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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA and the STATE OF NEW YORK *ex rel.* J. DOE,

Plaintiffs,

v.

A.R.E.B.A.-CASRIEL, INC. D/B/A ADDICTION CARE INTERVENTIONS CHEMICAL DEPENDENCY TREATMENT CENTERS and STEVEN YOHAY,

Defendants.

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

A.R.E.B.A.-CASRIEL, INC. D/B/A ADDICTION CARE INTERVENTIONS CHEMICAL DEPENDENCY TREATMENT CENTERS and STEVEN YOHAY,

Defendants.

COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA

16 Civ. 1760 (VSB)

JURY TRIAL DEMANDED

Plaintiff United States of America (the "United States" or the "Government"), by its attorney, Audrey Strauss, Acting United States Attorney for the Southern District of New York, brings this action against A.R.E.B.A.-CASRIEL, Inc. d/b/a/ Addiction Care Interventions Chemical Dependency Treatment Centers ("ACI") and Steven Yohay ("Yohay") (together "Defendants"), and alleges as follows:

PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the United States (the "Government") against ACI and Yohay under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* (the "FCA"), and the common law to recover treble damages sustained by, and civil penalties and restitution owed to, the Government, arising from Defendants' schemes to defraud the United States in connection with the submission of claims for payment to Medicaid.

2. As set forth more fully below, the United States alleges in this action that ACI, a New York City-based provider of inpatient and outpatient substance abuse addiction treatment services, and its majority owner and President, Steven Yohay, provided kickbacks and engaged in fraudulent conduct in connection with the admission of Medicaid beneficiaries into ACI's inpatient treatment program.

3. First, from January 2014 to December 2019, ACI, with the knowledge, involvement, and participation of Yohay, induced Medicaid beneficiaries to be admitted to ACI's inpatient treatment program by employing drivers who were compensated based in part on the volume of patients they recruited for admission into the program to: (1) solicit and transport potential new patients, including out-of-state residents, to ACI's facility when the individuals had not previously sought treatment at ACI or been previously treated at ACI; and (2) offer and

provide potential new patients with money, drugs, and/or alcohol, in violation of the Anti-Kickback Statute (the "AKS"), 42 U.S.C. § 1320a-7b(b).

4. Second, from October 2012 through March 2017, ACI, with the knowledge, involvement, and participation of Yohay, employed and paid an individual to purportedly provide translation services (which were rarely provided) in order to induce that individual, who was a full-time employee at an organization that refers individuals to substance abuse providers, to refer Medicaid patients to ACI. The payments provided to this "employee" for patient referrals constitute illegal kickbacks under the AKS.

5. Third, from July 2012 through July 2013, ACI admitted Medicaid patients into its inpatient treatment program who were not evaluated by a qualified health care professional as required by applicable state law and created medical forms containing a xeroxed copy of a physician's signature to make it appear that such an evaluation had occurred. After ACI's management, including Yohay, became aware of the documentation containing false signatures, ACI and Yohay did not disclose to Medicaid that ACI had been using forms for reimbursement containing false information and knowingly failed to return payments that it had improperly received from Medicaid.

JURISDICTION AND VENUE

6. This Court has jurisdiction over the claims brought under the FCA pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C. §§ 1331 and 1345, and over the unjust enrichment common law claim pursuant to 28 U.S.C. § 1345.

7. This Court may exercise personal jurisdiction over ACI and Yohay pursuant to 31 U.S.C. § 3732(a), which provides for nationwide service of process.

8. Venue lies in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) because ACI does business in this District and a substantial part of the acts complained of took place in this District.

PARTIES

9. Plaintiff is the United States of America and is suing on its own behalf and on behalf of the United States Department of Health and Human Services ("HHS") and its component agency, the Centers for Medicare and Medicaid Services ("CMS"), which is responsible for administering and overseeing the Medicaid program.

10. Defendant ACI is a provider of inpatient and outpatient substance abuse addiction treatment services that are reimbursed by Medicaid. ACI operates treatment centers located in Manhattan.

11. Defendant Steven Yohay is the majority owner, President and former CEO of ACI. During the relevant period, he was involved in the daily management and operations of ACI, including monitoring patient admissions and discharges, approving salaries and expenditures, overseeing staff, and making staffing and patient care decisions.

12. Relator Kaitlin Downes was a former intake coordinator and social worker at ACI. On March 8, 2016, the relator filed a complaint in the United States District Court for the Southern District of New York pursuant to the *qui tam* provisions of the FCA, alleging, *inter alia*, that Defendants engaged in an illegal kickback scheme involving drivers that it employed to solicit and recruit patients for admission to ACI's treatment programs.

BACKGROUND

I. The Anti-Kickback Statute and the False Claims Act

13. The FCA establishes treble damages liability to the United States for an individual who, or entity that, "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," or "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1). "Knowingly" is defined to include actual knowledge, reckless disregard and deliberate indifference. 31 U.S.C. § 3729(b)(1). No proof of specific intent to defraud is required. *Id.*

14. In addition to treble damages, the FCA also provides for assessment of a civil penalty for each violation or each false claim.

15. The AKS makes it illegal for individuals or entities to knowingly and willfully "offer[] or pay[] remuneration (including any kickback, bribe, or rebate) . . . to any person to induce such person … 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." 42 U.S.C. § 1320a-7b(b)(2). Violation of the AKS is a felony punishable by fines and imprisonment and can also result in exclusion from participation in federal healthcare programs. 42 U.S.C. § 1320a-7b(b)(2); 42 U.S.C. § 1320a-7(b)(7).

16. The AKS arose out of congressional concern that remuneration given to those who can influence healthcare decisions would result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect federal healthcare programs from these harms, Congress enacted a prohibition against the payment of kickbacks in any form.

17. The AKS defines remuneration to include anything of value, including "cash" or "in-kind" payments. 42 U.S.C. § 1320a-7b(b)(2).

18. As embodied in the Patient Protection and Affordable Care Act of 2010 ("PPACA"), Pub. L. No. 111-148, § 6402(f), 124 Stat. 119, *codified at* 42 U.S.C. § 1320a-7b(g), "a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of [the FCA]."

19. According to the legislative history of the PPACA, this amendment to the AKS was intended to clarify "that all claims resulting from illegal kickbacks are considered false claims for the purpose of civil actions under the False Claims Act, even when the claims are not submitted directly by the wrongdoers themselves." 155 Cong. Rec. S10854.

20. Compliance with the AKS, 42 U.S.C. § 1320a-7b(b), is a condition of payment under Medicaid, which is defined as a "Federal health care program" under the AKS.

21. HHS-OIG has established a safe harbor to the AKS that specifically sets forth the conditions under which the provision of free transportation services will not be deemed to be "remuneration" under the AKS. Specifically, health care providers may provide free or discounted local transportation to federal health care program beneficiaries when the following conditions are met: (1) the provider has a transportation policy that is applied uniformly and consistently; (2) the transportation's availability is not related to the past or anticipated volume or value of federal healthcare program business; (3) the transportation is not air, luxury or ambulance-level transportation; (4) the transportation is not publicly advertised or marketed, and drivers or others involved in arranging the transportation are not paid on a per-beneficiary-transported basis; (5) the transportation is available only to established patients (*i.e.*, a patient who has scheduled an appointment, or previously attended an appointment), within 25 miles of

the provider/supplier to or from which the patient is being transported (50 miles in a rural area), for the purpose of obtaining medically necessary items and services; and (6) the eligible entity bears the cost of the transportation. 42 C.F.R. § 1001.952(bb).

II. Medicaid

22. Medicaid is a joint federal and state program created in 1965 that provides healthcare benefits to certain groups, primarily the poor and disabled. 42 U.S.C. § 1396 *et seq*. Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates, and program administration rules in accordance with certain federal statutory and regulatory requirements. The state directly pays the healthcare providers for services rendered to Medicaid recipients, including physician-based services, with the state obtaining the federal share of the Medicaid payment from accounts which draw on the United States Treasury. *See* 42 C.F.R. § 430.0 *et al.*

23. The federal portion of each state's Medicaid payments, known as the Federal Medical Assistance Percentage ("FMAP"), is based on the state's per capita income compared to the national average. 42 U.S.C. § 1396d(b). Federal funding under Medicaid is provided only when there is a corresponding state expenditure for a covered Medicaid service to a Medicaid recipient. The federal government pays to the state the statutorily established share of the "total amount expended . . . as medical assistance under the State plan." 42 U.S.C. § 1396b(a)(1).

24. Medicaid claims arising from illegal kickbacks are not authorized to be paid pursuant to the Patient Protection and Affordable Care Act. 42 U.S.C. § 1320a-7b(g). Further, such claims are not payable under state regulatory regimes.

25. Providers who participate in the Medicaid program must sign enrollment agreements with their states that certify compliance with the state and federal Medicaid

requirements, including the AKS. In New York, the agreement requires the prospective Medicaid provider to agree that he or she will comply with all state and federal laws and Medicaid rules and regulations in billing the state Medicaid program for services or supplies furnished.

26. A substantial majority of individuals who received services at ACI were eligible for Medicaid.

FACTUAL ALLEGATIONS

I. Defendants' Use of Drivers to Solicit Medicaid Patients and Induce Admissions into ACI's Inpatient Treatment Program

27. From January 2014 to December 2019, ACI, with the knowledge, involvement, and participation of Yohay, improperly induced Medicaid beneficiaries to be admitted into ACI's inpatient treatment program by employing drivers, who were compensated based in part on the volume of patients they recruited for admission into the program, to solicit and transport potential new patients to ACI's facility. The drivers routinely targeted homeless individuals and sometimes offered them food, cash, money to purchase drugs, and/or alcohol to persuade them to enroll in the program. Most of the new enrollments into ACI's inpatient program resulted from the ACI drivers' solicitation efforts.

28. ACI employed approximately five to ten drivers at any given time to pick up individuals and transport them to ACI's inpatient treatment program.

29. ACI management, including Yohay, did not inquire as to where or how the drivers located potential patients. ACI did not provide its drivers routes or locations at which to pick up patients. Instead, ACI drivers were free to pick up individuals from wherever they chose.

30. ACI drivers rode in unmarked vehicles and picked up individuals from a wide range of locations, including parks, train stations, shelters, hospitals, under bridges, and other substance abuse treatment centers. The drivers would go to places that had a high number of individuals who were homeless or lacked stable housing, knowing that those individuals wanted temporary shelter and would offer them "three hots and a cot."

31. Often, ACI drivers picked up individuals who did not have any prior contact with ACI and transported them to ACI's facility for admission as inpatients. These individuals had not been treated previously at ACI and had not contacted ACI to schedule an appointment for admission.

32. On some occasions, ACI drivers offered potential patients money, sometimes to purchase drugs, to induce them to get into their vehicle and go to the facility. ACI drivers also sometimes offered to purchase alcohol for potential patients.

33. For example, in December 2016, a security guard reported to ACI's management that she saw ACI's lead driver hand a potential patient twenty dollars when the individual boarded his vehicle.

34. As an additional example, a former ACI patient reported that an ACI driver made contact with her in Newark, New Jersey, in an area where drug addicts are known to congregate, and gave her twenty dollars when she told him that she did not feel well and needed to "use." The patient used the money to purchase heroin and then returned to the van and injected the drug in the presence of the ACI driver. Approximately one year later, a different ACI driver picked up this patient and provided her twenty dollars to purchase heroin, which she injected in the presence of the driver, before transporting her to ACI.

35. ACI's management, including Yohay, were aware of allegations that the drivers offered money, drugs, and/or alcohol to individuals to persuade them to seek admission to ACI's inpatient program. However, they did not adequately investigate these allegations or take appropriate corrective actions in response.

36. Defendants also financially incentivized ACI's drivers to bring in new patients.

37. The drivers were expected to pick up a certain number of potential patients in order to be eligible for a pay raise. According to one former ACI driver, ACI imposed a quota under which drivers needed to pick up at least five potential patients per day to be eligible for a pay raise.

38. ACI paid, with Yohay's knowledge and approval, the driver who brought in the most new patients an annual salary of more than $200,000, as well as a bonus consisting of thousands of dollars.

39. To receive credit for bringing a potential new patient to ACI, the drivers often disregarded the individual's health or well-being. For example, on June 20, 2016, one of ACI's drivers brought in a potential patient, who was unconscious, for admission, instead of taking the individual to a hospital for medical treatment.

40. ACI's management, including Yohay, tracked on a daily basis the number of new patients that each driver brought to ACI for admission as well as the number who were ultimately admitted. The ACI admissions area contained a color-coded white board on which ACI noted the name of the patient, the patient's admission or discharge status, and the driver who brought the patient to ACI. Yohay relied on the ACI drivers to keep the inpatient program at or near capacity (which was approximately 95 beds).

41. Routinely, ACI management would report to Yohay the number of beds that were occupied, the number of patients brought to ACI by each driver, and the number of patients brought to ACI by each driver who were admitted for treatment. For example, on January 16, 2016, ACI's CEO reported via email to Yohay that:

> We currently have 82 beds full.
> . . . .
> Self [admission] – 2 of 5 admitted
> Cutts – 6 of 7 admitted
> Gerald – 1 of 1 admitted
> Gus – 4 of 8 admitted
> Terry – 4 of 5 admitted
> Brenda – 1 of 1 admitted

Yohay, well aware that ACI drivers regularly recruited homeless individuals, responded: "Mid month. Freezing weather. What happened?"

42. Additionally, an individual who served as ACI's CEO during part of the relevant time period sent almost daily messages to the individual who he considered to be the "lead" driver urging him to keep the "house full". The texts would generally include the number of individuals each driver brought to ACI and the number that were admitted, and encouraged the lead driver to keep ACI's inpatient population at full capacity.

43. Furthermore, ACI drivers often went to New Jersey to solicit potential patients, who were often homeless. After the potential patients agreed to go to ACI, ACI drivers would drive the individuals to soup kitchens and other locations where they would obtain identification documents containing a New York address. ACI drivers did this because ACI could only seek reimbursement for treatment provided to New York Medicaid beneficiaries, and identification containing a New York address would allow the patient to enroll in New York Medicaid. Many of these patients remained enrolled in New Jersey Medicaid while at ACI, and returned to New Jersey after their discharge from ACI. From January 2015 through August 2018, almost half of

the individuals admitted into ACI's inpatient program for the first time were also enrolled in New York Medicaid on the same day that they were admitted to ACI.

44. ACI failed to adequately supervise its drivers, did not provide them with any training (including any training regarding the AKS), and had no policies governing driver conduct. At least one driver who was employed by ACI did not even have a valid driver's license.

II. Defendants' Use of a Sham Employee to Obtain Referrals

45. In October 2012, ACI created a sham part-time Spanish "translator" position so that it could employ an individual to provide a stream of patient referrals. The individual was employed at Bronx Treatment Assessment Services ("TASC"), an organization that refers individuals to substance abuse clinics, like ACI, for treatment as an alternative to incarceration. Although the individual was purportedly placed on ACI's payroll to be a part-time Spanish "translator" and to perform remote translation services, she rarely provided any translation services. The individual translated for ACI a few times during the first two or three months of her employment, but did not perform any translation services thereafter, even though she remained on the payroll until March 2017. In total, ACI paid her more than $75,000 to induce her to refer patients to ACI.

46. Throughout the course of her employment with ACI, the individual provided ACI managers with lists of individuals who were being referred by TASC to ACI for substance abuse services. ACI provided services to many of these referred patients, and received reimbursement from Medicaid for these services.

47. For example, on February 28, 2014, the individual sent an email to ACI's CEO stating: "Hey, Just so you know this is every one I have ref[erred] to ACI O.P. [out patient] and

rehab[,]" The email included a lengthy list of names and the date each patient was admitted to ACI.

48. Throughout her employment, the individual periodically attended dinners with ACI's CEO and other ACI employees. However, at no time did ACI's managers ask the individual about her work at ACI.

49. On one occasion in 2014, the individual requested several thousand dollars from ACI's CEO so that she could pay her traffic tickets and court costs associated with driving with a suspended license. ACI, with Yohay's knowledge and approval, gave her the money, after ACI's CEO and Yohay requested a list reflecting the patients she had referred from TASC to ACI.

III. ACI's Use of Fraudulent Patient Evaluation Forms

50. From July 2012 through July 2013, ACI admitted certain patients into its inpatient program who were not properly evaluated by a qualified health professional for admission, as required by applicable state law. ACI staff fraudulently created medical forms containing a photocopied copy of a physician's signature to make it appear that such an evaluation had occurred.

51. Substance abuse treatment providers are required to assess patients and make a clinical determination as to the level of care the patient should receive. Based on the qualified health professional's evaluation, the provider determines the most clinically appropriate and medically necessary level of care for the patient, such as inpatient detoxification treatment or low intensity outpatient services. The proper level of care is determined by a variety of factors, including assessment of the patients' need for crisis or detoxification services (for instance,

determining possible medical complications from withdrawal), risk factors such as the presence of severe medical conditions, and other clinically relevant information.

52. The level of care determination affects the level of reimbursement received from Medicaid.

53. During the relevant time period, the level of care determination was supposed to be documented on admission criteria forms, which were part of a patient's file used to support claims for reimbursement from Medicaid. New York State Office of Alcohol and Substance Abuse Services ("OASAS") regulations require that level of care determinations be made only by qualified health professionals, who are individuals specified by OASAS as professionals in good standing with the appropriate licensing or certifying authority and have experience in the treatment of substance use disorders.

54. From July 2012 through July 2013, the admissions staff at ACI's inpatient facility, who were not qualified healthcare professionals, regularly completed admissions criteria forms using versions that have a photocopy of a doctor's signature. The admissions department kept a stack of the forms in the admissions area, which were blank except for the photocopied signature of a staff physician. Admissions staff filled in the criteria matching the level of care they believed a patient would qualify for, and recorded the date they completed the form next to the staff physician's photocopied signature.

55. After Yohay and ACI management became aware of ACI's use of forms containing false signatures, they did not disclose to Medicaid that ACI had created forms containing false information to support ACI's claims for reimbursement from Medicaid and did not return payments that ACI had improperly received from Medicaid.

CLAIMS FOR RELIEF

FIRST CLAIM

Violation of the False Claims Act: Presenting False Claims for Payment (31 U.S.C. § 3729(a)(1)(A))

56. The Government incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

57. The Government seeks relief against Defendants under Section 3729(a)(1)(A) of the False Claims Act.

58. Through the acts set forth detailing the use of kickbacks and false patient evaluation forms, Defendants knowingly, or acting with deliberate ignorance or reckless disregard for the truth, presented, or caused to be presented, false or fraudulent claims for payment to the Medicaid program in connection with services provided by ACI.

59. Medicaid made payments to ACI because of the false or fraudulent claims.

60. If Medicaid had known that the claims presented for payment were false or fraudulent and resulted from illegal kickbacks, it would not have paid the claims.

61. By reason of these false or fraudulent claims, the Government has sustained damages in a substantial amount to be determined at trial, and is entitled to treble damages plus a civil penalty for each violation.

SECOND CLAIM

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

62. The Government incorporates by reference each of the preceding paragraphs as if fully set forth herein.

63. The Government seeks relief against Defendants under 31 U.S.C. § 3729(a)(1)(B) of the False Claims Act.

64. Through the acts set forth above detailing the use of kickbacks and false patient evaluation forms, Defendants knowingly, or acting with deliberate ignorance or reckless disregard for the truth, made, used, and caused to be made and used, false records and statements material to the payment of false or fraudulent claims by the Medicaid program.

65. Defendants made and/or caused to be made numerous false records and statements, including false certifications of compliance with applicable federal and state laws and regulations and false patient evaluation forms.

66. If Medicaid had known that the records and statements were false, it would not have paid the claims.

67. By reason of these false records and statements, the Government has sustained damages in a substantial amount to be determined at trial, and is entitled to treble damages plus a civil penalty for each violation.

THIRD CLAIM

Violations of the False Claims Act: Reverse False Claims
(31 U.S.C. § 3729(a)(1)(G))

68. The Government incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

69. The Government seeks relief against Defendants under 31 U.S.C. § 3729(a)(l)(G).

70. Through the acts set forth above, Defendants knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government by knowingly failing to repay Medicaid the payments ACI had received for services provided to Medicaid beneficiaries for whom ACI had prepared and submitted false patient evaluation forms, once Defendants became aware of the use of these forms.

71. By reason of Defendants' failure to repay these funds, the Government has sustained damages in a substantial amount to be determined at trial, and is entitled to treble damages plus a civil penalty for each violation.

FOURTH CLAIM

Unjust Enrichment

72. The Government incorporates by reference each of the preceding paragraphs as if fully set forth herein.

73. Through the acts set forth above detailing the use of kickbacks and false patient evaluation forms, Defendants have received payments to which they were not entitled and therefore were unjustly enriched. The circumstances of these payments are such that, in equity and good conscience, Defendants should not retain those payments, the amount of which is to be determined at trial.

WHEREFORE, the United States respectfully requests judgment to be entered against Defendants as follows:

a. On the First, Second and Third Claims (FCA violations), a judgment for treble damages and civil penalties to the maximum amount allowed by law;

b. On the Fourth Claim (unjust enrichment), a judgment for damages to the extent allowed by law.

c. Granting the Government costs and such further relief as the Court may deem proper.

Dated: December 14, 2020
New York, New York

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