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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---X

UNITED STATES OF AMERICA, ex rel.
JOHN F. REILLY,

Plaintiff,

-against -

CATSKILL REGIONAL MEDICAL CENTER
f/k/a COMMUNITY GENERAL HOSPITAL
OF SULLIVAN COUNTY, et al.,

Defendants.

---X

00 Civ. 7906 (KMW)

COMPLAINT-IN-INTERVENTION
AGAINST APPLIED CONSULTING, INC.,
AND APPLIED CASEMANAGEMENT, INC.

For its complaint against Applied Consulting, Inc. ("Consulting") and Applied CaseManagement, Inc. ("CaseManagement"), the United States of America (the "Government" or the "United States"), by its attorney, Michael J. Garcia, United States Attorney for the Southern District of New York, alleges as follows:

I. NATURE OF ACTION

1. The United States brings this action to recover treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33.

A. Illegal Patient Referral Scheme

2. Defendants Consulting and CaseManagement (collectively, the "Applied Defendants") caused false and fraudulent claims and statements to be submitted to the United States in order for The Mount Vernon Hospital ("Mount Vernon"), Catskill Regional Medical Center f/k/a/ Community General Hospital of Sullivan County ("Catskill"), and another hospital (collectively, the "Hospitals") to obtain millions of dollars in payments for various healthcare services from 1997 through 2004. These false claims and statements arose from defendants' unlawful scheme to provide patients by receiving kickbacks or other illegal remuneration to induce patient referrals.

3. Defendants entered into illegal contractual arrangements (the "administrative services agreements" described in ¶¶ 52-72) with the Hospitals by which Consulting and CaseManagement referred patients for a fee to the hospitals' facilities.

4. The Hospitals in accord with the illegal administrative services agreements, knowingly paid prohibited fees to Consulting and CaseManagement in return for patient referrals in violation of New York State Medicaid regulations, 18 NYCRR §§ 504.6(d), 515.2, and 515.5, the New York State Anti-kickback Statute, New York Social Services Law §366-d(2), and the federal Anti-kickback Statute, 42 U.S.C. § 1320a-7b.

5. In turn, Consulting and CaseManagement, to whom the Hospitals knowingly provided kickbacks or other illegal remuneration, knowingly and willfully referred large numbers of Medicaid patients to the Hospitals in violation of state and federal law and regulation.

6. The Hospitals then knowingly submitted false and fraudulent claims and statements to the United States to receive Medicaid payments for services rendered to the

patients referred by Consulting and CaseManagement. The Hospitals obtained several million dollars' worth of payments from the United States for services rendered to the illegally referred patients.

7. Consulting and CaseManagement violated the False Claims Act, 31 U.S.C. § 3729(a)(1), by referring Medicaid patients to the Hospitals for a fee, knowing (*i.e.*, with actual knowledge, in deliberate ignorance of the truth, or with reckless disregard of the truth) that the Hospitals would seek reimbursement from Medicaid for the services provided to those patients and that the Hospitals were not entitled to payment for services based on prohibited patient referrals.

8. Consulting and CaseManagement violated the False Claims Act, 31 U.S.C. § 3729(a)(2), by causing the Hospitals to make false statements when presenting claims for payment to Medicaid. Through the illegal patient referral schemes, Consulting and CaseManagement referred Medicaid patients to the Hospitals' facilities, knowing (*i.e.*, with actual knowledge, in deliberate ignorance of the truth, or with reckless disregard of the truth) that the Hospitals would submit false statements to Medicaid when seeking reimbursement for the services provided to the Medicaid patients.

9. Consulting and CaseManagement violated the False Claims Act, 31 U.S.C. § 3729(a)(3), when they conspired with the Hospitals to present false claims and statements in connection with the Hospitals' submissions of claims to Medicaid for reimbursement for services provided to the patients that Consulting and CaseManagement referred to the Hospitals for a fee.

B. Mount Vernon's Operation of an Unlicensed Alcoholism Facility

10. From 1997 through 2004, Mount Vernon has knowingly operated an unlicensed alcoholism facility within the meaning of the New York State regulations governing the licensure of inpatient facilities providing services to persons suffering from alcoholism or substance abuse.

11. Specifically, from 1997 to 2004, defendants Mount Vernon has operated a "Medical Detoxification Unit" to treat Medicaid eligible patients suffering from alcohol and substance abuse and withdrawal that is unlicensed by the State of New York. Under New York State regulations, all "alcoholism facilities," like Mount Vernon's Medical Detoxification Unit, must be certified by the New York State Office of Alcoholism and Substance Abuse Services ("OASAS") in order to provide detoxification and treatment services. Mount Vernon knew or should have known that its Medical Detoxification Unit is required to be certified by OASAS. Nevertheless, Mount Vernon knowingly treated patients in the unit notwithstanding that Mount Vernon is not certified by OASAS. Mount Vernon knowingly submitted false and fraudulent claims and statements to the United States to receive millions of dollars' worth of Medicaid payments for services rendered to the patients treated in its unlicensed Medical Detoxification Unit.

12. CaseManagement also caused Mount Vernon to submit false and fraudulent claims in connection with Mount Vernon's operation of its unlicensed alcoholism facility.

13. CaseManagement knowingly contracted with Mount Vernon to provide preliminary financial review of Medicaid eligible patients desiring detoxification services; assist Mount Vernon's intake staff; provide consultation services in all matters relating to compliance

with OASAS rules and regulations; and advise Mount Vernon regarding staffing requirements and necessary credentials to its Medical Detoxification Unit.

14. Moreover, CaseManagement knowingly contracted with Mount Vernon to refer Medicaid eligible patients to Mount Vernon for treatment. CaseManagement then referred large numbers of Medicaid patients to Mount Vernon for treatment in its alcoholism facility knowing that Mount Vernon would seek reimbursement from Medicaid for the services provided to these patients and that Mount Vernon was not certified by OASAS to treat those patients in its Medical Detoxification Unit.

15. CaseManagement violated the False Claims Act, 31 U.S.C. § 3729(a)(1), by referring patients to Mount Vernon, knowing (*i.e.*, with actual knowledge, in deliberate ignorance of the truth, or with reckless disregard of the truth) that Mount Vernon was not licensed to operate an alcoholism facility or seek reimbursement from Medicaid for the medical services provided to the patients treated in that facility.

16. CaseManagement violated the False Claims Act, 31 U.S.C. § 3729(a)(2), by causing Mount Vernon to make false statements when submitting claims for payment to Medicaid. CaseManagement contracted with Mount Vernon to refer large numbers of Medicaid eligible patients to be treated in Mount Vernon's unlicensed alcoholism facility, knowing (*i.e.*, with actual knowledge, in deliberate ignorance of the truth, or with reckless disregard of the truth) that Mount Vernon would falsely certify that the services to the patients treated in its unlicensed alcoholism facility were provided in accordance with state law and regulations.

17. CaseManagement violated the False Claims Act, 31 U.S.C. § 3729(a)(3), by conspiring with Mount Vernon to submit or causing to be submitted false claims and statements

in connection with Mount Vernon's submission of claims to Medicaid for reimbursement for services provided in their unlicensed alcoholism facility.

II. JURISDICTION

18. The Court has subject matter jurisdiction to entertain this action under 28 U.S.C. §§ 1331 and 1345 and supplemental jurisdiction to entertain the common law and equitable causes of action pursuant to 28 U.S.C. § 1367(a). The Court may exercise personal jurisdiction over the defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the defendants resides or transacts business in the Southern District of New York, and at least one act proscribed by 31 U.S.C. § 3729 occurred in this District.

III. VENUE

19. Venue is proper in the Southern District of New York under 31 U.S.C. § 3732 and 28 U.S.C. § 1391(b) and (c) because at least one of the defendants resides or transacts business in this District.

IV. PARTIES

20. The United States brings this action on behalf of the Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Services ("CMS"), on behalf of the Medicaid program.

21. Relator John F. Reilly ("Reilly") is an individual residing in the State of New York. Pursuant to 31 U.S.C. § 3730(b), Reilly brought this action against the defendants on behalf of himself and the United States.

22. Defendant Consulting is a New York corporation with offices located at 555 West 57th Street, Suite 1326, New York, New York 10019. Consulting is affiliated with

CaseManagement, and purports to be in the business of providing consulting services to hospitals with inpatient and outpatient alcohol and substance abuse treatment programs.

23. Defendant CaseManagement is a New York corporation with offices located at 555 West 57th Street, Suite 1326, New York, New York 10019. CaseManagement is affiliated with Consulting, and purports to be in the business of providing consulting services to hospitals with inpatient and outpatient alcohol and substance abuse treatment programs.

V. THE LAW

A. The False Claims Act

24. The False Claims Act provides, in pertinent part, that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; . . .
>
> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages which the Government sustains because of the act of that person . . . .
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729.

25. Under the False Claims Act, a "claim" is defined as:

> any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

31 U.S.C. § 3729(c).

26. From 1997 to 2004, each time a referred patient was treated at the Hospitals' facilities, the Hospitals submitted an electronic certification to Medicaid stating that the medical services rendered to the patient were provided in accordance with state and federal law, and requested to be reimbursed for those services. Such electronic certifications constitute claims under the False Claims Act.

27. Based on Mount Vernon's and Catskill's own records tracking referrals from CaseManagement, from 1997 to 2004, Mount Vernon submitted false statements and claims relating to services provided to approximately 45 referred patients per month; and Catskill submitted false statements and claims relating to services provided to approximately 35 referred patients per month.

28. Based on Mount Vernon's own records tracking patients treated in the Medical Detoxification Unit, from 1997 to 2004 Mount Vernon treated approximately 80 patients per month in the Medical Detoxification Unit.

29. From 1997 to 2004, each time Mt. Vernon treated a patient in its detoxification units, it submitted an electronic certification to Medicaid stating that the medical services rendered to the patient were provided in accordance with state and federal law, and requested to

be reimbursed for those services. Such certifications constitute claims under the False Claims Act.

B. <u>The Medicaid Program – Federal Participation</u>

30. Medicaid is a joint federal-state program that provides health care benefits for certain groups, primarily the poor and disabled. The federal involvement in Medicaid is to provide matching funds and to ensure that states comply with minimum standards in the administration of the program.

31. The federal Medicaid statute sets forth the minimum requirements for state Medicaid programs to qualify for federal funding, which is called federal financial participation. 42 U.S.C. §§ 1396, *et seq*.

32. Each state's Medicaid program must cover hospital services. 42 U.S.C. § 1396a(10)(A); 42 U.S.C. § 1396d(a)(1)-(2).

33. Each state's Medicaid program must also have a fraud detection program, and the state plan must provide for exclusion of persons who have committed fraud. 42 C.F.R. § 455.1 "'Fraud' means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person [and] includes any act that constitutes fraud under applicable Federal or State law." 42 C.F.R. § 455.2.

C. <u>New York State Medicaid Regulations</u>

34. New York State Medicaid regulations explicitly prohibit Medicaid providers from seeking reimbursement for services rendered to patients who come to their facility through payment of referral fees.

35. New York State Medicaid regulations also explicitly prohibit Medicaid providers who are not licensed by the appropriate state agency from seeking reimbursement for services provided to patients.

36. Specifically, 18 N.Y.C.R.R.§ 504.1(b) requires that "[a]ny person who furnishes medical care, services or supplies for which payments under the medical assistance program are to be claimed . . . must enroll as a provider of services prior to being eligible to receive such payments . . ." *Id.* That regulation also provides that:

> If a license, registration or certification is required to render the medical care, services or supplies to be furnished, an applicant must hold a proper and currently valid license, registration and/or certification to be eligible to furnish the care, services or supplies under the medical assistance program.

Id. at § 504.1(c).

37. 18 N.Y.C.R.R. § 504.6(d) requires that a provider submit Medicaid claims only for services provided in compliance with Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State.

38. 18 N.Y.C.R.R. § 515.2(b) specifically prohibits as an "unacceptable practice":

> (5) Bribes and Kickbacks . . .
>
> (i) soliciting or receiving either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a person for any medical care, services or supplies for which payment is claimed under the program[; and]
>
> * * *
>
> (iii) offering or paying either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a

person for any medical care, services or supplies for which payment is claimed under the program.

* * *

(12) Failure to meet recognized standards. Furnishing medical care, services or supplies that fail to meet professionally recognized standards for health care or which are *beyond the scope of the person's professional qualifications or licensure.*

Id. at § 515.2(b) (emphasis added).

39. 18 N.Y.C.R.R. § 515.2(a) also specifically prohibits as an "unacceptable practice" conduct that is contrary to:

> (3) the official rules and regulations of the Departments of Health, Education and Mental Hygiene, including the latter department's offices and divisions, relating to standards for medical care and services under the program; or
>
> (4) the regulations of the Federal Department of Health and Human Services promulgated under title XIX of the Federal Social Security Act.

Id.

40. Title 18 provides further that "*no payments will be made to or on behalf of any person for the medical care, services or supplies furnished . . . in violation of any condition of participation in the program*," 18 N.Y.C.R.R. § 515.5 (a), (b)(emphasis added), and that Medicaid payments may be withheld "when [the Department] has reliable information that a provider is involved in fraud or willful misrepresentation involving claims submitted to the program," id. at § 518.7(a). In other words, in New York State all conditions of participation in the Medicaid program are conditions of payment.

41. To receive reimbursement from Medicaid in New York State, all providers who participate in electronic billing, as do the Hospital Defendants, must sign a Certification

Statement for Provider Utilizing Electronic Billing (the "Medicaid Electronic Certification") every year.

42. The Medicaid Electronic Certification reads, in pertinent part:

> I (or the entity) have furnished or caused to be furnished the care, services and supplies itemized *and done so in accordance with applicable federal and state laws and regulations.*
>
> * * *
>
> In submitting claims under this agreement I understand and agree that I (or the entity) *shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health as set forth in title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other publications of the Department, including Medicaid Management Information Systems Provider Manuals and other official bulletins of the Department. . .*

D. <u>The Federal Anti-Kickback Statute</u>

43. The federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), arose out of congressional concern that payoffs to those who can influence healthcare decisions will result in goods and services being provided that are medically unnecessary, of poor quality, or harmful to a vulnerable patient population. To protect the integrity of the program from these difficult to detect harms, Congress enacted a *per se* prohibition against the payment of kickbacks in any form, regardless of whether the particular kickback gave rise to overutilization or poor quality of care. First enacted in 1972, Congress strengthened the statute in 1977 and 1987 to ensure that kickbacks masquerading as legitimate transactions did not evade its reach. <u>See</u> Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare-Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

44. The Anti-Kickback Statute prohibits any person or entity from making or accepting payment to induce or reward any person for referring, recommending or arranging for federally-funded medical services, including services provided under the Medicaid program. In pertinent part, the statute states:

> (b) Illegal remuneration
>
> > (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind --
> >
> > > (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, . . .
> >
> > shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
> >
> > (2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person --
> >
> > (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, . . .
>
> shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1320a-7b(b). Violation of the statute can also subject the perpetrator to exclusion from participation in federal health care programs and, effective August 6, 1997, civil monetary

penalties of $50,000 per violation and three times the amount of remuneration paid. 42 U.S.C. § 1320a-7(b)(7) and 42 U.S.C. § 1320a-7a(a)(7).

E. The New York State Anti-Kickback Statute

45. The New York State Anti-Kickback Statute provides, in pertinent part, that:

> No medical assistance provider shall:
>
> > (a) solicit, receive, accept or agree to receive or accept any payment or other consideration in any form from another person to the extent such payment or other consideration is given: (i) for the referral of services for which payment is made . . .; or . . .
> >
> > (b) offer, agree to give or give any payment or other consideration in any form to another person to the extent such payment or other consideration is given: (i) for the referral of services for which payment is made . . .

New York Social Services Law § 366-d. Violation of the New York Anti-Kickback statute can subject the perpetrator to criminal prosecution, fines of between $500 and $10,000, and, if the perpetrator has obtained money or property through the violation, a fine not to exceed double the amount of the gain from the violation. *Id.*, § 366-d(c).

F. New York State Licensure Requirements for Alcoholism Facilities

46. The New York State Mental Hygiene Law and regulations promulgated thereunder require

> any provider of services to obtain the prior approval of the Commissioner of the Office of Alcoholism and Substance Abuse Services before operating any facility or program for persons suffering from alcoholism or alcohol abuse.

14 N.Y.C.R.R. § 374.1(a).

47. More specifically, the New York State Mental Hygiene regulations provide that

> [a] general hospital operating a ward, wing or unit for the provision of *alcoholism services* must have the prior approval and certification of the [Commissioner of the Office of Alcoholism and Substance Abuse Services] pursuant to Part 366 of this Title and, in addition, have appropriate authorization of the services by the Commissioner of the Department of Health in accordance with article 28 of the Public Health Law.

14 N.Y.C.R.R. § 374.1(a)(4) (emphasis added).

48. The New York State Mental Hygiene Law and regulations further

> prohibit any individual, association, corporation, or public or private agency from operating a residential facility, hospital or other institution for examination, diagnosis, care, treatment, rehabilitation or training of persons suffering from alcoholism or alcohol abuse without the prior approval and certification of the Commissioner of the Office of Alcoholism and Substance Abuse Services.

14 N.Y.C.R.R. § 374.2.

49. "Alcoholism services"

> is a general term for all services and activities designed to assist a patient to attain and adjust to abstinence from alcohol and other drugs, including resolution of family, social, psychological, medical, vocational and other problems which are associated with alcoholism.

14 N.Y.C.R.R. § 374.3(o). "Alcoholism services" includes, but is not limited to, examination, diagnosis, medical detoxification, and aftercare. 14 N.Y.C.R.R. § 374.3(p).

50. An "alcoholism facility" is defined as a facility with a

> discrete physical space, staff and management resources for the provision of examination, diagnosis, care, treatment, rehabilitation and room, board and support on a 24-hour-a-day basis for persons suffering from alcoholism or alcohol abuse, and which may, in

> addition, have resources for the provision of services to outpatients. . .

14 N.Y.C.R.R. § 374.3(a).

51. The Hospitals each operated an alcoholism facility within the meaning of the New York Mental Hygiene Law and regulations. Mount Vernon was not, however, certified by the Commissioner of OASAS to operate such a facility.

VI. DEFENDANTS' FRAUDULENT PATIENT REFERRAL SCHEME

A. The Sham "Administrative Services Agreements"

52. In or around 1997, Consulting and CaseManagement entered into purported administrative services agreements with the Hospitals to provide management and administrative services related to the hospitals' inpatient alcohol and substance abuse treatment programs. In actuality, as the Hospitals and Consulting and CaseManagement knew, the "administrative services agreements" were in fact sham contracts to disguise the fact that Consulting and CaseManagement were referring patients to the Hospitals for a fee.

53. On or about October 1, 1997, CaseManagement entered into an administrative services agreement with Mount Vernon (the "CaseManagement-Mount Vernon Agreement").

54. The CaseManagement-Mount Vernon Agreement required CaseManagement to provide 22 separate "administrative and other services" to Mount Vernon in exchange for a monthly fee of $60,000.

55. The vast majority of the purported services were rarely, if ever, provided and/or had little or no monetary value.

56. For example, the CaseManagement-Mount Vernon Agreement required CaseManagement to "advise [Mount Vernon] regarding staffing requirements and credentials necessary to maintain the detoxification service." This provision was of *de minimis* value as it entailed nothing more than requiring CaseManagement to provide Mount Vernon with a copy of the OASAS regulations, 14 N.Y.C.R.R. § 1034.8, which set forth the staffing and credentialing requirements for the operation of a detoxification service.

57. Similarly, the CaseManagement-Mount Vernon Agreement required CaseManagement to assist in the development of new treatment protocols appropriate for the Medical Detoxification Unit. Again, this services was of *de minimis* value because treatment protocols could be obtained for free from OASAS, and other state and federal agencies.

58. The fair market value of the services actually provided under the Agreement, including developing and maintaining "a marketing and outreach program," was substantially below the $60,000 monthly fee CaseManagement charged and Mount Vernon paid. The CaseManagement-Mount Vernon Agreement was a sham contract used to disguise the prohibited practice of referral of patients for a fee.

59. On or about November 1, 1997, CaseManagement entered into an administrative services agreement with Community General Hospital of Sullivan County, the predecessor of Catskill (the "CaseManagement-Catskill Agreement").

60. The CaseManagement-Catskill Agreement required CaseManagement to provide 22 separate "administrative and other services" to Catskill Regional in exchange for a monthly fee of $50,000.

61. The vast majority of the purported services were rarely, if ever, provided and/or had little or no monetary value. For example, the CaseManagement-Catskill Agreement required CaseManagement to advise Catskill Regional about staffing requirements and credentials needed to maintain a detoxification service. Based on Catskill's own documents, it had no need for such assistance.

62. The CaseManagement-Catskill Agreement also required CaseManagement to establish a staffing schedule to provide "necessary and regulated coverage" of the detoxification unit 24-hours per day, seven days per week. Again, based on Catskill's own documents, it had no need for and did not want such service.

63. The CaseManagement-Catskill Agreement also required CaseManagement to assist Catskill Regional in the preliminary financial review of patients presenting for detoxification services and to assist Catskill Regional staff in intake of patients. Again, based on Catskill's own documents, it had no need for and did not want such services, and moreover, CaseManagement never provided these services to Catskill Regional.

64. The CaseManagement-Catskill Agreement further required CaseManagement to "provide an on-site full-time Program Coordinator to interface with unit staff and to assure that services and assistance required by th[e] Agreement are rendered by" CaseManagement. Again, based on Catskill's own documents, it had no need for and did not want this service.

65. Moreover, as an OASAS-certified provider of an alcohol and substance abuse program for at least two decades, Catskill Regional had no need for the vast majority of the services CaseManagement was purportedly required to provide under the Agreement. Catskill

had been successfully operating a fully-functioning alcohol and substance abuse treatment unit for years before CaseManagement and Catskill entered into the sham contract.

66. The fair market value of the services actually provided under the CaseManagement-Catskill Agreement, including developing and maintaining "a marketing and outreach program," was substantially below the $50,000 monthly fee CaseManagement charged and Catskill Regional paid. The CaseManagement-Catskill Agreement was a sham contract used to disguise the prohibited practice of referral of patients for a fee.

67. On or about December 15, 1997, Consulting entered into an administrative services agreement with another hospital (the "Consulting Agreement").

68. The Consulting Agreement required Consulting to provide 22 separate "administrative and other services" to the other hospital in exchange for a monthly fee of $72,916.66.

69. As with the CaseManagement-Mount Vernon and CaseManagement-Catskill Agreements, the vast majority of the purported services under the Consulting Agreement were rarely, if ever, provided and/or had little or no monetary value.

70. For example, the Consulting Agreement required Consulting to "recommend to [the other hospital] improvements and enhancements to the physical site." Immediately prior to the commencement of the Agreement, the other hospital's detoxification unit had undergone extensive construction in connection with its certification by OASAS. Quite simply, there was no need for further "enhancements to the physical site," and, moreover, the hospital had already retained another consultant in connection with the construction related to the OASAS

certification. Further, Consulting did not have any engineering or architectural employees on staff to provide this service and the hospital had its own resources to accomplish this task.

71. Similarly, the Consulting Agreement required Consulting to "recommend equipment, furnishings, and consumables for the operation" of its detoxification unit. Providing for this service was completely unnecessary because the hospital has its own in-house purchasing department and participates in a buying group to obtain discounts.

72. The fair market value of the services actually provided under the Consulting Agreement, including developing and maintaining "an outreach program," was substantially below the $72,916.66 monthly fee Consulting charged and the hospital paid. The Consulting Agreement was a sham contract used to disguise the prohibited practice of referral of patients for a fee.

C. False and Fraudulent Claims and Statements

73. The Hospitals knowingly provided kickbacks or other illegal remuneration to induce Consulting and CaseManagement to refer thousands of those illegally obtained Medicaid patients to them for treatment for alcohol and substance abuse.

74. The Hospitals then knowingly submitted false and fraudulent claims to the United States in the form of requests for Medicaid reimbursement, and fraudulently obtained payments from the United States, in connection with patients referred to them by Consulting and CaseManagement in violation of the New York State Medicaid regulations, the New York State Anti-Kickback Statute, and the federal Anti-Kickback Statute, submitting such claims in violation of the False Claims Act.

75. Consulting and CaseManagement caused the Hospitals to make false claims and statements when presenting claims for payment to Medicaid. Through the illegal patient referral scheme, Consulting and CaseManagement referred Medicaid patients to the Hospitals' facilities knowing that the Hospitals would submit false certifications of compliance with the law to Medicaid when seeking reimbursement for the services provided to the Medicaid patients.

VII. MOUNT VERNON'S OPERATION OF AN UNLICENSED ALCOHOLISM FACILITY

76. From at least 1997 to2004, Mount Vernon has knowingly operated an alcoholism facility within the meaning of the New York State Mental Hygiene Law and regulations.

77. OASAS has never certified Mount Vernon to operate an alcoholism facility.

78. Mount Vernon and CaseManagement knew that Mount Vernon's alcoholism facility was required to be certified by OASAS.

79. From 1997 to 2004, Mount Vernon knowingly presented claims for reimbursement to New York State Medicaid for services provided to patients in Mount Vernon's unlicensed alcoholism facility.

80. The submission of claims for Medicaid reimbursement for treatment rendered at an unlicensed alcoholism facility constitutes an "unacceptable practice" under New York State Medicaid regulations, as well as the submission of false claims within the meaning of the False Claims Act.

81. Mount Vernon knowingly submitted claims for reimbursement to New York State Medicaid for services provided to patients in Mount Vernon's unlicensed alcoholism facility.

82. CaseManagement knowingly caused Mount Vernon to submit false claims for Medicaid reimbursement by knowingly referring patients for treatment to Mount Vernon's unlicensed alcoholism facility.

VIII. DAMAGES

83. The United States was damaged because of the acts of defendants in causing to be submitted and conspiring to submit false claims and statements in that they received kickbacks or other illegal remuneration from the Hospitals, and the Hospitals submitted claims for items and services for which they were not entitled to reimbursement.

84. Defendants profited unlawfully from the receipt of kickbacks and other illegal remuneration from the hospitals.

FIRST CAUSE OF ACTION

(False Claims Act: Presentation of False Claims)
(31 U.S.C. § 3729(a)(1))

85. Plaintiff repeats and realleges ¶¶ 1 through 84 as if fully set forth herein.

86. The defendants knowingly (*i.e.*, with actual knowledge, in deliberate ignorance of the truth, or with reckless disregard of the truth) caused to be presented false or fraudulent claims for payment or approval to the United States for services rendered to patients who had been unlawfully referred to the Hospitals' alcoholism facilities by Consulting and CaseManagement, to whom the Hospitals provided kickbacks or other illegal remuneration in violation of New York State Medicaid regulations, the New York State Anti-Kickback Statute, and the federal Anti-Kickback Statute.

87. By virtue of the false or fraudulent claims caused to be submitted or made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000, or $5,500 to $11,000, for each violation depending upon the date thereof.

SECOND CAUSE OF ACTION

(False Claims Act: Making or Using False Record or Statement to Cause Claim to be Paid)
(31 U.S.C. § 3729(a)(2))

88. Plaintiff repeats and realleges ¶¶ 1 through 84 as if fully set forth herein.

89. The defendants knowingly (*i.e.*, with actual knowledge, in deliberate ignorance of the truth, or with reckless disregard of the truth) caused to be made or used, false records or statements – *i.e.*, the false certifications and representations made or caused to be made by the Hospitals that the services were provided in compliance with all laws and regulations regarding the conditions of participation in and payment by the Medicaid program – to get false or fraudulent claims paid or approved by the United States.

90. By virtue of the false records or false statements caused to be made or used by Consulting and CaseManagement, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000, or $5,500 to $11,000, for each violation depending upon the date thereof.

THIRD CAUSE OF ACTION

(False Claims Act: Conspiring to Submit False Claims)
(31 U.S.C. § 3729(a)(3))

91. Plaintiff repeats and realleges ¶¶ 1 through 84 as though fully set forth herein.

92. Defendants conspired to defraud the United States by causing to be presented false or fraudulent claims for reimbursement from the United States for monies to which they were not entitled, in violation of 31 U.S.C. § 3729(a)(3). Specifically, the Hospitals agreed to pay kickbacks and illegal remuneration to Consulting and CaseManagement in violation of New York State regulations and the federal and New York State Anti-Kickback Statutes, thereby causing the United States to pay claims for health care services based on false claims and false statements that the services were provided in compliance with all laws and regulations regarding the conditions of participation in and payment by the Medicaid program.

93. By virtue of defendants' conspiracy to defraud the United States, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000, or $5,500 to $11,000, for each violation depending upon the date thereof.

FOURTH CAUSE OF ACTION

(False Claims Act: Presentation of False Claims in Connection with an Unlicensed Facility)
(31 U.S.C. § 3729(a)(1))

94. Plaintiff repeats and realleges ¶¶ 1 through 84as if fully set forth herein.

95. CaseManagement knowingly (*i.e.*, with actual knowledge, in deliberate ignorance of the truth, or with reckless disregard of the truth) caused to be presented false or fraudulent

claims for payment or approval to the United States for services rendered to patients at Mount Vernon's unlicensed alcoholism facility in violation of New York State Medicaid regulations.

96. By virtue of the false or fraudulent claims caused to be made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000, or $5,500 to $11,000, for each violation depending upon the date thereof.

FIFTH CAUSE OF ACTION

(False Claims Act: Making or Using False Record or Statement to Cause Claim to be Paid)
(31 U.S.C. § 3729(a)(2))

97. Plaintiff repeats and realleges ¶¶ 1 through 84 as if fully set forth herein.

98. CaseManagement knowingly (*i.e.*, with actual knowledge, in deliberate ignorance of the truth, or with reckless disregard of the truth) caused to be made or used, false records or statements – *i.e.*, the false certifications and representations made and caused to be made by Mount Vernon that the services were provided in compliance with all laws regarding the provision of health care services – to get false or fraudulent claims paid or approved by the United States.

99. By virtue of the false records or false statements caused to be made by defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000, or $5,500 to $11,000, for each violation depending upon the date thereof.

SIXTH CAUSE OF ACTION

(False Claims Act: Conspiring to Submit False Claims)
(31 U.S.C. § 3729(a)(3))

100. Plaintiff repeats and realleges ¶¶ 1 through 84 as though fully set forth herein.

101. CaseManagement entered into an agreement and conspired to defraud the United States by providing false or fraudulent claims for reimbursement from the United States for monies to which they were not entitled, in violation of 31 U.S.C. § 3729(a)(3). Specifically, CaseManagement agreed to refer patients to Mount Vernon's unlicensed alcoholism facility in violation of New York State Medicaid regulations, and thereby caused the United States to pay claims for health care services based on false claims and false statements that the services were provided in compliance with all laws regarding the provision of health care services whereas they were not so provided.

102. By virtue of CaseManagement's conspiracy to defraud the United States, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,000 to $10,000, or $5,500 to $11,000, for each violation depending upon the date thereof.

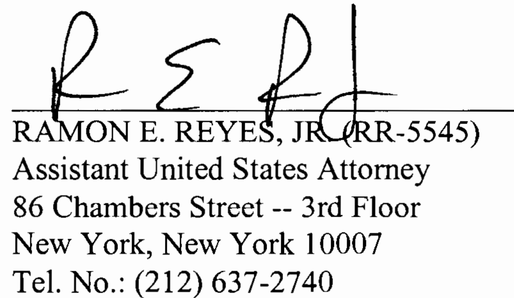
PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in its favor against defendants, jointly and severally, on the First, Second, Third, Fourth, Fifth, and Sixth Causes of Action under the False Claims Act, as amended, for the amount of the United

States' damages, trebled as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

Dated: New York, New York
September 9, 2005

MICHAEL J. GARCIA
United States Attorney for the
Southern District of New York
Attorney for the United States of America

By: 

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