UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

THE UNITED STATES OF AMERICA, COMMONWEALTH OF MASSACHUSETTS *ex rel.* MICHELLE McCORMICK, Plaintiffs, v. REGALCARE MANAGEMENT 2.0 LLC, REGALCARE MANAGEMENT GROUP, LLC, MAPLEWOOD OPCO, LLC, OC AZURE OF WORCESTER CENTER, LLC, RC GREENFIELD, LLC, RC HOLYOKE, LLC, 30 PRINCETON OPCO, LLC RC QUINCY, LLC, RC TAUNTON, LLC, REGALCARE AT HARWICH, LLC, SAUGUS OPCO, LLC, STERN THERAPY CONSULTANTS, TWIN OAKS OPCO, LLC, ELIYAHU MIRLIS, and HECTOR CARABALLO, Defendants.	20-cv-11805-IT **JURY TRIAL DEMANDED**

UNITED STATES AND COMMONWEALTH OF MASSACHUSETTS'
COMPLAINT IN INTERVENTION

TABLE OF CONTENTS

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INTRODUCTION

1. Medicare and Medicaid pay Skilled Nursing Facilities, or SNFs, to care for society's vulnerable—elderly, disabled, or poor Americans needing temporary care after hospitalization or while recovering from an illness, surgery, or injury. These government programs, however, only pay for services that are medically reasonable and necessary.

2. The defendants operated, or provided services to, SNFs in Massachusetts and Connecticut. Between 2017 to 2023, they engaged in systematic billing fraud to cheat Medicare

and Medicaid and increase their profits. They provided more expensive but unnecessary "care" to patients and then billed for it. And some even routinely falsified internal records to cover up their schemes. Through this fraud, the defendants collectively received millions in excessive and improper reimbursement from Medicare and Medicaid.

3. Now the United States, pursuant to the federal False Claims Act, and the Commonwealth of Massachusetts, pursuant to the Massachusetts False Claims Act and Massachusetts Medicaid False Claims Act, jointly file this Complaint-in-Intervention against the defendants to recover treble damages, restitution, and penalties for engaging in this fraud.

THE UNITED STATES DEFENDANTS

4. The United States brings this Complaint-In-Intervention against some of the captioned defendants. They include: RegalCare Management Group, LLC; Maplewood OPCO, LLC, d/b/a Maplewood Rehab and Nursing; Saugus OPCO, LLC, d/b/a Saugus Rehab and Nursing; Twin Oaks OPCO, LLC, d/b/a Twin Oaks Rehab and Nursing (collectively "RegalCare Management"); RegalCare Management's owner, Eliyahu Mirlis ("Mirlis"); RegalCare Management's Vice President of Clinical Reimbursement, Hector Caraballo ("Caraballo"); and Stern Therapy Consultants ("Stern"). These defendants are referred to herein as the "United States Defendants."

5. The United States alleges that between January 1, 2017 and September 30, 2019, the United States Defendants submitted or caused the submission of false claims to Medicare for unreasonable and medically unnecessary skilled nursing therapy services.

6. Against the United States Defendants, the United States seeks to recover damages, restitution, and civil penalties under the federal False Claims Act, 31 U.S.C. §§ 3729-33 ("FCA"), and under federal common law.

THE MASSACHUSETTS DEFENDANTS

7. The Commonwealth of Massachusetts brings this Complaint-In-Intervention against some of the captioned defendants. They include: RegalCare Management; RegalCare Management 2.0, LLC; RC Greenfield, LLC, d/b/a RegalCare at Greenfield, RegalCare at Harwich, LLC, RC Holyoke, LLC, d/b/a RegalCare at Holyoke, 30 Princeton OPCO, LLC, d/b/a RegalCare at Lowell, RC Quincy, LLC, d/b/a RegalCare at Quincy, RC Taunton LLC, d/b/a RegalCare at Taunton, OC Azure of Worcester Center, LLC, d/b/a RegalCare at Worcester, Maplewood OPCO, LLC, d/b/a Maplewood Rehab and Nursing, Saugus OPCO, LLC, d/b/a Saugus Rehab and Nursing, and Twin Oaks OPCO, LLC, d/b/a Twin Oaks Rehab and Nursing (collectively "RegalCare Massachusetts Facilities"); Mirlis; Caraballo; and Stern. These defendants are referred to herein as the "Massachusetts Defendants."

8. Massachusetts alleges that, between January 1, 2017 and September 30, 2023, the Massachusetts Defendants submitted or caused the submission of false claims to the Massachusetts Medicaid Program ("MassHealth") for unreasonable and medically unnecessary skilled nursing therapy services and for the provision of unreasonable and medically unnecessary skilled nursing services.

9. Against the Massachusetts Defendants, Massachusetts seeks to recover damages, restitution, and civil penalties under the Massachusetts False Claims Act, Mass. Gen. Laws. c. 12, §§ 5A-5O ("MFCA"); the Massachusetts Medicaid False Claims Act, Mass. Gen. Laws c. 118E, §§ 36, 40, and 44 ("MMFCA"), and under the common law.

JURISDICTION AND VENUE

10. This Court has subject matter jurisdiction over the FCA claims 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.

11. This Court has subject matter jurisdiction over the MFCA, MMFCA, and common law claims under 28 U.S.C. § 1367(a) and under 31 U.S.C. § 3732(b).

12. The Court may exercise personal jurisdiction over the United States Defendants and the Massachusetts Defendants pursuant to 31 U.S.C. § 3732(a), as the United States Defendants and the Massachusetts Defendants transact business in this District.

13. Venue lies in this District pursuant to 31 U.S.C. § 3732(a) because the United States Defendants and the Massachusetts Defendants transact business in this District and maintain businesses in this District.

PARTIES

14. Plaintiff United States is acting on behalf of the United States Department of Health and Human Services ("HHS"), including the Centers for Medicare and Medicaid Services ("CMS"), which administers the Health Insurance Program for the Aged and Disabled established by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, ("Medicare") and the Medicaid Program, 42 U.S.C. §§ 1396-1396w-5 ("Medicaid").

15. Plaintiff Massachusetts is a sovereign state and body politic duly organized by law and is represented by the Massachusetts Attorney General, who brings this action in the public interest and on behalf of the Massachusetts, its citizens, taxpayers, the Massachusetts Executive Office of Health and Human Services ("EOHHS") and MassHealth, which jointly administers the Massachusetts Medicaid program with the United States.

16. The relator, Michelle McCormick, is a physical therapist previously employed by Stern who provided physical therapy services to patients at RegalCare Management's Maplewood Rehab and Nursing, a SNF in Amesbury, Massachusetts between June 2017 and December 2019.

17. Defendant RegalCare Management Group, LLC was a Delaware corporation with a principal place of business in Edison, New Jersey. RegalCare Management Group, LLC operated SNFs located in Connecticut and Massachusetts from January 1, 2017, through its date of dissolution on December 30, 2022.

18. Defendant RegalCare Management 2.0, LLC is a Delaware corporation that owned and operated nursing homes and SNFs located and operating throughout Massachusetts between March 12, 2021 to the present.

19. Defendant Maplewood OPCO LLC, d/b/a Maplewood Rehab and Nursing ("Maplewood") was a Massachusetts corporation that owned and operated a SNF located in Amesbury, MA from approximately April 1, 2018 to February 16, 2021.

20. Defendant RC Greenfield LLC, d/b/a RegalCare at Greenfield is a Massachusetts corporation that has owned and operated a SNF located in Greenfield, MA since approximately September 1, 2022.

21. Defendant RegalCare at Harwich, LLC is a Massachusetts corporation that has owned and operated a SNF located in Harwich, MA since approximately December 22, 2020.

22. Defendant RC Holyoke LLC d/b/a RegalCare at Holyoke is a Massachusetts corporation that has owned and operated a SNF located in Holyoke, MA since approximately September 1, 2022.

23. Defendant 30 Princeton OPCO LLC, d/b/a RegalCare at Lowell is a Massachusetts corporation that has owned and operated a SNF located in Lowell, MA since approximately November 1, 2022.

24. Defendant RC Quincy LLC, d/b/a RegalCare at Quincy is a Massachusetts corporation that has owned and operated a SNF located in Quincy, MA since approximately September 1, 2022.

25. Defendant RC Taunton LLC, d/b/a RegalCare at Taunton is a Massachusetts corporation that has owned and operated a SNF located in Taunton, MA since approximately September 1, 2022.

26. Defendant OC Azure of Worcester Center LLC, d/b/a RegalCare at Worcester is a Massachusetts corporation that has owned and operated a SNF located in Worcester, MA since approximately February 1, 2022.

27. Defendant Saugus OPCO LLC, d/b/a Saugus Rehab and Nursing ("Saugus") is a Massachusetts corporation that owned and operated a SNF located in Saugus, MA from approximately April 1, 2018 to February 16, 2021.

28. Defendant Twin Oaks Opco LLC, d/b/a Twin Oaks Rehab and Nursing ("Twin Oaks") is a Massachusetts corporation that owned and operated a SNF located in Danvers, MA from approximately April 1, 2018 to February 16, 2021.

29. Defendant Stern is a New York corporation that provides consultant and management-based services to long-term care facilities. Between January 1, 2017 and September 30, 2019, RegalCare contracted with Stern to assist with the operation of RegalCare Management's SNFs including hiring and overseeing physical, occupational, and speech

pathology therapists who provided skilled nursing rehabilitation therapy services at RegalCare Management's SNFs.

30. Defendant Mirlis is a resident of the state of New Jersey and is the manager and Chief Executive Officer of RegalCare Management 2.0, LLC, and was the manager of RegalCare Management Group, LLC. According to corporate filings and the CMS nursing home ownership database, he is a managing employee and holds an ownership interest in each of the RegalCare Management's SNFs and the RegalCare Massachusetts Facilities. On his website, Mirlis purports to be a nursing home administrator, but his Connecticut, New York, and New Jersey Nursing Home Administrator licenses have lapsed due to non-renewal. He has never been licensed as a Nursing Home Administrator in Massachusetts.

31. While Mirlis testified that he did not receive compensation from RegalCare Management, he did "take draws from some of my companies, or loans or distributions if there's money there."

32. Defendant Caraballo is a resident of the state of Connecticut and is the Vice President of Clinical Reimbursement and Minimum Data Set ("MDS") for RegalCare Management 2.0, LLC and previously held that position for RegalCare Management Group, LLC. Caraballo is licensed as a practical nurse in Connecticut.

LEGAL AND FACTUAL BACKGROUND

I. THE FALSE CLAIMS ACT

33. The FCA establishes liability to the United States for any individual or entity that "knowingly presents, or causes to be presented, 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," 31 U.S.C. § 3729(a)(1)(B), or "conspires to commit a violation" of the above, 31 U.S.C. § 3729(a)(1)(C).

34. The FCA defines the term "claim" as any request or demand for money, whether under a contract or otherwise, presented to an officer, employee, or agent of the United States. 31 U.S.C. § 3729(b)(2)(A)(i). A "claim" is also a request or demand for money made to a contractor or other recipient if (1) the money is to be spent or used on the Government's behalf or to advance a Government program or interest and (2) if the Government provides, has provided, or will reimburse such contractor or other recipient for any portion of the money requested or demanded. *Id.* § 3729(b)(2)(A)(ii).

35. The FCA defines "knowingly" to include actual knowledge, deliberate indifference, and reckless disregard. 31 U.S.C. §3729(b)(1). No proof of specific intent to defraud is required. *Id.*

36. For purposes of the FCA, the term "material" means "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

37. The FCA provides that a person is liable to the United States for three times the amount of damages that the United States sustains because of the act of that person, plus a civil penalty as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990. 31 U.S.C. § 3729(a)(1). As of January 27, 2025, the minimum civil monetary penalty is $14,308 per claim, while the maximum penalty is $28,619 per claim. 28 C.F.R. § 85.5; 89 Fed. Reg. 106,308, 106,310 (Dec. 30, 2024).

II. THE MASSACHUSETTS FALSE CLAIMS ACT AND THE MASSACHUSETTS MEDICAID FALSE CLAIMS ACT

38. The MFCA establishes liability to Massachusetts for any individual or entity that "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," Mass. Gen. Laws, c. 12, § 5B(a)(1), or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," Mass. Gen. Laws, c. 12, § 5B(a)(2), or "conspires to commit a violation" of the above, Mass. Gen. Laws, c. 12, § 5B(a)(3).

39. The MFCA "was modeled on the similarly worded" FCA and is, therefore, analogous. *See Scannell v. Attorney Gen.*, 70 Mass. App. Ct. 46, 49 n. 4 & 51 (2007). Accordingly, courts construing the MFCA rely upon cases and treatises interpreting the FCA. *Id.* at 49 n. 4.

40. The MFCA provides that an individual or entity may be liable to Massachusetts for three times the amount of damages that Massachusetts sustained because of the individual's and/or entity's violation, including consequential damages, plus a civil penalty as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990. 31 U.S.C. § 3729(a)(1). As of January 27, 2025, the minimum civil monetary penalty is $14,308 per claim, while the maximum penalty is $28,619 per claim.

41. Under the MMFCA, a person who makes or causes to be made false claims to Medicaid or to retain payments from Medicaid that should not have been paid may be held civilly or criminally liable. *See* Mass. Gen. Laws, c. 118E, §§ 40 and 44 ("If any person violates the provisions of this chapter, the attorney general or a district attorney may bring a civil action, either in lieu of or in addition to a criminal prosecution, and recover three times the amount of damages sustained including the costs of investigation and litigation.").

42. The MMFCA states, in pertinent part: "Any person . . . who: (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this chapter; or (2) knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment; or (3) having knowledge of the occurrence of any event affecting his or her initial or continued right to any such benefit or payment, or the benefit of any other individual in whose behalf [they] applied for or is receiving such benefit or payment, conceals or fails to disclose such an event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized . . . shall be punished . . . ." Mass. Gen. Laws, c. 118E, § 40.

43. The elements of the MFCA and the MMFCA are effectively the same, both in reach and effect, as they require the same elements: (1) a false or fraudulent representation; (2) with knowledge; (3) in the submission of false claims to Medicaid (or the causing thereof): and (4) that was material to payment. As the MMFCA's elements essentially are identical to the MFCA's, caselaw interpreting the FCA is equally relevant to the MMFCA. *See Commonwealth v. Stirlacci*, 483 Mass. 775, 794 (2020) ("Federal cases concerning similar false health care claim provisions further demonstrate that the fact that a falsehood stems from a deliberate violation of established rules can support the inference that the false statement was made knowingly.").

III. SKILLED NURSING FACILITIES AND SKILLED NURSING REHABILITATION THERAPY SERVICES

44. A SNF, sometimes referred to as a subacute rehabilitation facility, is an inpatient facility that provides transitional short-term or long-term care to patients following a hospital stay. Patients are placed in SNFs to receive care and treatment after an illness, injury, or surgery with the goal of returning home.

45. SNFs employ numerous medical professionals who help provide care, including certified nurses' aides, registered nurses, licensed practical nurses, nurse practitioners, doctors, and therapists. Though generally a non-clinical position, Licensed Nursing Home Administrators manage the day-to-day operations of SNFs. This can include admissions, finances, and staff oversight.

46. Among the services patients receive at SNFs include: skilled nursing, medication management, assistance with activities of daily living ("ADL"), meal preparation and dietary counseling, wound care, cardiac rehabilitation, post-stroke rehabilitation, and skilled nursing rehabilitation therapy services.

47. Physicians prescribe skilled nursing rehabilitation therapy services after a surgery, illness, or injury to aid the patient with their recovery. Generally, therapy is prescribed for the patient to regain strength and independence, assist in the performance of ADLs, or to help the patient adapt to new health circumstances or social environments.

48. The type and amount of therapy a patient requires depends on the patient's health and condition after surgery, illness, or injury. Generally, there are three primary types of therapy disciplines: physical therapy, occupational therapy, and speech-language pathology. A patient may require one or more of these types of therapy during treatment and may need to receive one or more of these therapies more frequently.

49. Skilled nursing rehabilitation therapy is intended to be a short-term treatment option. As the patient progresses through their rehabilitation therapy, therapists are required to assess whether the patient has evidenced sufficient improvement to warrant reducing or ending the provision of one or more of the therapy disciplines as applicable.

IV. REGALCARE AND STERN

50. Between December 24, 2015, and December 23, 2016, RegalCare Management began operating SNFs in the state of Connecticut. RegalCare Management owned and operated approximately nine SNFs in Connecticut located in Greenwich, New Haven, New London, Norwich, Prospect, Southport, Torrington, Waterbury, and West Haven. The SNFs remained under RegalCare Management's ownership and operation until approximately July 2022.

51. In December 2017, RegalCare Management purchased and began operating three SNFs in the state of Massachusetts. RegalCare Management owned and operated the three SNFs—Maplewood, Twin Oaks, and Saugus—until April 2021, when it sold the facilities.

52. In March 2021, Mirlis established RegalCare Management 2.0, LLC.

53. Later that same year, RegalCare Management 2.0, LLC began operating SNFs in Massachusetts. Between December 2021 and through the date of this complaint, RegalCare Management 2.0, LLC has operated SNFs in Greenfield, Harwich, Holyoke, Lowell, Quincy, Taunton, and Worcester.

54. RegalCare Management's SNFs provided patients with skilled nursing rehabilitation therapy services and submitted claims seeking reimbursement for these services to Medicare. All of the RegalCare Massachusetts Facilities provided MassHealth patients with skilled nursing services and sought reimbursement for these services from MassHealth.

55. Between January 1, 2017 and September 30, 2019, RegalCare Management contracted with Stern to assist with the provision of skilled nursing rehabilitation therapy services at RegalCare Management's SNFs.

56. The contract required Stern to hire clinical staff for RegalCare Management's SNFs including, most relevantly, physical therapists, occupational therapists, and speech-

language pathologists. Stern's management was also responsible for setting therapists' schedules, through which they set the amount of time each therapist spent with patients.

57. RegalCare Management utilized a third-party billing company to submit claims to Medicare to obtain reimbursement for skilled nursing rehabilitation therapy services provided by Stern's therapists at RegalCare Management's SNFs. The third-party billing company submitted the claims to Medicare once a month for the prior month's services rendered.

58. Stern's executives performed checks to ensure that the resource utilization group ("RUG") level that RegalCare Management sought to bill Medicare for matched the skilled nursing rehabilitation therapy services documented for the patient. If Stern's executives identified discrepancies, they notified Mirlis, Caraballo, and the third-party billing company.

59. The third-party billing company only billed Medicare after receiving written instruction from RegalCare Management's executives, and in particular Caraballo, advising what patient to bill for and at what RUG level. RegalCare Management was responsible for ensuring that the medical record supported the RUG level the third-party billing company submitted for reimbursement to Medicare.

60. RegalCare Management and the RegalCare Massachusetts Facilities submitted Massachusetts Medicaid claims to MassHealth directly.

V. FEDERAL HEALTH CARE PROGRAMS

A. Medicare Coverage of Skilled Nursing Rehabilitation Therapy Services

61. Congress established the Medicare program in 1965 to provide health insurance coverage for people age 65 or older and for people with certain disabilities or afflictions. *See* 42 U.S.C. §§ 426, 426A.

62. The Medicare program is divided into four "Parts" that cover different services. Part A generally covers, among other services, skilled nursing and skilled nursing rehabilitation therapy services.

63. In order for skilled nursing rehabilitation therapy services to qualify for the Part A SNF benefit, the following conditions must be met: (1) the patient must require skilled nursing care or skilled rehabilitation services (or both) on a daily basis; (2) the daily skilled services must be services that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis; and (3) the services are provided to address a condition for which the patient received treatment during a qualifying hospital stay, or for a condition that arose while the patient was receiving care in a SNF (for a condition treated during the hospital stay). 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b).

64. Medicare requires that a physician or certain other practitioners certify that these three requirements are met at the time of a patient's admission to the SNF and re-certify the patient's continued need for skilled nursing rehabilitation therapy services at regular intervals thereafter. *See* 42 U.S.C. § 1395f(a)(2)(B); Medicare General Information, Eligibility, and Entitlement Manual, Ch. 4, § 40.3.

65. A *skilled* nursing rehabilitation therapy service must be "so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel." 42 C.F.R. § 409.32(a). Thus, skilled nursing rehabilitation therapy services can only be administered by, or under the supervision of, trained personnel such as physical therapists, occupational therapists, or speech language pathologists. *See* 42 C.F.R. § 409.31(a).

66. Skilled nursing rehabilitation therapy services generally do not include personal care services, such as the general supervision of exercises that have already been taught to a patient or the performance of repetitive exercises (*e.g.* exercises to improve gait, maintain strength or endurance, or assistive walking). *See* 42 C.F.R. § 409.33(d).

67. Medicare Part A will only cover skilled nursing rehabilitation therapy services that are medically "reasonable" and "necessary." *See* 42 U.S.C. § 1395y(a)(1)(A) ("[N]o payment may be made under part A or part B of this subchapter for any expenses incurred for items or services . . . which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member").

68. In the context of skilled nursing rehabilitation therapy services, this means that the services must be (1) consistent with the nature and severity of the patient's individual illness, injury, or particular medical needs; (2) consistent with accepted standards of medical practice; and (3) reasonable in duration and quantity. *See* Medicare Benefit Policy Manual, Ch. 8, § 30.

69. Medicare requires SNFs to maintain proper and complete documentation of the skilled nursing rehabilitation therapy services rendered to beneficiaries to assess whether those services were medically reasonable and necessary for payment determination. Thus, Congress requires that "no . . . payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which amounts are being paid or any prior period." 42 U.S.C. § 1395g(a).

70. Subject to requirements above, Medicare Part A covers up to 100 days of skilled nursing rehabilitation therapy services for a benefit period (i.e., spell of illness) following a

qualifying hospital stay of at least three consecutive days. 42 U.S.C. § 1395d(a)(2)(A); 42 C.F.R. § 409.61(b) & (c).

71. In order to submit claims to Medicare, each SNF is required to submit a Medicare Enrollment Application in which the SNF certifies, among other things, that:

> I agree to abide by the Medicare laws, regulations, and program instructions that apply to this provider . . . . 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 (including, but not limited to, the Federal anti-kickback statute and the Stark law) and on the provider's compliance with all applicable conditions of participation in Medicare.

B. Medicare Payment for SNF Rehabilitation Therapy Services

72. Prior to September 30, 2019, Medicare paid SNFs a pre-determined daily rate for each day of skilled nursing rehabilitation therapy services provided to a patient under a prospective payment system. *See* 63 Fed. Reg. 26,252; 26,259-60 (May 12, 1998).

73. The daily rate Medicare paid a SNF depended, in part, on the RUG to which a patient is assigned. Each distinct RUG reflected the anticipated costs of providing skilled rehabilitation therapy services to beneficiaries with similar characteristics or resource needs. *See* 64 Fed. Reg. 41,644 (July 30, 1999).

74. The RUG classification system in place between January 1, 2017 and September 30, 2019 included eight major classification categories including Rehabilitation Plus Extensive Services and Rehabilitation.

75. The Rehabilitation Plus Extensive Services and Rehabilitation categories are further broken down to five RUG levels for patients requiring rehabilitation therapy: Rehab Ultra High (typically signified as RU); Rehab Very High; Rehab High; Rehab Medium; and Rehab Low.

76. The RUG level to which a patient was assigned depended both upon the number of skilled therapy minutes and the number of skilled therapy disciplines (e.g., physical, speech, occupational) the patient received during a seven-day assessment period (also known as the "look back period"). The chart below reflected the requirements for the five rehabilitation RUG levels under the RUG classification system.

Rehabilitation RUG Level	**Requirements to Attain RUG Level**
Ultra High or RU	At least 720 minutes per week of total therapy combined from at least two therapy disciplines; one therapy discipline must be provided at least five days per week
Very High	Between 500 and 719 minutes per week of total therapy; one therapy discipline must be provided at least five days per week
High	Between 325 and 499 minutes per week of total therapy; one therapy discipline must be provided at least five days per week
Medium	Between 150 and 324 minutes per week of total therapy; there must be provided at least 5 days per week but can be any mix of therapy disciplines
Low	Minimum of 45 minutes per week of total therapy; therapy must be provided at least 3 days per week but can be any mix of therapy disciplines

74 Fed. Reg. 40,288, 40,332 (Aug. 11, 2009); 75 Fed. Reg. 42,886, 42, 894 (July 22, 2010).

77. Medicare paid the highest rate for those beneficiaries that fell into the Ultra High RUG level. This level was "intended to apply only to the most complex cases requiring rehabilitative therapy well above the average amount of service time." 63 Fed. Reg. at 26,258. In announcing the final prospective payment system rule for SNFs, CMS further explained that the RUG system "use[d] minimum levels of minutes per week as qualifiers. . . . These minutes are minimums and [were] not to be used as upper limits for service provision. . . . Any policy of holding therapy to the bare minimum, regardless of beneficiary need, [was] inconsistent with the statutory requirements . . . and will result in poor outcomes, longer lengths of stay, and a degradation in the facility's quality of care." 64 Fed. Reg. 41,644, 41,662 (July 30, 1999).

78. Medicare reimbursement also varied within each RUG level depending on (1) the patient's ability to perform certain ADLs, such as eating, toileting, bed mobility, and transfers (e.g., from a bed to a chair), and (2) the extent to which the patient needed "extensive services" such as intravenous treatment, a ventilator, tracheotomy, or suctioning.

79. ADL scores of A, B, C, L, or X were assigned to each patient. Patients who can perform an ADL without assistance would receive an "A." Patients who require limited assistance with one ADL would receive a "B." Patients who required minor assistance with multiple ADLs would receive a "C." Patients requiring extensive assistance with one ADL received an ADL score of "L," while patients requiring extensive assistance with several ADLs received a score of "X." The higher the letter, the greater the reimbursement paid under the RUG level.

80. The summary charts below show the difference that a RUG level and ADL score can have on the Medicare daily reimbursement rate. The charts reflect the adjusted urban rates that Medicare paid SNFs for skilled nursing rehabilitation therapy services in fiscal years 2017, 2018, and 2019. Medicare adjusted base rates annually and based on locality. 42 U.S.C. § 1395yy(e)(4)(E)(ii)(IV).

RUG Rates: Federal Rates for Fiscal Year 2017 – Urban

	Rehab with Extensive Services		**Rehab without Extensive Services**		
RUG Level	X	L	C	B	A
Ultra High	$804.36	$786.83	$609.80	$609.80	$509.89
Very High	$715.94	$642.32	$523.13	$453.02	$451.27
High	$648.65	$578.54	$455.85	$410.27	$361.19
Medium	$595.02	$545.94	$400.46	$375.92	$309.32
Low	$522.56	n/a	n/a	$389.35	$250.88

See 81 Fed. Reg. 51,970, 51,976 (Aug. 5, 2016)

RUG Rates: Federal Rates for Fiscal Year 2018 - Urban

	Rehab with Extensive Services		Rehab without Extensive Services		
RUG Level	X	L	C	B	A
Ultra High	$813.43	$795.71	$616.68	$616.68	$515.64
Very High	$724.03	$649.58	$529.04	$458.14	$456.37
High	$655.97	$585.07	$460.99	$414.90	$365.27
Medium	$601.74	$552.11	$404.98	$380.17	$312.81
Low	$528.47	n/a	n/a	$393.75	$253.71

See 82 Fed. Reg. 36,530, 36,537 (Aug. 4, 2017).

RUG Rates: Federal Rates for Fiscal Year 2019 – Urban

	Rehab with Extensive Services		Rehab without Extensive Services		
RUG Level	X	L	C	B	A
Ultra High	$832.61	$814.47	$631.22	$631.22	$527.80
Very High	$741.10	$664.89	$541.51	$468.94	$467.12
High	$671.44	$598.87	$471.86	$424.68	$373.88
Medium	$615.93	$565.12	$414.53	$389.13	$320.18
Low	$540.92	n/a	n/a	$403.03	$259.69

See 83 Fed. Reg. 49,832, 49,833 (Oct. 3, 2018).

81. Prior to the commencement of therapy in any discipline, a therapist certified in that discipline must evaluate the patient and develop a treatment plan that is approved by a physician. *See* 64 Fed. Reg. at 41,660-61; 42 C.F.R. §§ 409.17 and 409.23.

82. A SNF determined each patient's RUG as of "specific assessment reference dates," and the RUG as of that date then determined the daily reimbursement rate prospectively for a specific timeframe. The Medicare assessment schedule is as follows:

RUG Assessment Type	Assessment Reference Date Window (including grace days)	Medicare Payment Days Determined by RUG
5 day	Days 1 – 8	Days 1 – 14
14 day	Days 11 – 19	Days 15 – 30
30 day	Days 21 – 34	Days 31 – 60
60 day	Days 50 – 64	Days 61 – 90
90 day	Days 80 – 94	Days 91 – 100

76 Fed Reg. 26,364, 26,389 (May 6, 2011).

83. SNFs reported therapy treatment times for each assessment reference period on a MDS form that is completed as of each specific assessment reference date in a patient's stay. *See* 64 Fed. Reg. at 41,661; 42 C.F.R. § 413.343. The MDS is a standardized assessment tool through which SNFs comprehensively evaluate a patient's health status, functional capabilities, potential health problems. Not only does the MDS provide the basis for a plan of skilled nursing rehabilitation therapy services for the patient, but it also ultimately determined the RUG rate at which the SNF was paid.

84. SNFs transmitted the data directly to CMS. 42 C.F.R. § 483.20(f)(3). Completion of the MDS was a prerequisite to payment under Medicare. *See* 63 Fed. Reg. at 26,265. The MDS form required a certification by the provider stating, in part: "To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that [patients] receive appropriate and quality care, and as a basis for payment from federal funds." *See* MDS Version 3.0 for Nursing Home Resident Assessment and Care Screening. A patient's RUG information was also incorporated into the Health Insurance Prospective Payment System code, which Medicare used to determine the payment owed to the SNF. The code needed to be included on the CMS-1450 form, which SNFs submitted monthly to Medicare via intermediaries

known as Medicare Administrative Contractors that processed and paid Medicare claims. Medicare Claims Processing Manual, Ch. 25, § 75.5.

85. While a licensed practical nurse can gather data for an MDS, only a registered nurse can certify an MDS on behalf of a provider for Medicare.

86. SNFs were required to report the number of minutes of skilled rehabilitation therapy services the SNF provided to a patient during the seven-day look-back period, as well as the type(s) of therapy provided, on the MDS form. In particular, a SNF reported the number of days and minutes of therapy the SNF provided to a patient in each of the following skilled rehabilitation therapy disciplines: physical therapy, occupational therapy, and speech-language pathology. This information directly impacted the RUG level assigned to each patient and, therefore, the amount of reimbursement the SNF received for the patient.

87. In most instances, the RUG level determined Medicare payment prospectively for a defined period of time. *See* Fed. Reg. at 26,267. For example, if a patient was assessed on Day 14 of their stay and received 720 minutes of therapy during days 7 through 14 of the stay, then the SNF would be paid at the Ultra High RUG level for days 15 through 30 of the patient's stay.

88. The Medicare rules further imposed a requirement that SNFs report a so-called Change of Therapy if, after an assessment for a particular patient, "the intensity of therapy (that is, the total reimbursable therapy minutes . . .) changes to such a degree that it . . . no longer reflect[ed] the RUG[] classification and payment assigned" for the patient. *See* 76 Fed. Reg. at 48,518. Specifically, at the end of each 7-day period after an assessment, if the therapy delivered during that period did not match the last reported RUG, then the SNF was required to report the actual level of therapy being delivered in a Change of Therapy, and the reimbursement for that patient's care would be adjusted accordingly. *See id.* at 48,518-26.

89. Medicare only paid if the skilled nursing rehabilitation therapy services provided were reasonable and medically necessary to treat a Medicare beneficiary's condition. *See, e.g.*, CMS MLN Booklet, *Items and Services Not Covered Under Medicare* (December 2020) ("Medicare doesn't pay for medically unreasonable and unnecessary services and supplies to diagnose and treat a patient's condition. . . includ[ing] . . . excessive therapy"). A reasonable and medically necessary skilled nursing rehabilitation therapy service must be appropriate, including the duration and frequency that is considered appropriate for the service, and must be a service that meets, but does not exceed, the patient's medical need. *See* Medicare Program Integrity Manual, ch. 13, § 13.5.4.

90. On October 1, 2019, CMS shifted its Medicare payment model for skilled nursing rehabilitation therapy services from the RUG classification model to the Patient Driven Payment Model ("PDPM"). While the RUG model based reimbursement on therapy minutes, the PDPM sets the amount of reimbursement by assessing a patient's characteristics and needs.

C. MassHealth Coverage of SNF Services

91. In addition to billing to Medicare, the RegalCare Massachusetts Facilities also billed MassHealth, the Massachusetts Medicaid program, for SNF services. Medicaid is a joint state-federal program that provides health care benefits to certain eligible individuals, including low-income children, seniors, and people with disabilities. State governments create, manage, and fund their own Medicaid programs and the federal government reimburses a portion of costs if those programs meet minimum requirements set forth in federal Medicaid statutes. *See* 42 U.S.C. §§ 1396a, *et seq*.

92. To bill for services provided to members covered by MassHealth, each of the RegalCare Massachusetts Facilities entered into Nursing Facility Provider Contracts with

MassHealth. Pursuant to those contracts, a SNF must comply with, and be subject to, federal and state statutes, regulations, and other applicable laws governing its participation in MassHealth.

93. MassHealth also promulgates regulations covering MassHealth providers. The regulations governing SNFs and other long-term care facilities are set forth at 130 C.M.R. §§ 456.401 *et seq.*

94. The regulations governing all providers that participate in MassHealth are set forth at 130 C.M.R. §§ 450.000 *et seq.*

95. Under 130 C.M.R. § 450.204, MassHealth specifies that it "does not pay a provider for services that are not medically necessary."

96. Every provider that submits claims to MassHealth certifies when submitting a claim for payment that "the information submitted in, with, or in support of the claims is true, accurate, and complete." 130 C.M.R. § 450.223(C)(2)(e). Therefore, providers impliedly certify that they are complying with all applicable regulations when submitting claims for payment.

97. The MassHealth regulations governing overpayments state, "[a] provider must report in writing and return any overpayments to the MassHealth agency within 60 days of the provider identifying such overpayment or, for payments subject to reconciliation based on a cost report, by the date any corresponding cost report is due, whichever is later." 130 C.M.R. § 450.235(B).

98. A provider is liable to MassHealth for the full amount of any overpayments, or other monies owed under 130 C.M.R. §§ 450.000 *et seq.*, including but not limited to 130 C.M.R. § 450.235(B), or under any other applicable law or regulation. 130 C.M.R. § 450.260(A).

D. MassHealth Payment for SNF Services

99. As of April 2018, when the RegalCare Massachusetts Facilities began to operate SNFs in Massachusetts, in addition to paying co-payments for dual eligible members whose payment rates were determined by Medicare, MassHealth determined the amount it paid SNFs for each patient, based on a formula described in its payment regulations that considered nursing and other operating costs, capital costs, ancillary costs, and other factors. *See* 101 C.M.R. §§ 206.03-06 (Oct. 1, 2018). MassHealth determined the amount to pay each SNF per patient per day based on the patient's required medical needs, as calculated by "Management Minutes." *See* 101 C.M.R. § 206.04 (Oct. 1, 2018). Management Minutes are defined as "a method of measuring resident care intensity, or case mix, by discrete care-giving activities or the characteristics of residents found to require a given amount of care." *See* 101 C.M.R. § 206.02 (Oct. 1, 2018).

100. SNFs would determine a member's "Management Minute Range" by completing a Management Minute Questionnaire ("MMQ") a form issued by MassHealth to collect resident care information. The MMQ included a series of questions about the resident's care needs in a number of categories, including medications, skilled observations, hygiene, dressing, mobility, eating, continence, positioning, pressure ulcer prevention, skilled procedures, and other needs. The care provided to the residents in these categories during the period relevant to the MMQ led to the final MMQ score.

101. Based on the results of the MMQ, a management minute range would be determined for the patient reflecting the amount of care a resident required. This range corresponded with a Management Minutes Category referred to by a letter. For example,

category "J" had a MMQ range of 30.1 - 85.0 minutes and category "R" had a range of 225.1 - 245.0 minutes.

102. MassHealth's Long Term Care Services regulations in effect at the time specified that "The [SNF] must bill the Division at the [Management Minutes Category] determined by the completion of the MMQ." *See* 130 C.M.R. § 456.420(B) (Oct. 1, 2013)). Additionally, the regulations specified that providers could be subject to audits of MMQs and the Management Minutes Category determination, and that in the event that an audit determined violations of any regulations, rules, instructions, or procedures, the facility could be subject to fines. *See* 130 C.M.R. § 456.420(E-F) (Oct. 1, 2013).

103. The management minute categories and ranges were correlated with MassHealth-determined "payment groups," that correlated with standard payment amounts for nursing and operating costs related to that patient. *See* 101 C.M.R. § 206.02 (Oct. 1, 2017). Essentially, the more minutes of care per day required for a member, the higher the reimbursement for the provider.

104. MassHealth issued instructions to SNFs as to how to complete the MMQ via Appendix E of transmittal letter NF-53, issued on May 26, 2009. Per the instructions, SNFs were to submit an MMQ for newly admitted members at the end of 30 days from the date the member was admitted to the facility, or at the end of 30 days from when the patient became covered by MassHealth. Following that, MMQs were required to be submitted by SNFs every six months.

105. The MMQ was not allowed to include temporary conditions, which included any condition that required service for less than 50 percent of the month. Also, per the instructions, "**All MMQs claims must be medically necessary.** The member's score and category are based

upon the services provided and recorded through the nurse's and nurse's aide's documentation. When conflicting documentation exists, the lower score will be applied." (Emphasis added)

106. The instructions further specified that the member's medical record was to be the source of information included in the MMQ, and that the documentation of the conditions needed to be "complete, accurate, dated, and signed by the person performing the care." The instructions specified that "information from the physician's orders, monthly nursing summary, nursing progress and daily notes, MDS, care plan, ADL flow sheets, medication record, treatment record, and all pertinent documentation must be reviewed." The MMQ was also to be signed by a registered nurse before the submission of the MMQ data to MassHealth.

107. MMQ scores were typically submitted to MassHealth electronically in monthly batches to MassHealth's Provider Online Service Center, a web-based portal available to MassHealth providers to view information, submit and receive transactions, and conduct business with MassHealth online. The providers would then typically submit to MassHealth claims for long-term care services, also in monthly batches, also through the Provider Online Service Center. MassHealth's system would then connect the submitted claims to the MMQ payment group for each member to determine the reimbursement rates for the claims submitted by the RegalCare Massachusetts Facilities. As a result, if the MMQ score reflected a higher payment group than was accurate for the member, MassHealth would pay a higher, inaccurate rate for any claims associated with that member's MMQ score during that period.

108. As of February 1, 2018, the payment groups, management minute ranges, and standard payments were as follows.

Payment Group	Management Minute Range	Standard Payment
H	0-30	$14.45
JK	30.1-110	$39.54
LM	110.1-170	$68.38
NP	170.1-225	$96.34
RS	225.1-270	$117.67
T	270.1 and above	$146.39

See 101 C.M.R. § 206.02 (Oct. 1, 2018).

109. These rates were periodically updated and as of September 30, 2023, the final day of MassHealth's operation under this payment model, the rates were as follows.

Payment Group	Management Minute Range	Standard Payment
H	0-30	$19.56
JK	30.1-110	$52.05
LM	110.1-170	$93.29
NP	170.1-225	$130.40
RS	225.1-270	$158.08
T	270.1 and above	$186.09

See 101 C.M.R. § 206.04 (Dec. 9, 2022).

110. These standard payments rates were adjusted on a per-facility basis based on operating costs and other adjustments.

111. Effective October 1, 2023, MassHealth revised its payment structure to follow the PDPM, a case mix classification system provided by CMS to classify nursing facility patients into payment groups. *See* 101 C.M.R. § 206.04(1)(a).

E. MassHealth Claims for Payment of SNF Services

112. MassHealth directly paid SNFs for health care services, including nursing facility services provided to MassHealth members, on a fee-for-service basis. MassHealth also paid for health care services for members at SNFs via managed care entities ("MCEs"), which are under contract with MassHealth to administer benefits for MassHealth beneficiaries.

113. MassHealth members enrolled in an MCE plan must enroll in one of the MCEs approved by MassHealth. The MCE is responsible for arranging and paying for the member's health care services.

114. MassHealth pays for the services provided to MassHealth members enrolled in an MCE on a capitated basis from Medicaid funds that MassHealth receives from the United States and the Commonwealth. Each MCE contracts with providers within its network.

115. Massachusetts regulations do not distinguish among MassHealth members who receive MassHealth benefits on a fee-for-service basis and MassHealth members who receive benefits via MCEs. Consequently, payment for these services, whether the claims are submitted to MassHealth directly or through one of the MCEs, comes from MassHealth.

116. All claims submitted by providers for nursing home services provided to any MassHealth member, whether paid for by MassHealth directly or via an MCE, must comply with MassHealth regulations.

117. Claims submitted to MassHealth and MCEs are often submitted electronically in monthly batches by SNFs. Due to the enormous volume of claims being submitted by all MassHealth providers, MassHealth and MCEs utilize a semi-automated billing and payment system that automatically denies or approves a claim based on certain information submitted by the provider based on pre-programmed system edits created by a computer algorithm. For example, MassHealth may deny a claim because all information on the claim was not properly filled out. MassHealth does not, however, have the resources to evaluate each claim independently and approves most claims that contain the requested information. In short, because MassHealth providers submit claims certifying that such claims are compliant with all material conditions of payment, MassHealth providers bill and are paid largely on an honor

system. If MassHealth, an MCE, or the Attorney General's Office later learns that the claims should not have been paid—whether due to fraud or for any other reason—they must use other methods to recoup the payment for these claims, which has already been paid to the provider.

118. The Attorney General's Office has access to claims data submitted by the RegalCare Massachusetts Facilities through the Medicaid Management Information System ("MMIS"). This database allows investigators to export and review reports of claims information submitted to MassHealth by RegalCare Massachusetts Facilities' SNFs based on their billing and servicing provider IDs.

FACTUAL ALLEGATIONS

I. UNITED STATES DEFENDANTS INFLATED CLAIMS FOR SKILLED NURSING REHABILITATION THERAPY SERVICES TO MAXIMIZE REVENUE

119. Mirlis pushed for RegalCare Management to submit inflated claims at the Ultra High RUG levels to payors, including Medicare, for skilled nursing rehabilitation therapy services to increase RegalCare Management's revenue and to allow him to procure additional financing from banks to operate RegalCare's SNFs and to purchase new SNFs.

120. For example, in a May 23, 2018 email to two representatives of Meridian Capital, a New York-based finance company through which Mirlis obtained financing to purchase and operate RegalCare Management, Mirlis explained a recent drop in revenue at RegalCare Management's SNF in New Haven, Connecticut, by saying that RegalCare Management "had an issue with an MDS [nurse] that was coding pts lower than they should have been . . .[,]" which resulted in the Medicare reimbursement being "20 dollars a day lower which is resulting in the lower revenue number." But, he explained, RegalCare Management had "identified the issue and should see a change back to 2017 numbers in Medicare" payments per day.

121. Mirlis could not have promised such increased revenue from RegalCare Management's SNF in New Haven had RegalCare Management been coding patients, as it should have, on an individualized basis, according to their needs and circumstances.

122. Moreover, RegalCare Management sought to maximize RUG reimbursement prior to CMS replacing the RUG reimbursement model with the PDPM model for Medicare. Mirlis became concerned that RegalCare Management's SNF revenues would decline significantly under the PDPM reimbursement model.

123. In an August 10, 2018 email, more than a full year before the PDPM reimbursement model went into effect, Mirlis forwarded a PowerPoint presentation to Caraballo entitled "The Times They are a Changin' PDPM: Early Strategies for Success" created by a third-party healthcare consultant. On slide 26, under the heading of "Therapy Under PDPM," the top bullet advised that "Rehab Services will no longer drive SNF revenue."

124. In a training presentation entitled "Medicare Part A SNF Payment Reform: Patient Driven Payment Model," and shared by RegalCare Management's Vice President of Marketing with Stern's and RegalCare Management's managers, including Mirlis and Caraballo, on April 4, 2019, the fifth slide of the presentation advises that "PDPM shifts $$$ away from therapy to patient-specific services, conditions, characteristics & treatments" and "Untethers [physical therapy], [occupational therapy], and [speech-pathology therapy] utilization from reimbursement."

125. To ensure that RegalCare Management maximized its revenue for skilled nursing rehabilitation therapy services before the imposition of PDPM, Mirlis directed Caraballo to bill for as many Ultra High RUG claims for these services as feasible.

126. In a February 11, 2019 email regarding RegalCare Management's SNF at New Haven with the subject line "CENSUS," RegalCare Management's Vice President of Marketing asked Caraballo if he was "following all these [Level of Care] drops? We are using 3 weeks and then dropping. We've remained basically full so I can't refill with new [Medicare Part A's] just want to be sure we are maximizing [skilled nursing rehabilitation therapy services] wherever possible." Caraballo responded, cc'ing Mirlis, that he "did approve a bill to cut an additional three patients because their [RUG] score was in the lower 14. Something [Mirlis] is asking me to stay away from."

127. Notably, RegalCare Management's medical documentation evidenced a sudden shift in care when Medicare patients receiving skilled nursing rehabilitation therapy services at RegalCare transitioned from the RUG reimbursement model to the PDPM reimbursement model around October 1, 2019. For example, RegalCare patients GG[1] and TT received Ultra High RUG level skilled nursing rehabilitation therapy services up to September 30, 2019. On or immediately after October 1, 2019, however, when Medicare was no longer paying based on the minutes of therapy services provided, RegalCare Management's medical documentation noted both patients made sudden improvements and no longer required skilled nursing rehabilitation therapy services.

[1] The identity of the patients is known to the United States and Massachusetts. However, to preserve each patient's privacy, the United States and Massachusetts will only identify each patient in the Complaint-In-Intervention discussed by initials in this complaint.

A. Mirlis and Caraballo Direct RegalCare Management's Scheme to Maximize Billing For Skilled Nursing Rehabilitation Therapy Services

128. Mirlis pushed Carballo to have RegalCare Management bill for the highest amount of reimbursement possible for skilled nursing rehabilitation therapy services and for as many days as feasible.

129. In an email dated February 11, 2019, copying Mirlis, Caraballo sent the third-party billing company instructions to bill for Medicare patients based in RegalCare Management's SNFs in Southport and West Haven, CT, and Saugus, MA, at various RUG levels. In that email, Caraballo instructed the third-party billing company to submit claims for seven patients at RegalCare Management's SNF at Southport receiving skilled nursing rehabilitation therapy services, including five at "RUA," the lowest Ultra High RUG level. Mirlis complained to Caraballo about not billing at a higher Ultra High RUG level, stating, "RUA?? So many!!!" In response Caraballo stated that "[y]eah, without the ADL flow sheets in front of me, I can't change it. The therapy documentation alone didn't support the change." Mirlis, however, instructed Carballo to hold off billing Medicare until Carballo could adjust the documentation to increase the billing: "We need the adl flow sheets! Please lets [sic] hold off."

130. To satisfy Mirlis' directive to bill the maximum number of Ultra High RUG claims possible, Caraballo micromanaged admissions and MDS nurses in RegalCare Management's SNFs to ensure completion of admission and assessment documentation to support billing for skilled nursing rehabilitation therapy services at Ultra High RUG levels.

131. For example, on May 2, 2018 Caraballo sent an email to the MDS nurse at RegalCare Management's SNF in New London asking to "review the two patients that were taken off of Medicare yesterday? I'm looking through the notes for [patient MF], and I think we

might've missed an opportunity for [skilled nursing rehabilitation therapy services]. Would preferred [sic] to review together."

132. When RegalCare Management's admissions and MDS nurses properly documented a patient's need for skilled nursing rehabilitation therapy services to be below the Ultra High RUG level, or at lower Ultra High RUG levels, Caraballo altered the patient's MDS and ADL flow sheets—often times unbeknownst to the admissions and MDS nurses—to support the third-party billing company's submission of claims for reimbursement at the Ultra High RUG level on behalf of RegalCare Management.

133. For example, on September 18, 2018, Caraballo sent an email to the third-party billing company, cc'ing Mirlis and a Stern executive, containing a list of three patients in RegalCare Management's SNF at Twin Oaks and the RUG levels for which the third-party billing company should bill Medicare. For one of the patients, DH, Caraballo advised that the third-party biller should submit the claims at the Ultra High RUG level of RUA. Mirlis replied only to Caraballo: "Couldn[']t get a higher ADL for [DH]?" A higher ADL would have resulted in a higher Ultra High RUG level and more Medicare reimbursement. Caraballo responded, "I could get [RUB]. But it's in the middle of being exported. Needs to be accepted, then I can modify." Mirlis asked Carballo to confirm he upped the billing: "Ok. Let me know when you do it plz."

134. Caraballo did not have the ability to amend or alter Stern's therapists' documentation, because Stern was a separate company with separate recordkeeping systems. He did, however, have access to, and the ability to alter, the documentation completed by RegalCare's admissions and MDS nurses.

135. Caraballo completed and signed off on medical documentation, including MDS assessments, with the knowledge that he was a licensed practical nurse and unauthorized to do so at his licensing level. As Caraballo himself testified "Signing off on the MDS is complete, you have to be a [registered nurse]."

136. For example, patient CD was admitted to RegalCare Management's SNF in Waterbury, CT on or around April 17, 2019. After five days, on April 22, 2019, a RegalCare Management nurse assessed CD's ability to perform daily activities and submitted an ADL assessment s finding CD as independent, supervised, or requiring limited assistance on all other ADLs. Similarly, Stern's occupational therapist documented that CD was independent or requiring no set up, supervision, and no physical assist with all ADLs including mobility. Thereafter, Caraballo improperly corrected and completed RegalCare Management's ADL sections of CD's assessment and signed a correction request. He altered CD's mobility status as requiring a higher level of "extensive assist" than either the RegalCare Management nurse or the Stern occupational therapist had evaluated CD to be. By doctoring this paperwork, Caraballo inflated CD's Medicare billing level to an Ultra High RUG level and caused RegalCare Management to bill Medicare for skilled nursing rehabilitation therapy services for CD at the Ultra High RUG level until May 3, 2019, resulting in nearly $1,000 in damages to Medicare.

137. As another example, patient TD was admitted to RegalCare Management's SNF in Saugus in May 2019. On May 13, 2019, Stern's physical therapist documented that TD met adequate goals and should be discharged. Nevertheless, RegalCare Management, through Stern's therapists, continued to provide TD unnecessary skilled nursing rehabilitation therapy services, and billed Medicare for it, until June 27, 2019 – 44 days later. These services continued for TD because Caraballo "corrected" and completed TD's MDS assessment to

indicate that TD needed assistance with ADLs including mobility. This change resulted in RegalCare Management submitting claims to Medicare for skilled nursing rehabilitation therapy services provided to TD at the Ultra High and Very High RUG levels until her discharge on June 27, 2019, resulting in nearly $2,700 in impermissible reimbursement. Notably, on the date of discharge, despite receiving Ultra High and Very High RUG levels of skilled nursing rehabilitation therapy services for the entire period, TD was released without any further restorative therapy recommended.

138. As another example, patient RJ was readmitted to RegalCare Management's SNF at Waterbury on February 4, 2019 after a hospitalization for sepsis, respiratory failure, and pulmonary edema. According to Stern's Occupational Therapist, RJ needed only 9 days of therapy to reach a safe level of discharge to independent living. On March 7, 2019, however, Caraballo attested to a correction request for a "transcription error" on RJ's 5-day MDS assessment performed on February 11, 2019. Caraballo changed RJ's ADL section on the MDS assessment to indicate that RJ needed "extensive assistance" with mobility from the previously assessed "limited assistance." This change increased RegalCare Management's claim for billing to Medicare for skilled nursing rehabilitation therapy services to RUB from RUA, resulting in RegalCare Management receiving greater reimbursement for Ultra High RUG level services. This resulted in Medicare paying RegalCare Management more than $1,750 in reimbursement than it should have for this patient.

139. Moreover, Caraballo amended and altered medical documentation, including MDS assessments, without ever having visually assessed or spoken to the patient, and often without speaking to any clinician about the changes. Yet, in sworn testimony, he conceded that the person completing the MDS assessment should "obviously ha[ve] seen the patient, reviewed

the records, done everything that they needed to, right, respectively, and met with the individual interdisciplinary team to make sure that everybody is, you know, this is the accurate, you know, picture of this patient."

140. Caraballo and Mirlis sometimes dispensed with the charade of altering patient documentation post facto and instead told the third-party billing company to bill patients at RUG levels before the patients' assessment forms, including the MDS, were even completed.

141. For example, in an October 10, 2018 email in response to the third-party billing company's request for direction on what patients to bill for in RegalCare Management's SNF at Waterbury and at what RUG levels, Mirlis wrote, "Make the rugs all RUB, will adjust next month if need be." Upon information and belief, Mirlis directed such blanket billing because he wanted to report increased revenues to RegalCare Management's lender for financing related to the operation of RegalCare Management's SNFs.

142. As another example, in an email dated January 8, 2019, entitled "Month End," a RegalCare Management employee sent Caraballo "month end projections" of the RUG level for billing five patients, but noted that "therapy has not entered their minutes" for two of the patients. Despite that fact, Caraballo forwarded the projections to the third-party billing company, cc'ing Mirlis, and instructed the third-party billing company to submit the claims for those five patients to Medicare. When the third-party billing company asked if "those are the RUGs and accepted," Caraballo responded that "[t]hey are firm projections. Expected not to change." The third-party billing company representative responded that he "thought they were still going to enter minutes," which would be necessary to a determination of the RUG level.

143. As another example, Stern's executives complained that Stern's and RegalCare Management's patient records were not aligning because RegalCare Management was altering

records after treatment and prior to billing. In response, RegalCare, Stern, and the third-party billing company purportedly agreed to a process whereby admissions and MDS nurses at RegalCare Management's SNFs would complete the MDS forms first and Caraballo would review and "accept" the MDSs in RegalCare Management's electronic medical record system before billing. In reality, however, little changed. One month later, in May 2019, Caraballo sent the third-party billing company a list of 20 Medicare patients for RegalCare Management's SNF at Southport, along with the RUG levels for billing. At least nine of the 20 Medicare patients were billed at the Ultra High RUG level. The third-party billing company inquired why Caraballo was sending the list because the third-party billing company "can't enter RUGs until we see accepted" in RegalCare's electronic medical record. Caraballo responded, "Enter them. I'm guaranteeing you they're not gonna change." In response to the email from the third-party billing company, Mirlis separately responded, "I want a phone call!! Why all of a sudden are we having this retarded miscommunication."

B. Stern Conspired to Permit RegalCare Management to Bill Medicare for Medically Unreasonable and Unnecessary Skilled Nursing Rehabilitation Therapy Services at the Ultra High RUG Level

144. Stern also facilitated RegalCare Management, Mirlis, and Caraballo's scheme by scheduling physical, occupational, and speech pathology therapists to provide skilled nursing rehabilitation therapy services in an amount and frequency to justify billing at the Ultra High RUG level, regardless of medical need.

145. For example, on March 6, 2019, Mirlis emailed Philip Makowsky, Stern's Senior Regional Director for Connecticut and Massachusetts with the subject "Whats [sic] with therapists?" regarding RegalCare Management's SNFs at Maplewood, Twin Oaks, and Saugus. Makowsky responded that "[c]overage is very scarce and were [sic] pushing for max rugs the

best with what we have." After Mirlis sent a follow up email asking, "What rug scores are the [Medicare Part A] getting?," Makowsky replied, "Were [sic] pushing for [Ultra High] for all, but it depends on coverage."

146. At times, Stern's therapists balked at providing the amount and frequency of skilled nursing rehabilitation therapy services for certain patients because they assessed the patient did not need, or no longer needed, Ultra High RUG level skilled nursing rehabilitation therapy.

147. When such circumstances occurred, Stern's managers exerted employment pressure on therapists to continue providing the amount and frequency of skilled nursing rehabilitation therapy services to justify billing for the Ultra High RUG level.

148. For instance, in September 2019, Stern's rehabilitation manager for RegalCare Management's SNF at Maplewood, demanded that the relator provide physical therapy to two patients the relator assessed did not require, and could not tolerate, skilled nursing rehabilitation therapy services. When she refused, the rehabilitation manager threatened to terminate her. Rather than capitulate, the relator documented in each of the patients' therapy records that the patients did not have a present clinical need for physical therapy. In response, Stern posted a description for relator's job, and she resigned shortly after these events.

149. In another instance, Makowsky terminated a physical therapist working at RegalCare Management's SNF at Twin Oaks in March 2019. Prior to her termination, the therapist documented that Medicare patient KE had made no significant progress with therapy after February 14, 2019. Nevertheless, Stern continued to provide the patient with physical therapy. After terminating the therapist, Makowsky, who has no clinical background and lacked

the proper licensure to do so, signed the physical therapy notes "on behalf of" the terminated therapist for services rendered on 11 dates between January 16, 2019, and February 26, 2019.

150. Moreover, RegalCare Management certified KE to receive skilled nursing rehabilitation therapy services until March 24, 2019. At various times between February 3, 2019 and March 24, 2019, Caraballo made and signed off on changes to KE's MDS Assessment despite not being licensed as a nurse in Massachusetts and without having ever assessed the patient personally.

151. In some cases, Stern's therapists continued to document providing Ultra High RUG level skilled nursing rehabilitation therapy services while also documenting that the patients complained that they were physically unable to perform the therapy.

152. For example, patient GC, a 91-year-old female, was admitted to RegalCare Management's SNF at Waterbury on March 2, 2019 after hospitalization for congestive heart failure, pleural effusions, failure to thrive, severe malnutrition, and pneumonia. Prior to admission, GC's family expressed an interest in hospice care, which requires an assessment that the patient has six months or less to live, but RegalCare Management's SNF at Waterbury admitted GC. Despite GC's health concerns, Stern therapists, at the direction of Stern's management and RegalCare Management, performed Ultra High RUG levels of skilled nursing rehabilitation therapy services for GC. Stern's therapists repeatedly documented that the patient was "scared," "confused," "weak," and did not wish to participate in therapy. Patient GC died at RegalCare Management's SNF at Waterbury on March 30, 2019. RegalCare Management received over $17,000 from Medicare in reimbursement for providing medically unreasonable and unnecessary skilled nursing rehabilitation therapy services.

153. In another example, Patient EB was an 82-year-old female readmitted to RegalCare Management's SNF at Waterbury on May 7, 2019, after hospitalization for a compression fracture and aspiration pneumonia with a cardiac pacemaker. Prior to her readmission on May 7, 2019, EB received Ultra High RUG level skilled nursing rehabilitation therapy services. After her readmission, and over the course of the next nine days, Stern therapists continued to provide EB with Ultra High RUG level therapy despite her consistent complaints of fatigue and discomfort. On May 15, 2019, Stern's Occupational Therapist documented that EB was "very fatigued today, very poor activity tolerance, poor endurance. . . . Patient reported feeling 'dizzy'. Nursing aware . . . ." but noted that EB still received 45 minutes of occupational therapy. EB died the next day on May 16, 2019. RegalCare Management received over $4,700 from Medicare in reimbursement for providing medically unreasonable and unnecessary skilled nursing rehabilitation therapy services.

154. When patients either expressed a desire not to perform skilled nursing rehabilitation therapy, or could not perform the therapy, Stern's management required therapists to document that they spent the therapy time, often for up to 45 minutes, educating a patient on the need for therapy. The documentation did not explain the type, manner, and length of education provided to the patient. Utilizing the full amount of scheduled time for skilled nursing rehabilitation therapy services, even when therapy was not actually performed, facilitated RegalCare Management, Mirlis, and Caraballo's scheme to maximize RegalCare Management's billing for Ultra High RUG levels.

C. The Defendants' Scheme Resulted in Significant False Billing of Medicare

155. Mirlis' push to bill for the maximum reimbursement for skilled nursing rehabilitation therapy services proved successful, with nearly ever RegalCare Management SNF experiencing a significant increase in Ultra High RUG level billing.

156. For example, in an April 13, 2018 email, a Stern executive detailed his analysis of CMS' Program for Evaluating Payment Patterns Electronic Report ("PEPPER") for each of the nine RegalCare Management SNFs in Connecticut. The PEPPER alerts providers of areas of concern for CMS. The Stern executive identified the follow for the RegalCare Management SNFs:

a. Greenwich – RUA% is very high, billing days are up and [Length of Stay ("LOS")] is over 50 which is very good.

b. Southport – rehab days are trending down (from 5800 in 15 to 3200 in 17), [Ultra High's] are very high and we are off the charts with 90 day episodes of care which we should discuss. LOS is at 49 days and RUA is 12.1%.

c. West haven – rehab days are up about 500 from 2015 also a lot og [sic] 90 day assessments which need to be reviewed. LOS is 55 days and RUA is non-existent (so whatever your MDS is doing there should be replicated).

d. Waterbury – days up slightly, but enough high ADL's [sic] being billed (C's), nursing days down from 600 to 280, [Change of Therapy]'s down, [Ultra High's] up, 90 days LOS are creeping up which can be an issue, LOS is 43 and RUA's are 23.2!

e. New Haven – more than doubled their medicare days from 15 to 17 but it came with almost double the nursing days as well. 90 day episodes have shot up and now red flag with the LOS being 52 days. However the most worrisome part is the RUA's which is a whooping [sic] 30.4% the most billed rug in this building.

157. When asked about this email and whether it was troublesome that "RUA[] is very high" at nearly all of RegalCare Management's SNFs in Connecticut, Caraballo testified, "It would be, yes." Carballo went on to explain that it was troublesome because "the last of the three characters in the RUG score, indicates that the patient is high function. Assuming that the

score is accurate, it would indicate that it was a lot of therapy for a patient who is already high function."

158. Neither RegalCare Management nor Stern changed any of their practices despite being aware that RegalCare Management's SNFs were billing Medicare for Ultra High RUG skilled nursing rehabilitation therapy for a number of claims and for a length of days that would generate serious concern.

159. Between January 1, 2017 and September 30, 2019, RegalCare Management received approximately $259,034,672.70 from Medicare related to the submission of claims for the provision of Ultra High skilled nursing rehabilitation therapy services.

D. Medicare Claims Submissions

160. RegalCare Management, by and through Mirlis, Caraballo, and Sterns caused the submission of inflated claims for payment and received payment from Medicare for the provision of medically unreasonable and unnecessary skilled nursing rehabilitation therapy services. An example of claims submitted to Medicare for such patients during the Relevant Period is attached as Exhibit 1.

161. Medicare would not have paid these claims had it known of these violations.

162. To date, RegalCare management has not repaid any overpayments to Medicare stemming from the fact that it was not in compliance with federal laws and regulations concerning the Medicare program.

163. Compliance was an express precondition of payment with Medicare; every submission of a claim implicitly represents compliance with relevant statutes. Had Medicare known of the violations detailed herein, it would not have paid the claims that RegalCare Management, Mirlis, Caraballo, and Stern caused to be submitted.

II. MASSACHUSETTS DEFENDANTS INFLATED CLAIMS TO MASSHEALTH FOR THE PROVISION OF LONG-TERM CARE SERVICES AND SKILLED NURSING REHABILITATION THERAPY SERVICES

A. RegalCare's Scheme to Misrepresent Health Conditions of Patients to Drive Higher Reimbursements.

164. In addition to its scheme to submit claims to Medicare for medically unreasonable and unnecessary skilled nursing rehabilitation therapy services, which resulted in MassHealth making fraudulent co-payments to RegalCare Management for dual-eligible members, the RegalCare Massachusetts Facilities also submitted MMQ scores to MassHealth that misrepresented the health conditions of patients to drive increased reimbursements.

165. An email exchange in February 2019 reflects intentional attempts to fraudulently alter MMQ scores for MassHealth members. In this exchange, Mirlis asks Caraballo, "Can you get a list of all the Saugus [patients] that have a 'K' mmq? And exactly how many each points is at?" Caraballo responded with a list of nine residents and noted how many points each was away from the higher "L" reimbursement level. On that list, resident GB was 7.1 points away from the "L" level. Mirlis responded "Any way to find the 7.1 for [GB]?" Caraballo responded that he could have an employee look to see if there could have been something and asked if Mirlis wanted him to instruct the employee to look. Mirlis responded, "please look, yes."

166. Further communications between Caraballo and the employee reflect that Caraballo asked the employee to see "if we could have found the last 7.1 points." The employee responded that, "He does have behaviors that are not always documented and nurses don't write notes on his behaviors so I am doing education on ADL coding with the CNA's [sic]." Caraballo then responded to Mirlis that the employee had been "pushing . . . to get the documentation where it needs to be."

167. Mirlis responded by asking Caraballo, "Can we do a [significant change] for him to get the additional 7points [sic]?"

168. The Attorney General's Office has conducted an analysis of the RegalCare Massachusetts Facilities' MassHealth data, which reflects an increase in MMQ scores for certain members under Mirlis, RegalCare Management, Regal Care Management 2.0, LLC, and RegalCare Massachusetts Facilities' ownership.

169. RegalCare Management operated RegalCare Management's SNF at Maplewood from April 1, 2018, through February 16, 2021. There are twenty-one patients for whom Maplewood submitted MMQ scores before, during, and after operation by RegalCare Management. Of these twenty-one patients, nine had scores that were on average higher under RegalCare Management's operation than during both the twelve-month periods prior and subsequent to RegalCare Management's ownership and operation of the Maplewood SNF. In other words, according to their MMQ scores, they required more care under RegalCare Management than the prior and subsequent and unaffiliated SNF operators. For seven of the remaining twelve patients, scores increased over time during RegalCare Management's operation of the Maplewood SNF.

170. RegalCare Management operated RegalCare Management's SNF at Saugus from April 1, 2018, through February 16, 2021. There are twenty-three patients for whom Saugus submitted MMQ scores before, during, and after operation by RegalCare Management. Of these twenty-three patients, six had scores that were on average higher under RegalCare Management's operation than during both the twelve-month periods prior and subsequent to RegalCare Management's ownership and operation of the Saugus SNF. Again reflecting that they required more care under RegalCare Management than the prior, subsequent, and

unaffiliated SNFs. For thirteen of the remaining seventeen residents, scores increased over time during RegalCare Management's operation of the Saugus SNF.

171. RegalCare Management operated RegalCare Management's SNF at Twin Oaks from April 1, 2018 through February 16, 2021. There are thirteen long-term care patients for whom Twin Oaks submitted MMQ scores before, during, and after operation by RegalCare Management. Of these thirteen patients, six had scores that were on average higher under RegalCare Management's operation, than during both the twelve-month periods prior and subsequent to RegalCare Management's ownership and operation of the Twin Oaks SNF. Again reflecting that they required more care under RegalCare Management than the prior and subsequent nursing home operators. For six of the remaining seven patients, scores increased over time during RegalCare Management's operation of the Twin Oaks SNF.

172. For example, RL was a patient of RegalCare Management's SNF at Maplewood from at least January 2016 through April 2021, and, according to the MMIS data, for the twelve months prior to RegalCare Management's operation of Maplewood, his MMQ score was at both Level M and N, reflecting a MMQ managed minute range of 140.1 - 170.0 and 170.1 – 200.0, respectively. His MMQ score immediately prior to RegalCare Management's operation of the SNF, effective March 2018, was Level M. Thirteen months after RegalCare Management took control of Maplewood in March 2019, RL's score increased to Level P, reflecting a MMQ managed minute range of 200.1 – 225.0. In September 2019, while under Regal Care Management's ownership, his score further increased to Level R, reflecting a MMQ managed minute range of 225.1 – 245.0. His score remained at that level until March 2021, the month after RegalCare Management sold the facility, when his score decreased to Level N, reflecting a MMQ managed minute range of 140.1 - 170.0. During the period his score was at Level P and

R, MassHealth paid RegalCare Management's SNF at Maplewood, $132,496.09 for his long-term care services claims. If RegalCare Management had appropriately classified RL at Level N from March 2019 to February 2021, RegalCare Management would have been paid approximately $123,718.75 for RL's services, a difference of $8,777.34. RegalCare Management has not repaid MassHealth for the difference.

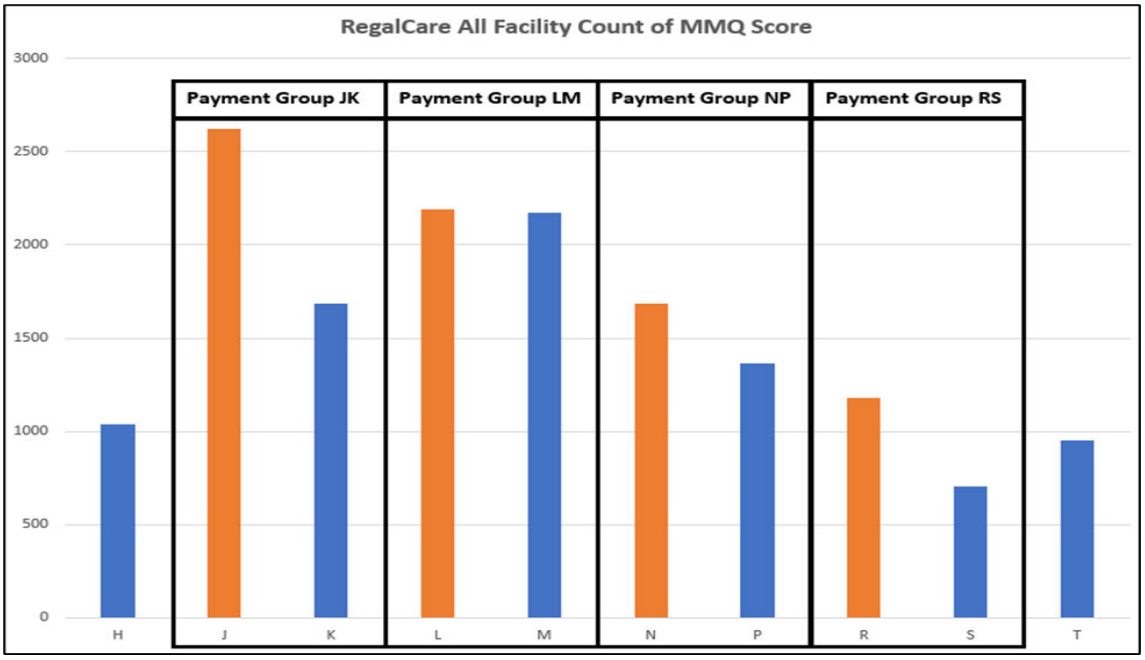
173. RK was a resident of RegalCare Management's SNF at Saugus from at least January 2016 through September 2023, and, according to the MMIS data, for the twelve months prior to RegalCare Management's operation of the facility, his MMQ score was Level L, reflecting a MMQ management minute range of 110.1-140.0. One year after RegalCare Management took over Saugus, in March 2019, his MMQ score was Level M, reflecting a MMQ management minute range of 140.1-170.0. In March 2020, still under RegalCare Management's operation, his score further increased to Level P, reflecting a MMQ managed minute range of 200.1 – 225.0. However, in April 2021, the first MMQ score submitted for him after RegalCare Management sold the facility, his score returned to Level M. During the period his score was at Level P, MassHealth paid RegalCare Management's SNF at Saugus $43,879 for his long-term care services claims. If RegalCare Management had appropriately classified RK at Level M from March 2020 through February 2021, RegalCare Management's SNF at Saugus would have been paid approximately $42,362.04 for RK's services, a difference of $1,516.96. RegalCare Management has not repaid MassHealth for the difference.

174. DD was a resident of RegalCare Management's SNF at Twin Oaks from at least January 2016 to March 2023, and, according to the MMIS data, for the twelve months prior to RegalCare Management's operation of the facility in April 2018, her MMQ score was Level N and P, reflecting a MMQ managed minute range of 170.1 - 200 and 200.1-225.0, respectively.

Her most recent MMQ score prior to RegalCare Management managing Twin Oaks, effective August 2017 was Level N. In January 2019, during RegalCare Management's operation, her score increased to Level S. The next month it decreased to Level R, where it remained until July 2019, when it increased to Level T. In January 2020 the score decreased to Level S where it remained until July 2020 when it decreased again to Level P. However, following that, it increased to Level T in January and February of 2021, the month after RegalCare Management stopped operating the facility. The day RegalCare Management stopped operating the facility, the score dropped from Level T to Level P. Five months later in July 2021, the score dropped further to Level M. During the months DD's score was at Level T, S, and R, MassHealth paid Twin Oaks $133,068.42 for her long-term care services claims. If RegalCare Management had appropriately classified DD at Level P and/or Level M from February 2019 to July 2020 and again in January and February 2021, RegalCare Management's SNF at Twin Oaks would have been paid approximately $114,808.43 for DD's services, a difference of $18,259.99. RegalCare Management has not repaid MassHealth for the difference.

175. Additionally, as noted above, MassHealth payment rates are organized by group, meaning that a patient assessed at MMQ score J and a patient assessed at MMQ score K may end up with the same rate of payment because those MMQ scores are in the same group.

176. The Attorney General's Office's analysis showed that RegalCare Massachusetts Facilities routinely submitted a high quantity of scores at the lower end of a payment group (i.e., a large number of scores for the patients with score J rather than score K), revealing that RegalCare Management and the RegalCare Massachusetts Facilities were working to ensure that its rates reached the next strata of payment, regardless of the patient's condition. The below chart shows a count of all MMQ scores submitted by the RegalCare Massachusetts Facilities.



B. MassHealth Claims Submissions

177. The RegalCare Management, by and through Mirlis, Caraballo, and Stern caused the submission of inflated claims for payment and received payment from MassHealth for the provision of medically unreasonable and unnecessary skilled nursing rehabilitation therapy services provided to dual-eligible members for whom MassHealth paid the patient co-pay portion of reimbursement. An example of claims submitted to MassHealth for such patients during the Relevant Period is attached as Exhibit 2.

178. Furthermore, the RegalCare Management 2.0, LLC and the RegalCare Massachusetts Facilities, by and through Mirlis and Caraballo, submitted or caused the submission of inflated claims for payment and received payment from MassHealth related to fraudulently inflated MMQ scores for which MassHealth paid RegalCare directly in fee-for-service claims and indirectly through its MCEs.

179. MassHealth would not have paid these claims had it known of these violations.

180. To date, RegalCare Management, RegalCare Management 2.0, LLC, and the RegalCare Massachusetts Facilities have not repaid any overpayments to MassHealth stemming from the fact that it was not in compliance with federal and state laws and regulations concerning the MassHealth program.

181. Compliance was an express precondition of payment with MassHealth; every submission of a claim implicitly represents compliance with relevant statutes. Had MassHealth known of the violations detailed herein, it would not have paid the claims that the Massachusetts Defendants submitted or caused to be submitted.

182. Between April 1, 2018 and September 30, 2023, MassHealth, directly in fee-for-service claims and indirectly through its MCEs, paid the RegalCare Massachusetts Facilities more than $63 million. A breakdown of the total amount the RegalCare Massachusetts Facilities were paid by MassHealth, its MCEs, and for crossover claims for dual eligible members including the total paid to each of the RegalCare Massachusetts Facilities below:

Name	Fee-For-Service	MCE	Crossover Prior to 9/30/2021
MAPLEWOOD REHAB AND NURSING	$8,766,761.52	$536,049.99	$731,042.21
REGALCARE AT GREENFIELD	$3,825,461.16	$541,019.59	$0.00
REGALCARE AT HARWICH LLC	$8,566,615.92	$649,989.31	$131,080.82
REGALCARE AT HOLYOKE	$3,529,374.80	$678,556.61	$0.00
REGALCARE AT LOWELL	$3,130,663.84	$565,520.32	$0.00
REGALCARE AT QUINCY	$1,854,156.72	$37,583.43	$0.00
REGALCARE AT TAUNTON	$3,709,421.75	$606,915.32	$0.00
REGALCARE AT WORCESTER	$8,956,126.43	$385,361.43	$0.00
SAUGUS REHAB AND NURSING	$7,590,457.52	$858,814.13	$673,110.92
TWIN OAKS REHAB AND NURSING	$7,816,353.07	$640,540.96	$922,492.16
Totals	**$57,745,392.73**	**$5,500,351.09**	**$2,457,726.11**

COUNT I
False Claims Act, 31 U.S.C. § 3729(a)(1)(A)
Presenting False Claims for Payment

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

184. The United States Defendants knowingly presented, or caused to be presented, to the United States, false or fraudulent claims for payment or approval, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1)(A), specifically, claims for payment to Medicare and Medicaid for medically unreasonable and unnecessary skilled rehabilitation therapy services.

185. By virtue of these false or fraudulent claims, the United States suffered damages in an amount to be determined at trial.

COUNT II
False Claims Act, 31 U.S.C. § 3729(a)(1)(B)
Use of False Statements

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

187. The United States Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims submitted to the United States, and the United States' payment of those claims was a reasonable and foreseeable consequence of the United States Defendants' statements and actions.

188. These false records and statements included misleading that the claims to Medicare for skilled nursing rehabilitation therapy services were reasonable and necessary.

189. The United States Defendants made or used, or caused to be made or used, such false records or statements with actual knowledge of their falsity, or with reckless disregard, or deliberate ignorance of whether they were false or fraudulent.

190. By virtue of these false or fraudulent claims, the United States suffered damages in an amount to be determined at trial.

COUNT III
False Claims Act, 31 U.S.C. § 3729(a)(1)(C)
Conspiracy to Submit False Claims

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

192. Mirlis, Caraballo, and Stern entered into an unlawful agreement to cause the presentation of false or fraudulent claims to the United States and performed acts in furtherance of this conspiracy. Mirlis, Caraballo, and Stern entered into an agreement to provide and/or bill for medically unreasonable and unnecessary skilled nursing rehabilitation therapy services to Medicare. Furthermore, Mirlis, Caraballo, and Stern used and directed the use of personnel and assets to effectuate those unlawful payments.

193. By virtue of the resulting false or fraudulent claims, the United States suffered damages in an amount to be determined at trial.

COUNT IV
Unjust Enrichment – United States

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

195. This is a claim for the recovery of monies by which RegalCare Management and Mirlis have been unjustly enriched.

196. By directly or indirectly obtaining from the United States, through federal healthcare programs, funds to which they were not entitled, RegalCare Management and Mirlis were unjustly enriched, and are liable to account and pay such amounts, or the proceeds therefrom, which are to be determined at trial.

COUNT V
Payment by Mistake – United States

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

198. This is a claim for the recovery of monies the United States paid directly or indirectly to RegalCare Management and Mirlis as a result of mistaken understandings of fact.

199. The United States' mistaken understandings of fact were material to its decisions to pay claims caused to be submitted by the United States Defendants to Medicare for skilled nursing rehabilitation therapy services.

200. The United States, acting in reasonable reliance on the truthfulness of the claims to Medicare for skilled nursing rehabilitation therapy services, paid monies directly or indirectly to RegalCare Management and Mirlis to which they were not entitled. Thus, the United States is entitled to recoup such monies, in an amount to be determined at trial.

COUNT VI
Massachusetts False Claims Act, Mass. Gen. Laws c. 12, § 5B(a)(1)
Presenting False Claims for Payment

201. Massachusetts incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

202. Between January 1, 2017 and September 30, 2023, the Massachusetts Defendants violated Mass. Gen. Laws c. 12, § 5B(a)(1) by knowingly presenting, or causing to be presented, false of fraudulent claims for payment or approval to MassHealth.

203. Specifically, the Massachusetts Defendants caused false or fraudulent claims for payment or approval to be presented to MassHealth for medically unreasonable and unnecessary skilled nursing rehabilitation therapy services for dual-eligible members and in the form of MMQ scores that improperly inflated the patient's health conditions to receive higher payments

from MassHealth. The Massachusetts Defendants' conduct was knowing because they possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

204. If MassHealth had known that the Massachusetts Defendants had caused false claims to be presented based on medically unreasonable and unnecessary skilled rehabilitation therapy services and inaccurate MMQ scores, MassHealth would not have made the payments and/or taken other appropriate action to ensure that the RegalCare SNFs did not receive payments to which they were not entitled, including by recouping payments through administrative processes or payment adjustments.

205. By virtue of the Massachusetts Defendants causing the submission of false claims to MassHealth, Massachusetts has suffered actual damages and is entitled to recover treble damages plus civil monetary penalties.

COUNT VII
Massachusetts False Claims Act, Mass. Gen. Laws c. 12, § 5B(a)(2)
Use of False Record or Statement

206. Massachusetts incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

207. During the Relevant Period, the Massachusetts Defendants caused to be made or used a false record or statement material to false or fraudulent claims, resulting in the RegalCare Massachusetts Facilities receiving payments from MassHealth to which they were not entitled.

208. Specifically, the Massachusetts Defendants caused to be made or used, documents reflecting medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and false MMQs, and associated documentation to receive higher payments from MassHealth.

209. The Massachusetts Defendants' conduct was knowing because they possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

210. If MassHealth had known that the Massachusetts Defendants had caused to be made or used documents reflecting medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and inaccurate MMQs and associated documentation, MassHealth would not have made the payments to the RegalCare Massachusetts Facilities for the associated claims, and/or would have taken other appropriate action to ensure that the RegalCare Massachusetts Facilities did not receive payments to which they were not entitled, including by recouping payment through administrative processes or payment adjustments.

211. By virtue of the Massachusetts Defendants' conduct, Massachusetts has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

COUNT VIII
Massachusetts False Claims Act, Mass. Gen. Laws c. 12, § 5B(a)(3)
Conspiracy

212. Massachusetts incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

213. Between January 1, 2017 and September 30, 2023, Mirlis and Caraballo conspired to cause the presentation of false or fraudulent claims to Massachusetts and performed acts in furtherance of this conspiracy.

214. Specifically, Mirlis and Caraballo conspired and performed acts to cause false or fraudulent claims for payment or approval to be presented for medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and in the form of

MMQ scores that improperly inflated the patient's health conditions to receive higher payments from MassHealth.

215. By virtue of Mirlis's and Caraballo's conduct, Massachusetts has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

COUNT IX
Massachusetts Medicaid False Claims Act,
Mass. Gen. Laws c. 118E, §§ 40(1),44
Presenting False Statements of Representations

216. Massachusetts incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

217. Between January 1, 2017 and September 30, 2023, the Massachusetts Defendants either knowingly and willfully or with willful blindness, made or caused to be made false statements or representations of material facts in the RegalCare Massachusetts Facilities' submissions to MassHealth for payment of long-term care services.

218. Specifically, the Massachusetts Defendants caused false or fraudulent statements or representations in the form of medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and MMQ scores that improperly inflated the patient's health conditions to receive higher payments from MassHealth.

219. If MassHealth had known that the Massachusetts Defendants had caused false statements or representations based on medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and inaccurate MMQ scores, MassHealth would not have made the payments and/or taken other appropriate action to ensure that the RegalCare Massachusetts Facilities did not receive payments to which they were not entitled, including by recouping payments through administrative processes or payment adjustments.

220. By virtue of the false statements or representations made by the Massachusetts Defendants, Massachusetts has suffered actual damages and is entitled to recover treble damages plus the costs of investigation and litigation, in accordance with Mass. Gen. Laws c. 118E, § 44.

COUNT X
Massachusetts Medicaid False Claims Act,
Mass. Gen. Laws c. 118E, §§ 40(2),44
Use of False Records or Statements

221. Massachusetts incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

222. Between January 1, 2017 and September 30, 2023, the Massachusetts Defendants either knowingly and willfully or with willful blindness, made or caused to be made false statements or representations of material facts used in MassHealth's determination of the RegalCare Massachusetts Facilities' right to payment for long-term care services.

223. Specifically, the Massachusetts Defendants caused to be made false statements or representations in the form of documents reflecting medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and false MMQs and associated documentation, which MassHealth used in determining the RegalCare Massachusetts Facilities' right to payment, that improperly inflated the patient's health conditions to receive higher payments from MassHealth.

224. If MassHealth had known that the Massachusetts Defendants had documents reflecting medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and inaccurate false MMQs and associated documentation, MassHealth would not have made the payments and/or taken other appropriate action to ensure that RegalCare Massachusetts Facilities did not receive payments to which they were not entitled, including by recouping payments through administrative processes or payment adjustments.

225. By virtue of the false statements or representations that the Massachusetts Defendants caused, Massachusetts has suffered actual damages and is entitled to recover treble damages plus the costs of investigation and litigation, in accordance with Mass. Gen. Laws ch. 118E, § 44.

COUNT XI
Mass. Gen. Laws c. 118E §§ 36(5), 44
Recovery of Overpayment

226. Massachusetts incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

227. Between January 1, 2017 and September 30, 2023, the Massachusetts Defendants caused false or fraudulent claims for medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and in the form of MMQ scores that improperly inflated the patient's health conditions to receive higher payments from MassHealth. MassHealth paid those claims.

228. By virtue of the RegalCare Massachusetts Facilities' submission of claims to MassHealth while in violation of 130 C.M.R. 456.420 and 130 C.M.R. § 450.00, *et seq.*, MassHealth made overpayments to the RegalCare Massachusetts Facilities.

229. The RegalCare Massachusetts Facilities are liable to repay Massachusetts for the amount received from these overpayments because they accepted responsibility for all overpayments as a condition of its participation as a MassHealth provider. *See* Mass. Gen. Laws c. 118E § 36(5). The Attorney General is authorized to bring a civil action for violations of Mass. Gen. Laws c. 118E. *See* Mass. Gen. Laws c. 118E, § 44.

COUNT XII
Breach of Contract – Massachusetts

230. Massachusetts incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

231. The RegalCare Massachusetts Facilities entered into valid contracts with MassHealth, for which adequate consideration was exchanged. The RegalCare Massachusetts Facilities breached their MassHealth provider contracts during the Relevant Period, by submitting or causing to be submitted false claims for payment to MassHealth for skilled nursing services that violated MassHealth regulations at 130 C.M.R. 456.420 and 130 C.M.R. § 450.00, *et seq*. because the RegalCare Massachusetts Facilities made or caused false or fraudulent statements or representations for medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and in the form of MMQ scores that improperly inflated the patient's health conditions to receive higher payments from MassHealth.

232. Each claim the RegalCare Massachusetts Facilities submitted or caused to be submitted that was not in compliance with MassHealth rules and regulations constitutes a breach of the RegalCare Massachusetts Facilities' Nursing Facility Provider Contracts.

233. By failing to comply with all applicable state and federal laws, regulations, and rules applicable to the MassHealth program, the RegalCare Massachusetts Facilities materially breached their MassHealth Nursing Facility Provider Contracts.

234. As a result of the RegalCare Massachusetts Facilities breach of their Nursing Facility Provider Contracts, Massachusetts has been damaged.

COUNT XIII
Unjust Enrichment – Massachusetts

235. Massachusetts incorporates by reference each of the preceding paragraphs as if fully set forth in this paragraph.

236. The Massachusetts Defendants caused false or fraudulent statements or representations for medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and in the form of MMQ scores that improperly inflated the patient's health conditions to receive higher payments from MassHealth.

237. Based on its unlawful submission of claims for medically unreasonable and unnecessary skilled rehabilitation therapy services for dual-eligible members and MMQ scores, the RegalCare Massachusetts Facilities received overpayments from MassHealth, which were retained by RegalCare Management, RegalCare Management 2.0, LLC, and Mirlis.

238. If the Massachusetts Defendants had not impliedly misrepresented its members' health conditions, MassHealth would not have paid these claims at these rates, which the RegalCare Massachusetts Facilities would not have been able to give to RegalCare Management, RegalCare Management 2.0, LLC, and Mirlis. By retaining monies improperly received from MassHealth, RegalCare Management, RegalCare Management 2.0, LLC, and Mirlis have retained funds that are the property of Massachusetts and to which they are not entitled.

239. It is unfair and inequitable for RegalCare Management and Mirlis to retain revenue from MassHealth for payments that they obtained in violation of MassHealth regulations.

240. By virtue of the Massachusetts Defendants' conduct, RegalCare Management, RegalCare Management 2.0, LLC, and Mirlis have been unjustly enriched and are liable to account and pay such amounts to Massachusetts.

PRAYER FOR RELIEF

The United States requests that judgment be entered in its favor and against RegalCare, Mirlis, Caraballo, and Stern as follows:

(a) On Counts I, II, and III (False Claims Act), for treble the United States' damages, together with the maximum civil penalties allowed by law;

(b) On Count IV (Unjust Enrichment), in the amount the defendants were unjustly enriched;

(c) On Count V (Payment by Mistake), in the amount the defendants illegally obtained and retained; and

(d) For pre- and post-judgment interest, costs, and other such relief as the Court may deem appropriate.

Massachusetts requests that judgment be entered in its favor and against RegalCare, Mirlis, Caraballo, and Stern as follows[2]:

(a) On Counts VI, VII, and VIII (Massachusetts False Claims Act), for the amount of Massachusetts' damages, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts, and civil penalties as required by Mass. Gen. Laws c. 12, § 5B, together with such other relief as may be just and proper;

(b) On Counts IX and X (Massachusetts Medicaid False Claims Act), for the amount of Massachusetts' damages, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts together with such relief as may be just and proper;

(c) On Count XI (Recovery of Overpayment), for the amount of Massachusetts' damages, as is proved at trial, and costs;

(d) On Count XII (Breach of Contract), for the amount of the Commonwealth's damages, as is proved at trial, and interest at the statutory rate of 12% pursuant to Mass. Gen. Laws c. 231, § 6C from the date of each breach of contract, together with such other relief as may be just and proper;

(e) On Count XIII (Unjust Enrichment), in the amount the defendant was unjustly enriched, as is proved as trial, and costs;

[2] The Recovery of Overpayment and Breach of Contract counts apply to RegalCare Management, RegalCare Management 2.0, LLC, and the RegalCare Massachusetts Facilities only. The Unjust Enrichment count applies to RegalCare Management, RegalCare Management 2.0, LLC, and Mirlis only.

(f) for pre- and post-judgment interest, costs, and other such relief as the Court may deem appropriate.

JURY DEMAND

Pursuant to Federal Rule of Civil Procedure 38, the United States and Massachusetts request a trial by jury.

Respectfully submitted,

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Dated: February 18, 2025

[redacted]

Exhibit 1

Patient initials	Dates of service	Date of payment	Location	Resource utilization group claimed	Medicare payment
T.A.	4/20/2019 – 4/30/2019	5/24/2019	Danvers, MA	Ultra High	$6,056.74
T.A.	5/1/2019 – 5/30/2019	7/16/2019	Danvers, MA	Ultra High	$13,218.17
E.S.B.	4/10/2019 – 4/30/2019	5/28/2019	Waterbury, CT	Ultra High	$15,124.93
E.S.B.	5/7/2019 – 5/16/2019	6/21/2019	Waterbury, CT	Ultra High	$4,707.85
S.H.B.	3/2/2019 – 3/16/2019	4/23/2019	Waterbury, CT	Ultra High	$9,662.58
S.H.B.	3/19/2019 – 3/31/2019	4/30/2019	Waterbury, CT	Ultra High	$7,802.77
S.H.B.	4/1/2019 – 4/30/2019	6/20/2019	Waterbury, CT	Ultra High	$12,057.86
S.E.B.	6/27/2018 – 6/30/2018	7/25/2018	Waterbury, CT	Ultra High	$2,733.57
S.E.B.	7/1/2018 – 7/27/2018	7/8/2019	Waterbury, CT	Ultra High	$13,747.68
G.P.C.	3/2/2019 – 3/30/2019	4/26/2019	Waterbury, CT	Ultra High	$17,013.84
G.F.C.	2/12/2019 – 2/28/2019	4/2/2019	Waterbury, CT	Ultra High	$9,678.05
G.F.C.	4/4/2019 – 4/30/2019	5/28/2019	Waterbury, CT	Ultra High	$11,070.33
G.F.C.	5/1/2019 – 5/31/2019	6/21/2019	Waterbury, CT	Ultra High	$7,887.69
C.J.D.	4/15/2019 – 4/30/2019	5/28/2019	Waterbury, CT	Ultra High	$10,975.69
C.J.D.	5/1/2019 – 5/3/2019	6/20/2019	Waterbury, CT	Ultra High	$959.98
K.L.E.	12/15/2018 – 12/31/2018	1/25/2019	Danvers, MA	Ultra High	$9,170.50
K.L.E.	1/6/2019 – 1/31/2019	4/2/2019	Danvers, MA	Ultra High	$12,943.78
K.L.E.	2/1/2019 – 2/28/2019	4/25/2019	Danvers, MA	Ultra High	$12,129.59
K.L.E.	3/1/2019 – 3/28/2019	4/18/2019	Danvers, MA	Ultra High	$9,741.05
D.J.F.	5/1/2019 – 5/31/2019	6/27/2019	Amesbury, MA	Ultra High	$11,877.67
D.J.F.	6/1/2019 – 6/28/2019	7/22/2019	Amesbury, MA	Ultra High	$10,345.07
G.J.G.	4/9/2019 – 4/30/2019	5/24/2019	Danvers, MA	Ultra High	$10,811.05
G.J.G.	5/1/2019 – 5/31/2019	6/26/2019	Danvers, MA	Ultra High	$12,752.32
G.J.G.	6/1/2019 – 6/10/2019	7/23/2019	Danvers, MA	Ultra High	$4,158.89
R.L.J.	6/2/2018 – 6/15/2018	7/23/2018	Waterbury, CT	Ultra High	$8,884.11
R.L.J.	6/18/2018 – 6/30/2018	7/27/2018	Waterbury, CT	Ultra High	$7,899.21
R.L.J.	7/1/2018 – 7/31/2018	8/20/2018	Waterbury, CT	Ultra High	$16,096.54
R.L.J.	8/1/2018 – 8/10/2018	9/21/2018	Waterbury, CT	Ultra High	$4,673.19
R.L.J.	2/4/2019 – 2/21/2019	3/22/2019	Waterbury, CT	Ultra High	$11,594.69
J.L.	4/26/2019 – 4/30/2019	5/24/2019	Danvers, CT	Ultra High	$3,292.51
J.L.	5/1/2019 – 5/20/2019	6/26/2019	Danvers, CT	Ultra High	$11,676.07
J.L.	5/22/2019 – 5/31/2019	6/27/2019	Danvers, CT	Ultra High	$4,914.11
J.L.	6/1/2019 – 6/30/2019	7/23/2019	Danvers, CT	Ultra High	$14,648.76
J.L.	7/1/2019 – 7/23/2019	8/20/2019	Danvers, CT	Ultra High	$10,811.05
J.L.	8/10/2019 – 8/23/2019	9/23/2019	Danvers, CT	Ultra High	$6,388.35
S.N.A.	4/30/2019 – 4/30/2019	5/28/2019	Waterbury, CT	Ultra High	$682.04
S.N.A.	5/1/2019 – 5/13/2019	6/21/2019	Waterbury, CT	Ultra High	$8,184.49
M.B.R.	4/5/2019 – 4/30/2019	5/21/2019	Amesbury, MA	Ultra High	$13,600.68

Patient initials	Dates of service	Date of payment	Location	Resource utilization group claimed	Medicare payment
M.B.R.	5/1/2019 – 5/21/2019	6/26/2019	Amesbury, MA	Ultra High	$10,310.37
M.T.T.	3/27/2019 – 3/31/2019	4/26/2019	Waterbury, CT	Ultra High	$3,410.20
M.T.T.	4/1/2019 – 4/16/2019	5/28/2019	Waterbury, CT	Ultra High	$8,170.53

Exhibit 2: MassHealth Paid Claims for Selected Members						
*Note- MMQ Scores and Amount Paid fields come from two separate claim lines and are combine in this chart for ease of reading.						
Patient Initials	**Date of Service From**	**Date of Service To**	**Date of Adjudication**	**Billing Provider**	**MMQ Score**	**Amount Paid**
RL	3/1/2019	3/31/2019	4/1/2019	MAPLEWOOD REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,319.97
RL	4/1/2019	4/30/2019	5/1/2019	MAPLEWOOD REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,116.10
RL	5/1/2019	5/31/2019	6/3/2019	MAPLEWOOD REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,302.30
RL	6/1/2019	6/30/2019	7/1/2019	MAPLEWOOD REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,099.00
RL	7/1/2019	7/31/2019	8/1/2019	MAPLEWOOD REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,302.30
RL	8/1/2019	8/31/2019	9/2/2019	MAPLEWOOD REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,302.30
RL	9/1/2019	9/11/2019	10/2/2019	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 2,473.02
RL	11/9/2019	11/30/2019	12/2/2019	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 5,326.42
RL	12/1/2019	12/31/2019	1/2/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,505.41
RL	1/1/2020	1/29/2020	2/3/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,021.19
RL	4/26/2020	4/30/2020	7/20/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 1,210.55
RL	5/1/2020	5/31/2020	6/1/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,505.41
RL	6/1/2020	6/30/2020	7/1/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,263.30
RL	7/1/2020	7/31/2020	8/3/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,401.56
RL	8/1/2020	8/31/2020	9/1/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,401.56
RL	9/1/2020	9/30/2020	10/2/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,162.80
RL	10/1/2020	10/31/2020	11/5/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,813.55
RL	11/1/2020	11/30/2020	12/1/2020	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,561.50
RL	12/1/2020	12/31/2020	1/1/2021	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,813.55
RL	1/1/2021	1/31/2021	2/1/2021	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,813.55
RL	2/1/2021	2/16/2021	2/19/2021	MAPLEWOOD REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 3,780.75
RK	3/1/2020	3/31/2020	4/1/2020	SAUGUS REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,102.39
RK	4/1/2020	4/13/2020	5/1/2020	SAUGUS REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 2,102.97
RK	8/1/2020	8/31/2020	9/1/2020	SAUGUS REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 5,986.14
RK	9/1/2020	9/30/2020	10/1/2020	SAUGUS REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 5,767.70
RK	10/1/2020	10/31/2020	11/2/2020	SAUGUS REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,642.10
RK	11/1/2020	11/30/2020	12/1/2020	SAUGUS REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,402.50
RK	12/1/2020	12/31/2020	1/1/2021	SAUGUS REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 6,642.10
RK	1/1/2021	1/21/2021	2/1/2021	SAUGUS REHAB AND NURSING	4P - MMQ SCORE 200.1 - 225.0	$ 4,233.10
DD	1/1/2019	1/31/2019	2/1/2019	TWIN OAKS REHAB AND NURSING	4S - MMQ SCORE 245.1 - 270.0	$ 7,078.85
DD	2/1/2019	2/28/2019	3/1/2019	TWIN OAKS REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 6,393.80
DD	3/1/2019	3/31/2019	4/2/2019	TWIN OAKS REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,078.85
DD	4/1/2019	4/30/2019	5/1/2019	TWIN OAKS REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 6,850.50
DD	5/1/2019	5/31/2019	6/3/2019	TWIN OAKS REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 7,061.18
DD	6/1/2019	6/30/2019	7/1/2019	TWIN OAKS REHAB AND NURSING	4R - MMQ SCORE 225.1 - 245.0	$ 6,833.40
DD	7/1/2019	7/31/2019	8/1/2019	TWIN OAKS REHAB AND NURSING	4T - MMQ SCORE 270.1 AND GREATER	$ 7,957.08
DD	8/1/2019	8/31/2019	9/2/2019	TWIN OAKS REHAB AND NURSING	4T - MMQ SCORE 270.1 AND GREATER	$ 7,957.08
DD	9/1/2019	9/30/2019	10/2/2019	TWIN OAKS REHAB AND NURSING	4T - MMQ SCORE 270.1 AND GREATER	$ 7,700.40
DD	10/1/2019	10/31/2019	11/1/2019	TWIN OAKS REHAB AND NURSING	4T - MMQ SCORE 270.1 AND GREATER	$ 8,367.52
DD	11/1/2019	11/30/2019	12/2/2019	TWIN OAKS REHAB AND NURSING	4T - MMQ SCORE 270.1 AND GREATER	$ 8,097.60
DD	12/1/2019	12/31/2019	1/3/2020	TWIN OAKS REHAB AND NURSING	4T - MMQ SCORE 270.1 AND GREATER	$ 8,367.52
DD	1/1/2020	1/31/2020	4/30/2020	TWIN OAKS REHAB AND NURSING	4S - MMQ SCORE 245.1 - 270.0	$ 7,472.24
DD	2/1/2020	2/29/2020	3/2/2020	TWIN OAKS REHAB AND NURSING	4S - MMQ SCORE 245.1 - 270.0	$ 6,990.16
DD	3/1/2020	3/31/2020	4/1/2020	TWIN OAKS REHAB AND NURSING	4S - MMQ SCORE 245.1 - 270.0	$ 7,472.24
DD	4/1/2020	4/20/2020	5/1/2020	TWIN OAKS REHAB AND NURSING	4S - MMQ SCORE 245.1 - 270.0	$ 4,820.80
DD	6/15/2020	6/30/2020	7/1/2020	TWIN OAKS REHAB AND NURSING	4S - MMQ SCORE 245.1 - 270.0	$ 3,856.64
DD	1/1/2021	1/31/2021	2/1/2021	TWIN OAKS REHAB AND NURSING	4T - MMQ SCORE 270.1 AND GREATER	$ 8,567.16
DD	2/1/2021	2/15/2021	2/19/2021	TWIN OAKS REHAB AND NURSING	4T - MMQ SCORE 270.1 AND GREATER	$ 4,145.40