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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA ex rel.: DR. GABRIEL FELDMAN, Plaintiff, - against - THE CITY OF NEW YORK, Defendant.	COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA AGAINST THE CITY OF NEW YORK 09 Civ. 8381 (JSR)
UNITED STATES OF AMERICA, Plaintiff-Intervenor, - against - THE CITY OF NEW YORK, Defendant.	

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

PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the United

States of America against the City of New York ("the City" or "defendant"), under the False Claims Act, 31 U.S.C. §§ 3729 et seq., to recover damages sustained by, and penalties owed to, the United States as the result of the City having knowingly presented or caused to be presented to the United States false claims for the payment of funds under the Medicaid Program, 42 U.S.C. § 1396 et seq., in connection with the provision of 24-hour care pursuant to the Personal Care Services ("PCS") Program, in excess of the amounts to which the City was lawfully entitled, from in or about 2000 through 2010, as more specifically detailed below.

2. Since 2000, approximately 17,500 people have received 24-hour personal care services from the City. Currently, the annual cost of such services range from $75,000 to 150,000 per individual. Upon information and belief, the City improperly authorized services for a substantial percentage of the thousands of Medicaid beneficiaries receiving this 24-hour care, resulting in damages to the United States of at least tens of millions of dollars.

3. The City's violations have resulted in patients receiving more services than necessary through the PCS Program, resulting in additional and unwarranted cost to taxpayers, and in other cases patients receiving fewer services through the Program than those patients truly needed, thus potentially endangering the health and welfare of those patients.

4. The United States also asserts claims against the

City in relation to the PCS program under the common law for unjust enrichment, payment under mistake of fact, and negligence.

JURISDICTION AND VENUE

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

6. Venue lies in this District pursuant to 31 U.S.C. § 3732(a), and 28 U.S.C. §§ 1391(b) and 1391(c), because the City of New York is a municipality partially situated within this district and because some of the false or fraudulent acts set out in 31 U.S.C. § 3729 occurred in this district.

PARTIES

7. Plaintiff is the United States of America on behalf of its agency the United States Department of Health and Human Services ("HHS").

8. Relator Dr. Gabriel Feldman is a licensed medical doctor in New York who is board certified in preventive medicine and public health and resides in New York, N.Y. Dr. Feldman is a local medical director employed by the New York County Health Services Review Organization ("NYCHSRO"), an organization that contracts with the City to provide certain medical review functions integral to the PCS program.

9. Defendant City of New York is a municipality of New York State and is comprised of Bronx, Kings, New York, Queens, and Richmond Counties.

FACTS

I. Background

10. Pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., the Medicaid Program was established in 1965 as a joint federal and state program to provide financial assistance to individuals with low incomes to enable them to receive medical care. Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates and program administration in accordance with certain federal statutory and regulatory requirements. The state directly pays the health care providers for services rendered to Medicaid recipients, with the state obtaining the federal share of the Medicaid payment from accounts that draw on the United States Treasury. 42 C.F.R. §§ 430.0 - 430.30.

11. The New York State Legislature established New York's Medicaid system in 1966, L. 1966, ch. 256, the year after Congress created the federally funded Medicaid program, see Pub. L. 89-97, 79 U.S. Stat 344. Under this system, Medicaid is administered at the state level by the New York State Department of Health ("DOH"). See N.Y. Pub. Health Law § 201(1)(v).

12. The State of New York has promulgated an extensive

and regulatory scheme governing the administration of the Medicaid program within the State. Part of this regulatory scheme relates to the Personal Care Services program.

A. Regulatory Framework for the Personal Care Services Program

13. The Personal Care Services ("PCS") program is a Medicaid funded program designed to provide cleaning, shopping, grooming, and basic aid services to Medicaid beneficiaries meeting certain criteria.

14. The PCS program can provide services ranging from a few hours per week to 24-hours per day, seven days a week. There are two types of 24-hour care service provided by the PCS program. First, the program provides "sleep-in" service, which is 24-hour care provided by a single personal care aide who provides daytime services and who sleeps in the patient's home, providing only limited night-time services. Sleep-in service costs approximately $75,000 per year per patient. Second, the program also provides a higher level of care referred to as "24-hour continuous care" or "split-shift" service. Split-shift service is provided by more than one aide, who does not sleep in the home, but instead provides uninterrupted 24-hour care for a patient who, because of his or her medical condition and disabilities, requires total assistance with toileting, walking, transferring and/or feeding at unscheduled times during the day and night. Split-shift service costs approximately $150,000 per year per patient.

15. Although PCS is a statewide program, New York City administers the PCS program within the City through the Human Resources Administration ("HRA"). HRA, in turn, administers the program through the Community Alternative Systems Agency ("CASA") system. In addition, HRA contracts with the NYCHSRO, which provides medical doctors, referred to as "local medical directors" ("LMDs"), to provide certain medical review functions integral to the PCS system, including, among other things, review and approval of cases in which split-shift service has been requested.

16. Since 2006, in New York City, Medicaid's PCS Program is funded 50% by the federal government and 50% by New York State. Prior to 2006, Medicaid's PCS Program was funded 50% by the federal government, 25% by New York State, and 25% by the City.

B. Criteria for Authorization

17. DOH has issued regulations governing the PCS program, including the eligibility of beneficiaries for services and the process for making eligibility determinations. See 18 NYCRR § 505.14. These regulations require that a patient's medical condition be "stable" and that the patient be "self-directing" to receive PCS services.

18. Under the regulations, "stable" means that a patient's condition (a) is not expected to exhibit either sudden deterioration or improvement; (b) does not require frequent medical or nursing judgment to determine changes in his or her plan of care;

and (c)(1) is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or (2) is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing. See id. § 505.14(a)(4)(i).

19. PCS is not available to patients who are not "self directing." Specifically, the regulations define "self-directing" with respect to a patient to mean that the patient "is capable of making choices about his/her activities of daily living, understanding the impact of the choice, and assuming responsibility for the results of the choice. Id. § 505.14(a)(4)(ii). Except where additional supervision is provided by family or other sources, "[p]atients who are nonself-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive personal care services . . . ." Id.

20. According to the regulations, when a local social services department, such as HRA, receives a request for services, it must determine the applicant's eligibility for medical assistance. The initial authorization for personal care services must be based, in relevant part, on a physician's order, called an "M-11q", a social worker's assessment, called an "M-11s", and a nursing assessment, called an "M-11r". Id. § 505.14(b)(1)-(2).

21. The regulations further provide that where

"split-shift" (i.e., continuous 24-hour care) is to be provided, an LMD determination as to the necessity and appropriateness of the services is required. Id. § 505.14(b)(4(i)).

22. An LMD determination is also required where there is a disagreement between the physician's order, the social worker assessment, or the nursing assessment as to the appropriate type, amount, or length of service, including where "sleep-in" 24-hour care is provided. Id.

23. In any circumstance where an LMD determination is required by the regulations (i.e., where "split shift" care is involved and/or where a disagreement exists among the physician's order and the social worker, nursing and other required assessments), the LMD "must review the physician's order and the social worker, nursing and other required assessments in accordance with the standards for levels of services set forth in subdivision (a) of the section, and is responsible for the final determination of the level and amount of care to be provided." Id. § 505.14(b)(4)(ii) (emphasis added).

24. In addition, the regulations provide that authorizations for services cannot be effective for more than six months absent special circumstances and in no case for more than twelve months. Id. § 505.14(b)(5)(iii).

25. The regulations are clear that all reauthorizations of services "shall follow the procedures outlined in paragraphs

(2)-(4)," i.e., reauthorizations must be based on the physician's order, social worker assessment, nursing assessment, and any LMD determination required for initial authorizations. Id. § 505.14(b)(5)(ix).

26. The regulations are also clear that PCS services can be provided only where medically necessary and where health and safety can be maintained in the home. Id. § 505.14(a)(4), (b)(3)(iv)(a)(1). HRA "must deny or discontinue personal care services when such services are not medically necessary or are no longer medically necessary or when [HRA] reasonably expects that such services cannot maintain or continue to maintain the client's health and safety in his or her home." Id. § 505.14(b)(5)(v)(a).

27. Moreover, a patient is eligible for PCS services only if it is determined that other services are not more appropriate. Id. § 505.14 (b)(2)(iv), (b)(3)(i)(v)(a).

28. Furthermore, absent prior authorization by HRA, no Medicaid funds may be disbursed to a vendor providing PCS services. See id. § 505.14 (b)(5). After finding an individual eligible for PCS services, HRA electronically transmits to DOH information concerning the number of hours and type of service that HRA has awarded to the individual. Based on that submission, a "prior authorization number" is generated by DOH, at which point the individual may begin receiving services and a vendor providing the personal care service may begin billing Medicaid for such service.

II. The City's False Statements Relating to the Provision of PCS Care

A. Improper Initial Authorizations for 24-Hour Care

29. For years, the City has been knowingly authorizing personal care services for individuals in violation of requirements of the regulations. In particular, although the regulations provide that an LMD "is responsible for the final determination of the level and amount of care to be provided", id. § 505.14(b)(4)(ii), CASA administrators have overruled LMD determinations concerning the appropriate level of care in the context of 24-hour care.

30. For example, on June 24, 2008, after examining Patient A, a 65-year old female with a diagnosis of dementia, a doctor affiliated with NYCHSRO recommended the provision of task-based services, i.e. PCS services for a limited number of hours a day. On June 25, 2008, an LMD determined that this patient did not require sleep-in service. The LMD based this determination on the affiliated doctor's examination, noting specifically that Patient A had little trouble ambulating, was alert, was not on medication, and had good judgment; he also noted that she needed some assistance with chores and stove precautions. That same day and notwithstanding the LMD's determination, an HRA administrator overruled the LMD and approved 24-hour sleep-in services for the patient.

31. In another case, on April 21, 2008, Patient B, an 83-year old woman, was examined by a doctor affiliated with NYCHSRO, who recommended that she receive PCS care for 10-12 hours per day.

On April 22, 2008, an LMD determined that she was eligible for 10 hours per day and should not receive 24-hour care because she had "no compelling night time needs." The next day, an HRA administrator overruled the LMD's determination and authorized 24-hour "sleep-in service."

32. Patient C, an 82-year old female with a history of dementia, anemia, renal failure, diabetes and hypertension, was receiving task-based services through the PCS program. In November 2005, the patient's doctor requested an increase in services to split-shift. On January 10, 2006, an LMD reviewed the request and the accompanying assessments and noted that, while the patient required assistance, the patient also "engages in self-endangering behavior" such as "getting out of bed without assistance" which has resulted in falls. The LMD noted that "even split shift service would be inadequate for this client" as she would be at risk during the home attendant's bathroom breaks when she would be unsupervised. Accordingly, the LMD concluded, the client "can no longer be safely serviced at home" and "is no longer appropriate" for home care services. Nonetheless, HRA overruled this determination and on February 24, 2006, split shift services were authorized. Split-shift services were reauthorized twice without an LMD before Patient C died on February 24, 2007.

B. Improper Reauthorizations for 24-Hour Care

33. The City has also routinely reauthorized 24-hour

personal care services for individuals who did not meet the requirements of the regulations. First, in virtually all cases, the City has reauthorized cases for split-shift services without first obtaining an LMD determination, in direct contravention of the relevant DOH regulation. See id. § 505.14(b)(5)(ix).

34. Likewise, the City has routinely contravened DOH regulations and reauthorized split-shift and sleep-in services without first obtaining or reviewing the nursing and/or social assessments required by the regulations. See 18 NYCRR § 505(b)(5)(ix). These knowing violations of the regulations have resulted in false submissions of claims for PCS service where the patients were not eligible for such services, either because the patients needed less care than is provided under the PCS program or because they needed a higher level of care than is provided under the PCS program.

35. For example, Patient D, a 75-year old patient with a diagnosis of dementia, lived with her daughter, and was receiving split-shift care. On September 16, 2008, an LMD determined that "the client tries to jump out of window several times a day and punches daughter so is dangerous to self and others and is inappropriate for home attendant service and a Higher Level of Care such as psychiatric facility is indicated. The client is unable to direct care, has inappropriate judgment, wanders, is up all night, and has shown oven/stove misuse." The LMD decision found that the patient should

be placed in an "appropriate facility." Despite the dangers posed by the patient to herself and others, she was not placed in a facility but remained in the PCS care.

36. In fact, split-shift services were reauthorized for Patient D on multiple occasions between April 1, 2009 and September 30, 2010 without the required nursing assessments or supervisory nursing assessments (M-11t). Split-shift service was subsequently reauthorized to March 3, 2011, without a nursing assessment or a supervisory nursing assessment. According to the case file, the last time a nursing assessment was performed on this clearly unstable patient was the summer of 2009, yet Patient D continued for more than a year to receive 24-hour personal care services.

37. In another case, Patient E, a 91-year old patient with Alzheimer's disease, received multiple reauthorizations for split-shift service without any nursing or social assessments having been performed -- despite an LMD's recommendation that she needed a higher level of care. Specifically, an LMD decision dated November 5, 2007, described the client's condition as "unstable," noting that she has "threatened to jump from the window, and will turn the stove on." A social assessment dated October 17, 2007, stated that the client is "very aggressive" and is a "danger to herself." Despite these clear signs of ineligibility for PCS services, HRA authorized split-shift service for Patient E on November 5, 2007.

38. Patient E subsequently received multiple

reauthorizations for split-shift service between December 5, 2007 and January 31, 2008, during which time no nursing assessments, supervisory assessments, or social assessments were performed. For the subsequent 12-month period beginning on January 14, 2008, service was reauthorized with no assessments having been performed. Service was again authorized from April 14, 2008 through September 30, 2008 with no assessments, and on October 10, 2008, service was reauthorized with a social assessment, but no nursing assessment or supervisory nursing assessment. Patient E died on January 1, 2009.

39. Moreover, in many other instances, split-shift care was reauthorized despite the failure to obtain required nursing assessments on a timely basis.

40. For example, Patient F was initially authorized for split-shift service in or about June 2003. He was reauthorized for continued split-shift service approximately every six months until he died in September 2007. During those years, no nursing assessments were conducted and there is no evidence in the file that any supervisory visits were ever conducted. Nevertheless, he was reauthorized for split-shift service on every occasion.

41. In 2008, Patient G was found to be eligible for only a limited number of hours of personal care service per day. However, the wife of Patient G was found to be eligible for split-shift care. In such circumstances, the spouses will share a home aide. This is referred to as a "mutual" or "shared" aide. As a result, the LMD

determined that Patient G was to receive split-shift but only so long as his spouse required that level of service. The spouse, however, died on July 13, 2008, yet the nursing assessment of July 27, 2008, indicated that the spouse was still alive and that split-shift care continued to be warranted. Further, subsequent nursing assessments noted that the spouse had died and that the level of service should be decreased. However, the CASA continued to reauthorize split-shift service and took no steps to determine whether the level of service for Patient G should be decreased.

42. The foregoing examples are not isolated instances or random mistakes. Rather, the City has engaged in a knowing or reckless pattern and practice of authorizing and reauthorizing PCS care in direct violation of the governing laws. As a result, the City improperly authorized PCS care, at the expense of Medicaid, for a substantial percentage of the thousands of Medicaid beneficiaries receiving PCS services during the relevant time period. The United States has made payments under the Medicaid program because of these improper authorizations, resulting in damages of at least tens of millions of dollars to the United States.

FIRST CLAIM

Violations of the False Claims Act
(31 U.S.C. § 3729 (a)(1) (2000))
Presenting False Claims for Payment

43. The United States incorporates by reference paragraphs 1 through 42 above as if fully set forth in this paragraph.

44. The United States seeks relief against the City under Section 3729(a)(1) of the False Claims Act, 31 U.S.C. § 3729(a)(1) (2000).

45. As set forth above, the City knowingly, or acting with deliberate ignorance or with reckless disregard for the truth, presented, or caused to be presented, to an officer, employee or agent of the United States, (1) false or fraudulent claims for Medicaid funding relating to 24-hour care under the PCS program and (2) such claims were false or fraudulent because the applicants were not eligible and/or defendants failed to assess whether the applicants were eligible to receive PCS services under 18 NYCRR § 505.14.

46. The United States made payments under the Medicaid program because of the false or fraudulent claims caused by the City.

47. By reason of the City's false or fraudulent claims, the United States has been damaged in a substantial amount to be determined at trial.

SECOND CLAIM

Violations of the False Claims Act
(31 U.S.C. § 3729 (a)(1)(B)(Supp. 2009))
Use of False Statements

48. The United States incorporates by reference paragraphs 1 through 42 above as if fully set forth in this paragraph.

49. The United States seeks relief against the City under Section 3729(a)(1)(B) of the False Claims Act, 31 U.S.C. § 3729(a)(1)(B) (Supp. 2009).

50. As set forth above, the City knowingly, or acting in deliberate ignorance or in reckless disregard of the truth, made, used, and caused to be made and used, false records and statements material to a false or fraudulent claim in connection with the submission of its claims for 24-hour personal care services under the Medicaid program.

51. The United States paid such false or fraudulent claims because of the acts and conduct of the City.

52. By reason of the City's false records and statements, the United States has been damaged in a substantial amount to be determined at trial.

THIRD CLAIM

Unjust Enrichment

53. The United States incorporates by reference paragraphs 1 through 42 above as if fully set forth herein.

54. The City enrolled patients in the PCS program even though certain patients were ineligible to receive such services and should have received services through a different program. The City has been unjustly enriched by this practice because, since January 1, 2006, the PCS program is not funded by the City, whereas alternative programs are.

55. Accordingly, the circumstances of the City's receipt of payments are such that, in equity and good conscience, it should not retain these payments, the amount of which is to be determined

at trial.

FOURTH CLAIM

Payment Under Mistake of Fact

56. The United States incorporates by reference paragraphs 1 through 42 above as if fully set forth herein.

57. The United States seeks relief against the City to recover monies paid under mistake of fact.

58. The United States made payments under the Medicaid program for services rendered under the erroneous belief that the City was entitled to payment of such funds. In making such payments, the United States relied upon and assumed the City had complied with the applicable Medicaid rules and regulations and that the City's claims for Medicaid reimbursement were consistent with Medicaid regulations. This erroneous belief was material to the United States' decision to pay these claims. In such circumstances, the United States' payment of federal funds under the Medicaid program was by mistake and was not authorized.

FIFTH CLAIM

Negligence

59. The United States incorporates by reference paragraphs 1 through 42 above as if fully set forth herein.

60. The United States seeks relief against the City to recover monies paid because of the City's negligence.

61. HRA was negligent in failing to comply with

regulations relating to the award of PCS services. The United States made substantial Medicaid payments that would not have been made but for HRA's misrepresentation that certain individuals were eligible for PCS services pursuant to the regulatory requirements even though those requirements had not been met.

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

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

(a) On the First and Second Claims for relief (Violations of the False Claims Act, 31 U.S.C. § 3729(a)(1) and 3729(a)(1)(B)), for treble the United States' damages, in an amount to be determined at trial, plus an $11,000 penalty per violation;

(b) On the First and Second Claims for Relief, an award of costs pursuant to 31 U.S.C. § 3729(a);

(c) On the Third Claim for Relief (Unjust Enrichment), in an amount to be determined at trial, together with costs and interest;

(d) On the Fourth Claim for Relief (Payment Under Mistake of Fact), in an amount to be determined at trial, together with costs and interest; and

(e) On the Fifth Claim for Negligence, in an amount to be determined at trial, together with costs and

interest; and

(f) awarding such further relief as is proper.

Dated: New York, New York
January 11, 2011

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CERTIFICATE OF SERVICE

I, Allison D. Penn, Assistant United States Attorney for the Southern District of New York, hereby certify that on January 11, 2011, I caused a copy of the foregoing Complaint to be served by electronic mail and Federal Express mail, upon the following:

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Dated: New York, New York
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