

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

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UNITED STATES OF AMERICA <u>ex rel.</u> ,	:	
DR. GABRIEL FELDMAN,	:	
	:	
Plaintiff,	:	09 Civ. 8381 (JSR)
	:	
v.	:	ECF Case
	:	
THE CITY OF NEW YORK,	:	
	:	
Defendant.	:	
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UNITED STATES OF AMERICA,	:	
	:	
Plaintiff-Intervenor,	:	
	:	
v.	:	
	:	
THE CITY OF NEW YORK,	:	
	:	
Defendant.	:	
-----	X	

**MEMORANDUM OF LAW IN SUPPORT OF THE UNITED STATES’  
MOTION FOR PARTIAL SUMMARY JUDGMENT**

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Plaintiff-intervenor the United States of America (the “Government” or “United States”) respectfully submits this memorandum of law in support of its motion for partial summary judgment.

#### PRELIMINARY STATEMENT

This case is about the New York City Human Resources Administration’s (“HRA”) knowing desertion of its gate-keeping role for the Medicaid Personal Care Services (“PCS”) program. As the sole administrator of the PCS program in New York City, HRA assumed the sole responsibility for implementing the state PCS regulations and determining whether personal care services were medically necessary and appropriate for patients in the City. This case concerns 24-hour services under the PCS program. As to that part of the program, the requirements of state regulation was clear: HRA was mandated to authorize (and reauthorize) 24-hour personal care services on the basis of a series of interlocking medical and social assessments that are described in the regulation. Further, for vulnerable patients receiving the highest level of care offered by the PCS program, *i.e.*, 24-hour split-shift care, the state PCS regulations required HRA to obtain independent medical reviews to determine whether it was appropriate to continue with such care or whether a change in care was needed. These independent medical reviews were not optional, nor were they reviews that HRA could disregard in its discretion. Rather, the state regulations mandated that HRA obtain and abide by those medical determinations. Put simply, HRA was not free to dispense or withhold PCS services as it wished, but instead was required to comply with specific and clear regulatory requirements designed to ensure the integrity of the PCS program and the health and safety of the patients.

In reality, however, HRA routinely authorized PCS care contrary to law. The undisputed facts show that HRA authorized care in contravention of decisions made by physicians employed by the City and, in at least one instance, did so as a political favor to a relative of a former Governor. The cost of care for that individual amounted to over \$60,000 – a rate that was double the cost of the care for which he was deemed qualified by the City’s doctors. *See infra* at 13-14, 17-19.

Further, the undisputed evidence shows that HRA, in full knowledge of the regulation's requirements, simply dispensed with critical portions of those requirements. Rubberstamping and standardless discretion, rather than adherence to regulatory requirements, were *de facto* policies for HRA's administration of the PCS program. *See infra* at 14-19.

Specifically, the state PCS regulations required HRA to base its authorization of personal care services on: (i) a physician's order describing the patient's condition, medication and regimens; (ii) a nursing assessment that, among other things, reviewed and interpreted the physician's order and recommended the level of care and number of hours needed by the patient; and (iii) a social worker assessment of the patient and his or her circumstances. No one of these assessments paints the complete picture needed to determine how much personal care service is medically necessary and whether such services can keep a patient safe and healthy in the home. Rather, each of these three assessments, by design, provides only a piece of the information needed to make that determination. The undisputed facts show that HRA *knew* it was required to obtain all of these assessments in order to authorize personal care services, but routinely failed to do so. Indeed, HRA expressly and recklessly allowed its employees to authorize care without obtaining or reviewing nursing assessments — which, under the regulation, was the assessment that provided the recommendation as to the amount of personal care service to be provided. *See infra* at 14-16.

Additionally, the state PCS regulations also required independent medical reviews of the authorization and reauthorization of *all* split-shift care. Yet, despite being well aware of this requirement, the standard practice at HRA was to dispense with such a review, thus allowing its employees to disregard both the state regulation and HRA's *own written policy*. *See infra* at 17.

HRA's abdication of its responsibility to administer the PCS program, which came at the expense of the taxpayers, clearly violated the False Claims Act, 31 U.S.C. § 3729, *et seq.* ("FCA"). By knowingly authorizing or reauthorizing 24-hour PCS care without the proper basis to do so, HRA

caused the vendors providing that care to submit claims for Medicaid reimbursements – claims that falsely implied that the service was authorized in accordance with the state regulation. Further, HRA caused the New York State Department of Health (“DOH”) to submit to the federal government CMS-64 forms falsely certifying that expenditures for PCS care in New York City were “allowable in accordance with applicable implementing [] state . . . regulations” for PCS. Finally, by transmitting to DOH and to vendors authorization and reauthorization notices that it knew to be in violation of the PCS Regulation, HRA made false statements and records to get false claims for Medicaid reimbursements paid by the federal government.

In short, the City is liable under the False Claims Act because HRA routinely and knowingly caused the presentment of false claims for federal Medicaid funds and, further, made false statements and records in violation of in violation of 31 U.S.C. § 3729(a)(1), 3729(a)(1)(A) and 3729(a)(1)(B). *See infra* at Points I and II. On these two bases, the Government is entitled to partial summary judgment.<sup>1</sup>

## THE STATUTORY AND REGULATORY FRAMEWORK

### **I. New York’s Medicaid PCS Program**<sup>2</sup>

The Medicaid Program was established in 1965 as a joint Federal and State program to enable individuals with low incomes to obtain medical care. 42 U.S.C. § 1396 *et seq.* Under Medicaid, each state, including New York, establishes its eligibility standards, benefit packages, payment rates and program administration in accordance with certain federal statutory and regulatory

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<sup>1</sup> The Government is seeking partial summary judgment to minimize the number of issues and facts that will be in dispute at a trial in this matter. In that regard, at trial, the Government will establish the full amount of federal Medicaid funds that had been improperly expended due to HRA’s flagrant and knowing violations of the PCS regulations through statistical extrapolation and based on a review of several hundred patient files. The Government also may present additional bases of liability against the City under the False Claims Act.

<sup>2</sup> Documents and transcripts cited herein (“Ex. \_”) are attached to the accompanying Declaration of Rebecca C. Martin, dated August 1, 2011 (“Martin Decl.”).

requirements. The state directly pays the health care providers for services rendered to Medicaid recipients, and obtains its federal share of the Medicaid payment from the United States Treasury. 42 C.F.R. § 430.0–30. The New York Medicaid system was established in 1966. *See* L. 1966, ch. 256.<sup>3</sup>

Personal care services refer to types of assistance provided to a patient in his or her home to help with the activities of daily living, such as cleaning, shopping and grooming. *See* 42 C.F.R. § 440.167. In New York, personal care services are available to eligible patients through the New York Medicaid program. *See* Plaintiff’s Statement of Undisputed Material Facts (“56.1 Stmt.”) at ¶ 21; *see also* 2008 MICSA Briefing Book, at 3 (Ex. 35). In New York, personal care services are administered through counties’ local social service departments, or local administrators, such as HRA. *See* 18 N.Y.C.R.R. § 505.14(b); Willard Dep. at 22:4-10, 167:10-168:1 (Ex. 23).<sup>4</sup>

## **II. The State Regulations Governing HRA’s Administration of Personal Care Services**

New York has promulgated regulations setting forth comprehensive rules and requirements for implementing the PCS program. *See* 18 N.Y.C.R.R. § 505.14 (the “PCS Regulation”). The PCS Regulation mandates that personal care services “can be provided only if the services are medically necessary and the social service district reasonably expects that the patient’s health and safety in the home can be maintained by the provision of such services as determined in accordance with [that] regulation.” *Id.* § 505.14(a)(4). The PCS Regulation also unambiguously establishes the factual basis on which this determination must be made. *See id.* § 505.14(b)(2)–(4), b(5)(ix).

### *i. Provision of Personal Care Services Is Allowed Only If It Is Medically Necessary and Is Consistent with the Patient’s Health and Safety*

The PCS Regulation reflects a basic recognition that personal care services are not always

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<sup>3</sup> A state must pay at least 40% of the non-federal share of each claim, and federal funds are used to pay the rest of the claim. *See* 42 U.S.C. § 1396a(a)(2). In 2001, the United States paid 50% of Medicaid claims submitted by New York State. Ex. 37(Form CMS-64 for 3Q 2001). By 2009, the federal share had increased to nearly 62%. Ex. 38 (Form CMS-64 for 3Q 2009).

<sup>4</sup> Deposition transcripts are cited herein as “[last name of witness] Dep.” HRA’s deposition, by its Rule 30(b)(6) witness Annette Holm Carela, is cited herein as “HRA Dep. I” and “HRA Dep. II”.

necessary or appropriate. For example, while personal care services help patients with certain tasks of daily living, they cannot replace skilled nursing or other types of health care services because PCS home aides, who typically lack medical training, are not permitted to render medical care, or even give patients their medication. *See, e.g.*, Soto Dep. at 104:11–105:18 (Ex. 21); Brady Dep. at 130:23–132:15 (Ex. 5).

Thus, under the PCS Regulation, the provision of personal care services under Medicaid is allowed “only if [it is] medically necessary.” 18 N.Y.C.R.R. § 505.14(a)(4). Further, the regulation also limits PCS service to circumstances where “the provision of such services” can be expected to ensure “the patient’s health and safety in the home.” *Id.*

*ii. 24-Hour PCS Service Can Only Be Authorized or Reauthorized Based on a Physician’s Order, a Nursing Assessment, and a Social Assessment*

As relevant here, there are two types of 24-hour personal care service available under New York’s PCS program—“sleep-in” service and “split-shift” service.<sup>5</sup> To ensure that these intensive services are both medically necessary and consistent with patients’ health and safety, the PCS Regulation requires a series of interlocking assessments to be made in connection with each initial authorization or subsequent reauthorization of either type of 24-hour care. *See* HRA Dep. II at 44:20–45:10 (Ex. 2). Specifically, these assessments include (i) the physician’s order; (ii) the social assessment; and (iii) the nursing assessment. *Id.*; *see also* 18 N.Y.C.R.R. § 505.14(b)(2), (3)(i)–(iii). Each assessment provides distinct information relevant to determining whether PSC services are medically necessary and adequate to maintain the patient’s health and safety in the home. Specifically:

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<sup>5</sup> “Sleep-in” is HRA’s term for personal care services provided by a single home attendant who stays with the client for 24 hours per day and sleeps in the client’s home. *See* 56.1 Stmt. ¶ 5. “Split-shift” is HRA’s term for “continuous 24-hour personal care services,” which is defined in the PCS Regulation as “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 and night.” *See* 18 N.Y.C.R.R. § 505.14(a)(3); HRA Dep. II at 47:12-17 (Ex. 2).

- The physician order is required to “accurately describe[e] the patient's medical condition and regimens, including any medication regimens, and the patient's need for assistance with personal care services tasks and [provide] . . . only such other information as the physician's order form requires.” *Id.* § 505.14(b)(3)(i)(a). The physician is expressly prohibited from recommending the number of hours of personal care services the patient should receive. *Id.*
- The nursing assessment is required to include (1) “a review and interpretation” of the physician’s order; (2) the primary diagnosis code; (3) an evaluation of the functions and tasks required by the patient; (4) the degree of assistance required for each function and task; (5) development of a plan of care with the patient or his/her representative; and (6) recommendations for authorization of services. *Id.* § 505.14(b)(3)(iii)(b); *see also* Willard Dep. at 189:8–22 (“The purpose of the nursing assessment is for a nurse to look at the individual's functional status, review and interpret the physician's order in terms of diagnosis, prognosis, medications and determine what assistance is necessary to support that individual in the community. . . . [It] should use the most current order in order to make sure that everything is timely and up to date ...”) (Ex. 23).
- The social assessment is prepared by a caseworker and provides information regarding the client's home environment, including formal and informal supports, such as family or friends. *See* 18 N.Y.C.R.R. § 505.14(b)(3)(ii)(a)-(b); *see also* Willard Dep. at 186:9–187:13, 254:15 - 255:7; Soto Dep. at 30:18 - 32:12 (Ex. 21).

Because these three assessments serve different purposes, the PCS Regulation requires local administrators to consider each of these assessments in connection with an initial authorization decision. *See, e.g.*, 18 N.Y.C.R.R. § 505.14(b)(2)-(3); Brady Dep. at 225:16–229:17 (Ex. 5). In addition, all of these assessments must be obtained for all subsequent *reauthorizations* of sleep-in and split-shift service as well. 18 N.Y.C.R.R. § 505.14(b)(5)(ix) (“Reauthorization for personal care services shall follow the procedures outlined in paragraphs (2) through (4) of this subdivision”).

iii. *For Split-Shift Care, an Independent Medical Review Is Also Required for Authorization and Reauthorization to Determine Whether Such Service Is Medically Necessary and Appropriate for the Patient's Health and Safety*

Split-shift care is the highest level of service in the PCS program. Not only is split-shift care costly to Medicaid, patients receiving split-shift care also often had the highest needs in terms of ensuring their health and safety.

For this service, the PCS Regulation provides the additional requirement of an independent medical review in order to determine whether split-shift care should be authorized or reauthorized. Specifically, the state regulations provide that for split-shift authorizations “An independent medical review of the 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). Further, an independent medical review must also be obtained for all subsequent reauthorizations of split-shift as well. *Id.* § 505.14(b)(5)(ix); *see also* Nov. 4, 2010 Holm Carela E-mail, at 1-2 (Ex. 24).

iv. *Local Administrators Are Required to Abide by the Determination of an Independent Medical Review as to the Level and Amount of PCS Care*

The PCS Regulation provides that, for each authorization or reauthorization requiring an independent medical review, the determination of such a review is “the *final determination* of the level and amount of care to be provided.” 18 N.Y.C.R.R. § 505.14(b)(4)(ii) (emphasis added). In New York City, the local professional director (“LPD”) has delegated the independent medical review responsibilities for PCS clients to contracted local medical directors (“LMDs”). *See* Brady Dep. at 52:17 – 53:24 (Ex. 5). Thus, the LMD decision on the level and amount of care is final unless the LPD overrules the LMD’s decision. *See* Willard Dep. at 23:12–20, 47:20–49:5, 165:11–167:9, 201:16–202:25 (Ex. 23); Soto Dep. at 58:5–59:5, 67:15–71:13 (Ex. 21). As HRA’s 30(b)(6) representative acknowledged in her deposition, the independent medical review by an LMD determines whether split-shift care remains necessary, and whether a different type of care, such as skilled nursing service, is

required to ensure the patient's health and safety. *See* HRA Dep. II at 351:12–352:14 (Ex. 2). As such, non-medical administrators cannot overrule an LMD's independent medical determination as to the level and amount of PCS care to provide to a patient, but must abide by that determination.

- v. *The PCS Regulation Conditions the Allowability of Personal Care Services on Whether the Local Administrator Complies with the Regulation's Requirements on Authorization and Reauthorization*

The PCS Regulation specifies that PCS services “can be provided *only if*” the requisite determinations as to the medical necessity of such service and its effect on the patient's health and safety have been made “in accordance with the regulation.” 18 N.Y.C.R.R. § 505.14(a)(4) (emphasis added). The state regulation further tasks the local administrator with making the “eligibility” determinations and provides that the administrator must make those determinations “in accordance with the regulation.” *Id.* § 505.14(b)(1); (b)(2)–(4), b(5)(ix). Thus, under the PCS State Regulation, the provision of personal care services is allowable for Medicaid purposes “only if” the local administrator's decision to authorize, or reauthorize, is “based” on the physician order, the nursing assessment, the social assessment and, for split-shift services, an independent medical review, as required by the regulation. *Id.*; *see also* Willard Dep. at 182:13–201:15, 245:21–246:17 (Ex. 23).

### III. **The Availability of Federal Medicaid Funding for Personal Care Services for Patients in New York Is Conditioned on Compliance with the PCS Regulation**

At all times relevant to this case, the Centers for Medicare and Medicaid Services (“CMS”) contributed federal funds to New York's Medicaid expenditures on personal care services. *See* Harper Dep. at 102:5–17 (Ex. 11). To obtain federal funding, New York was required to report both its projected and its actual Medicaid expenditures to CMS on a quarterly basis. Specifically, at the start of each quarter, New York submitted a CMS-25 Form to CMS to report its estimated Medicaid expenses for that quarter. *See* 42 C.F.R. § 430.30(b). CMS, based on that estimate, made federal funds available to New York in advance, after adding or deducting “any overpayment or underpayment” from the previous quarter. 42 U.S.C. § 1396b(d)(1) & (d)(2)(A); 42 C.F.R. § 430.30(d)(1), (3) & (4).

After the close of each quarter, New York submitted a Form CMS-64, which provided an accounting of the state's *actual* recorded Medicaid expenditures. *See* 42 C.F.R. § 430.30(c)(1) & (2). Federal law required submission of the Form CMS-64 because it enabled CMS to reconcile its advance payments to New York (based on estimated expenditures in the CMS-25) with the federal contribution owed to New York (based on the actual expenditures reported in the CMS-64). 42 U.S.C. § 1396b(d)(5); *see generally United States ex rel. Ven-A-Care v. Actavis Mid Atlantic LLC* (“*Ven-A-Care*”), 659 F. Supp. 2d 262, 265-66 (D. Mass. 2009).

To be eligible for federal funding, New York's Medicaid expenditures, including PCS expenditures, also had to be consistent with state – as well as federal – laws and regulations. In that regard, Office of Management and Budget Circular A-87 specifies that expenditures of federal grants by state and local governments must be “authorized or not prohibited under State [] laws or regulations.” 2 C.F.R. § 225, App. A(C)(1)(c); *see also State of New York v. Shalala*, 979 F. Supp. 177, 179 (S.D.N.Y. 1997), *aff'd*, 143 F.3d 119 (2d Cir. 1998) (OMB Circular A-87 “has the force of a regulation” in determining allowable Medicaid costs). Further, since 2001, CMS has required states to make an express certification, in each Form CMS-64, that all reported expenditures were “allowable in accordance with applicable implementing federal, state [] statutes, regulations, policies.” *See* New York Form CMS-64 for 3Q 2001 (the “2001 NY CMS-64”) (Ex. 37). States must make this certification in order to continue to receive federal contribution to their Medicaid expenditures. *See* Guhl Dep. at 129:11–130:3 (Ex. 64).

The PCS Regulation is the “primary regulation” governing the PCS program. Ng Dep. at 18:4–17 (Ex. 18); *see also* HRA Dep. II at 44:10–19, 48:10–49:4 (Ex. 2). That regulation expressly requires certain eligibility determinations to be made in order for PCS services to be provided. *See* 18 N.Y.C.R.R. § 505.14(a)(4). Thus, under OMB Circular A-87, personal care services for patients in New York are eligible for federal funding only if such services were authorized consistent with the

requirements of the PCS Regulation. *See* 2 C.F.R. § 225, App. A(C)(1)(c) (disallowing expenditure of Medicaid funds in a manner that is “prohibited under State . . . regulations”).

#### STATEMENT OF FACTS

### I. **HRA’s Administration of the PCS Program Is Characterized by Its Knowing and Wholesale Disregard of the PCS Regulation**

HRA has administered the PCS program in New York City since prior to 1981. *See generally* Jan. 28, 1981 Letter from HRA to B. Blum (“Jan. 28, 1981 HRA Ltr.”) (Ex. 34). However, while HRA assumed the local administrator’s mantle, it largely ignored the attendant responsibilities of making authorization and reauthorization decisions in accordance with the requirements of the PCS Regulation.

#### A. HRA’s Knowledge of Its Obligation to Administer the PCS Program in Accordance with the PCS Regulation

HRA has been aware, during all relevant times, that the PCS Regulation is the “primary regulation” governing HRA’s administration of the PCS program. *See* Ng Dep. at 17:25–18:17 (Ex. 18); *see also* Brady Dep. at 37:14–42:19 (recognizing PCS Regulation applied to HRA) (Ex. 5); Jan. 28, 1981 HRA Ltr. (Ex. 34). Indeed, in its contracts with vendors providing PCS services, HRA has consistently specified that the PCS Regulation is a state law or regulation that is applicable to the PCS program. *See, e.g.*, 2001 Vendor Contract, at 13, ¶ 5.1 (Ex. 33); *see also* Ng Dep. at 165:19–25, 168:12–169:8 (HRA’s current vendor contracts contain similar provision).

Further, HRA has known, since well before 2000, about the state regulatory requirements at issue in this case and that dictate the basis of authorization and reauthorization decisions. As a November 1992 reauthorization procedures manual shows, HRA has known – since at least 1992 – that the state regulation required it to obtain a physician’s order and to prepare a social assessment in connection with reauthorizing 24-hour PCS service. *See* 1992 Manual, at 10-11 (Ex. 30); *see also* HRA Dep. II at 49:21–50:10 (HRA intended for the manual to implement its understanding of the PCS

Regulation) (Ex. 2). HRA likewise has known since 1992 that the PCS Regulation required it to obtain an independent medical review in order to reauthorize a split-shift case. *See* 1992 Manual at 11; HRA Dep. II at 75:15–76:9.

In addition, HRA’s involvement in institutional reform litigations, such as *Mayer v. Wing*, 96 Civ. 788 (SAS) (S.D.N.Y.), also provided it notice of the state regulatory requirement that HRA must obtain and consider nursing assessments in reauthorizing 24-hour PCS care prior to 2000. Specifically, in a 1996 decision entering a preliminary injunction against HRA, the Court explained that, for reauthorizations, the PCS Regulation mandated that HRA follow “the same procedures [as] used for initial assessments, including . . . [the] nursing [] assessment[.]” *Mayer v. Wing*, 922 F. Supp. 902, 905 (S.D.N.Y. 1996) (citing 18 N.Y.C.R.R. § 505.14(b)(5)(ix)).

#### B. HRA’s Arbitrary and Reckless Approach to the PCS Program

Despite its role as administrator of the PCS program and its responsibility for the authorization of well over a billion dollars in personal care services each year, HRA ran the PCS program with little regard for fundamental requirements of the PCS Regulation, fostering an environment in which services were authorized in flagrant violation of that regulation.

HRA had an unwritten “policy” to require its case workers and supervisors to follow the 1992 Manual in processing reauthorizations. *See* HRA Dep. II at 165:16–22 (Ex. 2). In practice, however, HRA did not actually distribute that manual to its supervisors and case workers in the local offices (“CASAs”) responsible for processing reauthorizations — as evidenced by the testimony of supervisors and case workers uniformly denying awareness of the manual. *See, e.g.*, Kapsalis Dep. at 214:14–215:111 (senior supervisor unaware of any reauthorization manual prior to 2008) (Ex. 16); Jenkins Dep. at 49:16–25 (supervisor testifying to same) (Ex. 14); Shyne Dep. at 133:23–134:12 (case worker never received a copy of the 1992 Manual) (Ex. 20). Further, the 1992 Manual, which was the sole written guidance provided to employees responsible for conducting reauthorizations of personal

care services, did not instruct HRA staff that they should obtain a nursing assessment prior to authorizing care. *See* 1992 Manual at 10-11 (Ex. 30).

Moreover, although HRA recognized the PCS Regulation as the primary source of rules for administering the PCS program, it failed to make the regulation available to its officials, supervisors, and case workers. For example, HRA's current head of field operations, Annette Holm Carela, testified that she could not obtain a copy of the PCS Regulation during the seven-plus year period in which she served as a senior supervisor, a deputy CASA director, and a CASA director at HRA. *See* Holm Carela Dep. at 209:5–212:18 (Ex. 13).<sup>6</sup>

HRA's reckless and arbitrary approach to administering PCS care led to a program beset by irregularities and inconsistencies. Indeed, according to Dr. Ana Soto, a medical director at HRA who joined the agency in 2006, it was quickly apparent to her after starting at HRA that "each of the CASAs were sort of a kingdom of their own[,] and each director would have their set of rules or decisions, [as to] how they conducted their processes." Soto Dep. at 61:19–65:4 (Ex. 21). In other words, HRA had no "policy and procedure that went throughout the CASAs that this is the way we want this operation to be performed." *Id.* at 202:24–205:21.

HRA also was regularly subject to outside pressure to change its personal care service determinations, including from elected officials and advocacy groups requesting changes to the level or amount of service for PCS patients. *See* Eisner Dep. at 198:5-22 (Ex. 8); Ng Dep. at 116:15–117:2 (Ex. 18). At CASA 7, the issue of elected officials exerting pressure "to get more hours" had become so severe in 2008 that HRA had to replace the director of that CASA. *See* Brady Dep. at 170:22–

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<sup>6</sup> HRA also failed to keep track of rules and procedures relating to the PCS program. For example, when asked whether HRA had a "central depository or central location" for memos on developments in *Mayer v. Wing*, HRA's 30(b)(6) representative testified that no such depository existed, adding that "we should be so lucky." *See* HRA Dep. II at 54:21–55:2 (Ex. 2). HRA's failure to maintain records pertaining to Mayer is particularly telling because HRA posited, in this action, that *Mayer* led it to stop requiring independent medical reviews for reauthorizing split-shift care.

171:15 (Ex. 5); *see also* Feb. 7, 2008 Meeting Agenda (noting “Elected Official Advocacy” at CASA 7 and “same as CASA [6]”) (Ex. 36).

Such problems were not confined to any single CASA. For instance, in one case involving CASA 3, HRA provided split-shift care to [REDACTED] former Governor [REDACTED] an LMD – based on the review of a physician’s order, a nursing assessment, a social assessment and an additional physician report, and concluded that “according to the regulations set forth/outlined in NYSDSS 505.14, client qualifies for SI [sleep-in] service.” *See* Feb. 18, 2009 LMD Review (Ex. 42).

[REDACTED] unhappy with the LMD’s decision and contacted an acquaintance, Bill Cunningham, a former Director of Communications for Mayor Bloomberg and a deputy appointments officer [REDACTED] on March 27, 2009. *See* Cunningham Dep. at ¶ 8:8–10:16 (Ex. 6). [REDACTED] to Mr. Cunningham his desire to obtain split-shift, rather than sleep-in, service. *Id.* at 54:10–57:16. Mr. Cunningham, in turn, contacted New York City Deputy Mayor Linda Gibbs on the same day because home care services that [REDACTED] through HRA was “an area that reported to her.” *Id.* at 58:15–59:6. Specifically, Mr. Cunningham informed Deputy Mayor Gibbs [REDACTED] was not comfortable having someone sleep in his home and wanted to have two people provide his care. *See* Gibbs Dep. at 54:6–61:10 (Ex. 9).

Deputy Mayor Gibbs contacted HRA Commissioner Robert Doar [REDACTED] the same afternoon. *See id.* at 62:5–74:4. Commissioner Doar, in turn, contacted a HRA employee in charge of PCS vendor contracts, Arnold Ng; and, in less than an hour, Mr. Ng reported back to Commissioner Doar that vendors would provide split-shift care [REDACTED] Doar Dep. at 122:10–128:2, 136:13–23 (Ex. 7). By 6 p.m. that evening, Commissioner Doar advised Deputy Mayor Gibbs and Mr. Cunningham, “We are having provider switch to split shift asap I will let you know

when I have that confirmed.” See Mar. 27, 2009 Doar E-mail (Ex. 43).<sup>7</sup>

The director of CASA 3 was subsequently instructed to authorize split-shift services [REDACTED] [REDACTED] “indefinitely,” and was told that this directive had come from the Mayor’s Office. See Bartholomew Dep. at 56:12–61:22, 208:13–217:18, 247:18–254:21 (Ex. 4). Further, after a [REDACTED] sought to reinstate his split-shift services. See Sept. 30, 2009 Eisner E-mail (Ex. 47). After he learned [REDACTED] a higher level of care than could be provided by personal care services, Mr. Eisner observed in an e-mail to other HRA employees that “If he has a skilled nursing need, he’s not appropriate for personal care, right? At least until we get a call from the Mayor’s office.” *Id.*

Despite its being subjected to political pressure on a regular basis, and even though political pressure is not an appropriate basis for determining the level of PCS care, HRA has had “no policy” on how to protect the integrity of the PCS program in the face of such pressure. See HRA Dep. II at 376:18–377:4 (Ex. 2).

C. HRA’s Practice of Knowingly or Recklessly Disregarding the State Regulatory Requirements in Making Authorization and Reauthorization Decisions

HRA applied the same arbitrary and reckless approach to its core function as a local administrator — to make authorization determinations in accordance with the PCS Regulation and based on medical necessity and patient health and safety. See 18 N.Y.C.R.R. § 505.14(a)(4), (b)(5). Specifically, HRA routinely ignored the three requirements, as codified in the state regulation, that are at issue here: (i) to consider nursing assessments prior to reauthorizing 24-hour care, (ii) to obtain independent medical review prior to reauthorizing split-shift care, and (iii) to abide by the determination of the independent medical review as “final.” See *supra* at 4-7.

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<sup>7</sup> During this time, Commissioner Doar did not inquire into [REDACTED] for split-shift care and did not contact any case management staff [REDACTED] case or assessing the appropriate level and amount of care. See Doar Dep. at 122:

*i. HRA's Standard Practice Was to Ignore the Requirement for Considering Nursing Assessments Prior to Reauthorizing 24-Hour Care*

As a matter of policy, HRA did not – as its 30(b)(6) representative admitted in deposition – require its supervisors and case workers to obtain nursing assessments “prior to the reauthorization of [24-hour PCS] service” from 2000 to late 2008. *See* HRA Dep. II at 131:16–134:2 (Ex. 2); *see also* Holm Carela Dep. at 58:23–59:5 (prior to 2008, HRA did not require CASAs to “have a nursing assessment in its possession before reauthorizing 24-hour sleep-in care”), 62:11–17 (CASAs not required to obtain nursing assessments before reauthorizing split-shift care) (Ex. 13).<sup>8</sup> The failure to have a policy implementing the nursing assessment requirement made it a standard practice for HRA to reauthorize 24-hour care without first obtaining the nursing assessments: according to a case worker at CASA VII, half of his split-shift cases were reauthorized when he had not obtained the nursing assessments. *See* Hill Dep. at 33:7–34:24 (Ex. 12).

By way of illustration, the effect of HRA’s failure to require its staff to obtain nursing assessments prior to reauthorizing 24-hour service can be gleaned from a review of HRA’s patient files for a sample of twelve patients who received 24-hour PCS service.<sup>9</sup> In the cases of eleven of these patients

HRA reauthorized 24-hour sleep-in or split-shift services multiple times – more than eight years without obtaining any appropriate nursing assessments. *See* Martin Decl. at ¶¶ 64–80, 88-154. For each patient, thus, HRA repeatedly reauthorized PCS service with only a partial view

<sup>8</sup> Indeed, even after HRA started directing the CASAs in 2008 to obtain nursing assessments for reauthorizations, it did not issue any policy or directive requiring supervisors and case workers to review or examine the plan of care recommended by the nursing assessments. *See* Jenkins Dep. at 63:8–15 (the “full extent” of supervisor’s review is to check the dates of nursing assessments) (Ex. 14); Holm Carela Dep. at 227:8–228:10 (unaware of a policy requiring anyone at HRA to review the substance of nursing assessments).

<sup>9</sup> The facts about these twelve patients are summarized only to illustrate the effects of HRA’s reckless practices.

of the information that it was required to consider to determine whether such service was medically necessary or consistent with the patient's health and safety. In other words, HRA simply rolled the dice with respect to the patients' health and safety and the taxpayer's money.

The recklessness is exemplified by the fact that had HRA actually obtained the nursing assessments [REDACTED] learned that these assessments had found sleep-in care to be inadequate for her and recommended an increase in service. *See* Ex. 52 (recommending "increase tasks" for the patient). Further, [REDACTED] had HRA obtained the nursing assessments at the time of reauthorization, it would have learned that the assessments consistently indicated that split-shift was not necessary [REDACTED]

[REDACTED] *See* Martin Decl. at ¶¶ 81-86.

The nursing assessments indicate that he had only been assessed as needing task-based services (twelve hours or less per day) and had received split shift services only because he had shared those services [REDACTED] Ex. 51 (recommending "decrease tasks" for the patient).

Furthermore, in numerous cases, many nursing assessments that are obtained by HRA are not based on a current medical assessment. In the case [REDACTED] [REDACTED] each nursing assessment that *was* obtained by HRA long predated the physician order submitted in support of the relevant reauthorization. *See* Martin Decl. at ¶¶ 113-18, 140-54. Thus, even when HRA had a nursing assessment in these cases, that assessment failed to adhere to the regulatory and, indeed, commonsense, requirement that it include a "review and interpretation of the physician's order." § 505.14(b)(3)(iii)(b); *see also, e.g.*, Willard Dep. at 189:8-22 ("The purpose of the nursing assessment is for a nurse to look at the individual's functional status, *review and interpret the physician's order in terms of diagnosis, prognosis, medications* and determine what assistance is necessary to support that individual in the community. . . . The nursing assessment should use the most current order in order to make sure that everything is timely and up to date, yes.") (Ex. 23).

ii. *It Was a De Facto Policy at HRA to Ignore the Requirement for Independent Medical Review Prior to Reauthorizing Split-Shift Care*

As noted above, *see supra* at 10-11, HRA recognized as early as 1992 that the PCS Regulation required it to obtain an independent medical review prior to reauthorizing split-shift care. Nonetheless, from 2000 to November 2010, HRA ignored that requirement wholesale. *See, e.g.*, Holm Carela Dep. at 196:15–198:12 (before “the start of this litigation,” did not know that HRA had to obtain independent medical review prior to reauthorizing split-shift service) (Ex. 13); Kapsalis Dep. at 51:3–52:21 (unaware of this requirement before November 2010) (Ex. 16).

Consistent with these admitted practices, none of the patient files for the individuals referenced above, *see supra* at 15-16, reflect that an independent medical review was conducted any split-shift reauthorizations. For instance, between November 2002 and May 2005, HRA reauthorized split-shift care [REDACTED] six times, without making any request for independent medical review. *See* Martin Decl. at ¶¶ 108-12. Second, from December 2003 to June 2007, HRA approved eight split-shift [REDACTED] without any independent medical review by a LMD. *See id.* at ¶¶ 103-06; *see also* Shyne Dep. at 116:13–17 (case worker for the patient not aware of any independent medical review after initial authorization) (Ex. 20). Finally, between August 2008 and January 2010, HRA reauthorized split-shift care for [REDACTED] on four occasions without any independent medical review. *See* Martin Decl. at ¶ 81-87. Ignoring the state regulatory requirement for independent medical review, in short, was HRA’s *de facto* policy.

iii. *HRA Has Condoned Violations of the Requirement to Abide by the Final Determinations of the Independent Medical Reviews*

HRA’s reckless approach to administering the PCS program also can be gleaned from examples of its ongoing failure to comply with the requirement – under both the PCS Regulation and a May 2008 internal directive – to abide by the determinations of independent medical reviews. In August 2005, notwithstanding the clear requirement of the state regulation, *see* 18 N.Y.C.R.R. §

505.14(b)(4)(ii) (independent medical review determinations are “final”), HRA issued a memo to the PCS staff, instructing them on how to process administrative overrules of those determinations, by CASA directors and deputy directors, for unspecified “social and/or administrative reasons.” *See* Aug. 16, 2005 J. Turley Memo (“2005 Turley Memo”) (Ex. 25).

The 2005 Turley Memo codified, and officially condoned, a practice at HRA where CASA directors overruled the independent medical determinations of LMDs based on whatever factors the CASA directors deemed sufficient. *See* Soto Dep. at 41:21–46:13; 77:7–25 (Ex. 21); Brady Dep. at 48:9–51:21, 64:8–65:16 (Ex. 5). For example, in April 2005, an LMD conducted a medical review for [REDACTED] and determined that she required a higher level of care than the PCS program could provide. *See* Rosenberg Dep. at 198:3–201:13, 208:11–16 (Ex. 19). The then-director of CASA 3 Michael McAllister, however, overruled the LMD’s determination for an unspecified “administrative” reason, and approved split-shift PCS care for the patient. *See id.* at 201:14–204:17. For the next three years until the patient’s death, HRA gave no further consideration to an alternative, and more effective, service for that patient. *See* Martin Decl. at ¶ 78.

Similarly in November 2007, HRA [REDACTED] split shift personal care services despite a contrary independent medical review by an LMD. *Id.* at ¶¶ 64-66. On November 5, 2007, an LMD [REDACTED] was not appropriate for home care and that a higher level of care was necessary. *See* Soto Dep. at 167:22–171:12 (Ex. 21). The LMD based that determination on a nursing assessment, a physician’s report, and a letter from a nurse. *Id.* Despite the LMD’s decision, HRA [REDACTED] split-shift service for more than one year, until her death. *See id.*

In May 2008, Barbara Draimin, then-Director of Field Operations, e-mailed the CASA directors, instructing them that, rather than overruling LMD determinations administratively, they should present any disagreement to Dr. Soto for resolution. *See* May 29, 2008 Dramin E-mail (Ex. 26). HRA, however, has not abided by that e-mail directive, which generally conforms to the state

regulatory requirement. Specifically, while Dr. Soto deemed the May 2008 e-mail directive to reflect HRA's internal policy, *see* Soto Dep. at 58:5–59:5 (Ex. 21), HRA's 30(b)(6) representative opined that CASA directors retain the discretion to overrule LMD's independent medical determinations on “a case-by-case basis and depending on where the situation falls,” HRA Dep. II at 187:17–188:5 (Ex. 2).

**II. HRA Played a Pivotal Role in Connection with the Presentment of Claims for Medicaid Reimbursement by Vendors and by DOH**

PCS vendors and the state DOH both present claims for Medicaid funds in connection with the PCS program. Although HRA does not itself submit claims for reimbursements, it plays a critical role in both claim presentment processes. First, PCS vendors seek Medicaid reimbursements by periodically submitting claims to DOH. *See* Willard Dep. at 240:14–243:17 (Ex. 23). But whether these vendors will be reimbursed depends on HRA. The contracts between HRA and PCS vendors specify that the vendors have no right to reimbursements unless they have received authorizations from HRA for the services at issue. *See* Ng Dep. at 32:17–35:23 (Ex. 18). Further, HRA's contracts with vendors give HRA “the sole [] responsibility to determine” whether to authorize service, *see* 2001 Vendor Contract at 14 (Ex. 33), as well as the “nature of the service, the duration of the service, and the amount of hours that the client would receive,” *see* Ng Dep. at 22:4–13. After HRA makes its determinations, it electronically transmits the terms of its authorization and demographic information about the patient, to DOH, which then provides a “prior authorization” code to allow the vendor to obtain reimbursements. *See* HRA Dep. II at 222:17–229:19 (Ex. 2).

Second, issuing the “prior authorization” codes is a “pure[ly] billing” process on DOH's part, HRA Dep. II at 204:24–205:7, and did not require an independent analysis of whether HRA appropriately made the authorization determinations, *see id.* at 232:17–23. In other words, DOH relied on an implicit guarantee from HRA that it determined the duration, level, and amount of care “in accordance with [the PCS Regulation].” *See* 18 N.Y.C.R.R. § 505.14(a)(4). DOH used federal Medicaid funds to pay PCS vendors, *see* Brady Dep. at 143:3–8 (Ex. 5); HRA Dep. II at 44:10–19 (Ex.

2), and submitted, on a quarterly basis, the Form CMS-64 to CMS to detail DOH's Medicaid expenditures, including PCS expenditures, *see supra* at 10-11.

#### APPLICABLE LEGAL STANDARDS

### I. The Summary Judgment Standard

Pursuant to Rule 56(a), the Government may seek partial summary judgment by “identifying . . . the part of each claim . . . on which summary judgment is sought.” Fed. R. Civ. P. 56(a). Summary judgment should be granted with respect to each issue or element of a claim as to which “there is no genuine dispute as to any material fact.” *Id.*

Because summary judgment is proper when there is no genuine dispute as to a *material* fact, the mere existence of some alleged factual dispute does not defeat an otherwise properly supported motion for summary judgment. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249-50 (1985) (“[T]here is no issue for trial unless there is sufficient evidence favoring the nonmoving party for a jury to return a verdict for that party. If the evidence is merely colorable, or is not sufficiently probative, summary judgment may be granted”) (internal cites omitted). Further, conclusory allegations, conjecture, and speculation are insufficient to create a *genuine* issue of fact; *see Shannon v. New York City Transit Auth.*, 332 F.3d 95, 99 (2d Cir. 2003); *Knight v. U.S. Fire Ins.*, 804 F.2d 9, 12 (2d Cir. 1986); instead, “genuine factual issues” are limited to those that can “reasonably be resolved in favor of either party.” *Anderson*, 477 U.S. at 250.

### II. Elements of the False Claims Act Claims

31 U.S.C. § 3729(a)(1) imposes liability on any party that “knowingly present[ed], or caus[ed] to be presented, [to an officer or employee of the United States] . . . a false or fraudulent claim for payment or approval.”<sup>10</sup> Here, the Government’s § 3729(a)(1) claim is based on HRA’s false

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<sup>10</sup> On May 20, 2009, Congress amended the FCA in the Fraud Enforcement and Recovery Act of 2009 (“FERA”), Pub. L. No. 111-21, § 4. FERA amended, *inter alia*, 31 U.S.C. §§ 3729(a)(1) and 3729(a)(2) and re-designated these provisions as 31 U.S.C. §§ 3729(a)(1)(A) and 3729(a)(1)(B). *See*

and unlawful authorizations of personal care services, which caused vendors and DOH to submit false claims for Medicaid reimbursements. The City is liable under § 3729(a)(1) if the following elements are established: (i) HRA knowingly authorized PCS care in violation of the PCS Regulation, (ii) HRA's false and unlawful authorizations caused vendors and DOH to present claims to the federal government seeking federal funds, (iii) the reimbursement claims were false, and (iv) the false statements in the claims were material. See *United States ex rel. Anti-Discrimination Ctr. v. Westchester County* (“ADC I”), 668 F. Supp. 2d 548, 560, 568-69 (S.D.N.Y. 2009).

More specifically, “knowingly,” under the FCA, can be established without proving a specific intent to defraud. See 31 U.S.C. § 3729(b). Specifically, HRA can be found to have acted with the requisite *scienter* if it (i) had actual knowledge that it was violating the state regulation, (ii) acted in deliberate ignorance of such violations, or (iii) acted in reckless disregard of whether it was violating the regulation. See *United States ex rel. Mikes v. Straus*, 274 F.3d 687, 697 (2d Cir. 2001).

Second, “claim” is defined under the FCA to include “any request or demand . . . for money or property.” 31 U.S.C. § 3729(c). A statement can be a “claim” if, “within the payment scheme, the statement has the practical purpose and effect, and poses the attendant risk, of inducing wrongful payment.” *United States v. Rivera*, 55 F.3d 703, 710 (1st Cir. 1995). Further, a party, *e.g.*, HRA, can be deemed to have “caused” the submission of a false claim by another party, *e.g.*, DOH or a vendor, if HRA's action was “a substantial factor in bringing about” submission of the false claim and if submission of the false claim “was a normal consequence of the situation created” by HRA. *United*

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Pub. L. No. 111-21, § 4(f), 123 Stat. 1617, 1625 (FERA's amendments “apply to conduct on or after the date of enactment, except that” the amendment to 31 U.S.C. § 3729(a)(2) shall “take effect as if enacted on June 7, 2008, and apply to all claims under the [FCA] pending on or after [June 7, 2008]”). See *United States ex rel. Kirk v. Schindler Elevator Corp.*, 601 F.3d 94, 113 (2d Cir. 2010) (holding that § 3729(a)(1)(B) applies retroactively to claims pending before a court on or after June 7, 2008), *rev'd on other grounds*, 131 S. Ct. 1885 (2011). The amended Section 3729(a)(1)(A) provides for liability where defendant “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval[.]” The differing language of the pre- and post-amendment section has no effect here, since both apply to the conduct at issue.

*States ex rel. Schmidt v. Zimmer, Inc.*, 386 F.3d 235, 244-45 (3d Cir. 2004) (internal cites and quotation marks omitted).

Third, FCA reaches claims that are both legally and factually false. *See Mikes*, 274 F.3d at 696-97. A claim is “legally false” if it contains either (i) an “express false certification,” *i.e.*, where the claimant expressly, but falsely, certifies compliance with a statutory, regulatory, or contractual term, and “compliance [with such term] is a prerequisite to payment,” *id.*, at 697-98; or (ii) an “implied false certification,” *i.e.*, where a claimant, through the demand for payment, impliedly but falsely represents compliance with a statute, regulation or contractual term, which would preclude payment in the event of noncompliance, *id.* at 699-700.

Fourth, a false statement in a claim is “material,” for purposes of the FCA, if it has “a natural tendency to influence, or [is] capable of influencing,” the Government’s decision about whether to pay the claim. *See ADC I*, 668 F. Supp. 2d at 568-69 (citing and analyzing circuit decisions that endorse the “natural tendency” test of materiality); *see also* 31 U.S.C. § 3729(b)(4) (adopting the “natural tendency” standard for materiality for § 3729(a)(1)(B) claims).

Finally, the Government’s second claim is based on 31 U.S.C. § 3729(a)(1)(B). A defendant is liable under this provision if it “knowingly makes, uses, or caused to be made or used, a false record or statement material to a false or fraudulent claim.” *Id.*; *see also Kirk*, 601 F.3d at 113. Further, Congress has defined materiality for purposes of a § 3729(a)(1)(B) claim as “having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” 31 U.S.C. § 3729(b)(4).

## ARGUMENT

## POINT I

THE GOVERNMENT IS ENTITLED TO PARTIAL SUMMARY JUDGMENT ON ITS FIRST CLAIM BECAUSE HRA VIOLATED 31 U.S.C. § 3729(a)(1) AND § 3729(a)(1)(A)

**A. HRA Knowingly Authorized or Reauthorized 24-Hour PCS Care in Violation of the PCS Regulation in Each of the Three Scenarios**

The undisputed evidence shows that HRA’s authorizations and reauthorizations of 24-hour PCS care violated three requirements of the PCS Regulation. *See generally supra* at 13–19. First, in violation of the requirement that HRA consider valid nursing assessments before reauthorizing services, *see* 18 N.Y.C.R.R. § 505.14(b)(2)(iii), (b)(5)(ix), HRA had a standard practice of reauthorizing 24-hour care without even obtaining nursing assessments. *See* HRA Dep. II at 131:16–134:2 (Ex. 2); Jenkins Dep. at 49:16–25 (Ex. 14). Second, in violation of the requirement for obtaining independent medical reviews prior to reauthorizing split-shift services, *see* Nov. 4, 2010 Holm Carela E-mail (summarizing 18 N.Y.C.R.R. §§ 505.14(b)(4)(a)(ii), (b)(5)(ix)) (Ex. 24), HRA followed a *de facto* policy of reauthorizing split-shift care without independent medical reviews. *See supra* at 17. Third, in violation of the state regulation’s express instruction that independent medical determinations are “final,” *see* 18 N.Y.C.R.R. §§ 505.14(b)(4), HRA condoned, and continues to condone, its non-medical staff overruling such determinations. *See* HRA Dep. II at 184:3 – 192:7. In each scenario, moreover, HRA acted with actual knowledge or in reckless disregard of its violations of the PCS Regulation.

**1. HRA Knowingly Violated the PCS Regulation by Reauthorizing 24-Hour Services Without Obtaining Nursing Assessments**

The evidence shows beyond dispute that HRA knew that the PCS Regulation required HRA to consider nursing assessments prior to reauthorizing 24-hour services. *See* 56.1 Stmt. at ¶ 16. During all relevant times, HRA knew that 18 N.Y.C.R.R. § 505.14 governed its administration of the PCS program. *See* Ng Dep. at 18:4–17 (recognizing it as the “primary regulation”) (Ex. 18). As the

local PCS administrator for New York City, HRA had a clear duty to know the program's regulatory requirements, including the nursing assessment requirement. *See United States v. Mackby*, 261 F.3d 821, 828 (9th Cir. 2001) (“[p]articipants in the Medicare program have a duty to familiarize themselves with the legal requirements for payment”); *United States v. President and Fellows of Harvard Coll. (“Harvard College”)*, 323 F. Supp. 2d 151, 189 (D. Mass. 2004) (a program participant with a key role had a duty to understand the program's requirements). Further, HRA, through its involvement in the *Mayer* litigation, had *actual* notice of the nursing assessment requirement. *See Mayer*, 922 F. Supp. at 905 (PCS Regulation required HRA to consider nursing assessments for reauthorizations).

In practice, however, HRA knowingly or recklessly ignored the nursing assessment requirement in issuing reauthorizations. First, according to its 30(b)(6) representative, until November 2010, HRA's official policy on reauthorization procedures was that it was *not* necessary for HRA employees to obtain nursing assessments prior to reauthorizing 24-hour services. *See HRA Dep. II* at 131:16–134:2 (Ex. 2). Put simply, HRA knowingly maintained a policy that contravened a state regulatory requirement of which HRA had been aware. HRA thus had actual knowledge that it was reauthorizing care without first obtaining nursing assessments, in violation of the PCS Regulation.

Further, while HRA had notice of the nursing assessment requirement by 1996 at least, *see Mayer*, 922 F. Supp. at 905, the record shows that HRA utterly failed to communicate that requirement to its employees involved with processing reauthorizations. *See, e.g., Jenkins Dep.* at 46:19–47:9 (Ex. 14); *Kapsalis Dep.* at 205:17–207:3, 216:3–217:4 (Ex. 16); *Baron-Bowen Dep.* at 15:21–18:21, 25:22–29:9 (Ex. 3); *Hill Dep.* at 5:22–6:10, 38:24–40:8 (Ex. 12); *Guzman Dep.* at 104:17–107:8 (Ex. 10). Those employees, in turn, made a standard practice of reauthorizing 24-hour care without nursing assessments. Indeed, the single piece of written guidance, the 1992 Manual, did not require nursing assessments to be obtained for reauthorization purposes. *See 1992 Manual* at 10-11 (Ex. 30).

In each of the case set forth above, *see supra* at 15–17, HRA repeatedly and routinely failed

to require or obtain a nursing assessment prior to reauthorizing personal care sleep-in and split-shift services. *See* Martin Decl. at ¶¶ 64–156. Further, for multiple reauthorizations for which HRA *did* obtain a nursing assessment, the assessment was clearly generated without reference to the physician order as it predated such order. *See id.* Therefore, the assessment failed to incorporate current and critical medical information contained in the physician order, such as the patient’s current medical condition, medication and other regimens. In such cases, HRA failed to obtain a nursing assessment that met the requirements of the regulation. *See* § 505.14(b)(3)(iii)(b). Thus, HRA acted in reckless disregard of whether its employees were complying with, or violating, the PCS Regulation in authorizing 24-hour PCS services.

2. HRA Knowingly Violated the PCS Regulation by Reauthorizing Split-Shift Services Without Obtaining Independent Medical Determinations

Prior to 2000, HRA knew that the PCS Regulation required HRA to obtain independent medical determinations prior to reauthorizing split-shift services. *See* 56.1 Stmt. at ¶ 37. As HRA’s 30(b)(6) representative acknowledged, in 1992, HRA included this regulatory requirement in its official policy on the reauthorization “workflow.” *See* HRA Dep. II at 75:15–76:9 (Ex. 2); *see also* 1992 Manual at 11 (Ex. 30). Further, this requirement had always been clearly stated in the PCS Regulation. *See* Nov. 4, 2010 Holm Carela E-mail (Ex. 24); *see also* HRA Dep. II at 70:5–12 (acknowledging that the 1995 version of the regulation included this requirement) .

Nonetheless, from 2000 to November 2010, HRA wholly ignored the independent medical review requirement. *See* 56.1 Stmt. at ¶ 38. Specifically, because HRA did not make its employees aware of that requirement, *see, e.g.*, Holm Carela Dep. at 196:15–198:12 (Ex. 13), it became the *de facto* policy to reauthorize split-shift services when its employees failed to obtain an independent medical review. *See* Shyne Dep. at 106:25–127:11 (Ex. 20). As HRA was aware of the independent medical review requirement, it cannot dispute it knowingly violated the PCS Regulation, when it failed

to obtain an independent medical review prior to reauthorizing split-shift services. Accordingly, the Government is entitled to summary judgment on this element of its § 3729(a)(1) claim.

3. HRA Knowingly Violated the PCS Regulation by Condoning Its Non-Medical Staff's Overruling of Independent Medical Determinations

The PCS Regulation unambiguously states that, for purposes of authorizing and reauthorizing personal care services, independent medical review provides the “*final determination of the level and amount of care.*” 18 N.Y.C.R.R. § 505.14(b)(4)(ii) (emphasis added). As a local administrator, HRA knew, or must be deemed reckless for not knowing, that the state regulation required that it abide by independent medical determinations. *See Mackby*, 261 F.3d at 828; *Harvard College*, 323 F. Supp. 2d at 189.

Further, since October 2007, HRA has had actual notice that the PCS Regulation does not allow the overruling of independent medical determinations by non-medical staff at HRA. *See Brady Dep.* at 60:10–61:21 (Ex. 5). Indeed, in May 2008, the director of field operations at HRA instructed all the CASA directors to refer their disagreements with independent medical determinations to Dr. Soto, rather than overrule them administratively. *See August 2008 Dramin E-mail* (Ex. 26).

HRA, however, not only had condoned its non-medical staff's overruling of independent medical determinations before October 2007, but also has continued to condone such violations of the state regulation, despite having been made aware of what the regulation requires. *See Martin Decl.* at ¶¶ 43-80. Further, [REDACTED] shows that the disregard of independent medical determinations reaches the highest levels of HRA. *See id.* at ¶¶ 43-62. Indeed, according to its 30(b)(6) representative, HRA still follows a policy that allows non-medical staff at CASAs to overrule independent medical determinations on a “case-by-case basis.” *HRA Dep. II* at 187:17–188:5 (Ex. 2). Clearly, HRA's non-compliance with this aspect of the PCS Regulation did not result from any error or misunderstanding; instead, it reflected HRA's knowing and willful refusal to comply with a state

regulatory requirement. Thus, there is no genuine dispute that HRA knowingly violated the state regulation when it overruled an independent medical determination in authorizing or reauthorizing PCS services, and the Government therefore is entitled to summary judgment on this element of its § 3729(a)(1) claim..

**B. HRA Caused Vendors and DOH to Present Claims Seeking Federal Funds**

The undisputed evidence shows that HRA’s conduct caused the submission of two types of false claims seeking federal Medicaid funds. First, HRA’s improper authorization decisions led directly to vendors submitting DOH claims for reimbursement for services rendered in violation of the PCS Regulation. Second, HRA’s authorization decisions also caused DOH to submit false CMS-64 Forms to CMS on a quarterly basis.

1. HRA Caused Vendors to Present Claims for Reimbursement Seeking Federal Funds

It is well-established that requests for payments submitted to state Medicaid agencies, like DOH, “are actionable under § 3729(a)(1).” *Ven-A-Care*, 659 F. Supp. 2d. at 269 (collecting and analyzing prior decisions); *see also United States v. Rogan*, 459 F. Supp. 2d 692, 717 (N.D. Ill. 2006) (same), *aff’d*, 517 F.3d 449 (7th Cir. 2008). Here, there is no dispute about either the funding source for the PCS program – Medicaid – or the mechanism for paying the PCS vendors. *See* 56.1 Stmt. at ¶¶ 20-21. Specifically, a vendor seeks Medicaid reimbursements from DOH by submitting a request for payment, including a “prior authorization” code that HRA obtains from DOH for the vendor. *See* Willard Dep. at 237:14–238:14 (Ex. 23). DOH then pays the vendor using Medicaid funds, including funds from the federal government. *See* Brady Dep. at 143:3–8 (Ex. 5); HRA Dep. II at 44:10–19 (Ex. 2). The payment requests that PCS vendors submit to DOH, thus, are “claims presented to the federal government” under 31 U.S.C. § 3729(a)(1). *See Ven-A-Care*, 659 F. Supp. 2d. at 268-69; *Rogan*, 459 F. Supp. 2d at 717.

The evidence also demonstrates HRA had a critical role in determining whether PCS

vendors will receive Medicaid payments, and in what amounts. Specifically, under the contracts between HRA and the PCS vendors, the vendors have no right to payment unless HRA sends them authorizations to provide personal care services. *See also* Ng Dep. at 32:22–34:6 (Ex. 18). Further, these contracts specify that HRA has the “sole responsibility to determine” whether to authorize services, and the type, amount, and duration of services to be authorized. *Id.* at 22:5–13. Finally, once HRA communicated to DOH its determinations, DOH, relying on HRA’s eligibility determination, issued the prior authorization code, which entitled the vendor to bill DOH, in a “pure billing” process. *See* HRA Dep. II at 204:24–205:4 (Ex. 2); Willard Dep. at 236:23–243:20; 243:21–244:21 (Ex. 23).

Thus, the undisputed evidence shows that a decision by HRA to improperly authorize PCS service naturally led the vendors to submit requests for payments to DOH and that HRA knew that this would be the effect of its authorization decisions. Accordingly, the Court should find that HRA caused vendors to present claims seeking federal funds. *See Zimmer*, 386 F.3d at 244-45 (defendant causes presentment of claims if his action was a “substantial factor in bringing about” the submission of the claim and if submission of the claim is foreseeable).

## 2. HRA Caused DOH to Submit CMS-64 Forms to the Government

The undisputed facts show that, once each quarter since 2000, DOH submitted a CMS-64 Form to CMS. *See* Martin Decl. at ¶ 41. Under § 3729(a)(1), DOH’s submission of the CMS-64s qualified as presenting claims to the Government seeking federal funds. *See United States ex rel. Baker v. Cmty. Health Sys. Inc.*, 709 F. Supp. 2d 1084, 1116-17 (D.N.M. 2010); *cf. Harvard College*, 323 F. Supp. 2d at 179 (“backward-looking accounting document[]” of past expenditures is a “claim” under the FCA if “[its] practical purpose . . . [is] to induce and assure future disbursements”).

Further, the record establishes that, as the local administrator for the PCS program in New York City, HRA is responsible for “[a]pproving access to personal care services” and for “the

determination of the level of need for each individual case.” *See* 2008 MICSA Briefing Book at 3. In that regard, HRA’s authorization decisions – both as to whether service should be provided and as to the appropriate level or amount of services – are not subject to further review by DOH. *Id.*; *see also* HRA Dep. II at 232:17–23 (Ex. 2). Thus, once HRA authorized (or reauthorized) a vendor to provide personal care services, DOH paid the vendor for such services based on the term of HRA’s authorization. *See* 56.1 Stmt. at ¶ 20. These payments, in turn, were reflected as PCS expenditures in the quarterly CMS-64 Forms submitted to CMS. *See, e.g.*, 2001 NY CMS-64 (Ex. 37).

Thus, there can be no dispute that it was HRA’s decision to authorize PCS care that animated the process whereby DOH paid vendors with Medicaid funds and then submitted claims to the Government concerning such expenditures. Accordingly, the Court should find that HRA, through its role as a local PCS administrator, caused DOH to submit claims to the Government to seek federal Medicaid funds. *See Zimmer*, 386 F.3d at 244-45; *United States ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009) (a party “can cause [a] fraud by putting a fraudulent record into a system that he knows will ministerially crank out a fraudulent bill to the Government”).

**C. As a Result of HRA’s Violations of the Three Requirements in the PCS Regulation, Vendors’ and DOH’s Claims for Medicaid Funds Were False**

1. Falsity of the PCS Vendors’ Claims under the Implied Certification Standard

A claim is false under the “implied certification” standard where, within the relevant statutory or regulatory framework, the fact that a request for payment has been made implies “compliance with that statute or regulation.” *United States ex rel. Willard v. Humana Health Plan of Texas*, 336 F.3d 375, 382 (5th Cir. 2003); *see also ADC I*, 668 F. Supp. 2d at 566-67.

The state PCS regulatory scheme imposes two requirements before vendors can initiate services, or *a fortiori*, submit claims for providing such services. The regulation provides that services can be provided only if they are determined to be medically necessary and consistent with the health and safety of the patient “in accordance with the regulation.” 18 N.Y.C.R.R. § 505.14(a)(4). Thus,

where the services have not been determined to be medically necessary or consistent with health and safety in accordance with the regulations, services cannot be initiated or billed. Lest there be any ambiguity, the regulation further provides that authorization must be complete prior to the initiation of services. *Id.* § 505.14(b)(5). The regulation therefore makes clear that a vendor cannot provide or bill for services until HRA has authorized personal care services in accordance with the regulation. *See id.* § 505.14(a)(4) & (b)(5).

Further, the mechanics of submitting claims and obtaining reimbursement are designed to ensure that the regulatorily required authorization process occurs prior to payment of any PCS claims. *See* 18 N.Y.C.R.R. § 505.14(b)(5); *see also* Ng Dep. at 33:23–34:6 (PCS vendors cannot bill for services until HRA has issued authorization) (Ex. 18), Willard Dep. at 237:14–238:15 (PCS vendors must obtain prior authorization number from DOH prior to billing for services) (Ex. 23). Thus, because vendors can only submit claims for reimbursement if the services were determined “in accordance with the regulations” to be medically necessary and consistent with patient health and safety, submission of PCS claims by a vendor constituted an implicit certification that the services were determined to be so.

As discussed above, HRA violated three regulatory requirements in authorizing PCS service — the nursing assessment requirement, the independent medical review requirement, and the finality of the independent medical determination. *See supra* Point I.A. There is no genuine dispute that each requirement relates directly to HRA’s assessment of whether PCS service is medically necessary and consistent with the patient’s health or safety, and that the PCS Regulation only permits claims where these conditions are met. 18 N.Y.C.R.R. § 505.14(a)(4).<sup>11</sup> HRA’s compliance with

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<sup>11</sup> *See, e.g.*, 18 N.Y.C.R.R. § 505.14(b)(2) (requiring all authorization decisions to be “based” on physician order, nursing assessment and social assessment); § 505.14(b)(4) (additionally requiring an independent medical review by an LPD or designee for all authorizations of split-shift service and providing such determination be “final” with respect to the level and amount of service); § 505.14(b)(5)(ix) (authorization requirements apply to reauthorizations); HRA Dep. II at 351:12–

these requirements, accordingly, is a condition of payment. *See ADC I*, 668 F. Supp. 2d at 566-67. The submission of claims for services that were not authorized in compliance with these requirements falsely certifies that HRA made the medical necessity and patient health and safety determinations in accordance with the state regulation, thereby rendering the claim false. Accordingly, vendor reimbursement requests that are based on the improper authorizations from HRA are false for purposes of the FCA. *See id.*

## 2. Falsity of the CMS-64 Forms under the Express Certification Standard

A claim is false under the “express certification” standard if that claim “falsely certifies compliance with a particular statute, regulation or contractual term, where compliance is a prerequisite to payment.” *Mikes*, 274 F.3d at 698. In that regard, a false certification in a CMS-64 Form renders that CMS-64 Form a false claim. *See Baker*, 709 F. Supp. 2d at 1116-17.

Here, the undisputed evidence shows that, since the third quarter of 2001, the CMS-64 Forms that DOH submitted to the Government each (i) specified the amount of PCS expenditures during the quarter, and (ii) certified that such expenditures were “allowable in accordance with applicable implementing federal, state [] statutes, regulations, policies.” *See* 2001 NY CMS-64 (Ex. 37). The record shows, however, that HRA caused DOH to disburse Medicaid funds to vendors for PCS services that were not allowable under the PCS Regulation, *see supra* Point I.A, because HRA had authorized services in violation of the three state regulatory requirements, *see supra* Point I.C.1. Accordingly, the certification in each CMS-64 Form submitted by DOH since the third quarter of 2001 is “literally false” for purposes of the FCA.<sup>12</sup> *See Harvard College*, 323 F.3d at 180-81 (granting summary judgment to the Government as to the falsity of certification concerning disbursements).

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352:14 (independent medical review helps HRA assess medical necessity and patient’s health and safety), at 44:20 –45:10 (nursing assessments helps HRA assess the proper amount of care) (Ex. 2).

<sup>12</sup> HRA may posit that because the signatory to the CMS-64 Forms – various state officials – certified to their own knowledge and belief, the CMS-64 Forms are not false because the state officials

Further, there is no dispute that the certification at issue in the CMS-64 – whether costs for PCS services had been incurred in accordance with the PCS Regulation – is a “prerequisite for payment” for the Government. In that regard, New York could not continue to receive federal funding without submitting a certified CMS-64 form. *See* Guhl Dep. at 129:11–130:3 (Ex. 64). Accordingly, the Government is entitled to summary judgment as to the falsity of the CMS-64 Forms submitted by DOH since September 2001. *See ADC I*, 668 F. Supp. 2d at 561-65.

**D. The Falsehood Caused by HRA’s Unlawful Authorizations Is Material**

The test for materiality under the FCA – whether the falsity in a claim has the “natural tendency to influence, or [is] capable of influencing” the Government’s decision on whether to pay the claim – provides “an objective standard.” *United States v. Rogan*, 517 F.3d at 452; *see also Anti-Discrimination Ctr. of Metro New York v. Westchester County*, 06 Civ. 2860 (DLC), 2009 WL 1110572, at \*2 (S.D.N.Y. Apr. 22, 2009) (“*ADC II*”). Thus, the materiality of a falsehood in a claim does not turn on whether this federal officer or that federal employee notices the falsehood, nor does it require “a federal employee in a [decision-making] position to . . . testify.” *Rogan*, 517 F.3d at 452; *see also United States ex rel. Feldman v. Van Gorp*, 674 F. Supp. 2d 475, 480 (S.D.N.Y. 2009) (test for materiality “focuses on the potential effect of the false statement when it is made rather than [its] actual effect after it is discovered”). Instead, where a federal statute, regulation, or policy plainly disallows a false claim once the false statement has been corrected, the Court can find that “the false certifications meet the test for materiality as matter of law.” *See ADC II*, 2009 WL 1110572, at \*2; *see also Rogan*, 517 F.3d at 452.

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did not know of the City’s violations of the PCS Regulation. This argument lacks merit. It confuses the liability of the state official signing the form, which turns on the official’s knowledge and belief, with the truth or falsity of the CMS-64 Form itself, which does not turn on what the official knew or believed. Indeed, *Baker* shows that a CMS-64 Form containing a false certification can be “legally false,” even though the signatory may not be aware of such falsity. *See* 709 F. Supp. 2d at 1116 (refusing to dismiss FCA claim based on allegation that the CMS-64 forms were false without requiring allegation as to the signatory’s knowledge).

As relevant here, OMB Circular A-87 governs whether expenditures of federal Medicaid funds are allowable. *See New York v. Shalala*, 979 F. Supp. at 179 (OMB Circular A-87 “has the force of a regulation” in determining allowable Medicaid costs). More specifically, Circular A-87 expressly limits expenditure of federal Medicaid funds to costs that are “authorized or not prohibited under State [] law or regulations.” 2 C.F.R. § 225 App. A, ¶ C(1)(c). Here, the undisputed evidence shows that vendors and DOH made claims for Medicaid funds representing, expressly or implicitly, that the expenditures were for personal care services that were allowable under the PCS Regulation, because HRA had authorized such services in accordance with the state regulation. In fact, however, personal care services had been routinely authorized by HRA in violation of state regulatory requirements. Thus, under the PCS Regulation, claims for these services are not reimbursable.

Stated differently, the truth would have alerted the Government to the fact that it was being asked to reimburse PCS expenditures that were *not* “authorized or not prohibited under State [] law, or regulations.” OMB Circular A-87, in turn, would have prohibited federal Medicaid funds to be expended on such costs. *See* 2 C.F.R. § 225 App. A ¶ C(1)(c). Accordingly, the falsehood caused by HRA’s conduct plainly had “a natural tendency to influence” the Government’s decision to pay, and therefore should be deemed material as a matter of law. *See ADC II*, 2009 WL 1110572, at \*2.

## POINT II

### THE GOVERNMENT IS ENTITLED TO PARTIAL SUMMARY JUDGMENT ON ITS § 3729(a)(1)(B) CLAIM BECAUSE HRA KNOWINGLY MADE FALSE RECORDS OR STATEMENTS MATERIAL TO THE FALSE CLAIMS SUBMITTED BY VENDORS AND DOH

As courts have recognized, the scope of “liability under § 3729(a)(2) [the predecessor to § 3729(a)(1)(B)] is broader than [] liability under § 3729(a)(1).” *Harvard College*, 323 F. Supp. 2d at 194. Here, HRA is liable under § 3729(a)(1)(B) because HRA knowingly made, and transmitted to, DOH authorization notifications, which were (i) false under the implied certification standard, and (ii)

material to the claims that HRA and vendors submitted to, respectively, DOH and CMS, to seek Medicaid funds.<sup>13</sup>

The undisputed evidence shows that the authorization notifications contained HRA's determinations as to the appropriate type, duration, and amount of service for a PCS patient, as well as certain demographic data on the patient. *See* HRA Dep. II at 220:10–229:19 (Ex. 2). HRA was required to make these determinations based on its assessment of the medical necessity of PCS service and the patient's health and safety, and in accordance with the procedures set forth in the PCS Regulation. *See* 18 N.Y.C.R.R. § 505.14(a)(4). DOH, in turn, did not conduct any substantive review of HRA's determinations, but instead followed a “pure billing” process to issue prior authorization codes to vendor and, then, made Medicaid payments for PCS services. *See* HRA Dep. II at 193:4–205:7.

In short, under the framework of the PCS Regulation, HRA's authorization notification implicitly represented that the services being authorized had been assessed by HRA in accordance with the state regulations. *See* Willard Dep. at 244:22–245:17 (Ex. 23). In fact, however, HRA routinely ignored the mandates of the state regulation and failed to obtain medical and nursing assessments. *See supra* at 13-17. Thus, the authorization notifications sent by HRA to DOH were false under the “implied certification” standard. *See ADC I*, 688 F. Supp .2d at 566-67.

In addition, the undisputed evidence also shows that HRA made and transmitted the authorization notifications to DOH either with knowledge of their being in violation of the state regulatory requirements or in reckless disregard of such violations. *See supra* Point I.A. There

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<sup>13</sup> This section focuses on the City's liability for making false statements and records itself. The City also is liable under § 3729(a)(1)(B) because, as demonstrated above, *see supra* Point I, HRA caused vendors and DOH to submit false claims seeking Medicaid funds, which are themselves false records. *See Harvard College*, 323 F. Supp. 2d at 194; *see also Baker*, 709 F. Supp. 2d at 1116 n.33 (noting that similar “factual allegations concerning the false nature of the CMS 64 Forms submitted by the State comport with the Relator's allegations under § 3729(a)(1)(B)” against hospitals accused of Medicaid fraud).

