UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

ROBERT P. KANE,
By and on Behalf of the United States of America,
Relator,

State of New York, *ex rel.*
Robert P. Kane, Relator,

State of New Jersey, *ex rel.*
Robert P. Kane, Relator,

– against –

HEALTHFIRST, INC., *et al.*,

Defendants.

STATE OF NEW YORK and UNITED STATES OF AMERICA,

Plaintiff-Intervenors,

– against –

CONTINUUM HEALTH PARTNERS, INC.; BETH ISRAEL MEDICAL CENTER d/b/a MOUNT SINAI BETH ISRAEL; ST. LUKE'S-ROOSEVELT HOSPITAL CENTER d/b/a MOUNT SINAI ST. LUKE'S and MOUNT SINAI ROOSEVELT,

Defendants.

OPINION AND ORDER

11 Civ. 2325 (ER)

Ramos, D.J.:

Relator Robert P. Kane ("Kane" or the "Relator") filed this case in 2011 as a *qui tam* action under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729 *et seq.*, and related state laws.[1]

[1] Pursuant to the False Claims Act ("FCA") and New York False Claims Act ("NYFCA"), a private citizen, known as a "relator," with personal knowledge of fraud may file a *qui tam* action, in which he brings suit for himself and for the government and/or state in exchange for a share of the damages if the suit prevails. *See* 31 U.S.C. § 3730(b); N.Y. State Fin. Law § 189; *see also U.S. ex rel. Taylor v. Gabelli*, 345 F. Supp. 2d 313, 327 (S.D.N.Y. 2004)

In 2014, after investigating Kane's allegations, the United States Government (the "United States" or "Government") and the State of New York ("New York") elected to intervene as plaintiffs against three of the defendants named in Kane's Complaint. Presently before the Court are those defendants' motions to dismiss the United States' and New York's Complaints-in-Intervention, Docs. 20, 21, pursuant to Rules 9(b) and 12(b)(6) of the Federal Rules of Civil Procedure. Docs. 54, 52. For the following reasons, both motions are DENIED.

I. BACKGROUND

A. Factual Background[2]

This action stems from a software glitch on the part of Healthfirst, Inc. ("Healthfirst"), a private, non-profit insurance program, which caused three New York City hospitals to submit improper claims seeking reimbursement from Medicaid[3] for services rendered to beneficiaries of a managed care program administered by Healthfirst. Gov't Compl. (Doc. 20) ¶¶ 3-4, 20, 31-32. The hospitals—Beth Israel Medical Center d/b/a Mount Sinai Beth Israel ("Beth Israel"), St. Luke's-Roosevelt Hospital Center d/b/a Mount Sinai St. Luke's and Mount Sinai Roosevelt

(quoting *United States ex rel. Lamers v. City of Green Bay*, 168 F.3d 1013, 1016 (7th Cir. 1999)). Once a *qui tam* action has been initiated, it is the Government's prerogative either to intervene in and prosecute the case or to decline to intervene, thereby permitting the relator to proceed alone. *See id.*

[2] The "Facts" sections of the Complaints filed by the United States and New York are virtually, if not completely, identical, although their paragraph numbering does not perfectly overlap. *See* Gov't Compl. (Doc. 20) ¶¶ 16-39; New York Compl. (Doc. 21) ¶¶ 19-42. For clarity, the Court includes citations only to the United States' Complaint.

[3] In 1965, pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, Medicaid was established as a joint federal and state program to provide financial assistance for medical care to individuals with low incomes. Gov't Compl. ¶ 16. "Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates and program administration in accordance with certain federal statutory and regulatory requirements. The state pays the health care providers for services rendered to Medicaid recipients, with the state obtaining the federal share of the Medicaid payment from accounts that draw on the United States Treasury." *Id.* (quoting 42 C.F.R. §§ 430.0–30). New York's Medicaid system, which is administered by the State Department of Health ("DOH"), was created by the State Legislature in 1966. *Id.* ¶ 17 (citing N.Y. Pub. Health Law § 201(1)(v)).

("SLR"), and Long Island College Hospital ("LICH" and, collectively, the "Hospitals")[4]—all belonged to a network of non-profit hospitals operated and coordinated by Continuum Health Partners, Inc. ("Continuum"). *Id.* ¶ 3.[5] All three Hospitals were also members of the Healthfirst hospital network and provided care to numerous patients enrolled in Healthfirst's Medicaid managed-care plan. *Id.* ¶ 5.

Pursuant to a contract entered into by Healthfirst and the New York State Department of Health ("DOH") on October 1, 2005, Healthfirst provides certain "Covered Services," including hospital and physician services, to its Medicaid-eligible enrollees in exchange for a monthly payment from DOH. *Id.* ¶ 21.[6] Healthfirst's reimbursement for the Covered Services is limited to that monthly fee; it may *not* otherwise bill DOH on a "fee-for service" or other basis. *Id.* All doctors, hospitals, and providers that participate in the Healthfirst network must agree that the payment they receive from Healthfirst for Covered Services rendered to Healthfirst's Medicaid enrollees will constitute payment in full for those services, except for co-payments that may be

[4] LICH, although named as a defendant in Kane's initial Complaint, is not named in the Intervenor-Complaints filed by the Government and New York. *See* Docs. 20, 21. Moreover, on July 15, 2014, Kane filed a Notice of Voluntary Dismissal pursuant to Rule 41(a) of the Federal Rules of Civil Procedure, dismissing LICH and the other hospitals—besides Beth Israel and SLR—from the action. *See* Doc. 33.

[5] Continuum is a not-for-profit corporation that, at all relevant times, was a member of various not-for-profit hospitals, including the Hospitals named in this action. Gov't Compl. ¶ 13. In September 2013, Continuum and the Mount Sinai Hospital System merged certain aspects of the two hospital systems, bringing Beth Israel and SLR under the auspices of the newly created Mount Sinai Hospitals Group, Inc. ("Mount Sinai Hospitals Group") the sole member of each. *Id.*

[6] Pursuant to the Social Security Act, states may use managed-care organizations ("MCOs") to deliver Medicaid benefits and may require that individuals enroll with an MCO as a condition of receiving those benefits. *Id.* ¶ 18 (citing 42 U.S.C. § 1396u–2(a)(1)(A)). New York established a "managed care program," known as the Medicaid Managed Care ("MMC") Program, in Article 5 Title 11 of its Social Services Law. *Id.* (citing N.Y. Soc. Serv. Law § 364–j). Additionally, pursuant to Article 44 of the New York Public Health Law, DOH is authorized to certify Health Maintenance Organizations ("HMOs") to operate as MCOs within the State, with their operation and structure governed by State law. *Id.* ¶¶ 18-19 (citing N.Y. Pub. Health Law. § 4400 *et seq.*; N.Y. Comp. Codes R. & Regs. tit. 10, pt. 98). The DOH also authorizes Prepaid Health Services Plans ("PHSPs"), special-purpose New York HMOs in which a "substantial portion" of enrollees must be beneficiaries of government healthcare programs like Medicaid. *Id.* ¶ 19 (citing N.Y. Comp. Codes R. & Regs. tit. 10, pt. 98-1.1, 9.8-1.2(ff); N.Y. Pub. Health Law § 4403–a(1)).

collected from enrollees where applicable. *Id.* Healthfirst contracts with such providers ("Participating Providers") and pays them for the Covered Services they render to Healthfirst's Medicaid-eligible enrollees; in turn, Healthfirst is compensated through DOH's monthly payments. *Id.*

The error giving rise to the instant controversy relates to electronic remittances, issued by Healthfirst to its Participating Providers, which indicated the amount of any payment due for services rendered by the provider. *Id.* ¶ 30. These remittance statements also contained "codes" that signaled whether a provider could seek additional payment from secondary payors in addition to Healthfirst, such as Medicaid, other insurance carriers, or patients themselves. *Id.* The remittances submitted by Healthfirst for Covered Services rendered to its Medicaid-eligible enrollees should have contained codes informing providers that they could *not* seek secondary payment for such services, with the limited exception of co-payments from certain patients. *Id.*

Beginning in 2009, however, due to a software glitch, Healthfirst's remittances to Participating Providers erroneously indicated that they *could* seek additional payment for Covered Services from secondary payors. *Id.* ¶ 31. Consequently, electronic billing programs used by numerous Participating Providers automatically generated and submitted bills to secondary payors, including Medicaid. *Id.* Starting in or around January 2009, Continuum submitted claims to DOH on behalf of the Hospitals seeking additional payment for Covered Services rendered to Healthfirst enrollees, and DOH mistakenly paid the Hospitals for many of those improper claims. *Id.* ¶ 32.

In September 2010, auditors from the New York State Comptroller's office (the "Comptroller") approached Continuum with questions regarding the incorrect billing. *Id.* ¶ 33. Eventually, discussions among the Comptroller, Continuum, and the software vendor revealed

that the problem occurred when the codes used in Healthfirst's billing software were "translated" to codes used in Continuum's billing software. *Id.* On December 13, 2010, approximately two years after the problem first arose, the vendor provided a corrective software patch designed to prevent Continuum and other providers from improperly billing secondary payors like Medicaid for services provided to Healthfirst enrollees, along with an explanatory memorandum. *Id.* After the problem was discovered, Continuum tasked its employee, Relator Kane, with ascertaining which claims had been improperly billed to Medicaid. *Id.* ¶ 34. In late 2010 and early 2011, Kane and other Continuum employees reviewed Continuum's billing data in an effort to comprehensively "identify" all claims potentially affected by the software glitch. *Id.* In January 2011, the Comptroller alerted Continuum to several additional claims for which Continuum had billed Medicaid as a secondary payor. *Id.*

On February 4, 2011, approximately five months after the Comptroller first informed Continuum about the glitch, Kane sent an email to several members of Continuum's management, attaching a spreadsheet that contained more than 900 Beth Israel, SLR, and LICH claims—totaling over $1 million—that Kane had identified as containing the erroneous billing code. *Id.* ¶ 35. His email indicated that further analysis would be needed to confirm his findings and stated that the spreadsheet gave "some insight to the magnitude of the issue." *Id.*, Ex. B. There is no dispute that Kane's spreadsheet was overly inclusive, in that approximately half of the claims listed therein were never actually overpaid; nor is there any dispute that the spreadsheet correctly included "the vast majority of the claims that had been erroneously billed."

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