a plausible case that the surgeons' pay is so high that it must take their referrals into account. All these facts are smoke; and where there is smoke, there might be fire.

The answer to the second question is *the defendants*. The Stark Act's exceptions work like affirmative defenses in litigation. The burden of pleading these affirmative defenses lies with the

defendant. This is true even under the False Claims Act. And even if that burden lay with the relators, their pleadings meet that burden here.

We hold that the complaint states plausible violations of both the Stark Act and the False Claims Act. So we will reverse.

I. BACKGROUND

A. Factual Background

1. *The University of Pittsburgh medical system.* On this motion to dismiss, we take as true the facts alleged in the second amended complaint: The University of Pittsburgh Medical Center is a multi-billion-dollar nonprofit healthcare enterprise. The Medical Center is the parent organization of a whole system of healthcare subsidiaries, including twenty hospitals. The Medical Center is the sole member (owner) of each hospital.

More than 2,700 doctors, including dozens of neurosurgeons, work at these hospitals. The doctors are employed not by the hospitals, but by other Medical Center subsidiaries. Three of these subsidiaries matter here: University of Pittsburgh Physicians; UPMC Community Medicine, Inc.; and Tri-State Neurological Associates-UPMC, Inc.

These three subsidiaries employed many of the neurosurgeons who worked at the Medical Center's hospitals during the years at issue, from 2006 on. Pittsburgh Physicians' Neurosurgery Department employed most of the surgeons at issue. Tri-State employed two, and Community Medicine employed one. The Medical Center owns all three subsidiaries.

In short, the Medical Center owns both the hospitals and the companies that employ the surgeons who work in the hospitals.

2. *The neurosurgeons' compensation structure.* The surgeons who worked for the three subsidiaries here all had similar employment contracts. Each surgeon had a base salary and an annual Work-Unit quota. Work Units (or wRVUs) measure the value of a doctor's personal services. Every medical service is worth a certain number of Work Units. The longer and more complex the service, the more Work Units it is worth. Work Units are one component of Relative Value Units (RVUs). RVUs are the basic units that Medicare uses to measure how much a medical procedure is worth.

The surgeons were rewarded or punished based on how many Work Units they generated. If a surgeon failed to meet his yearly quota, his employer could lower his future base salary. But if he exceeded his quota, he earned a $45 bonus for every extra Work Unit.

3. *The neurosurgeons' alleged fraud and its effects on salaries and revenues.* This compensation structure gave the surgeons an incentive to maximize their Work Units. And the incentive seems to have worked. The surgeons reported doing more, and more complex, procedures. So the number of Work Units billed by the Neurosurgery Department more than doubled between 2006 and 2009.

Much of this increase allegedly stemmed from fraud. The relators accuse the surgeons of artificially boosting their Work Units: The surgeons said they

acted as assistants on surgeries when they did not. They said they acted as teaching physicians when they did not. They billed for parts of surgeries that never happened. They did surgeries that were medically unnecessary or needlessly complex. And they did these things, say the relators, "[w]ith the full knowledge and endorsement of" the Medical Center. App. 184 ¶190.

Fraud can be profitable. And here it allegedly was. With these practices, the surgeons racked up lots of Work Units and made lots of money. Most reported total Work Units that put them in the top 10% of neurosurgeons nationwide. And some received total pay that put them among the best-paid 10% of neurosurgeons in the country.

The surgeons' efforts proved profitable for the Medical Center too. The Medical Center made money off the surgeons' work on some of the referrals. And to boot, healthcare providers bill Medicare for more than just the surgeons' own Work Units. Whenever a surgeon did a procedure at one of the hospitals, the Medical Center also got to bill "for the attendant hospital and ancillary services." App. 166 ¶ 104. This part of the bill could be four to ten times larger than the cost of the surgeon's own services. So when the surgeons billed more, the Medical Center made more. "Indeed, in 2009," the Neurosurgery Department "was the single highest grossing neurosurgical department in the United States, with Medicare charges alone of $58.6 million." App. 163-64 ¶91.

B. Procedural History

The relators first filed suit in 2012. They alleged that the Medical Center, Pittsburgh Physicians, and a bevy of neurosurgeons had submitted false claims for physician services and for hospital services to Medicare and Medicaid. Four years later, the United States intervened as to the claims for physician services. The government settled those claims for about $2.5 million. It declined to intervene as to the claims for hospital services, but it let the relators maintain that part of the action in its stead.

After the government intervened, the District Court dismissed the first amended complaint without prejudice for failure to state a claim. The relators then filed their current complaint, asserting three causes of action against the Medical Center and Pittsburgh Physicians under the False Claims Act:

(1) one count of submitting false claims,

(2) one count of knowingly making false records or statements, and

(3) one count of knowingly making false records or statements material to an obligation to pay money to the United States.

The District Court again dismissed for failure to state a claim, this time with prejudice. The relators now appeal.

II. STANDARDS OF REVIEW AND PLEADING

We review a district court's dismissal for failure to state a claim de novo. *Vorchheimer v. Philadelphian*

Owners Ass'n, 903 F.3d 100, 105 (3d Cir. 2018). Our job is to gauge whether the complaint states a plausible claim to relief. *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009). *Plausible* does not mean *possible*. If the allegations are "merely consistent with" misconduct, then they state no claim. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007). There must be something in the complaint to suggest that the defendant's alleged conduct is illegal. *Id.* at 557, 127 S.Ct. 1955.

But *plausible* does not mean *probable* either. Our job is not to dismiss claims that we think will fail in the end. *See id.* at 556, 127 S.Ct. 1955. Instead, we ask only if we have "enough fact[s] to raise a reasonable expectation that discovery will reveal evidence of" each element. *Id.*

This is the baseline pleading standard for all civil actions. Fed. R. Civ. P. 8; *Iqbal*, 556 U.S. at 684, 129 S.Ct. 1937. But the relators allege claims for fraud. So they must also meet Rule 9(b)'s heightened pleading requirement. *United States ex rel. Moore & Co., P.A. v. Majestic Blue Fisheries, LLC*, 812 F.3d 294, 306-07 (3d Cir. 2016). That rule says that a party alleging fraud "must state with particularity the circumstances constituting fraud." Fed. R. Civ. P. 9(b).

III. THE STARK ACT AND THE FALSE CLAIMS ACT

A. The Stark Act

The Stark Act and its regulations broadly bar Medicare claims for many services referred by

doctors who have a financial interest in the healthcare provider. But the statute creates dozens of exceptions and authorizes the Department of Health and Human Services to make even more exceptions for financial relationships that "do[ ] not pose a risk of program or patient abuse." 42 U.S.C. § 1395nn(b)(4).

1. *Forbidden conduct.* The Stark Act opens with a broad ban. It forbids submitting Medicare claims for "designated health services" provided under a "referral" made by a doctor with whom the entity has a "financial relationship." *Id.* § 1395nn(a)(1). Understanding this ban requires exploring these three quoted terms, each of which has statutory and regulatory definitions.

The Stark Act lists several categories of *designated health services,* including inpatient hospital services. *Id.* § 1395nn(h)(6)(K). And inpatient hospital services include bed and board, interns' and residents' services, nursing, drugs, supplies, transportation, and overhead. 42 C.F.R. §§ 409.10(a), 411.351.

A *referral* is a doctor's request for a designated health service. 42 U.S.C. § 1395nn(h)(5)(A); 42 C.F.R. § 411.351. That definition is broad, but it has an important exception: services that a doctor performs personally do not count. 42 C.F.R. § 411.351. That makes sense; ordinarily, one cannot refer something to oneself. And the exception's boundaries also follow: it does not cover services by a doctor's associates or employees, or services incidental to the doctor's own services. *Id.*; *Medicare Program; Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships (Phase II);*

Interim Final Rule, 69 Fed. Reg. 16054, 16063 (Mar. 26, 2004).

Finally, *financial relationships* come in two forms: (1) ownership or investment interests and (2) compensation arrangements. 42 U.S.C. § 1395nn(a)(2). This case turns on the latter. The statute defines *compensation arrangement* to mean "any arrangement involving any remuneration between" a doctor and a healthcare provider. *Id.* § 1395nn(h)(1)(A). And *remuneration* "includes any remuneration, directly or indirectly, in cash or in kind." *Id.* § 1395nn(h)(1)(B).

2. *Exceptions.* On its face, the Stark Act's ban sweeps in lots of common situations. To separate the wheat from the innocuous chaff, Congress and the Department of Health and Human Services have created many exceptions. Here, the Medical Center argues that exceptions for four types of compensation arrangements could apply here: bona fide employment; personal services; fair-market-value compensation; and indirect compensation. *See id.* § 1395nn(e)(2), (e)(3); 42 C.F.R. § 411.357(*l*), (p).

All four exceptions have two elements in common. First, the doctor's compensation must not "take[ ] into account (directly or indirectly) the volume or value of the doctor's referrals. 42 U.S.C. § 1395nn(e)(2)(B)(ii); *accord id.* § 1395nn(e)(3)(A)(v); 42 C.F.R. § 411.357(l)(3), (p)(1)(i). Second, the doctor's compensation must not exceed *fair market value*. 42 U.S.C. § 1395nn(e)(2)(B)(i), (e)(3)(A)(v); 42 C.F.R. § 411.357(*l*)(3), (p)(1)(i).

In litigation, these exceptions are affirmative defenses. So once a plaintiff proves a prima facie violation of the Stark Act, the burden shifts to the defendant to prove that an exception applies. *United States ex rel. Kosenske v. Carlisle HMA, Inc.,* 554 F.3d 88, 95 (3d Cir. 2009).

3. *No built-in cause of action.* The Stark Act forbids the government to pay claims that violate the Act. 42 U.S.C. § 1395nn(g)(1). It demands restitution from those who receive payments on illegal claims. *Id.* § 1395nn(g)(2). And it creates civil penalties for submitting improper claims or taking part in schemes to violate the Act. *Id.* § 1395nn(g)(3), (4). But it gives no one a right to sue. *United States ex rel. Drakeford v. Tuomey*, 792 F.3d 364, 374 n.4 (4th Cir. 2015).

So the Stark Act never appears in court alone. Instead, it always come in through another statute that creates a cause of action—typically, the False Claims Act.

B. The False Claims Act

Under the False Claims Act, any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" is civilly liable to the United States. 31 U.S.C. § 3729(a)(1)(A). A Medicare claim that violates the Stark Act is a false claim under the False Claims Act. *Kosenske*, 554 F.3d at 94. The False Claims Act also makes liable anyone who "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)(B), (G).

IV. THE RELATORS PLEAD STARK ACT VIOLATIONS

A prima facie Stark Act violation has three elements: (1) a referral for designated health services, (2) a compensation arrangement (or an ownership or investment interest), and (3) a Medicare claim for the referred services. *See United States ex rel. Schmidt v. Zimmer, Inc.*, 386 F.3d 235, 241 (3d Cir. 2004). This combination of factors suggests potential abuse of Medicare. When they are all present, we let plaintiffs go to discovery.

Here, no one denies that the defendants made Medicare claims for designated health services. The issue is whether the complaint sufficiently alleges referrals and a compensation arrangement. We hold that it does. The alleged Medicare abuse is plausible and deserves more scrutiny.

A. The surgeons referred designated health services to the hospitals

The relators allege that "[e]very time [the neurosurgeons] performed a surgery or other procedure at the UPMC Hospitals, [they] made a referral for the associated hospital claims." App. 193 ¶234. They are right that these claims are referrals.

As mentioned, the law defines referrals broadly. A referral is a doctor's request for any designated health service that is covered by Medicare and provided by someone else. 42 C.F.R. § 411.351. Designated health services include bed and board, some hospital overhead, nursing services, and much more. 42 C.F.R. § 409.10(a). And the relators plead that as the surgeons performed more procedures,

those procedures required (and the hospital provided and "increased billings for[]] the attendant hospital and ancillary services including ... *hospital and nursing charges*." App. 166 ¶104 (emphasis added). So the plaintiffs plead that the surgeons referred designated health services to the hospitals.

Treating these services as referrals makes sense. The Stark Act's first step is to flag all potentially abusive arrangements. And doctors who generate profits for a hospital may be tempted to abuse their power, raising hospital bills as well as their own pay. These financial arrangements thus deserve a closer look. And they will get a closer look only if we call these arrangements what they are: doctors referring services to hospitals.

The Department of Health and Human Services agrees. In Phase I of its Stark Act rulemaking, it considered this point. It determined that "any hospital service, technical component, or facility fee billed by [a] hospital in connection with [a doctor's] personally performed service" counts as a referral. *Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships*, 66 Fed. Reg. 856, 941 (Jan. 4, 2001). This is true even "in the case of an inpatient surgery" where the doctor performs the surgery. *Id.*

Then, in Phase II of its rulemaking, the agency revisited the question and considered narrower definitions. For instance, many commenters suggested excluding "services that are performed 'incident to' a physician's personally performed services or that are performed by a physician's

employee" from the definition of a referral. 69 Fed. Reg. at 16063.

But the agency reasonably rejected these suggestions. A narrower view, it reasoned, would all but swallow at least one statutory exception. *Id.* And it explained that the availability of that and other exceptions did enough to protect innocent conduct. *Id.* "[T]his interpretation is consistent with the statute as a whole," which begins by casting a broad net to scrutinize all potential abuse. *Id.*

B. The relators' complaint alleges an indirect compensation arrangement

A referral is ripe for abuse only when the doctor who made it has a financial relationship with the provider. Only then can a doctor profit from his own referral. The financial relationship here is a compensation arrangement.

Compensation arrangements can be either direct or indirect. 42 C.F.R. § 411.354(c). The hospitals did not pay the surgeons directly. So if there is any compensation arrangement here, it is indirect. That requires three elements: First, there must be "an unbroken chain ... of persons or entities that have financial relationships" connecting the referring doctor with the provider of the referred services. *Id.* § 411.354(c)(2)(i). Second, the referring doctor must get "aggregate compensation ... that varies with, or takes into account, the volume or value of referrals." *Id.* § 411.354(c)(2)(ii). And third, the service provider must know, recklessly disregard, or deliberately ignore that the doctor's compensation "varies with, or takes into account, the volume or value of referrals."

Id. § 411.354(c)(2)(iii). (The parties do not challenge any of the regulations at issue, so we likewise assume that they are valid.) The complaint plausibly pleads enough facts to satisfy each element.

1. *An unbroken chain of entities with financial relationships connects the surgeons with the hospitals.* An unbroken chain of financial relationships links the surgeons to the hospitals. First, the Medical Center owns each hospital. Second, the Medical Center also owns three entities: Pittsburgh Physicians, Community Medicine, and Tri-State. Third, each of these three entities employs and pays at least one of the surgeons. That adds up to an unbroken chain of financial relationships. Neither party disputes this.

2. *The surgeons' suspiciously high compensation suggests that it took into account the volume and value of their referrals.* Next, the relators allege that the surgeons' aggregate compensation varied with, and took into account, their referrals.

The parties disagree about what it means for compensation to *vary with* referrals. Appellants argue that *varies with* requires only correlation. And compensation correlates with referrals here, they argue, because surgeons racked up more Work Units and earned more money by generating more referrals. So the surgeons' aggregate compensation allegedly varied with their referrals. Appellees, by contrast, deny that a correlation suffices. Rather, they insist that the law requires some form of causation.

We need not resolve the meaning of *varies with* here. Regardless, the complaint plausibly alleges that the surgeons' compensation *takes into account* the volume or value of their referrals. Under the Stark Act and its regulations, compensation *takes into account* referrals if there is a causal relationship between the two. And here, the surgeons' suspiciously high compensation suggests causation.

Compensation for personal services above the fair market value of those services can suggest that the compensation is really for referrals. This is just common sense. Healthcare providers would not want to lose money by paying doctors more than they bring in. They would do so only if they expected to make up the difference another way. And that way could be through the doctors' referrals.

This may not be obvious on the face of the statute and regulations. The Stark Act often treats *fair market value* as a concept distinct from *taking into account the volume or value of referrals.* For example, these two concepts are separate elements of many Stark Act exceptions. *E.g.*, 42 U.S.C. § 1395nn(e)(2) (bona fide employment), (e)(3) (personal service); 42 C.F.R. § 411.357(*l*) (fair-market-value compensation), (p) (indirect compensation). And the definition of an *indirect compensation arrangement* includes taking referrals into account, but not fair market value. 42 C.F.R. § 411.354(c)(2)(ii).

But the Act's different treatment of these concepts does not sever them. To start, just because a statute has two elements does not mean that one can never be evidence of the other. Theft requires taking another's property with intent. Those are two

elements, but the fact of taking property can be circumstantial evidence of intent.

So too here. Perhaps not all payments above fair market value are evidence of taking into account the doctor's referrals. But common sense says that marked overpayments are a red flag. Anyone would wonder why the hospital would pay so much if it was not taking into account the doctor's referrals for other services. And we do no violence to the statutory text by seeking an answer to that question.

The agency confronted this question directly. It remarked that even "fixed aggregate compensation can form the basis for a prohibited ... indirect compensation arrangement" if it "is *inflated* to reflect the volume or value of a physician's referrals." 69 Fed. Reg. at 16059 (emphasis added). The same is true of "unit-of-service-based compensation arrangements," like the one here. *Id.* Excessive compensation is thus a sign that a surgeon's pay in fact takes referrals into account.

So aggregate compensation that far exceeds fair market value is smoke. It suggests that the compensation takes referrals into account. And the relators here plead five facts that, viewed together, make plausible claims that the surgeons' pay far exceeded their fair market value. First, some surgeons' pay exceeded their collections. Second, many surgeons' pay exceeded the 90th percentile of neurosurgeons nationwide. Third, many generated Work Units far above industry norms. Fourth, the surgeons' bonus per Work Unit exceeded what the defendants collected on most of those Work Units. And finally, the government alleged in its settlement

agreement that the Medical Center had fraudulently inflated the surgeons' Work Units. That much smoke makes fire plausible.

a. Pay exceeding collections. Paying a worker more than he brings in is suspicious. And the complaint alleges that at least three surgeons (Drs. Bejjani, Spiro, and El-Kadi) were paid more than the Medical Center collected for their services. The complaint also alleges that the Medical Center credits surgeons with 100 percent of the Work Units that they generate, even if it cannot collect on all of them. So at least three surgeons (maybe more) were paid more than they bring in.

b. Pay exceeding the 90th percentile. The relators allege that "[c]ompensation exceeding the 90th percentile is widely viewed in the industry as a 'red flag' indicating that it is in excess of fair market value." App. 191 ¶223. The defendants do not deny this.

Several surgeons were paid more than the 90th percentile. For example, the relators point to the compensation of Drs. Abla, Spiro, Kassam, and Bejjani between 2008 and 2011. Apart from Dr. Spiro in 2008, each of these surgeons was paid more than even the highest estimate of the 90th percentile for all U.S. neurosurgeons in all four years. And depending on which estimate of the 90th percentile you use, they were sometimes paid two or three times more than the 90th percentile. Dr. Bejjani's 2011 bonus alone exceeded the 90th percentile of total compensation in some surveys.

c. Extreme Work Units. The relators also allege facts from which we can reasonably infer that the surgeons generated far more Work Units than normal. Many neurosurgeons "were routinely generating [Work Units] exceeding by an enormous margin the 90th percentile as reflected in widely-accepted market surveys." App. 171 ¶126. Even if we look only at the highest industry estimates, all but one of the surgeons reported Work Units above the 90th percentile in 2006 and 2007. In 2008 and 2009, eight of the twelve named surgeons exceeded the highest estimate of the 90th percentile. A few even seemed "super human," racking up *two to three times* the 90th percentile. App. 169 ¶ 117.

In short, most of the surgeons generated Work Units at or above the 90th percentile. Some of their numbers were unbelievably high. And because their pay depends in large part on their Work Units, it is fair to infer that most of their pay was also at or above the 90th percentile.

d. Bonuses exceeding the Medicare reimbursement rate. Once a surgeon had enough Work Units to earn bonus pay, the bonus per Work Unit was more than Medicare would pay for each one. The surgeons' bonus per Work Unit was $45. But the Medicare reimbursement rate was only about $35. So once surgeons became eligible for bonuses, the defendants took an immediate loss on every Work Unit submitted to Medicare.

On its own, this would not show that the surgeons were overpaid. Medicare and Medicaid are well known as bottom-billers. They pay less than private insurers. Though the defendants lost some money on

Medicare Work Units, perhaps they made it back with Work Units billed to other insurers.

But the relators also allege that "the majority of all claims submitted by the [defendants] ... were submitted to federal health insurance programs such as Medicare and Medicaid." App. 193 ¶233. We cannot assume that private payments suffice to make up the difference. Doing so would disregard our job at this stage: to draw reasonable inferences in favor of the plaintiffs.

In short, the defendants took an immediate financial hit on Work Units for a majority of their claims. This is yet another sign that the surgeons' pay took referrals into account.

The defendants disagree. They argue that the surgeons earn high salaries because of bona fide bargaining with their employers. Their salaries supposedly represent the market's demand for their surgical skill and experience.

This argument fails for two reasons. First, the complaint says nothing about the surgeons' skill and experience or the Pittsburgh market for surgeons. On this motion to dismiss, we cannot go beyond the well-pleaded facts in the complaint.

Second, a bare claim of bona fide bargaining is not enough. The Stark Act recognizes that related parties often negotiate agreements "to disguise the payment of non-fair-market-value compensation." *Kosenske*, 554 F.3d at 97. We trust that bona fide bargaining leads to fair market value only when neither party is "in a position to generate business for the other." *Id.*; 42 C.F.R. § 411.351 (defining "fair

market value" and "general market value"). But that is not true here. The surgeons and the Medical Center can generate business for each other. So we cannot assume that any bargaining was bona fide or that the resulting pay was at fair market value.

e. The possibility of fraud. Finally, the surgeons' high pay may have been based on fudging the numbers. Not only were their individual Work Units "significantly out of line with industry benchmarks," but the Neurosurgery Department as a whole realized astounding "annual growth rates of work [Units] ... of 20.3%, 57.1% and 20.0%" in 2007, 2008, and 2009. App. 171 ¶¶127-28. Two of the surgeons more than doubled their output in just a few years. The relators allege that the defendants got this growth by "artificially inflat[ing] the number of [Work Units] in a number of ways." App. 171 ¶130.

Alleging this fraud, the relators' first complaint included claims "relating to physician services submitted by" the defendants along with the "hospital claims" currently before us. App. 189 ¶217 (emphases in original) The government chose to intervene as to the former claims, settling them with the defendants for almost $2.5 million.

The relators' current complaint quotes that settlement agreement. In it, the government accused the surgeons of many fraudulent practices: They claimed to have acted as assistants when they did not. They claimed to have done more extensive surgeries than they did. And they chose the wrong codes for surgeries. So "claims submitted for these physician services resulted in more reimbursement

than would have been paid" otherwise. App. 188-89 ¶216.

We are careful not to overstate the point. This settlement is not an admission of guilt. It proves no wrongdoing. But at the 12(b)(6) stage, we are looking only for plausible claims, not proof of wrongs. And the government's choice to intervene after years of investigation and its allegations in the settlement are cause for suspicion.

The question is not whether a doctor was able to use an otherwise-valid compensation scheme as a vehicle for fraudulent billing. Not every fraudulent Medicare bill made at a hospital will give rise to a Stark Act violation. Here, however, where the compensation scheme produced results bordering on the absurd, relators plausibly assert that the system may have been designed with that outcome in mind.

The relators allege five sets of facts that suggest that the surgeons' pay far exceeded fair market value: pay exceeding collections, pay above the 90th percentile, extreme Work Units, bonuses above the Medicare reimbursement rate, and the settlement. That is plenty of smoke. We need not decide whether any of these allegations alone would satisfy the relators' pleading burden. Together, they plausibly suggest that the surgeons' pay took their referrals into account. Thus, the relators have pleaded more than enough facts to suggest an indirect compensation arrangement.

3. *The hospitals knew that the surgeons' compensation took their referrals into account.* The final element of an indirect compensation

arrangement is scienter. To show scienter, the relators' pleadings must allege that the hospitals that provided the referred services either (1) knew, (2) deliberately ignored, or (3) recklessly disregarded that the surgeons got "aggregate compensation that varie[d] with, or t[ook] into account, the volume or value of referrals." 42 C.F.R. § 411.354(c)(2)(iii). They allege this too.

To begin, the Medical Center controls all the hospitals and the surgeons' direct employers. It owns each hospital. And it owns Pittsburgh Physicians, Community Medicine, and Tri-State. So the Medical Center "has unfettered authority with respect to most members of the [medical system] and significant authority (including with respect to financial and tax matters) with respect to the remaining members." App. 146-47 ¶19 (quoting a Medical Center tax filing).

Further, many officers and board members of these entities overlapped. For example, one person simultaneously served as an executive vice president of the Medical Center as well as the president and a board member of Pittsburgh Physicians. And he signed surgeons' pay agreements for Pittsburgh Physicians. The relators identify nine others who served on the board of both the Medical Center and another entity in the medical system. Authority was so centralized that a single person signed a settlement agreement on behalf of all the defendants that were part of the medical system. And with common control comes common knowledge.

The common knowledge included both the surgeons' pay and their referrals. The Medical

Center took part in forming, approving, and implementing the surgeons' pay packages. So it knew their structure. The Medical Center also had a central coding and billing department that handled billing for its subsidiaries. So it knew about the surgeons' referrals.

With both sets of data in front of it, we can plausibly infer that the Medical Center knew the surgeons' compensation took their referrals into account. And as the Medical Center knew that, so did the hospitals. They had all the data right in front of them. They knew that the surgeons' pay and Work Units were out of line with industry survey data. Even if they did not actually know that the surgeons' pay and work levels were suspiciously high, they at least deliberately ignored or recklessly disregarded that fact. Thus, the complaint alleges that both the Medical Center and hospitals had scienter.

* * * * *

This means that the relators have successfully pleaded the third and final element of a Stark Act violation: scienter. But they must plead one more thing to survive a motion to dismiss. We must now consider whether the relators have pleaded a plausible prima facie case under the False Claims Act.

V. THE RELATORS PLEAD FALSE CLAIMS ACT VIOLATIONS

The relators plead their Stark Act claims as violations of the False Claims Act. So their pleadings must satisfy all the elements of the False Claims Act. They do. And they satisfy Rule 9(b)'s heightened

pleading standard. Last, we hold that the Stark Act's exceptions are not additional elements of a prima facie case. But even if they were, the relators have plausibly pleaded that no exception applies here.

A. The pleadings satisfy all three elements of the False Claims Act

To make out a prima facie case, the relators must plead three elements: " '(1) the defendant presented or caused to be presented to an agent of the United States a claim for payment; (2) the claim was false or fraudulent; and (3) the defendant knew the claim was false or fraudulent.' " *Schmidt*, 386 F.3d at 242 (quoting *Hutchins v. Wilentz, Goldman & Spitzer*, 253 F.3d 176, 182 (3d Cir. 2001)). They have alleged enough facts to plead all three elements.

First, by submitting claims to Medicare and other federal health programs, the defendants presented claims for payment to the government.

Second, the relators allege that these claims were false. A Medicare claim that violates the Stark Act is a false claim. *Kosenske*, 554 F.3d at 94. And we have already explained at length why the Medicare claims here plausibly violated the Stark Act.

Third, the relators' allegations plead scienter. Just like the Stark Act, the False Claims Act requires that the defendants know, deliberately ignore, or recklessly disregard the falsity of their claim. 31 U.S.C. § 3729(b)(1)(A). But it does not require a specific intent to defraud. *Id.* § 3729(b)(1)(B).

The claims are false because they allegedly violated the Stark Act. The question is whether the

defendants at least recklessly disregarded that possibility. The defendants had a centralized billing department and were familiar with the Stark Act itself, so they knew that they submitted Medicare claims for referred designated health services. That leaves only whether the defendants knew that the hospitals and surgeons had an indirect compensation agreement.

The complaint alleges that the defendants at least recklessly disregarded that possibility. They knew their own corporate structure. We have already explained how they knew or recklessly disregarded that the surgeons' pay varied with their referrals. And we have also explained how they knew or recklessly disregarded that their surgeons' pay far exceeded fair market value and thus plausibly took referrals into account. So the relators have pleaded a prima facie claim under the False Claims Act.

B. The pleadings satisfy Rule 9(b)

The relators' complaint also satisfies Rule 9(b)'s particularity requirement. To do so, the allegations must go well beyond Rule 8's threshold of plausibility. A mere plausible inference of illegality is not enough. Instead, "a relator must 'establish a "strong inference" that the false claims were submitted.' " *United States ex rel. Silver v. Omnicare, Inc.*, 903 F.3d 78, 92 (3d Cir. 2018) (quoting *Foglia v. Renal Ventures Mgmt.*, 754 F.3d 153, 158 (3d Cir. 2014)).

Rule 9(b)'s particularity requirement requires a plaintiff to allege " 'all of the essential factual background that would accompany the first

paragraph of any newspaper story—that is, the who, what, when, where, and how of the events at issue.' " *Majestic Blue Fisheries*, 812 F.3d at 307 (quoting *In re Rockefeller Ctr. Props., Inc. Secs. Litig.*, 311 F.3d 198, 217 (3d Cir. 2002)). The complaint gives us all these necessary details:

- Who? The defendants: the Medical Center and Pittsburgh Physicians.
- What? The defendants submitted or caused to be submitted false Medicare claims.
- When? From 2006 until now.
- Where? The Medicare claims were submitted from the Medical Center's centralized billing facility, while the referred services were provided at the Medical Center's twenty hospitals.
- How? When the Medical Center submitted a claim, it certified compliance with the Stark Act. The complaint makes all the allegations discussed above. We will not repeat them. But they detail exactly how these claims violated the Stark Act.

Rule 9(b) does not require the relators to plead anything more, such as the date, time, place, or content of every single allegedly false Medicare claim. The falsity here comes not from a particular misrepresentation, but from a set of circumstances that, if true, makes a whole set of claims at least prima facie false. It is enough to allege those circumstances with particularity. Doing so "inject[s] precision or some measure of substantiation into

[the] fraud allegation" and "place[s] the defendant on notice of the precise misconduct with which [it is] charged." *Alpizar-Fallas v. Favero*, 908 F.3d 910, 919 (3d Cir. 2018) (quoting *Frederico v. Home Depot*, 507 F.3d 188, 200 (3d Cir. 2007)) (last alteration in original; internal quotation marks omitted).

And the relators have done so. The second amended complaint runs 57 pages (plus exhibits) and comprises 257 numbered paragraphs. Dozens of these paragraphs go into great detail about specific physicians' Work Units and pay levels. The complaint compares those figures at length with industry benchmarks, medians, and 90th percentiles. It alleges specific ways that surgeons padded their bills, by for instance falsely reporting unperformed work assisting other surgeons or physically supervising residents and interns. The complaint also quotes the government's settlement agreement, alleging specific ways that surgeons had been padding their bills. The sum total of these allegations tells a detailed story about how the defendants designed a system to reward surgeons for creating and submitting false claims. *See Omnicare*, 903 F.3d at 91-92 (quoting *Foglia*, 754 F.3d at 158). And that is particular enough to satisfy Rule 9(b).

C. Pleading Stark Act exceptions under the False Claims Act

One final issue is how the Stark Act interacts with the False Claims Act. The defendants argue that the False Claims Act's elements of falsity and knowledge turn the Stark Act's exceptions into prima facie elements of the False Claims Act. On their reading,

the relators would have to plead that no exception applies here.

We reject that argument. The defendants retain the burden of pleading Stark Act exceptions even under the False Claims Act. And even if the relators bore that burden, they have met it here.

1. *The burden of pleading Stark Act exceptions stays with the defendant under the False Claims Act.* The defendants argue that the False Claims Act's knowledge and falsity elements turn the Start Act's exceptions into prima facie elements. Their logic is simple and cogent: The False Claims Act penalizes only false claims. 31 U.S.C. § 3729(a)(1). False claims include claims submitted in violation of the Stark Act. *See Kosenske*, 554 F.3d at 94. But if an exception to the Stark Act applies, then the claim is not false. And if the defendant thinks that an exception applies, then the defendant does not know that the claim is false. So, according to the defendants, to plead a False Claims Act claim based on Stark Act violations, a relator must plead that no Stark Act exception applies and that the defendant knows that none applies. Otherwise, the relator pleads neither falsity nor knowledge.

Though this argument has force, we reject it. Our precedent compels this result. Like this case, *Kosenske* was a False Claims Act case based on Stark Act violations. *Id.* It placed the burden of proving a Stark Act exception on the defendant. *Id.* at 95; *accord Tuomey*, 792 F.3d at 374. And we see no reason to split up the burdens of pleading and persuasion. It is thus the defendants' burden to plead

a Stark Act exception, not the relators' burden to plead that none exists.

2. *Even if the relators bore this pleading burden, they have met it.* In any event, the relators here plausibly plead that no Stark Act exception applies. The parties identify four that could apply here: exceptions for bona fide employment, personal services, fair-market-value pay, and indirect compensation. All four exceptions require that the surgeons' compensation not exceed fair market value and not take into account the volume or value of referrals.

We have already explained how the relators plausibly plead that the surgeons were paid more than fair market value. And that itself suggests that their pay may take into account their referrals' volume or value. So the relators plausibly plead that no Stark Act exception applies.

VI. CONCLUSION

Evaluating a motion to dismiss is "a context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Iqbal*, 556 U.S. at 679, 129 S.Ct. 1937. Our experience and common sense tell us that the relators state a plausible claim that the Medical Center and Pittsburgh Physicians have violated the Stark Act and the False Claims Act.

The facts they plead, if true, satisfy every element of those statutes: A chain of financial relationships linked the hospitals to the surgeons. The surgeons referred many designated health services to the hospitals, generating ancillary hospital services and

facility fees. It is plausible that their pay takes into account the volume of those referrals. The hospitals made Medicare claims for those referrals. And the defendants allegedly knew all this.

With all this smoke, a fire is plausible. So this case deserves to go to discovery. Once the discovery is in, it may turn out that there is no fire. We do not prejudge the merits. But this is exactly the kind of situation on which the Stark and False Claims Acts seek to shed light. We will thus reverse the District Court's dismissal and remand for further proceedings.

APPENDIX B

UNITED STATES COURT OF APPEALS,
THIRD CIRCUIT

UNITED STATES OF AMERICA, EX REL. J. WILLIAM BOOKWALTER, III, M.D.; ROBERT J. SCLABASSI, M.D.; ANNA MITINA

v.

UPMC; UNIVERSITY OF PITTSBURGH PHYSICIANS, D/B/A UPP DEPARTMENT OF NEUROSURGERY

J. WILLIAM BOOKWALTER, III, M.D.; ROBERT J. SCLABASSI, M.D.; ANNA MITINA,

Appellants.

No. 18-1693

Dated: December 20, 2019

(W.D. Pa. No. 2:12-cv-00145)

Present: SMITH, Chief Judge, and McKEE, AMBRO, CHAGARES, JORDAN, HARDIMAN, GREENAWAY, JR., SHWARTZ, KRAUSE, RESTREPO, BIBAS, MATEY, PHIPPS, and FUENTES,* Circuit Judges

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* Judge FUENTES's vote is limited to panel rehearing only.

SUR PETITION FOR REHEARING

Stephanos Bibas, Circuit Judge

The petition for rehearing filed by Appellees in the above-captioned case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in regular active service, it is hereby **ORDERED** that the petition for rehearing is **GRANTED IN PART**. A majority of the judges who participated in the decision of the Court having voted for rehearing, the petition for rehearing by the panel is **GRANTED.** The opinion and judgment filed September 17, 2019, are hereby **VACATED**. A subsequent opinion and judgment are herewith issued.

The majority has made changes to the language that appeared at pages 3–4, 6, 11, 15, 27–30, 32–33, 35–37, and 39–40 of the original opinion. Most of the material that appeared at pages 18–25 of the original opinion has been deleted. Judge AMBRO's opinion concur-ring in the judgment has been withdrawn.

A majority of the judges of the circuit in regular service not having voted for rehearing, the petition for rehearing by the Court en banc is **DENIED**.

APPENDIX C

UNITED STATES COURT OF APPEALS,
THIRD CIRCUIT

UNITED STATES OF AMERICA, EX REL. J. WILLIAM BOOKWALTER, III, M.D.; ROBERT J. SCLABASSI, M.D.; ANNA MITINA

v.

UPMC; UNIVERSITY OF PITTSBURGH PHYSICIANS, D/B/A UPP DEPARTMENT OF NEUROSURGERY

J. WILLIAM BOOKWALTER, III, M.D.; ROBERT J. SCLABASSI, M.D.; ANNA MITINA,

Appellants.

No. 18-1693

Argued: January 10, 2019

(Filed: September 17, 2019)

Before: AMBRO, BIBAS, and FUENTES, Circuit Judges.

OPINION OF THE COURT

BIBAS, Circuit Judge.

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Healthcare spending is a huge chunk of the federal budget. Medicare and Medicaid cost roughly a trillion dollars per year. And with trillions of dollars comes the temptation for fraud.

Fraud is a particular danger because doctors and hospitals can make lots of money for one another. When doctors refer patients to hospitals for services, the hospitals make money. There is nothing inherently wrong with that. But when hospitals pay

their doctors based on the number or value of their referrals, the doctors have incentives to refer more. The potential for abuse is obvious and requires scrutiny.

The Stark Act and the False Claims Act work together to ensure this scrutiny and safeguard taxpayer funds against abuse. The Stark Act forbids hospitals to bill Medicare for certain services when the hospital has a financial relationship with the doctor who asked for those services, unless an exception applies. And the False Claims Act gives the government and relators a cause of action with which to sue those who violate the Stark Act.

Here, the relators allege that the defendants have for years been billing Medicare for services referred by their neurosurgeons in violation of the Stark Act. The District Court found that the relators had failed to state a plausible claim and dismissed their suit.

This appeal revolves around two questions: First, do the relators offer enough facts to plausibly allege that the surgeons' pay varies with, or takes into account, their referrals? Second, who bears the burden of pleading Stark Act exceptions under the False Claims Act?

The answer to the first question is *yes*. The relators' complaint alleges enough facts to make out their claim. The surgeons' contracts make it very likely that their pay varies with their referrals. And the relators also make a plausible case that the surgeons' pay is so high that it must take referrals into account. All these facts are smoke; and where there is smoke, there might be fire.

The answer to the second question is *the defendants*. The Stark Act's exceptions work like affirmative defenses in litigation. The burden of pleading these affirmative defenses lies with the defendant. This is true even under the False Claims Act. And even if that burden lay with the relators, their pleadings meet that burden here.

We hold that the complaint states plausible violations of both the Stark Act and the False Claims Act. So we will reverse.

I. BACKGROUND

A. Factual Background

1. *The University of Pittsburgh medical system.* On this motion to dismiss, we take as true the facts alleged in the second amended complaint: The University of Pittsburgh Medical Center is a multi-billion-dollar nonprofit healthcare enterprise. The Medical Center is the parent organization of a whole system of healthcare subsidiaries, including twenty hospitals. The Medical Center is the sole member (owner) of each hospital.

More than 2,700 doctors, including dozens of neurosurgeons, work at these hospitals. The doctors are employed not by the hospitals, but by other Medical Center subsidiaries. Three of these subsidiaries matter here: University of Pittsburgh Physicians; UPMC Community Medicine, Inc.; and Tri-State Neurological Associates-UPMC, Inc.

These three subsidiaries employed many of the neurosurgeons who worked at the Medical Center's hospitals during the years at issue, from 2006 on.

Pittsburgh Physicians' Neurosurgery Department employed most of the surgeons at issue. Tri-State employed two, and Community Medicine employed one. The Medical Center owns all three subsidiaries. In short, the Medical Center owns both the hospitals and the companies that employ the surgeons who work in the hospitals.

2. *The neurosurgeons' compensation structure.* The surgeons who worked for the three subsidiaries here all had similar employment contracts. Each surgeon had a base salary and an annual Work-Unit quota. Work Units (or wRVUs) measure the value of a doctor's personal services. Every medical service is worth a certain number of Work Units. The longer and more complex the service, the more Work Units it is worth. Work Units are one component of Relative Value Units (RVUs). RVUs are the basic units that Medicare uses to measure how much a medical procedure is worth.

The surgeons were rewarded or punished based on how many Work Units they generated. If a surgeon failed to meet his yearly quota, his employer could lower his future base salary. But if he exceeded his quota, he earned a $45 bonus for every extra Work Unit.

3. *The neurosurgeons' alleged fraud and its effects on salaries and revenues.* This compensation structure gave the surgeons an incentive to maximize their Work Units. And the incentive seems to have worked. The surgeons reported doing more, and more complex, procedures. So the number of Work Units billed by the Neurosurgery Department more than doubled between 2006 and 2009.

Much of this increase allegedly stemmed from fraud. The relators accuse the surgeons of artificially boosting their Work Units: The surgeons said they acted as assistants on surgeries when they did not. They said they acted as teaching physicians when they did not. They billed for parts of surgeries that never happened. They did surgeries that were medically unnecessary or needlessly complex. And they did these things, say the relators, "[w]ith the full knowledge and endorsement of" the Medical Center. App. 184 ¶190.

Fraud can be profitable. And here it allegedly was. With these practices, the surgeons racked up lots of Work Units and made lots of money. Most reported total Work Units that put them in the top 10% of neurosurgeons nationwide. And some received total pay that put them among the best-paid 10% of neurosurgeons in the country.

The surgeons' efforts proved profitable for the Medical Center too. The Medical Center made money off the surgeons' work on some of the referrals. And to boot, healthcare providers bill Medicare for more than just the surgeons' own Work Units. Whenever a surgeon did a procedure at one of the hospitals, the Medical Center also got to bill "for the attendant hospital and ancillary services." App. 166 ¶ 104. This part of the bill could be four to ten times larger than the cost of the surgeon's own services. So when the surgeons billed more, the Medical Center made more. "Indeed, in 2009," the Neurosurgery Department "was the single highest grossing neurosurgical department in the United States, with Medicare charges alone of $58.6 million." App. 163-64 ¶ 91.

B. Procedural History

The relators first filed suit in 2012. They alleged that the Medical Center, Pittsburgh Physicians, and a bevy of neurosurgeons had submitted false claims for physician services and for hospital services to Medicare and Medicaid. Four years later, the United States intervened as to the claims for physician services. The government settled those claims for about $2.5 million. It declined to intervene as to the claims for hospital services, but it let the relators maintain that part of the action in its stead.

After the government intervened, the District Court dismissed the first amended complaint without prejudice for failure to state a claim. The relators then filed their current complaint, asserting three causes of action against the Medical Center and Pittsburgh Physicians under the False Claims Act:

(1) one count of submitting false claims,

(2) one count of knowingly making false records or statements, and

(3) one count of knowingly making false records or statements material to an obligation to pay money to the United States.

The District Court again dismissed for failure to state a claim, this time with prejudice. The relators now appeal.

II. STANDARDS OF REVIEW AND PLEADING

We review a district court's dismissal for failure to state a claim de novo. *Vorchheimer v. Philadelphian*

Owners Ass'n, 903 F.3d 100, 105 (3d Cir. 2018). Our job is to gauge whether the complaint states a plausible claim to relief. *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009). *Plausible* does not mean *possible*. If the allegations are "merely consistent with" misconduct, then they state no claim. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007). There must be something in the complaint to suggest that the defendant's alleged conduct is illegal. *Id.* at 557, 127 S.Ct. 1955.

But *plausible* does not mean *probable* either. Our job is not to dismiss claims that we think will fail in the end. *See id.* at 556, 127 S.Ct. 1955. Instead, we ask only if we have "enough fact[s] to raise a reasonable expectation that discovery will reveal evidence of" each element. *Id.*

This is the baseline pleading standard for all civil actions. Fed. R. Civ. P. 8; *Iqbal*, 556 U.S. at 684, 129 S.Ct. 1937. But the relators allege claims for fraud. So they must also meet Rule 9(b)'s heightened pleading requirement. *United States ex rel. Moore & Co., P.A. v. Majestic Blue Fisheries, LLC*, 812 F.3d 294, 306-07 (3d Cir. 2016). That rule says that a party alleging fraud "must state with particularity the circumstances constituting fraud." Fed. R. Civ. P. 9(b).

III. THE STARK ACT AND THE FALSE CLAIMS ACT

A. The Stark Act

The Stark Act protects the public fisc from Medicare and Medicaid fraud. The Act and its

regulations broadly bar Medicare claims for many services referred by doctors who have a financial interest in the healthcare provider. But the statute creates dozens of exceptions and authorizes the Department of Health and Human Services to make even more exceptions for financial relationships that "do[ ] not pose a risk of program or patient abuse." 42 U.S.C. § 1395nn(b)(4).

1. *Forbidden conduct.* The Stark Act opens with a broad ban. It forbids submitting Medicare claims for "designated health services" provided under a "referral" made by a doctor with whom the entity has a "financial relationship." *Id.* § 1395nn(a)(1). Understanding this ban requires exploring these three quoted terms, each of which has statutory and regulatory definitions.

The Stark Act lists several categories of *designated health services*, including inpatient hospital services. *Id. §* 1395nn(h)(6)(K). And inpatient hospital services include bed and board, interns' and residents' services, nursing, drugs, supplies, transportation, and overhead. 42 C.F.R. §§ 409.10(a), 411.351.

A *referral is* a doctor's request for a designated health service. 42 U.S.C. § 1395nn(h)(5)(A); 42 C.F.R. § 411.351. That definition is broad, but it has an important exception: services that a doctor performs personally do not count. 42 C.F.R. § 411.351. That makes sense; ordinarily, one cannot refer something to oneself. And the exception's boundaries also follow: it does not cover services by a doctor's associates or employees, or services incidental to the doctor's own services. *Id.*; *Medicare Program; Physicians' Referrals to Health Care Entities with*

Which They Have Financial Relationships (Phase II); Interim Final Rule, 69 Fed. Reg. 16054, 16063 (Mar. 26, 2004).

Finally, *financial relationships* come in two forms: (1) ownership or investment interests and (2) compensation arrangements. 42 U.S.C. § 1395nn(a)(2). This case turns on the latter. The statute defines *compensation arrangement* to mean "any arrangement involving any remuneration between" a doctor and a healthcare provider. *Id.* § 1395nn(h)(1)(A). And *remuneration* "includes any remuneration, directly or indirectly, in cash or in kind." *Id.* § 1395nn(h)(1)(B).

2. *Exceptions.* On its face, the Stark Act's ban sweeps in lots of common situations. To separate the fraudulent wheat from the innocuous chaff, Congress and the Department of Health and Human Services have created many exceptions. Here, the Medical Center argues that exceptions for four types of compensation arrangements could apply here: bona fide employment; personal services; fair-market-value compensation; and indirect compensation. *See id.* § 1395nn(e)(2), (e)(3); 42 C.F.R. § 411.357(*l*), (p).

All four exceptions have two elements in common. First, the doctor's compensation must not "take[ ] into account (directly or indirectly) the volume or value of" the doctor's referrals. 42 U.S.C. § 1395nn(e)(2)(B)(ii); *accord id.* § 1395nn(e)(3)(A)(v); 42 C.F.R. § 411.357(*l*)(3), (p)(1)(i). Second, the doctor's compensation must not exceed *fair market value*. 42 U.S.C. § 1395nn(e)(2)(B)(i), (e)(3)(A)(v); 42 C.F.R. § 411.357(*l*)(3), (p)(1)(i).

In litigation, these exceptions are affirmative defenses. So once a plaintiff proves a prima facie violation of the Stark Act, the burden shifts to the defendant to prove that an exception applies. *United States ex rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88, 95 (3d Cir. 2009).

3. *No built-in cause of action.* The Stark Act forbids the government to pay claims that violate the Act. 42 U.S.C. § 1395nn(g)(1). It demands restitution from those who receive payments on illegal claims. *Id.* § 1395nn(g)(2). And it creates civil penalties for submitting improper claims or taking part in schemes to violate the Act. *Id.* § 1395nn(g)(3), (4). But it gives no one a right to sue. *United States ex rel. Drakeford v. Tuomey*, 792 F.3d 364, 374 n.4 (4th Cir. 2015).

So the Stark Act never appears in court alone. Instead, it always come in through another statute that creates a cause of action—typically, the False Claims Act.

B. The False Claims Act

Under the False Claims Act, any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" is civilly liable to the United States. 31 U.S.C. § 3729(a)(1)(A). A Medicare claim that violates the Stark Act is a false claim under the False Claims Act. *Kosenske*, 554 F.3d at 94. The False Claims Act also makes liable anyone who "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)(B), (G).

IV. THE RELATORS PLEAD STARK ACT VIOLATIONS

A prima facie Stark Act violation has three elements: (1) a referral for designated health services, (2) a compensation arrangement (or an ownership or investment interest), and (3) a Medicare claim for the referred services. *See United States ex rel. Schmidt v. Zimmer*, *Inc.*, 386 F.3d 235, 241 (3d Cir. 2004). This combination of factors suggests potential abuse of Medicare. When they are all present, we let plaintiffs go to discovery.

Here, no one denies that the defendants made Medicare claims for designated health services. The issue is whether the complaint sufficiently alleges referrals and a compensation arrangement. We hold that it does. The alleged Medicare abuse is plausible and deserves more scrutiny.

A. The surgeons referred designated health services to the hospitals

The relators allege that "[e]very time [the neurosurgeons] performed a surgery or other procedure at the UPMC Hospitals, [they] made a referral for the associated hospital claims." App. 193 ¶234. They are right that these claims are referrals.

As mentioned, the law defines referrals broadly. A referral is a doctor's request for any designated health service that is covered by Medicare and provided by someone else. 42 C.F.R. § 411.351. Designated health services include bed and board, some hospital overhead, nursing services, and much more. 42 C.F.R. § 409.10(a). And the relators plead that as the surgeons performed more procedures,

those procedures required (and the hospital provided and "increased billings for[]] the attendant hospital and ancillary services including ... *hospital and nursing charges*." App. 166 ¶104 (emphasis added). So the plaintiffs plead that the surgeons referred designated health services to the hospitals.

Treating these services as referrals makes sense. The Stark Act's first step is to flag all potentially abusive arrangements. And doctors who generate profits for a hospital may be tempted to abuse their power, raising hospital bills as well as their own pay. These financial arrangements thus deserve a closer look. And they will get a closer look only if we call these arrangements what they are: doctors referring services to hospitals.

The Department of Health and Human Services agrees. In Phase I of its Stark Act rulemaking, it considered this point. It determined that "any hospital service, technical component, or facility fee billed by [a] hospital in connection with [a doctor's] personally performed service" counts as a referral. *Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships*, 66 Fed. Reg. 856, 941 (Jan. 4, 2001). This is true even "in the case of an inpatient surgery" where the doctor performs the surgery. *Id.*

Then, in Phase II of its rulemaking, the agency revisited the question and considered narrower definitions. For instance, many commenters suggested excluding "services that are performed 'incident to' a physician's personally performed services or that are performed by a physician's

employee" from the definition of a referral. 69 Fed. Reg. at 16063.

But the agency reasonably rejected these suggestions. A narrower view, it reasoned, would all but swallow at least one statutory exception. *Id.* And it explained that the availability of that and other exceptions did enough to protect innocent conduct. *Id.* "[T]his interpretation is consistent with the statute as a whole," which begins by casting a broad net to scrutinize all potential abuse. *Id.*

B. The relators' complaint alleges an indirect compensation arrangement

A referral is ripe for abuse only when the doctor who made it has a financial relationship with the provider. Only then can a doctor profit from his own referral. The financial relationship here is a compensation arrangement.

Compensation arrangements can be either direct or indirect. 42 C.F.R. § 411.354(c). The hospitals did not pay the surgeons directly. So if there is any compensation arrangement here, it is indirect. That requires three elements: First, there must be "an unbroken chain ... of persons or entities that have financial relationships" connecting the referring doctor with the provider of the referred services. *Id.* § 411.354(c)(2)(i). Second, the referring doctor must get "aggregate compensation ... that varies with, or takes into account, the volume or value of referrals." *Id.* § 411.354(c)(2)(ii). And third, the service provider must know, recklessly disregard, or deliberately ignore that the doctor's compensation "varies with, or takes into account, the volume or value of referrals."

Id. § 411.354(c)(2)(iii). (The parties do not challenge any of the regulations at issue, so we likewise assume that they are valid.) The complaint plausibly pleads enough facts to satisfy each element.

1. *An unbroken chain of entities with financial relationships connects the surgeons with the hospitals.* An unbroken chain of financial relationships links the surgeons to the hospitals. First, the Medical Center owns each hospital. Second, the Medical Center also owns three entities: Pittsburgh Physicians, Community Medicine, and Tri-State. Third, each of these three entities employs and pays at least one of the surgeons. That adds up to an unbroken chain of financial relationships. Neither party disputes this.

2. *The surgeons' compensation varies with, or takes into account, the volume and value of their referrals.* Next, the relators allege that the surgeons' aggregate compensation varied with, and took into account, their referrals. Under the Stark Act and its regulations, compensation *varies with* referrals if the two are correlated. And compensation *takes into account* referrals if there is a causal relationship between the two. The structure of the surgeons' contracts is enough to plead correlation. And the surgeons' suspiciously high compensation suggests causation.

a. The relators must show either correlation or causation between compensation and referrals. To start, we have to tease out the difference between *varies with* and *takes into account.* Section 411.354(c)(2)(ii) uses both phrases. But in other places, like the exceptions, the Stark Act and its

regulations use only *takes into account,* not *varies with.* 42 U.S.C. § 1395nn(e)(2)(B)(ii), (e)(3)(A)(v); 42 C.F.R. § 411.357(*l*)(3), (p)(1)(i). So *varies with* must mean something different from *takes into account.*

Here is the most natural reading of both phrases: *Takes into account* means actual causation. The doctor's pay must be based on or designed to reflect the volume or value of his referrals. But *varies with* means correlation. If compensation tends to rise and fall as the volume or value of referrals rises and falls, then the two vary with each other. This reading gives each phrase independent meaning. And it makes the scope of indirect compensation arrangements broader than the scope of the exceptions.

This makes sense. Correlation does not guarantee causation, but it is evidence of causation. So the agency reasonably decided to include as indirect compensation arrangements those where pay varies with referrals. 69 Fed. Reg. at 16059. That way, such arrangements get a closer look. Then, the defendant gets a chance to show that the correlation is mere coincidence, not causation. If it does, then the compensation arrangement can fit within a Stark Act exception. *Id.*

Our concurring colleague adopts a less natural reading. Instead of treating *varies with* as a broader phrase meaning correlation, he reads *takes into account* as broader. Conc. Op. 419-21. And he limits this broader phrase to causal relationships, whether explicit or "*implicit* (that is, unstated)." *Id.* So his reading of the causation requirement makes *varies with* (express causation) a subset of *takes into*

account (express or implied causation). But the Stark Act's text and structure are to the contrary.

Textually, the concurrence is right that, read in isolation, *varies with* sometimes implies causation. *Varies with* can mean correlation, however, and often does. Mathematicians sometimes use *A varies with B* causally, to mean that *A* is a function of *B*. But statisticians often say that *A* varies with *B* if *A* correlates with *B*. Thus, a correlation coefficient expresses the co-variance between two variables. Timothy C. Urdan, *Statistics in Plain English* 79-80 (2d ed., Psychology Press 2005); *see also* Paul McFedries, *Excel Data Analysis* 202 (4th ed. 2013) ("[A] correlation does not prove one thing causes another. The most you can say is that one number *varies with* the other.") (emphasis added).

Courts likewise use *varies with as* a synonym for correlation. Our Court has explained that "a correlation coefficient ... measures 'how consistently' the dependent variable *varies in correspondence with* the independent variable." *Jenkins v. Red Clay Consol. Sch. Dist. Bd. of Educ.*, 4 F.3d 1103, 1120 n.10 (3d Cir. 1993) (emphasis added). Other courts do too. *E.g.*, *N.A.A.C.P. v. City of Niagara Falls*, 65 F.3d 1002, 1005 n.2 (2d Cir. 1995) ("A 'correlation coefficient' is generated, demonstrating how consistently voter support for a candidate or group of candidates *varies with* the racial composition of the election districts.") (emphasis added) (quoting district court); *Citizens for a Better Gretna v. Gretna*, 636 F. Supp. 1113, 1126 n.32 (E.D. La. 1986) (same). So we can plausibly read *varies with* to mean correlation, not just causation.

And that is the point. Here, *varies with* is about correlation, not causation. As our concurring colleague notes, we do not think the Stark Act requires relators to plead a "perfect positive correlation" between doctors' pay and referrals. Conc. Op. 421. The beauty of the phrase *varies with* is that it carries little technical baggage yet "make[s] clear that there is no need to establish causation." Loan Originator Compensation Requirements Under the Truth in Lending Act (Regulation Z), Supplementary Information, 78 Fed. Reg. 11280, 11325-26 (Feb. 15, 2013) (explaining that the final rule uses *varies with* as a non-technical substitute for *correlates with*).

More importantly, as he admits, our concurring colleague's approach makes *varies with* into surplusage, robbing it of any useful role in the regulatory scheme. Conc. Op. 422. In 42 C.F.R. § 411.354(c)(2)(ii), for example, *varies with* would be redundant of every *takes into account.* It would do no work. By contrast, our reading casts *varies with* as the star of § 411.354(c)(2)(ii). *Takes into account* gets its turn to shine in the Stark Act exceptions, where *varies with* does not appear. *Id.* §§ 411.355, 357. On this reading, the scope of indirect compensation arrangements is broader than the scope of the exceptions. Each phrase does real work and serves an independent purpose.

Faced with two readings, one of which gives each phrase in a disjunctive list an operative meaning and another that makes a phrase surplus, we should follow the "elementary canon of construction" against surplusage. *Colautti v. Franklin*, 439 U.S. 379, 392, 99 S.Ct. 675, 58 L.Ed.2d 596 (1979); *United States v.*

Kouevi, 698 F.3d 126, 133-34 (3d Cir. 2012) (collecting cases).

Structurally, our approach also reinforces the Stark Act's design. It casts a wide net of initial suspicion, followed by narrower safe harbors. A correlation between pay and referrals suggests that hospitals are rewarding doctors for referrals. And healthcare providers get to use the Stark Act's exceptions to show that there is no problematic causal relationship. Only if they cannot should those cases go to discovery.

Our concurring colleague's approach would upend that structure by denying relators the discovery they need to prove their cases. In *Tuomey*, for example, hospital insiders linked pay with referrals only during discovery—not in the complaint. *Compare* First Amended Complaint, *United States ex rel. Drakeford v. Tuomey*, 976 F. Supp. 2d 776 (D.S.C. 2013) (No. 3:05-2858-MBS), ECF No. 151, *with* J.A. Combined Vols. I—XIII at 504-14, *Tuomey,* 792 F.3d 364 (No. 13-2219), ECF No. 39 (testimony of William (Paul) Johnson) (Tuomey's CFO admitting that he feared losing money if doctors treated patients offsite, so he analyzed the value of doctors' noncompete agreements that might recapture that revenue by requiring them to do their procedures at Tuomey's hospitals); *id.* at 1809-22 (testimony of Kimberly Saccone) (same, by senior consultant); *id.* at 335, 4594 (statement by Tuomey's lawyer Tim Hewson to CEO, several vice presidents, and key doctors at a recorded meeting on Jan. 19, 2004) ("Because of the Stark and Anti-kickback laws, you can't explicitly say, 'Well, it's because we're getting

all the referrals for these patients,' and of course that's what we're doing.").

And *Tuomey* was a close case at the motion-to-dismiss stage. Tuomey itself had received conflicting legal advice about whether its contracts violated the Stark Act. *Compare Tuomey*, 792 F.3d at 371-72 (advice from lawyer Kevin McAnaney), *with* First Am. Compl. 25 ¶¶97-98 (advice from law firm Hall & Render). The truth emerged only through the cleansing light of discovery, once the relators got to depose hospital executives and transcribe audio recordings of executive meetings. But our concurring colleague's approach would shut that door, dismissing such cases before discovery. That would make it all but impossible for the relator in the next *Tuomey* to prevail.

In short, at the pleading stage, a plaintiff must plead facts that make *either* correlation or causation plausible. Here, the relators do both.

b. The structure of the surgeons' contracts plausibly alleges correlation between their pay and referrals. The relators plead that two aspects of the surgeons' pay varied with their referrals: base salaries and bonuses. If the surgeons met their quota of Work Units, they protected their base salaries. And if they exceeded that quota, they earned a bonus for each additional Work Unit.

So the surgeons' pay was facially based only on the services they personally performed. But every time they "performed a surgery or other procedure at the UPMC Hospitals, [they] made a referral for the associated hospital claims," like nursing services or

hospital overhead. App. 193 ¶ 234. And the defendants got to bill Medicare for those referred services, which could be worth many times more than the surgeon's own services.

As a result, the surgeons' salaries rose and fell with their referrals. The more procedures they did at the hospitals, the more referrals they made, and the more they would earn by maintaining their base salaries and earning higher bonuses. And just as their salaries flowed, they also ebbed: the fewer procedures they did, the fewer referrals they made, and the less they got paid. Thus, their aggregate compensation varied with their referrals' volume and value.

The Fourth Circuit agrees. In *Tuomey*, as here, the doctors' base salaries and bonuses rose and fell each year "based solely on" their "personally performed professional services." 792 F.3d at 379 (internal quotation marks omitted). Our concurring colleague reads the Fourth Circuit's opinion as limited to compensation agreements that expressly give doctors a cut of expenses like technical or facility fees, beyond the work doctors do personally. Conc. Op. 422-23. But that reading overlooks *Tuomey*'s facts.

The *Tuomey* court did not say that the doctors there took a straight percentage cut of referrals. It says only that as doctors did more procedures, the number of Tuomey's referrals went up—and so did the doctors' compensation. *See* 792 F.3d at 379.

And the briefing in *Tuomey* clarifies any possible ambiguity about which collections affected pay by falling within the scope of a doctor's "personally

performed professional services." *Id.* (internal quotation marks omitted). The hospital there insisted that "[n]o component of the physicians' pay depended on the amount of Tuomey's charges or collections for facility fees." Appellant's Final Br. 44, *Tuomey*, 792 F.3d 364 (No. 13-2219), ECF No. 50. In fact, the hospital had rejected "suggested modifications" to its contracts that would have made "technical fees ... a component of the physicians' compensation." *Id.* Contrary to our concurring colleague, the *Tuomey* record shows that the doctors' pay was "based on their professional collections for services that they personally perform[ed], *not* on any billings or collections of the Hospital for its services." Mem. in Supp. of Def.'s Mot. to Dismiss 5, *Tuomey*, 976 F. Supp. 2d 776, ECF No. 64-1 (emphasis added). The same is true here.

But as the Fourth Circuit observed, these personally performed services almost always came with referrals for ancillary hospital services. 792 F.3d at 379. And the healthcare provider got to bill Medicare for those services. *Id.* The more procedures a doctor did at the hospital, the more referrals he made, and the more he could make in both base salary and bonuses. *Id.* Thus, the Fourth Circuit "th[ought] it *plain* that a reasonable jury could find that the physicians' compensation varied with the volume or value of actual referrals." *Id.* at 379-80 (emphasis added).

We agree with the Fourth Circuit's logic. It applies equally here. So the relators have pleaded that the surgeons' pay varied with their referrals.

Our concurring colleague fears that our rationale casts suspicion on any compensation agreement based on a doctor's "own labor." Conc. Op. 423. Not so. The Stark Act kicks in only when a doctor's pay varies with Medicare or Medicaid referrals tied to that doctor's personal labor. If a doctor's pay does not vary with the volume or value of Medicare or Medicaid referrals, the Stark Act plays no role.

But here, the relators have pleaded that the doctors' pay correlated with the value of their Medicare referrals. That correlation is enough to plead the second element of an indirect compensation arrangement. The relators need not also plead causation. But they do anyway.

c. The surgeons' suspiciously high compensation suggests causation. Compensation for personal services above the fair market value of those services can suggest that the compensation is really for referrals. This is just common sense. Healthcare providers would not want to lose money by paying doctors more than they bring in. They would do so only if they expected to make up the difference another way. And that way could be through the doctors' referrals.

This may not be obvious on the face of the statute and regulations. The Stark Act often treats *fair market value* as a concept distinct from *taking into account the volume or value of referrals.* For example, these two concepts are separate elements of many Stark Act exceptions. *E.g.*, 42 U.S.C. § 1395nn(e)(2) (bona fide employment), (e)(3) (personal service); 42 C.F.R. § 411.357(*l*) (fair-market-value compensation), (p) (indirect compensation). And the definition of an

indirect compensation arrangement includes taking referrals into account, but not fair market value. 42 C.F.R. § 411.354(c)(2)(ii).

But the Act's different treatment of these concepts does not sever them. To start, just because a statute has two elements does not mean that one can never be evidence of the other. Theft requires taking another's property with intent. Those are two elements, but the fact of taking property can be circumstantial evidence of intent.

So too here. Perhaps not all payments above fair market value are evidence of taking into account the doctor's referrals. But common sense says that marked overpayments are a red flag. Anyone would wonder why the hospital would pay so much if it was not taking into account the doctor's referrals for other services. And we do no violence to the statutory text by seeking an answer to that question.

The agency confronted this question directly. It remarked that even "fixed aggregate compensation can form the basis for a prohibited ... indirect compensation arrangement" if it "is *inflated* to reflect the volume or value of a physician's referrals." 69 Fed. Reg. at 16059 (emphasis added). The same is true of "unit-of-service-based compensation arrangements," like the one here. *Id.* Excessive compensation is thus a sign that a surgeon's pay in fact takes referrals into account.

So aggregate compensation that exceeds fair market value is smoke. It suggests that the compensation takes referrals into account. And the relators here plead five facts that, viewed together,

make plausible claims that the surgeons' pay exceeded their fair market value. First, some surgeons' pay exceeded their collections. Second, many surgeons' pay exceeded the 90th percentile of neurosurgeons nationwide. Third, many generated Work Units far above industry norms. Fourth, the surgeons' bonus per Work Unit exceeded what the defendants collected on most of those Work Units. And finally, the government alleged in its settlement agreement that the Medical Center had fraudulently inflated the surgeons' Work Units. That much smoke makes fire plausible.

i. Pay exceeding collections. Paying a worker more than he brings in is suspicious. And the complaint alleges that at least three surgeons (Drs. Bejjani, Spiro, and El-Kadi) were paid more than the Medical Center collected for their services. The complaint also alleges that the Medical Center credits surgeons with 100 percent of the Work Units that they generate, even if it cannot collect on all of them. So at least three surgeons (maybe more) were paid more than they bring in.

ii. Pay exceeding the 90th percentile. The relators allege that "[c]ompensation exceeding the 90th percentile is widely viewed in the industry as a 'red flag' indicating that it is in excess of fair market value." App. 191 ¶223. The defendants do not deny this.

Several surgeons were paid more than the 90th percentile. For example, the relators point to the compensation of Drs. Abla, Spiro, Kassam, and Bejjani between 2008 and 2011. Apart from Dr. Spiro in 2008, each of these surgeons was paid more than

even the highest estimate of the 90th percentile for all U.S. neurosurgeons in all four years. And depending on which estimate of the 90th percentile you use, they were sometimes paid two or three times more than the 90th percentile. Dr. Bejjani's 2011 bonus alone exceeded the 90th percentile of total compensation in some surveys.

iii. Extreme Work Units. The relators also allege facts from which we can reasonably infer that the surgeons generated far more Work Units than normal. Many neurosurgeons "were routinely generating [Work Units] exceeding by an enormous margin the 90th percentile as reflected in widely-accepted market surveys." App. 171 ¶ 126. Even if we look only at the highest industry estimates, all but one of the surgeons reported Work Units above the 90th percentile in 2006 and 2007. In 2008 and 2009, eight of the twelve named surgeons exceeded the highest estimate of the 90th percentile. A few even seemed "super human," racking up *two to three times* the 90th percentile. App. 169 ¶ 117.

In short, most of the surgeons generated Work Units at or above the 90th percentile. Some of their numbers were unbelievably high. And because their pay depends in large part on their Work Units, it is fair to infer that most of their pay was also at or above the 90th percentile.

iv. Bonuses exceeding the Medicare reimbursement rate. Once a surgeon had enough Work Units to earn bonus pay, the bonus per Work Unit was more than Medicare would pay for each one. The surgeons' bonus per Work Unit was $45. But the Medicare reimbursement rate was only

about $35. So once surgeons became eligible for bonuses, the defendants took an immediate loss on every Work Unit submitted to Medicare.

On its own, this would not show that the surgeons were overpaid. Medicare and Medicaid are well known as bottom-billers. They pay less than private insurers. Though the defendants lost some money on Medicare Work Units, perhaps they made it back with Work Units billed to other insurers.

But the relators also allege that "the majority of all claims submitted by the [defendants] ... were submitted to federal health insurance programs such as Medicare and Medicaid." App. 193 ¶233. We cannot assume that private payments suffice to make up the difference. Doing so would disregard our job at this stage: to draw reasonable inferences in favor of the plaintiffs.

In short, the defendants took an immediate financial hit on Work Units for a majority of their claims. This is yet another sign that the surgeons' pay took referrals into account.

The defendants disagree. They argue that the surgeons earn high salaries because of bona fide bargaining with their employers. Their salaries supposedly represent the market's demand for their surgical skill and experience.

This argument fails for two reasons. First, the complaint says nothing about the surgeons' skill and experience or the Pittsburgh market for surgeons. On this motion to dismiss, we cannot go beyond the well-pleaded facts in the complaint.

Second, a bare claim of bona fide bargaining is not enough. The Stark Act recognizes that related parties often negotiate agreements "to disguise the payment of non-fair-market-value compensation." *Kosenske*, 554 F.3d at 97. We trust that bona fide bargaining leads to fair market value only when neither party is "in a position to generate business for the other." *Id.*; 42 C.F.R. § 411.351 (defining "fair market value" and "general market value"). But that is not true here. The surgeons and the Medical Center can generate business for each other. So we cannot assume that any bargaining was bona fide or that the resulting pay was at fair market value.

v. The possibility of fraud. Finally, the surgeons' high pay may have been based on fudging the numbers. Not only were their individual Work Units "significantly out of line with industry benchmarks," but the Neurosurgery Department as a whole realized astounding "annual growth rates of work [Units] ... of 20.3%, 57.1% and 20.0%" in 2007, 2008, and 2009. App. 171 ¶¶127-28. Two of the surgeons more than doubled their output in just a few years. The relators allege that the defendants got this growth by "artificially inflat[ing] the number of [Work Units] in a number of ways." App. 171 ¶130.

Alleging this fraud, the relators' first complaint included claims "relating to physician services submitted by" the defendants along with the "hospital claims" currently before us. App. 189 ¶217 (emphases in original) The government chose to intervene as to the former claims, settling them with the defendants for almost $2.5 million.

The relators' current complaint quotes that settlement agreement. In it, the government accused the surgeons of many fraudulent practices: They claimed to have acted as assistants when they did not. They claimed to have done more extensive surgeries than they did. And they chose the wrong codes for surgeries. So "claims submitted for these physician services resulted in more reimbursement than would have been paid" otherwise. App. 188-89 ¶216.

We are careful not to overstate the point. This settlement is not an admission of guilt. It proves no wrongdoing. But at the 12(b)(6) stage, we are looking only for plausible claims, not proof of wrongs. And the government's choice to intervene after years of investigation and its allegations in the settlement are cause for suspicion.

The question is not whether a doctor was able to use an otherwise-valid compensation scheme as a vehicle for fraudulent billing. Not every fraudulent Medicare bill made at a hospital will give rise to a Stark Act violation. Here, however, where the compensation scheme produced results bordering on the absurd, relators plausibly assert that the system may have been designed with that outcome in mind.

The relators allege five sets of facts that suggest that the surgeons' pay exceeded fair market value: pay exceeding collections, pay above the 90th percentile, extreme Work Units, bonuses above the Medicare reimbursement rate, and the settlement. That is plenty of smoke. We need not decide whether any of these allegations alone would satisfy the relators' pleading burden. Together, they plausibly

suggest that the surgeons' pay took their referrals into account.

* * * * *

So the relators have met their burden twice over. They allege that the surgeons' pay correlated with their referrals. That alone is enough to meet their burden. They also plausibly allege causation. Thus, the relators have pleaded more than enough facts to suggest an indirect compensation arrangement.

3. *The hospitals knew that the surgeons' compensation varied with, or took into account, referrals.* The final element of an indirect compensation arrangement is scienter. To show scienter, the relators' pleadings must allege that the hospitals that provided the referred services either (1) knew, (2) deliberately ignored, or (3) recklessly disregarded that the surgeons got "aggregate compensation that varie[d] with, or t[ook] into account, the volume or value of referrals." 42 C.F.R. § 411.354(c)(2)(iii). They allege this too.

To begin, the Medical Center controls all the hospitals and the surgeons' direct employers. It owns each hospital. And it owns Pittsburgh Physicians, Community Medicine, and Tri-State. So the Medical Center "has unfettered authority with respect to most members of the [medical system] and significant authority (including with respect to financial and tax matters) with respect to the remaining members." App. 146-47 ¶19 (quoting a Medical Center tax filing).

Further, many officers and board members of these entities overlapped. For example, one person

simultaneously served as an executive vice president of the Medical Center as well as the president and a board member of Pittsburgh Physicians. And he signed surgeons' pay agreements for Pittsburgh Physicians. The relators identify nine others who served on the board of both the Medical Center and another entity in the medical system. Authority was so centralized that a single person signed a settlement agreement on behalf of all the defendants that were part of the medical system. And with common control comes common knowledge.

The common knowledge included both the surgeons' pay and their referrals. The Medical Center took part in forming, approving, and implementing the surgeons' pay packages. So it knew their structure. The Medical Center also had a central coding and billing department that handled billing for its subsidiaries. So it knew about the surgeons' referrals.

With both sets of data in front of it, we can plausibly infer that the Medical Center knew the surgeons' compensation varied with or took into account their referrals. And as the Medical Center knew that, so did the hospitals. They had all the data right in front of them. They knew that the surgeons' pay and Work Units were out of line with industry survey data. Even if they did not actually know that the surgeons' pay was correlated with their referrals, they at least deliberately ignored or recklessly disregarded that fact. Thus, the complaint alleges that both the Medical Center and hospitals had scienter.

* * * * *

This means that the relators have successfully pleaded the third and final element of a Stark Act violation: scienter. But they must plead one more thing to survive a motion to dismiss. We must now consider whether the relators have pleaded a plausible prima facie case under the False Claims Act.

V. THE RELATORS PLEAD FALSE CLAIMS ACT VIOLATIONS

The relators plead their Stark Act claims as violations of the False Claims Act. So their pleadings must satisfy all the elements of the False Claims Act. They do. And they satisfy Rule 9(b)'s heightened pleading standard. Last, we hold that the Stark Act's exceptions are not additional elements of a prima facie case. But even if they were, the relators have plausibly pleaded that no exception applies here.

A. The pleadings satisfy all three elements of the False Claims Act

To make out a prima facie case, the relators must plead three elements: " '(1) the defendant presented or caused to be presented to an agent of the United States a claim for payment; (2) the claim was false or fraudulent; and (3) the defendant knew the claim was false or fraudulent.' " *Schmidt*, 386 F.3d at 242 (quoting *Hutchins v. Wilentz, Goldman & Spitzer*, 253 F.3d 176, 182 (3d Cir. 2001)). They have alleged enough facts to plead all three elements.

First, by submitting claims to Medicare and other federal health programs, the defendants presented claims for payment to the government.

Second, the relators allege that these claims were false. A Medicare claim that violates the Stark Act is a false claim. *Kosenske*, 554 F.3d at 94. And we have already explained at length why the Medicare claims here plausibly violated the Stark Act.

Third, the relators' allegations plead scienter. Just like the Stark Act, the False Claims Act requires that the defendants know, deliberately ignore, or recklessly disregard the falsity of their claim. 31 U.S.C. § 3729(b)(1)(A). But it does not require a specific intent to defraud. *Id.* § 3729(b)(1)(B).

The claims are false because they allegedly violated the Stark Act. The question is whether the defendants at least recklessly disregarded that possibility. The defendants had a centralized billing department and were familiar with the Stark Act itself, so they knew that they submitted Medicare claims for referred designated health services. That leaves only whether the defendants knew that the hospitals and surgeons had an indirect compensation agreement.

The complaint alleges that the defendants at least recklessly disregarded that possibility. They knew their own corporate structure. We have already explained how they knew or recklessly disregarded that the surgeons' pay varied with their referrals. And we have also explained how they knew or recklessly disregarded that their surgeons' pay exceeded fair market value and thus plausibly took referrals into account. So the relators have pleaded a prima facie claim under the False Claims Act.

B. The pleadings satisfy Rule 9(b)

The relators' complaint also satisfies Rule 9(b)'s particularity requirement. This requires a plaintiff to allege " 'all of the essential factual background that would accompany the first paragraph of any newspaper story—that is, the who, what, when, where, and how of the events at issue.' " *Majestic Blue Fisheries*, 812 F.3d at 307 (quoting *In re Rockefeller Ctr. Props., Inc. Secs. Litig.*, 311 F.3d 198, 217 (3d Cir. 2002)). The complaint gives us all these necessary details:

- Who? The defendants: the Medical Center and Pittsburgh Physicians.
- What? The defendants submitted or caused to be submitted false Medicare claims.
- When? From 2006 until now.
- Where? The Medicare claims were submitted from the Medical Center's centralized billing facility, while the referred services were provided at the Medical Center's twenty hospitals.
- How? When the Medical Center submitted a claim, it certified compliance with the Stark Act. The complaint makes all the allegations discussed above. We will not repeat them. But they detail exactly how these claims violated the Stark Act.

Rule 9(b) does not require the relators to plead anything more, such as the date, time, place, or content of every single allegedly false Medicare claim. The falsity here comes not from a particular

misrepresentation, but from a set of circumstances that, if true, makes a whole set of claims at least prima facie false. It is enough to allege those circumstances with particularity. Doing so "inject[s] precision or some measure of substantiation into [the] fraud allegation" and "place[s] the defendant on notice of the precise misconduct with which [it is] *charged." Alpizar-Fallas v. Favero*, 908 F.3d 910, 919 (3d Cir. 2018) (quoting *Frederico v. Home Depot*, 507 F.3d 188, 200 (3d Cir. 2007)) (last alteration in original; internal quotation marks omitted). And the relators have done so.

C. Pleading Stark Act exceptions under the False Claims Act

One final issue is how the Stark Act interacts with the False Claims Act. The defendants argue that the False Claims Act's elements of falsity and knowledge turn the Stark Act's exceptions into prima facie elements of the False Claims Act. On their reading, the relators would have to plead that no exception applies here.

We reject that argument. The defendants retain the burden of pleading Stark Act exceptions even under the False Claims Act. And even if the relators bore that burden, they have met it here.

1. *The burden of pleading Stark Act exceptions stays with the defendant under the False Claims Act.* The defendants argue that the False Claims Act's knowledge and falsity elements turn the Start Act's exceptions into prima facie elements. Their logic is simple and cogent: The False Claims Act penalizes only false claims. 31 U.S.C. § 3729(a)(1). False claims

include claims submitted in violation of the Stark Act. *See Kosenske*, 554 F.3d at 94. But if an exception to the Stark Act applies, then the claim is not false. And if the defendant thinks that an exception applies, then the defendant does not know that the claim is false. So, according to the defendants, to plead a False Claims Act claim based on Stark Act violations, a relator must plead that no Stark Act exception applies and that the defendant knows that none applies. Otherwise, the relator pleads neither falsity nor knowledge.

Though this argument has force, we reject it. Our precedent compels this result. Like this case, *Kosenske* was a False Claims Act case based on Stark Act violations. *Id.* It placed the burden of proving a Stark Act exception on the defendant. *Id.* at 95; *accord Tuomey*, 792 F.3d at 374. And we see no reason to split up the burdens of pleading and persuasion. It is thus the defendants' burden to plead a Stark Act exception, not the relators' burden to plead that none exists.

2. *Even if the relators bore this pleading burden, they have met it.* In any event, the relators here plausibly plead that no Stark Act exception applies. The parties identify four that could apply here: exceptions for bona fide employment, personal services, fair-market-value pay, and indirect compensation. All four exceptions require that the surgeons' compensation not exceed fair market value and not take into account the volume or value of referrals.

We have already explained how the relators plausibly plead that the surgeons were paid more

than fair market value. And that itself suggests that their pay may take into account their referrals' volume or value. So the relators plausibly plead that no Stark Act exception applies.

D. Practical concerns

Our concurring colleague raises legitimate concerns about opening the floodgates of litigation. Top hospitals that offer doctors performance bonuses, he argues, could be sued and forced to suffer through discovery or to settle.

Although understandable, this fear is overstated. *Qui tam* actions face hurdles even before they reach a motion to dismiss. The government can dismiss them over the relator's objection. 31 U.S.C. § 3730(c)(2)(A). Federal courts are not the first line of defense against abusive suits; the Justice Department is. Indeed, it recently took a more aggressive approach to dismissing *qui tam* actions, urging its lawyers to consider dismissal every time the government decides not to intervene. Michael D. Granston, U.S. Dep't of Justice, Memorandum: Factors for Evaluating Dismissal Pursuant to 31 U.S.C. 3730(c)(2)(A), at 1 (2018).

While our Court has not yet specified the standard of review for a § 3730(c)(2)(A) dismissal, our sister circuits defer a great deal to the Justice Department. *Swift v. United States*, 318 F.3d 250, 252 (D.C. Cir. 2003) (recognizing the government's "unfettered right" to dismiss *qui tam* actions); *United States ex rel. Sequoia Orange Co. v. Baird-Neece Packing Corp.*, 151 F.3d 1139, 1145 (9th Cir. 1998) (adopting a "rational relation" test for reviewing dismissals).

That deference gives the government plenty of room to make good on its stated intention to scrutinize and dismiss more *qui tam* actions than in the past. So there is little reason to fear that a flood of frivolous cases will reach discovery.

VI. CONCLUSION

Evaluating a motion to dismiss is "a context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Iqbal*, 556 U.S. at 679, 129 S.Ct. 1937. Our experience and common sense tell us that the relators state a plausible claim that the Medical Center and Pittsburgh Physicians have violated the Stark Act and the False Claims Act.

The facts they plead, if true, satisfy every element of those statutes: A chain of financial relationships linked the surgeons to the hospitals. The surgeons referred many designated health services to the hospitals, generating ancillary hospital services and facility fees. Their pay necessarily varied with the volume of those referrals. The hospitals made Medicare claims for those referrals. And the defendants allegedly knew all this.

With all this smoke, a fire is plausible. So this case deserves to go to discovery. Once the discovery is in, it may turn out that there is no fire. We do not prejudge the merits. But this is exactly the kind of situation on which the Stark and False Claims Acts seek to shed light. We will thus reverse the District Court's dismissal and remand for further proceedings.

AMBRO, Circuit Judge, concurring in the judgment

The Stark Act prescribes strong medicine for a very specific evil. The core concern is that if doctors have financial interests in other medical service providers, they will have a monetary incentive to refer patients to those providers, even if that is not in the patient's best interest. For example, if a doctor owns a stake in an entity that does blood tests and other lab work, she or he might send patients to that entity for tests even though it is not as good as its competitors, or might recommend tests that the patient does not truly need. The key is that the doctor has a financial interest in the services that someone else performs.

That is very different from this case. The physicians operating at UPMC's neurosurgery department are, according to the terms of their contracts, paid for the work they personally perform. True, this encourages the surgeons to perform more procedures, creating a similar potential for misaligned interests as the arrangements proscribed by the Stark Act. And true, the relators have alleged significant fraud by the hospital, inflating the work these surgeons performed and billing the Government for things that never happened. The majority places great emphasis on the general atmospherics of fraud around UPMC, and certainly if these allegations are true, then the hospital has much it must answer for.

But the Stark Act is not concerned with general fraud and misrepresentation. Those claims were addressed by UPMC's settlement with the Government. Nor, as I read the statute and its accompanying regulations, are they concerned with

the entirely standard compensation structure between UPMC and these surgeons. The majority makes much of the notion that where there is smoke, there might also be fire, and I am sympathetic to that approach. In this case, however, I worry we are sending signals to hospitals throughout the Third Circuit, and the nation, that their routine business practices are somehow shady or suspicious and could leave them vulnerable to significant litigation, with all the trouble and expense that brings. Accordingly, I do not join in all the majority opinion's reasoning.

I do, however, agree with many of my colleagues' conclusions—enough that I am able to concur in allowing the case to proceed at this time. The Court is correct that there are referrals when one of the surgeons employed by UPMC's subsidiary UPP performs a procedure at a UPMC hospital. Although the physician's own part in the surgery is not a referred service, everything else that goes into the operation is, from the operating room itself to the equipment to the other hospital employees—nurses, anesthesiologists, medical technicians, and so on—involved. This is the "technical component of the surgical service." *See Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase I)*, 66 Fed. Reg. 856, 941 (Jan. 4, 2001). Because these are referred services for which the hospital billed Medicare, two of the three elements of a Stark Act violation are present. *See* Maj. Op. at 405-06 (stating the elements of a Stark Act claim as "(1) a referral for designated health services, (2) a compensation arrangement (or an ownership or investment interest), and (3) a

Medicare claim for the referred services."). The only question is whether there was a "compensation arrangement" within the meaning of the statute and regulations.

I also agree with the majority that the burden of pleading Stark Act exceptions falls on the defendants. We held in *United States ex rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88 (3d Cir. 2009), that these exceptions function as affirmative defenses. In theory things may be different in the context of a False Claims Act suit, where the relators bear the burden of proving intent and therefore must plead that the defendants knew the claims they submitted were false. If they fail to do so, it would likely be appropriate to dismiss on that basis. But the majority persuasively explains why that is not what we have at this time: because the language of the exceptions tracks the relevant definition of a compensation arrangement, it is virtually impossible that the exceptions could apply if the defendants are covered by the Stark Act in the first place. Moreover, in order to invoke any of the exceptions, the defendants would have to show compensation that did not exceed fair market value, and the majority aptly explains why, at least at the motion-to-dismiss stage, the complaint plausibly alleges that the defendants knew the compensation here did exceed that standard.

And I agree with the Court that the relators have adequately pleaded a causal relationship between the physicians' referrals to UPMC and their compensation. This is a close question for me, because many of the factors the majority points to as suspicious and indicating causation would likely be

present in many cases where nothing untoward has occurred. For example, aggregate compensation above the 90th percentile will be found, after all, in 10% of all cases by definition. The relators make much of the fact that the bonus for each "work relative value unit" ("wRVU") exceeds the Medicare reimbursement rate, but statistics cited in the complaint itself suggest that the $45/wRVU rate is actually below the national average compensation per wRVU. See Appellee's Br. at 49. (Dividing the listed median total compensation figures by the median wRVU totals from 2009 suggests a rate between $50 and $70 per wRVU. This is not mathematically precise, because these are median rather than average figures, but it is clear enough that $45 per wRVU is not aberrantly high. The difference is presumably made up through non-Medicare patients being charged at significantly higher rates.) Thus, for me, that the physicians accrued large wRVU totals does not especially suggest that their rate of compensation was excessive.

Another problem I have is the possibility that UPMC may have defrauded the Government by inflating the physicians' wRVU totals does not suggest that the surgeons were compensated for the value of their referrals, but that they were compensated for nothing, as the hospital (if these allegations are true) simply stole money from the Government and distributed some of those ill-gotten gains to the surgeons. That may well have been illegal, but it is not the kind of illegality covered by the Stark Act. Instead, these fraud claims were covered by the Government's $2.5 million settlement

with UPMC (which, for an organization that so dominates the market, is a modest figure), and are no longer before us.

I am therefore concerned if any one of these factors, standing alone, would be enough to raise a plausible inference of a Stark Act violation. But as the majority rightly notes, we are not dealing with only one of these indicators but with all of them together. In this context, I agree that there is enough "smoke," as the Court puts it, at this early stage. Very possibly there is no Stark Act problem here (whatever other problems there may have been with the UPMC neurosurgery department). But the collection of suspicious circumstances argues that the case should proceed to discovery so that we can find out one way or the other. I therefore concur in reversing the District Court and denying the motion to dismiss.

I write separately, however, because I cannot agree with the majority that the relators met their burden simply by pleading that the neurosurgeons' compensation *correlated* with the volume or value of their referrals. To show a compensation arrangement as defined by the Stark Act, relators must establish a number of elements, and, as the majority correctly states, only one of those elements is in doubt here: Did the surgeons receive "aggregate compensation ... that *varies with, or takes into account*, the volume or value of referrals" from the surgeons to UPMC (emphasis added)? My colleagues understand the phrase "takes into account" to mean an express cause-and-effect relationship between referrals and compensation, while "varies with," on its understanding, applies to any situation in which the physicians' compensation correlates with the volume

or value of their referrals. This means any situation where, if one tends to be higher, the other tends to be higher as well.

I disagree, as I do not think that this language includes cases of mere correlation standing alone. To begin with, I have some doubt that the drafters of this regulation actually intended for there to be much difference between "varies with" and "takes into account." But assuming that a difference does exist, I would most naturally read "varies with" to mean that compensation is *expressly* based, at least in part, on the volume or value of referrals. "Takes into account," then, is a broader term that can include *implicit* (that is, unstated) causal relationships *as well as explicit ones*, but still requires more than mere correlation.

These relationships are somewhat difficult to understand in the abstract (set theory is notoriously counterintuitive), so here is an example of how the concepts might play out. If one physician's contract provided for a certain base salary (say, $250,000) and then a bonus equal to a percentage of the hospital's revenues from any referred services, that would be compensation that "varies with" referrals. On the other hand, if another surgeon's contract only provides for a flat annual salary (say, $450,000), but there is evidence that the hospital chose the higher number because of the value it derived from the surgeon's referrals, that would be compensation that "takes into account" referrals, even though it does not expressly "vary with" them. Of course, if compensation explicitly "varies with" referrals, then it will also "take [them] into account," as on my reading the former is a subset of the latter.

As I read the regulations, however, neither term includes cases of correlation standing by itself without any alleged causal relationship.[1] This is consistent with common usage. If a baseball player's contract provided him a bonus for every base hit during the course of a season, we would not say that his compensation "varied with" his total number of runs batted in, even though hits and RBIs are closely correlated. The only dictionary I have found offering a definition of "varies with" is "to become different based on or according to some determining factor," or "to change according to something." *Vary with*, Idioms by The Free Dictionary, https://idioms.thefreedictionary.com/vary+with (last accessed August 15, 2019). Thus, in order for compensation to "vary with" a certain factor, that factor must be an express input to the compensation formula. Thus, where a surgeon gets a flat $250,000 annually but with an added referral bonus for the hospital's facility fee, the referral fees are an express input into the higher-than-$250,000 total compensation.

The majority acknowledges this usage of "vary with," yet goes on to suggest that statisticians (as distinct from mathematicians, apparently) also use it to mean simple correlation. And, to be fair, it does cite a handful of examples of the phrase being used this way. Several of the authorities it cites for this proposition, however, do not actually use the phrase. Our Court's decision in *Jenkins v. Red Clay Consol.*

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[1] The majority evidently agrees that "takes into account" suggests a causal relationship. I therefore focus on the interpretation of "varies with," which is where we disagree.

Sch. Dist. Bd. of Educ., 4 F.3d 1103, 1120 n.10 (3d Cir. 1993), instead used "varies in correspondence with." This is a meaningful distinction because "in correspondence with" contemplates simply that two things tend to move together *(i.e.*, are correlated), not that one of them changes directly as a function of the other. And the book on general statistics cited, as opposed to the one on data analysis in Microsoft Excel, offers only an explanation of the basic concepts of correlation; the phrase "vary with" or "varies with" does not appear either at the cited pages or elsewhere in the work. *See* Timothy C. Urdan, *Statistics in Plain English* 79-80 (3d ed., Psychology Press 2010).

That exposition of correlation does, however, expose a further problem with the majority's reading: correlation is not an absolute matter. Rather, it ranges from a perfect positive correlation of +1.00 to a perfect negative correlation of -1.00. *Id.* at 80. At what point along this range would the majority say that compensation "varies with" the volume or value of referrals? A correlation coefficient above 0.50? Above 0.75? The majority notes this ambiguity but does not resolve it, instead claiming that this lack of "technical baggage," Maj. Op. at 408, is a point in its favor.[2]

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[2] Indeed it is not clear from the majority's reading that a *negative* correlation would not suffice to show compensation that "varies with" referrals under the Stark Act regulations. The Federal Register commentary on a rule pertaining to the Truth in Lending Act that did use "vary with" essentially as a synonym for correlation made clear that the relationship could be positive or negative, so long as it is "consistent" *See* Loan Originator Compensation Requirements Under the Truth in

Of course, there is nothing before us to suggest exactly what the correlation coefficient is here. Instead we have only the general sense that two things will tend to happen at the same time. As UPMC points out, that is only a rough tendency. Two neurosurgeons might perform surgeries at UPMC on the same day each involving 10 wRVUs from the surgeons, but one surgery involves $100 of referrals to the hospital for facility services while the other involves $1,000. Under the contract in this case, those two surgeons would be paid the same amount for their two procedures (effectively $450, or $45 per wRVU, assuming they have enough wRVUs to get their productivity bonus for the year). How, then, can we say that compensation "varies with, or takes into account," the volume or value of referrals when two procedures with the same wRVUs, but wildly different amounts of referrals, will result in the same compensation?

The majority charges that my reading of the statute creates surplusage because I see "varies with" as a subset of "takes into account." There would thus be no meaningful difference between the full phrase "varies with, or takes into account," which appears three times in 42 C.F.R. § 411.354, and "takes into account" standing on its own, which appears three more times in § 411.354 and throughout § 411.357 (which defines the exceptions to the definition of compensation arrangements from § 411.354). That is correct; as noted, I suspect the

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Lending Act (Regulation Z), Supplementary Information, 78 Fed. Reg. 11280, 11326 (Feb. 15, 2013). Is the same true here? I would assume not, but the majority does not say.

difference in wording does not signify any change in meaning. Rather I would take "varies with" as an archetypal example of what it means to "take [something] into account." The latter expression can then occur on its own as a convenient shorthand for the full phrase.[3]

This usage is made clear by § 411.354(d), which uses "takes into account" on its own. That subsection defines "[s]pecial rules on compensation" applicable to the definitions in § 411.354(c)(2), where the full phrase "varies with, or takes into account," is used. It states that "[u]nit-based compensation ... is deemed not to take into account 'the volume or value of referrals' if the compensation is fair market value for services or items actually provided and does not vary during the course of the compensation arrangement in any manner that takes into account referrals." *Id.* § 411.354(d)(2). So whereas § 411.354(c)(2) speaks of compensation that "varies with, or takes into account," referrals, the special rule in § 411.354(d) states that compensation shall not be considered to "take into account" referrals if certain conditions are met. This implies that the drafters of these regulations did not intend any change in meaning

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[3] Contrary to the majority's suggestion, this does not deny or rob "vary with" of "any useful role in the regulatory scheme." Making explicit what would otherwise be implicit, or offering specific examples of general provisions, is a useful textual function even if the text would be fairly read to mean the same thing without the phrase in question. *See generally* Akhil Reed Amar, *Constitutional Redundancies and Clarifying Clauses*, 33 Val. U. L. Rev. 1, 7 (1998) (noting that the United States Constitution itself "contains a good many provisions that are best read as declaratory and clarifying.").

based on whether they included the words "varies with" in a given instance of this phrase.

The majority invokes *United States ex rel. Drakeford v. Tuomey*, 792 F.3d 364 (4th Cir. 2015), which held—after a jury trial where Tuomey Healthcare System was found to have violated the Stark Act—that a "reasonable jury could have found that Tuomey's contracts in fact compensated the[ir] physicians in a manner that varied with the volume or value of referrals." The Tuomey physicians' compensation depended on the hospital's "collections" for "the physicians' personally performed services." The majority's extraordinarily thorough analysis of the record in *Tuomey* suggests convincingly that, in fact, this meant only the portion of the hospital's collections that pertained directly to each physician's own labor. That would be analogous to the metric used here, wRVUs. Thus the majority sees *Tuomey* as supporting its position: the Fourth Circuit found that a similar contract structure could be understood as violating the Stark Act.

But the rub is this. The Fourth Circuit's opinion reflects, I believe, a different factual understanding: that "collections for the physicians' personally performed services" included *all collections by the hospital relating to the service*, not just to the physician's role in the service. Thus the Court states at one point that "there are referrals here, consisting of *the facility component of the physicians' personally performed services*, and the resulting facility fee billed by Tuomey [Healthcare] based upon that component." *Id.* at 379 (emphasis added) (internal citations and quotation marks omitted). Elsewhere the Court took pains to distinguish regulatory

language approving "productivity bonus[es] based on the fair market value of the work personally performed by a physician" because it "says nothing about the propriety of varying a physician's base salary based on the volume or value of referrals." *Id.* at 380 n.10. Again, the only theory the majority offers for why compensation here or in *Tuomey* varies with referrals is that compensation based on the work personally performed by a physician *inherently* varies with referrals, because each procedure a doctor performs will generate some referrals. But the Fourth Circuit was clear in its view that there was more than that present in *Tuomey*—compensation based not only on the collections from the surgeon's own labor but also the facility fees collected by the hospital. Even if that misread the facts of the case, it means that the Fourth Circuit did not actually adopt the majority's preferred rule of law.

Of course, *Tuomey* is a Fourth Circuit case and therefore not binding precedent. And although I believe my interpretation of the regulations is more apt solely as a linguistic matter, I also have a concern about the consequences of our decision on myriad innocent contractual arrangements. At its conclusion the majority opinion offers this summation of the case against UPMC:

> A chain of financial relationships linked the surgeons to the hospitals. The surgeons referred many designated health services to the hospitals, generating ancillary hospital services and facility fees. *Their pay necessarily varied with the volume of those referrals.* The hospitals made Medicare claims for those

> referrals. And the defendants allegedly knew all this.

Maj. Op. at 417 (emphasis added). For the most part this simply describes an arrangement where doctors are employed by hospitals to perform services at those hospitals, which is hardly suspicious. The only ingredient that transforms this innocuous set-up into a potential Stark Act violation is that the surgeons' pay "necessarily" varied with the volume of referrals. But the majority makes clear that *any* compensation based on a physician's own labor, in its view, "necessarily" varies with referrals.

Today's decision suggests, therefore, that any hospital that pays its affiliated physicians according to some metric of the work they personally perform at the hospital falls under suspicion of violating the Stark Act, and it can only restore its good name by pleading one of the statutory exceptions—presumably at the summary judgment stage at the earliest, *i.e.*, after discovery has already taken place. If this is so, I cannot see why most of the top hospitals in the country, many of whom likely employ similar compensation schemes to UPMC's, would not be vulnerable to a Stark Act lawsuit that could survive a motion to dismiss and proceed to discovery. Nor is it easy to say what those hospitals should do to avoid the prospect of litigation. If compensation that merely correlates with referrals, including correlation based solely on a physician's own work, is enough to place a hospital under suspicion of violating the Stark Act, then the only way to evade suspicion altogether, short of abandoning the widespread practice of hospitals employing their own doctors (whether directly or, as

here, through a subsidiary), would be to pay those doctors a flat annual salary—and a modest one at that.[4]

I do not believe that the Stark Act was written essentially to ban compensation based on wRVUs or other measures of a physician's own productivity, or that its implementing regulations have this effect. To the contrary, the statute and regulations repeatedly express their approval of these compensation schemes. *See, e.g.*, 42 U.S.C. § 1395nn(e)(2) (indented text) ("Subparagraph (B)(ii) shall not prohibit the payment of remuneration in the form of a

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[4] The majority suggests that my concern about "opening the floodgates of litigation" is "overstated" because the Government can dismiss frivolous *qui tam* actions over the relators' objections. Thus "[f]ederal courts are not the first line of defense against abusive suits; the Justice Department is." Maj. Op. at 417; *see also* 31 U.S.C. § 3730(c)(2)(A). That may be so, but it does not excuse us from playing our role and ensuring at the motion-to-dismiss stage that complaints are legally sufficient. "Where a complaint pleads facts that are merely consistent with a defendant's liability, it stops short of the line between possibility and plausibility of entitlement to relief." *Ashcroft v. Iqbal*, 556 U.S. 662, 678, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009) (quoting *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 557, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007)) (internal citations and quotation marks omitted). In other words, a complaint must plead facts that are not only consistent with the defendant's liability but in some measure suggest it, as opposed to any innocent explanation. *See id.* at 680, 129 S.Ct. 1937 (explaining that, in *Twombly*, the allegations were "consistent with an unlawful agreement" but "not only compatible with, but indeed ... more likely explained by, lawful ... behavior.") Here, however, the majority would allow the relators' suit to proceed based on nothing more than allegations of entirely innocuous conduct: a hospital paying its affiliated physicians based on the labor they personally perform at the hospital.

productivity bonus based on services performed personally by the physician."); 42 C.F.R. § 411.352(i)(3)(i) (expressly listing wRVU as an acceptable basis for a productivity bonus for group practice doctors); *Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II)*, 69 Fed. Reg. 16054, 16067 (Mar. 26, 2004) ("[A]ll physicians, whether employees, independent contractors, or academic medical center physicians, can be paid productivity bonuses based on work they personally perform.").

Thus, although I concur with the judgment of the majority that the relators here have done enough to survive a motion to dismiss, I cannot agree that correlation alone is enough to show that compensation "varies with, or takes into account, the volume or value of referrals" as required by § 411.354(c)(2)(ii). Instead I would hold that this language requires some showing of an actual causal relationship to establish an indirect compensation arrangement under the Stark Act.

APPENDIX D

UNITED STATES DISTRICT COURT,
W.D. PENNSYLVANIA

UNITED STATES OF AMERICA, EX REL. J. WILLIAM BOOKWALTER, III, ET AL.,

Plaintiffs,

v.

UPMC, ET AL.,

Defendants.

Civil Action No. 12-145

Signed 03/27/2018

ORDER

Cathy Bissoon, United States District Judge

Defendants' Motion to Dismiss (Doc. 99)[1] will be granted. In support of this ruling, the Court

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[1] At the onset, the Court dispenses with the notion that Defendants should be faulted, or owe an apology, for not adhering to the undersigned's "meet and confer" requirement as-relates to motions under Rule 12(b)(6). *See generally* Practices & Procedures (http://www.pawd.uscourts.gov/sites/pawd/files/JudgeBissoon-Chamber-Rules-Revised-20170214.pdf) at § II.A (requiring parties, in advance of motions-practice, to discuss whether pleading defects may be cured by amendment). The requirement does not "fit" the current procedural posture (*i.e.*,

incorporates by reference its analyses in the Order dated June 21, 2017 (Doc. 95), as well as the analyses in Defendants' current Motion-papers (Docs. 100 & 108).

In the June 21st Order, the Court expressed "strong doubts" regarding Plaintiffs' ability to overcome-by-amendment the numerous pleading deficiencies identified therein. *See* Doc. 95 at 2. Defense counsel is correct that Plaintiffs did not comply with the Court's instructions regarding amendment, *see* Doc. 100 at 1; but, in fairness, it now seems clear that they were directed to do that which could not be done. Indeed, had Plaintiffs' request to amend not been so vociferously stated, the Court might well have thought to allow, in the alternative, a second path: that Plaintiffs be permitted to stand on their pleadings and immediately proceed to appellate review. *See generally* S.B. v. KinderCare Learning Ctrs., 815 F.3d 150, 152 n.1 (3d Cir. 2016) (contemplating same).

In the end, the outcome remains unchanged. Plaintiffs by-now have abandoned all of their claims save those under the Stark Law. Defendants have made compelling arguments that Plaintiffs' current allegations do not plausibly identify a Stark-implicating compensation agreement, *see* Doc. 100 at 7-9, and the Court adopts their arguments and conclusions. Even were the Court to assume the

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Plaintiffs being afforded one last chance to amend their pleadings, following the Court's grant of a prior Motion to Dismiss based on detailed legal analyses; after which it was almost a foregone conclusion that Defendants again would test the legal-sufficiency of the amended claims).

contrary, Plaintiffs' underlying premise—that targeted-physicians conducted medically unnecessary, or unnecessarily complex, procedures—persists. *See, e.g.*, 2d Am. Compl. (Doc. 98) at ¶¶ 67, 82, 188-212. Plaintiffs' newly-amended pleadings offer no greater specificity, and they still fail to sufficiently allege "particular details of a scheme to submit false claims[,] paired with reliable indicia ... lead[ing] to a strong inference" that false claims actually were submitted. *See* Doc. 95 at 3 (citing and quoting binding Third Circuit authority).

In the face of this seemingly inevitable conclusion, Plaintiffs attempt to side-step it by suggesting that the wRVU-based compensation system, either generally or as applied by Defendants, constituted a *per se* violation of the Stark Law. The Court joins Defendants in rejecting this contention. There is no support for it, in the law or otherwise, and were such allegations enough, one can only imagine the proliferation of *qui-tam* lawsuits that would result. *See* Doc. 108 at 2-3 & n.2.[2]

Perhaps the clearest "shorthand" explanation for why Plaintiffs' claims remain deficient is one emphasized in the Court's prior Order: Plaintiffs

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[2] Tellingly, the case decisions cited by Plaintiffs' counsel are facially distinguishable. *See, e.g.*, Doc. 103 at 16 (citing cases in which healthcare systems allegedly offered salaries or bonuses well in excess of fair-market-value, essentially taking a loss on those specific services in exchange for windfalls resulting from increased referrals and "downstream income"). Defendants' wRVU-based compensation model is, on its face, productivity-related; and the "special sauce" needed to make Plaintiffs' claims plausible—sufficiently-specific allegations regarding a lack of medical necessity—remains conspicuously absent.

have not, and cannot, distinguish the presumably-lawful compensation/referral arrangements between the Relator-physician(s) and Defendant(s), and those of the purportedly malfeasant physicians. The only plausible distinction is Plaintiffs' contention—whether by express averment or through unspoken implication—that certain "bad actors" performed unnecessary or unnecessarily-complex medical procedures and the Relator(s) did not.[3]

For all of the reasons above, including those incorporated by reference herein and in the June 21st Order, Defendants' Motion to Dismiss **(Doc. 99)** is **GRANTED**, and this action is **DISMISSED WITH PREJUDICE**.

IT IS SO ORDERED.

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[3] In contravention of the Court's June 21st Order, a swath of the Second Amended Complaint brazenly reasserts the same allegations regarding lack-of-medical-necessity. *See* Doc. 98 at ¶¶188-212 (subsection titled, "[Physicians p]erforming more complex procedures than necessary [to] artificially inflate wRVUs"). Other instances have been omitted. *See* Doc. 100-1 (redlined-comparison of First and Second Amended Complaints, supplied by Defendants' counsel). The Court's June 21st Order is the law of the case, and Plaintiffs cannot evade it merely by extracting some or all references to "medical necessity."

APPENDIX E

UNITED STATES DISTRICT COURT,
W.D. PENNSYLVANIA

UNITED STATES OF AMERICA, EX REL. J. WILLIAM BOOKWALTER, III, ET AL.,

Plaintiffs,

v.

UPMC, ET AL.,

Defendants.

Civil Action No. 12-145

Signed 06/21/2017

ORDER

Cathy Bissoon, United States District Judge

For the reasons that follow, Defendants' Motion to Dismiss (Doc. 88) will be granted, and Plaintiffs will be afforded an opportunity to amend the complaint.

Counsel are familiar with the factual averments and legal issues presented, and the Court writes for their benefit only. Plaintiffs have initiated this *qui tam* action against Defendants under the False Claims Act ("FCA"), and the only remaining theories are that Defendants violated the Anti-Kickback Statute ("AKS") and the Stark Law. *See generally* Pls.' Opp'n (Doc. 91) at 1. Other allegations have

been released pursuant to settlement, *see id.* at 1, and Plaintiffs have disavowed the notion that "specific claims for payment are false because the underlying services were not medically necessary." *Id.* at 26.

In sum, Plaintiffs challenge Defendants' physician-compensation system, which is based on the doctors' "wRVU" production. "The more complex [a medical] procedure, the greater [the] number of wRVUs ... assigned." Am. Compl. (Doc. 31) at ¶ 79. Pursuant to the physicians' employment contracts, each doctor is required to generate a minimum number of wRVUs per calendar year in order to earn base compensation. *Id.* at ¶ 104. Once the minimum is achieved, the doctor receives "bonus pay," at a rate of $45 per wRVU generated, even though the federal healthcare program(s) compensate UPMC at "a lower rate of approximately $35 per wRVU." *Id.* at ¶ 105. Plaintiffs contend that this violates the AKS and Stark Law, which prohibit certain self-interested referral and ownership arrangements, because the wRVU compensation system encourages physicians to "perform[ ] medically unnecessary and/or [unnecessarily] complex surgeries," thereby driving up their wRVUs, and, consequently, their personal remuneration. *See* Pls.' Opp'n (Doc. 91) at 7.

Defendants' Motion challenges Plaintiffs' Amended Complaint on a number of different grounds, most of which center on the "plausibility" standard under *Iqbal/Twombly*, and the requirement that FCA allegations be plead with specificity under Federal Rule 9(b). *See generally* Defs.' Br. (Doc. 89) at 12-25. The Court agrees with Defendants that Plaintiffs' allegations, as currently plead, fail under the

plausibility and Rule 9(b) standards; their Motion will be granted; and their analyses are incorporated by reference herein.

Plaintiffs urge, however, that if Defendants' Motion is granted, they be afforded an opportunity to amend their pleadings in an attempt to state legally-viable claims. Pls.' Opp'n (Doc. 91) at 26-27. While the Court has strong doubts regarding their ability to do so, it will grant them one last, best chance to plead legally cognizable claims. In addition to Defendants' arguments, Plaintiffs also must be prepared to address the following.

Analyzing Plaintiffs' current pleadings is particularly difficult for two reasons: (1) the Amended Complaint contains averments regarding claims that since have been settled; and (2), Plaintiffs expressly have disavowed the notion that false claims were submitted because they were not "medically necessary." *See* discussions *supra.* As to the settled claims, they correspond to the only allegations in the Amended Complaint that approach the level of specificity contemplated under Rule 9(b). *See* Foglia v. Renal Ventures Mgmt., LLC, 754 F.3d 153, 156 (3d Cir. 2014) (Rule 9(b) requires a plaintiff to allege "particular details of a scheme to submit false claims[,] paired with reliable indicia that lead to a strong inference that claims were actually submitted") (citation to quoted source omitted); *compare* Stipulated Order of Dismissal (Doc. 78) (addressing dismissal of claims related to billing of assisting-physician services, services related to "residents, fellows and physician assistants," and "multi-level laminectomies" performed "on fewer levels than reflected" in claims for payment) *with*

Am. Compl. at ¶¶ 161-175, 176-203, 204-210 (providing greater specificity regarding these theories than as relates to Plaintiffs' physician-compensation theory).

Turning to "medical necessity," it is difficult to reconcile Plaintiffs' disavowal of such claims with their insistence that Defendants' compensation system encourages and/or induces unlawful referrals under the AKS and Stark Law. This is so because, in order to establish that additional (or more complex) surgeries were caused to be undertaken, by seemingly-inevitable implication, *they must show that a given procedure would fail the "medical necessity" standard. See* Pls.' Opp'n Br. (Doc. 91) at 7 (physicians inflated their wRVUs by "performing medically unnecessary and/or more complex surgeries when simpler and safer procedures were the standard of care"); *see also* Am. Compl. (Doc. 31) at ¶¶ 53, 67, 73 & 75 (emphasizing "medical necessity" standard, as applied under each federal healthcare program, including Medicare, Medicaid, TRICARE/CHAMPUS and FEHBP).

These conclusions notwithstanding, Plaintiffs posits that, while they expressly disavow "medical necessity" averments, "[t]his does not mean that evidence of the performance of medically unnecessary procedures is irrelevant" to their remaining claims, and they "fully intend to pursue such evidence in discovery." *See* Pls.' Opp'n (Doc. 91) at 26 n.11. The Court does not believe, however, that Plaintiffs can "have it both ways." Plaintiffs cannot properly be permitted to engage in a fishing-expedition to seek out claims whose medical necessity may be questioned, while at the same time

eschewing "medical necessity" averments to avoid the rigorous standards under Rule 9(b).

Furthermore, Plaintiffs must be prepared to offer more specific and plausible allegations in support of their AKS and Stark Law claims should they wish to avoid Defendants' arguments regarding the application of seemingly obvious exceptions built into the statutory framework. *See generally* Defs.' Br. (Doc. 89) at 12-25. While Plaintiffs retort that Defendants carry the burden of proving the exceptions are satisfied, and/or that such matters cannot properly be resolved at the 12(b)(b) stage, the lack of plausible and sufficiently-specific allegations of liability make their objections ring hollow. In the Amended Complaint, Plaintiffs recount page-after-page of boilerplate standards regarding the statutory and regulatory schemes, yet they offer only bald conclusions that "the [contracting] parties did not satisfy any exception[s]." *Compare, e.g.*, Am. Compl. (Doc. 31) at ¶¶ 81-95 (recounting standards under Stark Law, including detailed recitation of exceptions for "bona fide employment relationships," "personal service arrangements," "fair market value arrangements" and "indirect compensation relationships") *with id.* at ¶ 152 (flatly stating that the exceptions do not apply).[1] In addition, Plaintiffs'

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[1] The cases relied upon most heavily by Plaintiffs' counsel address scenarios involving exclusivity-agreements entered between providers and hospitals, *i.e.,* the providers could only refer patients to the medical facility in question, but they were assured to be the provider for any such services undertaken. *See, e.g.*, Kosenske v. Carlisle HMA, Inc., 554 F.3d 88, 91 (3d Cir. 2009) *and U.S.* v. Millennium Radiology, Inc., 2014 WL 4908275, *1 (S.D. Ohio Sept. 30, 2014). While by no means is

averments fail to offer a meaningful distinction between purportedly-unlawful claims, submitted pursuant to the "standard" compensation agreements of physicians targeted in the Amended Complaint, and the presumably-lawful claims submitted pursuant to *the Realtor-physician(s)' own compensation agreements. See* Defs.' Br. (Doc. 89) at 17.

Finally, even assuming Plaintiffs eventually do assert sufficiently specific and plausible averments in support of their AKS and Stark Law claims, the Court has no reason to believe that Defendants' arguments regarding the statutory exceptions could not properly be converted to summary judgment. The contractual dealings and provisions in question

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this a requirement for stating viable claim(s) under the AKS and/or Stark Law, the aforementioned decisions appear readily distinguishable from the legal theory in this case. Here, there is no suggestion that Defendants' physicians funneled referrals to a particular facility; rather, the physicians operated under standard physician contracts, and Plaintiffs contend that, in order to receive bonus compensation under those agreements, Defendants encouraged medically-unnecessary procedures to increase their wRVU ratings. Other than reciting the overarching legal standards, Plaintiffs' cases do not offer much in the way of meaningful comparison. Indeed, the only precedent broaching the instant scenario runs decidedly in Defendants' favor. *See* Bingham v. BayCare Health Sys., 2016 WL 8739056, *5 (M.D. Fla. Dec. 16, 2016) (granting summary judgment in favor of defendants on Stark Law claim because, among other things, compensation for the physicians was "comprised of a base salary and the physician[s'] productivity using ... wRVUs," "neither of which [we]re based on referrals") (emphasis added); *cf. also generally* discussion *infra* (contemplating potential conversion of Defendants' arguments to summary judgment).

would, presumably, speak for themselves, and the Court has difficulty imagining why, and what, discovery would be necessary for Plaintiffs properly to resist. Should such a conversion be requested, *and* should Plaintiffs persuade the Court that any modicum of discovery is appropriate (and cannot be avoided by way of a voluntary informational exchange), the parties may rest assured that any discovery granted would be narrowly limited, and expedited, so that the Court promptly may resolve the threshold issues.[2]

Consistent with the above, Defendants' Motion to Dismiss **(Doc. 88)** is **GRANTED,** and Plaintiffs' deadline for filing a curative amendment is **July 10, 2017**. No further opportunity for amendment will be afforded, and Plaintiffs must be prepared to make last, best efforts to state viable claims. *See generally* Renze v. Longo, 2017 WL 782893, *4 (WD. Pa. Mar. 1, 2017) ("[it] would be inequitable to require [a d]efendant, who already once has exhaustively and successfully defended [the plaintiff's] grievances, to respond to a continuous stream of ... attempted amendments") (citation to quoted source omitted). In

[2] Plaintiffs' current objection to Defendants' reliance on materials outside the pleadings likewise could be resolved through conversion to summary judgment. *See* Pl.'s Opp'n Br. (Doc. 91) at 1 n.1. To the extent that any such materials might shed light on the legal issues presented, and in the absence of specific objections that only may be remedied through discovery, the Court believes that informational-barriers should not be constructed to avoid a reasoned decision. As should be evident, moreover, the Court will have a watchful eye toward ensuring that discovery, if any, will not degenerate into a fishing-expedition.

amending, Plaintiffs shall account not only for the discussions herein, but also for Defendants' remaining arguments for dismissal. In addition, Plaintiffs' amended pleadings shall omit allegations in support of claims that have settled, as well as those made in support of "medical necessity," as disclaimed by their counsel. Finally, and although it probably goes without saying, the Court's grant of leave to amend does not extend an invitation for Plaintiffs to espouse new theories of putative-liability. *See* In re Chemed Corp., 2017 WL 1712530, *13 (D. Del. Apr. 25, 2017) (when a court grants leave for curative amendment, it properly may dismiss proposed amendments that exceed the bounds of what was considered) (collecting cases).

Once Plaintiffs have filed a second amended complaint, Defendants shall plead or otherwise respond by **July 28, 2017**.

IT IS SO ORDERED.[3]

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[3] In raising the prospect of a conversion to summary judgment, the Court does not mean to suggest that Defendants cannot properly establish their entitlement to dismissal under Rule 12(b). The point is that, should additional information prove useful, or should conversion be appropriate to reach obviously-implicated statutory exceptions, the Court will not countenance broad and unlimited discovery regarding matters unrelated.

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF
PENNSYLVANIA

UNITED STATES OF AMERICA, *EX REL.* J. WILLIAM BOOKWALTER, III, M.D., ROBERT J. SCLABASSI, M.D., AND ANNA MITINA,

Plaintiffs,

v.

UPMC; UPP, INC. D/B/A UPP DEPARTMENT OF NEUROSURGERY,

Defendants.

Case No. 2:12-cv-00145

REPLY IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS RELATORS' SECOND AMENDED COMPLAINT

Stripped of straw man diversions and *ad hominem* attacks, Relators' Opposition to Defendants' Motion to Dismiss the Second Amended Complaint ("SAC") confirms that the SAC does not and cannot state legally cognizable claims, as the Court essentially predicted in its decision on Defendants' first motion to dismiss. Relators offer no defense for their decision to retain irrelevant, disavowed or settled allegations in the face of the Court's direction to remove them. *See* Dkt. 95 ("MTD Order") at 2, 6;

Dkt. 100 ("MTD SAC") at 1-2, 15-17, 18-21. And they identify no new factual allegation to distinguish their sole remaining legal theory from the theory rejected in a District Court Opinion specifically identified by this Court as authoritative. *See* MTD Order at 4-5, n.1. Instead, without even acknowledging that their Opposition is, in effect, a request for reconsideration, Relators argue at length that this Court should reverse course, disregard the "only precedent broaching this scenario" (*id.*) and allow them to champion an *unprecedented* theory of liability—that wRVU-based compensation is "by its *very nature*" so problematic under the Stark Law that merely mentioning it states a claim for violation of the False Claims Act ("FCA"). *See* Opp'n at 8 (emphasis in original). Relator's implied objections to the Court's prior order should be overruled, and the SAC should be dismissed with prejudice to Relators. *Cf. Coulter v. Studeny*, No. CIV.A. 12-60, 2012 WL 5458923, at *1 (W.D. Pa. Nov. 8, 2012), *aff'd*, 522 F. App'x 147 (3d Cir. 2013) (denying motion for reconsideration where plaintiff "simply disagrees with this Court's prior ruling and seeks another bite at the litigation apple."). [1] The deficiencies in Relators' Opposition include the following:

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[1] Counsel for Defendants apologize to the Court for not formally conferring with Relators' counsel prior to filing the present motion, pursuant to the current version of this Court's Rule II(A). *See* Dkt. 103 ("Opp'n") at 1, n.1. Defendants respectfully submit that the oversight was inadvertent and will not be repeated. Moreover, in the context of this case, formal adherence to this rule would have been futile. The Court's June 21 Order made clear that once Relators filed their SAC, "[n]o further opportunity for amendment will be afforded." MTD Order at 6. And when the parties negotiated agreed motions on

1. The SAC should be dismissed because Relators admit it fails to meet the Court's instruction that they allege facts distinguishing "standard" wRVU-based physician employment contracts from those of the targeted physicians. MTD Order at 5, 6. In granting Defendants' first motion to dismiss, the Court marked the limits of a viable Stark Law theory by reference to the only available precedent, a decision in *Bingham v. BayCare Health System*, No. 8:14-CV-73-T-23JSS, 2016 WL 8739056 (M.D. Fla. Dec. 16, 2016). The Court observed that summary judgment had been granted there "in favor of defendants on [a] Stark Law claim because among other things, compensation for the physicians was 'comprised of a base salary and the physician[s'] productivity using . . . wRVUs,'" "neither of which [we]re based on referrals.'" MTD Order at 4-5 n.1 (emphasis in original). Rather than cite a contrary decision or plead distinguishing facts, Relators simply plow forward, hanging their entire Complaint on the unprecedented theory that *all* standard employment agreements under which hospital-affiliated practice groups routinely compensate physicians for wRVU-based productivity trigger the Stark Law because "by its *very nature* a wRVU-based compensation system results in aggregate compensation that varies with referrals." Opp'n at 6-

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the schedule for filing the SAC, the Motion to Dismiss, and Relators' Opposition, Relators' counsel never raised the prospect of seeking leave to amend again in order the cure a pleading defect. Nor have they done so since. Moreover, the issues joined on Defendants' Motion and Relators' Opposition show that the parties hold opposing views on whether Relators' wRVU-based theory of Stark liability states cognizable FCA claims.

7, 9 (emphasis in original). In other words, Relators posit that (a) every such contract violates the Stark Law on its face, (b) any relator who places such a contract at issue in a *qui tam* action has adequately alleged a Stark-implicating financial relationship, and (c) any such relator is entitled to conduct discovery, at the end of which the defendant will be given an opportunity to demonstrate that it "strictly complie[d] with the terms of a specific statutory or regulatory exception." *Id.* at 3. If such an extreme interpretation of the statute had been the law of the land, one would expect relators across the country to have filed a plethora of similar lawsuits over the 20 years in which Stark-based *qui tams* have been litigated.[2] And yet, Relators have not identified even one.

2. Like this Court and the court in *Bingham*, CMS has long held that physicians "can be paid in a manner that correlates to their own personal labor, including labor in the provision of [hospital services]," without running afoul of Stark provisions triggered by indirect compensation that varies with the value or volume of referrals. MTD SAC at 8 (quoting 66 Fed. Reg. 876). Reconciling this critical guidance with their strained interpretation of CMS regulations would seem essential to advancing Relators' theory, especially in a fraud case; yet Relators' diversionary discussion of Stark

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[2] Relators do not dispute the prevalence of wRVU-based compensation nor that the very agency allegedly victimized by this form of compensation is the agency that developed it as a means to measure the relative value of services physicians provide. *See* MTD SAC at 10.

regulations and CMS commentary fails even to address it. *See* Opp'n at 7-11. As Relators note, CMS has written that the technical component of a physician service rendered in a hospital can be a "referred" hospital service under certain provisions of the Stark Law (66 Fed. Reg. 856, 941), and that for some practitioners, "per click," unit-based and time-based compensation will vary in the aggregate with the value and volume of that "referred" technical component. *See* Opp'n at 7, 8-9, 18; 42 CFR 411.354(d)(2)-(3). But contrary to the import of Relator's theory, the CMS' guidance on which they rely (concerning per-click or unit-based compensation) does not cancel out the agency's contemporaneous guidance on compensation for personally performed hospital services. Obviously, to CMS, compensation that correlates to a physician's labor in the provision of hospital services is ***not*** "*by its very nature*" compensation that varies with the value and volume of technical component referrals. The flaw in Relators' theory is their incorrect assertion that wRVUs act as an accounting of the number of procedures performed. *Id.* at 7 ("since the more procedures a physician performs (each of which results in a referral to the hospital for the facility component of the services), the more he is paid."). CMS allocates wRVUs to particular procedures, and CMS does so based not on the value or volume of the resulting technical component, or on the time a surgeon spends in the OR, or on the number of "clicks," patients treated or procedures performed, but on a variety of measures accounting for the value and volume of *physician resources* expended to perform the procedure. *See* MTD SAC at 10. As such,

wRVU-based compensation does ***not*** "*by its very nature*" vary with the value or volume of *referrals*.

3. Retreating to their preferred terrain, Relators argue that the propriety of compensation based on personal productivity is not ripe on a motion to dismiss because it relates to exceptions to the Stark Law. Opp'n at 9. But here too, Relators fail to reconcile that assertion with contrary authority. Be it in an indirect compensation arrangement context or otherwise, a relator's failure to allege facts rendering personal productivity bonuses unlawful has been found dispositive at this stage. *E.g., U.S. ex rel. Obert-Hong v. Advocate Health Care*, 211 F. Supp. 2d 1045, 1050-51 (N.D. Ill. 2002) ("[p]ayments based on personally performed services are permissible," and dismissing allegations that productivity bonus under physicians' standard employment agreements with physician practice affiliate of health system violated Stark Law); *see also U.S. ex rel. Grandeau v. Cancer Treatment Centers of Am.*, No. 99 C 8287, 2005 WL 2035567 (N.D. Ill. Aug. 19, 2005) (dismissing Stark allegations related to productivity bonus).

4. Relators' lengthy discussion of Stark Law exceptions (Opp'n at 11-21) is simply a series of straw men, which essentially boil down to a refrain repeated throughout their Opposition: their claim that the SAC adequately alleges "Defendants cannot satisfy a statutory exception" because the 13 named physicians' compensation exceeded fair market value. *See id.* at 13, 15, 20. But, "there is no fair market value analysis at this first stage of determining whether an indirect compensation arrangement exists." *U.S. ex rel. Singh v. Bradford*

Reg'l Med. Ctr., 752 F. Supp. 2d 602, 626-627 (W.D. Pa. 2010); *cf.* MTD SAC at 9. In Relators' own words, "whether payments to the physicians were fair market value" or satisfied other requirements of a Stark Law exception are "irrelevant" to whether Relators have met their threshold burden to allege a Stark Law-implicating indirect compensation arrangement (Opp'n at 11-12, 14) [3] —which as discussed above, they have not.

5. Even if fair market value were a relevant consideration at this stage, the SAC simply does not plead facts making it plausible (let alone with the particularity required by Rule 9(b)) that each of the 13 physicians whose referrals the SAC purports to put at issue received compensation in excess of fair market value over the course of 10 years. Relators' response shows that the SAC does not cure the problems identified in the Court's prior Order. Opp'n at 11, n.5, 15-17. Both of the cases on which Relators rely to argue that a relator can "adequately plead above-fair-market value compensation when they compare physician compensation to benchmark salary data . . ." are factually inapposite. *Id.* at 15-16. [4] Even if such benchmark comparisons were

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[3] Relators' counsel, who also represented relators in *Bradford*, apparently recognized as much in that case. 752 F. Supp. 2d at 626-627 ("Relators' position is . . . that we should first determine whether an indirect compensation arrangement exists, which only requires an assessment of whether the compensation 'takes into account' referrals, not an analysis of 'fair market value'")

[4] Relators' selective quotes from *U.S. ex rel. Perales v. St. Margaret's Hosp.*, 243 F. Supp. 2d 843 (C.D. Ill. 2003) are materially inaccurate. Opp'n at 11 n. 5, 17-18. The portions left out show that the court granted summary judgment to the

pertinent, the SAC's portrayal of "benchmarked salary data" is rendered implausible by its own analytical flaws, which Defendants showed in their opening brief. MTD SAC at 14. [5] Moreover, the "physician compensation" the SAC purports to "compare" to those benchmarks references compensation information for only 4 of 13 surgeons, and the data quoted for these 4 supports nothing more than an inference that each was highly productive and paid accordingly. *Compare* Opp'n at 15 (salary chart), *with id.* at 20 (wRVU chart). [6] Thus, Relators' claim that Defendants engaged in a multi-year "scheme" with 13 surgeons does not hold

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defendant on relators' FCA claims premised on the Stark Law and Anti-Kickback violations, and noted:"[a]lthough the Court *could* infer that any excess amounts paid over fair value was intended to induce referrals," it declined to do so in that case. 243 F. Supp. 2d at 851 (emphasis added).

[5] Separately, the SAC reiterates allegations about a supposed gap between Medicare reimbursement and the physicians' annual base wRVU rate set by contract, to support the illogical assertion that standard employment contracts evidence Defendants' agreement to take an "immediate financial loss on Medicare procedures performed by these neurosurgeons" such that their compensation "does not constitute fair market value." SAC ¶¶ 100-102. As Defendants explained, Relators' own survey data make that inference implausible. *See* MTD SAC at 11-13. Relators offer no substantive response. *See* Opp'n at 16.

[6] Notably, none of the four physicians whose compensation serves as the basis for Relators' so-called "comparisons" are identified as part of the "first-assistant" allegations (SAC ¶¶ 135-136); only 2 of the four (Dr. Spiro and Dr. Kassam) are identified as part of the "teaching physician" allegations (*id.* ¶¶ 149, 170); and only one of the four (Dr. Bejjani) is identified as part of the "billing for services not rendered" allegations (*id.* at ¶¶ 180-184).

up to scrutiny under the *Iqbal/Twombly* plausibility standard. Nor do the allegations provide the "who, what, when, where, and how" required by Rule 9(b). MTD SAC at 14, 17-21 & n.8

6. Relators continue to rely on allegations concerning a series of settled "schemes" by which they claim certain subgroups of the 13 named physicians artificially inflated wRVUs. Opp'n. at 18-20. Curiously, despite having retained these allegations in the face of the Court's instruction that they be removed from the SAC (*see* MTD Order at 6), Relators now disavow them, stating "the complaint could dispense with these 'schemes' altogether . . ." Opp'n at 19-20 n. 7. And yet, the SAC remains cluttered with "scheme" allegations that Relators fail to connect to any Stark Law violation, *i.e.*, referrals for hospital services from a physician whose compensation varied with the value and volume of referrals (or exceeded fair market value) *because* the referring physician engaged in the alleged billing scheme. *See* MTD SAC at 5-6, 9-11, 15-17, 19-20; *see also* Dkt. 89 (MTD AC) at 5 n.4. As the Court recognized when it dismissed Relators' medically unnecessary procedure allegations on the last go round, to pursue their billing scheme, Relators must clearly define a universe of procedures where the alleged "scheme" gave rise to a Stark Law violation, and the SAC's general averments are insufficient to meet that requirement. MTD Order at 3. Relators' continued inability to satisfy the Court's demand in the form of the short plain statement required by Rule 8 confirms the implausibility of their claims that these schemes enabled Defendants to violate the Stark Law or the FCA.

7. Relators' response with respect to scienter is yet another admission that the SAC fails to plausibly allege this essential element of their FCA claims. Opp'n at 21-22; *cf. id.* at 10, n.6. Relators argue that all they need to allege is that the Defendants knew (as that term is defined under the FCA) that the Stark Law prohibited billing where a financial relationship with the referring physician violated the Stark Law. *Id.* at 21-22. But the relevant inquiry is not whether a defendant had general knowledge of what the law provided; general awareness of the law cannot support an inference that a defendant shared or recklessly disregarded a relator's view of the law's application in a particular case. This inquiry is particular pertinent when, in a case like this, the law is ambiguous and the relator's view of it is unprecedented. Relators' failure to plead facts showing that Defendants knew or recklessly disregarded that the standard employment agreements with each of the 13 named physicians violated the Stark Law, and submitted claims nevertheless, requires dismissal under *Iqbal*. MTD SAC at 21-22.

8. Relators' arguments related to Counts II and III are yet another thinly veiled request for reconsideration. Opp'n at 24-25. Both claims continue to fail in the first instance because Relators have not plausibly alleged a Stark Law violation. MTD SAC at 22. As to Count II, the SAC continues to primarily rely on a recitation of the statute and fails to identify which specific hospitals submitted which specific cost reports, and thereby maintains an approach that this Court previously found insufficient. *See* MTD Order at 2. Moreover, the SAC

(like the AC) fails to allege how *any* hospital participated in or had any knowledge of or acted in reckless disregard of the alleged compensation scheme. MTD SAC at 6, 15-16, 22. As to Count III, Relators' reliance on the existence of cost reports (Opp'n at 25) is similarly unavailing. Mere reference to cost reports is not an allegation that UPMC took any action to avoid a repayment obligation. Pleading an act of avoidance is essential to state a reverse FCA claim. *See* MTD SAC at 22. Moreover, contrary to Relators' suggestion, courts in this Circuit have repeatedly held that reverse FCA "claims *may not be redundant* of FCA claims asserted under other provisions of section 3729." *U.S. ex rel. Sobek v. Educ. Mgmt., LLC*, No. CIV.A. 10-131, 2013 WL 2404082, at *29 (W.D. Pa. May 31, 2013) (emphasis added); *see also* MTD AC at 28.

For all of these reasons and those set forth in Defendants' opening brief, the Court should dismiss the SAC in its entirety with prejudice to Relators.

Respectfully submitted,

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APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF
PENNSYLVANIA

UNITED STATES OF AMERICA, *EX REL.* J. WILLIAM BOOKWALTER, III, M.D., ROBERT J. SCLABASSI, M.D., AND ANNA MITINA,

Plaintiffs,

v.

UPMC; UPP, INC. D/B/A UPP DEPARTMENT OF NEUROSURGERY,

Defendants.

Case No. 2:12-cv-00145

MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS

INTRODUCTION

On June 21, 2017, after granting Defendants' first Motion to Dismiss, the Court afforded Relators "one last, best chance to plead legally cognizable claims" for violation of the False Claims Act ("FCA"). Dkt. 95 ("MTD Order"), at 2. The Court issued clear instructions, directing Relators: (1) to "omit allegations . . . made in support of 'medical necessity,'" (2) "to omit allegations in support of claims that have settled," and (3) to respond to

Defendants' arguments in their Motion to Dismiss, incorporated by reference into the Court's Order. *Id.* at 2, 6. Relators' Second Amended Complaint ("SAC") is remarkable for what Relators did *not* do: follow those instructions from this Court. *See* Dkt. 98. After receiving fair warning that the SAC needed to reflect their "last, best efforts," MTD Order at 6, Relators merely re-ordered allegations the Court already found to be deficient and then inserted excerpts from a settlement agreement in an obvious but misguided attempt to excuse defiantly retaining allegations the Court instructed them to delete.

Because Relators largely rehash the same allegations from their Amended Complaint ("AC") that were insufficient, incomprehensible or both, the Court's observations about the AC remain applicable: "[a]nalyzing Plaintiffs' current pleadings is particularly difficult." MTD Order at 2. For example, Relators have now apparently abandoned claims premised on violations of the Anti-Kickback Statute, limiting their remaining FCA claims to those predicated solely on alleged Stark Law violations.[1] They continue to disavow pursuing a theory that claims were false because surgeries were not medically necessary. Yet, inexplicably, the SAC

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[1] *See*, *e.g.*, Introduction to SAC, at 1-2 ("By knowingly submitting or causing the submission of claims for reimbursement based on referrals that violated the Stark Statute, Defendants violated the False Claims Act."); *id*. at ¶¶ 230-242; *see also Fernandez v. City of Jersey City*, Civ. A. No. 06-CV-0503, 2007 WL 2908247, at *2 (D.N.J. Oct. 2, 2007) ("If an amended complaint omits claims raised in the original complaint, the plaintiff generally has waived those omitted claims.") (citing *Young v. City of Mt. Rainer*, 238 F.3d 567, 572 (4th Cir. 2001)).

repeats largely verbatim the same medically unnecessary procedure allegations the Court instructed Relators to delete from the AC. *See* Ex. 1, Redline SAC ¶¶ 188-212.[2,3] Similarly, Relators continue to rely on allegations of physician billing "schemes" in a prior settlement agreement (contrary to the Court's instructions), *id.* ¶¶ at 131-187, contribute to the haystack in which Defendants (and the Court) must search for a needle to thread a coherent theory of liability under their remaining Stark Law theory. The SAC is anything but the plain clear statement required under Rule 8 and the Court's June 21, 2017 Order.

The Relators' SAC confirms the prescience of the Court's "strong doubts" about their ability to plead legally cognizable claims. MTD Order at 2. In the June 21 Order, the Court noted in particular that

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[2] Or, perhaps explicably. The only apparent reason for Relators to continue to include the salacious and unsupported medically unnecessary procedure allegations in their complaint is to stoke media attention, which those allegations did yet again. *See* "Ex-UPMC employees return to court with allegations of bonus pay," Pittsburgh Post-Gazette (July 26, 2017) ("The doctor incentive program, according to the lawsuit, violated federal law and resulted in a variety of illegal practices that pumped up physician billings, including performing more complex medical procedures than were necessary. . . ."), *available at*: http://www.post-gazette.com/business/healthcare-business/2017/07/26/Ex-UPMC-employees-return-to-court-with-allegations-on-bonus-pay/stories/201707210088.

[3] For the Court's reference, Defendants attach hereto as Exhibit 1 is a "redline" comparison between true and correct copies of the AC and the SAC. Any new text is in blue. Any text from the AC that was moved to a different section in the SAC is in green. Deleted text is in red.

Plaintiffs had "fail[ed] to offer a meaningful distinction between purportedly-unlawful claims, submitted pursuant to the 'standard' compensation agreements of physicians targeted in the Amended Complaint, and the presumably-lawful claims submitted pursuant to *the Relator-physician(s)' own compensation agreements*." *Id.* at 5 (emphasis in original). The SAC continues to allege that physicians operated under standard physician contracts, but does not (and cannot) allege an essential element to trigger the Stark Law: that Wrvu-based physician incentive compensation under those contracts "varies with, or takes into account, the volume or value of referrals or other business generated" for a UPMC-affiliated hospital. 42 C.F.R. § 411.354I(2)(i)-(iii). Thus, the SAC fails to allege a financial relationship that would trigger the referral and claim prohibitions of the Stark Law in the first place.

Instead, the SAC attempts to plead around this deficiency by asking the Court to infer something nefarious about 13 standard employment contracts because theoretical physician misconduct could have the effect of increasing compensation under those standard contracts. *E.g.,* Ex. 1, Redline SAC at ¶¶ 130-131. Yet again, Relators have failed to plead facts indicating that a physician's opportunity to defraud an employer out of incentive compensation renders the employer liable for violating the Stark Law, let alone the FCA. The small handful of arguably additional factual allegations Relators included in the SAC do not bridge that gap. The SAC does not make their claims any more plausible or meet Rule 9(b)'s particularity standard for pleading a

fraudulent scheme resulting in false claims; instead, it simply reveals the dearth of a factual predicate for Relators' sole remaining theory of liability under the Stark Law. For the reasons that follow and those presented in support of Defendants' first Motion to Dismiss,[4] Relators' complaint should be dismissed with prejudice and without leave to amend.

LEGAL STANDARD

Relators must meet both the Rule 12(b) and rigorous Rule 9(b) standards to state a claim for relief premised on the FCA. MTD Order at 2 ("Plaintiffs' allegations, as currently plead, fail under the plausibility and Rule 9(b) standards."); *Universal Health Servs., Inc. v. U.S. ex rel. Escobar*, 136 S. Ct. 1989, 2004 n. 6 (2016) ("False Claims Act plaintiffs must ... plead their claims with plausibility and particularity under Federal Rules of Civil Procedure 8 and 9(b)."); *see also U.S. ex rel. Petratos v. Genentech Inc.*, 855 F.3d 481, 489 (3d Cir. 2017); Defs.' MTD AC at 10-12 (discussion of legal standard). "The touchstone of the [Rule 12(b)] standard is plausibility." *Bistrian v. Levi*, 696 F.3d 352, 365 (3d Cir. 2012). The plausibility standard "asks for more than a sheer possibility that a defendant has acted unlawfully." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009); *see also Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557 (2007).

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[4] Defendants' Memorandum in Support of its Motion to Dismiss Relators' Amended Complaint ("Defs.' MTD AC") and Reply in Support of Defendants' Motion to Dismiss Relators' Amended Complaint ("Defs.' Reply"), are incorporated by reference herein. Dkt. 89 and 92.

In order to meet Rule 9(b)'s rigorous standard in an FCA case, Relators must provide "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that [such] claims were actually submitted." *Foglia v. Renal Ventures Mgmt.*, LLC, 754 F.3d 153, 156 (3d Cir. 2014) (citation and quotation marks omitted). "Describing a mere opportunity for fraud will not suffice." *Id.* at 158. Instead, the facts alleged by the Relator must "enable the court to draw an inference of fraud, and allegations in the form of conclusions or impermissible speculation as to the existence of fraud are insufficient." *U.S. ex rel. Thomas v. Lockheed Martin Aeroparts, Inc.*, No. 3:13-cv-183, 2016 WL 47882, at *3 (W.D. Pa. Jan. 4, 2016) (citation and quotation omitted).

ARGUMENT

As they did in their AC, Relators attempt to allege violations of the FCA in three counts, each now premised solely on an alleged "scheme to pay excessive compensation to the neurosurgeons in exchange for referrals" in violation of the Stark Law. Ex. 1, Redline SAC at ¶¶ 228, 239.[5] Relators' SAC contains nothing new to overcome the pleading deficiencies identified in the Court's MTD Order that doomed Relators' AC or to "account... for... Defendants' remaining arguments" in the first Motion to Dismiss. MTD Order at 6. Instead, Relators generally repeat the allegations from the

[5] Defendants' prior motion to dismiss included an overview of the False Claims Act, Stark Law, and Work Relative Value Units (wRVU), which is incorporated by reference herein. Defs.' MTD AC at 6-9.

failed AC. They continue to allege that Defendants' scheme arose out of standard employment contracts, Ex. 1, Redline SAC at ¶ 99, and to try, unsuccessfully, to repurpose their conclusory allegations of "fraudulent" billing schemes for physician professional services as support for their Stark Law theory, *id.* at ¶¶ 131-185. The majority of what is new in Relators' SAC consists of wholly conclusory assertions and legal argument designed to distinguish already-settled allegations from their own. *See*, *e.g.*, *id.* at ¶¶ 231-37. This is insufficient under *Iqbal, Twombly*, and Rule 9(b). Even in the most favorable light, the SAC fails to move Relators' speculative allegations from merely conceivable to plausible claims plead with requisite particularity. *See U.S. v. Medtronic, Inc.*, No. CV 15-6264, 2017 WL 2653568, at *3 (E.D. Pa. June 19, 2017) ("Ultimately, a complaint must contain facts sufficient to nudge any claim 'across the line from conceivable to plausible.'" (quoting *Twombly*, 550 U.S. at 570); *Escobar*, 136 S. Ct. at 2004 n.6 (2016).

Boiled down to its essence, Relators' Stark Law theory remains that certain neurosurgeons employed by UPMC-affiliated practice groups were paid, in their opinion, too much when compared to other neurosurgeons and that they received this excess compensation by operation of standard, wRVU-based employment contracts. As demonstrated below, that predicate theory of Stark Law liability fails for a number of reasons under applicable statutory and regulatory provisions. More significantly, however, that theory fails to plead a fraudulent scheme under the FCA in that it requires the Court to indulge two speculative assumptions that, at best, render a

fraudulent scheme only *conceivable* where Relators' burden is to allege facts that make that scheme *plausible* in the circumstances alleged. *See* MTD Order at 4. Relators assume, first, that generally-accepted, wRVU-based compensation models offer physicians an opportunity to inflate their wRVUs (and thus their compensation) through improper conduct, and, second, that UPMC hospitals caused those affiliated practice groups to adopt those generally-accepted compensation models for the purpose of enabling the physicians to engage in improper conduct and reward themselves for referrals. No fact in the SAC comes anywhere close to suggesting that such a scheme is plausible. More is required to commence costly litigation in federal court.

I. COUNT ONE FAILS TO ADEQUATELY PLEAD AN FCA VIOLATION FOR KNOWINGLY SUBMITTING, OR CAUSING TO BE SUBMITTED, FALSE CLAIMS FOR PAYMENT TO THE UNITED STATES.

To state a claim for violation of 31 U.S.C. § 3729(a)(1)(A), Count One of the SAC must contain allegations making it plausible that Relators could show: "(1) the defendant presented or caused to be presented to an agent of the United States a claim for payment; (2) the claim was false or fraudulent; and (3) the defendant knew the claim was false or fraudulent." *Hutchins v. Wilentz, Goldman & Spitzer*, 253 F.3d 176, 182 (3d Cir. 2001) (citations omitted). Relators must provide "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that [such]

claims were actually submitted." *Foglia*, 754 F.3d at156 (citation omitted and quotation marks). "Describing a mere opportunity for fraud will not suffice." *Id.* at 158.

Where, as here, Relators' FCA presentment claim is premised on a Stark Law violation, Relators must plausibly allege a Stark-implicating financial relationship, a referral, the submission of a claim as a result, and scienter—i.e., reliable indicia that Defendants actually submitted claims or caused claims to be submitted while knowingly or recklessly disregarding that the claims were false. *U.S. ex rel. Bartlett v. Ashcroft*, 39 F. Supp. 3d 656, 665-666 (W.D. Pa. 2014); *U.S. ex rel. Wilkins v. United Health Grp., Inc.*, No. CIV. 08-3425, 2011 WL 6719139, *2 (D.N.J. Dec. 20, 2011).

A. Relators Fail To Allege The Elements Of Any Stark-Implicating "Indirect Compensation Arrangement."

Relators fail to plausibly allege the core requirement of any Stark Law claim—a financial relationship that would trigger Stark Law prohibitions on referrals and billing. After explaining that a "financial relationship" triggering Stark Law prohibitions can be direct or indirect, Ex. 1, Redline SAC at ¶ 33, Relators baldly assert the existence of an "indirect compensation arrangement" between each physician and unspecified "UPMC hospitals," *id.* at ¶ 231. As laid out in detail in briefing on Defendants' first motion to dismiss, to support the legal conclusion that such an "indirect compensation arrangement" exists, Relators must allege a series of facts: (1) an unbroken chain of financial relationships

between the referring physician and an entity providing statutorily-defined "Designated Health Services" (*i.e.*, a DHS Entity); (2) aggregate compensation received from the organization in that chain with which the physician has a direct compensation arrangement (i.e., their direct employers) that "*varies with, or takes into account, the volume or value of referrals or other business generated*" for the DHS Entity; and (3) the DHS Entity has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, those facts. 42 C.F.R. § 411.354I(2)(i)-(iii) (emphasis added); *see also* Defs.' MTD AC at 8-10, 20. Indeed, because Relators allege that remuneration flows from a third party, not a DHS Entity, the Stark Law prohibition on referrals could ***only*** apply if that remuneration is shown to establish an "indirection compensation arrangement." 42 C.F.R. § 411.354. However, since Relators have not and cannot allege that wRVU-based physician compensation "varies with, or takes into account, the volume or value of referrals or other business generated," the SAC fails to allege a financial relationship that would trigger the referral and claim prohibitions of the Stark Law.

Compensating physicians based on their own hard work—their own professional wRVUs—is facially unproblematic under the Stark Law and does not, as a matter of law, "vary with, or take into account, the volume or value of referrals or other business generated" for the hospital. *See* Defs.' MTD AC at 8-9. That is because, under the Stark Law, the term "referral" does not include a physician's personally performed services. *See* 42 C.F.R. § 411.351 (defining "referral"). As such, the Government has consistently

concluded that physicians "can be paid in a manner that correlates to their own personal labor, *including labor in the provision of DHS*." *See* 66 Fed. Reg. 876 (Jan. 4, 2001) (emphasis added). Thus, the mere fact that a wRVU-based productivity bonus produces more compensation for a surgeon who performs more surgeries of higher complexity is not a fact that establishes that the bonus varies with, or takes into account, the volume or value of referrals or other business generated for the hospital. More is required to establish, and thus more facts are required to allege, the existence of a prohibited indirect compensation arrangement.

The Court recognized as much in its June 21 Order, citing *Bingham v. BayCare Health System. See* MTD Order at 4 n.1. In that case, the court granted summary judgment in favor of the defendants on the relator's Stark Law Claims finding that no indirect compensation arrangement existed because, in part, "the compensation for physicians employed by SC Physicians is comprised of a base salary and the physician's productivity (using work-relative-value units ('wRVUs')), neither of which are based on referrals." *Bingham v. BayCare Health System*, No. 8:14-CV-23JSS, 2016 WL 8739056 at *5 (M.D. Fla. Dec. 16, 2016).

Relators' failure to plausibly plead as an initial matter the existence of an indirect compensation agreement renders irrelevant their quibbling over their burden to plead the inapplicability of a statutory exception. *Compare* MTD Order at 4 ("[T]he lack of plausible and sufficiently-specific allegations of liability make [Relators' burden of proof] objections ring hollow."); *with* Ex. 1, Redline

SAC at ¶ 35 ("[I]t is the defendant's burden to show that an arrangement complies with an exception under the Stark Statute."). The question of whether a compensation arrangement fits into any exception only comes into play if the plaintiff first establishes that there is a Stark Law violation. *See U.S. ex rel. Singh v. Bradford Reg'l Med. Ctr.*, 752 F.Supp.2d 602, 626-627 (W.D. Pa. 2010) ("The logical structure of the Stark Act and applicable regulations ... suggest that the proper order is to first determine whether an indirect compensation arrangement exists, meaning whether it satisfies the definition, before turning to ... whether an exception applies."). Here, the SAC is devoid of plausible factual allegations on the elements of a qualifying financial relationship under the Stark Law, *i.e.*, that wRVU-based compensation varies with or takes into account volume and value of referrals. Since their FCA claims are solely premised on this deficiently pled Stark Law theory, the SAC should be dismissed on this ground alone.

B. Relators Have Not Plausibly Pled That The Purpose Of The UPP, Tri-State, And CMI Employment Compensation Was To Enable Physicians To Engage In Nefarious Conduct.

Despite the fact that standard contracts providing for wRVU-based physician compensation are facially unproblematic under the Stark Law, Relators' SAC again asks the Court to infer something nefarious about 13 such contracts without providing any factual support for this conclusion. *Cf. Cooper v. Pottstown Hosp. Co. LLC*, 651 F. App'x 114, 117 (3d

Cir. 2016) (declining to "infer nefarious intent based solely upon a party's conduct that is completely consistent with a contract that, on its face, bears no evidence of illegality"). As the Court pointed out, in their AC, the Relators "allege[d] that the physicians operated under standard physician contracts." MTD Order at n.1. The same is true in the SAC. Ex. 1, Redline SAC at ¶¶ 100; 105-106. The SAC adds nothing to distinguish the 13 named physicians' contracts from those of any other employment contracts, including Relator Bookwalter's own contract, and thus suffers the same fatal flaw as Relators' AC. MTD Order at 5 (noting that "Plaintiffs' averments fail to offer a meaningful distinction between purportedly-unlawful claims, submitted pursuant to the 'standard' compensation agreements of physicians targeted in the Amended Complaint, and the presumably-lawful claims submitted pursuant *to the Relator-physician(s)' own compensation agreements*.") (emphasis in original).

As the Court previously agreed, the standard employment contracts reflect a compensation model that tracks a widely-accepted, government-designed wRVU system. MTD Order at 2, 5 & n.1. As detailed in Defendants' prior briefing, Congress requires Medicare to use wRVUs to assess the effort, intensity, and associated cost of physician services, *see* 42 U.S.C. § 1395w-4(c), and to set the "Physician Fee Schedule," which determines reimbursement rates for physician services, Medicare Program, Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY2012, 76 Fed. Reg. 73026 (Nov. 28, 2011) (setting rates for CY2012); *see also* Medicare Program,

Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY2017, 81 Fed. Reg. 80170 (Nov. 15, 2016) (setting rates for CY2017); Defs.' MTD AC at 6-8; 15-16. Medical groups and employers, in turn, have adopted wRVUs to measure and value physician performance for purposes of compensation. *See* Defs.' MTD AC at 7-8. Yet, Relators allege that 13 employment contracts are illegal because they incorporate this very same, government-sanctioned performance measure.

Like Relators tried to do with their AC, the SAC relies on three sets of "facts" to support Relators' claim that the neurosurgeon's wRVU-based incentive compensation is illegal under the Stark Law: (1) a gap between Medicare reimbursement ($35 per wRVU) and the physician's annual base wRVU rate ($45), set by contract, Ex. 1, Redline SAC at ¶¶ 100-102; (2) high wRVUs generate high compensation for some physicians, *id.* at ¶¶ 111-130; and (3) physicians allegedly engaged in "schemes" to artificially inflate their wRVUs, *id.* at ¶¶ 131-212. But, Relators have not added anything new to the SAC to push their allegation that these standard employment contracts were actually part of a "scheme to pay excessive compensation to the neurosurgeons in exchange for referrals," *id.* at ¶ 228, from the realm of conceivable to plausible, let alone meet Rule 9(b)'s particularity standard.

1. The $45 per wRVU rate for calculating incentive compensation under the standard employment contracts does not support an inference of any prohibited compensation arrangement.

In the SAC, Relators reiterate verbatim the "fact" that there is a $10 gap between the Medicare reimbursement rate of $35 per wRVU and "the 'bonus pay' rate of $45 per wRVU" set in the standard employment agreement. *Id.* at ¶¶ 100-101. From this sole fact and without adding anything new, Relators leap to the illogical conclusion that "UPP, CMI[,] Tri-State, and UPMC have contractually agreed with the neurosurgeons to take an *immediate financial loss* on Medicare procedures that are performed by these neurosurgeons" and thus the compensation for the 13 named neurosurgeons "does not constitute fair market value and cannot be commercially reasonable in the absence of the financial benefit of the referrals made to the UPMC Hospitals." *Id.* at ¶ 102 (emphasis in original).

The Court previously found these same allegations insufficient to plausibly state a Stark Law violation. As detailed in Defendants' prior briefing, the $10 gap alleged by the Relator shows only that one payor (Medicare) at some point set a reimbursement rate lower than the per-wRVU rate for incentive compensation under the standard employment contracts.[6] *See* Defs.' MTD AC at 16. But, as Relator

[6] The SAC continues to allege that pursuant to the standard physician contracts, each neurosurgeon is required to generate a minimum number of wRVUs per year in order to earn base compensation. Ex. 1, SAC Redline at ¶ 100. Thus, by Relators'

Bookwalter well knows (and the Court observed), that "gap" is anything but nefarious and can be explained by reference to various factors, many of which are apparent from the face of the complaint. These factors include, for example, (a) the surgical specialty of a named neurosurgeon, (b) reimbursement rates paid by other insurers who reimburse UPP, Tri-State, and CMI for the physician's services, and (c) the fact that the gap appears in standard neurosurgery employment contracts, i.e., including Relators' contract. Thus, as the Court previously concluded, the $10 gap does not move Relators' theory into the realm of plausibility because Relators fail to distinguish the supposedly illegal compensation for the named neurosurgeons from the same, supposedly legal compensation arrangement for other physicians, like that of Relator Bookwalter. *See* MTD Order at 5.

Moreover, Relators' new references to "benchmark" survey data purportedly drawn from reports of the Medical Group Management Association ("MGMA"), the American Medical Group Association ("AMGA") and Sullivan Cotter & Associates ("SCA") actually undermine, rather than support, the plausibility of Relators' claim that the $10 gap shows the standard compensation arrangement somehow violates the Stark Law. *See, e.g., Curay–Cramer v. Ursuline Acad. of Wilmington, Delaware, Inc.*, 450 F.3d 130, 133 (3d Cir. 2006) ("Although we must accept as true all well-pled allegations. . . we need not credit the non-movant's conclusions of law or unreasonable

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own allegations the per-wRVU rate for a physician's total compensation could be something quite different than the $45.

factual inferences.") (citation omitted). The application of simple mathematics to the excerpted data Relators provide strongly suggests Relators misstate or misunderstand the relationship between Medicare reimbursement rates and per wRVU rates that underlie compensation in physician employment markets. For the 2009 values for each of the surveys cited, dividing the median compensation Relators report (*see* Ex. 1, Redline SAC at ¶¶ 220–222) by the median wRVU totals Relators report (*see id.* at ¶¶ 119–121) indicates that factors and sources of revenue other than the Medicare $35 per wRVU reimbursement rate drive per wRVU compensation rates:

Survey	2009 Median Compensation	2009 Median wRVUs	Effective Rate per-Wrvu	Apparent "Gap" from Medicare $35 per Wrvu
MGMA	$600,000	8,982	$66.8	**+$31.8**
AMCA	$548,186	8,910	$61.5	**+$26.5**
SCA	$529,500	10,240	$51.7	**+$16.7**

Relators will no doubt argue that little can be made of such a calculation for any number of reasons. But each of those reasons proves the fallacy of Relators' own inference that this same data drives the plausible conclusion that Defendants agreed "to take an *immediate financial loss* on Medicare procedures that are performed by these neurosurgeons" and that doing so would be commercially unreasonable in the absence of "the financial benefit of the referrals

[they] made to the UPMC Hospitals." *Id.* at ¶ 102 (emphasis in original). Compared to the median reflected in Relators' tables, a gap of $10 per wRVU from Medicare seems like a commercially reasonable bargain. Simply put, like Relators' reliance on abstract "benchmarks" to support inferences of nefarious conduct, Relators continued reliance on the concept of a $10 gap from Medicare does not give rise to a reasonable inference necessary to establish the plausibility of their allegation that the standard employment agreements at issue violate the Stark Law.

2. The "Productivity Report" and "benchmark" survey data do not support an inference of any prohibited compensation arrangement.

Relators allege that "numerous UPMC neurosurgeons were routinely generating wRVUs exceeding by an enormous margin the 90th percentile as reflected in widely-accepted market surveys." *Id.* at ¶ 126. They claim erroneously that this shows Defendants' wRVU-based incentive system "encouraged and incentivized" the 13 named neurosurgeons to artificially inflate wRVUs to compensate them for referrals to UPMC Hospitals. *Id.* at ¶ 115. Even viewing those allegations in a favorable light, the leap is too far to support the conclusion Relators assert. For example, several of the named physicians' wRVUs were close to or below the number of wRVUs performed by neurosurgeons at the 90th percentile reported by the three surveys. *Compare, e.g.*, *id.* at ¶ 112 (2009 wRVU figures for Drs. Aguilar (15,147), Atteberry (13,914), Mintz

(12,677) and Maroon (14,160)) to ¶¶ 119-121 (2009 90th percentile in MGMA (15,077), AGMA (14,286) and SCA (15,840)). Further, high productivity rates alone do not suggest that wRVUs are "artificially inflated." As with law firm billable hour reports, every group has top performers; that some attorneys are in the top tier does not support an inference that they got there illegally. Indeed, the numbers reported by Relators show that some of named neurosurgeons performed above the 90th percentile in fiscal years 2004, 2005 and 2006, ***before*** the alleged scheme even started. *Compare, e.g.*, *id.* at ¶ 112 (2004-2006 wRVU figures for Drs. Abla, El-Kadi, Horowitz, and Maroon), with *id.* at ¶¶ 119-121 (2004-2006 90th percentile wRVU levels in MGMA, AGMA, and SCA surveys); *id.* at ¶¶ 91, 98-99 (alleging Dr. Kassam became chair in mid-2006 (fiscal year 2007) and "shortly thereafter, under his leadership, the Department [of Neurosurgery] embarked upon a campaign to increase the volume of surgical procedures"). This data fails to support the inference Relators allege that something changed in 2006, or, more fundamentally, that the allegedly unlawful incentive compensation "scheme" was the cause.

3. Schemes to artificially inflate RVUs do not support an inference of any prohibited compensation arrangement.

Rather than follow the Court's instructions to "omit allegations in support of claims that have settled, as well as those made in support of 'medical necessity,' as disclaimed by their counsel," MTD Order at 6, Relators' double down, reiterating those allegations virtually wholesale. *See id.* at ¶¶ 130-212; *see also*

Dkt. 91, Relators' Opp'n to Defs.' MTD AC ("Relators' Opp'n") at 20 & nn. 8-9. But, just moving those allegations under the heading of a Stark Law violation and citing a settlement agreement do not solve the fatal flaw at the center of Relators' Stark Law-based FCA claims: the SAC fails to connect the dots between the alleged schemes and any Stark Law violation.

Relators claim that the compensation system "incentivized" and "encouraged ***the individual physicians*** to devise various 'creative' schemes to boost ***their*** wRVUs." Ex. 1, Redline SAC at ¶ 131 (emphasis added). What is missing (among other things) are any facts to show that such fraud actually occurred in furtherance of a nefarious compensation scheme. Notably, the allegations related to billing for one surgeon's services (*see id.* at ¶¶ 180-184) were part of a voluntary disclosure the UPMC Parties made to the government before even learning of Relators' action. *See* SAC Ex. 1 (Dkt. 98-1), at 2 (the Settlement Agreement).[7] That means that when Defendants identified an issue, they sought to fix the problem, not to hide it or use it to advance an alleged scheme to violate the Stark Law. Similarly, the "new" allegation that Relator Bookwalter allegedly discussed a "first assistant problem" with the chief of surgery at UPMC Shadyside—without any details of

[7] On July 15, 2016, the United States, Relators, UPMC, UPP and others entered into a settlement agreement and stipulated to dismissal with prejudice of certain of Relators' claims concerning reimbursement of physician services by federal health care programs. Relators attach a copy of that settlement agreement as an exhibit to their SAC ("the Settlement Agreement").

that conversation, whether the chief had any role in compensation decisions or that the conversation concerned wRVUs or compensation—does not support a plausible inference that physicians fraudulently billed themselves as first assistants in furtherance of a wRVU incentive compensation scheme. *See* Ex. 1, SAC Redline at ¶ 146. Even if the various schemes to inflate wRVUs were pled with sufficient particularity, at most those allegations suggest that some physicians may have received some wRVU credit for some services billed inaccurately. Importantly, however, no fact alleged in the SAC even suggests that any UPMC entity paying physician compensation engineered or was complicit in that alleged inaccurate billing *knowing* (or with reckless disregard) that it would produce compensation to the physician in a manner that "varies with, or takes into account, the volume or value of referrals or other business generated" for a UPMC Hospital. In the absence of that factual predicate, it remains implausible that Relators could show that an unlawful indirect compensation arrangement existed between any surgeon and that UPMC Hospital, *i.e.*, that any Defendant violated the Stark Law, let alone the FCA. Relators' allegations related to UPMCs' control over its subsidiaries, Relators' claim that UPMC must have had knowledge of and participated in creating and implementing the standard contract agreements, and Relator Dr. Sclabassi's characterization of a vague conversation he allegedly had with Dr. Kassam, *see id.* at ¶¶ 12-22, 90, 105-06, 110, 229, are unavailing for the same reason. None of those allegations, if true, would establish the existence of an indirect

compensation arrangement between any named physicians and any UPMC-affiliated hospital.

Relators' reliance on the Settlement Agreement is also unavailing. The SAC asserts multiple times that the Settlement Agreement concerning claims for physician services "did not settle allegations relating to false claims for hospital services submitted in violation of the Stark Statute[.]" *Id.* at ¶¶ 148, 177, 187. While the Settlement Agreement may have left open the door for Relators to bring Stark Law claims, it does not vouch for them. The Settlement Agreement plainly states that it is "neither an admission of liability by the UPMC Parties nor a concession by the United States that its claims are not well founded." SAC Ex. 1 (Dkt. 98-1) at 4. In other words, the Settlement Agreement did not purport to establish any facts, and Relators cannot rely on it to generate plausibility where none exists. Relators attempted this same argument in their Opposition to Relators' first Motion to Dismiss. Relators' Opp'n at 20, n. 9 (arguing that the Settlement Agreement "confirm[s] the 'plausibility'" of "allegations that [Defendants] submitted claims for physician services purportedly performed directly by the neurosurgeons, when they did not in fact provide the services as claimed"). The additional citations to the Settlement Agreement in Relators' SAC offer no reason why the Court should reverse course and now accept an argument it rejected the first time around.

C. Alleged "Schemes" To Artificially Inflate wRVUs Do Not Satisfy Rule 9(b).

Even if the SAC alleged a plausible connection between, on the one hand, the four schemes for physicians to artificially inflate their wRVUs and, on the other hand, a Stark Law violation—which as explained in Section B, *supra*, it does not—none of the schemes are pled with the particularity required by Rule 9(b). As the Court recognized when it dismissed Relators' medically unnecessary procedure allegations the last go-round, for a scheme to support a Stark Law violation, Relators must identify a universe of procedures where the alleged fraud happened, and generalized allegations that the fraudulent conduct *could* have happened are not a license to bypass Rule 9(b) and use discovery to fish for examples that might meet the description. *See* MTD Order at 3 (holding that in order for Relators' medical unnecessary procedure allegations to state a claim that "additional (or more complex) surgeries were caused to be undertaken" by Defendants' compensation system, Relators "*must show that a given procedure would fail the 'medical necessity' standard*" and rejecting Relators' argument that they can "expressly disavow 'medical necessity' averments" and still "'pursue such evidence in discovery'" (emphasis in original) (quoting in part Relators' Opp'n at 26 n. 11)); *see also, e.g., U.S. ex rel. Judd v. Quest Diagnostics, Inc.*, 638 F. App'x at 162, 163, 168-169 (3d Cir. 2015) (dismissing Stark-based FCA Claims and citing cases where complaints were deficient under Rule 9(b) because they lacked reliable indicia of referrals and claims resulting from alleged scheme).

With regard to the medically unnecessary procedure allegations, despite the Court's unambiguous warning not to do so, Relators yet again try to "'have it both ways,'" continuing to pursue "claims whose medical necessity may be questioned, while at the same time" failing to add any allegations of fact that would meet "the rigorous standards under Rule 9(b)." MTD Order at 3-4. Yet again, for the two types of surgical procedures referenced in the SAC, the SAC acknowledges that both procedures can be performed for the same condition, Ex. 1, Redline SAC ¶¶ 198-199, but the SAC is devoid of a shred of information about a single patient procedure that allegedly was not necessary when performed: not the name of the surgeon, not the date of the surgery, not the hospital at which it was performed. It also does not allege why any unidentified surgery involving the less complex procedure should have been performed instead of the more complex procedure—much less that the unidentified surgeon knew the more complex procedure was unnecessary. *See id.* at ¶¶ 188-212. By including their medically unnecessary procedure allegations, Relators have chosen to defiantly disregard this Court's explicit instructions to exclude them from their SAC while yet again advancing allegations that remain woefully deficient. The Court should, for those reasons, dismiss them with prejudice. MTD Order at 2, 3-4; *see also* Defs.' MTD AC at 28-33; Defs.' Reply at 1-2.

The SAC attempts the same end-run with regard to the three other alleged schemes for inflating wRVUs—trying to avoid Rule 9(b) by making sweeping, generalized allegations that certain billing

rules were not complied with, while eschewing averments of any particular procedure performed at any particular UPMC hospital where a particular employed neurosurgeon did something wrong in order to inflate his or her wRVUs. For example, the SAC reiterates broad generalizations regarding billing for services not rendered, but only mentions two physicians (Ex. 1, Redline SAC at ¶¶ 179-185), and the single allegation about an alleged "computer-based billing 'shortcut,'" (*id.* at ¶ 185), is wholly conclusory and fails to state plausibly and with particularity that any false claims were submitted as a result of this alleged scheme. Defs.' MTD AC at n. 4 & 14. The SAC also alleges only the broad outlines of how the alleged teaching physician scheme would work, lists only 8 of the 13 named physicians as even working at a teaching hospital, and then baldly claims that five physicians violated the teaching rules, without providing the specific facts required to plausibly allege that any of these physicians were not involved at the level required. Ex. 1, Redline SAC at ¶¶ 167-174. Likewise, while the SAC claims five of the named neurosurgeons "routinely violated" the Medicare rules for billing as a first assistant, it remains devoid of any allegations of any particular surgery at any particular UPMC hospital where any of these five physicians failed to perform the work necessary to qualify as a first assistant, and instead alleges only "on information and belief" that the "fraudulent[ ] billing" was "a common and pervasive occurrence." *Id.* at ¶¶ 136, 142, 144. This too is patently insufficient under Rule 9(b). *See, e.g.*, *U.S. ex rel. Thomas*, 2016 WL 47882, at *9 (dismissing FCA claims where "[r]ather than containing details of the alleged scheme, the complaint filed by [the

plaintiff] presents only the broad outlines, and the inferences it offers are not reasonably drawn") (citation and marks quotation omitted).[8]

The SAC's failure to specifically allege each physician's and hospital's involvement in each scheme likewise dooms Relators' attempt to use these generalized schemes to smear fraud across all hospital claims in connection with all surgeries performed by all thirteen of the named neurosurgeons. *See, e.g.*, *id.* at ¶¶ 233-234, 239-240. In *United States ex rel. Grubbs v. Kanneganti*, 565 F.3d 180 (5th Cir. 2009), the Fifth Circuit affirmed the dismissal of conspiracy claims under the FCA as to the hospital and doctors who were not specifically named in the relators' allegations related to an alleged agreement. *Id.* at 194. The court explained that "[e]ven taking the allegations as true—that various doctors over a period of years each submitted

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[8] *See also U.S. ex rel. Zwirn v. ADT Sec. Servs., Inc.*, No. CIV. 10-2639 KSH, 2014 WL 2932846, at *8 (D.N.J. June 30, 2014) (noting that "courts have held that allegations based on information and belief do not satisfy Rule 9(b) unless the complaint sets forth the facts upon which the belief is founded") (citation and quotation marks omitted); *Hericks v. Lincare Inc.*, No. CIV. A. 07-387, 2014 WL 1225660, at *5 (E.D. Pa. 2014) ("At a minimum, the plaintiff must support her allegation of fraud with essential factual background—the 'who, what, when, where, and how of the events at issue.'") (quoting *In re Rockefeller Ctr. Props., Inc. Sec. Litig.*, 311 F.3d 198, 217 (3d Cir. 2002)); *U.S. ex rel. Feldstein v. Organon, Inc.*, No. CIVA 07-CV-2690 (DMC), 2009 WL 961267, at *11 (D.N.J. Apr. 7, 2009), *aff'd on other grounds*, 364 F. App'x 738 (3d Cir. 2010) (dismissing fraud allegations as "highly speculative" because relator did "not detail any concrete evidence that supports his allegations").

certain false claims—[did] not, by itself, do more than point to a possibility of an agreement among them." *Id.* Similarly, the most Relators have alleged here is that some physician at some point may have gamed the Wrvu system, an allegation which constitutes a "mere opportunity for fraud" and is deficient under Rule 9(b). Defs.' MTD AC at 24-25; *Foglia*, 754 F.3d at 158 (citation omitted); *Judd*, 638 F. App'x at 168-69; *Hericks*, 2014 WL 1225660, at *9 (dismissing FCA claims "rooted in conjecture, speculation or supposition" where the plaintiff "asks the Court to assume that some claims at some point from some center must have resulted from illegal practices."). As with their medically unnecessary procedure allegations, Relators should not be able to bypass Rule 9(b)'s rigorous standard "to engage in a fishing-expedition to seek out claims" with the hope that they somehow may support their hypothesis. MTD Order at 4.

D. Relators Fail To Plausibly Allege Scienter Under The False Claims Act.

To show that claims submitted in violation of the Stark Law also violated the FCA, Relators must also plausibly plead scienter—i.e., reliable indicia that Defendants actually submitted claims or caused claims to be submitted ***when they knew or acted with reckless disregard that that the claims were false***. *U.S. ex rel. Bartlett*, 39 F. Supp. 3d at 665-666. Paraphrasing the FCA and the Stark Law, Relators generally allege that Defendants "were aware of the compensation arrangements with the Physicians, and had actual knowledge of, or acted in reckless disregard or deliberate ignorance of, the fact

that the Physicians received aggregate compensation that varied with, or took into account, the volume or value of referrals or other business generated by the Physicians for the hospitals." Ex. 1, Redline SAC at ¶ 232. But recounting the language of a statute is not enough, *Iqbal*, 556 U.S. at 678, and, as discussed above, wRVU-based compensation is generally understood *not* to take into account the volume or value of referrals or other business generated. *See supra* at 6-7. Relators have not pled facts rendering it plausible that this generally-accepted methodology for measuring, valuing, and rewarding physician productivity is in any way unlawful or that Defendants could somehow have divined this "fact." Defs.' MTD AC at 23-24; *see also generally* Section I.B-C, *supra*; *cf. Pottstown Hosp.*, 651 F. App'x at 117 (declining to "infer nefarious intent based solely upon a party's conduct that is completely consistent with a contract that, on its face, bears no evidence of illegality").

II. BECAUSE RELATORS FAIL TO ALLEGE PLAUSIBLE VIOLATIONS OF THE STARK LAW, COUNTS TWO AND THREE SHOULD ALSO BE DISMISSED.

Counts Two and Three of the SAC state additional variations of FCA violations predicated on the same insufficiently pled Stark Law violations discussed above. In Count Two, the SAC includes one additional conclusory paragraph related to cost reports in an attempt to bolster the claim that "UPMC, acting through its subsidiary hospitals, submitted annual cost reports for the UPMC Hospitals, and actively participated in the

preparation and approval of such cost reports. Such cost reports contained the certifications referenced above, and did not disclose that the arrangements at issue in this complaint violated the Stark Statute." Ex. 1, Redline SAC at ¶ 68. However, without first plausibly pleading an underlying violation of the Stark Law, any certifications based on these cost reports were not "false" and no FCA violation exists. And, moreover, even if they had alleged a predicate violation, Relators have made no attempt to allege which hospital submitted which cost report containing a false certification or by whom it was certified. Thus, Count Two fails under Rules 9(b) and 12(b)(6). *See* Defs.' MTD AC at 26-27.

The SAC includes no substantive revisions to Count Three of the AC. *See* Ex. 1, Redline SAC at ¶¶ 253-257. To plead their reverse false claim theory asserted in Count Three, Relators must allege facts showing that the defendant had a "clear" or established obligation to pay the government and "the defendant did not pay back to the government money or property that it was obligated to return." *U.S. ex rel. Quinn v. Omnicare Inc.*, 382 F.3d 432, 444 (3d Cir. 2004); 31 U.S.C. §3729(b)(3); *see also* Defs.' MTD AC at 27-28. Count Three fails for two reasons. First, as with Counts One and Two, the SAC pleads no predicate Stark Law violation plausibly with requisite particularity. Second, "[c]ourts within this circuit have consistently held that the reverse false claims provision is not a vehicle to simply recast an identical claim under a traditional false claim provision[]." *U.S. ex rel. LaPorte v. Premier Educ. Grp., L.P.*, No. 11-3523 (RBK/AMD), 2016 WL 2747195, at *18 (D.N.J. May 11, 2016). Relators

having done nothing more, Count Three should be dismissed.

CONCLUSION

For all the reasons set forth above, this Court should grant UPMC's Motion to Dismiss Relators' SAC and enter an order dismissing the SAC in its entirety with prejudice.

Respectfully submitted,

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