

UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF NEW YORK

-----X	
UNITED STATES OF AMERICA,	:
<i>EX REL.</i> DR. GABRIEL FELDMAN,	:
	:
Plaintiff,	:
	:
v.	:
	:
THE CITY OF NEW YORK,	:
	:
Defendant.	:
-----X	

Case No. 09 Civ. 8381 (JSR)

-----X	
UNITED STATES OF AMERICA,	:
	:
Plaintiff,	:
	:
v.	:
	:
THE CITY OF NEW YORK,	:
	:
Defendant.	:
-----X	

**MEMORANDUM IN SUPPORT OF THE CITY OF NEW YORK'S  
MOTION FOR SUMMARY JUDGMENT**

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**PRELIMINARY STATEMENT**<sup>1</sup>

Each year since 2000, New York State Medicaid’s personal care services program (“PCS”) has served as many as 50,000 poor and disabled City residents who want to continue living in their homes and communities. PCS involve assistance with activities of daily living, such as light housekeeping, preparing meals, toileting, dressing and bathing. Without such assistance, PCS recipients—who are typically frail and elderly, and in some cases blind or unable to walk on their own—would be left alone, or institutionalized against their will. Thus, PCS allow New Yorkers to exercise what President Obama has described as “one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.”

56.1 ¶ 1.

Consistent with federal disability policy, as long as PCS are provided in accordance with a Medicaid “State Plan” approved by the U.S. Secretary of Health and Human Services, the U.S. must reimburse the State for a portion of its expenditures through federal financial participation (“FFP”). The Medicaid Act does not allow the U.S. to involve itself in patient-specific decisions or policy, or to second guess local judgments. By bringing this case, the U.S. is seeking an end-run around this limitation by crying “fraud” when no fraud occurred. No violation of the Medicaid Act or regulations is alleged. Not one penny of federal funds went into the City’s coffers, to a City employee, or to a PCS provider for services not actually performed. 56.1 ¶¶ 33-37. Every single dollar at issue was used to provide PCS to poor, disabled and elderly City residents who indisputably needed assistance with activities of daily living. There is no False Claims Act case here and judgment should be entered for the City as a matter of law for at least three reasons:

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<sup>1</sup> Citations to “56.1 ¶ \_\_\_” are references to The City of New York’s Statement of Undisputed Material Facts Pursuant to Local Civil Rule 56.1, dated August 1, 2011.

The False Claims Act Does Not Apply. Under the Supreme Court’s decision in *Vermont Agency of Natural Resources v. U.S. ex rel. Stevens*, 529 U.S. 765, 780-88 (2000), states and their local arms are not subject to False Claims Act suits because they are not “persons” within the meaning of the Act. 56.1 ¶¶ 22-25. The Second Circuit and New York Court of Appeals have held that the City’s Human Resources Administration (“HRA”) is the local arm of New York State for purposes of administering the Medicaid program. Accordingly, no False Claims Act case lies against the City for HRA’s administration of the Medicaid program as a local arm of the State in this case.

Even If the Act Applies, There Is No False Claim. The claims at issue are 44 quarterly CMS-64 forms submitted by New York *State* to the U.S. between 2000 and 2010, by which the *State* sought FFP for a portion of the *State*’s Medicaid expenditures. 56.1 ¶¶ 41-42, 56-57. Those CMS-64s are allegedly “false” because (i) in some percentage of individual PCS cases, HRA in exercising its discretion as the local arm of the State allegedly did not properly document compliance with 18 N.Y.C.R.R. §§ 505.14(b)(1)-(2), (b)(4)(ii), and (b)(5)(ix) (the “State Assessment Provisions”) in assessing individuals for Medicaid PCS; and (ii) the *State* claimed FFP for PCS while certifying (on 7 forms) that “the information shown above and on the CMS-64 Summary Sheet and the Supporting Schedules is correct to the best of my knowledge and belief” or, (on 37 forms) that the expenditures are “allowable . . . to the best of my knowledge and belief.” Neither of these subjective statements of belief can form the basis for False Claims Act liability.

First, the U.S.’s “certification theory” only attaches liability to false statements of compliance with “those regulations that are a precondition to payment.” *Mikes v. Straus*, 274 F.3d 687, 699 (2d Cir. 2001). This legal limitation on False Claims Act liability requires the

U.S. to formally identify *in advance* of a claim's submission those requirements that are material to its payment decision to prevent *post hoc* boot-strapping of False Claims Act suits. Therefore, even if the U.S.'s allegations are true (which they are not), *Mikes* requires summary judgment for the City because compliance with the State Assessment Provisions is not a precondition to FFP. The U.S. cannot point to anything making the State Assessment Provisions a precondition to FFP. Indeed, the State could freely repeal the State Assessment Provisions tomorrow and FFP would still be required.

The U.S.'s undisputed practices confirm that the State Assessment Provisions have nothing to do with FFP:

- The CMS-64 is prepared using an automated process approved by the U.S. as containing all information necessary for FFP. Certification of "compliance" with the State Assessment Provisions is not required.

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- The federal FFP team could not check for compliance with the State Assessment Provisions (even if someone had told them to do so) because they do *not* maintain copies of the State Assessment Provisions and had not seen or heard of the regulations prior to their depositions in this case.
- The U.S.'s Financial Management Group Director testified that it was not necessary for her to be familiar with the State Assessment Provisions because "I work for the federal government and my job is to ensure that the federal rules are followed", not the State Assessment Provisions. 56.1 ¶ 89.

Thus, compliance with the State Assessment Provisions is not a precondition of FFP and cannot form the basis of False Claims Act liability.

Second, the U.S.'s certification theory requires a "false representation of *compliance* with a federal statute or regulation or a prescribed contractual term." *Mikes*, 274 F.3d at 699 (emphasis added). There is no alleged false representation of "*compliance*" with a federal or any

other statute, regulation or contractual term by the City. In fact, the word “*compliance*” is entirely absent from the vague CMS-64 certification. Under the relevant case law, the U.S.’s theory of “general compliance with the law” is not a basis for False Claims Act liability. *See, e.g., U.S. ex rel. Colucci v. Beth Israel Med. Ctr.*, No. 06 Civ. 5033 (DC), 2011 WL 1226267, at \*6 (S.D.N.Y. Mar. 30, 2011) (dismissing False Claims Act suit).

Third, no rational jury could find these certifications false. When asked what could make a CMS-64 certification false, the U.S.’s Rule 30(b)(6) witness responded: “When the person certifying it knowingly includes payments that are not allowable.” 56.1 ¶ 67. Yet, there is not a shred of evidence that the State employee who made the certification knew that any payment was allegedly not allowable. Thus, there is no record evidence that any certification is false *under the U.S.’s own formulation of falsity*.

Fourth, even if compliance with the State Assessment Provisions were relevant to FFP (which it is not), the U.S.’s case fails because it rests on incorrect understandings of those provisions:

- *The U.S. Attorney alleges:* The State Assessment Provisions direct the blind implementation of the “amount” of PCS recommended by an “independent medical reviewer” who does not see an applicant, but reviews paperwork completed by those who do in some circumstances.
  - *The law is:* The regulations give the Commissioner authority to determine the *number of hours* of PCS, even in the face of conflicting medical evidence. *Kuppersmith v. Dowling*, 668 N.Y.S.2d 381, 382 (App. Div. 1998), *aff’d* 93 N.Y.2d 90 (1999); 18 N.Y.C.R.R. § 505.14(b)(5)(i). The U.S.’s position cannot be squared with regulations, the case law, and the practical reality that the State Department of Health (“DOH”) overrules independent medical reviewers all the time. 56.1 ¶ 121. Indeed, since this litigation started, in deference to the U.S. Attorney’s view, the City has accepted the medical reviewer’s recommendation. In turn, in May 2011, when challenged, the City was reversed by the State DOH 100% of the time. 56.1 ¶ 125.
- *The U.S. Attorney alleges:* The State Assessment Provisions require independent medical review prior to *re-authorizing* “split shift” PCS.

- *The law is:* The narrow definition of “continuous 24-hour personal care services” in Section 505.14(a)(3) limits the types of cases that require independent medical review to a subset of cases. The U.S.’s theory that the regulation requires independent medical review for every authorization involving split-shift services must be rejected based on the plain language of the regulation.
- *The U.S. Attorney alleges:* The City abdicated its responsibility to obtain nursing assessments of individuals in the PCS program.
  - *The facts are:* The City has dozens of contracts with nursing agencies to conduct nursing assessments as required by law and at a minimum of every six months (or 180 days) for PCS patients. Contract nurses and attendants are required to inform HRA of any change in a patient’s condition that could affect the level or amount of PCS. 56.1 ¶ 112. The City has produced thousands of nursing and supervisory assessments for approximately 526 PCS patients the U.S. has focused on in this case, including 84 for the 4 patients in the complaint for which the U.S. alleges the City has none. The City has implemented procedures above and beyond the nursing assessment requirements in Section 505.14(b)(2). 56.1 ¶ 136.

In short, the City properly implemented the State Assessment Provisions. And that is fatal to U.S.’s case.

No Scierter. Judgment should be entered for the City because there is no evidence that the City knowingly presented or caused to be presented information to be included in a CMS-64 that the City knew was false. *See U.S. ex rel. Kreindler & Kreindler v. United Tech. Corp.*, 985 F.2d 1148, 1156 (2d Cir. 1993). There is no evidence that the City (i) knowingly did not comply with the State Assessment Provisions; (ii) ever falsely certified compliance with the State Assessment Provisions; or (iii) knew the State (falsely or not) certified the City’s compliance with the State Assessment Provisions. There is no record that anyone has ever certified the City’s compliance with the State Assessment Provisions, or that anyone required or relied on such a certification. Instead, the U.S. Attorney is trying to enter a policy debate in New York about how to cost-effectively and properly meet the needs of disabled individuals who wish to remain in their homes, with a view that too much was spent caring for them.

Moreover, the City did not benefit financially or otherwise by the complex, ten-year

alleged fraud. Based on the City's own share for PCS expenditures (more than \$1 billion during the period at issue), the City itself would be just as much of a victim of its so-called fraud as the U.S. On this record, no rational jury could make the implausible finding that the City knowingly acted so contrary to its own interest. Because "the factual context renders [the U.S.'s] claim implausible" the U.S. "must come forward with more persuasive evidence to support [its] claim than would otherwise be necessary." See *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). This it cannot do and has not done. The only evidence is that the City reasonably interpreted and implemented the PCS regulations to ensure that the program balances the needs, health and safety of an economically and physically challenged population against the legal requirements and fiscal realities of the program 56.1 ¶ 17. As a matter of law, there is no basis in the record to impose False Claims Act liability on the City.

## **BACKGROUND**

### **I. OVERVIEW OF NEW YORK'S PERSONAL CARE SERVICES PROGRAM**

In 1999, PCS evolved from an optional service to a federal mandate. 56.1 ¶ 12. PCS became the safety net program serving individuals choosing home, rather than institutional, care. 56.1 ¶¶ 15-18. In 2010, 42,362 of the three million Medicaid beneficiaries in the City received PCS at the request of their treating physician. 56.1 ¶ 15. In other words, over the last decade, the availability of PCS has prevented tens of thousands of poor, disabled New Yorkers from being institutionalized against their will, including Patients A-G identified in the complaint.<sup>2</sup>

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<sup>2</sup> A 2009 study found that 47 percent of participants in the City's PCS program are 81 years of age or older; more than 50 percent are cognitively impaired; over 67 percent have three or more chronic medical conditions; and 67 percent have a level of need comparable to a nursing home patient. 56.1 ¶ 16. Sections VI.D.-J. of the City's 56.1 Statement outline the disabilities and social conditions of Patients A-G.

“Personal care attendant services are not medical services, per se.” *Konstantinov v. Daines*, No. 114152/07, N.Y.L.J., Aug. 2, 2010 (Sup. Ct. N.Y. Cty. July 20, 2010). Rather, PCS involve assistance with activities of daily living. Level I services are nutritional and environmental support functions such as light housekeeping and preparing meals. Level II services include assistance with personal care functions such as toileting, dressing and bathing. 56.1 ¶ 92; 18 N.Y.C.R.R. § 505.14(a)(6)(ii). When provided 24-hours per day by an attendant who sleeps in the home, PCS are colloquially known as sleep-in service, and when by more than one attendant, split-shift service.<sup>3</sup> During the period from 2000 to 2010, approximately 19,000 individuals received 24-hour PCS. 56.1 ¶ 15.

PCS are provided by more than sixty-five entities under contract with the City. 56.1 ¶ 27. Those entities employ roughly 50,000 attendants, each with approximately forty hours of training who is currently paid approximately \$10/hour. 56.1 ¶ 29. Medicaid PCS providers’ bills are approved by the State and money is paid directly to providers by the State. 56.1 ¶¶ 30-31. The City receives nothing, even temporarily. In fact, the City—like the U.S.—reimburses the State for amounts paid to PCS providers pursuant to a statutory formula. 56.1 ¶¶ 33-34. Since 2000, the City’s annual share for the PCS program has been \$150-200 million. 56.1 ¶ 35. There is no dispute that one penny the Government seeks to recover in this case went to the City, or to a provider, for a service that was not actually provided. 56.1 ¶ 36.

## **II. Federal Financial Participation In Medicaid Personal Care Services**

Federal law *requires* FFP when New York expends Medicaid funds in accordance with the State Plan. *See* 42 U.S.C. § 1396b(a); 56.1 ¶ 5. The State Assessment Provisions are *not* incorporated into the State Plan and compliance with them by the City or State is *not* a

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<sup>3</sup> Split-shift cases were 2-3 percent and sleep-in cases were approximately 9-11 percent of the PCS caseload for 2000-2010.

precondition of FFP to the State. All PCS authorized for Patients A-G in the complaint meet the contractual preconditions for FFP.<sup>4</sup> 56.1 ¶¶ 148, 159, 172, 184, 197, 211 & 229.

The U.S.'s conduct confirms that the State Assessment Provisions are *not* preconditions to FFP. The State requests FFP by submitting to the U.S. a Quarterly Medicaid Statement of Expenditures known as a "CMS-64". 56.1 ¶ 40. The CMS-64 is "a summary of actual expenditures derived from source documents." 56.1 ¶ 41. The source documents are the e-MedNY automated system and its predecessor the MMIS automated system (together "e-MedNY"). 56.1 ¶ 45. The U.S. has examined and formally approved the e-MedNY system's design as providing information sufficient to determine "allowability" for FFP purposes. 56.1 ¶¶ 48-49. Significantly, e-MedNY says nothing about and requires no certification of compliance with the State Assessment Provisions. In fact, the CMS-64, federal statutes, regulations,

REDACTED applicable to FFP say nothing about the City's compliance with the State Assessment Provisions.

Each CMS-64 between 2000 and 2010 included expenditures on Line 23 or 23A that meet the federal requirements for PCS set forth in the State Plan and 42 C.F.R. § 440.167. 56.1 ¶ 71. Those costs were analyzed, checked, and tallied by the State DOH using the U.S.-certified and approved e-MedNY system. 56.1 ¶¶ 47-48, 70. A state official then certified his subjective belief that the billions of dollars of services reflected on the CMS-64 were accurate and/or "allowable" for FFP. 56.1 ¶¶ 55-57. The City plays no role in determining which expenditures are "allowable" for purposes of FFP. The City has no role in the preparation, submission, or

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<sup>4</sup> The State Plan includes only federal requirements related to PCS. In order to be eligible for FFP, PCS must be: (1) authorized for an individual by a physician within a plan of treatment or in accordance with a service plan approved by a State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or other location. 42 C.F.R. § 440.167; 56.1 ¶¶ 11, 18.

certification of the CMS-64 by the State to CMS, and in fact HRA officials did not know of the existence of the CMS-64 or its certification before this case. 56.1 ¶ 52.

From January 2000 through September 28, 2001, the seven CMS-64s submitted by the State included the following certification (in its entirety):

I, Executive Officer of the State Agency charged with the duties of administering (or supervising the administration of) the State Plan for the Medicaid Program as provided for in the Social Security Act, as amended, do certify that the information shown above and on the CMS-64 Summary Sheet and the Supporting Schedules is correct to the best of my knowledge and belief.

56.1 ¶ 56 (the “2000-01 Certification”). From December 31, 2001 through December 31, 2010 the thirty-seven CMS-64s submitted by the State included the following certification, in relevant part:

1. I am the executive officer of the state agency or his/her designee 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) ... 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 . . . .
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.

56.1 ¶ 57 (the “2002-10 Certification”) (emphasis added). The U.S.’s Rule 30(b)(6) witness who oversees the CMS-64 review team testified that a CMS-64 is false “[w]hen the person certifying it knowingly includes payments that are not allowable.” 56.1 ¶ 67. There is no evidence that anyone from the State included payments in any CMS-64 that the State knew were not allowable. Thus, there is no record evidence that any certification of a CMS-64 is false under the U.S.’s definition of falsity.

After receipt of the CMS-64, the U.S. reviews it to determine whether it agrees with the

State's view on "allowability" for FFP purposes.

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The relevant federal employees do *not*

maintain copies of the State Assessment Provisions—which are not incorporated into the approved State Plan—and had neither seen nor heard of the regulation prior to their preparation for depositions in this case. 56.1 ¶¶ 89-90. *No* training is provided to federal employees on Section 505.14

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REDACTED As a legal matter, compliance with the State Assessment Provisions is not a precondition of FFP. Indeed, federal law only permits the U.S. to withhold FFP from a state for violations of *federal* law and after notice and administrative hearing. 42 C.F.R. § 430.35.

## II. ELIGIBILITY FOR PCS AND THE STATE ASSESSMENT PROVISIONS

The State DOH is the "single state agency" charged to administer Medicaid (including PCS) pursuant to N.Y. Social Serv. Law § 363, *et seq.* The HRA Commissioner acts as the State's local arm in administering PCS. 56.1 ¶¶ 24-25. This includes responsibility for exercising his discretion to determine eligibility for PCS. *See* N.Y. Soc. Serv. Law § 365(4); 56.1 ¶ 124; *Kuppersmith v. Dowling*, 93 N.Y.2d 90, 94-95 (1999).

The procedures by which eligibility for PCS is determined are set forth in Section 505.14, as interpreted and applied by the State DOH and the courts. The first step in the initial PCS authorization process is a form provided by the patient's treating physician that describes the patient's medical condition and activities of daily living for which the patient requires assistance to avoid institutionalization. *Kuppersmith*, 93 N.Y.2d at 94-95. This form establishes the medical necessity for PCS. 56.1 ¶ 100. Then, HRA conducts a detailed review of the case, including social, nursing and home care assessments as described by the Court of Appeals in

*Kuppersmith*.<sup>5</sup> 93 N.Y.2d at 94-95. Throughout the relevant period, the City has had in place policies, mechanisms and contracts to authorize PCS based on the necessary physician's order, nursing and social assessments and, when needed, independent medical reviews. 56.1 ¶ 99-117.

After the assessments identify the level (Level I or Level II) and amount of care from an established list of services, the Commissioner authorizes the necessary hours to provide that amount of care. 505.14(b)(5)(i); 56.1 ¶ 124. One of HRA's medical review teams ("MRT"s) considers the patient's desires and her physician's recommendation, whether PCS can be provided consistent with the patient's plan of care, whether such services are medically necessary, and whether such services can maintain the patient's health and safety in her own home. 56.1 ¶ 107. In most cases, a "home care reviewer" completes the authorization form by following the LMD's recommendation as to number of hours. 56.1 ¶ 108. In a small minority of other cases, where applicable legal precedent or other facts or circumstances *suggest* a different judgment, the Commissioner may implement appropriate hours. 56.1 ¶¶ 109, 123-24. Legal precedent that is particularly relevant to this dispute includes: (i) *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996) which, as a practical matter, eliminated the need for independent medical review for re-authorizations of PCS, absent a "change" in the patient's assessments since the last authorization for PCS; and (ii) the myriad DOH decisions overruling independent medical reviewer determinations and/or the Commissioner's authorization of 24-hour "sleep-in" service because there is insufficient space for an attendant to live in the patient's home, and directing 24-hour "split-shift" services to maintain patient health and safety. 56.1 ¶¶ 121-22.<sup>6</sup>

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<sup>5</sup> Statutory authority for "fiscal assessments" referenced in *Kuppersmith* has since expired. And, the State DOH has directed that they shall not be performed. 56.1 ¶ [ ].

<sup>6</sup> State DOH Administrative Fair Hearing decisions are *stare decisis* and binding on the Commissioner. See *In re Charles A. Field Delivery Service, Inc.*, 66 N.Y.2d 516, 519 (1985); *Fells v. Hansell*, 910 N.Y.S.2d 485, at \*1-\*2 (App. Div. 2010).

PCS assessments “involve more than medical determinations.” *Kuppersmith*, 668 N.Y.S.2d at 382. Accordingly, “a social services agency is entitled to rely upon the views of its personnel, *even in the face of conflicting medical evidence.*” *Id.* at 382 (emphasis added). The Commissioner’s role in authorizing service is not merely to mechanically execute the recommendation of any one professional. Rather, the Commissioner’s “ultimate determination” of the level of PCS services involves the exercise of “reasoned judgment”. *DeGraffe v. City of N.Y.*, 907 N.Y.S.2d 436, at \*4 (Sup. Ct. N.Y. Cty. Jan. 8, 2010). When the Commissioner or State DOH “adopts one of several conflicting opinions [regarding eligibility for PCS], it is not the province of the court to substitute its judgment,” *Bentley v. Perales*, 478 N.Y.S.2d 203, 204 (App. Div. 1984), nor of the U.S. Attorney, under the guise of this False Claims Act suit. Working within the flexibility provided by the law and the programmatic constraints inherent in any public assistance program, HRA has implemented mechanisms to treat each PCS applicant fairly, while maintaining the appropriate balance between allowing disabled Medicaid beneficiaries to exercise their fundamental federal right to live independently and the legal and financial constraints on the PCS program. 56.1 ¶¶ 1, 12, 17, 124. There is no evidence that the Commissioner or any of his staff recklessly or knowingly submitted or caused the submission of a claim for payment to the U.S. that they knew was false. Accordingly, there is no basis to impose False Claims Act liability in this case.

### ARGUMENT

Summary judgment should be granted “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The

claim here is that the City knowingly ripped itself off. Because “the factual context renders [the U.S.’s] claim implausible,” to survive summary judgment the U.S. “must come forward with more persuasive evidence to support [its] claim than would otherwise be necessary.” *See Matsushita Elec. Indus. Co., Ltd.*, 475 U.S. at 587.

**I. THE CITY CANNOT BE HELD LIABLE FOR ADMINISTRATION OF THE MEDICAID PROGRAM BECAUSE IT IS THE “LOCAL ARM” OF THE STATE**

A state is not a “person” subject to liability under 31 U.S.C. § 3729(a). *Stevens*, 529 U.S. at 787-88. “Local arms” of a state are not False Claims Act “persons” either. *See, e.g., Stoner v. Santa Clara Cnty. Office of Educ.*, 502 F.3d 1116, 1122 (9th Cir. 2007) (holding county education office not “person” under *Stevens*); *U.S. ex rel. Adrian v. Regents of Univ. of Cal.*, 363 F.3d 398, 401-02 (5th Cir. 2004) (holding Regents of the University of California not “person” under *Stevens*). New York courts have made clear that the State’s election to discharge its Medicaid responsibilities through decentralized local agencies renders the City’s HRA Commissioner a “local arm” of the State when it administers Medicaid. *See Henrietta D. v. Bloomberg*, 331 F.3d 261, 286-87 (2d Cir. 2003) (“Local social service commissioners act on behalf of and as agents for the State. Each is a part of and the local arm of the single State administrative agency.”) (quoting *Thomasel v. Perales*, 78 N.Y.2d 561, 578 (1991) (Commissioner is “local arm” of State)); *see also MKB v. Eggleston*, 445 F. Supp. 2d 400, 437-37 (S.D.N.Y. 2006) (Rakoff, J.) (State liable for HRA’s acts under Medicaid Act). Accordingly, when the City’s HRA administers Medicaid, it is a local arm of the State and not a “person” that may be subject to liability under the False Claims Act. *Stevens*, 529 U.S. at 787-88.

**II. THE U.S. CANNOT PROVE ITS THEORY OF “FALSITY” IN THIS CASE BECAUSE COMPLIANCE WITH SECTION 505.14 IS NOT A PRE-CONDITION OF MEDICAID FFP**

The U.S.’s causes of action under 31 U.S.C. § 3729(a)(1) (2000) and § 3729(a)(1)(B) (2010) require proof of a “false claim.” *U.S. ex rel. Colucci*, 2011 WL 1226267, at \*6. Section

3729(a)(1)(B) also requires proof of a false statement used to get payment. *U.S. v. Huron Consulting Group, Inc.*, No. 09 Civ. 1800 (JSR), 2010 WL 3467054, at \*2 (S.D.N.Y. Aug. 25, 2010). A claim is “any request or demand, whether under a contract or otherwise, for money or property” from the U.S. 31 U.S.C. §3729(c) (2000). A claim is “false” when it is a “lie.” *U.S. ex rel. Mikes v. Straus*, 84 F. Supp. 2d 427, 438 (S.D.N.Y. 1999), *aff’d* 274 F.3d at 694.

To prove a false claim, the U.S. relies on a “certification theory”. Under this theory, liability only attaches to false statements of compliance with “those regulations that are a precondition to payment.” *Mikes*, 274 F.3d at 699. This requires the U.S. to formally identify *in advance* of a claim submission those requirements that are material to its payment decision.<sup>7</sup> Federal law *requires* FFP when New York expends Medicaid funds in accordance with the State Plan. *See* 42 U.S.C. § 1396b(a). The State Assessment Provisions are absent from the State Plan and federal law. The U.S. has cited no federal law identifying compliance with the State Assessment Provisions as a precondition to FFP for PCS. Because the U.S. did not set forth the State Assessment Provisions in advance as a precondition to FFP, they are legally irrelevant under the False Claims Act.<sup>8</sup>

The U.S.’s actual practices confirm that the State Assessment Provisions are not and have never been intended to be preconditions to FFP, and that the City’s compliance with the State

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<sup>7</sup> *See U.S. ex rel. Lamers v. City of Green Bay*, 168 F.3d 1013, 1020 (7th Cir. 1999) (“[T]he [False Claims Act] is not an appropriate vehicle for policing technical compliance with administrative regulations.”); *U.S. ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996) (“Violations of laws, rules, or regulations alone do not create a cause of action under the [False Claims Act].”).

<sup>8</sup> Apparently aware of this fatal defect and attempting to sidestep it, the U.S. points to the Office of Management and Budget’s Circular A-87 in support of its certification theory. However, Circular A-87 is not what the U.S. is making it out to be. It is a memo from the White House about “cost allocation” directing agency heads “responsible for administering programs that involve cost reimbursement contracts, grants, and other agreements with governmental units [to] issue regulations to implement the provisions of this Circular and its Attachments.” It has nothing to do with preconditions for FFP.

Assessment Provisions has never been viewed by the U.S. as material to its payment decision. Where, as here, “there is nothing in the record to show that [the responsible government official] took into account the actual substance of the certifications in deciding whether to approve the vouchers,” the defendant is entitled to summary judgment as a matter of law. *U.S. v. Southland Mgmt. Corp.*, 326 F.3d 669, 681 (5th Cir. 2003) (*en banc*).

First, the State’s CMS-64 is prepared using an automated process approved and certified by the U.S. itself to contain all of the information the U.S. requires for FFP. 56.1 ¶¶ 45-48. No information about compliance with State Assessment Provisions is required and, unsurprisingly then, no certification of compliance with State Assessment Provisions is required or made by anyone—City or State. 56.1 ¶ 85-88.

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The Financial Management Group

Director responsible for final decisions on FFP for CMS-64s left no dispute on this point when she testified that it was not necessary to be familiar with State regulations because “I work for the federal government and my job is to ensure that the federal rules are followed.” 56.1 ¶ 89.

Third, the U.S. has five employees at the State DOH’s offices working full-time on reviewing and approving the State’s CMS-64s for FFP. 56.1 ¶ 83. REDACTED

REDACTED

REDACTED and the head of the U.S. team had never been trained on the content of, or compliance with, State Assessment Provisions or even heard of the State Assessment Provisions until the day before his deposition. 56.1 ¶¶ 86, 88, 90.

Therefore, even if the State's certification in the CMS-64 attested to the City's compliance with the State Assessment Provisions (which it does not), and even if the City did not comply with the State Assessment provisions (which it did), *Mikes* requires summary judgment for the City because any purported certification by the State of the City's compliance with the State Assessment Provisions is not a pre-condition to FFP.<sup>9</sup>

**III. THE U.S. CANNOT PROVE ITS THEORY OF "FALSITY" IN THIS CASE BECAUSE NONE OF THE 44 FORM CMS-64S ATTESTS TO THE CITY'S "COMPLIANCE" WITH THE STATE ASSESSMENT PROVISIONS AS THE U.S. CONTENDS**

There can be no certification liability here for the additional reason that the CMS-64 certifications do *not* attest to the City's compliance with the State Assessment Provisions. There is no certification liability because the language in the CMS-64 certification is far too sweeping to support False Claims Act liability against the City for any alleged non-compliance with the State Assessment Provisions. In *U.S. ex rel. Colucci*, Judge Chin considered the following certification:

I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

2011 WL 1226267, at \*11. Applying *Mikes'* requirement that to be actionable the certification must certify compliance with a "particular" federal statute, *Colucci* concluded that "even if [plaintiff] had identified a statutory or regulatory violation by [defendant], the certification she identifies would be too general to support [False Claims Act] liability on an express false claim certification theory." *Id.* The Tenth Circuit reached the same result in *U.S. ex rel. Conner v. Salina Regional Health Center, Inc.*, holding that such a general statement could not form the

<sup>9</sup> See, e.g., *U.S. ex rel. Siewick v. Jamieson Sci. & Eng'g, Inc.*, 214 F.3d 1372, 1376 (D.C. Cir. 2000) (finding false certification no basis for False Claims Act suit because payment not conditioned on compliance); *U.S. ex rel. Joslin v. Cmty. Home Health of Md.*, 984 F. Supp. 374, 384-85 (D. Md. 1997) (same); *U.S. ex rel. Landers v. Baptist Mem'l Health Care Corp.*, 525 F. Supp. 2d 972, 978 (W.D. Tenn. 2007) (same).

basis of a false certification claim under the False Claims Act because the certification “contains only general sweeping language and does not contain language stating that payment is conditioned on perfect compliance with any particular law or regulation.” 543 F.3d 1211, 1219 (10th Cir. 2008); *see U.S. ex rel. Thomas v. Bailey*, No. 4:06CV00465 (JLH), 2008 WL 4853630, at \*10-\*13 (E.D. Ark. Nov. 6, 2008) (dismissing claim based on same certification).

Like the certification in *Colucci*, *Conner* and *Bailey*, the CMS-64 certification is “too general” and too “sweeping” to support False Claims Act liability. No federal witness in this case was able to identify with any particularity the statutes, regulations and policies subject to the certifications. 56.1 ¶¶ 65-66. The 2000-01 Certification ambiguously says that the information is subjectively “correct.” The 2002-10 Certification is even more general than the one in *Colucci* in saying that the expenditures are subjectively “allowable”—*i.e.*, they may be allowed if the State and U.S. agree on “allowability.”<sup>10</sup> There is no reference to “compliance” with the State Assessment Provisions (as the U.S. pretends), let alone “compliance” with any *particular federal* statute as required by *Mikes*. Accordingly, the certification here cannot be a basis for liability.

#### **IV. THE U.S. CANNOT PROVE ITS THEORY OF “FALSITY” IN THIS CASE BECAUSE NONE OF THE FORM CMS-64S INCLUDES A LIE**

In light of the testimony of the U.S.’s and the State’s witnesses, no rational jury could find the text of the Form CMS-64 certifications to be false. The Financial Management Branch Manager who oversees review of the State’s CMS-64, designated as the U.S.’s Rule 30(b)(6) witness in this case, was asked when a CMS-64 certification is false: “Q. When is a certification false?” He (as did his predecessor) answered clearly and logically: “When the person certifying it knowingly includes payments that are not allowable.” 56.1 ¶¶ 67-68. Yet, there is no evidence

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<sup>10</sup> Section 505.14 identifies allowable expenditures as “a provider’s documented costs that are necessary for the provider’s operation, are directly or indirectly related to recipients’ care, and are not expressly declared nonallowable by Federal or State law or regulations.” 18 N.Y.C.R.R. § 505.14(h)(7)(ii)(a)(3)(i). The U.S. has not alleged a violation of that subsection.

in the record that the State knowingly included any payment in any CMS-64 that is not “allowable”, and therefore there is no evidence in the record that any CMS-64 is false. The only evidence is to the contrary. The State DOH’s representative testified that the State’s CMS-64 certifications between 2000 and 2010 are true. 56.1 ¶¶ 72-73. Because the person who made the certification believes it was correct at the time it was made, the “lie” required by the False Claims Act is not present and no liability can attach to the CMS-64s.

**V. THE U.S. CANNOT PROVE ITS THEORY OF “FALSITY” IN THIS CASE BECAUSE THE CITY HAS PROPERLY IMPLEMENTED THE STATE ASSESSMENT PROVISIONS**

Although there is no basis for reaching this issue in light of the fatal legal flaws in the U.S.’s theory as set forth above, the U.S.’s theory of falsity fails based on the undisputed evidence that the City properly implemented the State Assessment Provisions.

**A. The U.S.’s Allegation That The City Improperly “Overrules” Local Medical Directors Is Wrong**

The U.S.’s theory of regulatory non-compliance is based on the incorrect notion that the State Assessment Provisions require the Commissioner to blindly defer to the recommendation of the independent medical reviewer for the number of PCS hours in all cases. Section 505.14(b)(4)(i)(a)-(c) sets forth certain circumstances in which “an independent medical review” of a PCS case shall be completed “by the local professional director, a physician designated by the local professional director or a physician under contract with the local social services department to review personal care services cases.” 18 N.Y.C.R.R. § 505.14(b)(4)(i). Of course, independent medical review is a misnomer, because the reviewer merely considers paperwork and does not see the patient. 56.1 ¶ 105. And, the reviewer need not be a physician. *See Matter of Marian v. Balch*, 676 N.Y.S.2d 712, 713 (App. Div. 1998).

The City has properly implemented Section 505.14(b)(4) and (5) as follows:

- At each HRA field office there is a Medical Review Team (“MRT”) that includes social

workers and registered nurses, as well as local medical directors (“LMDs”) who are physicians employed by an agency hired by HRA to provide “independent medical reviewers”. 56.1 ¶ 98. Pursuant to contract, LMDs make recommendations to the Commissioner when requested or required by § 505.14. 56.1 ¶¶ 104-07.

- LMDs memorialize their recommendations on a “Review Form” (the Form W-410), which is submitted to the MRT reviewer. Typically, the MRT reviewer will adopt the LMD recommendation for number of hours of service, incorporating it into a Home Care Reviewer’s Decision Form (Form M-28a) that is submitted to the MRT supervisor for approval. 56.1 ¶ 108.
- Sometimes, allegedly (in less than 3 percent of cases reviewed by the U.S.) the LMD recommendation is inconsistent with the facts, law, or judgment of the MRT or HRA staff. In these cases, the MRT members confer to reach a consensus. The case may be elevated to the LMD’s supervising physician, the local professional director, HRA’s Medical Director (a physician) or HRA senior staff. In all events, the facts and circumstances particular to a given patient are considered in reaching a decision as to how best to protect a patient’s health and safety and comply with applicable law. 56.1 ¶¶ 109, 120-24.

The complaint alleges that the City violated State regulations by improperly “overruling” the LMD recommendation for Patients A, B and C. However, only the Commissioner may *authorize hours* of PCS, so the whole concept of an “overrule” is a straw man. 18 N.Y.C.R.R. § 505.14(b)(5)(i); 56.1 ¶ 124. Further, in each case, the undisputed facts show that the LMD’s recommendation was reviewed and considered in the process described above and the appropriate number of hours to protect the patients’ health and safety in a non-institutional environment were authorized by the Commissioner consistent with his responsibility and authority to determine an applicant’s eligibility and consistent with the law. *Id.* § 505.14(b)(1); *see also* § 505.14(a)(4); § 505.14(b)(5); 56.1 ¶¶ 137, 149, 160. In each case, following the LMD’s recommendation blindly would have required violating the law and/or abandoning the patient.

Because “personal home care services are much more than purely medical determinations,” the City is tasked to authorize an appropriate number of PCS hours based on “the complex, multifaceted reality of providing personal care services to those in need.”

*Kuppersmith*, 93 N.Y.2d at 100. “[T]he local district determines whether the individual is eligible for personal-care services, and if so, the amount of medically necessary services.”

*DeLuca v. Hammons*, 927 F. Supp. 132, 134 (S.D.N.Y. 1996). In making the determination, HRA “is entitled to rely upon the views of its personnel, even in the face of conflicting medical evidence.” *Kuppersmith*, 668 N.Y.S.2d at 382.

The Commissioner, not the independent medical reviewer, has the ultimate responsibility for authorizing hours. 18 N.Y.C.R.R. § 505.14(b)(5)(i). Indeed, State DOH implements hours different than the recommendation of independent medical reviewers all the time. 56.1 ¶¶ 121-22. Contrary to the U.S.’s position, the Commissioner need not blindly follow the recommendation of an independent medical reviewer no matter how out of touch with the case law, directions from the State DOH, or the totality of a given patient’s circumstances it may be. The U.S.’s position represents an unprecedented and perverse intrusion into the State’s discretion under the Medicaid Act and paramount responsibility to protect and care for needy New Yorkers and to authorize hours for services “essential to the maintenance of the patient’s health and safety in his or her own home.” 18 N.Y.C.R.R. § 505.14(a)(1). Judgment should be entered for the City based on the U.S.’s baseless allegation that a contracted independent medical reviewer’s recommendation must be blindly followed by the Commissioner in all instances.

**B. The U.S.’s Allegation That Independent Medical Review Is Required For All “Split Shift” Cases Is Wrong**

The U.S.’s theory of regulatory non-compliance is also based on the incorrect notion that an LMD must make the determination that “split shift” services are to be re-authorized. There is no such regulatory requirement. 56.1 ¶¶ 126-29. First, the term “split shift” is not used in the regulations in connection with independent medical review. Rather, Section 505.14(b)(4)(i)(c) provides that there shall be an independent medical review on an initial authorization of PCS

where: “the case involves the provision of continuous 24-hour personal care services as defined in paragraph (a)(3) of this section.” Section 505.14(a)(3), however, does not cover all instances of the provision of uninterrupted care by more than one person. Rather, it is limited to those situations involving the provision of uninterrupted care by more than one person:

for a patient who, because of his/her medical condition and disabilities, requires total assistance with toileting and/or walking and/or transferring and/or feeding at unscheduled times during the day or night.

Thus, the statute’s narrow definition of “continuous 24-hour personal care services” is limited to a subset of cases involving the provision of uninterrupted care by more than one person. For example, where State ALJs order “the provision of uninterrupted care by more than one person” to patients who lack the housing space to accommodate a “sleep-in” aide, that situation does not fall within Section 505.14(a)(3). These binding Fair Hearing decisions cannot be squared with the U.S.’s theory that all “split shift” cases—regardless of reason for need—fall within Section 505.14(a)(3), and consequently require independent medical review. The U.S.’s theory that the regulation requires independent medical review of every case involving split shift or “the provision of uninterrupted care, by more than one person” must be rejected based on the plain language of the regulation.

Moreover, as a practical matter, the decision in *Mayer v. Wing*, 922 F. Supp. 902, 910 (S.D.N.Y. 1996), eliminated the need for independent medical review for re-authorizations of PCS absent a “change” in the patient’s condition. Following *Mayer*, HRA must “identify the specific medical, mental, social or economic change in the client’s circumstances that justifies the proposed reduction or discontinuation in services.” 56.1 ¶ 128. Since, absent a change in the patient’s circumstances a reduction in the patient’s services would be impermissible—and independent medical review would be meaningless—the City applied Section 505.14 reasonably and in good faith. 56.1 ¶ 128. Judgment should therefore be entered for the City on the U.S.’s

allegation that LMD review was required at re-authorization for Patients D and E, 56.1 ¶¶ 174, 186, and other “split shift” cases.

**C. The U.S.’s Allegation That The City Abdicated Its Responsibility To Obtain Nursing Assessments For Re-authorizations Is Wrong**

Section 505.14(b)(2) says PCS authorizations should be based, in part, on a nursing assessment. The U.S. incorrectly alleges the City did not obtain nursing assessments for PCS patients. The City’s vendors (as well as its own nurses, in some circumstances) conducted nursing assessments at a minimum of every six months (or 180 days) for PCS patients.

- The City has dozens of contracts with State-licensed nursing agencies to conduct nursing supervision and assessments twice a year at least.
- The agencies who conduct nursing assessments under City contracts are audited on a regular basis each year by HRA for regulatory compliance. 56.1 ¶ 133. The City has terminated certain contracts for failure to provide assessments in compliance with contractual requirements. 56.1 ¶¶ 134-35.
- Contract nurses and attendants are required to inform HRA of any change in a patient’s condition that could affect the level or amount of PCS. 56.1 ¶ 112.

In fact, the City has produced thousands of nursing assessments for approximately 526 PCS patients the U.S. has focused on in this case. As detailed extensively in the 56.1 Statement, there are at least 84 nursing and supervisory assessments for Patients D, E, F and G even though the U.S. alleges none were done. 56.1 ¶¶ 136, 183, 195, 210, 228. The allegation that the City did not obtain nursing assessments is simply incorrect, and judgment should be entered for the City on the U.S.’s allegation that the City did not obtain nursing assessments.

**VI. THERE IS NO BASIS IN THE RECORD TO FIND SCIENTER: THAT THE CITY KNOWINGLY PRESENTED WHAT IS KNOWN TO BE FALSE**

The City can only be held liable if the U.S. can prove “the knowing presentation of what is known to be false.” *U.S. Kreindler & Kreindler*, 985 F.2d at 1156 (citation omitted). Here that means that the City can only be held liable for knowingly presenting a CMS-64 that the City

knew was false. The record is devoid of any evidence of the City's scienter sufficient to find liability.

First, the alleged falsity here is an imaginary certification of compliance by the City with the State Assessment Provisions on a CMS-64. Yet, there is no evidence that the City was required to or did certify compliance with the State Assessment Provisions, ever. Likewise, there is no evidence that the City knew that the State was required to or did certify compliance with the State Assessment Provisions (because it did not). There is no record that anyone has ever certified the City's compliance with the State Assessment Provisions, or that anyone required or relied on such a certification. 56.1 ¶¶ 85-87. No basis exists to find that the City knowingly presented, or caused to be presented, a CMS-64 that the City knew was false.

Second, the City's implementation of Section 505.14, discussed in Part III above, is reasonable and in good faith. Any claim submitted based on the implementation of its reasonable interpretation of the State Assessment Provisions is not *knowingly* false as a matter of law. *See Safeco Ins. Co. of Am. v. Burr*, 551 U.S. 47, 69 (2007) (to be reckless, a statutory interpretation must be "objectively unreasonable"); *U.S. ex rel. K & R Ltd. P'ship v. Mass. Housing Fin. Agency*, 530 F.3d 980, 983 (D.C. Cir. 2008) (granting summary judgment to defendant where no showing that defendant's interpretation of statute "was unreasonable, much less why its interpretation constituted reckless disregard"); *see also U.S. ex rel. Colucci*, 2011 WL 1226267, at \*12 ("[G]iven the lack of clarity in the law, it cannot be said that defendants 'knew' the claims were false."); *U.S. ex rel. Raynor v. National Rural Utilities Cooperative Fin. Corp.*, No. 08-cv-00048 (LSC), at \*4 (D. Neb. June 29, 2011) (Doc. No. 177) (to determine legal falsity, court required to consider whether "defendants knew they had violated a statute or regulation"). Further, alleged "mismanagement—alone—of programs that receive federal

dollars is not enough to create [False Claims Act] liability.” *U.S. ex rel. Farmer v. City of Houston*, 523 F.3d 333, 339 (5th Cir. 2008). Accordingly, a cherry-picked handful of instances with missing paperwork or poor decision-making by HRA staff among the hundreds of thousands of assessments conducted over a ten-year period cannot illustrate recklessness. Any problems with the administration of the program are properly addressed through the U.S.’s administrative processes for resolving FFP disputes, 56.1 ¶ 9, and not a federal court lawsuit based on the False Claims Act. *See Mikes*, 274 F.3d at 699 (“[T]he False Claims Act was not designed for use as a blunt instrument to enforce compliance with medical regulations.”); *U.S. ex rel. Godfrey v. KBR, Inc.*, 360 F. App’x 407, 412 (4th Cir. 2010) (rejecting contention that “failure to meet staffing or other contractual requirements can support an [False Claims Act] claim on its own”); *Lamers*, 168 F.3d at 1020 (“[T]he [False Claims Act] is not an appropriate vehicle for policing technical compliance with administrative regulations.”); *Hopper*, 91 F.3d at 1266 (“Violations of laws, rules, or regulations alone do not create a cause of action under the [False Claims Act].”).

Finally, the City did not benefit financially or otherwise from the alleged fraud. No employee benefitted financially or otherwise from the alleged fraud either. Indeed, the alleged fraud cost the City hundreds of millions of dollars. The City appears to be just as much of a victim of the so-called “fraud” as the U.S. On this record, no rational jury could make the implausible finding that the City knowingly acted so contrary to its interest. *See Lamers*, 168 F.3d at 1019 (granting summary judgment to city based on “no reasonable inference” of knowing misrepresentation absent financial motive of the city-defendant).

The only evidence and rational finding in this case is that New York State, through the HRA Commissioner, intended to authorize no more and no fewer than the number of hours

necessary to keep clients safe and healthy in their homes in compliance with all applicable regulations, as well as court and administrative decisions. The record shows that mechanisms were implemented by HRA to treat each PCS applicant fairly, while maintaining the appropriate balance between allowing disabled Medicaid beneficiaries to exercise their fundamental federal right to live independently and the legal and financial limitations on PCS. 56.1 ¶ 17. There is no evidence that the Commissioner recklessly or knowingly submitted or caused to be submitted a claim for payment to the United States that he knew was false. There is no basis to impose False Claims Act liability in this case.

**CONCLUSION**

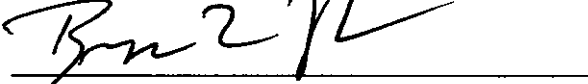
For the foregoing reasons, summary judgment should be entered for the City, and such other and further relief awarded as the Court deems just and proper.

Dated: August 1, 2011

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Respectfully submitted,

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