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COPY

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA and STATE OF NEW YORK *ex rel.* LOIS DORMAN, Plaintiffs, -against- ST. LUKE'S-ROOSEVELT HOSPITAL CENTER, CONTINUUM HEALTH PARTNERS, INC., SLR PSYCHIATRIC ASSOCIATES, RICHARD N. ROSENTHAL, M.D., PH.D. and DAVID WYMAN, Defendants.	08 Civ. 9716 (DC) COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA
UNITED STATES OF AMERICA, Plaintiff-Intervenor, -against- ST. LUKE'S-ROOSEVELT HOSPITAL CENTER, CONTINUUM HEALTH PARTNERS, INC., and SLR PSYCHIATRIC ASSOCIATES, Defendants.	

The United States of America, by and through 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 action brought by the United States of America ("United States") against defendants St. Luke's Roosevelt Hospital Center, Continuum Health Partners, Inc., and SLR Psychiatric Associates (hereinafter, collectively, the "Defendants") under the False Claims Act, as amended, 31 U.S.C. §§ 3729 *et seq.* (the "False Claims Act"), to recover damages sustained by, and penalties owed to, the United States as the result of Defendants having knowingly presented or caused to be presented to the United States false claims for the payment of funds under the Medicare Program, 42 U.S.C. § 1395 *et seq.*, and the Medicaid Program, 42 U.S.C. § 1396 *et seq.*, and, in excess of the amounts to which Defendants were lawfully entitled, as more specifically detailed *infra*.

2. The United States also asserts claims against defendants under the common law for unjust enrichment and payment under mistake of fact.

JURISDICTION AND VENUE

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

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

PARTIES

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

6. Relator Lois Dorman is a current employee of St. Luke's Roosevelt Hospital Center and resides in New York.

7. Continuum Health Partners, Inc. ("CHPI"), is a non-profit, corporate hospital network created under the laws of the State of New York.

8. St. Luke's Roosevelt Hospital Center (the "Hospital") is a member of CHPI.

9. SLR Psychiatric Associates ("SLR") is an unincorporated faculty practice group created by and located within the Hospital.

FACTUAL ALLEGATIONS

I. THE MEDICARE PART B PROGRAM

A. Regulatory Framework

10. The United States, through HHS, administers the Medicare program for the aged and disabled, established by Title XVIII of the Social Security Act. *See* 42 U.S.C. §§ 1395 *et seq*. Part A of the Medicare program provides federal payment for patient institutional care, including hospital, skilled nursing facility and home health care. *See* 42 U.S.C. §§ 1395c-1395i-4. Part B of the Medicare program provides supplemental insurance coverage for

medical and other services that are not covered by Part A. *See* 42 U.S.C. §§ 1395j-1395w-4.

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

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

13. The Medicare program covers a variety of different services including, among others, inpatient hospital services, outpatient hospital services, and physician services. Covered inpatient services include bed and board, nursing services and other related services, use of hospital facilities, drugs, biologicals, supplies, appliances, equipment, diagnostic and therapeutic items, medical or surgical services provided by certain interns or residents-in-training, and transportation services. *See* 42 C.F.R. § 409.10(a). Covered outpatient hospital services include hospital services and supplies furnished incident to a physician service to a hospital outpatient, and diagnostic services furnished to hospital outpatients. *See* 42 C.F.R. §§ 410.27 and 410.28.

14. As a general matter, hospital claims for inpatient and outpatient services are reimbursed by Medicare on the basis of diagnostic related groups under the Prospective Payment System (PPS).

15. One exception to the fee schedule payment method for physician services exists for teaching hospitals. The Medicare regulations provide that the costs of direct patient care by physicians may be reimbursable on a reasonable cost basis under Medicare if the hospital is a teaching hospital, the hospital formally elects to be reimbursed for such costs on a cost basis,

and the hospital complies with a number of conditions including a prohibition on separate physician billing for patient care services under the physician fee schedule. *See* 42 C.F.R. § 415.160; 42 C.F.R. § 415.60; 42 C.F.R. § 415.55. If the hospital does not elect to be reimbursed on a reasonable cost basis for the cost of direct patient care, direct patient care services are reimbursed through the physician fee schedule. *See* 42 C.F.R. § 415.160; § 415.102(a).

B. Medicare Cost Reports

16. To assist in the administration of Medicare Part A, CMS contracts with private non-governmental organizations or "fiscal intermediaries" to, *inter alia*, review and process claims for reimbursement submitted by health care providers, including the claims submitted by defendants. 42 U.S.C. § 1395h. At all times relevant hereto, CMS administered the Medicare program in the Southern District of New York through its fiscal intermediary Empire Medicare Services ("Empire").

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

18. In their annual cost reports, hospitals must identify and allocate their direct and indirect costs in accordance with the Medicare statute, regulations and CMS program instructions, that dictate whether a particular cost is reimbursable. Costs relating to inpatient

and outpatient care are included in the hospital's cost report. Costs that are not reimbursable under Part A, such as the cost of physician services for direct care, must be identified as non-reimbursable on the cost report.

19. Medicare relies upon the cost report to determine whether the hospital is entitled to more reimbursement than the interim payments that the hospital has received from Medicare during the course of the year, or whether the hospital was overpaid by Medicare, and, consequently, must reimburse Medicare for the excess amounts paid under the program during the course of the year. *See* 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

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

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

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

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

22. Thus, the hospital must certify that the Medicare cost report is (1) truthful, *i.e.*, that the cost information contained in the report is true and accurate; (2) correct, *i.e.*, that the hospital is entitled to reimbursement for the reported costs; (3) complete, *i.e.*, that the cost report is based upon all cost information known to the hospital; and (4) that the services identified in the cost report are billed in compliance with the law.

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

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

42 U.S.C. § 1320a7b(a)(3).

24. If a hospital fails properly to identify and allocate non-reimbursable costs on its annual cost reports, the result is that Medicare overpays the hospital unless the hospital's improper reporting (or cost allocation) is identified by the fiscal intermediary and/or corrected by the hospital.

C. Defendants' Improper Billing of Medicare

25. During 1999 through 2002, the costs for physician services for the direct care of psychiatric outpatients, *i.e.*, the "professional component" of the Hospital's outpatient psychiatric service, were a non-reimbursable expense on the Hospital's cost reports. During that period, in direct violation of the Medicare reimbursement rules, the Hospital knowingly failed properly to identify the professional component of the outpatient psychiatric services and failed properly to allocate those non-reimbursable costs on its cost reports, resulting in a substantial overpayment by Medicare to the Hospital over the period. The United States, through the Medicare program, would not have approved or paid such costs if Medicare had known that such expenses had been wrongfully included as reimbursable costs in the Hospital's cost reports.

II. THE MEDICAID PROGRAM

A. Regulatory Framework

26. Pursuant to the provisions of 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. The New York State Legislature established New York's Medicaid system in 1966, an extensive and complex regulatory scheme governing the administration of the Medicaid program within the state. 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). 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.

27. Medicaid reimburses medical care, services, and supplies which are medically necessary and appropriate, consistent with quality of care and generally accepted professional standards. 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 which draw on the United States Treasury. 42 C.F.R. §§ 430.0-430.30. Therefore, billings submitted to the New York Medicaid Program cause claims to be made both to the United States and the State of New York. Approximately one-half of each claim paid through the New York Medicaid Program is funded by the United States, with the balance funded by the State and local governments.

B. <u>Defendants' Improper Billing of Medicaid</u>

28. The Hospital provides both inpatient and outpatient psychiatric services. Those services are provided by salaried physicians, psychiatrists, psychologists, nurses, therapists, social workers and other professional staff and/or independent contractors.

29. NYS Office of Mental Health ("NYSOMH") regulations regulate mental health clinic billings in New York and "provide standards for reimbursement under the medical assistance program to NYSOMH certified out-patient programs for adults with a diagnosis of mental illness." 18 N.Y.C.R.R. § 588.1(a); *see also* 18 N.Y.C.R.R. § 588.1(d) ("the purpose of these regulations is to specify the fees or rates of reimbursement and any additional eligibility

criteria or limits which will apply to Medicaid-enrolled recipients in out-patient programs"). These regulations prohibit separate professional and institutional billings under Medicaid for outpatient psychiatric services, even if the Hospital later "carves out" the professional compensation from its cost report. *See, e.g.*, 18 N.Y.C.R.R. § 505.25(F)(2) ("The cost of routine physicians' services are included in the facilities rate or fee and shall not be billed separately.").

30. From 1998 through 2010, the Hospital submitted claims requesting reimbursement from Medicaid for, *inter alia*, outpatient psychiatric services provided by SLR. Based on a review of Medicaid paid claims data and a comparison of claims paid to SLR and institutional costs reimbursed to the Hospital for the same patient, the Government determined that from September 1998 to February 2010, the Hospital billed for and was paid for the institutional cost of claims for which SLR also separately billed Medicaid for the professional component. SLR and the Hospital double-billed Medicaid with respect to thousands of claims, for which Medicaid overpaid SLR by hundreds of thousands of dollars.

FIRST CLAIM

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

31. The United States incorporates by reference each of the preceding paragraphs one through thirty as if fully set forth in this paragraph.

32. As set forth above, defendants knowingly or acting with deliberate ignorance or with reckless disregard for the truth, presented, or caused to be presented, to an

officer, employee or agent of the United States, false or fraudulent claims for payment or approval in connection with its requests for reimbursement under the Medicare program.

33. The United States, through its Medicare carrier, paid such false or fraudulent claims because of the acts of defendants.

34. By reason of the acts and conduct of defendants in violation of 31 U.S.C. § 3729(a)(1), the United States has sustained damages in an amount to be determined at trial.

SECOND CLAIM

Violations of the False Claims Act
(31 U.S.C. § 3729 (a)(1)(A)(2010))
Making or Using a False Record or Statements under the Medicare Program

35. The United States incorporates by reference each of the preceding paragraphs one through thirty as if fully set forth in this paragraph.

36. The United States seeks relief against defendants under Section 3729(a)(1)(A) of the False Claims Act, 31 U.S.C. § 3729(a)(1)(A) (2010).

37. As set forth above, defendants knowingly, or in reckless disregard for the truth, presented and/or caused to be presented false or fraudulent claims for payment to federal agencies and/or entities that were recipients of federal funds.

38. By reason of defendants' false claims, the United States has sustained damages in a substantial amount to be determined at trial, and is entitled to a civil penalty as required by law for each violation.

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THIRD CLAIM

Violations of the False Claims Act
(31 U.S.C. § 3729(a)(1)(B)) (2010)
Use of False Statements under the Medicare Program

39. The United States incorporates by reference each of the preceding paragraphs one through thirty as if fully set forth in this paragraph.

40. As set forth above, defendants knowingly made, used, or caused to be made or used, false records or statements material to a false or fraudulent claim in connection with the submission of its claims for reimbursement relating to outpatient psychiatric services rendered by SLR's physicians under the Medicare program.

41. The United States, through its Medicare carrier, paid such false or fraudulent claims because of the acts of defendants.

42. By reason of the acts and conduct of defendant in violation of 31 U.S.C. § 3729(a)(1)(B), the United States has sustained damages in an amount to be determined at trial.

FOURTH CLAIM

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

43. The United States incorporates by reference each of the preceding paragraphs one through thirty as if fully set forth in this paragraph.

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

45. As set forth above, defendants knowingly or acting with deliberate ignorance or with reckless disregard for the truth, presented, or caused to be presented, to an

officer, employee or agent of the United States, false or fraudulent claims for payment or approval in connection with its requests for reimbursement under the Medicaid program.

46. The United States paid defendants under the Medicaid program because of the false or fraudulent claims of defendants.

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

FIFTH CLAIM

Violations of the False Claims Act
(31 U.S.C. § 3729 (a)(1)(A)(2010))
Making or Using a False Record or Statements under the Medicaid Program

48. The United States incorporates by reference each of the preceding paragraphs one through thirty as if fully set forth in this paragraph.

49. The United States seeks relief against defendants under Section 3729(a)(1)(A) of the False Claims Act, 31 U.S.C. § 3729(a)(1)(A) (2010).

50. As set forth above, defendants knowingly, or in reckless disregard for the truth, presented and/or caused to be presented false or fraudulent claims for payment to federal agencies and/or entities that were recipients of federal funds.

51. By reason of defendants' false claims, the United States has sustained damages in a substantial amount to be determined at trial, and is entitled to a civil penalty as required by law for each violation.

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SIXTH CLAIM

Violations of the False Claims Act (31 U.S.C. § 3729 (a)(1)(B)(2010)) Use of False Statements under the Medicaid Program

52. The United States incorporates by reference each of the preceding paragraphs one through thirty as if fully set forth in this paragraph.

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

54. As set forth above, defendants knowingly made, used, or caused to be made or used, false records or statements material to a false or fraudulent claim in connection with the submission of its claims for reimbursement relating to outpatient psychiatric services rendered by SLR's physicians under the Medicaid program.

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

56. By reason of defendants' false claims, the United States has been damaged in a substantial amount to be determined at trial.

SEVENTH CLAIM

Unjust Enrichment under the Medicare and Medicaid Programs

57. The United States incorporates by reference each of the preceding paragraphs one through thirty as if fully set forth in this paragraph.

58. By reason of the payments made by the United States to defendants, based on the claims for payment defendants submitted under the Medicare and Medicaid

programs, defendants were unjustly enriched. The circumstances of defendants' receipt of these payments are such that, in equity and good conscience, it should not retain these payments, the amount of which is to be determined at trial.

EIGHTH CLAIM

Payment Under Mistake of Fact under the Medicare and Medicaid Programs

59. The United States incorporates by reference each of the preceding paragraphs one through thirty as if fully set forth in this paragraph.

60. The United States seeks relief against defendants to recover monies paid under mistake of fact.

61. The United States paid defendants' claims submitted to the Medicare and Medicaid programs for services rendered by the Hospital under the erroneous belief that the Hospital was entitled to payment of such funds. In making such payments the United States relied upon and assumed the truth of the Hospital's representation that it had complied with the applicable rules and regulations and that the Hospital's claims for Medicare and Medicaid reimbursement were true and consistent with applicable regulations. This erroneous belief was material to the United States' decision to pay defendants. In such circumstances, the United States' payment of federal funds to defendants under the Medicare and Medicaid programs were by mistake and were not authorized.

62. Because of these payments by mistake, defendants have received monies to which they are not entitled.

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

PRAYER FOR RELIEF

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

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

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

(c) On the Fourth, Fifth, and Sixth Claims for Relief (Violations of the False Claims Act, 31 U.S.C. §§ 3729(a)(1), 3729(a)(1)(A) and 3729(a)(1)(B)), for treble the United States' damages, in an amount to be determined at trial, plus an $11,000 penalty for each false claim;

(d) On the Fourth, Fifth, and Sixth Claims for Relief, an award of costs pursuant to 31 U.S.C. § 3729(a);

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

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

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(g) Awarding such further relief as is proper.

Dated: New York, New York
February 5, 2013

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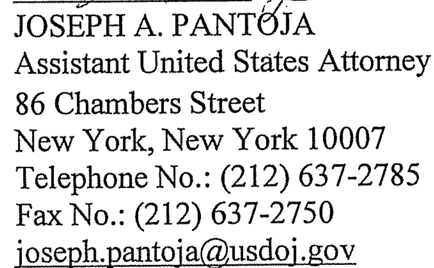
By: 
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