Strafford

Presenting a live 90-minute webinar with interactive Q&A

Medical Office Leases: Navigating Stark Law, Anti-Kickback Statute, Operational Restrictions, and More

Drafting to Address Reciprocal Easements, Ground Leases, HIPAA, ADA, and Environmental Issues Unique to Medical Office Use

TUESDAY, OCTOBER 20, 2020

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

William H. Maruca, Partner, **Fox Rothschild**, Pittsburgh, PA

James M. Pinna, Partner, **Hunton Andrews Kurth**, Richmond, VA

Daniel F. Shay, Attorney, **Alice G. Gosfield and Associates**, Philadelphia, PA

Mark R. Vowell, Partner, **Hunton Andrews Kurth**, Dallas, TX

The audio portion of the conference may be accessed via the telephone or by using your computer's speakers. Please refer to the instructions emailed to registrants for additional information. If you have any questions, please contact **Customer Service at 1-800-926-7926 ext. 1**.

42 C.F.R. §411.357 Exceptions to the referral prohibition related to compensation arrangements.

For purposes of §411.353, the following compensation arrangements do not constitute a financial relationship:

(a) *Rental of office space.* Payments for the use of office space made by a lessee to a lessor if the arrangement meets the following requirements:

(1) The lease arrangement is set out in writing, is signed by the parties, and specifies the premises it covers.

(2) The duration of the lease arrangement is at least 1 year. To meet this requirement, if the lease arrangement is terminated with or without cause, the parties may not enter into a new lease arrangement for the same space during the first year of the original lease arrangement.

(3) The space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease arrangement and is used exclusively by the lessee when being used by the lessee (and is not shared with or used by the lessor or any person or entity related to the lessor), except that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee's pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using the common areas.

(4) The rental charges over the term of the lease arrangement are set in advance and are consistent with fair market value.

(5) The rental charges over the term of the lease arrangement are not determined—

(i) In a manner that takes into account the volume or value of any referrals or other business generated between the parties; or

(ii) Using a formula based on—

(A) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated in the office space; or

(B) Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee.

(6) The lease arrangement would be commercially reasonable even if no referrals were made between the lessee and the lessor.

(7) If the lease arrangement expires after a term of at least 1 year, a holdover lease arrangement immediately following the expiration of the lease arrangement satisfies the requirements of paragraph (a) of this section if the following conditions are met:

(i) The lease arrangement met the conditions of paragraphs (a)(1) through (6) of this section when the arrangement expired;

(ii) The holdover lease arrangement is on the same terms and conditions as the immediately preceding arrangement; and

(iii) The holdover lease arrangement continues to satisfy the conditions of paragraphs (a)(1) through (6) of this section.

****

(y) *Timeshare arrangements*. Remuneration provided under an arrangement for the use of premises, equipment, personnel, items, supplies, or services if the following conditions are met:

(1) The arrangement is set out in writing, signed by the parties, and specifies the premises, equipment, personnel, items, supplies, and services covered by the arrangement.

(2) The arrangement is between a physician (or the physician organization in whose shoes the physician stands under §411.354(c) and—

(i) A hospital; or

(ii) Physician organization of which the physician is not an owner, employee, or contractor.

(3) The premises, equipment, personnel, items, supplies, and services covered by the arrangement are used—

(i) Predominantly for the provision of evaluation and management services to patients; and

(ii) On the same schedule.

(4) The equipment covered by the arrangement is—

(i) Located in the same building where the evaluation and management services are furnished;

(ii) Not used to furnish designated health services other than those incidental to the evaluation and management services furnished at the time of the patient's evaluation and management visit; and

(iii) Not advanced imaging equipment, radiation therapy equipment, or clinical or pathology laboratory equipment (other than equipment used to perform CLIA-waived laboratory tests).

(5) The arrangement is not conditioned on the referral of patients by the physician who is a party to the arrangement to the hospital or physician organization of which the physician is not an owner, employee, or contractor.

(6) The compensation over the term of the arrangement is set in advance, consistent with fair market value, and not determined—

(i) In a manner that takes into account (directly or indirectly) the volume or value of referrals or other business generated between the parties; or

(ii) Using a formula based on—

(A) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services provided while using the premises, equipment, personnel, items, supplies, or services covered by the arrangement; or

(B) Per-unit of service fees that are not time-based, to the extent that such fees reflect services provided to patients referred by the party granting permission to use the premises, equipment, personnel, items, supplies, or services covered by the arrangement to the party to which the permission is granted.

(7) The arrangement would be commercially reasonable even if no referrals were made between the parties.

(8) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act) or any Federal or State law or regulation governing billing or claims submission.

(9) The arrangement does not convey a possessory leasehold interest in the office space that is the subject of the arrangement.

[72 FR 51091, Sept. 5, 2007; 72 FR 68076, Dec. 4, 2007, as amended at 73 FR 48752, Aug. 19, 2008; 73 FR 57543, Oct. 3, 2008; 78 FR 78768, Dec. 27, 2013; 80 FR 71374, Nov. 16, 2015; 81 FR 12030, Mar. 8, 2016; 81 FR 80553, Nov. 15, 2016]

42 C.F.R. §1001.952 Exceptions.

The following payment practices shall not be treated as a criminal offense under section 1128B of the Act and shall not serve as the basis for an exclusion:

****

(b) *Space rental.* As used in section 1128B of the Act, "remuneration" does not include any payment made by a lessee to a lessor for the use of premises, as long as all of the following six standards are met—

(1) The lease agreement is set out in writing and signed by the parties.

(2) The lease covers all of the premises leased between the parties for the term of the lease and specifies the premises covered by the lease.

(3) If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.

(4) The term of the lease is for not less than one year.

(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.

(6) The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental. Note that for purposes of paragraph (b) of this section, the term *fair market value* means the value of the rental property for general commercial purposes, but shall not be adjusted to reflect the additional value that one party (either the prospective lessee or lessor) would attribute to the property as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid and all other Federal health care programs.

OFFICE OF INSPECTOR GENERAL

Special Fraud Alert

RENTAL OF SPACE IN PHYSICIAN OFFICES BY PERSONS OR ENTITIES TO WHICH PHYSICIANS REFER

February 2000

The Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse and waste in the Department's programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections.

To reduce fraud and abuse in the Federal health care programs, including Medicare and Medicaid, the OIG actively investigates fraudulent schemes that are used to obtain money from these programs and, when appropriate, issues Special Fraud Alerts that identify practices in the health care industry that are particularly vulnerable to abuse.

This Special Fraud Alert focuses on the rental of space in physicians' offices by persons or entities that provide health care items or services (suppliers)[(1)] to patients that are referred either directly or indirectly by their physician-landlords. In this Special Fraud Alert, we describe some of the potentially illegal practices the OIG has identified in such rental relationships.

Questionable Rental Arrangements For Space in Physician Offices

A number of suppliers that provide health care items or services rent space in the offices of physicians or other practitioners. Typically, most of the items or services provided in the rented space are for patients, referred or sent, either directly or indirectly, to the supplier by the physician-landlord. In particular, we are aware of rental arrangements between physician-landlords and:

- comprehensive outpatient rehabilitation facilities (CORFs) that provide physical and occupational therapy and speech-language pathology services in physicians' and other practitioners' offices;
- mobile diagnostic equipment suppliers that perform diagnostic related tests in physicians' offices; and
- suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that set up "consignment closets" for their supplies in physicians' offices.

The OIG is concerned that in such arrangements, the rental payments may be disguised kickbacks to the physician-landlords to induce referrals. We have received numerous credible reports that in many cases, suppliers, whose businesses depend on physicians' referrals, offer and pay "rents" -- either voluntarily or in response to physicians' requests -- that are either unnecessary or in excess of the fair market value for the space to access the physicians' potential referrals.

The Anti-Kickback Law Prohibits Any Payments to Induce Referrals

Kickbacks can distort medical decision-making, cause overutilization, increase costs and result in unfair competition by freezing out competitors who are unwilling to pay kickbacks. Kickbacks can also adversely affect the quality of patient care by encouraging physicians to order services or recommend supplies based on profit rather than the patients' best medical interests.

Section 1128B(b) of the Social Security Act (the Act) prohibits knowingly and willfully soliciting, receiving, offering or paying anything of value to induce referrals of items or services payable by a Federal health care program. Both parties to an impermissible kickback transaction are liable. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. The OIG may also initiate administrative proceedings to exclude persons from Federal health care programs or to impose civil money penalties for fraud, kickbacks and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act.[(2)]

Suspect Rental Arrangements For Space in Physician Offices

The questionable features of suspect rental arrangements for space in physicians' offices may be reflected in three areas:

- the appropriateness of rental agreements;
- the rental amounts; and
- time and space considerations.

Below, we examine these suspect areas, which separately or together may result in an arrangement that violates the anti-kickback statute, in order to help identify questionable rental arrangements between physicians and the suppliers to which they refer patients. This list is not exhaustive, but rather gives examples of indicators of potentially unlawful activity.

Appropriateness of Rental Agreements. The threshold inquiry when examining rental payments is whether payment for rent is appropriate at all. Payments of "rent" for space that traditionally has been provided for free or for a nominal charge as an accommodation between the parties for the benefit of the physicians' patients, such as consignment closets for DMEPOS, may be disguised kickbacks. In general, payments for rent of consignment closets in physicians' offices are suspect.[(3)]

Rental Amounts. Rental amounts should be at fair market value, be fixed in advance and not take into account, directly or indirectly, the volume or value of referrals or other business generated between the parties. Fair market value rental payments should not exceed the amount paid for comparable property. Moreover, where a physician rents space, the rate paid by the supplier should not exceed the rate paid by the physicians in the primary lease for their office space, except in rare circumstances. Examples of suspect arrangements include:

- rental amounts in excess of amounts paid for comparable property rented in arms-length transactions between persons not in a position to refer business;
- rental amounts for subleases that exceed the rental amounts per square foot in the primary lease;
- rental amounts that are subject to modification more often than annually;
- rental amounts that vary with the number of patients or referrals;
- rental arrangements that set a fixed rental fee per hour, but do not fix the number of hours or the schedule of usage in advance (i.e., "as needed" arrangements);
- rental amounts that are only paid if there are a certain number of Federal health care program beneficiaries referred each month; and

- rental amounts that are conditioned upon the supplier's receipt of payments from a Federal health care program.

Time and Space Considerations. Suppliers should only rent premises of a size and for a time that is reasonable and necessary for a commercially reasonable business purpose of the supplier. Rental of space that is in excess of suppliers' needs creates a presumption that the payments may be a pretext for giving money to physicians for their referrals. Examples of suspect arrangements include:

- rental amounts for space that is unnecessary or not used. For instance, a CORF requires one examination room and rents physician office space one afternoon a week when the physician is not in the office. The CORF calculates its rental payment on the square footage for the entire office, since it is the only occupant during that time, even though the CORF only needs one examination room;

- rental amounts for time when the rented space is not in use by the supplier. For example, an ultrasound supplier has enough business to support the use of one examination room for four hours each week, but rents the space for an amount equivalent to eight hours per week;

- non-exclusive occupancy of the rented portion of space. For example, a physical therapist does not rent space in a physician's office, but rather moves from examination room to examination room treating patients after they have been seen by the physician. Since no particular space is rented, we will closely scrutinize the proration of time and space used to calculate the therapist's "rent".

In addition, rental amount calculations should prorate rent based on the amount of space and duration of time the premises are used. The basis for any proration should be documented and updated as necessary. Depending on the circumstances, the supplier's rent can consist of three components: (1) exclusive office space; (2) interior office common space; and (3) building common space.

1. Apportionment of exclusive office space - The supplier's rent should be calculated based on the ratio of the time the space is in use by the supplier to the total amount of time the physician's office is in use. In addition, the rent should be calculated based on the ratio of the amount of space that is used exclusively by the supplier to the total amount of space in the physician's office. For example, where a supplier rents an examination room for four hours one afternoon per week in a physician's office that has four examination rooms of equal size and is open eight hours a day, five days per week, the supplier's prorated annual rent would be calculated as follows:

Physician Office Rent Per Day		**% of Physician Office Space Rented by Supplier**		**% of Each Day Rented by Supplier**		**No. of Days Rented by Supplier Per Year**		
annual rent of primary lease / no. of work days per year	X	sq. ft. exclusively occupied by supplier / total office sq. ft.	X	4 hours / 8 hours	X	52 days (i.e., 1 day per week)	=	Supplier's annual rent for exclusive space

2. Apportionment of interior office common space - When permitted by applicable regulations, rental payments may also cover the interior office common space in physicians' offices that are shared by the physicians and any subtenants, such as waiting rooms. If suppliers use such common areas for their patients, it may be appropriate for the suppliers to pay a prorated portion of the charge for such space. The charge for the common space must be apportioned among all physicians and subtenants that use the interior office common space based on the amount of non-common space they occupy and the duration of such occupation. Payment for the use of office common space should not exceed the supplier's pro rata share of the charge for such space based upon the ratio of the space used exclusively by the supplier to the total amount of space (other than common space) occupied by all persons using such common space.

3. Apportionment of building common space - Where the physician pays a separate charge for areas of a building that are shared by all tenants, such as building lobbies, it may be appropriate for the supplier to pay a prorated portion of such charge. As with interior office common space, the cost of the building common space must be apportioned among

all physicians and subtenants based on the amount of non-common space they occupy and the duration of such occupation. For instance, in the example in number one above, the supplier's share of the additional levy for building common space could not be split 50/50.

The Space Rental Safe Harbor Can Protect Legitimate Arrangements

We strongly recommend that parties to rental agreements between physicians and suppliers to whom the physicians refer or for which physicians otherwise generate business make every effort to comply with the space rental safe harbor to the anti-kickback statute. (See 42 CFR 1001.952(b), as amended by 64 FR 63518 (November 19, 1999)). When an arrangement meets all of the criteria of a safe harbor, the arrangement is immune from prosecution under the anti-kickback statute. The following are the safe harbor criteria, all of which must be met:

- The agreement is set out in writing and signed by the parties.
- The agreement covers all of the premises rented by the parties for the term of the agreement and specifies the premises covered by the agreement.
- If the agreement is intended to provide the lessee with access to the premises for periodic intervals of time rather than on a full-time basis for the term of the rental agreement, the rental agreement specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.
- The term of the rental agreement is for not less than one year.
- The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program.
- The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

Arrangements for office equipment or personal services of physicians' office staff can also be structured to comply with the equipment rental safe harbor and personal services and management contracts safe harbor. (See 42 CFR 1001.952(c) and (d), as amended by 64 FR 63518 (November 19, 1999)). Specific equipment used should be identified and documented and payment limited to the prorated portion of its use. Similarly, any services provided should be documented and payment should be limited to the time actually spent performing such services.

What To Do If You Have Information About Fraud and Abuse Against Medicare or Medicaid Programs

If you have information about physicians, DMEPOS suppliers, CORFs or other suppliers engaging in any of the activities described above, contact any of the regional offices of the Office of Investigations of the Office of Inspector General, U.S. Department of Health and Human Services, at the following locations:

Field Offices	States Served	Telephone
Boston	MA, VT, NH, ME, RI, CT	617-565-2664
New York	NY, NJ, PR, VI	212-264-1691
Philadelphia	PA, MD, DE, WV, VA, DC	215-861-4586
Atlanta	GA, KY, NC, SC, FL, TN, AL, MS	404-562-7603
Chicago	IL, MN, WI, MI, IN, OH, IA,	312-353-2740
Dallas	TX, NM, OK, AR, LA, CO, UT, WY, MT, ND, SD, NE, KS, MO	214-767-8406

Los Angeles	AZ, NV, So. CA	714-246-8302
San Francisco	No. CA, AK, HI, OR, ID, WA	415-437-7961

1. Persons or entities may be either suppliers or providers. For purposes of this Special Fraud Alert, we will refer to such persons as suppliers.

2. Some of the arrangements identified as suspect in this Special Fraud Alert may also implicate the Ethics in Patient Referrals Act, also known as the Stark law (section 1877 of the Act). The interpretation of the Stark law is under the jurisdiction of the Health Care Financing Administration (HCFA).

3. This Special Fraud Alert does not address the appropriateness of consignment closet arrangements under HCFA's DMEPOS supplier standards. The interpretation of the DMEPOS supplier standards is a matter under HCFA's jurisdiction.

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Wednesday, September 19, 2012

Hospital Chain HCA Inc. Pays $16.5 Million to Settle False Claims Act Allegations Regarding Chattanooga, Tenn., Hospital

Allegedly Provided Financial Benefits to Doctors' Group That Referred Patients to HCA-owned Facilities

HCA Inc., one of the nation's largest for-profit hospital chains, has agreed to pay the United States and the state of Tennessee $16.5 million to settle claims that it violated the False Claims Act and the Stark Statute, the Department of Justice announced today.

As alleged in the settlement agreement, during 2007, HCA, through its subsidiaries Parkridge Medical Center, located in Chattanooga, Tenn., and HCA Physician Services (HCAPS), headquartered in Nashville, Tenn., entered into a series of financial transactions with a physician group, Diagnostic Associates of Chattanooga, through which it provided financial benefits intended to induce the physician members of Diagnostic to refer patients to HCA facilities. These financial transactions included rental payments for office space leased from Diagnostic at a rate well in excess of fair market value in order to assist Diagnostic members to meet their mortgage obligations and a release of Diagnostic members from a separate lease obligation.

The Stark Statute restricts financial relationships that hospitals may enter into with physicians who potentially may refer patients to them. Federal law prohibits the payment of medical claims that result from such prohibited relationships.

"The Department of Justice continues to pursue cases involving improper financial relationships between health care providers and their referral sources, because such relationships can corrupt a physician's judgment about the patient's true healthcare needs," said Stuart F. Delery, the Acting Assistant Attorney General for the Department of Justice's Civil Division.

RELATED LINKS

Speeches and Press Releases

Videos

Photos

Blogs

Podcasts

“Physicians should make decisions regarding referrals to health care facilities based on what is in the best interest of patients without being induced by payments from hospitals competing for their business,” said Bill Killian, U.S. Attorney for the Eastern District of Tennessee.

“ Improper business deals between hospitals and physicians jeopardize both patient care and federal program dollars,” said Daniel R. Levinson, Inspector General of the Department of Health and Human Services. “Our investigators continue to work shoulder to shoulder with other law enforcement authorities to stop schemes that imperil scarce health care

resources.”

The civil settlement resolves a lawsuit, *United States ex rel. Bingham v. HCA*, No. 1:08-CV-71 (E.D. Tenn.), pending in federal court in the Eastern District of Tennessee under the *qui tam*, or whistleblower, provisions of the False Claims Act, which allow private citizens to bring civil actions on behalf of the United States and share in any recovery. As part of the civil settlement, HCA has agreed to pay $16.5 million to the United States and the state of Tennessee, with the federal portion representing $15,693,000 of the settlement amount. The whistleblower will receive an 18.5 percent share.

Also as part of the settlement, Parkridge Medical Center has entered into a comprehensive five-year Corporate Integrity Agreement with the Office of Inspector General of the U.S. Department of Health and Human Services to ensure its continued compliance with federal health care benefit program requirements.

This resolution is part of the government’s emphasis on combating health care fraud and another step for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced by Attorney General Eric Holder and Kathleen Sebelius, Secretary of the Department of Health and Human Services in May 2009. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in that effort is the False Claims Act, which the Justice Department has used to recover more than $9.4 billion since January 2009 in cases involving fraud against federal health care programs. The Justice Department’s total recoveries in False Claims Act cases since January 2009 are over $13.1 billion.

The case was handled by the Justice Department’s Civil Division, the U.S. Attorney’s Office for the Eastern District of Tennessee, the Office of Inspector General of the Department of Health and Human Services, the Defense Criminal Investigative Service (DCIS) and the Tennessee Bureau of Investigation (TBI). The claims settled by this agreement are allegations only, and there has been no determination of liability.

Component(s):
Civil Division

Press Release Number:
12-1133

Updated September 15, 2014

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

THOMAS BINGHAM,

Plaintiff,

v. Case No: 8:14-cv-73-T-23JSS

BAYCARE HEALTH SYSTEM,

Defendant.
_____/

REPORT AND RECOMMENDATION

THIS MATTER is before the Court on Plaintiff's Motion for Partial Summary Judgment on Liability (Dkt. 155) and Defendant's Motion for Summary Judgment, (Dkt. 156), which were referred to the undersigned for a report and recommendation. (Dkt. 179.) Plaintiff, relator Thomas Bingham, sued Defendant, BayCare Health System ("BayCare"), alleging violations of the Stark Law, 42 U.S.C. § 1395nn, the Anti-Kickback Statute, 42 U.S.C. § 1320a–7b, and the False Claims Act, 31 U.S.C. §§ 3729–3733. Plaintiff moves for partial summary judgment on his claim that BayCare violated the Stark Law by providing parking and tax savings at no charge to physicians working in medical office buildings affiliated with BayCare. BayCare moves for summary judgment on all of Plaintiff's claims. Because there is insufficient evidence to show that the physicians were provided free parking and tax savings or that BayCare provided these benefits for the purpose of inducing referrals, it is recommended that Plaintiff's Motion for Partial Summary Judgment be denied, and Defendant's Motion for Summary Judgment be granted.

BACKGROUND

Defendant, BayCare Health System, is a Florida non-profit corporation that operates St. Anthony's Hospital.[1] In 2004, BayCare entered into a Ground Lease with St. Pete MOB, LLC ("St. Pete MOB"), a third-party commercial real estate developer, to construct a medical office building on the St. Anthony's Hospital campus: the Heart Center Medical Office Building ("Heart Center MOB"). The Ground Lease was amended in 2005 and 2012. The Heart Center MOB was constructed in 2006 and, until 2016, was classified as tax-exempt by the Pinellas County Property Appraiser.

The Heart Center MOB is occupied by tenants St. Anthony's Primary Care, LLC ("SA Primary Care") and West Florida Cardiology Network, LLC ("WFC"), who employ physicians practicing at the Heart Center MOB. In 2013, BayCare opened another medical office building on the St. Anthony's Hospital campus: the Suncoast Medical Office Building ("Suncoast MOB"). The Suncoast MOB is occupied by tenant SC Physicians, LLC ("SC Physicians"), who employs physicians practicing at the Suncoast MOB. The Suncoast MOB is classified as tax-exempt by the Pinellas County Property Appraiser based on a charitable-purpose tax exemption. BayCare, through its contract with Healthcare Parking Systems of America, Inc., provides valet parking services at the Heart Center MOB and the Suncoast MOB.

Plaintiff, qui tam relator Thomas Bingham, is a certified real estate appraiser in Tennessee, unaffiliated with BayCare. He alleges in the First Amended Complaint that BayCare violated the Anti-Kickback Statute, 42 U.S.C. § 1320a–7b, and the Stark Law, 42 U.S.C. § 1395nn, by providing free parking, valet services, and tax benefits to the physicians at the Heart Center MOB and the Suncoast MOB to induce the physicians to refer patients to BayCare. (Dkt. 32.) He further

[1] BayCare is affiliated with St. Anthony's Hospital, Inc. and St. Anthony's Professional Buildings and Services, Inc., which are both Florida non-profit corporations and, along with BayCare, are referred to collectively as "BayCare."

alleges that BayCare submitted false claims to Medicare and Medicaid for services provided to patients unlawfully referred to BayCare, in violation of the False Claims Act, 31 U.S.C. §§ 3729–3733. (Dkt. 32.) Plaintiff's suit against BayCare comprises three counts: violations of the Anti-Kickback Statute (Count I), violations of the Stark Law (Count II), and liability under the False Claims Act (Count III) based on the actions underlying Counts I and II. Plaintiff's suit is premised on the central allegation that BayCare provided the following remuneration to the physicians at the Heart Center MOB and/or the Suncoast MOB to induce patient referrals: (1) parking rights, which allowed the physicians, their staff, and their patients to use parking facilities at no charge; (2) valet parking services, which were paid by BayCare and provided to the physicians, their staff, and patients; and (3) tax savings, which allowed the physicians to benefit from BayCare's tax exemption.

APPLICABLE STANDARDS

Summary judgment is proper if the evidence shows "that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). A disputed fact is material if the fact "might affect the outcome of the suit under the governing law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). A dispute is genuine "if the evidence is such that a reasonable jury could return a verdict for the non-moving party." *Id.* The movant bears the burden of establishing the absence of a dispute over a material fact. *Reynolds v. Bridgestone/Firestone, Inc.*, 989 F.2d 465, 469 (11th Cir. 1993). In considering a summary judgment motion, all evidence is viewed in the light most favorable to the non-movant. *Id.* Summary judgment is appropriate against a party that "fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Once the

moving party requests summary judgment on the absence of necessary evidence, the non-moving party must "go beyond the pleadings and . . . designate specific facts showing that there is a genuine issue for trial." *Id.* at 324.

ANALYSIS

Plaintiff contends BayCare violated both the Anti-Kickback Statute and the Stark Law by offering remuneration to physicians working at the Heart Center MOB and the Suncoast MOB in exchange for referrals to BayCare. Plaintiff relies on those alleged violations to form the basis of his claim that BayCare also violated the False Claims Act. The False Claims Act, 31 U.S.C. §§ 3729–3733, "is the primary law on which the federal government relies to recover losses caused by fraud." *McNutt ex rel. United States v. Haleyville Med. Supplies, Inc.*, 423 F.3d 1256, 1259 (11th Cir. 2005). Under 31 U.S.C. § 3729(a)(1) and (a)(2), the False Claims Act imposes liability on any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim."[2] 31 U.S.C. § 3729(a)(1). A person acts "knowingly" if he or she: (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. 31 U.S.C. § 3729(b)(1)(A). No proof of specific intent to defraud is required. 31 U.S.C. § 3729(b)(1)(B).

A violation of either the Stark Law or the Anti-Kickback Statute can form the basis of liability under the False Claims Act. (Dkt. 54 at 2–3.) With some distinct differences, both the Anti-Kickback Statute and the Stark Law forbid hospitals from offering any "remuneration" to a

[2] The Florida False Claims Act, §§ 68.081–68.092, Fla. Stat., mirrors the federal False Claims Act. *United States v. All Children's Health Sys., Inc.*, No. 8:11-CV-01687-T-27, 2013 WL 6054803, at *5 (M.D. Fla. Nov. 15, 2013).

physician in exchange for referrals if payment for the referred services can be made under a federal health care program. *Ameritox, Ltd. v. Millennium Labs., Inc.*, 803 F.3d 518, 521 (11th Cir. 2015).

A. Plaintiff's Motion for Partial Summary Judgment

Plaintiff moves for partial summary judgment on his claim that BayCare had a direct compensation arrangement with referring physicians practicing at the Heart Center MOB, which constitutes a prohibited financial relationship under the Stark Law. Specifically, Plaintiff argues that BayCare provided "direct in-kind remuneration to referring physicians in the form of a valuable parking easement and valet services, without charge." (Dkt. 155 at 1.)

The Stark Law, 42 U.S.C. § 1395nn, "prohibits doctors from referring Medicare patients to a hospital if those doctors have certain specified types of 'financial relationships' with that hospital" and "prohibits that same hospital from presenting claims for payment to Medicare for any medical services it rendered to such referred patients." *U.S. ex rel. Mastej v. Health Mgmt. Assocs., Inc.*, 591 F. App'x 693, 698 (11th Cir. 2014). Thus, the Stark Law prohibits a physician from referring Medicare or Medicaid patients to a hospital with which the physician has a financial relationship. A "financial relationship," which includes a direct or indirect "compensation arrangement," encompasses any arrangement involving remuneration between a physician and a hospital. 42 U.S.C. § 1395nn(a)(2)(B), (h)(1)(A); 42 C.F.R. § 411.354(a)(1)(ii). "Remuneration" is "any payment or benefit, made directly or indirectly, overtly or covertly, in cash or in kind." 42 C.F.R. § 411.351. To succeed on a claim under the Stark Law, a plaintiff must prove the following: (1) a "financial relationship" between the hospital and a physician; (2) a referral from the physician to the hospital for "designated health services"; and (3) a claim "present[ed] or caus[ed] to be presented" by the hospital to an entity for "designated health services furnished pursuant to a referral." 42 U.S.C. § 1395nn(a)(1).

Under the Stark Law, "[a] direct compensation arrangement exists if remuneration passes between the referring physician . . . and the [hospital] without any intervening persons or entities." 42 C.F.R. § 411.354(c)(1)(i). Therefore, in a direct compensation arrangement, remuneration passes directly between the referring physician and the hospital. BayCare argues that Plaintiff has failed to establish the existence of a direct compensation arrangement between BayCare and the referring physicians at the Heart Center MOB. As such, BayCare argues that Plaintiff has failed to establish the existence of a financial relationship between BayCare and the referring physicians, as required under the Stark Law.

According to Plaintiff, BayCare granted free parking directly to physicians who were making patient referrals to St. Anthony's Hospital, thus creating a direct financial relationship between BayCare and the referring physicians. (Dkt. 155 at 16.) Plaintiff cites to the Ground Lease to support his contention that "[t]he Ground Lease granted a direct easement for on-campus parking to subtenants (physicians) and their invitees (patients) as grantees." (Dkt. 155 at 2.) But, as expressed in the Ground Lease, the parking easement confers parking rights to "Tenant and Tenant's subtenants and invitees" (i.e., to St. Pete MOB, its subtenants, and its invitees)—not the referring physicians themselves. (Dkt. 155, Ex. 6, art. 17 § 1.) The Ground Lease identifies BayCare as "Landlord," and St. Pete MOB as "Tenant." (Dkt. 166, Ex. 6 at 1.) The Amended and Restated Ground Lease includes identical language. (Dkt. 155, Ex. 12.)

St. Pete MOB's subtenants are the tenants of the Heart Center MOB, which include SA Primary Care and WFC. (Dkt. 150, 74:5–13.) The tenants and referring physicians are not parties to the Ground Lease, and the tenants (such as WFC and SA Primary Care) have separate office leases with St. Pete MOB through which parking rights are conferred. (Dkt. 155, Ex. 7 at 2.) Therefore, referring physicians receive the benefit of parking through their employers (tenants of

the Heart Center MOB) who, by virtue of their office leases with St. Pete MOB, receive the benefit from St. Pete MOB through its Ground Lease with BayCare. The Ground Lease does not, therefore, provide evidence of a direct compensation arrangement between BayCare and the referring physicians.

Additionally, Plaintiff moves for summary judgment on its claim that BayCare provided valet parking to the physicians at the Heart Center MOB and that the provision of valet parking constitutes a direct compensation arrangement under the Stark Law. (Dkt. 155 at 5.) But Plaintiff fails to cite to any evidence showing that the Heart Center MOB physicians used valet parking. Rather, Plaintiff merely reiterates the undisputed fact that valet parking was offered at the Heart Center MOB through BayCare's contract with Healthcare Parking Systems of America, Inc., and BayCare paid the amounts shown on the invoices for valet services. (Dkt. 155, Ex. 5 at 14–16, Exs. 17–24.) This evidence does not show that the referring physicians were offered valet services or that they used valet services. Nor does not it show that patients who used valet services were referred by physicians at the Heart Center MOB.

Further, under the False Claims Act, a plaintiff must show that the defendant acted "knowingly." Plaintiff argues that BayCare acted with deliberate ignorance or reckless disregard by "fail[ing] to make reasonable inquiries or investigations into the appropriateness of paying for valet services and parking" at the Heart Center MOB. (Dkt. 155 at 7.) To establish this element, Plaintiff cites to the deposition of Carl Tremonti, the chief financial officer of St. Anthony's Hospital. But the seven-page deposition excerpt cited by Plaintiff provides no testimony from Mr. Tremonti regarding an inquiry or suspicion related to parking at the Heart Center MOB. Indeed, the issue of parking never arose in the portion of the deposition cited as an exhibit by Plaintiff.

(Dkt. 155, Ex. 35.) Therefore, Plaintiff has not provided evidence to show that BayCare acted knowingly, or with reckless disregard or deliberate indifference.

As such, Plaintiff fails to establish the existence of a financial relationship in the form of a direct compensation arrangement between BayCare and the referring physicians, which is the basis of Plaintiff's Motion for Partial Summary Judgment on its Stark Law claim. Accordingly, it is recommended that Plaintiff's Motion for Partial Summary Judgment be denied.

B. Defendant's Motion for Summary Judgment

1. Stark Law

To succeed on a claim under the Stark Law, a plaintiff must first prove the existence of a financial relationship between the hospital and a physician, which can include either a direct compensation arrangement or an indirect compensation arrangement. 42 U.S.C. § 1395nn(a)(1), (a)(2)(B), (h)(1)(A); 42 C.F.R. § 411.354(a)(1)(ii). As determined above, Plaintiff fails to provide evidence to show the existence of a direct compensation arrangement.

BayCare moves for summary judgment on Plaintiff's claim that BayCare had a financial relationship with referring physicians in the form of an indirect compensation arrangement. An indirect compensation arrangement exists if: (1) an "unbroken chain" of persons or entities with financial relationships exists between the referring physician and the hospital; (2) the referring physician receives aggregate compensation from the person or entity in the chain with which the physician has a direct financial relationship that "varies with, or takes into account, the volume or value of referrals" generated by the referring physician for the hospital; and (3) the hospital has either "actual knowledge of," or acts in "reckless disregard or deliberate ignorance of," the fact that the referring physician receives the described aggregate compensation. 42 C.F.R. §

411.354(c)(2). BayCare concedes that an unbroken chain of entities exists, therefore establishing the first element of an indirect compensation arrangement. (Dkt. 156 at 8.)

As to the second element of an indirect compensation arrangement, it must be shown that the referring physician receives aggregate compensation from the person or entity in the chain with which the physician has a direct financial relationship, and the aggregate compensation must vary, or take into account, the volume or value of referrals generated by the referring physician for the hospital. 42 C.F.R. § 411.354(c)(2)(i). In this case, the entity in the chain with which the referring physicians have a direct financial relationship is the corporate entity with whom the referring physicians are employed—i.e., their employers, tenants of the Heart Center MOB.[3] Therefore, it must be shown that the aggregate compensation paid to physicians by their employers varies with, or takes into account, the volume or value of referrals generated by the referring physicians for BayCare. But the employment agreements of physicians practicing at the Heart Center MOB show otherwise. For example, the employment agreements of physicians employed by SA Primary Care provide that the physicians' annual compensation is comprised of a base salary and a bonus, neither of which are based on referrals. (Dkt. 156, Ex. 4 at 14–15.) Indeed, the employment agreements expressly provide that the "Physician . . . shall not be compensated in any manner based upon the value or volume of 'designated health services' . . . Physician orders or requests." (Dkt. 156, Ex. 4 at 14–15.)

[3] According to WFC's practice administrator, Ina Roberts, WFC has never had, and currently does not have, physician owners. (Dkt. 156, Ex. 2 at ¶ 7.) Similarly, according to former president of St. Anthony's Hospital and current chief administrative officer of BayCare Medical Group, Inc., William G. Ulbricht, no physicians have an ownership interest in SA Primary Care or SC Physicians. (Dkt. 156, Ex. 3 at ¶¶ 4, 9–10.) Plaintiff has not provided evidence to establish the existence of physician-owned tenants at the Heart Center MOB or the Suncoast MOB. Rather, Plaintiff merely cites to the office lease between WFC's predecessor, The Heart and Vascular Institute, wherein Dr. Jeffrey Witt signed as "partner." (Dkt. 155, Ex. 7 at 47.) Therefore, Plaintiff has not shown that the "stand in the shoes" provision of the Stark Law applies. *See* 42 C.F.R. § 411.354(c)(2)(iv) ("[A] physician is deemed to 'stand in the shoes' of his or her physician organization if the physician has an ownership or investment interest in the physician organization."). Nonetheless, Plaintiff fails to provide evidence that Dr. Witt received aggregate compensation from St. Pete MOB in the manner described under the Stark Law.

Similarly, the compensation for physicians employed by SC Physicians is comprised of a base salary and the physician's productivity (using work-relative-value units ("wRVUs")), neither of which are based on referrals. (Dkt. 156, Ex. 5 at 15–18.); (Dkt. 156, Ex. 6 at 17–20.); (Dkt. 156, Ex. 7.) Additionally, the office lease between St. Pete MOB and the tenants of the Heart Center MOB provide that rent is calculated, in part, on the square footage of the leased space, thus imposing a higher rental payment on tenants leasing larger spaces. (Dkt. 156, Ex. 8 at 4 ¶ 3(a).) Plaintiff offers no evidence showing that physicians practicing in the Heart Center MOB or the Suncoast MOB receive compensation—whether it be free parking, rent concessions, or otherwise—from their employers that takes into account the volume or value of referrals.

In his response, Plaintiff merely expresses suspicion, stating: "To consider whether BayCare took into account referrals, query whether BayCare would purchase off-campus land, lease it at $150,000 per year below-market value, spend approximately $500,000 on maintenance and valet, and gratuitously convey easements or the right to free parking to non-referring physicians. A jury would most likely say 'No.'" (Dkt. 169 at 8.) *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986) (holding that the non-moving party "must do more than simply show that there is some metaphysical doubt as to the material facts"). And, as will be discussed below, there is no evidence to show that parking or rent concessions were provided to physicians of the Heart Center MOB or the Suncoast MOB gratuitously or based on referrals. Nor does Plaintiff provide evidence to support his claim that "the provision of valet and shuttle services" by BayCare to "patrons" of the Suncoast MOB constitutes a financial relationship between BayCare and referring physicians. (Dkt. 169 at 16.)

Additionally, even assuming that the second element of an indirect compensation arrangement has been met, Plaintiff offers no evidence to support a conclusion that BayCare acted

in reckless disregard or deliberate ignorance that referring physicians received parking and valet services—the third element required to establish the existence of an indirect compensation arrangement. Indeed, Plaintiff's discussion of this element is confined to the following sentence: "BayCare's scienter can be inferred from its knowledge of the identity of the easement grantees and the contracted scope and extravagant amount paid for for-profit entities' and physicians' valet services." (Dkt. 169 at 9.) This conclusory allegation is insufficient to survive summary judgment. *See Williamson Oil Co., Inc. v. Philip Morris USA*, 346 F.3d 1287, 1302 (11th Cir. 2003) (providing that evidence and theories that would require the jury to engage in speculation and conjecture are insufficient to survive summary judgment). Accordingly, because Plaintiff fails to designate specific facts showing there is a genuine issue for trial concerning the first element of a claim under the Stark Law—the existence of a financial relationship between BayCare and referring physicians—summary judgment is appropriate in BayCare's favor on Plaintiff's Stark Law claims. *See Earley v. Champion Int'l Corp.*, 907 F.2d 1077, 1080 (11th Cir. 1990) ("[T]he non-moving party still bears the burden of coming forward with sufficient evidence on each element that must be proved.").

2. Anti-Kickback Statute

The Anti-Kickback Statute, 42 U.S.C. § 1320a–7b, prohibits a hospital from financially inducing a person to refer a Medicare patient. 42 U.S.C. § 1320a–7b(b). Under 42 U.S.C. § 1320a-7b(b)(2), the Anti-Kickback Statute imposes criminal liability and penalties on any person who "knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person . . . to refer an individual to a person [for medical services] for which payment may be made in whole or in part under a [f]ederal health care program." *Mastej*, 591 F. App'x at 698. Thus,

the Anti-Kickback Statute prohibits the knowing and willful payment of remuneration to induce referrals for services that may be paid by Medicare. To succeed on a claim under the Anti-Kickback Statute, a plaintiff must prove that the defendant (1) knowingly and willfully (2) offered or paid any remuneration (3) to induce a physician to refer a patient for services (4) that may be paid by a federal health care program. *See* 42 U.S.C. § 1320a-7b(b)(2); *Mastej*, 591 F. App'x at 698 (citing *United States v. Vernon*, 723 F.3d 1234, 1252 (11th Cir. 2013)). A defendant acts "knowingly and willfully" under the Anti-Kickback Statute if it acts with knowledge that its conduct was unlawful. *United States v. Starks*, 157 F.3d 833, 838 (11th Cir. 1998). The Anti-Kickback Statute broadly defines "remuneration" as "transfers of items or services for free or for other than fair market value." 42 U.S.C. § 1320a–7a(i)(6). In this case, Plaintiff claims that parking (and related maintenance and repairs), valet parking, and tax savings constitute remuneration under the Anti-Kickback Statute.

a. Parking

To constitute remuneration, the parking services provided to physicians working in the Heart Center MOB must have been provided "for free or for other than fair market value." 42 U.S.C. § 1320a–7a(i)(6). Although the Anti-Kickback Statute does not define the term "fair market value," it has been defined as "the price a willing buyer would pay a willing seller . . . when neither is under compulsion to buy or sell." *Klaczak v. Consol. Med. Transp.*, 458 F. Supp. 2d 622, 678 (N.D. Ill. 2006); *see United States v. Draves*, 103 F.3d 1328, 1332 (7th Cir. 1997) ("The fair market value of property is commonly defined as the price a willing buyer would pay a willing seller for the property, when neither is under compulsion to buy or sell."). To prove that a defendant offered or paid remuneration, the plaintiff must compare the contracted rates with fair market value. *Klaczak*, 458 F. Supp. 2d at 679.

According to Patrick Marston, co-owner of St. Pete MOB, parking is not a line-item expense indicated on the statements provided to the tenants of the Heart Center MOB. (Dkt. 148 at 125: 21–126:9.) But, as stated repeatedly by Mr. Marston, parking (and related maintenance and repair) is factored into the leases for each tenant such that the cost of parking and maintenance is calculated into the tenant's rental payments. (Dkt. 148 at 125:21–126:17, 170:3–9, 271:25–272:4, 273:17–21, 275:2–5, 279:10–18, 284:10–12.) Additionally, BayCare's real estate expert, Michael P. Hedden, opines that parking is commonly provided to tenants—without an additional rent charge—as part of the amenities offered, and the rent charged to tenants of the Heart Center MOB is within the fair market value when accounting for parking. (Dkt. 156, Ex. 9 at 3, 25.); (Dkt. 149 at 131:11–25.)

Plaintiff offers no evidence showing either that the tenant's rental payments did not take parking into account or that the rental payments are not within the fair market value. *See Evers v. Gen. Motors Corp.*, 770 F.2d 984, 986 (11th Cir. 1985) ("[C]onclusory allegations without specific supporting facts have no probative value."); *U.S. ex rel. Jamison v. McKesson Corp.*, 900 F. Supp. 2d 683, 699 (N.D. Miss. 2012) (entering judgment in favor of the defendant, finding that the government failed to show that the alleged remuneration was not within fair market value).

Similarly, Plaintiff offers no evidence to show that the referring physicians at either the Heart Center MOB or the Suncoast MOB were offered valet services or that they did, in fact, use valet parking. Rather, according to former BayCare regional vice president Ford Kyes, he authorized the provision of valet services as a convenience to "patients and the visitors" to protect their health and safety, and such services were not provided to, or used by, physicians or their staff. (Dkt. 150 at 94:6–95:20.) Further, the invoices for valet parking provided to the Suncoast MOB and the physician agreements cited by Plaintiff do not constitute evidence of an offer by BayCare

to the referring physicians for valet parking, the use of valet parking by the referring physicians, or the use of valet parking by referred patients. (Dkt. 169, Exs. 8, 9, 10, 13, 14, 16.)

Nevertheless, even assuming that parking services were provided free or not within fair market value, there is no evidence to suggest, or prove, that BayCare offered or paid for such services for the purpose of inducing physicians to refer patients to St. Anthony's Hospital. *See Vernon*, 723 at 1256 (providing that the term "willfully," as used in the Anti-Kickback Statute, means that the act was committed "voluntarily and purposely, with the specific intent to do something the law forbids"); *U.S. ex rel. Parikh v. Citizens Med. Ctr.*, 977 F. Supp. 2d 654, 665 (S.D. Tex. 2013) ("Case law . . . consistently treats the [Anti-Kickback Statute's] inducement element as an intent requirement.").

Accepting Plaintiff's argument that a jury need only find that one purpose for providing parking services to referring physicians and their patients was to obtain referrals—as opposed to the sole or primary purpose—Plaintiff cites to no evidence showing that BayCare offered remuneration with the intent to induce referrals. *See United States v. McClatchey*, 217 F.3d 823, 835 (10th Cir. 2000) ("[A] person who offers or pays remuneration to another person violates the [Anti-Kickback Statute] so long as one purpose of the offer or payment is to induce Medicare or Medicaid patient referrals."); *see also United States v. LaHue*, 261 F.3d 993, 1006 (10th Cir. 2001) (discussing the plaintiff's evidence regarding inducement, including the parties' negotiations involving the exchange of payment for referrals); *U.S. ex rel. Pogue v. Diabetes Treatment Ctrs. of Am.*, 565 F. Supp. 2d 153, 162 (D.D.C. 2008) (discussing the plaintiff's circumstantial evidence regarding inducement, including detailed fair market value analysis showing that the defendant had paid its medical directors far in excess of the fair market value commensurate with their duties, the defendant's business model built chiefly on census growth, and negotiations focused on patient

referrals); *Klaczak*, 458 F. Supp. 2d at 680 (rejecting the plaintiff's indirect evidence of inducement, noting the lack of a "single comment, email, memo, or other indication" that the defendant knowingly and willfully participated in any kickback scheme).

Indeed, Mr. Marston testified that St. Pete MOB did not provide free or discounted services to physicians or tenants in the Heart Center MOB to induce them to refer patients to BayCare, BayCare did not ask St. Pete MOB to provide free or discounted services to tenants in the Heart Center MOB for the purpose of inducing referrals to BayCare, the tenants of the Heart Center MOB did not ask St. Pete MOB to provide free or discounted services in exchange for making referrals to BayCare, and BayCare did not have any input in the amount of rent charged to tenants by St. Pete MOB. (Dkt. 148 at 272:18–273:16.) Additionally, according to Mr. Kyes, physicians working in the Heart Center MOB could, by virtue of their medical staff privileges, refer patients to BayCare (and other hospitals where the physicians had privileges), but their medical staff privileges did not impose a requirement to refer patients to BayCare. (Dkt. 150 at 29:9–30:14, 41:24–45:5.) Accordingly, Plaintiff has failed to designate specific facts showing there is a genuine issue for trial concerning his claims that parking or valet services constitute remuneration under the Anti-Kickback Statute, or that BayCare offered such services for the purpose of inducing referrals.

b. Tax Exemption

Plaintiff alleges that BayCare provided a rent concession in the form of tax savings to the referring physicians at the Heart Center MOB by claiming an improper tax exemption, which constitutes remuneration under the Anti-Kickback Statute. (Dkt. 32 at ¶¶ 87, 92–93.) According to correspondence from BayCare to the Pinellas County Property Appraiser's Office, the Heart Center MOB was "inaccurately classified as tax exempt for tax years 2007–[2015]." (Dkt. 169,

Ex. 3 at 1.) Indeed, BayCare admits that the Heart Center MOB was improperly claimed as tax exempt, and correspondence from the Pinellas County Property Appraiser confirms the misclassification. (Dkt. 156 at 17; Dkt. 169, Ex. 4.) But, as shown by the tenant's leases and the testimony of Mr. Marston, the tenants were required to pay taxes under their leases with St. Pete MOB, and the tenants made such payments to St. Pete MOB. (Dkt. 156, Ex. 8 at 5 ¶ (c).); (Dkt. 148 at 24:19–21, 29:3–7, 33:8–21, 246:17–248:3.) Additionally, BayCare "ma[de] payment of past due taxes," and St. Pete MOB "has been collecting [property] taxes from tenants pursuant to the underlying lease agreements between [St. Pete MOB] and the tenants." (Dkt. 169, Ex. 3 at 3.) Moreover, even assuming that the Heart Center MOB tenants did not pay property taxes, no evidence shows that this alleged benefit would be passed to the referring physicians practicing at the Heart Center MOB, or that they were required to pay property taxes.

Additionally, Plaintiff claims that BayCare improperly claimed an ad valorem tax exemption for the Suncoast MOB, which was then bestowed on the referring physicians practicing at the Suncoast MOB. Underlying this claim is Plaintiff's contention that the property appraiser's determination granting a tax exemption was erroneous because the Suncoast MOB was not used for "charitable purposes," as required under Florida law, and BayCare "omitted material information" concerning its non-exempt use of the property. (Dkt. 169 at 12.) *See* §§ 196.012(1), 196.192, 196.196, Fla. Stat. (discussing ad valorem tax exemptions). Plaintiff also raises this issue in his declaration submitted in his response. (Dkt. 169, Ex. 7.)

According to the Pinellas County Property Appraiser's Office, "the exemption on [the Suncoast MOB], both land and building is and was proper for all years." (Dkt. 156, Ex. 11.) The entitlement to a tax exemption is a determination by the county property appraiser, whose assessments of property for ad valorem taxation purposes enjoy a presumption of validity. *See* §

196.193, Fla. Stat. (providing that all applications for exemptions are reviewed by the property appraiser who determines whether, among other things, the applicant uses the property predominantly or exclusively for exempt purposes, and who ultimately determines whether to grant a tax exemption); *Havill v. Scripps Howard Cable Co.*, 742 So. 2d 210, 212 (Fla. 1998) ("A presumption of validity attaches to the property appraiser's assessment of property for ad valorem taxation purposes.").

Plaintiff's argument is aimed at the Pinellas County Property Appraiser and the sufficiency or validity of its determination that the Suncoast MOB is entitled to an ad valorem tax exemption. (Dkt. 169 at 12–15, Exs. 7–11.) But Plaintiff's speculative contention and opinion that the property appraiser incorrectly granted a tax exemption does not create a genuine issue of material fact. *See S.E.C. v. Monterosso*, 756 F.3d 1326, 1333 (11th Cir. 2014) (providing that a party's "[s]peculation or conjecture cannot create a genuine issue of material fact, and a 'mere scintilla of evidence' in support of the nonmoving party cannot overcome a motion for summary judgment."); *Rutland v. State Farm Mut. Auto. Ins. Co.*, 426 F. App'x 771, 775 (11th Cir. 2011) (characterizing the plaintiff's argument that the defendant's calculations of a refund were erroneous as "unsupported and speculative contentions fall[ing] short of creating a genuine issue of material fact"). Further, challenges to the determination of a county official regarding property taxation are not before this Court. *See* § 194.171, Fla. Stat. (conferring jurisdiction on the state circuit courts to hear ad valorem tax assessment contests).

Therefore, Plaintiff fails to designate specific facts showing there is a genuine issue for trial concerning his claims that the Suncoast MOB was improperly claimed as tax-exempt and, therefore, that the tenants of the Suncoast MOB received the benefit of an improper tax exemption. Additionally, there is no evidence to show BayCare's intent—that is, that it offered or paid

remuneration to induce patient referrals—or to show that BayCare acted with knowledge that its conduct was unlawful.

CONCLUSION

Plaintiff has failed to designate specific facts showing there is a genuine issue for trial concerning the necessary elements under the Stark Law and Anti-Kickback Statute, namely the existence of a financial relationship between BayCare and referring physicians practicing at the Heart Center MOB or Suncoast MOB, as required under the Stark Law, and an offer or payment of remuneration by BayCare to referring physicians, as required under the Anti-Kickback Statute. Additionally, Plaintiff has failed to designate specific facts showing there is a genuine issue for trial concerning whether BayCare provided benefits to referring physicians for the purpose of inducing patient referrals. Given the lack of evidence, Plaintiff has not shown that genuine issues for trial remain concerning his claim under the False Claims Act. Accordingly, it is

RECOMMENDED:

1. Plaintiff's Motion for Partial Summary Judgment on Liability (Dkt. 155) be **DENIED**.
2. Defendant's Motion for Summary Judgment (Dkt. 156) be **GRANTED**, and judgment be entered in favor of Defendant, BayCare Health System, on Counts I, II, and III of the First Amended Complaint.

IT IS SO REPORTED in Tampa, Florida, on December 16, 2016.

JULIE S. SNEED
UNITED STATES MAGISTRATE JUDGE

NOTICE TO PARTIES

A party has fourteen days from this date to file written objections to the Report and Recommendation's factual findings and legal conclusions. A party's failure to file written objections waives that party's right to challenge on appeal any unobjected-to factual finding or legal conclusion the district judge adopts from the Report and Recommendation. *See* 11th Cir. R. 3-1.

Copies furnished to:
Counsel of Record

[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 16-17059

D.C. Docket No. 1:13-cv-23671-MGC

THOMAS BINGHAM,

Plaintiff-Appellant,

versus

HCA, INC.

Defendant-Appellee

Appeal from the United States District Court
for the Southern District of Florida

(July 31, 2019)

Before MARCUS, BLACK, and WALKER,* Circuit Judges.

WALKER, Circuit Judge:

---

* John M. Walker, Jr., United States Circuit Judge for the Second Circuit, sitting by designation.

This is a *qui tam* action brought under the False Claims Act by Plaintiff-Appellant Thomas Bingham ("Relator") against Defendant-Appellee HCA, Inc. ("HCA"). HCA is a healthcare services provider that owns and operates hospitals and surgery centers throughout the United States. Relator's claims relate to the Centerpoint Medical Center in Independence, Missouri (the "Centerpoint Claims") and the Aventura Hospital in Aventura, Florida (the "Aventura Claims"). On November 4, 2016, the district court (Cooke, J.) entered judgment in favor of HCA following its grant of summary judgment on the Centerpoint Claims and dismissal of the Aventura Claims on the pleadings. Relator appeals, arguing that the district court erred in granting both motions. For the reasons set forth below, we AFFIRM the judgment of the district court.

I. BACKGROUND

We begin with a brief overview of the False Claims Act, then describe the factual premise of Relator's claims, and conclude with the procedural history of the case.

A. Relator's Claims Under the False Claims Act

"The False Claims Act is the primary law on which the federal government relies to recover losses caused by fraud." *McNutt ex rel. United States v. Haleyville Med. Supplies, Inc.*, 423 F.3d 1256, 1259 (11th Cir. 2005). The False Claims Act "permits private persons to file a form of civil action (known as *qui*

tam) against, and recover damages on behalf of the United States from, any person who . . . 'knowingly presents, or causes to be presented . . . a false or fraudulent claim for payment or approval . . . [or] 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.'" *United States ex rel. Clausen v. Lab. Corp. of Am. Inc.*, 290 F.3d 1301, 1307 (11th Cir. 2002) (quoting 31 U.S.C. § 3729(a)(1)–(2)). For his services, the relator is entitled to a substantial percentage of the recovery. 31 U.S.C. § 3730(d).

Relator's claims under the False Claims Act are for certain allegedly improper Medicare payments received by HCA. The claims are predicated on his assertion that HCA violated the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b) ("AKS"), and 42 U.S.C. § 1395nn(a) (the "Stark Statute"), by providing sweetheart deals to certain physicians who leased space in medical office buildings developed by HCA in exchange for patient referrals from those physicians. Noncompliance with either statute is a bar to the receipt of Medicare payments, and therefore a violation of either statute can form the basis of liability under the False Claims Act for past Medicare payments attributable to the violations. *United States ex rel. Bingham v. HCA, Inc.*, No. 13-23671-CIV, 2016 WL 344887, at *2 (S.D. Fla. Jan. 28, 2016).

B. The Centerpoint Claims

In 2003, HCA began to develop the Centerpoint Medical Center, a new hospital and medical office building ("MOB") in Independence, Missouri. HCA hired Tegra Independence Medical Surgical, L.C. ("Tegra"), a third-party developer, to develop the MOB. As part of the development project, Tegra leased out space in the MOB to physicians. In 2012, Tegra sold the MOB for $50 million. Relator alleges that as part of the development of the MOB, HCA paid Tegra $4 million in allegedly improper subsidies, primarily through an initial lease and an arrangement involving parking facilities at the MOB, which Tegra passed on to physician tenants through payments under Cash Flow Participation Agreements ("CFPAs") between Tegra and physician tenants, low initial lease rates, restricted use waivers, and free office improvements. In exchange, Relator alleges, HCA received $260 million in Medicare and Medicaid payments from patients referred to HCA's hospital by the physician tenants.

Tegra offered CFPAs to any physician tenant who would sign a ten-year lease. The CFPA entitled the physician tenant to a pro-rata share of the property's operating cash flow, including proceeds from any sale of the building. A project manager for Tegra stated in an affidavit that a "ten-year lease term was longer than the average lease term in the market at the time the CFPAs were negotiated and executed." App'x 117-6 ¶ 21. The formula used to calculate a physician tenant's

payout under his or her CFPA depended on the amount of space that person leased. The leases entered into in 2006 and 2007 between Tegra and physician tenants who also signed on to CFPAs provided for a rental rate of $18.90 per square foot.

On January 1, 2005, an appraiser engaged by HCA, Holladay Properties ("Holladay"), performed a market rent study on the rental space in the MOB and concluded that the fair market rent range was $14.50 to $19.00 per square foot. This study assumed free parking and did not take into account the CFPAs. In June 2005, that appraisal was updated to reflect, among other things, Tegra's use of the CFPAs, and confirmed that the fair market rent range was still $14.50 to $19.00 per square foot. In 2007, Holladay certified that the business and lease terms were consistent with fair market value, signed the study, and provided it to HCA.

On June 18, 2007, Holladay prepared a Standard Business and Lease Terms Memorandum. The memorandum noted that the CFPAs were being offered to physician tenants and concluded that the fair market rent range was $21.50 to $23.50 per square foot. The memorandum stated that the increase in rental rates was due to higher construction costs.

Relator also alleges that HCA gave physician tenants restricted use waivers and free office improvements. In support, he points to one example in which a doctor wanted to install a digital rad machine, which, because it was non-standard, required modifications to his suite as well as the approval of HCA, as the operator

of the hospital. Relator alleges that HCA, rather than physician tenants, made free improvements to office spaces, based on the fact that the general contractor who worked with HCA applied for the building permits, and HCA was shown as the "owner" on the building permits, many of which were filed prior to the start of the physician tenant's lease.

C. The Aventura Claims

The Aventura Hospital is a hospital complex in Aventura, Florida that is owned and operated by HCA. In 2002, HCA recruited the Greenfield Group ("Greenfield") to develop a MOB adjacent to the Aventura Hospital. The alleged Aventura arrangement was broadly similar to the alleged Centerpoint arrangement. Relator alleges that HCA financed and subsidized Greenfield through a ground lease and development agreement. In 2007, Greenfield sold the MOB, and Relator alleges that profits were paid to physician tenants who partnered with Greenfield. Relator also alleges that HCA provided direct remuneration to referring physician tenants, including free parking rights and benefits, below market rents, subsidized common area maintenance, and free use permissions. Procedural History

On August 15, 2014, Relator filed his First Amended Complaint ("FAC"), and on February 23, 2015, the United States declined to intervene in the suit, as permitted by the False Claims Act. *See* 31 U.S.C. § 3730. On July 22, 2015, the parties jointly moved to stay discovery pending resolution of HCA's anticipated

motion to dismiss. The district court denied that motion, and discovery began. HCA then moved to dismiss Relator's complaint. On January 28, 2016, the district court dismissed the Aventura Claims without prejudice for failure to comply with Rule 9(b) of the Federal Rules of Civil Procedure but allowed the Centerpoint Claims to continue. On March 8, 2016, Relator filed his Second Amended Complaint ("SAC"), which included additional facts pertaining to the Aventura Claims. Thereafter, HCA moved for summary judgment on the Centerpoint Claims. On April 6, 2016, the district court, following a hearing, granted that motion. Finally, on October 14, 2016, the district court granted HCA's motion to strike impermissible facts in Realtor's SAC and dismissed the repleaded Aventura Claims. On November 4, 2016, the district court entered a final judgment that dismissed the Aventura Claims on the pleadings and granted summary judgment to HCA on the Centerpoint Claims. This appeal followed.

II. DISCUSSION

On appeal, Relator argues that the district court erred in entering final judgment in favor of HCA on both the Centerpoint and Aventura Claims. We find no error and affirm the district court's judgment.

A. Centerpoint Claims

i. Standard of Review

"We review the district court's grant of summary judgment de novo, applying the same legal standards that bound that court and viewing all facts and reasonable inferences in the light most favorable to the nonmoving party." *United States ex rel. Walker v. R&F Props. of Lake Cty., Inc.*, 433 F.3d 1349, 1355 (11th Cir. 2005) (internal quotation marks omitted). "Summary judgment is appropriate 'if the movant shows that there is no genuine dispute as to any material fact' such that 'the movant is entitled to judgment as a matter of law.'" *United States ex rel. Phalp v. Lincare Holdings, Inc.*, 857 F.3d 1148, 1153 (11th Cir. 2017) (quoting Fed. R. Civ. P. 56(a)). "Genuine disputes are those in which the evidence is such that a reasonable jury could return a verdict for the non-movant. For factual issues to be considered genuine, they must have a real basis in the record." *Ellis v. England*, 432 F.3d 1321, 1325–26 (11th Cir. 2005) (internal quotation marks omitted). The appeals court "will affirm a grant of summary judgment if it is correct for any reason." *United States v. $121,100.00 in U.S. Currency*, 999 F.2d 1503, 1507 (11th Cir. 1993).

ii. Anti-Kickback Statute Claims

Relator's first claim under the False Claims Act is predicated on his allegation that HCA violated the AKS. *See* 42 U.S.C. § 1320a-7b(b). The AKS

"broadly forbids kickbacks, bribes, and rebates in the administration of government healthcare programs." *Carrel v. AIDS Healthcare Found., Inc.*, 898 F.3d 1267, 1272 (11th Cir. 2018). In relevant part, it provides that "[w]hoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person . . . to refer 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 . . . shall be guilty of a felony." 42 U.S.C. § 1320a-7b(b)(2)(A).

An AKS violation thus requires that there be "remuneration" offered or paid in the transaction at issue. Because "remuneration" is not specifically defined in the statute, we must turn to "the common usage of words for their meaning." *In re Walter Energy, Inc.*, 911 F.3d 1121, 1143 (11th Cir. 2018) (internal quotation marks omitted). "To determine the ordinary meaning of a term, we often look to dictionary definitions for guidance." *Id*. Black's Law Dictionary defines "remuneration" in pertinent part as "[p]ayment; compensation." *Remuneration*, Black's Law Dictionary (11th ed. 2019). Compensation, in turn, cannot be given unless some sort of benefit is conferred. *See, e.g.*, *Compensation*, Black's Law Dictionary (11th ed. 2019) ("Remuneration and other benefits received in return for services rendered"). In a business transaction like those at issue in this case,

the value of a benefit can only be quantified by reference to its fair market value. *See also Klaczak v. Consol. Med. Transp.*, 458 F. Supp. 2d 622, 679 (N.D. Ill. 2006) ("Relators cannot prove that the Hospital Defendants received remuneration—something of value—without comparing the contracted rates with fair market value.").

This understanding of "remuneration" is supported by the definition of "remuneration" in 42 U.S.C. § 1320a-7a(i)(6), which relates to civil monetary penalties in connection with medical fraud. Although that definition is limited to that particular section of Title 42, it also defines "remuneration" to include the "transfer[ ] of items or services for free or for other than fair market value" and thus is consistent with our view of the correct definition. *Id.*

For these reasons, the issue of fair market value is not limited to HCA's safe harbor defense, as Relator suggests, but is rather something Relator must address in order to show that HCA offered or paid remuneration to physician tenants. Here, Relator argues that HCA passed remuneration to physician tenants through Tegra, so the critical question we must ask is whether physician tenants received anything of value from Tegra under or in connection with their leases in excess of the fair market value of their lease payments.

Relator first points to the "low-end" rents that physician tenants paid for space in the MOB. But Relator concedes that the proposed rents were within the

range of "market rates" for new construction. Appellant's Br. at 20. And although the fair market rent range increased between the 2005 and 2007 appraisals, the appraiser determined that the increase was due to higher construction costs. Moreover, judging from the leases that Relator attached to his FAC, it appears that many leases were entered into during 2005 and 2006, prior to the 2007 appraisal, which would make them less "low-end."

Relator also points to profits received by physician tenants through the CFPAs as evidence of unlawful remuneration. But Relator has not shown that these agreements conferred any benefit in excess of fair market value. CFPAs were offered only to tenants who would sign a ten-year lease, which was a longer term than the market average at the time those lease agreements were negotiated. In addition, Holladay's two market rent studies conducted during 2005 confirmed the same fair market rent range before and after taking into account the CFPAs, thereby demonstrating that these agreements did not confer any additional value to physician tenants.

Relator also argues that HCA made free improvements to the offices of certain physician tenants and gave certain physician tenants restricted use waivers. But neither of these allegations is supported by sufficient facts. Relator does not tie the improvements to specific physician tenants who were or could be referral sources, nor does he present evidence that the use waivers were anything other

than a standard exercise of discretion under the relevant leases or that HCA was required to ask for something in exchange for the use waivers. "[M]ere conclusions and unsupported factual allegations are legally insufficient to defeat a summary judgment motion." *Ellis*, 432 F.3d at 1326.

For these reasons, we conclude that Relator has not shown that HCA conveyed any remuneration to physician tenants of the Centerpoint MOB, and therefore that Relator's AKS claim fails on summary judgment.

iii. Stark Statute Claim

Relator's second claim under the False Claims Act pertaining to Centerpoint is that HCA violated the Stark Statute. *See* 42 U.S.C. § 1395nn(a). "In its most general terms, the Stark statute prohibits doctors from referring Medicare patients to a hospital if those doctors have certain specified types of 'financial relationships' with that hospital." *United States ex rel. Mastej v. Health Mgmt. Assocs., Inc.*, 591 F. App'x 693, 698 (11th Cir. 2014) (citing 42 U.S.C. § 1395nn(a)(1)(A)). The Stark Statute also "prohibits that same hospital from presenting claims for payment to Medicare for any medical services it rendered to such referred patients." *Id.* (citing 42 U.S.C. § 1395nn(a)(1)(B)). A prohibited "financial relationship" includes a "compensation arrangement," 42 U.S.C. § 1395nn(a)(2)(B), defined as "any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity [providing a designated health

service]," subject to certain exceptions, 42 U.S.C. § 1395nn(h)(1)(A). "Remuneration," in turn, "includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind." 42 U.S.C. § 1395nn(h)(1)(B). Both direct and indirect compensation arrangements are therefore prohibited under the Stark Statute.

In this case, there is no genuine factual dispute over whether a prohibited indirect compensation arrangement under the Stark Statute exists because it plainly does not. Regulations promulgated in part under 42 U.S.C. § 1395nn define an "indirect compensation agreement" as requiring, among other things, that compensation received by a referring physician "varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician." 42 C.F.R. § 411.354(c)(2)(ii). HCA has shown that there is no correlation between the size of physician tenants' space leases and their referrals to HCA, Appellee's Br. at 9, and Relator offers only conclusory statements that HCA "took into account the value of referrals" in planning the MOB, Appellant's Br. at 32–33. Even if Relator's contention is true, it does not show that the rental rates or other benefits allegedly given by HCA to any specific physician tenant are at all correlated with the volume or value of referrals from that physician tenant. Therefore, because there is no real basis in the record from which to conclude that compensation paid by HCA to physician tenants varies with or takes into account

the volume or value of referrals, there is no genuine factual dispute on this point. *See Ellis*, 432 F.3d at 1326.

Relator argues that the district court erred in considering this definition of an "indirect compensation arrangement" because it relates to exceptions under the Stark Statute rather than Relator's *prima facie* burden. But Relator waived this argument by failing to raise it before the district court. *See, e.g.*, *Denis v. Liberty Mut. Ins. Co.*, 791 F.2d 846, 848–49 (11th Cir. 1986) ("Failure to raise an issue, objection or theory of relief in the first instance to the trial court generally is fatal."). In fact, Relator cited approvingly to 42 C.F.R. § 411.354(c)(2) in his Opposition to Motion for Partial Summary Judgment. App'x 159 at 9.

For these reasons, we conclude that Relator has not shown that there is a financial relationship between HCA and physician tenants that violates the Stark Statute. We therefore agree with the district court that HCA was entitled to summary judgment regarding Relator's Centerpoint Claims.

B. Aventura Claims

The district court dismissed Relator's Aventura Claims because it concluded that Relator "impermissibly use[d] information learned through discovery to supplement [these] allegations," and that without this additional information, the SAC did not meet the heightened pleading standard of Rule 9(b). *Bingham v.*

HCA, Inc., No. 13-23671-CIV, 2016 WL 6027115, at *4 (S.D. Fla. Oct. 14, 2016). On appeal, Relator argues that both conclusions were erroneous. We disagree.

i. Grant of HCA's motion to strike information

On July 22, 2015, the parties jointly moved to stay discovery pending resolution of HCA's anticipated motion to dismiss. The district court denied that motion, and discovery began. HCA then moved to dismiss Relator's complaint. On January 28, 2016, the district court granted HCA's motion to dismiss Relator's Aventura Claims but allowed Relator to amend his complaint regarding these claims. Discovery, however, had proceeded while the district court considered and decided HCA's motion to dismiss. On March 8, 2016, Relator filed his SAC, adding additional facts pertaining to the Aventura Claims, including information obtained through discovery. Thereafter, HCA filed a second motion to dismiss Relator's Aventura Claims and a motion to strike certain alleged facts on the basis that Relator's SAC impermissibly used information learned through discovery, and that, without that information, the SAC did not meet the heightened pleading standard of Rule 9(b). The district court agreed and granted both motions. *Bingham*, 2016 WL 6027115, at *4.

We review the district court's grant of HCA's motion to strike alleged facts from Relator's SAC under Federal Rule of Civil Procedure 12(f) for an abuse of discretion. *See Branch Banking & Tr. Co. v. Lichty Bros. Constr., Inc.*, 488 F.

App'x 430, 434 (11th Cir. 2012); *McCorstin v. U.S. Dep't of Labor*, 630 F.2d 242, 244 (5th Cir. 1980). "[T]he abuse of discretion standard allows a range of choice for the district court, so long as that choice does not constitute a clear error of judgment." *In re Rasbury*, 24 F.3d 159, 168 (11th Cir. 1994) (internal quotation marks omitted).

Although courts should freely grant leave to amend pleadings, *see* Fed. R. Civ. P. 15(a)(2), amendments that include material obtained during discovery, prior to a final decision on the motion to dismiss, may not be appropriate in cases to which the heighted pleading standard of Rule 9(b) applies if the amendment would allow the plaintiff to circumvent the purpose of Rule 9(b), *see United States ex rel. Keeler v. Eisai, Inc.*, 568 F. App'x 783, 804–05 (11th Cir. 2014). Applying Rule 9(b) to False Claims Act claims "ensures that the relator's strong financial incentive to bring [a False Claims Act] claim—the possibility of recovering between fifteen and thirty percent of a treble damages award—does not precipitate the filing of frivolous suits." *United States ex rel. Atkins v. McInteer*, 470 F.3d 1350, 1360 (11th Cir. 2006). Indeed, "[t]he particularity requirement of Rule 9 is a nullity if Plaintiff gets a ticket to the discovery process without identifying a single claim." *Id.* at 1359 (internal quotation marks omitted).

We agree with the district court that, in this case, the goals of applying Rule 9(b) to False Claims Act cases are advanced by striking information in Relator's

SAC that was learned through discovery, prior to a final decision on the motion to dismiss, because, as discussed further below, Relator's FAC did not satisfy the heightened pleading standard of Rule 9(b). As the district court noted, it is important to discourage plaintiffs from being able to "learn the complaint's bare essentials through discovery" which could "needlessly harm a defendants' [sic] goodwill and reputation by bringing a suit that is, at best, missing some of its core underpinnings, and, at worst, are baseless allegations used to extract settlements." *Bingham*, 2016 WL 6027115, at *4 (quoting *Clausen*, 290 F.3d at 1313 n.24). Similarly, prohibiting a relator "to use discovery to meet the requirements of Rule 9(b) reflects, in part, a concern that a *qui tam* plaintiff, who has suffered no injury in fact, may be particularly likely to file suit as a pretext to uncover unknown wrongs." *Id.* at *5 n.4 (internal quotation marks omitted). Finally, allowing a relator to amend a complaint after discovery would force the government to decide whether or not to intervene in the case without complete information. *Id.* at *5.

For these reasons, we conclude that the district court did not abuse its discretion in granting HCA's motion to strike information in Relator's SAC that was obtained through discovery.

ii. Grant of Motion to dismiss

"We review de novo the district court's grant of a motion to dismiss under Fed. R. Civ. P. 12(b)(6) for failure to state a claim, accepting the factual allegations

in the complaint as true and construing them in the light most favorable to the plaintiff." *Glover v. Liggett Grp., Inc.*, 459 F.3d 1304, 1308 (11th Cir. 2006) (per curiam). "A plaintiff must plausibly allege all the elements of the claim for relief. Conclusory allegations and legal conclusions are not sufficient; the plaintiffs 'must state a claim to relief that is plausible on its face.'" *Feldman v. Am. Dawn, Inc.*, 849 F.3d 1333, 1339–40 (11th Cir. 2017) (citation omitted) (quoting and citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557, 570 (2007)).

Furthermore, "[a] complaint under the False Claims Act must meet the heightened pleading standard of Rule 9(b), which states '[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake.'" *Hopper v. Solvay Pharm., Inc.*, 588 F.3d 1318, 1324 (11th Cir. 2009) (second alteration in original) (quoting Fed. R. Civ. P. 9(b)). "A False Claims Act complaint satisfies Rule 9(b) if it sets forth facts as to time, place, and substance of the defendant's alleged fraud, specifically the details of the defendants' allegedly fraudulent acts, when they occurred, and who engaged in them." *Id.* (internal quotation marks omitted).

Considering Relator's complaint after excising the additional information obtained through discovery, we agree with the district court that the remaining allegations do not satisfy the pleading requirements of Rule 9(b). On appeal, Relator argues that it was incorrect for the district court to assume that all of the

additional facts in his SAC were learned through discovery. Appellant's Br. at 38. But Relator does not point to specific facts in the SAC that he learned prior to discovery. Instead, he points us back to his FAC, arguing that his FAC pleaded all of the "essential elements" of the Aventura Claims. Appellant's Br. at 38. These elements are stated in the FAC on "information and belief," however, and Relator does not state with any particularity how HCA conveyed remuneration directly or indirectly to specific tenants of the Aventura MOB. App'x 14 ¶ 131, 134–35. Similarly, Relator's allegations that leases entered into between HCA and Greenfield did not reflect fair market value are supported, if at all, only by Relator's own calculations regarding the value of the land. App'x 14 ¶ 133, 136.

On appeal, Relator also points to specific allegations in his SAC that find a parallel in the FAC. Appellant's Br. at 39. But these allegations are similarly devoid of facts regarding the substance of HCA's alleged misconduct and do not describe in any detail the alleged misconduct, when it occurred, and who engaged in it. *See Hopper*, 588 F.3d at 1324. For example, Relator states in a conclusory fashion that, based on information and belief, the total amount of the ground lease payment from HCA to Greenfield was less than fair market value. App'x 14 ¶ 135. Similarly, although Relator alleged that HCA's Aventura scheme included "[v]aluable inducements offered and paid to referring physicians to encourage them to locate and maintain their offices on HCA hospital campuses" and

"[c]ontrol over third-party medical office building owners' relationships with their physician tenants . . . so as to ensure the flow of remuneration to physicians who referred patients to HCA," Relator does not provide specific details or evidence to support his claims that long-term ground leases were "[g]rossly undervalued" or included "[o]verly generous" terms. *Id.* ¶ 5–6.

Therefore, we agree with the district court that Relator's allegations lack the "indicia of reliability" to support his Aventura Claims, *Bingham*, 2016 WL 6027115, at *5 (internal quotation marks omitted), and that Relator has therefore failed to state a claim under the False Claims Act with respect to his Aventura Claims.

C. Conclusion

For these reasons, we AFFIRM the district court's grant of judgment in favor of HCA regarding Relator's Centerpoint Claims and Aventura Claims.

AFFIRMED.