MATTHEW PODOLSKY
Acting United States Attorney
Southern District of New York
By: DAVID E. FARBER
Assistant United States Attorney
86 Chambers Street, Third Floor
New York, New York 10007
Telephone: (212) 637-2772
Email: david.farber@usdoj.gov

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA and THE STATES OF MARYLAND, NEW JERSEY, NEW YORK, TENNESSEE, TEXAS, AND THE CITY OF NEW YORK *ex rel.* SCOIF LLC, Plaintiffs, v. COMMUNITY OPTIONS, INC. and COMMUNITY OPTIONS OF NEW YORK, INC., Defendants.	20 Civ. 4684 (VEC) **COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA** **JURY TRIAL DEMANDED**
UNITED STATES OF AMERICA, Plaintiff-Intervenor, v. COMMUNITY OPTIONS, INC. and COMMUNITY OPTIONS NEW YORK, INC., Defendants.	

Plaintiff the United States of America (the "United States"), by and through its attorney, Matthew Podolsky, Acting United States Attorney for the Southern District of New York, alleges for its complaint-in-intervention as follows:

PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the United States against Community Options, Inc. ("COI"), and Community Options New York, Inc. ("CONY," and together with COI, "Defendants") under the False Claims Act, 31 U.S.C. §§ 3729-33 (the "FCA"), to recover damages and civil penalties arising from Defendants' submission of false claims to Medicaid for Day Habilitation services, as well as the improper retention of overpayments associated with Defendants' provision of Day Habilitation services. The United States also seeks to recover damages under the common law for unjust enrichment and payment by mistake.

2. CONY is a New York not-for-profit corporation that, among other things, operates a network of residential and non-residential facilities and programs for adults with developmental or intellectual disabilities throughout the State of New York ("New York" or the "State"). As part of its operations, CONY provides Day Habilitation services—which are programs intended to help adults with developmental or intellectual disabilities improve their independence and skills in daily activities and are provided at certified sites and in the community. CONY receives reimbursement from the New York Medicaid Program for those Day Habilitation services.

3. COI is a New Jersey not-for-profit corporation that, among other things, oversees CONY's operations in New York and provides administrative support, including a centralized billing team that handles the submission of claims for reimbursement to the New York Medicaid Program on behalf of CONY.

4. As further described below, during the period from January 1, 2017, through September 13, 2024 (the "Relevant Period"), Defendants violated the FCA by knowingly submitting and/or causing the submission of false claims for payment to Medicaid for Day Habilitation services that did not meet applicable requirements. In addition, Defendants violated

the FCA by knowingly and improperly avoiding the return of overpayments received from Medicaid for Day Habilitation services that did not meet applicable requirements.

5. In order to receive payment from the New York Medicaid Program for the provision of Day Habilitation services, Defendants were required to ensure that such services were delivered and documented in compliance with applicable program requirements promulgated by the New York State Office for People With Developmental Disabilities ("OPWDD"). More specifically, Defendants were required to, *inter alia,* comply with state regulations, including those set forth at 14 NYCRR § 635-10.5(c), and service documentation requirements promulgated by OPWDD concerning Day Habilitation services, including program day duration and face-to-face service delivery requirements, 14 NYCRR § 635-10.5(c)(6), maintenance of contemporaneous daily service and monthly summary documentation, *id.*, OPWDD Administrative Memoranda #2006-01, 2006-01R, maintenance and review of Life Plans and Staff Action Plans, 14 NYCRR §§ 635-10.5(c)(4)(iii), 635-99.1(bk), and maintenance and review of annual Level of Care Eligibility Determinations, 14 NYCRR § 633.10(a)(2), (collectively, the "OPWDD Requirements").

6. However, during the Relevant Period, Defendants failed to maintain adequate policies concerning the provision and documentation of Day Habilitation services consistent with the OPWDD Requirements and failed to adequately train their employees on compliance with the OPWDD Requirements. As a result, Defendants' employees failed to deliver and document CONY's provision of Day Habilitation services in accordance with the OPWDD Requirements.

7. Defendants understood that they were prohibited from submitting claims for reimbursement to New York's Medicaid Program for Day Habilitation services if the OPWDD Requirements were not met. Nonetheless, Defendants frequently submitted claims to Medicaid for Day Habilitation services that did not meet these requirements.

8. Defendants further understood that, as a provider of services under New York's Medicaid Program, CONY was required to adopt and implement an effective corporate compliance program that includes measures that prevent, detect, and correct non-compliance with Medicaid requirements, such as the OPWDD Requirements, as well as report and return identified overpayments to Medicaid.

9. Nonetheless, during the Covered Period, CONY failed to implement an effective compliance program concerning the provision and documentation of Day Habilitation services. Specifically, CONY did not conduct routine audits or reviews of Day Habilitation service documentation to ensure compliance with the OPWDD Requirements. In addition, when Defendants conducted non-routine reviews that identified their receipt and retention of overpayments associated with Day Habilitation services, they failed to report and return those overpayments to Medicaid.

10. By engaging in the above-referenced conduct, Defendants submitted, or caused to be submitted, thousands of false claims to Medicaid, and Defendants improperly avoided the return of overpayments associated with hundreds of claims paid by Medicaid, all in violation of the FCA.

JURISDICTION AND VENUE

11. 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 common law claims pursuant to 28 U.S.C. § 1345.

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

13. Venue lies in the Southern District of New York pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and 1391(c), because Defendants do business in this District, and Defendants' misconduct occurred in this District.

PARTIES

14. Plaintiff is the United States of America 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 & Medicaid Services ("CMS"), which administers the Medicaid program.

15. Defendant Community Options, Inc. is a New Jersey not-for-profit corporation that, among other things, oversees CONY's operations in New York and provides administrative support, including a centralized billing team, which handles CONY's submission of claims for reimbursement to the New York Medicaid Program. COI submitted claims for, and CONY received, at least $5 million annually in reimbursements from Medicaid since at least 2015.

16. Defendant Community Options New York, Inc. is a New York not-for-profit corporation that, among other things, operates a network of residential and non-residential facilities and programs for adults with developmental or intellectual disabilities throughout New York, including in Brooklyn, Manhattan, Queens, Binghamton, Vestal, Waverly, and Syracuse. Specifically, Defendant CONY provides, among other things, Day Habilitation services to adults with developmental or intellectual disabilities in New York at certified sites and in the community. CONY received, and COI submitted claims for, at least $5 million annually in reimbursements from Medicaid since at least 2015.

17. Relator SCOIF LLC is a single member Delaware limited liability company, formed for the express purpose of bringing this case, whose sole member is a former employee of CONY. On or about June 15, 2020, Relator filed a complaint in the United States District Court for the Southern District of New York, under the *qui tam* provisions of the FCA, alleging, *inter alia*, that Defendants submitted false claims to the New York Medicaid Program for the provision of Day Habilitation services that failed to meet applicable requirements.

BACKGROUND

I. The False Claims Act

18. 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," 31 U.S.C. § 3729(a)(1)(A); "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," 31 U.S.C. § 3729(a)(1)(B); 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)(G).

19. "Knowingly" is defined to include actual knowledge, reckless disregard, and deliberate ignorance. 31 U.S.C. § 3729(b)(1). No proof of specific intent to defraud is required. *Id.*

20. An "obligation," under the statute, includes the "retention of any overpayment." *Id.* § 3729(b)(3).

21. Section 6402(a) of the Patient Protection and Affordable Care Act of 2010 (Enhanced Medicare and Medicaid Program Integrity Provisions), Pub. L. No. 111-148, 124 Stat. 119, 753-56 (2010), amended the Social Security Act by adding a new provision that addresses what constitutes an overpayment under the FCA in the context of a federal health care program. Under this section, an overpayment is defined as "any funds that a person receives or retains under subchapter XVIII [Medicare] or XIX [Medicaid] to which the person, after applicable reconciliation, is not entitled." *See* 42 U.S.C. § 1320a–7k(d)(4)(B). In addition, this provision specifies in relevant part that an "overpayment must be reported and returned" within "60 days after the date on which the overpayment was identified." *Id.* § 1320a–7k(d)(2).

22. In accordance with these Medicaid Program Integrity Provisions, New York has promulgated regulations requiring providers who receive overpayments to report and return the overpayment to the State and notify the State's Office of the Medicaid Inspector General in writing

of the reason for the overpayment. *See* N.Y. Soc. Servs. Law § 363-d(6)(a). New York regulations further define an "overpayment" to include "any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake." 18 NYCRR § 518.1(c).

23. Knowing failure to return any overpayment, such as the claims for which CONY received an overpayment from Medicaid, constitutes a reverse false claim actionable under Section 3729(a)(1)(G) of the FCA.

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

II. The Medicaid Program

25. 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 created to provide financial assistance to qualified individuals with low income to enable them to receive medical care. 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 states directly pay the health care providers for services rendered to Medicaid recipients, with the states 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 seq*. The federal portion of each state's Medicaid payments, known as the Federal Medical Assistance Percentage, is generally based on the state's per capita income compared to the national average. 42 U.S.C. § 1396d(b).

26. The majority of states award contracts to private companies to evaluate and process claims for payment on behalf of Medicaid recipients. Typically, after processing the claims, these private companies then generate funding requests to the state Medicaid programs. Before the

beginning of each calendar quarter, each state submits to CMS an estimate of its Medicaid federal funding needs for the quarter. CMS reviews and adjusts the quarterly estimate as necessary and determines the amount of federal funding each state will be permitted to draw down as it incurs expenditures during the quarter. The state then draws down federal funding as actual provider claims are presented for payment. After the end of each quarter, the state then submits to CMS a final expenditure report, which provides the basis for adjustment to the quarterly federal funding amount (to reconcile the estimated expenditures to actual expenditures). *See* 42 C.F.R. § 430.30.

27. The Medicaid Home and Community-Based Services ("HCBS") waiver program ("HCBS Waiver") is authorized at § 1915(c) of the Social Security Act. The HCBS Waiver permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. Section 1915(c) of the Social Security Act authorizes the Secretary of HHS to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target groups of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. States participating in a HCBS Waiver must also comply with requirements promulgated by CMS at 42 C.F.R. Part 441, Subpart G.

III. Relevant New York Requirements

28. Day Habilitation services are programs intended to help adults with developmental or intellectual disabilities improve their independence and skills in daily activities. Day Habilitation services are face-to-face services provided outside of an individual's home, usually at a certified site or in the community. *See* 14 NYCRR § 635-10.4(b)(2). In New York, Day Habilitation services are overseen by OPWDD, and are reimbursed by New York's Medicaid Program pursuant to the HCBS Waiver between the State and CMS.

29. In order to receive payment from the New York Medicaid Program for the provision of Day Habilitation services, agencies providing such services are required to comply with the OPWDD Requirements, which are applicable state regulations and requirements promulgated by OPWDD, including among others:

a. Program Day Duration and Face-to-Face Service Delivery. Agencies must deliver and document the provision of Day Habilitation services in accordance with program day duration and face-to-face service delivery requirements. 14 NYCRR § 635-10.5(c)(6). These requirements provide that an agency may bill for a full unit of Day Habilitation service when the agency delivers and documents at least two face-to-face services delivered in accordance with the individual's Day Habilitation Plan and provides a program day duration of four to six hours. *Id.* § 635-10.5(c)(6)(i)(a). The agency may bill for a half unit of Day Habilitation service when the agency delivers and documents at least one face-to-face service delivered in accordance with the individual's Day Habilitation Plan and provides a program day duration of at least two hours. *Id.* § 635-10.5(6)(i)(b). The program day duration for Day Habilitation services is the length of time that the individual is actually participating in Day Habilitation service, and does not include time spent at, or traveling to or from, any other separately reimbursed service, time spent traveling to the first Day Habilitation activity or traveling home or to another service at the conclusion of the program day, and mealtimes. *Id.* § 635-10.5(c)(6)(ii).

b. Service Documentation. Agencies are required to maintain contemporaneous daily service documentation of the Day Habilitation services that are provided. *See* 14 NYCRR § 635-10.5(c)(4)(iii), (c)(6); *see also* 18 NYCRR § 517.3(b). In addition,

OPWDD has promulgated Day Habilitation service documentation standards, which require: (i) the consumer[1] name and Medicaid number, (ii) identification of the service provided; (iii) a daily description of the required minimum number of face-to-face services provided by staff; (iv) documentation that the program day duration requirement was met; (v) a description of the consumer's response to the service, documented at a minimum, in a monthly note; (vi) date of service; (vii) primary service location; (viii) verification of service provision by provider staff; (ix) signature and title of provider staff documenting the service, and (x) the date the service was documented. *See* OPWDD Administrative Memoranda 2006-01, 2006-01R. In addition, a monthly summary note is required that, at a minimum, summarizes the implementation of the individual's Day Habilitation Plan and addresses any issues or concerns. *Id.*

c. Life Plans and Day Habilitation Staff Action Plans. Agencies are also required to develop, maintain, and periodically review written person-centered service plans, including Life Plans (formerly known as Individual Service Plans) and Day Habilitation Staff Action Plans (formerly known as Day Habilitation Plans) for each individual to whom they provide Day Habilitation services. *See* 14 NYCRR §§ 635-10.5(c)(4)(iii), 635-99.1(bk); *see* also 42 C.F.R. § 441.301(c). The specific requirements for developing, maintaining, and periodically reviewing Life Plans and Day Habilitation Staff Action Plans are issued by OPWDD. *See, e.g.,* OPWDD Administrative Memoranda 2010-04, 2018-ADM-06, 2018-ADM-06R, 2018-ADM-06R2, 2012-01, 2018-09, 2018-09R.

[1] The OPWDD Requirements generally refer to the individual receiving Day Habilitation services as a "consumer."

d. Level of Care Eligibility Determinations. Agencies are also required to develop, maintain, and annually review the Level of Care Eligibility Determination ("LCED") for each individual receiving HCBS Waiver services, which includes, among other things, an assessment of the individual's functional capacity, and a review and evaluation of the individual's written plan of services and their progress in relation to that plan. *See* 14 NYCRR § 633.10(a)(2); *See also* 42 C.F.R. § 441.302(c).

30. Compliance with the OPWDD Requirements is material to Medicaid's decision to reimburse claims for Day Habilitation services. OPWDD's audit protocol for Day Habilitation services provides that missing records, the failure to document services, and documentation missing the required elements outlined above will result in full disallowance of claims when audited. In addition, OPWDD's audit protocol provides that claims will be reduced if a full unit of service was billed when only a half unit of service was documented, and the difference between the amount of the full unit of service and half unit of service will be disallowed.

31. Providers who participate in New York's Medicaid Program must sign enrollment agreements with the State that certify compliance with State and federal Medicaid requirements. The agreements require, in substance, that the Medicaid providers agree to comply with all State and federal laws and Medicaid rules and regulations in connection with providing services and care to patients and billing the State Medicaid Program for services or supplies furnished.

32. Medicaid providers must also affirmatively certify, as a condition of payment of the claims submitted for reimbursement by Medicaid, compliance with applicable federal and State laws and regulations.

33. New York State Social Services Law § 363-d also requires Medicaid providers to adopt and implement an effective compliance program, which shall include measures that prevent, detect, and correct non-compliance with Medicaid program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. This requirement includes, among other things, that providers establish and implement: (i) effective training and education, at orientation and at least annually thereafter, for its employees, chief executive and other senior administrators, managers and governing body members; (ii) an effective system for routine monitoring and identification of compliance risks, including internal monitoring and audits and, as appropriate, external audits, to evaluate the organization's compliance with Medicaid program requirements; and (iii) a system for promptly responding to, investigating, and correcting compliance issues as they are raised, to ensure ongoing compliance with Medicaid program requirements.

34. As a condition of receiving Medicaid reimbursement, Medicaid providers that receive at least $5 million annually from a state Medicaid program, must establish written policies outlining, among other things, detailed information about the FCA, any state laws pertaining to civil or criminal penalties for false claims and statements, and detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse. *See* 42 U.S.C. § 1396-a(a)(68).

FACTUAL ALLEGATIONS

I. Defendants Submitted, Or Caused The Submission Of, False Claims To Medicaid For Day Habilitation Services That Did Not Meet The OPWDD Requirements

35. As described above, in order to receive payment from the New York Medicaid Program for the provision of Day Habilitation services, Defendants were required to ensure that such services were delivered and documented in compliance with the OPWDD Requirements.

36. During the Relevant Period, Defendants failed to maintain adequate policies concerning the provision and documentation of Day Habilitation services consistent with the OPWDD Requirements and failed to adequately train their employees on compliance with the OPWDD Requirements. As a result, Defendants' employees failed to deliver and document CONY's provision of Day Habilitation services in accordance with the OPWDD Requirements, and Defendants billed Medicaid for these services.

37. Specifically, Defendants did not provide formal training to their Day Habilitation staff, coordinators, or regional directors on the OPWDD Requirements for Day Habilitation services at new employee orientations or annually thereafter. Additionally, Defendants did not provide new staff with guidance with respect to complying with the OPWDD Requirements. As a result, many of Defendants' staff members, coordinators, and directors were unaware of some or all of the applicable OPWDD Requirements, including how to calculate the duration of Day Habilitation services provided and how to properly document Day Habilitation services at the end of each month of service.

38. Further, in many instances, and contrary to the OPWDD Requirements, CONY: did not accurately complete and adequately maintain daily service documentation, monthly summaries, Life Plans, Staff Action Plans, and LCEDs for individuals enrolled in CONY's Day Habilitation programs; failed to complete such documentation in a timely manner; or failed to provide the necessary review and approval of Life Plans, Staff Action Plans, and LCEDs on a semi-annual or annual basis.

39. Since at least October 2015, Defendants knew that their Day Habilitation delivery and documentation standards did not meet the applicable OPWDD Requirements. In particular, in 2015, an OPWDD contractor conducted a Limited Fiscal Review ("LFR") of, among other things,

CONY's Day Habilitation services for the years 2010 to 2011, and issued an LFR Report to CONY on October 1, 2015. In that report, the OWPDD contractor identified a number of Day Habilitation service claims that lacked the documentation required by the OWPDD Requirements and sought repayment for those claims.

40. Moreover, as part of the LFR, the OPWDD contractor recommended that CONY take steps to ensure that all future Day Habilitation claims are supported with documentation that: (i) substantiates the duration standard for the units of service billed; and (ii) that shows consumers' responses to the services provided by the end of the month following the date of service. In response, CONY agreed with these recommendations and noted that "[a]ll CONY group day habilitation staff will be retrained in documentation standards," and "[b]efore each claim is billed, Executive Directors or [their] Designee will verify [that] all billings contain the required documentation which substantiates each claim."

41. Nevertheless, Defendants consistently failed to train and educate their staff, coordinators, and directors on the OPWDD Requirements for Day Habilitation services during the Relevant Period. As a result, Defendants submitted claims for, and received, reimbursement from the Medicaid for Day Habilitation services that did not meet the OPWDD Requirements.

II. Defendants Knowingly And Improperly Avoided The Return Of Overpayments Received From The Medicaid Program For Day Habilitation Services That Did Not Meet The OPWDD Requirements

42. As described above, as a provider of services under New York's Medicaid Program, CONY was required to adopt and implement an effective corporate compliance program that includes measures that prevent, detect, and correct non-compliance with Medicaid requirements, such as the OPWDD Requirements, as well as report and return identified overpayments to Medicaid.

43. Nonetheless, during the Relevant Period, CONY failed to implement an effective compliance program concerning the provision and documentation of Day Habilitation services. Specifically, CONY did not conduct routine audits or reviews of Day Habilitation service documentation to ensure compliance with the OPWDD Requirements. Additionally, CONY failed to conduct any audits of daily service records for its Day Habilitation programs.

44. Further, Defendants routinely ignored the procedures set forth in its own corporate compliance program, also known as its Quality Assurance ("QA") program.

45. For example, during the Relevant Period, Defendants' QA staff were supposed to perform audits and reviews to ensure CONY's compliance with Medicaid reimbursement rules and prepare internal audit reports detailing any areas where service documentation was insufficient. However, Defendants did not enforce this policy, and Defendants' QA staff did not conduct routine audits and reviews of Defendants' Day Habilitation services. Instead, Defendants frequently tasked their QA analysts with performing functions other than compliance reviews, including training new employees on how to use Defendants' electronic medical record program.

46. CONY was also required to report and return overpayments associated with Day Habilitation services that did not meet the OPWDD Requirements to Medicaid. Pursuant to Defendants' written corporate compliance plan, they were required to "take the appropriate steps to have the billing voided/reversed" and repay Medicaid after identifying an overpayment. Nonetheless, when Defendants conducted non-routine reviews that identified their receipt and retention of overpayments associated with Day Habilitation services, they failed to report and return those overpayments to Medicaid.

47. For example, in January 2022, during the course of a non-routine review, Defendants determined that CONY had failed to create and maintain monthly summary

documentation, in contravention of the OPWDD Requirements, for dozens of Day Habilitation clients in Manhattan, Brooklyn, and Queens, affecting hundreds of claims for reimbursement.

48. After identifying these "significant concerns surrounding program compliance," a senior CONY employee overseeing Day Habilitation services remarked that if Defendants were audited, all billing would have to be retracted for each month of service without a monthly summary note.

49. However, despite identifying hundreds of claims that failed to meet the OPWDD Requirements, and knowing that such deficiencies required Defendants to return payments for these claims, Defendants failed to return any money associated with such claims or even alert Medicaid to the identified overpayments. Instead, the senior CONY employee overseeing Day Habilitation services instructed their subordinate to create all of the missing monthly summary notes, in some instances up to a year after the Day Habilitation services in question were purportedly provided.

* * *

50. As result of the above-referenced improper practices, and in violation of the FCA, Defendants: (1) submitted, or caused to be submitted, thousands of false claims for Day Habilitation services to Medicaid; and (2) failed to report and return hundreds of thousands of dollars of overpayments associated with Day Habilitation services to Medicaid.

FIRST CLAIM

Violations of the False Claims Act: Presenting False Claims for Payment

31 U.S.C. § 3729(A)(1)(A)

51. The United States incorporates by reference each of the preceding paragraphs as if fully set forth herein.

52. The United States asserts claims against Defendants under 31 U.S.C. § 3729(a)(1)(A).

53. As a result of the improper practices set forth above in connection with the provision and billing of Day Habilitation services to Medicaid, Defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(A).

54. If Medicaid had known about the improper practices set forth above, it would have not paid the claims.

55. Defendants presented or caused to be presented these claims with actual knowledge of their falsity, or in deliberate ignorance or reckless disregard of whether or not they were false.

56. By reason of the false or fraudulent claims, the United States 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)

57. The United States incorporates by reference each of the preceding paragraphs as if fully set forth herein.

58. The United States asserts claims against the Defendants under 31 U.S.C. § 3729(a)(1)(B).

59. As a result of the improper practices set forth above in connection with the provision and billing of Day Habilitation services to Medicaid, Defendants made and used, or caused to be made and used, false records and statements that were material to the payment of false or fraudulent claims by Medicaid in violation of 31 U.S.C. § 3729(a)(1)(B). These false

records and statements include but are not limited to false statements that services were delivered and documented in accordance with the OPWDD Requirements and false certifications that the claims complied with applicable laws, regulations, and program instructions.

60. Defendants made, used, or caused to be made and used, these false records and statements with actual knowledge of their falsity, or in deliberate ignorance or reckless disregard of whether or not they were false.

61. By reason of the false or fraudulent claims, the United States 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)

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

63. The United States asserts claims against the Defendants under 31 U.S.C. § 3729(a)(1)(G).

64. As a result of the improper practices set forth above, Defendants knowingly made, used, or caused to be made or used, false records and/or statements material to an obligation to pay or transmit money or property, in the form of overpayments, to Medicaid, and knowingly concealed and knowingly and improperly avoided or decreased an obligation to pay or transmit money or property, in the form of overpayments, to Medicaid, in violation of 31 U.S.C. § 3729(a)(1)(G).

65. By reason of Defendants' failure to report and return such overpayments, the United States 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

66. The United States incorporates by reference each of the preceding paragraphs as if fully set forth herein.

67. Through the acts set forth above, Defendants have received Medicaid reimbursements to which they were not entitled and therefore have been 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 are to be determined at trial.

FIFTH CLAIM

Payment by Mistake

68. The United States incorporates by reference each of the preceding paragraphs as if fully set forth herein.

69. The United States seeks relief against Defendants to recover monies paid under mistake of fact.

70. The United States paid claims for Day Habilitation services provided to Medicaid beneficiaries based on the mistaken and erroneous belief that delivery and documentation of those services complied with the applicable OPWDD Requirements and requirements of Medicaid. These erroneous beliefs were material to the determination to pay for the claims submitted.

71. By reason of the foregoing, the United States has been damaged in a substantial amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, the United States respectfully requests judgment to be entered in its favor as follows:

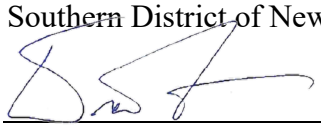
(i) On Counts One, Two, and Three (FCA violations), a sum equal to treble the United States' damages in an amount to be determined at trial, civil penalties to the maximum extent allowed by law, and an award of costs pursuant to 31 U.S.C. § 3729(a).

(ii) On Counts Four and Five (Unjust Enrichment and Payment by Mistake), a sum equal to the damages as allowed by law.

(iii) Such further relief as the Court may deem proper.

Dated: March 25, 2025
New York, New York

MATTHEW PODOLSKY
Acting United States Attorney for the
Southern District of New York



DAVID E. FARBER
Assistant United States Attorney
86 Chambers Street, Third Floor
New York, New York 10007
(212) 637-2772
david.farber@usdoj.gov

Counsel for the United States