JUDGE BUCHWALD

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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,

Plaintiff,

v.

LENOX HILL HOSPITAL,

Defendant.

COMPLAINT

12 Civ. _____

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 Lenox Hill Hospital ("Lenox Hill") 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 Lenox Hill'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. Lenox Hill knew that Medicare outlier payments were intended and authorized by Congress to compensate hospitals only for treating inpatients whose care involves extraordinarily high costs. Lenox Hill 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, Lenox Hill 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. Lenox Hill 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. Lenox Hill also knew that, by turbocharging, it could deceive the Medicare program into believing that the costs associated with inpatient medical care that Lenox Hill had provided were higher than they actually were, and thereby obtain more outlier payments than it was legally entitled to obtain.

7. Lenox Hill increased its outlier payments from Medicare starting in at least 2002 and continuing through August 7, 2003, for cases that either were not extraordinarily costly or were much less costly than Lenox Hill made them appear to be.

8. When Medicare amended the formula it used to determine outlier payments on August 8, 2003, Lenox Hill's outlier reimbursements plummeted down to an amount even lower than the hospital received in 1996.

9. Under the applicable statute of limitations, the earliest possible date for which the United States can seek a monetary recovery from Lenox Hill is February 21, 2002. When Lenox Hill 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 Lenox Hill 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 Lenox Hill 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 Lenox Hill

14. Lenox Hill is a New York not-for-profit corporation that operates an acute care hospital and is based in New York, New York. Together with various other affiliated hospitals, Lenox Hill is presently a component of North Shore-Long Island Jewish Health System.

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. Lenox Hill 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 reimbursed hospitals, including Lenox Hill, for Part A services through Medicare contractors which during the damages period were 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, Lenox Hill 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 or, in the case of the present, to the FI's successor, 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' ratio of costs to charges ("RCCs"). RCCs 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 ratio of cost to charges, or RCC. The RCC 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 RCC 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 RCC would equal 0.5 ($1 million divided by $2 million).

37. The product of the charges shown on the UB-92 multiplied by the RCC 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 RCC) - (DRG Payment + any IME Payment + any DSH Payment + any adjustment for new medical services or technology + 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 RCC used for the outlier payment calculation was derived from the hospital's most recent final settled cost report, the RCC 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 hospitals in the United States. 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 RCC 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 RCC that had not yet been updated 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. Lenox Hill 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 April 2001 through the end of the Damages Period, Lenox Hill's last settled cost report, which was used in computing the Lenox Hill's RCC, was from 1998. Accordingly, Lenox Hill's RCC during the Damages Period remained constant at 1998 levels, allowing Lenox Hill to reap especially large outlier payments when that RCC was multiplied by Lenox Hill's inflated charges.

V. LENOX HILL'S FRAUDULENT SCHEME

A. Lenox Hill Dramatically Increased Its Outlier Revenue by Manipulating Room and Board Charges Starting in 2001

46. Lenox Hill increased its charges, resulting in steadily and steeply increasing outlier payments from 1996 to 1999. In fact, the outlier payments Lenox Hill requested and received from the Government increased from $6.6 million in 1996 to $23.6 million in 1999. At

the same time, Lenox Hill's percentage of outlier payments to total Medicare revenue increased from 8.5% to 24.2%.

47. After Lenox Hill's outlier payments dropped slightly to $18.9 million in 2000 and continued to decline in 2001, the hospital embarked on a series of steep increases in its room and board rates. In May 2001, Lenox Hill increased its room and board rate by nearly 25%, from $2,933 per day to $3,666 per day. In October of 2001, Lenox Hill again increased its room and board rate by over 20%, to $4,400 per day. In July of 2002, that rate was increased by another 20% to $5,280 per day, and by October 2002 it had been increased to $6,172. Thus, in less than a year and a half, Lenox Hill's room and board rates more than doubled.

48. Lenox Hill's room and board rates in October 2002 were more than double the rate charged by other hospitals in New York City. St. Luke's Roosevelt Hospital Center, Mount Sinai Hospital, NYU Medical Center, the Hospital for Special Surgery and New York Presbyterian Hospital, for example, all charged room and board rates ranging between $2,000 and $3,000 per day during the same period.

49. Lenox Hill's Administrative Director of Financial Planning (the "Director of Financial Planning") knew that, due to the hospital's rate contracts with commercial payors, "virtually no one was paying these charges." Nonetheless, Lenox Hill used the inflated room and board charges as a basis to request Medicare outlier payments.

50. Lenox Hill was aware that Medicare outlier payments, by contrast, were highly sensitive to the hospital's room and board rates. Indeed, Lenox Hill's Executive Vice President and Chief Operating Officer (the "Executive VP and COO") from 1990 to 2009 conceded that "increasing charges can increase outlier payments." He further acknowledged that outlier payments were driven up by length of stay: "of the factors driving the [outlier] payments, one of

the biggest factors is length of stay. Length of stay drives up cost." He also stated that "having the highest length of stay led us to have higher outliers."

51. Medicare patients had a longer length of stay as compared to managed care patients, which resulted in additional outlier payments stemming from increases in room and board charges. The Executive VP and COO further explained that because "managed care companies managed length of stay of their patients … you really don't have the ability to keep [their patients] too long. Medicare on the other hand said, you guys manage it, it's your problem because we're paying you a fixed rate. If the patient stays a couple of extra days, we don't really care. We were bad performers."

52. Lenox Hill increased its room and board charges to generate additional outlier revenue to offset the use of a lower cost to charge ratio stemming from the settling of the 1998 cost report that had reduced Lenox Hill's outlier payments. In an email dated December 13, 2001, Lenox Hill's Director of Financial Planning advised Lenox Hill's Chief Financial Officer (the "CFO") from 1996 to 2005 that the settlement of Lenox Hill's 1998 cost report in April of that year "decimated" the amount of outlier payments the hospital received in the second quarter of 2001. This, he explained, along with the fact that "[Lenox Hill's] charge increase in mid May did not impact Medicare charges until the third quarter," was "why it has been … an uphill battle holding our own with the outlier revenue."

53. Lenox Hill turbocharged and generated additional outlier revenue through increasing its room and board charges in a manner untethered to the costs of the services provided by the hospital. Lenox Hill knew that these charge increases would disproportionately impact Medicare as opposed to other payors who did not actually pay the stated room and board price, and thereby generate additional outlier revenue.

B. Lenox Hill Continued to Selectively and Intentionally Increase Charges That Generated Substantial Outlier Payments in 2002

54. During the Damages Period, Lenox Hill turbocharged to obtain grossly inflated outlier payments by deceiving the Government that routine cases were extraordinarily costly and by overstating the costs of its legitimate outlier cases.

55. With the help of a consulting firm, Lenox Hill implemented rate increases on or around January 15, 2002, July 8, 2002, and October 1, 2002. The vast majority of additional revenue generated by these rate increases came from a single source: Medicare outlier payments.

56. Lenox Hill knew and anticipated that additional Medicare outlier payments would be responsible for 30% of the additional revenue generated by the January 15, 2002 rate increase. Lenox Hill expected the impact of additional Medicare outlier payments to be even larger for the July 8, 2002, and October 1, 2002 price increases: 68% and 69% of the additional revenue generated by these price increases, respectively, were projected to result from Medicare outlier payments. The methodology used for charge increases targeted those services that were most likely to generate additional payments, including Medicare outlier payments, irrespective of cost. The Executive VP and COO admitted that no other single payer was affected as much as Medicare by these charge increases.

57. Lenox Hill's focus on strategically manipulating charges to generate additional Medicare outlier payments is further evident in a June 25, 2002, analysis of the impact of proposed changes to Medicare's outlier regulations, in which the Director of Financial Planning estimated that the proposed increase in the outlier threshold would result in a significant loss of outlier payments, with "a potential impact of at least ($6 million)." He advised that "[t]he Hospital will have to strategically adjust charges to minimize this revenue reduction."

58. Similarly, in an email dated December 20, 2002, the Director of Financial Planning suggested to the Executive VP and COO that "[i]t would be advantageous to raise ancillary charges that are used disproportionately by Medicare outliers so to drive cost to these cases."

59. Moreover, when Lenox Hill had a cost report settled that required the hospital to use a lower cost to charge ratio that would reduce outlier payments, Lenox Hill intentionally attempted to offset this negative impact on outlier payments by increasing charges even further. As the Director of Financial Planning testified, the hospital increased its charges to offset lower RCCs: "Q. Was one of the reasons you thought charges should be increased was to offset the use of a lower cost to charge ratio? A. For me, yes, I guess, of course I knew and thought that."

60. Lenox Hill's rate increases substantially lowered its RCC as compared to other hospitals in New York. However, Lenox Hill benefitted from the time lag in settling cost reports and used the 1998 cost to charge ratio, rather than a contemporaneous cost to charge ratio, in calculating outlier payments stemming from 2002 and 2003. Thus, while Lenox Hill systematically drove down its actual cost to charge ratio by turbocharging, Lenox Hill continued to seek outlier payments based on the higher cost to charge ratio from 1998.

C. Lenox Hill Sought to Counteract CMS's Efforts to Reduce Outlier Payments

61. Lenox Hill's own documents and testimony by its executives and employees 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.

62. CMS raised the outlier threshold year after year in an effort to reduce its percentage of 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 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.*

63. At the same time that 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, Lenox Hill was increasing its charges faster than its costs were increasing, and therefore received large amounts of outlier payments it was not entitled to.

64. Lenox Hill specifically sought to offset the reduction in outlier payments that CMS had sought to achieve by increasing the outlier threshold. For example, in a December 2001 email, the Director of Financial Planning discussed the October 2001 charge increase and its impact on preventing the loss of outlier payments stemming from CMS's threshold increase: "It is certain that the October charge increase will neutralize the impact of the higher [outlier] threshold and then some." As a result, he anticipated that "the 2001 outlier revenue will be $14.4 million." His calculations proved remarkably accurate – following its charge increases, Lenox Hill received $14.6 million in outlier payments in 2001.

65. Accordingly, despite the fact that CMS significantly increased its outlier threshold each year from 2001 to 2003 in order to decrease outlier payments, Lenox Hill's outlier percentage increased substantially during that period from 15% in 2001 to more than 24% during the Damages Period. By contrast, after CMS changed the outliers formula in August 2003 to prevent turbocharging from impacting outlier payments, Lenox Hill's outlier ratio plummeted to 4.4% in 2004. Similarly, Lenox Hill's outlier payments increased from $14.5 million in 2001 to

more than $28 million in 2002 and approximately $18 million in 2003, portions of which Lenox Hill would not have received but for the turbocharging.

D. Lenox Hill's Targeted Charge Increases Bore No Rational Relationship to Increases in Its Actual Costs

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

67. Accordingly, although Lenox Hill's total Medicare inpatient costs increased by only 14% from 1996 to 2003, Lenox Hill's Medicare inpatient charges soared by more than 227%. In fact, from 1999 to 2000 and 2002 to 2003, Lenox Hill continued to increase its Medicare inpatient charges even though its Medicare inpatient costs were actually *decreasing*.

68. In total, from 1996 to 2003, Lenox Hill's Medicare inpatient *costs* increased by only $13 million, whereas its Medicare inpatient *charges* increased by more than $400 million. In other words, Lenox Hill's charges were increasing at a rate of over 30 times its increases in costs from 1996 through 2003.

69. As a result, Lenox Hill's Medicare inpatient charges (one of the factors in calculating outlier payments) were $532.5 million in 2002 and $576.9 million in 2003. By contrast, its Medicare inpatient costs were far lower: merely $109.9 million in 2002 and $107.4 million in 2003.

70. Lenox Hill's charges during the Damages Period, when adjusted to cost pursuant to the outlier regulations, were not rationally, reasonably, or consistently related to Lenox Hill's costs, and Lenox Hill was therefore prohibited from using them as the basis for requesting outlier payments. As Lenox Hill's Executive VP and COO stated, the rate increases developed by the hospital and its outside consultant in 2002 and 2003 bore "absolutely no relationship to our costs."

E. Lenox Hill Knew That Its Fraudulent Turbocharging Scheme Resulted in Excessive Outlier Payments

1. Lenox Hill 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

71. Lenox Hill 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.

72. Lenox Hill 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.

73. Lenox Hill 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.

74. Based on Lenox Hill's participation in the Medicare program, Lenox Hill 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.

75. 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).

76. 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.

77. 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").

78. 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.

79. 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."

80. 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. Lenox Hill Knew That It Was Receiving an Outlier Payments Windfall

81. Lenox Hill was aware throughout the Damages Period that it was receiving an outlier revenue windfall. Indeed, the Director of Financial Planning stated that one of his accomplishments was the "[i]dentification of opportunity to increase outlier revenue – selective charge increases -- $10,000,000." Lenox Hill's Executive VP and COO, moreover, acknowledged that the rate increases in 2002 and 2003 that were developed with the hospital's outside consultant "ha[d] an impact on outliers" and that, in fact, Medicare was affected more than any other single payer by Lenox Hill's charge increases.

82. Lenox Hill's annual outlier revenue increased, beginning in 1996, from $6.6 million dollars to more than $23.6 million annually by the end of 1999. In 2002 and 2003, Lenox Hill received operating outlier payments in the amount of $28.1 million and $17.9 million, respectively, a portion of which Lenox Hill was not entitled to and received only because it was turbocharging.

83. A hospital such as Lenox Hill 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.

84. It is especially egregious for hospitals such as Lenox Hill 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)).

85. 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, Lenox Hill'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.

86. Once Lenox Hill began to rapidly increase its charges, however, Lenox Hill's operating outlier payment percentage grew to 14.7% in 1997, 21.4% in 1998, and 24.2% in 1999, declining to 19.3% in 2000 and 14.9% in 2001. Lenox Hill's outlier percentage surged again during the Damages Period, however, to 24.6% in 2002, and 24% in 2003.

87. Lenox Hill's own documents and testimony by its executives and employees reveal that Lenox Hill's requests for additional outlier payments could not possibly be justified based on Lenox Hill's costs.

88. As Lenox Hill's Executive VP and COO confirmed that, during the Damages Period the hospital had no cost accounting system in place, "so that the specific detail of cost related to a specific unit or a specific service was really not that clear."

89. Lenox Hill's CFO clarified that the hospital "did not track expenses by clinical services," and in fact "didn't have the ability to do that." He explained that "the computer system that we had had limitations on what we could report," and although there were other computer systems available at the time that would have tracked expenses by clinical services, and despite his request "every day" that such a system be purchased, the hospital refused to do so.

90. Lenox Hill's Director of Financial Planning, moreover, confirmed that he never conducted any studies to evaluate how much charges needed to be increased to offset increases in cost. Instead, he "of course" knew and thought that charges should be increased to offset the use of a lower RCC, and was aware that the rate increases developed by Lenox Hill and its outside consultant in 2002 and 2003 "did not have to do with increases in cost."

91. Accordingly, as Lenox Hill's Executive VP and COO stated, the rate increases developed by the hospital and its outside consultant in 2002 and 2003 bore "absolutely no relationship to our costs."

92. These statements make abundantly clear that Lenox Hill did not ensure that its charge increases in 2002 and 2003 were justified by, or bore any relationship to, increases in

costs prior to seeking outlier reimbursements – nor could they have, because Lenox Hill's costs from 2002 to 2003 were decreasing.

93. In light of the above, Lenox Hill 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.

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 Lenox Hill 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 Lenox Hill 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. Lenox Hill 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 Lenox Hill'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, Lenox Hill's UB-92 claim forms constituted claims for outlier payments in all cases where Lenox Hill'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). Lenox Hill's billed charges as set forth on its UB-92s, however, were not reasonably, consistently, or otherwise rationally related to Lenox Hill'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 Lenox Hill's costs so as to reasonably reflect Lenox Hill'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, Lenox Hill's UB-92s constituted a false record submitted to get a false or fraudulent claim paid or approved.

100. Lenox Hill 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 Lenox Hill's false records or statements in an amount to be determined at trial.

PRAYER

WHEREFORE, plaintiff United States prays for judgment against Lenox Hill as follows:

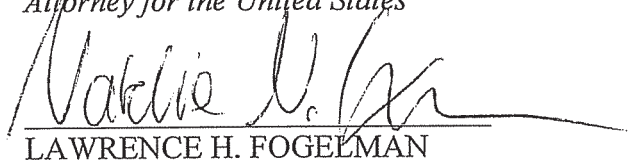
A. On the First Claim for Relief, treble the amount of actual damages sustained by the United States as a result of Lenox Hill's false or fraudulent claims, plus such civil penalties as are allowable by law;

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 Lenox Hill, 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
May 1, 2012

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

By: 

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