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**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF NEW YORK**

UNITED STATES OF AMERICA *ex rel.* WENDY MORALES,

Plaintiff and Relator,

-against-

TCPRNC, LLC d/b/a THE PLAZA REHAB AND NURSING CENTER *et al.*,

Defendants.

**COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA**

18 Civ. 9651 (GBD)

**JURY TRIAL DEMANDED**

UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

-against-

TCPRNC, LLC d/b/a THE PLAZA REHAB AND NURSING CENTER and CITADEL CONSULTING GROUP LLC d/b/a CITADEL CARE CENTERS LLC,-

Defendants.

The United States of America, by its attorney, Damian Williams, United States Attorney for the Southern District of New York, alleges for its complaint-in-intervention as follows:

## PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the United States under the False Claims Act (the "FCA") against Defendant TCPRNC, Inc., which owns and operates The Plaza Rehab And Nursing Center ("Plaza Rehab Center"), a skilled nursing facility in the Bronx, and Defendant Citadel Consulting Group LLC (collectively "Defendants"), which provides administrative services for the facility. Defendants fraudulently switched the type of Medicare coverage in which elderly Plaza Rehab Center residents were enrolled in order to maximize the Medicare payments Defendants received. The residents and their families often did not request, consent to, or know about the change to their healthcare coverage, which had the potential to impact their out-of-pocket payments, the scope of the services and care covered, and their drug coverage plan.

2. Skilled nursing facility residents, like others, have the exclusive right to choose their own healthcare insurance coverage. Qualifying individuals may enroll in the original parts of Medicare, known as Original Medicare, or in Medicare Advantage Plans, which are administered by private companies that contract with the government. The Centers for Medicare & Medicaid Services ("CMS") advises individuals to consider various factors in deciding between a Medicare Advantage Plan and Original Medicare, such as differences in out-of-pocket costs and doctor choice.

3. From September 1, 2016, to February 28, 2019 (the "Relevant Time Period"), Defendants violated the FCA by submitting, or causing to be submitted, false claims to Original Medicare seeking payment for care provided to Plaza Rehab Center residents whom Defendants had disenrolled from their self-selected Medicare Advantage Plans and enrolled in Original Medicare without obtaining the residents' consent or the consent of their authorized legal representatives. As a result, Defendants received higher payments than they would have otherwise received if these residents had remained enrolled in their Medicare Advantage Plans.

4. As early as 2015, CMS warned skilled nursing facilities that this precise fraudulent scheme was "unacceptable" and "noncompliant with regulatory requirements." Nonetheless, under pressure from Defendant Citadel Care Centers, LLC ("Citadel"), to decrease the number of residents enrolled in Medicare Advantage Plans, Plaza Rehab Center staff tried to hit a monthly quota of resident disenrollments.

5. Although Plaza Rehab Center had a process in which staff were supposed to have residents or their representatives sign forms memorializing their consent to an insurance change before disenrolling the residents from their Medicare Advantage Plan, Plaza Rehab Center staff frequently disenrolled residents from their Plan and enrolled them in Original Medicare without obtaining such a signed consent form. In addition, on many occasions, Plaza Rehab Center staff purportedly obtained the resident's consent, but the resident did not have the capacity to provide consent because of their health condition.

6. Plaza Rehab Center staff logged onto the Medicare.gov website, misrepresented their own identity, and used residents' personal information—without their consent—to switch a resident's insurance coverage elections. Plaza Rehab Center then submitted claims to Original Medicare for skilled nursing facility care provided to these residents, even though the residents had never, in fact, elected to enroll in Original Medicare.

7. The Government brings claims against Defendants under the FCA to recover treble damages sustained by, and civil penalties owed to, the Government resulting from the submission of false and fraudulent claims for reimbursement to Medicare. The Government also seeks to recover damages under common law for Defendants' unjust enrichment.

## JURISDICTION AND VENUE

8. This Court has jurisdiction over the claims brought under the FCA pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C. §§ 1331 and 1345, and over the common law claims pursuant to 28 U.S.C. § 1345.

9. The Court may exercise personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a), which provides for nationwide service of process.

10. Venue lies in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1391(b) and 1391(c) because Defendants reside and transact business in this District and a substantial part of the acts complained of took place in this District.

## PARTIES

11. Plaintiff is the United States of America. Through the Department of Health and Human Services ("HHS"), and more specifically through CMS, a component agency within HHS, the Government administers the Medicare Program.

12. Relator Wendy Morales resides in New York and is the granddaughter of Juan Zayas, a former resident of the Plaza Rehab Center.

13. Defendant TCPRNC, LLC d/b/a The Plaza Rehab And Nursing Center is a New York limited liability company that operates and manages the Plaza Rehab Center, a skilled nursing facility located at 100 West Kingsbridge Road, Bronx, NY 10468. The Plaza Rehab Center is part of the Citadel network of skilled nursing facilities that are located in the Bronx, New York.

14. Citadel Consulting Group LLC d/b/a Citadel Care Centers LLC, is a New York limited liability company that provides administrative services to skilled nursing facilities that are part of the Citadel skilled nursing facility network, including the Plaza Rehab Center. Citadel's principal place of business is located at 1000 Gates Avenue, Brooklyn, New York 11221.

## BACKGROUND

### I. MEDICARE PARTS A AND C

15. Medicare is a federally operated health insurance program administered by CMS, benefiting individuals 65 and older and the disabled. *See* 42 U.S.C. § 1395c *et seq*. Medicare covers up to 100 days of "skilled nursing care" per illness. The first 20 days are covered fully, and beneficiaries are required to make a daily co-payment starting on day 21 at the skilled nursing facility.

16. There are two main ways for qualifying individuals to enroll in Medicare. First, an individual may enroll in "Original Medicare," which includes Medicare Parts A and B. Part A covers inpatient and institutional care (including skilled nursing and rehabilitation care), while Part B covers physician, hospital, outpatient, and ancillary services and durable medical equipment.

17. Alternatively, an individual may elect to receive Part A and Part B benefits through a Medicare Advantage Plan pursuant to Medicare Part C. These Medicare Advantage Plans are operated and managed by Medicare Advantage Organizations, which are private insurers such as UnitedHealth Group, Anthem, and WellCare of New York. *See* 42 C.F.R. §§ 422.2, 422.503(b)(2).

18. CMS advises qualifying individuals to consider various factors in deciding between Original Medicare and a Medicare Advantage Plan for their health coverage. *See* CMS, *Compare Original Medicare & Medicare Advantage*, *available at* https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage. For example, certain Medicare Advantage Plans charge lower out-of-pocket costs to beneficiaries than Original Medicare, including with respect to deductibles, co-payments, and co-insurance. *See id.* Further, unlike Original Medicare, Medicare Advantage Plans cap out-of-pocket expenses that may be incurred by beneficiaries in a given year. *See id.* Medicare Advantage Plans

may also offer additional benefits to beneficiaries not provided by Original Medicare, such as coverage for vision, hearing, and dental services. *See id.*

19. Medicare beneficiaries can also obtain drug coverage in different ways, depending on whether they are enrolled in Original Medicare or a Medicare Advantage Plan. Beneficiaries enrolled in Original Medicare may enroll in an individual prescription drug plan offered by an insurer approved by CMS (a "Stand Alone Drug Plan"). Beneficiaries who enroll in a Medicare Advantage Plan may opt to enroll in a Medicare Advantage Plan that includes a prescription drug plan (a "Medicare Advantage Drug Plan"). The coverage offered by the various available prescription drug plans "varies by cost, coverage, convenience, and quality." CMS, *Things to think about when you compare Medicare drug coverage*, *available at* https://www.medicare.gov/Pubs/pdf/11163-Compare-Medicare-Drug-Coverage.pdf.

20. Original Medicare and Medicare Advantage Plans also differ in how providers must seek and receive reimbursement for claims. Under Original Medicare, CMS reimburses healthcare providers, like skilled nursing facilities, on a fee-for-service basis.

21. Payments from Original Medicare to institutional providers, such as skilled nursing facilities, are conditioned on their enrollment in the Medicare program. Institutional providers apply for enrollment by completing a Medicare enrollment application, known as a form CMS-855A. *See* CMS, Medicare Enrollment Application (Institutional Providers), Form CMS-855A, *available at* https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms855a.pdf. To complete such enrollment, institutional providers must: (1) certify that they will abide by applicable "Medicare laws, regulations and program instructions"; and (2) attest that the institutional provider understands that "payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions." *Id.*

22. Claims by skilled nursing facilities to Original Medicare for skilled nursing facility care are submitted on CMS Form-1450 UB-4. The CMS Form-1450 UB-4 form requires, among other things, the provider who signs the form to represent that "the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts."

23. When a healthcare provider furnishes medical services to a Medicare beneficiary enrolled in a Medicare Advantage Plan, however, the provider submits claims for payment to the Medicare Advantage Organization that operates the Medicare Advantage Plan. CMS pays the Medicare Advantage Organization a fixed, capitated (per beneficiary enrollee in each Medicare Advantage plan) amount each month for providing coverage for Medicare beneficiaries enrolled in the Part C plan.

24. It is well known within the skilled nursing facility industry that it is typically more profitable to admit residents who are enrolled in Original Medicare, sometimes referred to as "straight Medicare," than residents enrolled in Medicare Advantage Plans. Indeed, facility administrators sometimes try to increase the numbers of Original Medicare beneficiaries placed at their facility to increase revenues.

## II. CHANGES TO MEDICARE COVERAGE

25. Any changes to a Medicare beneficiary's healthcare coverage generally must be initiated by the beneficiary or their authorized legal representative. A skilled nursing facility is not permitted to disenroll one of its residents from a Medicare Advantage Plan without an informed and authorized election by the resident or the resident's legal representative.

26. Specifically, it is the "[Medicare Advantage Plan] eligible institutionalized individual" that "may at any time elect an [Medicare Advantage] plan or change his or her election from [a Medicare Advantage] plan to Original Medicare, to a different [Medicare Advantage] plan, or from

Original Medicare to [a Medicare Advantage] plan." 42 C.F.R. § 422.62. In cases where a resident is "adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf." 42 C.F.R § 483.10(b)(7).

27. By contrast, a skilled nursing facility may "[n]ot request or require residents or potential residents to waive . . . their rights to Medicare." 42 C.F.R § 483.15(a). Instead, skilled nursing facility residents possess the rights to: (i) self-determination "without interference;"; (ii) "be informed of, and participate in, his or her treatment," including regarding any proposed "changes to the plan of care" by a skilled nursing facility; and (iii) the "right to manage his or her financial affairs." 42 C.F.R § 483.10.

28. Consistent with these regulations, CMS has issued guidance relating to Medicare coverage elections in its Medicare Managed Care Manual. *See* CMS, Medicare Managed Care Manual (the "Manual"). The Manual instructs that, except in scenarios where state law has permitted an election by an authorized representative on behalf of a beneficiary, the beneficiary him or herself is the "only individual who may execute a valid request for enrollment in or disenrollment from [a Medicare Advantage Plan.]" *Id.* Ch. 2, § 40.2.1

29. In May 2015, CMS also issued a memorandum setting forth long-term care facilities' responsibilities to ensure that changes to a beneficiaries' healthcare coverage comply with applicable regulations. CMS, *Memo to Long Term Care Facilities on Disenrollment Issues* (May 26, 2015) (the "CMS Memorandum"). CMS reported that it had "continue[d] to see an unacceptable practice of [long-term care] facilities disenrolling beneficiaries from Medicare advantage prescription drug plans [ ] and enrolling them into stand-alone drug plans [ ] **without the beneficiary's or the representative's knowledge and/or complete understanding.**" *Id.* at 1 (emphasis in original). CMS

noted that this resulted in the beneficiary being enrolled back into Original Medicare and observed that this practice was "noncompliant with regulatory requirements." *Id.*

30. CMS again explained that "[a]ny change in a beneficiary's health care coverage must be initiated by the beneficiary or his/her representative." *Id.* CMS also stated that, in the event that the long-term facility assisted with a Medicare enrollment/disenrollment, the facility should provide adequate explanations to the resident (orally and in writing) and develop adequate policies and procedures. *Id.* at 1-2. For example, the CMS Memorandum instructed that the skilled nursing facility should explain to the resident, among other things, the impact regarding deductibles, copays, and loss of supplemental coverage, and that the beneficiary would no longer be a member of their Medicare Advantage Prescription Drug Plan. *Id.*

31. CMS also observed that the skilled nursing facility should develop "written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage" that, at minimum, identified the circumstances when a facility could assist a resident with a plan change, and required signed attestations regarding the information provided to residents ahead of any insurance plan change. *Id*. at 2.

32. CMS noted that it would report improper election decisions by skilled nursing facilities on residents' behalf for investigation as "fraud and abuse incidents." *Id.* Further, CMS explained that if a long-term care facility could not provide "documentation of a beneficiary's request to change enrollment," CMS would "consider the enrollment not to be legally valid, cancel the enrollment action and, if necessary and appropriate, reinstate the beneficiary's [Medicare Advantage or Medicare Advantage Drug Plan] [ ] coverage as if never disenrolled." *Id.*

## III. THE FALSE CLAIMS ACT

33. The FCA establishes liability to the United States for any person who "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)(A), or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," *id*. § 3729(a)(1)(B). "Knowingly" is defined to include actual knowledge, reckless disregard and deliberate indifference. *Id.* § 3729(b)(1). No proof of specific intent to defraud is required. *Id.*

## FACTUAL ALLEGATIONS

34. Starting in or about September 2016, Defendants launched an initiative to switch Plaza Rehab Center residents enrolled in Medicare Advantage Plans to Original Medicare upon their admission into the facility. The purpose of this initiative was to maximize the Medicare payments Defendants received for these residents and to boost the facility's revenues.

35. During the Relevant Time Period, Plaza Rehab Center staff, acting under the direction of Citadel, disenrolled many residents from their self-selected Medicare Advantage Plans and enrolled them in Original Medicare without obtaining the consent of the residents or their authorized representatives. Plaza Rehab Center then submitted claims to Original Medicare seeking reimbursement for care provided to these residents, despite the fact that residents had not elected to enroll in Original Medicare. As a result of this fraudulent conduct, Plaza Rehab Center received millions of dollars in Medicare reimbursements to which it was not entitled.

### a. Citadel pressured Plaza Rehab Center staff to disenroll residents from their self-selected Medicare Advantage plans and to enroll them in Original Medicare.

36. Citadel exerted pressure on Plaza Rehab Center staff to increase the number of residents enrolled in Original Medicare. Among other things, Citdael: (i) set a monthly quota for Medicare Advantage Plan disenrollments; (ii) identified potential candidates for disenrollment on a

monthly basis; and (iii) instructed the Plaza Rehab Center Admissions Director to disenroll specific residents from their Medicare Advantage Plans upon admission to the facility.

37. For example, during the Relevant Time Period, Citadel's then-Chief Strategy Officer—who was responsible for new admission practices—repeatedly called Plaza Rehab Center's Director of Admissions to encourage her, in sum and substance, to increase the number of residents disenrolled from their Medicare Advantage Plans. Citadel's Chief Strategy Officer set a monthly quota for disenrollments of approximately ten to fifteen patients per month.

38. Citadel closely tracked the number of Plaza Rehab Center residents who were enrolled in Original Medicare at any given time. Citadel and Plaza Rehab Center regularly circulated "DE" lists by email. "DE" was a reference to disenrollment. These "DE" lists consisted of names of residents that Defendants had identified as candidates for potential disenrollment from their Medicare Advantage Plans. Defendants used "DE" lists to track their progress on getting residents disenrolled from their Medicare Advantage Plan.

39. For instance, on April 25, 2017, Plaza Rehab Center's Director of Case Management emailed Citadel's Chief Strategy Officer (and others) a "potential DE list for this month." The list had been prepared by another Plaza Rehab Center employee. In response, Citadel's Chief Strategy Officer wrote, "This is all she has? NO WAY."

**b. Plaza Rehab Center staff disenrolled residents from their self-selected Medicare Advantage plans and enrolled them in Original Medicare without the residents' consent.**

40. Plaza Rehab Center staff disenrolled many residents from their Medicare Advantage Plans and enrolled them in Original Medicare without obtaining the consent of the residents or their authorized representatives.

41. Plaza Rehab Center staff were supposed to, at minimum, ensure that residents (or their

authorized representatives) signed "disenrollment forms" prior to effectuating any disenrollment of the resident from their Medicare Advantage Plan. This form included "acknowledgment[s]" to be signed by the resident (or their designated representative) and a Plaza Rehab Center employee. The first acknowledgment stated that "[t]he changes that will take place following this disenrollment have been fully explained to me and I am in complete agreement with this disenrollment." The second acknowledgment required the Plaza Rehab Center staff member to attest that he or she had verbally explained the "[disenrollment] issue" to the resident or another "responsible party."

42. Plaza Rehab Center staff knew that, at minimum, residents and staff were both supposed to sign this form—with a truthful attestation provided by a Plaza Rehab Center staff member regarding their conversation with the resident—prior to any insurance election decision effectuated by Plaza Rehab Center on a resident's behalf.

43. However, in many instances, Plaza Rehab Center staff disenrolled residents from their Medicare Advantage Plan and enrolled them in Original Medicare without obtaining a signed disenrollment form reflecting the resident's consent. Indeed, Plaza Rehab Center employees effectuated numerous disenrollments without ever speaking to the resident or their authorized representative or explaining the consequences of switching to Original Medicare.

44. Plaza Rehab Center admissions staff also conducted bedside disenrollments. During such interactions, Plaza Rehab Center staff would go to the residents' room and try to persuade them to agree to disenroll from their Medicare Advantage Plans.

45. Staff encouraged some residents to sign disenrollment forms even though they lacked the capacity to provide consent. Plaza Rehab Center performed mental status assessments on residents upon their admission to the facility. In many instances, Plaza Rehab Center staff discussed a disenrollment with the resident and purportedly obtained the resident's consent, but, according to

these residents' mental status assessments, the resident did not have the capacity to provide consent because of their health condition. Plaza Rehab Center regularly failed to consider the results of these mental health assessments in order to evaluate the capacity of residents to consent to the insurance change.

46. Even when Plaza Rehab Center staff obtained the consent of the resident or their representative, they typically did not fully explain in writing or orally the impact of the change in coverage, including (i) the potential changes to the resident's co-payments and deductibles; and (ii) the potential loss of supplemental coverage that was available under the resident's Medicare Advantage Plan.

47. Plaza Rehab Center staff would change a resident's coverage by logging on to the Medicare.gov website using the resident's personal information. When completing the information online to effectuate the disenrollment, Plaza Rehab Center staff often misrepresented that they were either: (i) the person listed on the enrollment form; (ii) a person helping the person listed on the enrollment form in completing the form; or (iii) a person authorized to act on behalf of the individual on the enrollment form under the laws of the State where the individual resided. Plaza Rehab Center staff used the website to disenroll the resident from their self-selected Medicare Advantage Drug Plan, which resulted in the resident automatically being disenrolled from their Medicare Advantage Plan and being enrolled into Original Medicare.

48. Defendants did not make efforts to offer Plaza Rehab Center residents assistance in re-enrolling in their Medicare Advantage Plan upon their discharge from the Plaza Rehab Center facility.

**c. Plaza Rehab Center staff billed Medicare for care provided to residents who were improperly disenrolled from their Medicare Advantage Plans without their consent, including residents who complained about the insurance change.**

49. Plaza Rehab Center staff submitted claims seeking reimbursement from Medicare for skilled nursing facility care provided to residents who had not consented to their enrollment in Original Medicare.

50. Using the CMS Form-1450/UB-04, Plaza Rehab Center staff submitted claims to Medicare for skilled nursing facility care provided to the residents. When submitting these claims, Plaza Rehab Center staff did not disclose that the resident had been enrolled in Original Medicare without their consent or that Plaza Rehab Center staff had made misrepresentations to effectuate the disenrollment on the Medicare.gov website. In such submissions, Plaza Rehab Center falsely certified that it had not knowingly or recklessly disregarded, misrepresented, or concealed facts that were material to the submitted claim. Further, by failing to comply with Medicare regulations and program instructions, Plaza Rehab Center rendered false its prior certifications regarding compliance with such requirements in its submitted Medicare enrollment application.

51. On July 3, 2017, Plaza's Director of Admissions emailed a "final" DE list that included seventeen Plaza Rehab Center residents enrolled in Medicare Advantage Plans, including Patient 1 and Patient 2.[1]

52. Plaza Rehab Center staff disenrolled Patient 1 and Patient 2 from their self-selected Medicare Advantage Plans, effective July 1, 2017, without these residents' knowledge or consent. Patient 1 and Patient 2 did not authorize Plaza Rehab Center staff to make any such elections on their behalf. Nonetheless, nine days after the insurance change was made effective, Citadel's Corporate

1 In order to protect the confidentiality of patients' personal health information, this Complaint does not include the names of specific Plaza Rehab Center residents. The Government will disclose the names of these residents to Defendants upon request.

Controller emailed Citadel's Accounts Receivable Supervisor, stating that she should "continue to obtain auth[irzation] from these residents" on the July 2017 "DE" list. But Defendants never obtained any such signed authorizations for Patient 1 and Patient 2.

53. After improperly switching the health coverage for Patient 1 and Patient 2, Plaza Rehab Center submitted claims to Medicare seeking payment for the skilled nursing facility care provided to these patients while they resided at the facility. Specifically, Plaza Rehab Center sought payment for skilled nursing facility care provided to Patient 1 from July 1, 2017 to August 1, 2017. Medicare paid $19,305.09 for this care. At the time of Patient 1's disenrollment from her Medicare Advantage Plan, however, CMS was paying a monthly capitated rate of only $829.91 to the Medicare Advantage Organization that administered Patient 1's Medicare Advantage Plan.

54. Plaza Rehab Center likewise submitted three claims to Medicare for skilled nursing facility care provided to Patient 2 from July 1, 2017 to September 19, 2017. Medicare paid $29,250.34 for this care. At the time of Patient 2's disenrollment from her Medicare Advantage Plan, CMS was paying a monthly capitated rate of $4,716.48 to the Medicare Advantage Organization that administered Patient 2's Medicare Advantage Plan.

55. On March 1, 2018, the Plaza Rehab Center's Director of Admissions circulated another "DE list" to Plaza Rehab Center and Citadel employees that identified Patient 3 and Patient 4 as candidates for disenrollment from their Medicare Advantage Plans. On or about March 1, 2018, Plaza Rehab Center employees disenrolled Patient 3 and Patient 4 from their self-selected Medicare Advantage Plans and enrolled them in Original Medicare. Patient 3 and Patient 4 did not authorize Defendants to make any such elections on their behalf. On or about March 5, 2018, that Director of Admissions sent an updated version of the "DE" list that included the notation "processed" next to Patient 3 and Patient 4's names.

56. Later that month, Patient 3 and Patient 4 raised the change in their insurance coverage with a Plaza Rehab Center social worker. Patient 3 told the Plaza Rehab Center social worker that no one had spoken to her about disenrollment. Patient 3 also showed the social worker correspondence from the private insurer that administered her Medicare Advantage Plan, stating that she no longer had coverage as of March 1, 2018. Patient 4 raised similar concerns with the Plaza Rehab Center social worker. The Plaza Rehab Center social worker emailed these concerns to the Plaza Rehab Center's Director of Admissions, noting that she had received such questions regarding disenrollment from other patients.

57. The Plaza Rehab Center sought and received reimbursement from Medicare for skilled nursing facility care provided to Patient 3 and Patient 4. Specifically, Plaza Rehab Center staff submitted three claims to Medicare for skilling nursing facility care provided to Patient 3 between March 1, 2018, and May 10, 2018. Medicare paid Plaza Rehab Center $39,570.91. At the time of Patient 3's disenrollment from her Medicare Advantage Plan, CMS was paying a monthly capitated rate of $1,163.14 to the private company that administered Patient 3's Medicare Advantage Plan.

58. Plaza Rehab Center submitted a claim to Original Medicare for skilled nursing facility care provided to Patient 4 from March 1, 2018, to March 29, 2018. Medicare paid $13,350.74 for that claim. At the time of Patient 4's disenrollment from her Medicare Advantage Plan, CMS was paying a monthly capitated rate of $1,006.76 to the private company that administered Patient 4's Medicare Advantage Plan.

59. As a result of the fraudulent changes to Plaza Rehab Center residents' Medicare coverage, the Government paid millions of dollars more for the skilled nursing care provided to these residents than it would have paid if the residents had remained enrolled in Medicare Advantage Plans.

## CLAIMS FOR RELIEF

### FIRST CLAIM

**Violation of the False Claims Act: Presenting False Claims for Payment (31 U.S.C. § 3729(a)(1)(A))**

60. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

61. The United States seeks relief against Defendants under Section 3729(a)(1)(A) of the False Claims Act.

62. Through the acts set forth above, Defendants knowingly, or acting with the deliberate ignorance or reckless disregard for the truth, presented, or caused to be presented, false or fraudulent claims for payment to Medicare for the care provided to Plaza Rehab Center residents who had been disenrolled from their self-selected Managed Care Advantage Plans and enrolled in Original Medicare without their consent or the consent of their authorized representatives.

63. By reason of these false or fraudulent claims, the Government has sustained damages in a substantial amount to be determined at trial, and is entitled to recover treble damages plus a civil monetary penalty for each false violation.

### SECOND CLAIM

**Violation of the False Claims Act: Use of False Statements (31 U.S.C. § 3729(a)(1)(B))**

23. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

24. The United States seeks relief against Defendants under Section 3729(a)(1)(B) of the False Claims Act.

25. Through the acts set forth above, Defendants knowingly, or acting with deliberate ignorance or reckless disregard for the truth, made, used, or caused to be made and used, false

records and statements material to the payment of false or fraudulent claims by Medicare for the care provided to Plaza Rehab Center residents who had been disenrolled from their self-selected Managed Care Advantage Plans and enrolled in Original Medicare without their consent or the consent of their authorized representatives.

26. By reason of these false records or statements, the Government has sustained damages in a substantial amount to be determined at trial, and is entitled to recover treble damages plus a civil monetary penalty for each violation.

## THIRD CLAIM

### Unjust Enrichment

27. The United States incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

28. Through the acts set forth above, Defendants have received payments to which they were not entitled and therefore were unjustly enriched. The circumstances of these payments are such that, in equity and good conscience, Defendants should not retain those payments, the amount of which is to be determined at trial

## PRAYER FOR RELIEF

WHEREFORE, the United States demands judgment against Defendants as follows:

A. On Counts One and Two (FCA violations), a sum equal to treble the United States' damages and civil penalties to the maximum amount allowed by law; and

B. On Count Three (unjust enrichment), a sum equal to the damages to the extent allowed by law; and

C. Such further relief as is proper.

Dated: June 21, 2022
New York, New York

Respectfully submitted,

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United States Attorney for the
Southern District of New York

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