No. __-____

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA,
EX REL. ANDREW GELBMAN,

Petitioner,

v.

CITY OF NEW YORK, NEW YORK CITY HEALTH
AND HOSPITALS CORPORATION,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

When a Petitioner invokes the False Claims Act (FCA), 31 U.S.C. § 3729 et seq. (Pet. App. 119a-156a), to assert that the Federal Government ("the Government") has been defrauded, it is well-settled that a plaintiff-relator must plausibly allege that an untrue statement or claim was made to the Government to gain a benefit under a federal benefits program, e.g. Medicaid program reimbursements. See § 3729(b)(2)(A) (Pet. App. 121a); *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 1996 (2016).

The Second Circuit determined that Petitioner failed to allege sufficient specificity in its Second Amended Complaint and dismissed the same pursuant to FRCP 9(b) and 12(b).

The first question presented is: whether the pleading standard should be different for False Claims Act claims against public sector Medicaid providers than it is for such claims against private sector Medicaid providers.

The second question presented is: whether the Second Circuit erred in drawing all inferences in favor of Respondents rather than drawing all reasonable inferences in favor of Petitioner.

The third question presented is: whether the scheme of fraud by The City of New York against the Government as set forth in Petitioner's Second Amended Complaint ((Pet. App. 1a-52a) "SAC") represents a plausible claim sufficient to avoid dis-

missal as per the standards set forth by this Court in *Ashcroft v. Iqbal*, 129 S. Ct. 1937 (2009), *Bell Atlantic Corp. v. Twombly*, 127 S. Ct. 1955 (2007), *Escobar*, 136 S. Ct. 1989, 1996 (2016) and FRCP 9(b).

PARTIES TO THE PROCEEDING

As per Rule 14.1(b), a list of all parties to the proceeding in the court whose judgment is sought to be reviewed is contained in the caption of the case.

CORPORATE DISCLOSURE STATEMENT

Not applicable. Appellant-relator is not a corporation.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner United States of America, ex rel. Andrew Gelbman, respectfully petitions this Court for a writ of certiorari to review the decision of the United States Court of Appeals for the Second Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals is unreported but is contained at Pet. App. 77a.

The district court's opinion dismissing the second amended complaint is unreported but is contained at Pet. App. 94a.

JURISDICTIONAL STATEMENT

The United States Court of Appeals for the Second Circuit entered its opinion and judgment on October 17, 2019. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

RELEVANT STATUTE & REGULATIONS

This petition involves provisions of the False Claims Act, 31 U.S.C. §§ 3729-33, as well as regulations involving the submission and payment of Medicaid claims to the United States of America. The relevant provisions are reproduced at Pet. App. 119a-157a.

INTRODUCTION

This case is different than virtually every other case ever brought under the modern-day False Claims Act.[1] The dispositive difference here is that multiple public actors, not *private* actors, falsely submitted 22,782,174 distinct claims, amounting to $14,222,457,278 in federal funds, as properly payable, when in fact they all contained fatal defects that should have resulted in their denial. These defects were known to all the governmental actors in question except for the United States.

In administering the Medicaid program, the United States has historically relied on the truthfulness of other governmental actors and, indeed, the program continues to rely on such truthfulness.

Atypical medical false claim involves a private actor, such as a health care provider, that submits a claim containing some infirmity or defect, and disguises the same to mislead the Government in order to obtain reimbursement or payment. See *U.S. ex rel. Chorches v. Am. Med. Response, Inc.*, 465 F.3d 71 (2nd Cir. 2017). Whether the misconduct is committed by a private or public actor is irrelevant to the standard of review. See *U.S. ex*

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[1] Cf. *U.S. ex rel. Feldman v. City of New York*, 808 F.Supp. 2d 641 (SDNY 2011) [making a false or fraudulent statement in support of claim submitted to the Federal government is sufficient to sustain a False Claim action for the purposes of § 3729(a)(1)(B) of the FCA.]; See also, *U.S. ex rel. Forcier v. CSC et al.*, 183 F.Supp 3d 510 (SDNY 2016). In both cases the same standard to applied public and private actors.

rel. Forcier v. CSC, et al., 183 F.Supp. 3d 510 (SDNY 2016). In both of the above cases, the same standard of review was applied to applied public and private actors. Here, it is the New York City government and the New York City-controlled Health and Hospitals Corporation (HHC) [hereinafter referred to collectively as the City of New York] with the connivance of the State government, acting to mislead the Federal government, resulting in massive and systematic fraudulent payments to the City. The City of New York operates the largest public health system in the nation, but it is only one of many across the country. No private actor would be permitted to subsidize their operations by defrauding the public insurance system, and neither should any public health system.

The Second Circuit Court of Appeals erred in failing to apply the same FCA pleading standard that they have previously applied in cases involving *private* bad actors who have defrauded Medicaid. See *U.S. ex rel. Chorches v. Am. Med. Response, Inc.*, 465 F.3d 71 (2nd Cir. 2017). In *Chorches*, the relator was an employee of a private actor who had inside knowledge of fraudulent activities related to claims made to Medicaid. In finding the *Chorches* claim sufficiently pleaded to survive a Rule 9(b) challenge, the court explained why it was not necessary for a relator to have knowledge of the entire lifecycle of the fraudulent scheme and that all reasonable inferences should be drawn in the relator's favor. *Chorches*, 865 F.3d at 78.

Strikingly, in the instant case, the court applied the *reverse* of the *Chorches* standard to the defendant public actors. Here, the court drew inferences in favor of the Respondents and their provider public hospitals. It beggars belief to presume that public actors should be held to a different standard than private actors and to do so is at odds with the legislative purpose of the FCA.

The False Claims Act (FCA), 31 U.S.C. § 3729 et seq., applies to those "who defraud the [Federal] Government." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 1995 (2016). It creates a cause of action for the submission of false claims for payment, and it allows private individuals to share in the recovery by filing suits on the Federal Government's behalf. *Id*. § 3730(b), (d).

This Court should grant the petition to address the Court of Appeals' application of a pleading standard that improperly drew inferences in favor the Respondents, which are governmental actors, not private actors. The Court of Appeals erroneously held the relator to a standard different than that in *Chorches* because the relator's knowledge deals with reported claim information rather than discussions within the billing provider(s). This Court should grant the petition to ensure that *Escobar's* rule operates uniformly, whether the defendant is public or private.

STATEMENT

Relator-Appellant Andrew Gelbman, a New York State Department of Health Information Technology Specialist II, gained first-hand knowledge of a massive scheme to defraud the United States of America in the course of his regular job responsibilities that included computer interrogation of the New York State Health Department's Medicaid Data Warehouse as well as attendance and participation in meetings regarding changes, and updates to, and maintenance of eMedNY—New York's Electronic Medicaid Claims Processing and Adjudication System. Mr. Gelbman became aware of a scheme by the Respondents City of New York and New York City Health and Hospitals Corporation via fraudulent Medicaid claims totaling over $14 billion which were paid but which should not paid. This scheme was hatched at the aforementioned 'Evolution Process Meetings' where changes and updates to eMedNY were routinely discussed between stakeholders, including the City of New York, and authorized by the State of New York.

The District Court granted the Respondents' motion to dismiss, see *United States of America ex rel. Gelbman v. City of New York*, No. 14-cv-00771 (S.D.N.Y. September 30, 2018), and a panel of the Court of Appeals for the Second Circuit affirmed in a summary order, see *United States of America ex rel. Gelbman v. City of New York*, No. 18-3162 (2d Cir. October 17, 2019) (Pet. App. 77a).

The Second Circuit's determination effectively frustrates the purpose of the False Claims Act to discourage fraudulent claims by a local government against the Federal Government, and is also contrary to their own recent precedent. *United States of America, ex rel. Chorches v. American Medical Response, Inc.*, 865 F.3d 71 (2d Cir. 2017).

This case involves issues of exceptional importance, regarding the pleading standard applicable in False Claims actions asserted against public sector defendants, to wit:

1. Whether a relator's claims against a *public sector* defendant are entitled to every reasonable favorable inference that can be drawn from the complaint.
2. Whether the pleading standard should be different for claims against public sector Medicaid providers than it is for private sector Medicaid providers, and
3. Whether a relator must have information regarding the genesis of the fraud or whether information regarding the execution of the fraud is equally sufficient to withstand a motion to dismiss.

Here, the fraud claimed consisted of multiple successful efforts by the City of New York to induce the State of New York to turn off algorithms designed to prevent the payment of ineligible Medicaid claims.

The typical case of a *private* health care system defrauding the United States was addressed by this Court in *Universal Health Servs. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016). There are, however, many *public* health care systems across the United States. Here, the largest public health care system in the nation submitted millions of claims for billions of dollars of Federal money over an extended period of years.

There is no logical reason why the standard set for private entities in *Escobar* should not apply to public entities such as the instant defendants. This egregious disregard of the public fisc of the United States of America, and the governing regulations of the State of New York upon which the United States relied in making the payments at issue merits close attention, and is of national import.

I. The Pleading Standard Set in *Iqbal, Twombley*, and *Chorches* Does Not Require a Plaintiff-Relator to Recite Every Manner in which False Claims were Submitted to Survive a Motion to Dismiss under FRCP 9(b). Instead, it Requires a Baseline of Plausibility, which the Court of Appeals Turned into a Virtual Bar.

A. Second Circuit Had Earlier Applied a Single, Sound Pleading Standard for False Claims Against Both Public and Private Actors.

Chorches made it clear that Rule 9(b) does not require a qui tam complaint to provide details of

actual bills or invoices submitted to the government, so long as the relator makes plausible allegations that lead to a strong inference that specific claims were indeed submitted and that information about the details of the claims submitted are peculiarly within the opposing party's knowledge. *Chorches*, 865 F.3d at 93.

Moreover, the Chorches court took notice that this view was consistent with the standards set in the Third, Fifth, Seventh, Ninth and Tenth and D.C. Circuits. *Chorches*, 865 F.3d. at 89-92. However, the same court found the First, Fourth, Sixth, Eighth, and Eleventh Circuits took somewhat different views, although ultimately not finding those views to be inconsistent with their holding. *Id*.

In the instant case, in its SAC (Pet. App. 1a-52a), Petitioner provided the actual data of claims submitted by Respondents which had been presented to the Federal government for payment. (Pet. App. 28a-40a) SAC ¶98-143. This information was taken directly by Petitioner from the New York State Medicaid Data Warehouse and provided details of actual billing submitted to the Government. *Id*. The source of said data was the submissions made by Respondents themselves. *Id*. Thus, the data *must* have been within the Respondents' peculiar knowledge. See *Chorches*, 865 F.3d at 93.

The Second Circuit found an infirmity warranting dismissal because Petitioner did not allege personal knowledge of the Expense Reports submitted to the Federal government containing the alleged

False Claims. However, the Second Circuit failed to acknowledge that the claims described by Petitioner were actual False Claims *paid* by the Federal Government and thus unwittingly erected a barrier inconsistent with the earlier precedent of the Second Circuit. In any event, Petitioner exceeded the standard erected in *Chorches* by providing claims data containing millions of false claims which were in fact, paid by the Federal Government. (Pet. App. 28a-40a) SAC ¶ 98-143, Ex. C (Pet. App. 54a). The Petitioner thus relied on *actual* claims rather than mere inference or speculation.

In *U.S. ex rel. Feldman v. City of New York*, 808 F.Supp. 2d 641, the SDNY found that it was sufficient to allege that the defendant in a False Claim action both made a false statement and a claim for payment from the Federal government to withstand a motion to dismiss. *Feldman*, F.Supp.2d at 655-56.

Here, the Petitioner provided numerous examples of false statements made by Respondents made in direct support of claims for payment made to the Federal government. SAC ¶ 98-143 (Pet. App. 28a-40a).

B. The Order Erects a New Standard that Largely Disarms Citizen-Attorney Generals under The False Claims Act.

It is a long-settled matter of law that FRCP 12(b)(6) requires a plausible allegation on the part of the Petitioner. *Ashcroft v. Iqbal*, 129 S. Ct. 1937

(2009), *Bell Atlantic Corp. v. Twombly*, 127 S. Ct. 1955 (2007).

It is also-well established that Rule 9(b) requires the court to accept all of Petitioner's factual allegations as true and to draw all reasonable inferences in Petitioner's favor. *Chorches*, 865 F.3d at 78 (Citing *Trs. of Upstate N.Y. Eng'rs v. Ivy Asset Mgmt.*, 843 F.3d 561, 566 (2nd Cir 2016); *Iqbal*, 129 S. Ct. at 1937; *Twombly*, 127 S. Ct. at 1955.)

New York's regulations requires a similar presumption regarding overpayments, to wit: 18 NYCRR § 519.18(g) provides that valid extrapolation from a statistical sampling creates a presumption, in the absence of evidence to the contrary, that such extrapolation is an accurate determination of total overpayments made.

In *Chorches*, also brought under the False Claims Act, 31 USC § 3729-3733, employees were instructed to prepare claims forms with false claims data to wrongfully maximize Medicare reimbursements. The workers who filled out the forms were clearly not themselves submitting the false billings to the Government. *Chorches*, 865 F.3d at 75-76.

In the instant matter, the SAC is clear that Petitioner, himself, had full and complete knowledge of the information contained in the claims defendants submitted (e.g., when medical services were provided, how much was billed, how much the USA paid, what services were rendered, etc.), and which was particularized in the SAC and Ex. C of same in

great detail, down to the dollar. SAC ¶ 98-143 (Pet. App. 28a-40a); Ex. C (Pet. App. 54a).

Contrary to the factually incorrect supposition by the Court of Appeals in this matter (Pet. App. 81a-82a, 84a), the fraudulent payments made for exemplar claims described in exacting detail in SAC and summarized in Exhibit C of the SAC are *actual totals of paid Medicaid claims*, and are *not* merely estimates. SAC ¶ 98-143, (Pet. App. 28a-40a), Ex. C (Pet. App. 54a).

Respondents do not dispute or negate the overpayments alleged in the SAC (e.g., Pet. App. 54a, attached as an Exhibit to the SAC) and are certainly not entitled to any inference of eMedNY error or correctable submission as speculated by the Second Circuit. (e.g., Pet. App. 87a). Contrary to the panel's ruling here, Petitioner has demonstrated that it has satisfied the standard set by an entirely different panel of the Second Circuit in *Chorches* (and under 18 NYCRR § 519.18(g)) that requires all reasonable and plausible inferences to be granted to Petitioners. *Chorches*, 865 F.3d at 78. This includes that the overpayments alleged in the SAC (Pet. App. 54a) were valid and undisputed. 18 NYCRR § 519.18(g).

Furthermore, as an employee of NYSDOH, Petitioner had first-hand knowledge of defendants' successful attempts to manipulate algorithms put in place to detect defective claims as defined by applicable law and regulation known as "edits." Respondents ensured the edits in question were set to 'pay

and report' rather than 'pend' or 'deny'—in effect turned off. SAC ¶13, 16, 63, and 65 (Pet. App. 6a, 7a, and 20a). While Petitioner did not have specific knowledge of the policy decisions made by Respondent-Appellants at higher levels to manipulate the edits, Petitioner did have specific knowledge that the edits *were* altered at the behest of Respondents. This comports squarely with the holding in *Chorches* that the typical relator cannot be expected to be present at every stage of the fraud. *Chorches*, 865 F.3d at 86.

Appellant-relator had firsthand knowledge that the edits *were* altered at the behest of Respondents and pre-trial discovery would further detail petitioner's plausible contentions. *Chorches* requires a common-sense approach, without which many if not most, frauds would never be able to be redressed in Court. *Chorches*, *Id*.

Incredibly, Respondents have never disputed that a massive looting of the public fisc indeed occurred. Petitioner's figures—obtained by virtue of his untrammeled access to the New York State Department of Health Data Warehouse as a New York State employee—in fact, demonstrate this occurred. It beggars belief to assume that so many billions of dollars paid for so many millions of claims over such an extended period of years were mere accidents or errors. Pet. App. 87a. Likewise, the panel's incorrect characterization of these amounts as "estimates" rather than as actual amounts goes to the heart of their determination that the SAC (Pet. App. 1a-52a) was insufficiently

particular in order to survive the Respondents' motion to dismiss. (Pet. App. 84a).

In fact Petitioner is entitled to a reasonable inference that a material fraud against the United States took place, because Petitioner calculated and provided the actual amount of $14,222,457,278 for 22,782,174 distinct false claims presented to the United States by the Respondents over a period of six (6) years. SAC, ¶ 165-166 (Pet. App. 46a); Ex. C to SAC (Pet. App. 54a). Further, no inference need to have been made regarding a tacit agreement to turn off edits where, in fact, the relator had actual first-hand knowledge of requests by the City to the State to turn off certain edits and that the same were, in fact, turned off. (see infra, Sec B, p 9.)

These actions facilitated these improper payments, including the Federal share of those payments, resulting in a material fraud against the Federal government. The summary order failed to make the reasonable inference that said claims resulted in massive fraud to the public fisc of the United States. Instead, the order joins the Respondents in unsupported speculation and draws inferences in favor of the defendant.

In so doing, the Second Circuit has unwittingly unleashed a new standard for public health care providers that will effectively nullify the legislative intent of the False Claims Act, which has to date resulted in the recovery of billions of dollars for the United States of America since its 1986 amendments. *U.S. ex rel. Dick v. Long Island Lighting*

Co., 912 F.2d 13 (2nd Cir. 1990) [purpose of the Qui Tam provisions of the False Claims Act is to encourage private individuals who aware of fraud being perpetrated against the government to bring such information forward.]

1. The SAC details how Respondent Induced Alteration of eMedNY's Computer Algorithms.

The panel found that Petitioner did not "detail how eMedNY was rigged (e.g., by altering eMedNY's computer algorithms. . ."). (Pet. App. 86a). Yet that is precisely what the SAC did. SAC ¶58-62 (Pet. App. 19a). The SAC describes an edit as "a complex series of algorithms and factors . . . [that] determined which Medicaid claims should be paid or not paid." Petitioner had first-hand knowledge of and participated in many Evolution Project Meetings, at which the City convinced the Health Department of the State of New York to improperly manipulate eMedNY's edits. SAC ¶15 (Pet. App. 6a-7a).

Petitioner described how at these meetings "policy considerations warranted the improper manipulation of edits by the New York State Department of Health so as to benefit the CITY OF NEW YORK". SAC ¶82 (Pet. App. 23a-24a).

The SAC also stated that Petitioner was aware that it was "common knowledge within . . . the New York State Department of Health . . . that the CITY OF NEW YORK'S Medicaid billers were to be protected and should be permitted to submit and be

paid claims notwithstanding non-compliance with laws which otherwise would have rendered said claims non-payable." SAC ¶ 87 (Pet. App. 25a).

Further, the SAC described how these claims, demonstrated by highly specific exemplars contained within, "are representative of numerous false claims made by Respondents to the UNITED STATES OF AMERICA. . . [and edits] which were [originally] designed to stop payment of these claims . . . were manipulated by HHC and the CITY OF NEW YORK, with the aid of the New York State Department of Health, to insure that these claims were instead paid." SAC ¶ 141 (Pet. App. 40a). In other words, the eMedNY edits that would have detected these defects were wrongfully set to 'pay and report' rather than to 'pend' or 'deny', in effect turned off, at the City's request.

In addition, the City was aware, by virtue of their participation in said Evolution Project Meetings, of the status of these edits and knew claims submitted with these defects would be paid, said defects notwithstanding. SAC ¶ 82 (Pet. App. 23-24a).

An overpayment includes any amount not authorized to be paid under the Medicaid 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) [emphasis added.] (Pet. App. 159a). Submission of these claims by the Respondents, despite being aware of these defects and knowing of the

status of the controlling edits, resulted in illegal overpayments to Respondents of billions of dollars.

The SAC further describes in great detail *how* the edits were manipulated. The Respondents submitted millions of claims containing made up, contrived prior approval codes, e.g., "'gibberish', submitted in place of the legally required prior authorization codes." SAC ¶153, (Pet. App. 43a). The edit that would have detected this defect was turned off, at the City's request, allowing the "gibberish" characters to suffice as the equivalent of actual prior authorization codes required by 18 NYCRR 540.6 (a)(1). (Pet. App. 168a). These "gibberish" numbers were made up of alphanumeric strings inserted into a field just to satisfy the requirement that actual prior approval numbers be inserted as a condition of payment. SAC ¶110 (Pet. App. 31a). But the edits were turned off to allow these prior approval-required claims to be paid, despite the entry of *any* random alphanumeric string placed in the prior approval code field.

Here, the undisputed practice of providing false Prior Approval (PA) numbers in so many claims for such large sums for so many years should be reasonably inferred in petitioner's favor as false or improper claims. It is respectfully submitted that the panel should have permitted the reasonable inference that the deliberate entry of a fictitious Prior Approval code rendered a claim false, given that the willful entry of such specious codes is an unacceptable practice or improper billing. See, *U.S.*

ex rel. Forcier v. CSC, et al., 183 F.Supp 3d 510 (SDNY 2016).

2. The SAC alleges that the "peculiar" knowledge giving rise to the claims at issue was, of necessity, within the Respondents' knowledge.

The City-owned and New York City Health and Hospitals-managed providers themselves inserted the false Prior Approval numbers, and also submitted double bills for patients they knew were under their care. SAC ¶ 98-143 (Pet. App. 28a-40a). They were responsible for maintaining records of proper enrollment for both individual medical providers and billing facilities and for maintaining records of dates of service to any individual patient. *Id*. Furthermore, it was based on Respondents willful disregard of their knowledge of the following facts that:

1. Claims containing invalid PA numbers were submitted. *Id*.
2. Bills for *outpatient* services for times when recipients were actually *inpatients*. *Id*.
3. Claims for unenrolled or expired enrollment providers were submitted. *Id*.
4. Claims for dates of service ineligible for payment under timeliness rules were also made. *Id*.

The panel's holding that Petitioner does not explain why he had no specific knowledge is belied

by the plain and specific language in the SAC itself. SAC ¶98-143 (Pet. App. 28a-40a).

As in *Chorches*, an easy inference should have been permitted to establish that petitioner's role at NYSDOH did not permit him to have possession of the CMS-64 claim forms actually submitted to the USA (although Petitioner did attach an exemplar in the SAC, it is clear that these claims were indeed submitted, as evidenced by his submission of *paid claims information drawn directly from the NYSDOH Data Warehouse*. *Chorches*, 865 F.3d at 78. It is well established that Rule 9(b) requires acceptance of Petitioner's factual allegations as true and to make all reasonable inferences in Petitioner's favor. *Chorches*, 865 F.3d at 78 (*Citing Trs. of Upstate N.Y. Eng'rs.*, 843 F.3d at 566; *Iqbal*, 129 S. Ct. at 1937; *Twombly*, 127 S. Ct. at 1955.)

Consistent with *Chorches*, it should have been enough to pass Rule 9(b) muster for Petitioner to demonstrate—as he did—that at the time Petitioner discovered the false claims at NYSDOH, his participation in the Evolution Project Meetings was first-hand evidence of a scheme to unlawfully bolster the financial health of defendants by allowing the edits to be manipulated in favor of the defendants' interests by ensuring they were set to 'pay and report' rather than 'pend' or 'deny' thereby in effect, turning the edits off.

It is respectfully submitted that this knowledge and agreement between the City and State permitted the Respondents to submit fatally defective and

false claims to eMedNY secure in the knowledge said claims would be and were, in fact, paid.

3. Petitioner Detailed that the Claim Submission Procedure By the City to the State Was Also, Simultaneously, Submission to the Federal government.

As shown on the flowchart attached as Exhibit B of the SAC (Pet. App. 53a), once a claim is approved for payment, the New York State Financial Management System (SFS) automatically notifies the Center for Medicaid and Medicare Services (CMMS) Financial Management System of the debit. As shown on said flowchart, there is no separate 'time of submission' to the Federal government. Ex. B of the SAC (Pet. App. 53a). The eligibility status at the time of NYS adjudication *is* the eligibility status at the time of submission to the Federal government. *Id*. The accuracy of said flowchart was not disputed by Respondents at any point.

4. Claims Set Forth in the SAC Represent the Final Status of "Paid" Claims, and the Second Circuit's Improper Speculation As To Why These Claims Were Not Defective is Irrelevant.

The relator's actual knowledge pertains to the final status of actual claims submitted for payment. The panel speculated that Respondents may

have corrected the claims at issue before submission, or that the eMedNY may have flagged the claims in error, or that NYSDOH disclosed all possible defects to the Federal government in a subsequent expense report. (Pet. App. 80a-82a).

Chorches made it clear that Rule 9(b) only requires that the relator make plausible allegations that lead to a strong inference that specific claims were indeed submitted and that information about the details of the claims submitted are peculiarly within the opposing party's knowledge. *Chorches*, 865 F.3d at 93.

Furthermore, the *Chorches* court held that all reasonable and plausible inferences must be granted to plaintiffs. *Chorches*, 865 F.3d at 78.

Here, the Petitioner provided exacting details of the final status of over twenty-two million claims to NYS Medicaid for over $14 billion Federal dollars over a period of six (6) years paid to the City-owned and HHC managed facilities that Respondents knew or should have known were false.

Respondents do not dispute the veracity of any of petitioner's factual statements—preferring to speculate about where, when, why, or how the claims at issue might have been corrected, but not that they were, in fact, actually corrected. (Pet. App. 80-82a, 84a).

Unfortunately, the panel adopted Respondents unsupported speculations rather than making any reasonable inference in Petitioner's favor. *Id*. The Respondents do not dispute that they received Fed-

eral money nor do Respondents dispute that those Federal payments were directly and contemporaneously triggered by their claim to eMedNY.

Where the relator in *Chorches* had specific knowledge of the internal falsification of records by the defendant provider, here the relator has detailed and specific knowledge of externally reported falsehoods by the Respondent providers. It is merely the converse of the same type of wrongful behavior.

5. The Respondents Do Not Dispute the Eligibility Status of Any Claim.

The Second Circuit accepted Respondents speculation that perhaps eMedNY was in error or that some remedial action might have rendered the claims at issue payable. (Pet. App. 84a).

However, Respondents never alleged that the claims at issue are, in fact, erroneous. It is also undisputed that no remedial action was, in fact, taken by Respondents.

In fact, no remedial action was possible for these claims. SAC ¶ 100 (Pet. App. 28a). For example, it is impossible to obtain 'prior approval' for a procedure already performed. Either the City-owned and HHC managed facilities had prior approval (PA) or they did not. SAC ¶ 110-11 (Pet. App. 31a). Nor is it possible for an inpatient client to simultaneously be an outpatient client—only one set of services (inpatient or outpatient) could be legitimately billed. SAC ¶ 121-23 (Pet. App. 34a). Nor is it possi-

ble to go back in time and bill within two (2) years of the provision of services after the calendar limit expired. SAC ¶ 104-5 (Pet. App. 29a). Either the claim was submitted within two (2) years or it was not. As to these matters of fact, and law, the panel should have restricted itself to the SAC and accompanying exhibits and not engage, as Respondents did, in mere speculation as to what might have happened to these claims.

II. Respondents Failed to Meet the Standard Imposed by Law For All Billing Providers Under Governing State Regulation.

A. The Respondents Had a Duty Imposed by Law to Not Submit Claims on Behalf of Unenrolled Medicaid Providers.

The panel concluded that there was no financial obligation to the Federal government on the part of Respondents. (Pet. App. 87a, 89a). However, any person who furnishes medical care, services or supplies for which payments under the medical assistance program are to be claimed **must** enroll as a provider of services prior to being eligible to receive such payments. 18 NYCRR 504.1(a). (Pet. App. 160a) [emphasis added.] In other words, in those claims where the provider was unenrolled, the prevaricating provider failed in a condition, imposed by law, for receiving Medicaid payments—which of necessity include Federal moneys. As a condition of receiving said payments, they further had a duty imposed by law to not make misrepresentations of

material fact. 18 NYCRR § 504.3(h). (Pet. App. 166a).

B. Respondents Breached Their Duty, Imposed by Law, to Be Candid with the Federal Government.

Medicaid fee for service providers are reimbursed by Medicaid based on the information they submit in support of their claims. Said information must be true, accurate and complete. 18 NYCRR § 504.3(h). (Pet. App. 166a). The law requires, and the system is based upon the presumption of, honest dealing between the providers and the State and Federal governments. The governing law in New York specifically requires such honest dealing and the Federal government understandably relies on such candor. *Id*.

Had the Federal government been aware that City-owned and HHC managed entities were routinely falsifying material parts of Medicaid claims —such as by deliberately entering false Prior Approval (PA) numbers—it is likely that the Federal government would not have paid such claims. In the present case, it is respectfully submitted that the fabrication of false PA numbers represents a material fraud against the United States since the submission and payment of such claims would, of necessity, and, in fact did, trigger Federal payments to the prevaricating provider. The fraud in the present case is even more egregious because the entities making the false claims are themselves publicly owned and controlled.

C. Respondents Had a Duty Imposed by Law to Know the Contents of the Medicaid Claims at Issue

Providers must maintain records demonstrating the right to receive payment for six years. 18 NYCRR § 504.3(a). (Pet. App. 166a). In other words, as a condition of receiving Medicaid reimbursement, the law imposes a duty to maintain good records of the contents and proof of the statements made in Medicaid claims. The need to create and maintain such records, of necessity, places the knowledge of the contents of the claims at issue—including the dates of service in the untimely claims, the enrolment status of providers in the unenrolled provider claims, the fraudulent PA numbers in the false PA claims—within the peculiar knowledge of the Respondents. If, as Respondents argue and the panel accepts, the details of the claims at issue were not within the peculiar knowledge of the City-owned and HHC managed entities then it is submitted that they failed in a duty imposed by law as a condition of receiving Medicaid payments—which of necessity include Federal moneys.

D. The Law and Relevant Regulations Recognize No Difference Between Public and Private Sector Providers.

The False Claims Act (FCA), 31 U.S.C. § 3729 et seq., applies to those "who defraud the [Federal] Government." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 1995 (2016).

The FCA contains no exemption or different pleading standard for public sector providers than for private sector providers.

Unfortunately the Second Circuit has unwittingly unleashed a new standard that will effectively nullify the legislative intent of the False Claims Act with respect to claims made against public sector providers. *Dick*, 912 F.2d at 13.

SUMMARY

As demonstrated by petitioners' unrebutted allegations of numerous false claims submitted, this case presents *exactly* the type of harm that the False Claims Act was designed prevent, by protecting the US Treasury and public fisc from both *private* and *public* fraud.

It is undisputed that:

1. All the claims at issue were claims for payment made to the Federal Government. SAC ¶ 43 (Pet. App. 15a).
2. All the claims at issue were made and submitted to the State and Federal government simultaneously. SAC Ex. B (Pet. App. 53a).
3. All the claims at issue were fatally defective at the time of their presentation for payment. SAC ¶ 98-143 (Pet. App. 28a-40a).
4. The City had an oversight responsibility for, and HHC had a management responsi-

bility for the Providers submitting the claims at issue. SAC ¶ 84 (Pet. App. 24a).

5. The City-owned and HHC managed Providers had a duty imposed by law to be candid with the Federal government, and failed in said duty. 18 NYCRR § 504.3(h) (Pet. App. 166a); SAC ¶ 98-143 (Pet. App. 28a-40a).

6. The City-owned and HHC managed Providers had a duty imposed by law to not submit Medicaid claims for unenrolled providers, and failed in said duty. 18 NYCRR 504.1(a) (Pet. App. SAC 160a); SAC ¶ 130 (Pet. App. 36).

7. The City-owned and HHC managed Providers submitting the claims at issue had a duty to maintain records of and to be aware of the contents of all Medicaid claims submitted to the Federal government, and failed in said duty. 18 NYCRR § 504.3(a) (Pet. App. 166a).

8. Medicaid claims are, ipso facto, claims made to the United States of America to the extent of Federal participation in the Medicaid program. SAC ¶ 74 (Pet. App. 22a).

9. Respondents make no claim that any remedial measures were ***actually*** undertaken regarding the claims at issue.

10. The City and HHC received and retained the Federal payments at issue. SAC ¶ 48 (Pet. App. 16a).

It is submitted that these undisputed facts render the claims at issue to be false claims under 31 USC § 3729, et seq. (Pet. App. 119a-157a).

Reasons for Granting the Petition

I. The adjudication of allegations of fraud by committed governmental entities against the Federal Government demands the same standard of review as was set in *Escobar* for such fraud alleged against private entities.

II. The Second Circuit has relied on *speculation* as to how the claims at issue *might* not have been false, rather than drawing all reasonable inferences in Petitioner's favor. Failure to reverse the Second Circuit's Order will establish a pleading standard that will make it practically impossible for such massive and systemic Medicaid fraud as is alleged here against the Government to be uncovered, much less adjudicated. No reasonable relator would take the risk inherent in exposing the misconduct that the False Claims Act was expressly designed to uncover, if the procedural bar of FRCP 9(b) was applied as the Second Circuit did here. See e.g. *U.S. ex rel. Dick v. Long Island Lighting Co.*, 912 F.2d 13 (2nd Cir. 1990).

III. The City of New York has not specifically denied any of the allegations in the SAC, which

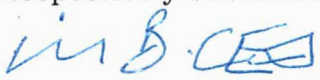
sets forth plausible claims of violations of the False Claims Act sufficient to satisfy the standards set forth by this Court in *Ashcroft v. Iqbal*, 129 S. Ct. at 1937, *Bell Atlantic Corp. v. Twombly*, 127 S. Ct. at 1955, *Escobar*, 136 S. Ct. at 1996 and FRCP 9(b).

CONCLUSION

For the foregoing reasons, the Court should grant the petition for certiorari.

Dated: January 14, 2020

Respectfully submitted,



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APPENDIX

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 14 CV 0771

UNITED STATES OF AMERICA,
ex rel. ANDREW GELBMAN,

Plaintiff,

—against—

THE CITY OF NEW YORK and
NEW YORK CITY HEALTH
AND HOSPITALS CORPORATION,

Defendants.

Hon. Vernon S. Broderick

SECOND AMENDED COMPLAINT

Jury Trial Demanded

The individual plaintiff herein, ANDREW GELBMAN, as relator, by his attorneys, the Law Office of Richard B. Ancowitz, and the Law Office of Sanford Rosenblum, complaining of the Defendants, alleges the following:

1. At all times hereinafter mentioned, the Defendant CITY OF NEW YORK was and is a municipality organized pursuant to the laws of New York State.

2. This Court has jurisdiction over the claims brought herein pursuant to 31 USC 3729 through 3733, and in particular 31 USC 3730 (a), and over all claims pursuant to this Honorable Court's general equitable jurisdiction.

3. Venue lies pursuant to 31 USC 3732 (a), given that the Defendants reside and can be found in this District.

The Parties

4. At all times hereinafter mentioned, Plaintiff ANDREW GELBMAN (hereinafter "Plaintiff" or "GELBMAN") has been employed by the State of New York, and specifically, Plaintiff has been employed by the State of New York, Department of Health, with the title of Information Specialist II since October 5, 2006.

5. Since initial hiring, and continuing to date, Plaintiff's employment duties and responsibilities have included:

- Perform Business & Systems Analysis for eMedNY
- Consult on evolution and system improvements for the eMedNY system.
- Consult on strategies for program implementation and verification.
- Perform detailed work with eMedNY data structures

- Perform a wide variety of Data Warehouse interrogations related to Medicaid management and fraud detection
- Consult on implementation of ICD-9/ICD-10 codesets
- Technical Writing especially letter and memoranda, interim reports and formal proposals.
- Consult on evolution of Medicaid Data Warehouse
- Evaluate project design proposals and project assessments
- Model Business Processes for the eMedNY system

6. At all times hereinafter mentioned, the Defendant CITY OF NEW YORK is a duly constituted municipality of the State of New York.

7. At all times hereinafter mentioned, the Defendant CITY OF NEW YORK has acted primarily via its agency, the Human Resources Administration/ Department of Social Services of The City of New York (hereinafter collectively referred to as "HRA" or "the City").

8. At all times hereinafter mentioned, the Defendant NEW YORK CITY HEALTH AND HOSPITALS CORPORATION (also sometimes known as New York City Health + Hospitals and hereinafter referred to as HHC or NYCHHC), was a public benefit corpora-

tion organized pursuant to the Chapter laws of the State of New York.

9. At all times hereinafter mentioned, the Defendant HHC functioned as a "component unit" of the Defendant CITY OF NEW YORK, and had numerous indicia of functioning as a de facto municipal agency of said CITY.

10. At all times hereinafter mentioned, the Comptroller of the City of New York produced comprehensive Financial Reports which indicated that "component units", such as HHC, were considered a part of the CITY.[1]

11. At all times hereinafter mentioned, the Financial Statements of HHC, as prepared by their independent auditor KMPG, described HHC as being a "component unit" of the Defendant CITY.[2]

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[1] E.g. Said report for the year ending June 30, 2014 can be found at http://comptroller.nyc.gov/wpcontent/uploads/documents/CAFR2014.pdf (see, *inter alia*, p. 56). Reports for the other years at issue herein can be found at http://comptroller.nyc.gov/reports/comprehensive-annual-financial-reports/

[2] E.g. Said report for the years 2014 and 2013 can be found at https://www. abo.ny. gov/annualreports/PARISAuditReports/FYE2014/Local/NewYorkCityHealthHospitalsCorporation2013-14.pdf. Reports for the other years at issue herein can be found at http://comptroller.nyc.gov/

Summary of Plaintiff's Contentions:
Defendants' Scheme to Defraud Medicaid

12. In the State of New York, the Medicaid program, a joint federal and state program, was at all times referenced herein administered by the New York State Department of Health (NYSDOH). eMedNY was the automated computer screening system used by NYSDOH to determine whether Medicaid claims were reimbursable by the UNITED STATES OF AMERICA. Medicaid claims for Long Term Care that originated from medical providers within the City of New York were billed through the CITY OF NEW YORK'S agency, HRA, and submitted to NYSDOH for a determination via eMedNY whether such claims were allowable. If the claims were allowable, NYSDOH submitted the claims to the UNITED STATES OF AMERICA for reimbursement.

13. It is alleged herein that Defendant CITY OF NEW YORK presented, or caused to be presented, Medicaid claims to THE UNITED STATES OF AMERICA, which it knew were legally and factually false. Defendant's knowledge of the falsity of these claims became known to Plaintiff through numerous project meetings, referred to as "Evolution Project Meetings", that Plaintiff participated in from 2006 through 2015 at which the meeting participants, including representatives from the CITY OF NEW YORK, its agency HRA, and participants from the State of New York's Department of Health, conspired to manipulate and rig the manner in which Medicaid claims submitted by HRA

were processed by eMedNY such that otherwise ineligible and legally non-compliant Medicaid claims were intentionally, knowingly and falsely certified and submitted to the UNITED STATE OF AMERICA at the behest of, and to the benefit of, the CITY OF NEW YORK. Such claims included those from physicians or other providers who were ineligible to participate in the Medicaid program, as well as claims that were prohibited under New York State and/or federal Medicaid laws from being paid because they were either untimely, lacked pre-authorization as required, or were duplicative, representing "double dipping" by providers.

14. These health care providers, as will be set forth in greater detail below, included provider entities owned, operated, managed, and/or controlled by the Defendants.

15. The Defendants knew that such false claims were being submitted on a regular basis and, in fact, Defendants made sure at these "Evolution Project Meetings" that these false claims would be systematically authorized by the New York State Department of Health and submitted to the UNITED STATES OF AMERICA such that Defendants would be reimbursed in order to avoid what it determined to be a catastrophic impact on the New York City Medicaid system as a whole, as well as the health care providers and health care recipients who relied upon it, if those claims were not to be reimbursed by the UNITED STATES OF AMERICA. In addition to the knowledge of this scheme obtained by Plaintiff in these many aforesaid "Evolution Project

Meetings", information contained in Defendants' own files and records also demonstrated to Plaintiff that recipient-health care providers of said benefits were not eligible or entitled, or were no longer eligible or entitled, to receive same. Examples of such claims, which the Plaintiff became aware of through his job with eMedNY, are set forth herein below.

16. The following back-drop of the financial crisis referenced above is critical to place the allegations herein in context. The CITY OF NEW YORK had a strong interest in ensuring the flow of health care services, from both private and public providers, to its residents. In particular, as concerns public health care providers, New York City's public hospitals have been described by a report published by the CITY OF NEW YORK as the "critical safety net" for treating low-income and uninsured residents of New York (See, "One New York, Health Care for Our Neighborhoods, Transforming Health + Hospitals", at page 5, *et seq,* archived at www1.nyc.gov/assets/home/downloads/pdf/reports/2016/Health-and-Hospitals-Report.pdf.) At all times referenced herein, there was a relationship between Defendant CITY OF NEW YORK and its public hospitals, all of which are owned by Defendant NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, a public benefit corporation, which although a *de jure* separate entity, operated as a *de facto* municipal agency of the CITY OF NEW YORK. Part of this relationship included, but was not limited to, substantial financial assistance being given to HHC by

Defendant CITY OF NEW YORK for the benefit of New York City residents. During the time period referenced herein, the financial assistance given by the CITY OF NEW YORK to HHC averaged almost $300 million dollars a year. (See *Manhattan Annual Public Meeting, Remarks, January 11, 2011, by Alan D. Aviles, President, NYC Health and Hospitals Corporation,* archived at http://www.nychealthandhospitals.org/manhattan-public-meeting/). In 2009, a financial crisis affecting the City's public hospitals became widely known when HHC announced that it was cutting $300 million from its budget by layoffs and otherwise ". . . . because of Medicaid cuts, rising expenses and a growing number of uninsured patients" (see article in Modern Healthcare, April 10, 2009, *"NYC health system faces even deeper cuts";* The New York Times, March 19, 2009 *"City's Public Hospital System to Cut jobs and Programs";* "The New York Times, February 22, 2010, *"City's Public Hospitals Fear Huge Loss in Subsidies").* According to HHC's President Alan Aviles, by early 2010, with an annual budget of $6 billion, HHC faced an "extraordinary" $1 billion dollar budget deficit (See *Manhattan Annual Public Meeting, Remarks, January 11, 2011, by Alan D. Aviles, President, NYC Health and Hospitals Corporation, ibid.).* By early 2011 HHC had reduced its deficit by about $300 million, however, HHC's Aviles warned: "Because the City continues to face its own multi-billion dollar deficits, we cannot expect our city government to make up for any further state cuts that may be imposed upon us." *(id.)* By April of

2016, the financial crisis had reached such proportions that a report issued by the City of New York stated: **". . .Without swift and aggressive action, Health + Hospitals is on the edge of a financial cliff."** (bold added) (See, *"One New York, Health Care for Our Neighborhoods, Transforming Health + Hospitals", ibid.,* at page 22).

17. It was against this backdrop that the motives of Defendant CITY OF NEW YORK can be understood. Nonetheless, the submission of fraudulent claims by the CITY OF NEW YORK to the UNITED STATES OF AMERICA was in violation of the laws of the State of New York and United States of America, and the Federal False Claims Act provides for, and indeed requires, recompense to the UNITED STATES OF AMERICA for the submission of said false claims.

The Medicaid Program

18. At all times hereinafter mentioned, Medicaid was and is a joint federal-state program designed to help provide assistance to eligible low-income individuals, as per 42 U.S.C. Sec. 1396, et seq. The Medicaid program is also designed to help provide assistance to eligible elderly and disabled persons.

19. Pursuant to the above-referred to legislation, each State, including the State of New York, establishes its own eligibility standards, payment rates, and program administration in accordance with federal law and regulation.

20. THE State of New York has promulgated an extensive regulatory scheme governing the administration of the Medicaid program within the State of New York.

21. As per this regulatory scheme, the State has delegated the authority to The CITY OF NEW YORK (and hence to HRA), the authority to administer the Medicaid program within its jurisdiction, the 5 counties which comprise the City of New York: New York, Kings, The Bronx, Richmond, and Queens.

22. HRA's Medical Assistance Program (MAP) is responsible for the administration of New York State's free and low-cost public health insurance programs for low-income, eligible New York City residents. These plans provide coverage for medical care through fee-for-service arrangements with participating medical providers or through managed care plans. MAP determines and maintains eligibility for applying and renewing consumers based upon criteria including income and/or resource levels for each of the available health insurance programs and their related services.

23. At all times hereinafter mentioned , the state "share" of Medicaid benefits paid was twenty-five per cent (25%), though said "share" could vary between 25 and 100%.

24. At all times hereinafter mentioned, the Defendant CITY OF NEW YORK "share" of Medicaid benefits was twenty-five per cent (25%) or less, given State law which enacted a "Local Share Cap", which placed a maximum limit on the share that a

local social services district, such as said Defendant, would be responsible for in a given year, with the excess to be borne by the State of New York. L. 2005, Ch. 58, Part C, Section 1, as applicable to the fiscal year commencing April 1, 2005.

25. At all times hereinafter mentioned, the UNITED STATES OF AMERICA has paid fifty per cent (50%) of all Medicaid benefits received by health care provider-recipients though said "share" could vary between 0 and 100%.

26. As used herein, the term "health care provider" refers to health care professionals who render medical services to residents of the CITY OF NEW YORK.

27. Health care provider", as used herein, includes hospitals, nursing homes, intermediate care facilities for the developmentally disabled, and managed care providers, and other persons or entities who have presented billing seeking payment for their related goods and/or services through the Medicaid program.

28. The CITY's responsibilities as part of included:

> A. Acting as a health care "provider" via New York City-owned, and New York City Health and Hospitals Corporation-owned facilities, pursuant to 18 NYCRR 504.1 (b) and 504.1 (d) (19), and submitted billings based upon services ostensibly rendered;

B. Via HRA, certifying and re-certifying providers of health care within the City of New York;

C. Via HRA, certifying and re-certifying recipients of health care as patients within the City of New York.

D. Via HRA, having oversight over the providing of services and the billing process;

E. Via the MICSA unit of HRA (Medical Insurance and Community Services Administration), having fraud detection responsibility and functions relative to said billings;

F. Via the MICSA unit of HRA, having collection responsibility and functions.

29. Said Medicaid billings, as germane to this action, were generated through care provided through the Long Term Care, Intermediate Care Facility for the Developmentally Disabled, and Managed Care-related Medicaid programs.

30. The STATE OF NEW YORK paid for 25% of all Medicaid benefits received by recipients.

31. The STATE OF NEW YORK, based upon information provided by the CITY OF NEW YORK, and on behalf of the CITY OF NEW YORK, presented claims for reimbursement of Medicaid expenses to the UNITED STATES OF AMERICA.

32. Upon information and belief, these claims were first submitted by the CITY OF NEW YORK to

the New York State Department of Health in an X-12/HIPPA compliant format, which then relied on the information submitted therein, and forwarded said claims, in the same format, to the UNITED STATES OF AMERICA, in order to obtain the Federal share of Medicaid expenditures, for both the State and the City's benefit.

33. These claims were initially presented to the UNITED STATES OF AMERICA on a weekly basis via a "Claims Adjudication Summary Report".

34. These claims were certified and presented to the UNITED STATES OF AMERICA by the New York State Department of Health via a quarterly report on a form denominated as a Form CMS-64 Certification. A copy of said form is attached as **Exhibit "A".**

35. Said Form CMS-64 Certification requires the executive officer of the state agency (in this case NYSDOH) to certify to the UNITED STATES OF AMERICA via the Department of Health and Human Services (HHS) and the Center for Medicare and Medicaid Services (CMS) that the report (1) only includes actual expenditures under the Medicaid program (not estimates) (2) that these expenditures are allowable by law, and (3) that the information shown is correct to the best of the state agency executive officer's knowledge and belief.

36. States of the UNITED STATES OF AMERICA and their subdivisions, including the counties of New York State and the CITY OF NEW YORK, respectively, are permitted to seek reimbursement of expenses

that are incurred in accordance with State statutes and regulations.

Summary of Legal Contentions

37. As set forth in detail herein below, the CITY OF NEW YORK failed to comply with Federal and State Law and Regulations in processing numerous requests for Medicaid benefits as submitted by health care providers, and thus allowed thousands of health care providers, including HHC, to improperly receive benefits on hundreds of thousands of occasions within the past six years.

38. The CITY OF NEW YORK, as billing agent for providers owned by and *de facto* owned and operated by with the CITY OF NEW YORK, submitted Medicaid claims via the STATE OF NEW YORK to the UNITED STATES OF AMERICA which were fraudulent and misleading to the UNITED STATES OF AMERICA, in order to induce them to pay monies to THE CITY OF NEW YORK that should not have been paid had Defendant complied with applicable law and regulation.

39. Defendant CITY OF NEW YORK caused the STATE OF NEW YORK to submit false claims to the UNITED STATES OF AMERICA, which Defendant knew were not in accord with applicable State statutes and regulations, and which were false and not properly compensable.

40. The CITY OF NEW YORK knowingly submitted, via the State of New York, claims to the UNITED

STATES OF AMERICA which were false, by virtue of their expressed and implied certification that these claims were in compliance with applicable federal and state Medicaid law and regulations, when in fact they were not in compliance.

41. The CITY OF NEW YORK and HHC violated New York State and Federal laws and regulations concerning the presentation of said false claims.

42. The CITY OF NEW YORK and HHC falsely certified to the UNITED STATES OF AMERICA and/or the STATE OF NEW YORK that said New York State and Federal laws and regulations had been complied with.

43. The representations made by the CITY OF NEW YORK and HHC to the UNITED STATES OF AMERICA and/or the STATE OF NEW YORK concerning the payment of Medicaid benefits were a material and substantial factor in causing the UNITED STATES OF AMERICA to pay said benefits to the CITY OF NEW YORK.

44. The CITY OF NEW YORK and HHC expressly and falsely represented its compliance with fundamental procedural requirements governing the submission of claims to the UNITED STATES OF AMERICA via the STATE OF NEW YORK.

45. The CITY OF NEW YORK and HHC impliedly and falsely represented its compliance with fundamental procedural requirements governing the submission of claims to the UNITED STATES OF AMERICA via the STATE OF NEW YORK.

46. On information and belief, the CITY OF NEW YORK and HHC knew that, had the UNITED STATES OF AMERICA known of the falsity and legal non-compliances of the Medicaid claims set forth herein, the UNITED STATES OF AMERICA would have refused reimbursement of such claims.

47. The CITY OF NEW YORK regularly and systematically authorized that Medicaid benefits be paid to health care providers and recipients in violation of STATE OF NEW YORK and UNITED STATES OF AMERICA Medicaid regulations, and thus allowed said certain health care providers to improperly receive Medicaid benefits, despite their lack of eligibility to receive same.

48. As described herein, the CITY OF NEW YORK and HHC knowingly and wrongfully submitted legally and factually false claims in a knowing, reckless disregard, and/or deliberate indifference to the rights of the UNITED STATES OF AMERICA and the STATE OF NEW YORK to be free from having false claims made against them, all in contravention of established laws and regulations.

49. Outside the City of New York, providers submit their claims to eMedNY, as more fully set forth below, directly, or through a private authorized billing agent who submits to eMedNY on their behalf. No other county or municipality in New York State had the oversight responsibilities which the CITY OF NEW YORK had, or served as a billing agent in the way that the CITY OF NEW YORK did. This allowed the CITY OF NEW YORK to have signifi-

cant leverage as to policy making, including claims processing decisions, throughout the Medicaid system. Because of the sheer concentration in NYC of the number of health care providers, and health care recipients, necessarily resulting in millions of claims and billions of dollars in the value of said claims, it gave the City of New York significant leverage in the policy considerations which determined the manner in which the eMedNY claims processing system was used. In this case this resulted in the manipulation and misuse of eMedNY as set forth below.

The Process of Obtaining Medicaid Benefits

50. As the administrator of the Medicaid program within the City of New York, the Defendant CITY OF NEW YORK had a non-delegable duty and responsibility to determine provider and recipient eligibility for receiving Medicaid benefits, as well as determining continuing eligibility to receive Medicaid benefits.[3]

51. For a period from six years prior to February 6, 2014, a health care provider who sought Medicaid reimbursement for their goods or services provided would enroll in the Medicaid program, and then upon rendering services to a Medicaid-eligible person, submit a "claim" for Medicaid benefits to Defendant CITY OF NEW YORK, i.e. financial

[3] Upon information and belief, under certain circumstances not relevant herein, these duties accrued to the State of New York on and after January 1, 2014.

remuneration for goods or services rendered, often via a practice management software, New York State's ePaces system, or via hard-copy.

52. As an alternative to sending hard-copy application packages, and representing the most commonly utilized method of making such claims, the authorized provider electronically submitted (in an approved format such as x-12/HIPAA compliant) data streams of application information and images of claim verification documents.

53. Each submitter must have passed a certification process in order to participate in Medicaid billing. As per HRA, the process is designed to ensure that the format of the files received follows the required format, and that the pass/fail rate meets the 90% acceptance mark.

54. Such health care provider claims, whether submitted electronically or via hard copy, would be received by HRA, which would then use a proprietary computer system known as eMedNY, to submit claims in the proper x-12/HIPAA compliant format to the New York State Department of Health.

55. Part of Plaintiff's job description, as stated above, was to work perform analysis upon the eMedNY system, as related to Medicaid management and fraud detection.

56. Plaintiff performed tasks consistent with said job description, since his hiring by the New York State Department of Health on October 5, 2006.

57. At all times mentioned herein, eMedNY was and is a computer system/program, set up by the State of New York to adjudicate Medicaid health care provider claims.

58. eMedNY would determine whether a claim should be paid, denied, pended (i.e. delayed), or otherwise disposed.

59. In addition to the above possible determinations, eMedNY could also indicate that although there existed valid reasons for a claim not to be paid, the claim should nevertheless be paid. These types of claims were sometimes referred to as "pay and report" claims.

60. If a claim was determined to be referred to as "pay and report", that was a determination by eMedNY that the claim should be paid.

61. That eMedNY determined how a claim should be disposed of based upon a complex series of algorhythms and factors, known as "edits", and thus determined which Medicaid claims should be paid or not paid.

62. The Electronic Data Image Transmission System (known as "EDITS", as distinguished from lower-case "edits", referenced above), was and is an HRA system designed, inter alia, to automate the current paper flow between submitters and HRA/DSS's Medical Insurance and Community Services Administration (MICSA) with electronic transfer of data and images and eligibility determinations.

63. The CITY OF NEW YORK relied upon the eMedNY system and the system's determinations, based upon the aforementioned "edits", that certain Medicaid health care provider claims be designated as "pay", "deny", or "pend".

64. Claims as described above could be and were designated as pay, notwithstanding that there were failed edits which flagged and/or highlighted infirmities, and sometimes glaring infirmities, which warranted denial of the claim. Claims with failed edits which were designated as claims which should be paid were also known within DOH as "pay and report" claims.

65. Specifically, at all times mentioned herein, the CITY OF NEW YORK adopted the design and programming of eMedNY by the STATE OF NEW YORK, such that certain Medicaid provider claims were designated to as "pay", "deny", "pend", or "pay and report".

66. Once eMedNY determined that health care providers should be paid based upon HRA-provided information, it systematically authorized monies to be paid and subsequently caused these monies to be paid to those providers.

67. The CITY OF NEW YORK, after having paid or caused to be paid said health care providers as per the parameters set by eMedNY, then sought recompense of said payments from the UNITED STATES OF AMERICA, in order to obtain the latter's statutory share, as described above.

68. Annexed as **Exhibit "B"** is a flow-chart which illustrates the aforementioned path which said Medicaid claims take, from initial provider submission to the CITY OF NEW YORK until payment of the federal share by the UNITED STATES OF AMERICA to the CITY OF NEW YORK.

69. Plaintiff respectfully incorporates said flow-chart as if fully set-forth herein, as an amplification of the above-described the path of said Medicaid claims, from the making of the claim by the provider, through claim processing, and concluding with payment by the UNITED STATES OF AMERICA.

70. By permitting the payment of false claims to health care providers who should not have lawfully been paid, the Defendant CITY OF NEW YORK systematically and routinely breached their duty to the taxpayers of the UNITED STATES OF AMERICA to not submit false claims.

71. The Defendant CITY's violations of law have resulted in providers receiving more payments than warranted as per the regulations promulgated pertinent to the Medicaid program, resulting in additional and unwarranted cost to taxpayers.

72. These services include Long Term Care, Residential Care, Intermediate Care for Developmentally Disabled persons, Managed Care, medical care, and related services.

73. Annexed hereto as **Exhibit C**[4] is a spreadsheet denominated "Summary of Long Term Care, Intermediate Care, Managed Care Medicaid Claims Paid, broken down by year, from 2009-2015. This spreadsheet delineates the "Edit Reason Codes" (described therein as "Edit Rsn Cd"), as well as an "Edit Reason Descriptions" (described therein as "Edit Rsn Descr") pertaining to the eMedNY "edits" described above, in the areas of billing described above. Also included are the number of claims per year, the average claim amount, and the Federal share at issue herein.

74. Said spreadsheet represents a list of the various "edits" which were used by eMedNY to describe billings ultimately falsely and improperly presented to and paid by the UNITED STATES OF AMERICA in the calendar years 2009 through 2015.

75. 18 NYCRR 504.3 (e) provides certain duties which the providers of health care related services must comply with, including submitting claims for payment only for services actually furnished, which were medically necessary and which were provided to eligible persons.

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[4] **Exhibit C** represents a summary of data not attached here, in compliance with this Local Civil Rule 5.2 of this Honorable Court's Electronic Case Filing Rules & Instructions. Said data is **excerpted** here, as same is too large to file electronically, and a full copy is available and can be provided to Defendant and to this Honorable Court via other media. Representative excerpts of this data are provided as parts of **Exhibits D and E,** discussed below.

76. 18 NYCRR 504.3 (h) provides that providers of health care related services must provide that the information provided in relation to any claim for payment "shall be true, accurate and complete".

77. 18 NYCRR 515.2 (b)(1) specifically proscribes the payment of Medicaid claims based upon the submission of false information by providers.

78. These regulations were systematically and routinely breached by the Defendants concerning their submission of Medicaid provider claims to the UNITED STATES OF AMERICA.

79. Requests for Medicaid reimbursement payments made by the UNITED STATES OF AMERICA were conditioned upon compliance with said regulations.

80. The CITY OF NEW YORK systematically and impliedly represented to the UNITED STATES OF AMERICA its own compliance with said regulations concerning the approval of Medicaid benefits.

81. Said representations were legally and factually false.

Plaintiff Witnessed a Scheme to Defraud Medicaid

82. GELBMAN was present at numerous meetings from 2006 through 2015, commonly referred to by participants as "Evolution Planning Meetings", on a regular basis, sometimes as often as 2-3 times per week, sometimes as little as once every few weeks, held between the CITY OF NEW YORK representatives from HRA and the New York State

Department of Health, in which it was averred by said HRA representatives that policy considerations warranted the improper manipulation of edits by the New York State Department of Health so as to benefit the CITY OF NEW YORK.

83. Present at these meetings were GELBMAN's supervisors and co-workers within the Department of Health, namely Jim Donnelly (during the years, 2006-2010), Mohammed Mufti (2010-2015), Dennis McFadden and Ray King (both 2006 – present), and Mark Malone and Steve Helman (both less frequently participating, but also from 2006 – present).

84. Present on behalf of THE CITY OF NEW YORK'S HRA were various administrators who were charged with the responsibility of assuring that the claims made were paid and, upon information and belief, insuring that the flow of medical services to New York City residents by New York City providers would continue in an unimpeded fashion.

85. It was clear to GELBMAN that all participants in said "Evolution Planning Meetings" from NYSDOH and HRA were carrying out the instructions that they had received from their superiors within NYSDOH and HRA, respectively.

86. These Evolution Planning Meetings took place at the Department of Health's Office of Health Insurance Programs, formerly known as Office of Medicaid Management, located at 150 Broadway, Riverview Center, Suite 480, Menands, New York, 12204, with the NYSDOH representatives mostly

participating in person, and with HRA representatives participating via conference call.

87. As a result, it was known to GELBMAN, and was also common knowledge within his own department and within the New York State Department of Health generally, that the CITY OF NEW YORK's Medicaid billers were to be protected, and should be permitted to submit and be paid claims notwithstanding non-compliance with laws which otherwise would have rendered said claims non-payable.

88. This was openly acknowledged on numerous occasions from 2006-present by the above-referred to NYSDOH meeting representatives in conversation with GELBMAN.

89. Specifically, GELBMAN had inquired of his supervisors, including Jim Donnelly and Mark Malone, as to why certain Medicaid claims were being paid, notwithstanding that they failed one or more edits.

90. GELBMAN's superiors stated that it was claimed by the CITY OF NEW YORK that failure to so protect the CITY OF NEW YORK would lead to financial ruin for numerous New York City-located providers and institutions, as well as lead to political problems for the administration of the CITY OF NEW YORK and financial disruptions of the New York State Medicaid program.

91. As a result, the CITY OF NEW YORK systematically and routinely sought and received improper reimbursement for Medicaid expenses in violation

of the aforementioned State regulations, given that the services – for a variety of reasons described in greater detail below – should not and could not have lawfully been provided and recompensed to the CITY OF NEW YORK.

92. To the extent that claims would not have been reimbursed by the UNITED STATES OF AMERICA had applicable laws been followed and the claims denied, City of New York providers, public and private, would have had to absorb the costs thereof.

93. As a result, the CITY OF NEW YORK attempted to avoid incurring such unreimbursed costs, and was able to insure that their claims would be transmitted by the State of New York to the USA, notwithstanding clear infirmities – described below – which should have otherwise caused these claims to be denied.

94. Further, given the "Local Share Cap" referred to in paragraph 18 above, said Defendant had little incentive to *not* cause false claims to be made to the UNITED STATES OF AMERICA, given that they would not have to pay the "Local" share of these expenses.

95. In addition, given the dire and precarious financial state of many of the Defendant CITY OF NEW YORK's wholly owned or indirectly owned medical providers and institutions, such as the Defendant NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, which were in significant measure dependent upon receiving funds from the UNITED STATES OF AMERICA, the Defendant CITY OF NEW YORK had a clear incentive to continue such false

representations and billings, in order to continue to maintain the financial health of these medical institutions.

96. It is well documented and even admitted by the CITY OF NEW YORK that HEALTH AND HOSPITALS CORPORATION, which owns and operates numerous public hospitals in the City of New York (including what are commonly known as Bellevue Hospital and Kings County Hospital Center), is presently, and has been at all times mentioned herein, in dire financial straits. A 2016 report issued by the City of New York ("One New York-Healthcare for Our Neighborhoods") concluded that after the sharp decline of critical safety-net funding and the increasing "safety-net funding gap" since at least 2007, "Without swift and aggressive action, Health + Hospitals is on the edge of a financial cliff." (see page 22 of that report). This report also notes that "A recent analysis by the Citizens Budget Commission has reached similar conclusions", referring to a 2012 report by CBC (id, at 22).

97. The Defendant systematically submitted, as a standard practice and a matter of policy, false claims to the UNITED STATE OF AMERICA, and this practice and policy was motivated by the Defendant's knowledge of a present and further developing financial crisis in delivering health care services to its residents.

Examples of Five Types of False Claims

98. A representative sampling of the edits contained in **Exhibit C** is set forth herein as **Exhibits D and E,** and contains nine (9) categories of edits each representing the payment of monies from the UNITED STATES OF AMERICA to the CITY OF NEW YORK, based upon false claims made by the CITY OF NEW YORK, as transmitted via the State of New York.

99. In certain of the nine types of false claims specified below, the CITY OF NEW YORK facilitated - and HHC actually engaged in - "double-dipping" by the providers, in allowing claims to be submitted and paid which had already been paid.

100. These claims, as made by health care providers to the CITY OF NEW YORK, including HHC, were each infirm for one or more reasons, and that said infirmities were known to the CITY OF NEW YORK, yet the City knowingly determined that said claims should be paid, and that false claims should be submitted to the UNITED STATES OF AMERICA for reimbursement of said claims, either in whole or in part.

101. The nine edits contained on **Exhibit D** are broken down by "Edit Reason Code", and each edit also describes a particular sum paid by the UNITED STATES OF AMERICA to the CITY OF NEW YORK in during the calendar years 2009 through 2015.

102. In edits numbered 00050, 00240, 00261, 00262, 00758, 00759, 01029, 01242, and 01244, the

Defendants made false claims concerning the medical services which were provided, and knew that these claims were materially defective and should not have been submitted to eMedNY in the first instance.

Claim Type #1: Untimely Claims – Edit #00240

103. For example, as per Edit Reason Code #00240 [described therein as "Over Two Year Old Claim Held For Future Adjudication"], $263,373,434 (federal share) was paid by the UNITED STATES OF AMERICA from 2009 through 2015, as per false claims presented by HHC and the CITY OF NEW YORK.

104. Medicaid regulations and in particular 18 NYCRR 540.6 (a)(3)(a) do not permit a claim to be paid more than two years after the care, services, or supplies were rendered, yet numerous such claims were nevertheless routinely and systematically falsely certified and presented to the UNITED STATES OF AMERICA outside of this time period by HHC and the CITY OF NEW YORK.

105. Numerous false claims were submitted by Defendant HHC and paid by the UNITED STATES OF AMERICA relating to this Edit Code, and exemplar claims are set forth below for each of the claim types described here. Additional exemplars of the above-referred to edits, and those that follow below, may be found at **Exhibit "E".**

Exemplar Claim – Edit 00240

106. BROOKLYN HOSPITAL CENTER (NPI 1326046467, MMIS ID 00243614) treated a patient on an inpatient basis and performed TOTAL ABDOMINAL HYSTERECTOMY (Procedure Cd. 684) for MALIGNANT NEOPLASM OF OVARY (Dx Cd. 1830) – beginning on 11/20/2004 and ending on 12/29/2004, inpatient claim **********998422 was submitted on or about 5/15/2009 under rate code 2946 and was adjudicated on 5/15/2009, a payment of $191,849.57 was made on 5/25/2009, of which $95,924.79 was the Federal Share (50%) despite having set eMedNY edit 00240 – OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION.

107. Medicaid regulations require that such claims be timely filed, yet such claims, representing capitation claims, were nevertheless presented to the UNITED STATES OF AMERICA by HHC and the CITY OF NEW YORK in an untimely manner.

108. The claims referable to Edit Codes 00240 were presented by the CITY, notwithstanding HHC and the CITY's knowledge that the provider and/or recipients of services were *ineligible* to make such Medicaid claims, due to the fact that these claims were untimely, stale, invalid, excluded from coverage, and should not have been submitted in the first instance by the provider HHC in 2009, and, correspondingly, should not have been presented for payment to the UNITED STATES OF AMERICA.

Claim Type #2: Failure To Present Valid Prior Approval – Edit #00050 and Edit #00129

109. As per Edit Reason Code #00050 [described therein as "Prior Approval Number Non-Numeric"], $ $469,936,674 was paid by the UNITED STATES OF AMERICA from 2009 to 2015 (Federal share), as per false claims presented by HHC and the CITY OF NEW YORK.

110. Medicaid regulations and in particular 18 NYCRR 540.6 (a)(1) does not permit certain claims to be submitted without proper prior authorization, where required, which these claims lacked, as gibberish numbers or letters were provided in the prior approval code field, yet such claims were falsely presented to the UNITED STATES OF AMERICA by HHC and by the CITY OF NEW YORK for reimbursement.

111. Numerous false claims were submitted by Defendants and paid by the UNITED STATES OF AMERICA relating to Edit Code 00050, and an exemplar claim are set forth herein.

Exemplar Claim – Edit 00050

112. NORTH CENTRAL BRONX HOSPITAL (NPI 1023024882, MMIS 00246171) treated a patient on an inpatient basis for SCHIZOAFFECTIVE DISORDER (Dx. Cd. 29532) performing NONEXCISIONAL DEBRIDEMENT OF WOUND (Proc. Cd. 8628) beginning on 4/14/2009 and ending on 8/19/2009, on or about

9/19/2009 inpatient claim **********290520 was submitted under rate code 2852 and was adjudicated on 9/19/2009 and on 9/28/2009 a payment of $103,434.63 was made of which $51,717.32 was federal share (50%) despite having set eMedNY edit 00050 – PRIOR APPROVAL NUMBER NON-NUMERIC.

113. These claims were presented by HHC and the CITY, notwithstanding their knowledge that the provider and/or recipients of services were ineligible to make such Medicaid claims, due to the fact that these claims were facially invalid, and should not have been paid in the first instance to the provider, and, correspondingly, should not have been presented for payment to the UNITED STATES OF AMERICA.

114. Similarly, as per Edit Reason Code #01029 [described therein as "required PA (prior approval) for rate code not found"], $119,054,243 was paid by the UNITED STATES OF AMERICA from 2009 to 2015, as per false claims presented by HHC and the CITY OF NEW YORK.

115. Specifically, Medicaid regulations and in particular 18 NYCRR 540.6 (a)(1) do not permit claims to be submitted without proper prior authorization, which these claims lacked, as *no* prior approval code was provided in the prior approval claim field, yet such claims were falsely presented to the UNITED STATES OF AMERICA by the CITY OF NEW YORK for reimbursement.

116. The following Medicaid regulations and policies do not permit payment, and in fact exclude coverage of, Assisted Living Program patient claims and Special Care Patient claims claims of these types without the requisite prior approvals and/or authorizations: 18 NYCRR 505.35 Assisted living programs, and more particularly subsections (a) and (h)(2) and (3); the New York State Medicaid Program Assisted Living Program (ALP) Manual Policy Guidelines Assisted Living Policy Manual Policy Guidelines, Version 2006 at page 5; and, the New York State Medicaid Program, Information for All Providers General Policy, Version 2011.

117. Numerous false claims were submitted by Defendants and paid by the UNITED STATES OF AMERICA relating to Edit Code 01029, and an exemplar claim is set forth herein.

Exemplar Claim – Edit 01029

118. BROOKDALE HOSPITAL MEDICAL CENTER ALP (MMIS 01891469) treated a patient on a residential basis with UNKNOWN AND UNSPECIFIED CAUSE (Proc. Cd. 7999) beginning on 6/1/2013 and ending on 6/30/2013 and on or about 7/12/2013 residential claim **********305330 was submitted under rate code 3309 and was adjudicated on 7/12/2013 and on 7/22/2013 a payment of $2594.40 of which $1297.20 was federal share (50%) despite having set eMedNY edit 01029 – REQUIRED PA FOR RATE CODE NOT FOUND.

119. These claims were presented by HHC and the CITY, notwithstanding their knowledge that the provider of services was *ineligible* to make such Medicaid claim, due to existing law and/or regulation requiring that prior approval be given by the New York State Department of Health.

Claim Type #3: Duplicative Claims – Edit #00758 and Edit #00759

120. As per Edit Reason Code #00758 [described therein as "duplicate inpatient/pharmacy claim"], $718,354,109 was paid by the UNITED STATES OF AMERICA in 2009 through 2015 (federal share), as per false claims presented by HHC and the CITY OF NEW YORK.

121. These claims were submitted by HHC and the CITY, notwithstanding their knowledge that the provider and/or recipient of services was *ineligible* to make such Medicaid claim, due to the fact a duplicate claim had already been presented and paid.

122. "Double-dipping" for the same services billed by a provider is on its face impermissible under state and federal Medicaid regulations and laws.

123. Numerous false claims submitted by Defendants and paid by the UNITED STATES OF AMERICA relating to this Edit Code, and exemplar claims are set forth herein:

Exemplar Claim – Edit 00758

124. LINCOLN MEDICAL/MENTAL HLTH (NPI 1427063270, MMIS 00246126) treated a patient on an inpatient basis for a diagnosis of CHRONIC RESPIRATORY FAILURE related to DIABETES WITH OTHER SPECIFIED MANIFESTATION, specifically procedure cd. 311 (TEMPORARY TRACHEOSTOMY) beginning on 4/15/2008 and ending on 5/14/2008, inpatient claim **********773622 was submitted under rate code 2946 on or about 4/10/2009 and was adjudicated on 4/10/2009, a payment of $464,910.56 was made on 4/20/2009 of which $232,455.28 was the Federal Share (50%) despite having set eMedNY edit 00758 – DUPLICATE INPATIENT/PHARMACY CLAIM.

125. As per Edit Reason Code #00759 [described therein as "duplicate inpatient/clinic"], $185,238,449 was paid by the UNITED STATES OF AMERICA in 2009 through 2015 (federal share), as per false claims presented by HHC and the CITY OF NEW YORK.

126. These claims were submitted by HHC and the CITY, notwithstanding their knowledge that the provider and/or recipient of services was *ineligible* to make such Medicaid claim, due to the fact a duplicate claim had already been presented and paid.

127. Numerous false claims submitted by Defendants and paid by the UNITED STATES OF AMERICA relating to this Edit Code, and exemplar claims are set forth herein:

Exemplar Claim – Edit 00759

128. HARLEM HOSPITAL CENTER (NPI 1033124961, MMIS 00246108) treated patient on an inpatient basis for Dx. Cd. 1481 (MALIGNANT NEOPLASM OF PYRIFORM SINUS) performing TEMPORARY TRACHEOSTOMY (Proc. Cd. 311) beginning on 6/8/2009 and ending on 9/11/2009, on or about 2/23/2010 inpatient claim **********303420 was submitted under rate code 2946 and was adjudicated on 3/1/2010, on 2/23/2010 a payment of $343,618.05 was made of which $171,809.03 was federal share (50%) despite setting eMedNY edit 00759 – DUPLICATE INPATIENT/CLINIC CLAIM.

Claim Type #4: Provider Ineligible – Edit # 01242 and Edit #01244

129. As per Edit Reason Codes #01242 and 01244 [described therein as "Order/Referring Provider Not in Active Status on Date of Service" and "Service Provider Not in Active Status on Date of Service", respectively], $29,993,213 and $41,439,167 were paid, respectively, by the UNITED STATES OF AMERICA in 2013, as per false claims presented by HHC and the CITY OF NEW YORK.

130. These claims were submitted by HHC and the CITY, in violation of 18 NYCRR 504.1(b)(1) notwithstanding their knowledge that the referring provider and the provider who actually rendered the services, respectively, were *ineligible* to make

such Medicaid claim, due to their failure to be properly enrolled in the Medicaid system.

131. 18 NYCRR 504.1(b)(1) prohibits payments to persons who are not enrolled as a provider of services in the Medicaid program.

132. Numerous false claims submitted by Defendants and paid by the UNITED STATES OF AMERICA relating to Edit Codes 01242 and 01244, and exemplar claims are set forth herein.

Exemplar Claim – Edit 01242

133. KINGSBROOK JEWISH MEDICAL CENTER (NPI 1356307656, MMIS 02998745) treated patient on an inpatient basis for OTHER SPECIFIED PULMONARY TUBERCULOSIS (Dx. Cd. 1184) and performed CLOSED ENDOSCOPIC BIOPSY OF BRONCHU (Proc. Cd. 3324) beginning on 10/8/2010 and ending on 11/1/2010, inpatient claim **********540720 was submitted under rate code 2946 on or about 2/1/2011 and adjudicated on 2/1/2011, a payment was made on 2/7/2011 for $20672.90 of which $10336.45 was Federal share (50%) despite having set eMedNY edit 01242 – ORDER/REFERRING PROVIDER NOT ON ACTIVE STATUS ON DATE OF SERVICE.

Exemplar Claim – Edit 01244

134. JACOBI MEDICAL CENTER (NPI 1679587679, MMIS 00246048) treated a patient on an inpatient basis for ACUTE GASTRIC ULCER WITH PERFORATION (Dx. Cd. 53110) performing SUTURE OF GASTRIC

ULCER SITE (Proc. Cd. 4441) beginning on 7/10/2007 and ending on 7/18/2007, on or about 1/20/2010 inpatient claim ********** 895222 was submitted under rate code 2946 and was adjudicated on 1/20/2010 and on 1/25/2010 a payment of $39,910.82 was made of which $19,955.41 was federal share (50%) despite having set eMedNY edit 1244 – SERVICE PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE.

Claim Type #5: Other Insurance Paid/Medicare Paid – Edit #00261 and Edit #00262

135. As per Edit Reason Code #00261 [described therein as "Other Insurance Paid"], and Edit Reason Code #00262 [described therein as "Medicare Paid"] $122,558,467 and 70,194,833 was paid, respectively, by the UNITED STATES OF AMERICA in 2009 through 2015 (Federal share), as per false claims presented by HHC and the CITY OF NEW YORK.

136. These claims were submitted by HHC and the CITY, notwithstanding their knowledge that the provider and/or recipient of services were *ineligible* to make such Medicaid claim, due to the fact that these claims had been previously paid by other insurers, including Medicare should not have been presented.

137. These payments represented "double-dipping" by providers, and should not have been presented to the UNITED STATES OF AMERICA, since the

Medicaid program is a payor of last resort, which can only properly pay for services not reimbursed by other insurance, as per 42 USC 1396a (25)(A) and (B) et seq. and 18 NYCRR 540.6(e)(1).

138. Numerous false claims submitted by Defendants and paid by the UNITED STATES OF AMERICA relating to this Edit Code, and exemplar claims are set forth herein:

Exemplar Claim – Edit 00261

139. JACOBI MEDICAL CENTER (NPI 1679587679, MMIS 00246048) treated a patient on an inpatient basis for Dx. Cd. 8052 (CLOSED FRACTURE OF DORSAL THORACIC VERTEBRAE) and performing Proc. Cd. 8105 (DORSAL AND DORSOLUMBAR FUSION) beginning on 5/28/2013 and ending on 6/12/2013, on or about 8/14/2013 inpatient claim **********201320 was submitted under rate code 2946 and adjudicated on 8/14/2013 and on 8/19/2013 a payment of $32,571.22 was made, of which $16,285.61 was federal share (50%) despite having set eMedNY edit 00261 – OTHER INSURANCE PAID.

Exemplar Claim – Edit 00262

140. JACOBI MEDICAL CENTER (NPI 1679587679, MMIS 00246048) treated a patient on an inpatient basis for Dx. Cd. 389 (PNEUMONITIS DUE TO INHALATION OF FOOD OR DRINK) and performing Proc. Cd. 9672 (CONTINUOUS INVASIVE MECHANICAL VENTILATION) beginning on 2/27/2013 and ending on

3/11/2013, on or about 8/12/2013 inpatient claim **********620820 was submitted under rate code 2946 and adjudicated on 8/12/2013 and 8/19/2013 a payment of $3256.00 was made, of which $1628 was federal share (50%) despite having set eMedNY edit 00262 – MEDICARE PAID.

141. All of the aforementioned exemplar claims are representative of numerous false claims made by Defendants to the UNITED STATES OF AMERICA, relative to these and numerous other edits which were designed to stop payment of these claims, but which were manipulated by HHC and the CITY OF NEW YORK, with the aid of the New York State Department of Health, to insure that these claims were instead paid.

142. The entire universe of false claims submitted by HHC and the CITY OF NEW YORK, for both public and private providers, as typified by the exemplar claims recited above, from 2009 through 2015, is contained in summary fashion in **Exhibit C,** and is excerpted in **Exhibits D and E.**

Discussion of Legal Contentions – Liability

143. In submitting the above-referred to Medicaid claims to the UNITED STATES OF AMERICA, the Defendants CITY OF NEW YORK and HHC impliedly represented that the claims properly submitted in accord with applicable federal and state regulations, and were not falsely made.

144. The Defendants also induced the NYSDOH to make false representations to the UNITED STATES OF AMERICA in the Form CMS 64 Certifications that the Medicaid claims being submitted for reimbursement to the USA complied with all applicable laws and regulations.

145. The UNITED STATES OF AMERICA would not have paid the claims referred to herein if they had known of said non-compliance with regulations, and if they had known that the claims were falsely made.

146. Said non-compliance was material to the payment decisions made by the UNITED STATES OF AMERICA.

147. The UNITED STATES OF AMERICA would have refused to pay these claims had they known of the falsity and legal non-compliance of same is evidenced by extensive references in law, regulation and the *New York State Medicaid Program, Information for all Providers,* General Policy, Version 2011-2, at page 23 that certain claims would not be paid, and are excluded, such as for:

A. Claims rendered outside the provider's period of eligibility;

B. Claims which require prior approval or authorization, which had not been obtained;

C. Claims which had previously paid, and for which further payment would result in a duplication of claims;

D. Claims which were received and paid which were untimely, and which should not have been paid.

148. Failing to disclose the legal non-compliances set forth hereinabove was fraudulent and constituted material omissions that induced the UNITED STATES OF AMERICA to reimburse such claims when they otherwise would have refused to pay had they known of such non-compliances.

149. Further demonstration that the UNITED STATES OF AMERICA would have refused to pay these claims had they known of the falsity and legal non-compliance of same is demonstrated by audits of the United States Department of Health and Human Services (DHHS), Office of Inspector (OIG), which have required various governmental entities, including the State of New York, to refund to the Federal Government the Federal Medicaid share where such entities submitted claims for services of providers who were not enrolled in New York's Medicaid program (see e.g. DHHS Office of Inspector General—Audit "Review of Medicaid Claims Made by Lake Grove Schools in New York," (A-02-06-01001), September 13, 2006); also, various publications and memoranda from CMS and the (Government Accountability Office ("GAO")[5]

[5] See e.g., United States Government Accountability Office Report to Congressional Requesters, January 2015, MEDICAID, Additional Federal Action Needed to Further Improve Third-Party Liability Efforts, GAO-15-208, also referencing prior GAO reports on the same issue since at least

further demonstrate the UNITED STATES OF AMERICA'S efforts to prevent payment to non-eligible medical providers.

150. The claims submitted by the Defendants on behalf of the various providers contained herein as set forth in the exemplar claims provided, and in the aggregate claims provided as well, were legally and factually false *ab initio,* and should not have been submitted in the first instance.

151. Defendants knew that the aforesaid claims were false and furthermore knew that, had the United States of America known of the falsity and legal non-compliance of such claims, the USA would have refused to pay such claims.

152. The fact that the Defendants knew that these claims were false and that the USA would not have paid such claims despite their legal non-compliances is evidenced by the manipulation of the edits in the eMedNY system to allow such claims to be submitted to the USA despite their non-compliances; that is to say, had these claims been in compliance with State and Federal Medicaid laws and regulations, THE CITY OF NEW YORK would not have needed to have prevailed upon the NYSDOH to manipulate the edits.

153. The manipulation of the edits was evidenced by the following, as referenced herein above: the "gibberish" submitted in place of the prior authorization codes; the submission and authorization of

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August 2001 at Page 8, and discussing at Page 1, CMS efforts to address this same issue.

claims that were on their face past the 2 year deadline; and the payment of claims from ineligible providers.

154. Concerning all of the above-described Medicaid claims made by the Defendants, representations were made therein by the Defendants to the UNITED STATES OF AMERICA concerning the services actually rendered, and concerning the compliance by the CITY OF NEW YORK with applicable law and regulation.

155. The above-referred to claims were legally and factually false.

156. The UNITED STATES OF AMERICA relied upon those representations in paying said claims.

157. In addition, the Defendants, acting as providers, had a duty to return monies received which represented false claims submitted, as per 31 USC 3729 (a)(1)(G) and as per the Patient Protection and Affordable Care Act ("PPACA") Section 6402 (d), which amended Part A of Title XI of the Social Security Act, 42 USC 1301, et seq.

158. Pursuant to the PPACA, Defendants were obligated to return overpayments based upon Medicaid claims made within 60 days after the date on which said payment was identified.

159. On each of the payment dates in the claims specified herein, and in the exemplars stated within, upon information and belief, each claim paid to the Defendants as providers was accompanied by a "remittance advice", which specified the amount

claimed as well as additional information describing infirmities in the claims.

160. For the claims set forth herein, Defendants were put on actual notice, and had constructive notice as well, that they overbilled for Medicaid reimbursements, and received monies to which they were not entitled under law given the various infirmities in their billings (e.g. duplicate claims, failure of prior approval, etc.).

161. Defendants not only failed to report these overbillings to either DOH or HHS within the requisite 60 day time period as required by law, upon information and belief, they still have not reported said overpayments to date, in violation of law.

Damages

162. Said spreadsheet at **Exhibit C** also depicts the aggregate monies paid to the CITY OF NEW YORK by the UNITED STATES OF AMERICA, broken down by "edits" which allowed monies to be improperly submitted and paid, from 2009 through 2015.

163. Exhibit F depicts the claims detail data for the summary contained as described in the paragraph above.

164. Said spreadsheet and detail data thus represents damages sustained by the UNITED STATES OF AMERICA, representing false claims presented by the CITY OF NEW YORK and HHC to the UNITED STATES OF AMERICA which, upon information and belief, is representative of monies paid by the

UNITED STATES OF AMERICA from calendar year 2009 through 2015.

165. Said spreadsheet also indicates that the amount of claims paid by the UNITED STATES OF AMERICA from 2009 through 2015, results in damages, exclusive of interest, penalties, or other damages, in the amount up to Fourteen Billion, Two Hundred and Twenty-Two Million, Four Hundred and Fifty-Seven Thousand, Two Hundred and Seventy-Eight Dollars ($14,222,457,278).

166. Said damages represent the pecuniary loss the pecuniary loss suffered by the UNITED STATES OF AMERICA, and represent twenty-three million, six hundred and thirty-thousand, five hundred and twenty-eight (23,630,528) Medicaid claims made by the CITY OF NEW YORK.

As And For a First Cause of Action by Plaintiffs on behalf of GELBMAN and on behalf of the UNITED STATES OF AMERICA: Presenting False Claims For Payment per 31 USC 3729 (a)(1)(A)

167. Plaintiffs repeat, reiterate and re-allege each and every allegation as set forth above of the within Amended Complaint with the same force and effect as though each were more fully set forth at length herein.

168. At all times herein mentioned, the Defendant did knowingly, or acting with deliberate ignorance or reckless disregard for the truth, pres-

ent or caused to be presented, false claims to the United States of America seeking payment and/or reimbursement of monies paid to Medicaid providers and/or benefit recipients, in violation of 31 USC 3729 (a)(1)(A).

169. It is claimed that a civil penalty be assessed against Defendant for not less than $5,500 and not more than $11,000 for each one of said claims, as per 31 USC 3729 (g), as adjusted upwards by applicable law.

170. Said claims related to the types of Long Term Care, Intermediate Care Facility for the Developmentally Disabled, and Managed Care-related Medicaid claims presented to the UNITED STATES OF AMERICA, as described herein.

171. In requesting payment, the CITY OF NEW YORK falsely certified and represented to the UNITED STATES OF AMERICA that the providers and or recipients of said services were eligible to receive said services, in contravention of applicable law and regulation, including but not limited to 18 NYCRR 360-1 and 18 NYCRR 360-3.

172. The presentation of said false claims to the UNITED STATES OF AMERICA caused the UNITED STATES OF AMERICA to suffer significant pecuniary losses, by paying false claims which, contrary to eligibility law and regulation, should not have been presented to them.

As And For a Second Cause of Action by Plaintiffs on behalf of GELBMAN and on behalf of the UNITED STATES OF AMERICA: Use of False Statements per 31 USC 3729 (a)(1)(B)

173. Plaintiffs repeat, reiterate and re-allege each and every allegation as contained herein, including those set forth in the First Cause of Action of the within Amended Complaint, with the same force and effect as though each were more fully set forth at length herein.

174. As set forth above, the Defendant did knowingly, or acting with deliberate ignorance and/or reckless disregard for the truth, made, used, or caused to be made or used, false records or statements material to a false or fraudulent claim, in connection with the submission of the aforementioned claims for Medicaid services rendered, in violation of 31 USC 3729 (a)(1)(B).

175. The CITY OF NEW YORK knowingly used false records in order to induce the UNITED STATES OF AMERICA to pay said false claims.

176. The use of false records, as presented to the UNITED STATES OF AMERICA, caused the UNITED STATES OF AMERICA to pay said claims to Defendant, and to suffer significant pecuniary losses as a result.

As And For a Third Cause of Action by Plaintiffs on behalf of GELBMAN and on behalf of the UNITED STATES OF AMERICA: Conspiracy per 31 USC 3729 (a)(1)(C)

177. Plaintiffs repeat, reiterate and re-allege each and every allegation as contained herein, including those set forth in the First and Second Causes of Action of the within Amended Complaint, with the same force and effect as though each were more fully set forth at length herein.

178. As set forth above, the Defendants did knowingly, or acting with deliberate ignorance and/or reckless disregard for the truth, conspire with the State of New York to make, use, or caused to be made or used, false claims to be submitted to the UNITED STATES OF AMERICA, in connection with the submission of the aforementioned claims for Medicaid services rendered, in violation of 31 USC 3729 (a)(1)(C).

179. There was an agreement between each of the Defendants and the New York State Department of Health to violate the False Claims Act, as stated above.

180. There were numerous overt acts from 2006 through 2015, including at each of the meetings between the above actors described above, which manifest a knowing and conscious implementation of said agreement, and a consequent conscious disregard for the rights of the UNITED STATES OF

AMERICA to not be required to pay Medicaid claims in contravention of Medicaid rules.

As And For a Fourth Cause of Action by Plaintiffs on behalf of GELBMAN and on behalf of the UNITED STATES OF AMERICA: Reverse False Claims – Unlawful Retention of Medicaid Paid Claims per 31 USC 3729 (a)(1)(G).

181. Plaintiffs repeat, reiterate and re-allege each and every allegation as contained herein, including those set forth in the First, Second, and Third Causes of Action of the within Amended Complaint, with the same force and effect as though each were more fully set forth at length herein.

182. Defendants each, as providers of health services, billed for and received benefits as part of the Medicaid program, as set forth herein.

183. That these benefits were in the form of over-payments known to Defendants, for which a duty existed under the Patient Protection and Affordable Care Act ("PPACA") and 31 USC 3729 (a)(1)(G) to report any "obligation" as per 31 USC 3729 (b)(3) – such as said overpayments – and return same.

184. Given the Defendant CITY OF NEW YORK's obligations, duties, and involvement in the billing process pertaining to all Medicaid providers, public and private in the City of New York as set forth

above, the CITY's failure to carry out said obligations and duties has resulted in liability for reverse false claims as set forth by 31 USC 3729 (a)(1)(G).

185. The sums claimed herein as damages represent netted false claims paid by the United States of America, the State of New York, and the City of New York, after appropriate adjustments had been made.

186. That said sums were wrongfully retained by Defendants, and upon information and belief, no recoupment of said funds were made by Defendants to any governmental entity.

WHEREFORE, Plaintiffs, as indicated above, demand judgment against the Defendants in the amount of Fourteen Billion, Two Hundred and Twenty-Two Million, Four Hundred and Fifty-Seven Thousand, Two Hundred and Seventy-Eight Dollars ($14,222,457,278) for each of the First, Second and Third Causes of Action, together with attorneys' fees, costs, disbursements, interest, statutory damages, and exemplary damages, including but not limited to treble damages and civil penalties as the law allows, and a civil penalty of not less than $5,500 and not more than $11,000 for each and every violation of the False Claims Act claimed herein, as per 31 USC 3729 (a)(1)(G), and as increased by applicable adjustments in law.

Dated: Albany, New York
September 5, 2017

Respectfully submitted,

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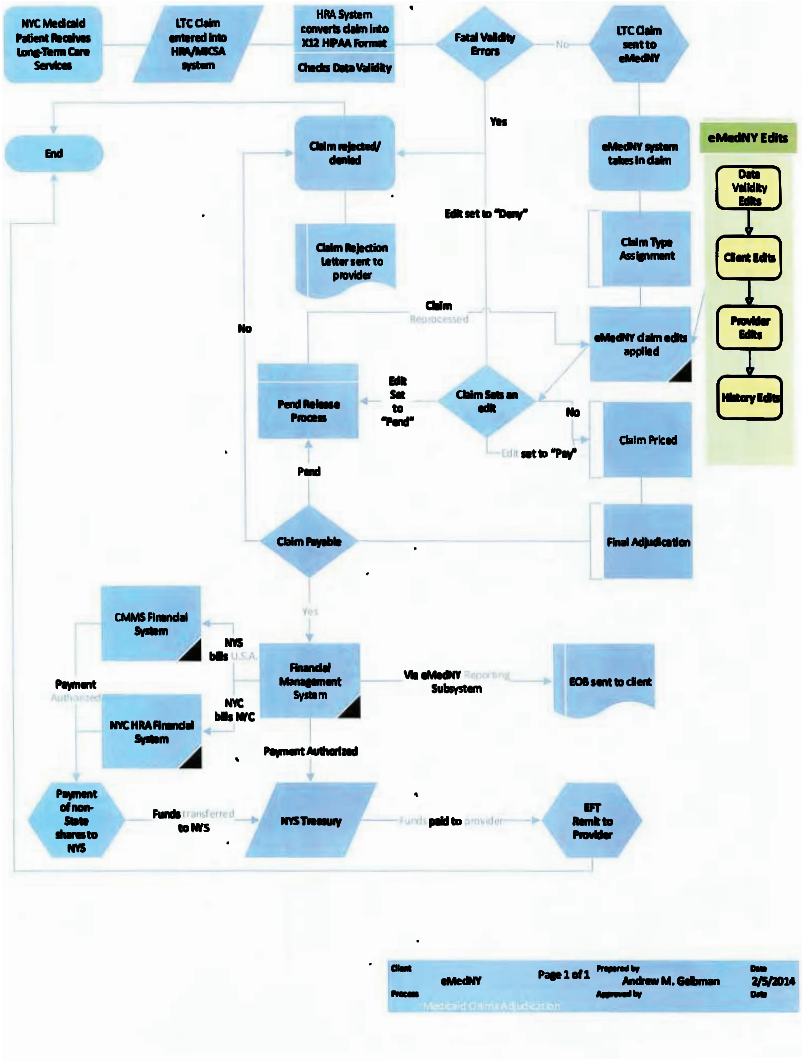
NYC Medicaid Patient Receives Long-Term Care Services
LTC Claim entered into HRA/MICSA system
HRA System converts claim into X12 HIPAA Format
Checks Data Validity
Fatal Validity Errors
No
LTC Claim sent to eMedNY
Yes
End
Claim rejected/ denied
eMedNY system takes in claim
eMedNY Edits
Data Validity Edits
Client Edits
Provider Edits
History Edits
Edit set to "Deny"
Claim Rejection Letter sent to provider
Claim Type Assignment
Claim Reprocessed
No
eMedNY claim edits applied
Pend Release Process
Edit Set to "Pend"
Claim Sets an edit
No
Claim Priced
Edit set to "Pay"
Pend
Claim Payable
Final Adjudication
Yes
CMMS Financial System
NYS bills
Financial Management System
Via eMedNY Reporting Subsystem
EOB sent to client
Payment Authorized
NYC bills NYC
NYC HRA Financial System
Payment Authorized
Payment of non-State shares to NYS
Funds transferred to NYS
NYS Treasury
Funds paid to provider
EFT Remit to Provider
Client
eMedNY
Page 1 of 1
Prepared by
Andrew M. Gellman
Date
2/5/2014
Process
Medicaid Claims Adjudication
Approved by
Date

SUMMARY OF LONG-TERM CARE, INTERMEDIATE CARE, AND MANAGED CARE MEDICAID CLAIMS PAID 2009-2015

2009

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00050	PRIOR APPROVAL NUMBER NON-NUMERIC	21,834,864	10,024	2,178
00123	AMOUNT CHARGED IS LESS THAN MEDICARE APPROVED AMOUNT	30,393	860	35
00131	THIRD PARTY INDICATED/OTHER INSURANCE AMT NOT SUBMITTED	57,628	14	4,116
00142	RECIPIENT BIRTH DATE NOT EQUAL FILE	117,716	47	2,505
00144	RECIPIENT SEX NOT EQUAL FILE	77,031	24	3,210
00152	RECIPIENT FILE INDICATES MEDICARE/NO MEDICARE PRESENT	166,932	114	1,464
00233	PROCEDURE INDICATES STERILIZATION/CHECK FORMS	1,539,218	826	1,863
00239	NO FAULT OR WORKMANS COMP INDICATED/NOT COVERED BY MEDICAID	777,545	94	8,272
00240	OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION	27,486,306	6,913	3,976
00260	MEDICARE PART B AND OR D INDICATED BUT RECIPENT HAS NO SUCH COVERAGE ON FILE	97,047,955	155,144	626
00261	OTHER INSURANCE PAID	38,146,469	43,834	870
00262	MEDICARE PAID	12,396,565	23,848	520
00397	AMOUNT IS 10% OR LS AMT ON PROCEDURE FILE	62	4	15
00674	INVALID ADJUST CODE FOR STATE TSN ADJUSTMENT/VOID	2,651,738	247	10,736
00713	CLIENT HAS MEDICARE PART B AND MEDICAID OTHER IS BLANK	99,265	28	3,545
00728	PA REQUIRED - STAY GT 15 DAYS OR LEVEL OF CARE CHANGED	2,442,280	1,722	1,418
00744	DIAGNOSIS CODE NOT VALID FOR AIDS RATE CODE	121,644	23	5,289
00758	DUPLICATE INPATIENT/PHARMACY CLAIM	126,812,070	24,766	5,120

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00759	DUPLICATE INPATIENT/CLINIC	50,031,941	4,771	10,487
00760	SUSPECT DUPLICATE	3,712	36	103
00795	COST OUTLIER CLAIM REQUIRES MANUAL PRICING	29,314,654	577	50,805
00833	RECIPIENT INELIGIBLE FOR PART OF THE SERVICE PERIOD ON DRG CLAIM	348,404	38	9,169
00927	MODIFIER INVALID FOR SUBMITTED PROCEDURE CODE	25,483	644	40
01047	DATE OF SERVICE SIX YEARS PRIOR TO DATE RECEIVED	619,050	38	16,291
01067	BED RETENTION DAYS OVER LIMIT FOR PATIENT STATUS	2,333,594	1,886	1,237
01131	PAYMENT NOT ALLOWED UNTIL MEDICARE INSURANCE IS MAXIMIZED	408,782,027	147,974	2,763
01141	PROVIDER EXCEPTION IND REQUIRES PEND (OMIG)	9,028,073	871	10,365
01172	PREPAID CAPITATION RECIPIENT - SERVICE COVERED WITHIN PLAN (DENY)	16,674	8	2,084
01197	SERVICE CONFLICT IN COMBO PRIOR SERVICE/CLAIM; PAY/RECORD FOR NOW	21,126,974	3,915	5,396
01220	DAY TREATMENT RATE INVALID FOR PRINCIPLE PROVIDER CODE	59,220	326	182
01242	ORDER/REFERRING PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	783,138	146	5,364
01244	SERVICE PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	4,508,058	2,389	1,887
01630	M/I PROCESSOR CONTROL NUMBER OR NO TSN FOUND FOR PROVIDER ID	82,663	7,506	11
01705	REVENUE CODE NOT ON DB	11,669,243	98,413	119
01724	LI DOS OUTSIDE FROM/THRU DATES	482,337	637	757
01737	VALUE CODE AMOUNT INVALID FOR SUBMITTED VALUE CODE	70,924,728	743,844	95
01995	SPECIAL INPUT EDIT (DOH)	2,651,738	247	10,736

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
01996	SPECIAL INPUT EDIT (PCG)	822,933	441	1,866
01997	SPECIAL INPUT EDIT (IPRO)	26,794,079	6,537	4,099
01999	CLAIM HAS BEEN SPECIAL INPUT BY NYS FA	2,251,688	742	3,035
02001	CLAIM PAYER PD AMT NOT EQUAL TO SUM OF LINE PAYER PD AMT	12,224	495	25
02015	MEDICARE COINSURANCE > 0 AND MEDICARE PAYMENT = 0	18,578,083	49,922	372
02020	MISSING BILLING NPI	39,010,852	42,554	917
02023	MISSING ATTENDING NPI	47,409,093	36,032	1,316
02024	MISSING OPERATING NPI	8,739,999	3,776	2,315
02025	MISSING RENDERING NPI	8,394,604	287,277	29
02033	INVALID ATTENDING NPI	777,469	3,459	225
02035	INVALID RENDERING NPI	313,799	10,899	29
02037	INVALID OTHER NPI	104,709	3,808	27
02042	REFERRING MMIS PROVIDER ID CAN NOT BE DERIVED	18,084,576	239,997	75
02043	ATTENDING MMIS PROVIDER ID CAN NOT BE DERIVED	153,391,704	500,258	307
02044	OPERATING MMIS PROVIDER ID CAN NOT BE DERIVED	41,787,395	10,458	3,996
02047	OTHER MMIS PROVIDER ID CAN NOT BE DERIVED	281,821	9,740	29
02050	INVALID NPI AND MMIS BILLING PROVIDER ID COMBINATION	526,290,590	1,234,061	426
02052	INVALID NPI AND MMIS REFERRING PROVIDER ID COMBINATION	8,088,025	75,926	107
02053	INVALID NPI AND MMIS ATTENDING PROVIDER ID COMBINATION	59,186,863	137,166	431
02054	INVALID NPI AND MMIS OPERATING PROVIDER ID COMBINATION	10,404,333	3,971	2,620
02055	INVALID NPI AND MMIS RENDERING PROVIDER ID COMBINATION	6,964,179	242,649	29

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
02056	INVALID NPI AND MMIS SUPERVISING PROVIDER ID COMBINATION	307,362	10,338	30
02063	TRANSPORTATION SERVICE PAID DURING THIS INPATIENT ADMISSION PERIOD	6,307,580	832	7,581
02066	DRUG CODE MISSING	764,971	412	1,857
02067	ATTENDING PROVIDER NOT LINKED TO BILLING PROVIDER	565,203,913	185,824	3,042
02068	PROVIDER RATE FOUND WITHOUT MATCHING ZIP/LOCATOR CODE	766,912,673	1,016,994	754
02071	ORDERING MMIS ID CAN NOT BE DERIVED FROM NPI	371,960	12,739	29
02075	NPI NOT ALLOWED FOR THIS CATEGORY OF SERVICE	1,644,535	49,148	33
02077	MORE LINES ON ADJUSTMENT THAN ORIGINAL	2,393	57	42
02079	MISSING OR INVALID POA CODE	28,580,726	6,809	4,197
02098	MEDICARE/OTHER INSURANCE AMOUNTS INVALID	25,357	10	2,536
	total	**3,292,407,885**	**5,466,129**	**602**

2010

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00050	PRIOR APPROVAL NUMBER NON-NUMERIC	26,302,299	11,338	2,320
00123	AMOUNT CHARGED IS LESS THAN MEDICARE APPROVED AMOUNT	9,435	405	23
00131	THIRD PARTY INDICATED/OTHER INSURANCE AMT NOT SUBMITTED	96,364	20	4,818
00142	RECIPIENT BIRTH DATE NOT EQUAL FILE	276,722	66	4,193
00144	RECIPIENT SEX NOT EQUAL FILE	119,730	43	2,784
00152	RECIPIENT FILE INDICATES MEDICARE/NO MEDICARE PRESENT	146,080	78	1,873
00233	PROCEDURE INDICATES STERILIZATION/CHECK FORMS	1,447,569	742	1,951
00239	NO FAULT OR WORKMANS COMP INDICATED/NOT	1,591,515	118	13,487

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
	COVERED BY MEDICAID			
00240	OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION	28,716,928	12,191	2,356
00260	MEDICARE PART B AND OR D INDICATED BUT RECIPENT HAS NO SUCH COVERAGE ON FILE	103,390,504	171,068	604
00261	OTHER INSURANCE PAID	42,935,990	34,626	1,240
00262	MEDICARE PAID	11,423,234	21,953	520
00561	DRUGS/SUPPLY CODE NOT ON FILE	20,002	34	588
00674	INVALID ADJUST CODE FOR STATE TSN ADJUSTMENT/VOID	3,644,718	284	12,834
00713	CLIENT HAS MEDICARE PART B AND MEDICAID OTHER IS BLANK	28,011	14	2,001
00728	PA REQUIRED - STAY GT 15 DAYS OR LEVEL OF CARE CHANGED	1,421,910	1,277	1,113
00744	DIAGNOSIS CODE NOT VALID FOR AIDS RATE CODE	65,311	24	2,721
00758	DUPLICATE INPATIENT/PHARMACY CLAIM	137,059,686	25,751	5,322
00759	DUPLICATE INPATIENT/CLINIC	36,893,738	2,841	12,986
00795	COST OUTLIER CLAIM REQUIRES MANUAL PRICING	31,921,684	725	44,030
00833	RECIPIENT INELIGIBLE FOR PART OF THE SERVICE PERIOD ON DRG CLAIM	407,306	48	8,486
00970	RECIPIENT NOT AUTHORIZED ON PRINCIPAL PROVIDER SYSTEM	67,623	227	298
00972	RECIPIENT NOT AUTHORIZED FOR LONG TERM CARE FOR SERVICE PERIOD	344,185	1,308	263
01047	DATE OF SERVICE SIX YEARS PRIOR TO DATE RECEIVED	673,251	325	2,072
01067	BED RETENTION DAYS OVER LIMIT FOR PATIENT STATUS	1,314,650	1,650	797
01131	PAYMENT NOT ALLOWED UNTIL MEDICARE INSURANCE IS MAXIMIZED	520,781,063	166,307	3,131
01141	PROVIDER EXCEPTION IND REQUIRES PEND (OMIG)	4,067,980	10,397	391

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
01172	PREPAID CAPITATION RECIPIENT - SERVICE COVERED WITHIN PLAN (DENY)	15,942	6	2,657
01197	SERVICE CONFLICT IN COMBO PRIOR SERVICE/CLAIM; PAY/RECORD FOR NOW	47,905,680	6,516	7,352
01220	DAY TREATMENT RATE INVALID FOR PRINCIPLE PROVIDER CODE	62,207	312	199
01240	RESTRICTED RECIPIENT INPATIENT SERVICE NOT PROVIDED/ORDERED/REFERRED BY PRIMARY PROVIDER	25,573	35	731
01242	ORDER/REFERRING PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	419,504	148	2,834
01244	SERVICE PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	5,751,416	5,133	1,120
01630	M/I PROCESSOR CONTROL NUMBER OR NO TSN FOUND FOR PROVIDER ID	39,942	3,699	11
01705	REVENUE CODE NOT ON DB	16,919,219	150,523	112
01724	LI DOS OUTSIDE FROM/THRU DATES	448,198	1,612	278
01737	VALUE CODE AMOUNT INVALID FOR SUBMITTED VALUE CODE	70,107,784	753,810	93
01739	OCCURRENCE DATE INVALID FOR SUBMITTED OCCURRENCE CODE	11,063	4	2,766
01995	SPECIAL INPUT EDIT (DOH)	3,644,718	284	12,834
01996	SPECIAL INPUT EDIT (PCG)	622,317	361	1,724
01997	SPECIAL INPUT EDIT (IPRO)	28,655,350	7,025	4,079
01999	CLAIM HAS BEEN SPECIAL INPUT BY NYS FA	712,122	2,013	354
02001	CLAIM PAYER PD AMT NOT EQUAL TO SUM OF LINE PAYER PD AMT	2,143	100	21
02015	MEDICARE COINSURANCE > 0 AND MEDICARE PAYMENT = 0	19,632,953	53,681	366
02063	TRANSPORTATION SERVICE PAID DURING THIS INPATIENT ADMISSION PERIOD	4,743,436	525	9,035
02066	DRUG CODE MISSING	0	5	0

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
02067	ATTENDING PROVIDER NOT LINKED TO BILLING PROVIDER	224,847,663	72,180	3,115
02068	PROVIDER RATE FOUND WITHOUT MATCHING ZIP/LOCATOR CODE	1,601,970,547	2,436,738	657
02077	MORE LINES ON ADJUSTMENT THAN ORIGINAL	1,347	21	64
02079	MISSING OR INVALID POA CODE	25,359,810	6,021	4,212
02105	PROVIDER IS NOT VALID FOR BARIATRIC SURGERY FOR OBESITY	690,630	267	2,587
02112	CROSSOVER IS A DUPLICATE OF A CLAIM IN HISTORY	1,453,293	2,055	707
02144	MEDICARE/MCO PAYER AMOUNTS NOT REASONABLE	195,944	476	412
	Total	**3,009,406,288**	**3,967,410**	**759**

2011

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00050	PRIOR APPROVAL NUMBER NON-NUMERIC	39,436,536	17,501	2,253
00123	AMOUNT CHARGED IS LESS THAN MEDICARE APPROVED AMOUNT	7,191	230	31
00142	RECIPIENT BIRTH DATE NOT EQUAL FILE	176,543	44	4,012
00144	RECIPIENT SEX NOT EQUAL FILE	99,140	23	4,310
00152	RECIPIENT FILE INDICATES MEDICARE/NO MEDICARE PRESENT	64,191	34	1,888
00233	PROCEDURE INDICATES STERILIZATION/CHECK FORMS	794,584	473	1,680
00239	NO FAULT OR WORKMANS COMP INDICATED/NOT COVERED BY MEDICAID	827,499	112	7,388
00240	OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION	31,235,759	15,060	2,074
00260	MEDICARE PART B AND OR D INDICATED BUT RECIPENT HAS NO SUCH COVERAGE ON FILE	114,584,510	192,813	594
00261	OTHER INSURANCE PAID	24,169,155	22,252	1,086
00262	MEDICARE PAID	11,564,615	21,311	543
00397	AMOUNT IS 10% OR LS AMT ON PROCEDURE FILE	91	6	15
00674	INVALID ADJUST CODE FOR STATE TSN ADJUSTMENT/VOID	3,140,514	281	11,176
00702	SERVICE DATE NOT WITHIN PA APPROVED DATE	88,897	53	1,677

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
	RANGE			
00713	CLIENT HAS MEDICARE PART B AND MEDICAID OTHER IS BLANK	78,430	31	2,530
00728	PA REQUIRED - STAY GT 15 DAYS OR LEVEL OF CARE CHANGED	122,312	149	821
00744	DIAGNOSIS CODE NOT VALID FOR AIDS RATE CODE	69,380	15	4,625
00758	DUPLICATE INPATIENT/PHARMACY CLAIM	125,046,104	24,328	5,140
00759	DUPLICATE INPATIENT/CLINIC	30,398,868	2,288	13,286
00795	COST OUTLIER CLAIM REQUIRES MANUAL PRICING	42,313,580	1,263	33,502
00833	RECIPIENT INELIGIBLE FOR PART OF THE SERVICE PERIOD ON DRG CLAIM	286,871	52	5,517
00903	ORDERING OR REFERRING PROVIDER ID OR LICENSE NUMBER NOT ON CLAIM	340	15	23
00927	MODIFIER INVALID FOR SUBMITTED PROCEDURE CODE	12,538	396	32
00972	RECIPIENT NOT AUTHORIZED FOR LONG TERM CARE FOR SERVICE PERIOD	595,952	1,463	407
01047	DATE OF SERVICE SIX YEARS PRIOR TO DATE RECEIVED	991,305	326	3,041
01067	BED RETENTION DAYS OVER LIMIT FOR PATIENT STATUS	237,647	923	257
01131	PAYMENT NOT ALLOWED UNTIL MEDICARE INSURANCE IS MAXIMIZED	604,698,937	190,533	3,174
01197	SERVICE CONFLICT IN COMBO PRIOR SERVICE/CLAIM; PAY/RECORD FOR NOW	50,437,122	6,209	8,123
01220	DAY TREATMENT RATE INVALID FOR PRINCIPLE PROVIDER CODE	65,922	400	165
01240	RESTRICTED RECIPIENT INPATIENT SERVICE NOT PROVIDED/ORDERED/REFERRED BY PRIMARY PROVIDER	26,720	36	742
01242	ORDER/REFERRING PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	270,749	141	1,920
01244	SERVICE PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	2,908,202	2,938	990
01630	M/I PROCESSOR CONTROL NUMBER OR NO TSN FOUND FOR PROVIDER ID	20,213	1,631	12
01705	REVENUE CODE NOT ON DB	6,492,855	82,586	79
01724	LI DOS OUTSIDE FROM/THRU DATES	720,635	680	1,060
01737	VALUE CODE AMOUNT INVALID FOR SUBMITTED VALUE CODE	116,872,688	1,049,474	111
01739	OCCURRENCE DATE INVALID FOR SUBMITTED OCCURRENCE CODE	3,152	5	630
01995	SPECIAL INPUT EDIT (DOH)	3,140,514	281	11,176
01996	SPECIAL INPUT EDIT (PCG)	663,177	248	2,674

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
01997	SPECIAL INPUT EDIT (IPRO)	21,814,077	4,800	4,545
01999	CLAIM HAS BEEN SPECIAL INPUT BY NYS FA	1,852,109	2,534	731
02001	CLAIM PAYER PD AMT NOT EQUAL TO SUM OF LINE PAYER PD AMT	4,911	458	11
02015	MEDICARE COINSURANCE > 0 AND MEDICARE PAYMENT = 0	13,163,917	35,663	369
02042	REFERRING MMIS PROVIDER ID CAN NOT BE DERIVED	5,066,015	38,677	131
02043	ATTENDING MMIS PROVIDER ID CAN NOT BE DERIVED	37,313,106	77,724	480
02063	TRANSPORTATION SERVICE PAID DURING THIS INPATIENT ADMISSION PERIOD	4,490,932	509	8,823
02067	ATTENDING PROVIDER NOT LINKED TO BILLING PROVIDER	3,588,518	718	4,998
02068	PROVIDER RATE FOUND WITHOUT MATCHING ZIP/LOCATOR CODE	684,503,840	1,087,535	629
02071	ORDERING MMIS ID CAN NOT BE DERIVED FROM NPI	151,506	5,049	30
02079	MISSING OR INVALID POA CODE	11,980,042	2,545	4,707
02112	CROSSOVER IS A DUPLICATE OF A CLAIM IN HISTORY	1,038,152	1,725	602
02144	MEDICARE/MCO PAYER AMOUNTS NOT REASONABLE	1,144,294	3,516	325
	Totals	**1,998,774,855**	**2,898,057**	**690**

2012

Edit Code	Description	Total Federal Share	Claims Filed	Avg. Claim
00050	PRIOR APPROVAL NUMBER NON-NUMERIC	56,625,244	18,302	3,094
0050	PRIOR APPROVAL NUMBER NON-NUMERIC	56,625,244	18,302	3,094
00123	AMOUNT CHARGED IS LESS THAN MEDICARE APPROVED AMOUNT	1,141	27	42
00131	THIRD PARTY INDICATED/OTHER INSURANCE AMT NOT SUBMITTED	475,686	145	3,281
00142	RECIPIENT BIRTH DATE NOT EQUAL FILE	250,743	62	4,044
00144	RECIPIENT SEX NOT EQUAL FILE	289,616	54	5,363
00152	RECIPIENT FILE INDICATES MEDICARE/NO MEDICARE PRESENT	112,582	59	1,908
00233	PROCEDURE INDICATES STERILIZATION/CHECK	482,860	297	1,626

Edit Code	Description	Total Federal Share	Claims Filed	Avg. Claim
	FORMS			
00239	NO FAULT OR WORKMANS COMP INDICATED/NOT COVERED BY MEDICAID	748,264	107	6,993
00240	OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION	36,207,031	13,690	2,645
00260	MEDICARE PART B AND OR D INDICATED BUT RECIPENT HAS NO SUCH COVERAGE ON FILE	100,509,747	178,136	564
00261	OTHER INSURANCE PAID	8,728,822	12,500	698
00262	MEDICARE PAID	10,837,092	20,338	533
00653	STATEMENT FROM DATE PRIOR TO ADMISSION DATE	30,446	19	1,602
00674	INVALID ADJUST CODE FOR STATE TSN ADJUSTMENT/VOID	1,784,832	175	10,199
00713	CLIENT HAS MEDICARE PART B AND MEDICAID OTHER IS BLANK	85,501	22	3,886
00728	PA REQUIRED - STAY GT 15 DAYS OR LEVEL OF CARE CHANGED	40,959	27	1,517
00744	DIAGNOSIS CODE NOT VALID FOR AIDS RATE CODE	5,723	4	1,431
00758	DUPLICATE INPATIENT/PHARMACY CLAIM	98,353,635	14,522	6,773
00759	DUPLICATE INPATIENT/CLINIC	23,344,047	1,836	12,715
00789	STATEMENT FROM DATE NOT EQUAL ADMIT DATE FOR DRG CLAIM	406,974	207	1,966
00795	COST OUTLIER CLAIM REQUIRES MANUAL PRICING	54,446,132	1,566	34,768
00833	RECIPIENT INELIGIBLE FOR PART OF THE SERVICE PERIOD ON DRG CLAIM	269,208	31	8,684
00927	MODIFIER INVALID FOR SUBMITTED PROCEDURE CODE	5,841	212	28
00939	ORDERING/REFERRING PROVIDER EXCLUDED PRIOR TO SERVICE/ORDER DATE	35,575	7	5,082
00970	RECIPIENT NOT AUTHORIZED ON PRINCIPAL PROVIDER SYSTEM	64,323	40	1,608
00972	RECIPIENT NOT AUTHORIZED FOR LONG TERM	292,158	498	587

Edit Code	Description	Total Federal Share	Claims Filed	Avg. Claim
	CARE FOR SERVICE PERIOD			
01029	REQUIRED PA FOR RATE CODE NOT FOUND	4,463,655	107,092	42
01047	DATE OF SERVICE SIX YEARS PRIOR TO DATE RECEIVED	327,871	45	7,286
01067	BED RETENTION DAYS OVER LIMIT FOR PATIENT STATUS	96,441	456	211
01131	PAYMENT NOT ALLOWED UNTIL MEDICARE INSURANCE IS MAXIMIZED	659,739,944	195,520	3,374
01141	PROVIDER EXCEPTION IND REQUIRES PEND (OMIG)	1,844,076	63,217	29
01172	PREPAID CAPITATION RECIPIENT - SERVICE COVERED WITHIN PLAN (DENY)	49,907	8	6,238
01173	PREPAID CAPITATION RECIPIENT-REFERRAL OR SPECIALIST ID INVALID	16,476	4	4,119
01180	ABORTION CODE INVALID FOR RECIPIENTS AGE	155	8	19
01197	SERVICE CONFLICT IN COMBO PRIOR SERVICE/CLAIM; PAY/RECORD FOR NOW	37,736,621	4,504	8,378
01220	DAY TREATMENT RATE INVALID FOR PRINCIPLE PROVIDER CODE	77,910	572	136
01240	RESTRICTED RECIPIENT INPATIENT SERVICE NOT PROVIDED/ORDERED/REFERRED BY PRIMARY PROVIDER	634,377	704	901
01242	ORDER/REFERRING PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	5,504,944	4,024	1,368
01244	SERVICE PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	7,234,222	4,945	1,463
01630	M/I PROCESSOR CONTROL NUMBER OR NO TSN FOUND FOR PROVIDER ID	21,999	1,763	12
01705	REVENUE CODE NOT ON DB	31,341	18	1,741
01724	LI DOS OUTSIDE FROM/THRU DATES	956,275	779	1,228
01737	VALUE CODE AMOUNT INVALID FOR SUBMITTED VALUE CODE	310,317,088	1,265,416	245

Edit Code	Description	Total Federal Share	Claims Filed	Avg. Claim
01739	OCCURRENCE DATE INVALID FOR SUBMITTED OCCURRENCE CODE	12,492	4	3,123
01995	SPECIAL INPUT EDIT (DOH)	1,787,345	176	10,155
01996	SPECIAL INPUT EDIT (PCG)	649,796	254	2,558
01997	SPECIAL INPUT EDIT (IPRO)	24,316,012	4,855	5,008
01999	CLAIM HAS BEEN SPECIAL INPUT BY NYS FA	64,730,789	10,924	5,926
02001	CLAIM PAYER PD AMT NOT EQUAL TO SUM OF LINE PAYER PD AMT	2,260	151	15
02015	MEDICARE COINSURANCE > 0 AND MEDICARE PAYMENT = 0	2,666,217	7,573	352
02016	MEDICARE MANAGED CARE (MCO) QUALIFIER 16 CONFLICTS WITH MEDICARE PART A OR PART B QUALIFIERS	667,030	1,500	445
02042	REFERRING MMIS PROVIDER ID CAN NOT BE DERIVED	46,924,105	206,611	227
02043	ATTENDING MMIS PROVIDER ID CAN NOT BE DERIVED	53,051,513	87,528	606
02063	TRANSPORTATION SERVICE PAID DURING THIS INPATIENT ADMISSION PERIOD	4,087,335	555	7,365
02066	DRUG CODE MISSING	1,070	16	67
02067	ATTENDING PROVIDER NOT LINKED TO BILLING PROVIDER	1,465,566	286	5,124
02071	ORDERING MMIS ID CAN NOT BE DERIVED FROM NPI	755,324	27,385	28
02074	UNITS GREATER THAN MAXIMUM	610,059	45	13,557
02077	MORE LINES ON ADJUSTMENT THAN ORIGINAL	8,020	360	22
02079	MISSING OR INVALID POA CODE	2,383,643	542	4,398
02112	CROSSOVER IS A DUPLICATE OF A CLAIM IN HISTORY	780,221	1,475	529
02139	PSYCHIATRIC RE-ADMISSION CLAIM	20,616,456	2,491	8,276
02144	MEDICARE/MCO PAYER AMOUNTS NOT REASONABLE	477,365	1,446	330

Edit Code	Description	Total Federal Share	Claims Filed	Avg. Claim
02157	DELAY REASON CODE 1 (PROOF OF ELIGIBILITY UNKNOWN) INVALID	1,804,991	794	2,273
02160	DELAY REASON CODE 4 (DELAY IN CERTIFYING PROVIDER) INVALID	960,875	1,112	864
02162	DELAY REASON CODE 7 (THIRD PARTY PROCESSING DELAY) INVALID	1,232,192	5,244	235
02163	DELAY REASON CODE 8 (DELAY IN ELIGIBILITY DETERMINATION) INVALID	10,142,350	4,177	2,428
02164	DELAY REASON CODE 9 (ORIGINAL CLAIM DENIED UNRELATED TO TIMELINESS EDITS) INVALID	2,822,866	2,489	1,134
02165	DELAY REASON CODE 10 (ADMINISTRATIVE DELAY IN THE PRIOR APPROVAL PROCESS) INVALID	331,043	15,823	21
02213	PYR 16 INVALID - CLIENT NOT ENRL IN MCARE ADVANT	10,352,205	27,382	378
	Total	**1,733,751,869**	**2,341,458**	**740**

2013

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00050	PRIOR APPROVAL NUMBER NON-NUMERIC	68,428,178	22,036	3,105
00123	AMOUNT CHARGED IS LESS THAN MEDICARE APPROVED AMOUNT	693	17	41
00131	THIRD PARTY INDICATED/OTHER INSURANCE AMT NOT SUBMITTED	290,504	142	2,046
00142	RECIPIENT BIRTH DATE NOT EQUAL FILE	233,090	80	2,914
00144	RECIPIENT SEX NOT EQUAL FILE	265,867	68	3,910
00152	RECIPIENT FILE INDICATES MEDICARE/NO MEDICARE PRESENT	118,027	29	4,070
00233	PROCEDURE INDICATES STERILIZATION/CHECK FORMS	241,484	157	1,538
00239	NO FAULT OR WORKMANS COMP INDICATED/NOT COVERED BY MEDICAID	487,069	88	5,535
00240	OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION	31,744,122	13,896	2,284
00260	MEDICARE PART B AND OR D INDICATED BUT RECIPENT HAS NO SUCH COVERAGE ON FILE	87,352,632	132,359	660
00261	OTHER INSURANCE PAID	3,160,439	2,760	1,145
00262	MEDICARE PAID	8,954,814	13,118	683

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00653	STATEMENT FROM DATE PRIOR TO ADMISSION DATE	6,972,802	2,312	3,016
00674	INVALID ADJUST CODE FOR STATE TSN ADJUSTMENT/VOID	633,872	33	19,208
00713	CLIENT HAS MEDICARE PART B AND MEDICAID OTHER IS BLANK	40,432	10	4,043
00728	PA REQUIRED - STAY GT 15 DAYS OR LEVEL OF CARE CHANGED	41,513	26	1,597
00744	DIAGNOSIS CODE NOT VALID FOR AIDS RATE CODE	7,496	3	2,499
00758	DUPLICATE INPATIENT/PHARMACY CLAIM	75,154,796	10,889	6,902
00759	DUPLICATE INPATIENT/CLINIC	16,178,133	1,472	10,991
00795	COST OUTLIER CLAIM REQUIRES MANUAL PRICING	33,018,017	689	47,922
00833	RECIPIENT INELIGIBLE FOR PART OF THE SERVICE PERIOD ON DRG CLAIM	433,805	54	8,033
00843	CALCULATED PAYMENT AMOUNT LT 0	6,558	654	10
00848	THIRD PARTY DAYS NOT EQUAL TO BILLING PERIOD	5,349,158	1,793	2,983
00854	SUSPEND MASS ADJUSTMENT/VOID	511,607	55	9,302
00970	RECIPIENT NOT AUTHORIZED ON PRINCIPAL PROVIDER SYSTEM	39,551	87	455
00972	RECIPIENT NOT AUTHORIZED FOR LONG TERM CARE FOR SERVICE PERIOD	486,213	519	937
01027	MA COV CD 06/09 MEDICARE APPVD AMOUNT MISSING	46,791	6	7,799
01029	REQUIRED PA FOR RATE CODE NOT FOUND	32,137,534	646,302	50
01047	DATE OF SERVICE SIX YEARS PRIOR TO DATE RECEIVED	912,922	255	3,580
01067	BED RETENTION DAYS OVER LIMIT FOR PATIENT STATUS	83,469	547	153
01131	PAYMENT NOT ALLOWED UNTIL MEDICARE INSURANCE IS MAXIMIZED	365,510,719	187,779	1,946
01141	PROVIDER EXCEPTION IND REQUIRES PEND (OMIG)	577,401	17,045	34
01145	PSYCHIATRIC DIAG/DRG INCONSISTENT WITH PSYCH EXEMPT UNIT CLAIM	930,203	172	5,408
01148	PSYCHIATRIC DIAG/DRG CODE IND PSYCH UNIT BILL RT	933,899	329	2,839
01172	PREPAID CAPITATION RECIPIENT - SERVICE COVERED WITHIN PLAN (DENY)	66,558	11	6,051
01197	SERVICE CONFLICT IN COMBO PRIOR SERVICE/CLAIM; PAY/RECORD FOR NOW	27,674,450	2,964	9,337
01220	DAY TREATMENT RATE INVALID FOR PRINCIPLE PROVIDER CODE	53,108	608	87
01240	RESTRICTED RECIPIENT INPATIENT SERVICE NOT	2,546,370	1,027	2,479

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
	PROVIDED/ORDERED/REFERRED BY PRIMARY PROVIDER			
01242	ORDER/REFERRING PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	6,258,348	13,256	472
01244	SERVICE PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	5,688,263	6,786	838
01245	RESTRICTED RECIPIENT INPATIENT SERVICE NOT PROVIDED/ORDERED/REFERRED BY PRIMARY PROVIDER/PEND FOR REVIEW	6,119	1	6,119
01724	LI DOS OUTSIDE FROM/THRU DATES	796,943	483	1,650
01737	VALUE CODE AMOUNT INVALID FOR SUBMITTED VALUE CODE	359,914,433	1,248,548	288
01739	OCCURRENCE DATE INVALID FOR SUBMITTED OCCURRENCE CODE	7,224	5	1,445
01995	SPECIAL INPUT EDIT (DOH)	637,118	48	13,273
01996	SPECIAL INPUT EDIT (PCG)	446,792	122	3,662
01997	SPECIAL INPUT EDIT (IPRO)	19,840,181	4,048	4,901
01999	CLAIM HAS BEEN SPECIAL INPUT BY NYS FA	70,838,070	9,984	7,095
02015	MEDICARE COINSURANCE > 0 AND MEDICARE PAYMENT = 0	1,477,822	3,540	417
02016	MEDICARE MANAGED CARE (MCO) QUALIFIER 16 CONFLICTS WITH MEDICARE PART A OR PART B QUALIFIERS	1,187,512	1,850	642
02042	REFERRING MMIS PROVIDER ID CAN NOT BE DERIVED	22,204,060	102,998	216
02043	ATTENDING MMIS PROVIDER ID CAN NOT BE DERIVED	20,583,173	17,121	1,202
02063	TRANSPORTATION SERVICE PAID DURING THIS INPATIENT ADMISSION PERIOD	3,385,562	441	7,677
02066	DRUG CODE MISSING	357	11	32
02067	ATTENDING PROVIDER NOT LINKED TO BILLING PROVIDER	1,289,946	80	16,124
02071	ORDERING MMIS ID CAN NOT BE DERIVED FROM NPI	317,375	7,092	45
02074	UNITS GREATER THAN MAXIMUM	2,818,923	151	18,668
02077	MORE LINES ON ADJUSTMENT THAN ORIGINAL	21,866	942	23
02079	MISSING OR INVALID POA CODE	879,884	339	2,596
02112	CROSSOVER IS A DUPLICATE OF A CLAIM IN HISTORY	238,027	541	440
02139	PSYCHIATRIC RE-ADMISSION CLAIM	45,627,226	5,307	8,598
02144	MEDICARE/MCO PAYER AMOUNTS NOT REASONABLE	99,603	204	488
02158	DELAY REASON CODE 2 (LITIGATION) INVALID	506,518	1,171	433
02159	DELAY REASON CODE 3 (AUTHORIZATION DELAYS)	25,876,306	68,092	380

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
	INVALID			
02162	DELAY REASON CODE 7 (THIRD PARTY PROCESSING DELAY) INVALID	1,636	79	21
02216	REFERRING MMIS PROVIDER ID CAN NOT BE DERIVED	58,793,468	392,255	150
02217	ATTENDING MMIS PROVIDER ID CAN NOT BE DERIVED	54,399,859	225,959	241
02219	ORDERING MMIS PROVIDER ID CAN NOT BE DERIVED	479,837	17,292	28
02223	DELAY REASON CODE 15 (NATURAL DISASTER) INVALID	352,505	105	3,357
02224	INPATIENT TO NH/ICF-DD/CHILDCARE DUPLICATE	1,878,559	570	3,296
	Total	**1,478,477,812**	**3,189,812**	**463**

2014

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00050	PRIOR APPROVAL NUMBER NON-NUMERIC	98,778,095	27,337	3,613
00131	THIRD PARTY INDICATED/OTHER INSURANCE AMT NOT SUBMITTED	54,975	73	753
00142	RECIPIENT BIRTH DATE NOT EQUAL FILE	28,422	16	1,776
00144	RECIPIENT SEX NOT EQUAL FILE	10,775	8	1,347
00152	RECIPIENT FILE INDICATES MEDICARE/NO MEDICARE PRESENT	42,595	30	1,420
00233	PROCEDURE INDICATES STERILIZATION/CHECK FORMS	150,772	87	1,733
00239	NO FAULT OR WORKMANS COMP INDICATED/NOT COVERED BY MEDICAID	876,082	119	7,362
00240	OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION	20,047,577	20,503	978
00260	MEDICARE PART B AND OR D INDICATED BUT RECIPENT HAS NO SUCH COVERAGE ON FILE	89,629,500	159,460	562
00261	OTHER INSURANCE PAID	2,304,887	2,569	897
00262	MEDICARE PAID	9,068,882	14,484	626
00653	STATEMENT FROM DATE PRIOR TO ADMISSION DATE	41,318,205	12,306	3,358

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00728	PA REQUIRED - STAY GT 15 DAYS OR LEVEL OF CARE CHANGED	13,663	10	1,366
00758	DUPLICATE INPATIENT/PHARMACY CLAIM	76,304,779	13,332	5,723
00759	DUPLICATE INPATIENT/CLINIC	15,727,714	1,363	11,539
00795	COST OUTLIER CLAIM REQUIRES MANUAL PRICING	39,555,322	1,337	29,585
00810	NUMBER OF DAYS BILLED GREATER THAN DAYS IN BILLING PERIOD	18,270	1	18,270
00833	RECIPIENT INELIGIBLE FOR PART OF THE SERVICE PERIOD ON DRG CLAIM	485,760	50	9,715
00843	CALCULATED PAYMENT AMOUNT LT 0	796	2,552	0
00848	THIRD PARTY DAYS NOT EQUAL TO BILLING PERIOD	33,913,932	7,393	4,587
00854	SUSPEND MASS ADJUSTMENT/VOID	19,283,347	29,616	651
00970	RECIPIENT NOT AUTHORIZED ON PRINCIPAL PROVIDER SYSTEM	204,747	305	671
00972	RECIPIENT NOT AUTHORIZED FOR LONG TERM CARE FOR SERVICE PERIOD	972,469	2,745	354
01002	RECIPIENT COVERED BY MEDICARE PART-B; RE-BILL WITH PART-B RATE	28,810	35	823
01027	MA COV CD 06/09 MEDICARE APPVD AMOUNT MISSING	113,937	13	8,764
01029	REQUIRED PA FOR RATE CODE NOT FOUND	37,372,226	784,632	48
01047	DATE OF SERVICE SIX YEARS PRIOR TO DATE RECEIVED	1,367,577	399	3,428
01067	BED RETENTION DAYS OVER LIMIT FOR PATIENT STATUS	52,231	690	76
01131	PAYMENT NOT ALLOWED UNTIL MEDICARE INSURANCE IS MAXIMIZED	256,543,212	193,726	1,324
01141	PROVIDER EXCEPTION IND REQUIRES PEND (OMIG)	269,778	11,149	24
01145	PSYCHIATRIC DIAG/DRG INCONSISTENT WITH PSYCH EXEMPT UNIT CLAIM	315,162	56	5,628

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
01148	PSYCHIATRIC DIAG/DRG CODE IND PSYCH UNIT BILL RT	483,774	156	3,101
01172	PREPAID CAPITATION RECIPIENT - SERVICE COVERED WITHIN PLAN (DENY)	5,569	4	1,392
01197	SERVICE CONFLICT IN COMBO PRIOR SERVICE/CLAIM; PAY/RECORD FOR NOW	29,314,525	3,258	8,998
01220	DAY TREATMENT RATE INVALID FOR PRINCIPLE PROVIDER CODE	13,893	193	72
01240	RESTRICTED RECIPIENT INPATIENT SERVICE NOT PROVIDED/ORDERED/REFERRED BY PRIMARY PROVIDER	2,434,964	1,134	2,147
01242	ORDER/REFERRING PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	7,425,093	18,773	396
01244	SERVICE PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	6,932,658	12,923	536
01292	DATE OF SERVICE TWO YEARS PRIOR TO DATE RECEIVED	28,657	27	1,061
01724	LI DOS OUTSIDE FROM/THRU DATES	1,195,410	846	1,413
01737	VALUE CODE AMOUNT INVALID FOR SUBMITTED VALUE CODE	306,032,887	1,117,244	274
01996	SPECIAL INPUT EDIT (PCG)	139,187	72	1,933
01997	SPECIAL INPUT EDIT (IPRO)	7,904,085	1,588	4,977
01999	CLAIM HAS BEEN SPECIAL INPUT BY NYS FA	4,573,921	8,799	520
02015	MEDICARE COINSURANCE > 0 AND MEDICARE PAYMENT = 0	1,110,529	2,119	524
02016	MEDICARE MANAGED CARE (MCO) QUALIFIER 16 CONFLICTS WITH MEDICARE PART A OR PART B QUALIFIERS	1,632,950	2,777	588
02042	REFERRING MMIS PROVIDER ID CAN NOT BE DERIVED	12,121,321	28,781	421
02043	ATTENDING MMIS PROVIDER ID CAN NOT BE DERIVED	12,136,512	21,659	560
02063	TRANSPORTATION SERVICE PAID DURING THIS	3,454,651	466	7,413

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
	INPATIENT ADMISSION PERIOD			
02067	ATTENDING PROVIDER NOT LINKED TO BILLING PROVIDER	286,050	74	3,866
02071	ORDERING MMIS ID CAN NOT BE DERIVED FROM NPI	61,032	2,355	26
02074	UNITS GREATER THAN MAXIMUM	1,522,756	70	21,754
02077	MORE LINES ON ADJUSTMENT THAN ORIGINAL	23,672	897	26
02105	PROVIDER IS NOT VALID FOR BARIATRIC SURGERY FOR OBESITY	193,966	119	1,630
02112	CROSSOVER IS A DUPLICATE OF A CLAIM IN HISTORY	283,840	1,104	257
02139	PSYCHIATRIC RE-ADMISSION CLAIM	29,687,476	3,273	9,070
02144	MEDICARE/MCO PAYER AMOUNTS NOT REASONABLE	78,570	153	514
02158	DELAY REASON CODE 2 (LITIGATION) INVALID	475,186	1,060	448
02159	DELAY REASON CODE 3 (AUTHORIZATION DELAYS) INVALID	77,956,960	177,420	439
02183	HOSPITAL LEAVE DAYS OR OTHER LEAVE OF ABSENCE DAYS THAT ARE CONSISTENT WITH A PLAN OF CARE ORDERED BY SUCH PATIENTS TREATING HEALTH CARE PROFESSIONAL HAVE BEEN EXCEEDED FOR THIS CLIENT FOR REIMBURSEMENT	112	1	112
02213	PYR 16 INVALID - CLIENT NOT ENRL IN MCARE ADVANT	131	1	131
02217	ATTENDING MMIS PROVIDER ID CAN NOT BE DERIVED	4,018,982	3,236	1,242
02223	DELAY REASON CODE 15 (NATURAL DISASTER) INVALID	3,291,606	675	4,876
02224	INPATIENT TO NH/ICF-DD/CHILDCARE DUPLICATE	10,933	5	2,187
02234	SERVICE LINE PROCEDURE CODE NOT COMPATIBLE TO CLAIM TYPE A OR L	133,242	3,129	43
	total	**1,259,819,599**	**2,700,787**	**466**

2015

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00050	PRIOR APPROVAL NUMBER NON-NUMERIC	101,906,214	28,698	3,551
00131	THIRD PARTY INDICATED/OTHER INSURANCE AMT NOT SUBMITTED	23,843	6	3,974
00152	RECIPIENT FILE INDICATES MEDICARE/NO MEDICARE PRESENT	34,198	28	1,221
00233	PROCEDURE INDICATES STERILIZATION/CHECK FORMS	117,417	82	1,432
00239	NO FAULT OR WORKMANS COMP INDICATED/NOT COVERED BY MEDICAID	1,280,338	139	9,211
00240	OVER TWO YEAR OLD CLAIM HELD FOR FUTURE ADJUDICATION	83,472,802	59,173	1,411
00260	MEDICARE PART B AND OR D INDICATED BUT RECIPENT HAS NO SUCH COVERAGE ON FILE	84,858,587	137,912	615
00261	OTHER INSURANCE PAID	3,112,705	3,262	954
00262	MEDICARE PAID	5,949,631	10,110	588
00653	STATEMENT FROM DATE PRIOR TO ADMISSION DATE	28,294,092	8,303	3,408
00664	ATTENDING PHYSICIAN LICENSE NUMBER MISSING	162,893,402	448,746	363
00674	INVALID ADJUST CODE FOR STATE TSN ADJUSTMENT/VOID	305,242	42	7,268
00727	NEAR DUPLICATE CLAIM IN HISTORY	152,843	10	15,284
00728	PA REQUIRED - STAY GT 15 DAYS OR LEVEL OF CARE CHANGED	13,420	10	1,342
00758	DUPLICATE INPATIENT/PHARMACY CLAIM	79,623,039	13,667	5,826
00759	DUPLICATE INPATIENT/CLINIC	12,664,008	1,201	10,545
00795	COST OUTLIER CLAIM REQUIRES MANUAL PRICING	30,690,836	866	35,440
00833	RECIPIENT INELIGIBLE FOR PART OF THE SERVICE PERIOD ON DRG CLAIM	892,606	69	12,936
00843	CALCULATED PAYMENT AMOUNT LT 0	2,386	2,955	1
00854	SUSPEND MASS ADJUSTMENT/VOID	26,282,534	31,739	828

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
00972	RECIPIENT NOT AUTHORIZED FOR LONG TERM CARE FOR SERVICE PERIOD	514,011	710	724
01027	MA COV CD 06/09 MEDICARE APPVD AMOUNT MISSING	56,920	17	3,348
01029	REQUIRED PA FOR RATE CODE NOT FOUND	45,080,828	865,140	52
01047	DATE OF SERVICE SIX YEARS PRIOR TO DATE RECEIVED	1,040,348	84	12,385
01067	BED RETENTION DAYS OVER LIMIT FOR PATIENT STATUS	72,525	1,060	68
01131	PAYMENT NOT ALLOWED UNTIL MEDICARE INSURANCE IS MAXIMIZED	210,752,783	185,505	1,136
01141	PROVIDER EXCEPTION IND REQUIRES PEND (OMIG)	206,515	8,113	25
01172	PREPAID CAPITATION RECIPIENT - SERVICE COVERED WITHIN PLAN (DENY)	64,394	5	12,879
01197	SERVICE CONFLICT IN COMBO PRIOR SERVICE/CLAIM; PAY/RECORD FOR NOW	26,570,374	2,794	9,510
01220	DAY TREATMENT RATE INVALID FOR PRINCIPLE PROVIDER CODE	36,829	512	72
01240	RESTRICTED RECIPIENT INPATIENT SERVICE NOT PROVIDED/ORDERED/REFERRED BY PRIMARY PROVIDER	2,715,698	1,182	2,298
01242	ORDER/REFERRING PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	9,331,437	21,678	430
01244	SERVICE PROVIDER NOT IN ACTIVE STATUS ON DATE OF SERVICE	8,416,348	16,973	496
01292	DATE OF SERVICE TWO YEARS PRIOR TO DATE RECEIVED	3,954	3	1,318
01724	LI DOS OUTSIDE FROM/THRU DATES	814,432	499	1,632
01737	VALUE CODE AMOUNT INVALID FOR SUBMITTED VALUE CODE	309,332,889	980,259	316
01995	SPECIAL INPUT EDIT (DOH)	305,242	42	7,268
01996	SPECIAL INPUT EDIT (PCG)	861,205	211	4,082

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
01997	SPECIAL INPUT EDIT (IPRO)	7,960,189	1,133	7,026
01999	CLAIM HAS BEEN SPECIAL INPUT BY NYS FA	44,368,553	17,169	2,584
02015	MEDICARE COINSURANCE > 0 AND MEDICARE PAYMENT = 0	217,258	453	480
02016	MEDICARE MANAGED CARE (MCO) QUALIFIER 16 CONFLICTS WITH MEDICARE PART A OR PART B QUALIFIERS	1,785,377	1,985	899
02023	MISSING ATTENDING NPI	5,493,182	5,191	1,058
02042	REFERRING MMIS PROVIDER ID CAN NOT BE DERIVED	3,883,485	1,729	2,246
02043	ATTENDING MMIS PROVIDER ID CAN NOT BE DERIVED	3,907,098	1,686	2,317
02046	SUPERVISING MMIS PROVIDER ID CAN NOT BE DERIVED	731	44	17
02063	TRANSPORTATION SERVICE PAID DURING THIS INPATIENT ADMISSION PERIOD	3,272,311	434	7,540
02067	ATTENDING PROVIDER NOT LINKED TO BILLING PROVIDER	292,355	6	48,726
02071	ORDERING MMIS ID CAN NOT BE DERIVED FROM NPI	1,871	37	51
02077	MORE LINES ON ADJUSTMENT THAN ORIGINAL	16,111	528	31
02079	MISSING OR INVALID POA CODE	126,766	15	8,451
02105	PROVIDER IS NOT VALID FOR BARIATRIC SURGERY FOR OBESITY	623,319	326	1,912
02112	CROSSOVER IS A DUPLICATE OF A CLAIM IN HISTORY	267,188	607	440
02139	PSYCHIATRIC RE-ADMISSION CLAIM	37,130,830	4,256	8,724
02144	MEDICARE/MCO PAYER AMOUNTS NOT REASONABLE	35,176	83	424
02158	DELAY REASON CODE 2 (LITIGATION) INVALID	1,058,429	1,732	611
02159	DELAY REASON CODE 3 (AUTHORIZATION DELAYS) INVALID	90,210,854	185,248	487

Edit Code	Description	Federal Share	Claims Filed	Avg. Claim
02213	PYR 16 INVALID - CLIENT NOT ENRL IN MCARE ADVANT	2,824	1	2,824
02217	ATTENDING MMIS PROVIDER ID CAN NOT BE DERIVED	8,644,342	3,923	2,204
02223	DELAY REASON CODE 15 (NATURAL DISASTER) INVALID	1,110,439	229	4,849
02231	INPATIENT CLAIM CONTAINS ALC DAYS - NEED TO SPLIT BILL	41,031	5	8,206
02232	ADMIT DATE PRIOR TO SERVICE BEG DATE FOR DRG OR PSYCH CLAIM	52,181	12	4,348
02234	SERVICE LINE PROCEDURE CODE NOT COMPATIBLE TO CLAIM TYPE A OR L	372,329	8,204	45
02248	INPATIENT DRG/EMERGENCY DEPARTMENT CLINIC CLAIMS DUPLICATE	197,866	34	5,820
	total	**1,449,818,970**	**3,066,875**	**473**

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 18-3162

SUMMARY ORDER

RULINGS BY SUMMARY ORDER DO NOT HAVE PRECEDENTIAL EFFECT. CITATION TO A SUMMARY ORDER FILED ON OR AFTER JANUARY 1, 2007 IS PERMITTED AND IS GOVERNED BY FEDERAL RULE OF APPELLATE PROCEDURE 32.1 AND THIS COURT'S LOCAL RULE 32.1.1. WHEN CITING A SUMMARY ORDER IN A DOCUMENT FILED WITH THIS COURT, A PARTY MUST CITE EITHER THE FEDERAL APPENDIX OR AN ELECTRONIC DATABASE (WITH THE NOTATION "SUMMARY ORDER"). A PARTY CITING TO A SUMMARY ORDER MUST SERVE A COPY OF IT ON ANY PARTY NOT REPRESENTED BY COUNSEL.

At a stated term of the United States Court of Appeals for the Second Circuit, held at the Thurgood Marshall United States Courthouse, 40 Foley Square, in the City of New York, on the 17th day of October, two thousand nineteen.

PRESENT:

PIERRE N. LEVAL,
SUSAN L. CARNEY,
Circuit Judges,
TIMOTHY C. STANCEU,
*Judge.**

UNITED STATES OF AMERICA,
EX REL. ANDREW GELBMAN,

Plaintiff-Appellant,

v.

CITY OF NEW YORK,
NEW YORK CITY HEALTH AND
HOSPITALS CORPORATION,

Defendants-Appellees.

FOR PLAINTIFF-APPELLANT:

BRIAN J. ISAAC, Pollack Pollack Isaac & DeCicco, LLP, New York, NY (Richard B. Ancowitz, Law Office of Richard B. Ancowitz, Albany, NY, *on the brief).*

FOR DEFENDANTS-APPELLEES:

JOSEPH V. WILLEY (Alan J. Brudner, *on the brief),* Katten Muchin Rosenman LLP, New York, NY.

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* Chief Judge Timothy C. Stanceu, of the United States Court of International Trade, sitting by designation.

Appeal from a judgment of the United States District Court for the Southern District of New York (Broderick, *J.).*

UPON DUE CONSIDERATION WHEREOF, IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that the judgment entered on September 30, 2018, is **AFFIRMED.**

Plaintiff-Appellant Andrew Gelbman appeals from the judgment of the District Court (Broderick, *J.),* dismissing his *qui tam* complaint filed under the False Claims Act (the "FCA"), 31 U.S.C. § 3729 *et seq.,* for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) and failure to plead fraud with particularity under Rule 9(b). We assume the parties' familiarity with the underlying facts, procedural history, and arguments on appeal, to which we refer only as necessary to explain our decision to affirm.

Gelbman alleges that the City of New York (the "City") and the Health and Hospitals Corporation ("HHC") (collectively, "Defendants-Appellees") submitted false claims to the United States government for reimbursement under the Medicaid program.[1] The second amended complaint (the "SAC") sets forth the following factual allegations relating to the alleged fraudulent scheme, which we take as true for the purposes of evaluating a motion to dismiss.

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[1] The Medicaid Act, 42 U.S.C. §§ 1396 *et seq.*, established a cooperative federal-state program designed to provide medical assistance to low-income individuals.

To obtain Medicaid reimbursements from the federal government, health care providers that operate within the City's jurisdiction submit their Medicaid claims to the City's Human Resources Administration (the "HRA"). HRA, in turn, relays these claims to the New York State Department of Health (the "NYSDOH"), the state agency charged with administering New York's state Medicaid plan.

NYSDOH then uses eMedNY—an automated computer screening system that was "design[ed] and program[ed]" by New York State—to determine whether a claim is reimbursable under Medicaid. App'x 34. Specifically, eMedNY runs the claims through a series of computer algorithms, called "edits," that classify each claim according to various characteristics that are relevant to billing and reimbursement. App'x 33. Based on these computer edits, eMedNY determines whether to pay or deny a claim. If the eMedNY system applies an "edit" indicating that a claim is flawed or otherwise ineligible, the provider is informed of the issue and has an opportunity to cure the error and resubmit the claim. The provider may also argue that the "edit" was applied in error or request an exception to the denial. *See* New York State Department of Health, New York State Electronic Medicaid System Remittance Advice Guideline 106-07 (2013).

NYSDOH then submits the paid claims, as determined by eMedNY, to the United States for reimbursement of the federal government's share of Medicaid expenditures. It does so through a CMS-64 Quarterly Expense Report (the "Expense

Report") that, *inter alia,* certifies to the United States that "[t]his report only includes expenditures under the Medicaid program . . . that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan approved by the Secretary." App'x 60.

Gelbman asserts, however, that Defendants-Appellees and NYSDOH have "conspired to manipulate and rig the manner in which Medicaid claims . . . [are] processed by eMedNY," such that claims that were flagged by eMedNY as ineligible for reimbursement under state or federal law are nevertheless being submitted to the federal government. App'x 23. Gelbman learned of the alleged fraudulent scheme through his employment as an "Information Specialist II" at NYSDOH, where he performed work on eMedNY, including "Medicaid management and fraud detection." App'x 21, 33. Gelbman alleges that, during various meetings held between the City and NYSDOH, certain unnamed HRA representatives "averred . . . that policy considerations warranted the improper manipulation of edits by [NYSDOH]," and that as a result of these meetings, Defendants-Appellees and NYSDOH manipulated the eMedNY system to ensure that certain ineligible claims were paid and submitted for reimbursement "so as to benefit the [City]." App'x 37. When Gelbman asked why certain Medicaid claims were being paid even though they were ineligible for reimbursement under state or federal law, his supervisors at NYSDOH explained that failure to do so would lead to "finan-

cial ruin" for the City's health care providers and "political problems" for the City. App'x 38.

Gelbman also alleges that he discovered "files and records" showing that the United States government had reimbursed the City on claims that eMedNY had, at some point in time, identified as (1) "untimely," (2) "submitted without proper prior authorization," (3) "duplicative," (4) submitted by providers who were not properly enrolled in the Medicaid program, or (5) had already been paid by another insurer or by Medicare. App'x 24, 41-48, 53-54. For each category of claims, the SAC identifies the laws that allegedly render the claim ineligible, as well as provides detailed payment information for more than 80 individual "exemplar" claims. App'x 41. Gelbman estimates that, from 2009 through 2015, the submission of these five types of Medicaid claims has resulted in the federal government overpaying the City by more than $14 billion in Medicaid reimbursements.

In February 2014, Gelbman filed suit on behalf of the United States under the *qui tam* provisions of the FCA. Gelbman asserts four FCA claims against Defendants-Appellees for (1) presenting a false claim, in violation of 31 U.S.C. § 3729(a)(l)(A); (2) making or using a false record or statement material to a false claim, in violation of § 3729(a) (l) (B); (3) conspiring to violate the FCA, in violation of § 3729(a) (l) (C); and (4) making or using a false record to avoid an obligation to pay the federal government *(i.e.,* a "reverse false claim"), in violation of § 3729(a)(l)(G). The United States declined to intervene in the action.

Defendants-Appellees sought dismissal of the SAC under Rule 12(b)(6) for failure to state a claim and under Rule 9(b) for failure to allege fraud with particularity. The District Court granted Defendants-Appellees' motion; denied Gelbman's request for leave to further amend his complaint; and dismissed the action with prejudice. Gelbman now appeals the District Court's dismissal of the SAC, but not its denial of leave to amend. For the reasons set forth below, we affirm the District Court's dismissal, primarily for the SAC's failure to satisfy Rule 9(b).

1. 31 U.S.C. §§ 3729(a)(l)(A), (B), and (C)

Gelbman's counts under §§ 3729(a)(l)(A), (B), and (C) of the FCA are subject to Rule 9(b), *see United States ex rel. Ladas v. Exelis, Inc.,* 824 F.3d 16, 26 (2d Cir. 2016), which requires a party alleging fraud to "state with particularity the circumstances constituting fraud." Fed. R. Civ. P. 9(b). We review *de novo* the dismissal of a complaint on Rule 9(b) grounds, *Ladas,* 824 F.3d at 26, taking as true a plaintiff's well-pleaded factual allegations, *United States ex rel. Chorches v. Am. Med. Response, Inc.,* 865 F.3d 71, 81 (2d Cir. 2017).

To satisfy Rule 9(b)'s particularity standard, a plaintiff must "(1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent." *Chorches,* 865 F.3d at 81 (citation omitted). We have "rigorously" enforced Rule

9(b), recognizing that the rule has a number of "salutary purposes," including (1) "provid[ing] a defendant with fair notice of a plaintiff's claim," (2) "safeguard[ing] a defendant's reputation from improvident charges of wrongdoing," and (3) "protect[ing] a defendant against the institution of a strike suit." *Ladas,* 824 F.3d at 25-26.

In dismissing the SAC, the District Court focused on Gelbman's failure to provide details about the eligibility status of the Medicaid claims *at the time* of their submission to the federal government. As the District Court noted, and as Gelbman does not dispute, the SAC assumes that NYSDOH submitted claims to the federal government that were ineligible for Medicaid reimbursement because these claims had, at some point prior to their submission, been flagged as ineligible by eMedNY. This assumption, however, presupposes a number of conditions. To begin, eMedNY's identification of a claim as ineligible might, itself, have been an error that NYSDOH later discovered and corrected. Alternatively, the health care providers might have corrected the underlying problem before submission. Moreover, because Gelbman fails to identify the specific Expense Reports that NYSDOH *actually* submitted to the federal government, the SAC leaves open the possibility that NYSDOH fully disclosed to the United States any potential defects in the claims submitted for reimbursement.[2] *See*

[2] Gelbman attaches to the SAC a blank, unsigned Expense Report that contains no information on the claims that Gelbman asserts were false.

Universal Health Servs., Inc. v. United States ex rel. Escobar, 136 S. Ct. 1989, 1996, 2003 (2016) (holding that "[a] misrepresentation" about a claim's compliance with the law "must be material to the Government's payment decision in order to be actionable under the [FCA]," and that the Government's payment of "a particular claim in full despite its actual knowledge that certain requirements were violated . . . is very strong evidence that those requirements are not material").

Of course, a *qui tam* complaint need not always allege, based on personal knowledge, the actual submission of false claims to the federal government. As we explained in *Chorches,* to survive dismissal under Rule 9(b) when the complaint pleads only on information and belief that fraudulent claims were actually submitted to the United States, a plaintiff must (1) "make plausible allegations that the bills or invoices actually submitted to the government were uniquely within [the defendant's] knowledge and control," and (2) "adduce specific facts supporting a strong inference of fraud." *Chorches,* 865 F.3d at 83 (internal quotation marks omitted).

Gelbman does neither in this case. The SAC does not "set[ ] forth facts establishing specific reasons why [the] information [contained in] the particular bills that were submitted for reimbursement is peculiarly within [Defendants-Appellees'] knowledge." *Id.* at 82 (internal quotation marks and alterations omitted). This omission is particularly noteworthy in light of Gelbman's position as an Information Specialist working on Medicaid reim-

bursement at NYSDOH, the agency responsible for submitting Medicaid claims to the federal government. Nor does the *qui tam* complaint "put[] forth particularized allegations of a scheme to falsify records" or "describe[] specific instances of the implementation of that scheme." *Id.* at 84. Instead, Gelbman alleges in a conclusory fashion that his superiors at NYSDOH "conspired" with an unknown number of unidentified "HRA representatives" to "manipulate and rig" eMedNY. App'x 23, 37. Gelbman does not detail how eMedNY was rigged *(e.g.,* by altering eMedNY's computer algorithms, or by making post-hoc adjustments to eMedNY payment determinations), or who carried out the rigging *(e.g.,* NYSDOH employees, City employees, or some unknown third party). As a result, we are left to speculate as to the specific design and implementation of a scheme that purportedly defrauded the federal government of more than $14 billion over the course of six years.

Gelbman's complaint therefore bears no more than the remotest resemblance to the *qui tam* complaint at issue in *Chorches,* a case that he relies on heavily. In that case, we considered whether Chorches—the trustee for the bankruptcy estate of Fabula, a medical technician—had alleged with sufficient particularity that the defendant, an ambulance company, falsified patient care reports so that they would qualify for Medicare reimbursement. *Chorches,* 865 F.3d at 75-78. Although Chorches failed to identify actual invoices submitted by the defendant to the federal government, we nevertheless allowed his FCA claims to proceed. *Id.*

at 82, 93. In doing so, however, we emphasized that the *qui tam* complaint's factual allegations showed that the defendant's "billing procedures . . . made it virtually impossible for most employees to have access to all the information necessary to certify on personal knowledge both that a particular invoice was submitted for payment and that the facts stated to justify the invoice were false." *Id.* at 82. We further concluded that "[the] allegations detail specific and plausible facts from which we may easily infer . . . that [the defendant] systematically falsified its records," noting in particular that the complaint named the "supervisory personnel" who directed the falsification of the reports; identified more than ten specific instances in which Fabula was ordered to fabricate documents; and explained in detail "both the scheme itself and the method by which [the defendant] executed the scheme." *Id.* at 77, 83-84. In light of Chorches's "plausible and particularized allegations," we concluded that his complaint survived dismissal under Rule 9(b). *Id.* at 85-86.

Gelbman, by contrast, offers no such detail, either as to his reasons for not having personal knowledge of the contents of the Expense Reports submitted to the federal government, or as to the contours of the Defendants-Appellees' alleged scheme to rig and manipulate eMedNY. Instead, his FCA claims under §§ 3729 (a) (l) (A), (B), and (C) rest on "speculation and conclusory allegations." *Id.* at 86 (citation omitted). We therefore affirm dismissal for failure to satisfy Rule 9(b)'s particularity standard.

2. 31 U.S.C. § 3729(a)(l)(G)

We have also applied Rule 9(b)'s heightened pleading standard to *qui tam* actions brought under § 3729(a)(l)(G) for reverse false claims. *See United States ex rel. Takemoto v. Nationwide Mut. Ins. Co.,* 674 F. App'x 92, 95 n.1 (2d Cir. 2017) (collecting cases); *see also Olson v. Fairview Health Servs. of Minnesota,* 831 F.3d 1063, 1074 (8th Cir. 2016) ("[I]t would be remarkable if relators could escape Rule 9(b)'s heightened pleading requirements for fraud by seeking recovery through subsection (a)(1)(G)."). Section 3729(a)(1)(G) prohibits a person from "knowingly mak[ing], us[ing], or caus[ing] 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 conceal[ing] or knowingly and improperly avoid[ing] or decreas[ing] an obligation to pay or transmit money or property to the Government." Accordingly, a claim under § 3729(a) (l) (G) requires the plaintiff to establish that the defendant had a financial obligation to the federal government.

Gelbman's reverse false claim theory thus fails for the same reason that his other FCA claims fail. As expressed above, the SAC does not plausibly allege that Defendants-Appellees caused the submission of false claims to the federal government. Accordingly, the SAC does not plausibly allege that Defendants-Appellees had any obligation to repay to the federal government any funds it received, directly or indirectly, as a result of the Medicaid claims it submitted to NYSDOH.

We therefore conclude that dismissal of Gelbman's reverse false claims action was warranted under Rule 9(b). *See Chesbrough v. VPA, P. C.,* 655 F.3d 461, 473 (6th Cir. 2011) (dismissing reverse claims theory because the relators "have not identified in their complaint any concrete obligation owed to the government").

* * *

We have considered Gelbman's remaining arguments and conclude that they are without merit. Accordingly, the District Court's judgment is **AFFIRMED.**

FOR THE COURT:

Catherine O'Hagan Wolfe, Clerk of Court

[SEAL]

/s/ CATHERINE O'HAGAN WOLFE

[LETTERHEAD UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT]

Date: October 17, 2019 DC Docket #: 14-cv-771

Docket #: 18-3162cv DC Court: SDNY (NEW YORK CITY)

Short Title: United States of America, ex r v. City of New York DC Judge: Broderick

BILL OF COSTS INSTRUCTIONS

The requirements for filing a bill of costs are set forth in FRAP 39. A form for filing a bill of costs is on the Court's website.

The bill of costs must:

* be filed within 14 days after the entry of judgment;
* be verified;
* be served on all adversaries;
* not include charges for postage, delivery, service, overtime and the filers edits;
* identify the number of copies which comprise the printer's unit;
* include the printer's bills, which must state the minimum charge per printer's unit for a page, a cover, foot lines by the line, and an index and table of cases by the page;

* state only the number of necessary copies inserted in enclosed form;
* state actual costs at rates not higher than those generally charged for printing services in New York, New York; excessive charges are subject to reduction;
* be filed via CM/ECF or if counsel is exempted with the original and two copies.

[LETTERHEAD UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT]

Date: October 17, 2019 DC Docket #: 14-cv-771

Docket #: 18-3162cv DC Court: SDNY (NEW YORK CITY)

Short Title: United States of America, ex r v. City of New York DC Judge: Broderick

VERIFIED ITEMIZED BILL OF COSTS

Counsel for

_____

respectfully submits, pursuant to FRAP 39 (c) the within bill of costs and requests the Clerk to prepare an itemized statement of costs taxed against the

_____

and in favor of

_____

for insertion in the mandate.

Docketing Fee _____

Costs of printing appendix
(necessary copies _____) _____

Costs of printing brief
(necessary copies _____) _____

Costs of printing reply brief
(necessary copies _____) _____

(VERIFICATION HERE)

_____
Signature

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

14-CV-771 (VSB)
Date Filed: September 30, 2018

UNITED STATES OF AMERICA
ex rel. ANDREW GELBMAN,

Plaintiff,

—against—

THE CITY OF NEW YORK and
NEW YORK CITY HEALTH
AND HOSPITALS CORPORATION,

Defendants.

OPINION & ORDER

Appearances:

Richard Bradley Ancowitz
Law Office of Richard B. Ancowitz
Albany, New York
Counsel for Plaintiff

Stephen Edward Kitzinger
New York City Law Department
New York, New York
Counsel for Defendant City

Joseph Victor Willey
Alan J. Brudner
Elizabeth Darrow Langdale
Katten Muchin Rosenman, LLP
New York, New York
Counsel for Defendants City and HHC

VERNON S. BRODERICK, *United States District Judge*:

Relator Andrew Gelbman ("Relator" or "Gelbman") brings this action under the *qui tam* provisions of the civil False Claims Act ("FCA"), which permit a private person to file an action on behalf of the Government. Before me are the motions of Defendants the City of New York ("City") and New York City Health and Hospitals Corporation ("HHC") to dismiss the second amended complaint pursuant to Rules 12(b)(6) and 9(b) of the Federal Rules of Civil Procedure. Because Relator fails to plausibly allege any type of false claim under the FCA and the second amended complaint otherwise fails to meet the pleading standard set forth in Rule 9(b), Defendants' motions are GRANTED.

I. Background

A. *Regulatory Background*

The Medicaid Act, enacted in 1965 as Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq.,* is a cooperative federal-state program designed to provide medical assistance to persons with insufficient resources to meet the costs of their necessary

medical care. Although states are not required to participate in Medicaid, states that choose to do so must formulate a "state plan"—a plan of administration that complies with both the Medicaid Act and regulations promulgated by the United States Department of Health and Human Services ("HHS"). *See* 42 U.S.C. § 1396a. Federal Medicaid funds are made available to states that have such a state plan that has been approved by HHS. *See* 42 U.S.C. §§ 1396a(b), 1396b.

New York State participates in Medicaid pursuant to New York Social Services Law. Federal law requires states to designate a "single state agency" to administer the state plan. *See* 42 U.S.C. §§ 1396a(a)(4) & (5); 42 C.F.R. § 431.10(b). In New York the designated agency is the New York State Department of Health ("NYSDOH"). *See* N.Y. Pub. Health Law § 201(1)(v); N.Y. Soc. Serv. Law §§ 363-a(1)–(3). Among other responsibilities, NYSDOH "promulgates all necessary regulations and guidelines for [Medicaid] Program administration."[1]

Although NYSDOH is primarily responsible for administering Medicaid in New York, some aspects of program administration are spread across other state agencies and local departments of social services. N.Y. Soc. Serv. Law §§ 365-n(2), (4). The five counties representing the City of New York share one local department of social services ("LDSS").

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[1] eMedNY Provider Manual, Information for All Providers, Introduction, "Forward," version 2011-1 (June 1, 2011), *available at* https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_ProvidersIntroduction.pdf.

N.Y. Soc. Serv. Law § 61(1). LDSSs are responsible for denying or approving recipients' Medicaid eligibility applications and for determining Medicaid recipients' access to certain services. *See* N.Y. Soc. Serv. Law § 364(1)(a); N.Y. Comp. Codes R. & Regs. tit. 18, § 404.1.

Medical providers *(e.g.,* physicians, hospitals, or nursing homes) that wish to participate as providers in the Medicaid program must submit an enrollment application to NYSDOH and, if approved by NYSDOH, sign a provider agreement with the New York State. N.Y. Comp. Codes R. & Regs. tit. 18, §§ 504.2(b); 504.4(a), (e). Participating providers who furnish services to Medicaid recipients submit their claims for payment to NYSDOH. N.Y. Soc. Serv. Law § 367-b(2); N.Y. Comp. Codes R. & Regs. tit. 18, §§ 540.6(b), 635.1(a). Most providers submit their claims electronically through eMedNY, a software system.

NYSDOH uses eMedNY to process Medicaid claims and payments for services. *See* N.Y. Soc. Serv. Law § 367-b(1)(c). Specifically, eMedNY "[r]eceives, reviews and pays claims submitted by the providers of health care for services rendered to eligible patients (enrollees)."[2] Claims in eMedNY may be paid, pended, or denied. *See* N.Y. Soc. Serv. Law § 367-b(8)(b)(1) (requiring prior to payment a "review for proper coding and such other review as

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[2] eMedNY Provider Manual, Information for All Providers, Introduction, "Medicaid Management Information System," version 2011-1 (June 1, 2011), *available at* https://www.emedny.org/providermanuals/allproviders/PDFS/Information_for_All_Providers-Introduction.pdf.

may be deemed necessary"); N.Y. Comp. Codes R. & Regs. tit. 18, § 504.8(c) (delineating prepayment review that "may deny claims, adjust claims to eliminate noncompensable items . . . correct . . . errors, pend claims for further audit or review, or approve the claim for payment").

LDSSs play a role in approving coverage of certain services that under State law are subject to a "prior approval" or "prior authorization" requirement.[3] When required, prior approval and prior authorization must be completed before a provider may submit a claim for services—a claim may be denied if prior approval and/or prior authorization were not completed or were denied for the service.[4]

B. *The Second Amended Complaint*[5]

Since October 5, 2006, Gelbman has worked as an "Information Specialist II" at NYSDOH. (Doc. 52 ("SAC") ¶ 4.) Gelbman's employment duties and responsibilities include, among other things, per-

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[3] *See* eMedNY Provider Manual, Information for All Providers–General Policy, "Prior Approval," "Prior Authorization," version 2011-2 (Oct. 20, 2011), *available at* https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf.

[4] *See supra* note 3.

[5] The following factual summary is drawn from the allegations of the second amended complaint unless otherwise indicated, which I assume to be true for purposes of this motion. *See Kassner v. 2nd Ave. Delicatessen Inc.,* 496 F.3d 229, 237 (2d Cir. 2007). My references to these allegations should not be construed as a finding as to their veracity, and I make no such findings.

forming business and systems analysis for eMedNY. *(Id.* ¶¶ 5, 12.) He also consults on strategies for program implementation and verification, evaluates project design proposals and project assessments, and models business processes for eMedNY. *(See id.* ¶ 5.) In 2014, while still employed by NYSDOH, Gelbman filed a complaint under seal in this case alleging several violations of the FCA.

Relator alleges that the City presented, or caused to be presented, Medicaid claims to the United States, "which it knew where legally and factually false." *(Id.* ¶ 13.) To support this allegation, Relator identifies meetings called "Evolution Project Meetings" that Relator participated in from 2006 through 2015, during which the meeting participants—including representatives from the City and NYSDOH—"conspired to manipulate and rig the manner in which Medicaid claims . . . were processed by eMedNY." *(Id.)* The Evolution Project Meetings occurred as often as two to three times per week. *(Id.* ¶ 82.) Gelbman's co-workers and supervisors were present at these meetings. *(Id.)* When Gelbman asked his supervisors why certain Medicaid claims were being paid despite not meeting the requisite criteria, his supervisors explained that the City would face "financial ruin" and "political problems [in] the administration." *(Id.* ¶ 90.)

The SAC describes examples of five types of false claims the City allegedly caused the State to pay, and to then submit to the United States for reimbursement. These types include "untimely" claims, *(id.* ¶¶ 103–08), claims involving "failure to present valid prior approval," *(id.* ¶¶ 109–19), "duplicative

claims," *(id.* ¶¶ 120–28), "provider ineligible" claims, *(id.* ¶¶ 129–34), and claims where "other insurance paid" or "Medicare paid," *(id.* ¶¶ 135–42). For each type of claim, Relator provides at least one "exemplar claim," which includes payment information such as dates, amounts, and the edit codes used in eMedNY.

Relator also alleges a relationship between the City and its public hospitals, all of which are owned by HHC. *(Id.* ¶ 16.) Part of this relationship included substantial financial assistance that the City provided to HHC, averaging almost $300 million per year. *(Id.)* HHC owns or indirectly owns certain of the City's medical providers, "which were in significant measure dependent upon receiving funds" for Medicaid claims from the United States. *(Id.* ¶ 95.) Through this relationship, "regulations were systematically and routinely breached" by both Defendants. *(Id.* ¶¶ 78, 102.)

II. Procedural History

On February 6, 2014, Relator filed a complaint under seal pursuant to the *qui tam* provisions of the FCA, which permit a private person to file an action on behalf of the Government. The Government declined to intervene in the action. (Doc. 34.)

On April 10, 2017, Relator amended his complaint, (Doc. 39), and the City moved to dismiss the amended complaint, (Doc. 44). With leave from the Court, Relator filed the SAC, (Doc. 52), adding HHC as a party, and the City's motion to dismiss

the amended complaint was dismissed as moot with leave to re-file, (Doc. 51).

On September 19, 2017, the City filed its motion to dismiss the SAC, (Doc. 57), and memorandum of law in support of its motion, (Doc. 58). On October 17, 2017, the Government requested leave to file a statement of interest ("SOI"), (Doc. 68), which I granted, (Doc. 70). On November 1, 2017, Relator filed his opposition to the City's motion, (Doc. 73), and supporting declaration and exhibits, (Doc. 74). The Government filed its SOI on November 8, 2017. (Doc. 76.) On December 15, 2017, the City filed its reply. (Doc. 79.)

On November 11, 2017, I held a pre-motion conference in connection with HHC's motion to dismiss the SAC, at which point I granted HHC leave to file its motion. On January 12, 2018, HHC filed its motion to dismiss the SAC, (Doc. 82), and memorandum of law in support of its motion, (Doc. 83). On February 22, 2018, Relator filed his opposition to HHC's motion, (Doc. 84), and supporting declaration and exhibits, (Doc. 85). On March 23, 2018, HHC filed its reply. (Doc. 86.)

III. Legal Standards

A. *Rule 12(b)(6)*

To survive a motion to dismiss under Rule 12(b)(6), "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal,* 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 570 (2007)). A

claim will have "facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* This standard demands "more than a sheer possibility that a defendant has acted unlawfully." *Id.* "Plausibility . . . depends on a host of considerations: the full factual picture presented by the complaint, the particular cause of action and its elements, and the existence of alternative explanations so obvious that they render plaintiff's inferences unreasonable." *L-7 Designs, Inc. v. Old Navy, LLC,* 647 F.3d 419, 430 (2d Cir. 2011).

In considering a motion to dismiss, a court must accept as true all well-pleaded facts alleged in the complaint and must draw all reasonable inferences in the plaintiff's favor. *See Kassner,* 496 F.3d at 237. A complaint need not make "detailed factual allegations," but it must contain more than mere "labels and conclusions" or "a formulaic recitation of the elements of a cause of action." *Iqbal,* 556 U.S. at 678 (internal quotation marks omitted). Although all allegations contained in the complaint are assumed to be true, this tenet is "inapplicable to legal conclusions." *Id.* A complaint is "deemed to include any written instrument attached to it as an exhibit or any statements or documents incorporated in it by reference." *Chambers v. Time Warner, Inc.,* 282 F.3d 147, 152 (2d Cir. 2002) (quoting *Int'l Audiotext Network, Inc. v. Am. Tel. & Tel. Co.,* 62 F.3d 69, 72 (2d Cir. 1995)).

B. *Rule 9(b)*

Because the FCA is an anti-fraud statute, *qui tam* complaints filed under the FCA must also comply with Rule 9(b) of the Federal Rules of Civil Procedure, which requires a plaintiff to plead fraud claims "with particularity." Fed. R. Civ. P. 9(b). To comply with Rule 9(b), a complaint must "(1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent." *United States ex rel. Chorches for Bankr. Estate of Fabula v. Am. Med. Response, Inc.,* 865 F.3d 71, 81 (2d Cir. 2017) *("Chorches")* (quoting *United States ex rel. Ladas v. Exelis, Inc.,* 824 F.3d 16, 25 (2d Cir. 2016)). "Rule 9(b) does not require that every *qui tam* complaint provide details of actual bills or invoices submitted to the government." *Id.* at 93. However, "the complaint must be supported by more than 'conclusory statements' or 'hypotheses,' and it must set forth 'particularized allegations of fact.'" *United States ex rel. Tessler v. City of New York,* 712 F. App'x 27, 29 (2d Cir. 2017) (summary order) (quoting *Ladas,* 824 F.3d at 26–27). Although Rule 9(b) permits scienter to be asserted generally, the Second Circuit has "repeatedly required plaintiffs to plead the factual basis which gives rise to a strong inference of fraudulent intent." *Id.* (quoting *O'Brien v. Nat'l Prop. Analysts Partners,* 936 F.2d 674, 676 (2d Cir. 1991)); *see also Universal Health Servs., Inc. v. United States ex rel.*

Escobar, 136 S. Ct. 1989, 2002 (2016) (observing that the FCA's scienter requirement is "rigorous").

IV. Discussion

A. *The Declarations of Richard P. Billera*

Relator submits the declarations of Richard P. Billera[6] in support of his oppositions to Defendants' motions to dismiss ("Billera Declarations"). (Docs. 71-1, 85.) The Billera Declarations, and their contents, are entirely extrinsic to the SAC, were created specifically for this litigation, and Relator has offered no credible basis on which I may consider them. Indeed, Relator himself concedes that "evidence from extrinsic sources is typically not to be used to oppose" a motion to dismiss. (Opp. City 5.)[7] Despite conceding the legal standard upon which motions to dismiss are evaluated, Realtor asserts that this case is unique and he should be permitted to submit extrinsic evidence "to demonstrate a lack of implausibility," and that the Billera

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[6] Billera is the Vice President and Chief Financial Officer of Ranejane, LLC, a company that, among other things, "provides consulting services to providers and contractors in dealing with Medicaid and Medicare claims, and in particular, claims involving the New York State Department of Health, and the United States Department of Health and Human Services." (Doc. 71-1 ¶ 1.)

[7] "Opp. City" refers to Relator's Memorandum of Law in Opposition to the Defendant City of New York's Motion to Dismiss the Second Amended Complaint, filed November 1, 2017. (Doc. 73.)

Declarations are "integral" to the SAC. In considering a motion to dismiss, I look to the allegations on the face of the complaint. *See supra* Part III.A. Relator's claims that the Billera Declarations should be deemed "integral" to the SAC are baseless, since Relator neither (1) had actual notice of the Billera Declarations, nor (2) relied upon them in framing the SAC—indeed, the Billera Declarations —specifically created as part of Relator's opposition to the motion to dismiss—did not exist at the time that the SAC was drafted. *See Chechele v. Scheetz,* 819 F. Supp. 2d 342, 347 (S.D.N.Y. 2011). The Billera Declarations fail to satisfy any of the exceptions that would permit me to consider them in deciding the pending motions, and I will disregard them.

B. *The FCA*

Relator alleges that Defendants violated the FCA by (1) presenting, or causing to be presented, false claims (in violation of 31 U.S.C. § 3729(a)(1)(A)); (2) making or using a false record or statement (in violation of § 3729(a)(1)(B)); (3) conspiring to submit or cause to be submitted a false claim or to make or use a false record or statement (in violation of § 3729(a)(1)(C)); and (4) making a false claim in order to avoid paying the Government—a so-called "reverse false claim" (in violation of § 3729(a)(1)(G)). (SAC ¶¶ 167–86.) Because the SAC fails to plausibly allege any type of false claim under the FCA and falls short of the pleading standard set forth in

Rule 9(b) of the Federal Rules of Civil Procedure, the SAC must be dismissed in its entirety.

1. Applicable Law

The FCA imposes liability for, among other things, "knowingly" presenting or causing to be presented, a false or fraudulent claim "for payment or approval." 31 U.S.C. § 3729(a). Although Congress has repeatedly amended the FCA, "its focus remains on those who present or directly induce the submission of false or fraudulent claims." *Escobar,* 136 S. Ct. at 1996. A "claim" includes direct requests to the Government for payment as well as claims for reimbursement under federal benefits programs. *Id.* Pursuant to the private, or *qui tam,* provisions of the FCA, a private person may bring a civil action on behalf of the Government, as a "relator," for violations of each act. 31 U.S.C. § 3730(b). If a relator brings such an action under the FCA, the Government may elect, within a set amount of time, to intervene in the action. 31 U.S.C. § 3730(b)–(c).

To prove a false claim under FCA §§ 3729(a)(1)(A) and 3729(a)(1)(B), a relator must show that the defendant "(1) made a claim, (2) to the [] government, (3) that is false or fraudulent, (4) knowing of its falsity, and (5) seeking payment from the federal treasury." *Bishop v. Wells Fargo & Co.,* 823 F.3d 35, 43 (2d Cir. 2016) (quoting *Mikes v. Straus,* 274 F.3d 687, 695 (2d Cir. 2001)), *abrogated on other grounds by Escobar,* 136 S. Ct. 1989. Under the FCA, "claims" include "direct requests to the

Government for payment as well as reimbursement requests made to the recipients of federal funds under federal benefits programs." *Escobar,* 136 S. Ct. at 1996. In order to demonstrate that a defendant acted knowingly, the relator must prove that the defendant had actual knowledge, acted in deliberate ignorance, or acted in reckless disregard of the falsity of the claims being submitted. *See* 31 U.S.C. § 3729(b)(1)(A).

a. *Factually False Claims*

Under the FCA, claims are either "factually" false or "legally" false. The typical FCA claim is a factually false claim and "involves an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided." *Mikes,* 274 F.3d at 697. A factually false claim may also be based on fraudulent inducement. This type of factually false claim alleges that the defendant made fraudulent representations to the Government to induce it to enter a contract, and although no false statements were made at the time of the actual claims for payment, they too are "actionable false claims" because the claims "derived from the original fraudulent misrepresentation." *United States ex rel. Feldman v. Van Gorp,* 697 F.3d 78, 91 (2d Cir. 2012) (quoting *United States ex rel. Longhi v. United States,* 575 F.3d 458, 468 (5th Cir. 2009)).

b. *Legally False Claims*

A legally false claim, meanwhile, is "predicated upon a false representation of compliance with a federal statute or regulation or a prescribed contractual term." *Mikes,* 274 F.3d at 696. There are two types of legally false claims: (i) express false certification claims and (ii) implied false certification claims. Express false certification occurs where "a party certifies compliance with a statute or regulation as a condition to governmental payment, but is not actually compliant." *Bishop,* 823 F.3d at 43 (internal quotation marks omitted). Implied false certification occurs "where the submission of the claim itself is fraudulent because it impliedly constitutes a certification of compliance." *Id.* A theory of implied false certification can be a basis for liability where two conditions are satisfied: "first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths." *Escobar,* 136 S. Ct. at 2001.

For a relator to state an FCA claim under a legally false theory, he must show that the misrepresentation about compliance is "material" to the Government's decision to pay. *Id.* At 2002–03 (explaining that this is because the FCA is not intended to be "'an all-purpose antifraud statute' or a vehicle for punishing garden-variety breaches of contract or regulatory violations" (quoting *Allison*

Engine Co. v. United States ex rel. Sanders, 553 U.S. 662, 672 (2008))). In order to be material, the misrepresentation must "hav[e] a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." *Id.* at 1996 (quoting 31 U.S.C. § 3729(b)(4)). The Supreme Court has explained that materiality is a "demanding" standard that requires a holistic assessment. *Id.* at 2003. Provisions are "not automatically material, even if they are labeled conditions of payment." *Id.* at 2001. For example, "if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material." *Id.* at 2003. Conversely, where "a reasonable person would realize" that the misrepresentation concerned an "imperative" aspect of the good or service, "a defendant's failure to appreciate the materiality of that condition would amount to 'deliberate ignorance' or 'reckless disregard' of the 'truth or falsity of the information' even if the Government did not spell this out." *Id.* at 2001–02.

c. *Reverse False Claims*

To state a "reverse false claim" under § 3729(a)(1)(G), a relator must show: "(1) proof that the defendant made a false record or statement (2) at a time that the defendant had a presently-existing obligation to the government—a duty to pay money or property." *United States ex rel. Kester v. Novartis Pharm. Corp.,* 43 F. Supp. 3d 332, 367

(S.D.N.Y. 2014) (internal quotation marks omitted). "Subsection (a)(1)(G) is referred to as the 'reverse false claims' provision because 'it covers claims of money owed to the government, rather than payments made by the government.'" *Id.* at 368 (quoting *United States ex rel. Capella v. Norden Sys., Inc.,* No. 3:94-CV-2063 (EBB), 2000 WL 1336487, at *10 (D. Conn. Aug. 24, 2000)).

2. Application

a. *Factually False Claims*

Relator fails to plausibly allege that Defendants submitted factually false claims for payment. The SAC merely alleges that "the City of New York and HHC knowingly submitted . . . factually false claims." (SAC ¶¶ 13, 48, 81, 150.) These allegations are the only allegations in the SAC that even mention a factually false claim, and they are entirely conclusory. To plead factual falsity, a relator must allege that a billed for service was either not provided or not described truthfully. *Mikes,* 274 F.3d at 697; *see also United States ex rel. Colucci v. Beth Israel Med. Ctr.,* 785 F. Supp. 2d 303, 313–14 (S.D.N.Y. 2011) (finding that plaintiff failed to state a claim under the factual falsity theory where it did not allege that the provider submitted claims for a falsified service or "for services rendered to fictitious patients"). Despite identifying a number a types of allegedly false claims, (*see, e.g.,* SAC ¶¶ 103–42), Relator does not identify a single claim relating to a service that was not provided or not truthfully described. Any claims based on a theory

that either the City or HHC submitted factually false claims for payment is therefore dismissed.

b. *Legally False Claims – Express Certification*

Relator similarly fails to plausibly allege that Defendants submitted legally false claims under an express certification theory. As an initial matter, the SAC does not distinguish between the legal standards governing implied and express certifications, nor does it specify which theory is being pursued.[8] Instead, the SAC alleges that "by virtue of their expressed [sic] and implied certification that these claims were in compliance with applicable federal and state Medicaid law" the City submitted false claims to the Government. (SAC ¶ 40.) This lack of clarity alone is a basis to dismiss the legally false claims. *See United States v. N.Y. Soc. for the Relief of the Ruptured & Crippled, Maintaining the Hosp. for Special Surgery,* No. 07 Civ. 292(PKC), 2014 WL 3905742, at *17 (S.D.N.Y. Aug. 7, 2014) (providing basis for dismissal of legally false claims where the complaint merely alleged that defendants "either expressly or impliedly submitted false legal certifications").

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[8] Relator's oppositions likewise fail to delineate between the legal standards governing implied and express certifications. While Relator is certainly correct that he is "permitted to allege both expressed [*sic*] and implied certification," (Opp. City 17), it does not follow that he need not respond to Defendants' separate arguments asserted under each legal standard.

Further, neither the SAC nor Relator's oppositions point to any certification that could serve as a basis for an express certification claim. Although the Second Circuit recently held that an alleged express certification need not certify compliance with a "particular" statute or regulation, *Bishop,* 870 F.3d at 106–07, such a claim must nevertheless plead an actual certification that was either (1) signed by the defendant or (2) caused to be signed because of the false claims alleged in the complaint. The SAC only describes one certification—the Form CMS-64—a form that by Relator's own admission is not required to be signed by the City or HHC.[9] (SAC ¶ 35 ("Form CMS-64 Certification requires the executive officers of the state agency (in this case NYSDOH) to certify. . . .").) Moreover, the Form CMS-64 attached to the SAC is blank and

[9] In its SOI, the Government asserts, correctly, that it would be sufficient for the SAC to plausibly allege that the City caused the submission of false claims, rather than submitting the claims itself. (SOI 7–8); *see also United States ex rel. Wood v. Allergan, Inc.,* 246 F. Supp. 3d 772, 819 (S.D.N.Y. 2017) ("Where the defendant is a non-submitting entity, courts merely ask 'whether that entity knowingly caused the submission of either a false or fraudulent claim or false records or statements to get such a claim paid. The statute makes no distinction between how non-submitting and submitting entities may render the underlying claim or statements false or fraudulent.'" (quoting *United States ex rel. Hutcheson v. Blackstone Med., Inc.,* 647 F.3d 377, 389 (1st Cir. 2011)), *rev'd on other grounds,* 899 F.3d 163 (2d Cir. 2018). Relator, however, does not allege that the City or HHC caused the submission of false claims: the SAC does not provide any non-conclusory facts to connect either of Defendants to the claims that the providers submitted for payment.

unsigned. (SAC Ex. A.) Because the SAC fails to plausibly allege that either Defendant certified compliance with a statute or regulation as a condition to governmental payment, Relator fails to state a claim under an express certification theory. *See United States ex rel. Hussain v. CDM Smith, Inc.,* No. 14-CV-9107 (JPO), 2017 WL 4326523, at *6 (S.D.N.Y. Sept. 27, 2017) ("Without an express certification, there is no express certification claim.").

c. *Legally False Claims – Implied Certification*

Relator's legally false claims also fail under an implied certification theory. The City argues, among other things, that the SAC does not plausibly allege that (1) the City submitted, or caused the submission of, any false claims; (2) the underlying provider claims were false; and (3) the edits were material to the Government's decision to pay the claims. (City Mem. 14–19.)[10] HHC argues, among other things, that the SAC fails to differentiate between the City and HHC, and it therefore fails to plausibly allege that HHC participated in a scheme to defraud the Government. (HHC Mem. 9–11.)[11]

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[10] "City Mem." refers to the Memorandum of Law in Support of Defendant the City of New York's Motion to Dismiss the Second Amended Complaint of Relator Andrew Gelbman, filed September 19, 2017. (Doc. 58.)

[11] "HHC Mem." refers to the Memorandum of Law in Support of Defendant New York City Health and Hospitals Corporation's Motion to Dismiss the Second Amended Complaint of Relator Andrew Gelbman, filed February 22, 2018. (Doc. 83.)

The crux of Relator's allegations is that certain edit codes *(e.g.,* "untimely claims," "lack of prior approval," "duplicative claims," "provider ineligible," "other insurance paid/Medicare paid") were applied to claims that various New York City medical providers submitted to Medicaid. Putting aside Defendants' argument that it is the State—not the City or HHC—that plays a role in submission of these claims, the SAC utterly fails to meet the pleading standards under Rules 12(b)(6) and 9(b). Although Relator provides details and descriptions of the edit codes themselves, he fails to allege how the existence of an edit rendered the claim false or why the claim was not ultimately entitled to payment. For example, the SAC does not allege that the edit code was still on the claim when the claim was paid. The SAC does not allege that the provider did not correct the alleged error before resubmitting the claim, and it does not allege any facts about the conduct that led the edit to occur (*e.g.,* that a medical provider was ineligible, who the provider was, instances of duplicate billing, who applied the edit code to the claim, etc.). Instead, the SAC incorporates the assumption that the edit codes themselves indicate that a claim was submitted "in violation of state and federal laws." (*See, e.g.,* SAC ¶¶ 41, 43.) This conclusory allegation, even when coupled with detail about the edit codes and exemplar claims, is insufficient to state a claim for fraud with particularity under Rule 9(b).

Because the SAC fails to plausibly allege that either Defendant failed to comply with a legal or

contractual requirement, Relator fails to state a claim under an implied certification theory.

d. *Reverse False Claims*

Nor do the allegations in the SAC plausibly allege any so-called "reverse false claims" under the FCA. In support of his reverse false claims, Relator alleges that various providers of health services billed for and received benefits that were "in the form of overpayments known to Defendants." (SAC ¶¶ 182–83.) The SAC, however, is devoid of any factual information to suggest that either Defendant owed a financial obligation to the Government. Relator's reverse false claim allegations—which essentially boil down to various providers allegedly receiving payment on false claims and thus retaining Government funds to which they were not entitled— are not an adequate basis on which to allege a reverse false claim. *See CDM Smith, Inc.,* 2017 WL 4326523, at *9 ("A complaint that 'makes no mention of any financial obligation that the defendant owed to the government' and 'does not specifically reference any false records or statements used to decrease such an obligation' must be dismissed." (quoting *Allergan, Inc.,* 246 F. Supp. 3d at 826)).

Contrary to Relator's arguments, the Second Circuit's opinion in *Chorches* does not alter this result. In *Chorches,* the bankruptcy estate of a medical technician brought an FCA claim against an ambulance company. *Chorches,* 865 F.3d at 75. The Second Circuit allowed the case to proceed

even though the relator had "not identified actual invoices that were submitted to the federal government" because "the particular bills that were submitted for reimbursement [were] peculiarly within [the defendant's] knowledge." *Id.* at 82 (internal quotation marks omitted). The Second Circuit held that the relator's claims were sufficient because he intricately detailed the "time period . . . during which the fraudulent scheme took place" as well as the "dates, both precise and approximate" of false claims and even "patient names" included in fraudulent bills. *Id.* at 83–84. All that the relator lacked was proof that the fraudulent bills had actually been submitted—*i.e.*, the "specific documents containing false claims"—which he did not have access to given the program at issue. The Second Circuit made clear, however, that pleading "on information and belief" still requires adducing "specific facts supporting a strong inference of fraud." *Id.* at 82 (internal quotation marks omitted).

Relator, relying on *Chorches,* argues that he provides "an enormous amount of final claims detail." (Opp. HHC 23.)[12] Alleging an enormous amount of detail about the edit codes, however, does not equate to a plausible reverse false claim, which requires "(1) proof that the defendant made a false record or statement (2) at a time that the defendant had a presently-existing obligation to the gov-

[12] "Opp. HHC" refers to Relator's Memorandum of Law in Opposition to the Defendant HHC's Motion to Dismiss the Second Amended Complaint, filed February 22, 2018. (Doc. 84.)

ernment—a duty to pay money or property." *Novartis Pharm. Corp.,* 43 F. Supp. 3d at 367 (internal quotation marks omitted). Relator does not point to any allegations in the SAC that support either of these requirements. Accordingly, Defendants' motions are also granted as to the reverse false claims.[13]

C. *Leave to Amend*

In the event of dismissal of the SAC, Relator requests leave to amend the SAC. (Opp. City 24.) However, the SAC is the third complaint filed by Relator in this matter. Indeed, Relator was granted leave to amend his complaint in response to the City's previously filed motion to dismiss. (*See* Doc. 51.) Courts may deny leave to amend in cases of, among other things, "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, [and/or] futility of amendment." *Ruotolo v. City of New York,* 514 F.3d 184, 191 (2d Cir. 2008) (internal quotation marks omitted). Here, I find that Relator's repeated failures to cure deficiencies, including after the filing of the City's initial motion to dismiss, warrant dismissal of his claims with

[13] Because the SAC only alleges a conspiracy in connection with the edit code scheme, there is no need to determine whether plaintiff has sufficiently alleged the elements of a conspiracy. *See United States ex rel. Mooney v. Americare, Inc.,* No. 06-CV-1806 (FB)(VVP), 2013 WL 1346022, at *6 (E.D.N.Y. Apr. 3, 2013).

prejudice. Accordingly, Relator's claims are dismissed with prejudice.

V. Conclusion

For the foregoing reasons, Defendants' motions to dismiss are GRANTED and Relator's claims are dismissed with prejudice. The Clerk of Court is respectfully directed to terminate the pending motions, (Docs. 57, 82), enter judgment for Defendants, and close this case.

SO ORDERED.

Dated: September 30, 2018
New York, New York

/s/ VERNON S. BRODERICK
Vernon S. Broderick
United States District Judge

§ 3729. False claims

(a) Liability for certain acts.—

(1) In general.—Subject to paragraph (2), any 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;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; 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 104-4101), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages.—If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions.—A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions.—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;

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

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

(c) Exemption from disclosure.—Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

(d) Exclusion.—This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986.

§ 3730. Civil actions for false claims

(a) Responsibilities of the Attorney General.—The Attorney General diligently shall investigate a violation under section 3729. If the Attorney General finds that a person has violated or is violating

section 3729, the Attorney General may bring a civil action under this section against the person.

(b) Actions by private persons.—(1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure.1 The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall—

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) Rights of the parties to qui tam actions.— **(1)** If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2)(A) The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Government may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the cir-

cumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the Government that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as—

(i) limiting the number of witnesses the person may call;

(ii) limiting the length of the testimony of such witnesses;

(iii) limiting the person's cross-examination of witnesses; or

(iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Government so requests, it shall be served with copies of all pleadings filed in the action and shall be sup-

plied with copies of all deposition transcripts (at the Government's expense). When a person proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the Government to intervene at a later date upon a showing of good cause.

(4) Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Government has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in such

other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the United States, if all time for filing such an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(d) Award to qui tam plaintiff.—(1) If the Government proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government2 Accounting Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the pro-

ceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(2) If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of section 3729 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the vio-

lation of section 3729, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the United States to continue the action, represented by the Department of Justice.

(4) If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) Certain Actions Barred.—(1) No court shall have jurisdiction over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

(2)(A) No court shall have jurisdiction over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought.

(B) For purposes of this paragraph, "senior executive branch official" means any officer or employee listed in paragraphs (1) through (8) of section 101(f) of the Ethics in Government Act of 1978 (5 U.S.C. App.).

(3) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.

(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were 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, Government2 Accountability Office, or other Federal report, hearing, audit, or investigation; or

(iii) from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.

(f) Government not liable for certain expenses.—The Government is not liable for expenses which a person incurs in bringing an action under this section.

(g) Fees and expenses to prevailing defendant.—In civil actions brought under this section by the United States, the provisions of section 2412(d) of title 28 shall apply.

(h) Relief from retaliatory actions.—

(1) In general.—Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop 1 or more violations of this subchapter.

(2) Relief.—Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action under this subsection may be brought in the appropriate district court of the United States for the relief provided in this subsection.

(3) Limitation on bringing civil action.—A civil action under this subsection may not be brought more than 3 years after the date when the retaliation occurred.

§ 3731. False claims procedure

(a) A subpena requiring the attendance of a witness at a trial or hearing conducted under section 3730 of this title may be served at any place in the United States.

(b) A civil action under section 3730 may not be brought—

(1) more than 6 years after the date on which the violation of section 3729 is committed, or

(2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

(c) If the Government elects to intervene and proceed with an action brought under 3730(b),1 the Government may file its own complaint or amend the complaint of a person who has brought an action under section 3730(b) to clarify or add detail to the claims in which the Government is intervening and to add any additional claims with respect to which the Government contends it is entitled to relief. For statute of limitations purposes, any such

Government pleading shall relate back to the filing date of the complaint of the person who originally brought the action, to the extent that the claim of the Government arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of that person.

(d) In any action brought under section 3730, the United States shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

(e) Notwithstanding any other provision of law, the Federal Rules of Criminal Procedure, or the Federal Rules of Evidence, a final judgment rendered in favor of the United States in any criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action which involves the same transaction as in the criminal proceeding and which is brought under subsection (a) or (b) of section 3730.

§ 3732. False claims jurisdiction

(a) Actions under section 3730.—Any action under section 3730 may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, transacts business, or in which any act proscribed by section 3729 occurred. A summons as required by the Federal Rules of Civil Procedure shall be issued by the appropriate district

court and served at any place within or outside the United States.

(b) Claims under State Law.—The district courts shall have jurisdiction over any action brought under the laws of any State for the recovery of funds paid by a State or local government if the action arises from the same transaction or occurrence as an action brought under section 3730.

(c) Service on State or local authorities.—With respect to any State or local government that is named as a co-plaintiff with the United States in an action brought under subsection (b), a seal on the action ordered by the court under section 3730(b) shall not preclude the Government or the person bringing the action from serving the complaint, any other pleadings, or the written disclosure of substantially all material evidence and information possessed by the person bringing the action on the law enforcement authorities that are authorized under the law of that State or local government to investigate and prosecute such actions on behalf of such governments, except that such seal applies to the law enforcement authorities so served to the same extent as the seal applies to other parties in the action.

§ 3733. Civil investigative demands

Currentness

(a) In general.—

(1) Issuance and service.—Whenever the Attorney General, or a designee (for purposes of this section), has reason to believe that any person may be in possession, custody, or control of any documentary material or information relevant to a false claims law investigation, the Attorney General, or a designee, may, before commencing a civil proceeding under section 3730(a) or other false claims law, or making an election under section 3730(b), issue in writing and cause to be served upon such person, a civil investigative demand requiring such person—

(A) to produce such documentary material for inspection and copying,

(B) to answer in writing written interrogatories with respect to such documentary material or information,

(C) to give oral testimony concerning such documentary material or information, or

(D) to furnish any combination of such material, answers, or testimony.

The Attorney General may delegate the authority to issue civil investigative demands under this subsection. Whenever a civil investigative demand is an express demand for any product of discovery, the Attorney General, the Deputy Attorney Gener-

al, or an Assistant Attorney General shall cause to be served, in any manner authorized by this section, a copy of such demand upon the person from whom the discovery was obtained and shall notify the person to whom such demand is issued of the date on which such copy was served. Any information obtained by the Attorney General or a designee of the Attorney General under this section may be shared with any qui tam relator if the Attorney General or designee determine it is necessary as part of any false claims act1 investigation.

(2) Contents and deadlines.—

(A) Each civil investigative demand issued under paragraph (1) shall state the nature of the conduct constituting the alleged violation of a false claims law which is under investigation, and the applicable provision of law alleged to be violated.

(B) If such demand is for the production of documentary material, the demand shall—

(i) describe each class of documentary material to be produced with such definiteness and certainty as to permit such material to be fairly identified;

(ii) prescribe a return date for each such class which will provide a reasonable period of time within which the material so demanded may be assembled and made available for inspection and copying; and

(iii) identify the false claims law investigator to whom such material shall be made available.

(C) If such demand is for answers to written interrogatories, the demand shall—

(i) set forth with specificity the written interrogatories to be answered;

(ii) prescribe dates at which time answers to written interrogatories shall be submitted; and

(iii) identify the false claims law investigator to whom such answers shall be submitted.

(D) If such demand is for the giving of oral testimony, the demand shall—

(i) prescribe a date, time, and place at which oral testimony shall be commenced;

(ii) identify a false claims law investigator who shall conduct the examination and the custodian to whom the transcript of such examination shall be submitted;

(iii) specify that such attendance and testimony are necessary to the conduct of the investigation;

(iv) notify the person receiving the demand of the right to be accompanied by an attorney and any other representative; and

(v) describe the general purpose for which the demand is being issued and the general nature of the testimony, including the primary areas of inquiry, which will be taken pursuant to the demand.

(E) Any civil investigative demand issued under this section which is an express demand for any product of discovery shall not be returned or

returnable until 20 days after a copy of such demand has been served upon the person from whom the discovery was obtained.

(F) The date prescribed for the commencement of oral testimony pursuant to a civil investigative demand issued under this section shall be a date which is not less than seven days after the date on which demand is received, unless the Attorney General or an Assistant Attorney General designated by the Attorney General determines that exceptional circumstances are present which warrant the commencement of such testimony within a lesser period of time.

(G) The Attorney General shall not authorize the issuance under this section of more than one civil investigative demand for oral testimony by the same person unless the person requests otherwise or unless the Attorney General, after investigation, notifies that person in writing that an additional demand for oral testimony is necessary.

(b) Protected material or information.—

(1) In general.—A civil investigative demand issued under subsection (a) may not require the production of any documentary material, the submission of any answers to written interrogatories, or the giving of any oral testimony if such material, answers, or testimony would be protected from disclosure under—

(A) the standards applicable to subpoenas or subpoenas duces tecum issued by a court of the United States to aid in a grand jury investigation; or

(B) the standards applicable to discovery requests under the Federal Rules of Civil Procedure, to the extent that the application of such standards to any such demand is appropriate and consistent with the provisions and purposes of this section.

(2) Effect on other orders, rules, and laws.—Any such demand which is an express demand for any product of discovery supersedes any inconsistent order, rule, or provision of law (other than this section) preventing or restraining disclosure of such product of discovery to any person. Disclosure of any product of discovery pursuant to any such express demand does not constitute a waiver of any right or privilege which the person making such disclosure may be entitled to invoke to resist discovery of trial preparation materials.

(c) Service; jurisdiction.—

(1) By whom served.—Any civil investigative demand issued under subsection (a) may be served by a false claims law investigator, or by a United States marshal or a deputy marshal, at any place within the territorial jurisdiction of any court of the United States.

(2) Service in foreign countries.—Any such demand or any petition filed under subsection (j) may be served upon any person who is not found within the territorial jurisdiction of any court of the United States in such manner as the Federal Rules of Civil Procedure prescribe for service in a foreign country. To the extent that the courts of the United States can assert jurisdiction over any such

person consistent with due process, the United States District Court for the District of Columbia shall have the same jurisdiction to take any action respecting compliance with this section by any such person that such court would have if such person were personally within the jurisdiction of such court.

(d) Service upon legal entities and natural persons.—

(1) Legal entities.—Service of any civil investigative demand issued under subsection (a) or of any petition filed under subsection (j) may be made upon a partnership, corporation, association, or other legal entity by—

(A) delivering an executed copy of such demand or petition to any partner, executive officer, managing agent, or general agent of the partnership, corporation, association, or entity, or to any agent authorized by appointment or by law to receive service of process on behalf of such partnership, corporation, association, or entity;

(B) delivering an executed copy of such demand or petition to the principal office or place of business of the partnership, corporation, association, or entity; or

(C) depositing an executed copy of such demand or petition in the United States mails by registered or certified mail, with a return receipt requested, addressed to such partnership, corporation, association, or entity at its principal office or place of business.

(2) Natural persons.—Service of any such demand or petition may be made upon any natural person by—

(A) delivering an executed copy of such demand or petition to the person; or

(B) depositing an executed copy of such demand or petition in the United States mails by registered or certified mail, with a return receipt requested, addressed to the person at the person's residence or principal office or place of business.

(e) Proof of service.—A verified return by the individual serving any civil investigative demand issued under subsection (a) or any petition filed under subsection (j) setting forth the manner of such service shall be proof of such service. In the case of service by registered or certified mail, such return shall be accompanied by the return post office receipt of delivery of such demand.

(f) Documentary Material.—

(1) Sworn certificates.—The production of documentary material in response to a civil investigative demand served under this section shall be made under a sworn certificate, in such form as the demand designates, by—

(A) in the case of a natural person, the person to whom the demand is directed, or

(B) in the case of a person other than a natural person, a person having knowledge of the facts and circumstances relating to such production and authorized to act on behalf of such person.

The certificate shall state that all of the documentary material required by the demand and in the possession, custody, or control of the person to whom the demand is directed has been produced and made available to the false claims law investigator identified in the demand.

(2) Production of materials.—Any person upon whom any civil investigative demand for the production of documentary material has been served under this section shall make such material available for inspection and copying to the false claims law investigator identified in such demand at the principal place of business of such person, or at such other place as the false claims law investigator and the person thereafter may agree and prescribe in writing, or as the court may direct under subsection (j)(1). Such material shall be made so available on the return date specified in such demand, or on such later date as the false claims law investigator may prescribe in writing. Such person may, upon written agreement between the person and the false claims law investigator, substitute copies for originals of all or any part of such material.

(g) Interrogatories.—Each interrogatory in a civil investigative demand served under this section shall be answered separately and fully in writing under oath and shall be submitted under a sworn certificate, in such form as the demand designates, by—

(1) in the case of a natural person, the person to whom the demand is directed, or

(2) in the case of a person other than a natural person, the person or persons responsible for answering each interrogatory.

If any interrogatory is objected to, the reasons for the objection shall be stated in the certificate instead of an answer. The certificate shall state that all information required by the demand and in the possession, custody, control, or knowledge of the person to whom the demand is directed has been submitted. To the extent that any information is not furnished, the information shall be identified and reasons set forth with particularity regarding the reasons why the information was not furnished.

(h) Oral Examinations.—

(1) Procedures.—The examination of any person pursuant to a civil investigative demand for oral testimony served under this section shall be taken before an officer authorized to administer oaths and affirmations by the laws of the United States or of the place where the examination is held. The officer before whom the testimony is to be taken shall put the witness on oath or affirmation and shall, personally or by someone acting under the direction of the officer and in the officer's presence, record the testimony of the witness. The testimony shall be taken stenographically and shall be transcribed. When the testimony is fully transcribed, the officer before whom the testimony is taken

shall promptly transmit a copy of the transcript of the testimony to the custodian. This subsection shall not preclude the taking of testimony by any means authorized by, and in a manner consistent with, the Federal Rules of Civil Procedure.

(2) Persons present.—The false claims law investigator conducting the examination shall exclude from the place where the examination is held all persons except the person giving the testimony, the attorney for and any other representative of the person giving the testimony, the attorney for the Government, any person who may be agreed upon by the attorney for the Government and the person giving the testimony, the officer before whom the testimony is to be taken, and any stenographer taking such testimony.

(3) Where testimony taken.—The oral testimony of any person taken pursuant to a civil investigative demand served under this section shall be taken in the judicial district of the United States within which such person resides, is found, or transacts business, or in such other place as may be agreed upon by the false claims law investigator conducting the examination and such person.

(4) Transcript of testimony.—When the testimony is fully transcribed, the false claims law investigator or the officer before whom the testimony is taken shall afford the witness, who may be accompanied by counsel, a reasonable opportunity to examine and read the transcript, unless such examination and reading are waived by the wit-

ness. Any changes in form or substance which the witness desires to make shall be entered and identified upon the transcript by the officer or the false claims law investigator, with a statement of the reasons given by the witness for making such changes. The transcript shall then be signed by the witness, unless the witness in writing waives the signing, is ill, cannot be found, or refuses to sign. If the transcript is not signed by the witness within 30 days after being afforded a reasonable opportunity to examine it, the officer or the false claims law investigator shall sign it and state on the record the fact of the waiver, illness, absence of the witness, or the refusal to sign, together with the reasons, if any, given therefor.

(5) Certification and delivery to custodian.—The officer before whom the testimony is taken shall certify on the transcript that the witness was sworn by the officer and that the transcript is a true record of the testimony given by the witness, and the officer or false claims law investigator shall promptly deliver the transcript, or send the transcript by registered or certified mail, to the custodian.

(6) Furnishing or inspection of transcript by witness.—Upon payment of reasonable charges therefor, the false claims law investigator shall furnish a copy of the transcript to the witness only, except that the Attorney General, the Deputy Attorney General, or an Assistant Attorney General may, for good cause, limit such witness to inspec-

tion of the official transcript of the witness' testimony.

(7) Conduct of oral testimony.—(A) Any person compelled to appear for oral testimony under a civil investigative demand issued under subsection (a) may be accompanied, represented, and advised by counsel. Counsel may advise such person, in confidence, with respect to any question asked of such person. Such person or counsel may object on the record to any question, in whole or in part, and shall briefly state for the record the reason for the objection. An objection may be made, received, and entered upon the record when it is claimed that such person is entitled to refuse to answer the question on the grounds of any constitutional or other legal right or privilege, including the privilege against self-incrimination. Such person may not otherwise object to or refuse to answer any question, and may not directly or through counsel otherwise interrupt the oral examination. If such person refuses to answer any question, a petition may be filed in the district court of the United States under subsection (j)(1) for an order compelling such person to answer such question.

(B) If such person refuses to answer any question on the grounds of the privilege against self-incrimination, the testimony of such person may be compelled in accordance with the provisions of part V of title 18.

(8) Witness fees and allowances.—Any person appearing for oral testimony under a civil inves-

tigative demand issued under subsection (a) shall be entitled to the same fees and allowances which are paid to witnesses in the district courts of the United States.

(i) Custodians of documents, answers, and transcripts.—

(1) Designation.—The Attorney General shall designate a false claims law investigator to serve as custodian of documentary material, answers to interrogatories, and transcripts of oral testimony received under this section, and shall designate such additional false claims law investigators as the Attorney General determines from time to time to be necessary to serve as deputies to the custodian.

(2) Responsibility for materials; disclosure.—(A) A false claims law investigator who receives any documentary material, answers to interrogatories, or transcripts of oral testimony under this section shall transmit them to the custodian. The custodian shall take physical possession of such material, answers, or transcripts and shall be responsible for the use made of them and for the return of documentary material under paragraph (4).

(B) The custodian may cause the preparation of such copies of such documentary material, answers to interrogatories, or transcripts of oral testimony as may be required for official use by any false claims law investigator, or other officer or employee of the Department of Justice. Such material,

answers, and transcripts may be used by any such authorized false claims law investigator or other officer or employee in connection with the taking of oral testimony under this section.

(C) Except as otherwise provided in this subsection, no documentary material, answers to interrogatories, or transcripts of oral testimony, or copies thereof, while in the possession of the custodian, shall be available for examination by any individual other than a false claims law investigator or other officer or employee of the Department of Justice authorized under subparagraph (B). The prohibition in the preceding sentence on the availability of material, answers, or transcripts shall not apply if consent is given by the person who produced such material, answers, or transcripts, or, in the case of any product of discovery produced pursuant to an express demand for such material, consent is given by the person from whom the discovery was obtained. Nothing in this subparagraph is intended to prevent disclosure to the Congress, including any committee or subcommittee of the Congress, or to any other agency of the United States for use by such agency in furtherance of its statutory responsibilities.

(D) While in the possession of the custodian and under such reasonable terms and conditions as the Attorney General shall prescribe—

(i) documentary material and answers to interrogatories shall be available for examination by the person who produced such material or answers, or

by a representative of that person authorized by that person to examine such material and answers; and

(ii) transcripts of oral testimony shall be available for examination by the person who produced such testimony, or by a representative of that person authorized by that person to examine such transcripts.

(3) Use of material, answers, or transcripts in other proceedings.—Whenever any attorney of the Department of Justice has been designated to appear before any court, grand jury, or Federal agency in any case or proceeding, the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony received under this section may deliver to such attorney such material, answers, or transcripts for official use in connection with any such case or proceeding as such attorney determines to be required. Upon the completion of any such case or proceeding, such attorney shall return to the custodian any such material, answers, or transcripts so delivered which have not passed into the control of such court, grand jury, or agency through introduction into the record of such case or proceeding.

(4) Conditions for return of material.—If any documentary material has been produced by any person in the course of any false claims law investigation pursuant to a civil investigative demand under this section, and—

(A) any case or proceeding before the court or grand jury arising out of such investigation, or any proceeding before any Federal agency involving such material, has been completed, or

(B) no case or proceeding in which such material may be used has been commenced within a reasonable time after completion of the examination and analysis of all documentary material and other information assembled in the course of such investigation, the custodian shall, upon written request of the person who produced such material, return to such person any such material (other than copies furnished to the false claims law investigator under subsection (f)(2) or made for the Department of Justice under paragraph (2)(B)) which has not passed into the control of any court, grand jury, or agency through introduction into the record of such case or proceeding.

(5) Appointment of successor custodians.—In the event of the death, disability, or separation from service in the Department of Justice of the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony produced pursuant to a civil investigative demand under this section, or in the event of the official relief of such custodian from responsibility for the custody and control of such material, answers, or transcripts, the Attorney General shall promptly—

(A) designate another false claims law investigator to serve as custodian of such material, answers, or transcripts, and

(B) transmit in writing to the person who produced such material, answers, or testimony notice of the identity and address of the successor so designated.

Any person who is designated to be a successor under this paragraph shall have, with regard to such material, answers, or transcripts, the same duties and responsibilities as were imposed by this section upon that person's predecessor in office, except that the successor shall not be held responsible for any default or dereliction which occurred before that designation.

(j) Judicial Proceedings.—

(1) Petition for enforcement.—Whenever any person fails to comply with any civil investigative demand issued under subsection (a), or whenever satisfactory copying or reproduction of any material requested in such demand cannot be done and such person refuses to surrender such material, the Attorney General may file, in the district court of the United States for any judicial district in which such person resides, is found, or transacts business, and serve upon such person a petition for an order of such court for the enforcement of the civil investigative demand.

(2) Petition to modify or set aside demand.— **(A)** Any person who has received a civil investigative demand issued under subsection (a) may file, in the district court of the United States for the judicial district within which such person resides, is found, or transacts business, and serve upon the false claims law investigator identified in such

demand a petition for an order of the court to modify or set aside such demand. In the case of a petition addressed to an express demand for any product of discovery, a petition to modify or set aside such demand may be brought only in the district court of the United States for the judicial district in which the proceeding in which such discovery was obtained is or was last pending. Any petition under this subparagraph must be filed—

(i) within 20 days after the date of service of the civil investigative demand, or at any time before the return date specified in the demand, whichever date is earlier, or

(ii) within such longer period as may be prescribed in writing by any false claims law investigator identified in the demand.

(B) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (A), and may be based upon any failure of the demand to comply with the provisions of this section or upon any constitutional or other legal right or privilege of such person. During the pendency of the petition in the court, the court may stay, as it deems proper, the running of the time allowed for compliance with the demand, in whole or in part, except that the person filing the petition shall comply with any portions of the demand not sought to be modified or set aside.

(3) Petition to modify or set aside demand for product of discovery.—(A) In the case of any civil investigative demand issued under subsection

(a) which is an express demand for any product of discovery, the person from whom such discovery was obtained may file, in the district court of the United States for the judicial district in which the proceeding in which such discovery was obtained is or was last pending, and serve upon any false claims law investigator identified in the demand and upon the recipient of the demand, a petition for an order of such court to modify or set aside those portions of the demand requiring production of any such product of discovery. Any petition under this subparagraph must be filed—

(i) within 20 days after the date of service of the civil investigative demand, or at any time before the return date specified in the demand, whichever date is earlier, or

(ii) within such longer period as may be prescribed in writing by any false claims law investigator identified in the demand.

(B) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (A), and may be based upon any failure of the portions of the demand from which relief is sought to comply with the provisions of this section, or upon any constitutional or other legal right or privilege of the petitioner. During the pendency of the petition, the court may stay, as it deems proper, compliance with the demand and the running of the time allowed for compliance with the demand.

(4) Petition to require performance by custodian of duties.—At any time during which any custodian is in custody or control of any documentary material or answers to interrogatories produced, or transcripts of oral testimony given, by any person in compliance with any civil investigative demand issued under subsection (a), such person, and in the case of an express demand for any product of discovery, the person from whom such discovery was obtained, may file, in the district court of the United States for the judicial district within which the office of such custodian is situated, and serve upon such custodian, a petition for an order of such court to require the performance by the custodian of any duty imposed upon the custodian by this section.

(5) Jurisdiction.—Whenever any petition is filed in any district court of the United States under this subsection, such court shall have jurisdiction to hear and determine the matter so presented, and to enter such order or orders as may be required to carry out the provisions of this section. Any final order so entered shall be subject to appeal under section 1291 of title 28. Any disobedience of any final order entered under this section by any court shall be punished as a contempt of the court.

(6) Applicability of federal rules of civil procedure.—The Federal Rules of Civil Procedure shall apply to any petition under this subsection, to the extent that such rules are not inconsistent with the provisions of this section.

(k) Disclosure exemption.—Any documentary material, answers to written interrogatories, or oral testimony provided under any civil investigative demand issued under subsection (a) shall be exempt from disclosure under section 552 of title 5.

(l) Definitions.—For purposes of this section—

(1) the term "false claims law" means—

(A) this section and sections 3729 through 3732; and

(B) any Act of Congress enacted after the date of the enactment of this section which prohibits, or makes available to the United States in any court of the United States any civil remedy with respect to, any false claim against, bribery of, or corruption of any officer or employee of the United States;

(2) the term "false claims law investigation" means any inquiry conducted by any false claims law investigator for the purpose of ascertaining whether any person is or has been engaged in any violation of a false claims law;

(3) the term "false claims law investigator" means any attorney or investigator employed by the Department of Justice who is charged with the duty of enforcing or carrying into effect any false claims law, or any officer or employee of the United States acting under the direction and supervision of such attorney or investigator in connection with a false claims law investigation;

(4) the term "person" means any natural person, partnership, corporation, association, or other legal

entity, including any State or political subdivision of a State;

(5) the term "documentary material" includes the original or any copy of any book, record, report, memorandum, paper, communication, tabulation, chart, or other document, or data compilations stored in or accessible through computer or other information retrieval systems, together with instructions and all other materials necessary to use or interpret such data compilations, and any product of discovery;

(6) the term "custodian" means the custodian, or any deputy custodian, designated by the Attorney General under subsection (i)(1);

(7) the term "product of discovery" includes—

(A) the original or duplicate of any deposition, interrogatory, document, thing, result of the inspection of land or other property, examination, or admission, which is obtained by any method of discovery in any judicial or administrative proceeding of an adversarial nature;

(B) any digest, analysis, selection, compilation, or derivation of any item listed in subparagraph (A); and

(C) any index or other manner of access to any item listed in subparagraph (A); and

(8) the term "official use" means any use that is consistent with the law, and the regulations and policies of the Department of Justice, including use in connection with internal Department of Justice

memoranda and reports; communications between the Department of Justice and a Federal, State, or local government agency, or a contractor of a Federal, State, or local government agency, undertaken in furtherance of a Department of Justice investigation or prosecution of a case; interviews of any qui tam relator or other witness; oral examinations; depositions; preparation for and response to civil discovery requests; introduction into the record of a case or proceeding; applications, motions, memoranda and briefs submitted to a court or other tribunal; and communications with Government investigators, auditors, consultants and experts, the counsel of other parties, arbitrators and mediators, concerning an investigation, case or proceeding.

519.18 Hearing procedure.

(a) The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action.

(b) Technical rules of evidence followed in a court of law will not be followed, but evidence must be relevant and material.

(c) Irrelevant and unduly repetitious testimony and cross-examination will be excluded.

(d) The appellant has the burden of:

(1) showing that the determination of the department was incorrect and that all claims submitted and denied were due and payable under the program, or that all costs claimed were allowable; and

(2) proving any mitigating factors affecting the severity of any sanction imposed.

Where the determination is based upon an alleged failure of the provider to comply with generally accepted business, accounting, professional or medical practices or standards of health care, the department must establish the existence of such practice or standard.

(e) Copies of records and documents in the possession of the department may be admitted into evidence as photocopies, however, the originals of such records and documents must be made available for inspection at the direction of the hearing officer whether in possession of the department or the appellant.

(f) Computer-generated documents prepared by the department or its fiscal agent to show the nature and amount of payments made under the program will be presumed, in the absence of direct evidence to the contrary, to constitute an accurate itemization of the payments made to a provider.

(g) An extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate

determination of the total overpayments made or penalty to be imposed. The appellant may submit expert testimony challenging the extrapolation by the department or an actual accounting of all claims paid in rebuttal to the department's proof.

(h) The decision after hearing must be supported by substantial evidence.

518.1 Scope.

(a) This Part sets forth the procedures for the recovery of overpayments determined to be due the department under the medical assistance program and for withholding payments otherwise due a provider.

(b) When the department has determined that any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, it may require repayment of the amount determined to have been overpaid.

(c) An overpayment includes 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.

(d) Recovery of overpayments may be made in connection with an audit, review or investigation under Part 515 or 517 of this Title, or in connection with other reviews or audits by authorized local,

State or Federal agencies available to the department.

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504.1 Policy and scope.

(a) The policy of this State is to make available to everyone, regardless of race, age, national origin or economic standing, uniform high quality medical care. In pursuit of this goal the department will contract with only those persons who can demonstrate that they are qualified to provide medical care, services or supplies and who can provide reasonable assurance that public funds will be properly utilized. Only qualified and responsible persons may be enrolled as providers of care, services and supplies.

(b)

(1) Any person who furnishes medical care, services or supplies for which payments under the medical assistance program are to be claimed; or who arranges the furnishing of such care, services or supplies; or who submits claims for or on behalf of any person furnishing or arranging for the furnishing of such care, services or supplies must enroll as a provider of services prior to being eligible to receive such payments, to arrange for such care, services or supplies or to submit claims for such care or supplies.

(2) Those persons who are required to enroll as providers of services under paragraph (1) of this

subdivision include, but are not limited to, laboratory directors, supervising pharmacists, nurse practitioners and physician's assistants.

(c) If a license, registration or certification is required to render the medical care, services or supplies to be furnished, an applicant must hold a proper and currently valid license, registration and/or certification to be eligible to furnish the care, services or supplies under the medical assistance program.

(d) The following definitions shall apply to this Part unless the context requires otherwise:

(1) *Affiliate* or *affiliated person* means any person having an overt, covert or conspiratorial relationship with another such that either of them may directly or indirectly control the other or such that they are under common control or ownership. For example, persons with an ownership or control interest in a provider; agents and managing employees of a provider; subcontractors; and wholly owned suppliers of a provider with whom the provider has significant business transactions are considered affiliated with each other. Similarly, providers sharing a common owner or managing employee are affiliated with each other.

(2) *Agent* means a person who has actual or apparent authority to obligate or to act for another.

(3) *Applicant* is any person who has submitted an application for enrollment.

(4) *Application for enrollment or application* means any document submitted by a person for the purpose of enrolling in the medical assistance program.

(5) *Conviction* or *convicted* means that a plea of guilty or no contest or a verdict of guilty has been entered in a Federal, State or local court, regardless of whether an appeal from the judgment is pending or whether a certificate of relief from civil disability has been granted.

(6) *Department* means the State Department of Social Services, or a local social services department where enrollment of specified provider types has been delegated to or retained by such local district (*e.g.,* in the case of certain transportation providers).

(7) *Enrollment* or *enrolling* is the process by which an applicant contracts with the department to participate in the medical assistance program as a provider of medical care, services or supplies.

(8) *Furnishes* means the provision of medical care, services or supplies, either directly or indirectly by supervising the provision of medical care, services or supplies or by prescribing or ordering care, services or supplies.

(9) *Indirect ownership interest* means an ownership interest in an entity that has an ownership interest in a provider. This term includes an ownership interest in any entity that has an indirect ownership interest in a provider.

(10) *Indictment* means an indictment has been handed down by a grand jury, or an accusatory instrument charging a crime which would be a felony under New York State law has been filed.

(11) *Managing employee* means a general manager, business manager, administrator, director, or other person who exercises operational or managerial control of a provider, or who directly or indirectly conducts the day-to-day operation of a provider.

(12) *Medicaid* is the program of State-administered medical assistance established by title XIX of the Social Security Act.

(13) *Medical assistance program* or *program* means the program of medical assistance for needy persons provided for in title 11 of article 5 of the Social Services Law.

(14) *Medicare* is the program of hospital and medical insurance established under title XVIII of the Social Security Act.

(15) *Ownership interest* means possession of equity in the capital, the stock or the profits of a provider.

(16) *Participation* is the ability and authority to furnish care, services or supplies to eligible recipients and to receive payment from the medical assistance program for such care, services or supplies.

(17) *Person* includes natural persons, corporations, partnerships, associations, clinics, groups and other entities.

(18) *Person with an ownership or control interest* means a person who:

(i) has an ownership interest totaling five percent or more in a provider;

(ii) has an indirect ownership interest equal to five percent or more in a provider;

(iii) has a combined direct and indirect ownership interest equal to five percent or more in a provider;

(iv) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the provider if that interest equals at least five percent of the value of the property or assets of the provider;

(v) is an officer or director of a provider that is organized as a corporation;

(vi) is a partner in a provider that is organized as a partnership.

(19) *Provider* is any person who has enrolled under the medical assistance program to furnish medical care, services or supplies; or to arrange for the furnishing of such care, services or supplies; or to submit claims for such care, services or supplies for or on behalf of another person. Only a provider may order or prescribe care, services or supplies, exclusive of in-patient hospital care, if such ordering or prescribing results in payment of more than 4,500 claims totaling $75,000 or more per year. The failure or refusal of a person who orders or prescribes such amounts to enroll as a provider in the medical assistance program will result in the denial of pay-

ment by the department for care, services or supplies ordered or prescribed by such person following such failure or refusal. For the purposes of this paragraph, "claim" has the same meaning as set forth in section 515.1(b)(3) of this Title.

(20) *Significant business transaction* means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or five percent of a provider's total operating expenses.

(21) *Subcontractor* means any person to which a provider has contracted or delegated some of its management functions, or its responsibilities for providing medical care, services or supplies; or its claiming or claims preparation or processing functions or responsibilities.

(22) *Supplier* means a person from whom a provider purchases goods and services used in carrying out its responsibilities under the medical assistance program (*e.g.,* a service bureau, or billing service, a commercial laundry, a manufacturer, or a pharmaceutical firm).

(23) *Wholly owned supplier* means a supplier whose total ownership interest is held by a provider or a person with an ownership or control interest in a provider.

(24) *Service bureau* means any person who provides claims processing or claims submission services for or on behalf of a provider, including a business agent, billing service or accounting firm.

(25) *Laboratory director* means an individual who has met the qualifications of a laboratory director as set forth in 10 NYCRR 19.2 and who has those responsibilities set forth in 10 NYCRR 58-1.2.

(26) *Supervising pharmacist* means the individual designated by a pharmacy on the pharmacy's State registration form as the licensed pharmacist having personal supervision of the pharmacy.

(27) *Nurse practitioner* means an individual who is licensed and currently registered as a professional nurse in the State and who is certified under section 6910 of the Education Law as a nurse practitioner.

(28) *Physician's assistant* means a person who is registered as a physician's assistant pursuant to section 6541 of the Education Law.

Section 504.3 - Duties of the provider.

504.3 Duties of the provider. By enrolling the provider agrees:

(a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department, the Secretary of the

United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health;

(b) to comply with the disclosure requirements of Part 502 of this Title with respect to ownership and control interests, significant business transactions and involvement with convicted persons;

(c) to accept payment from the medical assistance program as payment in full for all care, services and supplies billed under the program, except where specifically provided in law to the contrary;

(d) not to illegally discriminate on the basis of handicap, race, color, religion, national origin, sex or age;

(e) 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;

(f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission;

(g) to permit audits, by the persons and agencies denominated in subdivision (a) of this section, of all books and records or, in the discretion of the auditing agency, a sample thereof, relating to services furnished and payments received under the med-

ical assistance program, including patient histories, case files and patient-specific data;

(h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and

(i) to comply with the rules, regulations and official directives of the department.

540.6 Billing for medical assistance.

(a)

(1) Claims for payment for medical care, services or supplies furnished by any provider under the medical assistance program must be initially submitted within 90 days of the date the medical care, services or supplies were furnished to an eligible person to be valid and enforceable against the department or a social services district, unless the provider's submission of the claims is delayed beyond 90 days due to circumstances outside of the control of the provider. Such circumstances include but are not limited to attempts to recover from a third party insuror, legal proceedings against a responsible third-party or the recipient of the medical care, services or supplies or delays in the determination of client eligibility by the social services district. All claims submitted after 90 days must be accompanied by a statement of the reason for such delay and must be submitted within 30 days from the time submission came within the control of the provider, subject to the limitations of paragraph (3) of this subdivision.