JUDGE BUCHWALD

12 CV 1510

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Southern District of New York
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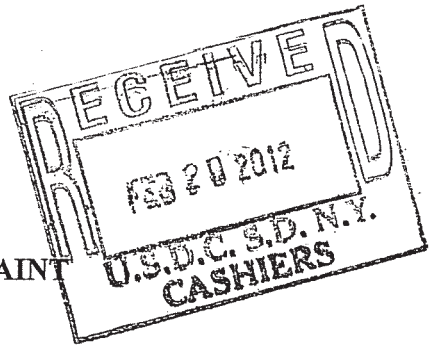


UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,	**COMPLAINT**
Plaintiff,	
v.	12 Civ. _____
BETH ISRAEL MEDICAL CENTER,	
Defendant.	

Plaintiff, United States of America, by its attorney Preet Bharara, United States Attorney for the Southern District of New York, alleges for its complaint against Beth Israel Medical Center ("Beth Israel") upon information and belief as follows:

I. INTRODUCTION

1. The United States brings this civil health care fraud action under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, to recover damages and civil penalties arising from Beth Israel's submission to the United States of false or fraudulent claims for Medicare outlier payments.

2. Outlier payments are reimbursements by the Medicare program to compensate hospitals for extraordinarily costly inpatient cases, as compared to average or typical costs

incurred in connection with inpatient care.

3. Beth Israel knew that Medicare outlier payments were intended and authorized by Congress to compensate hospitals only for treating inpatients whose care involves extraordinarily high costs. Beth Israel nevertheless manufactured excessive outlier payments by intentionally manipulating its charge structure to make it appear as though its treatment of certain inpatients was extraordinarily costly, when in fact it was not.

4. To obtain excessive outlier payments, Beth Israel increased its billed charges for providing medical care far in excess of any increase in the costs associated with that care, a practice commonly referred to as "turbocharging."

5. Beth Israel knew that the Medicare program relied on hospital charges, adjusted to cost pursuant to a regulatory formula, to serve as a proxy for costs to determine outlier payments.

6. Beth Israel also knew that, by turbocharging, it could deceive the Medicare program into believing that the costs associated with inpatient medical care that Beth Israel had provided were higher than they actually were, and thereby obtain more outlier payments than it was legally entitled to obtain.

7. Beth Israel increased its outlier payments from Medicare starting in 1998 and continuing through August 7, 2003, for cases that either were not extraordinarily costly or were much less costly than Beth Israel made them appear to be.

8. When Medicare amended the formula it used to determine outlier payments on August 8, 2003, Beth Israel's outlier reimbursements plummeted back down to their pre-turbocharging levels.

9. Under the applicable statute of limitations, the earliest possible date for which the United States can seek a monetary recovery from Beth Israel is February 21, 2002. When Beth Israel billed for outlier payments during the time from February 21, 2002, to August 7, 2003, it knew that it was not entitled to claim millions of dollars of these outlier payments, or acted in deliberate ignorance or reckless disregard of the fact that it was not entitled to claim millions of dollars of these outlier payments.

10. Accordingly, the United States seeks damages and civil penalties for each claim for an outlier payment submitted by Beth Israel to the Medicare program for inpatient stays with discharge dates from February 21, 2002 through August 7, 2003 (collectively, the "Damages Period").

II. JURISDICTION AND VENUE

11. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1345 and 31 U.S.C. § 3730(a).

12. Venue is proper in this district under 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b) because Beth Israel is located and transacts business in this district, and because the events or omissions giving rise to the claims alleged in this complaint occurred in this district.

III. PARTIES

A. The United States of America

13. Plaintiff is the United States of America, suing on behalf of the Centers for Medicare & Medicaid Services ("CMS") formerly known as the Health Care Financing Administration, a component of the United States Department of Health & Human Services ("HHS").

B. Defendant Beth Israel

14. Beth Israel is a private, not-for-profit corporation that operates an acute care hospital and is based in New York, New York. Together with certain other affiliated hospitals, including St. Luke's-Roosevelt Hospital Center, Long Island College Hospital, and the New York Eye and Ear Infirmary, Beth Israel is a component of Continuum Health Partners, Inc. ("Continuum"). Beth Israel's divisions include the Milton and Carroll Petrie Division, the Phillips Ambulatory Care Center, the Kings Highway Division, the Beth Israel Medical Group, and the Phillips Beth Israel School of Nursing.

IV. THE MEDICARE PROGRAM AND OUTLIER PAYMENTS

A. Medicare Reimbursement for Inpatient Care

15. In 1965, Congress enacted Title XVIII of the Social Security Act ("Medicare Act"), establishing the Medicare program to protect the health of the nation's elderly and infirm by paying for the costs of certain health care services. Among other things, the Medicare program reimburses hospitals for treating Medicare patients who are admitted to a hospital. 42 U.S.C. § 1395d(a)(1).

16. Part A of the Medicare program authorizes payment for institutional care, including inpatient hospital care, from a trust fund, known as the Medicare Trust Fund. 42 U.S.C. §§ 1395c-1395i-5. Generally, individuals are eligible for Medicare coverage under Part A if they worked for ten years in Medicare-covered employment and are either at least 65 years of age or, irrespective of age, suffer from certain disabilities or diseases.

17. Beth Israel submitted all of the Medicare inpatient claims at issue in this action pursuant to the provisions of Part A of the Medicare program. Under the Medicare Act, hospitals

and other entities or persons providing covered healthcare services under Part A are referred to as "providers."

18. CMS, a component of HHS, is directly responsible for the administration of the Medicare program. CMS reimburses hospitals, including Beth Israel, for Part A services through Medicare contractors called fiscal intermediaries ("FIs"). FIs typically are private insurance companies that are responsible for determining the amount of the payments to be made to hospitals and other providers. 42 U.S.C. § 1395h(a).

19. During the Damages Period, Beth Israel presented its inpatient claims for payment by CMS to Empire Healthchoice Assurance, Inc., the FI for the State of New York at the time.

20. After Congress established the Inpatient Prospective Payment System ("PPS") in 1983, Medicare began to reimburse providers a fixed amount of money for each patient stay based on the patient's condition, as classified by over 520 diagnosis-related groups ("DRGs"). DRGs reflect the average hospital resources required to treat Medicare beneficiaries with the respective diagnoses they cover, and determine how much the provider is entitled to be paid by Medicare for treating a patient with the applicable diagnoses.

21. Specifically, prior to the start of each federal fiscal year, CMS establishes a fixed national reimbursement rate per discharge. To compute the payment a hospital receives for a Medicare discharge, the national rate is adjusted by the relevant DRG, and additional adjustments are made to compensate providers for, among other things, treating low income patients and providing graduate medical education services.

22. To receive Medicare reimbursements, providers complete a standard billing form (the "UB-92"), which designates the principal and secondary diagnoses and procedures performed for each discharge on a DRG basis. These form UB-92s are then submitted by the

hospital to the FI, which draws down Medicare funds that are reserved in an account at a Federal Reserve Bank and makes payments to the hospital.

B. Medicare Cost Reports

23. To receive outlier payments, providers must also submit cost reports to the FI following the close of the provider's fiscal year. The FI then audits and/or reviews the cost report. A cost report is "settled" once the FI has reconciled interim payments previously made to the hospital with the data from the cost report. A cost report is "tentatively settled" when the FI has made a preliminary review of the as-filed cost report to determine if payment is due. A tentative settlement occurs within 60 days of acceptance of the cost report by the FI and before the cost report is audited.

24. FIs use cost report data to, among other things, calculate hospitals' cost-to-charge ratios ("CCRs"). CCRs are part of the formula that determines whether, and the extent to which, providers are entitled to outlier payments for inpatient care provided to Medicare patients.

C. Outlier Payments

25. In establishing the PPS, Congress recognized that health care providers will inevitably care for some patients whose inpatient stays are extraordinarily costly relative to other inpatient stays for similar conditions or illnesses. To encourage providers to treat such patients and insulate the providers from bearing inordinate losses due to these atypical costs, Congress authorized the Secretary of HHS to make supplemental "outlier payments." 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv) (collectively, the "Outlier Statute"). The Outlier Statute establishes that, for services to Medicare inpatients, providers may request payments over and above the standard DRG amount for cases "where charges, adjusted to cost," exceed certain dollar amounts. 42 U.S.C. § 1395ww(d)(5)(A)(ii). The Outlier Statute requires that these outlier

payments "be determined by the Secretary [of HHS] and . . . approximate the marginal cost of care beyond the cutoff point . . . ." 42 U.S.C. § 1395ww(d)(5)(A)(iii).

26. The Outlier Statute provides that outlier payments "shall . . . approximate" the marginal "cost" that a hospital incurs in treating inpatients, over and above the sum of the DRG payments, standard Medicare payment adjustments, and the fixed outlier threshold amount (the "outlier threshold"). The outlier threshold operates like the deductible in a typical insurance policy, in that providers can obtain no outlier payments unless and until the costs incurred by them exceed the threshold amount.

27. In federal fiscal year 1997, the outlier threshold was $9,700 per inpatient discharge. By federal fiscal year 2002, it had increased to $21,025 per inpatient discharge. The outlier threshold was raised again in 2003, to $33,560.

28. The applicable "cutoff point" for determining outlier payments is a monetary amount equivalent to the sum of (1) the applicable DRG payment, (2) certain other standard Medicare payment adjustments that qualifying hospitals are eligible to receive, and (3) the outlier threshold set by CMS. *See id.*

29. The legislative history of the Outlier Statute confirms that outlier payments are intended only for those inpatient stays for which the costs are extraordinary. *See* S. Rep. No. 98-23, at 51 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 191 (recognizing that "there will be cases within each [DRG] that will be extraordinarily costly to treat . . . because of severity of illness or complicating conditions, and [will] not [be] adequately compensated for under the DRG payment methodology"). This purpose also has been recognized by CMS. *See* 48 Fed. Reg. 39752, 39776 (Sept. 1, 1983) (outliers are "atypical" cases "that involve extraordinarily high costs" when compared to most discharges categorized in the same DRG).

30. The Outlier Statute provides that the outlier threshold should be set so that the amount of projected outlier payments to all hospitals for discharges in a fiscal year "may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." 42 U.S.C. § 1395ww(d)(5)(A)(iv). The term "total payments," as used in the statute, includes both DRG and outlier payments. See 69 Fed. Reg. 48916, 49275 (Aug. 11, 2004). Given this mandate, CMS each year evaluates past data to project the total DRG payments for the upcoming year, and selects an outlier threshold amount based on that projected total.

D. The Calculation of Outlier Payments

31. The procedure by which hospitals obtain inpatient outlier payments is set forth in two regulations, 42 C.F.R. §§ 412.80 and 412.84 (collectively, "the Outlier Regulations"). Section 2202.4 of CMS's Provider Reimbursement Manual (a manual created by CMS as guidance for providers participating in the Medicare program) defines charges as "the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients," and further provides that "[c]harges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient."

32. Section 2203 of the Provider Reimbursement Manual states in part that "each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program."

33. To obtain an outlier payment, a hospital first must submit to the FI the standard claim form UB-92, on which the hospital represents its actual charges (i.e., the amounts billed to the patient) for Medicare services and supplies provided to the government.

34. Under Section 2405.5(B) of the Provider Reimbursement Manual, payment for cost outliers must be specifically requested by the hospital. To request an outlier payment, the hospital must omit a particular code, Condition Code 66, from the UB-92. According to the Medicare Hospital Manual, the omission of Condition Code 66 from the UB-92 is equivalent to a request by the hospital for "any possible outlier payment," and the inclusion of Code 66 on the UB-92 means that the hospital "do[es] not want to claim [a] cost outlier payment." Hospital Manual, Transmittal No. 452 (July 1985).

35. Each hospital has its own "cost-to-charge ratio" or "CCR." The CCR is determined annually by dividing the hospital's yearly overall Medicare costs by its yearly overall Medicare charges.

36. During the Damages Period, to determine whether a particular inpatient stay was extraordinarily costly and thus merited an outlier payment, the FI used the hospital's charges for the inpatient stay as shown on the UB-92. The FI then multiplied the charges from the UB-92 by the CCR, derived from the hospital's most recently settled cost report. For example, if a hospital's most recently settled cost report showed that the hospital incurred $1 million in costs in treating Medicare patients and charged $2 million for providing that treatment, the CCR would equal 0.5 ($1 million divided by $2 million).

37. The product of the charges shown on the UB-92 multiplied by the CCR from the hospital's most recently settled cost report was deemed to be the hospital's costs for the inpatient stay ("Cost Amount"). The FI then compared that Cost Amount to the cutoff point – i.e., the

sum of three components: (1) the DRG payment that the hospital was due for that inpatient stay, (2) any other standard Medicare payment adjustments (such as IME and DSH payments) that the hospital was to receive for that inpatient stay, and (3) the applicable outlier threshold.

38. The Outlier Regulations provided that, if the Cost Amount exceeded the cutoff point, the FI should make outlier payments to the hospital. Pursuant to the Outlier Statute's requirement that outlier payments approximate a hospital's "marginal cost" in excess of the cutoff point, the Outlier Regulations provided for an outlier payment to the hospital equal to eighty percent (80%) of the difference between the Cost Amount and the cutoff point.

39. The Outlier Regulations' formula for computing outlier payments during the Damages Period may be summarized as follows: Outlier Payment = 80% x ((Charges x CCR) - (DRG Payment + any IME Payment + any DSH Payment + Outlier Threshold)). *See* 68 Fed. Reg. 34494, 34495 (June 9, 2003).

E. The Time Lag

40. Typically, at least two to three years elapse between the time a hospital submits a cost report to an FI and the time that the cost report is settled.

41. Since the CCR used for the outlier payment calculation was derived from the hospital's most recent final settled cost report, the CCR used by the FI to determine the hospital's costs for a particular inpatient stay typically was based on cost data that were at least two to three years old.

42. This time lag did *not* substantially affect the amount of outlier payments for most United States hospitals. Indeed, it did not have such an effect so long as a hospital's charges and the costs associated with those charges changed in roughly the same proportion during the period

between (a) the submission of a cost report and (b) the time the CCR derived from that cost report was used in the outlier payment formula in a later fiscal year.

43. As a result of the time lag, however, a hospital could manipulate the outlier system by turbocharging – *i.e.*, by inflating its charges without relation to its costs. Such turbocharging would cause the FI to multiply the increased charges billed for an inpatient stay by a CCR that had not yet been settled to reflect the recent increase in charges resulting from the hospital's turbocharging.

44. Accordingly, by taking advantage of the time lag, turbocharging hospitals could make it appear that the costs associated with an inpatient stay were higher than they actually were, and thereby could obtain outlier payments to which they were not entitled.

45. Beth Israel experienced a particularly pronounced time lag in settled cost reports, and was therefore in a particularly strong position to profit from turbocharging. In fact, from September 2001 through the end of the Damages Period, Beth Israel's last settled cost report, which was used in computing the Beth Israel's CCR, was from 1995. Accordingly, Beth Israel's CCR during the Damages Period remained constant at 1995 levels, allowing Beth Israel to reap especially large outlier payments when that CCR was multiplied by Beth Israel's inflated charges.

V. BETH ISRAEL'S FRAUDULENT SCHEME

A. Beth Israel Began to Dramatically Increase Its Charges in the Late 1990s

46. Beth Israel began increasing its charges in the late 1990s. The outlier payments it requested and received from the Government increased from $5.2 million in 1996 to $8.1 million in 1997. At the same time, Beth Israel's percentage of outlier payments to total Medicare revenue increased from 4.7% to 7.0%.

47. In early 1999, Beth Israel hired the National Revenue Group ("NRG"), a healthcare consulting firm, to recommend strategic charge increases that would lead to even greater outlier payments.

48. On April 16, 1999, Donald Modzelweski, Continuum's former Vice President of Reimbursement and Budget ("VP of Reimbursement"), wrote a memorandum regarding Beth Israel titled "1999 Increase in Room and Board Charges" in which he proposed "to increase room and board charges by $150 per day, for all accommodations with the exception of labor/delivery and nursery." Increases in maternity charges normally would not materially impact outlier payments because most Medicare patients are past the child bearing age, whereas increases in room-and-board charges are especially relevant to outlier payment levels because elderly patients on average tend to experience longer hospital stays. The memorandum noted that "[t]his increase was recommended by our consultants, the National Revenue Group and was included in the 1999 Budget."

49. On May 3, 1999, the VP of Reimbursement wrote another memorandum setting forth Beth Israel's profit maximizations strategy, as analyzed and proposed by NRG. The May 3, 1999 memorandum noted that "the maximization of Medicare outlier revenue" was a "major area[] of opportunity," and that "strategic increases to specific existing charges" would lead to "revenue enhancement." Beth Israel implemented a strategic price increase following this memorandum on December 7, 1999.

50. The following year, NRG was again involved in recommending specific price increases that Beth Israel implemented. As Kathy Dakis, Continuum's Vice President of Patient Financial Services ("VP of Patient Financial Services"), explained in an email dated September 19, 2000, NRG would provide "revisions to CPT codes, Changes to Descriptions, revised

Rev[enue] Codes and recommendations to change various charges (all sites)." The VP of Patient Financial Services also noted that "NRG will be recommending a different charge by levels of service. But believe me, we are going to try to to [sic] keep the charges high even at the lowest levels of service in the E.R." Frank DeGratto, Continuum's Vice President of Patient Accounting ("VP of Patient Accounting"), agreed that "this is a good start. … Go For The Gusto!!!!"

51. Beth Israel concentrated its charge increases most dramatically on non-maternity ward room-and-board charges, which most directly impacted Medicare patients.

52. In fact, on March 9, 2001, the VP of Reimbursement sent an email to various Beth Israel employees regarding the hospital's charge increases in 2000, in which he explained that, "in '00 we implemented a charge increase at BI to enhance Medicare cost outliers and to offset the negative impact of a lower RCC." This strategic price increase, the email explained, had resulted in an increase in outlier payments to Beth Israel's Petrie Division by $3.1 million, and to Beth Israel's Singer Division by $3.4 million.

53. Beth Israel implemented another charge increase recommended by NRG in 2001. On September 3, 2001, the VP of Patient Accounting sent an email requesting information on when the next charge increase proposed by NRG was going to be implemented, and instructed that "what ever [sic] charge increases NRG proposed, let's pu [sic] them in…". When, on September 7, 2001, an employee questioned whether NRG's recommendation to increase all medical supplies by 20% should also include pacemakers and other implants, the VP of Reimbursement responded "absolutely!"

B. Beth Israel's Turbocharging Practices During the Damages Period

54. During the Damages Period, Beth Israel turbocharged to deceive the Government into believing that routine cases were extraordinarily costly and to overstate even its legitimate outlier cases, in order to obtain grossly inflated outlier payments.

55. As Beth Israel's turbocharging continued through the years, Brendan Loughlin, the Executive Vice President and Chief Financial Officer of Continuum ("CFO"), wrote on January 7, 2003, that he "was feeling a bit giddy from the thought [of] getting $10 mil of outlier revenue at BI." Sharon Joy, the Senior Vice President for Financial Planning for Continuum ("SVP for Financial Planning"), who was in charge of, among other things, developing Beth Israel's budget, had become wary of Beth Israel's turbocharging being detected. Accordingly, she responded that "we just need to be a little careful about the level of charge increases and we might want to even be a little selective about what services we increase." Nevertheless, she stated that the projected additional outlier revenue resulting from Beth Israel's turbocharging in 2003 "made my day for sure!!"

56. Following his email exchange with the SVP for Financial Planning, on January 7, 2003, the CFO reached out to Michael Bruno, the Senior Vice President for Financial Operations and Reporting ("SVP for Financial Operations") in charge of, among other things, billing and collection for Beth Israel, to request his views on how to proceed with respect to outlier payments. On January 8, 2003, the SVP of Financial Operations replied "I think we ought to increase our charges. I think we should try to identify the services that are skewed most toward medicare outliers and increase those more. For example we may find that critical care units appear more frequently in medicare outliers than the average case, or they use respiratory therapy more. That way we could get the biggest bang for the buck." This response perfectly

summarizes the strategy – and the goal – that Beth Israel had followed up to that point in connection with turbocharging.

C. Beth Israel's Targeted Charge Increases Bore No Rational Relationship to Increases in Its Actual Costs

57. Data from Beth Israel's Medicare cost reports reveal that at the same time that Beth Israel's *costs* for treating Medicare patients were barely rising, its *charges* were increasing.

58. Accordingly, although Beth Israel's total Medicare inpatient costs increased by only 10% from 1996 to 2003, Beth Israel's Medicare inpatient charges soared by more than 200%. In fact, from 2001 to 2003, Beth Israel continued to increase its Medicare inpatient charges even though its Medicare inpatient costs were actually *decreasing*.

59. In total, from 1996 to 2003, Beth Israel's Medicare inpatient *costs* increased by only $17.4 million, whereas its Medicare inpatient *charges* increased by more than $285 million. In other words, Beth Israel's charges were increasing at a rate of over sixteen times its increases in costs from 1996 through 2003.

60. As a result, during the Damages Period Beth Israel's Medicare inpatient charges, which were a factor in determining outlier payments, were $545.4 million in 2002 and $554.6 million in 2003, while its Medicare inpatient costs were far lower: merely $178.7 million in 2002 and $169.6 million in 2003.

61. Beth Israel's charges during the Damages Period, when adjusted to cost pursuant to the outlier regulations, were not rationally, reasonably, or consistently related to Beth Israel's costs, and Beth Israel was therefore prohibited from using them as the basis for requesting outlier payments.

D. Beth Israel Knew That Its Fraudulent Turbocharging Scheme Resulted in Excessive Outlier Payments

1. Beth Israel Knew that the Government Intended To Make Outlier Payments Only for Extraordinarily High-Cost Cases and that the Government Uses Charges as a Proxy for Costs in Calculating Outlier Payments

62. Beth Israel knew that the purpose of outlier payments was to compensate hospitals for cases that were extraordinarily costly as compared to average cases within the same DRG.

63. Beth Israel also knew that outlier payments were calculated based on the product of a hospital's charges and its cost-to-charge ratios, so that the charges were adjusted to approximate the hospital's costs.

64. Beth Israel also knew that hospitals did not receive outlier payments unless its estimated or "adjusted" costs exceeded a certain dollar threshold above the norm, and that this threshold was set annually each year by the Government.

65. Based on Beth Israel's participation in the Medicare program, Beth Israel was required to familiarize itself with Medicare laws and regulations governing hospital reimbursement. Those laws and regulations provide that outlier payments are intended only for extraordinarily costly cases.

66. The Outlier Statute specifically provides that hospitals may request outlier payments where "charges, adjusted to cost" exceed the cutoff point, and further provides that the amount of the outlier payments shall approximate the "marginal cost of care" beyond the cutoff point. 42 U.S.C. § 1395ww(d)(5)(A)(ii), (iii) (emphasis added).

67. The Outlier Regulations essentially parallel the language of the Outlier Statute in requiring outlier payments to be based on "a hospital's charges for covered services, adjusted to operating and capital costs . . . ." 42 C.F.R. §§ 412.80(a)(2) and (3). Further, as discussed *supra*,

one of the Outlier Regulations, 42 C.F.R. § 412.84, is entitled "Payment for extraordinarily high cost cases (cost outliers)," and provides in various places that outlier payments are to be made only in "cost outlier cases." A related regulation, 42 C.F.R. § 412.2(a), provides, in reference to outlier payments, that "[a]n additional payment is made . . . for cases that are extraordinarily costly to treat," thereby also confirming the purpose of outlier payments.

68. CMS also repeatedly stated in the Federal Register that outlier payments were reserved for extraordinarily costly cases. *See*, e.g., 48 Fed. Reg. 39752, 39776 (Sept. 1, 1983) (outliers are "atypical" cases "that involve extraordinarily high costs"); 53 Fed. Reg. 38476, 38509 (Sept. 30, 1988) ("[o]utliers are defined as exceptionally . . . costly cases" and an outlier payment "by legislation is tied to the cost of the case"); *id.* at 38503 ("we believe the use of hospital-specific cost-to-charge ratios is essential to ensure that outlier payments are made for cases that have extraordinarily high costs, and not merely high charges").

69. In addition, Medicare laws and regulations provide for use of a hospital's charges to determine its costs so long as "this method reasonably reflects the costs." 42 U.S.C. § 1395x(v)(1)(A). The Outlier Regulations' formula is an example of a cost calculation method that uses adjusted charges as a proxy for costs.

70. Section 2202.4 of CMS's Provider Reimbursement Manual, moreover, defines charges as "the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients," and provides that "[c]harges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Section 2203 of the Provider Reimbursement Manual recognizes that the Government cannot – and does not seek to – control a provider's charge structure, but that for

purposes of receiving outlier payments any charges that are not related to costs are not allowable "for use in apportioning costs under the program."

71. In short, the meaning of the Outlier Statute and Regulations is reinforced by other Medicare laws and by the Provider Manual provisions. These various laws and manual provisions establish that, when hospitals seek outlier payments, their charges must be consistently related to costs such that when they are "adjusted to cost" pursuant to the outlier-payment formula set forth in the Outlier Regulations, the result will reasonably approximate the hospital's actual costs.

2. Beth Israel Knew That It Was Receiving an Outlier Payments Windfall

72. Beth Israel was aware throughout the Damages Period that it was receiving an outlier revenue windfall. As noted above, in his March 9, 2001 email to various Beth Israel employees, the VP of Reimbursement explained that Beth Israel's charge increase in 2000 was intended "*to enhance Medicare cost outliers* and to offset the negative impact of a lower RCC." (emphasis added). As also noted above, by January 7, 2003, the SVP for Financial Planning stated that there was a need to be "careful" and "even be a little selective about what services we increase" to avoid triggering a review by CMS or the FI that would have detected Beth Israel's turbocharging.

73. As a result of Beth Israel's charge increases, Beth Israel's annual outlier revenue increased, beginning in 1996, from $5.2 million dollars to more than $34 million annually by the end of 2001. During the Damages Period, Beth Israel received operating outlier payments in the amount of $29.4 million in 2002, and $14.6 million in 2003, a portion of which Beth Israel was not entitled to and received only because it was turbocharging.

74. A hospital such as Beth Israel that engages in turbocharging in an attempt to drive up outlier payments frustrates both the letter and the purpose of the outlier laws in order to obtain a windfall from the Medicare Trust Fund.

75. It is especially egregious for hospitals such as Beth Israel to deliberately turbocharge in order to thwart CMS's ability to (a) limit outlier payments to situations that are truly "extraordinarily high-cost cases," (*see* 42 C.F.R. § 412.84), (b) meaningfully adjust charges to cost as a basis of making outlier payments (*see* 42 U.S.C. § 1395ww(d)(5)(A)(ii)), or (c) limit a hospital's outlier payments to the marginal cost of care above the point where its actual costs, as meaningfully estimated pursuant to the outlier laws, are considered high enough to be eligible for outlier payments (*see* 42 U.S.C. § 1395ww(d)(5)(A)(iii)).

76. As stated above, hospitals are required to familiarize themselves with Medicare laws and regulations governing hospital reimbursement. These include the provision in the Outlier Statute that provides for the outlier threshold to be set to limit total outlier payments nationwide at an amount not "less than 5 percent nor more than 6 percent" of the sum of outlier plus DRG payments. 42 U.S.C. § 1395ww(d)(5)(A)(iv); *see also* 69 Fed. Reg. at 49275. In fact, in calendar year 1996, Beth Israel's operating outlier payment percentage (i.e., operating outlier payments divided by the sum of such payments plus DRG payments) was 5.2% – not far from the national average and within the nationwide target range.

77. Once Beth Israel began to rapidly increase its charges, however, Beth Israel's operating outlier payment percentage grew steadily to 14.8% in 1998, 17.4% in 1999, 20.1% in 2000, and 23.3% in 2001. Beth Israel's outlier percentage remained at this level during the damages period, at 23.7% in 2002, and 18.5% in 2003.

78. Beth Israel's own documents reveal that Beth Israel's requests for additional outlier payments could not possibly be justified based on Beth Israel's costs.

79. As an initial matter, when NRG was hired to conduct a "Medicare Outlier Sensitivity Analysis" and recommended its first set of price increases to maximize outlier revenue in July 1999, NRG did not take into account Beth Israel's costs. Instead, the "relevant information" NRG received from Beth Israel was limited to "DRG, charges, service area, and length of stay." At no time – either for this price increase or during later years – did Beth Israel or NRG review Beth Israel's costs to ensure that charges "adjusted to costs," after each successive charge increase, still bore a reasonable relationship to costs.

80. On March 9, 2001, the VP of Reimbursements explained in an email that the charge increase in 2000 was intended to "to enhance Medicare cost outliers and to offset the negative impact of a lower RCC." He did not mention – or review – how Beth Israel's costs related to this price increase.

81. On December 28, 2001, the CFO, in an email to the VP for Patient Accounting, specifically suggested that Beth Israel's strategy should be simply to "increase the charges more to reduce the negative impact" of an increasing outlier threshold. Beth Israel did not, however, determine whether an increase in charges was justified by an increase in its costs, much less whether a rational relationship existed between its adjusted charges and its costs.

82. Beth Israel continued this practice the following year. On November 22, 2002, the SVP for Financial Operations and Reporting, in an email to both the CFO and the SVP for Financial Planning, agreed that it "makes sense" for Beth Israel to "raise charges to offset the increase in the threshold" through "some strategic price increases." In a later email dated March 7, 2003, he further explained that Beth Israel's last round of price increases was "to maintain

revenue" from "increased outlier payments" due to "Medicare increas[ing] the threshold in October 2002." Beth Israel did not ensure that these charge increases were justified by, or bore any relationship to, increases in costs prior to seeking outlier reimbursements – nor could they have, because Beth Israel's costs in 2002 and 2003 were decreasing.

83. Hospitals that receive high outlier payments would be expected to serve patients with high acuity whose conditions require unusually costly treatment levels. However, published data regarding the Case Mix Indices ("CMI") nationwide indicate that, compared to other large urban hospitals that experienced a similar CMI and, therefore, needed a similar amount of resources for patient care, Beth Israel received a much higher share of outlier payments.

84. In light of the above, Beth Israel either knew, or acted in deliberate ignorance or reckless disregard of the fact that, it was receiving outlier payments in non-extraordinarily costly situations, and that in cases that truly were outliers, it was receiving payments that exceeded the actual marginal cost of care above the statutory cutoff point for outlier eligibility.

3. Beth Israel Manipulated the Medicare Program to Improperly Inflate Its Outlier Payments

85. Beth Israel's own documents reveal that it turbocharged with the goal of increasing outlier payments, and to circumvent CMS's congressionally-mandated effort to limit outlier payments through the use of the threshold.

86. As discussed above, CMS raised the outlier threshold year after year in an effort to reduce its percentage of outlier payments to DRGs plus outlier payments nationwide to the congressionally mandated range of between 5 and 6%. Based on this range, CMS established a target amount of nationwide outlier payments to DRGs plus outlier payments of 5.1%, and set the outlier threshold accordingly. *See* 68. Fed. Reg. 34494-01 at 34496 (June 9, 2003). Despite increasing thresholds, CMS's actual payout rate in 1999 and 2000 was 7.6%, in 2001 it was 7.7%

and in 2002 it was 7.9%. These overages, in total, resulted in CMS paying approximately $9.3 billion more in outlier payments from 1997 through 2002 than intended. *Id.*

87. At the same time as CMS was increasing the outlier threshold to reduce outlier payments and bring them down to the congressionally mandated target rate of between 5 and 6% nationwide, Beth Israel was increasing its charges faster than its increases in costs, and thereby receiving large amounts of outlier payments it was not entitled to.

88. On December 28, 2001, after learning that CMS had increased the outlier threshold to $21,025 for fiscal year 2002, the VP of Patient Accounting forwarded the CFO an email in which the VP of Patient Accounting asked whether "5% increases [would] help us to maintain our current pace of Medicare and Medicaid Cost Outliers in 2002." The CFO countered that Beth Israel should "increase the charges more to reduce the negative impact" of the increasing outlier threshold.

89. Beth Israel's turbocharging for fiscal year 2002 more than accomplished this goal. Despite the increasing outlier threshold, Beth Israel's outlier payments that year were $35.4 million, a portion of which Beth Israel would not have received but for the turbocharging.

90. When CMS announced that it would have to increase the threshold again for 2003, to mitigate higher than anticipated outlier payments the year before, the CFO in an email dated November 22, 2002, announced that Beth Israel again "should raise charges to offset the increase in the threshold" and suggested that "maybe [Beth Israel] can have some strategic price increases." The SVP for Financial Operations and Reporting responded: "makes sense to me."

91. On January 7, 2003, the CFO followed up by directing the SVP for Financial Planning, to determine what charge increases Beth Israel had to implement "to break even" with outlier payments.

92. When Beth Israel's chairs questioned the new charge increases Beth Israel announced in March 2003 and requested information about "how much if any of these raises we expect to see in new cash/increased revenue," the CFO explained that "the expectation is approx. $5.5 million in increased outlier payments which helps us get back to what we lost because Medicare increased the threshold in October 2002, so this strategy was to maintain revenue." The CFO went on to acknowledge that Beth Israel's strategy of increasing charges was not likely to produce the type of results going forward it experienced in the past, and had instead become "a mixed bag now because of the proposed changes in outlier reimbursement which will minimize any benefit from charge increases."

93. As a result of its turbocharging, Beth Israel through August 7, 2003, received improperly high outlier payments.

FIRST CLAIM FOR RELIEF

(False Claims Act – Presenting False or Fraudulent Claims to the United States, 31 U.S.C. § 3729(a)(1) (1986))

94. Plaintiff incorporates the allegations contained in Paragraphs 1 through 93 above.

95. Each UB-92 claim submitted, or caused to be submitted, by Beth Israel to the Medicare program, which resulted in an outlier payment during the Damages Period from February 21, 2002 through August 7, 2003, constitutes a false or fraudulent claim presented to the United States for payment or approval because Beth Israel engaged in a fraudulent scheme that resulted in its receipt of outlier payments it was not entitled to receive under either the Outlier Statute or the Outlier Regulations.

96. Beth Israel presented, or caused to be presented, the false or fraudulent claims, with knowledge that they were false, and/or with deliberate ignorance of their truth or falsity, and/or with reckless disregard for their truth or falsity.

97. The United States has sustained damages as a result of the Beth Israel's false or fraudulent claims in an amount to be determined at trial.

SECOND CLAIM FOR RELIEF

(False Claims Act – Making or Using a False Record or Statement to Get a False or Fraudulent Claim Paid or Approved, 31 U.S.C. § 3729(a)(2) (1986))

98. Plaintiff incorporates the allegations contained in Paragraphs 1 through 97 above.

99. By omitting the inclusion of Condition Code 66, Beth Israel's UB-92 claim forms constituted claims for outlier payments in all cases where Beth Israel's billed charges, adjusted to cost pursuant to the formula set forth in the Outlier Regulations, exceeded the sum of standard Medicare reimbursements plus the outlier threshold (the cutoff point). Beth Israel's billed charges as set forth on its UB-92s, however, were not reasonably, consistently, or otherwise rationally related to Beth Israel's costs when they were adjusted to cost pursuant to the Outlier regulations. In fact, these charges were set so that, when run through the regulatory formula used to determine outlier payments, these charges (a) would *not* be meaningfully adjusted to Beth Israel's costs so as to reasonably reflect Beth Israel's actual costs, (b) would grossly exaggerate those actual costs, and (c) would result in outlier payments that exceeded any reasonable approximation of the marginal cost of care above the cutoff point. Thus, Beth Israel's UB-92s constituted a false record submitted to get a false or fraudulent claim paid or approved.

100. Beth Israel made, used, or caused to be made or used, these false records or statements with knowledge they were false, and/or with deliberate ignorance of their truth or falsity, and/or with reckless disregard for their truth or falsity.

101. The United States has sustained damages as a result of Beth Israel's false records or statements in an amount to be determined at trial.

PRAYER

WHEREFORE, plaintiff United States prays for judgment against Beth Israel as follows:

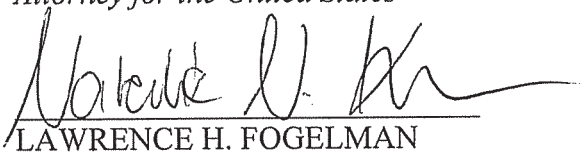
A. On the First Claim for Relief, treble the amount of actual damages sustained by the United States as a result of Beth Israel's false or fraudulent claims, plus such civil penalties as are allowable by law;

B. On the Second Claim for Relief, treble the amount of damages sustained by the United States as a result of the false records or statements made by Beth Israel, plus such civil penalties as are allowable by law; and

C. All other relief this Court deems just and proper.

Dated: New York, New York
February 28, 2012

PREET BHARARA
United States Attorney for the
Southern District of New York
Attorney for the United States

By: 

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