IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
ABINGDON DIVISION

UNITED STATES OF AMERICA, and COMMONWEALTH OF VIRGINIA, *ex rel.* Megan L. Johnson, Leslie L. Webb, and Kimberly Stafford-Payne,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 1:07-CV-000054
UNIVERSAL HEALTH SERVICES, INC., KEYSTONE EDUCATION AND YOUTH SERVICES, LLC, and KEYSTONE MARION, LLC, d/b/a MARION YOUTH CENTER	)	
Defendants.	)	

COMPLAINT

The United States of America and the Commonwealth of Virginia (the "Commonwealth") bring this action against Defendants Universal Health Services, Inc., ("UHS"), Keystone Education and Youth Services, LLC, ("Keystone Education"), and Keystone Marion, LLC, d/b/a Keystone Marion Youth Center ("KMYC"), to recover federal and state losses sustained by the Virginia Medical Assistance Program ("VMAP"), also known as Medicaid.

Beginning as early as approximately October 2005, and continuing until approximately the date of this Complaint, Defendants operated, or supervised the operation of, KMYC, a facility located at 225 Main Street, Marion, Virginia, that was licensed to operate as a Level C residential treatment facility to provide inpatient psychiatric services for patients under the age of 21. During this time, Defendants knowingly presented false and/or fraudulent claims for payment or approval, and/or made or used false records or statements material to false or

fraudulent claims for children who were Medicaid recipients ("Medicaid children") admitted to KMYC. Defendants' false or fraudulent claims and/or records or statements included representations that they provided inpatient psychiatric services to Medicaid children confined at KMYC in compliance with Federal and state regulations, when Defendants, in fact, operated, or caused the operation of, KMYC as a juvenile detention facility and failed to comply with the regulations.

Defendants violated provisions of the False Claims Act ("FCA"), 31 U.S.C. § 3729(a)(1), by knowingly presenting, or causing to be presented, false or fraudulent claims for payment or approval to an officer or employee of the United States Government and/or to the Virginia Department of Medical Assistance Services ("DMAS"), the legally designated state agency for the administration of Medicaid. Defendants also violated 31 U.S.C. § 3729(a)(1)(B),[1] by knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims. As a result, the United States and the Commonwealth of Virginia suffered damages and Defendants were unjustly enriched.

NATURE OF ACTION

1. The United States brings this action to recover treble damages and civil penalties under the FCA, 31 U.S.C. §§ 3729-33. The Commonwealth brings this action to recover damages and civil penalties under the Virginia Fraud Against Taxpayers Act ("VFATA"), Va.

[1] Public Law 111-21, the Fraud Enforcement and Recovery Act of 2009 ("FERA"), enacted May 20, 2009, amended 31 U.S.C. § 3729(a)(1)(B), formerly 31 U.S.C. § 3729(a)(2). FERA § 4(f) provided "[t]he amendments made by this section shall take effect on the date of enactment of the Act and shall apply to conduct on or after the date of enactment, except that (1) subparagraph (B) of section 3729(a)(1), as added by subsection (a)(1), shall take effect as if enacted on June 7, 2008, and apply to all claims under the False Claims Act (31 U.S.C. 3729, *et seq.*) that are pending on or after that date . . . ." Accordingly, FERA applies to the § 3729(a)(1)(B) claim, while the prior statute applies to the § 3729(a)(1) claim.

Code Ann. §§ 8.01-216.3(A)(1) and (2), and the Virginia Fraud Statute, Va. Code Ann. § 32.1 – 312(A)(1) and (2). The United States and the Commonwealth also seek the recovery of damages and other monetary relief under the common law or equitable theory of unjust enrichment.

2. The bases for this action are:

a. Defendants knowingly presented, or caused to be presented, to an officer or employee of the United States Government, false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1), and/or knowingly made, used, or caused to be made or used, false records or statements material to a false or fraudulent claim, in violation of 31 U.S.C. § 3729(a)(1)(B);

b. Defendants knowingly presented, or caused to be presented, to DMAS and VMAP, false or fraudulent claims for payment, in violation of Va. Code Ann. § 8.01-216.3(A)(1), and/or knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by DMAS, in violation of Va. Code Ann. § 8.01-216.3(A)(2);

c. Defendants obtained or attempted to obtain benefits or payments from DMAS by willfully making false statements, and by willfully misrepresenting or concealing material facts in false or fraudulent claims presented to DMAS, or in records or statements made, used, or caused to be made or used to obtain prior authorization for claims presented to DMAS, in violation of Va. Code Ann. § 32.1-312(A)(1) and (2); and

d. Defendants were unjustly enriched by retaining Medicaid funds paid for services not provided as claimed, to the detriment of the United States and the Commonwealth.

JURISDICTION AND VENUE

3. This Court has subject matter jurisdiction over the claim of the United States pursuant to 28 U.S.C. §§ 1331 and 1345, and 31 U.S.C. § 3732(a). This Court has supplemental jurisdiction to entertain the claims of the Commonwealth of Virginia pursuant to 28 U.S.C. § 1367(a) and 31 U.S.C. § 3732(b). This Court has supplemental jurisdiction to entertain the common law or equitable cause of action pursuant to 28 U.S.C. § 1367(a).

4. This Court has venue over these claims under 31 U.S.C. § 3732 and 28 U.S.C. §§ 1391(b) and (c), in that Defendants transacted business, or the acts underlying this action occurred, in the Western District of Virginia.

THE PARTIES

5. Plaintiffs are the United States on behalf of its agencies or instrumentalities including the Department of Health and Human Services and the Center for Medicaid Services, and the Commonwealth of Virginia, on behalf of DMAS.

6. Relators Megan L. Johnson, Leslie L. Webb, and Kimberly Stafford-Payne were employed as unlicensed therapists at KMYC.

7. Defendant UHS is a Delaware corporation headquartered in King of Prussia, Pennsylvania, and is self-described as "one of the largest investor-owned healthcare management companies." UHS purchased Defendants Keystone Education and Keystone Marion, LLC, d/b/a KMYC, in approximately October 2005.

8. Defendant Keystone Education is a Tennessee corporation headquartered in Nashville, Tennessee, is a subsidiary of UHS, and supervised the day-to-day operations of KMYC.

STATUTES AND REGULATIONS

The Medicaid Program

9. The Medicaid Program, as enacted by Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396, *et seq*., is a joint federal-state program that provides health care benefits for certain groups, primarily indigent and disabled individuals. The federal Medicaid statute establishes the minimum requirements for state Medicaid programs to qualify for federal funding. 42 U.S.C. § 1396a.

10. The federal portion of each state's Medicaid payments, known as the Federal Medical Assistance Percentage ("FMAP"), is based on a state's per capita income compared to the national average. 42 U.S.C. § 1396d(b). During all relevant times, the FMAP for the Commonwealth of Virginia was approximately 50 percent.

11. The Medicaid statute requires each participating state to implement and administer a state plan for medical assistance services which contains certain specified minimum criteria for coverage and payment of claims. 42 U.S.C. §§ 1396, 1396a(a)(13), 1396a(a)(30)(A).

Federal Regulations for Inpatient Psychiatric Services

12. 42 C.F.R. § 441, Subpart D, imposes specific requirements for inpatient psychiatric services provided to children covered by Medicaid ("Medicaid children"). These regulations require, among other things, that:

a. Inpatient psychiatric services for children must be "provided under the direction of a physician." 42 C.F.R. § 441.151(a)(1);

b. Inpatient psychiatric services "must involve 'active treatment,' which means implementation of a professionally developed and supervised individual plan of care, described in § 441.155 . . . ." 42 C.F.R. § 441.154;

c. The individual plan of care must –

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;

(2) Be developed by a team of professionals specified under § 441.156 in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge;

(3) State treatment objectives;

(4) Prescribe an integrated program of therapies, activities, and experiences designed to meet the [treatment] objectives; and

(5) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.

42 C.F.R. § 441.155(b).

d. The individual plan of care must be reviewed every 30 days by a team specified in § 441.156 to:

(1) Determine that services being provided are or were required on an inpatient basis, and

(2) Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

42 C.F.R. § 441.155(c).

e. The team developing, reviewing, and updating the individual plan of care must include, as a minimum, either –

(1) A Board-eligible or Board-certified psychiatrist;

(2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

> (3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

42 C.F.R. § 441.156(c).

State Regulations and the DMAS
Psychiatric Services Provider Manual

13. The Commonwealth's regulations provided that:

> A. Residential treatment programs (Level C) shall be 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address the special mental health and behavioral needs of a child or adolescent in order to prevent or minimize the need for more intensive inpatient treatment. Services must include, but shall not be limited to, assessment and evaluation, medical treatment (including drugs), individual and group counseling, and family therapy necessary to treat the child.
>
> B. Residential treatment programs (Level C) shall provide a total, 24 hours per day, specialized form of highly organized, intensive and planned therapeutic interventions that shall be utilized to treat some of the most severe mental, emotional, and behavioral disorders. Residential treatment is a definitive therapeutic modality designed to deliver specified results for a defined group of problems for children or adolescents for whom outpatient day treatment or other less intrusive levels of care are not appropriate, and for whom a protected, structured milieu is medically necessary for an extended period of time.
>
> * * *
>
> D. Active treatment shall be required. Residential Treatment, Therapeutic Behavioral and Community-Based Services for Children and Adolescents under age 21 shall be designed to serve the mental health needs of children. In order to be reimbursed for Residential Treatment (Level C)... the facility must provide active mental health treatment beginning at admission and it must be related to the recipient's principle diagnosis and admitting symptoms. To the extent that any recipient needs mental health treatment and his needs meet the medical necessity criteria for the service, he will be approved for these services. These services do not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care,

habilitation or academic educational needs of the recipients.

12 VAC 30-130-860.

14. DMAS, under its legal authority to administer Medicaid, issued the Psychiatric Services Provider Manual ("PSPM"), setting forth the covered services, limitations, and requirements for providers of inpatient psychiatric services.

a. The PSPM set forth the following requirements for the plan of care at admission:

> In accordance with federal requirements (42 CFR § 441.156), the team must establish a written Plan of Care at admission, which must be signed and dated by the attending or staff physician, indicating the physician has examined the child and approved the plan. The plan must include:
>
> - The diagnosis, symptoms, and complaints indicating the need for admission;
> - A description of the functional level of the recipient;
> - Recipient-specific treatment objectives with short- and long-term goals;
> - Orders for medications, treatments, therapies, etc.;
> - Plans for continuing care, including review of the Plan of Care;
> - Prognosis; and
> - Discharge plans.

PSPM, Ch. IV, at p. 4-5 (2004); PSPM, Ch. IV, at p. 4 (2007).

c. The PSPM set forth the following requirements for the Comprehensive Individual Plan of Care ("CIPOC"):

> The Comprehensive Individual Plan of Care (CIPOC) is a written plan developed for each recipient. The [CIPOC] must be completed no later than 14 days after admission for residential

treatment; the CIPOC must be completed before requesting continued stay. The [CIPOC] must:

- Be based on diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for inpatient care;

- Be developed by a team of professionals in consultation with the recipient, and the recipient's parents, legal guardians, or others in whose care the recipient will be released after discharge;

- State recipient-specific treatment objectives with measurable short- and long-term goals with target dates for achievement;

- Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and

- Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to achieve the recipient's discharge from inpatient status at the earliest possible time and ensure continuity of care with the recipient's family, school, and community upon discharge.

PSPM, Ch. IV, at p. 5 (2004); PSPM, Ch. IV, at p. 4-5 (2007).

d. The PSPM imposed the following requirements for inpatient psychiatric services:

> The provider is expected to aggressively treat individuals with a full range of therapies and educational and recreational activities. For residential treatment, all of the services must be provided at the facility as part of the therapeutic milieu. This includes medication management, psychotherapy, and an appropriate school program. Medicaid reimbursement for inpatient psychiatric services will not be available for inpatient stays during which active treatment, according to the goals and objectives related to the individual's diagnostic needs, is not provided . . . .

PSPM, Ch. IV, at p. 6 (2004); PSPM, Ch. IV, at p. 5 (2007).

e. The PSPM defined "active treatment" to mean "implementation of a professionally developed and supervised individual plan of care."

PSPM, Ch. IV, at p. 13 (2004); PSPM, Ch. IV, at p. 10 (2007).

f. The PSPM specified that:

> The active treatment plan must relate to the admission diagnosis and reflect *all of the following*:
>
> (a) A licensed professional (psychiatrist, clinical psychologist, licensed clinical social worker, licensed professional counselors, or clinical nurse specialist-psychiatric with education and experience with children and adolescents) provides individual therapy three out of seven days;
>
> (b) A minimum of 21 distinct sessions (excluding individual treatment, school attendance, and family therapy) of appropriate treatment interventions are provided each week (i.e., group therapy, with specific topics focused to patient needs; insight-oriented and/or behavior modifying). Play/art/music therapy, occupational therapy, and physical therapy may be included; however; these modalities of treatment must not be the major treatment modality;
>
> * * *
>
> (d) Active treatment and comprehensive discharge planning for aftercare placement and treatment must begin at admission.

PSPM, Ch. IV, at p. 15 (2004); PSPM, Ch. IV, at p. 12 (2007) (emphasis in original).

g. The PSPM set forth the "Residential Treatment Continuing Stay Criteria" to include:

> B. Intensity of Treatment: *All of the following services must be provided in order to meet continuing stay criteria:*
>
> 1. The multidisciplinary recipient-specific treatment plan must be updated every thirty (30) days. It must include recipient-specific long- and short-term goals, measurable objectives, and interventions with time frames for achievement; the treatment plan must be revised to

address goals achieved, unresolved problems, and any new problems which have arisen;

2. Services must continue to require the supervision of a physician; and

3. Integrated program of therapies including milieu therapy, activities, and experiences designed to meet the treatment objectives; active provision of interventions including individual, group, and, if applicable, family therapy as required . . . above.

PSPM, Ch. IV, at p. 16 (2004); PSPM, Ch. IV, at pp. 13-14 (2007) (emphasis in original).[2]

The "Prior Authorization" Requirement

15. DMAS requires providers of inpatient psychiatric services to obtain prior authorization from a DMAS contractor to admit or continue the admission of a Medicaid child to a residential treatment facility. Providers are generally required to obtain prior authorization before presenting and/or receiving payment for a Medicaid claim. DMAS requires that an initial request for prior authorization include the initial plan of care, treatment goals and objectives, treatment intervention provided, and discharge planning (including the estimated length of stay). PSPM, Ch. IV, at p. 8 (2004); PSPM, App. C, at p. 5 (2007). DMAS requires that prior authorization for continued stays for inpatient psychiatric services include the CIPOC or the most recent CIPOC 30-day progress update. The DMAS contractor, West Virginia Medical Institute ("WVMI") or KePRO, respectively, generally grants prior authorization for continued stays of 30, 60, or 90 days.

[2] The 2007 PSPM added a new paragraph 2 (not cited), and renumbered previous paragraphs 2 and 3 to paragraphs 3 and 4.

16. To obtain prior authorization for the continued stay of each Medicaid child at a residential treatment facility, providers are required to demonstrate compliance with the continuing stay criteria, including treatment planning and intensity of treatment, set forth in the PSPM. PSPM, Ch. IV, at p. 16 (2004); PSPM Ch. IV, at pp. 13-14 and App. C, at p. 6 (2007).

The False Claims Act

17. The FCA imposes civil liability against:

> (a) . . . Any person who—(1) Knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval . . . .

31 U.S.C. § 3729(a)(1). The FCA, as amended by FERA, also imposes civil liability against:

> (a)(1) . . . any person who—. . . (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.

31 U.S.C. § 3729(a)(1)(B).

18. A person who violates these FCA provisions is "liable to the United States Government for a civil penalty of not less than $5,500 and not more than $11,000,[3] plus 3 times the amount of damages which the Government sustains because of the act of that person . . . ."

19. The FCA defines "knowing" or "knowingly" as follows:

> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information—(1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard for the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729(b).

[3] The amounts were increased by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. § 2461 note; Public Law 104-410), for violations occurring on or after September 29, 1999.

The Virginia Fraud Against Taxpayers Act

20. The VFATA tracks the language of the FCA, except for the changes made by FERA, and provides, in part, that:

> A. Any person who:
>
> 1. Knowingly presents, or causes to be presented, to an officer or employee of the Commonwealth a false or fraudulent claim for payment or approval;
>
> 2. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Commonwealth;
>
> . . . shall be liable to the Commonwealth for a civil penalty of not less than $5,500 and not more than $11,000, plus three times the amount of damages sustained by the Commonwealth.

Va. Code Ann. § 8.01-216.3. For violations occurring prior to July 1, 2007, the civil penalties are not less than $5,000 and not more than $10,000.

21. The VFATA's definition of "knowing" and "knowingly" is identical to that of the FCA. Va. Code Ann. § 8.01-216.3(C).

The Virginia Fraud Statute

22. The Virginia Fraud Statute provides, in part, that:

> A. No person, agency or institution, . . . shall obtain or attempt to obtain benefits or payments where the Commonwealth directly or indirectly provides any portion of the benefits or payments pursuant to the Plan for Medical Assistance and any amendments thereto as provided for in § 32.1-325, hereafter referred to as "medical assistance" in a greater amount than that to which entitled by means of:
>
> 1. A willfull false statement;
>
> 2. By willful misrepresentation, or by willful concealment of any material facts. . . .

> B. Any person, agency or institution knowingly violating any of the provisions of subsection A of this section shall be liable for repayment of any excess benefits or payments received, plus interest on the amount of the excess benefits or payments at the rate of 1 1/2 percent each month for the period from the date upon which payment was made to the date upon which repayment is made to the Commonwealth. Such person, agency or institution, in addition to any other penalties provided by law, shall be subject to civil penalties.

Va. Code Ann. § 32.1 – 312.

FACTUAL ALLEGATIONS

The Fraud Scheme

23. Defendants implemented a scheme to defraud the United States and the Commonwealth by knowingly presenting false or fraudulent claims, and/or making false fraudulent records or statements material to false or fraudulent claims, that represented that they operated KMYC as a residential treatment facility providing inpatient psychiatric services to children, when in fact they operated KMYC as a juvenile detention facility. The fraud scheme included the following acts.

a. Defendants represented that they provided inpatient psychiatric services to Medicaid children under the direction of the facility's medical director, a licensed psychiatrist, when in fact neither the medical director nor any other licensed psychiatrist or physician provided the required direction.

b. Defendants represented that a team of professionals that included the medical director developed the treatment plan and CIPOC for each Medicaid child, when in fact neither the medical director nor any other licensed psychiatrist or physician participated on the team or provided substantive direction in the development of the CIPOCs.

c. Defendants represented that a team of professionals that included the medical director reviewed the CIPOC of each Medicaid child every thirty days, when in fact neither the medical director nor any other licensed psychiatrist or physician participated on the team or provided a substantive review of the CIPOCs.

d. Defendants represented that the CIPOC and 30-day updates for each Medicaid child were based on a diagnostic evaluation that included examination of the medical, psychological, social, behavioral and developmental aspects of the child's situation, when in fact the CIPOCs and 30-day updates were general, standardized, rote language that were not based on the required aspects of each Medicaid child's situation.

e. Defendants represented that KMYC provided active treatment to each Medicaid child that consisted of an integrated program of therapies, activities, and experiences designed to meet the treatment objectives prescribed in the CIPOC and 30-day updates, when in fact Defendants failed to provide the required therapeutic programs and instead provided the program of a juvenile detention facility.

24. Defendants used these false records or statements to obtain prior authorization from WVMI and KePRO, respectively, for the continued confinement of Medicaid children at KMYC and to justify the presentation of claims to DMAS that falsely or fraudulently billed such confinement as "inpatient psychiatric services."

Defendants Did Not Provide Inpatient Psychiatric Services

25. Beginning as early as approximately October 2005, and continuing until approximately the date of this Complaint, Defendants did not provide inpatient psychiatric services to Medicaid children confined to KMYC. Instead of treatment planning and "active

treatment" as required by Federal and state law, Defendants provided the program of a juvenile detention facility, as evidenced by the following acts.

a. KMYC's program was not conducted under the direction of a physician as required by 42 C.F.R. § 441.151(a)(1). Although a licensed psychiatrist held the title of medical director, he did not provide direction or supervision in planning, implementing, or supervising inpatient psychiatric services as required by Federal and state law. He did little more than manage medication and sign documents presented to him to make it appear that he was providing the required direction or supervision.

b. Treatment plans were not developed by a treatment team that included (1) a Board-eligible or Board-certified psychiatrist, (2) a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy, or (3) a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology, or who has been certified by the State or by the State psychological association, as required by 42 C.F.R. § 441.156(c). Instead, Defendants caused licensed and unlicensed therapists, utilization review personnel, and other untrained and non-professional employees to prepare treatment plans, CIPOCs, and/or 30-day updates without direction or supervision from the medical director or any other licensed psychiatrist or physician.

c. Treatment plans did not provide an integrated program of therapies, activities, and experiences designed to meet the treatment objectives of each Medicaid child as required by 42 C.F.R. § 441.155(b)(4). The treatment plans, CIPOCs, and/or 30-day updates were copied, standardized, rote forms that were not individualized therapies,

activities, and experiences designed to meet the treatment objectives of each Medicaid child.

d. Active treatment consisting of programs of therapies, activities, and experiences designed to meet treatment objectives of each Medicaid child was not provided as required by 42 C.F.R. § 441.154. Instead, Defendants operated KMYC as a juvenile detention facility and routinely provided, among other things:

(1) Unstructured, non-therapeutic activities such as watching television, playing video games, and playing "pick-up" basketball games;

(2) "Group therapy" sessions conducted for nominal periods of time or not conducted at all, that were documented as full sessions of thirty minutes or more;

(3) "Individual therapy," also known as "drive-by" therapy, consisting of five-minute interactions in a hallway or public room that were documented as thirty-minute therapy sessions;

(4) "Therapy" sessions conducted by unlicensed therapists without supervision by a licensed practitioner;

(5) Substantial periods of time during which Medicaid children were not treated by a psychiatrist or therapist; and

(6) "Provoking" or "escalating" Medicaid children to cause behaviors to justify extending their stays solely to increase Medicaid billings and payments.

False or Fraudulent Records or Statements

26. Beginning as early as approximately October 2005, and continuing until approximately the date of this Complaint, Defendants made, used, or caused to be made or used, false records or statements to make it appear that KMYC was providing Medicaid children with inpatient psychiatric services in compliance with Federal and state regulations when, in fact, they operated KMYC as a juvenile detention facility. The false records or statements included:

a. Treatment plans, CIPOCs, and/or 30-day updates that falsely represented that KMYC provided inpatient psychiatric services under the direction of a licensed psychiatrist;

b. Treatment plans, CIPOCs, and/or 30-day updates that falsely represented that the plans of care were developed by a treatment team that included a licensed psychiatrist;

c. Treatment plans, CIPOCs, and/or 30-day updates that falsely represented that an integrated program of therapies, activities, and experiences designed to meet the treatment objectives of each Medicaid child was prescribed or implemented;

d. Treatment plans, CIPOCs, and/or 30-day updates that falsely represented that KMYC had provided or was going to provide active treatment;

e. Treatment plans, CIPOCs, and/or 30-day updates that falsely represented that KMYC provided more than 21 distinct sessions of appropriate therapeutic interventions each week to each Medicaid child;

f. Treatment plans, CIPOCs, and/or 30-day updates that falsely represented that each Medicaid child continued to require inpatient psychiatric services at KMYC; and

g. Treatment plans, CIPOCs, and/or 30-day updates that falsely represented that KMYC was operated as a residential treatment facility providing inpatient psychiatric services to Medicaid children when in fact it was operated as a juvenile detention facility.

27. Between approximately October 2005, and approximately the date of this Complaint, Defendants knowingly used, or caused to be used, false records or statements, including those described above, to request prior authorization from WVMI and KePRO, respectively, to continue the confinement of numerous Medicaid children at KMYC. In reliance on these false records or statements, WVMI and KePRO, respectively, granted such prior authorization. As a result, Defendants presented, and received payment for, false or fraudulent claims.

False or Fraudulent Claims

28. Beginning as early as approximately October 2005, and continuing until approximately the date of this Complaint, Defendants knowingly presented, or caused to be presented, to DMAS, false or fraudulent claims for payment of "inpatient psychiatric services" for Medicaid children.

29. These claims were false or fraudulent because KMYC did not provide inpatient psychiatric services in compliance with Federal and state regulations and guidelines, and instead provided confinement like that of a juvenile detention facility.

Specific False or Fraudulent Conduct

Medicaid Child "AE"

30. From approximately June 16, 2005, through approximately September 22, 2006, twelve year-old "AE" was admitted to KMYC for inpatient psychiatric services. Defendants

made, used, and/or caused to be made or used, records representing that "AE's" inpatient psychiatric services were directed by the medical director, that his CIPOC and/or 30-day updates were prepared by a team that included the medical director, and that "AE" was being provided with active treatment during his confinement at KMYC. These records were false in that:

a. The services provided to "AE" were not provided under the direction of the medical director or any other physician as required by federal and state regulations;

b. The team that developed and updated "AE's" CIPOCs did not include the medical director or any of the other health care professionals required by federal and state regulations;

c. The CIPOC and 30-day updates for "AE" were general, standardized, rote statements that were not based on an examination of the medical, psychological, social, behavioral and developmental aspects of "AE's" therapeutic needs; and

d. Defendants did not provide "AE" with active treatment, in that, among other things, his individual and group sessions did not address his individualized problems, referral complaints, and psychiatric symptoms, he was not provided with appropriate family therapy, and he was placed into a program of non-individualized behavior modification like that of a juvenile detention facility, with the focus on "follow directions," "avoid write-ups," "earn points," and other similar non-specific goals, together with the frequent use of physical restraints.

31. On the approximate dates in column (1), Defendants knowingly made, used, or caused to be made or used, a false 30-day update described in column (2), to obtain prior authorization for "AE's" confinement at KMYC for the period stated in column (3), and presented false or fraudulent claims on the approximate dates stated in column (4) for the service

dates indicated in column (5), which were paid on the dates in column (6) and in the amounts set forth in column (7):

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Date	**30-day Update Period**	**Confinement Dates Authorized**	**Date Claim Presented**	**Dates of Service of False Claim**	**Date Paid**	**Amount Paid**
9/13/05	8/12/05-9/7/05	9/11/05-12/11/05	10/10/05 11/7/05 12/12/05	9/1/05-9/30/05 10/1/05-10/31/05 11/1/05-11/30/05	10/21/05 11/18/05 12/30/05	$10,730.10 $11,087.77 $10,730.10
12/22/05	11/8/05-12/6/05	12/12/05-3/11/06	1/17/06 2/10/06 3/7/06 4/24/06	12/1/05-12/31/05 1/1/06-1/31/06 2/1/06-2/28/06 3/1/06-3/11/06	1/27/06 2/24/06 3/17/06 5/5/06	$11,087.77 $11,087.77 $10,014.76 $3,934.37
3/11/06	2/1/06-2/28/06	3/12/06-4/12/06	5/25/06	3/12/06-3/31/06	6/9/06	$7,153.40
4/12/06	3/1/06-3/28/06	4/13/06-7/13/06	5/25/06 6/8/06 7/31/06 8/7/06	4/1/06-4/30/06 5/1/06-5/31/06 6/1/06-6/30/06 7/1/06-7/13/06	6/9/06 6/23/06 8/11/06 8/18/06	$10,730.10 $11,087.77 $10,730.10 $4,900.74

Medicaid Child "RH"

32. From approximately June 5, 2006, through approximately May 2007, fourteen year-old "RH" was admitted to KMYC for inpatient psychiatric services. Defendants made, used, and/or caused to be made or used, records representing that "RH's" inpatient psychiatric services were directed by the medical director, that his CIPOC and/or 30-day updates were prepared by a team that included the medical director, and that "RH" was being provided with active treatment during his confinement at KMYC. These records were false in that:

a. The services provided to "RH" were not provided under the direction of the medical director or any other physician as required by federal and state regulations;

b. The team that developed and updated the CIPOC and 30-day updates for "RH" did not include the medical director or any of the other health care professionals required by federal and state regulations;

c. The CIPOC and 30-day updates for "RH" were general, standardized, rote statements that were not based on an examination of the medical, psychological, social, behavioral and developmental aspects of RH's therapeutic needs, but reflected a pattern of "cutting and pasting" sections from previous 30-day updates; and

d. Defendants did not provide "RH" with active treatment in that, among other things, his individual and group sessions did not address his individualized problems, referral complaints, and psychiatric symptoms, and he was placed into a program of non-individualized behavior modification like that of a juvenile detention facility, with the focus on "get no write-up," "not to instigate," "control anger," "take time," "ignore negativity," "mind your own business," and other similar non-specific goals, together with the frequent use of physical restraints.

33. On the approximate dates in column (1), Defendants knowingly made, used, or caused to be made or used, a false CIPOC or 30-day update described in column (2), to obtain prior authorization for "RH's" confinement at KMYC for the period stated in column (3), and presented false or fraudulent claims on the approximate dates stated in column (4) for the service dates indicated in column (5), which were paid on the dates in column (6) and in the amounts set forth in column (7):

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Date	**CIPOC/30-Day Update Period**	**Confinement Dates Authorized**	**Date Claim Presented**	**Dates of Service of False Claim**	**Date Paid**	**Amount Paid**
6/19/06	6/5/06-6/19/06	6/5/06-9/5/06	7/31/06 8/7/06 9/13/06 10/6/06	6/5/06 - 6/30/06 7/1/06 - 7/31/06 8/1/06 - 8/31/06 9/1/06 - 9/5/06	8/11/06 8/18/06 9/22/06 10/20/06	$2,340.00 $2,945.00 $2,945.00 $475.00
9/1/06	7/26/06-8/23/06	9/6/06 - 12/4/06	2/12/07 4/2/07 12/13/06 3/6/07	9/6/06 - 9/30/06 10/1/06-10/31/06 11/1/06-11/30/06 12/1/06-12/4/06	2/23/07 4/13/07 12/22/06 3/16/07	$2,375.00 $2,945.00 $2,850.00 $380.00
11/30/06	10/18/06-11/13/06	12/5/06 - 2/2/07	3/6/07	12/5/06-12/31/06	3/16/07	$2,565.00

Medicaid Child "RS"

34. From approximately September 26, 2006, through approximately August 29, 2007, thirteen year-old "RS" was admitted to KMYC for inpatient psychiatric services. Defendants prepared, and caused the preparation of, records that represented that "RS's" inpatient psychiatric services were directed by the medical director, that his CIPOC and 30-day updates were prepared by a team that included the medical director, and that "RS" was being provided with active treatment during his confinement at KMYC. These records were false in that:

a. The services provided to "RS" were not provided under the direction of the medical director or any other physician as required by federal and state regulations;

b. The team that developed and updated the CIPOCs for "RS" failed to include the medical director or any of the other health care professionals required by federal and state regulations;

c. The CIPOC and 30-day updates for "RS" were general, standardized, rote statements that were not based on an examination of the medical, psychological, social, behavioral and developmental aspects of "RS's" therapeutic needs, but reflected a pattern of "cutting and pasting" sections from previous 30-day updates and

d. Defendants did not provide "RS" with active treatment in that, among other things, his group sessions did not address his individualized problems, referral complaints, and psychiatric symptoms, and he was placed into a program of non-individualized behavior modification like that of a juvenile detention facility, with the focus on "be good," "take time," "ignore the other person," "avoid negativity," "don't get

mad," "have positive interactions," "follow staff directions," "stay in assigned area," "listen to teacher," "do work," "avoid PRTs [physical restraint techniques]," "mind your own business," and other similar non-specific goals, together with the frequent use of physical restraints and seclusion.

35. On the approximate dates in column (1), Defendants knowingly made, used, or caused to be made or used, a false plan of care or 30-day update described in column (2), to obtain prior authorization for "RS's" confinement at KMYC for the period stated in column (3), and presented false or fraudulent claims on the approximate dates stated in column (4) for the service dates indicated in column (5), which were paid on the dates in column (6) and in the amounts set forth in column (7):

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Date	**Plan of Care/30-Day Update Period**	**Confinement Dates Authorized**	**Date Claim Presented**	**Dates of Service of False Claim**	**Date Paid**	**Amount Paid**
9/27/06	9/27/06	9/26/06-12/24/06	11/9/06 12/13/06 5/7/07	10/1/06-10/31/06 11/1/06-11/30/06 12/1/06-12/24/04	11/24/06 12/22/06 5/18/07	$11,686.38 $11,309.40 $9,047.52
3/20/07	2/13/07-3/12/07	3/25/07-3/31/07	5/10/07	3/25/07 - 3/31/07	5/25/007	$2,638.86
6/19/07	5/8/07-6/4/07	6/23/07 - 7/23/07	8/6/07 8/6/07 8/6/07	6/23/07 - 6/30/07 7/1/07 - 7/22/07 7/23/07 - 7/25/07	8/17/07 8/17/07 8/17/07	$3,015.84 $8,650.40 $1,179.60

Other Medicaid Children

36. From as early as October 1, 2005, and continuing until approximately the date of this Complaint, Defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval, and knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims for numerous other Medicaid children, including but not limited to those described below.

37-95. On the approximate dates stated in column (1) for the Medicaid child identified by initials in column (2), Defendants knowingly made, used, or caused to be made or used, a

false plan of care, CIPOC, or 30-day update to obtain prior authorization for the confinement dates stated in column (3), and on the approximate dates stated in column (4), presented false or fraudulent claims for the dates of service stated in column (5), that were paid on the dates in column (6) for the amounts stated in column (7):

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Par	**Date**	**Child**	**Confinement Dates Authorized**	**Date Claim Presented**	**Dates of Service of False Claim**	**Date Paid**	**Amount Paid**
37	10/19/05	BA	10/18/05-12/8/05	11/7/05 12/12/05	10/1/05-10/31/05 11/1/05-11/30/05	11/18/05 12/30/05	$11,087.77 $10,730.10
38	12/9/05	BA	12/9/05-3/9/06	1/17/06 2/28/06 6/26/06	12/1/05-12/31/05 1/1/06-1/31/06 2/1/06-2/28/06	1/27/06 3/1/06 7/7/06	$11,087.77 $11,087.77 $10,014.76
39	3/14/06	BA	3/10/06-5/10/06	4/24/06 5/11/06	3/1/06-3/31/06 4/1/06-4/30/06	5/5/06 5/26/06	$11,087.77 $10,730.10
40	9/29/06	BA	8/12/06-9/25/06	10/6/06 1/3/07	8/12/06-8/31/06 9/1/06-9/25/06	1/19/07 10/20/06	$9,424.50 $7,539.60
41	11/22/06	BA	11/1/06-12/30/06	12/13/06 2/26/07	11/10/06-11/30/06 12/1/06-12/30/06	12/22/06 3/9/07	$7,916.58 $11,309.40
42	10/7/05	CB	10/5/05-12/5/05	11/7/05 12/12/05 1/17/06	10/5/05-10/31/05 11/1/05-11/30/05 12/1/05-12/5/05	11/18/05 12/30/05 1/27/06	$2,790.00 $2,700.00 $450.00
43	12/16/05	CB	12/6/05-2/5/06	2/10/06 2/10/06	12/6/05-12/31/05 1/1/06-1/31/06	2/24/06 2/24/06	$2,340.00 $2,790.00
44	2/7/06	CB	2/16/06-4/27/06	4/24/06 5/11/06 6/12/06	2/1/06-2/28/06 3/1/06-3/31/06 4/1/06-4/27/06	5/5/06 5/26/06 6/23/06	$2,790.00 $2,430,00 $2,520.00
45	5/10/06	CB	4/28/06-6/29/06	5/25/06 6/12/06 7/31/06	4/28/06-4/30/06 5/1/06-5/31/06 6/1/06-6/29/06	6/9/06 6/23/06 8/11/06	$270.00 $2,790.00 $2,610.00
46	6/30/06	CB	6/30/06-7/13/06	8/7/06 9/25/06	6/30/06-6/30/06 7/1/06-7/13/06	8/18/06 10/06/06	$95.00 $1,235.00
47	12/5/05	DB	12/2/05-3/2/06	1/17/06 2/10/06 2/10/06 3/7/06	12/1/05-12/1/05 12/2/05-12/31/05 1/1/06-1/31/06 2/1/06-2/28/06	1/27/06 2/24/06 2/24/06 3/17/06	$357.67 $10,730.10 $11,087.77 $10,014.76
48	3/9/06	DB	3/3/06-6/2/06	4/24/06 5/11/06 7/31/06 5/7/07	3/1/06-3/31/06 4/1/06-4/30/06 6/1/06-6/2/06 5/1/06-5/31/06	5/5/06 5/26/06 8/11/06 5/18/07	$11,087.77 $10,730.10 $715.34 $11,087.77
49	6/16/06	DB	6/3/06-7/5/06	4/2/07 5/4/07	7/1/06-7/5/06 6/3/06-6/30/06	4/13/07 5/18/07	$1,884.90 $10,014.76
50	7/13/06	DB	7/6/06-8/5/06	8/7/06 9/13/06 4/2/07	7/6/06-7/31/06 8/1/06-8/5/06 8/5/06-8/5/06	8/18/06 9/22/06 4/13/07	$9,801.48 $1,507.92 $376.98
51	8/25/06	DB	8/6/06-10/4/06	9/13/06 10/6/06 5/4/07	8/6/06-8/31/06 9/1/06-9/30/06 10/1/06-10/4/06	9/22/06 10/20/06 5/18/07	$9,801.48 $11,309.40 $1,507.92
52	10/11/06	DB	10/5/06-11/29/06	11/9/06 5/4/07	10/5/06-10/31/06 11/1/06-11/14/06	11/24/06 5/18/07	$10,178.46 $4,900.74

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Par	**Date**	**Child**	**Confinement Dates Authorized**	**Date Claim Presented**	**Dates of Service of False Claim**	**Date Paid**	**Amount Paid**
53	12/5/05	HD	12/2/05-3/2/06	2/10/06 2/10/06 3/7/06	12/2/05-12/31/05 1/1/06-1/31/06 2/1/06-2/28/06	2/24/06 2/24/06 3/17/06	$10,730.10 $11,087.77 $10,014.76
54	3/2/06	HD	3/3/06-5/31/06	4/24/06 5/11/06 6/8/06	3/1/06-3/31/06 4/1/06-4/30/06 5/1/06-5/31/06	5/5/06 5/26/06 6/23/06	$11,087.77 $10,730.10 $11,087.77
55	7/18/06	HD	7/2/06-8/16/06	8/29/06 9/13/06 5/4/07	7/2/06-7/31/06 8/1/06-8/15/06 8/16/06-8/16/06	9/8/06 9/22/06 5/18/07	$11,309.40 $5,654.70 $376.98
56	8/11/06	HD	8/17/06-9/15/06	9/13/06 10/6/06	8/17/06-8/31/06 9/1/06-09/15/06	9/22/06 10/20/06	$5,654.70 $5,654.70
57	12/11/06	HD	10/31/06-11/29/06	12/13/06 2/26/07	11/1/06-11/29/06 10/31/06-10/31/06	12/22/06 3/9/07	$10,932.42 $376.98
58	12/18/06	HD	11/30/06-12/29/06	2/26/07 2/26/07	11/30/06-11/30/06 12/1/06-12/29/06	3/9/07 3/9/07	$376.98 $10,932.42
59	2/12/07	HD	12/30/06-1/8/07	2/26/07	12/30/06-12/31/06	3/9/07	$753.96
60	11/2/05	ZD	10/20/05-1/20/06	3/3/06 3/3/06 3/3/06 3/3/06	10/20/05-10/31/05 11/1/06-11/30/06 12/1/05-12/31/05 1/1/06-1/20/06	3/17/06 3/17/06 3/17/06 3/17/06	$4,292.04 $10,730.10 $11,087.77 $7,153.40
61	1/24/06	ZD	1/21/06-4/21/06	3/3/06 3/6/06 2/26/07 2/26/07	1/21/06-1/31/06 2/1/06-2/28/06 3/1/06-3/31/06 4/1/06-4/21/06	3/17/06 3/17/06 3/9/07 3/9/07	$3,934.37 $10,014.76 $11,087.77 $7,511.07
62	4/27/06	ZD	4/22/06-7/22/06	5/25/06 6/8/06 2/26/07 2/26/07	4/22/06-4/30/06 5/1/06-5/31/06 6/1/06-6/30/06 7/1/06-7/22/06	6/9/06 6/23/06 3/9/07 3/9/07	$3,219.03 $11,087.77 $10,730.10 $8,293.56
63	10/27/05	RD	10/25/05-11/25/05	11/10/05	10/25/05-10/31/05	11/25/05	$2,503.69
64	11/1/05	JD	11/4/05-11/4/05	3/14/06 3/14/06	10/4/05-10/31/05 11/1/05-11/4/05	3/24/06 3/24/06	$2,520.00 $360.00
65	11/3/05	JD	11/5/05-1/29/06	12/12/05 1/17/06 2/10/06	11/5/05-11/30/05 12/1/05-12/31/05 1/1/06-1/29/06	12/30/05 1/27/06 2/24/06	$2,340.00 $2,790.00 $2,610.00
66	1/30/06	JD	1/30/06-3/30/06	2/10/06 5/1/06 2/26/07	1/30/06-1/31/06 2/1/06-2/28/06 3/1/06-3/30/06	2/24/06 5/12/06 3/9/07	$180.00 $2,520.00 $2,700.00
67	4/4/06	JD	3/31/06-6/30/06	7/31/06 8/14/06 8/14/06 8/14/06	6/1/06-6/30/06 3/31/06-3/31/06 4/1/06-4/30/06 5/1/06-5/31/06	8/11/06 8/25/06 8/25/06 8/25/06	$2,700.00 $357.67 $10,730.10 $11,087.77
68	7/10/06	JD	7/1/06-8/30/06	8/7/06	7/1/06-7/28/06	8/18/06	$2,565.00
69	2/3/06	JE	1/30/06-2/28/06	3/7/06 3/7/06	1/30/06-1/31/06 2/1/06-2/28/06	3/17/06 3/17/06	$715.34 $10,014.76
70	3/7/06	JE	1/30/06-4/30/06	4/24/06 5/11/06	3/1/06-3/31/06 4/1/06-4/30/06	5/5/06 5/26/06	$11,087.77 $10,730.10
71	5/3/06	JE	5/1/06-8/1/06	6/8/06 8/7/06 8/29/06 9/13/06	5/1/06-5/31/06 7/1/06-7/31/06 6/1/06-6/30/06 8/1/06-8/1/06	6/23/06 8/18/06 9/8/06 9/22/06	$11,087.77 $11,686.38 $10,730.10 $376.98

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Par	**Date**	**Child**	**Confinement Dates Authorized**	**Date Claim Presented**	**Dates of Service of False Claim**	**Date Paid**	**Amount Paid**
72	11/7/05	JI	10/25/05-1/25/06	11/22/05 12/12/05 2/10/06 3/27/06	10/25/05-10/31/05 11/1/05-11/30/05 1/1/06-1/25/06 12/1/05-12/31/05	12/9/05 12/30/05 2/24/06 4/7/06	$2,503.69 $2,700.00 $2,250.00 $2,790.00
73	6/21/06	JI	6/23/06-7/23/06	2/26/07	7/1/06-7/15/06	3/9/07	$1,330.00
74	8/4/06	BJ	7/19/06-10/17/06	9/1/06 10/6/06 11/9/06 2/15/07	07/19/06-07/31/06 09/01/06-09/30/06 10/01/06-10/17/06 08/31/06-08/31/06	9/15/06 10/20/06 11/24/06 3/2/07	$1,235.00 $11,309.40 $6,408.66 $376.98
75	10/23/06	BJ	10/18/06-12/16/06	12/13/06 1/22/07 2/12/07 4/2/07	11/01/06-11/30/06 12/17/06-12/31/06 10/18/06-10/31/06 12/01/06-12/16/06	12/22/06 2/2/07 2/23/07 4/13/07	$11,309.40 $5,654.00 $5,277.72 $6,031.68
76	11/2/05	ML	10/31/05-12/24/05	12/13/05 1/17/06	11/1/05-11/30/05 12/1/05-12/31/05	12/30/05 1/27/06	$2,700.00 $2,790.00
77	12/27/05	ML	12/25/05-3/25/06	3/10/06 4/24/06 7/31/06	1/1/06-1/31/06 3/26/06-3/31/06 2/1/06-2/28/06	3/24/06 5/5/06 8/11/06	$2,790.00 $2,250.00 $2,520.00
78	3/29/06	ML	3/26/06-4/9/06	4/24/06 5/11/06	3/1/06-3/25/06 4/1/06-4/9/06	5/5/06 5/26/06	$540.00 $810.00
79	1/3/06	CM	12/29/05-1/29/06	2/10/06 2/10/06	12/29/05-12/31/05 1/1/06-1/29/06	2/24/06 2/24/06	$1,073.01 $10,372.43
80	1/30/06	CM	1/30/06-4/30/06	3/7/06 3/7/06 6/12/06	1/30/06-1/31/06 2/1/06-2/28/06 3/1/06-3/28/06	3/17/06 3/17/06 6/23/06	$715.34 $10,014.76 $9,657.09
81	11/8/05	NM	11/3/05-1/31/06	12/12/05 1/18/06 2/28/06	11/3/05-11/30/05 12/1/05-12/31/05 1/1/06-1/31/06	12/30/05 1/27/06 3/10/06	$10,014.76 $11,087.77 $11,087.77
82	8/11/06	NM	8/3/06-10/1/06	9/13/06 10/6/06 11/9/06	8/3/06-8/31/06 9/1/06-9/30/06 10/1/06-10/1/06	9/22/06 10/20/06 11/24/06	$10,932.42 $11,309/40 $376.98
83	10/17/06	NM	10/2/06-10/3/06	11/9/06	10/2/06-10/3/06	11/24/06	$753.96
84	11/14/05	KN	11/15/05-12/15/05	1/17/06	12/1/05-12/31/05	1/27/06	$11,087.77
85	12/16/05	KN	12/15/05-3/16/06	3/27/06 3/27/06 4/24/06	1/1/06-1/31/06 2/1/06-2/28/06 3/1/06-3/16/06	4/7/06 4/7/06 5/5/06	$11,087.77 $10,014.76 $5,722.72
86	3/17/06	KN	3/17/06-4/12/06	4/24/06 5/11/06	3/17/06-3/31/06 4/1/06-4/30/06	5/5/06 5/26/06	$5,365.05 $10,730.10
87	4/17/06	KN	4/13/06-6/5/06	6/8/06 7/31/06	5/1/06-5/31/06 6/1/06-6/5/06	6/23/06 8/11/06	$11,087.77 $1,788.35
88	6/16/06 8/4/06	KN	6/9/06-7/4/06	7/31/06 9/1/06	6/1/06-6/5/06 6/9/06-6/30/06	8/11/06 9/15/06	$1,073.01 $1,980.00
89	2/1/06	RR	1/28/06-4/28/06	2/28/06 3/7/06 4/24/06 10/2/06	1/28/06-1/31/06 2/1/06-2/28/06 3/1/06-3/31/06 4/1/06-4/28/06	3/10/06 3/17/06 5/5/06 10/13/06	$1,430.68 $10,014.76 $11,087.77 $9,657.09
90	12/5/05	PR-J	12/2/05-2/28/06	3/7/06 3/27/06 3/27/06	2/1/06-2/28/06 12/2/05-12/31/05 1/1/06-1/31/06	3/17/06 4/7/06 4/7/06	$10,014.76 $10,730.10 $11,087.77

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Par	**Date**	**Child**	**Confinement Dates Authorized**	**Date Claim Presented**	**Dates of Service of False Claim**	**Date Paid**	**Amount Paid**
91	12/9/05 12/15/05	Ro.St.	12/10/05-2/10/06	1/17/06 2/10/06 3/7/06	12/1/05-12/31/05 1/1/06-1/31/06 2/1/06-2/10/06	1/27/06 2/24/06 3/17/06	$11,087.77 $11,087.77 $3,576.70
92	2/10/06	Ro.St.	2/11/06-5/11/06	3/14/06 4/24/06 5/11/06	2/11/06-2/28/06 3/1/06-3/31/06 4/1/06-4/30/06	3/24/06 5/5/06 5/26/06	$6,438.06 $11,087.77 $10,730.10
93	5/17/06	Ro.St.	5/12/06-6/29/06	6/8/06	5/1/06-5/31/06	6/23/06	$11,087.77
94	2/17/06	MT	2/17/06-5/17/06	3/7/06 4/24/06 5/11/06 6/8/06	2/17/06-2/28/06 3/1/06-3/31/06 4/1/06-4/30/06 5/1/06-5/17/06	3/17/06 5/5/06 5/26/06 6/23/06	$4,292.04 $11,087.77 $10,730.10 $6,080.39
95	6/2/06	MT	6/19/06-9/19/06	8/14/06 9/13/06 8/21/06 9/13/06 10/6/06 2/26/07	5/18/06-5/31/06 6/19/06-6/30/06 7/1/06-7/31/06 8/1/06-8/31/06 9/1/06-9/16/06 9/17/06-9/19/06	8/25/06 8/25/06 9/1/06 9/22/06 10/20/06 3/9/07	$4,292.04 $4,292.04 $11,636.08 $11,636.08 $6,031.68 $1,130.94

COUNT ONE
Violations of the False Claims Act – False or Fraudulent Claims
(31 U.S.C. § 3729(a)(1))

96. The United States incorporates by reference paragraphs 1 through 95 above as if fully set forth in Count One.

97. The United States seeks relief against Defendants under the False Claims Act, 31 U.S.C. § 3729(a)(1).

98. Between approximately October 2005 and approximately the date of this Complaint, in connection with the foregoing conduct, Defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval by DMAS.

99. As described in this Complaint, these claims were materially false or fraudulent in that, among other things, they claimed that KMYC provided inpatient psychiatric services in compliance with Federal and state regulations when, in fact, Defendants provided the services of a juvenile detention facility and failed to comply with the regulations.

100. As a result of this conduct, Defendants caused the United States to suffer actual damages in an amount to be determined at trial.

COUNT TWO
Violations of the False Claims Act – False Records or Statements
(31 U.S.C. § 3729(a)(1)(B))

101. The United States incorporates by reference paragraphs 1 through 95 above as if fully set forth in Count Two.

102. The United States seeks relief against Defendants under the False Claims Act, 31 U.S.C. § 3729(a)(1)(B).

103. Between approximately October 2005 and approximately the date of this Complaint, in connection with the foregoing conduct, Defendants knowingly made, used, or caused to be made or used, false records or statements, including plans of care, CIPOCs, and/or 30-day updates.

104. As described in this Complaint, these records or statements were false in that, among other things, they represented that KMYC provided inpatient psychiatric services to Medicaid children in compliance with the applicable Federal and state regulations when, in fact, Defendants provided the services of a juvenile detention facility and failed to comply with the regulations.

105. These false records or statements were provided to DMAS prior authorization contractors WVMI and KePRO, respectively, to obtain authorization for the continued confinement of Medicaid children at KMYC, and were material to false or fraudulent claims, including those described in paragraphs 23 through 95 of this Complaint, in that prior authorization was required before Defendants could present claims and/or receive payment for the continued confinement of Medicaid children at KMYC.

106. As a result of this conduct, Defendants caused the United States to suffer actual damages in an amount to be determined at trial.

COUNT THREE
Violations of the Virginia Fraud Against Taxpayers Act – False or Fraudulent Claims
(Va. Code Ann. § 8.01-216.3(A)(1))

107. The Commonwealth incorporates by reference paragraphs 1 through 95 above as if fully set forth in Count Three.

108. The Commonwealth seeks relief against Defendants under the Virginia Fraud Against Taxpayers, Va. Code Ann. § 8.0-216.3(A)(1).

109. Between approximately October 2005, and approximately the date of this Complaint, in connection with the foregoing conduct, Defendants knowingly presented, or caused to be presented, to DMAS, false or fraudulent claims for payment or approval.

110. As described in this Complaint, these claims were false in that, among other things, they represented that KMYC provided inpatient psychiatric services to Medicaid children in compliance with the applicable Federal and state regulations when, in fact, Defendants provided the services of a juvenile detention facility and failed to comply with the regulations.

111. As a result of this conduct, Defendants caused the Commonwealth to suffer actual damages in an amount to be determined at trial.

COUNT FOUR
Violations of the Virginia Fraud Against Taxpayers Act – False Records or Statements
(Va. Code Ann. § 8.01-216.3(A)(2))

112. The Commonwealth incorporates by reference paragraphs 1 through 95 above as if fully set forth in Count Four.

113. The Commonwealth seeks relief against Defendants under the Virginia Fraud Against Taxpayers Act, 8.01-216.3(A)(2).

114. Between approximately October 2005 and approximately the date of this Complaint, in connection with the foregoing conduct, Defendants knowingly made, used, or caused to be made or used false records or statements, including plans of care, CIPOCs, and/or 30-day updates, to get false or fraudulent claims paid or approved by DMAS.

115. As described in this Complaint, these records or statements were false in that, among other things, they represented that KMYC provided inpatient psychiatric services to Medicaid children in compliance with the applicable Federal and state regulations when, in fact, Defendants provided the services of a juvenile detention facility and failed to comply with the regulations.

116. These false records or statements were provided to DMAS prior authorization contractors WVMI and KePRO, respectively, to obtain prior authorization for the continued confinement of Medicaid children at KMYC, and to get false or fraudulent claims, including those described in paragraphs 23 through 95 of this Complaint, paid or approved for payment.

117. As a result of this conduct, Defendants caused the Commonwealth to suffer actual damages in an amount to be determined at trial.

COUNT FIVE
Violation of Virginia Fraud Statute
(Va. Code §§ 32.1-312(A)(1) and (2))

118. The Commonwealth incorporates by reference paragraphs 1 through 95 above as if fully set forth in Count Five.

119. Between approximately October 2005 and approximately the date of this Complaint, Defendants obtained or attempted to obtain payments from DMAS by means of willful false statements, and/or willful misrepresentations of fact or by willful concealment of

material facts, to obtain prior authorization for the continued confinement of Medicaid children at KMYC.

120. The Commonwealth, through DMAS, made substantial payments of money in reimbursement of Medicaid claims in justifiable reliance upon the defendants' false statements and/or willful misrepresentations or willful concealment of material facts.

121. As a result of this conduct, Defendants caused the Commonwealth to suffer actual damages in an amount to be determined at trial.

COUNT SIX
Unjust Enrichment

122. The United States and the Commonwealth incorporate by reference paragraphs 1 through 95 above as if fully set forth in Count Six.

123. Between approximately October 2005, and approximately the date of this Complaint, Defendants retained Medicaid funds paid for services not provided as claimed.

124. In equity and good conscience, Defendants should not be allowed to retain these funds and they should be returned to the United States and the Commonwealth.

125. Defendants were unjustly enriched in an amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs, the United States of America and the Commonwealth of Virginia, pray judgment be entered in their favor and against Defendants as follows:

1. The Court order, pursuant to Counts One and Two, that Defendants pay the United States triple the amount of its damages to be determined, plus civil penalties of up to $11,000 for each false claim; for all costs of this civil action; and for such other and further relief as the Court deems just and equitable;

2. The Court order, pursuant to Counts Three and Four, that Defendants pay the Commonwealth triple the amount of its damages to be determined, plus civil penalties of up to $10,000 for each false claim presented before July 1, 2007, and $11,000 for each false claim presented on or after July 1, 2007; for all costs of this civil action; and for such other and further relief as the Court deems just and equitable;

3. The Court order, pursuant to Count Five that Defendants pay the amount of damages to the Commonwealth, prejudgment interest, plus fees and costs;

4. The Court order, pursuant to Count Six, that Defendants pay the amount by which they were unjustly enriched to the United States and to the Commonwealth, prejudgment interest, plus fees and costs;

5. The Court award such other and further relief as is just, equitable and proper; and

6. A Jury Trial is Requested.

DATED this 2nd day of March, 2010.

UNITED STATES OF AMERICA:

TONY WEST
Assistant Attorney General
Civil Division

TIMOTHY J. HEAPHY
United States Attorney
Western District of Virginia

/s/ Rick A. Mountcastle
Rick A. Mountcastle, VSB #19768
Sara Bugbee Winn, VSB # 35924
Assistant United States Attorneys
P.O. Box 1709
Roanoke, VA 24008-1709
540/857-2254; 540/857-2283 (fax)

/s/ Brian J. McCabe
Joyce R. Branda
Renee Brooker
Brian J. McCabe, VSB #41693
Attorneys, Civil Division
U.S. Department of Justice
P.O. Box 261, Ben Franklin Station
(202) 616-4875; (202) 514-0280 (fax)

COMMONWEALTH OF VIRGINIA:

/s/ Erica J. Bailey
Erica J. Bailey, VSB #68202
Assistant Attorney General
Office of the Attorney General
900 East Main Street
Richmond, VA 23219
804/786-2452