UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
ATHENS DIVISION

UNITED STATES OF AMERICA ex rel. RALPH WILLIAMS, Plaintiffs, v. MONROE HMA, LLC d/b/a WALTON REGIONAL MEDICAL CENTER; TENET HEALTHCARE CORPORATION, and its subsidiaries: TENET HEALTHSYSTEM GB, INC. d/b/a ATLANTA MEDICAL CENTER, NORTH FULTON MEDICAL CENTER, INC., d/b/a NORTH FULTON REGIONAL HOSPITAL, TENET HEALTHSYSTEM SPALDING, INC., d/b/a SPALDING REGIONAL MEDICAL CENTER, HILTON HEAD HEALTHSYSTEM, L.P., d/b/a HILTON HEAD HOSPITAL; and HISPANIC MEDICAL MANAGEMENT, INC. d/b/a CLINICA DE LA MAMA; CLINICA DE LA MAMA, INC., d/b/a CLINICA DE LA MAMA, AND CLINICA DEL BEBE, Including their affiliated parent or successor corporations: INTERNATIONAL CLINICAL MANAGEMENT SERVICES, INC. and COTA MEDICAL MANAGEMENT GROUP, INC., Defendants.	)	Case No. 3:09-CV-130 (CDL)

COMPLAINT IN INTERVENTION OF THE UNITED STATES

INTRODUCTION

This is an action against defendants to recover treble damages, restitution, and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33, and the common law for their participation in a kickback scheme in violation of the federal Anti-kickback Statute, 42 U.S.C.

§ 1320a-7b(b), that resulted in the submission of false claims to Medicaid and Medicare, during the period from 2000 through 2013.

Defendant Tenet Healthcare Corporation ("Tenet") is one of the largest hospital chains in the United States. Tenet subsidiaries named as defendants include four hospitals in Georgia and South Carolina: Tenet Healthsystem Gb, Inc. d/b/a Atlanta Medical Center; North Fulton Medical Center, Inc., d/b/a North Fulton Regional Hospital; Tenet HealthSystem Spalding, Inc. d/b/a Spalding Regional Medical Center; and Hilton Head Healthsystem, L.P., d/b/a Hilton Head Hospital (collectively referred to as "Tenet Hospitals").

The remaining hospital defendant is Monroe HMA, LLC d/b/a Clearview Regional Medical Center (f/k/a Walton Regional Medical Center) ("Walton"), which at all times pertinent to the Complaint was part of the chain of hospitals previously owned by Health Management Associates, Inc. ("HMA"), and is now owned by Community Health Services, Inc. The remaining defendants are Hispanic Medical Management, Inc. d/b/a Clinica De La Mama; Clinica De La Mama, Inc. d/b/a Clinica De La Mama; and Clinica De La Mama and Clinica Del Bebe, including their affiliated corporations, International Clinical Management Services, Inc. and Cota Medical Management Group, Inc. (collectively "Clinica").

Beginning as early as 2000, one of the Tenet Hospitals paid remuneration to Clinica, under the guise of various agreements, in return for which Clinica would send primarily undocumented, pregnant Hispanic women from its prenatal clinics to deliver their babies at the particular Tenet Hospital. The other Tenet Hospitals also subsequently engaged in the same scheme to obtain patient referrals. Walton entered into a similar agreement with Clinica in 2008 in return for obstetric patient referrals. These patients would then be eligible for emergency Medicaid services when they gave birth. By knowingly entering into these contracts in return for patient referrals, the Tenet Hospitals and

Walton violated federal and state law, and submitted false certifications to the Medicare and State Medicaid programs that they were in compliance with such federal and state laws, including the Anti-kickback Statute. Claims to the Georgia and South Carolina State Medicaid programs for patients illegally referred from Clinica resulted in the States' payment of tens of thousands of ineligible Medicaid claims over the course of more than a decade.

In addition, the Tenet Hospitals and Walton took advantage of the Medicare Disproportionate Share (DSH) program, 42 C.F.R. § 412.106, which permits hospitals that treat large numbers of low-income patients, including Medicaid patients, to seek additional federal funds from the Medicare program. The Tenet Hospitals and Walton sought such payments based on figures that included Clinica patients illegally referred pursuant to the kickback scheme. In sum, Tenet, the Tenet Hospitals and Walton knowingly submitted false claims and statements to both the Medicare and Medicaid programs as a result of the kickback scheme with Clinica.

JURISDICTION AND VENUE

1. This Court has subject matter jurisdiction over this matter under 28 U.S.C. § 1345. The Court has supplemental jurisdiction to entertain the common law causes of action under 28 U.S.C. § 1367(a). The Court may exercise personal jurisdiction over the defendants, and venue is appropriate in this Court, under 31 U.S.C. § 3732(a) and (b), because at least one of the defendants transacts business in this District and submitted or caused to be submitted or conspired to submit false claims in this District.

THE PARTIES

2. Plaintiff United States, acting through the Department of Health and Human Services ("HHS"), administers the Health Insurance Program for the Aged and Disabled established by Title XVIII of the Social Security Act (Act), 42 U.S.C. §§ 1395 *et seq*. (Medicare),

and Grants to States for Medical Assistance Programs pursuant to Title XIX of the Act, 42 U.S.C. §§ 1396 *et seq.* ("Medicaid").

3. Plaintiff-Relator Ralph Williams is an individual and a resident of the State of Georgia.

4. Plaintiff, the state of Georgia, acting through its Department of Community Health, administers its Medicaid program. The state of Georgia has intervened pursuant to the Georgia False Medicaid Claims Act, O.C.G.A. §§ 49-4-168, *et seq.* and the Georgia Medical Assistance Act, OCGA § 49-4-146.1(b).

5. Defendant HMA Monroe, LLC d/b/a Walton Regional Medical Center n/k/a/ Clearwater Regional Medical Center ("HMA Monroe"), is located in Monroe, Walton County, Georgia, and is a Georgia limited liability company. HMA Monroe's principal office was located at 5811 Pelican Bay Blvd., Suite 500, Naples, Florida, 34108-2710.

6. Defendant Tenet Healthcare Corporation is a Nevada for-profit corporation doing business in the Middle District of Georgia. Its principal office address is 13737 Noel Road, Suite 100, Dallas, Texas, 75240.

7. Defendant Tenet, through its subsidiaries and affiliates, does business in Georgia as Atlanta Medical Center (in Atlanta), North Fulton Regional Hospital (in Roswell), Spalding Regional Medical Center (in Griffin), and as Hilton Head Regional Hospital in Hilton Head, South Carolina. The address of the headquarters for each of these Tenet hospitals is 1445 Ross Avenue, Suite 1400, Dallas, Texas, 75202.

8. Defendants Hispanic Medical Management, Inc. d/b/a Clinica de la Mama and Clinica de la Mama, Inc. d/b/a Clinica de la Mama, at all relevant times, were Georgia corporations doing business in the Middle District of Georgia, with offices (clinics) in Norcross,

Lawrenceville, Roswell, Smyrna, Plaza Fiesta (Chamblee) and Forest Park, Georgia and in Hilton Head, South Carolina. Hispanic Medical Management ("HMM") and Clinica de la Mama have affiliates and successor related entities. Relevant affiliates and successors include International Clinical Management Services, Inc. d/b/a Clinica del Bebe and Cota Medical Management Group, Inc. d/b/a Clinica de la Mama.

THE LAW

9. The False Claims Act provides in pertinent part that:

> Any person who —
>
> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
>
> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; [or]
>
> (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; . . .
>
> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information —
>
> (1) has actual knowledge of the information;
>
> (2) acts in deliberate ignorance of the truth or falsity of the information; or
>
> (3) acts in reckless disregard of the truth or falsity of the information,
>
> and no proof of specific intent to defraud is required.

31 U.S.C. § 3729(a), (b).[1] *See also* 28 C.F.R. § 85.3(a)(9) (detailing current civil penalties of not less than $5,500 and not more than $11,000 for violations of the FCA).

10. The federal Anti-kickback Statute ("AKS") arose out of congressional concern that remuneration given to those who can influence healthcare decisions would corrupt the medical decision-making process, and result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of federal health care programs from these difficult-to-detect harms, Congress enacted a *per se* prohibition against the payment of kickbacks in any form, regardless of whether the particular kickback gave rise to overutilization of federal healthcare services or poor quality of care. First enacted in 1972, Congress strengthened the statute in 1977 and 1987 to ensure that kickbacks masquerading as legitimate transactions did not evade its reach. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142; and Medicare and Medicaid Patient Protection Act of 1987, Pub. L. No. 100-93.

11. The AKS prohibits any person or entity from knowingly and willfully offering, paying, soliciting, making or accepting payment to induce or reward any person or entity for referring, recommending or arranging any good or item for which payment may be made in whole or in part by a federal health care program, which includes any State health program such as the

[1] The FCA was amended pursuant to Public Law 111-21, the Fraud Enforcement and Recovery Act of 2009 ("FERA"), enacted May 20, 2009. Given the nature of the claims at issue, Sections 3729(a)(1), 3729(a)(2) and 3729(a)(3) of the prior statute, and Section 3729(a)(1)(A), 3729(a)(1)(B) and 3729(a)(1)(C) of the revised statute are all applicable here. Sections 3729(a)(1) and 3729(a)(2) apply to conduct that occurred before FERA was enacted, and sections 3729(a)(1)(A) and 3729(a)(1)(C) apply to conduct after FERA was enacted. Section 3729(a)(1)(B) is applicable to all claims in this case by virtue of Section 4(f) of FERA, which makes the new changes to that provision applicable to all claims for payment pending on or after June 7, 2008.

Georgia and South Carolina Medicaid programs (a federally-funded medical service) or health program funded in part by the federal government. 42 U.S.C. §§ 1320a-7b(b) and 1320a-7b(f). In pertinent part, the AKS states:

> (b) Illegal remunerations
>
> * * *
>
> (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or overtly, in cash or in kind —
>
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
>
> (B) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,
>
> shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1320a-7b(b).

12. In addition to criminal penalties, a violation of the AKS can also subject the perpetrator to exclusion from participation in federal health care programs (42 U.S.C. §1320a-7(a)), civil monetary penalties of up to $50,000 per violation (42 U.S.C. §1320a-7a(a)(7)), and three times the amount of remuneration paid, offered, solicited, or received, regardless of whether any part of the remuneration is for a lawful purpose. 42 U.S.C. §1320a-7a(a).

13. In 2010, Congress amended the AKS to state that "a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of [the FCA]." Patient Protection and Affordable Care Act of 2010 (PPACA), § 6402(f), 42 U.S.C. § 1320a–7b(g).

14. The Georgia and South Carolina Medicaid Programs are Federal Health Care Programs under the Anti-kickback Statute, subjecting Defendants to liability under the Anti-kickback Statute and Georgia and South Carolina laws that incorporate compliance with that statute. 42 U.S.C. § 1320a-7b(f)(2).

15. The Georgia Medical Assistance Act, O.C.G.A. § 49-4-146.1(b), the Georgia Medicaid regulations and the Georgia provider participation agreement prohibit providers from paying for referrals of Medicaid patients.

16. The South Carolina Provider Self-Referral Act of 1993, S.C. Code Ann. § 44-113-60 (1993), prohibits providers from paying for referrals of Medicaid patients. The South Carolina Medicaid regulations and provider participation agreement require compliance with all applicable federal and state laws and regulations, including the Anti-kickback Statute.

THE MEDICARE AND MEDICAID PROGRAMS

A. The Medicare Program

17. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program, to pay for the costs of certain healthcare services. Entitlement to Medicare is based on age, disability or affliction with end-stage renal disease. 42 U.S.C. §§ 426, 426A.

18. Part A of the Medicare Program authorizes payment for institutional care, including hospital, skilled nursing facility and home health care. *See* 42 U.S.C. §§ 1395c-1395i-4. In addition, hospitals that treat large numbers of low-income patients, including Medicaid patients, may seek additional federal funds through the Medicare Disproportionate Share (DSH) program, 42 C.F.R. § 412.106. The formula for determining such funding takes into account the number of patients treated by a given hospital who were eligible for

Medicaid at the time of their treatment. 42 U.S.C. § 1395ww(d)(5)(F)(vi); 42 C.F.R. § 412.106(b)(4)(i).

19. HHS is responsible for the administration and supervision of the Medicare program. The Centers for Medicare and Medicaid Services (CMS) is an agency of HHS and is directly responsible for the administration of the Medicare program.

20. To participate in Medicare, medical providers must first sign enrollment agreements in which they certify that they "understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with * * * the Federal anti-kickback statute." CMS Form 855A, Medicare Enrollment Application - Institutional Providers.

21. As a further prerequisite to payment by Medicare, including payment of Medicare DSH funds, CMS also requires hospitals to submit annually a form CMS-2552, more commonly known as the hospital cost report. *See* 42 U.S.C. § 1395g(a); 42 C.F.R. § 413.20; s*ee also* 42 C.F.R. § 405.1801(b)(1). CMS makes payments retrospectively (after the services are rendered) to hospitals for inpatient and outpatient services. In determining how much reimbursement a hospital is due based on its yearly cost report, the Medicare program takes into account whether the hospital has served a "disproportionate share" of low-income patients. Roughly speaking, the more low-income (including Medicaid) patients treated by a hospital, the greater the amount paid to the hospital pursuant to the Medicare DSH provisions.

22. Medicare relies upon the hospital cost report to determine whether the provider is entitled to more reimbursement than already received through interim payments, or whether the provider has been overpaid and must reimburse Medicare. 42 C.F.R. §§ 405.1803, 413.60 and

413.64(f)(1). In order to be reimbursed by Medicare, a hospital executive must execute an express certification in the cost report. The cost report states as follows:

> MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, 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.

This advisory is followed by the actual certification language itself:

> CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)
> I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by [name of facility, ID number of facility] for the cost reporting period beginning [date] and ending [date] and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of the health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

B. The Medicaid Program

23. The Medicaid Program was also created in 1965 as part of the Social Security Act, which authorized federal grants to states for medical assistance to low-income, blind or disabled persons, or to members of families with dependent children or qualified pregnant women or children. The Medicaid Program is a jointly funded federal-state program and is administered by CMS at the federal level. Within broad federal rules, each state determines eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.

24. Medicaid providers submit claims for payment to states, which pay the claims and obtain the federal portion of the payment from accounts which draw on the United States Treasury. After the end of each calendar quarter, the state submits to CMS a final expenditure report, which provides the basis for adjustment to the quarterly federal funding amount (to reconcile the estimated expenditures to actual expenditures). 42 C.F.R. §§ 430.0-430.30 (1994). The federal share of Medicaid expenditures varies by state and can fluctuate annually.

25. Federal law requires that state Medicaid programs make disproportionate share hospital (also known as DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. 42 U.S.C. § 1396r–4(b)(1)(A)-(B).

26. Although undocumented aliens are not eligible for regular Medicaid coverage, such persons may seek care at Federally Qualified Healthcare Centers, commonly known as community health centers, for little or no cost. *See* Public Health Service Act, § 330, 42 U.S.C. § 254b.

27. In addition, undocumented aliens are eligible for certain types of Emergency Medical Assistance, pursuant to 42 U.S.C. § 1396b(v). Emergency Medical Assistance ("EMA") is the part of the Medicaid program that provides coverage for emergency conditions, including childbirth for undocumented aliens.

28. Emergency labor and delivery by undocumented, otherwise eligible aliens, is considered an emergency medical condition under the Medicaid program pursuant to 42 U.S.C. § 1396b(v)(2) and § 1396b(v)(3). A child born to a woman approved for EMA for her delivery is eligible for what is known as Newborn Medicaid.

29. As Georgia Medicaid providers, hospitals are required to execute "Statements of Participation", commonly referred to as provider agreements. (A copy of the Georgia Medicaid provider agreement executed by Walton is attached hereto as Exhibit 1.)[2]

30. The provider agreements entered into by hospitals mandate compliance with the Georgia Medicaid rules that prohibit paying or accepting, directly or indirectly, kickbacks for referrals. The agreements further state that "Payment shall be made in conformity with the provisions of the Medicaid program, applicable federal and state laws, rules and regulations promulgated by the U.S. Department of Health and Human Services and the State of Georgia and the Department's policies and procedures manuals in effect on the date the service was rendered." *Id.* at ¶ 4.D.

31. The Georgia Department of Community Health prohibits hospital providers from, *inter alia*, paying kickbacks for referrals of Medicaid patients. (A copy of the Georgia Department of Community Health (DCH), Part I Policies and Procedures for Medicaid/PeachCare for Kids, Chapter 100, p. I-19, "General Conditions of Participation", is attached as Exhibit 2.) For example, Chapter 400 of the Part I Policies and Procedures for Medicaid/PeachCare for Kids authorizes the Georgia Department of Community Health to deny reimbursement for "[n]oncompliance with any of the Division's applicable policies and procedures" and to recoup reimbursement when a provider fails to "comply with all terms and conditions of participation related to the service(s) for which a claim has been paid." Chapter 400, p. IV-14, at ¶ 405(E) and p. IV-16, at ¶ 407(f).

32. In Georgia, provider hospitals participating in the Medicaid program submit claims for hospital services rendered to Medicaid beneficiaries to the Georgia Department of

[2] Where noted, personal information has been redacted from the exhibits to this Complaint.

Community Health for payment, either directly or through a State designee such as a fiscal intermediary or managed care organization.

33. At all times relevant to this Complaint, the Tenet Hospitals in Georgia and Walton were required to submit Medicare hospital cost reports to Georgia Medicaid in addition to CMS.

34. In South Carolina, provider hospitals participating in the Medicaid program submit claims for hospital services rendered to Medicaid beneficiaries to the South Carolina Department of Health and Human Services.

35. As South Carolina Medicaid providers, hospitals are required to execute a contract with the South Carolina Department of Health and Human Services, commonly referred to as a provider agreement. (A copy of a South Carolina Medicaid provider agreement is attached hereto as Exhibit 3.)

36. The provider agreements entered into by hospitals mandate compliance with all federal and state laws and regulations, including those rules that prohibit paying or accepting, directly or indirectly, kickbacks for referrals. (*Id.*, Section N.) The agreements further state in relevant part: "The Provider shall certify that all statements, reports and claims, financial and otherwise, are true, accurate, and complete, and the Provider shall not submit for payment, any claims, statements, or reports which he knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, this Contract and SCDHHS policy." *Id.*, Article VI, ¶ A.

37. At all times relevant to this Complaint, the Tenet Hospital in South Carolina was required to submit Medicare hospital cost reports to South Carolina Medicaid in addition to CMS. *Id.*, Article III, ¶ C.

38. Compliance with the Anti-kickback Statute is a condition of payment for both Medicare and Medicaid. The Tenet Hospitals and Walton have been enrolled as providers in the Medicare program, and the Georgia or South Carolina Medicaid Programs, during all times relevant to this action.

SPECIFIC ALLEGATIONS

A. Clinica

39. In or around May 1998, two Georgia residents, Tracey Cota (formerly Erwin) and Ed Cota, established a corporation named Georgia Network Management d/b/a Clinica del Bebe, which in turn opened a prenatal clinic under the name Clinica del Bebe, in Norcross, Georgia. Clinica del Bebe offered prenatal care to pregnant, undocumented Hispanic patients. Clinica del Bebe typically charged a flat fee of anywhere from $1,200-$1,700 per patient, depending on how far along the patient was in her pregnancy and how many visits, lab work, etc, would be required. Clinica del Bebe typically collected this fee in cash from the patients.

40. In addition to providing prenatal care, Clinica del Bebe also assisted patients with filing their Emergency Medicaid Application with the Georgia Department of Community Health, through its Division of Family and Children Services ("DFACS").

41. The physicians who provided prenatal care at Clinica del Bebe did not receive any payment from Clinica del Bebe or the patients for their services. The physicians received payment for deliveries when they billed the Georgia Medicaid program.

42. Certain physicians who saw patients at Clinica del Bebe also sent mid-level providers such as nurse practitioners and nurse midwives to see patients in their stead. These mid-level providers also did not receive any payment from Clinica del Bebe or the patients for their services.

43. Clinica del Bebe patients typically delivered their babies at Northside Hospital in Atlanta, Georgia.

44. As the volume of patients from Clinica del Bebe increased, Clinica del Bebe personnel improved the administrative coordination between the hospital and the clinic with respect to the patients' Emergency Medicaid Applications. At no time did Clinica del Bebe enter into any contracts with Northside Hospital with respect to either administrative or translation services.

45. At some point in 1998 or 1999, Ed Cota ceased to hold any ownership interest in Clinica del Bebe.

46. In 1998, Ed Cota opened a prenatal clinic known as Clinica de la Mama on Buford Highway in Norcross, Georgia. Clinica de la Mama was in direct competition with Clinica del Bebe. Ed Cota also opened other Clinica de la Mama clinics in Austell and Cumming, Georgia.

47. Clinica del Bebe closed at some time in the summer or fall of 1999. The majority of patients seen at Clinica del Bebe transferred to Clinica de la Mama. At some point in 1999, Tracey Cota began working at Clinica de la Mama.

48. Clinica de la Mama operated in a fashion similar to Clinica del Bebe, and Clinica de la Mama patients typically delivered at Northside Hospital.

B. Clinica's Relationship with the Tenet Hospitals

1. Atlanta Medical Center

49. Atlanta Medical Center ("AMC") is a Tenet-owned and operated hospital in Atlanta, Georgia. AMC was formerly known as Georgia Baptist Medical Center and was

acquired by Tenet in 1997. For many years, AMC operated an obstetric and gynecology ("OB/GYN") residency program, until its program accreditation was revoked in 2008.

50. In February 1999, an Associate Medical Director at AMC contacted Tracey Cota regarding her work at Clinica del Bebe. Ms. Cota subsequently met with three medical directors from AMC and gave them a tour of Clinica del Bebe.

51. AMC personnel expressed interest in opening a clinic similar to Clinica del Bebe, but with staffing by AMC physicians, who would in turn provide training to OB/GYN residents at AMC. AMC personnel made clear that AMC needed more obstetric patient volume.

52. AMC decided to pursue the opening of a new clinic, and AMC personnel began negotiating with Tracey Cota at Clinica del Bebe.

53. AMC wanted Clinica del Bebe to open and manage a new residency clinic on the south side of Atlanta. Clinica sought for AMC to provide the physician services, and Clinica would be compensated for running the clinic by retaining cash payments from the patients. Clinica del Bebe would pay the majority of the clinic's expenses, with AMC covering the remainder, possibly through a rent subsidy or management fee.

54. During negotiations in 1999, AMC personnel forwarded a draft contract along these lines to Tenet's inside and outside counsel.

55. Tenet legal counsel expressed concern that the proposed deal violated the Anti-kickback Statute because AMC was providing physician services at no cost to Clinica del Bebe, while allowing the clinic to keep all the proceeds from the physicians' services at the clinic.

56. In response to the legal advice, AMC attempted to structure an arrangement whereby AMC would keep the cash payments from the patients, but would compensate Clinica

at roughly the same amount of money as the clinic estimated it would have collected in cash for services at the clinic. The amount paid to Clinica by AMC would be labeled a monthly management fee.

57. During the latter part of the negotiations with AMC, Tracey Cota ceased her involvement in Clinica del Bebe and Clinica del Bebe closed.

58. After the closure of Clinica del Bebe, AMC personnel continued negotiating with Tracey Cota. Ed Cota also joined in the negotiations with AMC personnel. The Cotas began negotiating with AMC on behalf of Clinica de la Mama.

59. Tracey Cota later married Ed Cota in December 2000. They separated in 2008 and later divorced. They remained in business together until September 2010.

60. In 1999, Tracey Cota incorporated Hispanic Medical Management, Inc. ("HMM") as a holding company, with ownership by family members of both her and Ed Cota. In 2000, HMM merged with Clinica de la Mama and became HMM d/b/a Clinica de la Mama. Tracey and Ed Cota became majority owners of HMM in 2000, along with three local physicians as minority shareholders.

61. During the negotiations with AMC, Ed Cota repeatedly advised AMC personnel that by signing the agreement with HMM, HMM would also ensure that patients from other Clinica de la Mama facilities would be referred to AMC for delivery of their babies.

62. In December 1999, Tracey Cota advised the CEO of AMC regarding the locations of the other Clinica de la Mama clinics and the volume of business at each one. (A copy of this memorandum is attached hereto as Exhibit 4.)

63. Consistent with this expectation of referrals from other Clinica de la Mama facilities, AMC personnel set up a special intake process for Clinica de la Mama patients from all

Clinica facilities, not simply the new residency clinic to be established in conjunction with AMC. AMC assigned a special patient class code, "UC", to the Clinica patients to monitor patient volumes and other financial metrics.

64. In February 2000, Ed Cota advised certain physician shareholders of Clinica de la Mama that the most important issue with AMC was to ensure as many admissions as possible to AMC from Clinica de la Mama facilities.

65. During negotiations in early 2000, Bruce Buchanan became the AMC CEO. Buchanan advised a Tenet corporate executive on March 10, 2000, that if AMC did not sign the contracts with HMM, HMM would pursue a relationship with another hospital.

66. In or around March 15, 2000, AMC executed an "Affiliation Agreement" with HMM, whereby AMC paid a monthly "management fee" of at least $42,350 per month, and also covered patient laboratory costs and certain equipment. (A copy of this agreement is attached hereto as Exhibit 5.) Buchanan signed on behalf of AMC and the Cotas signed on behalf of HMM.

67. In or around March 15, 2000, AMC also executed a "Marketing Consulting Agreement" with HMM, whereby AMC paid $1,000 per month, and up to $2,000 in expenses, to HMM for marketing the new residency clinic. (A copy of this agreement is attached hereto as Exhibit 6.)

68. AMC and Clinica opened the new residency clinic on Cleveland Avenue on the south side of Atlanta. Clinica de la Mama leased the space at Cleveland Avenue from Dr. David Williams, a member of AMC's Board of Directors.

69. At around the same time the residency clinic on Cleveland Avenue opened, AMC began receiving Clinica de la Mama patients from other Clinica locations as well.

70. Clinica was able to direct referrals to particular hospitals based on its control of the patients who sought services and its leverage over the physicians who saw those patients. Although Clinica did not employ the physicians or mid-level service providers, Clinica controlled who would be given time slots to see patients at its facilities, and could ensure that only physicians who agreed to deliver at a particular hospital were given slots.

71. After being given a particular slot of time, a physician could send a mid-level practitioner to cover that shift and might see few or no Clinica patients at all until delivery. Physicians, however, sought access to these time slots, with the expectation of being reimbursed by Medicaid for the subsequent delivery of the baby.

72. Depending on what day a patient arrived for her initial visit, the patient was assigned to a particular doctor and told where she would deliver her child. Clinica would provide the patient with a Clinica identification (ID) card, which would be presented to the hospital where the patient delivered her baby. The ID card listed both the physician to whom the patient had been assigned and the hospital where the patient was told to deliver her baby.

73. To ensure that patients went to the hospital selected by Clinica, even if another hospital was closer to their home, Clinica personnel falsely told patients that their Medicaid benefits were only good at the hospital listed on their ID card, or that they might face questions about their Medicaid eligibility if they went elsewhere.

74. In April 2000, Ed Cota again advised certain physician shareholders at Clinica de la Mama that it was important to send more patients to AMC for delivery. Ed Cota indicated that physicians with existing time slots at clinics who refused to send patients to AMC for delivery would be replaced by physicians who would.

75. Following execution of the two contracts with HMM, Tracey Cota sent monthly reports to AMC personnel, detailing patient volume and admissions sent to AMC from the residency clinic and all of Clinica's other facilities.

76. In July 2000, for example, Tracey Cota sent a management report to AMC personnel detailing the number of expected deliveries at AMC from all of Clinica's facilities, broken down by each clinic. The report reflected that only a small percentage of the expected deliveries were coming from the residency clinic.

77. In September 2000, Tracey Cota reported on the actual deliveries of Clinica patients at AMC for August 2000. The report reflected that very few deliveries were performed for patients being treated at the residency clinic. Instead, the majority of Clinica patient referrals were coming from other Clinica locations.

78. Despite having previously advised legal counsel that the purpose of the contracts with Clinica was to provide training for OB/GYN residents through the residency clinic, AMC management expressed no concern about the low volume of patients being seen at the residency clinic and delivering at AMC.

79. The monthly management fee being paid to HMM of $42,350 was excessive in light of the low volume of patients seen at the residency clinic.

80. In or around June of 2000, a Tenet corporate attorney performed a "legal audit" of the contract between AMC and HMM, and reported there was no fair market value justification for the compensation rate set by the contract. The attorney further noted that AMC provided no documentation of these expenses or methodology to justify the payments under the contract.

81. The primary individuals at AMC who expressed concern about the low numbers of patients at the residency clinic were the physician faculty members of the OB/GYN residency program at AMC.

82. Although the original contract called for the residency clinic to be open six days per week, from 9 to 5, the clinic did not have enough patients for the residents to staff it six days a week. In reality, the OB/GYN residents were at the clinic no more than two days per week.

83. Bill Moore replaced Bruce Buchanan as CEO of AMC in the fall of 2001. AMC personnel continued to meet regularly with Tracey Cota, with a continued focus on information regarding patient volume and admissions from all of Clinica's facilities, not just the residency clinic.

84. Even though the residency clinic, which eventually moved to Forest Park, Georgia, continued to see few patients, AMC continued to pay Clinica based on the deliveries from the other Clinica facilities.

85. The relationship between AMC and Clinica continued until July 2012. (Copies of certain of these agreements are attached as Exhibit 7.) After a retroactive extension of the contract expired in June 2003, AMC continued to make payments to Clinica without a written contract in place for over two years.

86. In or around April or May of 2004, AMC was having difficulty internally justifying why it was paying over $40,000 per month to HMM for managing a clinic that was only generating $20,000 per month in revenue.

87. Around this time, AMC personnel wanted to transition to a new type of contract, similar to the services contract in place with Clinica at another Tenet hospital, North Fulton

(discussed *infra*), because AMC's legal department thought it would be cleaner. The payment amounts to HMM under the contract, however, would remain roughly the same.

88. Despite having previously been told by counsel that it would be potentially illegal to permit Clinica to retain the patient fees at the residency clinic staffed by AMC physicians and residents, AMC personnel advised Tracey Cota that she would be able to retain such fees in order to ensure that Clinica was making the same amount as under the previous contract, even if the management fee was changed.

89. In 2005, as part of their efforts to prepare a "cleaner" contract with Clinica, AMC personnel increased the fee for translation services to be provided by Clinica to $23.50 per hour. AMC did so despite knowing that Clinica was only receiving $16.50 for the same services from North Fulton (discussed *infra*). AMC also increased the hourly fee paid to Clinica for Medicaid eligibility services in order to ensure that Clinica would continue to make roughly the same amount of money.

90. In January 2006, under the new AMC services contract (Exh. 7), Clinica began retaining the patient fees at the residency clinic. Although the new contract called for Tenet to pay a utilization fee to Clinica to use the clinic 2 ½ days per week for residency training, Tenet was also paying a nurse midwife to staff the clinic on virtually a full-time basis. Clinica in turn kept the fees paid by the patients for the services provided by the nurse midwife and the AMC residents and physicians.

91. Throughout the time period of the contracts with Clinica, the AMC OB/GYN residency program was fraught with problems, including lack of supervision of residents at the residency clinic and the hospital. In 2007, the Accreditation Council for Graduate Medical Education ("ACGME") found that the AMC OB/GYN residency program was "egregiously

noncompliant with ACGME's requirements for Graduate Medical Education . . . ." (A copy of this letter is attached hereto as Exhibit 8.)

92. The ACGME terminated the AMC OB/GYN residency program in 2008. Nevertheless, AMC continued its relationship with Clinica.

93. In 2008, the Chief Financial Officer at AMC noted that Clinica was not even required to submit an invoice to receive its monthly payment. Instead, AMC paid automatically based on the contract.

94. AMC continued to receive patients referred by Clinica and submitted claims to the Georgia Medicaid program for those patients between March 2000 and 2012. The referrals of Clinica patients based on the kickback scheme resulted in unlawful and fraudulent claims to Georgia EMA for the deliveries and to Georgia Newborn Medicaid for the newborns' care. The United States incorporates by reference the specific examples of false claims submitted to the Georgia Medicaid program set forth in paragraph 130 of the Georgia Complaint in Intervention, (ECF No. 55).

95. AMC submitted cost reports to the Medicare and Georgia Medicaid programs and falsely certified compliance with the Anti-kickback Statute on a yearly basis between 2001 and 2012.

96. In every year from 2001 through 2012, AMC sought additional reimbursement from the Medicare DSH program based on figures that included Clinica patients referred pursuant to the kickback scheme.

2. North Fulton Hospital

97. North Fulton Regional Hospital is a Tenet-owned and operated hospital in Roswell, Georgia. In contrast to AMC, North Fulton did not have an OB/GYN residency program.

98. Sometime in or around July or August 2000, the CEO of AMC arranged for a meeting between the Cotas and the CEO of North Fulton, John Holland. Holland expressed awareness of the "success" AMC was having in its relationship with HMM and the Clinica clinics.

99. Holland advised the Cotas that he wanted them to set up a clinic in Roswell, Georgia, that would send patients to North Fulton. In response, Clinica suggested that Hispanic translators would be necessary if Clinica began referring patients to North Fulton. Holland then offered to pay HMM to provide translators and for "community outreach."

100. At the time of the negotiations, North Fulton did not have a large Hispanic patient population and had no need of translators absent a promised influx of Hispanic patients to be referred by Clinica.

101. Northside Hospital was the dominant player in the obstetric services market in the metro Atlanta area at that time. Historically, Northside Hospital delivered more babies on an annual basis than any other community hospital in the United States. Holland specifically referenced wanting to compete with Northside.

102. The Cotas advised that they operated clinics where physicians, including Drs. A and B, saw patients whom they admitted to Northside. Ed Cota told Holland that Clinica patients delivered a significant number of babies per year at Northside.

103. The Cotas and Holland discussed how to ensure that Drs. A and B would shift their admissions from Northside to North Fulton.

104. Ed Cota told Drs. A and B that he had a new arrangement with Tenet at North Fulton, and that they needed to do their Clinica deliveries at North Fulton rather than Northside. Drs. A and B refused, noting, among other things, that North Fulton was farther from some patients' homes than Northside.

105. Northside Hospital learned of Clinica's efforts to move Clinica patients to North Fulton. Clinica made a presentation to Northside Hospital, proposing that Northside pay HMM for a vaguely described set of services, but Northside declined to pay. Clinica was already assisting Clinica patients who delivered at Northside Hospital with Medicaid eligibility paperwork at no charge to Northside.

106. In response to the refusal by Drs. A and B to move their Clinica patients to North Fulton, Ed Cota told the physicians that they could no longer see Clinica patients because he intended to direct the patients to deliver at North Fulton. In or around June 2001, Drs. A and B were barred from seeing patients at any Clinica facility.

107. Following the initial meeting in 2000 until November 2001, the Cotas met with Holland in person at least monthly and held constant conversations regarding the proposed deal.

108. In contrast to the AMC arrangement, the proposed North Fulton arrangement provided for the Cotas to keep the payments made by the patients for services at the new clinic in Roswell.

109. While the negotiations concerning payments by North Fulton for translation, marketing and other services continued, Holland expressed concern that the monthly payment to HMM would be a big budget item, and requested assurances that he would see enough deliveries

to justify the expense to North Fulton. Holland advised the Cotas that he wanted at least 50 deliveries per month from Clinica facilities.

110. On or about August 8, 2001, a North Fulton employee prepared a business plan for North Fulton that explicitly linked the awarding of the contract to a promised shift in patient referrals from Northside Hospital to North Fulton by the Cotas: "Clinica De La Mama will begin directing admissions from to [sic] NFRH upon completion of the contract. They have stated that they will shift 100% of their volume from Northside to NFRH which would bring an estimated 1,000 – 1,200 deliveries in the first year." The memo went on to note, "All deliveries will be Medicaid." (A copy of this report is attached hereto as Exhibit 9.)

111. North Fulton personnel analyzed the relationship with Clinica by preparing pro formas demonstrating that the Medicaid revenues to North Fulton from the expected patient referrals would far exceed the estimated payments to Clinica.

112. On or around October 30, 2001, Holland signed a contract with HMM, whereby North Fulton ostensibly paid HMM to provide various services for a monthly fee of between $42,680 and $53,480. (A copy of this contract is attached hereto as Exhibit 10.) The Cotas executed the contract on behalf of HMM.

113. Upon execution of the North Fulton contract, the Cotas immediately began sending Clinica patients to North Fulton. The Cotas informed Holland that they had removed Drs. A and B because they refused to deliver Clinica patients at North Fulton.

114. The Cotas later introduced Holland to Dr. C, whom they had retained to replace Drs. A and B and deliver their patients at North Fulton. Holland was aware that Dr. C was replacing the two physicians who had refused to deliver Clinica patients at North Fulton.

115. As agreed to with Holland, the Cotas opened a Clinica facility in Roswell and referred the majority of those patients to North Fulton for deliveries. Dr. C understood that in order to keep his position at Clinica, he had to deliver his patients at North Fulton or occasionally at AMC, depending on instructions from the Cotas.

116. When deliveries were lower, Tenet Hospital executives expressed dissatisfaction with the Clinica relationship. In 2008, AMC CEO Moore reported that his hospital had seen a "marked decrease" in deliveries, but noted that he had assumed that it was because Clinica patients were being directed to other Tenet hospitals. (A copy of this email is attached hereto as Exhibit 11.) He explained, "June also marked the time when Clinica fired [certain physicians] so I assumed the volume from the clinics they used to staff was being directed to North Fulton. If NFMC has not seen an increase then we have a problem. Our volume from January through May from Clinica exceeded our previous two year's volume. The drop off had all come in the last three months." *Id*.

117. When it became clear that patients were not being directed within the Tenet network of hospitals, Tenet executives expressed disappointment and pledged to raise the issue with Clinica. The North Fulton CEO wrote, "June-August Clinica volumes for 2007 and 2008 were 349 and 340, respectively. Based on our flat volume and Bill's [AMC's] decline, this would lead us to believe Clinica is diverting to another program. Our contract is up for re-negotiation within the next 60-90 days. Wes [NF CFO] and I are going to handle this so we will ask some questions during our discussions with Ed and Tracey." *Id*.

118. Similarly, an internal report relating to North Fulton Regional Hospital notes, "Contacted Clinica leadership and physician to ensure that there is no redirect of business; by

month end volumes were up to previous levels; an increased number of deliveries scheduled for February." (A copy of this report is attached hereto as Exhibit 12.)

119. Dr. C eventually stopped seeing patients at Clinica, and Holland suggested that Dr. D replace him. Dr. D then began seeing patients at Clinica facilities who would then be referred to North Fulton for deliveries.

120. North Fulton renewed the contract with HMM or a related Clinica entity several times, starting in 2003 and ending in September 2013. (Copies of the contracts are attached as Exhibit 13.)

121. In addition to dealing with Holland, the Cotas also dealt with the Chief Operating Officer ("COO") at North Fulton, Elizabeth Lamkin. Lamkin made clear that North Fulton had a quota for admissions that Clinica was expected to meet, and held meetings to compare admission numbers to ensure the quota was being met.

122. In or around June 2006, while contract renewal discussions were ongoing, Holland was promoted to Senior Vice President of Operations for Tenet's Southern States Region, and his interim replacement as CEO, David Anderson, questioned the Clinica contract.

123. After learning that Anderson was questioning the contract, Ed Cota met with Anderson and made clear how many patients Clinica was sending to North Fulton, and threatened to cease patient referrals if North Fulton did not renew the contract.

124. Shortly thereafter, North Fulton again renewed the contract with the Cotas, and the Cotas continued to send Clinica patients to North Fulton, as they had done since 2001.

125. In 2005, during discussions regarding contract renewal, the Chief Nursing Officer at North Fulton questioned the fair market value of the contract in a lengthy email to North Fulton executives. The Chief Nursing Officer provided examples of work called for by the

contract that was not performed, or lacked proof of performance. She concluded her email by writing, "I have many questions and concerns about what we really are getting for over ½ million expense per year." (A copy of this email is attached as Exhibit 14.)

126. Nevertheless, North Fulton renewed the contract even after learning in 2006 that it was being billed for marketing work that was never performed by Clinica personnel.

127. North Fulton continued to receive patients referred by Clinica and submitted claims to the Georgia Medicaid program for those patients between November 2001 and September 2013. The United States incorporates by reference the specific examples of false claims submitted to the Georgia Medicaid program set forth in paragraph 130 of the Georgia Complaint in Intervention.

128. North Fulton submitted cost reports on a yearly basis to the Medicare and Georgia Medicaid programs between 2001 and 2012, and falsely certified compliance with the Anti-kickback Statute.

129. Between 2002 and 2012, North Fulton sought additional reimbursement from the Medicare DSH program based on figures that included Clinica patients referred pursuant to the kickback scheme.

3. Spalding Regional Medical Center

130. Spalding Regional Medical Center ("Spalding") is a Tenet hospital in Griffin, Georgia.

131. In late 2003, the CEO of Spalding, John Quinn, contacted Tracey Cota, and explained that he was aware of Clinica's relationship with AMC, and wanted Clinica to open a clinic in Griffin and refer Hispanic Medicaid patients to Spalding from that clinic.

132. The Cotas met with Quinn and Ed Cota explained the Clinica model to him. At that time, Spalding did not have large numbers of deliveries of Hispanic women.

133. Ed Cota advised Quinn that if Clinica opened a new clinic, the Cotas could send 30-40 deliveries a month to Spalding.

134. Quinn asked for a copy of Clinica's contract with North Fulton, which provided for payments ostensibly for translation and marketing services. Although Spalding had no existing need for translation services given its low numbers of Hispanic patients, Spalding contracted for such services, in return for Clinica opening a clinic and sending Hispanic Medicaid patients to Spalding.

135. In October 2003, Quinn included "implent[ing] the Clinica de la Mama program" as one of four personal goals required to be submitted to Greg Burfitt, his Tenet supervisor, to increase market share. (A copy of this report is attached hereto as Exhibit 15.)

136. In or around April 1, 2004, Spalding executed a contract with Clinica. (A copy of this agreement is attached hereto as Exhibit 16.)

137. Quinn provided to Clinica a list of doctors who might be willing to see patients at the clinic and deliver them at Spalding. The Cotas arranged for two of the doctors on the list to staff the new clinic and deliver the Clinica patients at Spalding.

138. Quinn was very clear that he expected the contract with Clinica to generate patient referrals to Spalding.

139. The new clinic did not generate the expected amount of referrals to Spalding, and Quinn cancelled the contract after only a few months. Quinn advised that he was cancelling the contract due to insufficient delivery volume from Clinica.

140. Spalding received patients referred by Clinica and submitted claims to the Georgia Medicaid program for those patients in 2004. The United States incorporates by reference the specific examples of false claims submitted to the Georgia Medicaid program set forth in paragraph 130 of the Georgia Complaint in Intervention.

141. Spalding submitted cost reports to the Medicare and Georgia Medicaid programs in 2004, and falsely certified compliance with the Anti-kickback Statute.

142. In 2004, Spalding sought additional reimbursement from the Medicare DSH program based on figures that included Clinica patients referred pursuant to the kickback scheme.

4. Hilton Head Hospital

143. Hilton Head Hospital is a Tenet hospital in Hilton Head, South Carolina.

144. In May 2005, Elizabeth Lamkin, the former North Fulton COO who had dealt with Clinica, became the CEO at Hilton Head. Lamkin's promotion to CEO was based in part on her success at growing the obstetric business at North Fulton, which was largely attributable to the Clinica relationship.

145. As CEO, Lamkin was under pressure from Tenet corporate to hit expected financial targets, or risk losing out on bonuses or being replaced.

146. In late 2005, Lamkin contacted Tracey Cota and told her that Hilton Head had a large Hispanic population, but the hospital was losing patients to a competing hospital.

147. Lamkin wanted Clinica to set up a clinic on Hilton Head to refer patients to the hospital. The Cotas met with Lamkin, who asked for the same contractual arrangement as at North Fulton, which involved payments ostensibly for translation, marketing and other services.

148. Lamkin made clear that she wanted 30 deliveries per month from Clinica.

149. The Regional Director of Business Development at Hilton Head, Gary Lang, was also involved in the Clinica contract. Lang arrived at Hilton Head in 2006, but his position was with Tenet corporate and he was on Tenet's corporate payroll.

150. In or around November 2006, the Cotas signed a contract with Hilton Head, established a new clinic, and began referring patients to Hilton Head for deliveries. (A copy of this agreement is attached hereto as Exhibit 17.)

151. Lamkin and Lang were aware that Hilton Head was paying for referrals from Clinica.

152. Similar to the other Tenet Hospitals, Hilton Head employees prepared pro formas demonstrating that the Medicaid revenues to Hilton Head from the expected patient referrals would far exceed the estimated payments to Clinica.

153. Hilton Head personnel attributed "a dramatic increase in OB cases" to the Clinica contract.

154. Hilton Head renewed its contract with Clinica at various times.

155. Hilton Head renewed the contract with Clinica despite internal awareness by Hilton Head employees that there was no way to track the hours worked by Clinica employees with respect to certain tasks.

156. Hilton Head received Medicaid patients referred by Clinica and submitted claims to the South Carolina Medicaid program for those patients between 2006 and 2011. Examples of such claims are listed below.

CLAIM DATE	PAYMENT DATE	ADMISSION DATE	DISCHARGE DATE	MEMBER INITIALS	PAYEE PROVIDER MEDICAID ID	BILLED AMOUNT	PAID AMOUNT
12/9/2006	12/15/2006	10/23/2006	10/25/2006	A	388966	$7,122.43	$1,399.08
4/11/2007	4/20/2007	3/2/2007	3/5/2007	B	388966	$16,620.60	$3,759.36
2/27/2008	3/7/2008	1/10/2008	1/12/2008	C	388966	$7,828.00	$3,192.20
11/5/2009	11/13/2009	7/26/2009	7/30/2009	D	388966	$29,702.21	$7,801.12
5/7/2010	5/14/2010	3/16/2010	3/18/2010	E	388966	$15,235.38	$4,066.69

157. Hilton Head submitted cost reports on a yearly basis to the Medicare and South Carolina Medicaid programs between 2006 and 2011, and certified compliance with the Anti-kickback Statute.

158. In 2008-2011, Hilton Head sought additional reimbursement from the Medicare DSH program based on figures that included Clinica patients referred pursuant to the kickback scheme.

5. Knowledge of Corporate Officials at Tenet

159. By 2003, Tenet's Director of Regional Business Development for the Southeast Region, Bill Henning, had met Ed Cota and begun discussing opening more Clinica facilities in connection with other Tenet hospitals outside of Georgia and South Carolina. Henning arranged for the Cotas to meet with hospital executives at Kenner Regional Hospital, a Tenet hospital in Kenner, Lousiana.

160. The Kenner Hospital executives made clear that they were aware of the referral relationship between Clinica and the Tenet hospitals around Atlanta. The executives advised the Cotas that they wanted to replicate the profitable program in place at North Fulton. The Kenner executives did not pursue anything with Clinica, however, and no additional efforts took place.

161. In 2004, Henning called a meeting with the Cotas and the CEOs of AMC and North Fulton, Moore and Holland. The meeting was held at Tenet's regional facility in Atlanta. Henning asked for an update from the CEOs, with an eye toward expanding the Clinica operation to other Tenet hospitals. He specifically asked the CEOs how Clinica was impacting admissions at AMC and North Fulton, and how Clinica could increase future business there and at other Tenet hospitals.

162. In response to these questions, Moore and Holland explained that they were pleased with the Clinica relationship, and provided updated delivery numbers for Clinica patients, including specific percentages of admissions going to each of their hospitals broken down by each of the Clinica facilities.

163. Tenet held quarterly regional CEO meetings, which were attended by corporate regional executives and business directors as well. Clinica was a frequent topic of discussion in terms of how to grow the business and increase referrals and deliveries of Clinica patients.

164. Other regional employees were well aware of Clinica's importance as a source of referrals to Tenet hospitals. In a 2007 email, Tenet's Southern Regional corporate office described the Clinica patient referrals "as a large part of the Georgia inventory" of Medicaid. (A copy of this email is attached hereto as Exhibit 18.)

165. In a 2006 document, Tenet stated that its "ongoing relationship with Clinica de la Mama (OB clinics for Hispanic patients) . . . results in an excellent referral source for deliveries." (A copy of this email is attached hereto as Exhibit 19.)

166. In other emails, Tenet executives discussed whether they could "get Clinica to send us the business" without also contracting for translation services because of the way Clinica held North Fulton "hostage." (A copy of this email is attached hereto as Exhibit 20.)

C. Clinica's Relationship with Walton

167. Walton Regional Medical Center ("Walton") is a hospital in Monroe, Georgia. In 2008, Walton was part of the HMA chain of hospitals.

168. In or around November 2007, the Director of Business Development at Tenet's Hilton Head Hospital, Gary Lang, left Tenet and became the CEO of Walton.

169. Walton was not doing well financially, and Lang was hired to turn the hospital around.

170. Looking for a way to increase referrals quickly, Lang contacted the Cotas and asked them to do for him what they had done for the Hilton Head CEO, i.e. increase deliveries at the hospital. Lang noted the amount of hospital revenue that could be generated by 300 deliveries per year.

171. Lang offered to pay thousands of dollars per month in return for 30 deliveries per month. The contract, however, was drafted to look like the other Clinica contracts with the Tenet hospitals. It provided that Walton would pay approximately $20,000 per month to HMM, ostensibly for services. Lang said that he would rush the contract through for approval.

172. Lang and then-CFO at Walton, Jeff Grimsley, sought and obtained approval from a Divisional Senior Vice President, Brad Jones, and Divisional Vice President of Finance, Bob Stiekes, to enter into the agreement with Clinica. (A copy of this memorandum is attached hereto as Exhibit 21.)

173. Lang and Grimsley told HMA corporate personnel that the purpose of the Clinica agreement was to "grow OB service line volume." *Id.*

174. Lang and Grimsley's request for approval of the contract states, "Clinica has contracts with two Tenet Health facilities (Atlanta Medical Center and North Fulton Hospital) to

provide the delivery of services for their patients. The option to provide an alternative delivery site in the form of Walton Regional was very attractive to Clinica and its patients and families." *Id.* The memorandum also states that there is an agreement involving two obstetricians "through which on-site clinic support and hospital deliveries will be provided by them in support of this relationship." *Id.*

175. Lang and Grimsley created and submitted to HMA corporate a financial feasibility analysis in support of their request for approval of the Clinica contract. The analysis reflects the expectation that payments to Clinica will result in a significant increase in deliveries and Medicaid revenue at Walton. It also reflects the expectation that each payment to Clinica from Walton would be paid for with Medicaid reimbursements. (A copy of this memorandum is attached hereto as Exhibit 22.)

176. In or about March 24, 2008, Walton signed a contract with HMM that provided for a monthly payment of approximately $20,000, ostensibly for services. (A copy of this contract is attached hereto as Exhibit 23.)

177. Lang provided leads to Clinica on physicians who could staff a clinic and send patients to Walton.

178. Instead of opening a new clinic for Walton, Clinica decided to retain two of the physicians recommended by Lang to staff an already established clinic in Lawrenceville, Georgia, that had been sending patients to North Fulton. In order to satisfy the need for referrals to Walton, the Cotas re-directed certain referrals from Lawrenceville to Walton.

179. Consistent with its relationship with the Tenet Hospitals, Clinica closely tracked the number of deliveries it referred to Walton. (Samples of such records of deliveries at Walton are attached hereto as Exhibit 24.)

180. In April 2009, Relator Williams became the Chief Financial Officer at Walton. One of Relator's duties as Walton CFO was to monitor contracts and approve payment of invoices.

181. Walton used a computerized contract monitoring system that flagged expiration dates and other important information about its contracts. The Walton CFO was responsible for inputting contractual information into the system.

182. Shortly after he joined Walton, Relator found a hard copy of the contract between Walton and Clinica in his desk drawer.

183. The Clinica contract had not been input into the contract monitoring system. The failure to place this contract in the system was unusual and outside of normal business practices.

184. Relator Williams could not confirm that interpreter services were being provided by Clinica specifically as called for by the contract provisions.

185. For example, the Director of Nursing Services at Walton, Sharon Queen, told Relator that Walton used AT&T interpreter services via telephone when a need arose for interpreter services.

186. Relator directly questioned Lang about the agreement with Clinica. Lang informed Relator that he came to Walton from his marketing job at a Tenet hospital in Hilton Head, South Carolina, and that the Hilton Head facility had the same contract with Clinica. Lang also indicated that Clinica referrals generated large volumes of Medicaid deliveries for Tenet.

187. As with Spalding, however, the referrals did not rise to the levels expected by hospital management. In or about August 2009, Lang cancelled the contract.

188. Relator received for processing a cover letter and "final invoice" to Walton from Clinica. (The letter and enclosures are attached hereto as Exhibit 25.)

189. The "final invoice" referenced above includes a report entitled "Schedule of Deliveries by Hospital" for August 2009 and September 2009. *See id.*, pp. 6-10 (patient identification redacted). The report includes patient names, Medicaid approval status, estimated delivery dates and which of the five Clinica clinics would be managing the Clinica patient referred to Walton. The "Final Invoice" also includes a report entitled "Deliveries by Month Hospital." That report shows Clinica patient names and dates of OB deliveries at Walton in June and July 2009. *Id.*

190. The "final invoice" dated August 6, 2009 includes purported time records for Clinica personnel working at Walton: fully 238.75 hours of time was billed for the 18-day period of July 1, 2009 through July 18, 2009. *See id.*, p. 2. This reflects an average of 13.26 hours of each day covered by the invoice during which Clinica personnel were allegedly providing interpreter services at Walton.

191. Similarly, the partial invoice, dated July 8, 2009, includes purported time records for Clinica personnel at Walton for June 2009: 412.50 hours of time was billed for the 30-day month of June. *See id.*, p. 13. This reflects an average of 13.75 hours a day during which Clinica personnel were purportedly providing interpreter services at Walton.

192. After the Walton contract was cancelled, Tracey Cota redirected referrals from the Lawrenceville clinic back to North Fulton, which continued to have a contract with Clinica.

193. In 2008 and 2009, Walton regularly and routinely presented claims to Georgia Medicaid for the obstetric services provided to the patients illegally referred by Clinica. The United States incorporates by reference the specific examples of false claims submitted to the Georgia Medicaid program set forth in paragraph 110 of the Georgia Complaint in Intervention.

194. Walton submitted cost reports on a yearly basis to the Medicare and Georgia Medicaid programs between 2008 and 2009, and certified compliance with the Anti-kickback Statute.

195. In 2008 and 2009, Walton also sought additional reimbursement from the Medicare DSH program based on figures that included Clinica patients referred pursuant to the kickback scheme.

COUNT I
(False Claims Act, 31 U.S.C. § 3729(a)(1) and (a)(1)(A))

196. Plaintiff United States repeats and realleges each allegation in each of the preceding paragraphs as if fully set forth herein.

197. As a result of the kickbacks paid by the Tenet Hospitals and Walton to Clinica in return for patient referrals, in violation of the federal Anti-kickback Statute, 42 U.S.C. § 1320a-7b(b), all of the claims presented by Tenet, the Tenet Hospitals and Walton to Medicaid and Medicare for services rendered as a result of such referrals, or for reimbursement based in part on such referrals, are false or fraudulent. Accordingly, Clinica knowingly caused the presentation of and the Tenet Hospitals and Walton knowingly submitted false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1) and (a)(1)(A).

198. By virtue of the false or fraudulent claims the defendants presented or caused to be presented, the United States has suffered actual damages and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

COUNT II
(False Claims Act, 31 U.S.C. § 3729(a)(1)(B))

199. Plaintiff United States repeats and realleges each allegation in each of the preceding paragraphs as if fully set forth herein.

200. The defendants made, used, and caused to be made or used, false records or statements — *i.e.*, the false certifications and representations made and caused to be made by defendants when initially submitting the false claims for payments and the false certifications made by Tenet, the Tenet Hospitals and Walton in submitting the cost reports — to get false or fraudulent claims paid and approved by the United States.

201. By virtue of the false records or statements used by the defendants, the United States has suffered actual damages and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

COUNT III
(False Claims Act, 31 U.S.C. § 3729(a)(3) and (a)(1)(C))

202. Plaintiff United States repeats and realleges each allegation in each of the preceding paragraphs as if fully set forth herein.

203. Tenet and the Tenet Hospitals conspired with Clinica to pay kickbacks to Clinica in violation of the federal Anti-kickback Statute, 42 U.S.C. § 1320a-7b(b)(2), to induce Clinica's referral of patients to the Tenet Hospitals, thereby causing all of the Tenet Hospitals' claims to Medicaid and Medicare for such patients or for reimbursement based in part on such referrals to be false or fraudulent. Accordingly, Tenet, the Tenet Hospitals and Clinica conspired to defraud the United States by getting false or fraudulent claims allowed or paid, in violation of 31 U.S.C. § 3729(a)(3) and (a)(1)(C).

204. By virtue of the conspiracy by the defendants, the United States has suffered actual damages and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

COUNT IV
(False Claims Act, 31 U.S.C. § 3729(a)(3) and (a)(1)(C))

205. Plaintiff United States repeats and realleges each allegation in each of the preceding paragraphs as if fully set forth herein.

206. Walton and Clinica conspired to pay kickbacks to Clinica in violation of the federal Anti-kickback Statute, 42 U.S.C. § 1320a-7b(b)(2), to induce Clinica's referral of patients to Walton, thereby causing Walton's claims to Medicaid and Medicare for such patients or for reimbursement based in part on such referrals to be false or fraudulent. Accordingly, Walton and Clinica conspired to defraud the United States by getting false or fraudulent claims allowed or paid, in violation of 31 U.S.C. § 3729(a)(3) and (a)(1)(C).

207. By virtue of the conspiracy by the defendants, the United States has suffered actual damages and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

COUNT V
(Unjust Enrichment)

208. Plaintiff United States repeats and realleges each allegation in each of the preceding paragraphs as if fully set forth herein.

209. The United States claims the recovery of all monies by which defendants have been unjustly enriched.

210. By obtaining monies as a result of their violations of federal and state law, defendants were unjustly enriched, and are liable to account and pay such amounts, which are to be determined at trial, to the United States.

COUNT VI
(Payment Under Mistake of Fact)

211. Plaintiff United States repeats and realleges each allegation in each of the preceding paragraphs as if fully set forth herein.

212. This is a claim for recovery of monies paid by the United States to Tenet, the Tenet Hospitals and Walton as a result of mistaken understandings of fact.

213. The false claims which Tenet, the Tenet Hospitals and Walton caused to be submitted or submitted to the United States were paid by the United States based upon mistaken or erroneous understandings of material fact.

214. The United States, acting in reasonable reliance on the truthfulness of the claims and the truthfulness of the above defendants' certifications and representations, paid Tenet, the Tenet Hospitals, and Walton, certain sums of money to which they were not entitled, and Tenet, the Tenet Hospitals, and Walton are thus liable to account for and pay such amounts, which are to be determined at trial, to the United States.

Prayer for Relief

WHEREFORE, Plaintiff United States of America requests that judgment be entered in its favor and against defendants as follows:

1. On the First, Second, Third and Fourth Counts under the False Claims Act for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

2. On the Fifth and Sixth Counts, for the amount of the United States' damages for

payment by mistake and unjust enrichment, for the damages sustained and/or amounts by which the defendants were unjustly enriched or by which defendants retained illegally obtained monies, plus interest, costs, and expenses, and all such further relief as may be just and proper.

Respectfully submitted,

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Assistant Attorney General

MICHAEL J. MOORE
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MIDDLE DISTRICT OF GEORGIA

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ATTORNEYS FOR THE
UNITED STATES OF AMERICA

Dated: March 18, 2014

CERTIFICATE OF SERVICE

This is to certify that on this date, I have filed the foregoing Complaint in Intervention of the United States with the Clerk of the United States District Court using the CM/ECF system, which will automatically send notification of such filing to the attorneys of record in this case.

This 18th day of March, 2014.

BY: s/Charles W. Byrd
CHARLES W. BYRD
ASSISTANT UNITED STATES ATTORNEY