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APPENDIX A

United States Court of Appeals
for the Fifth Circuit

No. 22-10137

UNITED STATES OF AMERICA, *ex rel.*, HOWARD BECK, M.D.,

Plaintiff—Appellant,

versus

ST. JOSEPH HEALTH SYSTEM; COVENANT HEALTH SYSTEM; COVENANT MEDICAL CENTER; COVENANT MEDICAL GROUP,

Defendants—Appellees.

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 5:17-CV-52

(Filed Feb. 1, 2023)

Before WIENER, HIGGINSON, and WILSON, *Circuit Judges.*

PER CURIAM:*

Relator-Appellant Howard Beck, M.D. ("Relator") alleges that Defendants-Appellees healthcare entities

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* This opinion is not designated for publication. *See* 5TH CIR. R. 47.5.

("Defendants") engaged in an illegal scheme to pay physicians for patient referrals. We lack jurisdiction over this matter because the notice of appeal was untimely.

The relevant dates are as follows: The district court granted summary judgment for Defendants and entered judgment on November 30, 2021. On December 10, 2021, Relator moved the district court to alter or amend the judgment pursuant to FED. R. CIV. P. 59(e). This motion was denied on December 14 for failure to include a certificate of conference. That same day, Relator filed a second identical motion to alter or amend the judgment with the requested certificate of conference. On January 12, 2022, Relator's second motion was denied. Relator filed his notice of appeal on February 9, 2022.

"[T]he timely filing of a notice of appeal in a civil case is a jurisdictional requirement." *Bowles v. Russell*, 551 U.S. 205, 214 (2007). Parties ordinarily have 30 days from entry of judgment to file such a notice, FED. R. APP. P. 4(a)(1)(A),[1] but this requirement is tolled by a timely post-judgment motion pursuant to Fed. R. Civ. P. 59 or 60. *See* FED. R. APP. P. 4(a)(4)(A)(iv), (v), (vi). If thus tolled, the time begins to run again from the decision on the last timely post-judgment motion. *See id.* There is an exception, however: A successive post-judgment motion that seeks the same or similar relief

[1] The government did not intervene here; therefore, the ordinary 30-day deadline under FED. R. APP. P. 4(a)(1)(A) applies. *See U.S. ex rel. Eisenstein v. City of New York, New York*, 556 U.S. 928, 931 (2009).

as an earlier filed post-judgment motion does not further toll the time to appeal. *See Charles L.M. v. N.E. Indep. Sch. Dist.*, 884 F.2d 869, 870 (5th Cir. 1989) (holding that a successive identical post-judgment motion does not toll the time to appeal as recognized by "well-established authority in this and other circuits"); *see also Thomas v. Stafflink, Inc.*, 855 F. App'x 983, 984 (5th Cir. 2021), *cert. denied*, 142 S. Ct. 1386 (2022) (finding a notice of appeal untimely due to this principle); *Edwards v. 4JLJ, L.L.C.*, 976 F.3d 463, 465 (5th Cir. 2020) (same). Our court has held, so we are bound, that this holds true when the second motion is identical to the first. *Id.* The 30-day time for appeal ran from the district court's denial of Relator's first Rule 59(e) motion.

This longstanding rule aims to prevent gamesmanship of the time to file an appeal. *See Charles L.M.*, 884 F.2d at 871 ("The interest of finality requires that parties generally get only one bite at the rule 59(e) apple for the purpose of tolling the time for bringing an appeal."). While the situation here does not implicate gamesmanship, it falls within our precedent that a successive identical post-judgment motion does not serve to toll the deadline. *See id.* If ever a party is at risk of an untimely notice of appeal under this principle, it may file notice to preserve its appeal, even while a post-judgment motion is pending. *See Ross v. Marshall*, 426 F.3d 745, 751-52 (5th Cir. 2005).

Defendants' motion to dismiss is GRANTED, and this appeal is DISMISSED.

APPENDIX B

United States Court of Appeals
for the Fifth Circuit

No. 22-10137

UNITED STATES OF AMERICA, *ex rel*, HOWARD BECK, M.D.,

Plaintiff—Appellant,

versus

ST. JOSEPH HEALTH SYSTEM; COVENANT HEALTH SYSTEM; COVENANT MEDICAL CENTER; COVENANT MEDICAL GROUP,

Defendants—Appellees.

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 5:17-CV-52

(Filed Feb. 1, 2023)

Before WIENER, HIGGINSON, and WILSON, *Circuit Judges.*

JUDGMENT

This cause was considered on the record on appeal and was argued by counsel.

IT IS ORDERED and ADJUDGED that the appeal is DISMISSED for lack of jurisdiction.

IT IS FURTHER ORDERED that plaintiff-appellant pay to defendants-appellees the costs on appeal to be taxed by the Clerk of this Court.

APPENDIX C

United States Court of Appeals
for the Fifth Circuit

No. 22-10137

UNITED STATES OF AMERICA, *ex rel*, HOWARD BECK, M.D.,

Plaintiff—Appellant,

versus

ST. JOSEPH HEALTH SYSTEM; COVENANT HEALTH SYSTEM; COVENANT MEDICAL CENTER; COVENANT MEDICAL GROUP,

Defendants—Appellees.

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 5:17-CV-52

ON PETITION FOR REHEARING EN BANC

(Filed May 4, 2023)

Before WIENER, HIGGINSON, and WILSON, *Circuit Judges.*

PER CURIAM:

Treating the petition for rehearing en banc as a petition for panel rehearing (5TH CIR. R. 35 I.O.P.), the petition for panel rehearing is DENIED. Because no

member of the panel or judge in regular active service requested that the court be polled on rehearing en banc (FED. R. APP. P. 35 and 5TH CIR. R. 35), the petition for rehearing en banc is DENIED.

APPENDIX D

United States Court of Appeals
for the Fifth Circuit

No. 22-10137

UNITED STATES OF AMERICA, *ex rel*, HOWARD BECK, M.D.,

Plaintiff—Appellant,

versus

ST. JOSEPH HEALTH SYSTEM; COVENANT HEALTH SYSTEM; COVENANT MEDICAL CENTER; COVENANT MEDICAL GROUP,

Defendants—Appellees.

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 5:17-CV-52

(Filed Apr. 5, 2022)

Before JONES, DUNCAN, and ENGELHARDT, *Circuit Judges.*

PER CURIAM:

IT IS ORDERED that Appellees' motion to dismiss the appeal as untimely and for lack of jurisdiction is CARRIED WITH THE CASE.

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

UNITED STATES OF AMERICA *ex rel.* HOWARD BECK, M.D., Plaintiff, v. ST. JOSEPH HEALTH SYSTEM, *et al.*, Defendants.	)	Civil Action No. 5:17-CV-052-C

ORDER

(Filed Jan. 12, 2022)

For the reasons stated in the Court's Order of November 30, 2021, it is hereby **ORDERED** that Relator's Second Rule 59(e) Motion to Reconsider Order Granting Defendants' Motion for Summary Judgment (Motion to Alter or Amend Judgment) be **DENIED**.[1]

[1] Relator identifies no manifest error of fact or law, presents no new evidence, makes no legitimate argument that the Motion for Reconsideration is necessary to prevent a manifest injustice, and points to no intervening change in controlling law.

SO ORDERED.

Dated January 12, 2022.

/s/ Sam Cummings
SAM R. CUMMINGS
SENIOR UNITED STATES
DISTRICT JUDGE

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

UNITED STATES OF AMERICA *ex rel.* HOWARD BECK, M.D., Plaintiff, v. ST. JOSEPH HEALTH SYSTEM, *et al.*, Defendants.	)	Civil Action No. 5:17-CV-052-C

ORDER

(Filed Dec. 14, 2021)

The Court **ORDERS** that Relator's Rule 59(e) Motion to Reconsider Order Granting Defendant's Motion for Summary Judgment (Motion to Alter or Amend Judgment) be **DENIED** as the same fails to include a certificate of conference. *See* N.D. Tex. Local Civil Rule 7.1 h ("Note: if a motion is not listed, a brief and certificate of conference are required.").

SO ORDERED.

Dated December 14, 2021.

/s/ Sam Cummings
SAM R. CUMMINGS
SENIOR UNITED STATES
DISTRICT JUDGE

APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

UNITED STATES OF AMERICA *ex rel.* HOWARD BECK, M.D., Plaintiff, v. ST. JOSEPH HEALTH SYSTEM, *et al.*, Defendants.	)	Civil Action No. 5:17-CV-052-C

ORDER

(Filed Nov. 30, 2021)

Before the Court are the Parties' Cross Motions for Summary Judgment. Having considered the Motions, the Parties' briefing, and all applicable law, the Court is of the opinion that Defendants' Motion for Summary Judgment should be **GRANTED** for the reasons argued therein and that Relator's Motion for Partial Summary Judgment should be **DENIED**).[1]

[1] The Court adopts the reasoning and arguments of Defendants' briefing as contained and included herein.

I.
BACKGROUND

On September 30, 2016, Howard Beck, M.D. ("Relator") filed the above-styled and -numbered civil action against St. Joseph Health System ("SJHS"), Covenant Health System ("CHS"), Covenant Medical Center ("CMC"), and Covenant Medical Group ("CMG") (collectively "Defendants") pursuant to the False Claims Act, 31 U.S.C. §§ 3729-33, the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), and the Stark Statute, 42 U.S.C. § 1395nn. Relator alleges that Defendants knowingly defrauded the federal government and the state of Texas by submitting and/or causing the submission of false claims for reimbursement to Medicare, 42 U.S.C. § 1395 *et seq.*, and Medicaid, 42 U.S.C. § 1396 *et seq.*, thereby violating specific provisions of the False Claims Act, the Anti-Kickback Statute, the Stark Statute, as well as various state laws. More specifically, Relator alleges that Defendants have engaged in a scheme to pay improper compensation to Covenant Medical Group physicians to induce said physicians to refer patients—including Medicare and Medicaid patients—to Covenant Medical Center for inpatient and ancillary services, including admissions, lab work, and radiology.[2]

Defendants now seek summary judgment as to each and every claim that has been asserted. Conversely, Relator seeks a partial summary judgment

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[2] Relator contends that the compensation offered to physicians as an inducement for referrals includes overall compensation above fair market value and in excess of what is commercially reasonable.

and asks the Court to find that Defendants have entered into a prohibited financial relationship with at least one physician in violation of the Stark Statute, 42 U.S.C. § 1395nn, and that the alleged financial compensation agreements with said physician falls outside the scope of any applicable exception to the Stark Statute's referral prohibition.

II.
STANDARD

Summary judgment is appropriate when "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *Tagore v. United States*, 735 F.3d 324, 328 (5th Cir. 2013). A material fact is one that might affect the outcome of the case under the governing law; a dispute concerning a material fact is genuine if the evidence is such that a reasonable jury could return a verdict for the non-moving party. *Tagore*, 735 F.3d at 328 (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)) (quotations omitted). To determine whether a genuine dispute exists such that the case must be submitted to a jury, courts must consider all of the evidence in the light most favorable to the non-moving party, draw all reasonable inferences in favor of the non-moving party, refuse to make credibility determinations or weigh the relative strength of the evidence, and disregard all evidence favorable to the movant that the jury would not be required to believe. *Haverda v. Hays County*, 723 F.3d 586, 591 (5th Cir. 2013).

If the burden at trial would be on the non-moving party, the movant must merely demonstrate "that there is an absence of evidence to support the non-moving party's case." *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986); *Bayle v. Allstate Ins. Co.*, 615 F.3d 350, 355 (5th Cir. 2010). The burden then shifts to the non-moving party to produce evidence showing the existence of a genuine issue of material fact for trial. *Bayle*, 615 F.3d at 355; Fed. R. Civ. P. 56(e). To meet this burden, the non-movant must go beyond the pleadings and present specific facts indicating a genuine issue for trial. *Bayle*, 615 F.3d at 355. "[C]onclusory statements, speculation, and unsubstantiated assertions" are not specific facts and are not sufficient to defeat a motion for summary judgment. *RSR Corp. v. Int'l Ins. Co.*, 612 F.3d 851, 857 (5th Cir. 2010).

III.
DISCUSSION

Relator's Motion for Continuance and Relator's Evidentiary Objections

For essentially the reasons stated in Defendant's Reply Brief, the Court **ORDERS** that Relator's Motion for Continuance be **DENIED**. Specifically, Relator has failed to adequately explain why additional discovery is essential to rebut Defendant's Motion for Summary Judgment.[3] As to Relator's evidentiary objections, the

[3] Relator's Motion for Continuance is also procedurally improper because a motion made under Rule 56(d) "must be filed separately and may not be included in the response to the motion for summary judgment, brief in support thereof, or any other

Court **ORDERS** that the same be **OVERRULED**. *See Patel v. Texas Tech Univ.*, 941 F.3d 743, 746 (5th Cir. 2019) (citations omitted) ("Although the substance or content of the evidence submitted to support or dispute a fact on summary judgment must be admissible . . . , the material may be presented in a form that would not. in itself, be admissible at trial."); *see also Maurer v. Independence Town*, 870 F.3d 380, 384 (5th Cir. 2017) ("At the summary judgment stage, evidence need not be authenticated or otherwise presented in an admissible form.") (citations omitted).[4]

Public Disclosure Bar—Qui Tam Actions[5]

"The public disclosure bar of the False Claims Act deprives the district court of jurisdiction whenever *qui tam* relators bring a suit based on publically available information." *U.S. ex rel. Jamison v. McKesson Corp.*, 649 F.3d 322, 324 (5th Cir. 2011). In determining whether the public disclosure bar applies, the Fifth

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document." *Roe v. Johnson Cty., Tex.*, 2021 WL 197427, at *4 (N.D. Tex. Jan. 20, 2021).

[4] To the extent Relator takes issues with Defendants' Exhibits 20-21 and 23-25, the Court notes that Defendants do not rely on those prior pleadings or submissions as evidence of any material factual contentions—rather, Defendants simply point to the same to provide context and background information. Additionally, the Court notes that Relator has now withdrawn his objection to Defendants' Exhibit 87. *See* Doc. 222 at p. 3, n. 1.

[5] "*Qui tam* is an abbreviation for *qui tam pro domino rege quam pro se ipso in hac parte sequitur*, which means 'who as well for the king as for himself sues in this matter.'" *U.S. ex rel. Grubbs v. Kanneganti.* 565 F.3d 180, 184 n.5 (5th Cir. 2009) (citing Black's Law Dictionary 1262 (7th ed. 1999)).

Circuit has employed "a three-part test, asking 1) whether there has been a 'public disclosure' of allegations or transactions, 2) whether the *qui tam* action is 'based upon' such publicly disclosed allegations, and 3) if so, whether the relator is the 'original source' of the information." *Id.* at 327.

Defendants assert that Relator's allegations were publically disclosed through four different sources, including: (1) Covenant Medical Group's Internal Revenue Services Form 990s from 2012 through 2013; (2) MGMA Physician Compensation and Production Surveys and the AMGA Medical Group Compensation and Financial Surveys; (3) the Wall Street Journal's searchable database, "*Behind the Numbers: Medicare Unmasked*."; and (4) Centers for Medicare & Medicaid Services Medicare Provider Utilization and Payment Data.[6]

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[6] The Court's analysis is based upon these documents—rather than Relator's First Amended Complaint. *See United States ex rel. Solomon v. Lockheed Martin Corp.*, 878 F.3d 139, 143-44 (5th Cir. 2017) (examining only the relator's original complaint in evaluating the FCA's public disclosure bar); *see also United Slates ex rel. Jamison v. McKesson Corp.*, 649 F.3d 322, 33I n.19 (5th Cir. 2011) (disregarding information the relator obtained through conversations and investigation after filing the original complaint in light of court's conclusion that "we must focus on the original complaint . . . when evaluating whether [the relator's] action was based on the allegations in the public disclosures"). In any event, even if the Court were to analyze Relator's First Amended Complaint. the public disclosure bar would apply to both pleadings.

i. Whether there has been a Public Disclosure of Allegations or Transactions?

"The first element of the jurisdictional bar asks whether there has been a public disclosure of allegations or transactions. As this Court has recognized, the plain language of the statute suggests three sub-parts to this element: (1) public disclosure; (2) in a particular form specified in the statute; and (3) of allegations or transactions." *U.S. ex rel. Colquitt v. Abbott Labs.*, 864 F. Supp. 2d 499, 517 (N.D. Tex. 2012), *aff'd sub nom. United States ex rel. Colquitt v. Abbott Labs.*, 858 F.3d 365 (5th Cir. 2017).[7] "The public disclosure bar is triggered only by public disclosures 'in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media.'" *Id.* (quoting 31 U.S.C. § 3730(e)(4)(A)).[8]

Here, the four sources of publically available information alleged in Relator's Complaint—(1) Covenant Medical Group's Internal Revenue Services Form 990s

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[7] *See United States ex rel. Hendrickson v. Bank of Am., N.A.*, 343 F. Supp. 3d 610, 623 (ND, Tex. 2018) ("Prior to the 2010 amendments, courts viewed a jurisdictional challenge under the FCA as the equivalent of a motion for summary judgment because it [was] necessarily intertwined with the merits. It is unclear whether the 2010 version of the public-disclosure bar is still a jurisdictional barrier or whether it is now an affirmative defense.").

[8] Other circuits have "read section 3730(e)(4) . . . to preclude *qui tam* suits based on information that would have been equally available to strangers to the fraud transaction had they chosen to look for it as it was to the relator." *U.S. ex rel. Stinson, Lyons, Gerlin & Bustamante, P.A. v. Prudential Ins. Co.*, 944 F.2d 1149, 1155-56 (3d Cir. 1991).

from 2012 through 2013; (2) MGMA Physician Compensation and Production Surveys (the "MGMA Reports") and the AMGA Medical Group Compensation and Financial Surveys (the "AMGA Reports"); (3) the Wall Street Journal's searchable database, "*Behind the Numbers: Medicare Unmasked*."; and (4) Centers for Medicare & Medicaid Services Medicare Provider Utilization and Payment Data ("CMS Data")—all constitute a "public disclosure" within the meaning of the False Claims Act.[9]

Specifically, the MGMA Reports, the AMGA Reports, and the CMS Data all fit within the broadly construed "news media" channel of public disclosures because they are on publicly available websites. *See*, *e.g.*, *United States ex rel. Repko v. Guthrie Clinic, P.C.*, 2011 WL 3875987, at *7-8 (M.D. Pa. Sept 1, 2011) (holding that four websites that collected and disseminated financial information to the public—both for free and for a subscription fee depending on the type of information sought—and provided searchable online databases and articles, were "news media" for purposes of the public disclosure bar); *U.S. ex rel. Brown v. Walt Disney World Co.*, 2008 WL 2561975, at *4, n.7 (M.D. Fla. June 24, 2008) (determining that "[t]he Internet can qualify as 'news media' within the meaning of" the False Claims Act).

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[9] Relator does not appear to contest that CMG's Internal Revenue Services Form 990s and the Wall Street Journal's searchable database, "*Behind the Numbers: Medicare Unmasked*" constitute public disclosures within the meaning of the False Claims Act.

ii. Whether this Qui Tam Action is Based Upon such Publicly Disclosed Allegations?

Next, in order to survive summary judgment, a relator must "produce evidence sufficient to show that there is a genuine issue of material fact as to whether his action was based on those public disclosures." *Jamison*, 649 F.3d at 327. A relator's complaint is based upon public disclosures if "one could have produced the substance of the complaint merely by synthesizing" the public disclosures' description of the scheme. *Id.* at 331. Furthermore, "if a *qui tam* action is even partly based upon public allegations or transactions . . . ," then the public disclosure bar applies. *U.S. ex rel. Fried v. W. Indep. Sch. Dist.*, 527 F.3d 439, 442 (5th Cir. 2008).

The Fifth Circuit has recently adopted a test to determine whether public disclosures "contain sufficient indicia of an FCA violation to bar a subsequently filed FCA complaint":

> Under this approach, "the combination of X and Y must be revealed, from which the readers or listeners may infer Z." Z is an inference of fraud under the FCA, while X and Y are two required elements for the inference: "a misrepresented state of facts and a true state of facts."

United States ex rel Solomon v. Lockheed Martin Corp., 878 F.3d 139, 144 (5th Cir. 2017). Courts are clear that the public disclosure bar prohibits *qui tam* actions "when either the allegation of fraud or the critical elements of the fraudulent transaction themselves were

in the public domain." *Id.* at 145. When the "elements of a fraudulent transaction are present in public disclosures, those public disclosures need not allege fraud in explicit language." *Id.* at 145-46 (finding relator's complaint was based upon public disclosures when publicly available reports alleged facts that made "a potentially fraudulent scheme readily identifiable.").

Here, Relator based the entirety of his claims on the publicly available information identified above. The crux of Relator's Original Complaint, First Amended Complaint, and Disclosure Statements, is an alleged "scheme" wherein Defendants compensate CMG's physicians at above fair market value—purportedly evidenced by CMG's financial losses—to induce referrals to CMC for inpatient and ancillary services. The X—misrepresented state of facts, according to Relator—in this equation is that Defendants were in compliance with all federal laws when they sought reimbursement from Medicare. The Y—true state of facts, according to Relator—is that Defendants were actually in violation of the AKS and Stark Law by virtue of the alleged above fair market value compensation paid to the CMG physicians.

However, Relator's allegations are entirely reliant on the four sources of public disclosures previously discussed: (1) Covenant Medical Group's Internal Revenue Services Form 990s from 2012 through 2013; (2) the MGMA Reports and AMGA Reports; (3) the Wall Street Journal's searchable database, "*Behind the Numbers: Medicare Unmasked*."; and (4) the CMS Data. Thus, it is clear that the critical elements of the

alleged scheme—compensation paid to CMG physicians, procedures performed at CMC by CMG physicians, and CMG's losses—are all in the public domain, and Relator cites to those public sources directly. In other words, the scope of Relator's action is more than just similar to the publicly disclosed allegations—it is essentially identical.

Recognizing that he must add more to the equation than publicly available allegations to proceed with his *qui tam* lawsuit, Relator relies heavily on how he "synthesiz[ed] the [public] information" to develop his claims. The process of synthesizing, however, involved nothing more than looking at CMG's Form 990s, "compar[ing] the salaries . . . to the national benchmarks," and determining that there are "several doctors who are compensated at greater than the 90th percentile." *See* Defs.' App. 1539 at p. 35:12-23; *see also* Defs.' App. 1069-70 at Interrogatory No. 7.

In fact, Relator made clear during his deposition that his analysis of publicly available information—which he admittedly relied upon and purportedly "synthesized" to reach a conclusion—was limited by the information provided on the face of those public documents. While the public data reflected certain physicians' *total* compensation, for example, Relator lacked information regarding specific components of physician pay, including compensation from productivity incentives, base pay, medical directorships, call coverage and more. *See id.* at 1565-66 at pp. 187:23-188:7. Relator's inability to analyze *non-public* physician compensation data therefore hindered his "synthesis".

Furthermore, while Relator attempts to buoy his "whistleblower" status with a claim that he synthesized the information in light of his personal knowledge of "the Lubbock market," this is far from sufficient to fend off the application of the public disclosure bar. *See id.* at 1554 at p. 74:12-17. Moreover, courts have repeatedly stressed, a FCA complaint is "based upon" public disclosures if "one could have produced the substance of the complaint merely by synthesizing" the public disclosures' description of the scheme. *Jamison*, 649 F.3d at 331. More importantly, Relator undermines the value of his purported "synthesis" of the public disclosures by acknowledging that "[t]his type of scheme is not unknown to the Federal Government." In other words, the publicly available information and the Government's purported knowledge of "[t]his type of scheme" were *already* sufficient to "set the government on the trail of the fraud," according to Relator. *Jamison*, 649 F.3d at 329. The information in the public domain is therefore more than sufficient to make "a potentially fraudulent scheme readily identifiable." *Solomon*, 878 F.3d at 146.

In addition, the publicly available bond disclosure statement filed by SJHS stating that CMG's "turnaround plan centered on aggressive physician compensation changes" provides further evidence that the transactions at issue in this matter, including the purportedly high physician compensation at CMG, were already in the public domain. *See* Defs.' App. 699; 1566 at p. 188:17-22. As a result, the Government had more than enough information to investigate the "potentially

fraudulent scheme" without Relator's input—eviscerating Relator's claimed role as a true "whistleblower" under the False Claims Act.

Similar to the relator in *Solomon* who unsuccessfully argued that his experience working for the defendant allowed him to efficiently search the publicly available sources of information to support his claims, Relator also contends that he brought "outside information to find specific things" on The Wall Street Journal database, for example, insisting that "you have to know what it is you are looking for." *See id.* at 1543 at p. 50:3-7. Courts, however, are not concerned with "the overall probability of someone inferring fraudulent activity from the public disclosures"; instead, the focus is on whether they "*could have* made the inference." *Solomon*, 878 F.3d at 146.

Accordingly, the Court concludes that Relator has failed to produce evidence sufficient to show that there is a genuine issue of material fact as to whether this action is based upon the four sources of public disclosures discussed above.[10]

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[10] To the extent Relator argues that part of the insider information he has brought to the table is "CMG's ability to pay excessive compensation to its physicians, involving payments by CHS/CMC to CMG of millions of dollars annually pursuant to annual Master Coordinating Agreement," the Court notes that Relator did not obtain this information until discovery—as evidenced by the mere fact that Relator did not cite to said Master Coordinating Agreement in his disclosure statements or reference it in his Original Complaint or First Amended Complaint. In addition, Relator claims he had insider information regarding "CMG's payment of excessive compensation to its physicians—

iii. Whether Relator is the Original Source of the Information?

Having determined that there have been public disclosures, and that Relator's Complaint is "based upon" those disclosures, the only remaining question for the Court to consider is whether Relator was the original source of the information. *See Little v. Shell Expl. & Prod Co.*, 690 F.3d 282, 294 (5th Cir. 2012) ("[O]nly if a public disclosure has occurred . . . will it become relevant whether the relator was an original source for the information.").

The Fifth Circuit employs a two-part test to determine the original source exception: "(1) the relator must demonstrate that he or she has direct and independent knowledge of the information on which the allegations are based[;] and (2) the relator must demonstrate that he or she has voluntarily provided the information to the Government before filing his or her *qui tam* action." *Solomon*, 878 F.3d at 146.

a. Did Relator have direct and independent knowledge of the information on which the allegations are based?

Here, Relator does not qualify as an original source under either version of the False Claims Act

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even those with relatively low production and collection rates—despite annual losses by CMG regularly exceeding $20 million." However, the key elements of this alleged "insider information"—the excessive compensation and CMG's losses—are readily available through the four previously discussed public disclosures.

because Relator does not possess "direct and independent knowledge" or independent knowledge that "materially adds" to the publicly disclosed allegations or transaction.[11] Relator devotes little space to his original source argument, relying again on his claimed status as an "industry insider." However, Relator fails to address Defendants' arguments regarding how his knowledge is neither direct nor independent.[12]

Relator relies on his own Affidavit to support his claim that his "insider information" materially adds to the publicly disclosed allegations. However, the same inconsistencies that plague his Disclosure Statements, Complaint, and discovery responses are present here. For example, Relator claims that he had "many conversations with Dr. Satish Patel," an Emergency Physician who was employed at CMG. *See* Relator's App. at 000011, ¶ 32. But "Dr. Satish Patel" is not referenced

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[11] To the extent Relator argues that the 2010 amendment to the False Claims Act expanded the definition of an original source to include those who have knowledge that "materially adds" to the publically disclosed allegation, the Court notes that said distinction is of no difference. *See United States ex rel. Lockey v. City of Dall.*, 576 Fed. App'x 431, 437-38 (5th Cir. 2014) (finding that "[w]hile the language in the current version of the statute differs from the 'direct and independent knowledge' language in the prior version of the statute," the "outcome is the same.").

[12] Moreover, Relator—who has never been employed by CMG or any of the other Defendants—had no means of obtaining independent knowledge of the alleged fraudulent scheme. *See, e.g.*, *Rockwell Int'l Corp. v. United States*, 549 U.S. 457, 475 (2007) (concluding that relator's knowledge fell short because he was not employed by the defendant during the relevant time period and thus could not have known about the predicate conduct and subsequent false statements to the Government.).

in Relator's Disclosure Statements, Complaint, or discovery responses. Relator also points to the Burrell Memo as evidence of his "insider" status, but as Defendants note in their briefing, neither the Complaint nor Relator's initial Disclosure Statement cite to or even reference the Burrell Memo and there is no indication that Relator ever discussed the memo with Dr. Burrell himself *See* Doc. 186 at p. 31; Defs.' App. 1072 at Interrogatory *No.* 10.[13]

In addition, Relator relies on a memorandum from Dr. Michael Chamales to support his original source status, but this alleged memorandum is not cited in Relator's Disclosure Statements, Complaint, or discovery responses. *See* Relator's App. at 000012-13, ¶ 37. To be clear, Relator had a statutory obligation to provide the government with "a copy of the complaint and written disclosure of *substantially all material evidence*" prior to filing suit. 31 U.S.C. § 3730(b)(2) (emphasis added). Relator cannot now manufacture evidence to show that he "materially add[ed]" to the publicly available allegations and escape the application of the public disclosure bar. Nothing in Relator's briefing alters the conclusion that Relator does not qualify as an original source under the False Claims Act. Accordingly, for the reasons argued within Defendants' briefing, the

[13] To the extent Relator allegedly had conversations with 12 "witnesses during investigation of allegations and transactions that form the basis of this action," the Court notes that there is no evidence in the record that any of these individuals discussed physician compensation or other issues that are relevant to, or form the basis of, Relator's allegations. *See* Defs.' App. 1062-63 at Interrogatory No. 3; *see also* Defs.' App. 1500-02.

Court concludes that Relator's claims are precluded by application of the public disclosure bar and summary judgment is **GRANTED** in favor of Defendants on all counts.

Relator's False Claims Act Claims—Presentment and False Claims (Counts 1-3)[14]

Counts 1 and 2 allege that Defendants violated Section 3729(a)(1)(A) and (B) of the False Claims Act by presenting claims to federal healthcare programs that were rendered false by underlying violations of the Anti-Kickback Statute and the Stark Statute. Count 3 alleges that Defendants violated Section 3729(a)(1)(B) by making false statements and representations that were material to those claims. More specifically, Relator alleges that Defendants falsely certified compliance with the Anti-Kickback and the Stark Statute when submitting "claims for interim payments" and "hospital cost reports."

However, and for the reasons stated in Defendants' briefing, the Court finds that Defendants are entitled to summary judgment on Counts 1 through 3 because: (1) there is no evidence that Defendants violated the Anti-Kickback or the Stark Statute and, therefore, Relator cannot establish the False Claims Act's falsity element; and (2) there is no evidence that

[14] Assuming, arguendo, that Relator's claims are not barred by the public disclosure bar, the Court will—in the alternative—proceed to address the merit of Relator's claims.

Defendants acted with the requisite scienter under the False Claims Act.

1. Relator's Briefing Does Not Point to Evidence of an AKS Violation

Although Relator's Complaint is premised on a broad kickback scheme, Relator makes no meaningful effort to support his Anti-Kickback Statute claims. Moreover, the statute simply does not apply to compensation paid by CMG to its employed physicians and Relator fails to show that the remaining Defendants provided remuneration to CMG physicians willfully with intent to induce referrals.

(a) CMG Physician Compensation Is Not "Remuneration" Under the AKS

The Anti-Kickback Statute specifically provides that the statute does not apply to "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services." 42 U.S.C. § 1320a-7b(b)(3)(B) (emphasis added). Similarly, the parallel regulatory exception states that prohibited remuneration under the Anti-Kickback Statute "does not include *any amount* paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made . . . under Medicare, Medicaid or other Federal

health care programs." 42 C.F.R. § 1001.952(i) (emphasis added).

Relator does not dispute that the physicians at issue in this case are *bona fide* employees of CMG, and instead essentially argues that the *bona fide* employment provisions do not apply because compensation was not commercially reasonable in light of the group's losses and exceeded fair market value. As an initial matter, the evidence does *not* demonstrate that any compensation exceeded fair market value or was commercially unreasonable. And, in any event, CMG is simply not required to affirmatively prove those elements for the AKS's employment safe harbor to apply. In *United States v. Vista Hospice Care, Inc.*, 2016 WL 3449833 (N.D. Tex. June 20, 2016), this Court held that when a relator does not dispute that payments were made to employed physicians, "Defendants need not present further evidence showing that they had a bona fide employment relationship with [the physicians]." *Id.* at *22.

Relator cites to *United States v. Crinel* in support of his assertion that CMG must affirmatively prove that compensation was fair market value for the *bona fide* employee safe harbor to apply. Doc. 201 at p. 12. However, *Crinel* is easily distinguishable from the current matter. In particular, the court in that case held that co-conspirators are not immune from federal prosecution where they engaged in "a scheme to provide benefits to individuals ineligible to receive them" simply because they are employed by the co-conspirator. *United States v. Crinel*, 2015 WL 3755896, at *6 (E.D.

La. June 16, 2015). This case does not involve similar allegations, and—in any event—*Crinel* does not stand for the proposition that a defendant must affirmatively prove that employee compensation is fair market value for the *bona fide* employee sate harbor to apply.

While other safe harbors require defendants to establish that certain forms of remuneration, like equipment lease payments, are fair market value and commercially reasonable, the Department of Health and Human Services ("HHS") did not include those elements as prerequisites to the employment safe harbor. HHS has clearly stated:

> This statutory exemption permits an employer to pay an employee in whatever manner he or she chooses for having that employee assist in the solicitation of Medicare . . . business.[15]

Thus, while CMG's employed physicians were paid in a manner that was commercially reasonable and consistent with fair market value, CMG is simply not required to prove those elements for the *bona fide* employment safe harbor to apply.

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[15] *See Medicare and Medicaid Programs: Fraud and Abuse OIG Anti-Kickback Provisions*, 54 Fed. Reg. 3088, 3093 (Jan. 23, 1989).

(b) SJHS, CHS and CMC Did Not Provide Remuneration to CMG Physicians Willfully with Intent to Induce Referrals

With respect to the remaining Defendants, Relator asserts that SJHS, CHS and CMC also seek to avoid liability under the Anti-Kickback Statute by asserting the *bona fide* employment safe harbor. Defendants have never argued that CMG physicians were employed by these Defendants, or that the employment safe harbor applies to them. Instead, Relator has not established an Anti-Kickback Statute violation as to SJHS because there is simply no evidence that it provided prohibited remuneration to CMG or its employed physicians at all, and there is no evidence that any transfers from CHS or CMC to CMG to assist with the group's operating costs were provided willfully with the intent to induce referrals to CMC.

Defendants' conduct is consistent with law-abiding intent. Rather than responding to specific arguments on this point, Relator asserts that "[i]t does not matter whether Defendants intended to be lawful or not" and that he "need only prove that the act of offering or referring in return for or to induce referrals was done knowingly and willfully." Doc. 201 at p. 13. Relator's assertion, however, is inconsistent with Fifth Circuit precedent, which holds that a defendant engages in "willful" conduct if he acts "with the specific intent to do something the law forbids." *United States v. Gibson*, 875 F.3d 179, 188 (5th Cir. 2017) (internal citations omitted). Contrary to Relator's assertion, determining "whether Defendants intended to be lawful or not" is

precisely what matters in the context of an Anti-Kickback-based False Claims Act action. Relator's failure to prove intent under the statute is fatal to his AKS-based FCA claims.

Defendants' briefing cites to an array of evidence demonstrating law-abiding intent. For example:

> Immediately upon joining CMG, General McCamy's first order of business was to address physician compensation and other factors impacting CMG's operating costs and losses.
>
> General McCamy renegotiated approximately 120 physician employment contracts to bring the salaries down from the 75th percentile to the 50th percentile per wRVU based on physician compensation survey data.
>
> General McCamy never financially incentivized or pressured CMG physicians to refer to CHS facilities.
>
> Dr. Burke testified that: (i) there was never a requirement to refer to CMC or any other Covenant entity; and (ii) he was not penalized financially (or in any other manner) if he did not refer services to CMC or another Covenant entity.
>
> Neither the Physician Employment Agreements nor the MCAs require referrals to CMC.
>
> CMG works with Integrated Healthcare Strategies ("IHS"), an outside consultant and valuation expert, regarding compensation-related decisions.

> IHS reviews compensation for individual physicians annually, at the time of contract renewal, and on an *ad hoc* basis.
>
> IHS annually prepares Physician Compensation Manuals for CHS to "provide a source of reference in the day-to-day administration of [the] physician compensation program" and "provide high-level guidance around salary ranges and placement within the ranges."
>
> CMG conducts annual compensation and productivity reviews for each of its physicians to ensure that salaries remained fair market value and commercially reasonable.

The evidence laid out above demonstrates that Defendants' conduct and physician compensation practices were consistent with law-abiding intent, which—despite Relator's assertion—does in fact matter when assessing liability under the Anti-Kickback Statute. Rather than contending with the evidence cited in Defendants' opening brief, Relator implies—but does not specifically argue—that Defendants' efforts to monitor referrals and other key metrics are somehow indicative of unlawful intent. *See*, *e.g.*, Doc. 201 at pp. 26-27, 32, 46.

But, tracking important metrics like patient referrals is essential for large integrated hospital systems like CHS. In fact, Richard Parks explained that monitoring referrals is a "standard normative practice to keep up with clinical service lines' contribution margin[,] be it orthopedics, general surgery, [or] pediatrics." Defs.' Reply App. 5, at p. 84:17-23. Tracking

physician referrals also allowed CHS to identify and address issues timely. For example, if physician referrals reflected a change in volume, then a renegotiation with a particular insurance company may be necessary to "get back in network." Defs.' Reply App. 6, at p. 146:12-20. Or tracking such metrics may help identify an issue with physician competence or "not having the right equipment or technology." *Id.* at p. 146:12-24. Accordingly, far from being an "abnormal procedure," such monitoring is a "best practice" for integrated health systems like CHS. Defs.' Reply App. 5, at p. 84:17-23. For these reasons, Relator fails to establish a violation of the Anti-Kickback Statute.

2. Relator Does Not Point to Evidence of a Stark Violation

Relator fails to prove a Stark Law violation because: (1) neither CMG nor SJHS are "Entities" under Stark; (2) there is no evidence of a prohibited "financial relationship" between the CMG-employed physicians and CHS or CMC; and (3) there is no evidence that an exception to the Stark Law does not apply.[16]

(a) CMG and SJHS Are Not "Entities" Under the Stark Law

Relator cannot prove the most fundamental element of the Stark Law with respect to CMG and

[16] The Court need not assess whether an exception applies because Relator has not shown an underlying Stark Law violation.

SJHS—that they are Entities that provide designated health services ("DHS"). CMG provides personally performed physician services, which, by definition, are not DHS. Doc. 186 at p. 45. SJHS similarly does not furnish DHS and, as a California corporation that is not enrolled in the Medicare program, it does not and cannot present claims to Medicare for DHS. *Id.* Relator makes no attempt to respond to Defendants' arguments and has therefore waived them. *See*, *e.g.*, *Kellam v. Metrocare Servs.*, 2013 WL 12093753, at *3 (N.D. Tex. May 31, 2013) ("[T]he failure to respond to arguments constitutes abandonment or waiver of the issue."). Because CMG and SJHS are not Entities, Relator's Stark Law claims against those Defendants necessarily fail.

Relator's Response also argues that "it is not sufficient . . . to show simply that SJHS and CMG are not hospital entities under the Stark Law . . . [because both] CHS/CMC violated the Stark Law, and . . . SJHS and CMG caused the false claims to be submitted to the Government in violation of the FCS [*sic*]." Doc. 201 at p. 44. As discussed below, Relator cannot prove that CHS and CMC violated the Stark Law. Moreover, Relator's newly asserted causation theory fails to pass muster under federal pleading requirements, let alone the summary judgment standard,

The FCA's causation standard employs traditional notions of proximate causation to determine whether there is a sufficient nexus between the conduct of the party and the ultimate presentation of the false claim . . . ." *United States ex rel. Sikkenga v. Regence Bluecross Blueshield of Utah*, 472 F.3d 702,

714-15 (10th Cir. 2006) (abrogated on other grounds). Under federal law, an act will be deemed a proximate cause of a result if the act is a "substantial factor in the sequence of responsible causation, and if the [result] is reasonably foreseeable or anticipated as a natural consequence." *Hecht v. Commerce Clearing House, Inc.*, 897 F.2d 21, 23-24 (2d Cir. 1990). Relator's Response does not present a single piece of evidence showing that SJHS or CMG caused the submission of a false claim.

(b) There Is No Evidence of an Applicable "Financial Relationship" Between CMG Physicians and CHS or CMC

The next question is whether Relator has shown that the two remaining Defendants (CHS or CMC) entered *direct* or *indirect* financial relationships with CMG physicians. 42 C.F.R. § 411.353(a).

Relator has failed to establish a *direct* compensation relationship because there is no evidence showing that CHS or CMC paid CMG physicians directly "without any intervening persons or entities." *Id.* at § 411.354(c)(1)(i). Next, Relator has not established the necessary elements to prove an *indirect* relationship: (1) an "unbroken chain" of financial relationships between the CMG physicians and CHS or CMC; (2) aggregate physician compensation that "varies with the volume or value of referrals"; and (3) "actual knowledge" by the Entities that the compensation so varies. *Id.* at § 411.354(c)(2). Critically, Relator fails to address two of these essential elements—an unbroken chain

and actual knowledge—except for in his brief recitation of the black-letter law. *See* Doc. 201 at pp. 16-17, Relator's failure to discuss, let alone prove, these two elements, in addition to his failure to prove that physician compensation "varies with the volume or value of referrals," dooms his Stark-based claims.

i. No Evidence of an "Unbroken Chain"

Relator's failure to substantively respond to Defendants' arguments regarding the lack of an "unbroken chain" constitutes a waiver. *See*, *e.g.*, *Kellam*, 2013 WL 12093753, at *3. The closest Relator comes to addressing this element is when he alleges that "[a]lthough CMG physicians were employed by CMG, it is undisputed that their cash compensation was paid, in large part, by CHS which owned and operated the hospital, CMC." Doc. 201 at p. 31. To the extent the Court construes this allegation as a substantive response that saves Relator from waiver, it is still far from sufficient to establish an "unbroken chain" for the reasons discussed in Defendants' Response to Relator's Motion for Partial Summary Judgment. *See* Doc. 199 at pp. 10-12. Relator's failure to establish part one of the three-part test—an "unbroken chain"—negates his ability to prove an indirect financial relationship between CMG physicians and CHS or CMC, and, accordingly, his Stark-based claims against those Defendants fail for that reason alone.

ii. No Evidence That Physician Compensation Varies with or Takes into Account the Volume or Value of Referrals

While Relator ignored the first essential element of an indirect financial relationship, Relator's Response does address the second element—whether CMG physician compensation varied with or took into account the volume or value of referrals to CMC. In support of his assertion that CMG physician compensation took into account or varied with the volume or value of referrals to CMC, Relator argues the following:

> "[U]nder CMG's Physician Employment Agreements, each physician's compensation, including that of Dr. Juan Kurdi, 'varies with, or otherwise reflects' the volume or value of their referrals to CHS/CMC . . . . Specifically, the compensation of CMG physicians, including that of Dr. Kurdi, increased with every Medicare-reimbursable procedure, after a threshold amount was met, that Dr. Kurdi referred to CMC." Doc. 201 at p. 24.
>
> "Because of [the] Incentive Payment provision of the Physician Employment Agreements, each time a CMG physician, including Dr. Kurdi, performs a Medicare-reimbursable procedure upon a Medicare beneficiary the physician's compensation under his or her Physician Employment Agreement increases." *Id.* at p. 28.
>
> Relator goes on to argue that "by operation of the Physician Employment Agreements

> between CMG and its physicians, whenever a physician performs a Medicare-reimbursable procedure CMC (and thus CHS and SJMS [*sic*]) makes more money as a result of the referral, and the referring physician, including Dr. Kurdi, makes more money." *Id.*

As Defendants' address in their Response to Relator's Motion for Partial Summary Judgment, these arguments and the evidence on which Relator relies fail as a matter of law to show that CMG's physician compensation formula—which is expressly permitted under the Stark Law and which CMS has explicitly endorsed—"takes into account" the volume or value of referrals, as that phrase is defined in the Stark Law's implementing regulations. *See* Doc. 199 at pp. 12-14. CMC's ability to separately bill a facility fee based on CMG physicians' procedures personally performed at CMC does not change this fact. Contrary to Relator's assertion, CMG physicians' clinical compensation is based solely on the wRVUs they generate for their personally performed services with no regard or reference to any separate facility or technical charge that CMC might also be able to submit. Defendants noted in their Response that CMS has explicitly disavowed Relator's understanding of the "takes into account" provision under the Stark Law, yet Relator has offered nothing to dispute this fact. *See* Doc. 199 at p. 14, quoting *Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations*, 85 Fed. Reg. 77492, 77539 (Dec. 2, 2020) ("[W]ith respect to employed physicians, a productivity bonus will not take into account the volume or value of the physician's referrals solely

because corresponding hospital services . . . are billed each time the employed physician personally performs a service.").

Relator suggests—but does not expressly argue—that yearly re-negotiation of physician contracts somehow proves that CMG physician compensation varies with or takes into account the volume or value of referrals. *See* Doc. 201 at p. 25. However, as Relator is aware, General McCamy endeavored to align compensation per wRVU with fair market value and any re-negotiation of physician contracts does not suggest that compensation varies with or takes into account the volume or value of referrals.

Relator also references CHS's purported efforts to measure or track CMG referrals in an attempt to prove that physician compensation varies with or takes into account the volume or value of referrals. *See*, *e.g.*, *id.* at p. 25 ("measuring CMG's referrals was important to Parks and Grigson"); p. 26 ("Kothmann developed a system for tracking referrals"); p. 27 ("In Frick's opinion, CHS kept track of patients referred by CMG physicians to CHS owned hospitals for ancillary services . . . ,"); p. 32 ("Defendants regularly kept reports tracking revenues generated by referrals of CMG physicians, including Dr. Kurdi."). First, measuring important data and metrics in no way shows that CMG physician compensation varies with or takes into account the volume or value of referrals, as that concept is defined by the Stark Law and its implementing regulations. Moreover, there is no indication that such purported efforts had an impact on CMG's black-and-white

compensation formula which is applied uniformly to all CMG physicians.

Because Relator is unable to establish part two of the three-part test, he cannot prove the existence of an indirect financial relationship necessary to establish a Stark violation.

iii. No Evidence of "Actual Knowledge"

Relator mentions the critical third element of an indirect financial arrangement—actual knowledge that aggregate CMG physician compensation varies with, or takes into account, the volume or value of referrals—just *once* in his entire Response, and only during his general recitation of the applicable law. Doc. 201 at p. 17. Relator therefore waives any argument regarding the existence of "actual knowledge." Even if Relator had not waived his argument, there is no evidence that CHS or CMC ever had "actual knowledge" that CMG physician compensation varied with the volume or value of their referrals to CMC, as thoroughly discussed in Defendants' Response. *See* Doc. 199 at p. 15-16.

Accordingly, Relator has failed to satisfy the third element of the three-part test, rendering him unable to prove the existence of an indirect financial relationship. Relator therefore fails to prove a Stark violation,

and the Court need not consider whether an exception could possibly apply.[17]

3. The Response Does Not Point to Evidence of Knowledge Under the False Claims Act

Relator's Response does nothing to change the fact that there is no evidence that Defendants acted with "knowledge" under the False Claims Act. Despite Relator's attempt to cast General McCamy's efforts to reduce physician compensation in nefarious terms—including a suggestion that he "rigged" the contracts—General McCamy (and CMG) always acted with law-abiding intent and with the ultimate goal of serving the Lubbock community. *See* Reply App. 7, at p. 153:20-22. This included:

> McCamy addressing physician compensation as his first order of business upon joining CMG, which included renegotiating dozens of contracts (Doc. 186 at p. 50);
>
> McCamy engaging the services and expertise of IHS to review compensation for all CMG physicians to ensure that compensation

[17] Without satisfying his threshold burden of proving an underlying violation of the Stark Law, Relator's claim fails regardless of whether a Stark exception is met or not. However, the evidence is clear that compensation CMG paid to its physicians was consistent with fair market value, did not take into account the volume or value of referrals to CMC, and was commercially reasonable—as discussed thoroughly in Defendants' Response to Relator's Motion for Partial Summary Judgment. *See* Doc. 199 at pp. 16-23.

> remained fair market value and commercially reasonable (*id.* at pp. 50-51);
>
> CMG paying its physicians based on metrics and data provided by IHS (*id.* at p. 51);and
>
> CMG conducting annual compensation and productivity reviews for each of its physicians to ensure that salaries remained fair market value and commercially reasonable.

Thus, the Court concludes that there is no genuine issue of fact as to knowledge and summary judgment is **GRANTED** in favor of Defendants as to Relator's False Claims Act Counts.

Relator's False Claims Act—Conspiracy Claim (Count 4)

Relator does not deny that a claim for conspiracy under the False Claims Act will not stand independently if the underlying False Claims Act violations are dismissed. *See United States ex rel. Coppock v. Northrop Grumman Corp.*, 2003 WL 21730668, at *14, n. 17 (N.D. Tex. July 22, 2003) (holding that "secondary liability for conspiracy under § 3729(a)(3) cannot exist without a viable underlying claim"). Accordingly, and having dismissed Relators claims under § 3729(a)(1)(A) and § 3729(a)(1)(B), Relator's conspiracy claim necessarily fails as well.

Even assuming Relator's claims under § 3729(a)(1)(A) and (13) could plausibly survive summary judgment. there is no evidence establishing the essential elements of a conspiracy claim under § 3729(a)(1)(C) of

the False Claims Act—"(1) the existence of an unlawful agreement between defendants to get a false or fraudulent claim allowed or paid by [the government] and (2) at least one act performed in furtherance of that agreement." *United States ex rel. Farmer v. City of Houston*, 523 F.3d 333, 343 (5th Cir. 2008).

Here, there is no evidence that Defendants entered an "unlawful agreement" to submit false claims. Recognizing that he is unable to offer any proof of an agreement, explicit or otherwise, to defraud the government—the very "essence of a conspiracy"—Relator directs the Court to "the agreements between and among" Defendants as discussed within his briefing. *See* Doc. 201 at p. 43; *United States ex rel. Graves v. ITT Educ. Servs., Inc.*, 284 F. Supp. 2d 487, 509 (S.D. Tex. 2003). However, the only "agreements" Relator references in his Response are Physician Employment Agreements, the Master Coordinating Agreement, and the Merger Agreement between CHS and CMC. Each of these agreements represents lawful business relationships and in no way evidences that Defendants "shared a specific intent to defraud the Government." *Farmer*, 523 F.3d at 343. Relator is therefore unable to establish the first element of proving a conspiracy and summary judgment is **GRANTED** in favor of Defendants on Count 4.

Relator's California Unfair Competition Act Claim (Count 5)[18]

To bring a claim for violation of California's Unfair Competition Act, Cal. Bus. & Prof. Code §§ 17200 *et seq.*, a plaintiff must show either (1) an "unlawful, unfair or fraudulent business act or practice," or (2) "unfair, deceptive, untrue or misleading advertising." *See Somerville v. Stryker Orthopaedics*, 2009 WL 2901591, at *2 (N.D. Cal. Sept. 4, 2009). However, a claim arising under this particular act must be tied to California activities. *See Fontenberry v. MV Transp., Inc.*, 984 F. Supp. 2d 1062, 1067 (ED. Cal. 2013). In fact, an out-of-state plaintiff, like Relator, can only pursue a claim under the California Unfair Competition Law ("UCL") outside of California where "the unlawful conduct that forms the basis of the out-of-state plaintiff's claim occurs *in California*." *Id.* (emphasis added) (citing *Sullivan v. Oracle Corp.*, 51 Cal. 4th 1191, 1207-09 (2011)); *see Terpin v. AT&T Mobility, LLC*, 399 F. Supp. 3d 1035, 1047 (C.D. Cal. 2019) ("Unless the legislature explicitly indicates otherwise, if the liability-creating conduct occurs outside of California, California law generally should not govern that conduct.").

Here, none of the conduct at issue in the Relator's Complaint occurred in California. Relator, a Lubbock, Texas-based physician, brings claims in Texas for activities occurring exclusively in Texas. Specifically,

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[18] To be clear, the Court notes that Relator—upon request by the Texas Attorney General's Office—voluntarily dismissed all claims previously asserted under the Texas Medicaid Fraud Prevention Act. *See* Docs. 203-04.

Relator's claims focus on alleged payments made by a Texas medical group to Texas physicians purportedly to induce referrals of Texas patients (or certainly non-California patients) to a Texas hospital that serves the Lubbock, Texas community. Other than a single reference to SJHS's corporate headquarters being in California—Defs.' App. 988 at 10—Relator has not alleged, let alone provided evidence establishing, a single California activity supporting his UCL claim. Moreover, Relator fails to provide any evidence that SJHS committed any unlawful acts in California. Instead, Relator relies on standard business practices between a health system and its corporate parent that are far from unlawful. SJHS's normal, lawful conduct in interacting with its subsidiaries is far from sufficient to circumvent the presumption against extra-territorial application of the UCL. Accordingly, and because Relator cannot use exclusively Texas conduct to support liability under California's UCL, summary judgment is **GRANTED** in favor of Defendants on Count 5.[19]

IV.
CONCLUSION

For the reasons stated herein, the Court **ORDERS** that Defendants' Motion for Summary Judgment be **GRANTED** and that Relator's Motion for

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[19] As Defendants assert, Relator arguably lacks standing to assert a UCL claim. *See*, *e.g.*, *Branzell v. Cal. Cryobank LLC*, 480 F. Supp. 3d 1080, 1089 (C.D. Cal. 2020) (dismissing with prejudice UCL claims brought by a Texas resident against a California company for activities occurring outside the state of California.).

Partial Summary Judgment be **DENIED**. Any and all pending Motions are, likewise, **DENIED**—including Relator's Motion to Reconsider Second Motion to Compel Discovery and Second Motion to Extend Deadline for Expert Disclosure as Relator has failed to show good cause for the requested relief. Judgment shall be entered accordingly.

SO ORDERED.

Dated November 30, 2021.

/s/ Sam Cummings
SAM R. CUMMINGS
SENIOR UNITED STATES
DISTRICT JUDGE

APPENDIX H

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
LUBBOCK DIVISION

UNITED STATES OF AMERICA *ex rel.* HOWARD BECK, M.D., Plaintiff, v. ST. JOSEPH HEALTH SYSTEM, *et al.*, Defendants.	)	Civil Action No. 5:17-CV-052-C

JUDGMENT

(Filed Nov. 30, 2021)

For the reasons stated in the Court's Order of even date,

IT IS ORDERED, ADJUDGED, AND DECREED that the above-styled and -numbered civil action be **DISMISSED** with prejudice. This Judgment fully and finally resolves of all claims asserted. Costs shall be taxed against Relator.

SIGNED this 30th day of November, 2021.

/s/ Sam R. Cummings
SAM R. CUMMINGS
SENIOR UNITED STATES
DISTRICT JUDGE