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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 - VNSNY CHOICE *et al.*, Defendants.	:	**13 Civ. 4261(RA)(SN)**
UNITED STATES OF AMERICA, Plaintiff-Intervenor, - against - VNS CHOICE; VNS CHOICE COMMUNITY CARE; and VISITING NURSE SERVICE OF NEW YORK, Defendants.	:	**COMPLAINT-IN-INTERVENTION OF THE UNITED STATES**

The United States of America (the "United States" or the "Government"), by its attorney Joon H. Kim, Acting 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 VNS Choice d/b/a VNSNY Choice, VNS Choice Community Care, and Visiting Nurse Service of New York (collectively "Defendants") 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, Defendants submitted claims to Medicaid for monthly capitation payments for VNS Choice Managed Long-Term Care Plan members to which they were not entitled, and knowingly avoided reimbursing Medicaid for payments they had improperly received, by engaging in the following conduct: (a) failing to timely disenroll 365 members of the VNS Choice Managed Long-Term Care Plan ("the 365 Ineligible Members") from January 1, 2011 to March 31, 2015, and improperly collecting capitation payments for the 365 Ineligible Members for the months following the date each member should have been disenrolled; and (b) with respect to some of the 365 Ineligible Members, failing to reimburse Medicaid for capitation payments after becoming aware that the members should have been disenrolled at an earlier date and that Defendants were not entitled to these payments.

JURISDICTION AND VENUE

2. This Court has subject matter jurisdiction over the Government's FCA claim 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 Defendants, 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 at least one of the Defendants 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 Visiting Nurse Service of New York ("VNSNY") is a New York not-for-profit corporation with its principal place of business in New York, New York. VNSNY is organized to provide home and community-based health care and supportive services, and provides support to its affiliated organizations, including VNS Choice and VNS Choice Community Care.

6. Defendant VNS Choice is a New York not-for-profit corporation with its principal place of business in New York, New York. VNS Choice administers managed health care plans available to residents of the New York City metropolitan area and certain upstate areas. In particular, VNS Choice administers a Managed Long-Term Care Plan (the "Choice MLTCP") for Medicaid beneficiaries under which it arranges for health and long-term care services on a capitated basis pursuant to a Managed Long-Term Care Partial Capitation Model Contract ("MLTC Contract") with the New York State Department of Health ("DOH").

7. Defendant VNS Choice Community Care ("Choice Community Care") is a New York not-for-profit corporation with its principal place of business in New York, New York. Until January 2015, when it relinquished its home care services agency license to DOH, Choice Community Care furnished care management and home health care services to members of the Choice MLTCP. VNS Choice is the sole corporate member of Choice Community Care.

8. Relator David Heisler ("Heisler") is a licensed clinical social worker and a former employee of Defendants. On or about June 20, 2013, Heisler filed an action under the *qui tam*

provisions of the FCA, alleging, *inter alia*, that VNS Choice failed to disenroll individuals who were no longer eligible for the Choice MLTCP. Heisler filed an amended complaint on or about January 6, 2014. Heisler currently resides in Philadelphia, Pennsylvania.

The False Claims Act

9. 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).

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

11. "Knowingly," within the meaning of the FCA, is defined to include reckless disregard, 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).

12. 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 subchapeter." 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.

13. 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

14. 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 the 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.*

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

16. 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).

17. New York's Medicaid program is transitioning into Managed Care, a New York State-sponsored health insurance program for people who have little or no income and are eligible for Medicaid. Medicaid recipients enroll in Managed Care plans administered by Managed Care Organizations ("MCOs") that provide medical care and other services.

18. Pursuant to Title 19, Section 1932 of the Social Security Act, New York has established a Medicaid managed long-term care program. MCOs operate Managed Long-Term Care Plans ("MLTCPs"), like the Choice MLTCP, and receive monthly capitation payments for each member enrolled in the MLTCP in exchange for arranging and providing certain community-based long-term care services, such as care management, skilled nursing services, physical therapy, speech therapy, occupational therapy, and preventive services. During the relevant period, the monthly capitation payment for a Choice MLTCP member was generally $3,800 - $4,200.

19. The requirements for an MLTCP are set out in the MLTC Contract. VNS Choice entered into an MLTC Contract with DOH.

20. During much of the relevant period, VNS Choice, 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).

21. Among other requirements, to be eligible for managed long-term care, an applicant must be assessed as needing community-based long-term care services, as specified by the MLTC Contract, for more than 120 days from the effective date of enrollment. Community-based long-term care 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, or adult day health care. *Id.* at Art. IV(B)(6).

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

22. The MLTC Contract sets forth various circumstances under which the plan must disenroll a member. *Id.* at Art. V(D). For example, the plan must initiate disenrollment within five business days from the date the plan knows a member no longer resides in the service area, a member has been absent from the service area for a specified number of consecutive days[2], a member is hospitalized for 45 consecutive days or longer, a member is no longer eligible to receive Medicaid benefits, or a member is no longer eligible for the MLTCP based on the last comprehensive assessment of the member's condition and needs. *Id.* at Art. V(D)(4). The plan also must initiate the disenrollment of MLTCP members who voluntarily request to be disenrolled.

Defendants' Improper Conduct

23. During the period January 1, 2011 through March 31, 2015, VNS Choice failed to timely disenroll 365 Choice MLTCP members as required by the MLTC Contract and regulatory requirements. As a result, Defendants improperly continued to collect monthly capitation payments for these members. In many instances, Defendants continued to collect capitation payments for several months after the date the member should have been disenrolled, during which time VNS Choice provided no health care services to the member.

24. Approximately half of the subject 365 Ineligible Members moved out of the VNS Choice service area or left the service area for extended periods of time, which triggered the disenrollment obligation. VNS Choice knew that many of these members had left the service area and were no longer receiving services, but still continued to receive and retain the monthly capitation payments for the these members.

[2] The specified period was 60 consecutive days under the contact in place through 2011, and was changed to 30 consecutive days in the 2012 contract that remains in effect.

25. Other members notified VNS Choice of their desire to disenroll from the Choice MLTCP or repeatedly refused services but were not timely disenrolled. For example, one member requested to be disenrolled in May 2013 and did not receive any services thereafter, but VNS Choice did not disenroll her until March 2014. Defendants improperly received over $35,000 in capitation payments as a result of this delay.

26. VNS Choice also failed to promptly disenroll members after determining that they no longer met managed long-term care eligibility criteria based on a comprehensive reassessment. For example, although VNS Choice concluded in July 2013 that one member no longer required the level of community-based long-term services to be eligible for the MLTCP, VNS Choice did not disenroll the member until December 2013. Defendants improperly received over $14,000 in capitation payments as a result of this delay.

27. On occasion, VNS Choice also failed to timely disenroll members who had died or who had been hospitalized for 45 or more days, as required under the MLTC Contract. As a result of not timely disenrolling these members, Defendants improperly received over $200,000 in capitation payments to which they were not entitled.

28. Although Defendants ultimately — albeit belatedly — disenrolled the 365 Ineligible Members, they never reimbursed Medicaid for the monthly capitation payments that were improperly received for these members. Defendants often knew that the member should have been disenrolled earlier and that they therefore were not entitled to the most recent capitation payments. However, despite this knowledge of the overpayments from Medicaid, Defendants failed to take steps to return these funds to Medicaid, and did not advise Medicaid that the members should been disenrolled earlier.

FIRST CLAIM

Violations of the False Claims Act: Failure to Repay Government Funds (31 U.S.C. § 3729(a)(1)(G))

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

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

31. Through the acts set forth above, Defendants knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government, by knowingly failing to repay to Medicaid the capitation payments received for Choice MLTCP members once Defendants became aware that such members should have been disenrolled and that Defendants therefore were not entitled to those payments.

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

SECOND CLAIM

Unjust Enrichment

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

34. Through the acts set forth above, Defendants have received managed long-term care monthly capitation payments to which they were not entitled and therefore were unjustly enriched. The circumstances of these payments are such that, in equity and good conscience, Defendants should not retain those payments, the amount of which is to be determined at trial.

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

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

b. On the Second 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: July 14, 2017
New York, New York

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