FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

UNITED STATES OF AMERICA and **THE STATE OF OKLAHOMA** *ex rels.* Jamie Duffield and Diana Harris, and **JAMIE DUFFIELD** and **DIANA HARRIS**, individually,

Plaintiffs,

v.

CHC HOLDINGS, LLC, d/b/a CARTER HEALTHCARE, STANLEY F. CARTER, and **BRAD CARTER**,

Defendants.

DOCKET NO. 17-cv-826 (HE)

FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)

JURY TRIAL DEMANDED

FIRST AMENDED COMPLAINT AND DEMAND FOR JURY TRIAL

Plaintiff and *qui tam* Relators Jamie Duffield and Diana Harris, by and through their undersigned counsel Johnson & Jones, P.C. and Brown, LLC, allege of personal knowledge as to their own observations and actions, and on information and belief as to all else, as follows:

I.
PRELIMINARY STATEMENT

1. This is a *qui tam* action on behalf of the United States of America under the federal False Claims Act, 31 U.S.C. §§ 3729 *et seq.* (the "FCA"); on behalf of the State of Oklahoma under the Oklahoma Medicaid False Claims Act, 63 Okla. Stat. §§ 5053.1 *et seq.* (the "OMFCA"); and on behalf of both the United States and Oklahoma (collectively, the "Governments") under the common law to recover treble the actual damages sustained by, and civil penalties and restitution owed to, the Governments as a result of a scheme by CHC Holdings, LLC, d/b/a Carter Healthcare ("Carter" or the "Agency"), Stanley F. Carter, and Brad Carter to commit fraud.

2. Specifically, Defendants knowingly submitted to the Governments claims for reimbursement that were either legally or factually false, or both, in that those claims:

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2. Specifically, Defendants knowingly submitted to the Governments claims for reimbursement that were either legally or factually false, or both, in that those claims:

a. were made on behalf of patients whose referring providers Defendants had compensated, in violation of the federal Anti-Kickback Statute;

b. reflected diagnoses that had been purposefully "upcoded" in order to improperly obtain higher levels of reimbursement;

c. were made on behalf of patients whom Carter kept under care for extended periods without certification by a physician, in violation of Medicare/Medicaid rules; and/or

d. reflected billing for services that were not medically necessary.

3. Thus, Defendants knowingly (a) presented or caused to be presented false claims to the Governments; (b) made or caused to be made or used false records or statements material to these false claims; and (c) conspired to cause these claims to be presented and/or these records or statements to be made or used, causing the Governments to pay several millions of dollars in reimbursements that should not have been paid.

4. The original Complaint and this First Amended Complaint ("FAC") in this action were filed *in camera* and under seal pursuant to 31 U.S.C. § 3730(b)(2). A copy of the original Complaint, along with written disclosure of substantially all material evidence and information that Relators possess, was served on the Attorney General of the United States and the Acting United States Attorney for the Western District of Oklahoma, pursuant to 31 U.S.C. § 3730(b)(2) and Fed. R. Civ. P. 4(d), and on the Attorney General for the State of Oklahoma pursuant to Okla. Stat. 12 § 2004 and 63 § 5053.2(B)(2). A copy of this FAC was also served on these officials, but it will not be served on Defendants unless and until the Court so orders.

II.
JURISDICTION AND VENUE

5. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331, because this action is brought for violations of the federal False Claims Act, 31 U.S.C. § 3729 *et seq.* (as amended), a federal statute.

6. The Court has subject matter jurisdiction over the state-law and common-law claims pursuant to 28 U.S.C. § 1345.

7. The Court has personal jurisdiction over Defendants because Defendants (a) are residents of, and are licensed to transact and do transact business in, this District; and/or (b) have carried out their fraudulent scheme in this District.

8. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391 (b)(2), because Defendants can be found in, are licensed to do business in, and transact or have transacted business in this District, and events and omissions that give rise to these claims have occurred in this District. This District is the locus of the fraud.

9. The original Complaint was filed within the period prescribed by 31 U.S.C. § 3731(b).

III.
NO PUBLIC DISCLOSURE; INDEPENDENT AND MATERIAL KNOWLEDGE OF VIOLATIONS OF THE FALSE CLAIMS ACT

10. Relators make the allegations in this FAC based on their own knowledge, experience and observations.

11. Relators are original sources of the information they have given to the Governments regarding Defendants' knowing engagement in conduct violative of federal and state law, and resulting in the payment by the Governments of the false or fraudulent claims that Defendants made and caused to be made. This conduct includes, but is not limited to, violations of the FCA and the OMFCA.

12. There has been no public disclosure, relevant under 31 U.S.C. § 3730(e), of the "allegations or transactions" in this FAC; or, to the extent that any such public disclosure has been made, Relators have knowledge that is independent of and materially adds to that public disclosure.

IV.
THE PARTIES

A. Plaintiff the United States

13. Relators bring this action on behalf of Plaintiff the United States of America. At all times relevant to this FAC, the United States, acting through the Centers for Medicare & Medicaid Services ("CMS"), has reimbursed Defendants, through the Medicare and Medicaid programs, for the provision of home-health and hospice care, at-home durable medical equipment, pharmacy services, and related services and treatments to eligible individuals. Thus, the United States has a cause of action on behalf of its agencies, CMS and HHS, and on behalf of the Medicare and Medicaid programs.

B. Plaintiff the State of Oklahoma

14. Relators bring this action on behalf of Plaintiff the State of Oklahoma. At all times relevant to this FAC, the State of Oklahoma, acting through the Oklahoma Health Care Authority has reimbursed Defendants, through the Medicaid program (known as SoonerCare in Oklahoma), for the provision of home-health and hospice care, at-home durable medical equipment, pharmacy services, and related services and treatments to eligible individuals. Thus, the State of Oklahoma has a cause of action on behalf of its agency the Oklahoma Health Care Authority, and on behalf of the SoonerCare program.

C. Plaintiff and Relator Jamie Duffield

15. Relator Duffield also brings this action on behalf of herself and the United States.

16. Duffield is a citizen of the United States and, at all relevant times, has been a resident of Cherokee County, State of Oklahoma.

17. Duffield worked for Defendants as a Professional Services Coordinator ("PSC") from June or July of 2012 until April of 2017. She was based out of the Agency's location at 200 East Harris Circle, Suite A, Tahlequah, Oklahoma 74464 (the "Tahlequah Office").

18. Duffield resigned from Carter in April of 2017.

19. In her capacity as a PSC for Defendants, Duffield observed Defendants' violations of the FCA, the OMFCA, and other federal and state statutes and regulations.

D. Plaintiff and Relator Diana Harris

20. Relator Harris also brings this action on behalf of herself and the United States.

21. Harris is a citizen of the United States and, at all relevant times, has been a resident of Muskogee County, State of Oklahoma.

22. Harris worked as a PSC, based out of the Agency's location at 3005 Azalea Park Drive, Muskogee, Oklahoma, 74401 (the "Muskogee Office") and the Tahlequah Office, for the seven or eight years prior to the filing of the original Complaint.

23. In her capacity as a PSC for Defendants, Harris observed Defendants' violations of the FCA, the OMFCA, and other federal and state statutes and regulations.

E. Defendants

24. Defendant CHC Holdings, LLC, d/b/a Carter Healthcare ("Carter" or the "Agency"), is a business corporation that, on information and belief, was formed and exists under the laws of the State of Oklahoma.

25. According to its website, Carter is "a leading healthcare provider focused on delivering outcomes-based results and the highest quality of Home-Health, Hospice, At-Home

Medical Equipment, and Pharmacy Services to thousands of clients in the comfort of their homes."[1]

26. According to its website, Carter operates in eight states: Florida, Kansas, Missouri, Ohio, Oklahoma, Pennsylvania, Texas, and West Virginia. There are more Carter locations in Oklahoma than in any other state.[2]

27. Carter's corporate headquarters are located at 3105 S. Meridian Ave., Oklahoma City, Oklahoma 73119.[3]

28. On information and belief, Defendant Stanley F. Carter is the President of Carter.

29. On information and belief, Defendant Brad Carter is the Corporate Compliance Officer of Carter and serves as its General Counsel. He also has responsibilities and functions for the Agency in the areas of Human Resources and Quality Assurance.

30. Carter operates through separately incorporated regional and local offices. On information and belief, Carter operates both the Tahlequah Location and the Muskogee Location, where Relators worked.

31. On information and belief, during all times relevant herein, the majority of Defendants' patients – also referred to as "clients" – have been beneficiaries of the Medicare or Medicaid programs explained below.

V.
MEDICARE AND MEDICAID/SOONERCARE

A. The Medicare Program

Medicare Overview and Provider Enrollment

32. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the

[1] *See* https://www.carterhealthcare.com/ (last accessed Aug. 25, 2020).
[2] *See* https://www.carterhealthcare.com/Locations_V1.aspx (last accessed Aug. 25, 2020).
[3] *See* https://www.carterhealthcare.com/Contact.aspx (last accessed Aug. 25, 2020).

Medicare program, to pay for certain healthcare services provided to certain segments of the population. Entitlement to Medicare is based on age, disability, or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 1395 *et seq*.

33. HHS, through CMS, administers the Medicare program.

34. CMS pays for part-time (intermittent), medically necessary skilled in-home care that is delivered by a nurse, physical therapist, occupational therapist, and/or speech-language therapist, and is ordered by a physician – in other words, the kind of care that Defendants purport to provide – under the Part A Medicare benefit. *See* 42 U.S.C. §§ 1395c *et seq.*

35. CMS enters into agreements with healthcare providers such as Defendants to establish their eligibility to participate in the Medicare program. Individuals or entities who are participating providers in Medicare, such as Defendants, may seek reimbursement from CMS for services rendered to patients who are program beneficiaries.

36. During the times relevant herein, to become and remain an authorized participant in Part A of the program, a provider must certify as follows:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. … I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions …, and on the supplier's compliance with all applicable conditions of participation in Medicare.

CMS Form-855A (07/11), §15, no. 3.[4]

37. Compliance with applicable Medicare program rules and regulations is material to the government's decision to pay and its subsequent payment of claims. In order to be reimbursable by Medicare, services must be medically necessary. *See* 42 U.S.C. § 1395y(a)(1)(A); 42 C.F.R. § 411.15(k)(1).

[4] *Available at* https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf (last accessed Aug. 25, 2020).

The Medicare Claims Process

38. In order to receive reimbursement from Medicare, providers such as Defendants must submit a claim form. *See* Form CMS-1500.[5] That claim form requires the provider to make the following certification:

> In submitting this claim for payment from federal funds, I certify that: 1) ***the information on this form is true, accurate and complete*** … 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) ***this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment*** ... 5) ***the services on this form were medically necessary*** ….

Id., at 2 (emphasis added).

39. A provider may also submit the electronic equivalent of this claim form, which includes substantially similar notices and certifications.

40. CMS guidance as to electronic claims submission is found in Chapter 24 of the Medicare Claims Processing Manual, CMS Publication No. 100-04 (the "Claims Manual").[6] Among other things, the guidance specifies the minimum content of the enrollment form that a local Medicare Administrative Contractor ("MAC")[7] may use to sign up providers to submit claims electronically. Per the Claims Manual, such an enrollment form must contain, and the enrolling provider must acknowledge, at least the following statements:

> The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' A/B MACs or CEDI:
>
> * * *

[5] *Available at* https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf (last accessed Aug. 25, 2020).

[6] *Available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf (last accessed Aug. 25, 2020).

[7] A MAC is a private insurer contracted by the federal government to process medical claims for Medicare beneficiaries in a particular geographic jurisdiction. MAC jurisdictions can be found at https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/AB-Jurisdiction-Map-Jun-2019.pdf (last accessed June 7, 2020). At all times relevant herein, the MAC for Oklahoma has been Novitas.

> 7. That it will submit claims that are accurate, complete, and truthful;
>
> * * *
>
> 12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsified or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law; [and]
>
> * * *
>
> 14. That it will research and correct claim discrepancies[.]

Claims Manual, Chapter 24 § 30.2.

41. The submission of such a certification, if false, is a violation of the Federal False Claims Act, 31 U.S.C. § 3729(a).

42. Each such false certification is a separate violation of the FCA.

B. The Medicaid Program

43. In conjunction with Medicare, Congress enacted Medicaid under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq*.

44. Medicaid is a jointly funded cooperative venture between the federal and state governments to provide health care to certain groups, primarily the poor and the disabled. *See* 42 C.F.R. §§ 430.0 *et seq*.

45. Home Healthcare is one of the health benefits covered by Medicaid.

46. Under the Medicaid program, the federal government pays a specified percentage of each state's Medicaid program expenditures, called the Federal Medical Assistance Percentage. *See* 42 U.S.C. § 1396d(b).

47. At all times relevant to this FAC, the United States has paid the State of Oklahoma its Federal Medical Assistance Percentage, and the state itself has funded the remainder of the program expenditures.

48. The Medicaid program of the State of Oklahoma is called SoonerCare, and is administered by the Oklahoma Health Care Authority.

49. In order to enroll as a Medicaid provider, a physician or institution must agree to abide by the rules, regulations, policies and procedures governing reimbursement, and to keep and allow access to records and information required by Medicaid. In order to receive Medicaid funds, enrolled providers in Oklahoma, together with authorized agents, employees, and contractors, are required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and all policies and procedures applicable to SoonerCare.

50. Oklahoma has adopted the use of Form CMS-1500 for claims. *See* Oklahoma Health Care Authority Provider Billing and Procedures Manual (Nov. 2017),[8] at 5-54 - 5-55. In order to receive reimbursement from SoonerCare, providers such as Defendants must submit the CMS-1500 claim form. *Id.*

51. At all times relevant herein, Carter has been an enrolled SoonerCare provider. This Defendant has received reimbursement from the Oklahoma Health Care Authority for outpatient care it provided to patients insured through SoonerCare.

52. Defendants have an unwritten but official policy to accept very few patients insured through SoonerCare, and have instructed their PSCs to discourage doctors from referring such patients to the Agency. On information and belief, this is because SoonerCare does not reimburse fully or quickly enough to satisfy Defendants.

[8] *Available at* https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=21360&libID=20342 (last accessed Aug. 25, 2020).

VI.
DEFENDANTS' FRAUDULENT ACTS

A. Defendants Tie the Compensation Provided to Their PSCs and Their Medical Directors to the Number of Patients They Refer to Carter.

53. One of Relators' main duties as PSCs for the Agency was to recruit doctors to serve as "Medical Directors." PSCs are instructed to identify doctors in their geographic area whose practices have high percentages of patients on Medicare, and then to recruit those doctors as "Medical Directors."

54. The main responsibility of a Medical Director, in turn, is to refer patients to Carter.

55. PSCs are "ranked" according to the number of Medicare patients they bring to the Agency, either indirectly from the Medical Directors the PSCs recruited, or directly from hospitals.

56. PSCs are required to "bring in" at least ten to fifteen Medicare patients per month to keep their jobs. PSCs are paid an additional $150 for each Medicare referral per month in excess of their individual goals.

57. The top fifteen PSCs in the Agency are referred to as "Elite Marketers" or "Elite Performers," and are rewarded with medals and gifts, given larger expense accounts than lower-ranking – i.e., less "productive" – PSCs, and invited to attend expenses-paid corporate meetings. Lower-ranking PSCs are not given these benefits.

58. During her tenure as a PSC, Relator Duffield was an "Elite Marketer" who received gifts including a designer handbag, had the use of a monthly expense account of up to $2,000, and attended expenses-paid corporate meetings in Melbourne and Fort Lauderdale, Florida.

59. A PSC recruits a doctor to serve as a Medical Director by offering a monthly "salary," the amount of which depended in part upon the number of patients the doctor could refer to Carter.

60. Medical Directors who refer 3-4 patients per month are usually paid approximately $500 per month, and those who refer more patients are paid more. Higher-ranking PSCs have discretion to offer compensation they think is necessary to entice doctors to become Medical Directors.

61. These policies have been communicated to PSCs by Defendant Brad Carter, and by Defendant Stanley F. Carter, in conference calls, meetings, and via emails.

62. Defendants Brad Carter and Stanley F. Carter have final approval of Medical Directors' contracts, including their compensation.

63. Each Medical Director is expected to hold a monthly "case conference" with Carter medical staff, in order to review patients' charts and to sign orders and care plans. This is used as a smokescreen and purported to be an opportunity for the doctor to hear from the staff members who were actually providing patients' day-to-day care, so that the doctor can have a full picture of the patients' status and can adjust their care as needed. It is for these case conferences that the Agency uses as cover and justification to the outside world why Medical Directors are paid. However, in many instances, these monthly "conferences" consist of a staff member merely bringing a Medical Director's charts to his or her office, and taking them back to Carter's offices once they are signed without any actual discussion of the charts.

64. Sometimes Defendants have Medical Directors sign orders and care plans for patients the Medical Directors have not yet examined or even seen, including patients who are on other doctors' services.

65. Medical Directors are expected to maintain (or increase) their level of referrals, on a month-to-month basis. Failure to do so can result in their not being "given" a monthly case

conference (and so not being paid for that month), or even in their being dropped from the program altogether.

66. For example, in approximately October or November of 2016, Relator Duffield was instructed by Cassie Knori-Baker, the Agency's Associate Director of Operations ("ADO") at the Tahlequah Office, to fire three Medical Directors for lack of "productivity." Among these three doctors was one whose wife, on information and belief, was hospitalized and in a coma. Relator Duffield refused to fire them.

67. As another example, on January 5, 2017, Knori-Baker wrote the following in an email to Relator Duffield:

> We are needing new referrals badly …. [Defendant] Brad [Carter] is wanting the ADOs to do a monthly report to determine ***what medical directors are going to get a case conference*** based on SOC [Starts Of Care, i.e., new referrals] and active pts on service. I don't know if this is a bad thing or a good thing due to some of them getting upset ***because they will not be getting paid*** or a good thing because they might send more. I just wanted you to be aware of the changes.

Exhibit A (email from Cassie Knori-Baker to Relator Duffield, January 5, 2017; emphasis added).

68. Knori-Baker wrote again on January 30, 2017. That email included a chart showing the patients attributable to three particular Medical Directors who had been recruited by Relator Duffield, along with certain metrics for each, including "Cost/Ref," i.e., what the Agency was paying each of these Medical Directors for each referral. *See* **Exhibit B** (email from Cassie Knori-Baker to Relator Duffield, January 30, 2017).

69. In that email, Knori-Baker pointed out that the amounts "we are paying per referral" for two of the Medical Directors were "really bad," given the Medical Directors' relative lack of productivity. She wrote: "Until these [patient] numbers get up we cannot have a case conference" with two of the three Medical Directors, and that she was "waiting on a response from [Defendant]

Brad [Carter]" about the third Medical Director, who apparently merited special consideration "due to him being attached to Hospice," as opposed to only Home Health. *Id.*

70. Similarly, Jessica Hoover, a Director of Operations for the Agency, emailed Relator Duffield on March 8, 2017, about one of the Medical Directors referenced in Knori-Baker's January 30 email:

> I advised Cassie [Knori-Baker] to cancel [that doctor's] March case conference over a month ago, before his case conference in February. Having 4 patients on service is not enough to fill an hour of time for him or for us. If he can get 6-8 patients by April, we can absolutely have a meeting with him, although that still won't fill an hour of time. 10-20 patients is more realistic to make the doctor's time and our time worthwhile.

Exhibit C (email from Jessica Hoover to Relator Duffield, copying Cassie Knori-Baker, March 8, 2017). Although Hoover couched her email as concern for "the doctor's time and our time," the practical result of canceling the doctor's case conference was that he was not paid for that month.

71. This doctor was eventually dropped by Carter as a Medical Director because he was not "producing."

72. The practices and policies described above are followed on the instructions and with the full knowledge of Defendants Stanley F. Carter and Brad Carter.

B. Defendants Frequently Upcode to Maximize Reimbursement.

73. In order to receive Medicare or Medicaid reimbursement for a patient's home health care, a provider must fill out and submit an Outcome and Assessment Information Set (OASIS) at certain times in that patient's history:

a. **Start of Care:** when a new patient is admitted to the home health agency's service;

b. **Resumption of Care:** when care is resumed after an interruption (typically an in-patient stay at a hospital or other facility);

c. **Follow-Up:** when a re-assessment is necessary to re-certify the patient or for some other reason;

d. **Transfer to an Inpatient Facility:** whether discharged from the agency or not; and

e. **Discharge from the Agency** (not to an in-patient facility).

See Centers for Medicare & Medicaid Services OASIS-C2 Item Set-Effective 1/1/17, *at* 3.[9]

74. The OASIS form has spaces to input diagnoses and other information that determine, among other things, the reimbursement the agency will receive for that patient's care. *See id.*

75. Carter's field nurses, as one of their duties, fill out OASIS forms as required while visiting the patients, using Agency-provided laptops.

76. After leaving the home of a patient for whom he or she had just filled out a new OASIS form, the field nurse is required to contact the Agency so that a "Quality Assurance" employee at the Oklahoma City headquarters can remotely log onto the nurse's laptop to make changes to the OASIS form. On information and belief, a field nurse is not able to open the documentation for his or her next visit until this "Quality Assurance" procedure has been completed on the outstanding OASIS form.

77. On information and belief, the changes made are usually much more than corrections that might come under the heading "Quality Assurance." Rather, they are typically changes that maximize the Agency's reimbursement. These include changing the order of diagnoses (e.g., where a patient legitimately had multiple diagnoses, making sure that the most lucrative diagnosis was entered as the primary diagnosis) and upcoding individual diagnoses to maximize reimbursement.

78. For instance, patients are almost always coded as needing assistance in walking, in order to maximize the reimbursement the Agency would receive. Stan Carter justified this coding

[9] *Available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-C2-Item-Set-Effective_1_1_17a.pdf (last accessed Aug. 25, 2020).

practice in a meeting with PSCs by stating that virtually every patient has a cane – whether he or she actually uses it or not.

79. Carter field nurses complained about this "Quality Assurance" process to Relators Duffield and Harris on more than one occasion, and Relators each saw the process take place on a nurse's laptop on at least one occasion.

80. The practices described above are followed on the instructions and with the full knowledge of Defendants Stanley F. Carter and Brad Carter.

C. Defendants Obtain Reimbursements for Treatments and Services that are Not Medically Necessary.

81. Physical therapy is "ordered" for all or virtually all Carter patients, whether or not it is actually medically indicated. Often these orders are added during the "Quality Assurance" process described above.

82. In turn, the Agency seeks and obtains reimbursement from Medicare and/or Medicaid for all of these orders.

83. Many of the patients for whom physical therapy is "ordered" cannot benefit from physical therapy. Nevertheless, the Agency seeks and obtains reimbursement for physical therapy on behalf of even those patients.

84. This is done on the instructions and with the full knowledge of Defendants Stanley F. Carter and Brad Carter.

D. Defendants Concealed Patients from Medicare Audits by Switching to Alias Identification Numbers

85. Medicare pays home health agencies like Carter under a prospective payment system ("PPS"). Under PPS, an agency will receive half of the estimated base payment for an

episode of home health care when it submits a claim at the initiation of the episode of care, and half upon the conclusion of the episode, subject to adjustments.[10]

86. For home health services initiated prior to January 1, 2020, Medicare limits each episode of care to at most 60 days.[11]

87. A Medicare beneficiary may receive unlimited episodes of care. However, home health services may be renewed only if supported by a physician recertification, which requires a new assessment of the patient's needs and a plan of care.[12]

88. Carter routinely kept patients on home health services for periods longer than 60 days without obtaining new assessments and plans of care. To avoid regulatory scrutiny, Carter "switched" such long-staying patients by discharging them from services, then readmitting them under a different provider CMS Certification Number ("CCN").[13]

89. Carter's decision to switch patients to different CCNs was made without any prior consultation with the patients or their physicians, without the required new assessment, and without any medical justification.

90. Carter used multiple CCNs for a single office. For example, the Tahlequah Office used two different CCNs: 377637 and 377692. CCN 377637, which was registered to Carter Healthcare at 2846 East 101st Street, Tulsa, OK 74137, was associated with "Tahlequah 1" or

[10] *See* Home Health PPS, *available at* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index?redirect=/HomeHealthPPS/01_overview.asp (last accessed Aug. 24, 2020).
[11] *See* "Medicare Claims Processing Manual, Ch. 10" § 10.1.5, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf (last accessed Aug. 24, 2020).
[12] *See* Medicare Benefit Policy Manual, Ch. 7 §§ 10.3, 30.5.1, 30.5.2, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf (last accessed Aug. 25, 2020).
[13] Each Medicare-certified provider has a unique six-digit CCN.

"TAH 1."[14] CCN 377692, which was registered to Carter Healthcare of Oklahoma, LLC at 1103 East 13th Street, Suite C, Grove, OK 74344, was associated with "Tahlequah 2" or "TAH 2."[15]

91. The following illustrates Carter's patient switching:

a. September 28, 2012: Patient "Romeo" is admitted to "Tahlequah 1";

b. July 19, 2014: Romeo is discharged from "Tahlequah 1";

c. July 24, 2014: Romeo is readmitted to "Tahlequah 1";

d. March 19, 2015: Romeo is discharged from "Tahlequah 1";

e. March 26, 2015: Romeo is admitted to "Tahlequah 2";

f. March 17, 2016: Romeo is discharged from "Tahlequah 2";

g. April 25, 2016: Romeo is readmitted to "Tahlequah 1."

92. On June 9, 2015, Knori-Baker sent an email listing five patients who were discharged in March and April 2015, and readmitted in May 2015. In response, Director of Operations Taylor Willetts wrote that those patients "were discharged from the TAH org due to cms f2f [face-to-face], and later re admitted under TAH 2. Even though it was over 30 days before they were restarted, they still count as re admits and we will not be able to give credit for them."

93. In a follow-up email, Brad Carter wrote, "These were D/C'd under old provider and readmitted under new? If that's the case then yes they are re-admits for purposes of SOC figures."

94. On or about July 2016, Director of Marketing Charlotte Dickens sent an email to Carter staff with instructions to discharge numerous home health patients in Oklahoma and Texas and readmit them on different CCNs.

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[14] *See* "Carter Healthcare", *available at* https://www.seniorresource.com/home-care/Oklahoma/Tulsa/Carter-Healthcare~7667/; Oklahoma HHCAHPS Survey, *available at* https://data.medicare.gov/api/views/gudb-6wtt/rows.pdf?app_token=U29jcmF0YS0td2VraWNrYXNz0 (last accessed Aug. 25, 2020).

[15] *See* "Carter Healthcare of Oklahoma, LLC", *available at* https://www.seniorresource.com/home-care/Oklahoma/Grove/Carter-Healthcare-Of-Oklahoma,-Llc~7712/; Oklahoma HHCAHPS Survey, *available at* https://data.medicare.gov/api/views/gudb-6wtt/rows.pdf?app_token=U29jcmF0YS0td2VraWNrYXNz0 (last accessed Aug. 25, 2020).

95. Relator Duffield asked Dickens how staff should explain the rationale of this "Big Switch" to physicians. In response, Dickens stated words to the effect that "it was no big deal," and that Carter just wanted to readmit patients using a different number.

96. Between July and September 2016, Carter discharged 41 patients from "Tahlequah 1" and readmitted them under "Tahlequah 2".

97. Carter's internal records showed that these 41 patients had all been on service for over a year on the current episode of care, far beyond Medicare's 60-day cutoff. Furthermore, most of these patients were not on their first episode of care.

98. Carter submitted false claims to Medicare for these patients as if they had received a new assessment and plan of care for each 60-day period.

99. In 2016, Carter's Director of Nursing Assistant Angela Ragsdale told individuals including Relators that the patients involved in Carter's switches had been receiving Carter's services for a long time. Ragsdale stated that Carter "beat Medicare" by successfully concealing these patients from audits.

E. Carter Paid a Hospital and its Physicians to Induce Referrals

100. Northeastern Health System ("NHS") operates a hospital located at 1400 East Downing Street, Tahlequah, OK 74464.

101. Several of Carter's Medical Directors are physicians employed by or otherwise affiliated with NHS, including Tye Ward, Paul Hobbs, Brent Rotton, Jena Rogers, James Madison, John Fell, and Larry Sumner. As alleged above, Carter compensates its Medical Directors based upon the volume of their patient referrals to Carter.

102. Carter's Tahlequah Office occupies a building owned by NHS. Carter pays NHS rent for the use of said office space.

103. Individuals including Dickens and Knori-Baker told Relator Duffield that Carter's rent payments for the Tahlequah Office exceed fair market value, and that the excess rent pays for the salary of a case manager at NHS.

104. Using its financial contributions as leverage, Carter exerted pressure on NHS to refer patients to Carter.

105. On June 1, 2015, Brad Carter sent a letter to Woodliff touting Carter's home health services. The letter also stated that Carter's NHS-affiliated Medical Directors "have respectfully asked that they be notified by [NHS's] case management team before changing the agency that they have ordered", i.e. changing from Carter to another agency. On information and belief, Brad Carter wrote this letter without consulting the NHS-affiliated Medical Directors. Instead, Brad Carter merely invoked the Medical Directors to provide cover for the letter's true intent of pressuring NHS to keep sending referrals to Carter.

106. In approximately 2015 or 2016, Knori-Baker told Relator Duffield that Stanley and Brad Carter were dissatisfied with NHS's low patient referral numbers.

107. Knori-Baker instructed Duffield to speak with NHS management regarding referrals. Specifically, Knori-Baker told Duffield to inquire about why referrals to Carter were low, where referrals were going to besides Carter, and how Carter could help increase referrals. Knori-Baker also told Duffield to state that Stanley and Brad Carter would visit NHS if referral numbers did not improve.

108. Over the course of several in-person meetings, Duffield conveyed the above message to NHS case managers Pamela Berry and Rendy Rucker, Director of Case Management Christy Morgan, and Chief Executive Officer Brian Woodliff. The overall response from these NHS individuals was that NHS would work on referring more patients to Carter.

109. At Knori-Baker and Brad Carter's instruction, Duffield placed a list of Carter's NHS-affiliated Medical Directors on a wall in NHS's case management office, and told NHS case managers to make sure that the patients of these Medical Directors are referred to Carter.

110. At Knori-Baker's instruction, Duffield told NHS's case managers that when NHS providers showed patients a list of home health agencies to choose from, Carter's name should be on the top of that list.

111. On information and belief, NHS referrals to Carter increased.

112. Carter leveraged its financial contributions to cause NHS to increase its referrals.

VII.
THE STATUTORY FRAMEWORK

A. The Federal False Claims Act

113. The False Claims Act, 31 U.S.C. §§ 3729 (the "FCA"), establishes treble damages liability for an individual or entity that:

a. "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," 31 U.S.C. § 3729(a)(l)(A);

b. "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)(l)(B); or

c. "conspires to defraud the [United States] Government by getting a false or fraudulent claim allowed or paid," *id.* § 3729(a)(l)(C).

114. "Knowing," within the meaning of the FCA, is defined to include reckless disregard and deliberate indifference. *Id.*

115. In addition to treble damages, the FCA also provides for assessment of a civil penalty for each violation or each false claim.[16]

[16] 31 U.S.C. § 3729(a)(1)(G) provides a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410). The Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, 28 U.S.C. 2461 note, substituted a

116. The FCA also provides for payment of a percentage of the United States' recovery to private individuals (or "Relators") who bring suit on behalf of the United States under the FCA. *See* 31 U.S.C. § 3730(d).

B. The Oklahoma Medical False Claims Act

117. The Oklahoma Medical False Claims Act, 63 Okla. Stat. §§ 5053.1 *et seq*. (the "OMFCA"), tracks the federal False Claims Act very closely.

118. The OMFCA has a *qui tam* provision whereby "[a] person may bring a civil action for a violation of the Oklahoma Medicaid False Claims Act for the person and for this state. The action shall be brought in the name of the state." *Id.* § 5053.2.

C. The Federal Anti-Kickback Statute

119. The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b) (the "AKS"), reflects, in part, congressional desire to protect patients and federal healthcare programs, including Medicare and Medicaid, from the harms that could occur if third-party providers were allowed to provide or arrange for financial benefits to flow to those institutions that made use of the third party's services or products.

120. In pertinent part, the AKS makes it a crime "to offer[] or pay[] any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program" 42 U.S.C. § 1320a-7b(b)(2)(A).

different statutory formula for calculating inflation adjustments on an annual basis. Following that formula, on January 29, 2018, the Department of Justice promulgated a Final Rule increasing the penalty for FCA violations occurring after November 2, 2015. For such penalties assessed after January 29, 2018, the minimum penalty is $11,181 and the maximum is $22,363. *See* 28 C.F.R. § 85.5; 83 Fed. Reg. 3945 (January 29, 2018).

121. A violation of the AKS is a *per se* violation of the FCA. 42 U.S.C. § 1320a-7b(g).

FIRST CLAIM FOR RELIEF
FEDERAL FALSE CLAIMS ACT: PRESENTATION OF FALSE CLAIMS

122. Relators repeat and re-allege all preceding paragraphs of this FAC inclusive, as if fully set forth herein.

123. Throughout the statutory period, Defendants presented reimbursement claims to CMS which:

a. were made on behalf of patients for whom Defendants had compensated referring providers, in violation of the federal Anti-Kickback Statute;

b. reflected diagnoses that had been purposefully "upcoded" in order to improperly obtain higher levels of reimbursement;

c. were made on behalf of patients whom Carter kept under care for extended periods without certification by a physician, in violation of Medicare/Medicaid rules; and/or

d. reflected billing for services that were not medically necessary,

all as described herein.

124. For each of those claims, Defendants certified that:

a. the information on the claim form was true, accurate and complete;

b. they had provided or would provide sufficient information required to allow CMS to make an informed eligibility and payment decision;

c. the claim complied with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment; and

d. the services for which reimbursement was claimed were medically necessary.

125. Each such certification was false.

126. Accordingly, Defendants knowingly presented false or fraudulent claims to CMS for payment in violation of 31 U.S.C. § 3729(a)(l)(A).

127. The submission by Defendants of these false claims and certifications caused the United States, through its agency CMS and that agency's Medicare and Medicaid programs, to pay out sums that it would not have paid if CMS had been made aware of the falsity of Defendants' claims and certifications.

128. Each false or fraudulent claim submitted to the United States is a separate violation of the FCA.

129. By reason of the false or fraudulent claims that Defendants knowingly presented, the United States has been damaged, and continues to be damaged, in a substantial amount to be proven at trial. Relators therefore respectfully request an order awarding the United States treble damages plus a civil monetary penalty for each violation, and awarding Relators the maximum award permitted under 31 U.S.C. § 3730(d).

SECOND CLAIM FOR RELIEF
FEDERAL FALSE CLAIMS ACT: MAKING OR USING FALSE RECORD OR STATEMENT TO CAUSE FALSE CLAIM TO BE PAID

130. Relators repeat and re-allege all preceding paragraphs of this FAC inclusive, as if fully set forth herein.

131. As described above, throughout the statutory period, Defendants knowingly and falsely certified, stated, and/or represented that, in seeking reimbursement for services and treatments that were provided but were unnecessary, Defendants were in full compliance with applicable federal and state laws, including but not limited to 42 U.S.C. § 1320c-5.

132. As described above, Defendants used false records and statements when they submitted these claims for reimbursement.

133. Accordingly, Defendants knowingly used false records or statements material to false or fraudulent claims to CMS for payment in violation of 31 U.S.C. § 3729(a)(l)(B).

134. The submission by Defendants of these false records or statements caused the United States, through its agency CMS and through that agency's Medicare and Medicaid programs, to pay out sums that it would not have paid if CMS had been made aware of the falsity of Defendants' records or statements.

135. Each submission of a false record or statement is a separate violation of the FCA.

136. By reason of the false or fraudulent records or statements that Defendants knowingly submitted, the United States has been damaged, and continues to be damaged, in a substantial amount to be proven at trial. Relators therefore respectfully request an order awarding the United States treble damages plus a civil monetary penalty for each violation, and awarding Relators the maximum award permitted under 31 U.S.C. § 3730(d).

THIRD CLAIM FOR RELIEF
FEDERAL FALSE CLAIMS ACT: CONSPIRING TO SUBMIT FALSE CLAIMS

137. Relators repeat and re-allege all preceding paragraphs of this FAC inclusive, as if fully set forth herein.

138. As set forth above, Defendants conspired with each other to seek and obtain from CMS reimbursement for services and treatments that were provided but were unnecessary.

139. Accordingly, Defendants knowingly conspired to defraud CMS by getting false or fraudulent claims allowed or paid, in violation of 31 U.S.C. § 3729(a)(3) (1986), and conspired to commit violations of 31 U.S.C. §§ 3729(a)(1)(A) and 3729(a)(1)(B), in violation of 31 U.S.C. § 3729(a)(1)(C).

140. By reason of the false or fraudulent claims that Defendants conspired to get allowed or paid, or by reason of their conspiracy to violate 31 U.S.C. §§ 3729(a)(1)(A) and 3729(a)(1)(B), the United States has been damaged, and continues to be damaged, in a substantial amount to be proven at trial. Relators therefore respectfully request an order awarding the United States treble

damages plus a civil monetary penalty for each violation, and awarding Relators the maximum award permitted under 31 U.S.C. § 3730(d).

FOURTH CLAIM FOR RELIEF
OKLAHOMA MEDICAL FALSE CLAIMS ACT:
PRESENTATION OF FALSE CLAIMS

141. Relators repeat and re-allege all preceding paragraphs of this FAC inclusive, as if fully set forth herein.

142. Throughout the statutory period, Defendants presented reimbursement claims to the Oklahoma Health Care Authority, via its SoonerCare program.

143. For each of those claims, Defendants certified that:

a. the information on the claim form was true, accurate and complete;

b. they had provided or would provide sufficient information required to allow the Oklahoma Health Care Authority to make an informed eligibility and payment decision;

c. the claim complied with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment; and

d. the services for which reimbursement was claimed were medically necessary.

144. Each such certification was false.

145. Accordingly, Defendants knowingly presented false or fraudulent claims to the Oklahoma Health Care Authority for payment in violation of 63 Okla. Stat. § 5053.1(B)(1).

146. The submission by Defendants of these false claims and certifications caused the State of Oklahoma, through the Oklahoma Health Care Authority and that agency's SoonerCare program, to pay out sums that it would not have paid if the Oklahoma Health Care Authority had been made aware of the falsity of Defendants' claims and certifications.

147. Each false or fraudulent claim submitted to the United States is a separate violation of the OMFCA.

148. By reason of the false or fraudulent claims that Defendants knowingly presented, the State of Oklahoma has been damaged, and continues to be damaged, in a substantial amount to be proven at trial. Relators therefore respectfully request an order awarding the State of Oklahoma treble damages plus a civil monetary penalty for each violation, and awarding Relators the maximum award permitted under 63 Okla. Stat. § 5053.4.

FIFTH CLAIM FOR RELIEF
OKLAHOMA MEDICAL FALSE CLAIMS ACT: MAKING OR USING
FALSE RECORD OR STATEMENT TO CAUSE FALSE CLAIM TO BE PAID

149. Relators repeat and re-allege all preceding paragraphs of this FAC inclusive, as if fully set forth herein.

150. As described above, throughout the statutory period, Defendants knowingly and falsely certified, stated, and/or represented that, in seeking reimbursement from the Oklahoma Health Care Authority via its SoonerCare program, Defendants were in full compliance with applicable federal and state laws.

151. As described above, Defendants used false records and statements when they submitted these claims for reimbursement.

152. Accordingly, Defendants knowingly used false records or statements material to false or fraudulent claims to the Oklahoma Health Care Authority for payment in violation of 63 Okla. Stat. § 5053.1(B)(2).

153. The submission by Defendants of these false claims and certifications caused the State of Oklahoma, through the Oklahoma Health Care Authority and that agency's SoonerCare program, to pay out sums that it would not have paid if the Oklahoma Health Care Authority had been made aware of the falsity of Defendants' claims and certifications.

154. Each false or fraudulent claim submitted to the United States is a separate violation of the OMFCA.

155. By reason of the false or fraudulent claims that Defendants knowingly presented, the State of Oklahoma has been damaged, and continues to be damaged, in a substantial amount to be proven at trial. Relators therefore respectfully request an order awarding the State of Oklahoma treble damages plus a civil monetary penalty for each violation, and awarding Relators the maximum award permitted under 63 Okla. Stat. § 5053.4.

SIXTH CLAIM FOR RELIEF
OKLAHOMA MEDICAL FALSE CLAIMS ACT:
CONSPIRING TO SUBMIT FALSE CLAIMS

156. Relators repeat and re-allege all preceding paragraphs of this FAC inclusive, as if fully set forth herein.

157. As set forth above, Defendants conspired with each other to seek and obtain reimbursement from the Oklahoma Health Care Authority using false claims.

158. Accordingly, Defendants knowingly conspired to defraud the State of Oklahoma by getting false or fraudulent claims allowed or paid, in violation of 63 Okla. Stat. § 5053.1(B)(2).

159. By reason of the false or fraudulent claims that Defendants conspired to get allowed or paid, or by reason of their conspiracy to violate 63 Okla. Stat. § 5053.1(B)(2), the State of Oklahoma has been damaged, and continues to be damaged, in a substantial amount to be proven at trial. Relators therefore respectfully request an order awarding the State of Oklahoma treble damages plus a civil monetary penalty for each violation, and awarding Relators the maximum award permitted under 63 Okla. Stat. § 5053.4.

PRAYER FOR RELIEF

WHEREFORE, Relators respectfully request that this Court enter judgment in their favor and that of the United States, and against Defendants, granting the following:

(A) On the First, Second, and Third Claims for Relief (violations of the FCA, 31 U.S.C. §§ 3729(a)(l)(A)-(C)), an award to the United States for treble its damages, in an amount to be determined at trial, plus the maximum penalty allowable for each false claim submitted in violation of the FCA;

(B) On the First, Second, and Third Claims for Relief, an award to Relators in the maximum amount permitted under 31 U.S.C. § 3730(d);

(C) On the First, Second, and Third Claims for Relief, an award to the United States for its costs pursuant to 31 U.S.C. § 3729(a)(3);

(D) On the Fourth, Fifth, and Sixth Claims for Relief (violations of the OMFCA, 63 Okla. Stat. §§ 5053.1(B)(1)-(3)), an award to the State of Oklahoma for treble its damages, in an amount to be determined at trial, plus the maximum penalty allowable for each false claim submitted in violation of the OMFCA;

(E) On the Fourth, Fifth, and Sixth Claims for Relief, an award to Relators in the maximum amount permitted under 63 Okla. Stat. § 5053.4;

(F) On the Fourth, Fifth, and Sixth Claims for Relief, an award to the State of Oklahoma for its costs pursuant to 63 Okla. Stat. § 5053.1(D);

(G) And on all Claims for Relief,

1. An award to Relators of the reasonable attorneys' fees, costs, and expenses they incurred in prosecuting this action;

2. Awards to the United States, the State of Oklahoma, and Relators for their costs of court;

3. Awards to the United States, the State of Oklahoma, and Relators for pre- and post-judgment interest at the rates permitted by law; and

(H) Such other and further relief as this Court may deem to be just and proper.

FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)

DEMAND FOR TRIAL BY JURY

Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Relators demand trial by jury on all questions of fact raised by this First Amended Complaint.

Dated: September 22, 2020

Respectfully submitted,

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FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)

CERTIFICATE OF SERVICE

I hereby certify that on September 22, 2020, I caused a true copy of the First Amended Complaint in the matter captioned *United States of America ex rels. Jamie Duffield and Diana Harris v. CHC Holdings, LLC, d/b/a Carter Healthcare, Stanley Carter, and Brad Carter* to be served upon the following:

by email to

Scott Maule, Healthcare Fraud Coordinator
Office of the United States Attorney
Western District of Oklahoma
210 West Park Avenue, Suite 400
Oklahoma City, Oklahoma 73102
scott.maule@usdoj.gov

and

Christopher Robinson
Office of the Attorney General
State of Oklahoma
313 NE 21st Street
Oklahoma City, OK 73105
christopher.robinson@oag.ok.gov

by USPS Registered Mail, Return Receipt Requested, to

Office of the Attorney General of the United States
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

/s/ Patrick S. Almonrode
Patrick S. Almonrode