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**UNITED STATES DISTRICT COURT  
 SOUTHERN DISTRICT OF NEW YORK**

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UNITED STATES OF AMERICA <u>ex rel.</u> ,	:	
DR. GABRIEL FELDMAN,	:	09 Civ. 8381 (JSR)
	:	
Plaintiff,	:	<b><u>FIRST AMENDED COMPLAINT-</u></b>
	:	<b><u>IN-INTERVENTION OF PLAINTIFF-</u></b>
v.	:	<b><u>INTERVENOR THE UNITED</u></b>
	:	<b><u>STATES OF AMERICA</u></b>
THE CITY OF NEW YORK,	:	
	:	
Defendant.	:	
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UNITED STATES OF AMERICA,	:	
	:	
Plaintiff-Intervenor,	:	
v.	:	
	:	
THE CITY OF NEW YORK,	:	
	:	
Defendant.	:	
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The United States of America, by its attorney, Preet Bharara, United States Attorney for the Southern District of New York, alleges for its first amended complaint as follows:

**PRELIMINARY STATEMENT**

1. This is a civil fraud action brought by the United States of America against the

City of New York (“the City” or “defendant”), under the False Claims Act, 31 U.S.C. §§ 3729-3733 (“FCA”), to recover damages sustained by, and penalties owed to, the United States as a result of the City’s policies and practices of falsely authorizing 24-hour personal care services pursuant to the Personal Care Services (“PCS”) program administered by the City, which is approximately 50% funded by the United States under the Medicaid Program. Since in or about 2000, the City’s fraudulent policies and practices have involved (i) knowingly presenting, or causing to be presented, to the United States false claims for payment of federal funds in excess of the amounts that were allowable under the applicable federal and state Medicaid statutes and regulations; and (ii) making or using false records or statements material to such false claims.

2. Since 2000, approximately 17,500 people have received 24-hour personal care services through the PCS program administered by the City. Currently, the annual cost of such services ranges from \$75,000 to \$150,000 per individual. Upon information and belief, it has been the City’s policy and/or practice to disregard the state Medicaid regulations’ requirements on the medical and clinical bases necessary to authorize or reauthorize 24-hour care under the PCS program. For example, although the state Medicaid regulations specify that a physician “is responsible for the final determination of the level and amount of care to be provided” under the PCS program, the City has knowingly overruled physicians’ determinations about the appropriate care, and authorized 24-hour PCS care instead.

3. Further, it has been the standard operating procedure for the City to disregard the state Medicaid regulations’ express requirement that a local medical director (“LMD”) – a doctor under contract with the City – make the determination that 24-hour continuous care (or split-shift care) is appropriate. The City has uniformly reauthorized split-shift care – the most expensive type of care under the PCS program – without first obtaining the LMD’s

determination on the need for such care. The City has also habitually ignored the state Medicaid regulations and reauthorized patients for 24-hour care, without even obtaining, much less reviewing, patient assessments prepared by nurses and social workers. In fact, the City recently acknowledges that “in some instances assessments were collected from vendors . . . after a service had been authorized.” February 8, 2011 Letter from New York City to the Hon. Jed S. Rakoff. HRA caseworkers have confirmed that nursing assessments were missing in a substantial percentage of cases that were authorized.

4. As result of these and other policies and practices knowingly disregarding the regulatory requirements for the PCS program, the City improperly authorized and reauthorized 24-hour care for a substantial percentage of the thousands of Medicaid beneficiaries enrolled in the PCS program.

5. In connection with improperly authorizing 24-hour care, the City submitted weekly authorization reports to the New York State Department of Health (“DOH”), setting forth each authorization for PCS services that had been approved by the City, including authorizations made in violation of the state Medicaid regulations. In reliance on these false reports, DOH approved and paid for PCS services. Further, in reliance on these reports, DOH submitted on a quarterly basis claims to the federal government for the federal share of the PCS claims. Because of the City’s knowing noncompliance with state Medicaid regulations, those quarterly reports reflected PCS expenditures wrongly authorized by the City and also contained false certifications as to the allowability of such expenditures under the state Medicaid regulations. Thus, the City’s weekly submissions of false authorization information caused DOH to submit to the United States false claims concerning PCS program expenditures.

6. Since 2000, the United States has, based on the false and inflated quarterly

claims submitted by DOH in reliance on the City's statements, contributed the federal share to the PCS program expenditures in New York City, including for improperly authorized 24-hour care. Thus, as result of the City's issuance of improper authorizations and making of false statements and records, the United States has incurred at least tens of millions of dollars in damages.

7. In addition to causing pecuniary harm to the United States, the City's policies and practices also have, in many cases, caused patients in the PCS program to receive more services than necessary. In other cases, the City caused patients in the PCS program to receive fewer services than they needed, thus potentially endangering their health and welfare.

#### **JURISDICTION AND VENUE**

8. This Court has jurisdiction over the claims brought under the FCA pursuant to 31 U.S.C. § 3730(a), and 28 U.S.C §§ 1331, 1345, over the remaining claims pursuant to 28 U.S.C. § 1345, and over all claims pursuant to the Court's general equitable jurisdiction.

9. Venue lies in this District pursuant to 31 U.S.C. § 3732(a), and 28 U.S.C. §§ 1391(b) and 1391(c), because the City of New York is a municipality partially situated within this District and because some of the false or fraudulent acts set out in 31 U.S.C. § 3729 occurred in this District.

#### **PARTIES**

10. Plaintiff is the United States of America on behalf of its agency the United States Department of Health and Human Services ("HHS").

11. Relator Dr. Gabriel Feldman is a licensed medical doctor in New York who is board certified in preventive medicine and public health and resides in New York, N.Y. Dr. Feldman is a local medical director employed by the New York County Health Services Review

Organization (“NYCHSRO”), an organization that contracts with the City to provide certain medical review functions integral to the PCS program.

12. Defendant the City of New York is a municipality of New York State, and is comprised of Bronx, Kings, New York, Queens, and Richmond Counties.

## FACTS

### **I. BACKGROUND**

#### **A. The PCS Program Within Medicaid**

13. Pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, the Medicaid Program was established in 1965 as a joint federal and state program to provide financial assistance to individuals with low incomes to enable them to receive medical care. Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates and program administration in accordance with certain federal statutory and regulatory requirements. The state directly pays the health care providers for services rendered to Medicaid recipients, with the state obtaining the federal share of the Medicaid payment from accounts that draw on the United States Treasury. See 42 C.F.R. §§ 430.0 - 430.30.

14. The New York State Legislature established New York’s Medicaid system in 1966, L. 1966, ch. 256, the year after Congress created the federally funded Medicaid program, see Pub. L. 89-97, 79 U.S. Stat 344. Under New York’s system, Medicaid is administered at the state level by DOH. See N.Y. Pub. Health Law § 201(1)(v). The State of New York, through DOH, has promulgated an extensive regulatory scheme governing the administration of the Medicaid program within the state.

15. The PCS program is a Medicaid-funded program designed to provide services, such as cleaning, shopping, grooming and basic aid services, to Medicaid beneficiaries meeting

certain criteria and that typically are furnished in the homes of those beneficiaries. See 42 C.F.R. § 440.167. Pursuant to the New York City Medicaid cap, the City's programmatic costs with respect to the PCS program have been fixed since 2006.

16. In New York, the PCS program provides services ranging from a few hours per week, where a Medicaid beneficiary needs assistance only for some specific functions or tasks, to 24-hours per day, seven days a week. State Medicaid regulations set forth comprehensive rules and requirements for the PCS program in New York. See generally 18 N.Y.C.R.R. § 505.14. Specifically, under these regulations, Medicaid funding is available for PCS services only when those services are “essential to the maintenance of [a beneficiary’s] health and safety in his or her home, as determined by the social services district in accordance with the regulations of [DOH].”

Id. § 505.14(a)(1). In addition, the state Medicaid regulations also provide express requirements regarding the medical and clinical bases necessary for authorizing various levels and amounts of care.

17. As relevant here, there are two types of 24-hour care under the PCS program in New York. First, a patient in the PCS program may receive “sleep-in” service, which is 24-hour care by a single personal care aide who provides daytime services and sleeps in the patient’s home, providing only limited nighttime services. Sleep-in service costs approximately \$75,000 per year per patient.

18. Second, the PCS program also provides a higher level of care, commonly referred to as “continuous 24-hour care” or “split-shift” service, which typically requires two or more aides, who do not sleep in the home, but instead provide uninterrupted 24-hour care for a patient who, because of his or her medical condition and disabilities, requires total assistance

with toileting, walking, transferring and/or feeding at unscheduled times during the day and night. See 18 N.Y.C.R.R. § 505.14(a)(3). Split-shift service costs approximately \$150,000 per year per patient.

**B. Administration of the PCS program in New York City**

19. While PCS is a statewide program, the City, through its Human Resources Administration (“HRA”), administers the PCS program within its jurisdiction. HRA, in turn, administers the program through its Community Alternative Systems Agency (“CASA”) system.

20. HRA does not directly provide personal care services. Rather, HRA contracts with a number of for-profit and not-for-profit vendors, which provide services to Medicaid beneficiaries in New York City.

21. As the administrator of the PCS program in its jurisdiction, the City has the responsibility for determining whether providing a specific level and amount of services for a patient in the PCS program is “in accordance with the [state Medicaid] regulations.” See 18 N.Y.C.R.R. § 505.14(a)(1). Upon information and belief, the City has been aware of its obligation to authorize PCS care only in accordance with the state Medicaid regulations.

22. Once the City determines that a patient qualifies for services under the PCS program, it issues an authorization notice to the patient and a vendor, which describes the level and amount of services and the duration for such services. Unless it has obtained such an authorization notice from the City, a vendor cannot receive Medicaid payment from DOH for providing PCS services to a patient in New York City. See 18 N.Y.C.R.R. § 505.14(b)(5).

23. Further, on a weekly basis, the City submits to DOH a record that identifies, among other things, each patient for whom the City had authorized PCS services during the previous week, the level, amount and duration of services, and the vendor designated to provide

such services (the “weekly authorization list”).

24. In reliance on the City’s weekly authorization list, DOH generates for each patient a “prior authorization,” which is DOH’s approval to allow vendors to commence and bill for the PCS services authorized by the City. Only with DOH’s prior authorization can vendors provide, bill and be paid by DOH for PCS services. In short, DOH relies on the City’s weekly authorization list for purposes of determining whether to make Medicaid payments to vendors that provide PCS services to patients in New York City.

**C. The State Medicaid Regulatory Requirements for Initial Authorization of 24-Hour Care Services under the PCS program and for Reauthorization of 24-Hour Care Services**

25. Under New York’s Medicaid regulations, the City must, before authorizing the initiation of 24-hour care services under the PCS program, ascertain that such services “are medically necessary” and that “the patient’s health and safety can be maintained by the provision of such services.” See 18 N.Y.C.R.R. § 505.14(a)(4). Further, a patient is eligible for PCS services only if it is determined by the City that other services are not more appropriate. *Id.* § 505.14 (b)(2)(iv), (b)(3)(i)(v)(a).

26. The state Medicaid regulations also specify certain criteria that patients must meet to participate in the PCS program and the medical and social work bases necessary for the City to make its authorization decision.

27. First, the regulations require the City to determine that a patient’s medical condition is “stable,” and that the patient is “self-directing.” *Id.* §§ 505.14(a)(4)(i)–(ii).

28. Under the state Medicaid regulations, “stable” is defined to mean that a patient (a) is not expected to exhibit either sudden deterioration or improvement; (b) does not require frequent medical or nursing judgment to determine changes in his or her plan of care; and (c)(1)

if physically disabled and in need of routine supportive assistance, does not need skilled professional care in the home; or (2) if physically disabled or frail and elderly, does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing. See *Id.* § 505.14(a)(4)(i). If a patient’s condition is not stable, he or she is not eligible for PCS services.

29. Being “self-directing,” under the state Medicaid regulations, means that a patient “is capable of making choices about his/her activities of daily living, understanding the impact of the choice, and assuming responsibility for the results of the choice.” *Id.* § 505.14(a)(4)(ii). Further, except where additional supervision is provided by family or other sources, “[p]atients who are nonself-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive personal care services . . .” *Id.*

30. In addition, before the City can authorize the initiation of 24-hour care, the state Medicaid regulations require the City to obtain and to review “a physician’s order,” “a social assessment,” and “a nursing assessment.” *Id.* §§ 505.14(b)(2)(i)–(iii).

31. Further, the state Medicaid regulations also require the City to obtain independent medical reviews from a LMD in certain situations.<sup>1</sup> See *id.* § 505.14(b)(4)(i). For example, before the City can authorize the provision of split-shift (i.e., continuous 24-hour care), it must obtain an LMD’s determination that such level of care is medically necessary and appropriate. See *id.* § 505.14(b)(4)(i)(c). Similarly, an LMD determination also is required where there is a disagreement between the physician’s order, the social worker assessment, and/or the nursing assessment as to the appropriate type, amount, or length of service, including

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<sup>1</sup> HRA contracts with New York County Health Services Review Organization (“NYCHSRO”), which provides, *inter alia*, physicians to review personal care services cases. These physicians are referred to as “local medical directors” or “LMDs.”

where “sleep-in” 24-hour care is provided. See *id.* § 505.14(b)(4)(i)(a).

32. In any circumstance in which the City is required to obtain an LMD’s independent medical review (e.g., where split-shift care is involved), the state Medicaid regulations expressly provide that the LMD “is responsible for the final determination of the level and amount of care to be provided.” *Id.* § 505.14(b)(4)(ii) (emphasis added).

33. Under the state Medicaid regulations, the City’s authorizations for services cannot be effective for more than six months absent special circumstances and in no case for more than twelve months. See 18 N.Y.C.R.R. § 505.14(b)(5)(iii). In order to reauthorize care, the City must again determine whether provision of PCS care is appropriate pursuant to the state Medicaid regulations.

34. The state Medicaid regulations are clear that all reauthorizations of services “shall follow the procedures outlined in paragraphs (2)-(4),” *i.e.*, reauthorizations must be based on the physician’s order, social worker assessment, nursing assessment, and any LMD determination required for initial authorizations. See 18 N.Y.C.R.R. § 505.14(b)(5)(ix). Thus, for patients receiving split-shift 24-hour care, the City is required to obtain LMD determinations for each reauthorization of such split-shift care.

35. The regulations are also clear that PCS services can be provided only where medically necessary and where health and safety can be maintained in the home. *Id.* § 505.14(a)(4), (b)(3)(iv)(a)(1). Further, the City “must deny or discontinue personal care services when such services are not medically necessary or are no longer medically necessary or when [HRA] reasonably expects that such services cannot maintain or continue to maintain the client’s health and safety in his or her home.” *Id.* § 505.14(b)(5)(v)(a).

**D. The Payment Process for PCS Services in New York City**

36. Although the City contracts with vendors who provide PCS services in New York City, the City does not process the payments for the vendors. Instead, vendors receive Medicaid payments for authorized services from DOH through a fiscal intermediary.

37. During all relevant times, DOH has used one of two electronic record systems – WMS and eMedNY – to process prior authorizations and payments for services. DOH obtains from the City’s weekly authorization lists the information necessary for its electronic system to process such authorizations and payments, including among other things, whether a patient has been authorized to receive PCS services, the level and amount of services authorized, and the duration of such authorization. DOH relies directly on this information, received exclusively from the City’s weekly authorization lists, to determine whether to disburse Medicaid funds to vendors for serving patients in New York City and the amounts of such disbursements. Thus, the City’s authorizations, as reflected in the weekly authorization lists, determine whether DOH pays out Medicaid funds to PCS vendors and the amount of that disbursement.

38. To obtain the federal share of PCS program expenditures, New York State submits, on a quarterly basis, a Quarterly Medicaid Statement of Expenditures, also known as the CMS-64 form (“CMS-64”), to the Centers for Medicare and Medicaid Services (“CMS”), a component within HHS. Excerpts from New York’s CMS-64s for the third quarter of 2004, the fourth quarter of 2008, and the fourth quarter of 2009 are attached hereto as Exhibits A-C.

39. Each of New York State’s CMS-64s specifies the amount of expenditures on PCS services during the relevant quarter. Under federal rules and regulations, the State is permitted to seek the federal share only of those PCS expenditures that had been incurred in accordance with applicable state and local statutes and regulations. See generally OMB Circular

A-87. Furthermore, in connection with each CMS-64 submitted after October 2001, New York State expressly certified to HUD that the “report only includes expenditures . . . that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies.” See CMS-64 dated January 24, 2005 (Ex. A).

40. Based on the express and implicit certifications made by New York State in connection with its CMS-64 submissions, the United States paid or approved the federal share of New York’s PCS expenditures, including PCS program expenditures for patients in New York City, to the State’s Medicaid account.

## **II. THE CITY’S POLICIES AND PRACTICES OF IMPROPERLY AUTHORIZING 24-HOUR CARE AND MAKING FALSE STATEMENTS OR RECORDS**

41. Upon information and belief, the City knew that it had to comply with the specific requirements in the State Medicaid regulations. The City, however, has maintained policies and practices pursuant to which it routinely, and knowingly, authorized or reauthorized 24-hour PCS care in violation of the regulatory requirements.

### **A. The City’s Practice of Improperly Overruling LMD Determinations**

42. As noted above, the State Medicaid regulations provide that an LMD “is responsible for the final determination of the level and amount of care to be provided.” See 18 N.Y.C.R.R. § 505.14(b)(4)(ii). In practice, however, CASA administrators have overruled LMD determinations concerning the appropriate level of care for patients requesting 24-hour care from the PCS program.

43. For example, on June 24, 2008, after examining Patient A, a 65-year old female with a diagnosis of dementia, a doctor affiliated with NYCHSRO recommended the provision of task-based services, *i.e.*, PCS services for a limited number of hours a day. On June 25, 2008, an LMD determined that this patient did not require sleep-in service. The LMD based this

determination on the affiliated doctor's examination, noting specifically that Patient A had little trouble ambulating, was alert, was not on medication, and had good judgment. The LMD also noted that she needed some assistance with chores and stove precautions. On that same day, and notwithstanding the LMD's determination, an HRA administrator overruled the LMD and approved 24-hour sleep-in services for the patient.

44. In another case, on April 21, 2008, Patient B, an 83-year old woman, was examined by a doctor affiliated with NYCHSRO, who recommended that she receive PCS care for 10-12 hours per day. On April 22, 2008, an LMD determined that she was eligible for 10 hours per day and should not receive 24-hour care because she had "no compelling night time needs." The next day, an HRA administrator overruled the LMD's determination and authorized 24-hour "sleep-in service."

45. Similarly, Patient C, an 82-year old female with a history of dementia, anemia, renal failure, diabetes and hypertension, was receiving task-based services through the PCS program. In November 2005, the patient's doctor requested an increase in services to split-shift. On January 10, 2006, an LMD reviewed the request and the accompanying assessments and noted that, while the patient required assistance, the patient also "engages in self-endangering behavior" such as "getting out of bed without assistance" which had resulted in falls. The LMD noted that "even split shift service would be inadequate for this client" as she would be at risk during the home attendant's bathroom breaks when she would be unsupervised. Accordingly, the LMD concluded, the client the client "is no longer appropriate" for services under the PCS program. Nevertheless, HRA overruled this determination and on February 24, 2006, split shift services under the PCS program were authorized. Split-shift services were reauthorized twice without an LMD determination before Patient C died on February 24, 2007.

46. The City's actions in the cases of Patients A, B, and C were not isolated or random events. Its practices clearly violate the State Medicaid regulations. In overruling LMDs and authorizing care for these patients, the City has caused DOH to issue prior authorizations to vendors, who have then provided and billed DOH for PCS services authorized in violation of the Medicaid regulations. Further, the City's practice of improperly overruling LMD determinations and submission of false weekly authorization lists caused DOH to present false claims to CMS. For example, in May 2009, DOH submitted a CMS-64 for the fourth quarter of 2008 and certified that all of the PCS program expenditures in that report were "allowable in accordance with [the] applicable . . . state . . . regulations." CMS-64 dated May 24, 2009 (Ex. B). That certification was false because that CMS-64, in fact, included expenditures for PCS services provided to Patient A, which are not allowable under the state Medicaid regulation.

47. Because the United States has contributed the federal share to New York state's expenditures on PCS services, including for patients for whom the City improperly authorized services after overruling LMD determinations, the City's practice has caused the United States to pay claims for services authorized in violation of the State Medicaid regulations.

**B. The City's Policy or Practice of Improperly Reauthorizing Split-Shift Care without Obtaining LMD Determinations**

48. Although DOH regulations expressly require the City to obtain an LMD determination before it can reauthorize split-shift services under the PCS program, *see* 18 N.Y.C.R.R. § 505.14(b)(5)(ix), the City has maintained a policy, or a regular practice that amounts to an official policy, of reauthorizing split-shift services without any LMD determination.

49. For example, Patient D, a 75-year old female with a diagnosis of dementia, lived with her daughter, and was receiving split-shift care. On September 16, 2008, an LMD

noted that “[Patient D] tries to jump out of window several times a day and punches daughter,” and determined that she “is dangerous to self and others,” and that a higher level of care was indicated. The LMD further found that Patient D “is unable to direct care, has inappropriate judgment, wanders, is up all night, and has shown oven/stove misuse.” Nonetheless, the City reauthorized split-shift services for Patient D on multiple occasions between April 1, 2009 and September 30, 2010, without obtaining any LMD determination. Further, the reauthorizations took place without the required nursing assessments or supervisory nursing assessments. Split-shift service was subsequently reauthorized through March 3, 2011, without a nursing assessment or a supervisory nursing assessment. According to the case file, the last time a nursing assessment was performed on this clearly unstable patient was the summer of 2009, yet Patient D continued for more than a year to receive 24-hour personal care services.

50. In another case, Patient E, a 91-year old patient with Alzheimer’s disease, received multiple reauthorizations for split-shift service without an LMD determination. Specifically, in a decision dated November 5, 2007, an LMD described the client’s condition as “unstable,” noting that she has “threatened to jump from the window, and will turn the stove on.” Similarly, a social assessment dated October 17, 2007, stated that the client is “very aggressive” and is a “danger to herself.” The City authorized split-shift service for Patient E on November 5, 2007. The City then reauthorized split-shift services for Patient E twice, without obtaining an LMD authorization on either occasion, before she died on January 1, 2009.

51. Separate and apart from the City’s failure to obtain an LMD determination for split-shift reauthorizations for Patient E, the City also failed to obtain needed nursing, supervisory and social assessments. Specifically, Patient E received multiple reauthorizations for split-shift service between December 5, 2007 and January 31, 2008, during which time no

nursing assessments, supervisory assessments, or social assessments were performed. For the subsequent 12-month period beginning on January 14, 2008, service was reauthorized with no assessments having been performed. Service was again authorized from April 14, 2008 through September 30, 2008 with no assessments, and on October 10, 2008, service was reauthorized with a social assessment, but no nursing assessment or supervisory nursing assessment. Patient E died on January 1, 2009.

52. Patient D's and E's cases are illustrations of the City's policy or practice, in virtually all cases involving PCS patients with split-shift care, to reauthorize such care without obtaining any LMD determination. Pursuant to this policy or practice, the City has improperly issued reauthorization notices for Patients D and E, as well as thousands of other similarly-situated patients with split-shift care. The City also has routinely submitted to DOH false weekly authorization lists, which included split-shift reauthorizations done in direct contravention of the State Medicaid regulation.

53. The City's policy or practice of reauthorizing split-shift care without obtaining any LMD determinations has caused DOH to present numerous false claims to CMS. For example, in March 2010, DOH submitted a CMS-64 for the fourth quarter of 2009 and certified that all of the PCS program expenditures in that report were "allowable in accordance with [the] applicable . . . state . . . regulations." CMS-64 dated March 31, 2010 (Ex. C). That certification was false because that CMS-64, in fact, included expenditures for PCS services provided to Patient D, which are not allowable under the State Medicaid regulation.

54. Because the United States has contributed the federal share to New York State's expenditures on PCS services, including for the thousands of patients for whom the City improperly reauthorized split-shift services without LMD determinations, the City's policy or

practice has caused millions of dollars in damages to the United States.

**C. The City's Policy or Practice of Improperly Reauthorizing 24-Hour Care Without First Reviewing Nursing Assessments**

55. The State Medicaid regulations clearly required the City to base its authorization and reauthorization decisions for PCS services on, among other things, both a social worker and a nursing assessment. *See* 18 N.Y.C.R.R. § 505.14(b)(1)–(2). The City, however, made it a policy, or at least a regular practice, either not to obtain nursing assessments before reauthorizing 24-hour care for patients in the PCS program, or not to review the nursing assessments that it had received. Indeed, the City has admitted that “in some instances assessments were collected from vendors . . . after a service had been authorized.” HRA caseworkers have confirmed that nursing assessments were missing in a substantial percentage of cases that were authorized.

56. As detailed above, the City failed to obtain the assessments required for the reauthorization of care for Patients D and E. In addition, the City repeatedly reauthorized split-shift 24-hour care for Patient F for four years without reviewing a nursing assessment. Specifically, Patient F initially was authorized for split-shift service in or about June 2003. From June 2003 until Patient F died in September 2007, no nursing assessment was ever conducted, and there is no evidence in the file that any supervisory visits were ever conducted. Nonetheless, during those years, the City reauthorized continued split-shift service for Patient F approximately every six months.

57. Patient G's case provides another example of the City's policy or practice of reauthorizing 24-hour split-shift care without first reviewing nursing assessments. In 2008, Patient G was found to be eligible for only a limited number of hours of personal care service per day. However, because the wife of Patient G was found to be eligible for split-shift care, she and

Patient G were allowed to share a "mutual" or "shared" aide. As a result, the LMD determined that Patient G was to receive split-shift but only so long as his spouse required that level of service. After Patient G's spouse died on July 13, 2008, however, the City continued to reauthorize split-shift service for him, and repeatedly made those decisions without reviewing nursing assessments. In fact, when a nursing assessment was finally done almost a full year later in July 2009, the City did not obtain or review that assessment, which recommended a decrease in the level of services for Patient G, until September 2010 -- *i.e.*, more than two years after Patient G's spouse had died and more than a year after the nursing assessment was done.

58. As detailed above, Patients D's and E's case histories likewise illustrate the City's policy or practice of disregarding the nursing assessment requirement. For Patient D, the City has continually reauthorized split-shift care for her between April 2009 and September 2010, with the current reauthorization extending to March 3, 2011. The City, however, has not obtained a nursing assessment for Patient D since the summer of 2009. Further, the most recent reauthorization was issued without a supervisory nursing assessment.

59. In Patient E's case, the City reauthorized split-shift service between December 5, 2007, and January 31, 2008, during which time the City did not obtain any nursing assessments, supervisory assessments, or social assessments. For the subsequent 12-month period beginning on January 14, 2008, the City reauthorized split-shift service for Patient E twice – on April 14, 2008, and October 10, 2008 – with no nursing assessments having been performed.

60. The four examples described above underscore the City's policy or practice of reauthorizing 24-hour care without having reviewed nursing assessments. Based on that policy or practice, the City improperly issued authorization notices to vendors and patients, and it also

sent DOH false weekly authorization lists, which concealed the fact that the City's reauthorizations of 24-hour PCS services did not comply with the state Medicaid regulations.

61. Further, the City's policy or practice of ignoring the nursing assessment requirement has caused DOH to present false claims to CMS. For example, in January 2004, DOH submitted a CMS-64 for the third quarter of 2004, certifying that all of the PCS program expenditures in that report were "allowable in accordance with [the] applicable . . . state . . . regulations." *See, e.g.*, CMS-64 dated January 24, 2005 (Ex. A). That certification is false. Because the City failed to obtain or review any nursing assessment before reauthorizing 24-hour split-shift services for Patient F, the costs of those services, which were not included in the January 2005 CMS-64, were not allowable under the state Medicaid regulation.

62. Because the United States has contributed the federal share to New York State's expenditures on PCS services, including for patients for whom the City improperly reauthorized 24-hour services without reviewing nursing assessments, this policy or practice has caused millions of dollars in damages to the United States.

63. Based on the policies and practices described above, the City has improperly authorized or reauthorized 24-hour care, at the expense of Medicaid and the United States, for a substantial percentage of the thousands of Medicaid beneficiaries in New York City who have received 24-hour PCS services since 2000.

64. Further, these above-described policies and practices evince a knowing, and fundamental, disregard on HRA's part for the requirements of the State Medicaid regulations.

**FIRST CLAIM**

**Violations of the False Claims Act  
(31 U.S.C. § 3729 (a)(1) (2000))  
Presenting False Claims for Payment**

65. The United States incorporates by reference paragraphs 1 through 64 above as if fully set forth in this paragraph.

66. The United States seeks relief against the City under Section 3729(a)(1) of the False Claims Act, 31 U.S.C. § 3729(a)(1) (2000).

67. As set forth above, the City knowingly, or acting with deliberate ignorance or with reckless disregard for the truth, presented, or caused to be presented, to an officer, employee or agent of the United States, (1) false or fraudulent claims for Medicaid funding relating to 24-hour care under the PCS program, and (2) such claims were false or fraudulent because the applicants were not eligible and/or the City failed to assess whether the applicants were eligible to receive 24-hour PCS care under 18 NYCRR § 505.14.

68. The United States made payments under the Medicaid program because of the false or fraudulent claims caused by the City.

69. By reason of the City's false or fraudulent claims, the United States has been damaged in a substantial amount to be determined at trial.

**SECOND CLAIM**

**Violations of the False Claims Act  
(31 U.S.C. § 3729 (a)(1)(B)(Supp. 2009))  
Use of False Statements**

70. The United States incorporates by reference paragraphs 1 through 64 above as if fully set forth in this paragraph.

71. The United States seeks relief against the City under Section 3729(a)(1)(B) of

the False Claims Act, 31 U.S.C. § 3729(a)(1)(B) (Supp. 2009).

72. As set forth above, the City knowingly, or acting in deliberate ignorance or in reckless disregard of the truth, made, used, and caused to be made and used, false records and statements material to a false or fraudulent claim for federal Medicaid funds, in connection with the submission of claims for personal care services under the the PCS program.

73. The United States paid such false or fraudulent claims because of the acts and conduct of the City.

74. By reason of the City's false records and statements, the United States has been damaged in a substantial amount to be determined at trial.

### **THIRD CLAIM**

#### **Payment Under Mistake of Fact**

75. The United States incorporates by reference paragraphs 1 through 64 above as if fully set forth herein.

76. The United States seeks relief against the City to recover monies paid under mistake of fact.

77. The United States made payments under the Medicaid program for services rendered under the erroneous belief that DOH and the vendors providing PCS care under contracts with the City were entitled to payment of such funds. In making such payments, the United States relied upon and assumed that the City, in authorizing or reauthorizing 24-hour PCS care, had complied with the applicable Medicaid rules and regulations, and that the claims for Medicaid reimbursement were for expenditures allowable in accordance with the relevant Medicaid rules and regulations. This erroneous belief was material to the United States' decision to pay these claims. In such circumstances, the United States' payment of federal funds

under the Medicaid program was by mistake and was not authorized.

#### **FOURTH CLAIM**

##### **Negligence**

78. The United States incorporates by reference paragraphs 1 through 64 above as if fully set forth herein.

79. The United States seeks relief against the City to recover monies paid because of the City's negligence.

80. The City was negligent in failing to comply with regulations relating to the award of PCS services. The United States made substantial Medicaid payments that would not have been made but for the City's misrepresentation that certain individuals were eligible for PCS services pursuant to the regulatory requirements even though those requirements had not been met.

81. By reason of the foregoing, the United States was damaged in a substantial amount to be determined at trial.

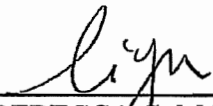
WHEREFORE, plaintiff, the United States, requests that judgment be entered in its favor and against the City as follows:

- (a) On the First and Second Claims for relief (Violations of the FCA, 31 U.S.C. § 3729(a)(1) and 3729(a)(1)(B)), for treble the United States' damages, in an amount to be determined at trial, plus an \$11,000 penalty per violation of the FCA;
- (b) On the First and Second Claims for Relief, an award of costs pursuant to 31 U.S.C. § 3729(a);
- (c) On the Third Claim for Relief (Payment Under Mistake of Fact), in an

- amount to be determined at trial, together with costs and interest; and
- (d) On the Fourth Claim for Negligence, in an amount to be determined at trial, together with costs and interest; and
- (f) awarding such further relief as is proper.

Dated: New York, New York  
February 23, 2011

PREET BHARARA  
United States Attorney for the  
Southern District of New York

By:   
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# Exhibit A

Quarterly Medicaid Assistance Expenditures  
For the Medical Assistance Program

State: New York

Quarter Ended: 09/30/2003

Certification				
CMS 64 Summary Sheet	Medical Assistance Payments		State and Local Administration	
	Total	Federal Share	Total	Federal Share
	(A)	(B)	(C)	(D)
Net Expenditures Reported In This Period (Sum of Items 6, 7 and 8 Less 9 and 10)	11,456,132,250	6,040,836,802	290,528,106	158,250,182

I certify that:

1. I am the executive officer of the state agency or his/her designate authorized by the state to submit this form.
2. This report only includes expenditures under the Medicaid program under title XIX of the Social Security Act (the Act), and as applicable, under the Children's Health Insurance Program (CHIP) under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan approved by the Secretary and in effect during the Quarter Ended indicated above under Title XIX of the Act for the Medicaid program, and as applicable, under Title XXI of the Act for the CHIP.
3. The expenditures included in this report are based on the state's accounting of actual recorded expenditures, and are not based on estimates.
4. The required amount of state and/or local funds were available and used to match the state's allowable expenditures included in this report, and such state and/or local funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures.
5. Federal matching funds are not being claimed on this report to match any expenditure under any Medicaid and/or CHIP state plan amendment that was submitted after January 2, 2001, and that has not been approved by the Secretary effective for the Quarter Ended indicated above.
6. The information shown above and on the Form CMS-64 Summary Sheet and the Supporting Schedules is correct to the best of my knowledge and belief.

Date: 1/28/2004 1:00:10 PM	Signature: William H. McKinnis	Title: Central Office
----------------------------	--------------------------------	-----------------------

User Performing Certification: ZG09

Footnotes:  
New York originally certified the CMS-64 on 12/30/03. Bill McKinnis of CO inadvertently uncertified the CMS-64 on January 28, 2004 by error.

The completed Budget, Expenditure and supporting forms are to be submitted via the on-line MBES/CBES system to the Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Finance, Systems and Quality Group, Division of Financial Management, located at Mailstop S3-13-15, 7500 Security Blvd., Baltimore, Maryland 21244-1850.

Quarterly Medicaid Statement of Expenditures  
For the Medical Assistance Program  
Summary Sheet

State: New York

Quarter Ended: 09/30/2003

		Medical Assistance Payments		State and Local Administration	
		Total Computable	Federal Share	Total Computable	Federal Share
		(A)	(B)	(C)	(D)
<b>Section A. Quarterly Status of Funding</b>					
1	Awards Received During The Quarter For The Quarter Being Reported And Prior Quarters		6,158,310,442		173,601,000
2	Awards Received During The Quarter For Subsequent Quarters		0		0
3A	Interest: Received On Medicaid Recoveries		0		
3B	Interest: Assessed On Disallowances		0		0
4	Medicare Overpayment Collection Under Sec. 1914 and 42 CFR 447.30		0		0
5	Other		0		0
<b>Section B. Expenditures Reported for Period</b>					
6	Expenditures In This Quarter	11,213,298,685	5,919,267,963	167,803,120	87,018,882
7	Adjustments Increasing Claims For Prior Quarters	424,311,020	213,624,221	124,940,325	72,840,884
8	Other Expenditures	652,401,026	328,210,308	0	0
9A	Collections: Third Party Liability	(45,281,985)	(19,964,353)		
9B	Collections: Probate	(7,621,424)	(4,033,713)		
9C	Collections: Identified Through Fraud And Abuse Effort	(4,761,053)	(2,687,094)		
9D	Collections: Other	(19,232,073)	(10,167,198)	0	0
9E	Misc.	0	0	0	0
10A	Adjustments Decreasing Claims For Prior Quarters: Federal Audit	0	0	0	0
10B	Adjustments Decreasing Claims For Prior Quarters: Other	(659,891,188)	(331,968,886)	(2,215,339)	(1,609,584)
10C	Adjustments Decreasing Claims For Prior Quarters: Overpayment Adjustments (Attach 64.9O)	(97,090,758)	(51,444,446)		
11	Net Expenditures Reported In This Period (Sum of Items 6, 7 and 8 Less 9 and 10)	11,456,132,250	6,040,836,802	290,528,106	158,250,182

Medical Assistance Expenditures By Type Of Service  
For The Medical Assistance Program  
Expenditures In This Quarter

State: New York

Quarter Ended: 09/30/2003

Medical Assistance Payments		Total Comp. (A)	Federal Share						Total Federal Share (G)
			FMAP 52.95% Incr FMAP 52.95% (B)	IHS Facility Services 100% (C)	Fam. Plan. Services 90% (D)	Optional Breast or Cerv. Cancer Services (E)	Other & Prompt Pay		
							Other % (Oth) Prompt Pay (PP) (F)	Federal Share	
1A	Inpatient Hospital Services - Regular Payments	1,536,034,169	813,250,415 0	0	55,774	57,528	* 0.65% # 52.95%	0 0	813,363,717
1B	Inpatient Hospital Service - DSH Adjustment Payments	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
2A	Mental Health Facility Services - Regular Payments	107,856,077	57,074,537 0	0	0	43,280	* 0.65% # 52.95%	0 0	57,117,817
2B	Mental Health Facility Services - DSH Adjustment Payments	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
3	Nursing Facility Services	2,108,908,751	1,116,667,184 0	0	0	0	* 0.00% # 52.95%	0 0	1,116,667,184
4A	Intermediate Care Facility Services - Mentally Retarded: Public Providers	410,364,776	217,288,149 0	0	0	0	* 0.00% # 52.95%	0 0	217,288,149
4B	Intermediate Care Facility Services - Mentally Retarded: Private Providers	204,937,952	108,514,646 0	0	0	0	* 0.00% # 52.95%	0 0	108,514,646
5	Physicians' Services	88,541,171	46,563,185 0	0	452,080	65,541	* 65.00% # 52.95%	0 0	47,080,806
6	Outpatient Hospital Services	460,308,604	242,737,075 0	0	1,517,981	126,749	* 65.00% # 52.95%	0 0	244,381,805
7	Prescribed Drugs	1,054,357,570	554,396,429 0	0	6,396,903	150,246	* 65.00% # 52.95%	0 0	560,943,578
7A1	Drug Rebate Offset - National Agreement	(276,309,088)	(146,305,662) 0	0	0	0	* 0.00% # 52.95%	0 0	(146,305,662)
7A2	Drug Rebate Offset - State Sidebar Agreement	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
8	Dental Services	74,933,561	39,674,553 0	0	0	3,398	* 65.00% # 52.95%	0 0	39,677,951
9	Other Practitioners' Services	45,961,323	24,314,506 0	0	37,015	292	* 65.00% # 52.95%	0 0	24,351,813
10	Clinic Services	411,525,522	213,967,680 0	0	6,681,627	4,984	* 65.00% # 52.95%	0 0	220,654,291
11	Laboratory And Radiological Services	30,657,242	15,866,666 0	0	568,573	39,077	* 65.00% # 52.95%	0 0	16,474,316
12	Home Health Services	276,997,777	146,666,454 0	0	0	4,749	* 65.00% # 52.95%	0 0	146,671,203
13	Sterilizations	2,527,176	1,008,810 0	0	559,768	0	* 0.00% # 52.95%	0 0	1,568,578
14	Abortions No. 0	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
15	EPSDT Screening Services	14,154,742	7,388,372 0	0	181,129	0	* 0.00% # 52.95%	0 0	7,569,501
16	Rural Health Clinic Screening	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
17A	Medicare Health Insurance Payments - Part A Premiums	330,952	175,239 0	0	0	0	* 0.00% # 52.95%	0 0	175,239
17B	Medicare Health Insurance Payments - Part B Premiums	85,215,084	45,121,387 0	0	0	0	* 0.00% # 52.95%	0 0	45,121,387

\* Optional Breast & Cervical Cancer Services calculated at an Enhanced FMAP rate of 65% and/or the IHS Services rate of 100%

\*\* Lines are calculated at the increased FMAP rate of 52.95% with exception of DSH which is calculated at the regular FMAP rate of 52.95%

\* = Other , # = Prompt Pay

Medical Assistance Expenditures By Type Of Service  
For The Medical Assistance Program  
Expenditures In This Quarter

State: New York

Quarter Ended: 09/30/2003

Medical Assistance Payments		Total Comp.	Federal Share						Total Federal Share
			FMAP 52.95% Incr FMAP 52.95%	IHS Facility Services 100%	Fam. Plan. Services 90%	Optional Breast or Cerv. Cancer Services	Other & Prompt Pay		
							Other % (Oih) Prompt Pay (PP)	Federal Share	
		(A)	(B)	(C)	(D)	(E)	(F)	(G)	
17C1	120% - 134% Of Poverty	2,708,242	0	0	0	0	* 100.00% # 52.95%	2,708,242 0	2,708,242
17C2	135% - 175% Of Poverty	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
17D	Coinsurance And Deductibles	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
18A	Medicaid Health Insurance Payments: Managed Care Organizations (MCO)	1,075,992,181	569,531,795 0	0	350,252	0	* 0.00% # 52.95%	0 0	569,882,047
18B	Medicaid Health Insurance Payments: Prepaid Health Plans (PHP)	37,828,946	20,030,427 0	0	0	0	* 0.00% # 52.95%	0 0	20,030,427
18C	Medicaid Health Insurance Payments: Group Health Plan Payments	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
18D	Medicaid Health Insurance Payments: Coinsurance And Deductibles	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
18E	Medicaid Health Insurance Payments: Other	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
19	Home And Community-Based Services	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
20	Home And Community-Based Care For Functionally Disabled Elderly	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
21	Community Supported Living Services	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
22	Programs Of All-Inclusive Care Elderly	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
23	Personal Care Services	533,164,507	282,310,604 0	0	0	3	* 65.00% # 52.95%	0 0	282,310,607
24	Targeted Case Management Services	100,490,962	53,209,950 0	0	0	18	* 65.00% # 52.95%	0 0	53,209,968
25	Primary Care Case Management Services	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
26	Hospice Benefits	15,367,171	8,136,917 0	0	0	0	* 0.00% # 52.95%	0 0	8,136,917
27	Emergency Services for Undocumented Aliens	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
28	Federally-Qualified Health Center	0	0	0	0	0	* 0.00% # 52.95%	0 0	0
29	Other Care Services	608,000,790	321,931,797 0	0	7,295	405	* 65.00% # 52.95%	0 0	321,939,497
30	Total	9,010,856,160	4,759,521,115 0	0	16,808,397	496,270	* 0.00% # 52.95%	2,708,242 0	4,779,534,024

\* Optional Breast & Cervical Cancer Services calculated at an Enhanced FMAP rate of 65% and/or the IHS Services rate of 100%

\*\* Lines are calculated at the increased FMAP rate of 52.95% with exception of DSH which is calculated at the regular FMAP rate of 52.95%

\* = Other, # = Prompt Pay

**Exhibit B**

Quarterly Medicaid Assistance Expenditures  
For the Medical Assistance Program

State: New York

Quarter Ended: 12/31/2008

Certification				
CMS 64 Summary Sheet	Medical Assistance Payments		State and Local Administration	
	Total	Federal Share	Total	Federal Share
	(A)	(B)	(C)	(D)
Net Expenditures Reported In This Period (Sum of Items 6, 7 and 8 Less 9 and 10)	10,822,638,974	6,338,444,756	331,443,985	179,492,813

I certify that:

1. I am the executive officer of the state agency or his/her designate authorized by the state to submit this form.
2. This report only includes expenditures under the Medicaid program under title XIX of the Social Security Act (the Act), and as applicable, under the Children's Health Insurance Program (CHIP) under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan approved by the Secretary and in effect during the Quarter Ended indicated above under Title XIX of the Act for the Medicaid program, and as applicable, under Title XXI of the Act for the CHIP.
3. The expenditures included in this report are based on the state's accounting of actual recorded expenditures, and are not based on estimates.
4. The required amount of state and/or local funds were available and used to match the state's allowable expenditures included in this report, and such state and/or local funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures.
5. Federal matching funds are not being claimed on this report to match any expenditure under any Medicaid and/or CHIP state plan amendment that was submitted after January 2, 2001, and that has not been approved by the Secretary effective for the Quarter Ended indicated above.
6. The information shown above and on the Form CMS-64 Summary Sheet and the Supporting Schedules is correct to the best of my knowledge and belief.

Date: 5/26/2009 1:14:01 PM	Signature: Nicholas Meister	Title: Chief Accountant
----------------------------	-----------------------------	-------------------------

User Performing Certification: k1n3

Footnotes:

The completed Budget, Expenditure and supporting forms are to be submitted via the on-line MBES/CBES system to the Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Finance, Systems and Quality Group, Division of Financial Management, located at Mailstop S3-13-15, 7500 Security Blvd., Baltimore, Maryland 21244-1850.

Quarterly Medicaid Statement of Expenditures  
For the Medical Assistance Program  
Summary Sheet

State: New York

Quarter Ended: 12/31/2008

		Medical Assistance Payments				State and Local Administration	
		Total Computable	Federal Share			Total Computable	Federal Share
			Medicaid	ARRA	Total		
		(A)	(B)	(C)	(D)	(E)	(F)
<b>Section A. Quarterly Status of Funding</b>							
1	Awards Received During The Quarter For The Quarter Being Reported And Prior Quarters				5,934,123,000		180,110,000
2	Awards Received During The Quarter For Subsequent Quarters				0		0
3A	Interest: Received On Medicaid Recoveries				0		
3B	Interest: Assessed On Disallowances				0		0
4	Medicare Overpayment Collection Under Sec. 1914 and 42 CFR 447.30				0		0
5	Other				0		0
<b>Section B. Expenditures Reported for Period</b>							
6	Expenditures In This Quarter	11,409,075,819	5,717,006,425	974,936,654	6,691,943,079	185,145,372	95,273,684
7	Adjustments Increasing Claims For Prior Quarters	245,127,650	122,705,325	0	122,705,325	158,100,670	90,544,149
8	Other Expenditures	0	0	0	0	0	0
9A	Collections: Third Party Liability	(26,371,197)	(13,015,624)	0	(13,015,624)		
9B	Collections: Probate	(11,719,958)	(6,630,926)	0	(6,630,926)		
9C	Collections: Identified Through Fraud And Abuse Effort	(149,813,185)	(87,904,553)	0	(87,904,553)		
9D	Collections: Other	(21,967,404)	(12,680,578)	0	(12,680,578)	0	0
9E	Misc.	0	0	0	0	0	0
10A	Adjustments Decreasing Claims For Prior Quarters: Federal Audit	(19,056,840)	(17,151,156)	0	(17,151,156)	0	0
10B	Adjustments Decreasing Claims For Prior Quarters: Other	(180,569,569)	(90,665,600)	0	(90,665,600)	(11,802,057)	(6,325,020)
10C	Adjustments Decreasing Claims For Prior Quarters: Overpayment Adjustments (Attach 64.9O)	(422,066,342)	(248,155,211)	0	(248,155,211)		
11	Net Expenditures Reported In This Period (Sum of Items 6, 7 and 8 Less 9 and 10)	10,822,638,974	5,363,508,102	974,936,654	6,338,444,756	331,443,985	179,492,813

Medical Assistance Expenditures By Type Of Service  
For The Medical Assistance Program  
Expenditures In This Quarter

State: New York

Quarter Ended: 12/31/2008

Medical Assistance Payments		Total Comp.	Federal Share						Total Federal Share
			FMAP 50% Incr FMAP 58.78%	IHS Facility Services 100%	Fam. Plan. Services 90%	Optional Breast or Cerv. Cancer Services	Other & Prompt Pay		
							Other % (Oth) Prompt Pay (PP)	Federal Share	
		(A)	(B)	(C)	(D)	(E)	(F)		(G)
1A	Inpatient Hospital Services - Regular Payments	1,418,869,087	708,965,880 124,494,409	0	152,255	499,300	* 0.00% # 50.00%	0 0	834,111,844
1B	Inpatient Hospital Service - DSH Adjustment Payments	269,643,134	134,821,567 0	0	0	0	* 0.00% # 50.00%	0 0	134,821,567
2A	Mental Health Facility Services - Regular Payments	122,693,107	61,346,553 10,772,455	0	0	0	* 0.00% # 50.00%	0 0	72,119,008
2B	Mental Health Facility Services - DSH Adjustment Payments	4,900,000	2,450,000 0	0	0	0	* 0.00% # 50.00%	0 0	2,450,000
3	Nursing Facility Services	2,142,063,198	1,071,027,667 188,072,458	0	0	5,112	* 0.00% # 50.00%	0 0	1,259,105,237
4A	Intermediate Care Facility Services - Mentally Retarded: Public Providers	542,486,778	271,243,389 47,630,339	0	0	0	* 0.00% # 50.00%	0 0	318,873,728
4B	Intermediate Care Facility Services - Mentally Retarded: Private Providers	213,578,838	106,789,419 18,752,222	0	0	0	* 0.00% # 50.00%	0 0	125,541,641
5	Physicians' Services	55,348,715	27,256,355 4,786,216	0	491,187	188,657	* 0.00% # 50.00%	0 0	32,722,415
6	Outpatient Hospital Services	288,935,818	143,782,353 25,248,181	0	517,277	517,634	* 0.00% # 50.00%	0 0	170,065,445
7	Prescribed Drugs	998,612,306	494,131,187 86,769,436	160,784	8,782,346	280,141	* 0.00% # 50.00%	0 0	590,123,894
7A1	Drug Rebate Offset - National Agreement	(385,935,812)	(192,967,906) (33,885,164)	0	0	0	* 0.00% # 50.00%	0 0	(226,853,070)
7A2	Drug Rebate Offset - State Sidebar Agreement	(40,420,948)	(20,210,474) (3,548,959)	0	0	0	* 0.00% # 50.00%	0 0	(23,759,433)
8	Dental Services	72,681,586	36,330,301 6,379,601	0	0	13,639	* 0.00% # 50.00%	0 0	42,723,541
9	Other Practitioners' Services	51,496,559	25,718,251 4,516,125	0	52,420	1,178	* 0.00% # 50.00%	0 0	30,287,974
10	Clinic Services	394,890,386	194,565,432 34,165,690	186,628	4,958,198	41,460	* 0.00% # 50.00%	0 0	233,917,408
11	Laboratory And Radiological Services	29,652,109	14,591,255 2,562,224	0	187,505	169,820	* 0.00% # 50.00%	0 0	17,510,804
12	Home Health Services	456,626,989	228,293,026 40,088,255	0	0	26,609	* 0.00% # 50.00%	0 0	268,407,890
13	Sterilizations	1,045,678	0	0	941,110	0	* 0.00% # 50.00%	0 0	941,110
14	Abortions No. 0	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
15	EPSDT Screening Services	1,471,169	727,503 127,749	0	14,548	0	* 0.00% # 50.00%	0 0	869,800
16	Rural Health Clinic Screening	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
17A	Medicare Health Insurance Payments - Part A Premiums	116,468,838	58,234,419 10,225,964	0	0	0	* 0.00% # 50.00%	0 0	68,460,383
17B	Medicare Health Insurance Payments - Part B Premiums	140,709,371	70,354,685 12,354,283	0	0	0	* 0.00% # 50.00%	0 0	82,708,968

\* Optional Breast & Cervical Cancer Services calculated at an Enhanced FMAP rate of 65% and/or the IHS Services rate of 100%

\*\* Lines are calculated at the increased FMAP rate of 58.78% with exception of DSH which is calculated at the regular FMAP rate of 50%

\* = Other , # = Prompt Pay

Medical Assistance Expenditures By Type Of Service  
For The Medical Assistance Program  
Expenditures In This Quarter

State: New York

Quarter Ended: 12/31/2008

Medical Assistance Payments		Total Comp.	Federal Share						Total Federal Share
			FMAP 50% Incr FMAP 58.78%	IHS Facility Services 100%	Fam. Plan. Services 90%	Optional Breast or Cerv. Cancer Services	Other & Prompt Pay		
							Other % (Oth) Prompt Pay (PP)	Federal Share	
(A)	(B)	(C)	(D)	(E)	(F)		(G)		
17C1	120% - 134% Of Poverty	9,212,008	0	0	0	0	* 100.00% # 50.00%	9,212,008 0	9,212,008
17C2	135% - 175% Of Poverty	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
17D	Coinsurance And Deductibles	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
18A	Medicaid Health Insurance Payments: Managed Care Organizations (MCO)	1,999,941,512	999,970,756 175,594,865	0	0	0	* 0.00% # 50.00%	0 0	1,175,565,621
18B1	Prepaid Ambulatory Health Plan	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
18B2	Prepaid Inpatient Health Plan	39,945,226	19,972,613 3,507,191	0	0	0	* 0.00% # 50.00%	0 0	23,479,804
18C	Medicaid Health Insurance Payments: Group Health Plan Payments	4,017,674	2,008,837 352,752	0	0	0	* 0.00% # 50.00%	0 0	2,361,589
18D	Medicaid Health Insurance Payments: Coinsurance And Deductibles	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
18E	Medicaid Health Insurance Payments: Other	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
19	Home And Community-Based Services	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
20	Home And Community-Based Care For Functionally Disabled Elderly	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
22	Programs Of All-Inclusive Care Elderly	37,915,584	18,957,792 3,328,988	0	0	0	* 0.00% # 50.00%	0 0	22,286,780
23	Personal Care Services	696,017,171	348,008,177 61,110,236	0	0	530	* 0.00% # 50.00%	0 0	409,118,943
24	Targeted Case Management Services	108,422,715	54,211,358 9,519,514	0	0	0	* 0.00% # 50.00%	0 0	63,730,872
25	Primary Care Case Management Services	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
26	Hospice Benefits	29,119,559	14,556,852 2,556,183	0	0	3,806	* 0.00% # 50.00%	0 0	17,116,841
27	Emergency Services for Undocumented Aliens	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
28	Federally-Qualified Health Center	0	0	0	0	0	* 0.00% # 50.00%	0 0	0
29	Other Care Services	335,874,541	167,762,783 29,459,145	23,605	261,104	22,914	* 0.00% # 50.00%	0 0	197,529,551
30	Total	10,156,282,896	5,062,900,030 864,940,358	371,017	16,357,950	1,770,800	* 0.00% # 50.00%	9,212,008 0	5,955,552,163

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\* = Other , # = Prompt Pay

## **Exhibit C**

Quarterly Medicaid Assistance Expenditures  
For the Medical Assistance Program

State: New York

Quarter Ended: 12/31/2009

Certification				
CMS 64 Summary Sheet	Medical Assistance Payments		State and Local Administration	
	Total	Federal Share	Total	Federal Share
	(A)	(B)	(C)	(D)
Net Expenditures Reported in This Period (Sum of Items 6, 7 and 8 Less 9 and 10)	12,469,860,680	7,578,103,758	283,056,746	145,617,727

I certify that:

1. I am the executive officer of the state agency or his/her designate authorized by the state to submit this form.
2. This report only includes expenditures under the Medicaid program under title XIX of the Social Security Act (the Act), and as applicable, under the Children's Health Insurance Program (CHIP) under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan approved by the Secretary and in effect during the Quarter Ended indicated above under Title XIX of the Act for the Medicaid program, and as applicable, under Title XXI of the Act for the CHIP.
3. The expenditures included in this report are based on the state's accounting of actual recorded expenditures, and are not based on estimates.
4. The required amount of state and/or local funds were available and used to match the state's allowable expenditures included in this report, and such state and/or local funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures.
5. Federal matching funds are not being claimed on this report to match any expenditure under any Medicaid and/or CHIP state plan amendment that was submitted after January 2, 2001, and that has not been approved by the Secretary effective for the Quarter Ended indicated above.
6. The information shown above and on the Form CMS-64 Summary Sheet and the Supporting Schedules is correct to the best of my knowledge and belief.

Date: 3/31/2010 9:48:21 AM	Signature: Nicholas Meister	Title: Chief Accountant
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User Performing Certification: k1n3

Footnotes:

The completed Budget, Expenditure and supporting forms are to be submitted via the on-line MBES/CBES system to the Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Finance, Systems and Quality Group, Division of Financial Management, located at Mailstop S3-13-15, 7500 Security Blvd., Baltimore, Maryland 21244-1850.

Quarterly Medicaid Statement of Expenditures  
For the Medical Assistance Program  
Summary Sheet

State: New York

Quarter Ended: 12/31/2009

		Medical Assistance Payments				State and Local Administration	
		Total Computable	Federal Share			Total Computable	Federal Share
			Medicaid	ARRA	Total		
		(A)	(B)	(C)	(D)	(E)	(F)
<b>Section A. Quarterly Status of Funding</b>							
1	Awards Received During The Quarter For The Quarter Being Reported And Prior Quarters				0		0
2	Awards Received During The Quarter For Subsequent Quarters				0		0
3A	Interest: Received On Medicaid Recoveries				0		
3B	Interest: Assessed On Disallowances				0		0
4	Medicare Overpayment Collection Under Sec. 1914 and 42 CFR 447.30				0		0
5	Other				0		0
<b>Section B. Expenditures Reported for Period</b>							
6	Expenditures In This Quarter	12,720,540,462	6,373,225,038	1,375,580,467	7,748,805,505	202,728,208	104,776,772
7	Adjustments Increasing Claims For Prior Quarters	347,045,048	173,522,523	10,388,130	183,910,653	81,810,837	41,583,664
8	Other Expenditures	279,936	139,968	0	139,968	0	0
9A	Collections: Third Party Liability	(56,538,146)	(25,604,499)	(6,550,783)	(32,155,282)		
9B	Collections: Probate	(10,257,961)	(5,071,984)	(1,188,898)	(6,260,882)		
9C1	Recoveries: Fraud, Waste and Abuse Efforts	(247,422,248)	(123,711,125)	(28,561,352)	(152,272,477)		
9C2	Recoveries: OIG Compliant False Claims Act	0	0	0	0		
9D	Collections: Other	(41,605,030)	(20,829,556)	(4,799,636)	(25,629,192)	0	0
9E	Misc.	0	0	0	0	0	0
10A	Adjustments Decreasing Claims For Prior Quarters: Federal Audit	0	0	0	0	0	0
10B	Adjustments Decreasing Claims For Prior Quarters: Other	(103,443,232)	(51,721,615)	(1,266,719)	(52,988,334)	(1,482,299)	(742,709)
10C	Adjustments Decreasing Claims For Prior Quarters: Overpayment Adjustments (Attach 64.90)	(138,711,650)	(69,356,809)	(16,076,143)	(85,432,952)		
10D	Adjustments/Decreasing Prior Qtrs - Perm	(26,499)	(13,249)	0	(13,249)	0	0
11	Net Expenditures Reported In This Period (Sum of Items 6, 7 and 8 Less 9 and 10)	12,469,860,680	6,250,578,692	1,327,525,066	7,578,103,758	283,056,746	145,617,727

Medical Assistance Expenditures By Type Of Service  
For The Medical Assistance Program  
Expenditures In This Quarter

State: New York

Quarter Ended: 12/31/2009

Medical Assistance Payments		Total Comp.	Federal Share						Total Federal Share
			FMAP 50% Incr FMAP 61.59%	IHS Facility Services 100%	Fam. Plan. Services 90%	Optional Breast or Cerv. Cancer Services	Other & Prompt Pay		
							Other % (Oth) Prompt Pay (PP)	Federal Share	
		(A)	(B)	(C)	(D)	(E)	(F)		(G)
1A	Inpatient Hospital Services - Regular Payments	676,424,156	337,874,424 78,319,291	0	10,270	431,534	* 0.00% # 50.00%	0	416,635,519
1B	Inpatient Hospital Service - DSH Adjustment Payments	819,533,774	409,766,887 0	0	0	0	* 0.00% # 50.00%	0	409,766,887
1C	Inpatient Hospital Services - Supplemental Payments	0	0	0	0	0	* 0.00% # 50.00%	0	0
1D	Inpatient Hospital Services - GME Payments	0	0	0	0	0	* 0.00% # 50.00%	0	0
2A	Mental Health Facility Services - Regular Payments	96,602,203	48,301,102 11,196,195	0	0	0	* 0.00% # 50.00%	0	59,497,297
2B	Mental Health Facility Services - DSH Adjustment Payments	0	0	0	0	0	* 0.00% # 50.00%	0	0
3A	Nursing Facility Services - Regular Payments	1,743,003,738	871,501,643 202,014,081	0	0	293	* 0.00% # 50.00%	0	1,073,516,017
3B	Nursing Facility Services - Supplemental Payments	0	0	0	0	0	* 0.00% # 50.00%	0	0
4A	Intermediate Care Facility Services - Mentally Retarded: Public Providers	610,462,091	305,231,046 70,752,556	0	0	0	* 0.00% # 50.00%	0	375,983,602
4B	Intermediate Care Facility Services - Mentally Retarded: Private Providers	148,306,224	74,153,112 17,188,691	0	0	0	* 0.00% # 50.00%	0	91,341,803
4C	Intermediate Care Facility Services - Mentally Retarded: Supplemental Payments	0	0	0	0	0	* 0.00% # 50.00%	0	0
5A	Physician and Surgical Services - Regular Payments	47,051,417	23,209,162 5,379,884	0	128,916	318,404	* 0.00% # 50.00%	0	29,036,366
5B	Physician and Surgical Services - Supplemental Payments	0	0	0	0	0	* 0.00% # 50.00%	0	0
6A	Outpatient Hospital Services - Regular Payments	232,225,817	115,433,919 26,757,582	0	128,926	789,574	* 0.00% # 50.00%	0	143,110,001
6B	Outpatient Hospital Services - Supplemental Payments	0	0	0	0	0	* 0.00% # 50.00%	0	0
7	Prescribed Drugs	126,861,739	62,943,641 14,590,336	130,280	138,578	448,631	* 0.00% # 50.00%	0	78,251,466
7A1	Drug Rebate Offset - National Agreement	(165,404,778)	(82,702,389) (19,170,414)	0	0	0	* 0.00% # 50.00%	0	(101,872,803)
7A2	Drug Rebate Offset - State Sidebar Agreement	(50,409,651)	(25,204,825) (5,842,479)	0	0	0	* 0.00% # 50.00%	0	(31,047,304)
8	Dental Services	22,427,458	11,202,077 2,596,642	0	0	15,147	* 0.00% # 50.00%	0	13,813,866
9A	Other Practitioners Services - Regular Payments	31,109,156	15,549,088 3,604,279	0	6,297	2,588	* 0.00% # 50.00%	0	19,162,252
9B	Other Practitioners Services - Supplemental Payments	0	0	0	0	0	* 0.00% # 50.00%	0	0
10	Clinic Services	141,684,576	70,336,893 16,304,092	285,531	642,587	7,327	* 0.00% # 50.00%	0	87,576,430
11	Laboratory And Radiological Services	12,065,953	5,886,837 1,364,569	0	33,106	166,071	* 0.00% # 50.00%	0	7,450,583

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\* = Other , # = Prompt Pay

Medical Assistance Expenditures By Type Of Service  
For The Medical Assistance Program  
Expenditures In This Quarter

State: New York

Quarter Ended: 12/31/2009

Medical Assistance Payments		Total Comp.	Federal Share					Other & Prompt Pay		Total Federal Share
			FMAP 50% Incr FMAP 61.59%	IHS Facility Services 100%	Fam. Plan. Services 90%	Optional Breast or Cerv. Cancer Services	Other % (Oth) Prompt Pay (PP)	Federal Share		
									(A)	
12	Home Health Services	542,740,875	271,340,813 62,896,800	0	0	38,513	* 0.00% # 50.00%	0	334,276,126	
13	Sterilizations	145,519	0	0	130,967	0	* 0.00% # 50.00%	0	130,967	
14	Abortions No. 0	0	0	0	0	0	* 0.00% # 50.00%	0	0	
15	EPSDT Screening Services	496,077	248,038 57,495	0	1	0	* 0.00% # 50.00%	0	305,534	
16	Rural Health Clinic Screening	0	0	0	0	0	* 0.00% # 50.00%	0	0	
17A	Medicare Health Insurance Payments - Part A Premiums	170,730,072	85,365,036 19,787,615	0	0	0	* 0.00% # 50.00%	0	105,152,651	
17B	Medicare Health Insurance Payments - Part B Premiums	145,743,041	72,871,521 16,891,618	0	0	0	* 0.00% # 50.00%	0	89,763,139	
17C1	120% - 134% Of Poverty	8,734,142	0	0	0	0	* 100.00% # 50.00%	8,734,142	8,734,142	
17D	Coinsurance And Deductibles	0	0	0	0	0	* 0.00% # 50.00%	0	0	
18A	Medicaid Health Insurance Payments: Managed Care Organizations (MCO)	316,442,352	158,221,176 36,675,669	0	0	0	* 0.00% # 50.00%	0	194,896,845	
18B1	Prepaid Ambulatory Health Plan	0	0	0	0	0	* 0.00% # 50.00%	0	0	
18B2	Prepaid Inpatient Health Plan	51,362,528	25,681,264 5,952,917	0	0	0	* 0.00% # 50.00%	0	31,634,181	
18C	Medicaid Health Insurance Payments: Group Health Plan Payments	0	0	0	0	0	* 0.00% # 50.00%	0	0	
18D	Medicaid Health Insurance Payments: Coinsurance And Deductibles	0	0	0	0	0	* 0.00% # 50.00%	0	0	
18E	Medicaid Health Insurance Payments: Other	0	0	0	0	0	* 0.00% # 50.00%	0	0	
19A	Home and Community-Based Services - Regular Payment (Waiver)	0	0	0	0	0	* 0.00% # 50.00%	0	0	
19B	Home and Community-Based Services - State Plan 1915(i) Only Payment	0	0	0	0	0	* 0.00% # 50.00%	0	0	
19C	Home and Community-Based Services - State Plan 1915(j) Only Payment	0	0	0	0	0	* 0.00% # 50.00%	0	0	
22	Programs Of All-Inclusive Care Elderly	3,150,818	1,575,409 365,180	0	0	0	* 0.00% # 50.00%	0	1,940,589	
23A	Personal Care Services - Regular Payment	665,041,650	332,518,286 77,077,739	0	0	3,301	* 0.00% # 50.00%	0	409,599,326	
23B	Personal Care Services - SDS 1915(j)	0	0	0	0	0	* 0.00% # 50.00%	0	0	
24A	Targeted Case Management Services - Community Case-Management	66,760,936	33,380,468 7,737,592	0	0	0	* 0.00% # 50.00%	0	41,118,060	
24B	Case Management - State Wide	0	0	0	0	0	* 0.00% # 50.00%	0	0	

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\* = Other , # = Prompt Pay