UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 18-20428 CR-UNGARO

/O'SULLIVAN

18 U.S.C. § 371
42 U.S.C. § 1320a-7b(b)(2)(A)
18 U.S.C. § 2
18 U.S.C. § 982(a)(7)

UNITED STATES OF AMERICA

vs.

ROSA MARIA BAEZ,

Defendant.
_____/

INDICTMENT

The Grand Jury charges that:

GENERAL ALLEGATIONS

At all times material to this Indictment:

The Medicare Program

1. The Medicare Program ("Medicare") was a federal health care program providing benefits to persons who were 65 or older or disabled. Medicare was administered by the United States Department of Health and Human Services ("HHS"), through its agency, the Centers for Medicare and Medicaid Services ("CMS"). Individuals who received benefits under Medicare were referred to as Medicare "beneficiaries."

2. Medicare was a "health care benefit program," as defined by Title 18, United States Code, Section 24(b).

3. "Part A" of the Medicare program covered certain eligible home health care costs for medical services provided by a home health agency ("HHA") to beneficiaries who required home health services because of an illness or disability that caused them to be homebound.

4. Physicians, clinics, and other health care providers, including HHAs, that provided services to Medicare beneficiaries were able to apply for and obtain a "provider number." A health care provider that received a Medicare provider number was able to file claims with Medicare to obtain reimbursement for services provided to beneficiaries. A Medicare claim was required to set forth, among other things, the beneficiary's name and Medicare identification number, the services that were performed for the beneficiary, the date the services were provided, the cost of the services, and the name and provider number of the physician or other health care provider who ordered the services.

5. CMS did not directly pay Medicare Part A claims submitted by Medicare-certified HHAs. CMS contracted with different companies to administer the Medicare Part A program throughout different parts of the United States. In the State of Florida, CMS contracted with Palmetto Government Benefits Administrators ("Palmetto"). As administrator, Palmetto was to receive, adjudicate and pay claims submitted by HHA providers under the Part A program for home health services. Additionally, CMS separately contracted with companies in order to review HHA providers' claims data. CMS first contracted with TriCenturion, a Program Safeguard Contractor. Subsequently, on December 15, 2008, CMS contracted with SafeGuard Services, a Zone Program Integrity Contractor. Both TriCenturion and SafeGuard Services safeguarded the Medicare Trust Fund by reviewing HHA providers' claims for potential fraud, waste, and/or abuse.

Part A Coverage and Regulations

Reimbursements

6. The Medicare Part A program reimbursed 100% of the allowable charges for participating HHAs providing home health care services only if the patient qualified for home health benefits. A patient qualified for home health benefits only if:

(a) the patient was confined to the home, also referred to as homebound;

(b) the patient was under the care of a physician who specifically determined there was a need for home health care and established the Plan of Care ("P.O.C."); and

(c) the determining physician signed a certification statement specifying that the beneficiary needed intermittent skilled nursing, physical therapy, speech therapy, or a continued need for occupational therapy; that the beneficiary was confined to the home; that a POC for furnishing services was established and periodically reviewed; and that the services were furnished while the beneficiary was under the care of the physician who established the P.O.C.

Record Keeping Requirements

7. Medicare Part A regulations required HHAs providing services to Medicare beneficiaries to maintain complete and accurate medical records reflecting the medical assessment and diagnoses of their patients, as well as records documenting the actual treatment of the patients to whom services were provided and for whom claims for reimbursement were submitted by the HHA. These medical records were required to be sufficiently complete to permit Medicare, through Palmetto and other contractors, to review the appropriateness of Medicare payments made to the HHA under the Part A program.

8. Among the written records required to document the appropriateness of home health care claims submitted under Part A of Medicare was a (i) POC that included the physician

order for home health care, diagnoses, types of services/frequency of visits, prognosis/rehabilitation potential, functional limitations/activities permitted, medications/treatments/nutritional requirements, safety measures/discharge plans, goals, and the physician's signature; and (ii) a signed certification statement by an attending physician certifying that the patient was confined to his or her home and was in need of the planned home health services.

9. Medicare Part A regulations required provider HHAs to maintain medical records of every visit made by a nurse, therapist, or home health aide to a beneficiary. The record of a nurse's visit was required to describe, among other things, any significant observed signs or symptoms, any treatment and drugs administered, any reactions by the patient, any instruction provided to the patient and the understanding of the patient, and any changes in the patient's physical or emotional condition. The home health nurse, therapist, and aide were required to document the hands-on personal care provided to the beneficiary as the services were deemed necessary to maintain the beneficiary's health or to facilitate treatment of the beneficiary's primary illness or injury. These written medical records were generally created and maintained in the form of "clinical notes" and "home health aide notes/observations."

10. Medicare regulations allowed Medicare certified HHAs to subcontract home health care services to nursing companies, therapy staffing services agencies, registries, or groups (nursing groups), which would bill the certified HHA. The HHA would, in tum, bill Medicare for all services provided to beneficiaries by the subcontractor. The HHA's professional supervision over subcontracted-for services required the same quality controls and supervision as of its own salaried employees.

The Defendant, Relevant Entity, and Individuals

11. Eternity Life Health Care Inc. ("ETERNITY") was a Florida corporation, located at 5785 NW 151st Street, Miami Lakes, Florida, that purported to do business in Miami-Dade County as an HHA.

12. Defendant **ROSA MARIA BAEZ,** a resident of Miami-Dade County, was the registered agent of ETERNITY.

13. Individual 1 was a resident of Miami-Dade County.

14. Individual 2 was a resident of Miami-Dade County.

COUNT 1
Conspiracy to Defraud the United States and Pay and Receive Health Care Kickbacks (18 U.S.C. § 371)

1. The General Allegations section of this Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. From in or around July of 2016, through in or around December of 2017, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

ROSA MARIA BAEZ,

did knowingly, that is, with the intent to further the objects of the conspiracy, and willfully, combine, conspire, confederate, and agree with others, known and unknown to the Grand Jury, to commit certain offenses against the United States, that is:

a. to defraud the United States by impairing, impeding, obstructing, and defeating through deceitful and dishonest means, the lawful government functions of the United States Department of Health and Human Services in its administration and oversight of the Medicare program, in violation of Title 18, United States Code, Section 371; and

b. to violate Title 42, United States Code, Section 1320a-7b(b)(2)(A), by knowingly and willfully offering and paying remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, in return for referring an individual to a person for the furnishing and arranging for the furnishing of an item and service for which payment may be made in whole or in part under a federal health care program, that is, Medicare.

Purpose of the Conspiracy

3. It was a purpose of the conspiracy for **ROSA MARIA BAEZ** and her co-conspirators to unlawfully enrich themselves by: (a) offering, paying, soliciting and receiving kickbacks and bribes in return for referring beneficiaries to ETERNITY to serve as patients; (b) offering, paying, soliciting and receiving kickbacks and bribes in return for serving as patients of ETERNITY; and (c) submitting and causing the submission of claims to Medicare for home health services that ETERNITY purported to provide to those recruited beneficiaries.

Manner and Means of the Conspiracy

The manner and means by which **ROSA MARIA BAEZ** and her co-conspirators sought to accomplish the objects and purpose of the conspiracy included, among others, the following:

4. **ROSA MARIA BAEZ** paid and caused the payments of kickbacks and bribes to beneficiaries in exchange for serving as patients at ETERNITY.

5. **ROSA MARIA BAEZ** and her co-conspirators caused ETERNITY to submit claims to Medicare for home health services purportedly provided to the recruited Medicare beneficiaries.

6. **ROSA MARIA BAEZ** and her co-conspirators caused Medicare to pay ETERNITY based upon the claims submitted for home health services purportedly provided to the recruited beneficiaries.

Overt Acts

In furtherance of the conspiracy, and to accomplish its objects and purpose, at least one of the co-conspirators committed and caused to be committed in the Southern District of Florida, at least one of the following overt acts, among others:

1. On or about July 5, 2017, **ROSA MARIA BAEZ** paid Individual 2 approximately $1,400 to pay and cause the payment of a kickback to Medicare beneficiary A.P. for serving as a patient at ETERNITY.

2. On or about November 29, 2017, **ROSA MARIA BAEZ** paid Individual 2 approximately $1,600 to pay and cause the payment of a kickback to Medicare beneficiary L.S. for serving as a patient at ETERNITY.

All in violation of Title 18, United States Code, Section 371.

COUNTS 2-3
Payment of Kickbacks in Connection with a Federal Health Care Program
(42 U.S.C. § 1320a-7b(b)(2)(A))

1. The General Allegations section of this Indictment is re-alleged and incorporated by reference as though fully set forth herein.

2. On or about the dates set forth below as to each count, in Miami-Dade County, in the Southern District of Florida, and elsewhere, the defendant,

ROSA MARIA BAEZ,

did knowingly and willfully offer and pay any remuneration, including kickbacks and bribes, directly and indirectly, overtly and covertly, in cash and in kind, as set forth below, in return for

referring an individual to a person for the furnishing and arranging for the furnishing of any item and service for which payment may be made in whole and in part under a federal health care program, that is, Medicare, as set forth below:

Count	Approximate Date of Kickback	Medicare Beneficiary	Approximate Kickback Amount
2	July 5, 2017	A.P.	$1,400
3	November 29, 2017	L.S.	$1,600

In violation of Title 42, United States Code, Section 1320a-7(b)(2)(A) and Title 18, United States Code, Section 2.

FORFEITURE
(18 U.S.C. § 982(a)(7))

1. The allegations contained in this Indictment are re-alleged and incorporated by reference as though fully set forth herein for the purpose of alleging forfeiture to the United States of certain property in which the defendant, **ROSA MARIA BAEZ**, has an interest.

2. Upon conviction of a violation of Title 18, United States Code, Section 371, as alleged in Count 1 of this Indictment, or of Title 42, United States Code, Section 1320a-7b(b)(2)(A), as alleged in Counts 2 through 3 of this Indictment, the defendant shall forfeit to the United States, pursuant to Title 18, United States Code, Section 982(a)(7), any property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of such violation.

3. The property to be forfeited includes, but is not limited to, the sum of money equal in value to the gross proceeds traceable to the commission of the offenses alleged in this Indictment, approximately $253,049, which the United States will seek as a forfeiture money judgment as part of the defendant's sentence.

4. 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 the property which cannot be divided without difficulty,

the United States shall be entitled to forfeiture of substitute property pursuant to Title 21, United States Code, Section 853(p).

All pursuant to Title 18, United States Code, Section 982(a)(7); and the procedures set forth at Title 21, United States Code, Section 853, as made applicable through Title 18, United States Code, Section 982(b)(1).

A TRUE BILL

FOREPERSON

BENJAMIN G. GREENBERG
UNITED STATES ATTORNEY

MIESHA SHONTA DARROUGH
ASSISTANT UNITED STATES ATTORNEY