CIVIL COVER SHEET ATTACHMENT

DEFENDANTS

CAREONE MANAGEMENT LLC; MILLENNIUM HEALTHCARE CENTERS II, LLC d/b/a CAREONE AT CRESKILL; CAREONE AT MADISON AVENUE, LLC d/b/a CAREONE AT MADISON AVENUE; CAREONE AT PARSIPPANY TROY HILLS, LLC d/b/a CAREONE AT MORRIS; 493 BLACK OAK RIDGE ROAD, LLC d/b/a CAREONE AT WAYNE; 800 RIVER ROAD OPERATING COMPANY, LLC d/b/a WOODCREST HEALTH CARE CENTER; 11 HISTORY LANE OPERATING COMPANY, LLC d/b/a CAREONE AT JACKSON; ELMWOOD EVESHAM ASSOCIATES, LLC d/b/a CAREONE AT EVESHAM; CAREONE AT BIRCHWOOD, LLC d/b/a CAREONE AT THE HIGHLANDS; CAREONE AT EAST BRUNSWICK, LLC d/b/a CAREONE AT EAST BRUNSWICK; 1621 ROUTE 22 WEST OPERATING, LLC d/b/a CAREONE AT SOMERSET VALLEY f/k/a SOMERSET VALLEY REHAB & NURSING CENTER; MILLENNIUM HEALTHCARE CENTERS, II, LLC d/b/a CAREONE AT VALLEY; CAREONE AT WALL, LLC d/b/a CAREONE AT WALL; KING JAMES CARE CENTER OF MIDDLETOWN, LLC d/b/a CAREONE AT KING JAMES; HHC, LLC d/b/a CAREONE AT HOLMDEL; CARE TWO, LLC d/b/a CAREONE AT LIVINGSTON; CAREONE AT MOORESTOWN, LLC d/b/a CAREONE AT MOORESTOWN; 101 WHIPPANY ROAD, LLC d/b/a CAREONE AT HANOVER TOWNSHIP

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA, STATE OF NEW JERSEY, *ex rel.* MARGARET GATHMAN, **Plaintiff-Relator,** **v.** **CAREONE MANAGEMENT LLC; MILLENNIUM HEALTHCARE CENTERS II, LLC d/b/a CAREONE AT CRESKILL; CAREONE AT MADISON AVENUE, LLC d/b/a CAREONE AT MADISON AVENUE; CAREONE AT PARSIPPANY TROY HILLS, LLC d/b/a CAREONE AT MORRIS; 493 BLACK OAK RIDGE ROAD, LLC d/b/a CAREONE AT WAYNE; 800 RIVER ROAD OPERATING COMPANY, LLC d/b/a WOODCREST HEALTH CARE CENTER; 11 HISTORY LANE OPERATING COMPANY, LLC d/b/a CAREONE AT JACKSON; ELMWOOD EVESHAM ASSOCIATES, LLC d/b/a CAREONE AT EVESHAM; CAREONE AT BIRCHWOOD, LLC d/b/a CAREONE AT THE HIGHLANDS; CAREONE AT EAST BRUNSWICK, LLC d/b/a CAREONE AT EAST BRUNSWICK; 1621 ROUTE 22 WEST OPERATING, LLC d/b/a CAREONE AT SOMERSET VALLEY f/k/a SOMERSET VALLEY REHAB & NURSING CENTER; MILLENNIUM HEALTHCARE CENTERS, II, LLC d/b/a CAREONE AT VALLEY; CAREONE AT WALL, LLC d/b/a CAREONE AT WALL; KING JAMES CARE CENTER OF MIDDLETOWN, LLC d/b/a CAREONE AT KING JAMES; HHC, LLC d/b/a CAREONE AT HOLMDEL; CARE TWO, LLC d/b/a CAREONE AT LIVINGSTON; CAREONE AT MOORESTOWN, LLC d/b/a CAREONE AT MOORESTOWN; 101 WHIPPANY ROAD, LLC d/b/a CAREONE AT HANOVER TOWNSHIP,** **Defendants.**	:	**CIVIL ACTION NO.** **FILED UNDER SEAL** **JURY TRIAL DEMANDED**

RECEIVED
AUG 15 2017
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WILLIAM T. WALSH
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COMPLAINT
[FILED UNDER SEAL]

Qui Tam Plaintiff-Relator MARGARET GATHMAN, through her attorneys, on behalf of the United States of America and the State of New Jersey, brings this action against Defendant CareOne Management LLC and the above-captioned Defendants (hereinafter "CareOne"), and alleges as follows:

I. INTRODUCTION

1. This is an action brought by Relator Gathman – a former top billing insider at CareOne with direct, firsthand knowledge of two fraudulent schemes alleged herein: (1) falsely reporting by CareOne of "bad debt" in its cost reports to Medicare that did not meet the regulatory requirements for inclusion, as CareOne never sought to collect these amounts in the first place, in violation 42 C.F.R. § 489.13 and Section 310 of the Medicare Provider Reimbursement Manual; and (2) a scheme by CareOne to defraud the New Jersey Medicaid for a systemic, widespread failure to apply a beneficiary's income to the cost of care, resulting in false claims to New Jersey Medicaid and New Jersey Managed Medicaid.

Scheme One: Fraud on Medicare

2. Relator Gathman seeks to recover damages and civil penalties on behalf of the United States of America arising from false claims caused to be made and/or presented by CareOne and/or its agents, servants, and/or employees in violation of the False Claims Act, 31 U.S.C. §§3729, *et seq.*, as amended (hereafter "FCA"). Care One has violated §3729(a)(1) of the Act by causing to be submitted for approval or payment cost reports in violation of the explicit terms of 42 C.F.R. § 489.13; and has also violated §3729(a)(2) of the FCA by knowingly causing to be made or used a false record or statement (*i.e.* a cost report containing a false certificate of compliance) which was used to get false claims paid or approved by the Federal Government.

3. The Medicare statute provides that non-Medicare patients shall not be forced to

share the cost of treatment for Medicare patients. 42 U.S.C. § 1395x(v)(1)(A)(i); 42 C.F.R. § 413.89(d). This ban on cross-subsidization effectively requires that "the necessary costs of efficiently delivering covered services to individuals covered by" Medicare "will not be borne by individuals not so covered." *Id.*

4. Although the costs incurred for most of the care provided to Medicare patients are borne by the Federal Government, individual Medicare patients are often responsible for both deductible and coinsurance payments for hospital care and skilled nursing care.

5. If Medicare patients fail to pay this portion of their care, Medicare allows for reimbursement of these "bad debts" so long as certain criteria are met. 42 C.F.R. § 413.89(e).

6. Bad debts in the Medicare context are defined as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services." 42 C.F.R. § 413.89(b)(1). Such debts are "attributable to the deductibles and coinsurance amounts" billed to Medicare patients. *Id.* at §413.89(a).

7. For reimbursement of bad debt arising from nonpayment of coinsurance and deductible amounts due from Medicare patients, a skilled nursing facility or hospital must satisfy the following four criteria: (1) the debt must be related to covered services and derived from deductible and coinsurance amounts; (2) the provider must be able to establish that reasonable collection efforts were made; (3) the debt was actually uncollectible when claimed as worthless; and (4) sound business judgment established that there was no likelihood of recovery at any time in the future. *See* 42 C.F.R. § 413.89(e).

8. Here, CareOne knowingly submitted false claims to Medicare for reimbursement of its purported "bad debts" that were, in actuality, not allowable reimbursable costs from Medicare because CareOne did not make, or document, any collection efforts to recoup this

purported bad debt as required by 42 C.F.R. § 413.89(e)(2), and thus, this so-called "bad debt" was not "actually uncollectible when claimed as worthless" as required by 42 C.F.R. § 413.89(e)(3).

9. During the time period from 2012-2016, CareOne lacked contemporaneously prepared documentation to demonstrate pursuant to 42 C.F.R. § 413.89(e) that any reasonable collections efforts were made for all these non-allowable bad debt costs submitted to Medicare for reimbursement.

10. As a result, CareOne submitted false claims directly to Medicare for total reimbursement of this purported "bad debt," falsely certifying that it had made reasonable and documented collection efforts (when it had not) and that the bad debt was "worthless" (when it was not).

11. Care One received payment by the Federal Government for this purported "bad debt."

Scheme Two: Fraud on New Jersey Medicaid

12. Beginning in 2013-2014, CareOne submitted claims for payment from New Jersey Managed Medicaid with **zero income** reported for the Medicaid beneficiaries.

13. By intentionally and willfully failing to report any income for its Medicaid beneficiaries, CareOne submitted bills to New Jersey Managed Medicaid resulting in overpayments for nearly every Managed Medicaid resident in each one its centers, which averaged 350 residents per month. This pattern of submitting false claims to the New Jersey Medicaid persisted until at least December 2015.

14. Relator Gathman has direct, personal knowledge that these false claims were submitted via bills to New Jersey Managed Medicaid on the CMS-1450 form (also known as the

UB-04 form), which were used for the electronic billing of institutional charges to Managed Medicaid Agencies.

15. For each and every submission to New Jersey Medicaid, CareOne explicitly and implicitly certified on the UB-04 form that there were no misrepresentations or falsifications of essential information on the billing form.

16. Acting in reckless disregard and/or deliberate ignorance of the truth, CareOne regularly routinely billed New Jersey Medicaid for several years with no (or inaccurate) offset(s) for a beneficiary's income, which resulted in overpayments by New Jersey Medicaid for many residents in each one its centers.

17. CareOne never repaid these overpayments back to New Jersey Medicaid.

18. This pattern of submitting false claims to the New Jersey Medicaid persisted from at least 2014 until approximately January 2016.

19. This widespread and longstanding Medicaid fraud occurred despite actual knowledge that no income for any beneficiary was used to offset the amount billed to New Jersey Medicaid.

20. As a direct result of CareOne's fraud on New Jersey Medicaid it unlawfully retained a significant amount of Medicaid funds, exceeding approximately $1 million in Fee for Service Medicaid (FFS) and $1 million in Managed Medicaid.

II. <u>PARTIES</u>

A. *Qui Tam* Relator Margaret Gathman

21. Relator Gathman brings this lawsuit on behalf of the United States pursuant to 31 U.S.C. §3729, *et seq.*, as amended.

22. A former top billing insider at CareOne, Relator Gathman has significant experience as a billing professional, serving as Assistant Regional Controller for CareOne from

April 2005 through July 2012. In that role, Relator Gathman managed Medicare Bad Debt Process and audits for approximately 70 facilities; implemented Medicaid and Pending Medicaid processes for CareOne centers; created tracking tools and developed relationships with local and state Medicaid officials as part of Medicaid Task Force; prepared and conducted collection and compliance training materials and webinars for staff across approximately 70 facilities; managed business operations for 11 CareOne facilities including eight skilled-nursing facilities and two home care agencies and a long-term acute care hospital; audited, managed and trained all business office personnel; reviewed Medicare Bad Debt Cost Reports for compliance; prepared monthly updates of progress and created tracking tools to assist regional managers, controllers and accountants in managing outstanding bad debt; and compiled and reconciled Medicare Bad Debt Logs, Medicare advance payments and general ledger accounts, and cost reports for approximately 70 CareOne facilities, among other roles and responsibilities. Relator Gathman's resume is attached hereto as **Exhibit A**.

23. In July 2012, Relator Gathman left CareOne to work for Atrium Health and Senior Living as the Regional Director of Accounts Receivable, where she was responsible for accounts receivable for nine centers including five skilled-nursing facilities, three assisted living facilities and a ventilator unit. In that role, she also managed all Receivables, Medicare Bad Debt and was in charge of responding to inquiries from Medicaid Recovery Audit Contractors regarding overpayments.

24. On August 19, 2015, Relator Gathman was re-hired by CareOne to serve as the Director of Shared Business Services. In that capacity, she oversaw Revenue and Accounts Receivable, implemented and managed the centralized billing program for CareOne's New Jersey operations. In that role, Relator Gathman maintained personal knowledge of centralized

billing of CareOne, including billing to Medicare and Medicaid.

25. On August 12, 2016, Relator Gathman ended her employment relationship with CareOne.

B. Defendant CareOne

26. CareOne is a corporation duly organized under the laws of the State of Delaware with its principal place of business located at 173 Bridge Plaza North, Fort Lee, New Jersey 07024.

27. CareOne is a senior care company with approximately 68 care centers located in 9 states. The company operates nursing homes and also has a hospice component, home healthcare agencies and a pharmacy company.

28. In New Jersey, CareOne manages approximately 21 sub-acute care, long term nursing care and assisted living healthcare facilities for the elderly. With over 15,000 employees and $1 billion in revenues, CareOne is New Jersey's largest privately-owned Post Acute and Long Term Care provider and one of the largest privately owned healthcare companies in the United States.

III. JURISDICTION AND VENUE

29. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §1331, and 31 U.S.C. §3732, the latter of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§3729 and 3730.

30. There have been no public disclosures of the allegations or transactions contained herein that bar jurisdiction under 31 U.S.C. §3730(e).

31. This Court has personal jurisdiction over the defendants pursuant to 31 U.S.C. §3732(a) because that section authorizes nationwide service of process and because CareOne has at least minimum contacts with the United States and can be found in, resides, or transacts or has

transacted business in the District of New Jersey.

32. Venue exists in the United States District Court for the District of New Jersey pursuant to 31 U.S.C. §3732 (a) because any one of the Defendants can be found in, reside, or transact business in this District, or because any act proscribed by 31 U.S.C. §3729 occurred in the District of New Jersey.

IV. VIOLATION OF FALSE CLAIMS ACT

A. Scheme to Submit False Cost Reports to Medicare Resulting in Overpayment

33. Medicare was created in 1966 when Title XVIII of the Social Security Act was adopted. The Centers for Medicare and Medicaid Services ("CMS") is the United States federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

34. The Federal Government pays prospectively Medicare claims submitted by those skilled nursing facilities ("SNFs") participating in the Medicare program, later requiring each such SNF to submit annually a Medicare cost report on CMS Form 2540-10.

35. Care One has violated §3729(a)(1) of the FCA, 31 U.S.C. §§3729, *et seq*., by causing Medicare cost reports to be submitted for approval or payment in violation of the explicit terms of 42 C.F.R. § 489.13; and has violated §3729(a)(2) of the FCA, by knowingly causing to be made or used a false record or statement (*i.e.* a cost report to Medicare containing a false certificate of compliance) that was used to get false claims paid or approved by the Federal Government.

36. The Medicare statute provides that non-Medicare patients shall not be forced to share the cost of treatment for Medicare patients. *See* 42 U.S.C. § 1395x(v)(1)(A)(i).

37. This ban on cross-subsidization effectively requires that "the necessary costs of efficiently delivering covered services to individuals covered by" Medicare "will not be borne by individuals not so covered." *Id.*

38. Although the costs incurred for most of the care provided to Medicare patients are

borne by the Federal Government, individual Medicare patients are often responsible for both deductible and coinsurance payments for care.

39. If Medicare patients fail to pay this portion of their care, Medicare allows for reimbursement of these "bad debts" so long as certain criteria are met. 42 C.F.R. § 413.89(e).

40. Bad debts in the Medicare context are defined as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services." 42 C.F.R. § 413.89(b)(1). Such debts are "attributable to the deductibles and coinsurance amounts" billed to Medicare patients. *Id.* at §413.89(a).

41. For reimbursement of bad debt arising from nonpayment of coinsurance and deductible amounts due from Medicare patients, a skilled nursing facility or hospital must satisfy the following four criteria: (1) the debt must be related to covered services and derived from deductible and coinsurance amounts; (2) the provider must be able to establish that reasonable collection efforts were made; (3) the debt was actually uncollectible when claimed as worthless; and (4) sound business judgment established that there was no likelihood of recovery at any time in the future. *See* 42 C.F.R. § 413.89(e).

42. In its Medicare Provider Reimbursement Manual ("PRM"), CMS defines "reasonable collection effort" as follows:

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

PRM, Chapter 3, Section 310.[1]

43. CMS requires that "[t]he provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc." PRM, Chapter 3, Section 310 B.

44. It has been CMS's longstanding policy that when an account is in collection, a provider cannot have determined the debt to be uncollectible and cannot have established that there is no likelihood of recovery under the regulations found at 42 C.F.R. §413.89(e) and in Chapter 3 of the PRM.[2] According to CMS, until a provider's reasonable collection effort (including the use of a collection agency as well as in-house efforts) has been completed, unpaid deductible and coinsurance amounts cannot be recognized as a Medicare bad debt.[3]

45. Here, CareOne knowingly submitted false claims to Medicare for reimbursement of its purported "bad debts" that were, in actuality, not allowable reimbursable costs from Medicare because CareOne did not make, or document, any collection efforts to recoup this purported bad debt as required by 42 C.F.R. § 413.89(e)(2), and thus, this so-called "bad debt" was not "actually uncollectible when claimed as worthless" as required by 42 C.F.R. § 413.89(e)(3).

46. Recoupments of Medicare bad debt are required to be reported on subsequent cost reports. These monies were retained by Care One and not returned to Medicare.

47. Relator Gathman has direct, personal knowledge that CareOne made no collection efforts to recoup this purported "bad debt" prior to making false claims to Medicare seeking reimbursement for it. She has direct, personal knowledge that this Medicare fraud

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[1] *See* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html (last visited on June 2, 2017) ("The Provider Reimbursement Manual – Part 1").
[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0824.pdf (last visited June 2, 2017).
[3] *Id.*

occurred at the following CareOne facilities:

Legal Name	D/B/A	Address	NPI Number	Medicare Billing Number
Millennium Healthcare Centers II, LLC	Care One at Creskill	221 County Rd. Cresskill, NJ 07626-1605	1225037922	315313
Care One at Madison Avenue, LLC	Care One at Madison Avenue	151 Madison Avenue Morristown, NJ 07960	1316946007	315488
Care One at Parsippany –Troy Hills, LLC	Care One at Morris	100 Mazdabrook Rd. Parsippany, NJ 07054	1851390546	315468
493 Black Oak Ridge Road, LLC	Care One at Wayne	493 Black Oak Ridge Road Wayne, NJ 07470	1861491540	315477
800 River Road Operating Company, LLC	Woodcrest Health Care Center	800 River Road New Milford, NJ 07646	1386643062	315306
11 History Lane Operating Company, LLC	Care One at Jackson	11 History Lane Jackson, NJ 08527	1932108693	315240
Elmwood Evesham Associates, LLC	Care One at Evesham	870 East Route 70 Marlton, NJ 08053	1831198399	315464
Care One at Birchwood, LLC	Care One at The Highlands	1350 Inman Ave. Edison, NJ 08820	1427057983	315132
Care One at East Brunswick, LLC	Care One at East Brunswick	599 Cranbury Road East Brunswick, NJ 08816	1669471124	315472
1621 Route 22 West Operating, LLC	Care One at Somerset Valley f/k/a Somerset Valley Rehab & Nursing Center	1621 Route 22 West Bound Brook, NJ 08805	1548372618	315002
Millennium Healthcare Centers, II, LLC	Care One at Valley	300 Old Hook Road Westwood, NJ 07675	1457350928	315369
Care One at Wall, LLC	Care One at Walk	2621 State Route 138 Wall Township, NJ 07719-9660	1659370344	315485
King James Care Center of Middletown, LLC	Care One at King James	1040 Highway 36 Middletown, NJ 07748	1598764060	315087
HHC, LLC	Care One at Holmdel	188 Highway 34 Holmdel, NJ 07733	1821097387	315092
Care Two, LLC	Care One at Livingston	68 Passaic Avenue Livingston, NJ 07039	1558360255	315479
Care One at Moorestown, LLC	Care One at Moorestown	895 Westfield Rd. Moorestown, NJ 08057-2123	1265431969	315482
101 Whippany Road, LLC	Care One at Hanover Township	101 Whippany Road Whippany, NJ 07981	1912267279	315511

48. During the time period from 2012-2016, CareOne lacked contemporaneously prepared documentation to demonstrate pursuant to 42 C.F.R. § 413.89(e) that any reasonable collections efforts were made for all these non-allowable bad debt costs submitted to Medicare for reimbursement.

49. CareOne submitted claims directly to Medicare for total reimbursement of this purported "bad debt," falsely certifying that it had make reasonable and documented collection efforts (when it had not) and that the "bad debt" was "worthless" (when it was not).

50. CareOne submits cost reports to Medicare for each of its locations by National Provider Number ("NPI") and its Medicare billing number (NSC/PTAN number). CMS requires healthcare provider such as CareOne to submit annually a cost report. Cost reports are the final "claim" that a provider submits to the Medicare program for items and services rendered to Medicare beneficiaries. At the end of the fiscal year, CareOne was required to, and did in fact, file a cost report with its designated Medicare fiscal intermediary stating the amount of reimbursement it claimed it was due for the year. *See* 42 U.S.C. § 1395g(a); 42 C.F.R. §§ 413.20; 413.335(b)(2) ("In addition to the Federal per diem payment amounts, SNFs receive payment for bad debts of Medicare beneficiaries, as specified in §413.89 of this part"); *see also* 42 C.F.R. § 405.1801(b)(1) ("In order to be paid for covered services furnished to Medicare beneficiaries, a provider must file a cost report with its contractor as specified in § 413.24 of this chapter. For purposes of this subpart, the term 'provider' includes a hospital (as described in part 482 of this chapter), hospice program (as described in § 418.3 of this chapter), critical access hospital (CAH), comprehensive outpatient rehabilitation facility (CORF), renal dialysis facility, Federally qualified health center (FQHC), home health agency (HHA), rural health clinic (RHC), skilled nursing facility (SNF), and any other entity included under the Act.").

51. As required by federal law, CareOne submitted the cost reports to Medicare, which included a Bad Debt Log that captured amounts of bad debt owed to CareOne. An exemplar Bad Debt Log used by CareOne is attached hereto as **Exhibit B.** Relator Gathman developed the template of this exemplar Bad Debt Log for CareOne, and thus, Relator Gathman has direct personal knowledge of CareOne's cost reports and its Bad Debt Logs. *See* **Exhibit B**; **Exhibit C** (FORM CMS-2540-10), which is CMS's sample bad debt log form.

52. For nearly every cost report submitted to Medicare from CareOne's New Jersey centers listed above, CareOne falsely certified that the cost reports were not infected, as they were, by an unlawful activity, including, but not limited to, seeking dollar-for-dollar reimbursement from Medicare for non-allowable costs for bad debt that CareOne never attempted to collect in the first instance, as required by 42 C.F.R. § 413.89.

53. CareOne made express false certifications for each cost report it submitted to Medicare annually for the years 2012-2016. CareOne is paid by Medicare on an interim basis for services and items rendered; however, in order to retain eligibility for those payments, CMS requires providers such as CareOne to submit annually a cost report. Cost reports are the final "claim" that a provider believes it is due for the year. *See* 42 U.S.C. § 1395g(a); 42 C.F.R. § 413.20; *see also* 42 C.F.R. § 405.1801(b)(1).

54. Medicare cost reports contain the following certification by providers, such as CareOne:

> MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK

> OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.
>
> I HEREBY CERTIFY that I have read the above certification statement and that ***I have examined the accompanying electronically filed or manually submitted cost report*** and the Balance Sheet and Statement of Revenue and Expenses prepared by [Provider Name(s) and Provider CCN(s)] for the cost reporting period beginning ___ and ending ____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that ***I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.***

Exhibit D (FORM CMS-2540-10) (emphasis added).

55. In addition, the CMS-2540-10 Form, at Line 9, specifically requests the skilled nursing facility to "Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries." *See* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R5P241.pdf (last visited on June 2, 2017) at p. 41-20. According to the instructions for the Form, skilled nursing facilities must: "Enter 'Y' for yes or 'N' for no in column 1. ***If you answer "Y" in column 1, submit a completed Exhibit 1 or internal schedules duplicating the documentation requested on Exhibit 1 to support the bad debts claimed.***" *Id.* (emphasis added).

56. Exhibit 1 to Form CMS-2540-10 is depicted in **Exhibit C**, attached hereto.

57. The CMS-2540-10 form also requires a provider to document the "Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased," and states that this information should be obtained from the provider's files and should correlate with the beneficiary name, HIC number,

and dates of service shown in columns 1, 2 and 3 of this exhibit. The dates in column 6 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See CFR 413.89(f), and CMS Pub. 15-1, §§308, 310, and 314)." *See* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R5P241.pdf (last visited on June 2, 2017) at p. 41-20. Column 10 on the CMS-2540-10 Form is where "Total Medicare Bad Debts" were submitted to Medicare. *See id.* at p. 41-21; **Exhibit C**.

58. In submitting its cost reports to Medicare, CareOne explicitly and implicitly certified compliance with the above certification language on the CMS-2540-10 Form, attached hereto as **Exhibit D**.

59. These express and implied certifications were false because CareOne submitted false claims to Medicare for reimbursement of bad debts that were not allowable costs because CareOne did not make, or document, any collection efforts to recoup this bad debt as required by 42 C.F.R. §413.89(e)(2), and thus, this bad debt was not "actually uncollectible when claimed as worthless" as required by 42 C.F.R. §413.89(e)(3).

60. Relator Gathman has direct, personal knowledge that CareOne made no collection efforts to recoup a large portion of this "bad debt" prior to making false claims to Medicare seeking reimbursement for all such unallowable "bad debt."

61. CareOne knowingly failed to make any collection efforts prior to submitting these false claims to Medicare. A large amount of claims were submitted to secondary insurance carriers. When the carriers failed to pay the claim often for timeliness, the balances were written off and claimed as "bad debt." In these cases, CareOne submitted false claims to Medicare for full reimbursement of these "bad debts," without first billing a Medicare

beneficiary to collect on the "bad debt," and without making any collection efforts prior to billing Medicare.

62. CareOne knowingly executed this scheme to defraud Medicare and with the requisite scienter. As Relator Gathman observed firsthand, CareOne undertook a *post hoc* effort to cover-up their lack of collection efforts by preparing false, "back-dated" statements and collection letters that were never actually sent to Medicare beneficiaries. Many of these false collections statements never even included the recipients' addresses, as they were never actually sent by CareOne. This was a complete ruse to justify the false cost reports seeking reimbursement for non-allowable bad debt. Relator Gathman observed these false collection letters firsthand on numerous occasions that were prepared in the preparation of cost reports and ***after*** CareOne had already submitted cost reports claiming non-allowable bad debts for those Medicare beneficiaries.

63. Relator Gathman discovered the magnitude of this cover-up of CareOne's false claims of non-allowable bad debts on its cost reports in approximately November/December 2015 when Stacy Ashworth ("Ashworth"), the former director of Jackson billing office, requested CareOne letterhead for several of CareOne's centers (Evesham, East Brunswick and Highlands). When Relator Gathman asked Ashworth why she needed the letterhead, Ashworth informed her that it was for the collection letters she was retroactively preparing for the Bad Debt Logs. Accordingly, as of November/December 2015, these CareOne centers had not undertaken reasonable collection efforts, making the "bad debts" not allowable on the false cost reports.

64. In the course of her employment, Relator Gathman also discovered that these "back-dated" false collection letters were also being prepared by Angela Bayarovich

("Bayarovich") and Angela Kelly ("Kelly"), Regional Business Office Managers for New Jersey, reportedly at the direction of Kevin Howe, the former Vice President of Revenue and Accounts Receivable at CareOne. Bayarovich also created "back-dated" false collection letters when she determined that the billing statements that were created failed to include an actual address for the purported recipient, which demonstrates that they were not billed prior to the bad debt submission to Medicare on the cost reports or within the time frames required by Medicare.

65. Relator Gathman has direct, personal knowledge of CareOne's "back-dated" false collection statements.

66. Further, CareOne's billing software program, Point Click Care (PCC), implemented in 2012-2014, had a function to electronically generate the collection letters to Medicare beneficiaries. However, this software function was not utilized and senior CareOne billing personnel, including Bayarovich and Kelly, manually prepared these "back-dated" false statements and collection letters. For a large portion of the original billing statements to Medicare beneficiaries on the PCC the addresses were blank. Therefore, Bayarovich recreated "back-dated" false collection statements to make it appear as if that reasonable collection efforts had been performed in accordance with 42 C.F.R. § 413.89(e)(2) when they were not. Medicare beneficiaries were not timely billed prior to the bad debt submission to Medicare on the cost reports. Relator Gathman has direct, personal knowledge of this fraud.

67. Relator Gathman has detailed inside knowledge of instances where the cost reports contained requests to Medicare seeking payment for bad debt that were never sought to be collected by CareOne. For example, during a conversation on early 2016, Lauren Jesch ("Jesch"), the Business Office Manager at CareOne's Cresskill, New Jersey location (NPI

1225037922; Medicare Billing No. 315313) indicated she was putting "bad debt" on logs that had been waived as part of the CareOne's hardship program. The CareOne hardship program was that if Medicare beneficiaries proved a financial hardship, the CareOne center would then write off the copay which meant it ***should not*** be claimed on the cost reports. Jesch sent Relator Gathman an email indicating that she had been instructed by the regional controller for CareOne, Cassidy Bancroft ("Bancroft"), to ***include*** as "bad debt" the copays that were written off under CareOne's hardship program.

68. Relator Gathman observed firsthand the copies of submissions of false claims to Medicare with fraudulent cost reports on CareOne's Bad Debt Logs.

69. In early 2016, Relator Gathman raised this cost report issue to the Compliance Officer at CareOne, Linda Martin ("Compliance Officer Martin"). Relator Gathman forwarded Jesch's email to the Compliance Officer Martin, and requested that Compliance Officer Martin send a clarification to the CareOne centers stating this was not an acceptable practice.

70. After Relator Gathman advised Compliance Officer Martin of this unlawful practice, Compliance Officer Martin scheduled a conference call with the administrator, Cheryl Dorn, Jesch, and Bayarovich to discuss the issue of CareOne's submitting cost reports to Medicare with non-allowable "bad debts." Bayarovich confirmed that Bancroft had in fact instructed billing officers to include as bad debt the copays that were written off under CareOne's hardship program.

71. In January 2016, Relator Gathman reviewed the Medicare coinsurance collections. Beginning in February 2016, Relator Gathman implemented a new process for ensuring that all residents and families would have explained and been notified in writing of the coinsurance obligation within three (3) days of admission. These meetings were to be

documented in or uploaded to the PCC software. Additionally, Relator Gathman implemented biweekly calls with the administrators to ensure these meetings and the appropriate collection process was in place. By June 2016, nearly every CareOne facility was collecting 100% or more of the Medicare coinsurance due from the residents. Also any coinsurance waived due to financial hardship was being written off instead of included on the Medicare Bad Debt Logs. As reflected on the spreadsheet attached as **Exhibit E**, CareOne's collections surpassed previous coinsurance collections, which demonstrates that when appropriate collection processes are followed, the actual collections improved.

72. As a result of CareOne's false statements, false or fraudulent claims and false cost report submissions, CareOne wrongfully obtained payments from Medicare to which they were not entitled.

73. None of the Bad Debt Logs with the unallowable claims for reimbursement for bad debt were corrected by CareOne, however, and CareOne unlawfully retained payments from Medicare resulting from these false cost reports.

74. As a direct result of CareOne's fraud on Medicare it unlawfully retained significant federal funds exceeding approximately $10 million.

75. The FCA provides that any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the United States for payment or approval is liable for a civil penalty of up to $11,000 for each such claim, plus three times the amount of the damages sustained by the United States.

76. The FCA allows any person having information about a false or fraudulent claim against the United States to bring an action for himself and the United States, and to share in any recovery. Relator Gathman now seeks treble damages and penalties for each false claim and each

false statement under the False Claims Act 31 U.S.C. §3729, *et seq.*, as amended.

V. VIOLATION OF NEW JERSEY FALSE CLAIMS ACT

77. Medicaid is a federal health insurance system that is administered by the states and is available to low-income individuals and families who meet eligibility requirements determined by federal and state law (herein referred to as "Medicaid Beneficiaries"). Medicaid pays for items and services pursuant to plans developed by the states, including New Jersey, and approved by the Department of Health and Human Services ("HHS") through CMS. *See* 42 U.S.C. § 1396a(a)-(b).

78. States, including New Jersey, pay health care providers according to established rates, and the Federal Government then pays a statutorily established share of "the total amount expended . . . as medical assistance under the State plan." *See* 42 U.S.C. § 1396b(a)(1).

79. In New Jersey, the Department of Human Services ("DHS"), is the State agency responsible for operating the Medicaid program. Within DHS, the Division of Medical Assistance and Health Services administers the Medicaid program. DHS employees work at Medical Assistance Customer Centers ("MACC") throughout the State to assist Medicaid Beneficiaries.

80. Under the New Jersey Medicaid program, the "available income" of Medicaid participants receiving care in a nursing facility should be applied against the cost of care. N.J.A.C. 8:85-1.16(a)(2017). This is referred to as "Patient Pay Liability" or PPL.

81. The County Welfare Agencies (CWAs) collect and calculate PPL information for LTC clients to offset the cost of care in an institutional setting. The Personal Responsibility ("PR") form calculates the PPL. The PR form has three different categories which represent an individual Medicaid beneficiary's living arrangement. A PR-1 form is for a nursing facility; a PR-2 form is for an assisted living facility; and a PR-3 form is for home-based living. *See*

http://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2014/14-15_Qualified_Income_Trust.pdf at FAQ No. 16 (last visited on June 2, 2017); **Exhibit F** (PR-1 form). A new form must be created whenever an individual has a change in circumstances such as an increase or decrease in income, or if they change their living arrangement. All changes in circumstances must be reported to the appropriate eligibility determining agency when they occur, as required on the Medicaid application.

82. The PR form determines the total monthly amount a Medicaid beneficiary pays the facility.

83. After the provision for the beneficiary's Personal Needs Allowance ("PNA")[4] is met, and then after provision for other allocations such as maintenance of spouse and/or dependent's home are satisfied, the remainder of the Medicaid beneficiary's income shall be applied to the cost of care in the nursing facility, which includes per diem, bed reserve and other allowable expenses. N.J.A.C. § 8:85-1.16 (a)(2017).

84. Beginning in 2013-2014, CareOne submitted claims for payment from New Jersey Managed Medicaid with **zero income** reported for the Medicaid beneficiaries.

85. By intentionally and willfully failing to report any income for its Medicaid beneficiaries, CareOne submitted bills to New Jersey Managed Medicaid resulting in overpayments for nearly every Managed Medicaid resident in each one its centers, which averaged 350 residents per month. This pattern of submitting false claims to the New Jersey Medicaid persisted until at least December 2015.

86. Relator Gathman has direct, personal knowledge that these false claims were submitted via bills to New Jersey Managed Medicaid on the CMS-1450 form (also known as the

[4] PNA is intended for residents to spend at their discretion on items such as telephone expenses, certain meals, friends, cards to send to family, reading materials, or hobbies.

UB-04 form), which were used for the electronic billing of institutional charges to Managed Medicaid Agencies. *See* **Exhibit G** (available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1104CP.pdf) (last visited on June 2, 2017).

87. On the UB-04 form, there is a Notice to all entities submitting a CareOne that states: "THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S)." *Id.*

88. Further, the UB-04 states that the "[s]ubmission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts." *Id.*

89. Section 8 of the UB-04 form also contains the following certification: "For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws." *Id.*

90. For each and every submission to New Jersey Medicaid, CareOne explicitly and implicitly certified on the UB-04 form that there were no misrepresentations or falsifications of essential information on the billing form. The administrator had to sign a monthly certification which was then input electronically to the state's site along with the billing.,

91. Relator Gathman has direct and personal knowledge that CareOne submitted claims for payment from New Jersey Managed Medicaid without offsetting any beneficiary's

income beginning in 2014. Acting in reckless disregard and/or deliberate ignorance of the truth, CareOne regularly routinely billed New Jersey Medicaid for several years with no offset or inaccurate offsets for the beneficiary's income, which resulted in overpayments for nearly every resident in each one its centers, which averaged 350 residents per month.

92. This pattern of submitting false claims to the New Jersey Managed Medicaid persisted from 2012 until at least January 2016.

93. The Medicaid regulations also stipulate that the facility is required to submit adjusted claims for any overpayments in a timely manner. In nearly all of the NJ centers, these adjustments were not being submitted starting in 2012 and continuing through 2016 for both the Managed Medicaid and the FFS Medicaid participants. In several centers the failure to adjust these overpayments dated back several years prior to 2012. The time frame for submission was clarified by CMS to be within 60 days of the date the overpayment was identified.

94. Regional Revenue Directors, Angela Kelly and Angela Bayrovich were instructed in early 2016 to ensure that their business office managers created adjusted claims in order to return these overpayments, which they failed to do.

95. This widespread and longstanding Medicaid fraud occurred despite actual knowledge that no income for any beneficiary was used to offset the amount billed to New Jersey Medicaid. The resulting overpayments appeared on the monthly Accounts Receivable reports which were submitted to the accounting department.

96. As a direct result of CareOne's fraud on New Jersey Medicaid it unlawfully retained a significant amount of Medicaid funds, exceeding approximately $1 million in Fee For Service Medicaid (FFS) and $1 million in Managed Medicaid.

CAUSES OF ACTION

Count I

False Claims Act 31 U.S.C. §3729(a)(1)(A)

97. Relator Gathman repeats and realleges each and every allegation contained in the paragraphs above as though fully set forth herein.

98. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §3729, *et seq.*, as amended.

99. By virtue of the acts described above, CareOne knowingly presented or caused to be presented, false or fraudulent claims to officers, employees or agents of the United States Government for payment or approval under the Medicare program, within the meaning of 31 U.S.C. §3729(a)(1).

100. CareOne submitted cost reports to Medicare seeking reimbursement for bad debts that were not allowable pursuant to 42 C.F.R.§ 489.13 and the Manual because CareOne had never made any collection efforts before submitting the false claim to Medicare.

101. The cost reports on the Form CMS-2540-10 certifications filed by CareOne include non-allowable "bad debts" on the Bad Debt Log, thus causing the certification alleged herein on Form CMS-2540-10 reports to be "false records or statements."

102. The United States, unaware of the falsity of the records, statements and claims made or caused to be made by CareOne, paid and continues to pay the claims that would not be paid but for the unlawful conduct set forth in detail in this Complaint.

103. Certification of compliance on Form CMS-2540-10 is an absolute condition precedent to healthcare providers such as CareOne retaining the funds paid by the Medicare.

104. CareOne did not correct its Bad Debt Logs, and CareOne unlawfully retained payments from Medicare resulting from these false cost reports.

105. But for the above violations of the FCA caused by CareOne, Medicare would not have paid for, *inter alia,* CareOne's claims for reimbursement of bad debts to which CareOne was not and is not entitled.

106. By reason of CareOne's acts, the United States has been damaged, and continues to be damaged, in substantial amount to be determined at trial.

107. Additionally, the United States is entitled to the maximum penalty of $11,000 for each and every false and fraudulent claim made and caused by defendants arising from their unlawful conduct as described herein.

Count II
False Claims Act 31 U.S.C. §§3729 (a)(1)(B)

108. Relator Gathman repeats and realleges each and every allegation contained in the paragraphs above as though fully set forth herein.

109. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §3729, *et seq*., as amended.

110. By virtue of the acts described above, CareOne knowingly made, used, or caused to be made or false or fraudulent records and statements including the Bad Debt Logs, the costs reports, and the false "back-dated" collection letters, and omitted material facts, in order to get false and fraudulent claims paid or approved under the Medicaid program, within the meaning of 31 U.S.C. § 3729(a)(1)(B).

111. These false "back-dated" collection letters and also Bad Debt Logs were false records and/or statements material to a false or fraudulent claim, pursuant to 31 U.S.C. § 3729(a)(1)(B).

112. The United States, unaware of the falsity of these above-referenced records, statements and claims made or caused to be made by CareOne, paid and continues to pay the

claims that would not be paid but for the unlawful conduct set forth in detail in this Complaint.

113. By reason of CareOne's acts, the United States has been damaged, and continues to be damaged, in substantial amount to be determined at trial.

114. Additionally, the United States is entitled to the maximum penalty of $11,000 for each and every false and fraudulent claim made and caused to be made by defendants arising from their unlawful conduct as described herein.

Count III
New Jersey False Claims Act – N.J.S.A. § 2A:32C-3(b)

115. Relator Gathman repeats and realleges each and every allegation contained in the paragraphs above as though fully set forth herein.

116. CareOne knowingly made, used or caused to be made or used, false records or false statements material to the foregoing false or fraudulent claims to get these false or fraudulent claims paid and approved by the State of New Jersey, in violation of N.J.S.A. § 2A:32C-3(b).

117. CareOne knowingly made and/or submitted false records or false statements that were material, and on information and belief continue to be material, to the false and fraudulent claims for payments it made to the State of New Jersey for Medicaid reimbursements and benefits.

118. CareOne's material false records or false statements are set forth above and include, but are not limited to, claim forms and/or records that resulted in the overpayment by New Jersey Medicaid.

119. These said false records or false statements were made, used or caused to be made or used, with CareOne's actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

120. As a direct and proximate result of these materially false records or false statements, and the related false or fraudulent claims made by CareOne, the State of New Jersey has suffered damages and, therefore, is entitled to recovery as provided by the New Jersey False Claims Act in an amount to be determined at trial, plus a civil penalty of not less than and not more than the civil penalty allowed under the federal False Claims Act.

PRAYER FOR RELIEF

WHEREFORE, Relator Gathman, on behalf of the United States of America and the State of New Jersey, requests the Court enter the following relief:

A. That CareOne be ordered to cease and desist submitting cost reports with non-allowable bad debts;

B. That CareOne be ordered to cease and desist all violations of 31 U.S.C. §3729, *et seq.* alleged in this Complaint;

C. That this Court enter judgment against CareOne, in an amount equal to three times the amount of damages the United States and the State of New Jersey has sustained because of CareOne's actions, plus a civil penalty of not less than $5,500 and not more than $11,000 for each violation of 31 U.S.C. §3729, *et seq.* and/or § 2A:32C-3 of the New Jersey False Claims Act;

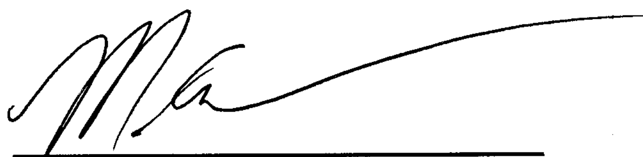
D. That Relator Gathman be awarded the maximum amount allowed pursuant to §3730(d) of the False Claims Act and/or § 2A:32C-7 of the New Jersey False Claims Act;

E. That Relator Gathman be awarded all costs of this action, including attorneys' fees and expenses, and all interest;

F. That Relator Gathman recover such other relief as the Court deems just and proper; and

G. The Relator Gathman be granted a trial by jury on all issues so triable.

Dated: August 14, 2017



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Attorneys for Relator Margaret Gathman

CERTIFICATE OF SERVICE

I hereby certify that I caused a true and correct copy of the foregoing Complaint to be served upon the following on the date and manner listed below:

VIA REGISTERED MAIL,
RETURN RECEIPT REQUESTED

Hon. Jeff Sessions
Attorney General of the United States
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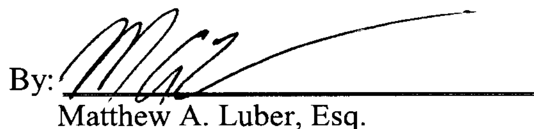
By: 
Matthew A. Luber, Esq.

Date: August 4, 2017