UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES and STATE OF NEW YORK ex rel. JOHN DOE, Plaintiff, v. WESTCHESTER COUNTY HEALTH CARE CORPORATION, Defendant.	11 CV 5329 (CM) (MHD) Filed under seal Pursuant to 31 U.S.C. § 3730(b)(2)

AMENDED COMPLAINT AND DEMAND FOR JURY TRIAL

This is a civil action by JOHN DOE, whose true identity has been provided to the United States Attorney's Office for the Southern District of New York and the New York Attorney General's office ("Relator"), on his own behalf and on behalf of the United States of America and the State of New York against defendant WESTCHESTER COUNTY HEALTH CARE CORPORATION ("WCHCC") under the *qui tam* provisions of the False Claims Act, 31 U.S.C. §§ 3729 et seq., and the New York False Claims Act, New York State Fin. Law § 187 et seq., for treble damages, civil penalties, and other relief arising from WCHCC's claims for and receipt of Medicare and Medicaid reimbursements from the United States Department of Health and Human Services (HHS) and the New York State Medicaid program.

1. From at least as early as 2005 to the filing of this compliant, WCHCC has engaged in schemes to defraud the United States and the State of New York by presenting false claims for reimbursement to the Medicare and Medicaid program, failing to return overpayments by Medicare and Medicaid, and offering kickbacks and potential kickbacks affecting services provided to Medicare and Medicaid patients.

2. More specifically, WCHCC knowingly engaged in billing for professional services by uncredentialed nurse practitioners; billing for services rendered without required progress notes, physician signatures or other supporting records; billing for hospital stays without the required certification or recertification of medical necessity; routinely failing to collect copayments from psychiatric inpatients to induce utilization of services; and offering potential kickback payments to private-practice physicians in return for increased patient referrals.

3. In connection with the above-described improper activities, WCHCC obtained and has retained a substantial amount of Medicare and Medicaid reimbursements, in an amount to be determined at trial.

I. PARTIES

4. The United States, through HHS, and the State of New York, through its Medicaid program, are the real plaintiff parties-in-interest in this complaint.

5. HHS headquarters is located at 200 Independence Avenue S.W., Washington, D.C., 20201. The New York State Medicaid program is administered by the New York State Department of Health through its Office of Medicaid Management ("OMM"). NYSDOH and OMM are located at Corning Tower, Empire State Plaza, Albany, New York, 12237

6. Through his employment with WCHCC, the relator had direct and independent knowledge of WCHCC's improper conduct with respect to the Medicare and Medicaid programs. At all relevant times, relator was employed by WCHCC in an executive position.

7. Defendant WCHCC is a public benefit corporation established under Article 10-C of the New York Public Authorities Law, N.Y. Pub. Auth. Law §§ 3300 et seq. WCHCC is a "person" under the FCA and is not FCA-immune under the Eleventh Amendment.

8. WCHCC operates the Westchester Medical Center (WMC), a 643-bed hospital providing both inpatient and outpatient services. Its principal office is located at 100 Woods Road, Valhalla, New York 10595.

9. WMC's Behavioral Health Center (BHC), located in a freestanding facility on the WMC campus, provides a wide range of inpatient, outpatient, community-based and emergency behavioral health services. It has a staff of over 300 employees and an annual budget of approximately $40 million. Programs include six inpatient units, a Comprehensive Psychiatric Emergency Program, an Assertive Community Treatment program, an outpatient clinic, and a training program accredited by the Accreditation Council for Graduate Medical Education.

II. JURISDICTION AND VENUE

10. The court has subject matter jurisdiction over the federal claims alleged in this complaint under 28 U.S.C. §§ 1331 (federal question) and 1345 (United States as plaintiff), and 31 U.S.C. § 3732(a) (False Claims Act). Jurisdiction over the state law claims arises under 31 U.S.C. § 3730(b) (False Claims Act jurisdiction over state law false claims actions arising from the same transaction or occurrence) and 28 U.S.C. § 1367 (supplemental jurisdiction).

11. The court has personal jurisdiction over the defendant pursuant to 31 U.S.C. § 3732(a) because the defendant can be found, resides, or transacts business in this District. Section 3732(a) further provides for nationwide service of process.

12. This action is not based on facts underlying a pending, related action.

13. This action is not brought by a former or present member of the armed forces against a member of the armed forces arising out of such person's service in the armed forces.

14. This action is not brought against a Member of Congress, a member of the judiciary, or a senior executive branch official.

15. This action is not based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.

16. This action is not based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or General Accounting Office report, hearing, audit, or investigation, or from the news media. Further, the relator is an original source of the information, in that, through his employment with WMC, he is an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under this section, which is based on the information. Therefore, to the extent any of these allegations is deemed to have been based upon a public disclosure, the relator is an original source of this information within the meaning of the False Claims Act and is expressly excepted from its public disclosure bar.

17. Additionally, substantially the same allegations or transactions as alleged in this action have not been publicly disclosed (i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party; (ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or (iii) from the news media. Further, the relator is an original source of the information, in that relator either (i) prior to a public disclosure under subsection 31 U.S.C.§ 3730(e)(4)(a) voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2)

has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and has voluntarily provided the information to the Government before filing this action.

18. Venue is proper in this district pursuant to 31 U.S.C. §§ 3732(a) and 1391 because WCHCC can be found, resides, and transacts business in the Southern District of New York; an act proscribed by 31 U.S.C. § 3729 occurred within this District; and a substantial part of the events or omissions giving rise to the claims occurred in this District. Section 3732(a) further provides for nationwide service of process.

III. MEDICARE AND MEDICAID

19. Medicare, enacted in 1965 under Title XVIII of the Social Security Act, is a third party reimbursement program that underwrites medical expenses of the elderly and the disabled. 42 U.S.C.§§ 1395 et seq. Medicare is administered by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Reimbursements are paid from the federal Supplementary Medical Insurance Trust Fund. Medicare Part A covers hospital services; Part B generally covers physicians' services, including medical and surgical treatment and outpatient treatment and diagnosis. Part B, 42 U.S.C. §§ 1395j et seq.; 1395l (payment of benefits).

20. Medicaid, enacted in 1965 under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., is a medical assistance program for indigent and other needy people that is financed by joint Federal and State funding and is administered by the States according to federal regulations, oversight, and enforcement. Each State implements its version of Medicaid according to a State Plan that has been approved by HHS. Within broad Federal regulatory and

policy guidelines (42 C.F.R. § 430 et seq., and CMS publications), the states determine who is Medicaid-eligible, what services are covered, and how much to reimburse health care providers. The states, through intermediaries, also receive provider claims for program reimbursements, evaluate those claims, make payments to the providers, and present the claims to HHS for reimbursement of the Government's share.

21. In New York, the state Department of Health (NYSDOH) is responsible for administering the state Medicaid Program.

IV. FALSE CLAIMS ACTS

22. Section 3729 of the False Claims Act prior to its amendment on May 20, 2009 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 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; [or]
>
> (7) knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, 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.

(c) For purposes of this section, “claim” includes 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.

23. Section 3729(a) of the False Claims Act as amended May 20, 2009 provides, in pertinent part, that:

(1) [A]ny person who—

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; [or]

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than $ 5,000 and not more than $ 10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(b) For purposes of this section—

(1) the terms "knowing" and "knowingly"—

(A) mean that a person, with respect to information—

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) The term "claim"—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property; . . . .

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

24. The Patient Protection and Affordable Care Act, P.L. 111-148, 124 Stat. 119 (March 23, 2010) makes the failure to reimburse Medicare or Medicaid for an overpayment within 60 days a statutory reverse false claims violation. Under 42 U.S.C. § 1320a-7k(d), the failure to timely return an overpayment is an "obligation" to the government within the meaning of 31 U.S.C. § 3729(b)(3) of the False Claims Act. Recipients of an overpayment from Medicare and Medicaid must report it and return the overpayment by 60 days from when it was identified, or the date any corresponding cost report is due, whichever is later.

25. The Social Security Act 42 U.S.C. § 1320a-7b, provides, in pertinent part:

(b)(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, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item 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.

***

(g) Kickbacks. In addition to the penalties provided for in this section or section 1128A [42 USCS § 1320a-7a], a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code [31 USCS §§ 3721 et seq.].

26. The New York False Claims Act provides, in pertinent part:

[A]ny person who: (a) knowingly presents, or causes to be presented, to any employee, officer or agent of the state or a local government, a false or fraudulent claim for payment or approval; [or]

(b) 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 state or a local government . . .

shall be liable: (i) to the state for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, plus three times the amount of damages which the state sustains because of the act of that person; and (ii) to any local government for three times the amount of damages sustained by such local government because of the act of that person.

New York False Claims Act § 189.1.

V. DEFENDANT'S FRAUDULENT SCHEMES

A. Billing for professional services by uncredentialed nurse practitioners

27. Medicare does not cover services provided by nurse practitioners (NPs) which the NPs are not legally authorized to perform.

28. From October 1, 2008, and possibly earlier, through at least July 2010, Family Health Nurse Practitioners (FNPs) provided professional services in the BHC outpatient center and psychiatric emergency room (PED), but they did not have either the educational prerequisites or appropriate credentials to do so.

29. WMC received Medicare and Medicaid reimbursement for such non-covered services.

30. WMC's senior management, including the Chief Compliance Officer, when it learned of the improper payments, knowingly failed to report and return them, thereby violating section 3729(a)(1)(g) of the False Claims Act. Moreover, WMC continued to bill for and to receive payments for these services for several additional months after senior-level executives learned of the improper billing and payments.

31. Specifically, from the beginning of 2008 (if not earlier) through the summer of 2010, WMC employed three full-time FNPs in BHC's outpatient clinic and in the Psychiatric Emergency Department. The FNPs performed psychiatric evaluations, prescribed psychiatric medication, practiced psychotherapy, and directed the clinical activities of registered nurses (who were not NPs), psychiatric residents, medical students and other staff in the care of psychiatric inpatients and outpatients. However, under regulations promulgated by the New York State Department of Education, only nurse practitioners with specific training and credentials in psychiatry may perform such services. The FNPs were not authorized to provide such psychiatric services nor to be primary providers of care in a psychiatric facility. Although the FNPs worked in collaboration with psychiatric attending physicians under written agreements and protocols, physicians did not directly, routinely supervise the FNPs daily clinical activities.

32. Emergency Department inpatient and outpatient services were billed to Medicare and Medicaid as technical fees (Part A); outpatient services provided in the psychiatric clinic were billed as professional services on a fee-for-service basis, predominantly to patients covered under Medicaid and for which WMC received a special "COPS" (Comprehensive Outpatient Psychiatric Services) rate of approximately $370 per patient visit.

33. The FNPs who performed services in psychiatry included Maria Taylor (NYSED License #331014) who provided services principally in the psychiatric outpatient clinic from about November 2008 through September 2010; and Kim Conklin (Lic. #332776) and Linda Beyer (Lic. #334273), who performed clinical evaluation and management services to patients in acute psychiatric crisis in the Psychiatric Emergency Department (PED) and in a contiguous inpatient unit designated as the "EOB." Maria Taylor was hired July 16, 1987, Kim Conklin on November 1, 2007 and Linda Beyer on June 7, 2004.

34. Through communications including, but not necessarily limited to, communication from staff to Chief Medical Officer Renee Garrick, WMC's senior management knew or should have known of the issue of improper NP credentials no later than April 2010. Nevertheless, FNPs improperly continued to provide psychiatric services in the BHC through at least August 2010

35. On information and belief, WMC's senior management made little or no effort to investigate the magnitude of nor to rectify prior or subsequent billing for the FNP's clinical services to Medicare and Medicaid patients. Instead, WMC illegally continued to bill Medicare and Medicaid for these services.

36. On information and belief, individuals under the direction of WMC's Chief Medical Officer may have altered documents to conceal the fact that management was aware that the FNPs were providing services outside their privileges.

B. Billing for services without progress notes, physician signatures or other supporting records

37. WMC routinely billed Medicaid and Medicare for services provided to patients in the BHC psychiatric outpatient clinic (POC) when the patients' charts did not contain the required progress notes, physician signatures and other supporting information, as required by Medicare, New York State Department of Health (NYDOH), and New York State Department of Mental Hygiene.

38. WMC senior managers learned of these deficiencies in 2007, if not earlier. Nevertheless, WMC's management continued billing without adequate documentary support; did not notify either State or Federal authorities of their findings; and did not attempt to repay funds that had been improperly obtained.

39. As an example, on February 1, 2008, Cathy Ciavarello, the manager of the psychiatric outpatient clinic (POC), sent a memorandum to Dominick Lepore, then Vice President of the BHC, stating, "I am deeply concerned about billing practices in the BHC outpatient department." Her memorandum documented more than 60 specific patient dates of service in which medical records lacked any progress note in support of billed charges, including one patient for whom she "found that we had billed . . . for a total of 30 visits for which there is no clinical documentation in CRIS to substantiate the visit." (CRIS is the BHC's computerized medical record system.)

40. E-mail messages in 2007 and 2008 among Ciavarello, Lepore, Debbie Cross, MD (Medical Director of the POC), Robert Shaw (Vice President of Finance overseeing all billing and collection functions), Mark Fersko (Senior Vice President of Finance) and others show that all of these individuals were aware of significant problems with billing and documentation in the Psychiatric Outpatient Clinic during this period. The messages reveal that senior-level managers insisted that patient charges be processed without seeking to determine whether appropriate documentation existed to support the charges.

41. No later than mid-June, 2010, soon after being made aware of the documents, Relator shared Ciavarello's February 1, 2008 memorandum and some of the related e-mail messages and other information with Marsha Casey, Executive Vice President for Clinical and Professional Services, and to Patti Ariel, Vice President and Chief Compliance Officer.

42. As an additional example, in January or February 2010, BHC management conducted an informal review of 50 patient charts in the POC and learned that some physicians routinely failed to review and co-sign the progress notes of resident physicians in training before WMC billed for these professional services, as required under Medicare regulation, and that a large proportion of billed services were not supported by written and signed treatment plans, as required under New York State Mental Hygiene law and DOH regulations. These findings were brought to the attention of Casey and Ariel in about February 2010. However, none of Casey, Ariel, nor Ariel's direct supervisors, Michael Israel, Chief Executive Officer, and Julie Switzer, Executive Vice President and General Counsel, notified Federal or State authorities of improper Medicaid or Medicare payments received for services provided in the Psychiatric Outpatient Clinic, either within the required 60-day notice period or until August 2010 at the earliest.

43. As a third example, in April 2010 the New York Office of the Medicaid Inspector General (OMIG) informed WMC that it would conduct a medical record audit of the POC. Note that at this time, Ariel was already aware of improper billing in the POC as described in paragraph 41, which WMC had not reported to authorities. An introductory meeting with two OMIG auditors was held at WMC on April 22, 2010. Auditors indicated that the audit would cover services provided in the POC from April 1, 2004 through December 31, 2007, and that total Medicaid payments to WMC that were "at risk" for this period amounted to $5.4 million. The OMIG audit began in May 2010.

44. Among those who attended the April 22, 2010 meeting were Ariel; Mark Fersko (Senior Vice President, Finance); Fersko's subordinate Robert Shaw (Vice President, Finance) who held responsibility for all WMC's billing and collection functions; Bruce Anderson, Vice President overseeing the BHC, and other executives and staff members from the BHC, Compliance and Finance departments.

45. Subsequent to the meeting, Ariel attempted to stop the OMIG audit through informal means, working through intermediaries to influence the New York Medicaid Inspector General. Although OMIG did not cancel the audit, the lead auditor, Mario Felidi, Project Coordinator in OMIG's New York City office, was reassigned and the audit was delayed.

46. Ariel assembled a team of clinical and Compliance Office staff to review the same charts that OMIG requested for audit. Ariel's internal review found that more than 40 percent, and perhaps as many as 60 percent of the patient visits billed lacked adequate documentary support. Casey informed Relator that Ariel shared her findings with Michael Israel, Chief Executive Officer, Julie Switzer, Executive Vice President and General Counsel, and members of

the Board of Directors. Still, WMC did not report this information to Medicare or Medicaid authorities.

47. Despite Ariel's, Fersko's, Casey's, Switzer's, Israel's and other senior executives' specific knowledge of widespread, material deficiencies in the Psychiatric Outpatient Clinic's compliance with state and federal requirements in 2004-2007 (through Ariel's internal audit), in 2007-2008 (through the Ciavarello memorandum) and in 2009-2010 (through the 50-record sample that BHC management had compiled), to Relator's knowledge no one at WMC has notified either Medicare or Medicaid officials of known erroneous or fraudulent billings. Yet, Fersko, Shaw, Lepore and possibly other executives had knowledge of these matters as early as 2007, and Casey and Ariel became knowledgeable of these matters no later than February 2010.

C. Fraudulent Medicare billing for hospital stays

48. Medicare and Medicaid law and regulations require that a qualified physician certify, and at subsequent intervals recertify, the medical necessity of a beneficiary's treatment in an inpatient psychiatric setting.

49. WMC billed Medicare for inpatient hospitalizations at the BHC without required certifications/recertifications from at least 2008, if not earlier, through at least 2010, if not later.

50. WMC's management, when it learned it had received improper payments in violation of the certification requirements, knowingly failed to report and return them, thereby violating section 3729(a)(1)(g) of the False Claims Act.

51. The required physician's statement should certify that the inpatient psychiatric facility admission was medically necessary either for treatment which could reasonably be expected to improve the patient's condition, or for diagnostic study. The physician's

recertification should state that inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary either for treatment that could reasonably be expected to improve the patient's condition, or for diagnostic study.

52. The hospital records must indicate that the services furnished were either intensive treatment services [or] admission and related services necessary for diagnostic study, or equivalent services.

53. In about November 2009, Fersko (Senior Vice President) told Relator that he had learned several months earlier that BHC physicians were not consistently certifying and recertifying the need for hospitalization of the BHC's Medicare patients. Fersko told Relator that he had "taken care of it."

54. Joe Borgess, MD, the WMC Vice President overseeing the utilization management function, also told Relator that the certification issue had been a problem, but that utilization review (UR) nurses reporting to Borgess were now monitoring Medicare certification in the BHC and that the problem had been corrected.

55. Neither Fersko nor Borgess indicated that any attempt had ever been made to determine the extent to which patients had not been duly certified or to determine whether any payments for services to Medicare patients should have been refunded to Medicare.

56. On or about July 9, 2010, a UR nurse informed Relator that, "The Medicare recerts are a mess again on [inpatient units] B2 and A2." Three days later, a physician informed Relator, "I am quite concerned about the deficiencies [related to recertification] in my unit and the potential liability they generate. These problems are not new."

57. Executive Vice President Casey was informed of deficiencies in certification/recertification on July 21, 2010. Casey subsequently informed Ariel, Chief Compliance Officer. Yet despite the direct knowledge of Fersko, Casey and Ariel, and likely Israel and Switzer, to whom Ariel reports, none of these certification problems have been reported to CMS, and WCHCC has not refunded any payments to Medicare for failure to properly certify Medicare patients' need for continued inpatient hospitalization.

D. Failing to collect copayments from psychiatric inpatients

58. WMC routinely waived the collection of copayments from psychiatric inpatients without making a good faith determination of the patient's financial need or a reasonable effort at collection.

59. The routine failure to collect copayments from patients is a violation of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, and billing Medicare and Medicaid for amounts that include kickbacks is a violation of the False Claims Act.

60. As an example, BHC inpatients who were verified to be Medicare beneficiaries were not screened for financial need, while such screens were routinely performed for uninsured patients or for insured patients with limited or no inpatient mental health benefits. Therefore, any waiver of copayments for Medicare beneficiaries cannot be defended based on "a good faith determination of the patient's financial need."

61. Moreover, WMC made only minimal, sporadic and ineffectual attempts to comply with the statutory requirements to collect copayments from Medicare beneficiaries. No attempt was made to collect copayments from Medicare beneficiaries or their families at the time of admission or during a hospitalization. Medicare beneficiaries who subsequently presented for

services at WMC, and who had not paid copayments due from prior psychiatric hospitalization, were not seen by Finance Department personnel to inquire about payment of past-due accounts.

62. Furthermore, on at least two occasions, Mark Fersko, Senior Vice President of Finance who directly oversees WMC's billing and collection functions, openly censured Relator for suggesting that administrative functions be enhanced to facilitate determinations of financial need and to improve collection of copayments and deductibles.

63. As examples, for Medicare patients discharged from the BHC in 2009, copayments were collected for only 22 of 331 accounts (7%). Of these 22 collected copayments, almost one-third (7) were collected from the patient's supplemental insurance plan, rather than directly from the patient. For those patients under 65 – who were presumably covered under Medicare solely due to a disability – copayments of any amount were collected on only 12 accounts (less than 5%); six of these (50%) were collected from supplemental insurance plans.

64. Overall, among 267 mentally-disabled Medicare beneficiaries discharged from the BHC in 2009, WMC collected $293,000 in copayments and deductibles. About $5,000 – less than 2% of the total – came directly from patients and their families.

E. Rewarding private-practice physicians in return for increased patient referrals

65. WMC offered financial incentives to a private practice neurosurgery group in exchange for a promise of patient referrals from the group, in potential violation of the Anti-Kickback Statute and the False Claims Act.

66. The Neurosurgical Group of Westchester (NGW), based in Harrison, New York, is one of the largest neurosurgery practices in the six-county Lower Hudson Valley. It performs

surgery and provides neurosurgery consultation and emergency on-call services to many of the community hospitals in Westchester County.

67. In or about February 2010, Relator was asked to attend an early-morning meeting with his boss Marsha Casey, Gary Brudnicki, Michael Israel, the chairmen of the departments of neurosurgery (Raj Murali, M.D.) and neurology (Brij Singh Ahluwalia, M.D. The meeting was held ostensibly to discuss the possible merger of NGW with the neurosurgery practice of the New York Medical College (NYMC), headed by Dr. Murali, which served as the principal provider of neurosurgery services at WMC. Although WMC did not have direct ownership of or a direct financial interest in either practice, it provided significant financial support to Dr. Murali's practice through one or more agreements with NYMC. In part, it appeared that Jack Stern, M.D., the leader and part owner of NGW, wanted to know whether this financial support would continue if his practice were to merge with Dr. Murali's.

68. During this meeting, Brudnicki directly asked Dr. Stern, "If we go along with this [proposed merger], how many [neurosurgery] cases will you bring to WMC?" Dr. Stern replied that he and his colleagues practiced at many of the surrounding hospitals, and that they could easily move a significant number of neurosurgery cases to WMC.

69. Subsequent to the meeting, WMC offered various payment incentives to NGW to help bring the merger to completion.

COUNTS

COUNT I

Federal False Claims Act Violations
31 .S.C. § 3729(a)(1), (2) and (7)

70. Relator realleges paragraphs 1 through 69 above as if fully set forth herein.

71. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §§ 3729-32, prior to the May 20, 2009 amendment.

72. Through the acts described above and otherwise, WCHCC, by and through its agents and employees knowingly presented, or caused to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval; knowingly made, used, or caused to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; and knowingly made, used, or caused to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

73. The Government was unaware of the falsity of the records, statements, and claims made or submitted by WCHCC.

74. The false and fraudulent representations and claims WCHCC made to the Government were material to the Government's decisions to make Medicare and Medicaid payments to WCHCC.

75. Had the Government known of the false or fraudulent nature of WCHCC's representations and claims, it would not have made the Medicare and Medicaid payments to WCHCC,

76. By reason of WCHCC's violations of the False Claims Act, the United States has suffered economic loss.

COUNT II
Federal False Claims Act Violations
31 U.S.C. § 3729(a)(1)(A), (B), and (G)

77. Relator realleges paragraphs 1 through 69 above as if fully set forth herein.

78. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §§ 3729-32, as amended on May 20, 2009.

79. Through the acts described above and otherwise, WCHCC, by and through its agents and employees knowingly presented, or caused to be presented, a false or fraudulent claim for payment or approval; knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim; and knowingly made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government.

80. The Government was unaware of the falsity of the records, statements, and claims made or submitted by WCHCC.

81. The false and fraudulent representations and claims WCHCC made to the Government were material to the Government's decisions to make Medicare and Medicaid payments to WCHCC.

82. Had the Government known of the false or fraudulent nature of WCHCC's representations and claims, it would not have made the Medicare and Medicaid payments to WCHCC.

83. By reason of WCHCC's violations of the False Claims Act, the United States has suffered economic loss.

COUNT III
New York False Claims Act violations--N.Y. State Fin. Law § 189(1)(a)

84. Relator realleges paragraphs 1 through 69 above.

85. In connection with claims for Medicaid funds, from at least 2008 to the present, in the Southern District of New York and elsewhere, the WCHCC engaged in a practice of knowingly presenting and causing to be presented to one or more employees, officers, or agents of the State of New York or a local government, false and fraudulent claims for payment and approval, that is, by namely by submitting invoices and supporting documentation that were false or fraudulent, and that falsely impliedly and expressly certified WCHCC's compliance with applicable law, rules, regulations, and other Medicaid program requirements, in violation of section 189(1)(a) of the New York False Claims Act.

86. The State of New York has paid funds to WCHCC upon the false, fictitious, or fraudulent claims described in this complaint.

87. Had the State of New York known of the false and fraudulent nature of WCHCC's claims, it would not have paid Medicaid monies to WCHCC.

88. The State of New York has been damaged by the defendant's wrongful conduct.

COUNT IV
New York False Claims Act Violations--N.Y. State Fin. Law § 189(1)(B)

89. Relator realleges paragraphs 1 through 69 above.

90. In connection with claims for Medicaid funds, from at least 2008 to the present, in the Southern District of New York and elsewhere, WCHCC engaged in a practice of knowingly making, using, and causing to be made false records or statements to get false or fraudulent claims paid or approved by the State of New York or a local government, by creating fraudulent documents including, but not limited to, false and fraudulent attendance records, case notes, and

other documents required for or material to claims for Medicaid funds, in violation of N.Y. State Fin. Law § 189(1)(b).

91. The State of New York has paid funds to WCHCC upon the false, fictitious, and fraudulent claims described in this complaint.

92. Had the State of New York known of the false and fraudulent nature of WCHCC/s records and statements, it would not have paid Medicaid monies to WCHCC.

93. The State of New York has been damaged by the WCHCC's wrongful conduct.

PRAYER FOR RELIEF

WHEREFOR, Relator, on behalf of himself and on behalf, and in the name of the Government of the United States, demands judgment against WCHCC as follows:

A. Ordering WCHCC to cease and desist from violating the False Claims Act, 31 U.S.C. §§ 3729-3732.

B. On Counts I and II, against WCHCC in the amount of three times the amount of damages the United States has sustained because of WCHCC's actions, plus a civil penalty of $11,000 for each act in violation of the False Claims Act, as provided by 31 U.S.C. § 3729(a) and other applicable law, with interest.

C. Awarding Relator the maximum amount available under the False Claims Act, 31 U.S.C. § 3730(d), for bringing Counts I and II, namely, 25 percent of the proceeds of the action by judgment or settlement of the claim if the Government intervenes in the matter (or pursues its claim through any alternate remedy available to the Government, 31 U.S.C. § 3730(c)(5)), or, alternatively, 30 percent of the proceeds of the action by judgment or settlement of the claim, if the Government declines to intervene.

D. On Counts III and IV, against WCHCC in the amount of three times the amount of damages which New York State has sustained actions for each act of the defendants in violation of the New York False Claims Act, as provided by N.Y. State Fin. Law §189(1)(g)(ii); plus a penalty of $12,000 for each act in violation of the New York False Claims Act as provided by New York State Fin. Law § 189(1)(g).

E. On Counts III and IV, awarding the relator the maximum amount available under the New York False Claims Act for bringing this action, namely, 25 percent of the proceeds of the action by judgment or settlement of the claim if the New York attorney general elects to convert the qui tam action into an attorney general enforcement action, or to permit the Southern District of New York to convert the action into a civil enforcement action by New York City, or the New York attorney general or New York City elects to intervene in the qui tam action (or pursues the state's claim through any alternate action; or, alternatively, 30 percent of the proceeds of the action by judgment or settlement of the claim, if the New York attorney general or New York City does not elect to intervene or convert the action, pursuant to N.Y. State Fin. Law § 190(5)(c) and (6).

F. As to all Counts in this Complaint, awarding Relator all reasonable expenses that were necessarily incurred in prosecution of this action, plus all reasonable attorneys' fees and costs, as provided by 31 U.S.C. §§ 3730(d) and (h); and New York State Fin. Law § 190(7); and

G For such other relief for the United States and Relator as this Court deems appropriate.

JURY DEMAND

Pursuant to Federal Rule of Civil Procedure 38, Relator hereby demands trial by jury.

Dated: New York, New York
October 10, 2012

Timothy J. McInnis
Richard F. Bernstein
McINNIS LAW

By: _____/s/_____
Richard F. Bernstein
521 Fifth Avenue, Suite 1700
New York, New York 10175
(212) 292-4573
Attorneys for Relator John Doe