UNITED STATES ATTORNEY'S OFFICE

Southern District of New York

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MANHATTAN U.S. ATTORNEY RECOVERS $70 MILLION IN MEDICAID FALSE CLAIMS ACT LAWSUIT AGAINST NEW YORK CITY

PREET BHARARA, the United States Attorney for the Southern District of New York, announced today that the United States has settled a civil health care False Claims Act lawsuit it filed in January 2011 against the City of New York (the "City") for $70 million. The lawsuit alleges that the City improperly administered the Medicaid personal care services program ("PCS") by authorizing personal care services for Medicaid beneficiaries without the legally required assessments and approvals. The lawsuit further alleges that between 2000 and 2010, the United States paid tens of millions of dollars in reimbursements for these services. The settlement was approved yesterday and entered in Manhattan federal court today by U.S. District Court Judge JED S. RAKOFF.

Manhattan U.S. Attorney PREET BHARARA said: "Medicaid's personal care services program provides a vital lifeline for elderly and disabled beneficiaries, which is why it is so important that the program is run correctly and efficiently. With today's settlement, we are taking an important step toward restoring the integrity of this program and ensuring that all beneficiaries get the level of care and service they require and to which they are entitled."

According to the Complaint and other court filings in the case:

The City, through the New York City Human Resources Administration ("HRA"), administers the PCS program. HRA determines -- typically on an annual or six-month basis -- whether to authorize or reauthorize 24-hour PCS service for Medicaid beneficiaries. Under New York State Medicaid regulations, HRA must base its authorization and reauthorization decisions on physicians' orders, nursing assessments and social assessments. For patients receiving the highest-level of service, independent medical reviews are required.

As alleged in the Complaint, HRA often failed to obtain the required assessments or reviews. For example, until late 2010, HRA typically would not obtain the independent medical reviews before reauthorizing continuous 24-hour PCS service. Similarly, until late 2010, HRA frequently did not obtain and review the necessary nursing assessments before reauthorizing 24-hour PCS services for patients. In addition, the United States contended that HRA sent thousands of authorization notices to the State and to PCS vendor agencies even though it had failed to comply with the applicable state Medicaid regulations in making these authorization determinations, creating the impression that HRA's authorizations had been made in accordance

with the state Medicaid regulations. The United States contended that this, in turn, caused the federal Medicaid program to spend tens of millions of dollars on reimbursements on PCS services that the City authorized improperly.

Under the settlement, the City agreed to pay $70 million to the United States under the False Claims Act. Further, the City explicitly acknowledged in the settlement: that "the state Medicaid regulation for the PCS program generally requires HRA to base its authorization of 24-hour PCS care on a physician's, nurse's, and social assessment, as well as, in certain cases, an independent medical review;" and that "from 2000 to late 2010, HRA re-authorized 24-hour PCS care for certain patients without having physically obtained certain physician's, nurse's, and/or social assessments, and/or having obtained independent medical reviews." The City also acknowledged that "since the United States commenced its investigation of this matter, HRA has adopted additional policies and procedures designed to ensure full compliance" with the state Medicaid regulation governing the PCS program, including, specifically, to obtain independent medical reviews in connection with reauthorizing certain 24-hour PCS care. Finally, the City acknowledged that "the settlement agreement, including the settlement amount, is fair, reasonable, and adequate under the facts and circumstances."

Mr. BHARARA thanked the Office of Inspector General for the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid Services, and the Civil Division of the U.S. Department of Justice for their assistance with the case.

This lawsuit was initiated by a whistle-blower under the *qui tam* provisions of the False Claims Act, which allow private citizens to sue for fraud on behalf of the United States and to share in any recovery.

This case is being handled by the Office's Civil Frauds Unit. Assistant U.S. Attorneys REBECCA C. MARTIN, JEFFREY S. OESTEREICHER, LI YU, SARAH NORTH, ALLISON PENN, and DANIEL P. FILOR are in charge of the case.

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