SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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THE PEOPLE OF THE STATE OF NEW YORK
by ELIOT SPITZER, Attorney General of
the State of New York,

Plaintiff,

COMPLAINT

Index No.

- against -

STATEN ISLAND UNIVERSITY HOSPITAL and
CHAPS COMMUNITY HEALTH SERVICES, INC.,

Defendants.

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Plaintiff, the People of the State of New York, by Eliot Spitzer, Attorney General of the State of New York, complaining of the above-named defendants, alleges upon information and belief, that:

Preliminary Statement

1. Staten Island University Hospital ("SIUH") defrauded New York State of millions of dollars through a sophisticated overcharging scheme, taking advantage of a Medicaid program designed to encourage medical care in underserved, usually poor, neighborhoods. To persuade medical providers to operate in underserved areas, the State Medicaid program pays a premium rate to providers who operate special satellite clinics called "part-time clinics", which provide services for fewer than 60 hours per month. SIUH operated over 500 part-time clinics through CHAPS Community Health Services, Inc. ("CHAPS"). In 1999, facing financial shortfalls because of prior regulatory violations and poor management of its costs, SIUH officers embarked on a plan to unlawfully bill the State at the premium rate for 21 CHAPS part-time clinics which were operating more than 60 hours per month, knowing full well that the hospital was only entitled to bill at the

premium rate if the part-time clinics operated for less than 60 hours per month. Indeed, SIUH officials had been warned by their own outside law firm that their conduct could turn SIUH into a "scofflaw", including the violation of laws with criminal sanctions.

2. In addition to the fraudulent billing for the 21 clinics which operated more than 60 hours per month, CHAPS also received an improperly inflated rate for every patient visit to each of the more than 500 CHAPS clinics. This inflated rate was the result of SIUH and CHAPS executives submitting inaccurate financial information to the State in a certified document used by the Medicaid program to set the reimbursement rate for services rendered at all of the CHAPS clinics. This additional misrepresentation led CHAPS to bill every patient visit at every CHAPS clinic at the improperly inflated rate and thereby cost the State additional millions of dollars.

The Parties

3. Plaintiff State of New York ("State") was at all times relevant to this action a sovereign state of the United States of America. The New York State Department of Health ("DOH") administers the New York State Medicaid Program ("Medicaid"), which pays for necessary medical services for needy persons through reimbursement of authorized Medicaid providers.

4. Defendant SIUH is a not-for-profit corporation, with its main office located at 475 Seaview Avenue, Staten Island, New York, and was at all times relevant hereto, an authorized provider of services to New York State Medicaid recipients.

5. Defendant CHAPS is a not-for-profit corporation with its principal place of business located at 360 Seaview Avenue, Staten Island, New York; SIUH is the sole member of CHAPS under New York law, with ultimate power over the organization.

Background

6. The New York State Medicaid program pays for medical assistance for certain individuals and families with low incomes and limited resources. This program, which is jointly funded by the Federal, State and local governments, but primarily administered by each state, became law in 1965. Medicaid is the largest source of funding for medical and health-related services for people with limited income. New York State expends over $44 billion per year on the New York Medicaid program.

7. SIUH is a not-for-profit corporation headquartered in Staten Island, New York. Its annual operating budget exceeds $500 million. SIUH has 785 beds and its North Division Hospital is one of the three main hospitals of the North Shore-LIJ Health System. SIUH describes itself as a "leader in the innovation of technology-based medicine" and boasts an Institute for Cancer and Blood-Related Diseases, a multi-specialty Medical Arts Pavilion, a 10-bed Regional Burn Center, a Trauma Center, a Center for Women's Health and numerous specialty programs and "patient services centers" located throughout Staten Island. SIUH is authorized by the New York State Department of Health to provide services to Medicaid patients and to submit claims to the Medicaid program to be reimbursed for such services according to Medicaid regulations.

8. From 1989 to July 2000, the President and Chief Executive Officer of SIUH was Americo "Rick" Varone. Joseph Pisani was Executive Vice President of SIUH until the end of 2000. James Walsh was an employee of SIUH later designated as Executive Director of CHAPS, and Alfred Glover was Senior Vice President of SIUH. Numerous other SIUH officers and employees also had knowledge of the violations described in this Complaint.

9. SIUH has a significant record of past Medicaid overbilling violations. In particular,

in September 1999, following an investigation by the Attorney General's office, SIUH entered into a settlement agreement with the State of New York in which it agreed to pay back $45 million to Medicaid, and to provide additional free services, for prior overbilling of Medicaid. SIUH also pledged to adhere to governing state and federal regulations, including billing regulations.

10. At the time of the Attorney General's investigation leading to the 1999 settlement, SIUH officers were concerned about the impact of the loss of their illegal revenue stream. They calculated that the hospital would lose approximately $41 million of revenue each year. CEO Rick Varone told his senior officers that the hospital was "hemorrhaging" money, and needed to increase its revenues.

11. Moreover, the hospital had entered into a number of long-term real estate contracts with an SIUH doctor ("the doctor") and his affiliates, on terms favorable to those persons. The doctor has been described in an FBI report as an associate of the Gambino crime family who has been involved in awarding contracts at SIUH to contractors controlled by organized crime. In addition, the doctor pressured other SIUH physicians to refer their patients to have testing and screening procedures done by companies affiliated with the doctor.

12. Rather than cutting excessive expenses and reforming managerial inefficiencies, the hospital embarked on additional billing and rate fraud. The activity began in 1998 (during negotiations leading to the 1999 settlement), when SIUH purchased a network of clinics owned by a diagnostic and treatment center known as CHAPS. Before being purchased, CHAPS had operated fewer than 10 clinics, primarily in Brooklyn.

13. CHAPS was, at the time, operating part-time clinics under the aegis of a special Medicaid program designed to enhance access to medical care to underserved neighborhoods and populations. A special, higher reimbursement rate was provided to operators of part-time neighborhood clinics. This type of facility had originally been "established as a separate category of service to encourage the provision of basic preventive health care in community-based settings easily accessible to the general public and to groups targeted for particular services (e.g., senior citizens)." Envisioned as entities providing limited services such as health screening or immunizations, the part-time clinics were subject to less stringent standards, were strictly limited as to hours (less than 60 per month), had a streamlined approval process, and were reimbursed for those limited hours by Medicaid at a much higher rate, sometimes nearly eight times the rate Medicaid paid physicians for the same services provided in other settings.

14. In order to take advantage of the higher reimbursement rate paid to the CHAPS clinics, SIUH immediately began placing CHAPS under its administrative and financial control, and began transferring SIUH's existing clinics into the CHAPS organization, vastly expanding the number of clinics operating under the "CHAPS" name. SIUH appointed its senior employees to run CHAPS, and had authority over virtually all aspects of the clinics' operations.

BILLING FRAUD:
"SCOFFLAW" CLINICS BILLING EXCESSIVE RATES

15. From January 1999 to March 2002, SIUH ran at least 21 clinics under the CHAPS umbrella that purported to be special part-time clinics, when, in truth, they were not. Most obviously, these 21 purportedly "part-time" clinics were all operating substantially in excess of the 60-hour monthly maximum for billing premium incentive rates. SIUH took advantage of the special financial incentives and other regulatory exemptions granted to "part-time" clinics by operating a network of medical offices that should have complied with the "part-time" clinic billing limitations, or billed Medicaid for the additional patients at the usually much lower rate paid to physicians, or invested the money and effort necessary to meet the health, safety and regulatory obligations of "full time" clinics. Instead, SIUH sought excessive compensation from Medicaid while escaping those more stringent health and safety requirements.

16. SIUH executives had been repeatedly warned that this practice was illegal. For example, in April 1998, Garfunkel, Wild & Travis, SIUH's outside law firm (hereinafter the "outside counsel") warned CEO Rick Varone in writing that at least one SIUH clinic, and perhaps more, "are still violating the 60-Hour rule of part-time clinics." The lawyers noted that "at certain locations it appears that CHS [a group of clinics] is running 50-hour per week schedules." (Emphasis in original)

17. This warning was followed up in July 1998, when the outside counsel memorialized a "detailed" voice message left for SIUH's then-general counsel Karen Gallinari. The handwritten notes report that SIUH was told that it "abs unequiv shld not continue op. in viol of p/t regs," and

was warned that the clinic could be "shut down" because "you in essence b/come a 'scofflaw.'" (Emphasis in original.)

18. In addition, the notes reflect that SIUH faced potential criminal liability. The message "refer[red]" Gallinari to specific provisions of the Public Health Law, including Section 12-b, which criminalizes regulatory violations. That section provides, in pertinent part: "A person who willfully violates . . . any regulation lawfully made . . . under authority of this chapter . . . is punishable by imprisonment not exceeding one year, or by a fine not exceeding two thousand dollars or by both." According to the notes, the message concluded that, given the ongoing Attorney General's investigation, it was not a "good idea" for SIUH to "give ammo re a pattern." (Emphasis in original.)

19. The State warned SIUH as well, and did so directly. In a November 1998 meeting attended by top SIUH executives, including Varone, as well as lawyers from SIUH's outside counsel, investigators from the Attorney General's Office warned SIUH that part-time clinic operation could not exceed 60 hours per month. In a "Power Point" presentation, after reviewing preliminary indications of such violations, the Attorney General's staff wrote unambiguously: "SIUH demonstrably on notice."

20. The State's advice was echoed by SIUH's outside counsel. In February 1999, it wrote SIUH Senior Vice President Al Glover that, as part of a "compliance template" intended to make sure that "part-time clinics are operated in a compliant manner," SIUH needed to "[e]nsure that each part-time clinic site operates less than 60 hours per month."

21. Throughout the spring of 1999, CEO Varone and other SIUH employees received information concerning deficiencies at "part-time" clinics operated by Dr. Susan Levit, a clinic operator and also one of SIUH's highest-paid doctors. In February, Glover received a memorandum

from one subordinate reporting that multiple Levit sites were "operating more than 15 hrs. a week." Another memorandum from a different subordinate reported that one supposedly "part-time" clinic was operating 60 hours per week (that clinic was also described as unclean and otherwise "non-compliant" with safety and health regulations).

22. The next month, an SIUH audit (sent to, among others, Glover and Varone) showed that another clinic was operating "approximately **84 hours per month.**" (Bold in original.) A report dated March 18, 1999, which was forwarded to CEO Varone and Executive Vice President Pisani, stated that each of the Levit clinics described in the report was operating in violation of the part-time clinic regulations.

23. At the same time these reports were coming in, outside counsel was giving additional advice to SIUH. In March 1999, a lawyer wrote a memorandum to files to memorialize a conversation with Joseph Pisani, then Executive Vice President of SIUH. The lawyer reported learning that a clinic was operating on a full-time basis and calling Pisani to tell him he had to "roll back the hours" of the clinic. The memorandum stated that, if he did not, "he jeopardizes all Medicaid billings of the [clinic]." Pisani's response was recorded: "He told me that he would not do so because he could not operate an UrgiCenter on a part-time basis even though that's what it legally is." The clinic continued to operate – and bill Medicaid – in violation of the regulations.

24. Outside counsel repeatedly advised CEO Varone that SIUH had to comply with the part-time clinic regulations and that DOH would seek to enforce compliance. Counsel advised the hospital executives that SIUH needed to inform DOH whenever a clinic operated in violation of the regulations and that the clinics could not operate beyond the 60-hour limitation unless SIUH (a) secured an operating certificate as a full time clinic through an expensive and rigorous process or (b) got approval from DOH. SIUH obtained neither.

25. The advice was not followed despite overwhelming evidence that the clinics were operating without regard to regulations. A May 15, 1999 memo to a SIUH Vice President from a SIUH administrator who inspected the clinics updated the reports on Dr. Levit's clinics, noting that multiple site visits had been made to the Levit clinics, that ongoing and multiple deficiencies were occurring, and that efforts to correct the deficiencies, which included violations of the hours of operation regulations, had not succeeded. The memo recited specific deficiencies for each of the clinics observed, indicating that all were over the part-time hours limitation, and recommended that Levit's sites "be closed or the 15 hour week schedules be enforced until [full-time standards were met]. The locations operating in temporary capacity, until 1220 Ave. P opens, should also have schedules reduced to 15 hours per week for minimal exposure."

26. That memo came to CEO Varone on May 18, 1999, with a copy to Executive Vice President Pisani. In a cover memo, one of SIUH's Vice Presidents stated that she agreed with the recommendation to "close or reduce the sites' hours to fifteen until the items on the list are corrected. . . . I do not believe that the structural adjustments can be made unless the sites are closed or the hours reduced to allow time for construction." Despite acknowledging this warning, and purporting to approve changes to the operations of the clinics, Varone and Pisani in fact did nothing to prevent the clinics from operating in excess of the part-time clinic regulations.

27. In December 1999, SIUH sent DOH a draft application (known as a "Certificate of Need" or "CON") seeking permission to convert 22 "part-time" clinics, including 14 of the clinics for which it was systematically overbilling, into full-time clinics. By submitting the draft application, SIUH was seeking DOH input before it made an official submission, as the conversion process required the clinics to meet stringent and costly health and safety requirements similar to that of a hospital, rather than the lower standards at which they currently operated. At the time it submitted the draft CON, SIUH materially failed to disclose to DOH that any of these clinics were illegally operating in excess of the 60-hour limitation and were submitting inflated reimbursement claims to Medicaid.

28. SIUH formally submitted the Certificate of Need to DOH in March 2000. Again it failed to disclose that the purported "part-time" clinics were overbilling and operating unlawfully. Moreover, the application was incomplete, as DOH informed SIUH in April 2000. SIUH never provided the additional information, and the application was never completed. SIUH continued to violate the regulations and to overbill for the services provided at the purported "part-time" clinics.

29. In June 2000, CEO Varone resigned from SIUH. From the CHAPS purchase in December 1998 to his last day on the job, SIUH/CHAPS illegally operated 21 “part-time” clinics and billed Medicaid an unlawfully excessive rate.

30. After Varone's departure, SIUH remained on notice that its clinics were operating unlawfully. In an October 2000 panel discussion attended by CHAPS officials, New York State Department of Health officials reiterated the State's firm position on the "part-time" clinics. As reported by a CHAPS official in an e-mail to SIUH's general counsel as well as senior officers Al Glover, James Walsh, and others, the providers were explicitly told: "[t]he max is 60 hours per month not 15 hours per week. There is no waiver on this."

Continued Violations and Misleading Representations

31. While continuing to overbill the State, SIUH and CHAPS executives repeatedly misled DOH. In a meeting with DOH in November 2000, CHAPS executives made a disclosure to DOH that was misleading because it omitted material information about regulatory violations. CHAPS executives told a DOH representative that a "couple" of the clinics were over the 60-hour limit, and because of the volume of patients at one of the clinics, 1250 Shakespeare Avenue in the Bronx, they would not be able to comply with the regulation at that clinic. When asked if they should close this one clinic, the DOH representative told them to keep it open for the present, and shortly thereafter told CHAPS to apply for emergency operating approval. Neither CHAPS nor SIUH ever did so. While seeking to induce DOH officials to accede to "one" violation, CHAPS failed to disclose to DOH that numerous other clinics were operating over 60 hours per month at that time.

32. In the wake of the Attorney General's renewed investigation in early 2002, SIUH made an additional disclosure, and that was – once again – misleading. In an April 24, 2002, letter to DOH from CHAPS executive director James Walsh, CHAPS informed DOH that only 12 clinics were operating illegally by exceeding the part-time hours restriction. As it had earlier, CHAPS underreported the number of clinics operating illegally. And although SIUH had been defrauding the State for years, it represented that breaching the part-time restriction was due in large part to an influx of patients "as a result of the terrorist attack on September 11, 2001."

33. The misrepresentations did not end there. In May 2003, SIUH's outside counsel made a submission to the Office of the Attorney General in an effort to persuade the State that SIUH had no liability in connection with the investigation leading to this action. Reviewed by SIUH's senior management, the submission stated that SIUH lacked notice that its actions were wrongful. It read: "Neither CHAPS nor SIUH knew, nor had reason to know or believe, that non-compliance with the 60 hour definition could lead to a claim that the services provided in excess of the hours limitation were not reimbursable, let alone to consideration of possible institutional criminal wrongdoing." As demonstrated by paragraphs 17-18 and 23 of this Complaint, this statement was not true. Outside counsel had explicitly warned SIUH management of these potential consequences. But, at the date of the May 2003 submission, State investigators did not know of these warnings because SIUH had not agreed to waive the attorney-client privilege. The privilege was later waived and the outside counsel's warning notes and memorandum were produced.

Medicaid Losses Resulting From SIUH/CHAPS Fraudulent "Part-Time Clinic" Billing

34. Each Medicaid claim is submitted pursuant to a certification in which an SIUH employee certifies that the claims are made in compliance with all applicable Medicaid regulations. As set forth above, SIUH was running at least 21 purported part-time clinics in knowing violation of the law. It had repeatedly been warned by its lawyers and the State as to the consequences of its actions, and told for years by its employees that it was acting unlawfully. It nevertheless repeatedly certified to the State that it was in full compliance with all applicable Medicaid regulations. In reliance upon those false certifications, DOH made Medicaid payments to SIUH and CHAPS, payments that were based on the high part-time rate to which SIUH was not entitled.

35. From January 1999 to March 2002, SIUH and CHAPS billed and received millions of dollars from Medicaid for the operation of the 21 medical part-time clinics that operated over 60 hours per month.

RATE SETTING FRAUD:
THE CHAPS 1999 COST REPORT

36. In addition to the 21 fraudulent "part-time" clinics, SIUH and CHAPS obtained excessive reimbursement for all of the CHAPS clinics through the submission of other false data to DOH, resulting in payment of excessive reimbursement.

37. At the time of the CHAPS purchase in December 1998, SIUH already operated over 500 part-time clinics. SIUH immediately instituted administrative changes that transferred the existing SIUH clinics to the CHAPS operation.

38. A "cost report" is a financial document submitted to DOH setting forth the expenses attributable to certain programs at a medical facility. Through a series of calculations known to participants in the Medicaid program, DOH uses this information to determine the reimbursement rate paid for Medicaid services at the facility. False information provided in a cost report can result in an artificially high reimbursement rate.

39. DOH regulations allowed CHAPS to claim on its cost report those costs paid directly by CHAPS as well as certain costs incurred by SIUH on behalf of CHAPS, such as the cost of shared administrative services, billing services and capital costs. The formula for determining how much of SIUH's capital costs could be included on the CHAPS cost report (the "capital cost formula") was based on the square footage of the facilities depreciable by CHAPS as a percentage of the total square footage of all buildings depreciable by SIUH.

40. CHAPS misreported the relevant information on its 1999 Cost Report, making the report false and misleading. The 1999 Cost Report inappropriately included, in the capital cost formula, the square footage of facilities that were not depreciable by CHAPS because they were not owned by CHAPS. In addition, CHAPS improperly double-counted the cost of some rented facilities by first claiming the rental expense as a direct cost, and then inappropriately including the square footage of these same facilities in the capital cost formula.

41. Thus, CHAPS improperly inflated the percentage of SIUH's costs that were attributable to CHAPS and thereby improperly increased the Medicaid reimbursement rate granted to CHAPS by DOH.

42. As a result of the inflated cost figures submitted to DOH, the Medicaid reimbursement rate for CHAPS was wrongly calculated for the years 1999 to 2003, resulting in overpayments by Medicaid to SIUH and CHAPS of millions of dollars.

AS AND FOR THE FIRST CAUSE OF ACTION:
FRAUDULENT BUSINESS PRACTICE – EXECUTIVE LAW §63(12)

43. The State repeats and realleges the foregoing paragraphs of this Complaint as if fully set forth herein.

44. The acts and practices alleged herein constitute conduct proscribed by §63(12) of the Executive Law, in that defendants engaged in repeated fraudulent or illegal acts or otherwise demonstrated persistent fraud or illegality in the carrying on, conducting or transaction of business.

AS AND FOR THE SECOND CAUSE OF ACTION:
FRAUD AND INTENTIONAL MISPRESENTATION

45. The State repeats and realleges the foregoing paragraphs of this Complaint as if fully set forth herein.

46. In reliance upon the claims submitted by SIUH and CHAPS, through the actions and omissions of their senior managers, for the activities described above with respect to the 21 SIUH/CHAPS clinics fraudulently billing at the part-time clinic rate, Medicaid overpaid SIUH and CHAPS an amount to be determined.

47. By reason of the foregoing, the State is entitled to recover of defendants an amount yet to be determined in compensatory damages and is also entitled to recover exemplary damages, plus interest at the highest legal rate.

AS AND FOR THE THIRD CAUSE OF ACTION:
UNJUST ENRICHMENT

48. The State repeats and realleges the foregoing paragraphs of this Complaint as if fully set forth herein.

49. SIUH and CHAPS were not entitled to submit claims to Medicaid and receive payment for services in violation of Medicaid program regulations, including the part-time clinic regulations and the Cost Report instructions.

50. By reason of the foregoing, defendants have been unjustly enriched to the detriment of the State and are liable to the State in an amount to be determined.

AS AND FOR THE FOURTH CAUSE OF ACTION:
OVERPAYMENT OF PUBLIC FUNDS

51. The State repeats and realleges the foregoing paragraphs of this Complaint as if fully set forth herein.

52. The acts and practices of all defendants complained of herein constitute a misappropriation of public property by the defendants, in violation of Executive Law § 63-C.

53. By reason of the foregoing, the State is entitled to restitution in an amount to be determined from defendants.

AS AND FOR THE FIFTH CAUSE OF ACTION:
MONIES HAD AND RECEIVED

54. The State repeats and realleges the foregoing paragraphs of this Complaint as if fully set forth herein.

55. Defendants were not entitled to bill Medicaid for reimbursement at any rates other than the appropriate rates set by Medicaid rules and regulations. Accordingly, defendants were not entitled to receive payment for Medicaid services that were not properly billable.

56. By reason of the foregoing, defendants have damaged the State in an amount to be determined, and are liable to the State therefore.

AS AND FOR THE SIXTH CAUSE OF ACTION:
RECOVERY OF STATUTORY DAMAGES
WITH RESPECT TO THE PART-TIME CLINIC OVERPAYMENTS
PURSUANT TO SOCIAL SERVICES LAW §145-b

57. The State repeats and realleges the foregoing paragraphs of this Complaint as if fully set forth herein.

58. During the periods of time described in this Complaint, defendants knowingly by means of false statements or representations, or by deliberate concealment of material facts or by other fraudulent schemes or devices, obtained payment for themselves and others in an amount to be determined, for services purportedly furnished pursuant to the laws of the State of New York, including the Social Services Law, the Medicaid Program Regulations and the Medicaid part-time clinic regulations.

59. By reason of the foregoing, defendants are liable to the State pursuant to Social Services Law § 145-b for three times the amounts falsely overstated, plus interest at the highest legal rate.

WHEREFORE, the State demands judgment.

I. Under the First Cause of Action, the State demands judgment enjoining and restraining defendants, their affiliates, assignees, subsidiaries, successors and transferees, officers, directors, partners, agents and employees, and all other persons acting or claiming to act on their behalf or in concert with them, from engaging in any conduct, conspiracy, contract, agreement, arrangement or combination, and from adopting or following any practice, plan, program, scheme, artifice or device similar to, or having a purpose and effect similar to, the conduct complained of above, and damages in an amount to be determined; and

II. Under the Second Cause of Action, the State demands judgment against defendants in an amount to be determined plus exemplary damages; and

III. Under the Third, Fourth, and Fifth Causes of Action, the State demands judgment against defendants in an amount to be determined; and

IV. Under the Sixth Cause of Action, the State demands judgment against defendants in an amount to be determined, including actual and statutory treble damages; and

V. Under all Causes of Action, the State also demands:

A. Interest from the date of defendants' receipt of the overpayments, as provided in Social Services Law § 145-b;

B. The costs and disbursements of this action;

C. Attorney's fees; and

D. Such other and further relief as this Court deems just and reasonable.

Dated: New York, New York
May 17, 2005

ELIOT SPITZER
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By:_____

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