UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

UNITED STATES OF AMERICA, and THE STATE OF INDIANA, *ex rel.* THOMAS P. FISCHER,	)	
Plaintiffs,	)	
v.	)	No. 1:14-cv-01215-RLY-DLP
COMMUNITY HEALTH NETWORK, INC. *et al.*,	)	
Defendants.	)	

ENTRY ON DEFENDANT'S MOTION TO DISMISS UNITED STATES' COMPLAINT IN INTERVENTION

Community Health Network, Inc. and its subsidiaries comprise an integrated system of hospitals and physicians throughout central Indiana. After investigating and discovering what it believed to be a scheme of improperly compensating physicians and presenting fraudulent Medicare reimbursement claims, the United States seeks damages and penalties against Community for violating the federal False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq.*, the federal Physician Self-Referral Prohibition (the "Stark Law"), 42 U.S.C. § 1395nn, and federal common law. Community now moves to dismiss United States' Complaint in Intervention pursuant to Rules 12(b)(6) and 9(b). For the reasons that follow, that motion is **DENIED**.

I. Procedural and Factual Background

Community, a non-profit corporation headquartered in Indianapolis, Indiana, and its non-profit and for-profit subsidiaries and affiliates provide a full-service integrated

health system in central Indiana. (Filing No. 96, Compl. ¶ 8). On July 21, 2014, Thomas Fischer, who served as Community's Chief Financial Officer from October 2005 until November 2013, filed a *qui tam* complaint against Community and several of its subsidiaries and affiliates. (*Id.* ¶ 7; Filing No. 1, Relator Compl.). Fischer alleged, *inter alia*, that Community had violated the FCA and the Indiana False Claims and Whistleblower Protection Act, Ind. Code § 5-11-5.5-1 *et seq.*, by engaging in a five-year "scheme to pay improper compensation to physicians to induce them to illegally refer patients" in violation of the Stark Law. (Relator Compl. ¶¶ 1-2). Following a multi-year investigation into Fischer's allegations, the Government elected to intervene in part and declined to intervene in part. (Filing No. 86, Notice of Election to Intervene).

The Government's Complaint alleged the following facts, which the court takes as true and draws all reasonable inferences therefrom in the Government's favor. *Bilek v. Fed. Ins. Co.*, 8 F.4th 581, 586 (7th Cir. 2021). Beginning in 2008 or 2009, Community aggressively recruited hundreds of physicians, including breast surgeons, cardiovascular specialists, and neurosurgeons, by offering and paying salaries that were significantly higher than what those physicians received in their own practices. (Compl. ¶¶ 51-52). Community pursued these hires—referred to by Community as "integrations"—to secure those physicians' referrals and out of concern that those referrals would "leak" to Community's local competitors. (*Id.* ¶ 51). The salaries Community paid these physicians were well above fair market value. (*Id.* ¶ 52). Community could afford to do this by calculating the "hospital reimbursement differential" based on each physicians' historical referral and utilization patterns. (*Id.*). Medicare reimburses hospitals at a

higher rate for certain services when they are provided in a hospital instead of a physician's office. (*Id.*). Community, then, stood to receive more in Medicare reimbursement for these services after the physicians became Community employees because those services would be provided at Community hospitals rather than at the physicians' practices. (*Id.*).

Community's upper-level management was aware of the Stark Law's requirement that physician compensation must be fair market value and not determined in a manner that considers the value or volume of referrals. (*Id.* ¶ 53). To that end, Community engaged a valuation firm, Sullivan Cotter & Associates ("Sullivan Cotter"), to analyze the salaries Community paid its physicians and to prepare an opinion on whether the proposed compensation plans represented fair market value under the Stark Law. (*Id.*). Sullivan Cotter made clear to Community that in order for compensation to be presumptively within the range of fair market value, physician compensation needed to be below the 75th percentile of national benchmark salary data or the compensation per productivity needed to be less than the 60th percentile. (*Id.*). When the compensation meets neither of these benchmarks, Sullivan Cotter deemed it to be outside the range of fair market value but could still be justified according to certain "business judgment factors." (*Id.*). Despite this guidance, Community set the physicians' salaries at the 90th percentile of national benchmark data. (*Id.*). Moreover, to induce a favorable opinion, Community did not provide Sullivan Cotter with accurate compensation information. (Compl. ¶¶ 53, 104-13).

In 2013, Community engaged a second valuation expert, Katz Sapper & Miller ("KSM"), to analyze the compensation that Community had paid its physicians in 2012 and the first half of 2013. (*Id.* ¶ 54). KSM concluded that the compensation was "staggering" and "high compared to productivity in all specialties and primary care." (*Id.*). For example, the compensation and compensation per productivity for cardiologists, electrophysiologists, invasive cardiologists, and vascular surgeons were above the 90th percentile. (*Id.*).

Despite this information, Community continued to pay its physicians salaries that were above fair market value and continued to submit claims to Medicare for health services improperly referred by its physicians. (*Id.*). Additionally, Community conditioned awarding incentive compensation to its physicians on the physicians meeting a target of "hospital downstream revenue specific to the physician." (*Id.* ¶ 55). Under this system, physician compensation was determined in a manner that considered the volume or value of referrals to Community, which was prohibited under the Stark Law. (*Id.*). Yet, Community continued to submit claims to Medicare for services referred by their physicians. (*Id.*).

Based on these and other allegations, which the court will address in more detail below, the Government asserts five causes of action against Community, three under the False Claims Act and two under federal common law: (1) claims under 31 U.S.C. § 3729(a)(1)(A) for submitting materially false and fraudulent Medicare reimbursement claims for designated health services rendered to patients who were referred by physicians in violation of the Stark Law; (2) claims under 31 U.S.C. § 3729(a)(1)(B) for

submitting false statements of compliance with the Stark Law for the purpose of getting false or fraudulent claims paid by the United States and that were material to the United States' payment of those claims; (3) claims under 31 U.S.C. § 3729(a)(1)(G) for making false records and statements of compliance with the Stark Law that were material to the United States' obligation to pay money; (4) a claim for payment by mistake based on the United States' payment for claims for designated health services based on the mistaken belief that those claims were not false or fraudulent; and (5) a claim for unjust enrichment to recover the payments to which Community was not entitled.

II. Standard

To avoid dismissal under Rule 12(b)(6), the complaint must "state a claim to relief that is plausible on its face." *Jackson v. Blitt & Gaines, P.C.*, 833 F.3d 860, 862 (7th Cir. 2016) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 678.

Because the government's claims arise under the False Claims Act, an anti-fraud statute, they are subject to Rule 9(b)'s heightened pleading standard. *United States ex rel. Berkowitz v. Automation Aids, Inc.*, 896 F.3d 834, 839 (7th Cir. 2018). Under Rule 9(b), a party alleging fraud "must state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b).

III. Statutory Framework

The court begins by setting out the statutory framework that forms the basis for the Government's allegations. The court first lays out the relevant portions of the FCA before turning to the relevant provisions of the Stark Law.

A. The False Claims Act

To state a claim under the FCA, the Government must show that: "(1) the defendant made a statement in order to receive money from the government; (2) the statement was false; (3) the defendant knew that the statement was false; and (4) the false statement was material to the government's decision to pay or approve the false claim." *U.S. ex rel. Marshall v. Woodward, Inc.*, 812 F.3d 556, 561 (7th Cir. 2015). Knowledge under the FCA includes actual knowledge, deliberate ignorance, or reckless disregard for the truth; specific intent to defraud is not required. *Id.* (citing 42 U.S.C. § 3729(b)(1)). The FCA defines material as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." *Id.* at 563 (citing 42 U.S.C. § 3729(b)(4)).

B. The Stark Law

The Stark Law broadly prohibits a physician who has a "financial relationship" with an entity—such as a hospital—from making a referral to that entity for certain designated health services for which the United States will provide a reimbursement under Medicare. 42 U.S.C. § 1395nn(a)(1), (g)(1); 42 C.F.R. § 411.353(a); *U.S. ex rel. Drakeford v. Tuomey Healthcare Sys., Inc.* ("*Tuomey I*"), 675 F.3d 394, 397 (4th Cir. 2012). The statute also prohibits hospitals from submitting a claim for payment under Medicare for services provided pursuant to an improper referral. 42 U.S.C. §

1395nn(a)(1)(B); 42 C.F.R. § 411.353(b); *United States v. Rogan*, 517 F.3d 449, 452 (7th Cir. 2008).

The Stark Law establishes certain exceptions to what constitutes a "financial relationship." One of those exceptions is a *bona fide* employment relationship. 42 U.S.C. § 1395nn(e)(2); 42 C.F.R. § 411.357(p). That exception provides that payment to a physician by an employer does not violate the Stark Law if, *inter alia*, the payment: (1) "is consistent with the fair market value of the services," (2) "is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician," and (3) "is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer[.]" 42 U.S.C. § 1395nn(e)(2).[1]

IV. Discussion

Community seeks dismissal of each of the Government's claims. The court begins with Community's arguments that the Government's FCA claims should be dismissed under Rule 12(b)(6). Next, the court addresses whether the Government's Complaint was pleaded with sufficient particularity under Rule 9(b). Finally, the court addresses the viability of the Government's common law claims.

A. Whether the Government Alleged a Plausible FCA Claim Under Rule 12(b)(6)

[1] The exception also requires that "the employment is for identifiable services" and the employment meets any other requirements imposed by the Secretary of Health and Human Services. 42 U.S.C. § 1395nn(e)(2). Those elements are not at issue in this case.

Community argues dismissal under Rule 12(b)(6) is appropriate for three reasons: (1) the Government failed to plead that the compensation paid to the physicians violated the Stark Law; (2) the FCA is not an enforcement mechanism for the Stark Law; and (3) the Government failed to plead materiality. The court addresses each argument in turn.

1. The Government Plausibly Alleged Violations of the Stark Law

Community seeks dismissal on the grounds that the Government has not alleged a plausible FCA claim because the Complaint lacks any allegations that Community cannot satisfy the requirements of the *bona fide* employment exception under the Stark Act. Specifically, Community argues the Government did not allege the compensation paid to the physicians: (1) exceeded fair market value; (2) was determined in a manner that took into account the volume or value of referrals; and (3) was commercially unreasonable.

Community's argument is without merit. Whether the *bona fide* employment exception applies is an affirmative defense that the Government need not anticipate or address in its complaint. *See, e.g., United States ex rel. Bookwalter v. UPMC*, 946 F.3d 162, 169 (3d Cir. 2019), *cert. denied,* 140 S. Ct. 2720 ("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 v. Halifax Hosp. Med. Ctr.*, No. 6:09-CV-1002-ORL-31, 2012 WL 921147, at *5 (M.D. Fla. Mar. 19, 2012) (rejecting argument that dismissal is appropriate because the Government failed to plead that an exception did not apply, stating "nothing in [the Stark Law's] language requires that the applicability of such exceptions be denied in the initial pleadings"); *United States v. Rogan*, No. 02 C 3310, 2006 WL 8427270, at *17 (N.D. Ill.

Oct. 2, 2006), *aff'd,* 517 F.3d 449 (7th Cir. 2008) ("Once the United States has demonstrated proof of each element of a violation of the Anti-Kickback and/or Stark Statutes, the burden shifts to the defendant to establish that his conduct was protected by a safe harbor or exception; the United States need not prove, as an element of its case, that defendant's conduct does not fit within a safe harbor or exception.").

Even if this were not the case, the Government's Complaint plausibly alleged that the *bona fide* employment relationship exception does not apply. First, the Government has plausibly alleged that the compensation arrangement exceeded fair market value. The Complaint contains numerous allegations regarding how Community's valuation consultants identified benchmarks to evaluate fair market value, and the Complaint identifies which physicians' compensation exceeded fair market value and in which years. (*See* Compl. ¶¶ 53, 124, 211, 224, 251, 290). For example, the Complaint alleged that according to Sullivan Cotter, Community's own valuation consultant, in order to qualify as presumptively fair market value, physician compensation needed to be below the 75th percentile of national benchmark salary data, or the compensation per productivity needed to be less than the 60th percentile. (*Id*. ¶¶ 89-98). When presented with the compensation plan for Community's breast care surgeons, Sullivan Cotter determined that the total cash compensation ("TCC") for the first year of the compensation plan fell within the bounds of fair market value. (*Id.* ¶ 97). However, the Complaint further alleged that Community intentionally provided falsely inflated data, and that Sullivan Cotter relied on that falsely inflated data to render a favorable opinion. (*Id.* ¶¶ 104-16).

Had Community provided accurate data, Sullivan Cotter would not have concluded that the proposed compensation plan was fair market value. (*Id.* ¶ 112).

Similarly, the Complaint alleged the compensation plans for Community's cardiovascular specialists and neurosurgeons did not qualify as fair market value. (*See, e.g.*, *id.* ¶¶ 180-91 (alleging Sullivan Cotter determined that most of the cardiovascular specialists received compensation that exceeded benchmark or threshold percentiles); *id.* ¶¶ 271-77 (alleging Sullivan Cotter estimated compensation plans for Community's neurosurgeons exceeded fair market value)). Despite knowing these compensation plans were not fair market value, the Complaint alleges Community still submitted claims to Medicare that were referred by specialists in violation of the Stark Law. (*Id.* ¶¶ 125, 225, 291).

As for the Government's allegations that Community improperly considered the volume or value of physician referrals in setting physician compensation, the Complaint contains numerous allegations to that effect. (*See id.* ¶¶ 293-306). Community's incentive compensation was comprised of three components, including "service line financial performance." (*Id.* ¶ 295). The service line financial performance component, which made up 25 percent of the total incentive compensation for which a physician was potentially eligible, could be met by "meeting targeted revenues generated by referrals from the physician to the hospital." (*Id.* ¶ 296). The Complaint further alleged that the service line financial performance component was conditioned on "hospital downstream revenue specific to the physician." (*Id.* ¶ 298). Based on these allegations, the Complaint

plausibly alleged that Community determined physician compensation in a manner that took into account the volume or value of their referrals.

In sum, the Government has plausibly alleged an FCA violation.

2. Stark Law Violations Are Enforceable Through the FCA

Community next argues that the Government failed to state a plausible FCA claim because the FCA is not an enforcement mechanism for Stark Law violations. For support, Community points to Congress' disparate treatment of the Anti-Kickback statute and the Stark Law in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010) ("PPACA"). In the PPACA, Congress amended the Anti-Kickback statute to create a private cause of action under the FCA. 42 U.S.C. § 1320a-7b(g). While Congress amended the Stark Law in other ways through the PPACA, Congress did not amend the law to provide a private cause of action. According to Community, this indicates Congress' intent that the FCA is not a vehicle to enforce the Stark Law.

This argument also fails. Community does not cite any authority to support this interpretation of the Stark Law, and Community does not address the weight of post-PPACA caselaw permitting the FCA to enforce the Stark Law. *See, e.g.*, *Bookwalter*, 946 F.3d at 169 (because it does not provide a private right of action, the "Stark Act never appears in court alone. Instead, it always come[s] in through another statute that creates a cause of action—typically, the False Claims Act"); *Tuomey I*, 792 F.3d at 396 ("Because the Stark Law does not create its own right of action, the United States sought relief under the False Claims Act . . . ."). Because the FCA is a proper vehicle to enforce the Stark Law, dismissal on this ground is not appropriate.

3. The Government Plausibly Alleged Materiality

Community next argues dismissal under 12(b)(6) is appropriate because the Government failed to plead that Community's alleged violations were material to the government's decision to pay. The court disagrees.

It is unlawful under the FCA to knowingly present a false or fraudulent claim for payment to the United States. *United States ex rel. Prose v. Molina Healthcare of Illinois, Inc.*, 10 F.4th 765, 772 (7th Cir. 2021). But not all false statements are actionable under the FCA. *Id.* A successful FCA claim must also satisfy a strict materiality requirement. *Id.* (citing *Universal Health Servs., Inc. v. United States ex rel. Escobar* ("*Escobar*"), 136 S. Ct. 1989, 1996 (2016)). "Materiality look[s] to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation." *Escobar*, 136 S. Ct. at 2003 (citation omitted) (alteration in original). Whether something is material "cannot rest on 'a single fact or occurrence as always determinative.'" *Id.* at 2001 (quoting *Matrixx Initiatives, Inc. v. Siracusano*, 563 U.S. 27, 39 (2011)); *see also United States ex rel. Escobar v. Universal Health Servs., Inc.* ("*Escobar II*"), 842 F.3d 103, 109 (1st Cir. 2016) ("[C]ourts are to conduct a holistic approach to determining materiality in connection with a payment decision, with no one factor being necessarily dispositive.").

The Court in *Escobar* identified a non-exhaustive list of factors that might contribute to determining materiality, including whether the government identifies a particular provision as a condition of payment, 136 S. Ct. at 2001, whether compliance goes to the "essence of the bargain," *id.* at 2003 n.5 (citation omitted), whether the

alleged violation is "minor or insubstantial," *id.* at 2003, and what steps the Government took when it was aware of the violation, *id.* at 2003-04. On the final factor, the Court explained:

> [P]roof of materiality can include, but is not necessarily limited to, evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement. Conversely, if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material. Or, if the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material.

Id.

Applying a holistic approach to determining materiality, the court concludes that the Government has adequately alleged that Community's alleged Stark Law violations were material to the Government's decision to pay. First, the Complaint alleged that the Stark Law prohibits the Government from paying Medicare claims submitted in violation of the statute. (Compl. ¶¶ 20, 340 (citing 42 U.S.C. § 1395nn(a)(1), (g)(1)). This statutory requirement is echoed by the accompanying regulations, which require an entity to return any payment for health services performed pursuant to an improper referral. 42 C.F.R. § 411.353(d). While "statutory, regulatory, and contractual requirements are not automatically material, even if they are labeled conditions of payment," they are still "relevant" evidence in favor of materiality. *Escobar*, 136 S. Ct. at 2001. Community also submitted Medicare enrollment applications in which Community certified compliance with the Stark Law, further reinforcing materiality. (Compl. ¶¶ 38-40).

Second, the Complaint alleged that compliance with the Stark Law "goes to the essence of Medicare's bargain with participating healthcare providers." (*Id.* ¶ 343). The Complaint explains that the law ensures services are "not provided merely to enrich the parties in a financial relationship at the expense of federal health programs and their beneficiaries." (*Id.*). The Complaint also points to several cases brought by the United States in which entities or individuals submitted claims that violated the Stark Law. (*Id.* ¶¶ 344-49). It is notable that the Complaint alleged that a representative of Sullivan Cotter reminded Community's Compensation Committee that "the Tuomey case was lost and paid a huge settlement." (*Id.* ¶¶ 216, 219). According to the Complaint, this was a reference to *U.S. ex rel. Drakeford v. Tuomey* ("*Tuomey II*"), 792 F.3d 364 (4th Cir. 2015), in which the United States obtained a judgment against a hospital that had a compensation arrangement with physicians that did not qualify for an exception to the Stark Law, including because the compensation exceeded fair market value. This indicates the Compensation Committee was aware that the Government had pursued cases like this in the past.

Finally, the Complaint explains that the alleged violations are not minor or insubstantial because they "implicate the core concerns of the [Stark Law]." (Compl. ¶ 350). Community "knowingly and systematically paid physicians compensation that was excessive or that took into account the volume or value of referrals that resulted in thousands of false Medicare claims." (*Id.*). These allegations plausibly allege materiality under the Supreme Court's holistic approach to determining materiality.

Community's best argument is that despite actual knowledge of the potential violations, the Government continued paying Community since July 2014 when the relator filed his *qui tam* complaint, which is strong evidence that the requirements were not material. It is true that if the government continues to pay for claims "despite actual knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material." *Escobar*, 136 S. Ct. at 2003–04; *see also United States v. Sanford-Brown, Ltd.*, 840 F.3d 445, 447 (7th Cir. 2016) (affirming summary judgment in favor of defendant where relator "offered no evidence that the government's decision to pay SBC would likely or actually have been different had it known of SBC's alleged noncompliance with Title IV regulations"). But this is simply one factor among many, and *Escobar* directs that courts consider them holistically. At this stage, the Government need only plausibly allege materiality, and the parties can relitigate this issue after further discovery. *See, e.g.*, *Prose*, 10 F.4th at 777 (concluding at motion to dismiss stage that "this argument is better saved for a later stage, once both sides have conducted discovery," despite argument that violations were not material because the government continued paying the defendant and twice renewed its contract with the defendant after relator filed the action).

Community's remaining arguments are without merit. Community argues that PPACA's creation of the Self-Referral Disclosure Protocol, which allows the Secretary of Department of Health and Human Services to reduce the penalty for self-disclosed violations of the Stark Law, indicates that the sanctions set forth in the Stark Law are discretionary. *See* 42 U.S.C. § 6409(a). Community then cites to *D'Agostino v. ev3, Inc.*,

845 F.3d 1 (1st Cir. 2016), and argues that when false or fraudulent representations "could have" influenced the Government's payment of claims, FCA liability does not attach. *Id.* at 7. Community's reliance on *D'Agostino* is misplaced, and Community fails to point to any other authority supporting its argument. The holding in *D'Agostino* related only to the causation requirement of the plaintiff's FCA claim: "We hold only that causation is an element of the fraudulent inducement claims D'Agostino alleges and that the absence of official action by the FDA establishing such causation leaves a fatal gap in this particular proposed complaint." *Id.* at 9. To the extent the court considered materiality, and it did so only in passing, that analysis addressed the government's continued reimbursement following the relator's allegations. *See id.* at 8 ("The fact that CMS has not denied reimbursement for Onyx in the wake of D'Agostino's allegations casts serious doubt on the materiality of the fraudulent representations that D'Agostino alleges."). As discussed above, that factor, while relevant, is not dispositive. *D'Agostino* did not speak to whether Stark Law penalties are discretionary, nor did it establish that discretionary penalties may not be enforced through the FCA.

Furthermore, it is not clear why the existence of the Self-Referral Disclosure Protocol, which appears to only give the Secretary the ability to reduce penalties in situations where a physician self-reports, means that all penalties under the Stark Law are discretionary. Community has provided no support for that proposition.

Finally, Community suggests that Stark Law violations without overutilization allegations are not material. That argument can be dispensed with quickly because overutilization is not an element in the statute. *See* 42 U.S.C. § 1395nn(a)(1).

Community does not cite to any authority concluding that an FCA claim based on Stark Law violations must allege overutilization.

For the foregoing reasons, the court concludes the Government plausibly alleged an FCA claim under Rule 12(b)(6).

B. Whether the Government Pleaded Violations of the Stark Law and FCA with Sufficient Particularity Under Rule 9(b)

Having determined that the Government plausibly alleged violations of the FCA and Stark Law, the court now considers whether the Complaint satisfies Rule 9(b)'s pleading requirements. To survive a motion to dismiss, a fraud claim must allege the "'who, what, when, where, and how' of the fraud—'the first paragraph of any newspaper story.'" *United States ex rel. Berkowitz v. Automation Aids, Inc.*, 896 F.3d 834, 839 (7th Cir. 2018) (quoting *United States ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 853 (7th Cir. 2009)).

Community does not dispute that the Government adequately pleaded the first element of a Stark Law violation—that the physicians had a financial relationship with Community. Community argues that the Government made conclusory allegations that no Stark Law exception applies and failed to plead that the compensation arrangement was not fair market value, that the compensation was determined in a manner that took into account the volume or value of referrals, or that the compensation was not commercially reasonable. As explained above, however, whether an exception applies is an affirmative defense that the Government is not required to address in its Complaint.

But even putting that to one side, the Government has satisfied the more stringent pleading requirements for a fraud claim. The Complaint, which runs more than 80 pages (plus exhibits) in length and contains 370 numbered paragraphs, includes detailed allegations regarding how the physician compensation arrangement for the different specialty groups exceeded fair market value compared to various benchmarks, (Compl. ¶¶ 84-85, 93-94, 164, 175, 181-90, 211, 251), that Community provided false information to obtain a favorable ruling from Sullivan Cotter, (*id.* ¶¶ 97, 104-14, 254), and that at the end of it all, Community submitted false claims to Medicare for payment, (*id.* ¶¶ 55, 122, 222, 288, 307). The Complaint also identifies which physicians' compensation exceeded fair market value and in which years, and it provides specific examples of claims that were submitted to Medicare for direct health services that had been improperly referred by Community physicians. (*Id.* ¶¶ 53, 124, 211, 224, 251, 290; Filing Nos. 96-4, Breast Surgeon Claims; 96-5, Cardiovascular Specialists Claims; 96-6, Neurosurgeons Claims; 96-7, Physicians Incentive). Additionally, the Complaint explains how Community's compensation arrangement considered the volume or value of referrals. (Compl. ¶¶ 293-306). In short, the Complaint has alleged the who, what, when, where, and how of the alleged fraud.

C. Whether the Government's Common Law Claims May Proceed

Finally, the court addresses whether the Government's claims for payment by mistake and unjust enrichment may proceed.

"The government by appropriate action can recover funds which its agents have wrongfully, erroneously, or illegally paid." *United States v. Berkeley HeartLab, Inc.*, No.

CV 9:14-230-RMG, 2017 WL 4803911, at *7 (D.S.C. Oct. 23, 2017) (citation omitted). To state a federal common law claim for payment by mistake, the Government must plausibly allege that it "made . . . payments under an erroneous belief which was material to the decision to pay . . . ." *United States v. Mead*, 426 F.2d 118, 124 (9th Cir. 1970). As for unjust enrichment, "a person is unjustly enriched if the retention of [a] benefit would be unjust." *United States v. Rogan*, No. 02 C 3310, 2006 WL 8427270, at *27 (N.D. Ill. Oct. 2, 2006), *aff'd,* 517 F.3d 449 (7th Cir. 2008) (quoting Restatement of Restitution, § 1 (1937)). To state a federal claim for unjust enrichment, the Government must plausibly allege that: (1) it had a reasonable expectation of payment; (2) Community should reasonably have expected to pay; or (3) "society's reasonable expectations of person and property would be defeated by nonpayment." *Id.* (quoting *Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985, 993-94 (4th Cir. 1990)).

Community seeks dismissal on three grounds, the first two of which require no additional discussion as they relate to arguments the court has already addressed.[2] Community's third argument is that these claims must be dismissed because the equities require it. Community argues the Complaint does not allege that Community submitted reimbursement claims for health services that were not performed or were not medically necessary, and it would be unfair if Community were forced to repay Medicare funds for medically necessary services that were performed for the patients' benefit.

[2] Those arguments are that the common law claims are derivative of the allegedly infirm FCA claim and that the Government failed to plead materiality. As discussed at length above, neither of those arguments have merit.

This argument largely mirrors Community's overutilization argument that the court rejected. Further, to the extent this argument addresses the merits of the Government's claims—that Community was unjustly enriched or paid by mistake—it is premature. Whether Community violated the Stark Law and the FCA is the heart of the case, and for the reasons laid out above, the Government has plausibly alleged violations of those laws. As a result of those alleged violations, it is plausible that Community received payment to which it was not entitled and was thereby unjustly enriched.

V. Conclusion

For the foregoing reasons, Defendant's Motion to Dismiss United States' Complaint in Intervention (Filing No. 151) is **DENIED**.

SO ORDERED this 20th day of October 2021.

RICHARD L. YOUNG, JUDGE
United States District Court
Southern District of Indiana

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