IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
CIVIL DIVISION

UNITED STATES OF AMERICA *ex rel.* [UNDER SEAL]	)	
Relator,	)	**Civil Action No. 3:17-cv-01280**
v.	)	**TO BE FILED IN CAMERA AND UNDER SEAL**
[UNDER SEAL],	)	
Defendant.	)	

DOCUMENT TO BE KEPT UNDER SEAL

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
CIVIL DIVISION

UNITED STATES OF AMERICA *ex rel.* CAMILO RUIZ, D.O.	)	
	)	**CIVIL ACTION**
Relator,	)	
	)	**CASE NO. 3:17-CV-01280**
v.	)	
	)	**TO BE FILED IN CAMERA AND UNDER SEAL**
HOSPITAL CORPORATION OF AMERICA (HCA); HCA HOLDINGS, INC. D/B/A HCA HEALTHCARE; HCA, INC.; HCA HEALTHCARE CORPORATION; HCA HEALTHCARE, INC.; AVENTURA HOSPITAL AND MEDICAL CENTER; BAYSHORE MEDICAL CENTER; BLAKE MEDICAL CENTER; BRANDON REGIONAL HOSPITAL; CHIPPENHAM HOSPITAL; CLEAR LAKE REGIONAL MEDICAL CENTER; CONROE REGIONAL MEDICAL CENTER; FAWCETT MEMORIAL HOSPITAL; JFK MEDICAL CENTER; KENDALL REGIONAL MEDICAL CENTER; KINGWOOD MEDICAL CENTER; LARGO MEDICAL CENTER; LAWNWOOD REGIONAL MEDICAL CENTER; LOS ROBLES HOSPITAL AND MEDICAL CENTER; MEDICAL CENTER OF TRINITY; MEDICAL CITY FORT WORTH; MEDICAL CITY HOSPITAL; MEDICAL CITY MCKINNEY; MEDICAL CITY PLANO; MEMORIAL HOSPITAL; METHODIST HOSPITAL; MOUNTAIN VIEW HOSPITAL; NORTH FLORIDA REGIONAL MEDICAL CENTER; NORTHSIDE HOSPITAL & TAMPA BAY HEART INSTITUTE; NORTHWEST MEDICAL CENTER; OAK HILL HOSPITAL; OCALA REGIONAL MEDICAL CENTER; ORANGE PARK MEDICAL CENTER; OSCEOLA REGIONAL MEDICAL CENTER; PALMS	)	**DO NOT PUT IN PRESS BOX** **DO NOT ENTER ON PACER**

WEST HOSPITAL; PLANTATION GENERAL HOSPITAL; RAULERSON HOSPITAL; REGIONAL MEDICAL CENTER BAYONET POINT; REGIONAL MEDICAL CENTER OF SAN JOSE; SAINT LUCIE MEDICAL CENTER; SOUTH BAY HOSPITAL; SUNRISE HOSPITAL & MEDICAL CENTER; UNIVERSITY HOSPITAL AND MEDICAL CENTER; WEST FLORIDA HOSPITAL; WEST HOUSTON MEDICAL CENTER; and WESTSIDE REGIONAL MEDICAL CENTER,	)
***Defendants*.**	)

RELATOR'S FIRST AMENDED COMPLAINT UNDER THE FEDERAL FALSE CLAIMS ACT

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Summary of the Action

1. This is an action for treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729–3732.

2. Defendants Hospital Corporation of America, HCA Holdings, Inc. d/b/a HCA Healthcare, HCA, Inc., HCA Healthcare Corporation, and HCA Healthcare, Inc. (collectively referred to as "HCA") own and operate a national for-profit hospital system based in Nashville, Tennessee. HCA currently owns and operates approximately 172 hospitals in the United States and United Kingdom.

3. Over the course of the last seven years, HCA has engaged in a systematic practice of maximizing revenues by inducing hospitalists and other physicians at HCA hospitals to increase inpatient admissions without regard to whether such admissions were medically necessary.

4. HCA has targeted hospitalists because hospitalists or primary care physicians are usually responsible for ultimately deciding whether a patient should be admitted to a hospital. *See* Medicare Benefit Policy Manual 100-02, Ch. 1, Sec. 10. The model for determining inpatient admissions at HCA hospitals revolves around the decision-making of hospitalists or primary care physicians.

5. When a patient presents to the emergency department, three options exist: (a) go home, (b) admit to observation, or (c) direct admit to hospital without observation. These three options lead to major differences in Medicare payments to a hospital. For the time period 2010-2015 at HCA hospitals nationally, inpatient admissions resulted in average increased Medicare payments of $9280 per admission as compared to outpatient status.

6. Outpatient care includes treating a patient in the emergency room[1] and sending her home as well as outpatient observation, in which a patient is treated, assessed, and observed for up to 48 hours to determine whether her condition has improved enough to be discharged or instead requires admission to the hospital as an inpatient. *See* Medicare Benefit Policy Manual 100-2, Ch. 6, Sec. 20.6.

7. When a hospital admits a beneficiary as an inpatient who should have received the same treatment at a lower level of care, Medicare pays a reimbursement amount that is a multiple of the reimbursement amount the hospital would have received had it billed for the services as an outpatient. Hospitals can significantly increase their Medicare reimbursement revenues by admitting a patient who should not have been admitted, but only observed or released.

8. In the last six years, HCA's tactics have led to an enormous escalation in inpatient admissions of Medicare patients. As discussed in detail below, this escalation in inpatient admissions has occurred at many HCA hospitals within the HCA East Florida Division and throughout the United States.

9. This case is about corporate financial interests subverting medical decision-making through a nationwide scheme by HCA to increase inpatient admissions for reimbursement objectives, not medical need.

10. In addition to causing Medicare to pay for unnecessary inpatient stays, these admissions exposed Medicare beneficiaries to the dangers inherent in any hospital stay, including but not limited to hospital-acquired infections.

[1] The terms "emergency department" (ER) and "emergency room" (ER) are used interchangeably in this First Amended Complaint.

11. Observation services are appropriate when a Medicare beneficiary presents to the emergency room ("ER") with symptoms whose treatment or monitoring requires more time to assess than the typical ER visit. Observation is used to help the physician decide whether the patient needs to be admitted or can be discharged.

12. Medicare reimburses for observation services as outpatient services, even if the patient stays in the hospital overnight. As with inpatient admissions, observation services must be reasonable and necessary for treatment of the patient's medical condition in order to be reimbursed by Medicare.

13. For revenue reasons, HCA has implemented aggressive strategies to require hospitalists and other primary care physicians to admit patients as inpatients rather than observe, monitor, and discharge the patients as outpatients.

14. More than 50 million people are enrolled in Medicare. There are approximately 4,700 inpatient hospital facilities enrolled as Medicare providers. In 2012, Medicare paid hospitals approximately $119 billion for inpatient services and $46 billion for outpatient services. *See* MedPAC Report to the Congress: Medicare Payment Policy, March 2015, p. 53, Table.

15. The magnitude of the Medicare Program requires Medicare to trust hospitals and doctors to prioritize the needs of beneficiaries, rather than their own financial self-interests, in making admission decisions.

16. HCA's executive management developed and implemented practices and procedures that violate that trust and instead induced doctors to admit Medicare patients as inpatients.

17. These policies and practices were adopted for HCA's financial gain rather than clinical reasons and included: 1) directing hospitalists to move more patients into inpatient status

instead of observation status; 2) sending regular monitoring reports to physicians with detailed data about their inpatient admissions and observation cases compared to other physicians within the respective HCA Division; 3) creating and fostering competition among hospitalists to reduce observation cases and increase inpatient admissions; 4) reprimanding and threatening termination of hospitalists whose observation case data fell more than 1.0 standard deviation higher than other hospitalists within the respective HCA Division; 5) employing case managers and administrators to pressure hospitalists to move patients into inpatient status and then quickly discharge them; 6) directing, monitoring, and pressuring hospitalists to increase referrals of inpatients to HCA's employed specialists; 7) orchestrating a massive escalation in inpatient admissions of Medicare patients based on common diagnoses; and 8) criticizing and removing hospitalists who did not fall in line with the HCA "strategic agenda" for increased inpatient reimbursements.

18. With respect to these policies and practices, HCA implemented extensive centralized monitoring and enforcement systems to achieve its revenue-driven objectives for inpatient admissions. HCA's national executive management team maintains tight corporate control over the operations of its hospitals through a hierarchy of subordinate executives within HCA's geographic divisions and individual hospitals. HCA hospitals are organized under geographic divisions with HCA executives in positions of management for each division. The hospital executives report to the division executives and the division executives all report to HCA's national executives located at HCA headquarters in Nashville, Tennessee.

19. HCA's scheme has sought: (1) higher reimbursements from inpatient admissions as compared to observation or outpatient treatment, and (2) increased referrals of inpatients to HCA-employed specialists for consultations and follow-up care. As discussed below, HCA's scheme has succeeded at enormous expense to the Medicare Program.

20. As a result of HCA's tactics and the consequent escalation in Medicare inpatient admissions in the last six years, HCA's hospital system has claimed and received massive overpayments from the Medicare Program to which they were not entitled.

21. In making these payments, the Medicare Program was unaware of HCA's scheme and could not have known that HCA was presenting false claims to Federal Healthcare Programs. HCA's scheme and the scope of HCA's scheme were virtually undetectable without the knowledge of HCA' internal tactics and the application of that knowledge in a comprehensive analyses of HCA's claims to the Medicare Program over the last six years.

22. Relator conducted extensive analyses of Florida claims data and national Medicare claims data. The analyses demonstrate the scope of HCA's scheme. The data analyses focused on 8 categories of common diagnoses reported as admitting diagnoses or primary diagnoses over the time period 2010-2016. Both the Florida claims data and national Medicare claims data demonstrate the results of HCA's widespread scheme to increase admission rates of Medicare patients.

23. The data analyses demonstrate HCA's escalating Medicare admission rates associated with the same admitting diagnoses or primary diagnoses over the time period 2010-2016. The data analyses also demonstrate HCA's excessive admission rates contrary to the national average rates at non-HCA hospitals.

Jurisdiction and Venue

24. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1345 because the United States is the Plaintiff. In addition, the Court has subject matter jurisdiction over the FCA cause of action under 28 U.S.C. § 1331.

25. This Court has personal jurisdiction over HCA pursuant to 31 U.S.C. § 3732(a) because HCA has its national headquarters in Nashville, Tennessee.

26. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b)-(c) and 31 U.S.C. § 3732(a) because at least one of the Defendants can be found in, resides in and transacts business in the Middle District of Tennessee.

Parties

27. The qui tam plaintiff ("Relator") is Camilo Ruiz, D.O., a hospitalist physician who has worked at Defendant Aventura Hospital and Medical Center in Aventura, Florida between 2011 and the present.

28. Dr. Ruiz brings this action on behalf of the United States of America, including the United States Department of Health & Human Services ("HHS") and, specifically, its operating division, the Centers for Medicare & Medicaid Services ("CMS"). At all times relevant to this First Amended Complaint, CMS was an operating division of HHS that administered and supervised the Medicare Program.

29. Defendants Hospital Corporation of America, HCA Holdings, Inc. d/b/a HCA Healthcare, HCA, Inc., HCA Healthcare Corporation, and HCA Healthcare, Inc. (collectively referred to as "HCA") own and operate a national for-profit hospital system based in Nashville, Tennessee. HCA currently owns and operates approximately 172 hospitals in the United States and United Kingdom.

30. The individual HCA hospitals listed as Defendants are as follows with their principal place of business and provider identification numbers:

Prov ID	Facility Name	Street Address	City	State	Zipcode
100131	Aventura Hospital and Medical Center	20900 Biscayne Boulevard	Aventura	FL	33180

450097	Bayshore Medical Center	4000 Spencer Highway	Pasadena	TX	77504
100213	Blake Medical Center	2020 59th Street West	Bradenton	FL	34209
100243	Brandon Regional Hospital	119 Oakfield Drive	Brandon	FL	33511
490112	Chippenham Hospital	7101 Jahnke Road	Richmond	VA	23225
450617	Clear Lake Regional Medical Center	500 Medical Center Boulevard	Webster	TX	77598
450222	Conroe Regional Medical Center	504 Medical Center Boulevard	Conroe	TX	77304
100236	Fawcett Memorial Hospital	21298 Olean Boulevard	Port Charlotte	FL	33952
100080	JFK Medical Center	5301 South Congress Avenue	Atlantis	FL	33462
100209	Kendall Regional Medical Center	11750 Southwest 40th Street	Miami	FL	33175
450775	Kingwood Medical Center	22999 U.S. Highway 59 North	Kingwood	TX	77339
100248	Largo Medical Center	201014th Street Southwest	Largo	FL	33770
100246	Lawnwood Regional Medical Center & Heart Institute	1700 South 23rd Street	Fort Pierce	FL	34950
050549	Los Robles Hospital and Medical Center	215 West Janss Road	Thousand Oaks	CA	91360
100191	Medical Center of Trinity	9330 State Road 54	Trinity	FL	34655
450672	Medical City Fort Worth	900 Eighth Avenue	Fort Worth	TX	76104
450647	Medical City Hospital	7777 Forest Lane	Dallas	TX	75230
450403	Medical City McKinney	4500 Medical Center Drive	McKinney	TX	75069
450651	Medical City Plano	3901 West 15th Street	Plano	TX	75075
100179	Memorial Hospital	3625 University Boulevard	Jacksonville	FL	32216
450388	Methodist Hospital	7700 Floyd Curl Drive	San Antonio	TX	78229

290039	MountainView Hospital	3100 North Tenaya Way	Las Vegas	NV	89128
100204	North Florida Regional Medical Center	6500 Newberry Road	Gainesville	FL	32605
100238	Northside Hospital & Tampa Bay Heart Institute	6000 49th Street North	Saint Petersburg	FL	33709
100189	Northwest Medical Center	2801 North State Road 7	Margate	FL	33063
100264	Oak Hill Hospital	11375 Cortez Boulevard	Brooksville	FL	34613
100212	Ocala Regional Medical Center	1431 Southwest First Avenue	Ocala	FL	34471
100226	Orange Park Medical Center	2001 Kingsley Avenue	Orange Park	FL	32073
100110	Osceola Regional Medical Center	700 West Oak Street	Kissimmee	FL	34741
100269	Palms West Hospital	13001 Southern Boulevard	Loxahatchee	FL	33470
100167	Plantation General Hospital	401 Northwest 42nd Avenue	Plantation	FL	33317
100252	Raulerson Hospital	1796 Highway 441 North	Okeechobee	FL	34972
100256	Regional Medical Center Bayonet Point	14000 Fivay Road	Hudson	FL	34667
050125	Regional Medical Center of San Jose	225 North Jackson Avenue	San Jose	CA	95116
100260	Saint Lucie Medical Center	1800 Southeast Tiffany Avenue	Port Saint Lucie	FL	34952
100259	South Bay Hospital	4016 Sun City Center Boulevard	Sun City Center	FL	33573
290003	Sunrise Hospital & Medical Center	3186 South Maryland Parkway	Las Vegas	NV	89109
100224	University Hospital and Medical Center	7201 North University Drive	Tamarac	FL	33321
100231	West Florida Hospital	8383 North Davis Highway	Pensacola	FL	32514
450644	West Houston Medical Center	12141 Richmond Avenue	Houston	TX	77082
100228	Westside Regional Medical Center	8201 West Broward Boulevard	Plantation	FL	33324

The Medicare Program

31. Enacted in 1965, Title XVIII of the Social Security Act, 42 U.S.C. § 1395, et seq., establishes the Health Insurance for the Aged and Disabled Program, commonly known as the Medicare Program or, simply Medicare.

32. Medicare is comprised of four parts: Part A which provides Hospital Insurance Benefits, Part B which provides Medical Insurance Benefits, Part C which establishes Medicare Advantage (or managed care) plans, and Part D which provides for Prescription Drug Benefits. Relevant to this First Amended Complaint are Parts A and B.

33. Medicare Part A is a 100 percent federally-funded health insurance program for qualified individuals aged 65 and older, younger people with qualifying disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant). *See* 42 U.S.C. §§ 426, 426A.

34. The majority of Medicare Part A's costs are paid by United States citizens through their payroll taxes. The benefits covered by Medicare Part A include inpatient hospital care and other institutional care, including skilled nursing facility and home health care services. *See* 42 U.S.C. §§ 1395c –1395i-5.

35. Medicare Part B establishes a voluntary supplemental insurance program that pays for various medical and other health services and supplies, including physician services, physical, occupational, and speech therapy services and hospital outpatient services. See 42 U.S.C. §§ 1395k, 1395m, 1395x.

36. Most hospitals, including HCA's national hospital system, derive a substantial portion of their revenue from the Medicare Program.

37. Medicare is administered by the Centers for Medicare & Medicaid Services (CMS). At all times relevant to this First Amended Complaint, CMS contracted with private contractors referred to as "fiscal intermediaries," "carriers," and "Medicare Administrative Contractors," to act as agents in reviewing and paying claims submitted by healthcare providers. Payments are made with federal funds. *See* 42 U.S.C. § 1395h; 42 C.F.R. §§ 421.3, 421.100.

38. To participate in the Medicare Program, health care providers enter into provider agreements with the Secretary of HHS. 42 U.S.C. § 1395cc. The provider agreement requires the provider to agree to conform to all applicable statutory and regulatory requirements for reimbursement from Medicare, including the provisions of Section 1862 of the Social Security Act and Title 42 of the Code of Federal Regulations.

39. As part of that agreement, the provider must sign the following certification:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to [me]. The Medicare laws, regulations, and program instructions are available through the [Medicare] contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the [provider's] compliance with all applicable conditions of participation in Medicare.

Form CMS-855A; Form CMS-8551.

40. Among the legal obligations of participating providers is the requirement not to make false statements or misrepresentations of material facts concerning payment requests. *See* 42 U.S.C. § 1320a-7b(a)(1)-(2); 42 C.F.R. §§ 1320a-7b(a)(1)-(2), 413.24(f)(4)(iv).

The Medicare Program's Requirements for Inpatient Status

41. Medicare reimburses only services that are "reasonable and necessary for the diagnosis or treatment of illness or injury . . . ." *See* 42 U.S.C. § 1395y(a)(1)(A). In submitting claims for payment to Medicare, providers must certify that the information on the claim form

presents an accurate description of the services rendered and that the services were reasonably and medically necessary for the patient.

42. Federal law provides that it is the obligation of the provider of health care services to ensure that services provided to Medicare beneficiaries are "provided economically and only when, and to the extent, medically necessary[,]" and are "[s]upported by evidence of medical necessity." 42 U.S.C. § 1320c-5(a)(1), (3).

43. "[T]he medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary." Medicare Program Integrity Manual, Ch. 6, Section 6.5.2.

44. Medicare defines an inpatient as a person who has been formally admitted to a hospital by a physician for the purpose of receiving inpatient services. *See* CMS Publication 100-02, Medicare Benefit Policy Manual, Ch. 1, § 10 (Rev. 189).

45. The decision to admit a beneficiary as an inpatient is made by the treating physician, who must consider several clinical factors including the beneficiary's medical history, the severity of the beneficiary's symptoms, and the expected care. *See* CMS, *Medicare Benefit Policy Manual* (MBPM), Pub. No. 100-02, Ch. 1, § 10.

46. The Medicare Program Integrity Manual states that "inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting." *See* Medicare Program Integrity Manual, Ch. 6, Section 6.5.2.

47. Medicare requires that hospitals implement a utilization review plan to ensure that all inpatient admissions are medically necessary. See 42 C.F.R. § 482.30

48. The Inpatient Prospective Payment System ("IPPS") reimburses hospitals for acute care inpatient services. This is a system developed for Medicare to classify inpatient hospital cases into one of 538 Diagnostic Related Groups ("DRGs"), which were expected to have similar hospital resource use.

49. Since 1983 DRGs have been used to determine how much Medicare pays the hospital. Patients within each category are similar clinically and are expected to consume a similar level of hospital resources. A payment rate is established for each DRG.

50. Each stay is classified into a Medicare severity diagnosis related group (MS-DRG). These groups are based on the beneficiary's primary and secondary diagnoses and the procedures the hospital performed, as well as other factors. Each MS-DRG generally falls into one of three severity levels, depending on the beneficiary's secondary diagnoses. For example, a beneficiary with no secondary diagnoses that increase the complexity of care would be in a low-severity MS-DRG, a beneficiary with asthma would be in a medium-severity MS-DRG, and a beneficiary with pneumonia would be in a high-severity MS-DRG. Medicare pays hospitals a different payment rate for each MS-DRG.[2] Payment rates are adjusted by a variety of facility-level factors, such as a geographic factor to account for differences in labor costs.

51. Hospital outpatient services, including care rendered in a hospital ED or when a beneficiary receives "observation" services, are reimbursed under the hospital Outpatient Prospective Payment System (OPPS) by Medicare Part B. All outpatient services are classified into groups called Ambulatory Payment Classifications (APCs).

52. When a hospital bills Medicare for outpatient visits, the claim typically includes many services. Under the OPPS, each service has an associated Medicare payment rate. For most

[2] DRGs and MS-DRGs will be collectively referred to as DRGs for clarity.

services, Medicare pays 80 percent of this rate, while the beneficiary is responsible for the remaining 20 percent. *See* Social Security Act, § 1833(t); 42 CFR § 419.40(b); CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 4, § 30.

53. Services in each APC are similar in clinical conditions and resources required for treatment. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per patient encounter.

54. Medicare classifies observation services as a type of hospital outpatient care. Observation services help the physician determine the cause of a patient's symptoms to decide if the patient needs to be admitted as an inpatient or may be discharged.

55. Typically observation services are ordered for patients who present to the emergency department and who require a significant period of treatment or monitoring to inform a decision by physicians concerning their admission or discharge. Observation services include short-term treatment, assessment, and reassessment provided while a decision is being made about discharge or admission.

56. A patient may receive observation services in an emergency department, a dedicated observation unit, or in any bed in the hospital. A patient receiving observation services receives all nursing, medical care, diagnostic tests (e.g., laboratory tests, x-rays and other radiological tests), therapy, and prescriptions ordered by her physician, as well as a bed and food for the duration of her stay.

57. Medicare expects that a decision whether to discharge a patient receiving observation services or admit her as an inpatient will occur in less than 48 hours, and usually in less than 24 hours. *See* CMS Publication 100-02, Medicare Benefit Policy Manual, Ch. 6, § 20.6 (Rev. 189).

58. At all times relevant to this First Amended Complaint, observation services were billed as a time-based service, with the minimum period of observation that was reimbursable being eight hours.

59. Since 2008, hospitals may bill a composite APC for extended assessment and management of any patient who receives observation services for eight or more hours who had an ED visit the day that observation services began or the previous day. *See* CMS Publication 100-04, Medicare Claims Processing Manual, Ch. 4 § 290.5.1 (Rev. 787).

60. Medicare reimburses hospitals for surgical procedures on either an inpatient or an outpatient basis, depending on whether the patient has been formally admitted as an inpatient (and subject to medical necessity review). Medicare designates certain procedures as payable only when performed on an inpatient basis. Medicare's rationale for designating certain procedures as "inpatient only" is that either the nature of the procedure, the typical underlying physical condition of patients who require the procedure, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged dictates that Medicare payment is appropriate only if the service is furnished on an inpatient basis. *See* CMS Publication 100-04, Medicare Claims Processing Manual, Ch. 4 §180.7 (Rev. 787).

61. These procedures are called "inpatient only" procedures. CMS publishes a list of "inpatient only" procedures annually. All other Medicare-covered procedures may be provided---and paid by Medicare---on either an inpatient or an outpatient basis, depending upon the individual patient's clinical condition and reaction to the surgery, including any complications that occur. An individualized assessment of the patient's condition must be made instead of routinely admitting all patients who have a certain procedure not listed on the inpatient only list.

62. Medicare guidance directs hospitals to not bill for routine observation following all outpatient surgery, as a period of postoperative monitoring during a standard recovery period (e.g., 4-6 hours) is included in Medicare reimbursement for outpatient surgery. *See* CMS Publication 100-04, Medicare Claims Processing Manual, Ch. 4 §290.2.2 (Rev. 787).

63. The Medicare Program Integrity Manual instructs FIs and MACs that in order for a claim for inpatient care to be payable: Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis. *See* CMS Publication 100-08, Medicare Program Integrity Manual, Ch. 6 § 6.5.2 (Rev. 656).

64. Following the discharge of a Medicare beneficiary from a hospital, the hospital submits a patient-specific claim for interim reimbursement for items and services furnished to the beneficiary during his or her hospital stay. 42 C.F.R. §§413.1, 413.60, 413.64. Hospitals submit claims on Form CMS-1450, also called Form UB-04. Claims for inpatient services are submitted to Medicare Part A. Claims for observation and other outpatient services, including ED visits and outpatient surgery, are submitted to Medicare Part B.

The 2-Midnight Policy and HCA's Exploitation of Vulnerabilities in CMS's Enforcement Capabilities

65. Until Fiscal Year 2014, Medicare guidance advised physicians to "use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis." *See* CMS Publication 100-02, Medicare Benefit Policy Manual, Ch. 1, § 10 (Rev. 189).

66. In fiscal year (FY) 2014, CMS implemented "the 2-midnight policy" to further address the appropriateness of inpatient hospital admissions. *See* 78 Fed. Reg. 50506 (Aug. 19, 2013). The policy established that inpatient payment is generally appropriate if physicians expect beneficiaries' care to last at least 2 midnights; otherwise, outpatient payment would generally be appropriate.

67. CMS implemented the 2-midnight policy to address vulnerabilities in hospitals' billing of short inpatient stays and long outpatient stays and the associated cost to Medicare and beneficiaries. Before the policy was implemented, CMS found that a significant portion of payments for short inpatient stays—i.e., stays lasting less than 2 midnights—were improper because the services should have been billed as outpatient services. CMS, Comprehensive Error Rate Testing, *Medicare Fee-for-Service 2014 Improper Payment Report*, July 2015.

68. Before the 2-midnight policy was implemented, OIG found that Medicare paid hospitals more for short inpatient stays than for outpatient stays, on average, and that some hospitals were far more likely to use short inpatient stays rather than outpatient stays. OIG, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, OEI-02-12-00040, July 2013. OIG "concluded that hospitals have a financial incentive to use short inpatient stays." *See* OIG, "Vulnerabilities Remain Under Medicare 2-Midnight Hospital Policy" (OEI-02-15-00020) (December 19, 2016).

69. The 2-Midnight Policy established that inpatient stays lasting at least 2 midnights from the date of inpatient admission will be presumed appropriate for payment. Those lasting less than 2 midnights may be reviewed by CMS for compliance with the policy. CMS identified several circumstances under which a stay—though short—would nevertheless be appropriate and consistent with the policy.

70. These circumstances include stays with: inpatient-only procedures; mechanical ventilation initiated during the visit; an unforeseen circumstance, such as the beneficiary's death, transfer to another hospital, or leaving against medical advice; or 2 midnights or longer in the hospital when outpatient time prior to admission is added to inpatient time. See 80 Fed. Reg. 70540–70541 (July 8, 2015) and CMS, *Frequently Asked Questions: 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013*.

71. Since the 2-Midnight policy was implemented, CMS has engaged in limited reviews of short inpatient stays. CMS's Medicare Administrative Contractors reviewed medical records for small samples of short inpatient stays. If the results of the sample indicated poor compliance with the policy, the contractors educated the hospital and conducted further reviews.

72. On December 19, 2016, the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) issued a report, "Vulnerabilities Remain Under Medicare 2-Midnight Hospital Policy" (OEI-02-15-00020).

73. The report's findings were based on an examination of paid Medicare Part A and Part B hospital claims (without undertaking a review of the underlying medical records) from federal fiscal years 2013 and 2014. For purposes of the report, HHS-OIG defined a "short stay" as one that lasted less than two midnights. A "long stay" was defined as a stay of two midnights or more.

74. The 2016 OIG report "found that the number of inpatient stays decreased and the number of outpatient stays increased since the implementation of the 2-midnight policy." "Despite these changes, vulnerabilities still exist." *Id.*

75. "Hospitals are billing for many short inpatient stays that are potentially inappropriate under the 2-midnight policy, and some of these stays are for similar reasons as short

outpatient stays. This raises concerns that Medicare is paying differently for similar care and may reflect hospitals' financial incentives to use inpatient stays." *Id.*

76. "CMS needs to address these vulnerabilities by improving oversight of hospital billing under the 2-midnight policy and increasing protections for beneficiaries." *Id.*

77. OIG and CMS have been generally aware of the potential for fraud and abuse with hospitals moving patients into inpatient status for reasons of higher reimbursement, but OIG and CMS were not aware of HCA's illegal scheme revealed in this case. HCA's scheme and the scope of that scheme were virtually undetectable without the insider knowledge, investigation, and analyses presented in this action.

Defendants' Tactics to Increase Inpatient Admissions Without Regard to Medical Necessity

Introduction to Dr. Ruiz's Work at Aventura Hospital

78. Dr. Ruiz originally interviewed for an employed hospitalist position with Aventura Hospital and Medical Center on June 7th, 2011. His interview was with Dr. Andres Soto and with the former Aventura Chief Executive Officer, Heather Rohan, who has since been promoted to HCA's TriStar Division. During this interview Soto and Rohan stated that they were developing the hospitalist model within their facility to "support" or generate referrals to their employed physician specialists.

79. Dr. Ruiz's employment contract was finalized in October of 2011. In January of 2012 Dr. Ruiz learned that Aventura planned to switch all of its employed hospitalists to EmCare.

80. On about January 3, 2012 all hospitalists including the Medical Director, Andres Soto, received a 90-day termination notice. Mary Germann, Director of HCA Physician Services, delivered the termination notice at a face-to-face meeting with the hospitalists. She stated that HCA and EmCare were embarking on a "hybrid" venture for their hospitalist model.

81. Two representatives from EmCare, Clayton Swalstad and Steve Bartow, also attended this meeting and spoke with the hospitalists. Bartow's explanation for the change was that the hospitalists would now be paid on a "eat what you kill model."

82. As Dr. Ruiz made the transition to EmCare, he witnessed HCA administrators' focus on the hospitalists' referral patterns to HCA employed specialists. Dr. Ruiz also became aware of Aventura administrators pressuring and inducing the hospitalists to order "soft" inpatient admissions without legitimate medical necessity. Inpatient admissions led to higher reimbursements for the hospital system and more referrals to HCA employed specialists.

83. Dr. Andres Soto attempted to guide the hospitalist group during the EmCare transition but he did not carry out the HCA/EmCare mandates that he was given and he was terminated on August 24, 2012. The interim director was Dr. Mylissa Graber, an emergency room physician employed by EmCare.

84. In November of 2012, Dr. Hamid Feiz[3] was hired to manage the EmCare hospitalist group and develop graduate medical education programs within Aventura Hospital. Under his management, EmCare terminated physicians who did not comply with the referral patterns demanded by Aventura administrators.

85. In June of 2013, Dr. Ruiz was terminated without cause (despite his contract stating that just cause was required) because Aventura administrators required higher numbers of referrals to HCA-employed specialists.

86. Dr. Ruiz left Aventura Hospital in August of 2013 to work at another facility. He returned to work at Aventura Hospital in October of 2014 after being offered an independent contractor agreement by Preferred Care Partners and Medica Health. At that time, Dr. Ruiz

[3] HCA subsequently promoted Dr. Feiz to Chief Medical Officer at JFK Medical Center.

contacted a former colleague from his HCA/EmCare days, Dr. Darilo Chirino, who had since left and gone to work at another hospital system. Dr. Ruiz and Dr. Chirino both signed direct hospitalist contracts with Preferred Care Partners. Since October of 2014, Dr. Ruiz has worked as a hospitalist at Aventura under his independent contractor agreement with Preferred Care Partners.

HCA Issued Regular Monitoring Reports to Hospitalists

87. Throughout the time periods that Dr. Ruiz worked at Aventura since 2011, Dr. Ruiz received monthly "report cards" or monitoring reports from Aventura's administration.

88. These monitoring reports were routinely circulated to hospitalists, executives and staff at Aventura, and HCA executives managing the HCA East Florida Division.

89. The monitoring reports tracked each physician's percentages of inpatient admissions to the hospital, average length of stay for inpatient cases, above average costs for inpatient cases, average total costs for inpatient cases, variable costs, above average direct costs for inpatient cases, top ten consulting physicians used with the numbers of referrals to each consulting physician, procedure counts, case mix index, clinical severity level, DRG, observation case count, average observation charges, observation length of stay, observation cases over 24 hours, observation above average charges, and observation primary diagnoses.

90. These multiple categories tracked by HCA administrators generally concerned hospital reimbursement, not quality of patient care.

91. The monitoring reports tracked numerous data points for each physician on a monthly basis and annual basis.

92. For example, for the time period March 2014 to February 2015, the HCA monitoring reports listed Dr. Ruiz's total inpatient admissions as 444 and total outpatient cases as 220.

93. The HCA monitoring reports also listed the "Top Ten Consulting Physicians Used" and the "Top Ten Consulting Specialties Used" by Dr. Ruiz and the case counts for each physician and specialty consulted.

94. The HCA monitoring reports listed the numbers and types of procedures Dr. Ruiz performed or ordered both for inpatients and outpatients.

95. The monitoring reports also listed the cases per payer type for each physician.

96. The most detailed data in the HCA monitoring reports concerned observation cases. Observation cases indicate a physician's decision not to admit a patient. As previously noted, observation cases generate less revenue for hospitals than inpatient admissions. As will be shown, the HCA data targeted physicians' decisions to observe rather than admit – decisions that HCA penalized in their physician retention practices.

97. The monitoring reports listed the following data for each physician: the observation case counts, the average observation charges, observation length of stay in hours, above average observation length of stay in hours, observation cases over 24 hours, above average observation charges, and top 10 observation primary diagnoses.[4]

98. With respect to these data points, the monitoring reports compared Dr. Ruiz's numbers with the overall average numbers for all other hospitalists within the HCA East Florida Division. For each category, the monitoring reports provided a scale grading the hospitalist's level of performance as a numerical standard deviation. If a hospitalist was above 1 standard deviation from other hospitalists in the HCA East Florida Division, then the scale presented a red warning

[4] One of the data points in the HCA monitoring reports for every hospitalist within HCA East Florida hospitals was the "Top 10 Observation Primary Diagnoses." HCA East Florida hospital administrators monitored the leading diagnosis codes for observation cases and directed hospitalists to use these codes to support inpatient admissions instead of observation status.

message. If a hospitalist was above .5 standard deviations from other hospitalists in the HCA East Florida Division, then the scale presented a yellow warning message.

99. For the time period March 2014 to February 2015, the HCA monitoring reports listed Dr. Ruiz's observation case count as 74. The average observation charges were $37,565---1.72 standard deviations over the average observation charges for all hospitalists within the HCA East Florida Division. Consequently, that data point contained a red warning graph on Dr. Ruiz's report.

100. Among Dr. Ruiz's observation cases, 72.86% had above average length of stays as compared to all hospitalists within the HCA East Florida Division. Dr. Ruiz's above average observation length of stay cases placed him 7.55 standard deviations above the average for HCA East Florida hospitalists. Dr. Ruiz's report contained another red warning graph for this data point.

101. Another data point evaluated the number of Dr. Ruiz's observation cases over 24 hours. According to the monitoring report, 52 of 70 cases met this criterion. Such cases were 4.03 standard deviations over the average for all other HCA East Florida hospitalists. Consequently, Dr. Ruiz's monitoring report contained another red warning graph for this data point.

102. With respect to above average observation charges, Dr. Ruiz was 3.16 standard deviations above the average for HCA East Florida hospitalists. He received another red warning message with respect to this data point.

The Monitoring Reports Functioned as Quotas for Hospitalists

103. These report cards communicated the constant message to hospitalists that HCA administrators were scrutinizing the numbers of their inpatient admissions, their numbers of referrals to HCA employed specialists, their numbers of observation cases, the length of such

observations cases, the charges for such observation cases, and the diagnoses associated with such observation cases.

104. The report cards' benchmarks functioned as quotas in each category with the hospitalists competing against each other and being compared against each other every month with warning messages about any deviation above .5 standard deviations from all other hospitalists within the HCA East Florida Division. Hospitalists with any numbers beyond 1 standard deviation would receive reprimands from Aventura's administration and threats of termination.

105. HCA's monitoring reports resulted in decreased observation cases and a corresponding increase in the more-profitable admissions. The observation case data for the Aventura Hospitalists Group evidence this fact.

106. As a group, the Aventura hospitalists' observation charges, observation length of stay, above average observation length of stay, observation over 24 hours, and above average observation charges all fell below the averages for HCA East Florida hospitalists.

107. During the time period of March 2014 to February 2015, Aventura hospitalists' overall average observation charges fell to 1.59 standard deviations below the average for all hospitalists in HCA East Florida. The Aventura hospitalists' above average observation length of stay fell to .42 standard deviations below the average for all hospitalists in the HCA East Florida Division. The Aventura hospitalists' observation cases over 24 hours stay fell to .61 standard deviations below the average for all hospitalists in the HCA East Florida Division. And the Aventura hospitalists' above average observation charges fell to .67 standard deviations below the average for all hospitalists in the HCA East Florida division.

108. This same trend continued in the following year with observation data points falling even further. From March 2015 to February 2016, the Aventura hospitalists' observation

charges, observation length of stay, above average observation length of stay, observation over 24 hours, and above average observation charges fell further below the averages for HCA East Florida hospitalists. The Aventura hospitalists' average observation length of stay fell to 1.59 standard deviations below the average for all hospitalists in HCA East Florida. The Aventura hospitalists' above average observation length of stay fell to .78 standard deviations below the average for all hospitalists in the HCA East Florida Division. The Aventura hospitalists' observation cases over 24 hours stay fell to .87 standard deviations below the average for all hospitalists in the HCA East Florida Division. And the Aventura hospitalists' above average observation charges fell to .85 standard deviations below the average for all hospitalists in the HCA East Florida Division.

109. As Aventura hospitalists felt HCA's intense scrutiny of observation cases, inpatient admissions dramatically increased as discussed below. The continuous aggressive scrutiny and discouragement of a physician's decisions to recommend observation over admission at Aventura was part of HCA's strategy to induce physicians not to order observation status and instead order inpatient admission to the hospital.

HCA Administrators Directed Hospitalists to Increase Inpatient Admissions and Decrease Observation Cases

110. Prior to Dr. Ruiz, the previous physician who had the Preferred Care and Medica Health HMO contracts placed most Medicare patients in inpatient status. This was financially beneficial for the hospital but the Aventura administrators noticed that once Dr. Chirino and Dr. Ruiz began working that the observation cases increased and the inpatient admissions decreased.

111. With their extensive program to monitor inpatient admissions and observation cases, HCA administrators at Aventura were not pleased with the reduction in inpatient admissions and consequent reductions in hospital revenues. Consequently, they scheduled multiple meetings

with Dr. Ruiz and other hospitalists and directed these physicians to increase their inpatient admissions and move more observation cases to inpatient status.

112. In April of 2015, Aventura's former Chief Medical Officer, Dr. Sebastian Strom,[5] created a separate monitoring profile that specifically tracked inpatient and observation case data for Dr. Ruiz and Preferred Care Partners. This custom profile was in addition to the numerous systematic profiles used by HCA East Florida administrators to track inpatient admission and observation data for all physicians at all hospitals within that Division.

113. On April 13, 2015, Theresa Caruso, the Executive Assistant to Dianne Goldenberg, Aventura's Chief Executive Officer, sent an email to Dr. Ruiz and other hospitalists stating that Goldenberg wanted to have a meeting regarding "observation management." These meetings were scheduled on a quarterly basis.

114. The following individuals were invited to these meetings:

Dr. Darilo Chirino and Dr. Camilo Ruiz (Preferred Care Partners)
Dr. Hamid Feiz (AHMC Hospitalist & GME Programs)
Dr. Venkat Kalidindi (EmCare)
Dr. Brigido Legaspi and/or Dr. Christine Rice (IPC)
Dr. Francisco Molina (FLACS / Team Health)
Dr. Manuel Anton (Chief Medical Officer of the HCA East Florida Division)
Dianne Goldenberg (Aventura's Chief Executive Officer)
Dr. Sebastian Strom (Aventura's Chief Medical Officer)
Alias Bert (Aventura's Chief Financial Officer)

115. Dr. Manuel Anton was the Chief Medical Officer of the HCA East Florida Division from approximately 2011-2018. The East Florida Division is composed of 14 HCA hospitals discussed further below.

[5] HCA subsequently promoted Dr. Strom to Division Chief Medical Officer of the HCA South Atlantic Division.

116. At these meetings, Goldenberg and Bert provided Dr. Ruiz and other physicians with reports tracking the numbers of their observation and inpatient cases, explained how they would penalize physicians for observation cases, and directed the physicians to move more cases from observation status to inpatient status and increase the numbers of inpatient admissions. During the meeting Goldenberg stated that there would be a "day of reckoning" for the physicians who did not follow HCA's directives.

117. On September 17, 2015, Dr. Strom, Dianne Goldenberg, and Elisa Bert met with Dr. Ruiz and again directed him to move more patients into inpatient status. At this meeting, Dr. Strom stated to Dr. Ruiz, "Physicians that do not change patients into inpatient status as expected will be taken to a peer review process with letters placed in their physician quality files."

118. On December 17, 2015, Dr. Strom and Elisa Bert met with Dr. Ruiz to discuss again HCA's directive to move more patients into inpatient status. Dr. Strom met with Dr. Ruiz again on December 22, 2015 concerning his management of observation cases. During this private meeting, Dr. Strom complained about the fact that he was facing higher rates of denials of inpatient claims from Medicare HMO payers (Preferred and Medica) and that he required increased documentation to legitimize inpatient rates and expedite the appeals process. Also, he directed Dr. Chirino and Dr. Ruiz to participate in phone conferences with him and the insurance medical directors to provide further evidence supporting inpatient admissions.

119. On March 24, 2016, Dr. Strom and Elisa Bert again met with Dr. Ruiz to discuss again HCA's directive to move more patients into inpatient status and newly instituted point system to penalize doctors. At this meeting, Dr. Strom and Ms. Bert gave a report to Dr. Ruiz called "Aventura UM Committee Report" for the February 2015-January 2016 time period.

120. This report evaluated 349 inpatient cases and 258 outpatient cases in which Dr. Ruiz was the attending physician.

121. The report first listed various data points concerning Dr. Ruiz's inpatient cases: case mix index, patient age, average risk of mortality level, and average severity level. For each category, the report listed the results for Dr. Ruiz's inpatient cases and then provided a statistical comparison to all other hospitalists within HCA East Florida hospitals.

122. The Aventura UM Committee Report listed Dr. Ruiz's average inpatient age as 71.7 compared to the average inpatient age of 64.9 for all other hospitalists within HCA East Florida hospitals. The Report listed a standard deviation of 4.25 for this category.

123. The Report listed the "Average Risk of Mortality Level" for Dr. Ruiz's inpatients as 2.01 as compared to 1.82 for all other hospitalists within HCA East Florida hospitals. The standard deviation listed was 1.73.

124. The Report also listed the "Average Severity Level" for Dr. Ruiz's inpatients as 2.18 as compared to 2.08 for all other hospitalists within HCA East Florida hospitals. The standard deviation listed was 0.84.

125. The Report then listed the average length of stay for Dr. Ruiz's inpatients as 5.77 compared to 5.18 for all other hospitalists within HCA Florida East hospitals. The Report listed the standard deviation was 1.28.

126. The Report also listed the "% of Cases Above Average Length of Stay" as 46.42% for Dr. Ruiz compared to the overall average of 37.74% for all other hospitalists within HCA East Florida hospitals. The Report listed Dr. Ruiz's standard deviation in this category as 1.78.

127. At this meeting, Dr. Strom and Ms. Bert criticized Dr. Ruiz for having inpatients with average lengths of stay above the average benchmarks for other hospitalists within HCA East

Florida hospitals. HCA-Aventura's administrators demanded that Dr. Ruiz and other hospitalists move patients into inpatient status and then quickly discharge them out of the hospital. The reason for this demand was that reimbursement was significantly higher for inpatient admissions as compared to outpatient visits but reimbursement was generally not higher for longer lengths of inpatient stays. For inpatient admissions, hospitals are generally paid based on the diagnosis-related group (DRG), not the length of stay.

128. The Aventura UM Committee Report given to Dr. Ruiz also listed his "average observation length of stays (hours)" as 34.85 as compared to an average of 27.35 for all other hospitalists within HCA East Florida hospitals. The standard deviation listed was 2.81. The percentage of observation length of stays over 24 hours was 65.04% compared to the average of 47.78 for all other hospitalists. The standard deviation was 1.96.

129. Dr. Strom and Ms. Bert focused on these observation cases in their discussion with Dr. Ruiz and told him that he was required to move more patients into inpatient status instead of observation status.

130. Dr. Strom and Ms. Bert also provided graphs that tracked Dr. Ruiz's average observation length of stay, average inpatient length of stay, and average consultants used for the time period of January 2015 through December 2015. HCA-Aventura administrators used this data to direct Dr. Ruiz to move more patients into inpatient status, to use more consultants for "treating" inpatients, and then to move the inpatients out of the hospital because longer lengths of stay resulted in higher costs but generally not higher reimbursement.

131. In that same month---March of 2016---Aventura administrators intensified the pressure on physicians even higher with the "New Point System for Medical Staff Membership." Under this Point System published by the Aventura CEO to all physicians on medical staff, "1

point is assessed after each consecutive month that a provider has a monthly average length of stay that is 1 or more standard deviations higher than that of the peer group." "A total of 2 points will be assessed in the event that the provider's length of stay for the consecutive outlier month is 2 or more standard deviations higher than that of the peer group."

132. The Point System rules provide that "[p]oints automatically expire after 1 year." "Additionally, providers have the opportunity to expunge points early through voluntary participation in education activities or through sustained improvements in performance."

133. Under the Aventura Point System, physicians with unexpired points faced escalating penalties based on the number of their points, including non-renewal of staff membership and revocation of medical staff membership.

134. With Dr. Ruiz's average length of stay for observation cases being at a level of 2.81 standard deviations above the average for other hospitalists within the HCA East Florida division according to the Aventura UM Committee Report, he would be assessed 2 points for every consecutive month that his standard deviation exceeded 2 in this category. If he accumulated 4 points in this category, he would face non-renewal of medical staff membership. If he accumulated 5 or more points in this category, he would face revocation of medical staff membership and privileges.

135. For physicians facing the economic pressures of job security exerted by HCA administrators, the easiest solution was to move patients into inpatient status and then quickly discharge them and not face HCA's punitive scrutiny of observation cases. This consequence was the underlying objective of HCA East Florida administrators. As discussed below, that is exactly what has happened at HCA East Florida hospitals over the last six years.

136. The HCA-Aventura executives met with multiple hospitalists groups (IPC, TeamHealth/FLACS, and EmCare) to communicate the same message of directing the physicians to move more patients from observation status to inpatient status.

137. Some HCA physicians and staff members protested these practices and procedures and then quit or had their positions terminated by Defendants. Others acquiesced to protect their salaries.

138. The IPC group did not follow the Aventura administrators' mandates and that group was removed from the medical staff at Aventura.

HCA Has Implemented Intrusive Strategies to Monitor and Manage Patient Admissions and Discharges Based on Reimbursement Objectives

139. At Aventura Hospital patient discharges have operated under two different administrative rules. For observation cases and outpatient cases, delays in discharge are acceptable and abused to roll patients into inpatient status. For inpatient cases, delays in discharge are not acceptable and physicians are criticized and penalized for delays.

140. In numerous cases, Dr. Ruiz discharged patients from outpatient visits yet administrative issues delayed their discharges and Aventura's administration classified and billed these patient visits as inpatients admissions. In other instances, administrative issues delayed inpatient discharges and Dr. Ruiz sent emails to the Aventura CEO, Dianne Goldenberg, and the Aventura Chief Medical Officer, Dr. Strom, because of the adverse consequences to Dr. Ruiz from HCA's aggressive monitoring system. Dr. Ruiz and other hospitalists were under constant and intense pressure to move observation cases into inpatient status and move inpatients out of the hospital.

141. Dr. Ruiz and Dr. Chirino received regular communications from administrative case managers regarding observation cases. Their questions and requests were usually designed to steer observation patients into inpatient status.

142. Case managers at Aventura have also routinely sent preprinted faxes to hospitalists and attending primary care physician stating, "You are currently out of compliance with Medicare" and directing the hospitalists to sign a Medicare Order Form with a pre-checked box that states "Admit to inpatient status." Above the pre-checked box is a preprinted statement: "I expect the patient will require hospital care for TWO MIDNIGHTS OR MORE. (Documentation must be present in the medical record to support the expectation of two or more midnights.)."

143. Dr. Ruiz has routinely received this form from case managers at Aventura even in situations when the patient was not in the hospital for any period of time close to two midnights and even when Dr. Ruiz did not expect the patient to be in the hospital for two midnights. Yet Aventura's case managers have routinely sent this fax warning Dr. Ruiz and other physicians, "You are currently out of compliance with Medicare. Please sign the attached Medicare Order form and fax back to: 305-682-7031."

144. Dr. Ruiz sought to place patients in the appropriate observation or inpatient status. However, Aventura's administration continued to communicate the message that his observation cases were too high in number and his inpatient admissions were too low. When Dr. Ruiz refused to alter his independent judgment regarding a patient's status, Aventura's administrators have attempted to remove Dr. Ruiz from the medical staff.

145. Aventura's administrators wanted to remove Dr. Ruiz and Dr. Chirino from the medical staff so that more HMO Medicare patients treated by Dr. Ruiz and Dr. Chirino would be transferred to the EmCare hospitalist group controlled by the hospital administration.

146. The Aventura administration resorted to using peer review letters to document contrived criticisms of Dr. Ruiz's patient care. On September 28, 2016 and October 5, 2016 Dr. Ruiz received two separate quality review letters. Neither had any substantive merit.

147. As discussed below, HCA's tactics have led to dramatic increases in Medicare inpatient admissions as compared to national and Florida norms.

Florida Claims Data Demonstrate HCA's Statewide Scheme

Introduction to Analyses of Florida Claims Data

148. From his experience working under HCA's administration, Dr. Ruiz identified 8 categories of common diagnoses used and monitored by HCA's administration to move patients into inpatient status either directly from the emergency department or from observation status. These 8 diagnostic categories are (1) nonspecific chest pain/ atherosclerosis, (2) dizziness or vertigo, (3) other lower respiratory disease, (4) syncope, (5) nausea and vomiting, (6) abdominal pain, (7) malaise and fatigue, and (8) spondylosis, disc disorders or other back problems.

149. Dr. Ruiz directed and conducted extensive analyses of Florida claims data and national Medicare claims data. As discussed below, the analyses demonstrate the scope of HCA's scheme, the detrimental impact on Medicare patients, and the damages to the Medicare Program from excessive admissions of Medicare patients.

150. The following summarizes the findings regarding inpatient admission rates associated with these 8 diagnostic categories reported as admitting or primary diagnoses at HCA Florida hospitals.

151. Using hospital discharge and emergency department admission data for Medicare patients in Florida, the analyses compared patterns of inpatient admissions between HCA Florida hospitals and non-HCA Florida hospitals associated with these 8 categories of admitting or principal diagnoses. The analyses included the share of observation unit patients admitted as

inpatients by hospital, by diagnosis group, and by time period. The data analyses separately reported the share of Medicare patients admitted from the emergency room, including patients in observation units before admission.

152. The Florida claims data include all-payer and emergency department data for approximately 100 percent of inpatient and emergency department encounters. The analyses reported only data for patients with Medicare fee-for-service as the principal payer. The Florida data capture records from 237 non-HCA Florida hospitals and 43 HCA Florida hospitals over the time period 2010-2015.

Hospitals	**Number of Hospitals**	**Medicare Admissions**
Non HCA	237	3,949,268
HCA East	10	265,361
Aventura	1	46,492
Other HCA	32	850,540

153. The Florida claims data include variables for principal and admitting diagnoses as reported by hospitals in Florida. The admitting diagnosis code is the "condition identified by the physician at the time of the patient's admission requiring hospitalization." (*See* Medicare Claims Processing Manual Section 10.2). [6] The principal diagnosis is the "condition established after study to be chiefly responsible for the admission." *Id.*

[6] The Medicare Claims Processing Manual Section 10.2, titled "Inpatient Claim Diagnosis Reporting," states in pertinent part:

> "On inpatient claims providers must report the principal diagnosis. The principal diagnosis is the condition established after study to be chiefly responsible for the admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered…Other diagnosis codes are required on inpatient claims and are used in determining the appropriate MS-DRG. The provider reports the full codes for up to twenty-four additional conditions if they coexisted at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay…The Admitting Diagnosis Code is required for inpatient hospital claims subject to

154. The data analyses considered the admitting diagnosis code discussed above which is the "condition identified by the physician at the time of the patient's admission requiring hospitalization." The data analyses also considered the principal diagnoses reported by the hospitals.

155. Patients' diagnoses were categorized using the diagnoses codes listed in the principal and admitting diagnoses variables. The diagnoses codes were grouped together using the Agency for Healthcare Research's Clinical Classification Software (CCS) grouping scheme (some conditions can be described using a number of individual diagnosis codes). Patients were classified hierarchically based on the number of the CCS grouping and whether the code appeared in the admitting or principal diagnosis variables so that patients are assigned to one and only one condition group. Patients who spent time in an observation unit were identified based on whether patients had positive values for the observation unit charges variable.

156. The analyses reported the results for Aventura Hospital, all HCA East Florida[7] hospitals (excluding Aventura Hospital)[8], all HCA Florida hospitals, and all non-HCA Florida hospitals.

A/B MAC (A) review. The admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization."

[7] HCA East Florida is a division of 15 HCA hospitals spanning from South Miami Dade, Broward, Palm Beach, and St Lucie counties. The HCA East Florida Division includes Aventura Hospital & Medical Center, Highlands Regional Medical Center, JFK Medical Center, JFK Medical Center North, Kendall Regional Medical Center, Lawnwood Regional Medical Center, Mercy Hospital, Northwest Medical Center, Palms West Hospital, Plantation General Hospital, Raulerson Hospital, Sister Emmanuel Hospital, St. Lucie Medical Center, University Hospital & Medical Center, and Westside Regional Medical Center.

[8] Throughout this First Amended Complaint when referring to HCA East Florida hospitals, Aventura Hospital is excluded. The data analyses evaluated and compared the admission rates at Aventura Hospital with the other hospitals in the HCA East Florida Division.

The Florida Claims Data Demonstrates Excessive Admissions from Observation Status at HCA Florida Hospitals Compared to Non-HCA Florida Hospitals

157. As discussed in detail below, detailed analyses of the Florida claims data demonstrate a major problem of excessive hospitalizations of Medicare patients at HCA Florida hospitals both directly from the emergency department and from observation status.

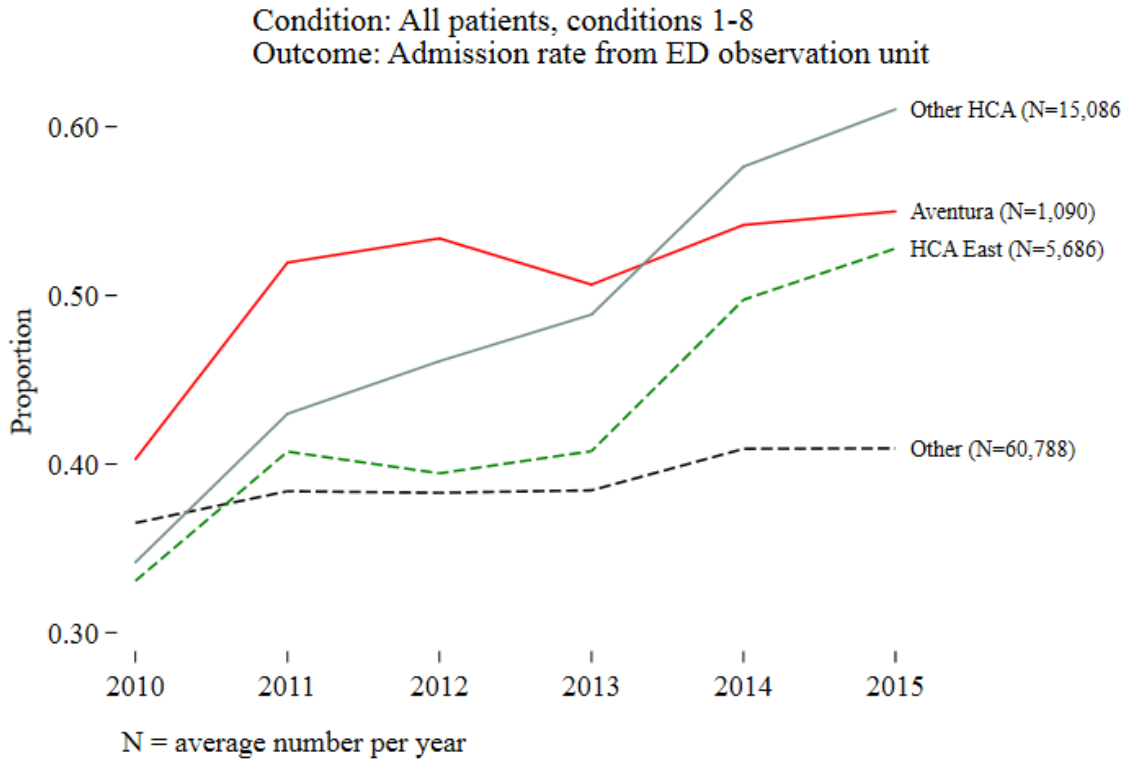
158. For these 8 diagnostic categories at HCA Florida hospitals overall, the Medicare admission rates from observation status increased from 34 percent in 2010 to 59 percent in 2015. At HCA Florida hospitals overall, every year the Medicare admission rates from observation status increased, moving from 34 percent in 2010 to 43 percent in 2011, 45 percent in 2012, 47 percent in 2013, 56 percent in 2014, and 59 percent in 2015.

159. These increases were far above the statewide averages at non-HCA Florida hospitals. Between 2010 and 2013 at non-HCA Florida hospitals, the Medicare inpatient admission rates for patients in observation status stayed steady at 38 percent and then increased slightly to 41 percent in 2014 and 2015.

160. In contrast at HCA Florida hospitals overall, the Medicare inpatient admission rates from observation status increased significantly from 34 percent in 2010 to 59 percent in 2015.

161. At HCA East Florida hospitals (excluding Aventura), the admission rates from observation status increased from 33 percent in 2010 to 53 percent in 2015. At Aventura Hospital, the admission rates from observation status increased from 40 percent in 2010 to 55 percent in 2015.

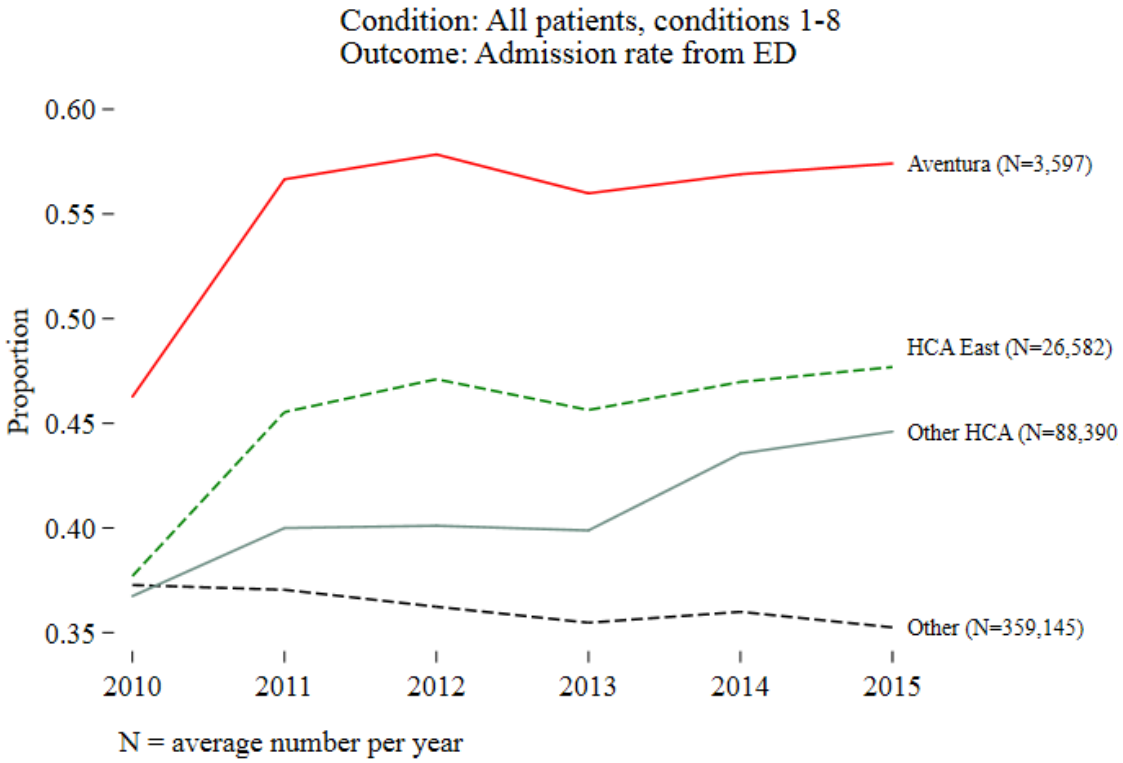
162. The following graph illustrates the elevated Medicare admission rates from observation status at HCA Florida Hospitals overall, Aventura Hospital, and HCA East Florida hospitals as compared to non-HCA Florida hospitals. In the graphs of the Florida data analyses, the black dotted lines for "Other" refer to non-HCA Florida hospitals.



Florida Claims Data Demonstrates Excessive Overall Admission Rates Associated with 8 Diagnostic Categories at HCA Florida Hospitals Compared to Non-HCA Florida Hospitals

163. Regardless of observation status, the overall Medicare admission rates from the emergency department ("ED") at HCA Florida hospitals were also significantly above statewide averages for non-HCA Florida hospitals.

164. At non-HCA Florida hospitals the overall Medicare admission rates associated with these 8 diagnostic categories decreased from 37 percent in 2010 to 35 percent in 2015. In contrast at HCA Florida hospitals, the admission rates increased from 37 percent in 2010 to 46 percent in 2015. The following graph illustrates the elevated admission rates at HCA Florida hospitals compared to non-HCA Florida hospitals.



165. The graphs for the individual diagnoses repeatedly reflect surging admission rates at HCA Florida hospitals far above the averages at non-HCA Florida hospitals. The graphs also reflect parallel rising lines for Aventura Hospital, HCA East Florida hospitals, and HCA Florida hospitals overall, evidencing HCA's coordinated strategy.

166. Detailed data for each diagnostic category are discussed more fully below.

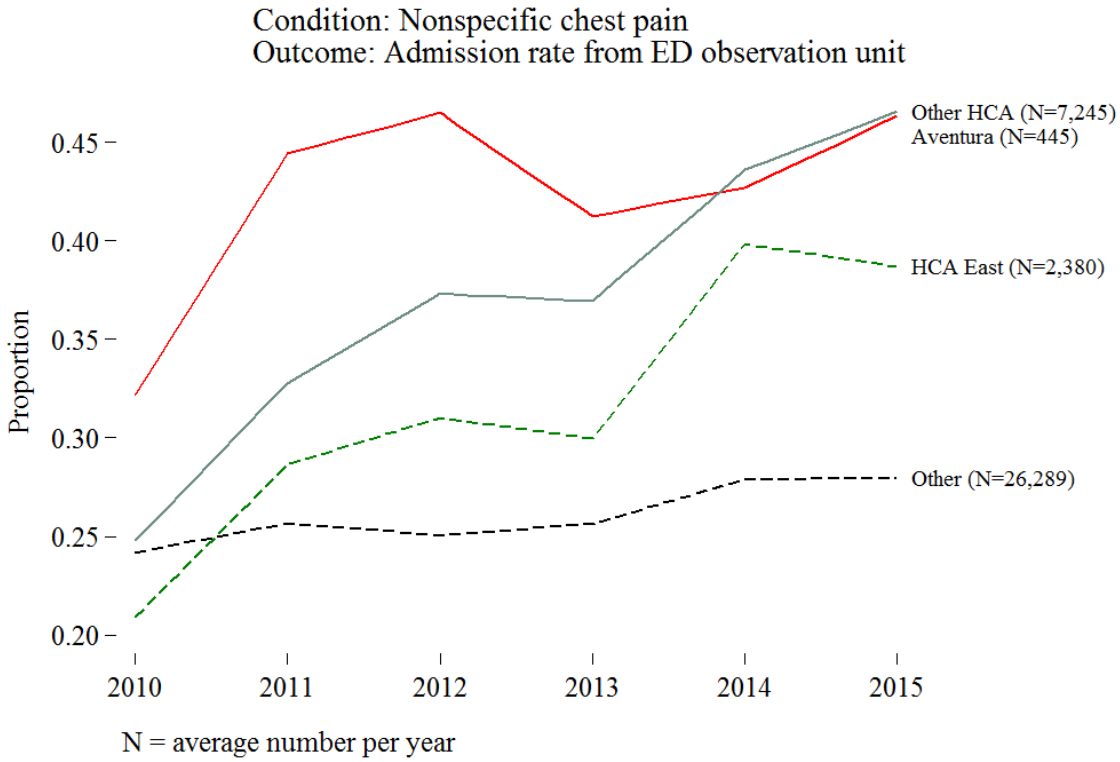
HCA Florida Hospitals' Rates of Inpatient Admissions with Admitting Diagnosis or Principal Diagnosis of Nonspecific Chest Pain

167. Nonspecific chest pain includes ICD 9 Codes 786.5, 786.59, 786.51, 414.01, and 411.1 and ICD 10 Codes R079, R0789, R072, and I2510.[9]

[9] ICD-10 codes were used for the fourth quarter of 2015 and 2016 claims data due to the transition to the ICD-10 coding system beginning on October 1, 2015.

168. In 2010 at non-HCA Florida hospitals, Medicare patients with an admitting diagnosis or principal diagnosis of "non-specific chest pain" were admitted 24 percent of the time as inpatients from observation status. That percentage stayed stable in subsequent years, increasing slightly to 26 percent in 2011, 25 percent in 2012, 26 percent in 2013, 28 percent in 2014, and 28 percent in 2014.

169. In contrast, at HCA Florida hospitals between 2010 and 2015, the percentages of these Medicare patients moved from observation status to inpatient status increased significantly. The following graph illustrates the elevated levels of inpatient admission rates for these patients at HCA Florida hospitals far above the norm of non-HCA Florida hospitals. The rates at non-HCA Florida hospitals are shown in the graph as a black dotted line labeled "Other."



170. As shown in the green dotted line for HCA East Florida hospitals overall (excluding Aventura), the percentage of these patients moved from observation status to inpatient status

increased significantly between 2010 and 2015. In 2010 at HCA East Florida hospitals, only 21 percent of these patients were moved from observation status to inpatient status. By 2014 at HCA East Florida hospitals, 40 percent of these Medicare patients were moved from observation status to inpatient status.

171. Overall Florida HCA hospitals exhibited similar significant increases in patients with nonspecific chest pain moved from observation status to inpatient status. In 2010, 24 percent of these patients in observation status were moved to inpatient status---which was consistent with the average at non-HCA Florida hospitals. Yet in subsequent years at Florida HCA hospitals overall, the percentages of these patients moved from observation status to inpatient status increased every year, moving from 24 percent in 2010 to 32 percent in 2011, 36 percent in 2012, 35 percent in 2013, 43 percent in 2014, and 45 percent in 2015.

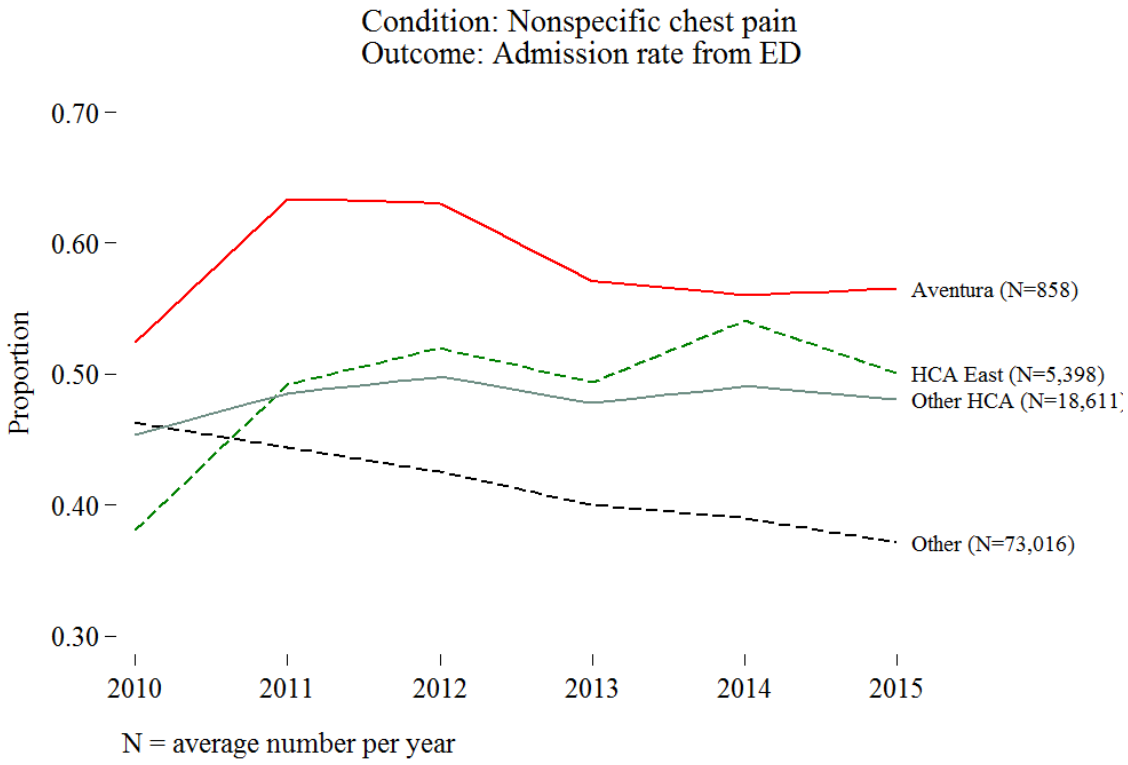
172. As shown above on the red line representing Aventura, the percentage of these patients admitted to the hospital from observation status moved from 32 percent in 2010 to 45 percent in 2011, 47 percent in 2012, 41 percent in 2013, 43 percent in 2014, and 46 percent in 2015.

173. Regardless of observation status, the overall admission rates for these Medicare patients were also significantly elevated at HCA Florida hospitals.

174. At non-HCA Florida hospitals, the admission rate for Medicare patients with nonspecific chest pain as admitting diagnosis or principal diagnosis declined from 46 percent in 2010 to 44 percent in 2011, 43 percent in 2012, 40 percent in 2013, 39 percent in 2014, and 37 percent in 2015. In contrast, at Aventura Hospital the admission rates for these patients increased from 52 percent in 2010 to 63 percent in 2011, 63 percent in 2012, 57 percent in 2013, 56 percent

in 2014, and 57 percent in 2015. HCA East Florida hospitals also had rising admission rates for these patients.

175. The following graph illustrates Aventura's and HCA East Florida hospitals' elevated admission rates for these patients as compared to non-HCA Florida hospitals depicted as "Other":



HCA Florida Hospitals' Rates of Inpatient Admissions with Admitting Diagnosis or Principal Diagnosis of Dizziness or Vertigo

176. Dizziness or vertigo includes ICD 9 Code 780.4 and ICD 10 Code R42.

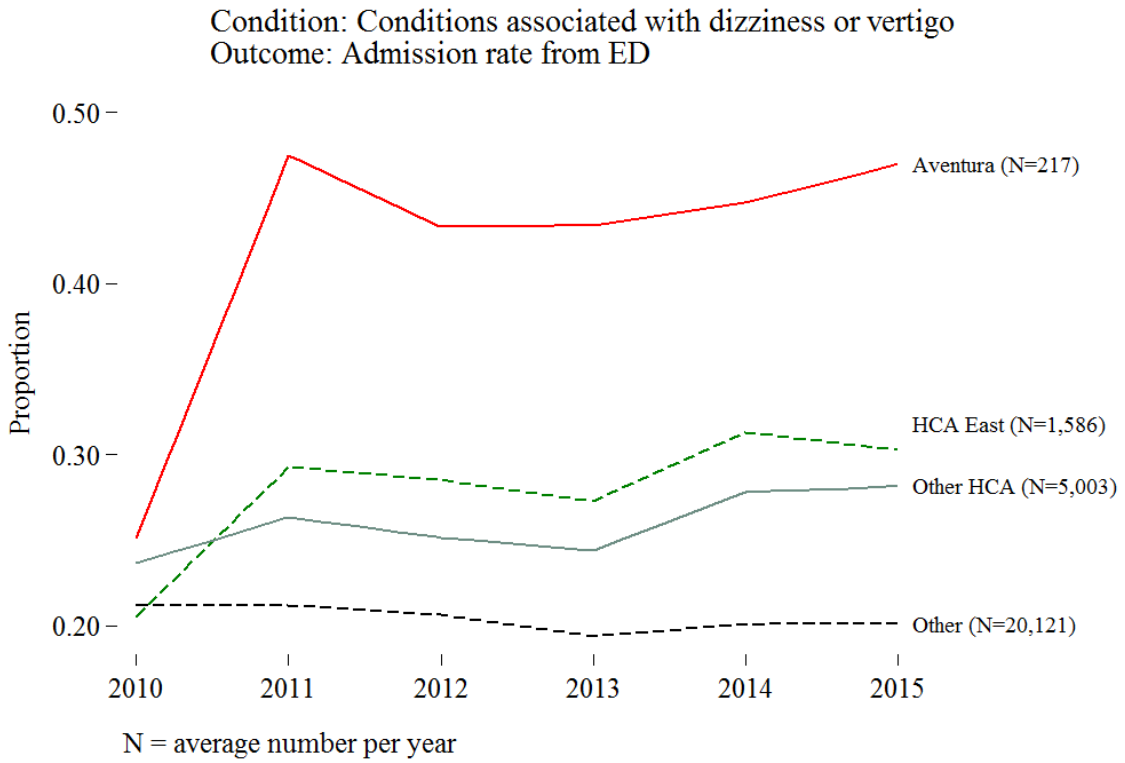
177. In 2010 at non-HCA Florida hospitals, Medicare patients with an admitting diagnosis or principal diagnosis of dizziness or vertigo were admitted 22 percent of the time as inpatients from observation status. That percent stayed stable in subsequent years, increasing

slightly to 26 percent in 2011, 26 percent in 2012, 24 percent in 2013, 28 percent in 2014, and 26 percent in 2015.

178. In contrast at HCA Florida hospitals overall, the admission rates for these patients increased significantly between 2010 and 2015. In 2010 at HCA Florida hospitals overall, 28 percent of these Medicare patients were moved from observation status to inpatient status. By 2015 at HCA Florida hospitals overall, 48 percent of these Medicare patients were moved from observation status to inpatient status.

179. Regardless of observation status, the overall admission rates for these patients at HCA Florida hospitals also increased significantly above the norm at non-HCA Florida hospitals.

180. At non-HCA Florida hospitals, the admission rates for Medicare patients with dizziness or vertigo as admitting diagnosis or principal diagnosis stayed stable at 21 percent in 2010, 21 percent in 2011, 21 percent in 2012, 19 percent in 2013, 20 percent in 2014, and 20 percent in 2015. In contrast, as illustrated in the following graph, the admission rates for these patients at HCA Florida hospitals were significantly higher:



HCA Florida Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of "Other Lower Respiratory Disease"

181. Other lower respiratory disease includes ICD 9 Codes 786.2, 786.05, 786.09, 786.52, and 786.07 and ICD 10 Codes R05, R0602, R0600, R0781, and R062.

182. In 2010 at non-HCA Florida hospitals, Medicare patients with an admitting diagnosis or principal diagnosis of "other lower respiratory disease" were admitted 64 percent of the time as inpatients from observation status. That percentage declined slightly in subsequent years, moving to 61 percent in 2011, 64 percent in 2012, 60 percent in 2013, 61 percent in 2014, and 61 percent in 2015.

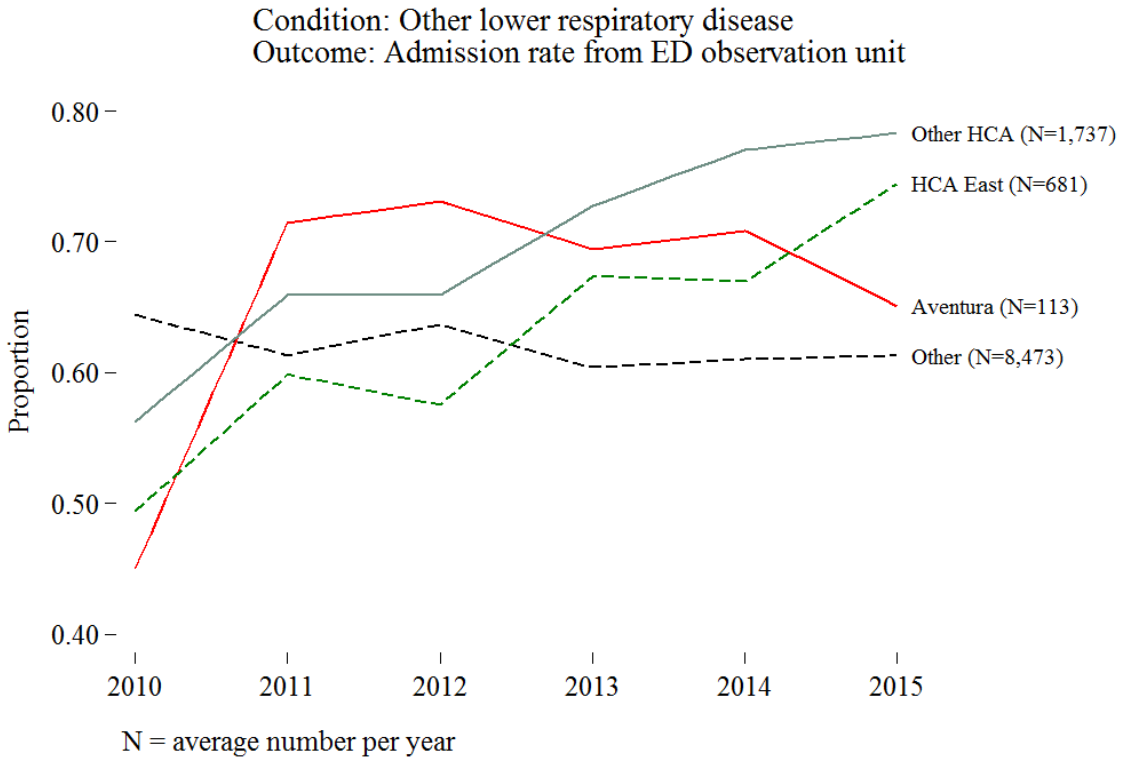
183. In contrast at HCA Florida hospitals overall between 2010 and 2015, the percentages of these Medicare patients moved from observation status to inpatient status increased significantly. In 2010, 53 percent of these patients were moved from observation status to inpatient

status. That percentage increased to 65 percent in 2011, 64 percent in 2012, 71 percent in 2013, 74 percent in 2014, and 77 percent in 2015.

184. At Aventura, the percentage of these patients admitted to the hospital from observation status moved from 45 percent in 2010 to 71 percent in 2011, 73 percent in 2012, 69 percent in 2013, 71 percent in 2014, and 65 percent in 2015.

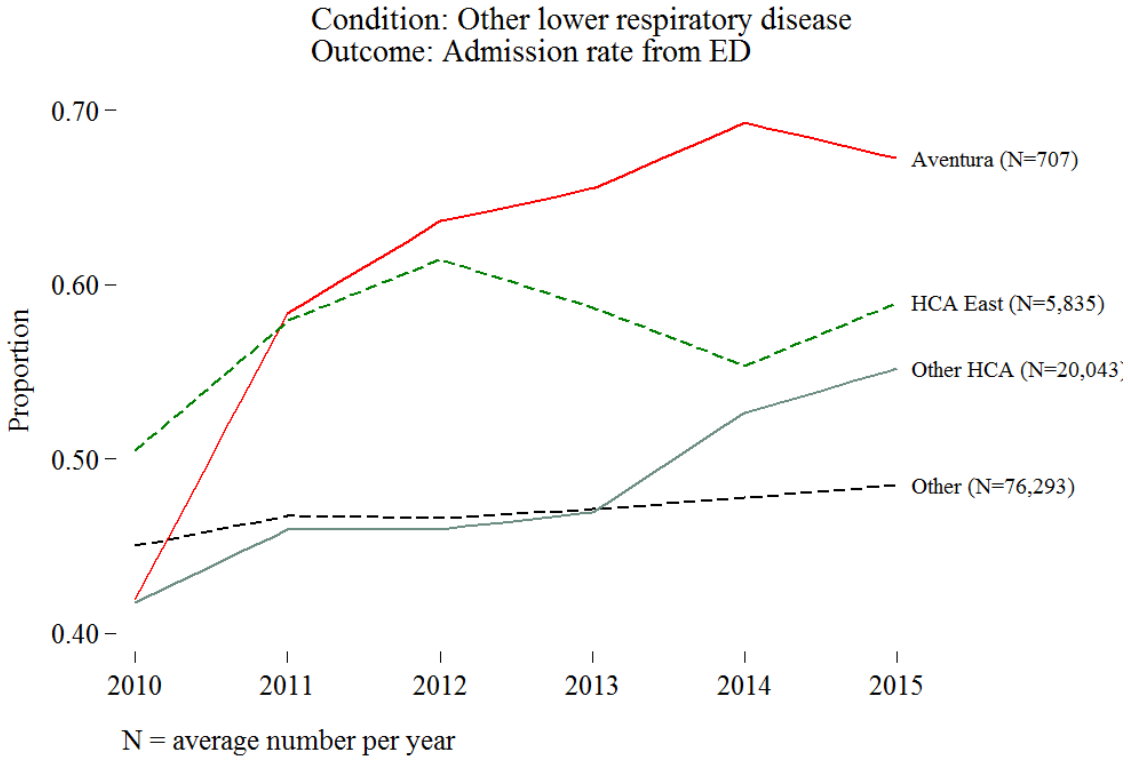
185. At HCA East Florida hospitals overall (excluding Aventura), the percentage of these patients admitted to the hospital from observation status increased from 49 percent in 2010 to 60 percent in 2011, 58 percent in 2012, 67 percent in 2013, 67 percent in 2014, and 74 percent in 2015.

186. The following graph illustrates HCA Florida hospitals' rising admission rates from observation status with respect to the admitting or principal diagnosis of other lower respiratory disease.



187. Regardless of observation status, the overall admission rates for these patients at HCA Florida hospitals also increased significantly above the norm at non-HCA Florida hospitals.

188. At HCA Florida hospitals overall, the admission rates for these patients increased from 44 percent in 2010 to 56 percent in 2015. These rates were significantly above the norm at non-HCA Florida hospitals as illustrated in the graph below. Aventura's admission rates and other HCA East Florida hospitals' admission rates for these patients were even higher.



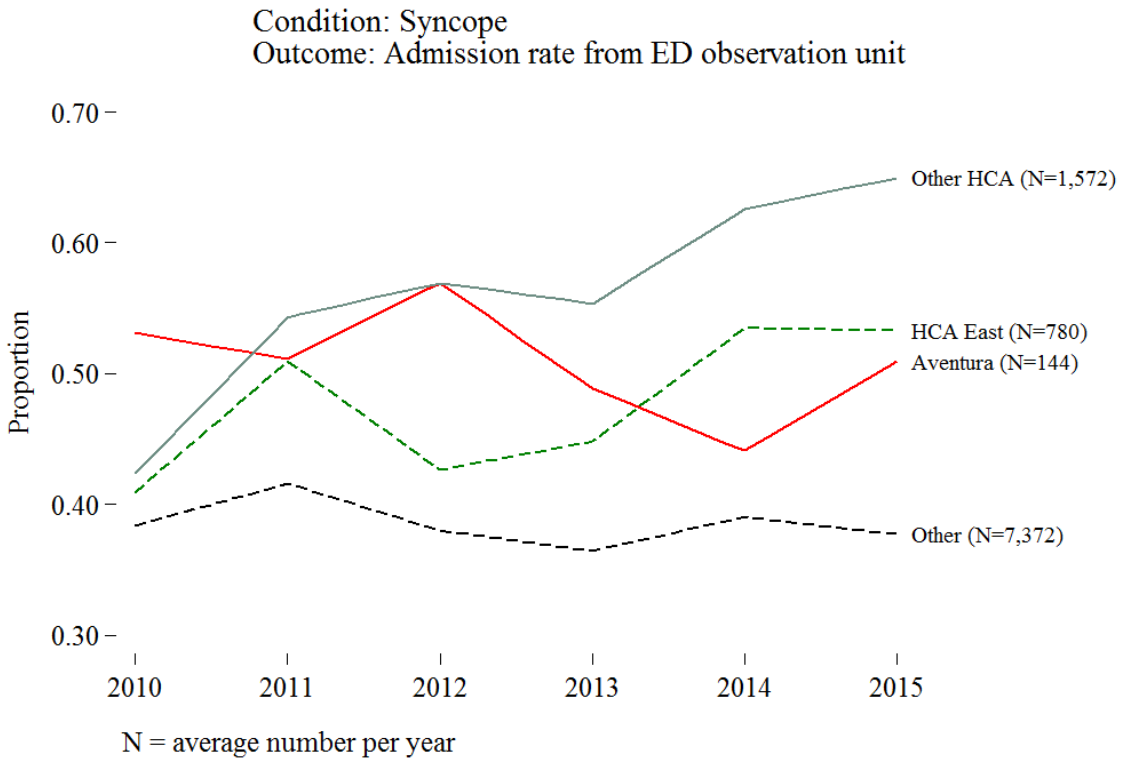
189. At Aventura Hospital, the admission rates for these patients increased from 42 percent in 2010 to 58 percent in 2011, 64 percent in 2012, 65 percent in 2013, 69 percent in 2014, and 67 percent in 2015. At HCA East Florida hospitals (excluding Aventura), the admission rates for these patients increased from 50 percent in 2010 to 58 percent in 2011, 61 percent in 2012, 59 percent in 2013, 55 percent in 2014, and 59 percent in 2015.

HCA Florida Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of Syncope

190. Syncope includes ICD 9 Code 780.2 and ICD 10 Code R55.

191. In 2010 at non-HCA Florida hospitals, Medicare patients with an admitting or principal diagnosis of syncope were admitted 38 percent of the time as inpatients from observation status. That percentage stayed stable in subsequent years, moving to 42 percent in 2011, 38 percent in 2012, 36 percent in 2013, 39 percent in 2014, and 38 percent in 2015.

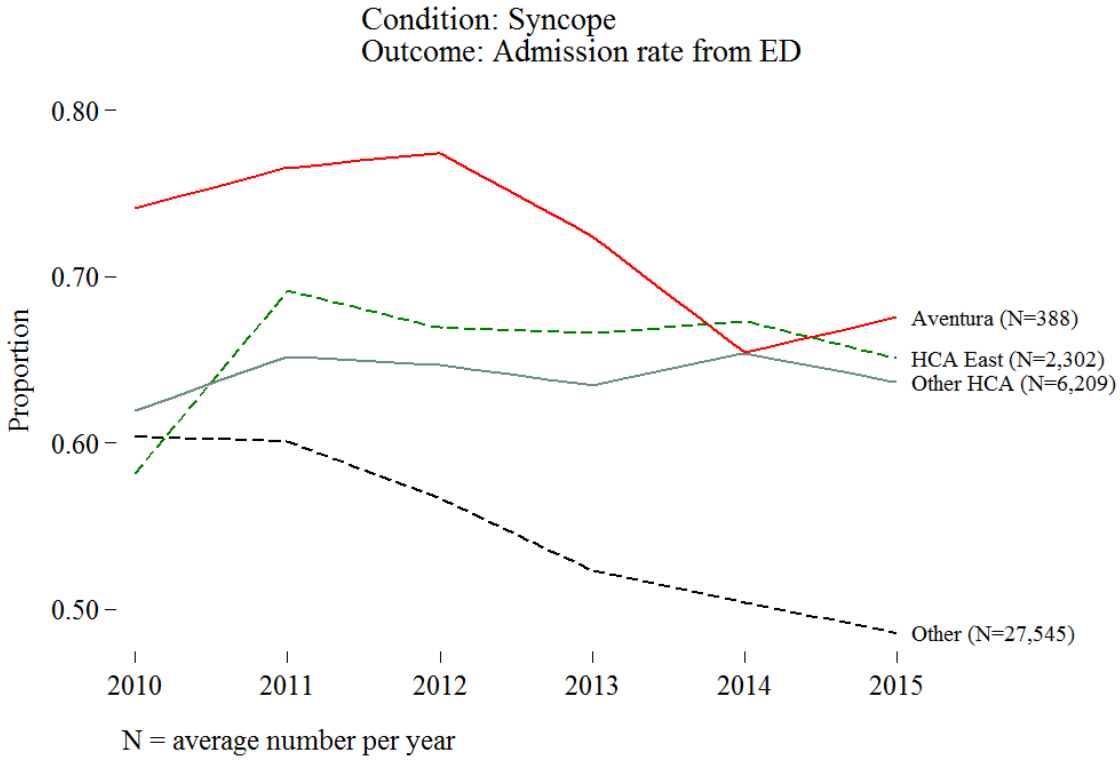
192. In contrast at HCA Florida hospitals overall, the percentages of these patients admitted to the hospital from observation status increased from 43 percent in 2010 to 53 percent in 2011, 52 percent in 2012, 52 percent in 2013, 59 percent 2014, and 61 percent in 2015. The following graph again illustrates the rising admission rates for these patients in observation status, particularly in the time frame of 2013-2015 for HCA Florida hospitals overall.



193. Regardless of observation status, the admission rates of these patients at HCA Florida hospitals were significantly elevated over admission rates at non-HCA Florida hospitals.

194. At non-HCA Florida hospitals, the overall admission rate for patients with an admitting or principal diagnosis of syncope declined from 60 percent in 2010 to 52 percent in 2013, 50 percent in 2014, and 49 percent in 2015.

195. In contrast at Florida HCA hospitals, the overall admission rates for these patients increased from 62 percent in 2010 to 66 percent in 2014 and 64 percent in 2015. The following graph illustrates HCA Florida hospitals' admission rates for these patients as compared to non-HCA Florida hospitals:



196. At Aventura Hospital, the admission rates for these patients were significantly elevated over the average rates at non-HCA Florida hospitals for all 5 years, moving from 74

percent in 2010 to 77 percent in 2011, 77 percent in 2012, 72 percent in 2013, 65 percent in 2014, and 68 percent in 2015.

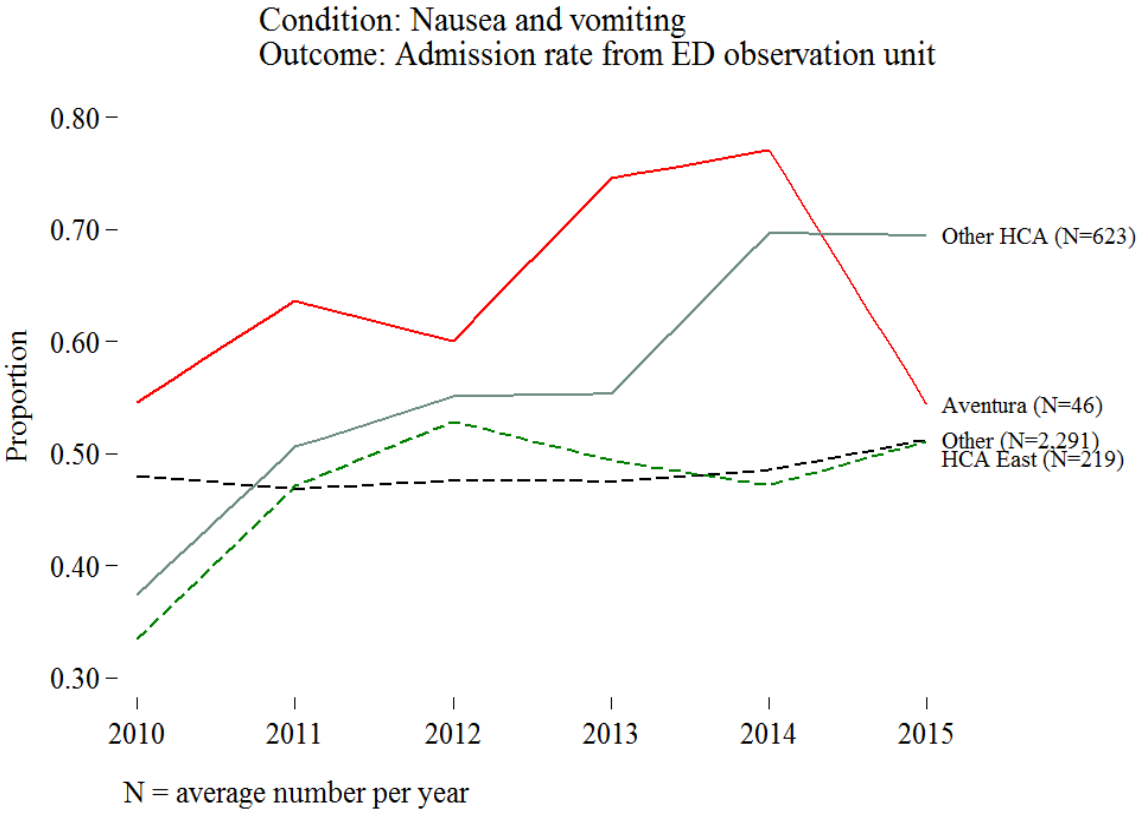
HCA Florida Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of Nausea and Vomiting

197. Nausea and vomiting include ICD 9 Codes 787.01, 787.02, and 787.03 and ICD 10 Codes R112, R1110, R110, and R1111.

198. In 2010 at non-HCA Florida hospitals, Medicare patients with an admitting diagnosis or principal diagnosis of "nausea and vomiting" were moved 48 percent of the time from observation status to inpatient status. That percentage stayed stable at non-HCA Florida hospitals in subsequent years: 47 percent in 2011, 48 percent in 2012, 47 percent in 2013, 48 percent in 2014, and 51 percent in 2015.

199. In contrast at HCA Florida hospitals overall, the percentages of these patients moved from observation status to inpatient status escalated between 2010 and 2015. In 2010 at HCA Florida hospitals, 37 percent of these patients were moved from observation status to inpatient status. That percentage moved to 50 percent in 2011, 55 percent in 2012, 55 percent in 2013, 65 percent in 2014, and 65 percent in 2015.

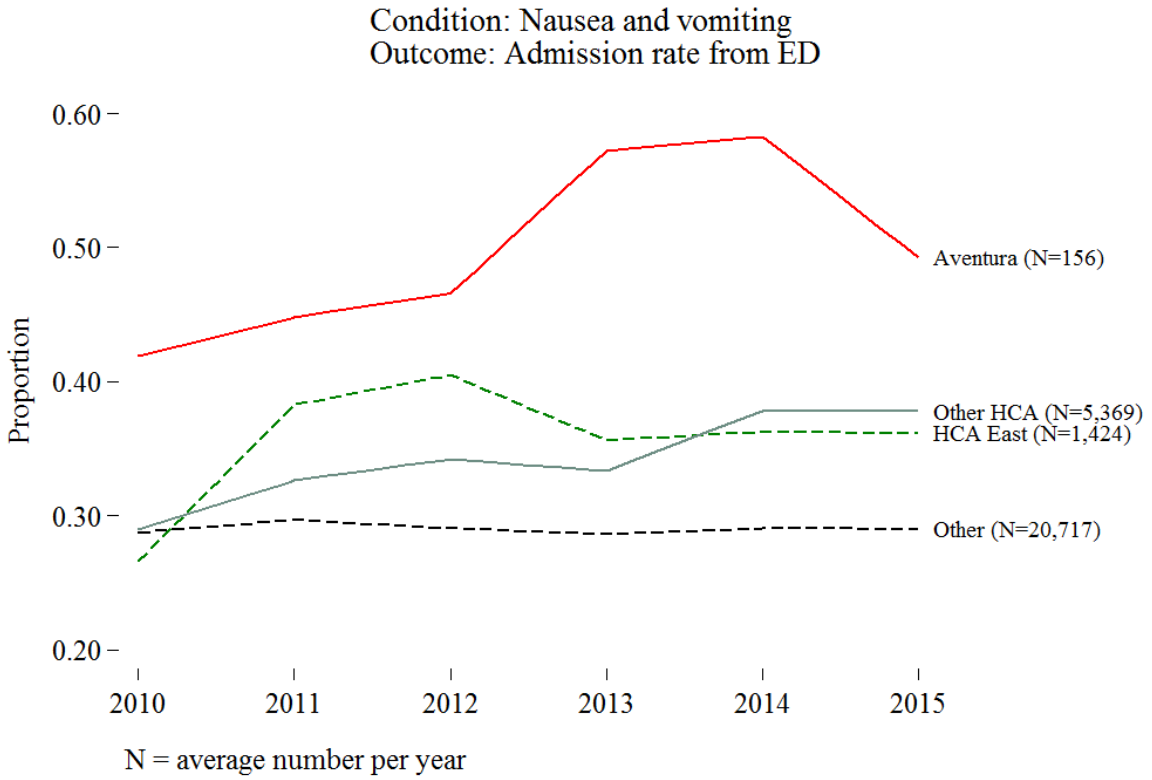
200. The following graph illustrates HCA Florida hospitals' admission rates for these patients from observation status as compared to non-HCA Florida hospitals:



201. Regardless of observation status, the admission rates of these patients at HCA Florida hospitals were significantly elevated over admission rates at non-HCA Florida hospitals.

202. At non-HCA Florida hospitals between 2010-2015, the admission rates for these patients stayed stable at 29 percent. In contrast, at HCA Florida hospitals, the overall admission rates for these patients increased from 29 percent in 2010 to 38 percent in 2015. The admission rates at Aventura were even higher.

203. The following graph illustrates HCA Florida hospitals' admission rates for these Medicare patients as compared to the admission rates at non-HCA Florida hospitals depicted as "Other":



HCA Florida Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of Abdominal Pain

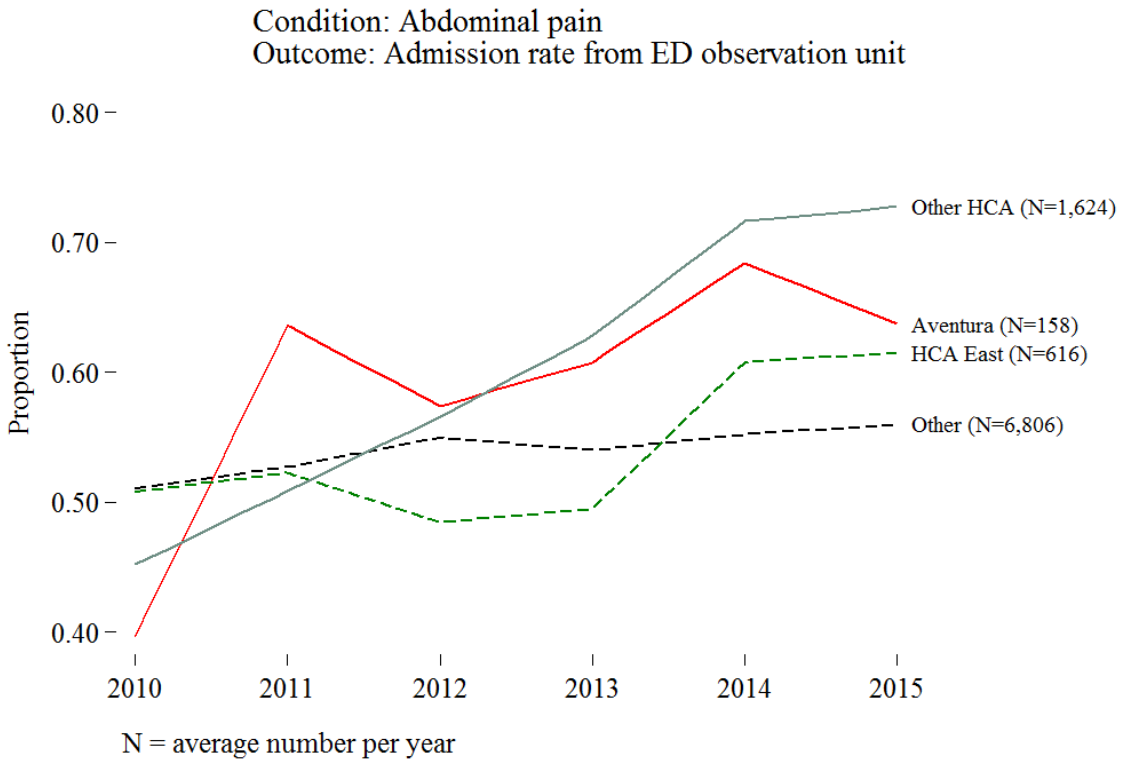
204. Abdominal pain includes ICD 9 Codes 789, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, and 789.09 and ICD 10 Codes R102, R109, F1010, R1011, R1012, R1013, R1030, R1031, R1032, R1033, and R1084.

205. In 2010 at non-HCA Florida hospitals, Medicare patients with an admitting diagnosis or principal diagnosis of abdominal pain were admitted 51 percent of the time as inpatients from observation status. That percentage stayed stable in subsequent years, increasing slightly to 53 percent in 2011, 55 percent in 2012, 54 percent in 2013, 55 percent in 2014, and 56 percent in 2015.

206. In contrast at HCA Florida hospitals, the percentage of these patients admitted from observation status increased from 47 percent in 2010 to 52 percent in 2011, 54 percent in 2012, 59 percent in 2013, and 69 percent in 2014, and 70 percent in 2015.

207. At Aventura, the percentage of these Medicare patients admitted to the hospital from observation status increased from 40 percent in 2010 to 64 percent in 2011, 57 percent in 2012, 61 percent in 2013, 68 percent in 2014, and 64 percent in 2015.

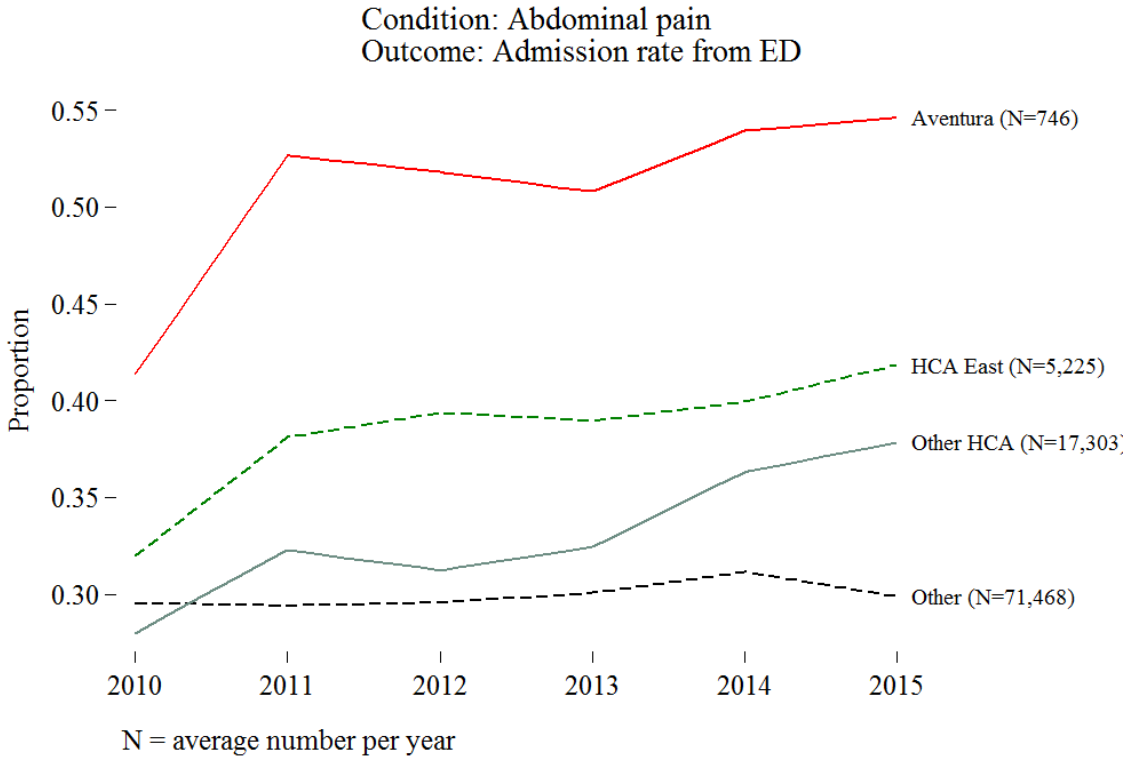
208. The following graph illustrates HCA Florida hospitals' admission rates for these patients from observation status as compared to non-HCA Florida hospitals.



209. Regardless of observation status, the admission rates of these patients at HCA Florida hospitals were significantly elevated over admission rates at non-HCA Florida hospitals.

210. At non-HCA Florida hospitals between 2010 and 2015, the admission rates for these patients stayed stable at 29-31 percent.

211. In contrast at HCA Florida hospitals overall, the admission rates for these patients moved from 29 percent in 2010 to 39 percent in 2015. At HCA East Florida hospitals, the admission rates for these patients moved from 32 percent in 2010 to 42 percent in 2015. At Aventura Hospital, the admission rates for these patients moved from 41 percent in 2010 to 55 percent in 2015. The following graph illustrates the increasing admission rates for these patients at HCA Florida hospitals while admission rates at non-HCA Florida hospitals stayed stable at lower levels.



HCA Florida Admission Rates Associated with Admitting or Principal Diagnosis of Malaise and Fatigue

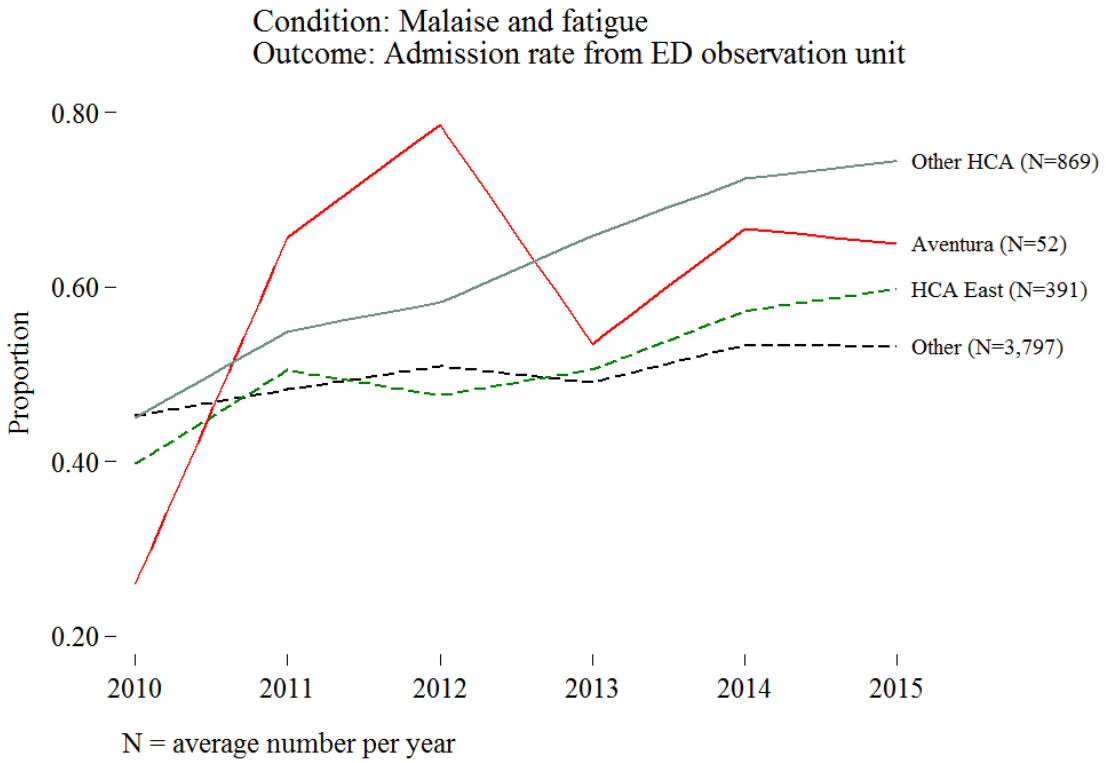
212. Malaise and fatigue include ICD 9 Codes 780.79 and ICD 10 Codes R531, R5383, and R5381.

213. In 2010 at non-HCA Florida hospitals, Medicare patients with an admitting diagnosis or principal diagnosis of malaise and fatigue were admitted 45 percent of the time as inpatients from observation status. That percentage stayed relatively stable in subsequent years, increasing slightly to 48 percent in 2011, 51 percent in 2012, 49 percent in 2013, 53 percent in 2014, and 53 percent in 2015.

214. In contrast at HCA Florida hospitals overall, the percentage of these patients moved from observation status to inpatient status jumped significantly, moving from 42 percent in 2010 to 54 percent in 2011, 56 percent in 2012, 61 percent in 2013, 68 percent in 2014, and 70 percent in 2015.

215. At HCA East Florida hospitals overall (excluding Aventura), the percentage of these patients admitted to the hospital from observation status moved from 40 percent in 2010 to 60 percent in 2015.

216. The following graph illustrates HCA Florida hospitals' admission rates for these patients from observation status as compared to non-HCA Florida hospitals:



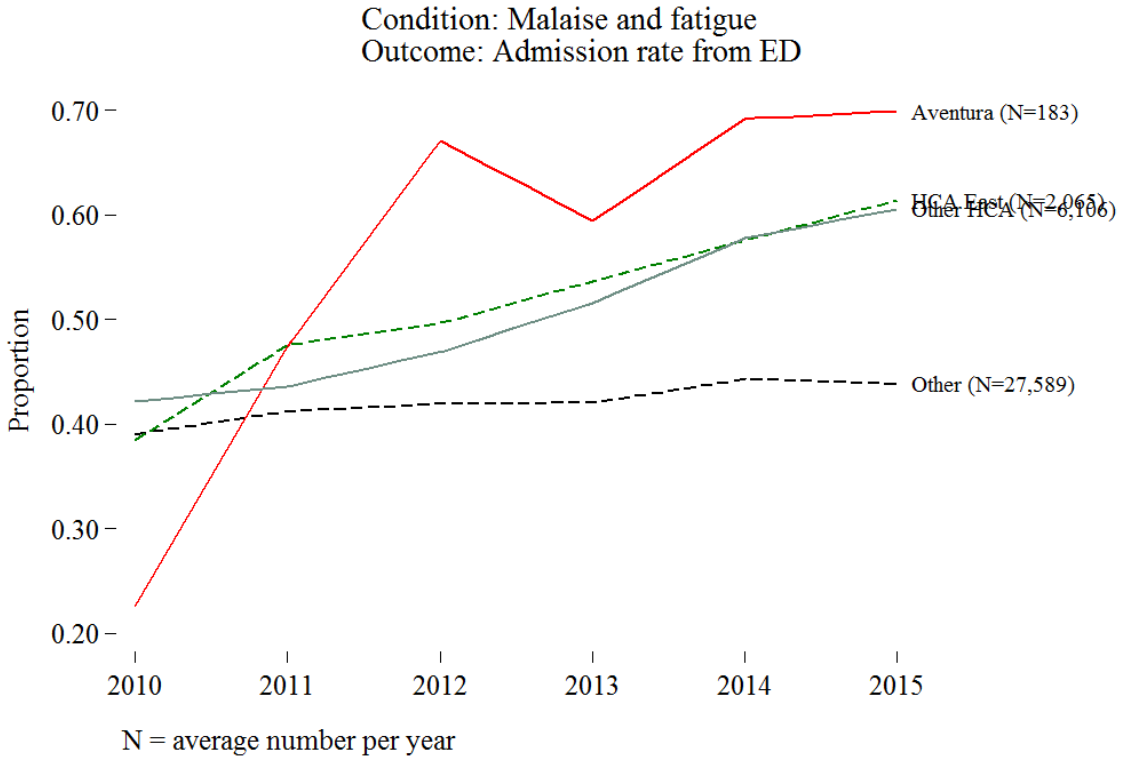
217. Regardless of observation status, the admission rates of these patients at HCA Florida hospitals were significantly elevated over admission rates at non-HCA Florida hospitals.

218. At non-HCA Florida hospitals between 2010 and 2015, the admission rates for Medicare patients with malaise and fatigue as admitting diagnosis or principal diagnosis stayed relatively stable at 39 percent in 2010, 41 percent in 2011, 42 percent in 2012, 42 percent in 2013, and 44 percent in 2014 and 2015.

219. In contrast at HCA Florida hospitals overall, the admission rates for these patients increased each year, moving from 41 percent in 2010 to 45 percent in 2011, 48 percent in 2012, 52 percent in 2013, 58 percent in 2014, and 61 percent in 2015.

220. At HCA East Florida hospitals between 2010 and 2015, the admission rates for these patients moved from 38 percent in 2010 to 61 percent in 2015.

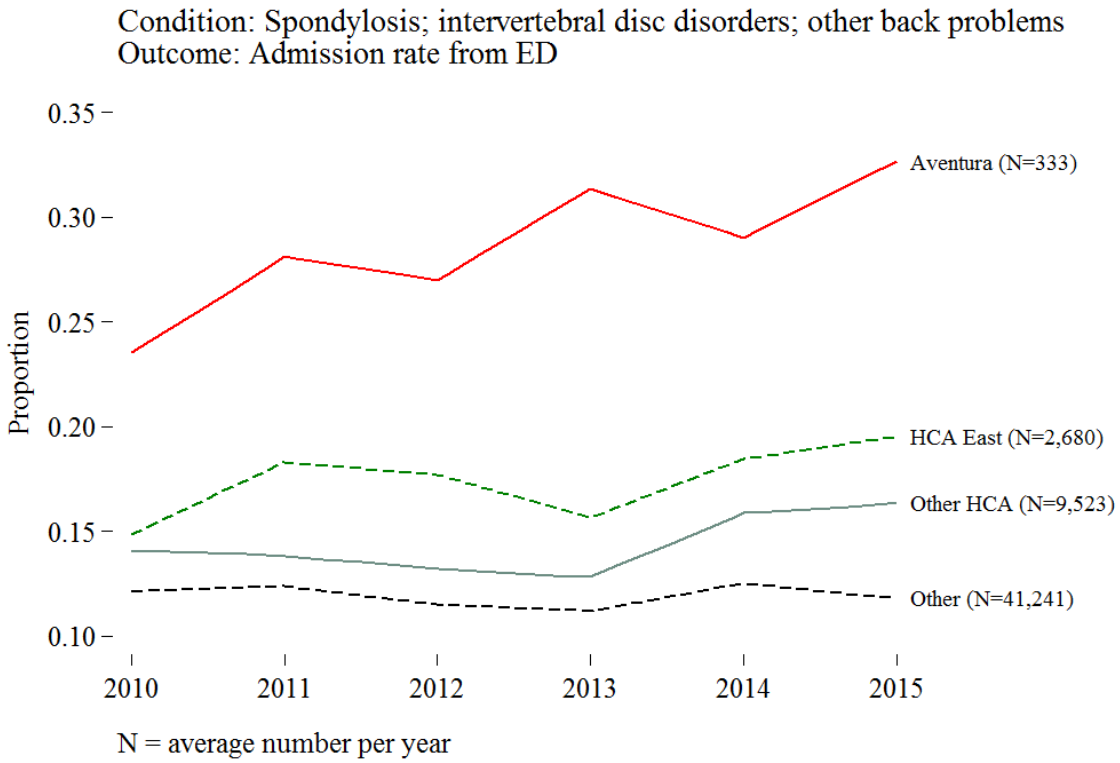
221. The following graph illustrates HCA Florida hospitals' elevated admission rates for these patients as compared to non-HCA Florida hospitals:



HCA Florida Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of Spondylosis, Disc Disorders, or Other Back Problems

222. Spondylosis, disc disorders, or other back problems include ICD 9 Codes 724.2, 724.5, 723.1, 724.1, and 724.3 and ICD 10 Codes M542, M545, M546, M549, and M4806.

223. Medicare patients with an admitting or principal diagnosis of spondylosis, intervertebral disc disorders, or other back problems experienced significantly elevated admission rates at Aventura Hospital and HCA East Florida hospitals as compared to non-HCA Florida hospitals.

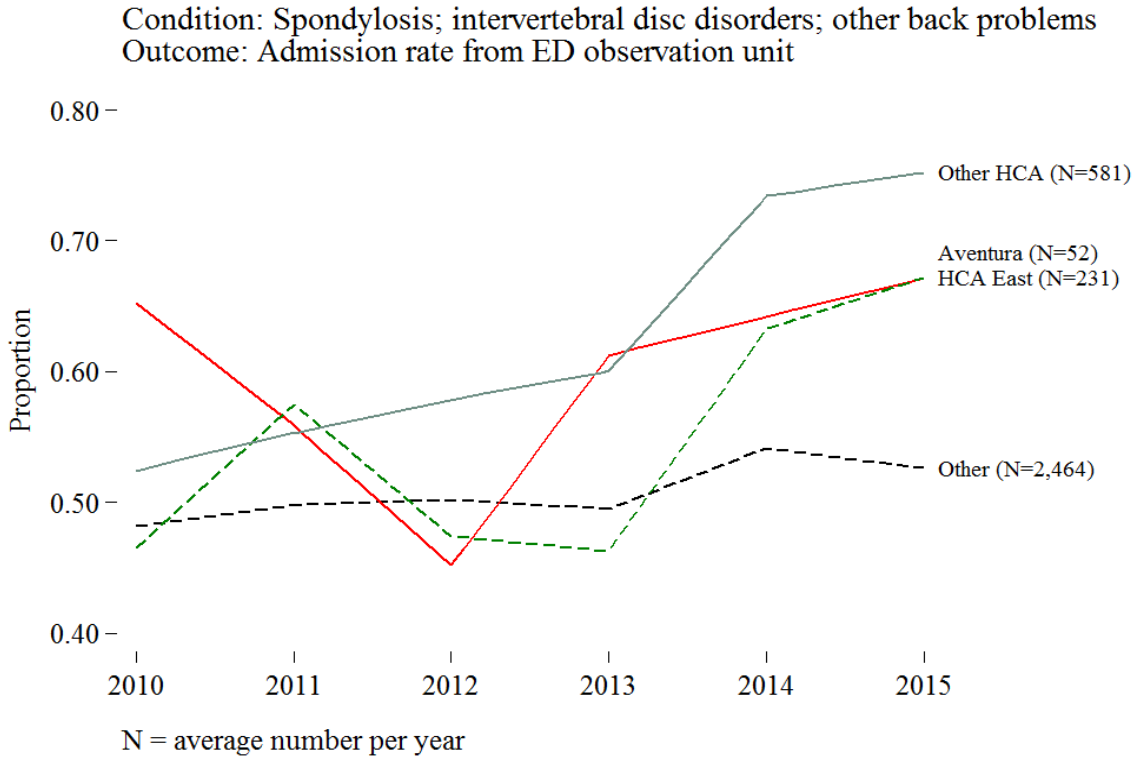


224. These patients also experienced significantly high admission rates from observation status at HCA Florida hospitals between 2010-2015.

225. In 2010 at Non-HCA Florida hospitals, patients with an admitting diagnosis or principal diagnosis of spondylosis, intervertebral disc disorders, or other back problems were admitted 48 percent of the time as inpatients from observation status. That percentage stayed stable in subsequent years: 50 percent in 2011, 50 percent in 2012, 50 percent in 2013, 54 percent in 2014, and 53 percent in 2015.

226. In contrast at HCA Florida hospitals overall, the percentages of these patients admitted to the hospital from observation status increased from 51 percent in 2010 to 73 percent in 2015. At HCA East Florida hospitals overall (excluding Aventura), the percentages of these patients admitted to the hospital from observation status increased from 46 percent in 2010 to 67 percent 2015.

227. The following graph illustrates HCA Florida hospitals' elevated admission rates for these patients from observation status as compared to non-HCA Florida hospitals:



National Medicare Claims Data Demonstrate the Scope of HCA's Scheme

Summary of National Medicare Claims Data

228. Analyses of national Medicare claims data focused on the same 8 diagnostic categories identified by Dr. Ruiz and reported as admitting or principal diagnoses at HCA hospitals and non-HCA hospitals throughout the United States.

229. The national Medicare claims data analyzed in this case included the Medicare claims data submitted by over 3,200 short-term acute care hospitals, commonly referred to by CMS as "STACs." The analyses of national Medicare claims data included each fiscal year from 2010-2016.

230. Analyses of the national Medicare claims data demonstrate a major national problem of excessive admissions of Medicare patients at HCA hospitals both directly from the emergency department and from observation status.

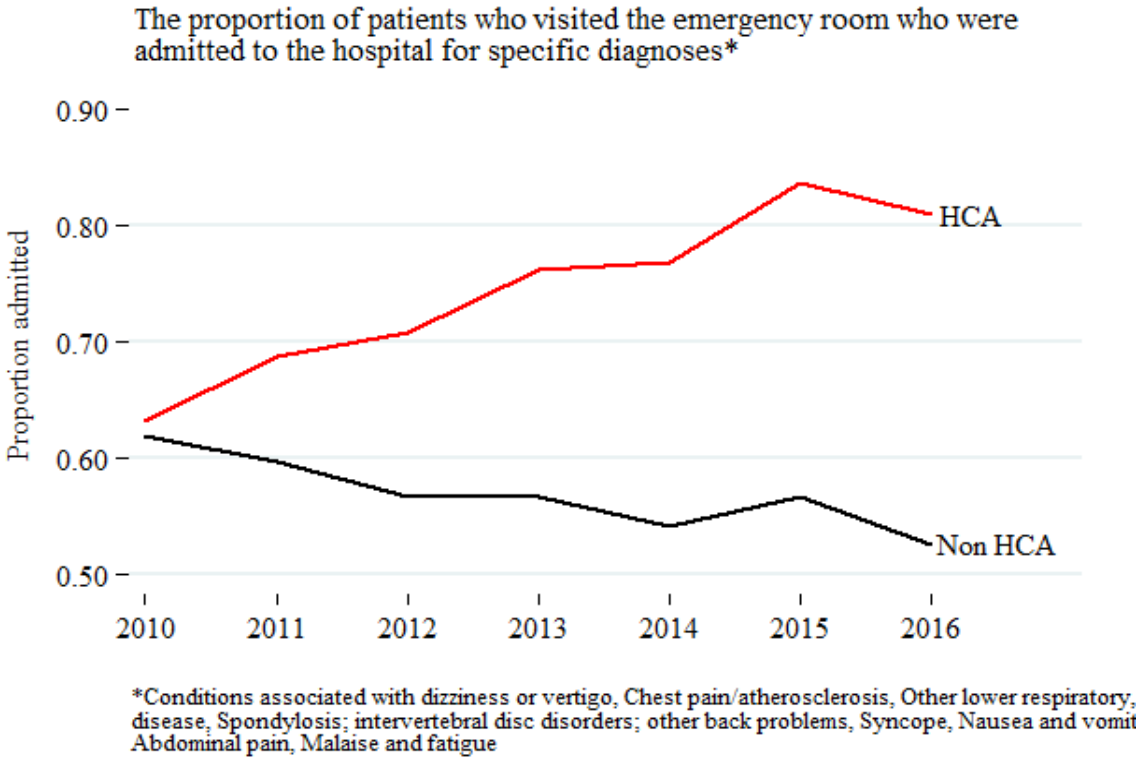
231. The analyses of national Medicare claims data focused on the same 8 diagnostic categories reported as admitting or principal diagnoses. These 8 diagnostic categories are (1) nonspecific chest pain//atherosclerosis, (2) dizziness or vertigo, (3) other lower respiratory disease, (4) syncope, (5) nausea and vomiting, (6) abdominal pain, (7) malaise and fatigue, and (8) spondylosis, disc disorders or other back problems.

232. The detailed data relied upon by Realtor include: (1) the admission rates for all diagnoses, the 8 diagnostic categories combined, and each diagnostic category at each HCA hospital during 2010-2016, (2) the numbers of inpatients admissions and ED visits for all diagnoses, the 8 diagnostic categories, and each diagnostic category at each HCA hospital during 2010-2016, (3) and average admission rate calculations for non-HCA hospitals, all HCA hospitals, HCA Florida hospitals, HCA East Florida Division hospitals, HCA Florida hospitals not in the East Florida Division, and HCA hospitals not in Florida.

233. At non-HCA hospitals the overall admission rates associated with these 8 diagnostic categories declined from 62 percent in 2010 to 60 percent in 2011, 57 percent in 2012, 57 percent in 2013, 54 percent in 2014, 57 percent in 2015, and 53 percent in 2016.

234. In contrast, the admission rates at HCA hospitals show the opposite pattern of rising admission rates. At HCA hospitals the national admission rates associated with these 8 diagnostic categories increased from 63 percent in 2010 to 69 percent in 2011, 71 percent in 2012, 76 percent in 2013, 77 percent in 2014, 84 percent in 2015, and 81 percent in 2016.

235. In 2010 the overall admission rates at HCA hospitals for these 8 diagnostic categories were 1 percentage point above the admission rates at non-HCA hospitals. The differential increased in each of the following years, moving to 9 percentage points in 2011, 14 percentage points in 2012, 19 percentage points in 2013, 23 percentage points in 2014, 27 percentage points in 2015, and 28 percentage points in 2016. The following graph illustrates HCA hospitals' admission rates rising while non-HCA hospitals' admissions rates declined.

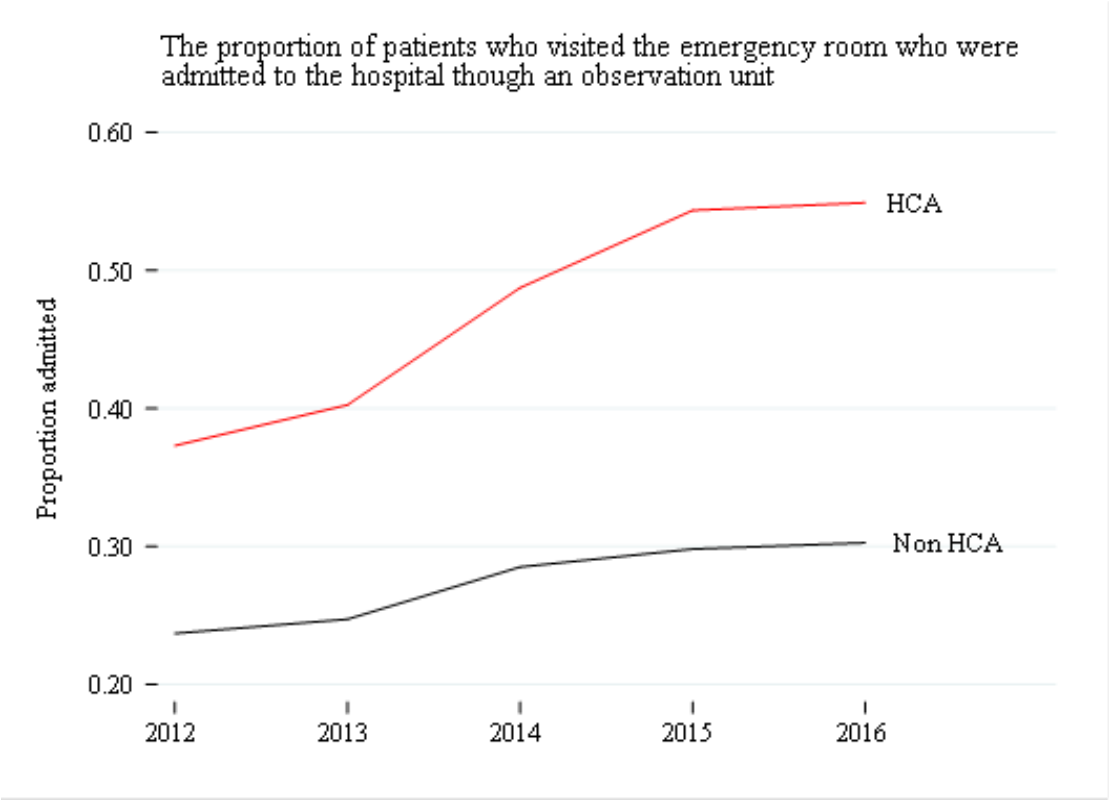


236. These results reflect admission rates for Medicare beneficiaries presenting to emergency departments at all HCA hospitals. HCA's scheme has been led by a subset of 41 hospitals with extraordinary admission rates resulting in large Medicare overpayments for excessive inpatient admissions. That subset of 41 HCA hospitals named as Defendants is discussed below.

237. In the years 2013-2016, the national Medicare claims data for the individual diagnostic categories repeatedly reflect surging admission rates at HCA hospitals far above the national norms and contrary to the trends at non-HCA hospitals. The detailed data for each diagnostic category is discussed more fully below.

238. The national Medicare claims data also evidence the results of HCA's strategy to increase the numbers of Medicare patients moved from observation status to inpatient status.

239. From 2012-2016, for all diagnoses at non-HCA hospitals, the admission rates from observation status stayed between 24-30 percent. In contrast at HCA hospitals nationally, the admission rates from observation status jumped from 37 percent in 2012 to 40 percent in 2013, 49 percent in 2014, 54 percent in 2015, and 55 percent in 2016.



240. The national Medicare claims data analyses also demonstrate HCA's scheme to increase admissions from observation status.

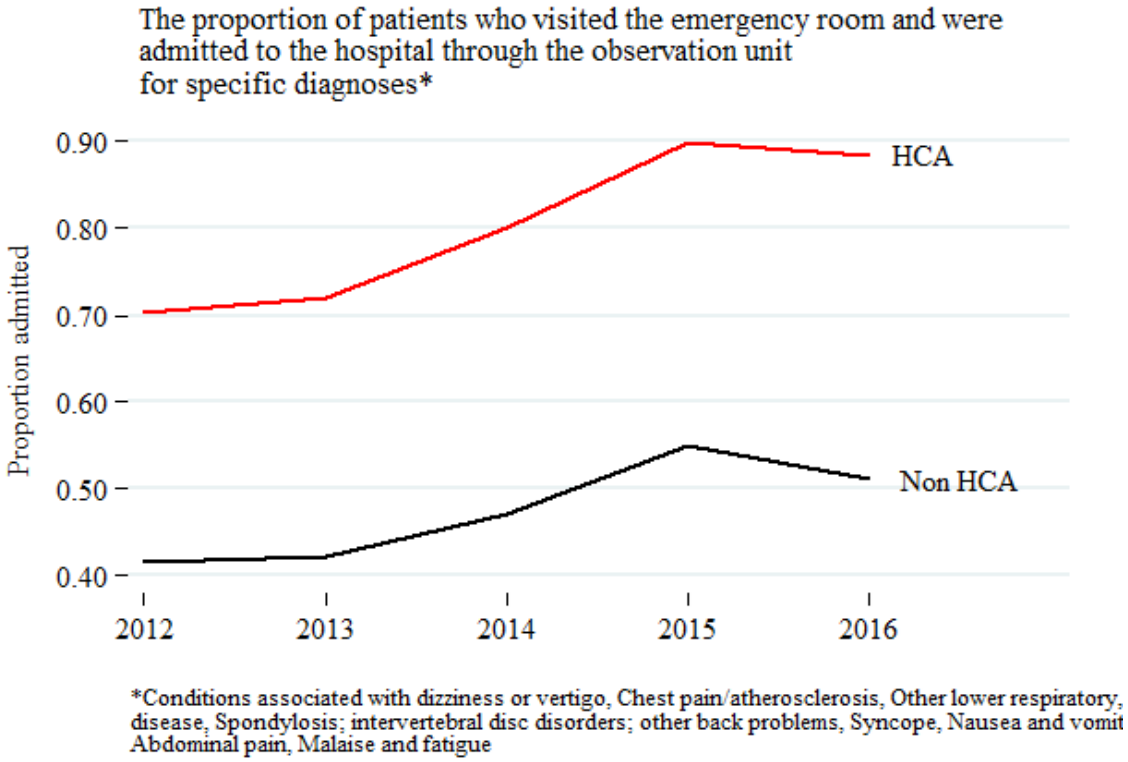
241. For all diagnoses at non-HCA hospitals over the time period 2012-2016, the admission rates for Medicare patients from observation status stayed between 24-30 percent.

242. In contrast at HCA hospitals nationally, the admission rates from observation status moved from 37 percent in 2012 to 40 percent in 2013, 49 percent in 2014, 54 percent in 2015, and 55 percent in 2016.

243. In 2012, HCA hospitals' admission rate from observation status for all diagnoses was 13 percentage points higher than the admission rate from observation status at non-HCA hospitals. The gap widened in each of the subsequent years, moving to 15 percentage points in 2013, 20 percentage points in 2014, 24 percentage points in 2015, and 25 percentage points in 2016.

244. By 2015 and 2016, HCA hospitals' national rate of admissions for all diagnoses from observation status (54 and 55 percent) was nearly double the national rate at non-HCA hospitals (30 percent).

245. With respect to the 8 diagnostic categories, from 2013-2016, at non-HCA hospitals the average rate of admission from observation status was 49 percent. In contrast at HCA hospitals, the national average rate of admission from observation status was 85 percent.



National Medicare Claims Data Confirm Excessive Admission Rates for Each of the 8 Diagnostic Categories

HCA Hospitals' Rates of Admissions with Admitting or Principal Diagnosis of Nonspecific Chest Pain

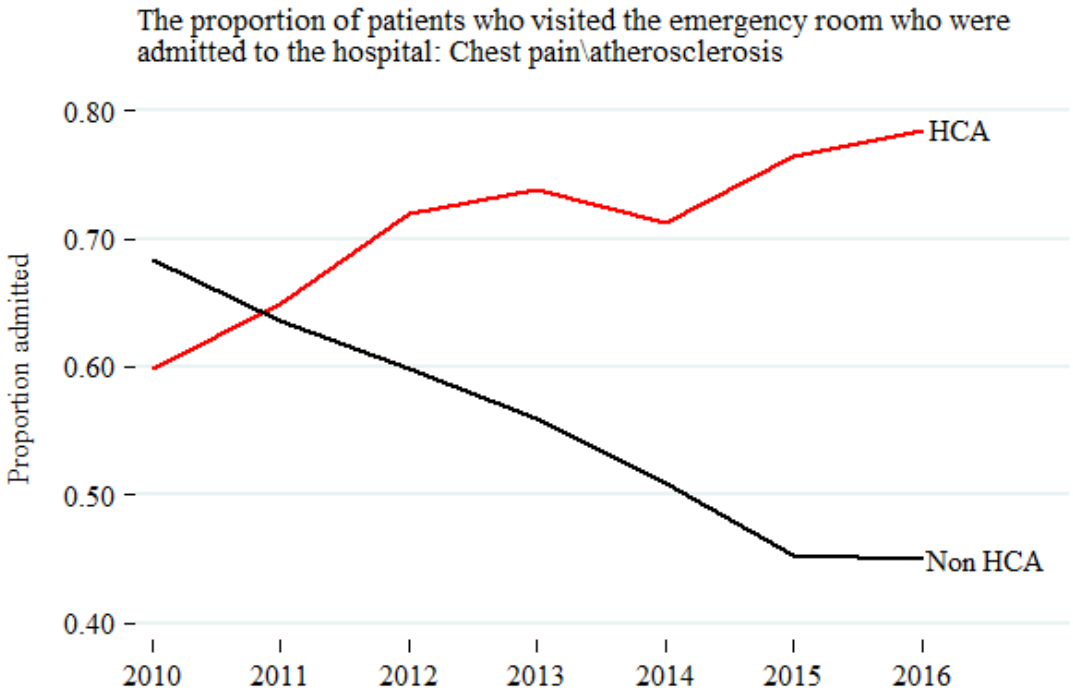
246. Nonspecific chest pain includes ICD 9 Codes 786.5, 786.59, 786.51, 414.01, and 411.1 and ICD 10 Codes R079, R0789, R072, and I2510.[10]

247. At non-HCA hospitals nationally, the admission rate for Medicare patients with nonspecific chest pain as admitting diagnosis or principal diagnosis declined from 68 percent in 2010 to 64 percent in 2011, 60 percent in 2012, 56 percent in 2013, 51 percent in 2014, 45 percent in 2015, and 45 percent in 2016.

[10] ICD-10 codes were used for the fourth quarter of 2015 and 2016 claims data due to the transition to the ICD-10 coding system beginning on October 1, 2015.

248. In contrast, the opposite happened at HCA hospitals, with national admission rates for these patients increasing from 59 percent in 2010 to 65 percent in 2011, 72 percent in 2012, 74 percent in 2013, 71 percent in 2014, 76 percent in 2015, and 79 percent in 2016.

249. For the time period 2010-2016, the claims data show a widening gap between the admission rates for these Medicare patients at HCA hospitals compared to non-HCA hospitals. In 2010, HCA hospitals' national admission rate for these patients was 9 percentage points **below** non-HCA hospitals. A major swing occurred in the following years, with HCA hospitals' admission rates for these patients increasing every year to 12 percentage points **above** non-HCA hospitals in 2012, 18 percentage points **above** non-HCA hospitals in 2013, 20 percentage points **above** non-HCA hospitals in 2014, 31 percentage points **above** non-HCA hospitals in 2015, and 34 percentage points **above** non-HCA hospitals in 2016.



250. HCA's national admission rates associated with an admitting or principal diagnosis of nonspecific chest pain moved from 9 percentage points **below** non-HCA hospitals in 2010 to 34 percentage points **above** non-HCA hospitals in 2016.

251. Each year from 2012-2016, HCA's national admission rates from observation status for Medicare patients with an admitting or principal diagnosis of nonspecific chest pain were approximately double the rate at non-HCA hospitals.

252. In 2012 at non-HCA hospitals, the national average rate of admission for these patients from observation status was 32 percent. The rate at HCA hospitals was 62 percent.

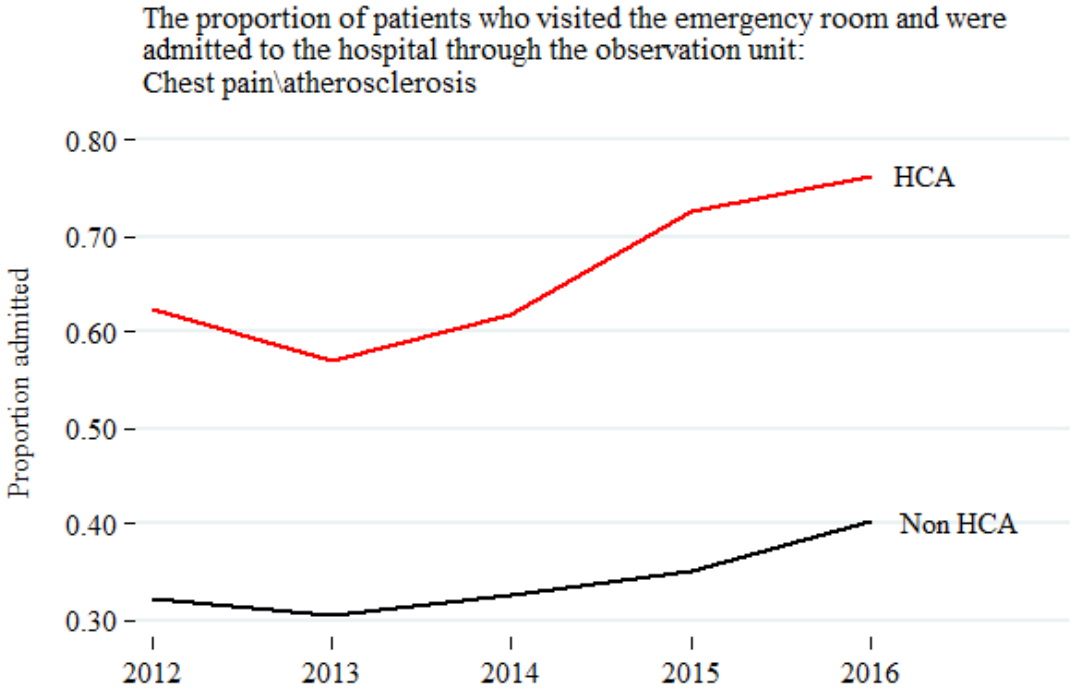
253. In 2013 at non-HCA hospitals, the national average rate of admission for these patients from observation status was 30 percent. The rate at HCA hospitals was 57 percent.

254. In 2014 at non-HCA hospitals, the national average rate of admission for these patients from observation status was 33 percent. The rate at HCA hospitals was 62 percent.

255. In 2015 at non-HCA hospitals, the national average rate of admission for these patients from observation status was 35 percent. The rate at HCA hospitals was 73 percent.

256. In 2016 at non-HCA hospitals, the national average rate of admission for these patients from observation status was 40 percent. The rate at HCA hospitals was 76 percent.

257. HCA's national admission rate for these patients from observation status jumped from 57 percent in 2013 to 76 percent in 2016.



HCA Hospitals' Rates of Admissions with Admitting Diagnosis or Principal Diagnosis of Dizziness or Vertigo

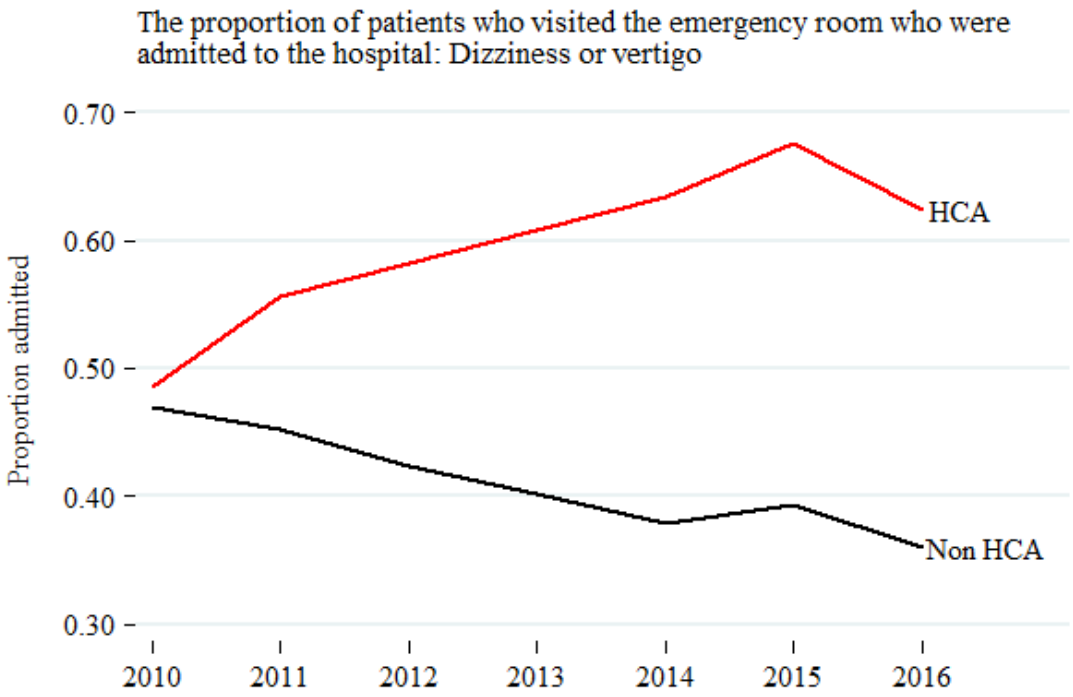
258. Dizziness or vertigo includes ICD 9 Code 780.4 and ICD 10 Code R42.

259. At non-HCA hospitals, the national admission rates for Medicare patients with dizziness or vertigo as admitting diagnosis or principal diagnosis declined from 47 percent in 2010 to 45 percent in 2011, 42 percent in 2012, 40 percent in 2013, 38 percent in 2014, 39 percent in 2015, and 36 percent in 2016.

260. In contrast, the opposite happened at HCA hospitals as admission rates for these patients increased from 48 percent in 2010 to 56 percent in 2011, 58 percent in 2012, 61 percent in 2013, 63 percent in 2014, 68 percent in 2015, and 62 percent in 2016.

261. The claims data again show a widening gap between the admission rates at HCA hospitals compared to non-HCA hospitals. In 2011, HCA hospitals' admission rate for these patients was 11 percentage points above non-HCA hospitals. That gap increased to 16 percentage

points in 2012, 21 percentage points in 2013, 23 percentage points in 2014, 29 percentage points in 2015, and 26 percentage points in 2016.



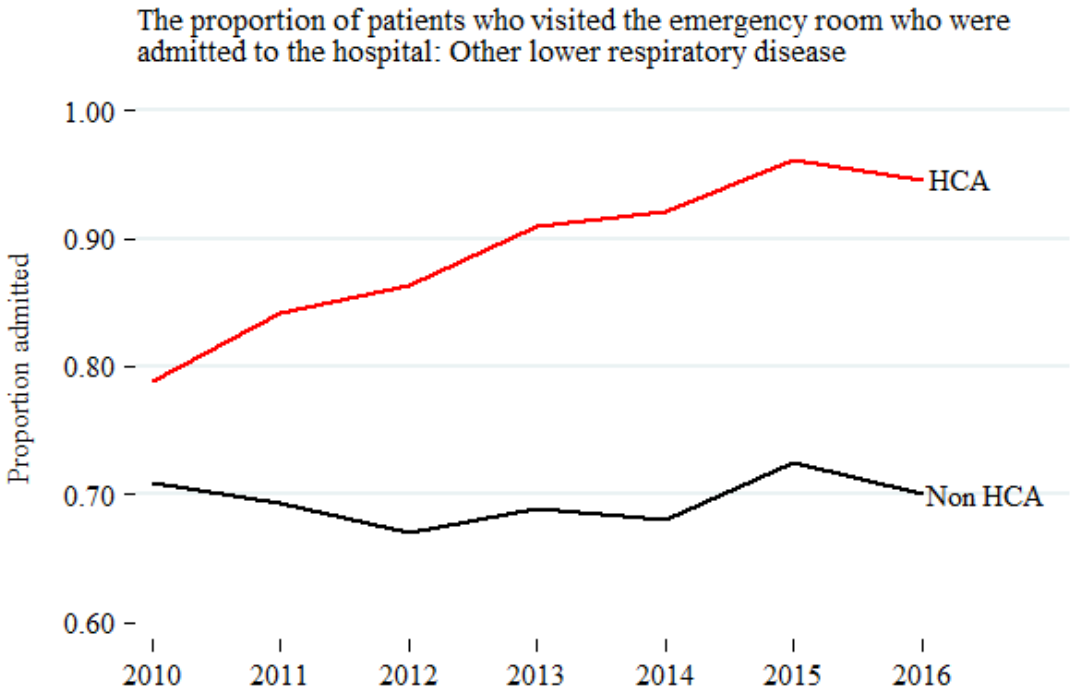
HCA Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of "Other Lower Respiratory Disease"

262. Other lower respiratory disease includes ICD 9 Codes 786.2, 786.05, 786.09, 786.52, and 786.07 and ICD 10 Codes R05, R0602, R0600, R0781, and R062.

263. In 2010 at non-HCA hospitals, Medicare patients with an admitting diagnosis or principal diagnosis of "other lower respiratory disease" were admitted 70 percent of the time as inpatients. That percentage stayed stable in subsequent years, moving to 69 percent in 2011, 67 percent in 2012, 69 percent in 2013, 68 percent in 2014, 73 percent in 2015, and 70 percent in 2016.

264. In contrast, at HCA hospitals between 2010 and 2016, the percentages of these patients admitted as inpatients increased from 78 percent in 2010 to 84 percent in 2011, 86 percent in 2012, 91 percent in 2013, 92 percent in 2014, 96 percent in 2015, and 95 percent in 2016.

265. The national Medicare claims data again show a widening gap between the admission rates at HCA hospitals compared to non-HCA hospitals. In 2010, HCA hospitals' admission rate for these patients was 8 percentage points above non-HCA hospitals' rate. That gap increased to 15 percentage points in 2011, 19 percentage points in 2012, 22 percentage points in 2013, 24 percentage points in 2014, 23 percentage points in 2015, and 25 percentage points in 2016.



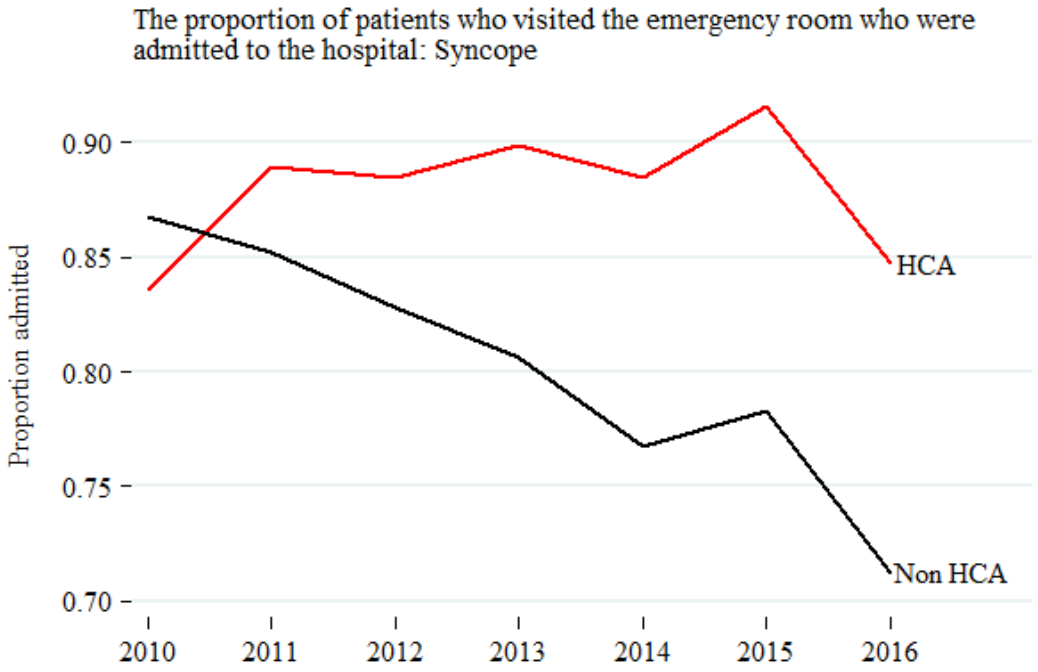
HCA Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of Syncope

266. Syncope includes ICD 9 Code 780.2 and ICD 10 Code R55.

267. At non-HCA hospitals, the overall admission rate for Medicare patients with an admitting diagnosis or principal diagnosis of syncope declined from 85 percent in 2011 to 83 percent in 2012, 81 percent in 2013, 77 percent in 2014, 78 percent in 2015, and 71 percent in 2016.

268. In contrast, the admission rates for these patients at HCA hospitals increased in multiple years, moving from 83 percent in 2010 to 89 percent in 2011, 88 percent in 2012, 90 percent in 2013, 88 percent in 2014, 92 percent in 2015, and 85 percent in 2016.

269. The national Medicare claims data again demonstrate another widening gap between the admission rates at HCA hospitals as compared to the admission rates at non-HCA hospitals. In 2010, HCA hospitals' admission rate for these patients was 3 percentage points **below** the admission rate at non-HCA hospitals. In 2011, HCA hospitals' admission rate for these patients was 4 percentage points **above** non-HCA hospitals. That gap increased to 5 percentage points in 2012, 9 percentage points in 2013, 11 percentage points in 2014, 14 percentage points in 2015, and 14 percentage points again in 2016.



HCA Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of Nausea and Vomiting

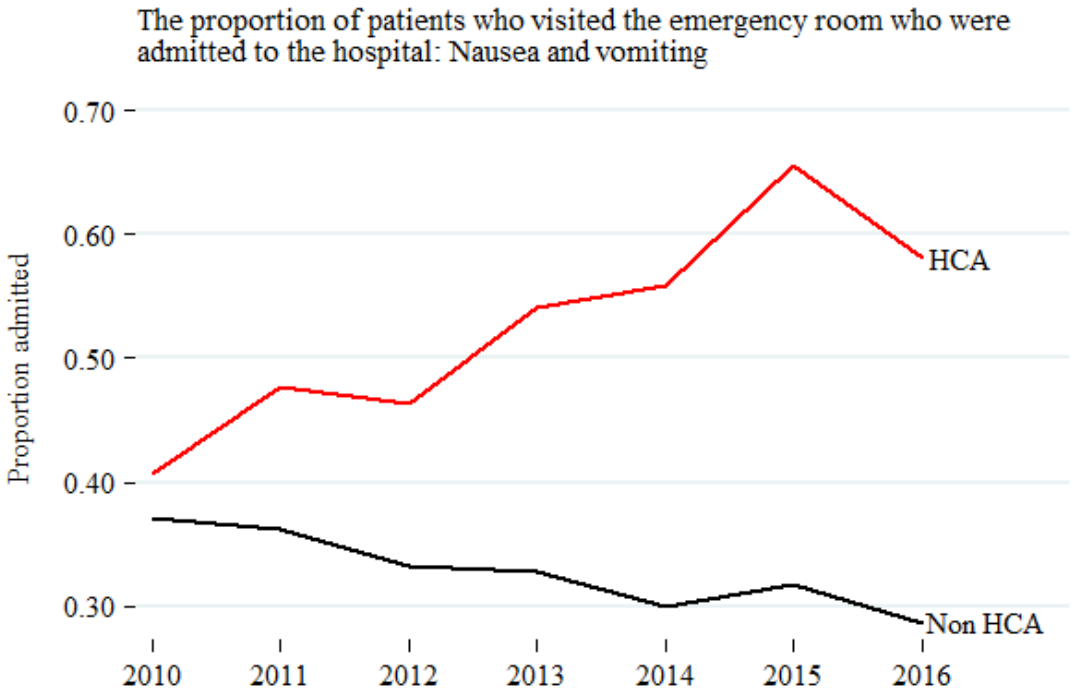
270. Nausea and vomiting include ICD 9 Codes 787.01, 787.02, and 787.03 and ICD 10 Codes R112, R1110, R110, and R1111.

271. In 2010 at non-HCA hospitals, Medicare patients with an admitting diagnosis or principal diagnosis of "nausea or vomiting" were admitted 37 percent of the time as inpatients. That percentage declined in subsequent years, moving to 36 percent in 2011, 33 percent in 2012, 33 percent in 2013, 30 percent in 2014, 32 percent in 2015, and 29 percent in 2016.

272. In contrast, at HCA hospitals between 2010 and 2016, the percentages of these patients admitted to inpatient status escalated to levels double the rates at non-HCA hospitals. In 2010, 40 percent of these patients were moved to inpatient status. That percentage increased to 48 percent in 2011, 54 percent in 2013, 56 percent in 2014, 66 percent in 2015, and 58 percent in 2016.

273. In 2015, the admission rate for these patients at HCA hospitals (66 percent) was more than double the rate at non-HCA hospitals (32 percent). In 2016, the admission rate for these patients at HCA hospitals (58 percent) was exactly double the rate at non-HCA hospitals (29 percent).

274. The national Medicare claims data again show a widening gap between the admission rates at HCA hospitals compared to non-HCA hospitals. In 2010, HCA hospitals' admission rate for these patients was 3 percentage points above non-HCA hospitals. That gap increased to 12 percentage points in 2011, 13 percentage points in 2012, 21 percentage points in 2013, 26 percentage points in 2014, 34 percentage points in 2015, and 29 percentage points in 2016.



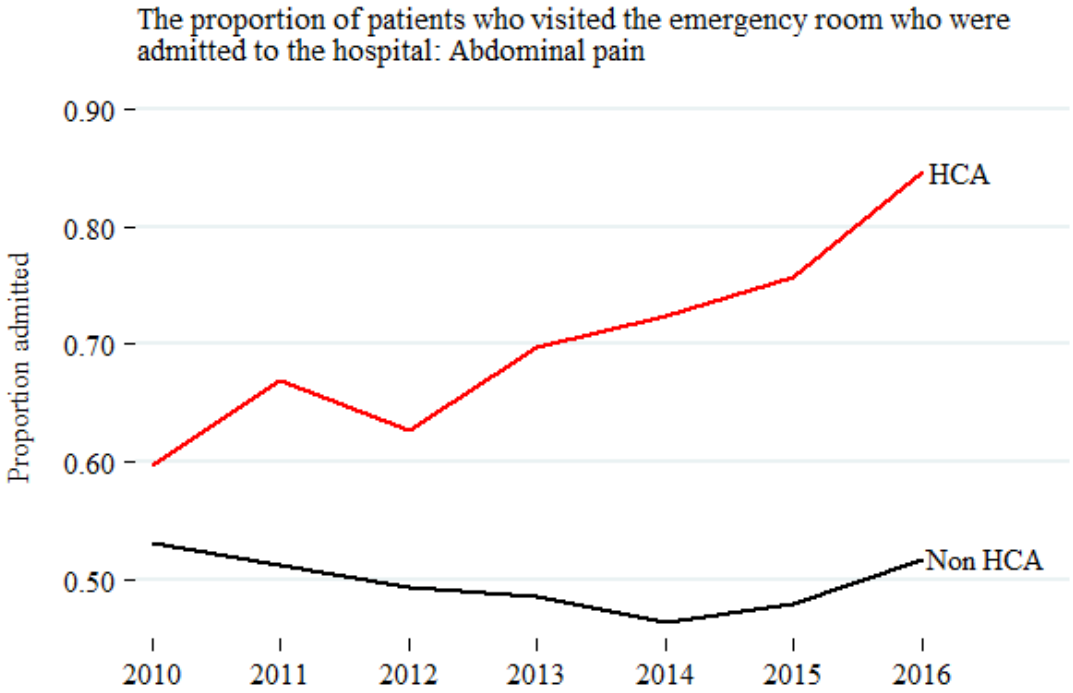
HCA Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of Abdominal Pain

275. Abdominal pain includes ICD 9 Codes 789, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, and 789.09 and ICD 10 Codes R102, R109, F1010, R1011, R1012, R1013, R1030, R1031, R1032, R1033, and R1084.

276. At non-HCA hospitals between 2010 and 2016, the admission rates for these patients declined in multiple years, moving from 53 percent in 2010 to 51 percent in 2011, 49 percent in 2012, 49 percent in 2013, 46 percent in 2014, 48 percent in 2015, and 52 percent in 2016.

277. In contrast, at HCA hospitals between 2010 and 2016, the percentages of these patients admitted to inpatient status increased significantly. In 2010, 59 percent of these patients were moved to inpatient status. That percentage increased to 67 percent in 2011, 70 percent in 2013, 72 percent in 2014, 76 percent in 2015, and 85 percent in 2016.

278. The national Medicare claims data again shows a widening gap between the admission rates at HCA hospitals compared to non-HCA hospitals. In 2010, HCA hospitals' admission rate for these patients was 6 percentage points above the rate at non-HCA hospitals. That gap increased to 16 percentage points in 2011, 14 percentage points in 2012, 21 percentage points in 2013, 26 percentage points in 2014, 28 percentage points in 2015, and 33 percentage points in 2016.



HCA Admission Rates Associated with Admitting or Principal Diagnosis of Malaise and Fatigue

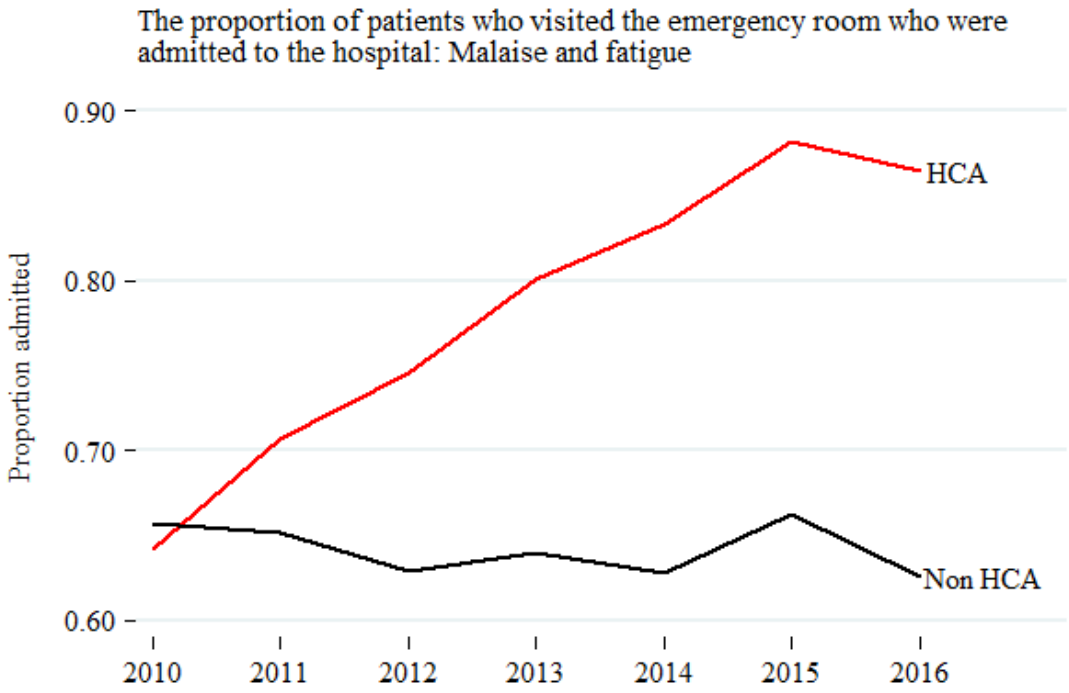
279. Malaise and fatigue include ICD 9 Codes 780.79 and ICD 10 Codes R531, R5383, and R5381.

280. At non-HCA hospitals between 2010 and 2016, the admission rates for Medicare patients with malaise and fatigue as admitting diagnosis or principal diagnosis stayed stable at 65 percent in 2010, 65 percent in 2011, 63 percent in 2012, 64 percent in 2013, 63 percent in 2014, 66 percent in 2015, and 63 percent in 2016.

281. In contrast at HCA hospitals nationally, the admission rates for these patients increased significantly, moving from 64 percent in 2010 to 71 percent in 2011, 75 percent in 2012, 80 percent in 2013, 83 percent in 2014, 88 percent in 2015, and 86 percent in 2016.

282. The claims data again show a widening gap between the admission rates at HCA hospitals compared to non-HCA hospitals. In 2010, HCA hospitals' admission rate for these

patients was 1 percentage point **below** the admission rate at non-HCA hospitals. One year later in 2011, HCA hospitals' admission rate for these patients was 6 percentage points **above** the admission rate at non-HCA hospitals. That gap increased in each of the following years, moving to 12 percentage points in 2012, 16 percentage points in 2013, 20 percentage points in 2014, 22 percentage points in 2015, and 23 percentage points in 2016.



HCA Hospitals' Admission Rates Associated with Admitting or Principal Diagnosis of Spondylosis, Disc Disorders, or Other Back Problems

283. Spondylosis, disc disorders, or other back problems include ICD 9 Codes 724.2, 724.5, 723.1, 724.1, and 724.3 and ICD 10 Codes M542, M545, M546, M549, and M4806.

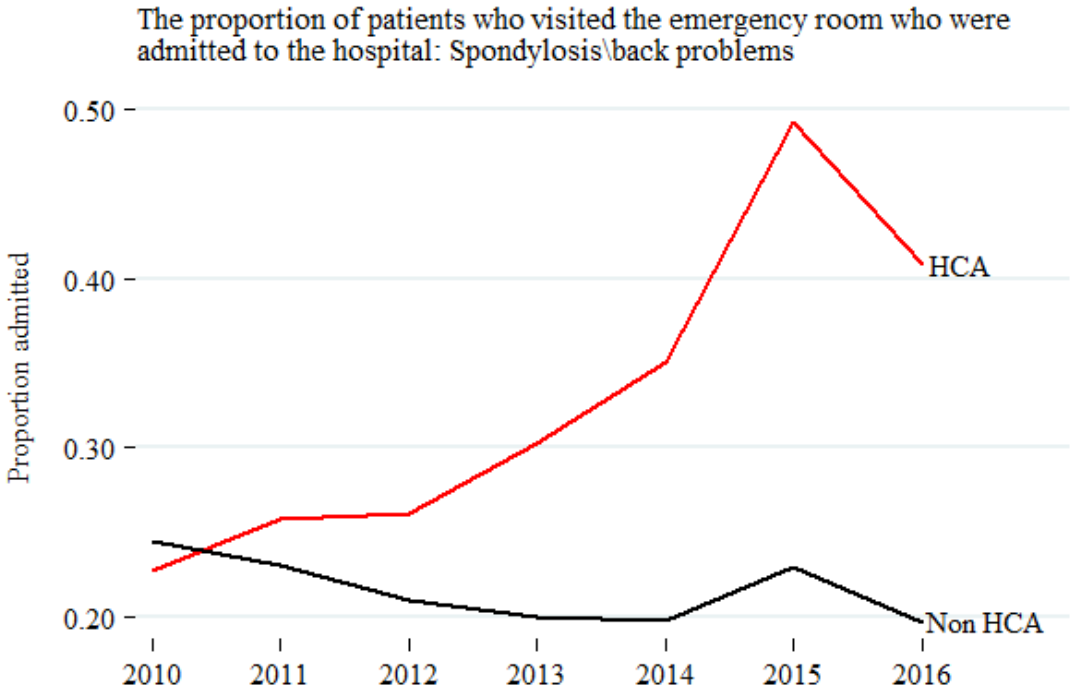
284. Patients with an admitting or principal diagnosis of spondylosis, intervertebral disc disorders, or other back problems have experienced significantly elevated admission rates at HCA hospitals as compared to non-HCA hospitals.

285. In 2010 at non-HCA hospitals, Medicare patients with an admitting diagnosis or principal diagnosis of spondylosis, intervertebral disc disorders, or other back problems were admitted 24 percent of the time as inpatients. The admission rate declined below that level in each of the six subsequent years at non-HCA hospitals, moving to 23 percent in 2011, 21 percent in 2012, 20 percent in 2013, 20 percent in 2014, back up to 23 percent in 2015, and then back down to 20 percent in 2016.

286. In contrast at HCA hospitals between 2010 and 2016, inpatient admissions for these patients escalated to levels double the rates at non-HCA hospitals. In 2010, 22 percent of these patients were moved to inpatient status. That percentage increased to 26 percent in 2012, 30 percent in 2013, 35 percent in 2014, 49 percent in 2015, and 41 percent in 2016.

287. In both 2015 and 2016, the admission rates for these patients at HCA hospitals were over double the rate at non-HCA hospitals. (49 percent at HCA hospitals compared to 23 percent at non-HCA hospitals in 2015 and 41 percent at HCA hospitals compared to 20 percent at non-HCA hospitals in 2016).

288. The claims data again show a widening gap between the admission rates associated with these admitting or principal diagnoses at HCA hospitals compared to non-HCA hospitals. In 2010, HCA hospitals' admission rate for these patients was 2 percentage points **below** the admission rate at non-HCA hospitals. By 2013, HCA hospitals' admission rate for these patients was 10 percentage points **above** the rate at non-HCA hospitals. That gap increased to 15 percentage points in 2014, 26 percentage points in 2015, and 21 percentage points in 2016.



National Medicare Claims Data Demonstrate HCA's Strategy to Increase Admissions from Observation Status

289. The detailed data relied upon by Realtor include: (1) the admission rates from observation status for all diagnoses, the 8 diagnostic categories combined, and each diagnostic category at each HCA hospital during 2012-2016, (2) the numbers of inpatients admissions from observation status and ED visits for all diagnoses, the 8 diagnostic categories, and each diagnostic category at each HCA hospital during 2012-2016, (3) and average admission rates from observation status for non-HCA hospitals, all HCA hospitals, HCA Florida hospitals, HCA East Florida Division hospitals, HCA Florida hospitals not in the East Florida Division, and HCA hospitals not in Florida during 2012-2016.

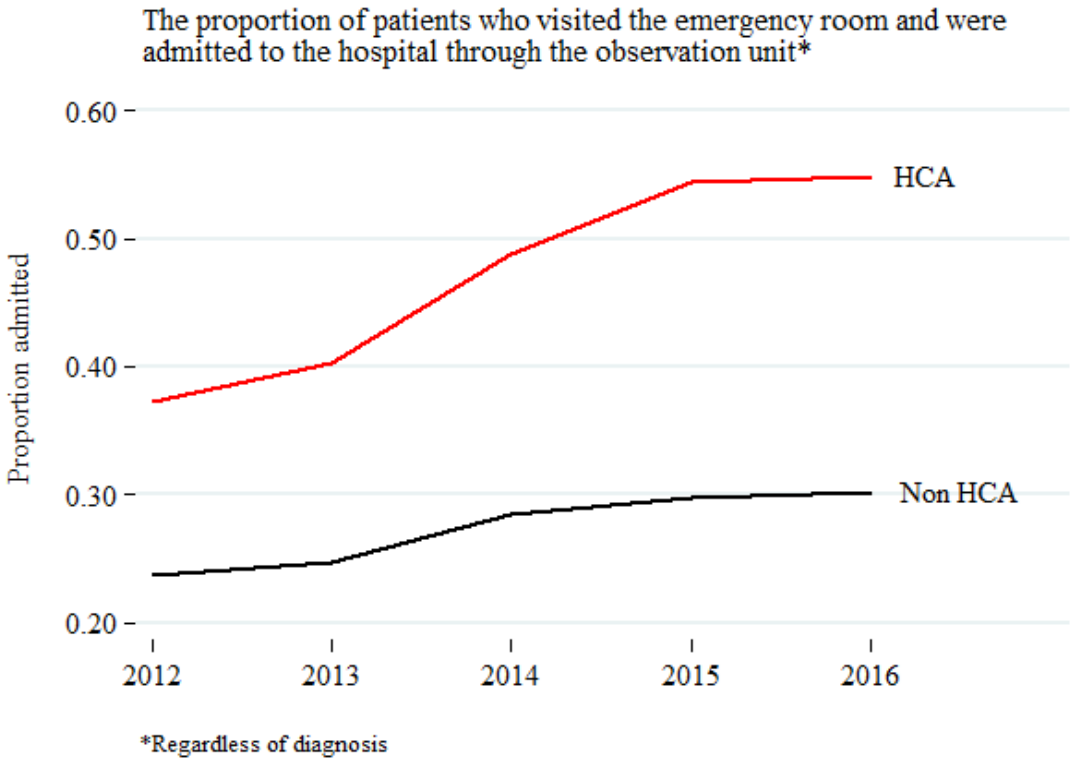
290. For all diagnoses at non-HCA hospitals over the time period 2012-2016, the admission rates for Medicare patients from observation status stayed between 24-30 percent. At

non-HCA hospitals the average national admission rate from observation status was 24 percent in 2012, 25 percent in 2013, 29 percent in 2014, 30 percent in 2015, and 30 percent in 2016.

291. In contrast at HCA hospitals nationally, the admission rates from observation status moved from 37 percent in 2012 to 40 percent in 2013, 49 percent in 2014, 54 percent in 2015, and 55 percent in 2016.

292. In 2012, HCA hospitals' admission rate from observation status was 13 percentage points higher than the admission rate from observation status at non-HCA hospitals. The gap widened in each of the subsequent years, moving to 15 percentage points in 2013, 20 percentage points in 2014, 24 percentage points in 2015, and 25 percentage points in 2016.

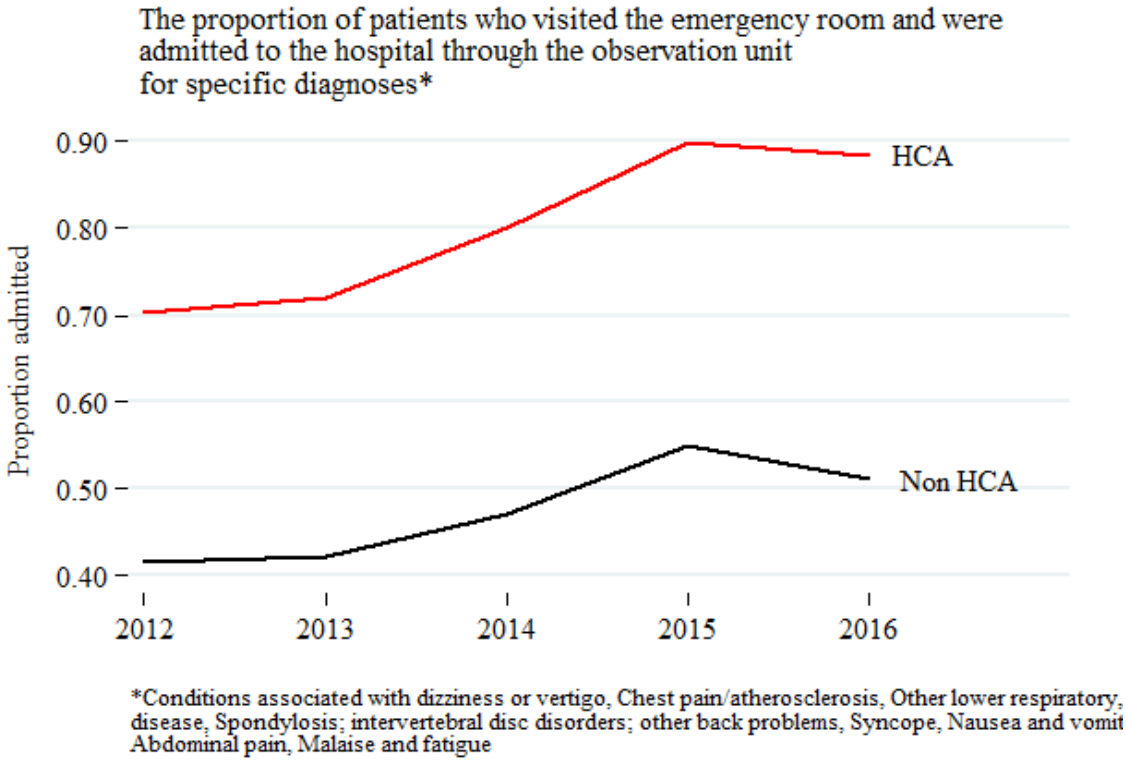
293. By 2015 and 2016, HCA hospitals' national rate of admissions from observation status (54 and 55 percent) was nearly double the national rate at non-HCA hospitals (30 percent).



294. Among major hospital systems, HCA hospitals' rates of Medicare admissions from observation status were the highest in the United States between 2014-2016. For example, in 2014, HCA's rate of admissions from observation status was 49 percent, while Prime Healthcare's rate was 24 percent, Community Health's rate was 32 percent, and Tenet Healthcare's rate was 33 percent. In 2015, HCA's rate of admissions from observation status was 54 percent, while Prime Healthcare's rate was 20 percent, Community Health's rate was 34 percent, and Tenet's rate was 34 percent. In 2016, HCA hospitals' rate of admission from observation status was 55 percent, while Prime Healthcare's rate was 25 percent, Community Health's rate was 36 percent, and Tenet's rate was 37 percent.

295. With respect to the 8 diagnostic categories overall, from 2013-2016, the average rate of admission from observation status at non-HCA hospitals was 49 percent. In contrast, the rate at HCA hospitals was 85 percent.

296. With respect to the 8 diagnostic categories overall at HCA hospitals, the national average rate of admission from observation status jumped from 70 percent in 2012 to 90 percent in 2015 and 88 percent in 2016.



The Leading 41 HCA Hospitals with Excessive Admission Rates

Summary of Medicare Admission Rates

297. The national Medicare claims data demonstrate excessive admission rates across HCA's national hospital system. The 41 HCA hospitals named as Defendants have led HCA's scheme with extraordinary admission rates and damages to the Medicare Program. These 41 hospitals are listed in alphabetical order as follows:

Aventura Hospital and Medical Center
Bayshore Medical Center
Blake Medical Center
Brandon Regional Hospital
Chippenham Hospital
Clear Lake Regional Medical Center
Conroe Regional Medical Center
Fawcett Memorial Hospital
JFK Medical Center
Kendall Regional Medical Center

Kingwood Medical Center
Largo Medical Center
Lawnwood Regional Medical Center
Los Robles Hospital and Medical Center
Medical Center of Trinity
Medical City Fort Worth
Medical City Hospital
Medical City McKinney
Medical City Plano
Memorial Hospital
Methodist Hospital
Mountain View Hospital
North Florida Regional Medical Center
Northside Hospital & Tampa Bay Heart Institute
Northwest Medical Center
Oak Hill Hospital
Ocala Regional Medical Center
Orange Park Medical Center
Osceola Regional Medical Center
Palms West Hospital
Plantation General Hospital
Raulerson Hospital
Regional Medical Center Bayonet Point
Regional Medical Center of San Jose
Saint Lucie Medical Center
South Bay Hospital
Sunrise Hospital & Medical Center
University Hospital and Medical Center
West Florida Hospital
West Houston Medical Center
Westside Regional Medical Center

298. Among these 41 hospitals, 26 are located in Florida, including 11 hospitals that are members of the HCA East Florida Division. The other 15 hospitals are located in Texas, Nevada, Virginia, and California.

299. The following summarizes admission rates at the 41 HCA hospitals named as Defendants in this First Amended Complaint.

300. The detailed data relied upon by Realtor include: (1) the admission rates for all diagnoses, the 8 diagnostic categories combined, and each diagnostic category at each of the 41 HCA hospitals during 2010-2016, (2) the numbers of inpatients admissions and ED visits for all

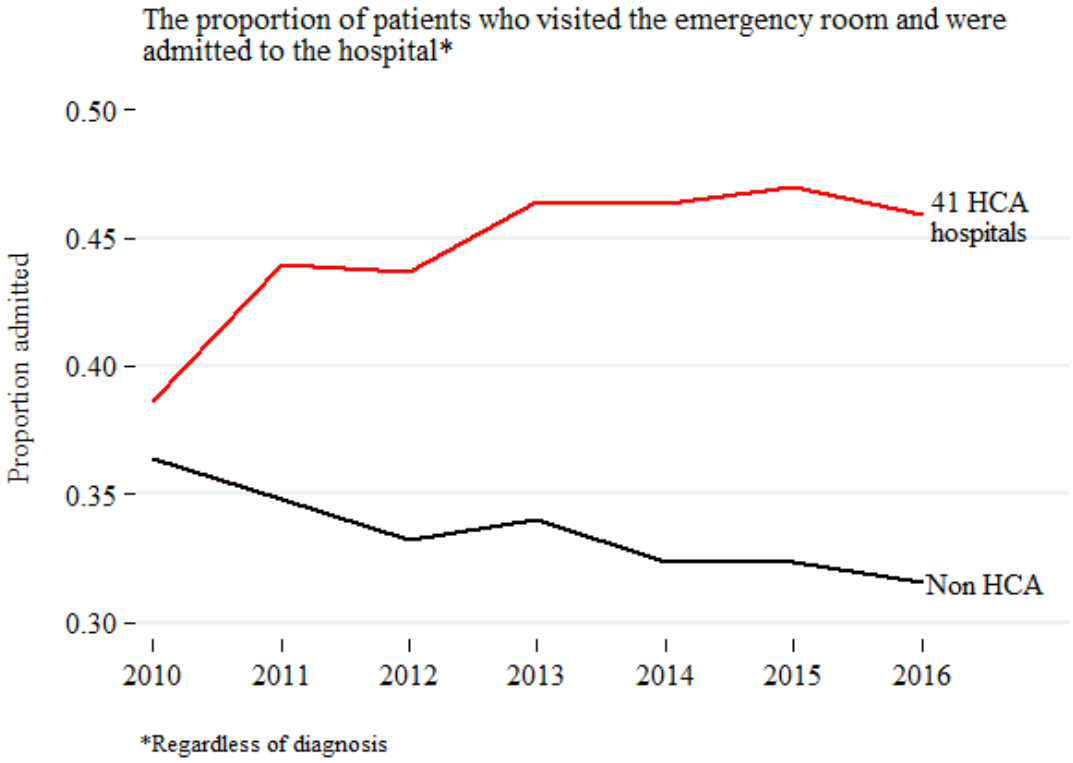
diagnoses, the 8 diagnostic categories, and each diagnostic category at each of the 41 HCA hospitals during 2010-2016, (3) and average admission rate calculations for non-HCA hospitals, all HCA hospitals, HCA Florida hospitals, HCA East Florida Division hospitals, HCA Florida hospitals not in the East Florida Division, HCA hospitals not in Florida, and the 41 HCA hospitals combined.

301. All of the admission rates discussed in the following paragraphs are for Medicare patients only at these 41 HCA hospitals.

302. For the years 2013-2016, the overall admission rate for all diagnoses at these 41 hospitals was 46 percent as compared to the national average of 33 percent at non-HCA hospitals.

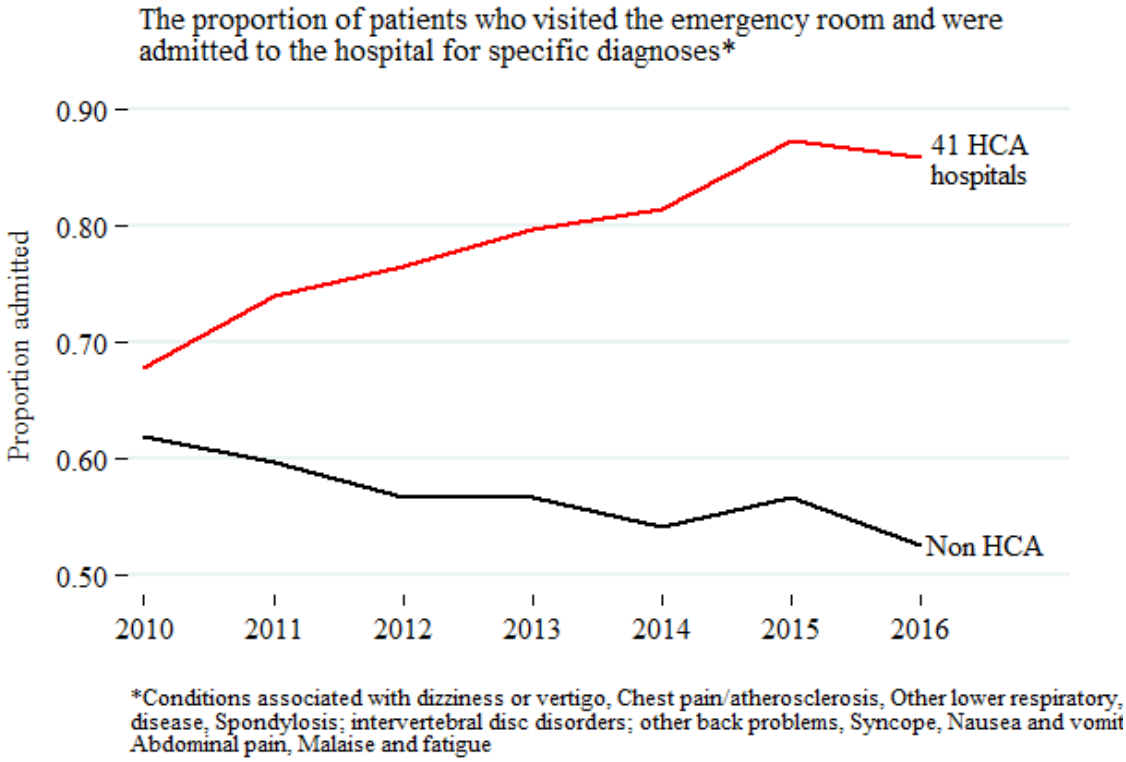
303. For all diagnoses and the 8 diagnostic categories, the graphs repeatedly reflect a widening gap between the admission rates at these 41 HCA hospitals compared to the admission rates at non-HCA hospitals. As discussed above, with respect to the 8 diagnostic categories, the data analyses focused on admitting or primary diagnoses reported by the hospitals.

304. The following graph illustrates overall admission rates for all diagnoses at these 41 HCA hospitals as compared to the average national rates at non-HCA hospitals. The graph illustrates the rising admission rates for all diagnoses at the 41 HCA hospitals while admission rates declined at non-HCA hospitals.



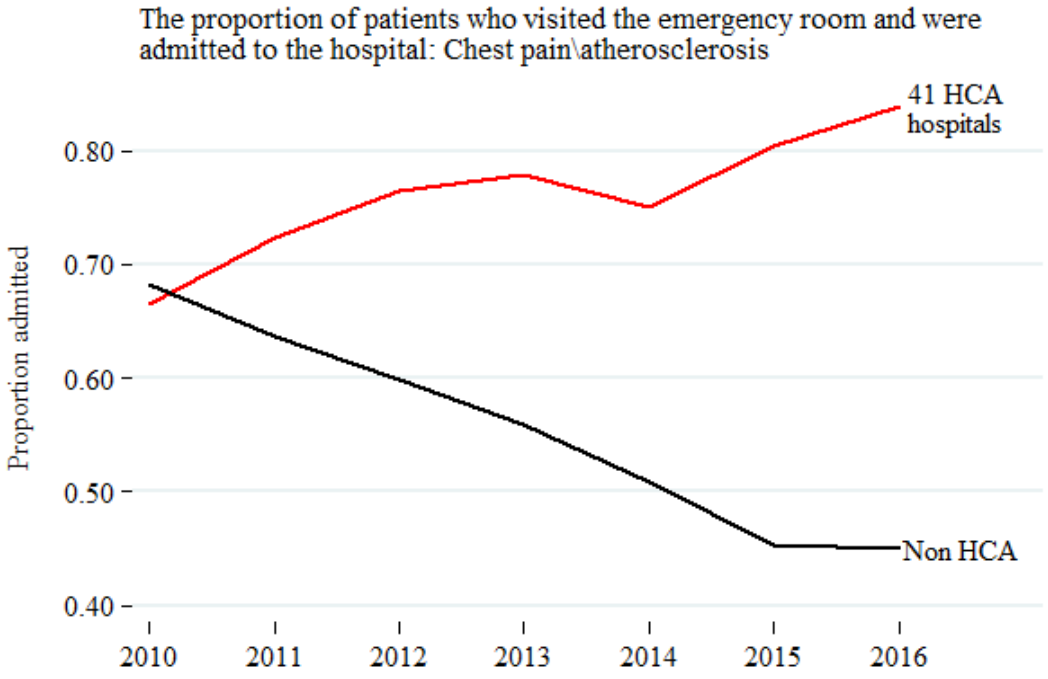
305. For the years 2013-2016 at these 41 hospitals, the average admission rate associated with the 8 diagnostic categories was 84 percent as compared to the national average of 55 percent at non-HCA hospitals.

306. With respect to the 8 diagnostic categories overall, the following graph illustrates the elevated admission rates of Medicare patients at these 41 HCA hospitals as compared to the national average admission rates at non-HCA hospitals.

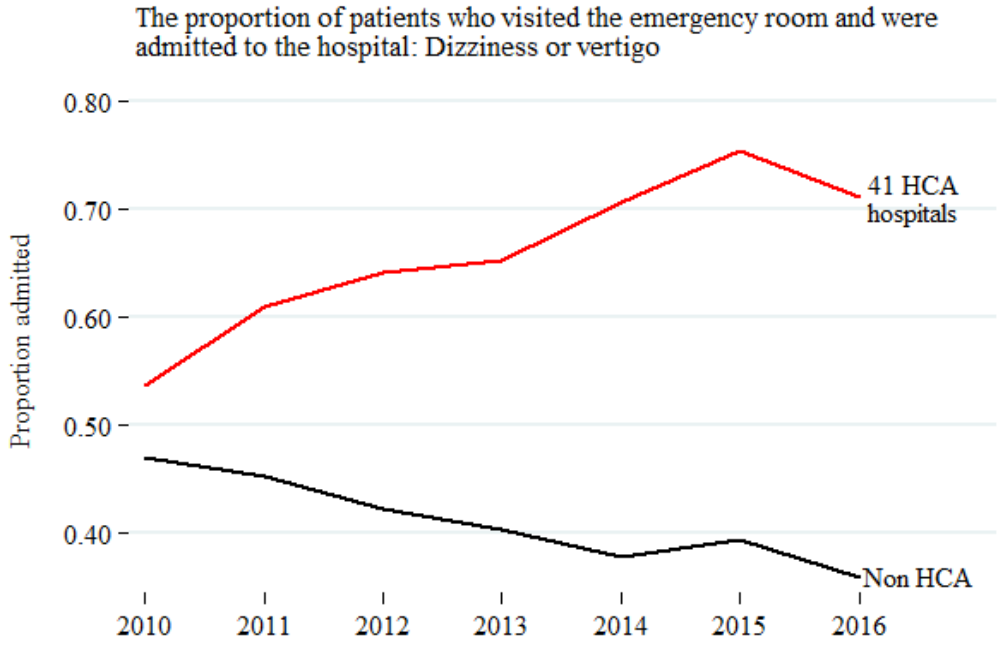


307. For each of the 8 diagnostic categories, the graphs illustrate the rising admission rates at these 41 HCA hospitals far above and contrary to patterns of national average admission rates at non-HCA hospitals.

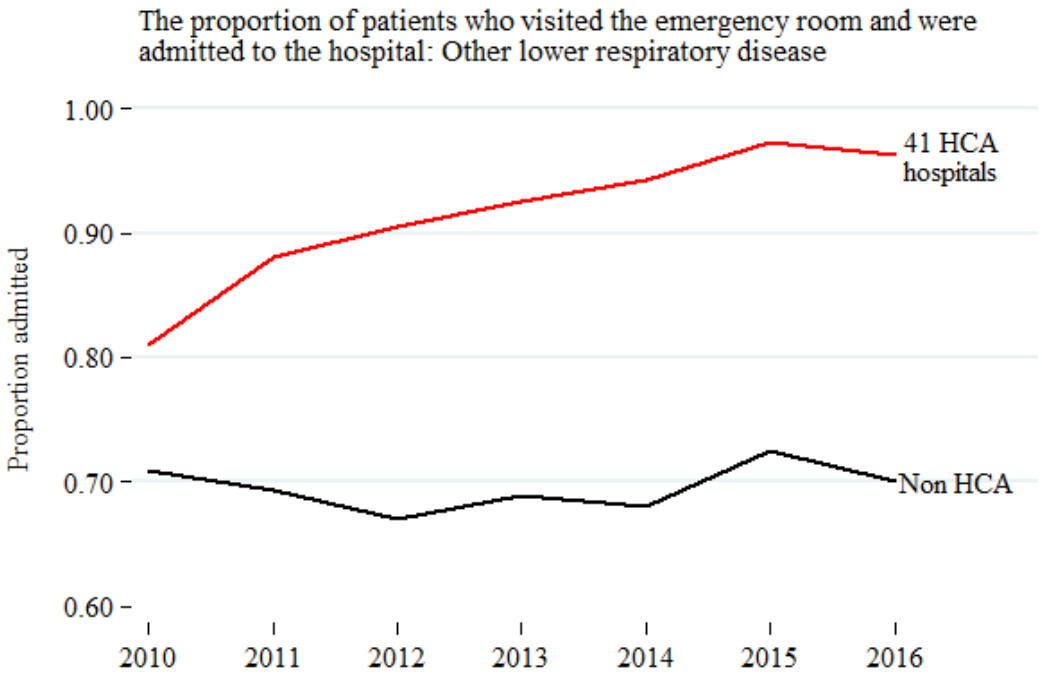
308. With respect to the diagnostic category of non-specific chest pain, the following graph illustrates the elevated admission rates at these 41 HCA hospitals as compared to non-HCA hospitals.



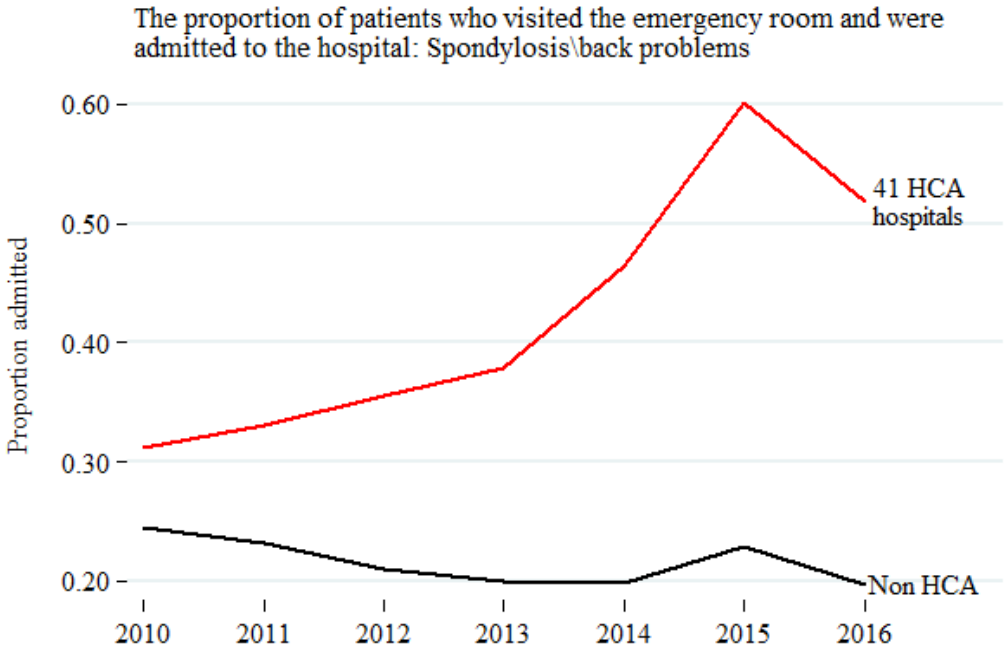
309. With respect to the diagnostic category of dizziness or vertigo, the following graph illustrates the elevated admission rates at these 41 HCA hospitals as compared to non-HCA hospitals.



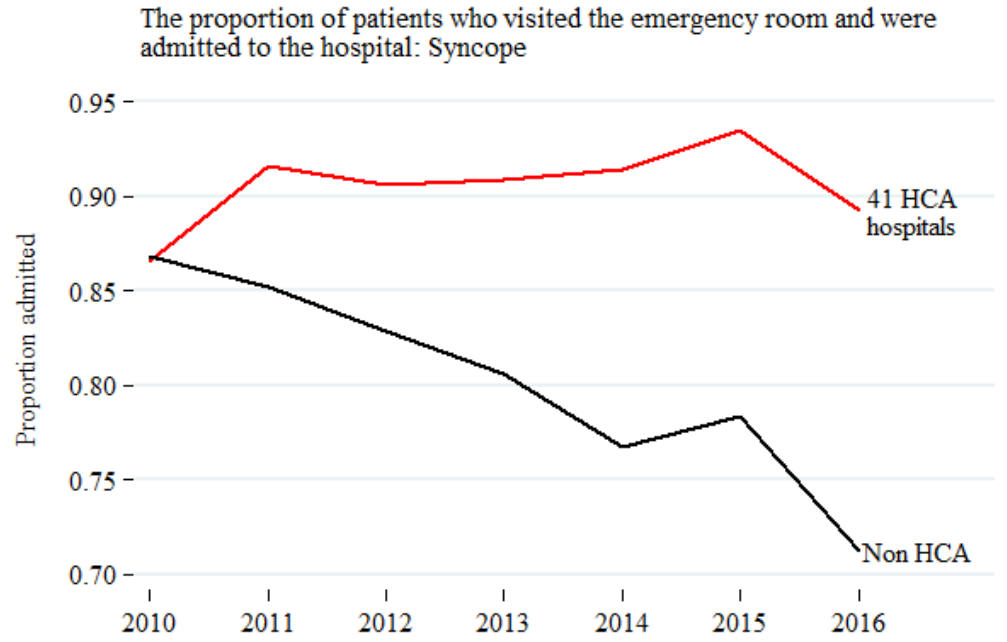
310. With respect to the diagnostic category of other respiratory disease, the following graph illustrates the elevated admission rates at these 41 HCA hospitals as compared to non-HCA hospitals.



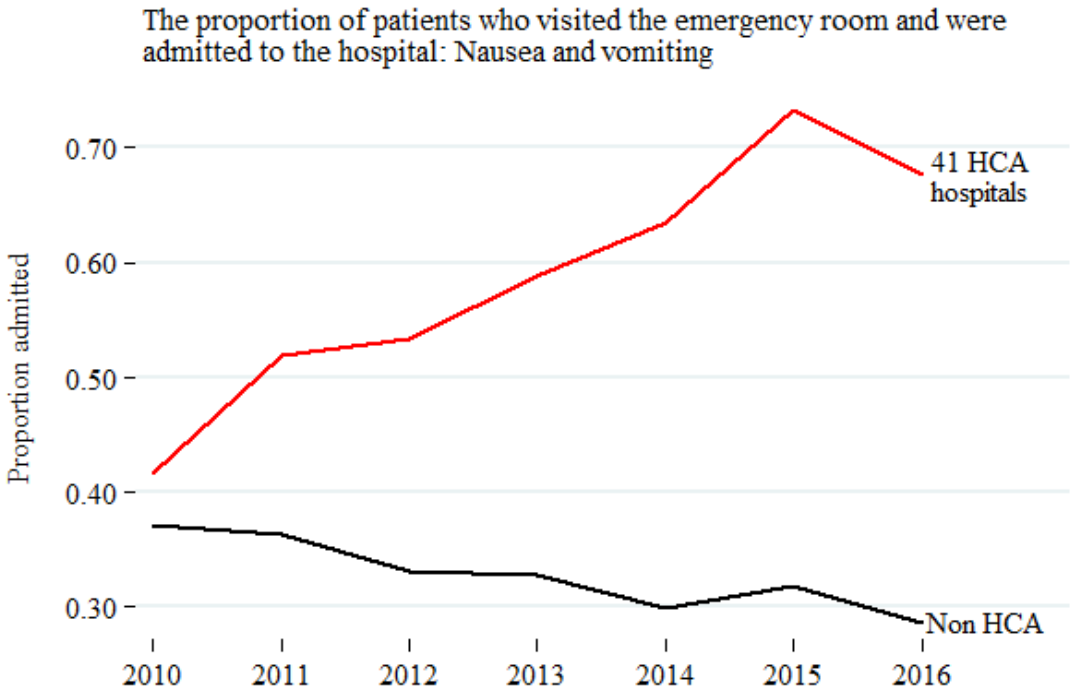
311. With respect to the diagnostic category of spondylosis/back problems, the following graph illustrates the elevated admission rates at these 41 HCA hospitals as compared to non-HCA hospitals.



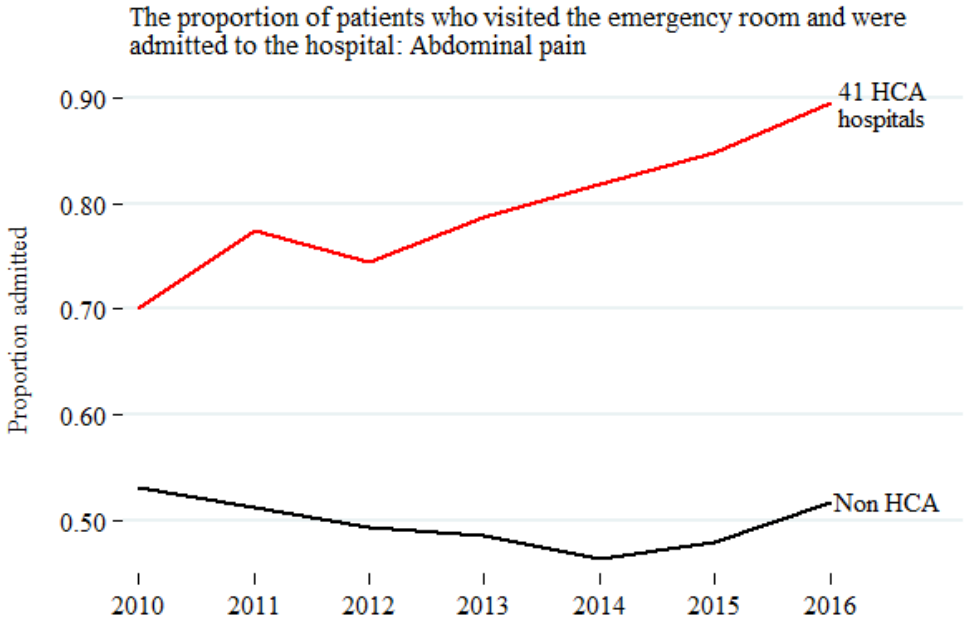
312. With respect to the diagnostic category of syncope, the following graph illustrates the elevated admission rates of Medicare patients at these 41 HCA hospitals as compared to the national average admission rates at non-HCA hospitals.



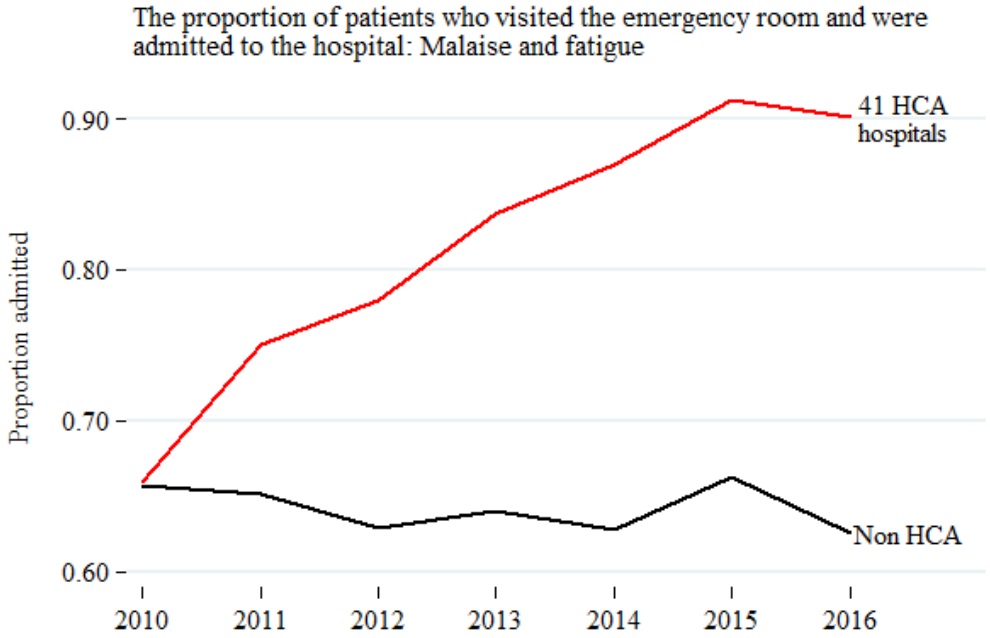
313. With respect to the diagnostic category of nausea and vomiting, the following graph illustrates the elevated admission rates of Medicare patients at these 41 HCA hospitals as compared to the national average admission rates at non-HCA hospitals.



314. With respect to the diagnostic category of abdominal pain, the following graph illustrates the elevated admission rates at these 41 HCA hospitals as compared to non-HCA hospitals.



315. With respect to the diagnostic category of malaise and fatigue, the following graph illustrates the elevated admission rates at these 41 HCA hospitals as compared to non-HCA hospitals.



Summary of Medicare Admission Rates from Observation Status

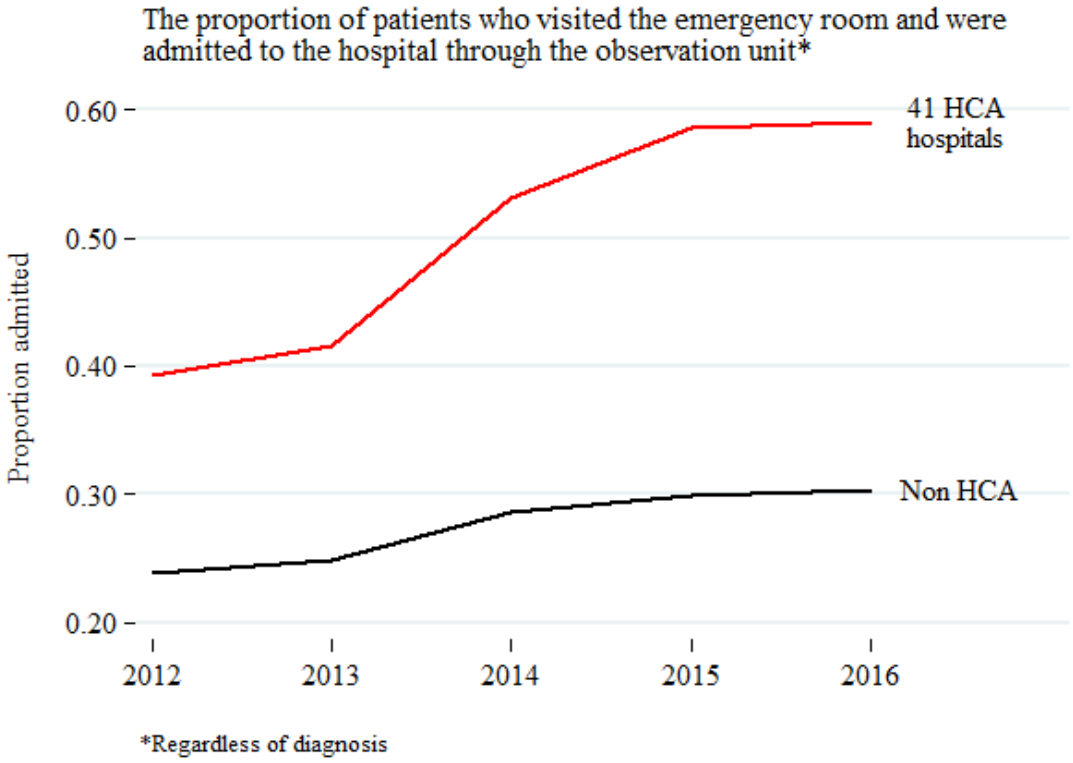
316. Most of these 41 HCA hospitals also experienced significant increases in their admission rates from observation status.

317. The detailed data relied upon by Realtor include: (1) the admission rates from observation status for all diagnoses, the 8 diagnostic categories combined, and each diagnostic category at each of the 41 HCA hospitals during 2012-2016, (2) the numbers of inpatients admissions from observation status and ED visits for all diagnoses, the 8 diagnostic categories, and each diagnostic category at each of the 41 HCA hospitals during 2012-2016, (3) and average admission rates from observation status for non-HCA hospitals, all HCA hospitals, HCA Florida hospitals, HCA East Florida Division hospitals, HCA Florida hospitals not in the East Florida Division, HCA hospitals not in Florida during 2012-2016, and the 41 HCA hospitals combined.

318. Between the years 2012-2016 at non-HCA hospitals nationally, the admission rate for all diagnoses from observation status stayed stable at 24-30 percent. In contrast at these 41 HCA hospitals, the admission rate for all diagnoses from observation status jumped from 39 percent in 2012 to 53 percent in 2014 and 59 percent in 2015 and 2016.

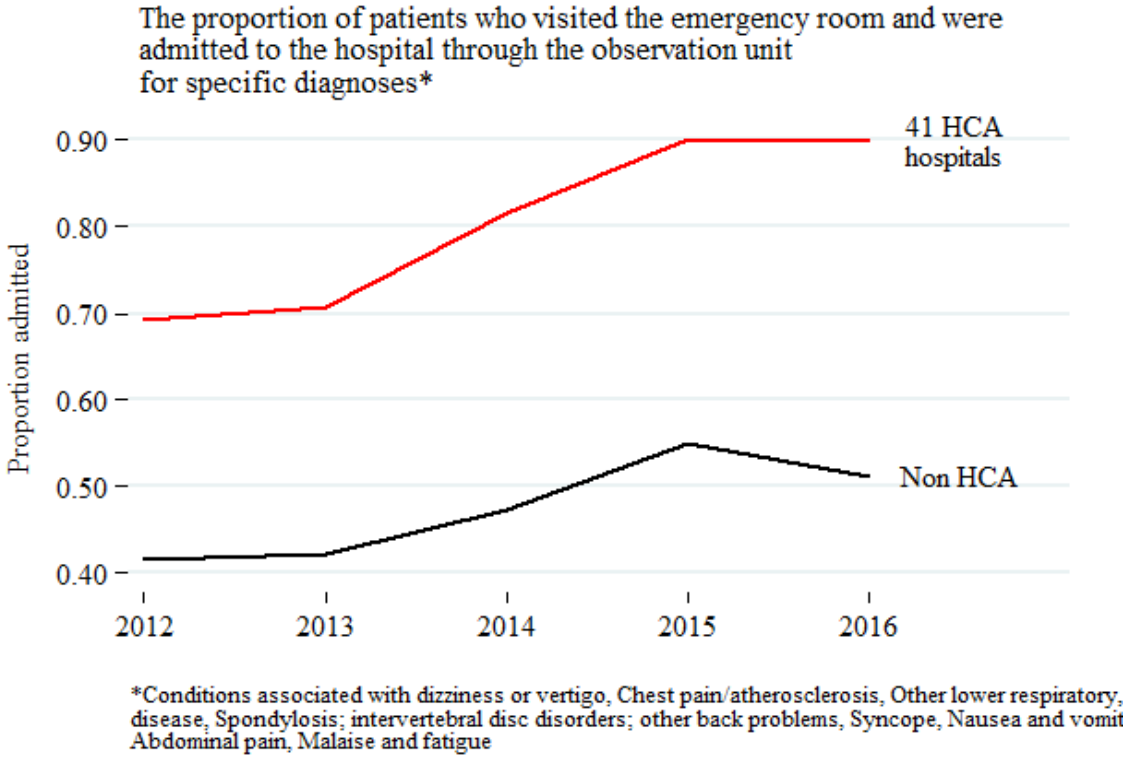
319. From 2013-2016 at non-HCA hospitals, the average rate of admission for all diagnoses from observation status was 29 percent. At these 41 HCA hospitals, the overall admission rate for all diagnoses from observation status was 54 percent.

320. The following graph illustrates the elevated admission rates from observation status for all diagnoses at these 41 HCA hospitals compared to non-HCA hospitals.



321. With respect to the 8 diagnostic categories, from 2013-2016 at non-HCA hospitals, the national average admission rate from observation status was 49 percent. In contrast at these 41 HCA hospitals, the average admission rate from observation status was 85 percent.

322. With respect to the 8 diagnostic categories, the following graph illustrates the elevated overall admission rates from observation status at these 41 HCA hospitals compared to non-HCA hospitals.



Summary of Estimated Damages to Medicare Program

323. For the years 2013-2016 at these 41 HCA hospitals, the excessive admission rates associated with the 8 diagnostic categories represented approximately 72,434 excessive admissions of Medicare patients. Based on Medicare payment data for these 41 HCA hospitals, the estimated damages to the Medicare Program are approximately $588.52 million.

324. For the years 2013-2016 at these 41 hospitals, the overall excessive admission rates (not limited to the 8 diagnostic categories) represented approximately 112,735 excessive admissions of Medicare patients with damages to the Medicare Program of approximately $1.28 billion.

Overview of Admission Rates at Each of the 41 HCA Hospitals

325. These 41 HCA hospitals and their admission rates for Medicare patients are discussed in alphabetical order.

326. With respect to the 8 diagnostic categories overall and the individual diagnostic categories, all of the following admission rates are based on analyses of the diagnoses reported as admitting or principal diagnoses.

Aventura Hospital and Medical Center

327. Aventura Hospital and Medical Center is a member of the HCA East Florida Division. Among these 41 hospitals during the time period 2013-2016, Aventura had the highest admission rate for all diagnoses of 59 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Aventura was 89 percent as compared to the national average of 55 percent at non-HCA hospitals.

328. In 2014 and 2015, Aventura's admission rate for all diagnoses was 60 percent---almost double the national average (32 percent) at non-HCA hospitals.

329. Between 2010 and 2016, the national average admission rate for all diagnoses at non-HCA hospitals declined from 36 percent in 2010 to 35 percent in 2011, 33 percent in 2012, 34 percent in 2013, 32 percent in 2014, 32 percent in 2015, and 32 percent in 2016.

330. In contrast, Aventura's admission rates for all diagnoses jumped from 47 percent in 2010 to 60 percent in 2013, 60 percent in 2014, 60 percent in 2015, and 59 percent in 2016.

331. With respect to the 8 diagnostic categories, the average admission rates at non-HCA hospitals nationally decreased from 62 percent in 2010 to 60 percent in 2011, 57 percent in 2012, 57 percent in 2013, 54 percent in 2014, 57 percent in 2015, and 53 percent in 2016. In contrast,

Aventura's admission rate for the 8 diagnostic categories overall increased from 65 percent in 2010 to 91 percent in 2015 and 89 percent in 2016.

332. In 2010, with respect to the 8 diagnostic categories, the admission rate at Aventura was 65 percent and only 3 percentage points above the national average rate of admission at non-HCA hospitals. That differential jumped to 19 percentage points in 2011, 26 percentage points in 2012, 31 percentage points in 2013, 34 percentage points in 2014 and 2015, and 36 percentage points in 2016.

Bayshore Medical Center

333. For the time period 2013-2016, the admission rate at Bayshore Medical Center for all diagnoses was 43 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Bayshore Medical Center was 84 percent as compared to the national average of 55 percent at non-HCA hospitals.

334. With respect to the 8 diagnostic categories, the average admission rates at non-HCA hospitals nationally decreased from 62 percent in 2010 to 60 percent in 2011, 57 percent in 2012, 57 percent in 2013, 54 percent in 2014, 57 percent in 2015, and 53 percent in 2016. In contrast, the admission rates for these 8 diagnostic categories at Bayshore Medical Center jumped from 68 percent in 2010 to 73 percent in 2011, 75 percent in 2012, 81 percent in 2013, 84 percent in 2014, 89 percent in 2015, and 83 percent in 2016.

335. In 2010, with respect to the 8 diagnostic categories, the admission rate at Bayshore was only 6 percentage points above the national average rate of admission at non-HCA hospitals. That differential jumped to 13 percentage points above in 2011, 18 percentage points above in 2012, 24 percentage points above in 2013, 30 percentage points above in 2014, 32 percentage points above in 2015, and 30 percentage points above in 2016.

336. The admission rates for all diagnoses at Bayshore also experienced significant jumps between 2010-2016. In 2010, the admission rate for all diagnoses at Bayshore was 33 percent---3 percentage points **below** the national average at non-HCA hospitals (36 percent). Yet by 2014, the admission rate for all diagnoses at Bayshore was 44 percent---12 percentage points **above** the national average at non-HCA hospitals (32 percent). That trend continued in 2015 and 2016 when the admission rate for all diagnoses at Bayshore moved to 45 percent---13 percentage points above the national average of 32 percent at non-HCA hospitals.

Blake Medical Center

337. For the time period 2013-2016, the admission rate at Blake Medical Center for all diagnoses was 50 percent as compared to the national average admission rate of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Blake Medical Center was 88 percent as compared to the national average of 55 percent at non-HCA hospitals.

338. Between 2010 and 2016, the national average admission rate for all diagnoses at non-HCA hospitals declined from 36 percent in 2010 to 35 percent in 2011, 33 percent in 2012, 34 percent in 2013, 32 percent in 2014, 32 percent in 2015, and 32 percent in 2016.

339. In contrast, the admission rate for all diagnoses at Blake Medical Center jumped from 39 percent in 2010 to 51 percent in 2015 and 50 percent in 2016.

340. With respect to the 8 diagnostic categories, the admission rate at Blake Medical Center moved from 77 percent in 2011 and 2012 to 85 percent in 2013 and 2014, 91 percent in 2015, and 88 percent in 2016.

341. In 2010, with respect to the 8 diagnostic categories, the admission rate at Blake Medical was the same as the national average rate of admission at non-HCA hospitals (62 percent). In the following years the admission rates for the 8 diagnostic categories at Blake Medical jumped

far above the rates at non-HCA hospitals, moving 13 percentage points above in 2011, 20 percentage points above in 2012, 28 percentage points above in 2013, 31 percentage points in 2014, 34 percentage points above in 2015, and 35 percentage points above in 2016.

Brandon Regional Hospital

342. For the time period 2013-2016, the admission rate for all diagnoses at Brandon Regional Medical Center was 46 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Brandon Regional was 85 percent as compared to the national average of 55 percent at non-HCA hospitals.

343. At Brandon Regional, the overall admission rate for all diagnoses jumped from 40 percent in 2010 to 46 percent in 2014, 48 percent in 2015, and 47 percent in 2016. These jumps were the opposite of declining admission rates at non-HCA hospitals nationally.

344. With respect to the 8 diagnostic categories, the admission rates at Brandon Regional moved from 68 percent in 2010 to 90 percent in 2015 and 87 percent in 2016.

345. In 2010, with respect to the 8 diagnostic categories, the admission rate at Brandon Regional (68 percent) was only 6 percentage points above the national average Medicare admission rate at non-HCA hospitals (62 percent). In the following years that differential increased to 22 percentage points above in 2011, 24 percentage points above in 2012, 24 percentage points above in 2013, 29 percentage points in 2014, 33 percentage points above in 2015, and 34 percentage points above in 2016.

Chippenham Hospital

346. Between 2010 and 2016, Chippenham Hospital experienced remarkable increases in its admission rates of Medicare patients.

347. In 2010, the overall admission rate for all diagnoses at Chippenham was 27 percent---9 percentage points **below** the national average at non-HCA hospitals (36 percent). Yet by 2015, the overall admission rate for all diagnoses at Chippenham was 43 percent---11 percentage points **above** the national average at non-HCA hospitals (32 percent).

348. The admission rate for all diagnoses at Chippenham jumped from 27 percent in 2010 to 38 percent in 2011, 37 percent in 2012, 42 percent in 2013, 40 percent in 2014, 43 percent in 2015, and 41 percent in 2016. These jumps were the opposite of declining admission rates at non-HCA hospitals nationally.

349. With respect to the 8 diagnostic categories, the admission rates at Chippenham moved from 22 percent in 2010 to 46 percent in 2011, 54 percent in 2012, 68 percent in 2013, 76 percent in 2014, 78 percent in 2015, and 77 percent in 2016. While admission rates declined at non-HCA hospitals for these 8 diagnostic categories, the admission rates at Chippenham increased by approximately 350 percent between 2010 and 2016.

350. In 2010, with respect to the 8 diagnostic categories, the admission rate at Chippenham was 40 percentage points **below** the national average rate of admission at non-HCA hospitals. In the following years the admission rates for the 8 diagnostic categories at Chippenham jumped **above** the average rates at non-HCA hospitals, moving 20 percentage points above in 2014, 21 percentage points **above** in 2015, and 24 percentage points **above** in 2016.

Clear Lake Regional Medical Center

351. For the time period 2013-2016, the admission rate for all diagnoses at Clear Lake Regional Medical Center was 53 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Clear Lake was 88 percent as compared to the national average of 55 percent at non-HCA hospitals.

352. The admission rate for all diagnoses at Clear Lake moved from 42 percent in 2011 to 56 percent in 2015 and 57 percent in 2016. With respect to the 8 diagnostic categories, the admission rate at Clear Lake Regional moved from 76 percent in 2011 to 88 percent in 2014, 92 percent in 2015, and 90 percent in 2016. All of these patterns were contrary to declining average admission rates at non-HCA hospitals discussed above.

353. In 2010, with respect to the 8 diagnostic categories, the admission rate at Clear Lake was the same as the national average rate of admission at non-HCA hospitals (62 percent). In the following years the admission rates for the 8 diagnostic categories at Clear Lake jumped far above the rates at non-HCA hospitals, moving 16 percentage points above in 2011, 20 percentage points above in 2012, 22 percentage points above in 2013, 34 percentage points in 2014, 35 percentage points above in 2015, and 37 percentage points above in 2016.

Conroe Regional Medical Center

354. For the time period 2013-2016, the admission rate for all diagnoses at Conroe Regional Medical Center was 51 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Conroe Regional Medical Center was 88 percent as compared to the national average of 55 percent at non-HCA hospitals.

355. With respect to the 8 diagnostic categories, the admission rate at Conroe Regional moved from 62 percent in 2010 to 94 percent in 2015 and 93 percent in 2016.

356. In 2010, with respect to the 8 diagnostic categories, the admission rate at Conroe Regional was the same as the national average rate of admission at non-HCA hospitals (62 percent). In the following years the admission rates for the 8 diagnostic categories at Conroe Regional jumped far above the rates at non-HCA hospitals, moving to 18 percentage points above

in 2013, 30 percentage points in 2014, 37 percentage points above in 2015, and 40 percentage points above in 2016.

357. The same pattern emerges in Conroe Regional's Medicare admission rates for all diagnoses. In 2010, the admission rate for all diagnoses at Conroe Regional was only 4 percentage points above the national average at non-HCA hospitals. In the following years that differential increase to 19 percentage points above in 2014, 21 percentage points above in 2015, and 18 percentage points above in 2016.

Fawcett Memorial Hospital

358. For the time period 2013-2016, the admission rate for all diagnoses at Fawcett Memorial Hospital was 42 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Fawcett Memorial Hospital was 85 percent as compared to the national average of 55 percent at non-HCA hospitals.

359. With respect to the 8 diagnostic categories, the admission rate at Fawcett Memorial moved from 74 percent in 2011 to 86 percent in 2015 and 2016.

360. In 2010, with respect to the 8 diagnostic categories, the admission rate at Fawcett Memorial (75 percent) was 13 percentage points above the national average rate of admission at non-HCA hospitals (62 percent). In the following years the admission rates for the 8 diagnostic categories at Fawcett Memorial escalated far above the rates at non-HCA hospitals, moving to 30 percentage points in 2014, 29 percentage points above in 2015, and 33 percentage points above in 2016.

JFK Medical Center

361. JFK Medical Center is a member of the HCA East Florida Division. For the time period 2013-2016, the admission rate for all diagnoses at JFK Medical Center was 40 percent as

compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at JFK Medical Center was 82 percent as compared to the national average of 55 percent at non-HCA hospitals.

362. In 2010, with respect to the 8 diagnostic categories, the admission rate at JFK Medical (78 percent) was 16 percentage points above the national average rate of admission at non-HCA hospitals (62 percent). In the following years the admission rates for the 8 diagnostic categories at JFK Medical escalated higher above the rates at non-HCA hospitals, moving to 27 percentage points in 2014 and 2015 and 30 percentage points above in 2016.

Kendall Regional Medical Center

363. Kendall Regional Medical Center is a member of the HCA East Florida Division. For the time period 2013-2016, the admission rate for all diagnoses at Kendall Regional Medical Center was 51 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Kendall Regional was 86 percent as compared to the national average of 55 percent at non-HCA hospitals.

364. The admission rate for all diagnoses at Kendall Regional moved from 44 percent in 2010 and 2011 to 52 percent in 2015 and 55 percent in 2016. With respect to the 8 diagnostic categories, the admission rate at Kendall Regional moved from 52 percent in 2010 to 95 percent in 2015 and 86 percent in 2016.

365. In 2010, with respect to the 8 diagnostic categories, the admission rate at Kendall Regional was 10 percentage points **below** the national average rate of admission at non-HCA hospitals. In the following years the admission rates for the 8 diagnostic categories at Kendall Regional jumped **above** the rates at non-HCA hospitals, moving to 24 percentage points above in

2012 and 2013, 29 percentage points **above** in 2014, 38 percentage points **above** in 2015, and 33 percentage points **above** in 2016.

366. The same pattern emerges in Kendall Regional's admission rates for all diagnoses. In 2010, the admission rate at Kendall Regional for all diagnoses was the same as the national average at non-HCA hospitals (36 percent). In the following years the admission rates for all diagnoses at Kendall Regional escalated far above the rates at non-HCA hospitals, moving to 18 percentage points above in 2014, 20 percentage points above in 2015, and 23 percentage points above in 2016.

Kingwood Medical Center

367. For the time period 2013-2016, the admission rate for all diagnoses at Kingwood Medical Center was 49 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Kingwood was 87 percent as compared to the national average of 55 percent at non-HCA hospitals.

368. The admission rate for all diagnoses at Kingwood moved from 38 percent in 2010 to 50 percent in 2014 and 2015. With respect to the 8 diagnostic categories, the admission rate at Kingwood moved from 65 percent in 2010 to 88 percent in 2014, 92 percent in 2015, and 84 percent in 2016.

369. In 2010, with respect to the 8 diagnostic categories, the admission rate at Kingwood was only 3 percentage points above the national average rate of admission at non-HCA hospitals. In the following years the admission rates for the 8 diagnostic categories at Kingwood escalated far above the rates at non-HCA hospitals, moving to 25 percentage points above in 2013, 34 percentage points above in 2014, 35 percentage points above in 2015, and 31 percentage points above in 2016.

370. The same pattern emerges in Kingwood's admission rates for all diagnoses. In 2010, the admission rate for all diagnoses at Kingwood (38 percent) was 2 percentage points above the national average at non-HCA hospitals (36 percent). In the following years the admission rates for all diagnoses at Kingwood escalated far above the rates at non-HCA hospitals, moving to 15 percentage points above in 2013, 18 percentage points above in 2014 and 2015, and 16 percentage points above in 2016.

Largo Medical Center

371. For the time period 2013-2016, the admission rate for all diagnoses at Largo Medical Center was 53 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Largo Medical Center was 89 percent as compared to the national average of 55 percent at non-HCA hospitals.

372. With respect to the 8 diagnostic categories, the admission rate at Largo Medical Center moved from 80 percent in 2011 to 90 percent in 2015 and 91 percent in 2016.

373. In 2010, with respect to the 8 diagnostic categories, the admission rate at Largo Medical was 14 percentage points above the national average rate of admission at non-HCA hospitals. In the following years the admission rates for the 8 diagnostic categories at Largo Medical escalated far above the rates at non-HCA hospitals, moving to 30 percentage points above in 2012, 32 percentage points above in 2013, 30 percentage points above in 2014, 33 percentage points above in 2015, and 38 percentage points above in 2016.

374. The same pattern emerges in Largo Medical's Medicare admission rates for all diagnoses. In 2010, the admission rate for all diagnoses at Largo Medical (44 percent) was 8 percentage points above the national average at non-HCA hospitals (36 percent). In the following years the admission rates for all diagnoses at Largo Medical escalated far above the rates at non-

HCA hospitals, moving to 22 percentage points above in 2013, 23 percentage points above in 2014, 20 percentage points above in 2015, and 18 percentage points in 2016.

Lawnwood Regional Medical Center

375. Lawnwood Regional Medical Center is a member of the HCA East Florida Division. For the time period 2013-2016, the admission rate for all diagnoses at Lawnwood Regional Medical Center was 49 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Lawnwood was 88 percent as compared to the national average of 55 percent at non-HCA hospitals.

376. With respect to the 8 diagnostic categories, the admission rate at Lawnwood moved from 77 percent in 2011 to 89 percent in 2014, 92 percent in 2015, and 86 percent in 2016.

377. With respect to the 8 diagnostic categories, the admission rates at Lawnwood moved from 17 percentage points above the rate at non-HCA hospitals in 2011 to 25 percentage points above in 2012, 28 percentage points above in 2013, 35 percentage points above in 2014, 35 percentage points above in 2015, and 33 percentage points above in 2016.

378. With respect to all diagnoses, the admission rates at Lawnwood moved from 44 percent in 2010 to 49 percent in 2013, 51 percent in 2014, and 49 percent in 2015. These rates were far higher and contrary to the trends at non-HCA hospitals where average admission rates for all diagnoses decreased from 36 percent in 2010 to 32 percent in 2014 and 2015.

Los Robles Hospital and Medical Center

379. In 2010, the admission rate for all diagnoses at Los Robles Hospital (37 percent) was only 1 percentage point above the national average at non-HCA hospitals (36 percent). By 2015 and 2016, the Medicare admission rate for all diagnoses at Los Robles Hospital (43 percent) was 11 percentage points above the national average at non-HCA hospitals (32 percent).

380. With respect to the 8 diagnostic categories, in 2010, the admission rate at Los Robles (69 percent) was 7 percentage points above the national average at non-HCA hospitals (62 percent). By 2015 and 2016, the admission rate at Los Robles for the 8 diagnostic categories was 30 percentage points above the average national rate at non-HCA hospitals.

Medical Center of Trinity

381. For the time period 2013-2016, the admission rate for all diagnoses at Medical Center of Trinity was 48 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Medical Center of Trinity was 88 percent as compared to the national average of 55 percent at non-HCA hospitals.

382. With respect to the 8 diagnostic categories at non-HCA hospitals between the years 2010-2016, average admission rates declined from 62 in 2010 to 53 percent in 2016. In contrast, the admission rates at Medical Center of Trinity increased from 79 percent in 2010 to 86 percent in 2011, 88 percent in 2012, 90 percent in 2013, 88 percent in 2014, 90 percent in 2015, and 85 percent in 2016.

383. With respect to the 8 diagnostic categories, the admission rates at Medical City of Trinity moved from 17 percentage points above the average rate at non-HCA hospitals in 2010 to 31 percentage points above in 2012, 33 percentage points above in 2013, 34 percentage points above in 2014, 33 percentage points above in 2015, and 32 percentage points above in 2016.

384. With respect to all diagnoses, the admission rates at Medical City of Trinity moved from 42 percent in 2010 to 48 percent in 2013, 49 percent in 2014, and 49 percent in 2015. These rates were far higher and contrary to the trends at non-HCA hospitals where average admission rates for all diagnoses declined from 36 percent in 2010 to 32 percent in 2014 and 2015.

Medical City Fort Worth

385. For the time period 2013-2016, the admission rate for all diagnoses at Medical City Fort Worth was 51 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Medical City Fort Worth was 94 percent as compared to the national average of 55 percent at non-HCA hospitals.

386. The admission rate for all diagnoses at Medical City Fort Worth moved from 43 percent in 2010 to 54 percent in 2013, 49 percent in 2014, 49 percent in 2015, and 50 percent in 2015.

387. With respect to the 8 diagnostic categories at non-HCA hospitals between the years 2010-2016, average admission rates declined from 62 in 2010 to 53 percent in 2016. In contrast, the admission rates for the 8 diagnostic categories at Medical City Fort Worth moved from 86 percent in 2011 to 92 percent in 2013, 93 percent in 2014, 97 percent in 2015, and 94 percent in 2016.

388. In 2010, with respect to the 8 diagnostic categories, the admission rate at Medical City Fort Worth (86 percent) was 24 percentage points above the national average rate of admission at non-HCA hospitals (62 percent). In the following years the admission rates for the 8 diagnostic categories at Medical City Fort Worth increased even higher above the rates at non-HCA hospitals, moving to 26 percentage points above in 2011, 29 percentage points above in 2012, 35 percentage points above in 2013, 39 percentage points above in 2014, 40 percentage points above in 2015, and 41 percentage points above in 2016.

389. The same pattern emerges in Medical City Fort Worth's admission rates for all diagnoses. In 2010, the admission rate for all diagnoses at Medical City Fort Worth (43 percent) was 7 percentage points above the national average at non-HCA hospitals (36 percent). In the

following years the admission rates for all diagnoses at Medical City Fort Worth escalated higher above the rates at non-HCA hospitals, moving to 20 percentage points above in 2013, 17 percentage points above in 2014 and 2015, and 18 percentage points above in 2016.

Medical City Hospital

390. In 2010, the admission rate for all diagnoses at Medical City Hospital was 39 percent or only 3 percentage points above the national average at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Medical City Hospital was 60 percent or 2 percentage points **below** the national average rate at non-HCA hospitals (62 percent).

391. In the following years, the admission rates at Medical City Hospital moved far above the national average rates at non-HCA hospitals.

392. Between 2010 and 2013, the admission rate for all diagnoses at Medical City Hospital moved from 39 percent to 48 percent or 14 percentage points above the rate at non-HCA hospitals (34 percent). In 2015, the admission rate for all diagnoses at Medical City Hospital was 48 percent again and 16 percentage points above the national average rate at non-HCA hospitals (32 percent).

393. With respect to the 8 diagnostic categories, the admission rates at Medical City Hospital moved from 60 percent in 2010 to 79 percent in 2015 and 2016. With respect to the 8 diagnostic categories, the admission rate at Medical City Hospital moved from 2 percentage points **below** the national average at non-HCA hospitals in 2010 to 26 percentage points above the national average at non-HCA hospitals in 2016.

Medical City McKinney

394. The admission rates for all diagnoses at Medical City McKinney jumped from 38 percent in 2010 to 51 percent in 2013, moving from 2 percentage points to 17 percentage points

above the national averages at non-HCA hospitals. In 2014, 2015, and 2016, the admission rates for all diagnoses at Medical City McKinney stayed at levels 13-16 percentage points above the national averages at non-HCA hospitals.

395. With respect to the 8 diagnostic categories, the admission rates at Medical City McKinney jumped from 62 percent in 2010 to 92 percent in 2015. With respect to the 8 diagnostic codes, the admission rates jumped from 6 percentage points above the national average rates at non-HCA hospitals in 2010 to 20 percentage points above in 2013, 29 percentage points above in 2014, 35 percentage points above in 2015, and 30 percentage points above in 2016.

Medical City Plano

396. For the time period 2013-2016, Medical City Plano's admission rate for all diagnoses was 54 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Medical City Plano was 87 percent as compared to the national average of 55 percent at non-HCA hospitals.

397. The admission rate for all diagnoses at Medical City Plano jumped from 39 percent in 2010 to 60 percent in 2013 and stayed elevated in subsequent years at 54 percent in 2014, 52 percent in 2015, and 51 percent in 2016.

398. With respect to the 8 diagnostic categories, the admission rate at Medical City Plano moved from 70 percent in 2010 to 88 percent in 2012 and 2013, 81 percent in 2014, 92 percent in 2015, and 87 percent in 2016. With respect to the 8 diagnostic codes, the admission rates jumped from 8 percentage points above the national average rates at non-HCA hospitals in 2010 to 20 percentage points above in 2011, 29 percentage points above in 2012, 31 percentage points above in 2013, 27 percentage points above in 2014, 35 percentage points above in 2015, and 34 percentage points above in 2016.

Memorial Hospital

399. For the time period 2013-2016, the admission rate for all diagnoses at Memorial Hospital was 46 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Memorial Hospital was 83 percent as compared to the national average of 55 percent at non-HCA hospitals.

400. With respect to the 8 diagnostic categories, the admission rates at Memorial Hospital moved from 77 percent in 2012 to 87 percent in 2015 and 88 percent in 2016. With respect to the 8 diagnostic codes, the admission rates at Memorial jumped from 7 percentage points above the national average rates at non-HCA hospitals in 2010 to 22 percentage points above in 2013, 24 percentage points above in 2014, 30 percentage points above in 2015, and 35 percentage points above in 2016.

Methodist Hospital

401. The admission rates for all diagnoses at Methodist Hospital moved from 2 percentage points **below** the national average admission rates at non-HCA hospitals in 2010 to 8 percentage points **above** in 2014, 9 percentage points **above** in 2015, and 8 percentage points **above** in 2016. While admission rates for all diagnoses at non-HCA hospitals declined from 36 percent in 2010 to 32 percent in 2014, 2015, and 2016, the admission rates for all diagnoses at Methodist increased from 32 percent in 2010 to 40-41 percent in 2013, 2014, 2015, and 2016.

402. With respect to the 8 diagnostic categories, the admission rates at Methodist Hospital moved from 60 percent in 2010 to 81 percent in 2016.

403. With respect to the 8 diagnostic categories, the admission rates at Methodist Hospital moved from 2 percentage points **below** the national average at non-HCA hospitals in 2010 to 21 percentage points **above** in 2015 and 28 percentage points **above** in 2016.

Mountain View Hospital

404. For the time period 2013-2016, the admission rate for all diagnoses at Mountain View Hospital was 45 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Mountain View Hospital was 81 percent as compared to the national average of 55 percent at non-HCA hospitals.

405. With respect to the 8 diagnostic categories, the admission rates at Mountain View Hospital were far above the national averages at non-HCA hospitals every year: 87 percent in 2011, 84 percent in 2012, 76 percent in 2013, 77 percent in 2014, 84 percent in 2015, and 84 percent in 2016. With respect to the 8 diagnostic codes, the admission rates at Mountain View moved from 19 percentage points above the national average rates at non-HCA hospitals in 2013 to 23 percentage points above in 2014, 27 percentage points above in 2015, and 31 percentage points above in 2016.

North Florida Regional Medical Center

406. For the time period 2013-2016, the admission rate for all diagnoses at North Florida Regional Medical Center ("North Florida") was 52 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at North Florida was 81 percent as compared to the national average of 55 percent at non-HCA hospitals.

407. The admission rate for all diagnoses at North Florida moved from 45 percent in 2010 to 53 percent in 2015 and 55 percent in 2015.

408. With respect to the 8 diagnostic categories, the admission rate at North Florida moved from 69 percent in 2010 to 81 percent in 2014, 84 percent in 2015, and 84 percent in 2016. With respect to the 8 diagnostic codes, the admission rates at North Florida jumped from 7

percentage points above the national average rates of admission at non-HCA hospitals in 2010 to 16 percentage points above in 2013, 27 percentage points above in 2014, 27 percentage points above in 2015, and 31 percentage points above in 2016.

Northside Hospital & Tampa Bay Heart Institute

409. For the time period 2013-2016, the admission rate for all diagnoses at Northside Hospital & Tampa Bay Heart Institute ("Northside") was 48 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Northside was 90 percent as compared to the national average of 55 percent at non-HCA hospitals.

410. With respect to the 8 diagnostic categories, admission rates at Northside were increasingly elevated above the national average rates at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rates at Northside were 21 points above the national average rates at non-HCA hospitals in 2010, 23 percentage points above in 2011, 28 percentage points above in 2012, 29 percentage points above in 2013, 34 percentage points above in 2014, 37 percentage points above in 2015, and 34 percentage points above in 2016.

Northwest Medical Center

411. Northwest Medical Center is a member of the HCA East Florida Division. For the time period 2013-2016, the admission rate for all diagnoses at Northwest Medical Center was 52 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Northwest Medical Center was 91 percent as compared to the national average of 55 percent at non-HCA hospitals.

412. With respect to the 8 diagnostic categories, the admission rates at Northwest moved from 80 percent in 2011 to 92 percent in 2013, 89 percent in 2014, 95 percent in 2015, and 89 percent in 2016.

413. With respect to the 8 diagnostic categories, the admission rates at Northwest were 20 points above the national average rates at non-HCA hospitals in 2011, 24 percentage points above in 2012, 35 percentage points above in 2013 and 2014, 38 percentage points above in 2015, and 36 percentage points above in 2016.

414. While patient volumes for the 8 diagnostic categories were lower than at other HCA East Florida hospitals, the exceptionally high admission rates at Northwest evidence the scheme within the HCA East Florida Division.

Oak Hill Hospital

415. For the time period 2013-2016, the admission rate for all diagnoses at Oak Hill Hospital was 44 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Oak Hill was 86 percent as compared to the national average of 55 percent at non-HCA hospitals.

416. With respect to the 8 diagnostic categories, the admission rates at Oak Hill were significantly elevated each year, moving from 76 percent in 2011 to 87 percent in 2012, 84 percent in 2013, 81 percent in 2014, 87 percent in 2015, and 88 percent in 2016.

417. With respect to the 8 diagnostic categories, the admission rates at Oak Hill were increasingly elevated over the average rates at non-HCA hospitals, moving from 16 points above the national average rates at non-HCA hospitals in 2010 and 2011 to 20 percentage points above in 2012, 27 percentage points above in 2013 and 2014, 30 percentage points above in 2015, and 35 percentage points above in 2016.

Ocala Regional Medical Center

418. With respect to the 8 diagnostic categories, the admission rates at Ocala Regional Medical Center were increasingly elevated over the average rates at non-HCA hospitals, moving from 12 points above the national average rates at non-HCA hospitals in 2010 to 20 percentage points above in 2011, 21 percentage points above in 2012, 22 percentage points above in 2013, 25 percentage points above in 2014, 26 percentage points in 2015, and 28 percentage points above in 2016.

419. With respect to the 8 diagnostic categories in 2015, the admission rate at Ocala was 83 percent as compared to the average rate of 57 percent at non-HCA hospitals. In 2016, the admission rate at Ocala for these diagnostic categories was 81 percent as compared to the average rate of 53 percent at non-HCA hospitals.

Orange Park Medical Center

420. For the time period 2013-2016, the admission rate for all diagnoses at Orange Park Medical Center was 48 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Orange Park Medical Center was 84 percent as compared to the national average of 55 percent at non-HCA hospitals.

421. The admission rate for all diagnoses at Orange Park Medical Center increased from 39 percent in 2010 to 48 percent in 2013, 51 percent in 2014, and 48 percent in 2015. With respect to the 8 diagnostic categories, the admission rate jumped from 65 percent in 2011 to 81 percent in 2014, 89 percent in 2015, and 85 percent in 2016.

422. With respect to the 8 diagnostic codes, the admission rates at Orange Park jumped from 13 percentage points **below** the national average rates of admission at non-HCA hospitals in

2010 to 23 percentage points **above** in 2013, 27 percentage points **above** in 2014, 32 percentage points above in 2015, and 32 percentage points **above** in 2016.

Osceola Regional Medical Center

423. For the time period 2013-2016, the admission rate for all diagnoses at Osceola Regional Medical Center was 51 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Osceola Regional Medical Center was 88 percent as compared to the national average of 55 percent at non-HCA hospitals.

424. With respect to the 8 diagnostic categories, the admission rate at Osceola Regional Medical Center jumped from 76 percent in 2012 to 87 percent in 2013, 92 percent in 2015, and 91 percent in 2016.

425. With respect to the 8 diagnostic categories, the admission rates at Osceola Regional Medical Center were increasingly elevated over the average rates at non-HCA hospitals, moving from 15 points above in 2010 to 30 percentage points above in 2013 and 2014, 35 percentage points above in 2015, and 38 percentage points above in 2016.

Palms West Hospital

426. Palms West Hospital is a member of the HCA East Florida Division. For the time period 2013-2016, the admission rate for all diagnoses at Palms West Hospital was 59 percent as compared to the national average of 33 percent at non-HCA hospitals.

427. Between 2010 and 2016, the national average admission rate for all diagnoses at non-HCA hospitals declined from 36 percent in 2010 to 35 percent in 2011, 33 percent in 2012, 34 percent in 2013, 32 percent in 2014, 32 percent in 2015, and 32 percent in 2016.

428. In contrast, Palm West's admission rates for all diagnoses jumped from 44 percent in 2010 to 57 percent in 2013, 61 percent in 2014, 61 percent in 2015, and 58 percent in 2016. These jumps almost match the increases in admission rates at Aventura Hospital discussed above.

429. Like Aventura Hospital, in 2014 and 2015, Palm West Hospital's admission rate for all diagnoses was 61 percent---almost double the national average (32 percent) at non-HCA hospitals.

430. With respect to all diagnoses, the admission rates at Palms West were increasingly elevated above the average rates at non-HCA hospitals, moving from 8 points above in 2010 to 23 percentage points above in 2013, 29 percentage points above in 2014 and 2015, and 26 percentage points above in 2016

431. With respect to the 8 diagnostic categories from 2013-2016, the admission rate at Palms West Hospital was 90 percent as compared to the national average of 55 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rates at Palms West Hospital were significantly elevated each year, moving from 85 percent in 2012 and 2013 to 88 percent in 2014, 100 percent in 2015, and 90 percent in 2016. Although patient volumes were lower at Palms West compared to other HCA East Florida hospitals, the high admission rates at Palms West evidence the scheme within the HCA East Florida Division.

Plantation General Hospital

432. Plantation General Hospital is a member of the HCA East Florida Division. For the years 2013-2016, the admission rate for all diagnoses at Plantation General Hospital was 47 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Plantation General Hospital was 86 percent as compared to the national average of 55 percent at non-HCA hospitals.

433. The admission rate for all diagnoses at Plantation General moved from 33 percent in 2011 to 45 percent in 2012, 47 percent in 2013, 48 percent in 2014, and 46 percent in 2015 and 2016.

434. With respect to all diagnoses, the admission rates at Plantation General moved from 2 percentage points **below** the average rates at non-HCA hospitals in 2011 to 13 points **above** in 2013, 16 percentage points **above** in 2014, and 14 percentage points **above** in 2015 and 2016

435. With respect to the 8 diagnostic categories, the admission rate at Plantation General escalated from 47 percent in 2011 to 70 percent in 2012, 77 percent in 2013, 83 percent in 2014, and 90 percent in 2015 and 2016. Although patient volumes were lower at Plantation General compared to other HCA East Florida hospitals, the major increases in admission rates at Plantation General evidence the scheme within the HCA East Florida Division.

Raulerson Hospital

436. Raulerson Hospital is a member of the HCA East Florida Division. For the time period 2013-2016, the admission rate for all diagnoses at Raulerson Hospital was 38 percent as compared to the national average of 33 percent at non-HCA hospitals.

437. With respect to the 8 diagnostic categories during the time period 2013-2016, the admission rate at Raulerson Hospital was 91 percent as compared to the national average of 55 percent at non-HCA hospitals.

438. With respect to the 8 diagnostic categories, the admission rates at Raulerson jumped from 53 percent in 2011 to 93 percent in 2012, 94 percent in 2013, 84 percent in 2014, 92 percent in 2015, and 92 percent in 2016.

439. Although the patient volumes were lower at Raulerson Hospital compared to other HCA East Florida hospitals, the major increase in admission rates for patients in the 8 diagnostic categories evidence the scheme within the HCA East Florida Division.

Regional Medical Center Bayonet Point

440. For the time period 2013-2016, the admission rate for all diagnoses at Regional Medical Center Bayonet Point ("RMCBP") was 52 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at RMCBP was 92 percent as compared to the national average of 55 percent at non-HCA hospitals.

441. Between 2010 and 2016 at non-HCA hospitals, the national average admission rate for all diagnoses declined from 36 percent in 2010 to 35 percent in 2011, 33 percent in 2012, 34 percent in 2013, 32 percent in 2014, 32 percent in 2015, and 32 percent in 2016.

442. In contrast at RMCBP, the admission rate for all diagnoses moved from 44 percent in 2010 to 51 percent in 2011, 53 percent in 2012, 54 percent in 2013, 52 percent in 2014, 50 percent in 2015, and 51 percent in 2016.

443. With respect to the 8 diagnostic categories, the admission rates at RMCBP were significantly elevated every year, moving from 79 percent in 2010 to 89 percent in 2011, 92 percent in 2012 and 2013, 91 percent in 2014, and 93 percent in 2015 and 2016.

444. With respect to the 8 diagnostic codes, the admission rates at RMCBP jumped from 17 percentage points above the national average rates of admission at non-HCA hospitals in 2010 to 29 percentage points above in 2011, 35 percentage points above in 2012 and 2013, 37 percentage points above in 2014, 36 percentage points above in 2015, and 40 percentage points above in 2016.

Regional Medical Center of San Jose

445. The admission rates for all diagnoses at Regional Medical Center of San Jose ("RMCSJ") jumped from 29 percent in 2010 to 44 percent in 2015 and 2016. The admission rates for all diagnoses moved from 7 percentage points **below** the national average at non-HCA hospitals in 2010 to 12 percentage points **above** in 2015 and 2016.

446. With respect to the 8 diagnostic categories, the admission rates at RMCSJ jumped from 67 percent in 2010 to 85 percent in 2015 and 88 percent in 2016.

447. With respect to the 8 diagnostic codes, the admission rates at RMCSJ jumped from 5 percentage points above the national average rates of admission at non-HCA hospitals in 2010 to 22 percentage points above in 2014, 28 percentage points above in 2015, and 35 percentage points above in 2016.

St. Lucie Medical Center

448. St. Lucie Medical Center is a member of the HCA East Florida Division. For the time period 2013-2016, the admission rate for all diagnoses at St. Lucie was 47 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at St. Lucie was 88 percent as compared to the national average of 55 percent at non-HCA hospitals.

449. The admission rate for all diagnoses at St. Lucie jumped from 33 percent in 2010 to 50 percent in 2014 and 2015.

450. With respect to all diagnoses, the admission rates at St. Lucie moved from 3 percentage points **below** the average rates at non-HCA hospitals in 2010 to 14 points **above** in 2013, 18 percentage points **above** in 2014, 16 percentage points **above** in 2015, and 13 percentage points **above** in 2016.

451. With respect to the 8 diagnostic categories, the admission rate at St. Lucie moved from 76 percent in 2011 to 87 percent in 2013, 85 percent in 2014, 93 percent in 2015, and 88 percent in 2016.

452. With respect to the 8 diagnostic codes, the admission rates at St. Lucie jumped from 7 percentage points above the national average rates of admission at non-HCA hospitals in 2010 to 24 percentage points above in 2012 and 2013, 31 percentage points above in 2014, 34 percentage points above in 2015, and 35 percentage points above in 2016.

South Bay Hospital

453. For the time period 2013-2016, the admission rate for all diagnoses at South Bay Hospital was 45 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at South Bay Hospital was 88 percent as compared to the national average of 55 percent at non-HCA hospitals.

454. The overall admission rate for all diagnoses at South Bay Hospital increased from 34 percent in 2010 to 43 percent in 2013, 45 percent in 2014, 49 percent in 2015, and 45 percent in 2016. With respect to all diagnoses, the admission rates at South Bay moved from 2 percentage points **below** the average rates at non-HCA hospitals in 2010 to 12 points **above** in 2014, 17 percentage points **above** in 2015, and 13 percentage points **above** in 2016.

455. With respect to the 8 diagnostic categories, the admission rate at South Bay Hospital moved from 79 percent in 2011 to 95 percent in 2015 and 91 percent in 2016.

456. With respect to the 8 diagnostic codes, the admission rates at South Bay jumped from 1 percentage point above the national average rates of admission at non-HCA hospitals in

2010 to 26 percentage points above in 2012, 25 percentage points above 2013, 27 percentage points above in 2014, and 38 percentage points above in 2015 and 2016.

Sunrise Hospital & Medical Center

457. For the time period 2013-2016, the admission rate for all diagnoses at Sunrise Hospital & Medical Center ("Sunrise") was 45 percent as compared to the national average of 33 percent at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rate at Sunrise was 78 percent as compared to the national average of 55 percent at non-HCA hospitals.

458. With respect to the 8 diagnostic categories, the admission rates at Sunrise jumped from 64 percent in 2011 to 84 percent in 2015 and 2016. With respect to the 8 diagnostic categories, the admission rates at Sunrise moved from 6 percentage points **below** the average rates at non-HCA hospitals in 2010 to 17 percentage points **above** in 2014, 27 percentage points **above** in 2015, and 31 percentage points **above** in 2016.

University Hospital and Medical Center

459. University Hospital and Medical Center is a member of the HCA East Florida Division. For the time period 2013-2016, the admission rate for all diagnoses at University Hospital was elevated at 46 percent as compared to the national average of 33 percent at non-HCA hospitals.

460. With respect to all diagnoses, the admission rates at University moved from 1 percentage point above the average rates at non-HCA hospitals in 2010 to 12 points above in 2014, 17 percentage points above in 2015, and 18 percentage points above in 2016.

461. With respect to the 8 diagnostic categories during 2013-2016, the admission rate at University Hospital was 87 percent as compared to the national average of 55 percent at non-HCA hospitals.

462. With respect to the 8 diagnostic categories, the admission rates at University Hospital were elevated each year, moving from 81 percent in 2010 to 86 percent in 2011 and 2012, 83 percent in 2013, 82 percent in 2014, 97 percent in 2015, and 89 percent in 2016.

463. Although the patient volumes were lower in some years at University Hospital compared to other HCA East Florida hospitals, the elevated admission rates for Medicare patients in the 8 diagnostic categories and the significant increase in admission rates for all diagnoses evidence the scheme within the HCA East Florida Division.

West Florida Hospital

464. For the time period 2013-2016, the admission rate for all diagnoses at West Florida Hospital was 44 percent as compared to the national average of 33 percent at non-HCA hospitals. The admission rates for all diagnoses at West Florida Hospital moved from 35 percent in 2010 to 44 percent in 2014 and 2015 and 45 percent in 2016.

465. With respect to all diagnoses, the admission rates at West Florida moved from 1 percentage point **below** the average rates at non-HCA hospitals in 2010 to 12 points **above** in 2014 and 2015 and 13 percentage points **above** in 2016.

466. With respect to the 8 diagnostic categories during 2013-2016, the admission rate at West Florida Hospital was 82 percent as compared to the national average of 55 percent at non-HCA hospitals.

467. With respect to the 8 diagnostic categories, the admission rates increased from 60 percent in 2011 to 65 percent in 2012, 75 percent in 2013, 79 percent in 2014, 86 percent in 2015, and 85 percent in 2016.

468. In 2011, with respect to the 8 diagnostic categories, the admission rate at West Florida was **identical** to the average national rate at non-HCA hospitals (60 percent). In the

following years, the admission rates at West Florida increased to far above the rates at non-HCA hospitals, moving to 18 percentage points **above** in 2013, 25 percentage points **above** in 2014, 29 percentage points **above** in 2015, and 32 percentage points **above** in 2016.

West Houston Medical Center

469. For the time period 2013-2016, the admission rate for all diagnoses at West Houston Medical Center was 49 percent as compared to the national average of 33 percent at non-HCA hospitals.

470. While average admission rates declined at non-HCA hospitals nationally, the admission rates for all diagnoses at West Houston increased from 40 percent in 2010 to 51 percent in 2014, 51 percent in 2015, and 49 percent in 2016.

471. With respect to all diagnoses, the admission rates at West Houston Medical Center moved from 4 percentage points above the average rates at non-HCA hospitals in 2010 to 12 points above in 2013, 19 percentage points above in 2014 and 2015, and 17 percentage points above in 2016.

472. With respect to the 8 diagnostic categories during 2013-2016, the admission rate at West Houston Medical Center was 94 percent as compared to the national average of 55 percent at non-HCA hospitals.

473. Although the volumes of patients were lower than most of the other 40 HCA hospitals named as Defendants, the rates of admission for the 8 diagnostic categories were extraordinary. Over the time period 2010-2016, admission rates at West Houston were increasingly elevated above the national average rates at non-HCA hospitals. With respect to the 8 diagnostic categories, the admission rates at West Houston moved from 15 points above the national average rates at non-HCA hospitals in 2010 to 21 percentage points above in 2011, 27 percentage points

above in 2012, 34 percentage points above in 2013, 41 percentage points above in 2014, 43 percentage points above in 2015, and 39 percentage points above in 2016.

Westside Regional Medical Center

474. Westside Regional Medical Center is a member of the HCA East Florida Division. For the time period 2013-2016, the admission rate for all diagnoses at Westside Regional Medical Center was 48 percent as compared to the national average of 33 percent at non-HCA hospitals.

475. With respect to all diagnoses, the admission rates at Westside increased from 40 percent in 2012 to 50 percent in 2014 and 2015.

476. With respect to all diagnoses, the admission rates at Westside moved from 7 percentage points above the average rates at non-HCA hospitals in 2012 to 15 percentage points above in 2013, 18 percentage points above in 2014 and 2015, and 12 percentage points above in 2016.

477. With respect to the 8 diagnostic categories for the time period 2013-2016, the admission rate at Westside was 93 percent as compared to the national average of 55 percent at non-HCA hospitals.

478. With respect to the 8 diagnostic categories, the admission rates at Westside moved from 75 percent in 2011 to 93 percent in 2013, 92 percent in 2014, 95 percent in 2015, and 92 percent in 2016.

479. Although the volumes of patients were lower than most of the other 40 HCA hospitals named as Defendants, the rates of admission for the 8 diagnostic categories at Westside were extraordinary and evidence the scheme within the HCA East Florida Division. The admission rates at Westside moved from 14 points above the national average rates at non-HCA hospitals in 2010 to 21 percentage points above in 2011, 22 percentage points above in 2012, 36 percentage

points above in 2013, 38 percentage points above in 2014 and 2015, and 39 percentage points above in 2016.

Defendants' Knowledge of Their Submission of False Claims and False Certifications

480. At all times relevant to this First Amended Complaint, Defendants were aware of CMS' guidance regarding when Medicare payment for an inpatient admission was appropriate, and when to bill Medicare for observation services. Defendants were aware that nursing and medical care and diagnostic testing can be provided and billed as observation services when needed to determine whether a Medicare beneficiary's condition required inpatient admission instead of admitting a beneficiary whenever evaluation of her condition would take longer than an ED visit.

481. Defendants submitted claims to Medicare on Form UB-92 HCFA-1450 and Form UB-04 CMS-1450. For inpatient services the Defendant Hospitals submitted an inpatient claim form (Type of Bill 11X). For observation services the Defendant Hospitals should have submitted an outpatient claim form (Type of Bill 13X). Each claim form contains an express certification by the provider. For example, claims submitted on Form UB-04 CMS-1450 contain an express certification that, among other things: "the billing information as shown on the face hereof is true, accurate and complete"; and "the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts."

482. Defendants knew that it was material to Medicare's decision to pay inpatient claims whether inpatient services were reasonable and necessary for the patient's health as opposed to outpatient or observation services.

483. Defendants knew that to bill Medicare for observation services they should submit an outpatient claim (Type of Bill 13X) listing the appropriate HCPCS codes that map to an APC

for the care that was furnished to the patient instead of billing on an inpatient claim form (Type of Bill 11X).

484. By submitting inpatient claim forms using ICD-9-CM codes that map to a DRG that are used exclusively for inpatient admissions that they were representing to Medicare that the patient required inpatient admission.

485. Defendants knew that they submitted inpatient claims to Medicare using ICD-9-CM codes that map to a DRG representing that inpatient admission was necessary and that inpatient services were provided for patients who did not require inpatient admission and who either (a) received only observation services; or (b) who received medically unnecessary inpatient services.

486. For financial reasons Defendants chose to not order or bill for outpatient or observation services. The certifications on each such claim that the billing information was true, accurate and complete, and that "the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts" were false because the patient's medical condition did not require inpatient admission and the care actually provided was consistent with outpatient or observation services or treatment.

487. In addition to the interim patient-specific claim payments, hospitals are required to annually submit a Medicare Cost Report. The Medicare Cost Report determines a provider's Medicare reimbursable costs for a fiscal year. *See* 42 U.S.C. § 1395g(a); 42 C.F.R. §413.20. The cost report is the provider's final claim for payment from the Medicare program for the services rendered to all program beneficiaries for a fiscal year. Medicare relies on the Medicare Cost Report to determine whether the provider is entitled to more reimbursement than already received through

interim payments, or whether the provider has been overpaid and must reimburse Medicare for the overpayment. *See* 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

488. Each Medicare Cost Report contains an express certification that must be signed by the chief hospital administrator or a responsible designee of the administrator. The Medicare Cost Report Certification, which is a preface to the cost report's certification, provides the following prominent warning:

> MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST RPEORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES, AND/OR IMPRISONMENT MAY RESULT.

489. This advisory is followed by the actual certification language itself:

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

CMS Form 2552, Medicare Cost Report.

490. Each HCA hospital executed and submitted a hospital cost report to Medicare annually that contained the quoted certification. The certifications were false in that the cost reports included inpatient days associated with paid inpatient claims that should have been billed as outpatient observation services or outpatient treatment, in violation of the Medicare law, regulations and Manual guidance regarding billing for inpatient services.

491. At all times relevant to this First Amended Complaint, Defendants received communications and guidance from MACs and other Medicare contractors regarding appropriate billing for outpatient, observation, and inpatient services. At all times relevant to this First Amended Complaint, Defendants understood and disregarded Medicare laws, regulations and program instructions regarding the use of outpatient or observation services and the medical necessity of inpatient services.

492. Defendants knew that the claims and certifications that they submitted, or caused to be submitted, to Medicare were false, or else deliberately ignored, and/or were recklessly indifferent to, the truth or falsity of those certifications and claims.

Relator's Extensive Analyses of Diagnoses Codes Submitted by Hospitals to Medicare Do Not Constitute a Public Disclosure

493. The False Claims Act, 31 U.S.C. § 3730(e)(4), as amended in March of 2010, provides as follows,

> (4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed (i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party; (ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or (iii) from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.
>
> (B) For purposes of this paragraph, "original source" means an individual who either (i) prior to a public disclosure under subsection (e)(4)(A), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.

494. As an initial requirement, the potential public disclosure at issue must occur through one of the specific sources enumerated in the statute.

495. There are three groups of specific sources enumerated in 31 U.S.C. § 3730(e)(4)(A): (1) "a criminal, civil or administrative hearing,"(statutory language prior to March

23, 2010) or "a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party," (current statutory language); (2) "the news media," and (3) "a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation" (statutory language prior to March 23, 2010) or "a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation" (current statutory language).

496. Prior to Relator filing this action, the allegations at issue as to any Defendant were never publicly disclosed in any of the specific sources enumerated in the statute.

497. The diagnoses codes submitted by HCA hospitals to CMS do not fall within any of the three groups of specific sources enumerated in 31 U.S.C. § 3730(e)(4)(A).

498. First, the diagnoses codes submitted by hospitals to CMS do not represent "a criminal, civil or administrative hearing" or "a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party." 31 U.S.C. § 3730 (e)(4)(A)(i).

499. Second, the diagnoses codes submitted by hospitals to CMS do not represent "the news media." 31 U.S.C. § 3730 (e)(4)(A)(ii).

500. Third, diagnoses codes submitted by hospitals to CMS are not "congressional," "administrative," "Government Accountability Office" or "other Federal" reports, hearings, audits or investigations. In exposing the false claims at issue, Relator did not use any report authored by the government.

501. Diagnoses codes submitted by hospitals to CMS do not constitute any of the specific sources enumerated in the False Claims Act---prerequisites to the public disclosure defense. The inquiry ends there without further need to examine whether the additional requirements of the "public disclosure" defense are satisfied.

502. Further, Relator has not issued any request to the government under the Freedom of Information Act. In preparing this case, Relator has not received, used, or relied on any government response to any request under the Freedom of Information Act.

Over Two Billion Numeric Codes in a Vast Database Did Not Alert the Government to the False Claims at Issue

503. Federal Circuit Courts, District Courts, and the United States Department of Justice have recognized that the function of "public disclosure" is to "alert" the government with "a clear and substantial indication of foul play" so as to "set the government squarely on the trail of the alleged fraud."

504. The public disclosure bar does not apply when the government must comb through the myriad of transactions performed by the various industry defendants in search of false claims. Rather, as recognized by federal courts and the Department of Justice, a public disclosure must "set forth easily identifiable defendants engaged in clear methods of fraudulent activity."

505. Each fiscal year the Medicare claims file contains numeric codes submitted by Medicare providers with respect to approximately 12 million inpatient admissions for that year. The full annual Medicare claims data file typically has 14 million to 16 million lines of numeric codes submitted by Medicare providers for inpatient admissions. With up to 6 diagnoses codes and 9 procedure codes for each admission,[11] there are up to approximately 180 million numeric codes within Medicare claims data each year signifying specific diagnoses and procedures for Medicare patients. Buried within this massive database of millions of numeric codes are the diagnoses codes related to this case.

[11] In 2010 Medicare expanded the 6 diagnoses codes to 25 codes and expanded the 9 procedure codes to 25 codes.

506. For example, over the time period at issue in this case, there were over 2 billion numeric codes submitted by Medicare providers to CMS concerning inpatient admissions. None of the 2 billion codes contains any allegation of fraud or false claims. The numeric codes are innocuous numbers.

507. The hundreds of millions of numeric codes submitted by Medicare providers each year did not sufficiently alert the government to false claims submitted by HCA hospitals. To conclude otherwise would mean that the federal government is "alerted" to every false claim evidenced by any numeric code within a vast database of over 300 million codes submitted by Medicare providers each year to CMS.

508. Unless there has been a public disclosure of allegations of false claims or fraudulent transactions through one of the specific channels enumerated in the False Claims Act, then the source and extent of Relator's knowledge are irrelevant and there is no need to consider whether Relator satisfies the "original source" exception to the public disclosure defense.[12]

Count I---Presenting False Claims in Violation of 31 U.S.C. § 3729(a) (1)(A)

509. The preceding paragraphs are incorporated by reference as though fully set forth herein.

510. In pertinent part, the Federal False Claims Act establishes liability for "any person who…knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval." *See* 31 U.S.C. § 3729(a)(1)(A).

[12] The facts would satisfy the original source exception if it applied.

511. Defendants knowingly or in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, presented or caused to be presented false claims "for payment or approval" to the United States in violation of 31 U.S.C. § 3729(a)(1)(A).

512. This is a claim for treble damages and penalties under the Federal False Claims Act, 31 U.S.C. § 3729, *et seq*., as amended.

513. Through the acts described above, Defendants knowingly or in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, presented or caused to be presented, false claims to officers, employees or agents of the United States Government within the meaning of 31 U.S.C. § 3729(a)(1)(A).

514. The United States was unaware of the falsity of the records, statements and claims made or caused to be made by Defendants. In reliance on the accuracy of the claims, information, records, and certifications submitted by Defendants, the United States paid and continues to pay claims that would not be paid if Defendants' illegal conduct was known.

515. As a result of Defendants' acts, the United States has sustained damages, and continues to sustain damages, in a substantial amount to be determined at trial.

516. Additionally, the United States is entitled to civil penalties for each false claim made or caused to be made by Defendants arising from their illegal conduct as described above.

517. Defendants knowingly (as "knowingly" is defined by 31 U.S.C. 3729(b)(1)) presented or caused to be presented false or fraudulent claims for payment or approval to the United States. Specifically, Defendants knowingly submitted false claims to Medicare on Forms UB-92 HCFA-1450, UB-04 CMS-1450, Type of Bill 11X signifying an inpatient claim, and CMS-2552 for payment of medically unnecessary inpatient admissions that should have been classified and billed as outpatient/observation cases.

518. By virtue of Defendants' false or fraudulent claims, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

Count II---False Claims Act: Making or Using False Records or Statements, 31 § U.S.C. 3729(a)(1)(B)

519. The preceding paragraphs are incorporated by reference as though fully set forth herein.

520. In pertinent part, the Federal False Claims Act establishes liability for "any person who…knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." *See* 31 U.S.C. § 3729(a)(1)(B).

521. This is a claim for treble damages and penalties under the Federal False Claims Act, 31 U.S.C. § 3729, *et seq.,* as amended.

522. Through the acts described above, Defendants knowingly made, used, or caused to be made or used, false records and statements. Through the acts described above, Defendants knowingly made, used, or caused to be made or used, false records and statements, and omitted material facts, to get false claims paid or approved, within the meaning of 31 U.S.C. § 3729(a)(1)(B).

523. Defendants knowingly made, used, or caused to be made or used false records or statements with the intent to get or cause these false claims to be paid by the United States.

524. The United States was unaware of the falsity of the records, statements, certifications, and claims made or caused to be made by Defendants. The United States paid and continues to pay claims that would not be paid if Defendants' illegal conduct was known.

525. By virtue of the false records or false claims made by Defendants, the United States sustained damages and therefore is entitled to treble damages under the Federal False Claims Act

in an amount to be determined at trial.

526. Additionally, the United States is entitled to civil penalties for each false claim made and caused to be made by Defendants arising from their illegal conduct as described above.

527. Defendants knowingly (as "knowingly" is defined by 31 U.S.C. 3729(b)(1)) made, used, or caused to be made or used, false records or statements material to false or fraudulent claims paid or approved by the United States. Specifically, Defendants knowingly made false statements to Medicare on Forms CMS-855A, CMS-8551, UB-92 HCFA-1450, UB-04 CMS-1450, Type of Bill 11X signifying an inpatient claim, and CMS-2552, regarding, inter alia, Defendants' compliance with Medicare requirements and the accuracy of Defendants' billing information and cost data.

528. By virtue of the Defendants' false records and statements, the United States incurred damages.

Count III-Conspiring to Submit False Claims in Violation of 31 U.S.C. § 3729(a)(1)(C) Against All Defendants

529. Relator repeats and realleges the allegations and statements contained in all of the preceding paragraphs as though fully set forth herein.

530. In pertinent part, the Federal False Claims Act establishes liability for "any person who….conspires to commit a violation of subparagraph (A),(B),(D),(E),(F), or (G)." 31 U.S.C. § 3729(a)(1)(C).

531. This is a claim for penalties and treble damages under the False Claims Act, 31 U.S.C. § 3729, *et seq.*, as amended.

532. Through the acts described above, Defendants acting in concert with each other and other contractors, agents, partners, and/or representatives, conspired to knowingly present or cause to be presented, false claims to the United States and knowingly made, used, or caused to be made

or used, false records and statements, and omitting material facts, to get false claims paid or approved.

533. As a result, the United States was unaware of the false claims submitted and caused by Defendants and the United States paid and continues to pay claims that would not be paid if the Defendants' illegal conduct was known to the United States.

534. By reason of Defendants' acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

535. By virtue of Defendants' conspiracy to defraud the United States, the United States sustained damages and is entitled to treble damages under the Federal False Claims Act, to be determined at trial, plus civil penalties for each violation.

Count IV---Submission of Express and Implied False Certifications in Violation of 31 U.S.C. § 3729(a)(1)(B) Against All Defendants

536. Relator repeats and realleges the allegations and statements contained in all of the preceding paragraphs as though fully set forth herein.

537. In pertinent part, the False Claims Act establishes liability for "any person who…knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." *See* 31 U.S.C. § 3729(a)(1)(B). .

538. In reliance on the Defendants' express and implied certifications, the United States made payments to Defendants under Federal Healthcare Programs. If the United States had known that Defendants' certifications were false, their payments would not have been made to Defendants for each of the years in question.

539. By virtue of the false records, false statements, and false certifications made by Defendants, the United States sustained damages and is entitled to treble damages under the False Claims Acts, to be determined at trial, plus a civil penalty for each violation.

Count V---Knowingly Causing and Retaining Overpayments in Violation of 31 U.S.C. § 3729(a)(1)(G) Against All Defendants

540. Relator repeats and realleges the allegations and statements contained in all of the preceding paragraphs as though fully set forth herein.

541. The False Claims Act also establishes liability for any person who "knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." *See* 31 U.S.C. § 3729(a)(1)(G). The False Claims Act defines "obligation" as "an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment." *See* 31 U.S.C. § 3729(b)(3).

542. Defendants have knowingly caused and retained overpayments from Federal Healthcare Programs arising from Defendants' violations of federal laws discussed above.

543. By virtue of Defendants causing and retaining overpayments from the Medicare Program, the Medicaid Program, and other Federal Healthcare Programs, the United States sustained damages and is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty for each violation.

Count VI--- False Record to Avoid an Obligation to Refund Against All Defendants

544. Relator repeats and realleges the allegations and statements contained in all of the preceding paragraphs as though fully set forth herein.

545. The False Claims Act also establishes liability for any person who "knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." *See* 31 U.S.C. § 3729(a)(1)(G).

546. Defendants knowingly made and used, or caused to be made or used, false records or false statements, i.e., the false certifications made or caused to be made by Defendants in

submitting the cost reports, to conceal, avoid, or decrease an obligation to pay or transmit money or property to the United States.

547. By virtue of the false records or false statements made by the Defendants, the United States sustained damages and therefore is entitled to treble damages, to be determined at trial, plus civil penalties for each violation.

Prayers for Relief

548. On behalf of the United States, Relator requests and prays that judgment be entered against Defendants in the amount of the United States' damages, trebled as required by law, such civil penalties as are required by law, for a qui tam relator's share as specified by 31 U.S.C. §3730(d), for attorney's fees, costs and expenses as provided by 31 U.S.C. §3730(d), and for all such further legal and equitable relief as may be just and proper.

Jury trial is hereby demanded.

This 19th of November, 2018.

Respectfully submitted,

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CERTIFICATE OF SERVICE

This is to certify that I have this day served a copy of the Relator's First Amended Complaint by depositing a true and correct copy of same by Certified Mail in the United States Mail, postage prepaid, addressed as follows:

The Honorable Attorney General Matthew G. Whitaker
Attorney General of the United States
Attention: Seal Clerk
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This 19th day of November, 2018.

Jerry E. Martin