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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

-----X
UNITED STATES OF AMERICA ex rel.:
NAJMUDDIN PERVEZ,

Plaintiff,
- against -

:
COMPLAINT-IN-INTERVENTION
: OF THE UNITED STATES OF AMERICA
:
: 01 Civ. 2745 (LAK)

BETH ISRAEL MEDICAL CENTER,

Defendant.

-----X

The United States of America, by and through its attorney, Michael J. Garcia, United States Attorney for the Southern District of New York, having filed a notice of intervention pursuant to 31 U.S.C. § 3730(b)(4), alleges for its complaint-in-intervention as follows:

PRELIMINARY STATEMENT

1. This is a civil action brought by relator Najmuddin Pervez on his own behalf and on behalf of the United States of America ("United States") against Beth Israel Medical Center ("Beth Israel" or "defendant") under the False Claims Act, 31 U.S.C. §§ 3729 et seq. (the "False Claims Act"), to recover

damages sustained by, and penalties owed to, the United States as the result of the defendant having knowingly presented or caused to be presented to the United States false claims for the payment of funds disbursed under Part A of the Medicare Program, 42 U.S.C. §§ 1395c-1395i-4, in excess of the amounts to which Beth Israel was lawfully entitled, from in or about 1992 through 2001, as more specifically detailed infra.

2. The United States brings additional claims against Beth Israel under the False Claims Act and under the common law for fraud, unjust enrichment, and payment under mistake of fact.

JURISDICTION AND VENUE

3. This Court has jurisdiction over the claims brought under the False Claims Act pursuant to 31 U.S.C. § 3730(a), and 28 U.S.C §§ 1331, 1345, over the remaining claims pursuant to 28 U.S.C. § 1345, and over all claims pursuant to the Court's general equitable jurisdiction.

4. Venue lies in this District pursuant to 31 U.S.C. § 3732(a), and 28 U.S.C. §§ 1391(b) and 1391(c), because Beth Israel is located in this District, does business in this District, and because many of the acts complained of herein took place in this District.

PARTIES

5. Plaintiff is the United States of America on behalf of its agency the United States Department of Health and Human Services ("HHS")/Public Service Agency.

6. Relator Najmuddin Pervez is a former employee of Beth Israel who resides in New York City. He was employed by Beth Israel from July 1973 through July 1991, initially as a supervisor of reimbursement and later as a Senior Vice President, Professional Financial Services.

7. Defendant Beth Israel is a New York not-for-profit corporation that operates a teaching hospital and other health care facilities in New York City. Beth Israel provides medical care and related services, including out-patient services at, inter alia, the Phillips Ambulatory Care Center (PACC). During the period at issue, Beth Israel consisted of three in-patient divisions: the Petrie Division, located at 16th Street and First Avenue, the Singer Division, located at 170 East End Avenue, and the Kings Highway Division, located at 3201 Kings Highway, Brooklyn, New York. Beth Israel maintains its principal place of business in New York, New York, and is one of four institutions that comprises Continuum Health Partners, Inc.

FACTS

I. Background

8. The United States, through HHS, administers the Medicare program for the aged and disabled, established by Title XVIII of the Social Security Act. See 42 U.S.C. §§ 1395 et seq. Part A of the Medicare program provides federal payment for patient institutional care, including hospital, skilled nursing facility and home health care. See 42 U.S.C. §§ 1395c-1395i-4. Part B of the Medicare program provides supplemental insurance coverage for medical and other services that are not covered by Part A. 42 U.S.C. §§ 1395j-1395w-4.

9. The Centers for Medicare and Medicaid Services ("CMS") is the governmental body that is responsible for the administration of the Medicare program.

10. Under the Medicare program, CMS makes payments to hospitals for inpatient and outpatient services after the services are rendered. Medicare enters into provider agreements with hospitals that govern the hospital's participation in the program.

11. Under the Medicare program, services provided to patients are reimbursed according to two different methods. For Part A services rendered to inpatients, as a general matter, Medicare reimburses based on diagnostic related group (DRG) under the Prospective Payment System (PPS), with certain exceptions as

discussed, in part, in ¶¶ 22 through 27, infra. For Part B services rendered to out-patients, prior to October 1, 2000, Medicare reimbursed based on cost. Subsequent to that time, Medicare reimburses based on an out-patient PPS.

12. To assist in the administration of Medicare Part A, CMS contracts with private non-governmental organizations or "fiscal intermediaries" to, inter alia, review and process claims for reimbursement submitted by health care providers, including the claims submitted by defendants. 42 U.S.C. § 1395h.

13. At all times relevant hereto, CMS administered the Medicare program in the Southern District of New York through its fiscal intermediary Empire Medicare Services ("Empire").

14. As a prerequisite to payment by Medicare, CMS requires hospitals to submit a Medicare cost report annually at the conclusion of the hospital's fiscal year. The cost report is the final claim that a hospital files with the fiscal intermediary identifying its costs for services rendered to Medicare beneficiaries and stating the amount of reimbursement to which the hospital believes it is due for the year. See 42 U.S.C. § 1395g(a); 42 C.F.R. § 413.20; see also 42 C.F.R. § 405.1081(b)(1).

15. Medicare relies upon the cost report to determine whether the hospital is entitled to more reimbursement than the interim payments that the hospital has received from Medicare

during the course of the year, or whether the hospital was overpaid by Medicare, and, consequently, must reimburse Medicare for the excess amounts paid under the program during the course of the year. See 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

16. Every Medicare cost report contains a "Certification" that must be signed by the chief administrator of the hospital or a responsible designee of the administrator. The Medicare cost report certification page includes the following notice:

Misrepresentation or falsification of any information contained in this Cost Report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

17. The responsible hospital official is required to certify, in pertinent part, that:

to the best of my knowledge and belief, [the cost report and the balance sheet and the statement of revenue and expenses] is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

18. Thus, the hospital must certify that the Medicare cost report is (1) truthful, i.e., that the cost information contained in the report is true and accurate; (2) correct, i.e.,

that the hospital is entitled to reimbursement for the reported costs; (3) complete, i.e., that the cost report is based upon all cost information known to the hospital; and (4) that the services identified in the cost report are billed in compliance with the law.

19. Furthermore, the hospital has the legal obligation to disclose to Medicare through its fiscal intermediary all known errors and omissions in its claims for Medicare reimbursement, including those costs identified in its cost reports:

Whoever ... having knowledge of the occurrence of any event affecting (A) [a hospital's] initial or continued right to any such benefit or payment ... conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized ... shall in the case of such a ... concealment or failure ... be guilty of a felony. . .

42 U.S.C. § 1320a7b(a)(3).

20. At all times relevant hereto, Beth Israel was required to -- and did -- submit its annual Medicare cost reports to the government through Empire.

21. At all times relevant hereto, Beth Israel was required to -- and did -- certify its annual Medicare cost reports.

II. Beth Israel's Fraudulent Conduct

A. Beth Israel Knowingly Made False Statements to Obtain Medicare Reimbursement for Costs Related to Its Physicians' Faculty Practice Plan

22. In their annual Medicare cost reports, hospitals must assign all of their annual direct and indirect costs to cost centers in accordance with the Medicare statute, regulations and CMS program instructions, that dictate whether a particular cost is reimbursable.

23. A hospital must establish a separate cost center for each service or activity that is not reimbursed by Medicare and that should receive a share of the hospital's overhead costs, i.e., a non-reimbursable cost center. A hospital must allocate expenses to these cost centers just as it allocates expenses to a cost center established for services or activity that is reimbursed by Medicare, i.e., a reimbursable cost center.

24. If a hospital assigns a cost that is not reimbursable by Medicare to a reimbursable cost center on its cost report, rather than to a non-reimbursable cost center, the result is that Medicare overpays the hospital unless the hospital's improper reporting (or cost allocation) is identified by the fiscal intermediary and/or corrected by the hospital.

25. Pursuant to Medicare Part A reimbursement rules, hospitals may not recover from Medicare costs expended to support services provided by hospital physicians in their private out-

patient clinical practices. The reimbursement rules provide that when a hospital expends money for its physicians' private practices, those costs must be included in a non-reimbursable cost center on the cost report, i.e., identified as costs that are not reimbursed by Medicare.

26. If a direct cost that is attributable to a hospital's physician's private out-patient practice is improperly included in one of the hospital's reimbursable cost centers, Medicare will be caused to reimburse the hospital for costs for which it is not responsible under the law. For example, if the cost of medical supplies used in a physician's private out-patient practice is improperly included in a reimbursable cost center for medical supplies that are legitimately used by the hospital for its in-patients, rather than in a non-reimbursable cost center, the hospital will receive an inflated reimbursement from Medicare for the cost of those medical supplies.

27. Moreover, under Medicare regulations, a hospital's overhead costs must be allocated among all of the hospital's cost centers, including both its reimbursable and non-reimbursable cost centers. 42 C.F.R. §413.24(d)(1).

28. At all times relevant hereto, Beth Israel had a contractual arrangement with its physicians known as a "faculty practice plan" or "FFP" under which its physicians provided medical care to their private out-patients in Beth Israel's

facilities that are owned, controlled and paid for by Beth Israel, and under which Beth Israel paid the costs of providing those services and performed the billing and fee collection on behalf of the physicians.

29. During the years 1992 through 2001, in direct violation of the Medicare reimbursement rules, Beth Israel knowingly included costs incurred in support of its physicians' private practices under the FFP on its Medicare cost reports in reimbursable costs centers rather than, as required, in non-reimbursable costs centers. The costs for which Beth Israel improperly claimed reimbursement included costs associated with physician and staff salaries, supplies, equipment, administrative overhead, capital expenditures, and costs associated with income guaranteed to physicians participating in the FFP irrespective of the services they provided.

30. In addition, as a result of Beth Israel's fraudulent placement of costs associated with its physicians' private practices in reimbursable cost centers, Beth Israel fraudulently inflated its Medicare reimbursement for indirect or overhead costs that were incurred in support of the activities identified in its reimbursable cost centers.

31. The fact that Beth Israel did not assign the costs associated with its physicians' private practices to non-reimbursable cost centers resulted in the allocation of a greater

percentage of Beth Israel's overhead costs to its reimbursable cost centers than is allowed by the Medicare rules.

32. It was not until in or about 2002, when Beth Israel learned that the Government was investigating the reimbursement that the hospital had received from Medicare for costs associated with its FPP program, that Beth Israel ceased its unlawful practices and established a non-reimbursable cost center for its FPP expenses. Thus, for the first time, in its 2002 Medicare cost report, Beth Israel included non-reimbursable cost centers to capture its FPP costs.

33. The United States, through the Medicare program, paid Beth Israel millions of dollars for these false or fraudulent claims for FPP costs as a result of the acts and conduct of Beth Israel. The United States, through the Medicare program, would not have approved or paid such costs if Medicare had known that such costs had been wrongfully included in reimbursable costs centers on Beth Israel's cost reports.

B. Beth Israel Knowingly Made False Statements to Obtain Inflated Medicare Reimbursement for Other Costs

(i) Fund-raising and Marketing

34. Hospitals are required to establish a separate non-reimbursable cost center for costs associated with fund-raising because Medicare does not pay for such costs.

35. Medicare pays for marketing (or advertising) costs incurred in connection with a hospital's public relations

activities only if the marketing is primarily concerned with presenting a good public image and is related to patient care. Medicare, however, does not pay for marketing costs spent to promote and increase patient use of services that are not properly related to patient care.

36. During the years 1992 through 2001, Beth Israel's cost reports did not include non-reimbursable cost centers for fund-raising or marketing costs, or otherwise make an offsetting adjustment for the costs, even though Beth Israel engaged in these activities. Accordingly, Beth Israel charged all costs associated with these activities to Medicare regardless of whether the costs were in fact reimbursable under the law.

37. As a direct result of Beth Israel's conduct, the share of overhead costs that it assigned to its reimbursable cost centers was fraudulently inflated to include overhead costs associated with unallowable fund-raising and marketing costs, with the result that Beth Israel received a greater reimbursement from both Medicare Part A and Part B than that to which it was lawfully entitled.

38. The United States, through the Medicare program, paid Beth Israel more than a million dollars for these false or fraudulent claims for fund-raising and marketing costs as a result of the acts and conduct of Beth Israel. The United States, through the Medicare program, would not have approved or

paid such fund-raising and marketing costs if Medicare had known that the costs had been wrongfully included in reimbursable cost centers on Beth Israel's cost reports.

(ii) Methadone Maintenance Treatment Program

39. Beth Israel operates an ambulatory Methadone Maintenance Treatment Program ("MMTP"), which uses approximately 23 off-site clinics within the New York City area.

40. During the period 1992 through 2001, Beth Israel understated on its cost reports costs associated with the MMTP for old and new capital building and fixtures, and for maintenance and repairs. Beth Israel reported these costs in non-reimbursable cost centers, but consistently understated the square footage of the individual MMTP clinics from its calculations for each year.

41. By understating or under-reporting these costs, Beth Israel improperly reduced the share of its overhead allocated to non-reimbursable cost centers, and correspondingly increased the share that was allocated to its reimbursable cost centers, thereby obtaining inflated reimbursement from Medicare for its overhead costs.

42. The United States, through the Medicare program, overpaid Beth Israel millions of dollars in overhead costs as a result of Beth Israel's fraudulent treatment of its MMTP costs. The United States, through the Medicare program, would not have

approved or paid such costs if Medicare had known of Beth Israel's wrongful conduct.

(iii) Living Quarters and Parking

43. Through its wholly owned subsidiary, East 17th Street Properties, Inc., Beth Israel provides residential housing for its staff in several buildings, including Gilman Hall and Baird Hall. During the years 1992 through 2001, Beth Israel included the costs associated with the buildings on its cost reports, but it never applied its rental revenues for the buildings to offset or reduce those costs. Therefore, Beth Israel improperly included the costs of a revenue producing activity, i.e., its rentals, on its cost report without reducing those costs by the rents/revenue that it received, nor did it establish a non-reimbursable cost center for such costs.

44. Accordingly, because Beth Israel incurred overhead costs associated with the operation of its residential buildings and included them in its reimbursable cost centers, the share of overhead costs assigned to its reimbursable costs centers was fraudulently inflated, with the result that Beth Israel received a greater reimbursement from Medicare for overhead costs.

45. Beth Israel has parking spaces in several garages near its hospital facility and rents these spaces to employees and visitors. For fiscal year 1992, Beth Israel did not record

an offset sufficient to accurately reflect the revenues that it had received from the rentals of these parking spaces.

46. The United States, through the Medicare program, overpaid Beth Israel millions of dollars in overhead costs as a result of Beth Israel's fraudulent treatment of its residential housing costs, as well as sums related to parking. The United States, through the Medicare program, would not have approved or paid such costs if Medicare had known of Beth Israel's wrongful conduct.

C. Beth Israel Knowingly Made False Statements Concerning Its Kings Highway Division

47. Under the Medicare program, the government reimburses ancillary services, such as radiology and laboratory services, provided to hospital out-patients in clinics, emergencies rooms, or through sub-providers, for example rehabilitation units, based on a ratio of the hospital's total overall costs for the service(s) over the hospital's total charges for the ancillary service(s), i.e., a "cost to charge ratio."

48. In its cost report, a hospital must calculate the ratio of the costs it estimates it will incur for each ancillary service divided by the gross charges, including charges for Medicare and non-Medicare patients, billed by the hospital for that particular service. During the period relevant hereto, see infra, at paragraph 50, these ratios were then multiplied by the

actual Medicare charges for the outpatient ancillary service billed by the hospital to determine the Medicare reimbursable cost for each service.

49. If the ratio of the costs to charges is inflated, such as by overstating a hospital's costs (in the numerator of the fraction) or understating the hospital's gross charges (in the denominator), the result is that Medicare pays an inflated reimbursement for the cost to the hospital.

50. In accord with the Office of Inspector General's Provider Self-Disclosure Protocol, 63 *Federal Register* 58399-402 (Oct. 30, 1998), on May 24, 2002, and in subsequent submissions, Beth Israel made a voluntary disclosure to the United States that, for the years 1995 through 1999, it had obtained inflated reimbursements from Medicare by misrepresenting information in its cost reports related to the operation of its Kings Highway Division. This false information caused Beth Israel's costs to be overstated on the hospital's cost reports.

51. Beth Israel admitted to the United States that it had improperly excluded charges for ancillary services related to its Kings Highway Division in order to obtain an artificially higher ratio of costs to charges. The overstated ratio of costs to charges was applied to the Medicare charges for Kings Highway Division patients, resulting in inflated reimbursement to Beth Israel.

52. In addition, Beth Israel admitted to the United States that, in each of the relevant Medicare cost reports, Beth Israel had reduced the charges for certain diagnostic and related tests performed on an outpatient basis, known as "Referred Ambulatory" charges, without any legitimate basis for the reduction. This improper reduction in charges further inflated the ratio of costs to charges in Beth Israel's cost reports.

53. The United States, through the Medicare program, paid Beth Israel millions of dollars based on Beth Israel's use of an inflated ratio of costs to charges as a result of the acts and conduct of Beth Israel. The United States, through the Medicare program, would not have approved or paid Beth Israel, in part, based on this inflated ratio of costs to charges if Medicare had know that the ratio was fraudulent.

FIRST CLAIM

**Violations of the False Claims Act
(31 U.S.C. § 3729 (a) (1))
Presenting False Claims for Payment**

54. The United States incorporates by reference paragraphs 1 through 53 above as if fully set forth herein.

55. The United States seeks relief against Beth Israel under Section 3729(a) (1) of the False Claims Act, 31 U.S.C. § 3729(a) (1).

56. As set forth above, Beth Israel knowingly or acting with deliberate ignorance or with reckless disregard for

the truth, presented, or caused to be presented, to an officer, employee or agent of the United States, false and fraudulent claims for payment or approval in connection with the submission of its cost reports, and its requests for reimbursement under the Medicare program.

57. The United States paid Beth Israel under the Medicare program because of the fraudulent conduct of defendant.

58. By reason of Beth Israel's false claims, the United States has been damaged in a substantial amount to be determined at trial.

SECOND CLAIM

Violations of the False Claims Act (31 U.S.C. § 3729 (a) (2)) Use of False Statements

59. The United States incorporates by reference paragraphs 1 through 53 above as if fully set forth herein.

60. The United States seeks relief against Beth Israel under Section 3729(a) (2) of the False Claims Act, 31 U.S.C. § 3729(a) (2).

61. As set forth above, Beth Israel knowingly or acting in deliberate ignorance or in reckless disregard for the truth, made, used, and caused to be made and used, false records and statements, in order to get false or fraudulent claims paid or approved by the United States in connection with the

submission of its cost reports, and its requests for reimbursement under the Medicare program.

62. The United States paid such false or fraudulent claims because of the acts and conduct of Beth Israel.

63. By reason of Beth Israel's false claims, the United States has been damaged in a substantial amount to be determined at trial.

THIRD CLAIM

Common Law Fraud

64. The United States incorporates by reference paragraphs 1 through 53 above as if fully set forth herein.

65. Beth Israel made material misrepresentations of fact to the United States with knowledge of, or in reckless disregard of, their truth, in connection with Beth Israel's requests for reimbursement under the Medicare program.

66. Beth Israel intended that the United States would rely upon the accuracy of the false representations referred to above.

67. The United States made substantial payments of money under the Medicare program to Beth Israel in justifiable reliance upon Beth Israel's false representations.

68. Beth Israel's actions caused the United States to be damaged in a substantial amount to be determined at trial.

FOURTH CLAIM

Unjust Enrichment

69. The United States incorporates by reference paragraphs 1 through 53 above as if fully set forth herein.

70. By reason of the payments made by the United States to Beth Israel, based on the claims for payment Beth Israel submitted under the Medicare program, Beth Israel was unjustly enriched. The circumstances of Beth Israel's receipt of these payments are such that, in equity and good conscience, it should not retain these payments, the amount of which is to be determined at trial.

FIFTH CLAIM

Payment Under Mistake of Fact

71. The United States incorporates by reference paragraphs 1 through 53 above as if fully set forth herein.

72. The United States seeks relief against Beth Israel to recover monies paid under mistake of fact.

73. The United States paid Beth Israel based on the cost reports submitted by Beth Israel under the erroneous belief that Beth Israel was entitled to payment of such funds. In making such payments the United States relied upon and assumed the truth of Beth Israel's representation that it had complied with the applicable Medicare rules and regulations and that Beth Israel's claims for Medicare reimbursement were true. This

erroneous belief was material to the United States' decision to pay Beth Israel. In such circumstances, the United States' payment of federal funds to Beth Israel under the Medicare program was by mistake and was not authorized.

74. Because of these payments by mistake, Beth Israel has received monies to which it is not entitled.

75. By reason of foregoing, the United States was damaged in a substantial amount to be determined at trial.

WHEREFORE, plaintiff, the United States, requests that judgment be entered in its favor and against defendant Beth Israel as follows:

- (a) On the First and Second Claims for relief (Violations of the False Claims Act, 31 U.S.C. § 3729(a)(1) and (2)), for treble the United States' damages, in an amount to be determined at trial, plus a \$10,000 penalty for each false claim presented prior to September 29, 1999, and an \$11,000 penalty for each false claim presented after September 29, 1999;
- (b) On the First and Second Claims for Relief, an award of costs pursuant to 31 U.S.C. § 3729(a);
- (c) On the Third Claim for Relief (Common Law Fraud), in an amount to be determined at trial, together with costs and interest;

- (d) On the Fourth Claim for Relief (Unjust Enrichment), in an amount to be determined at trial, together with costs and interest;
- (e) On the Fifth Claim for Relief (Payment Under Mistake of Fact), in an amount to be determined at trial, together with costs and interest; and
- (f) awarding such further relief as is proper.

Dated: New York, New York
November 30, 2005

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Attorney for the United States

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