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IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

EASTERN DIVISION

UNITED STATES OF AMERICA, and the STATE OF CALIFORNIA, ex rel. MARTIN MANSUKHANI,

Plaintiffs,

v.

PRIME HEALTHCARE SERVICES, INC.; PRIME HEALTHCARE FOUNDATION, INC.; PRIME HEALTHCARE MANAGEMENT, INC.; DESERT VALLEY HOSPITAL; HIGH DESERT HEART VASCULAR INSTITUTE, A CALIFORNIA PROFESSIONAL MEDICAL

CASE NO. 5:18-cv-00371-RGK-SHK

SECOND AMENDED COMPLAINT FOR VIOLATION OF THE FEDERAL FALSE CLAIMS ACT [31 U.S.C. § 3729 et seq.], THE CALIFORNIA FALSE CLAIMS ACT [Cal. Gov't Code § 12650 et seq.], and the CALIFORNIA INSURANCE FRAUDS PREVENTION ACT [Cal. Ins. Code § 1871 et seq.]

DEMAND FOR JURY TRIAL

1 CORPORATION; DR. PREM REDDY, M.D., FACC, HIGH DESERT HEART
2 INSTITUTE MEDICAL CORPORATION; A & A SURGERY
3 CENTER, A MEDICAL CORPORATION; DR. SIVA
4 ARUNASALAM, M.D.; and, SIVA ARUNASALAM, M.D., A
5 PROFESSIONAL MEDICAL CORPORATION,
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7 Defendants.
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SECOND AMENDED COMPLAINT

Plaintiff-Relator Martin Mansukhani, through his attorneys, on behalf of the United States of America (the "Government," or the "Federal Government") and the State of California ("the State," "California," or the "Plaintiff-State"), for his Second Amended Complaint against Defendants Prime Healthcare Services, Inc., Prime Healthcare Foundation, Inc., Prime Healthcare Management, Inc., Desert Valley Hospital, High Desert Heart Vascular Institute, A California Medical Corporation, Dr. Prem Reddy, M.D., FACC (collectively "Prime" or "Prime Defendants"), and Dr. Siva Arunasalam, M.D., Dr. Siva Arunasalam, M.D., a Professional Medical Corporation, High Desert Heart Institute Medical Corporation, and A & A Surgery Center, A Medical Corporation (collectively "Dr. Siva Defendants") ("Prime Defendants" and "Dr. Siva Defendants" referred to collectively herein as "Defendants"), alleges, based upon personal knowledge, relevant documents, and information and belief, as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States of America and the State of California arising from false and/or fraudulent records, statements, and claims made and caused to be made by Defendants and/or their agents and employees in violation of the federal False Claims Act, 31 U.S.C. § 3729 *et seq.* (the "FCA" or the "Act"), the California False Claims Act, Cal. Gov't Code § 12650 *et seq.*, and the California Insurance Frauds Prevention Act, Cal. Ins. Code § 1871 *et seq.*

2. This qui tam case is brought against Defendants for knowingly defrauding the federal Government, the State of California, and private insurers operating in California, in connection with Medicare, Medicaid, and other government-funded and private health insurance programs.

3. As alleged below, in the fall of 2015, Dr. Prem Reddy, the owner and founder of Prime, a hospital network that dominates pockets of the California health care market, struck a deal with Dr. Siva Arunasalam ("Dr. Siva"), a cardiologist with a

lucrative private practice and ambulatory surgical center which competed with Desert Valley Hospital ("DVH")—the crown jewel of the Prime health care system. Dr. Reddy wanted Dr. Siva's patients, particularly the ones receiving high-cost procedures such as cardiac catheterizations at Dr. Siva's surgical center. Dr. Siva wanted to get rich, and needed help paying off some lingering liabilities, possibly remnants of charges from the California Medical Board for negligent care which resulted in issuance of a public reprimand against him (since rescinded). The two men came to a mutually beneficial agreement. In exchange for ownership of Dr. Siva's practice and surgery center (which was quickly closed, thus funneling patients to DVH), Dr. Reddy agreed to pay Dr. Siva $10 million — at least three times the fair market value of the practices — and to employ him at a steeply inflated salary.

4. Both Dr. Reddy and Dr. Siva, the executives of their respective institutions, knew and intended that Dr. Siva would receive an outsized salary and above-market payment for his practices in exchange for referring his patients to DVH where they would receive the same services at higher prices.

5. These payments, and Prime's subsequent submission of claims for payment on services provided to those illegally referred patients, violate the Anti-Kickback Statute, the Stark Law, the False Claims Act, the California False Claims Act, the California Insurance Code, and the California Penal Code.

6. In addition, since at least 2015, Prime has submitted to government-funded and private health insurers, fraudulently inflated claims for devices, such as implants, paid by those insurers on a "pass-through" basis.

7. Defendants have submitted and caused to be submitted thousands of fraudulent claims to private insurers and to federal and state-funded health care programs for falsely inflated devices and for services provided pursuant to kickback-tainted referrals from the Dr. Siva Defendants, with whom the Prime Defendants had a financial relationship not falling within a Stark safe harbor. Each submission is a false or fraudulent claim in violation of the federal and California False Claims Acts and the

California Insurance Code.

8. Based on the foregoing laws, qui tam plaintiff Martin Mansukhani seeks, through this action, to recover damages and civil penalties arising from the false or fraudulent records, statements and/or claims that the Defendants made or caused to be made by seeking payment from private insurers and government-funded health care programs for fraudulently inflated device claims and services performed pursuant to referrals from the Dr. Siva Defendants, to whom the Prime Defendants had made improper payments.

II. PARTIES

9. Plaintiff-Relator Martin Mansukhani is a finance professional who currently resides in the United Kingdom. He has spent more than ten years in the fields of health care finance and operations. From July 18, 2012 through August 18, 2017, he was a Regional CFO for Prime. His responsibilities during this period shifted. From July 2012 through March 2014, he oversaw Prime entities DVH, Desert Valley Medical Group, Chino Valley Medical Center, Montclair Hospital, and San Dimas Community Hospital. In March 2014, Montclair Hospital and San Dimas Community Hospital were removed from his oversight. Then in June 2016, DVH was likewise removed. In March 2017, only a few months prior to his termination, Relator regained responsibility for Montclair Hospital. Relator was abruptly terminated in August 2017. Relator believes his termination was in retaliation for his voicing of concerns about the issues described herein.

10. "The Prime Defendants" - The Prime health care system is comprised of a variety of private corporate entities that are owned and controlled by Defendant Dr. Prem Reddy, M.D., FACC ("Dr. Reddy") and/or trusts established for the benefit of Dr. Reddy and his family. These entities include Defendant Prime Healthcare Services, Inc., Defendant Prime Healthcare Foundation, Inc., Defendant Prime Healthcare Management, Inc., and more than a dozen individual hospitals, including Defendant DVH. All of the Prime Hospitals are owned by either Defendant Prime

Healthcare Services, Inc., or Defendant Prime Healthcare Foundation, Inc.

11. Defendant Prime Healthcare Services, Inc. is a for-profit California corporation founded by Dr. Reddy in 2001. It is incorporated in Delaware and located at 3300 East Guasti Road, Ontario, California, 91761. Dr. Reddy is the Chairman, President, and CEO of Prime Healthcare Services, Inc.

12. Defendant Prime Healthcare Foundation, Inc. is a not-for-profit California corporation formed by Dr. Reddy in 2007. It is incorporated in Delaware and located at 3300 East Guasti Road, Ontario, California, 91761. Dr. Reddy is the Chairman, President, and CEO of Prime Healthcare Foundation, Inc.

13. Defendant Prime Healthcare Management, Inc. is a for-profit California corporation founded by Dr. Reddy in 2004. It is incorporated in Delaware and located at 3300 East Guasti Road, Ontario, California 91761. Defendant Prime Healthcare Management, Inc. provides management, consulting, and support services to hospitals owned by Defendants Prime Healthcare Services, Inc. and Prime Healthcare Foundation, Inc. Dr. Reddy is the President of Prime Healthcare Management, Inc.

14. Defendant Desert Valley Hospital, Inc. is a 148-bed acute care hospital located at 16850 Bear Valley Road, Victorville, California. It was acquired by Defendant Prime Healthcare Services, Inc. in 2001.

15. Defendant High Desert Heart Vascular Institute, a California Professional Medical Corporation ("HDHVI"), is a California professional medical corporation located at 3300 E. Guasti Rd., 3rd Floor, Ontario, CA 91761. Both Dr. Reddy and his wife, Dr. Venkamma Reddy, have been listed as the CEO of High Desert Heart Vascular Institute in various filings with the California Secretary of State. Dr. Venkamma Reddy is the registered owner of HDHVI. In 2015, HDHVI purchased the High Desert Heart Institute and the A&A surgery center from Dr. Siva Arunasalam.

16. Defendant Dr. Prem Reddy, M.D., FACC, is a cardiologist by training and the founder, Chairman, President, and CEO of the Prime health care system. He is primarily responsible for directing the activities of the Prime entities, including the

Prime Defendants named herein.

17. Dr. Reddy and his executive team have little interest in, or patience for, corporate formalities. As a result, the ownership and control of the various Prime entities is fluid and changes to meet Dr. Reddy's needs. For example, as described herein, in 2014, Dr. Reddy directed the formation of a professional medical corporation called the High Desert Heart Vascular Institute ("HDHVI"), for which he served as the CEO. As detailed below, the sole purpose of HDHVI was to purchase Dr. Siva's competing cardiology practice. It had no independent value or purpose. Though Dr. Reddy personally negotiated the acquisition of Dr. Siva's practice on behalf of Prime, he appears to have made his wife the registered owner of HDHVI (and occasionally listed her as a Director and the CEO of HDHVI) despite the fact that, to Relator's knowledge, she never participated in operating the company. Because of this failure to respect the corporate form, and the substantial overlapping ownership and control among the Prime entities, the acts of each Prime Defendant are imputed to the others, and all Prime entities and affiliates, including those named here as defendants, will be referred to as "Prime" or the "Prime Defendants."

18. Defendant Dr. Siva Arunasalam, M.D. ("Dr. Siva") is a cardiologist licensed to practice in California. Until their sale, Dr. Arunasalam was the sole owner of High Desert Heart Institute Medical Corporation and A & A Surgery Center, a Medical Corporation. Dr. Arunasalam is also the President and owner of Siva Arunasalam, M.D., a Professional Medical Corporation.

19. Defendant High Desert Heart Institute Medical Corporation ("HDHI") was a professional corporation formed in September 2001. Dr. Siva Arunasalam was the sole owner and CEO of HDHI. HDHI is no longer believed to be an active corporation.

20. Defendant A & A Surgery Center, A Medical Corporation ("A&A") was a medical corporation incorporated in June 2012. Dr. Siva Arunasalam was the sole owner and President of A&A. A&A is no longer believed to be an active corporation.

21. Defendant Siva Arunasalam, M.D., A Professional Medical Corporation is a professional medical corporation incorporated in June 2009. Dr. Arunasalam is the sole owner and President of Siva Arunasalam, M.D., A Professional Medical Corporation.

22. Dr. Siva moved money between and among himself, his professional corporation, HDHI, and A&A without respect for the corporate form of each. For this reason, and because each is believed to have received remuneration for the benefit of Dr. Siva personally in connection with the fraudulent transactions described herein, these defendants will be referred to collectively as the "Dr. Siva Defendants." The conduct of Dr. Siva described herein was performed in his individual capacity, and in his capacity as owner and/or controller of the various Dr. Siva Defendant entities.

III. JURISDICTION AND VENUE

23. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331, and 31 U.S.C. § 3732, the latter of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730. This Court has jurisdiction over the claims under the California False Claims Act pursuant to 31 U.S.C. § 3732(b), and over the remaining state law claims asserted in this Complaint pursuant to 28 U.S.C. § 1367.

24. Under 31 U.S.C. § 3730(e), and the analogous provisions of California's False Claims Act, there has been no statutorily relevant public disclosure of the "allegations or transactions" in this Complaint. Even if there had been any such public disclosure, Relator is an original source of the allegations herein because he has direct, independent and material knowledge of the information that forms the basis of this complaint, and voluntarily disclosed that information to the Government and the State before filing.

25. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because that section authorizes nationwide service of process and because Defendants have minimum contacts with the United States. Moreover,

Defendants can be found in and have transacted business in the Central District of California.

26. Venue is proper in the Central District of California pursuant to 28 U.S.C. §§ 1391(b) and 1395(a) and 31 U.S.C. § 3732(a) because Defendants can be found in and/or transact or have transacted business in this district. At all times relevant to this Complaint, Defendants regularly conducted, and continue to conduct, substantial business within this district and/or maintain employees and offices in this district.

IV. APPLICABLE LAW

A. The Federal and California False Claims Act

27. The federal False Claims Act (the "FCA" of "Act") was originally enacted during the Civil War. Congress substantially amended the Act in 1986 – and, again, in 2009 and 2010 – to enhance the ability of the United States Government to recover losses sustained as a result of fraud against it. The Act was amended after Congress found that fraud in federal programs was pervasive and that the Act, which Congress characterized as the primary tool for combating government fraud, was in need of modernization. Congress intended that the amendments would create incentives for individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf.

28. The FCA prohibits, inter alia: (a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim; (c) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government; and (d) conspiring to violate any of these sections of the FCA. 31 U.S.C. §§ 3729(a)(1)(A)-(C), and (G). Any person who

violates the FCA is liable for a civil penalty of thousands of dollars for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. § 3729(a)(1).

29. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. The FCA requires that the Complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

30. The California False Claims Act prohibits similar conduct as that prohibited by the Federal FCA, allows plaintiffs to bring an action on the State's behalf, and provides analogous remedies to those provided in the Federal FCA. As set forth below, Defendants' actions alleged in this Complaint also constitute violations of the California False Claims Act, Cal. Gov't Code § 12650 *et seq*.

B. California Insurance Fraud Prevention Act

31. The California Insurance Frauds Prevention Act ("CIFPA"), Cal. Ins. Code § 1871.7, makes it unlawful to "knowingly employ runners, cappers, steerers, or other persons to procure clients or patients . . . to perform or obtain services or benefits under a contract of insurance or that will be the basis for a claim against an insured individual or his or her insurer." Cal. Ins. Code § 1871.7(a). CIFPA further imposes civil penalties for any violation of Cal. Penal Code § 550, which makes it unlawful to: (1) "[k]nowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim" (Cal. Penal Code § 550(a)(5)); (2) "[k]nowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit" (Cal. Penal Code § 550(a)(6)); (3) "[p]resent or cause to be presented any writing or statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact" (Cal. Penal Code § 550(b)(1)); and (4) "[p]repare or

make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact" (Cal. Penal Code § 550(b)(2)). It is additionally unlawful to aid, abet, solicit, and/or conspire with any person to do any of the above. Id.

32. Any person who violates CIFPA is subject to civil penalties between $5,000 and $10,000, plus an assessment of not more than three times the amount of each claim for compensation submitted pursuant to the contract of insurance. Cal. Ins. Code § 1871.7(b). This penalty is assessed for "[e]ach fraudulent claim presented to an insurance company by a defendant." Id.

33. The California Insurance Frauds Prevention Act is modeled after the federal and California False Claims Acts. As such, it permits a private person, i.e., a qui tam plaintiff, to bring suit to enforce CIFPA's provisions. Cal. Ins. Code § 1871.7(e)(1).

34. The purpose of CIFPA is to protect and compensate California for the harm to the state that insurance fraud causes and to assist the state to "more effectively investigate and discover insurance frauds, [and] halt fraudulent activities." Cal. Ins. Code § 1871(a).

C. Federal and State Funded Health Care Programs

1. The Medicare Program

35. Medicare is a federally-funded health insurance program which provides for certain medical expenses for persons who are over 65, who are disabled, or who suffer from End Stage Renal Disease. The Medicare program is administered through the Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS").

36. The Medicare program has four parts: Part A, Part B, Part C, and Part D. Medicare Part A, the Basic Plan of Hospital Insurance, covers the cost of hospital

services and post-hospital nursing facility care. Medicare Part B, the Voluntary Supplemental Insurance Plan, covers the cost of services performed by physicians and certain other health care providers, such as services provided to Medicare patients by physicians, laboratories, and diagnostic testing facilities. See 42 U.S.C. §§ 1395k, 1395l, 1395x(s). Medicare Part C covers certain managed care plans, and Medicare Part D provides subsidized prescription drug coverage for Medicare beneficiaries.

37. To administer the Medicare program, private insurance companies act as agents of the Department of Health and Human Services, making payments on behalf of the program beneficiaries and providing other administrative services. 42 U.S.C. §§ 1395h and 1395u. These companies are called "carriers." See 42 C.F.R. § 421.5(c). Through local carriers, Medicare establishes and publishes the criteria for determining what services are eligible for reimbursement or coverage. This information is made available to the providers who seek reimbursement from Medicare.

a. Medicare Contracts and Claims Submission

38. Medicare reimburses health care providers for the costs of providing covered health services to Medicare beneficiaries. See 42 U.S.C. § 1395x(v)(1)(A). In order to bill Medicare Part A, a provider must submit an electronic or hard-copy claim form called the UB-04 (also known as the CMS 1450) to the appropriate Medicare carrier. To bill Medicare Part B, a provider must submit an electronic or hard-copy claim form called the CMS 1500 (formerly known as HCFA 1500) to the appropriate Medicare carrier. These forms describe, among other things, the provider, the patient, the referring physician, the service(s) provided by procedure code, the related diagnosis code(s), the dates of service, and the amount charged. The provider certifies on the CMS 1500 claim form that the information provided is truthful and that the services billed on the form were "medically indicated and necessary." The provider certifies in the UB-04 that "[s]ubmission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate, and complete."

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39. In addition, each Medicare provider must sign a provider agreement and by so doing must agree to comply with all Medicare requirements including the fraud and abuse provisions. A provider who fails to comply with these statutes and regulations is not entitled to payment for services rendered to Medicare patients.

40. At all times relevant to this action, the local carriers that reviewed and approved the claims at issue in this case based their review upon the enrollment information and claim information provided by the Defendants, and relied on the veracity of that information in determining whether to pay the claims submitted by Defendants.

41. As a prerequisite to payment, Medicare also requires hospitals to submit annually a Form CMS-2552-10 (previously form HCFA-2552), more commonly known as the Hospital Cost Report. Cost reports are the final claim that a provider submits to the fiscal intermediary for items and services rendered to Medicare beneficiaries.

42. Every Hospital Cost Report contains a "Certification" that must be signed by the chief administrator of the provider or a responsible designee of the administrator. Through this certification, the provider confirms that the cost report is "a true, correct and complete statement" and that the services identified "were provided in compliance with [the laws and regulations regarding the provision of the health care services]." The certification also states, inter alia: "if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result."

b. Medicare Payments for Hospital and Physician Services

43. Medicare pays hospitals for providing inpatient and outpatient care. Since 1983, Medicare, Medicaid, and other federally-funded health insurance programs have reimbursed hospitals for inpatient care through a prospective payment system based on classification of patients through Diagnosis Related Groups ("DRGs"). DRGs are

groups of clinically similar diagnoses and/or procedure codes, which are presumed to have similar resource utilization. Medicare pays a fixed amount per case by DRG.

44. Payments for outpatient hospital services are also based on a bundled, per-case payment system. Hospitals use Ambulatory Payment Classification ("APC") codes to bill for costs associated with outpatient services. Similar to the DRG-based payment system for inpatient services, Medicare reimburses hospitals for outpatient services through standardized payments determined by the APC to which the claim is assigned.

45. Each claim is assigned one or more APCs based on the procedure codes (i.e., HCPCS code, as described below) included on the claim form. Unlike inpatient DRG payments, where the hospital generally receives only one DRG payment per case, hospitals can receive multiple APC payments for the same outpatient case, depending on the nature of the services provided.

46. Generally speaking, implantable devices, such as replacement joints or pacemakers, are covered by Medicare as part of the "bundled" APC or DRG payment. However, new medical devices may be eligible for "add on" payments. In these cases, Medicare may make an additional payment based, in part, on the provider's cost for the device. *See* 42 C.F.R. §§ 412.88, 419.66.

47. Physician services provided to either inpatients or outpatients are billed and reimbursed separately from the hospital's DRG- or APC-based payment. Physician services are reimbursed through a payment system based on the Healthcare Common Procedure Coding System ("HCPCS"). HCPCS is a standardized coding system that groups procedures based on the level of professional effort required to render the service. Medicare pays physicians a fixed "global" amount for their services when they are performed in a physician's office. This payment includes both a "professional" component to compensate for the physician's services and a "facility" component to compensate for the cost of office space, supplies, etc.

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48. When a physician performs services in a hospital setting (either inpatient or outpatient), Medicare pays the physician a "professional" fee, but does not pay the physician the "facility fee." Instead, the hospital is reimbursed for these costs through the DRG or APC payment.

49. The dichotomy between the professional and overhead components of the Medicare payment is more complicated where the physicians provide services through "provider-based" physicians' offices. Medicare allows certain physician practices to be considered part of the hospital facility, even when they are not physically located in a traditional hospital facility. If a provider practice qualifies as "provider based," the physicians may bill for their professional services the same way they would bill for services performed in a traditional hospital outpatient department, and then the hospital may bill the "facility" component of the service using the APC system. See 42 CFR § 413.65. As a general matter, Medicare pays hospitals substantially more for the "facility" component of provider-based physician services than it pays to independent physicians who provide the same services in an office setting.

2. The Medicaid Program

50. Medicaid is a public assistance program providing for payment of medical expenses for low-income and disabled patients. In California, the program is known as "Medi-Cal." Funding for Medi-Cal is shared between the Federal Government and the State of California.

51. Federal regulations require each state to designate a single state agency responsible for the Medicaid program. In California, this is the Department of Health Care Services ("DHCS"). The agency must create and implement a "plan for medical assistance" that is consistent with Title XIX and with the regulations of the Secretary of HHS. Although Medicaid is administered on a state-by-state basis, the state programs adhere to federal guidelines. Federal statutes and regulations restrict the items and services for which the federal government will pay through its funding of state Medicaid programs.

52. Each provider that participates in the Medicaid program must sign a provider agreement with his or her state. California requires any prospective Medi-Cal provider to declare that s/he "will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as established in the Medi-Cal Provider Manual." All institutional providers must similarly agree "to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200) [including the Anti-Kickback provision cited below], and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters." Further, the provider must agree "that it shall not engage in or commit fraud or abuse." "Fraud" is defined as "intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person" and includes "any act that constitutes fraud under applicable federal or state law." "Abuse" includes "practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency."

53. Medi-Cal, like Medicare, generally pays providers a flat fee based on the procedures performed and professional services rendered. However, in some instances, where the cost of a device used in a procedure may be very high, Medi-Cal will pay on a "pass-through" basis. This means that the cost of the device, usually an implant, will be carved out of the DRG or APC-based payment and be paid separately. The provider is usually paid for the device on a "cost-plus" basis, *i.e.*, the cost paid by the provider for the device plus a small percentage. Other government-funded and private insurers, including those referenced below as well as workers' compensation insurers, similarly pay for certain devices on a pass-through basis.

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3. Other Federal and State-Funded Health Care Programs

54. The Federal Government administers other health care programs including, but not limited to, TRICARE/CHAMPUS, CHAMPVA, and federal workers' compensation programs.

55. TRICARE/CHAMPUS, administered by the United States Department of Defense, is a health care program for individuals and dependents affiliated with the armed forces. 10 U.S.C. § 1071 *et seq.*; 32 C.F.R. § 199.4(a).

56. CHAMPVA, administered by the United States Department of Veterans Affairs, is a health care program for the families of veterans with 100 percent service-connected disability. 38 U.S.C. § 1781 *et seq.*; 38 C.F.R. § 17.270(a).

57. The Federal Employees' Compensation Act provides workers' compensation coverage, including coverage of medical care received as a result of a workplace injury, to federal and postal employees. The Act is administered by the Department of Labor, Division of Federal Employees' Compensation. 5 U.S.C. § 8101 *et seq.*; 20 C.F.R. § 10.0 *et seq.*

58. California provides health care benefits to certain individuals, based either on the person's financial need, employment status, or other factors. To the extent those programs are covered by California's False Claims Act, those programs are referred to in this Complaint as "state-funded health care programs."

D. The Stark Law

59. A section of the Social Security Act, 42 U.S.C. § 1395nn (commonly known as the "Stark Law"), prohibits a hospital (or other entity providing health care items or services) from submitting claims to, or receiving payment from, Medicare or Medicaid (see 42 U.S.C. § 1396b(s)) for services rendered based on patients referred by physicians who have a "financial relationship" (as defined in the statute) with the hospital that does not fall within a "safe harbor."

60. In enacting the Stark Law, Congress found that improper financial relationships between physicians and entities to which they refer patients can

compromise the physicians' professional judgment as to whether an item or service is medically necessary, safe, effective, and of good quality. Congress relied on various academic studies consistently showing that physicians who had financial relationships with medical service providers used more of those providers' services than similarly situated physicians who did not have such relationships. The statute was designed specifically to reduce the loss suffered by the Medicare program due to such increased questionable utilization of services.

61. Congress enacted the Stark Law in two parts, commonly known as Stark I and Stark II. Enacted in 1989, Stark I applied to referrals of Medicare patients for clinical laboratory services made on or after January 1, 1992 by physicians with a prohibited financial relationship with the clinical lab provider. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6204, 103 Stat. 2106, 2236.

62. In 1993, Congress amended the Stark Law (Stark II) to cover referrals for additional designated health services. See Omnibus Budget Reconciliation Act of 1993, Pub. Law 103-66, § 13562, Social Security Act Amendments of 1994, Pub. Law 103-432, § 152. The Stark Law now applies to the following twelve "designated health services" (DHS): (1) inpatient and outpatient hospital services; (2) physical therapy; (3) occupational therapy; (4) radiology; (5) radiation therapy (services and supplies); (6) durable medical equipment and supplies; (7) parenteral and enteral nutrients, equipment and supplies; (8) prosthetics, orthotics, and prosthetic devices and supplies; (9) outpatient prescription drugs; (10) home health services, (11) clinical laboratory services, and (12) outpatient speech-language pathology services. See 42 U.S.C. § 1395nn(h)(6).

63. In pertinent part, the Stark Law provides:

> (a) Prohibition of certain referrals
>
> (1) In general. Except as provided in subsection (b), if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then – (A) ***the physician may not make a referral to the entity*** for the furnishing of designated health services for which payment otherwise may be made [by Medicare or Medicaid]; and (B) ***the entity may not present or cause to be presented a claim*** under this title or bill to

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> any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under (A).

3 42 U.S.C. § 1395nn(a)(1) (emphasis added). Therefore, a physician is prohibited from
4 making referrals for DHS payable by Medicare or Medicaid to an entity with which he
5 or she has an improper financial relationship. In addition, providers may not bill
6 Medicare or Medicaid for DHS furnished as a result of a prohibited referral.

7 64. In addition, **no payment may be made** by the Medicare or Medicaid
8 programs for DHS provided in violation of 42 U.S.C. § 1395nn(a)(1). See 42 U.S.C.
9 §§ 1395nn(g)(1); 1396b(s).

10 65. Finally, if a person collects payments billed in violation of 42 U.S.C.
11 § 1395nn(a)(1), that person **must refund those payments** on a "timely basis," defined
12 by regulation not to exceed 60 days. See 42 U.S.C. § 1395nn(g)(2); 42 C.F.R.
13 § 411.353(d); 42 C.F.R. § 1003.101.

14 **1. Financial Relationships Under Stark**

15 66. The Stark Law's enforcing regulations broadly define a "financial
16 relationship" as "[a] direct or indirect ownership or investment interest . . . in any
17 entity that furnishes DHS" or "[a] direct or indirect compensation arrangement . . .
18 with an entity that furnishes DHS." 42 C.F.R. § 411.354(a)(1). (An entity is defined
19 to "furnish" DHS if it performs or bills for the service. 42 C.F.R. § 411.351.)

20 67. A "compensation arrangement" is "any arrangement involving
21 remuneration, direct or indirect, between a physician (or a member of a physician's
22 immediate family) and an entity." 42 C.F.R. § 411.354(c).

23 68. A "direct compensation arrangement" exists "if remuneration passes
24 between the referring physician (or a member of his or her immediate family) and the
25 entity furnishing DHS without any intervening persons or entities." 42 C.F.R.
26 § 411.354(c)(1).

27 69. An "indirect compensation arrangement" exists if: "(i) [b]etween the
28 referring physician (or a member of his or her immediate family) and the entity

1 furnishing DHS there exists an unbroken chain of any number (but not fewer than one)
2 of persons or entities that have financial relationships [as defined above] between them
3 (that is, each link in the chain has either an ownership or investment interest or a
4 compensation arrangement with the preceding link); (ii) [t]he referring physician (or
5 immediate family member) receives aggregate compensation from the person or entity
6 in the chain with which the physician (or immediate family member) has a direct
7 financial relationship that varies with, or takes into account, the volume or value of
8 referrals or other business generated by the referring physician for the entity furnishing
9 the DHS . . . . ; and (iii) [t]he entity furnishing DHS has actual knowledge of, or acts
10 in reckless disregard or deliberate ignorance of, the fact that the referring physician (or
11 immediate family member) receives aggregate compensation that varies with, or takes
12 into account, the volume or value of referrals or other business generated by the
13 referring physician for the entity furnishing the DHS." 42 C.F.R. § 411.354(c)(2).

14 **2. Stark Safe Harbors**

15 70. There are several safe harbors for direct and indirect financial
16 arrangements, but the requirements must be met precisely to apply.
17 71. For example, there is a safe harbor for "isolated transactions, such as a
18 one-time sale of property or a practice." However, the following conditions must be
19 met: (1) the amount of remuneration must be "[c]onsistent with the fair market value
20 of the transaction; and (ii) [n]ot determined in a manner that takes into account
21 (directly or indirectly) the volume or value of any referrals by the referring physician
22 or other business generated between the parties[;] (2) [t]he remuneration provided must
23 be commercially reasonable even if the physician made no referrals to the entity[; and]
24 (3) [t]here are no additional transactions between the parties for 6 months after the
25 transaction, except transactions specifically excepted. . .and commercially reasonable
26 post-closing adjustments." 42 C.F.R. § 411.357(f). (Excepted transactions include
27 those financial relationships which fall under another Stark safe harbor.)
28 / / /

72. In addition, compensation paid pursuant to a "bona fide employment relationship" may fall within a safe harbor under the Stark Law, but only if: (1) the employment is for identifiable services; (2) the amount of remuneration under the employment (i) is consistent with the fair market value of the services; and (ii) 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) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer. 42 C.F.R. § 411.357(c).

73. Similarly, compensation paid pursuant to a "personal services arrangement" between a provider and a physician may be considered proper under the Stark Law, but only if the compensation to be paid over the term of the arrangement is set in advance, does not exceed the fair market value for the services, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties (unless the agreement falls within a narrowly defined physician incentive plan). 42 C.F.R. § 411.357(d).

74. A catch-all "fair market value" safe harbor allows entities to compensate physicians for services so long as several provisions are met, including that the arrangement is commercially reasonable and the compensation is set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of the physician's referrals. 42 C.F.R. § 411.357(l).

75. Finally, the safe harbor for indirect compensation arrangements requires that the compensation received is fair market value for the services actually provided and is not determined "in any manner that takes into account the volume or value of referrals or other business generated" by the referring physician. 42 C.F.R. § 411.357(p).

76. For all of the safe harbors above, a fixed payment may be considered to "take into account" the volume or value of referrals or other business generated by a referring physician when the payment amount or rate is set based on historical or

expected referrals. *See United States ex rel. Drakeford v. Tuomey Healthcare Sys.*, 675 F.3d 394, 408 (4th Cir. 2012); *United States ex rel. Singh v. Bradford Reg'l Med. Ctr.*, 752 F. Supp. 2d 602, 631 (W.D. Pa. 2010); 69 Fed. Reg. 16054, 16059 (Mar. 26, 2004) ("It is important to bear in mind that, depending on the circumstances, fixed aggregate compensation can form the basis for a prohibited direct or indirect compensation arrangement. This will be the case if such fixed aggregate compensation takes into account the volume or value of referrals (for example, the fixed compensation exceeds fair market value for the items or services provided or is inflated to reflect the volume or value of a physician's referrals or other business generated).").

77. Violations of the Stark Law may subject the physician and the billing entity to exclusion from participation in federal health care programs and various financial penalties, including: (a) a civil money penalty of up to $15,000 for each service included in a claim for which the entity knew or should have known that the payment should not be made; and (b) an assessment of three times the amount claimed for a service rendered pursuant to a referral the entity knows or should have known was prohibited. See 42 U.S.C. §§ 1395nn(g)(3), 1320a-7a(a).

E. The Federal Anti-Kickback Statute

78. The Medicare and Medicaid Fraud and Abuse Statute ("Anti-Kickback Statute"), 42 U.S.C. § 1320a-7b(b), was enacted under the Social Security Act in 1977. The Anti-Kickback Statute arose out of Congressional concern that payoffs to those who can influence health care decisions will result in goods and services being provided that are medically inappropriate, unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of federal health care programs from these difficult to detect harms, Congress enacted a prohibition against the payment of kickbacks in any form, regardless of whether the particular kickback actually gives rise to overutilization or poor quality of care.

79. The Anti-Kickback Statute prohibits any person or entity from making or accepting payment to induce or reward any person for referring, recommending, or arranging for the purchase of any item or service for which payment may be made under a federally-funded health care program. 42 U.S.C. § 1320a-7b(b). The statute ascribes liability to both sides of an impermissible kickback relationship.

80. Claims for reimbursement for items or services that result from kickbacks constitute false claims under the False Claims Act. 42 U.S.C. § 1320a-7b(g).

81. Similar to the Stark Law, the Anti-Kickback Statute contains regulatory "safe harbors." It is the defendant's burden to show strict compliance with all requirements of a safe harbor in order to avoid liability for an arrangement that would otherwise violate the Statute.

82. For example, "remuneration" under the Anti-Kickback statute "does not include any payment made to a practitioner by a hospital or other entity where the practitioner is selling his or her practice to the hospital or other entity, so long as the following four standards are met: (i) [t]he period from the date of the first agreement pertaining to the sale to the completion date of the sale is not more than three years[;] (ii) [t]he practitioner who is selling his or her practice will not be in a professional position after completion of the sale to make or influence referrals to, or otherwise generate business for, the purchasing hospital or entity for which payment may be made under Medicare, Medicaid or other Federal health care programs[;] (iii) [t]he practice being acquired must be located in a Health Professional Shortage Area (HPSA), as defined in Departmental regulations, for the practitioner's specialty area[;] [and] (iv) [c]ommencing at the time of the first agreement pertaining to the sale, the purchasing hospital or entity must diligently and in good faith engage in commercially reasonable recruitment activities that: (A) [m]ay reasonably be expected to result in the recruitment of a new practitioner to take over the acquired practice within a one year period and (B) [w]ill satisfy the conditions of the practitioner recruitment safe harbor in accordance with paragraph (n) of this section." 42 C.F.R. § 1001.952(e)(2).

1 83. Exemptions also exist for contracts for employment or personal services.
2 The personal services safe harbor applies to payments to an agent as long as the
3 aggregate compensation to the agent is set in advance, is "consistent with fair-market
4 value," and is not determined "in a manner that takes into account the volume or value
5 of any referrals or business otherwise generated between the parties." 42 C.F.R.
6 § 1001.952(d).
7 84. The employment safe harbor applies to all remuneration paid by an
8 employer to a bona fide employee "for employment in the furnishing of any item or
9 service for which payment may be made in whole or in part under" any Federal health
10 care program. 42 C.F.R. § 1001.952(i). This safe harbor provides a defense against
11 Anti-Kickback Statute liability only where a bona fide employee is compensated
12 exclusively for the provision of professional services that are covered by a federal
13 health care program. Any payments to an employee that are not, in fact, made for the
14 provision of covered professional services do not fall within the safe harbor.
15 85. The act of referring a patient to a hospital or other provider is not a
16 "furnishing" of a covered "item or service." Therefore, any payments made to an
17 employee to compensate that employee for making referrals are not covered by the
18 employee Anti-Kickback safe harbor. This is true even if the majority of an
19 employee's compensation is for the provision of legitimate professional services. As
20 to payments made to induce referrals and to compensate for an employee's act of
21 referring a patient, the Anti-Kickback Statute is violated and the safe harbor does not
22 apply.
23 86. Violation of the Anti-Kickback Statute subjects the violator to exclusion
24 from participation in federal health care programs, civil monetary penalties, and
25 imprisonment of up to five years per violation. 42 U.S.C. §§ 1320a-7(b)(7), 1320a-
26 7a(a)(7).
27 87. Compliance with the Anti-Kickback Statute is a precondition to
28 participation as a health care provider under the Medicare and Medicaid programs.

88. Either pursuant to provider agreements, claim forms, or in some other appropriate manner, hospitals and physicians who participate in federal health care programs generally must certify that they have complied with the applicable federal rules and regulations, including the Anti-Kickback Statute.

89. Any party convicted under the Anti-Kickback Statute must be excluded (i.e., not allowed to bill for services rendered) from federal health care programs for a term of at least five years. 42 U.S.C. § 1320a-7(a)(1). Even without a conviction, if the Secretary of HHS finds administratively that a provider has violated the statute, the Secretary may exclude that provider from federal health care programs for a discretionary period (in which event the Secretary must direct the relevant state agencies to exclude that provider from the state health programs), and may consider imposing administrative sanctions of $50,000 per kickback violation. 42 U.S.C. § 1320a-7(b).

90. The enactment of these various provisions and amendments demonstrates Congress' commitment to the fundamental principle that federal health care programs will not tolerate the payment of kickbacks. Thus, compliance with the Stark Law and Anti-Kickback Statute is a prerequisite to a provider's right to receive or retain payments from Medicare, Medicaid and other federal health care programs.

91. In addition, California Welfare & Institutions Code similarly prohibits the solicitation, receipt, offer, or payment of any kickback, bribe, or rebate to induce the referral of patients for services or merchandise. Cal. Welf. & Inst. Code §§ 14107.2(a)-(b).

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V. ALLEGATIONS

A. Defendants Submitted and Caused the Submission of False Claims for Services Provided to Patients Referred as a Result of Kickbacks Paid to Dr. Siva

1. Prime's Purchase of Dr. Siva's Practice and Surgery Center

92. DVH is a 148-bed acute care hospital in Victorville, California. Dr. Prem Reddy established DVH in 1994 and it serves today as the flagship hospital in Dr. Reddy's Prime health care group.

93. In March 2012, DVH opened its "Heart Center" which it touted as bringing together cardiac and vascular surgeons, interventional cardiologists, anesthesiologists, and interventional radiologists. The 50,000 ft. expansion included, among other expensive additions, two cardiac catheterization laboratories as well as a substantial expansion of the hospital's surgical capacities.

94. The High Desert Heart Institute ("HDHI") was founded by Dr. Siva Arunasalam, a board-certified cardiologist. "Dr. Siva" (as he prefers to be called) employed two to three additional physicians to support his work and ran a lucrative practice. Dr. Siva performed many procedures at A&A Surgical Center ("A&A"), an associated surgical facility that he founded and owned. Through HDHI and A&A, Dr. Siva provided primary care and cardiac monitoring services as well as diagnostic services, including some invasive ones. For example, Dr. Siva provided echocardiography, vascular ultrasound, nuclear stress testing, pulmonary function testing, enhanced external counter pulsation (EECP), and cardiac catheterizations. Based on the geographic location and the nature of Dr. Siva's practice, Relator believes that a majority of his patients were Medicare beneficiaries. Medicare paid Dr. Siva over $3.23 million in 2014 and $2.99 million in 2015.

95. Dr. Siva had privileges at DVH and performed some of his procedures there, but when possible, he kept his patients within HDHI and/or A&A. Given his proximity to DVH and the nature of his practice, Dr. Siva was a major competitor to the hospital and to Dr. Reddy, especially after the opening of DVH's Heart Center.

96. Due in part to Dr. Siva, the cardiac catheterization labs at DVH were not being used to full capacity for most of 2015. Dr. Reddy was eager to increase their volume and decided to purchase Dr. Siva's practice (HDHI) and associated surgery center (A&A) in order to do so.

97. In October 2015, without consulting DVH's Chief Executive Officer or the Relator, who was then DVH's Chief Financial Officer, Dr. Reddy executed a Medical Practice Asset Purchase Agreement ("APA") and Provider Employment Agreement ("Employment Agreement") to purchase HDHI and A&A and to employ Dr. Siva. The agreements were effective October 30, 2015.

98. Under the APA, a shell corporation called High Desert Heart Vascular Institute ("HDHVI") agreed to purchase HDHI and A&A. HDHVI is a California professional corporation owned by Dr. Venkamma Reddy (Dr. Reddy's wife) with financial relationships with other Prime entities. Its management consists entirely of Prime executives and staff. According to the Statement of Information filed with the California Secretary of State in September 2016, Dr. Reddy was the CEO, Troy Schell (General Counsel for Prime Healthcare Services) was the Secretary, and Michael Heather (CFO for Prime Healthcare Services) was the CFO. Further, the APA directs that communications to HDHVI be directed to Desert Valley Medical Group.

99. Dr. Reddy formed HDHVI to serve as the vehicle for acquiring HDHI and A&A. HDHVI purchased HDHI and A&A's assets (including accounts receivable but excluding accrued accounts payable) and took over the practices' leases, licenses, contracts, records, and "goodwill." In exchange, HDHVI agreed to pay Dr. Siva, or one of his affiliated entities, a total of $10 million in several installments over the course of 10 years.

100. Under the terms of the agreement, Dr. Siva was to be paid $1.3 million in cash up front. Another $1.7 million was to be paid to a creditor of Dr. Siva's. There was a further $500,000 to be placed in escrow. Finally, additional payments were to

be made to Dr. Siva as follows: $500,000 after six months, and $6 million paid yearly over the course of six years starting in 2020.

101. In conjunction with the APA, Dr. Siva entered into the Employment Agreement with HDHVI. Under this agreement, Dr. Siva was to be paid $1.2 million a year and was eligible for a productivity bonus of 20% of the net profit from his practice. Technically, Dr. Siva's salary was subject to reduction if the $1 million annual guarantee described herein was not met. Specifically, "in the event Doctor/Owner does not meet the Guarantee of one Million dollars ($1,000,000) per year as outlined in Section 8 of the APA, then Doctor's/Owner's Base Salary will be reduced to meet the Guarantee."

2. Immediately After Purchasing HDHI and A&A, Dr. Reddy Closed A&A and Dr. Siva Transferred His Procedures to DVH

102. The first thing Dr. Reddy did after the transaction was complete was to shut down A&A's operations. The date of the purchase was Friday, October 30, 2015. HDHVI shut down A&A shortly thereafter.

103. Shutting down A&A was a key component of the agreement between Dr. Reddy and Dr. Siva. Though A&A had been a profitable business, it competed with DVH for cardiac procedures. By shutting it down, Dr. Reddy ensured that Dr. Siva would perform his procedures at DVH going forward.

104. From then on, Dr. Siva brought patients to DVH for testing and procedures that he had performed previously at his surgery center. For example, the increase in catheterizations Dr. Siva performed at DVH was swift and substantial. From January through October 2015, Dr. Siva treated an average of 8.1 patients a month at DVH's cardiovascular lab. In November 2015, following his transaction with HDHVI, Dr. Siva treated 21 patients at DVH. In December, Dr. Siva treated 23 patients. From October to December 2015, his catheterization procedures at DVH increased three-fold. Dr. Siva's referrals to Prime entities, including DVH, have

continued since 2015. For example, Dr. Siva performed a dual chamber pacemaker insertion on an inpatient basis at DVH on a Medicare patient on September 16, 2016.

3. The Payments to Dr. Siva were Based on the Volume and Value of His Referrals and Intended to Induce His Referrals to DVH

105. The amounts that HDHVI paid Dr. Siva reflected the value of his patient referrals, not the value of the practice that HDHVI had acquired. Shortly after the transaction, DVH assigned Relator to manage HDHVI's financials, which had been thrown into disarray when A&A shut down. In January 2016, less than two months after the date of the acquisition, Relator calculated that the value of HDHVI's assets were only $1.3 million and that its liabilities were $2.2 million. Subtracting the negative value of HDHVI's net assets from the discounted present value of the acquisition price (over $7.6 million), Relator booked $8.7 million in "goodwill" associated with the purchases. The amount reflected the difference between the price paid for Dr. Siva's practice and the value of the practice itself. Even if Dr. Siva's liabilities had not been part of the transaction, the goodwill still amounted to $6.4 million—a significant premium over the value of the assets.

106. The premium that Dr. Siva received for his practice reflected the value of the procedures that Dr. Reddy expected him to perform at DVH.

107. Demonstrating that the purchase price for HDHI and A&A was well above the value of the assets purchased, and that most of the payment was to induce Dr. Siva to refer his patients to Prime, HDHVI was unable to generate sufficient revenue to meet its financial obligations following the transaction. HDHVI's revenues plummeted immediately following the acquisition of HDHI and the closure of A&A, such that it lacked revenue sufficient to cover its expenses, including Dr. Siva's new $1.2 million a year salary. In addition to these steeply falling revenues, Dr. Siva refused to pay liabilities his practices had accrued prior to their sale, despite the explicit language of the APA.

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108. Relator, assuming that the transaction was legitimate, sought to execute the contract while also maintaining the integrity of the books of the relevant Prime entities. It quickly became clear that this was impossible and never what Dr. Reddy or Dr. Siva had intended. At Dr. Siva's insistence, for example, Relator was forced to use a portion of the escrow money to cover HDHI's previously accrued liabilities that Dr. Siva was refusing to pay, thereby, in practical terms, giving this money to Dr. Siva. Mike Sarian, Prime President of Operations, specifically authorized the release of $250,000 from the escrow account to cover accrued accounts payable that Dr. Siva was supposed to be personally responsible for.

109. Around February or March 2016, Relator was finally able to stabilize HDHVI by transferring the company's non-physician payroll to DVH, which reduced HDHVI's expenses relative to its still anemic revenues. HDHVI was supposed to reimburse DVH for the costs it incurred from taking on payroll, but this never happened. In addition, the $1 million annual "management fees" to be paid to Desert Valley Medical Group per the APA were also never paid.

110. However, shortly thereafter, Relator's careful balance was disrupted again when additional revenue was siphoned away from HDHVI. After Dr. Siva's surgery center was closed, his practice continued to perform some diagnostics and procedures, such as imaging and labs. But around March or April 2016, these services began being billed by the hospital and this revenue flowed to DVH instead of HDHVI. This was done either through movement of equipment and patients to DVH or the conversion of HDHVI to a "provider-based" facility, also known as a "1206(d) clinic." If HDHVI became provider-based, this would have allowed Prime to bill for services performed there at hospital rates (which are generally substantially higher than rates paid to physician offices).

111. Subsequently, the entire value of the "goodwill" had to be written off as impaired, which reflected the reality that HDHVI had no prospect of generating revenue sufficient to justify the amount that Prime had paid.

112. Dr. Siva's $1.2 million annual salary was also above fair market value and intended to ensure he continued to bring patients to Prime facilities. The other cardiologists at DVH, who performed work similar to that done by Dr. Siva, made less than half of that — $450,000-$500,000 per year. Dr. Siva also made more than twice the median compensation of cardiologists reported for 2015 ($483,653) and substantially above the 90th percentile compensation reported for cardiologists in 2017 ($733,541) as reported by the American Medical Group Association, one of the leading surveys for physician compensation.

113. By staggering Dr. Siva's excessive purchase payments over several years, and employing him at an above-market rate, Dr. Reddy ensured that Dr. Siva not only ceased running his competing surgery center, but continued to actively bring patients to the Prime hospitals, even though there were several other options he could have utilized in the area.

4. The Defendants Intended for Dr. Siva to Refer Patients to DVH in Exchange for Payments from HDHVI

114. The objective of the transaction between Prime and Dr. Siva was for Prime to pay Dr. Siva $10 million in return for a stream of patient referrals to DVH. This intention is evident both from Dr. Siva's and Dr. Reddy's communications with the Relator and from the many errors and inconsistencies in the APA, which served to mask the unlawful referral scheme and was ignored by the parties as soon as the ink was dry.

a. In Private Communications, the Defendants Acknowledged that the Purpose of the Transaction was to Pay Dr. Siva for Referrals to DVH

115. Dr. Siva and Dr. Reddy informed the Relator on multiple occasions that the purpose of the transaction was for Dr. Siva to refer patients to DVH in exchange for payments from Prime.

116. As the Relator sought solutions to HDHVI's financial problems in late 2015 and early 2016, Dr. Siva made clear to him in text conversations that he expected

to be paid in full notwithstanding HDHVI's financial distress, precisely because of the referrals he was bringing to DVH.

117. In a text message to Relator on November 25, 2015, Dr. Siva proposed that DVH loan HDHVI $1 million, "[s]ince DVH will make a considerable profit because of additional procedures from me." Relator forwarded this message to DVH CEO Fred Hunter.

118. Dr. Siva further informed Relator that part of Dr. Reddy's motivation for the transaction, and why Dr. Siva received the inflated payments called for in the APA, was because Dr. Siva would bill for his office services at higher hospital rates going forward. In another text message on November 25, 2015, when trying to convince Relator that DVH should loan money to HDHVI, Dr. Siva wrote: "the idea for Prem to buy was all the procedures done at HDHI [would] be billed under [the] hospital billing code. Because of higher reimbursement. Stress test at office setting is 900 vs 1800 at the hospital." Relator again forwarded this message to DVH CEO Fred Hunter.

119. In another text message on January 8, 2016, as Relator was still struggling to balance HDHVI's books, Dr. Siva wrote: "DVH is making all the money from my procedures. From Nov to Dec. I p[er]formed over 100 cases. Of course you[] are going to have cash flow problems because half the money I generated is now coming to DVH but all the exp[e]nses are still with HDHI. Part of the agreement was mon[ey] from DVH will be used for our exp[e]nses."

120. Dr. Siva continued: "My conversation with Dr. Reddy was exactly over this issue. In fact he was annoyed that the hospital is not billing for nuclear, CT and Echo because of higher reimbursement."

121. On February 9, 2016, Dr. Siva reiterated: "You have 3 cardiologists on your payroll in DVH are any of them generating income from the clinic. The answer is NO. But we are. But all the profit is going to hospital. 70% of Cath lab volume is mine."

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122. Following the transfer of Dr. Siva's diagnostic and lab procedures to DVH, Dr. Siva complained to Relator that he should be credited for the revenues he brought to the hospital in the form of the new diagnostics and procedures. On May 2, 2016, Dr. Siva wrote to Relator: "I'm always waiting for my rent and paycheck. My expense account has not been paid. I'm always paying late fees on my accounts. All the money is now going to the hospital. CHF clinic Nuclear Angiograms CT scan ECHO LABS X-RAY DOPPLERS THAT MEANS 90% of all income Yet all expenses are still coming out of HDHI. This is ridiculous."

123. On May 13, 2016, Dr. Siva continued: "Since March 1st 80% of the income generated by me is now going to the hospital. Since shutting down AandA surgery 4 million/year of my income is going to the hospital and now an additional 4 million/year of HDHI income is going to the hospital." Relator forwarded this message to DVH CEO Fred Hunter.

124. Consistent with his understanding that his payment was in return for his referrals, Dr. Siva regularly threatened to "go on vacation," thereby ceasing his flow of referrals, if he was not paid in full. On February 9, 2016, Dr. Siva wrote to Relator: "I can solve this by not working and cancelling all my cases." Later in the day he continued: "Maybe I should take a couple of months off until you guys figure things out. And if I do there will be no practice when I get back." Again on May 13, 2016, after expressing his frustration that he did not feel he was being paid timely, he threatened: "I was to take a week off next week but if this continues I will take a month off so to give you all time to get this resolved[.]"

125. Dr. Reddy confirmed to Relator that he also considered Dr. Siva's contract contingent on his continued referrals of procedures to DVH. When Relator asked about a possible loan to HDHVI, Dr. Reddy and Michael Sarian (President of Hospital Operations for Prime Healthcare Services) asked him for a summary of the procedures Dr. Siva had brought to DVH in order to determine whether they would free up funding for HDHVI. The Director of IT ran these numbers for them and the

business office likely monetized the value of the procedures. The papers were drawn up for DVH to loan HDHVI up to $1 million but Relator does not know whether the agreement was ever executed or whether the credit line was drawn upon. Nonetheless, by considering a loan to HDHVI based on the value of the procedures that Dr. Siva performed at DVH, Prime demonstrated that it knew it was paying for patient referrals.

b. Dr. Reddy Entered into the Agreement Without Consulting DVH Management or Performing a Valuation of Dr. Siva's Services

126. Dr. Reddy negotiated the agreement with Dr. Siva without notifying or involving other DVH executives. Relator, whom Prime normally included in acquisition discussions because of his role as CFO for DVH, was excluded entirely. The CEO for DVH was similarly excluded. In fact, neither Relator not the CEO knew of the transaction until early November, after A&A was shut down.

127. As soon as he learned of the transactions, Relator began pressing Dr. Reddy for an accounting of the due diligence that had been done to support the purchase and, in particular, the purchase price. Relator discovered that, in fact, no due diligence had been done. Despite the existence of a "Side Letter Agreement" that amended the APA to require the parties to the APA to "retain legal counsel and/or other consultants and experts to review the APA and the [Provider Employment Agreement] and provide comments and recommendations to assess whether the terms of the APA and [Provider Employment Agreement] each in their entirety, respectively, meet relevant federal and state laws and regulations," a valuation firm was not hired until December 2015 and only due to Relator's insistence.

c. HDHVI Continued to Pay Dr. Siva Even as He Failed to Comply with Multiple Provisions of the APA

128. The unlawful purpose of the transaction is also evident in the parties' immediate nonperformance under the APA. The APA is nonsensical as a purchase contract, with several internally contradictory contract terms and key terms and attachments missing. For example, section 6, describing the "Purchase Price,"

arguably the most important provision, states: "The purchase price for the Assets shall be Five Million Dollars ($5,000,000) plus Two Million Dollars ($2,000,000), (collectively, the 'Purchase Price') . . ." (i.e., $7 million) and then goes on to describe total payments of $10 million. "Schedule 7" — which is supposed to provide instructions for handling the escrow funds — doesn't exist. The inconsistency of key terms shows that the APA served to paper a handshake agreement, rather than to govern the terms of an arm's length transaction.

129. There are multiple guarantees in the APA that the parties ignored from the very outset of the arrangement. For example, Dr. Siva, through and with HDHI/A&A, guaranteed "return of [Dr. Reddy's] investment" and the payment of management fees of $1 million/year. These "management services" were to be provided through Desert Valley Medical Group ("DVMG"). DVMG had no involvement in the operation of Dr. Siva's practice, was never expected to, and even if it did, management fees of $1 million per year would be extraordinarily high for a practice the size of Dr. Siva's. These management fees were never paid and Dr. Reddy never insisted on fulfillment of these terms. In addition, Dr. Siva guaranteed that HDHVI would generate cash collections of at least $5 million a year, and to the extent it did not, gave Dr. Reddy the option to offset the difference from Dr. Siva's salary or the purchase price under the APA. Both parties knew when making the agreement, however, that Prime would shut down A&A and most of HDHI's lucrative diagnostic procedures were going to be transferred to DVH, thus ravaging HDHVI's anticipated revenues. In fact, as of December 2015, HDHVI had net revenue of $336,043 (annualized to $4 million/year) and this revenue would drop sharply again early in 2017.

130. Dr. Siva continued to receive full payment of his salary and the purchase price even though HDHVI's annualized net revenue was less than the guarantee in the APA and Dr. Siva had not paid the required management fees. In conversations with Dr. Reddy, Dr. Reddy indicated to the Relator that he expected Dr. Siva to receive all

the payments contemplated in the APA. HDHVI's continued payments reflected Prime's interest in continuing to receive a stream of patient referrals from Dr. Siva.

5. Defendants Violated the False Claims Act , California False Claims Act, and California Insurance Frauds Prevention Act

131. The payments made to Dr. Siva under the APA and Employment Agreement to induce his referrals of patients to DVH and other Prime entities violate the Stark Law, the Anti-Kickback Statute, the California Insurance Code, the California Penal Code, the Federal and California False Claims Acts, and the California Insurance Frauds Prevention Act.

132. Following its acquisition, HDHVI billed for procedures performed on large numbers of Medicare, Medi-Cal, and privately insured patients. For example, between March 2016 and March 2017, the top 10 payors that Defendants billed for HDHVI's services were as follows:

1. Medicare (as a Secondary Payor)
2. Joint Medicare/Medi-Cal ("Medi-Medi")
3. Medi-Cal Managed Care (Inland Empire Health Plan Medi-Cal)
4. Traditional Medicare
5. Blue Cross
6. Medicare Advantage (Inland Empire Health Plan Medicare)
7. United Health Care Senior PPO
8. Blue Shield (BSCCA, BS & BS OOS)
9. Traditional Medi-Cal
10. TriCare West (Triwest)

133. None of the safe harbors under the Stark Law or AKS exempt the Defendants from liability. The payments made to Dr. Siva under the APA and the Employment Agreement significantly exceeded the fair market value of Dr. Siva's practice. (Indeed, HDHVI could not support the financial weight of Prime's purchase price due to its significant excess over the revenue that Dr. Siva generated.) Because

the payments were above fair market value, the Defendants do not meet the Stark Law's safe harbors for isolated transactions, bona fide employment relationships, personal services arrangements, indirect compensation arrangements, or other physician compensation. For the same reasons, the Defendants do not satisfy the conditions for any of the safe harbors under the AKS. For example, the Defendants do not meet the conditions for the exemption for practice sales because, among other reasons, Dr. Siva was in a position to make referrals to DVH following the transaction and did so repeatedly. The Defendants also do not meet the conditions for the employment or personal services exemptions because Dr. Siva's aggregate compensation exceeded fair market value and compensated him for the volume or value of his referrals to DVH.

134. Violations of the Stark Law and AKS are material to the Government's decision to pay the claims that the Defendants submitted for payment or approval under government-funded health insurance programs. Defendants billed Medi-Cal and private insurers for procedures performed after the unlawful payments to Dr. Siva to refer patients to DVH and other Prime entities. All claims made to private and government-funded health insurance programs as a result of services tainted by these unlawful payments are false and/or fraudulent within the meaning of the Federal and California False Claims Acts and the California Insurance Frauds Prevention Act.

B. Defendants Submitted False Claims for Pass-Through Products Billed at Fraudulently Inflated Rates

135. Implantable medical devices, such as pacemakers or joint replacements, can be a major expense for hospitals. Prime executives, including Dr. Reddy, monitored the cost of implantable devices closely and focused on strategies for reducing that cost. For example, hospital executives at Prime were required to prepare a monthly spreadsheet, called the "Implant Log," that listed every procedure performed at the hospital that involved an implant. This spreadsheet included: the patient's name, medical record number, insurer, date of birth, and age; the surgeon's name; the date of

service; the name of the manufacturer of the implant; a description of the procedure; the "total cost" of the implant(s); whether the procedure was performed on an inpatient or outpatient basis; the inpatient or outpatient reimbursement; the cost of the implant as a percentage of the reimbursement; and a comment field or "Required Approval" field which frequently listed the purchase order number of the relevant implant. The logs split patients into "Medicaid Patients," "FFS" patients (i.e., commercially-insured patients), and "DRG" patients (i.e., Medicare patients). These implant logs were required to be sent to Prime's senior executives, including Dr. Reddy, Mike Heather, Mike Sarian, Rabi Reddy Alla (Vice President of Professional Services),and the Vice President of Supply Chain (Lisa Ottem and then her successor), on a monthly basis.

136. Prime's Implant Log tracked implantable devices across all payors, including Medicare, Medicaid, and private insurers.

137. For Medicare and other payors that reimburse Prime for procedures on a DRG basis, Prime's policy was that the hospital's reimbursement for the procedure had to be at least twice the cost of the implant. Prime's senior executives used the Implant Log to determine if hospitals were complying with that policy.

138. Other payors reimburse certain medical devices, generally high-cost implants, on a "pass-through" basis. This means that rather than the cost of the device being included in the procedure payment, the device is paid separately based on the cost to the provider to procure it. Providers are required to report to insurers the price they paid for the device used and are frequently required to document this price through submission of an invoice showing the provider's purchase price.

139. For payors that reimbursed Prime on a pass-through basis, Prime used the Implant Log for a different and fraudulent purpose. The Implant Log spreadsheets listed Prime's "total cost of implants," which was the amount Prime had paid to purchase the implants. Prime executives monitored the total cost of implants listed in the Implant Log and required hospitals to submit the invoices for those implants to Prime's headquarters in Ontario, California. There, Prime falsified the invoices to

1 show a higher price than Prime had actually paid for the devices. Prime submitted the
2 falsified invoice information to payors to generate higher cost-based reimbursement
3 for implantable devices.

4 140. The payors that reimburse Prime for implantable devices on a cost basis
5 include Medi-Cal and private insurers. Many of Prime's Implant Logs, for example,
6 list the reimbursement for implantable devices furnished to Medicaid patients as
7 "$XX,XXX+INVOICE+5%."

8 141. Prime's falsification of invoices was systematic and systemic. Prime has
9 several regional "business offices" which handle billing and collections for all of the
10 Prime entities. Billing and collections for implantable devices, however, are
11 centralized at Prime's Ontario headquarters. Prime has a team of 3–4 employees in
12 Ontario dedicated to falsifying invoices and purchase orders to make it appear that
13 Prime spent more on implants than it in fact did. The leader of that team is Sheila
14 Reddy, Dr. Reddy's niece.

15 142. Ms. Reddy was in her early 20's when she was made the Vice President
16 and Director of Patient Accounting, and put in charge of the corporate billing function
17 within the Ontario Business Office in late 2014 or early 2015. Ms. Reddy's office
18 became a falsification factory—a team of people dedicated to falsifying documents on
19 an industrial scale. Ms. Reddy, and others working at her direction, directed Prime's
20 billers, including those in the Ontario office as well as those in the regional business
21 offices, to send to Ms. Reddy's team, all implant purchase orders and invoices before
22 relevant services were billed. Ms. Reddy's team then physically altered the invoices
23 and purchase orders to make it appear that Prime had spent more on the implants than
24 it, in fact, had. This way, for any claims involving implants that were paid on a pass-
25 through basis, Prime's reimbursement would be fraudulently increased.

26 143. Relator was told about this misconduct around the winter of 2015 or early
27 2016 by Sue Bachle, then the Director of Prime's San Dimas Business Office. Ms.
28 Bachle showed Relator examples of the falsified invoices. Relator instructed Ms.

Bachle not to participate in this fraudulent conduct and she assured Relator that she was not permitting falsification of invoices for any of the billings from the hospitals she oversaw, which included Chino, Montclair, San Dimas, and Glendora. However, to her knowledge, with the possible exception of Centinela for a brief period when the Head of its Business Office refused to comply with Ms. Reddy's directive, the business offices associated with all other Prime hospitals were submitting falsified implant invoices to government and private payors in order to obtain fraudulently inflated reimbursement.

144. Around the same time period, Ms. Bachle told Relator that a corporate-wide directive had gone out to all of the billing offices to submit their implant invoices to the Ontario Business Office.

145. Through this fraudulent scheme, Prime Healthcare Services and Prime Healthcare Foundation submitted or caused the submission of the altered invoices to insurers, including Medicaid and private insurers, to claim inflated reimbursement for procedures involving implantable devices.

146. These claims are false and/or fraudulent within the meaning of the federal and California False Claims Acts and the California Insurance Frauds Prevention Act.

Count I
False Claims Act
31 U.S.C. §§ 3729(a)(1)(A)-(C) and (G)

147. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Complaint as if fully set forth herein.

148. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. § 3729, *et seq.*, as amended.

149. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the United States Government for payment or approval.

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150. By virtue of the acts described above, Defendants knowingly made or used, or caused to be made or used, false or fraudulent records or statements material to false or fraudulent claims.

151. By virtue of the acts described above, Defendants knowingly concealed overpayments from the United States Government and failed to remit such overpayments.

152. By virtue of the acts described above, Defendants, their agents, employees and other co-conspirators knowingly conspired to submit false claims to the United States, make or use false records or statements material to false or fraudulent claims, and to conceal and fail to remit overpayments from the United States.

153. The Government, unaware of the falsity of the records, statements and claims made or caused to be made by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' illegal conduct.

154. By reason of Defendants' acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

155. Additionally, the United States is entitled to the maximum penalty permitted for each and every violation alleged herein.

Count II
California False Claims Act
Cal. Gov't Code §§ 12651(a)(1)-(3), (7)

156. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Complaint as if fully set forth herein.

157. This is a claim for treble damages and penalties under the California False Claims Act.

158. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the California State Government for payment or approval.

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159. By virtue of the acts described above, Defendants knowingly made, used, or caused to be made or used false records and statements material to claims presented to the California State Government.

160. By virtue of the acts described above, Defendants knowingly and improperly made or used or caused to be made or used, false records and statements material to an obligation to pay or transmit money to the California State Government, and knowingly and improperly concealed, avoided, and decreased an obligation to pay or transmit money or property to the California State Government.

161. By virtue of the acts described above, Defendants conspired to defraud the California State Government through the acts above.

162. The California State Government, unaware of the falsity of the records, statements and claims made, used, presented or caused to be made, used or presented by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' unlawful conduct.

163. By reason of Defendants' acts, the State of California has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

164. Additionally, the California State Government is entitled to the maximum penalty of $11,000 for each and every violation alleged herein.

Count III
California Insurance Frauds Prevention Act
Cal. Ins. Code § 1871.7

165. Relator realleges and incorporates by reference the allegations contained in all paragraphs of the Complaint as if fully set forth herein.

166. This is a claim for treble damages and penalties under the California Insurance Frauds Prevention Act, Cal. Ins. Code § 1871.7, as amended (referred to in this Count as "the Act"). The Act provides for civil recoveries against persons who violate the provisions of the Act or the provisions of California Penal Code §§ 549 or 550, including recovery of up to three times the amount of any fraudulent claims, and fines of between $5,000 and $10,000 for each such claim. Cal. Ins. Code §1871.7(b).

1 167. The Act makes it unlawful to "knowingly employ runners, cappers,
2 steerers, or other persons . . . to procure clients or patients to perform or obtain services
3 or benefits under a contract of insurance or that will be the basis for a claim against an
4 insured individual or his or her insurer." Cal. Ins. Code § 1871.7(a)
5 168. Subsection (b) of Cal. Ins. Code § 1871.7 provides for civil recoveries
6 against persons who violate the provisions of Penal Code sections 549 or 550. Section
7 550 of the Penal Code prohibits the following activities, among others:
8 (a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:
9 (5) Knowingly prepare, make, or subscribe any writing, with the intent to
10 present or use it, or to allow it to be presented, in support of any false or fraudulent claim.
11 (6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.
12 (b) It is unlawful to do, or to knowingly assist or conspire with any person to do any of the following:
13 (1) Present or cause to be presented any written or oral statement as part
14 of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any
15 false or misleading information concerning any material fact.
16 (2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or
17 in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any
18 false or misleading information concerning any material fact.
19 169. By virtue of the acts described in this Complaint, Defendants knowingly
20 presented or caused to be presented, false or fraudulent claims in violation of Penal
21 Code §§ 550(a)-(b).
22 170. Private insurers, unaware of the falsity of the records, statements and
23 claims made or caused to be made by Defendants, paid and continue to pay the claims
24 that would not be paid but for Defendants' unlawful conduct.
25 171. The California State Government is entitled to receive three times the
26 amount of each claim for compensation submitted in violation of Cal. Ins. Code
27 § 1871.7. Additionally, the California State Government is entitled to the maximum
28 penalty of $10,000 for each and every violation alleged herein.

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VI. PRAYER FOR RELIEF

WHEREFORE, Mr. Mansukhani prays for judgment against the Defendants as follows:

1. That Defendants cease and desist from violating 31 U.S.C. § 3729 *et seq.*, Cal. Gov't Code § 12650 *et seq.*, and Cal. Ins. Code § 1871.7.

2. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States has sustained because of Defendants' actions, plus the maximum civil penalty for each violation of 31 U.S.C. § 3729;

3. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the State of California has sustained because of Defendants' actions, plus a civil penalty of $10,000 for each violation of Cal. Gov't Code § 12651;

4. That this Court enter judgment against Defendants in an amount equal to three times the amount of each claim for compensation submitted by Defendants in violation of Cal. Ins. Code § 1871.7, plus a civil penalty of $10,000 for each violation of Cal. Ins. Code § 1871.7(a)-(b);

5. That Plaintiff-Relator Mansukhani be awarded the maximum amount allowed pursuant to § 3730(d) of the False Claims Act and the comparable provisions of the California False Claims Act and California Insurance Frauds Prevention Act;

6. That Plaintiff-Relator Mr. Mansukhani be awarded all costs of this action, including attorneys' fees and expenses; and

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1 7. That Plaintiff-Relator Mr. Mansukhani recover such other relief as the
2 Court deems just and proper.
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4 Dated: April 24, 2020 By: */s/ Justin T. Berger*

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DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Plaintiff-Relator Martin Mansukhani hereby demands a trial by jury on all claims so triable.

Dated: April 24, 2020

By: *__/s/ Justin T. Berger__*

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CERTIFICATE OF SERVICE

I hereby certify that on April 24, 2020, I electronically filed the foregoing **SECOND AMENDED COMPLAINT FOR VIOLATION OF THE FEDERAL FALSE CLAIMS ACT [31 U.S.C. § 3729 et seq.], THE CALIFORNIA FALSE CLAIMS ACT [Cal. Gov't Code § 12650 et seq.], and the CALIFORNIA INSURANCE FRAUDS PREVENTION ACT [Cal. Ins. Code § 1871 et seq.]** with the Clerk of Court using the CM/ECF system which will automatically send an e-mail notification of such filing to the following attorneys of record.

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