

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA

v.

GREGORY WEST

CASE NO. 8:07-cr-527-T26MAP
18 U.S.C. § 1349
18 U.S.C. § 1347

INFORMATION

The United States Attorney charges:

COUNT ONE
(Conspiracy - 18 U.S.C. § 1349)

A. Introduction

At times material to this Information:

The Medicaid Program

1. The Medicaid program, as established by Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations, authorized Federal grants to States for medical assistance to low-income persons who are age 65 and over, blind, disabled, or members of families with dependent children or qualified pregnant women or children (herein referred to as "Medicaid beneficiaries" or "Medicaid recipients"). The Centers for Medicare and Medicaid Services ("CMS"), previously known as the Health Care Finance Administration, or HCFA, was an agency of the United States Department of Health and Human Services ("HHS"), and was the federal government body responsible for the administration of the Medicaid program. CMS, in turn, authorized each state to establish a state agency to oversee the Medicaid program.

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2. The Florida Medicaid Program was authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. Florida further established the Agency for Health Care Administration ("AHCA") as the single state agency authorized to administer the Florida Medicaid program.

3. It was necessary for the states electing to participate in the Medicaid program to comply with the requirements imposed by the Social Security Act and regulations of the Secretary of HHS.

4. The federal government reimbursed the states for a portion of the states' Medicaid expenditures based on a formula tied to the per capita income in each state. The federal share of Medicaid expenditures (otherwise referred to as "federal financial participation" or "FFP"), varied from a minimum of 50% to as much as 83% of a state's total Medicaid expenditures. In Florida, the FFP equaled approximately 59% of the state's total Medicaid expenditures.

5. Certain health care practitioners, healthcare facilities, or health care plans that met the conditions of participation and eligibility requirements and that were enrolled in Medicaid could provide, and be reimbursed for rendering, Medicaid-covered services to Medicaid beneficiaries.

6. There were several ways in which reimbursement was made to health care providers, of which capitation reimbursement was one. Capitation reimbursement applied to health maintenance organizations ("HMOs") and certain other providers. Said HMOs and providers were paid a fixed amount each month for each beneficiary or member (per capita) enrolled to receive services from that HMO or provider.

Background

7. Generally, through its subsidiaries, Parent Plans, Inc. (a pseudonym for an existing public company known to the defendant, referred to herein as "PARENT"), a legal entity created under Delaware law, operated as a provider of managed health care services, targeted to government-sponsored health care programs, focusing on Medicaid and Medicare.

8. Among other business activities, PARENT provided Medicaid services in a number of states, including Florida. PARENT was paid independently by each state's Medicaid program to provide managed care services to Medicaid beneficiaries residing in that state.

9. PARENT was one of the largest providers of managed care services in Florida, where it enrolled Medicaid patients into one of its two plans, SUBSIDIARY-1 (a pseudonym for an existing plan known to the defendant, referred to herein as "SUBSIDIARY-1") and SUBSIDIARY-2 (a pseudonym for an existing plan known to the defendant, referred to herein as "SUBSIDIARY-2"). Both SUBSIDIARY-1 and SUBSIDIARY-2 were wholly-owned subsidiaries of PARENT and legal entities created under Florida law. As noted above, AHCA was the agency charged with administering the Florida Medicaid program.

10. To govern aspects of the provision of additional Florida Medicaid program services, that is, certain behavioral health care services, to Florida Medicaid beneficiaries, Florida Statute 409.912(4)(b) was enacted, effective June 7, 2002, which read, in pertinent part:

To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued

pursuant to this paragraph shall require 80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency.

11. Thus, beginning in or about mid-2002, AHCA began covering the additional program services, that is, said certain behavioral health care services, via contracts which included provisions for the new services to be delivered to Florida Medicaid beneficiaries through a capitated arrangement.

12. Thereafter, since in or about mid-2002, through its SUBSIDIARY-1 and SUBSIDIARY-2 plans, PARENT contracted with AHCA to provide a variety of services to Florida Medicaid beneficiaries, including community behavioral health services (also sometimes referred to as "mental health services").

13. Per the relevant contracts between AHCA and SUBSIDIARY-1 and SUBSIDIARY-2, the PARENT entities SUBSIDIARY-1 and SUBSIDIARY-2 were paid on a flat or "capitated" rate for each beneficiary or member enrolled in one of the two health plans. The capitated rate varied depending on age, sex, geographic location, and other factors.

14. Also per the relevant AHCA contracts, as said contracts related to providing said community behavioral health services in accordance with Florida law, SUBSIDIARY-1 and SUBSIDIARY-2 were allowed to retain 20% of the related premiums received from AHCA to cover the entities' administrative expenses and overhead. As to the remaining 80%, said AHCA contracts and Florida law required that any funds not expended or paid directly or indirectly to community behavioral health

services providers solely for the provision of the services had to be returned to the state (AHCA contracts including such 80/20 provisions are referred to herein as "80/20 contracts").

15. The AHCA 80/20 contracts therefore included language identical, or substantially similar, to the following:

Community Behavioral Health Services Annual 80/20 Expenditure Report.

1. By April 1 of each year, Health Plans shall provide a breakdown of expenditures related to the provision of community behavioral health services, using the spreadsheet template provided by the Agency (see Section XII, Reporting Requirements). In accordance with Section 409.912, F.S., eighty percent (80%) of the Capitation Rate paid to the Health Plan by the Agency shall be expended for the provision of community behavioral health services. In the event the Health Plan expends less than eighty percent (80%) of the Capitation Rate, the Health Plan shall return the difference to the Agency no later than May 1 of each year.
 - a. For reporting purposes in accordance with this Section, 'community behavioral health services' are defined as those services that the Health Plan is required to provide as listed in the Community Mental Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations handbook.
 - b. For reporting purposes in accordance with the Section 'expended' means the total amount, in dollars, paid directly or indirectly to community behavioral health services providers solely for the provision of community behavioral health services, not including administrative expenses or overhead of the plan. If the report indicates that a portion of the capitation payment is to

be returned to the Agency, the Health Plan shall submit a check for that amount with the Behavioral Health Services Annual 80/20 Expenditure Report that the Health Plan provides to the Agency."

16. To facilitate the required reporting of expenditures relating to the provision of said community behavioral health care services, AHCA provided each participating health plan in Florida, including SUBSIDIARY-1 and SUBSIDIARY-2, with a worksheet titled Financial Worksheet For Behavioral Healthcare, or other similar title (such worksheet is referred to herein as "AHCA Behavioral Healthcare Worksheet"), that was organized in a manner to calculate and present to AHCA the amount of refund, if any, due AHCA under the relevant 80/20 contracts.

17. Said AHCA Behavioral Healthcare Worksheet required, in part, each participating health plan, including SUBSIDIARY-1 and SUBSIDIARY-2, to provide AHCA with the plan's true and correct expenditure information relating to the plan's provision of behavioral health care services, defined as those services that the plan was required to provide per the Community Mental Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations handbook.

18. GREGORY WEST, the defendant herein, worked for PARENT, or one of its wholly-owned subsidiaries, from in or about March of 2003, through the date of this Information.

B. The Conspiracy

19. Beginning in or about mid-2002, and continuing through at least October of 2007, within the Middle District of Florida, and elsewhere,

GREGORY WEST,

defendant herein, knowingly and willfully did combine, conspire, confederate and agree with others to execute and attempt to execute a scheme and artifice to defraud a health care benefit program, that is, the Florida Medicaid program, and to obtain, by means of materially false pretenses, representations, and promises, money and property owned by, and under the control of, a health care benefit program, that is, the Florida Medicaid program, in connection with the delivery of and payment for health care benefits, items, and services, in violation of Title 18, United States Code, Section 1347.

C. The Manner and Means of the Conspiracy

20. The manner and means by which the conspirators sought to accomplish the objects of the conspiracy included, among others, the following:

(a) It was part of the conspiracy that, to fraudulently reduce PARENT's contractual payback obligations to AHCA under the 80/20 contracts, and thereby correspondingly benefit PARENT through an increase in profits, PARENT, acting through its officers and employees, would and did falsely and fraudulently inflate expenditure information included within AHCA Behavioral Healthcare Worksheets for calendar years mid-2002 through 2006 for the SUBSIDIARY-1 and SUBSIDIARY-2 plans through various acts and strategies including, but not limited to:

- i. falsely and fraudulently including expenses in the relevant AHCA Behavioral Healthcare Worksheets for PARENT plans SUBSIDIARY-1 and SUBSIDIARY-2 that were not expenses incurred by the plans in providing the required community behavioral health services as defined and listed in the Community Mental Health Services Coverage and Limitations Handbook and the Mental Health Targeted Case Management Coverage and Limitations handbook;
- ii. creating a wholly-owned entity named SUBSIDIARY-3 (a pseudonym for an existing entity), and then using said entity to conceal and falsely and fraudulently inflate the SUBSIDIARY-1 and SUBSIDIARY-2 plans' true and actual expenses incurred in providing the required community behavioral health services; and
- iii. submitting said false and fraudulent AHCA Behavioral Healthcare Worksheets to AHCA.

(b) It was further a part of the conspiracy that, to conceal PARENT's false and fraudulent reporting of expenditure information to AHCA, PARENT, through its officers and employees, including the defendant, acting within the scope of their duties and authorities, would and did falsely and fraudulently provide certified Medicaid behavioral health encounter data to AHCA.

(c) It was further a part of the conspiracy that PARENT's officers and employees, acting within the scope of their duties and authorities, would and did engage in meetings and other conduct in a concerted and organized effort to conceal and cover-up the false and fraudulent nature of PARENT's various expenditure information and encounter data submissions to AHCA.

All in violation of Title 18, United States Code, Section 1349.

FORFEITURES

1. The allegations contained in Count One of this Information are hereby realleged and incorporated by reference for the purpose of alleging forfeitures pursuant to the provision of Title 18, United States Code, Section 982(a)(7).

2. From his engagement in the conspiracy charged in Count One to violate Title 18, United States Code, Section 1347, relating to a health care benefit program, all in violation of Title 18, United States Code, Section 1349, defendant,

GREGORY WEST,

shall forfeit to the United States of America, pursuant to Title 18, United States Code, Section 982(a)(7), any and all right, title, and interest he may have in any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense, including but not limited to, a sum of money equal to the amount of proceeds obtained as a result of such offense.

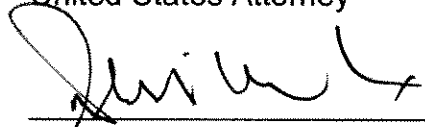
3. If any of the property described above, as a result of any act or omission of the defendant:

- a. cannot be located upon the exercise of due diligence;
- b. has been transferred or sold to, or deposited with, a third party;
- c. has been placed beyond the jurisdiction of the court;
- d. has been substantially diminished in value; or
- e. has been commingled with other property which cannot be divided without difficulty,

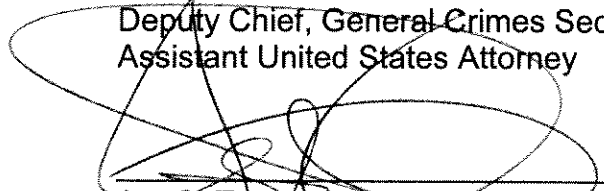
the United States of America shall be entitled to forfeiture of substitute property under the provisions of Title 21, United States Code, Section 853(p), as incorporated by Title 18, United States Code, Section 982(b)(1).

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