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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA *ex rel.* DAVID HEISLER; and STATE OF NEW YORK *ex rel.* DAVID HEISLER, Plaintiffs, - against - CENTERLIGHT HEALTHCARE and CENTERLIGHT HEALTH SYSTEM, Defendants.	:	**13 Civ. 8502 (LAK)(GWG)**
UNITED STATES OF AMERICA, Plaintiff-Intervenor, - against - CENTERLIGHT HEALTHCARE, INC. Defendant.	:	**COMPLAINT-IN-INTERVENTION OF THE UNITED STATES**

The United States of America (the "United States" or the "Government"), by its attorney Geoffrey S. Berman, United States Attorney for the Southern District of New York, having filed a Second Notice of Partial Intervention pursuant to 31 U.S.C. §§ 3730(b)(2) and (4), alleges for its Complaint-In-Intervention as follows:

PRELIMINARY STATEMENT

1. The Government brings this Complaint-In-Intervention seeking damages and penalties against CenterLight Healthcare, Inc. ("CenterLight Healthcare" or "Defendant") under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* (the "FCA"), and the common law for unjust enrichment. As set forth more fully below, from April 1, 2012 to September 30, 2015 (the "Relevant Period"), CenterLight Healthcare (a) submitted or caused to be submitted false claims to Medicaid for monthly capitation payments for 186 CenterLight Managed Long-Term Care Plan members who resided in adult homes and who, for at least some portion of their enrollment in the CenterLight Managed Long-Term Care Plan, did not receive required community-based long-term care services and therefore were not eligible for the CenterLight Managed Long-Term Care Plan (the "186 Adult Home MLTCP Members"); and (b) knowingly avoided reimbursing Medicaid for capitation payments that CenterLight Healthcare received for many of the 186 Adult Home MLTCP Members after CenterLight Healthcare became aware that such members should have been dis-enrolled at an earlier date and that it was not entitled to those payments.

JURISDICTION AND VENUE

2. This Court has subject matter jurisdiction over the Government's FCA claims pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C. §§ 1331 and 1345, and over the Government's common law claim pursuant to 28 U.S.C. § 1345.

3. This Court may exercise personal jurisdiction over Defendant, and venue is proper in this District pursuant to 31 U.S.C. § 3732(a) as well as 28 U.S.C. § 1391(b) because Defendant resides and transacts business in this District and a substantial part of the acts complained of took place in this District.

PARTIES

4. 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, and its component agency, the Centers for Medicare and Medicaid Services.

5. Defendant CenterLight Healthcare is a New York not-for-profit corporation that administered a Managed Long-Term Care Plan (the "CenterLight MLTCP") pursuant to a Managed Long-Term Care Partial Capitation Model Contract (the "MLTC Contract") with the New York State Department of Health ("DOH"). Under the MLCT Contract, CenterLight Healthcare was required to arrange for community-based long-term care services ("CBLTC services") for beneficiaries of the New York State Medicaid Program who enrolled in the plan.

6. Relator David Heisler ("Heisler") is a licensed clinical social worker who currently resides in Philadelphia, Pennsylvania. On or about November 27, 2013, Heisler filed an action under the *qui tam* provisions of the FCA, alleging, *inter alia*, that CenterLight Healthcare improperly enrolled individuals who were not eligible for membership in the CenterLight MLTCP.

The False Claims Act

7. The FCA reflects Congress's objective to "enhance the Government's ability to recover losses as a result of fraud against the Government." S. Rep. No. 99-345, at 1 (1986).

8. As relevant here, the FCA establishes civil penalties and treble damages liability to the United States for an individual or entity that:

i. "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a)(1)(A); or

ii. "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government," *id.* § 3729(a)(1)(G).

9. "Knowingly," within the meaning of the FCA, is defined to include reckless disregard of, or deliberate indifference to, the truth or falsity of information. *Id.* § 3729(b)(1). An "obligation," under the statute, includes the "retention of any overpayment." *Id.* § 3729(b)(3).

10. 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 [Title XVIII or XIX] to which the person, after applicable reconciliation, is not entitled under such subchapter." 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." 42 U.S.C. § 1320a–7k(d)(2). Failure to return any overpayment constitutes a reverse false claim actionable under section 3729(a)(1)(G) of the FCA.

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

Medicaid and the Medicaid Managed Long-Term Care Program

12. 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 individuals with low incomes to enable them to receive medical care. Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates, and program administration in accordance with certain federal statutory and regulatory requirements. The state directly pays health care plans or providers for

services rendered to Medicaid recipients, with the state obtaining the federal share of the Medicaid payment from accounts that draw on the United States Treasury. *See* 42 C.F.R. §§ 430.0 *et al.*

13. In New York, Medicaid is administered at the state level by DOH. *See* N.Y. Pub. Health Law § 201(1)(v).

14. New York Medicaid regulations require plans and providers to "submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons." 18 N.Y.C.R.R. § 504.3(e).

15. Medicaid recipients in New York enroll in managed care plans administered by Managed Care Organizations ("MCOs") that provide medical care and other services. New York's Medicaid program is transitioning into a "managed care" system operating through the MCOs rather than a traditional "fee for service" program, where the State makes payments directly to the servicing provider.

16. MCOs operate Managed Long-Term Care Plans ("MLTCPs"), like the CenterLight MLTCP, and receive monthly capitation payments for each member enrolled in the MLTCP in exchange for arranging and providing CBLTC services. During the Relevant Period, the monthly capitation payment for a CenterLight MLTCP member was generally $3,600 - $3,800.

17. The requirements for an MLTCP are set out in the MLTC Contract. CenterLight Healthcare entered into an MLTC Contract with DOH.

18. During much of the Relevant Period, CenterLight Healthcare, like other MLTCPs, was responsible for using a standardized assessment instrument to assess an applicant's

eligibility for enrollment.[1] *See* 2012 Model MLTC Contract Art. IV(B)(4). The MLTCP is required to conduct a comprehensive reassessment of the member at least every six months to verify the member's ongoing managed long-term care eligibility. *Id.* at Art. V(J)(5).

19. Among other requirements, to be eligible for managed long-term care, an applicant must be assessed as needing CBLTC services, as specified by the MLTC Contract, for more than 120 days from the effective date of enrollment. CBLTC services include, but are not limited to, nursing services in the home, therapies in the home, home health aide services, personal care services in the home, and adult day health care. *Id.* at Art. IV(B)(6).

Defendant's Fraudulent Conduct

20. During the period from March 2012 through early 2014, the CenterLight MLTCP enrolled hundreds of Medicaid beneficiaries who resided in adult homes. CenterLight Healthcare was required to ensure that these adult home residents received medically necessary health and CBLTC services. In exchange, CenterLight Healthcare received monthly capitation payments from Medicaid.

21. In order to provide skilled nursing and home health aide services to CenterLight MLTCP members who resided in adult homes, CenterLight Healthcare contracted with several licensed home care services agencies ("LHCSAs").

22. CenterLight Healthcare failed to adequately oversee and monitor the care provided by these LHCHAs. CenterLight Healthcare did not ensure that the LHCSAs consistently provided required CBLTC services to CenterLight MLTCP members who resided in adult homes, and failed to ensure that these vulnerable members' medical needs were met.

[1] In late 2014, a state contractor, Maximus, started to assume the responsibility for determining an individual's initial managed long-term care eligibility.

CenterLight Healthcare was aware that some of the LHCHAs provided a substandard level of care and did not maintain proper documentation reflecting the services provided, but failed to promptly take necessary steps to address these issues.

23. With respect to the 186 Adult Home MLTCP Members, CenterLight Healthcare submitted or caused to be submitted claims to Medicaid for capitation payments for months where no CBLTC services were provided to the member. Indeed, many of the 186 Adult Home MLTCP Members did not receive any CBLTC services for most of the months during which they were enrolled in the CenterLight MLTCP. If Medicaid had known that the 186 Adult Home MLTCP Members were not receiving CBLTC services, it would have not made capitation payments to CenterLight Healthcare for these members.

24. CenterLight Healthcare failed to timely dis-enroll the 186 Adult Home MLTCP Members even though they were no longer eligible for the CenterLight MLTCP. As a result, CenterLight Healthcare received capitation payments to which it was not entitled.

25. In 2014, CenterLight Healthcare conducted a "reassessment project" designed to determine whether CenterLight MLTCP members residing in adult homes should remain in the plan or whether their needs could instead be adequately met by the care available in the adult home. As a result of this review, over 200 CenterLight MLTCP members were dis-enrolled from the plan, including many of the 186 Adult Home MLTCP Members. CenterLight Healthcare knew that a number of these members should have been dis-enrolled earlier because they were not eligible for managed long-term care, and that it was not entitled to capitation payments it had previously collected for these members. However, despite this knowledge of overpayments from Medicaid, CenterLight Healthcare fraudulently retained these funds and made no attempt to advise Medicaid that the members should have been dis-enrolled earlier.

FIRST CLAIM

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

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

27. The United States seeks relief against Defendant under 31 U.S.C. § 3729(a)(1)(A).

28. Through the acts set forth above, CenterLight Healthcare knowingly, or acting with deliberate ignorance or reckless disregard for the truth, presented, or caused to be presented, false or fraudulent claims to Medicaid for capitation payments for the 186 Adult Home MLTCP Members who were not eligible for managed long-term care.

29. The Government made capitation payments to CenterLight Healthcare under the Medicaid program because of the false or fraudulent claims.

30. 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: Failure to Repay Government Funds (31 U.S.C. § 3729(a)(1)(G))

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

32. The United States seeks relief against Defendant under 31 U.S.C. § 3729(a)(1)(G).

33. Through the acts set forth above, CenterLight Healthcare 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 to Medicaid the capitation payments it received for the 186 Adult Home MLTCP Members once CenterLight Healthcare became aware that such members should have been dis-enrolled and that it therefore was not entitled to those payments.

34. By reason of CenterLight Healthcare's 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.

THIRD CLAIM

Unjust Enrichment

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

36. Through the acts set forth above, CenterLight Healthcare has received managed long-term care monthly capitation payments to which it was not entitled and therefore was unjustly enriched. The circumstances of these payments are such that, in equity and good conscience, CenterLight Healthcare 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 in its favor against Defendant as follows:

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

b. On the Third Claim (Unjust Enrichment), a sum equal to the damages to be determined at trial, along with costs and interest;

c. Granting the United States such further relief as the Court may deem proper.

Dated: March 27, 2018
New York, New York

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