IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

UNITED STATES OF AMERICA, AND THE STATE OF DELAWARE, ex rel. MALIKA SPRUILL and DOUGLAS SPRUILL, Plaintiffs, CONNECTIONS COMMUNITY SUPPORT PROGRAMS, INC, Defendant.	)	Civil Action No. 19-475-CFC

UNITED STATES' COMPLAINT IN INTERVENTION

The UNITED STATES OF AMERICA hereby alleges as follows:

1. The United States of America partially intervenes in this action and brings claims against Defendant Connections Community Support Programs, Inc. ("Connections" or "Defendant") pursuant to the False Claims Act, 31 U.S.C. §§ 3729-3733, and common law, to recover treble damages sustained by, and civil penalties owed to, the United States based on Defendant's conduct.

2. From at least January 1, 2015, through at least October 31, 2019 ("the relevant time period"), Connections, one of the largest providers of outpatient mental health and substance abuse services ("mental health services" or "mental health treatment") in Delaware, fraudulently billed Medicare and Medicaid by at least (i) billing for mental health services rendered by individuals whose professional qualifications did not allow them to bill Medicare or Medicaid for reimbursement under the names of individuals whose qualifications did allow for reimbursement and (ii) billing Medicaid for mental health services using incorrect procedure codes for the person performing the service, resulting in higher payments to Connections than

were permitted. In falsely certifying the identity of the individual providing the mental health service, Connections, in violation of the False Claims Act, caused Medicare and Medicaid to pay for millions of dollars in services for which Connections was not entitled to reimbursement.

JURISDICTION AND VENUE

3. This Court has subject matter jurisdiction over this action pursuant to 31 U.S.C. § 3730(a), and 28 U.S.C. §§ 1345, 1355, and supplemental jurisdiction over the common law and equitable causes of action under 28 U.S.C. § 1367(a).

4. This court may exercise personal jurisdiction over Defendant pursuant to 31 U.S.C. § 3732(a) and (b), and because the acts committed as described herein occurred in Delaware.

5. Venue is proper in the District of Delaware under 31 U.S.C. § 3732(a), 28 U.S.C. §§ 1391(b) and 1395(a) because Connections transacts business within this District, and the events giving rise to this action occurred within this District.

THE PARTIES

6. Plaintiff United States of America brings this action on behalf the United States Department of Health and Human Services ("HHS") and its operating division, the Centers for Medicare and Medicaid Services ("CMS"). CMS administers the Medicare and Medicaid programs.

7. Relators Malika Spruill and Douglas Spruill are former employees of Connections who allege that Defendant violated the False Claims Act by submitting false or fraudulent claims to Medicare and Medicaid.

8. Defendant Connections is a 26 U.S.C. § 501(c)(3) non-profit organization formed under the laws of the State of Delaware with its principle place of business in Wilmington, Delaware.

BACKGROUND

A. False Claims Act

9. The False Claims Act establishes liability to the United States for an individual who, 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," *id.* § 3729(a)(1)(B). "Knowingly" is defined to include actual knowledge, reckless disregard, or deliberate indifference. *Id.* § 3729(b)(1). No proof of specific intent to defraud is required. *Id.*

B. Medicare Part B

10. Medicare is a federal health insurance program for people 65 and older and for people under 65 with certain disabilities. *See* 42 U.S.C. § 1395. Medicare is administered through CMS, a division of HHS, and administration is further delegated to administrative and program safeguard contractors. Medicare Part B (Medical Insurance) covers physician services and laboratory tests.

11. During the relevant time period, Novitas Solutions, Inc. was the Medicare Administrative Contractor responsible for processing Medicare Part B claims in Delaware.

12. In order to bill Medicare for services provided to Medicare beneficiaries, physicians and certain legal entities must apply for enrollment in the Medicare program by submitting an enrollment application. Medicare, through its administrative contractors, evaluates

the representations and certifications contained on the enrollment application and determines whether to permit the individual or entity to enroll.

13. The "National Provider Identifier" ("NPI") is a standard and unique health identifier for health care providers. All providers and practitioners must have an assigned NPI number prior to enrolling in Medicare, which then permits providers and practitioners to bill Medicare and receive payment.

14. At all times relevant hereto, providers seeking to enroll in the Medicare program were required to sign a certification agreeing to abide by Medicare laws, regulations and program instructions. Providers were also required to certify that the information contained in their enrollment application was "true, correct, and complete," and agree to notify the Medicare administrative contractor within 90 days of any changes to the information.

15. To obtain payment for services they provide to Medicare beneficiaries, Medicare-enrolled providers file "claims" with the Medicare administrative contractor for their region. The basic requirement for any claim to be payable by Medicare is that the service must be "reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. § 1395y(a)(1)(A). What is "reasonable and necessary" is determined by accepted practices in the medical community, as further defined by statute, by regulation, by National Coverage Determinations issued by CMS, and by Local Coverage Determinations and guidance issued by the Medicare administrative contractor.

16. The Medicare statute provides that "No payment shall be made to any provider of services or other person . . . unless there has been furnished such information as may be necessary in order to determine the amount due such provider or other person[.]" 42 U.S.C. § 1395l(e).

17. When submitting claims for payment to Medicare, providers use payment codes corresponding to the services provided. These codes are commonly referred to as "Current Procedural Terminology" or "CPT" codes. By submitting claims for payment using CPT codes, providers represent to Medicare that they have provided the services corresponding to the codes and in accordance with the laws, rules, and regulations applicable to those codes.

18. To obtain Medicare reimbursement for certain outpatient items or services, providers submit a claim form known as the CMS 1500 form ("CMS 1500") or its electronic equivalent, known as the 837P format. Among the information the provider includes on a CMS 1500 or through the 837P format are certain five-digit codes, including CPT codes and Healthcare Common Procedure Coding System ("HCPCS") codes, that identify the services rendered and for which reimbursement is sought, and the NPI of the "rendering provider."

19. When submitting claims to Medicare, providers certify on the CMS 1500, *inter alia*, that (a) the services rendered are medically indicated and necessary for the health of the patient; (b) the information on the claim form is "true, accurate, and complete"; (c) "the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare"; and (d) the provider understands that "payment and satisfaction of this claim will be from Federal and State funds, that any false claims, statement, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws." After a February 2012 revision to the CMS 1500, providers further certify that their claims comply "with all applicable Medicare . . . laws, regulations, and program instructions for payment[.]" CMS 1500 also requires providers to acknowledge that: "Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete

or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties."

20. Similarly, when enrolling to submit claims electronically, providers certify that they will submit claims that are "accurate, complete, and truthful."

21. Health care providers are prohibited from knowingly presenting or causing to be presented claims for items or services that the person knew or should have known were not medically necessary, or knew or should have known were false or fraudulent. 42 U.S.C. §§ 1320a-7a(a)(1); 1320a-7(b)(7) (permitting exclusion of providers for the foregoing violations).

22. A provider has a duty to familiarize itself with the statutes, regulations, and guidelines regarding coverage for the Medicare services it provides. *Heckler v. Cmty. Health Servs. of Crawford Cty., Inc.*, 467 U.S. 51, 64 (1984).

23. Because it is not feasible for the Medicare program, or its contractors, to review medical records corresponding to each of the millions of claims for payment it receives from providers, the program relies on providers to comply with Medicare requirements and relies on providers to submit truthful and accurate certifications and claims.

24. Generally, once a provider submits a CMS 1500, or the electronic equivalent, to the Medicare program, the claim is paid directly to the provider, in reliance on the foregoing certifications, without any review of supporting documentation, including medical records.

C. Medicare Coverage of Claims Submitted for Mental Health Services

25. Medicare Part B pays for diagnostic and/or behavioral mental health treatment provided by certain eligible professionals. The professionals CMS has deemed eligible to bill for mental health treatment are physicians, clinical psychologists ("CP"), clinical social workers ("CSW" or "LCSW"), clinical nurse specialists ("CNS"), nurse practitioners ("NP"), physician

assistants ("PA"), certified nurse-midwives ("CNM"), and independently practicing psychologists ("IPP"). CMS will, accordingly, reimburse for claims submitted by eligible professionals who have personally provided mental health treatment.

26. Medicare Part B will also pay for mental health treatment billed "incident to" the professional services of a physician, CP, CNS, NP, PA, or CNM. That means that, so long as Medicare's "incident to" requirements are met, mental health treatment supervised by a physician or nonphysician practitioner ("NPP") but performed by a different eligible professional can be billed under the physician's or NPP's NPI. As such, CMS will reimburse a service billed "incident to" a physician's or NPP's professional services at the same rate as the supervising physician or NPP.

27. Medicare does not authorize, and will not reimburse for, services billed "incident to" an LCSW's professional services. In other words, an LCSW is only authorized to bill Medicare under his or her NPI for mental health services he or she has personally performed.

28. Medicare does not consider Certified Alcohol and Drug Counselors ("CADC"), Licensed Chemical Dependency Professionals ("LCDP"), Certified Co-occurring Disorders Professionals ("CCDP"), or social workers who do not meet the requirements of a CSW, *see* 42 U.S.C. § 1395x(hh), as eligible professionals who are authorized to bill for mental health services. Accordingly, Medicare does not reimburse for mental health treatment provided by such "non-eligible" professionals.

29. During the relevant time period, Connections billed Medicare under Part B for services, including but not limited to mental health services, by submitting claims for reimbursement to Novitas Solutions, Inc.

D. Medicaid

30. Medicaid is a joint federal-state program created in 1965 that provides healthcare benefits for certain groups, primarily the poor and disabled. Each state administers a state Medicaid program. The federal Medicaid statute requires each participating state to implement a plan containing certain specified minimum criteria for coverage and payment of claims. 42 U.S.C. §§ 1396, 1396a(a)(13), 1396a(a)(30)(A).

31. CMS administers Medicaid on the federal level. Within broad federal rules, each state determines eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. The states directly pay providers, with the states obtaining the federal share of the payment from accounts that draw on the United States Treasury. 42 C.F.R. §§ 430.0-430.30. The federal share of Medicaid expenditures varies by state and can fluctuate annually.

32. Delaware's Medicaid program is administered through the Delaware Division of Medicaid & Medical Assistance ("DMMA") within Delaware Health and Social Services ("DHSS").

33. In Delaware, Medicaid benefits are provided mainly through managed care organizations ("MCOs") under contract with the state to provide health services to eligible individuals enrolled in their plans.

34. The claims for payment submitted to the MCOs are deemed to be "claims" under the False Claims Act since the managed care plan is a "contractor, grantee, or other recipient," the money is being used "to advance a Government program or interest," and the Government provides or has provided a portion of the money requested or will reimburse the MCO for a portion of the money requested.

35. The vast majority of all Delaware Medicaid providers enter into direct contracts with the MCOs. Through the contracts, the provider is required to agree, *inter alia*, to the terms and conditions contained therein, including that it will comply with all Delaware Medical Assistance Program ("DMAP") rules, regulations, and policies, that submitted claims are correctly coded, and that all information submitted is true, accurate, and complete.

36. Some Medicaid recipients are excluded from managed care or receive health services prior to enrollment with an MCO. Health services for these individuals are billed fee for service ("FFS") directly to and paid by DMMA through a fiscal agent. The Delaware Medicaid policies apply to FFS claims.

37. When a provider enrolls with FFS in Delaware, it must enter into a contract with DMMA's Delaware Medical Assistance Program (the "Medicaid Enrollment Agreement").

38. In connection with the Medicaid Enrollment Agreement, the provider is required to, *inter alia*, agree to the terms and conditions contained therein, including that it will comply with all DMAP rules, regulations, and policies, that submitted claims are correctly coded, and that all information submitted is true, accurate, and complete.

39. Generally, once a provider submits a claim to Medicaid through an MCO or FFS, the claim is paid directly to the provider, in reliance on the foregoing certifications, without any review of supporting documentation, including medical records.

40. As with Medicare, to obtain reimbursement from Medicaid for certain outpatient items or services, providers submit a CMS 1500 form or its electronic equivalent. Among the information the provider includes on a CMS 1500 are CPT codes and HCPCS codes that identify the services rendered and for which reimbursement is sought.

41. The two current Delaware Medicaid MCOs are Highmark Health Options and AmeriHealth Caritas Delaware. DMMA has contracted with Highmark Health Options since on or about January 1, 2015, and AmeriHealth Caritas since on or about January 1, 2018. Prior to AmeriHealth Caritas, UnitedHealthcare was a Delaware MCO until on or about December 31, 2017.

E. Delaware Medicaid and MCO Coverage of Claims Submitted for Mental Health Services

42. Medicaid (hereinafter defined to include FFS and MCOs) will pay for diagnostic and/or behavioral mental health treatment provided by appropriately licensed professionals. The rate at which Medicaid will reimburse for mental health treatment, or the determination as to whether the treatment is reimbursable at all, is dependent on the qualification of the rendering provider and the CPT or HCPCS code used to bill for the mental health service.

43. For FFS, Highmark Health Options, and AmeriHealth Caritas, payment for such services is governed by Delaware's Medicaid policy.

44. Pursuant to Delaware Medicaid policy, counseling, therapy, and alcohol or drug assessment services performed by unlicensed clinicians are not payable utilizing CPT codes 90791 (Psychiatric Diagnostic Evaluation), 90792 (Psychiatric Diagnostic Evaluation w/ Medical Services), 90832 (Psychotherapy w/ Patient 30 Minutes), 90834 (Psychotherapy w/ Patient 45 Minutes), 90837 (Psychotherapy w/ Patient 60 Minutes), and 90853 (Group Psychotherapy) (together, the "Mental Health CPT Codes"). When these services are performed by unlicensed clinicians, they are billed under the supervising practitioner's NPI, but Delaware's Medicaid policy requires that such services be billed to Medicaid under HCPCS codes H0001, H0004, and H0005 (the "H Codes"), which results in a lower reimbursement amount than the Mental Health CPT Codes (except in some limited circumstances that are not applicable here).

45. The professionals that Delaware Medicaid policy has deemed licensed, and thus eligible to bill for mental health treatment, include physicians, psychologists, licensed clinical social workers ("LCSW"), advanced practice nurses ("APN"), nurse practitioners ("NP"), licensed professional counselors of mental health ("LPCMH"), licensed marriage and family therapists ("LMFT"), and licensed chemical dependency professionals ("LCDP"). Medicaid will, accordingly, reimburse for claims submitted by appropriately licensed professionals who have personally provided mental health treatment at the reimbursement rates provided for by the Mental Health CPT Codes.

46. For UnitedHealthcare, payment is governed by Delaware's Medicaid policy along with a more restrictive supervisory protocol addendum to the provider contract, which was signed by Connections' authorized representative in 2011.

47. UnitedHealthcare's supervisory protocol addendum requires that eligible non-credentialed clinicians' training and education include: (1) professional license eligibility; *and* (2) a minimum of a Master's degree in a mental health/substance abuse related field.

48. As a result, when UnitedHealthcare was the MCO, billing for mental health services using the H Codes was not allowed. Moreover, any reimbursement for services performed by an unlicensed non-master's level clinician was not allowed.

49. During the relevant time period, Connections billed Medicaid for services, including but not limited to mental health services.

STATUTE OF LIMITATIONS

50. The claims in this matter relate back to the filing of the *qui tam* complaint and are therefore timely under 31 U.S.C. § 3731(b).

FACTUAL ALLEGATIONS

A. Medicare and Medicaid Enrollment Applications

51. In or around June 2007, Connections submitted an application to Medicare to enroll as a Multi-Specialty Clinic providing mental health and drug and alcohol treatment. An authorized Connections representative signed the Medicare enrollment application and the required certifications as a "Director/Officer" of Connections. During the relevant time period, Defendant was enrolled as a provider of healthcare services to Medicare beneficiaries. Under the terms of the provider agreements, Connections agreed to comply with all of the conditions imposed upon it by the applicable federal law and regulations, including the requirement that it submit claims for reimbursement in accordance with those laws and regulations.

52. As set forth below, Connections knew, recklessly disregarded, or was deliberately ignorant of, the conditions for reimbursement of services under the Medicare program.

53. All Medicare enrollment applications submitted by Connections contained the following certifications:

a. "I have read the contents of this application."

b. "My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program."

c. "I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations and program instructions are available through the Medicare contractor."

d. "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 . . . ."

e. "I agree to notify the Medicare contractor of any future changes to the information" contained in the application within 90 days (or 30 days for certain types of changes)."

f. "I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare . . . ."

g. "[I] will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

54. The eligible professionals employed by Connections who were authorized to bill Medicare for their services each submitted to Medicare a provider enrollment form that allowed Connections to receive Medicare payments for the services billed under the NPIs of those eligible professionals.

55. During the relevant time period, Connections was a participant in the Medicaid program.

56. At least as of December 21, 2015, Connections entered into the Medicaid Enrollment Agreement.

57. In the Medicaid Enrollment Agreement, Connections agreed to a number of certifications. For example:

a. "The Provider agrees, as a participant in the programs under the authority of the Delaware Medical Assistance Program (DMAP), to abide by the rules, regulations, policies and procedures of the DMAP, and comply with any of the terms, conditions, and requirements as set forth herein;"

b. "The submission by or on behalf of the Provider of any claim for payment under the DMAP shall constitute certification by the Provider that the items or

services for which payment is claimed were in compliance with the DMAP rules, regulations and policies, including but not limited to: that the items or services were actually rendered by the Provider … [and] that the claim is correctly coded in accordance with billing instructions prescribed by the DMAP; and, that all information submitted with or in support of the claim is true, accurate, and complete."

c. "I understand in endorsing or depositing checks or accepting electronic fund transfers that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State law."

d. "The Provider is responsible for the proper licensure and actions of his/her employees. The DMAP will regard any failure to comply with the DMAP's rules, regulations or policies or any negligent or fraudulent act by such an employee against the DMAP as an action of the Provider."

58. In addition, Connections entered into direct contracts with the MCOs.

59. Connections entered into a contract with Highmark Health Options on or about March 5, 2015. In the Highmark Health Options contract, Connections agreed to at least the following certifications:

a. "By signing the completed form, transmitting a claim electronically, or billing a Highmark Delaware Member for applicable Coinsurance, Copayment, or Deductible amounts, either directly or through an agent, the Participating Provider shall be deemed to certify that the procedures and/or services claimed are adequately documented in both medical and billing records, have

been rendered by the Participating Provider and that the Participating Provider is entitled to receive payment from Highmark Delaware and/or Member within the terms, conditions, and limitations of this Agreement, the applicable Member Benefit Plan, the applicable benefit policies and Highmark Delaware's Provider Manual."

b. "Participating Provider further agrees that the submission of each claim constitutes a certification that it has complied with all applicable Federal and State laws including, but not limited to, the federal anti-kickback law and stark law and program requirements in connection with such claims and the services provided therein."

60. Connections entered into a contract with AmeriHealth Caritas on or about December 13, 2017. In the AmeriHealth Caritas contract, Connections agreed to at least the following certifications:

a. "Provider recognizes that payments made by ACDE pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACDE and/or the Agency, in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to, the submission of false claims/statements for payment by Provider, it's employees or agents. Provider shall be required to comply with all policies and procedures as developed by ACDE and the Agency, including but not limited to the requirements set forth in the Provider Manual and the Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may

include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACDE."

b. "Provider agrees to comply with all applicable Medicaid laws, regulations (including applicable sub-regulatory guidance) and Agency Contract provisions."

c. "Provider understands and agrees that each claim Provider submits to the State or ACDE constitutes certification that Provider has complied with all applicable Federal and State law (including, but not limited to, the Federal anti-kickback law and Stark law) and Program requirements in connection with such claims and the services provided therein."

61. Connections entered into a contract with UnitedHealthcare on or about April 15, 2011. That contract was terminated on or about December 31, 2017. In the UnitedHealthcare contract, Connections agreed to at least the following certifications:

a. "Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of,

or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH."

b. UnitedHealthcare's Provider Manual also required the provider to agree that "[w]hen you submit a claim or encounter information you are certifying the information is accurate, complete and truthful."

62. Connections also resubmitted and recertified the accuracy of its enrollment information on its periodic revalidation applications, which allow it to continue participating in and submitting claims for reimbursement under the Delaware Medicaid program.

63. As set forth below, Connections knew, recklessly disregarded, or was deliberately ignorant of, the conditions for reimbursement of services under the Delaware Medicaid program and the applicable MCO contracts.

B. Treatment Locations

64. Connections provides outpatient mental health treatment services at locations throughout Delaware, including at facilities located in Dover ("the Dover Clinic"), Millsboro ("the Millsboro Clinic"), Harrington ("the Harrington Clinic"), Newark ("the Newark Clinic"), Seaford ("the Seaford Clinic"), Smyrna ("the Smyrna Clinic"), and Wilmington ("the Wilmington Clinic").

65. The Dover Clinic has operated out of a number of locations and is currently located at 1114 S. DuPont Highway, Dover, DE. The Dover Clinic has treated Medicare and Medicaid patients during the relevant time period.

66. The Millsboro Clinic has operated out of a number of locations and is currently located at 315 Old Landing Road, Millsboro, DE. The Millsboro Clinic has treated Medicare and Medicaid patients during the relevant time period.

67. The Harrington Clinic is located at 1 East St., Harrington, DE 19952 and has treated Medicaid patients during the relevant time period.

68. The Newark Clinic is located at 1423 Capitol Trail, Newark, DE and has treated Medicare and Medicaid patients during the relevant time period.

69. The Seaford Clinic has operated out of a number of locations and is currently located at 123 Pennsylvania Avenue, Seaford, DE. The Seaford Clinic has treated Medicare and Medicaid patients during the relevant time period.

70. The Smyrna Clinic has operated out of a number of locations and is currently located at 320 N. High Street, Smyrna, DE. The Smyrna Clinic has treated Medicare and Medicaid patients during the relevant time period.

71. The Wilmington Clinic has operated out of a number of locations and is currently located at 500 W. 8th Street, Wilmington, DE. The Wilmington Clinic has treated Medicare and Medicaid patients during the relevant time period.

C. Connections' Electronic Submission of Claims

72. During the relevant time period, Connections providers billed Medicare and Medicaid for mental health treatment services utilizing the Mental Health CPT Codes.

73. Connections and its providers used an electronic health record system to submit claims to Medicare and Medicaid for reimbursement.

74. Each time Connections entered into a Medicare Electronic Data Interchange ("EDI") Enrolling Agreement, which allowed Connections and its providers to electronically submit claims to Medicare, Connections, through its authorized representative, certified, *inter alia*:

a. "That [the provider] will be responsible for all Medicare claims submitted to CMS or a designated CMS contractor by itself, its employees, or its agents."

b. "That [the provider] will submit claims that are accurate, complete, and truthful."

c. "That [the provider] will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law."

d. "That [the provider] will research and correct claim discrepancies."

75. The EDI Agreements further required Connections' authorized representative to attest that:

a. "Any provider who submits Medicare claims electronically to CMS or its contractors remains responsible for those claims as those responsibilities are outlined on the EDI Enrollment. . . . The provider furnishing the item or service for whom payment is claimed under the Medicare Program retains the responsibility for any claim regardless of the format it chooses to use to submit the claim."

b. "I understand that any individual who knowingly and willfully makes or causes to be made any false claim or false statement or false representation of a material fact in any application to the federal government for benefits or

> payment with respect to the Medicare program may be subject to civil and/or criminal enforcement action which may result in fines, penalties, damages and/or imprisonment."

76. Each Connections provider who submitted a claim to Medicare through Connections' electronic health record system had to certify which provider rendered the service billed to Medicare. The provider who rendered the service is commonly referred to as the "bill to" provider, and it is that provider's NPI that is submitted in connection with the claim for reimbursement.

77. Connections was required to and did make substantially similar certifications to electronically bill Medicaid. Pursuant to Delaware Medicaid policy, "Providers are responsible for the accuracy, truthfulness, and completeness of all claims submitted to DMAP." Moreover, by submitting a claim to Medicaid using the Mental Health CPT Codes, Connections certified that an appropriately licensed provider was the rendering provider in accordance with Medicaid policy.

D. Connections' Submission of False Claims to Medicare

78. The rate at which Medicare reimburses mental health treatment, or the determination as to whether Medicare will reimburse mental health treatment at all, is dependent on the qualification of the "bill to" provider.

79. Medicare claims records from January 2015 through October 2019 demonstrate that Connections providers at the Dover, Millsboro, Newark, Seaford, Smyrna, and Wilmington Clinics utilized the Mental Health CPT Codes to submit over 15,000 claims to Medicare for reimbursement for mental health services Connections provided to Medicare patients. Medicare

paid Connections over $760,000.00 as a result of its claims for reimbursement for services billed under the Mental Health CPT Codes.

80. Connections was only eligible for reimbursement for mental health services provided by eligible professionals, including physicians, CPs, LCSWs, CNSs, NPs, PAs, CNMs, and IPPs. Accordingly, Medicare only reimbursed Connections for those claims in which the claim certified that the mental health treatment was provided by an eligible professional, such as an LCSW.

81. Connections providers, however, regularly and knowingly submitted or caused to be submitted claims to Medicare for reimbursement under the Mental Health CPT Codes for services its providers certified were performed by an eligible professional, such as an LCSW, when the service was actually performed by a "non-eligible" professional, such as a CADC, CCDP, or social worker who did not meet the requirements of a CSW.

82. Out of the approximately 15,000 claims Connections submitted to Medicare for reimbursement between January 2015 and October 2019, over 4,000 of those claims falsely certified that an LCSW or other eligible professional employed by Connections was the rendering provider when, in fact, the rendering provider was a "non-eligible" professional who was not authorized to bill Medicare and falsely billed for services for which Connections was not entitled to reimbursement from Medicare.

83. For example,

a. On December 4, 2015, Patient C.F. received mental health treatment billed under CPT Code 90834 at the Dover Clinic. The claim for reimbursement certified that M.S., LSCW, NPI XXXXXX2259, was the rendering provider.

In reality, R.A., identified by Connections as an "Other Counselor," was the rendering provider.

b. On February 23, 2016, Patient B.S. received mental health treatment billed under CPT Code 90853 at the Dover Clinic. The claim for reimbursement certified that M.S., LCSW, NPI XXXXXX5909, was the rendering provider. In reality, C.W., identified by Connections as an "Other Counselor," was the rendering provider.

c. On March 23, 2016, Patient R.J. received mental health treatment billed under CPT Code 90832 at the Dover Clinic. The claim for reimbursement certified that M.S., LCSW, NPI XXXXXX5909, was the rendering provider. In reality, A.C., identified by Connections as a "CADC," was the rendering provider.

d. On September 16, 2017, Patient W.W. received mental health treatment billed under CPT Code 90853 at the Dover Clinic. The claim for reimbursement certified that M.S., LCSW, NPI XXXXXX5909, was the rendering provider. In reality, S.S. identified by Connections as an "Other Counselor," was the rendering provider.

e. On August 08, 2018, Patient K.P. received mental health treatment billed under CPT Code 90832 at the Dover Clinic. The claim for reimbursement certified that L.C., LCSW, NPI XXXXXX8187, was the rendering provider. In reality, K.H., identified by Connections as an "Other Counselor, Peer Specialist," was the rendering provider.

f. On January 29, 2019, Patient T.B. received mental health treatment billed under CPT Code 90791 at the Dover Clinic. The claim for reimbursement certified that L.C., LCSW, NPI XXXXXX8187, was the rendering provider. In reality, D.M., identified by Connections as an "Other Counselor," was the rendering provider.

g. On October 24, 2019, Patient S.M. received mental health treatment billed under CPT Code 90832 at the Dover Clinic. The claim for reimbursement certified that L.C., LCSW, NPI XXXXXX8187, was the rendering provider. In reality, L.S., identified by Connections as an "Other Counselor," was the rendering provider.

h. On May 12, 2015, Patient R.S. received mental health treatment billed under CPT Code 90853 at the Smyrna Clinic. The claim for reimbursement certified that M.S., LSCW, NPI XXXXXX2259, was the rendering provider. In reality, Z.H., identified by Connections as a "CADC," was the rendering provider.

i. On June 14, 2016, Patient M.D. received mental health treatment billed under CPT Code 90834 at the Smyrna Clinic. The claim for reimbursement certified that M.S., LSCW, NPI XXXXXX2259, was the rendering provider. In reality, H.E., identified by Connections as a "CADC, Other Counselor," was the rendering provider.

j. On July 31, 2017, Patient Y.M. received mental health treatment billed under CPT Code 90791 at the Smyrna Clinic. The claim for reimbursement certified that R.T., LCSW, NPI XXXXXX6375, was the rendering provider. In reality,

A.B., identified by Connections as an "Other Counselor," was the rendering provider.

k. On February 8, 2018, Patient L.S. received mental health treatment billed under CPT Code 90853 at the Smyrna Clinic. The claim for reimbursement certified that R.T., LCSW, NPI XXXXXX6375, was the rendering provider. In reality, J.S., identified by Connections as an "Other Counselor," was the rendering provider.

l. On April 2, 2018, Patient M.M. received mental health treatment billed under CPT Code 90853 at the Smyrna Clinic. The claim for reimbursement certified that R.T., LCSW, NPI XXXXXX6375, was the rendering provider. In reality, F.G., identified by Connections as a "CADC," was the rendering provider.

m. On February 3, 2015, Patient J.T. received mental health treatment billed under CPT Code 90832 at the Newark Clinic. The claim for reimbursement certified that K.C., LCSW, NPI XXXXXX2486, was the rendering provider. In reality, L.F., identified by Connections as a "CCDP-D," was the rendering provider.

n. On May 4, 2016, Patient D.R. received mental health treatment billed under CPT Code 90834 at the Newark Clinic. The claim for reimbursement certified that M.S., LSCW, NPI XXXXXX2259, was the rendering provider. In reality, A.R., identified by Connections as a "CADC," was the rendering provider.

o. On January 26, 2017, Patient N.D. received mental health treatment billed under CPT Code 90834 at the Newark Clinic. The claim for reimbursement

certified that M.S., LSCW, NPI XXXXXX2259, was the rendering provider. In reality, P.D., identified by Connections as a "CCDP-D" was the rendering provider.

p. On June 1, 2018, Patient L.H. received mental health treatment billed under CPT Code 90837 at the Newark Clinic. The claim for reimbursement certified that M.S., LSCW, NPI XXXXXX2259, was the rendering provider. In reality, E.T., identified by Connections as an "Other Counselor," was the rendering provider.

q. On October 7, 2019, Patient R.H. received mental health treatment billed under CPT Code 90837 at the Newark Clinic. The claim for reimbursement certified that M.S., LSCW, NPI XXXXXX2259, was the rendering provider. In reality, J.P., identified by Connections as an "Other Counselor," was the rendering provider.

r. On May 8, 2015, Patient C.S. received mental health treatment billed under CPT Code 90791 at the Millsboro Clinic. The claim for reimbursement certified that K.C., LCSW, NPI XXXXXX2486, was the rendering provider. In reality, M.M., identified by Connections as an "Other Counselor," was the rendering provider.

s. On May 10, 2016, Patient J.H. received mental health treatment billed under CPT Code 90834 at the Millsboro Clinic. The claim for reimbursement certified that K.C., LCSW, NPI XXXXXX2486, was the rendering provider. In reality, P.T., identified by Connections as a "CADC," was the rendering provider.

t. On April 14, 2017, Patient K.L. received mental health treatment billed under CPT Code 90832 at the Millsboro Clinic. The claim for reimbursement certified that C.S., LCSW, NPI XXXXXX9938, was the rendering provider. In reality, J.R., identified by Connections as an "Other Counselor," was the rendering provider.

u. On March 13, 2018, Patient A.C. received mental health treatment billed under CPT Code 90837 at the Millsboro Clinic. The claim for reimbursement certified that K.C., LCSW, NPI XXXXXX2486, was the rendering provider. In reality, C.H., identified by Connections as an "Other Counselor," was the rendering provider.

v. On October 25, 2019, Patient K.D. received mental health treatment billed under CPT Code 90853 at the Millsboro Clinic. The claim for reimbursement certified that C.J., LCSW, NPI XXXXXX5806, was the rendering provider. In reality, M.H., identified by Connections as an "Other Counselor," was the rendering provider.

w. On March 16, 2018, Patient V.B. received mental health treatment billed under CPT Code 90837 at the Seaford Clinic. The claim for reimbursement certified that K.C., LCSW, NPI XXXXXX2486, was the rendering provider. In reality, S.R., identified by Connections as an "Other Counselor," was the rendering provider.

x. On May 15, 2018, Patient D.C. received mental health treatment billed under CPT Code 90853 at the Seaford Clinic. The claim for reimbursement certified that L.B., LCSW, NPI XXXXXX7189, was the rendering provider. In reality,

S.P., identified by Connections as an "Other Counselor," was the rendering provider.

y. On July 17, 2019, Patient K.W. received mental health treatment billed under CPT Code 90837 at the Seaford Clinic. The claim for reimbursement certified that C.J., LCSW, NPI XXXXXX5806, was the rendering provider. In reality, J.G., identified by Connections as an "Other Counselor," was the rendering provider.

z. On July 29, 2019, Patient M.S. received mental health treatment billed under CPT Code 90853 at the Seaford Clinic. The claim for reimbursement certified that C.J., LCSW, NPI XXXXXX5806, was the rendering provider. In reality, J.J., identified by Connections as a "Peer Specialist," was the rendering provider.

aa. On August 8, 2019, Patient S.W. received mental health treatment billed under CPT Code 90832 at the Seaford Clinic. The claim for reimbursement certified that C.J., LCSW, NPI XXXXXX5806, was the rendering provider. In reality, D.W., identified by Connections as an "Other Counselor," was the rendering provider.

bb. On June 15, 2015, Patient B.L. received mental health treatment billed under CPT Code 90791 at the Wilmington Clinic. The claim for reimbursement certified that K.C., LCSW, NPI XXXXXX2486, was the rendering provider. In reality, T.S., identified by Connections as a "CADC," was the rendering provider.

cc. On December 14, 2016, Patient S.T. received mental health treatment billed under CPT Code 90832 at the Wilmington Clinic. The claim for reimbursement certified that M.S., LCSW, NPI XXXXXX5909, was the rendering provider. In reality, C.A., identified by Connections as an "Other Counselor," was the rendering provider.

dd. On August 8, 2017, Patient J.C. received mental health treatment billed under CPT Code 90834 at the Wilmington Clinic. The claim for reimbursement certified that L.T., LCSW, NPI XXXXXX6088, was the rendering provider. In reality, R.S., identified by Connections as a "CADC, Master Therapist," was the rendering provider.

ee. On April 6, 2018, Patient L.L. received mental health treatment billed under CPT Code 90837 at the Wilmington Clinic. The claim for reimbursement certified that L.T., LCSW, NPI XXXXXX6088, was the rendering provider. In reality, A.C., identified by Connections as an "Other Counselor," was the rendering provider.

ff. On November 27, 2018, Patient D.G. received mental health treatment billed under CPT Code 90837 at the Wilmington Clinic. The claim for reimbursement certified that J.R., LCSW, NPI XXXXXX8834, was the rendering provider. In reality, R.P., identified by Connections as a "Master Therapist," was the rendering provider.

gg. On September 4, 2019, Patient L.L. received mental health treatment billed under CPT Code 90853 at the Wilmington Clinic. The claim for reimbursement certified that L.T., LCSW, NPI XXXXXX6088, was the

rendering provider. In reality, D.S., identified by Connections as a "CADC, Master Therapist," was the rendering provider.

84. At times, Connections providers utilized an LCSW as the "bill to" provider when submitting claims for reimbursement to Medicare at a specific location even though the LCSW used as the "bill to" never treated patients at that location. For example, Relator Malika Spruill has never treated patients at the Millsboro Clinic. Despite knowing that Relator Malika Spruill did not provide patient services at the Millsboro Clinic, Medicare claims records demonstrate that between February 2016 and June 2018 Connections providers regularly used Relator Malika Spruill and her NPI as the "bill to" when billing Medicare for mental health services when other providers – and not Malika Spruill – provided the patient service.

85. Every time a Connections provider selected an eligible professional, such as an LCSW, as the "bill to" provider when submitting a claim for reimbursement to Medicare under the Mental Health CPT Codes, when a "non-eligible" provider rendered the mental health service being billed for, the Connections provider did so with actual knowledge that the "bill to" provider was not the rendering provider or with deliberate ignorance or reckless disregard of the truth or falsity of the fact that the "bill to" provider did not render the services for which Connections billed Medicare.

86. Connections' submission of false or inaccurate claims was material to Medicare's reimbursement determination because it directly affected the amount of reimbursement: absent Connections' false claims, Connections was not eligible to be reimbursed by Medicare at all for those services.

87. Connections' submission of false or inaccurate claims was material to Medicare's reimbursement determination because the government has a vested interest in ensuring that only properly licensed or credentialed providers are rendering mental health treatment.

88. Connections and its providers knew that the qualification of the "bill to" provider was a material fact to Medicare's determination whether to reimburse for mental health treatment. For example, Local Coverage Determination L35101, which sets forth the criteria for reimbursement for certain mental health services billed under the Mental Health CPT Codes, only allows for reimbursement when a psychiatrist, CP, CSW, psychiatric nurse practitioner, CNS, or PA is the rendering provider.

89. In addition, the Medicare Benefit Policy Manual and specific guidance from Novitas Solutions Inc. makes clear that services furnished incident to an LCSW's or CSW's personal professional service are not reimbursable by Medicare.

90. Connections knew that if it submitted claims for payment for services billed under the Mental Health CPT Codes that were performed by ineligible providers, Medicare would not reimburse such claims.

91. If CMS had known that Connections was falsely or fraudulently representing that a service was performed by an eligible professional such as an LCSW when it was not, CMS would not have paid the claim.

92. Accordingly, Connections was not entitled to reimbursement for any claim submitted in connection with the Mental Health CPT Codes in which Connections falsely certified that the rendering provider was an eligible professional such as an LCSW when the actual rendering provider was a different "non-eligible" professional.

93. Medicare claims records from January 2015 through October 2019 demonstrate that Medicare paid Connections more than $225,000.00 as a direct result of Connections falsely submitting over 4,000 false claims to Medicare representing that an eligible professional rendered a patient service billed under the Mental Health CPT Codes when, in fact, a "non-eligible" professional rendered the patient service instead.

E. Connections' Submission of False Claims to Medicaid

94. The rate at which Medicaid will reimburse mental health treatment, or the determination as to whether certain MCOs will reimburse mental health treatment at all, is dependent on the qualification of the rendering provider and the CPT or HCPCS Code used to bill for the mental health service.

95. Medicaid claims records from January 2015 through October 2019 demonstrate that Connections providers at the Dover, Harrington, Millsboro, Newark, Seaford, Smyrna, and Wilmington Clinics utilized the Mental Health CPT Codes to submit at least 257,212 claims to Medicaid for reimbursement for mental health services Connections provided to Medicaid patients. Medicaid paid Connections over $14,743,321.95 as a result of its claims for reimbursement for services billed under the Mental Health CPT Codes.

96. For FFS, Highmark Health Options, and AmeriHealth Caritas, Connections was only eligible for reimbursement for mental health services provided by licensed professionals including physicians, psychologists, LCSWs, LPCMHs, LMFTs, NPs, APNs, and LCDPs using the Mental Health CPT Codes. Accordingly, when FFS, Highmark Health Options, and AmeriHealth Caritas reimbursed Connections at the higher rate for services billed under the Mental Health CPT Codes, they did so because, in billing under those Codes, Connections certified that the mental health treatment was provided by an appropriately licensed professional.

97. Connections providers, however, regularly and knowingly submitted or caused to be submitted claims to FFS, Highmark Health Options, and AmeriHealth Caritas for reimbursement under the Mental Health CPT Codes for services its providers certified were performed by an appropriately licensed professional when the service was actually performed by a professional who was considered unlicensed pursuant to Delaware Medicaid policy.

98. When an unlicensed professional rendered mental health services, Connections should have billed FFS, Highmark Health Options, and AmeriHealth Caritas using the H Codes. When Connections submitted a false claim that represented that an appropriately licensed professional performed the service when, in reality, it was performed by an unlicensed professional, Connections received a partial overpayment that it should not have received.

99. For UnitedHealthcare, Connections was only eligible for reimbursement for mental health services under the Mental Health CPT Codes when those services were provided by an individual considered appropriately licensed under Delaware Medicaid policy or who met UnitedHealthcare's supervisory protocol addendum.

100. When a clinician who was not considered licensed under Delaware Medicaid policy and who did not meet the requirements of the supervisory protocol addendum rendered mental health services, Connections was entirely ineligible to bill UnitedHealthcare for any reimbursement. For every time that Connections submitted false claims that represented that a professional eligible to bill UnitedHealthcare under the Mental Health CPT Codes performed the service when, in reality, it was performed by a professional who was not eligible to bill UnitedHealthcare under the Mental Health CPT Codes, Connections received a complete overpayment that it should not have received.

101. Out of the approximately 257,212 claims Connections submitted to Medicaid, approximately 67.9% of those claims falsely certified that an eligible clinician rendered the service utilizing the Mental Health CPT Code when, in fact, the rendering provider was a "non-eligible" professional who was either not authorized to bill Medicaid or whose services Connections were not entitled to full reimbursement from Medicaid under the Mental Health CPT Codes.

102. For example,

a. On January 2, 2015, Patient L.L. received mental health treatment billed under CPT Code 90834 at the Wilmington Clinic to UnitedHealthcare. The claim was billed under L.S., LPCMH, NPI XXXXXX2388. By submitting a claim under CPT Code 90834, Connections certified that a licensed provider or a master's level clinician otherwise eligible under the supervisory protocol was the rendering provider. In reality, the rendering provider, T.S., met neither of those requirements.

b. On February 6, 2015, Patient K.H. received mental health treatment billed under CPT Code 90853 at the Newark Clinic to UnitedHealthcare. The claim was billed under S.N., LCSW, NPI XXXXXX1140. By submitting a claim under CPT Code 90853, Connections certified that a licensed provider or a master's level clinician otherwise eligible under the supervisory protocol was the rendering provider. In reality, the rendering provider, L.B., met neither of those requirements.

c. On June 13, 2016, Patient T.P. received mental health treatment billed under CPT Code 90832 at the Dover Clinic to UnitedHealthcare. The claim was

billed under F.E., LPCMH, NPI XXXXXX2574. By submitting a claim under CPT Code 90832, Connections certified that a licensed provider or a master's level clinician otherwise eligible under the supervisory protocol was the rendering provider. In reality, the rendering provider, A.C., met neither of those requirements.

d. On November 29, 2016, Patient N.N. received mental health treatment billed under CPT Code 90834 at the Millsboro Clinic to UnitedHealthcare. The claim was billed under C.S., LCSW, NPI XXXXXX9938. By submitting a claim under CPT Code 90834, Connections certified that a licensed provider or a master's level clinician otherwise eligible under the supervisory protocol was the rendering provider. In reality, the rendering provider, A.T., met neither of those requirements.

e. On March 13, 2017, Patient D.L. received mental health treatment billed under CPT Code 90791 at the Smyrna Clinic to UnitedHealthcare. The claim was billed under R.T., LCSW, NPI XXXXXX6375. By submitting a claim under CPT Code 90791, Connections certified that a licensed provider or a master's level clinician otherwise eligible under the supervisory protocol was the rendering provider. In reality, the rendering provider, G.M., met neither of those requirements.

f. On May 25, 2017, Patient M.C. received mental health treatment billed under CPT Code 90853 at the Harrington Clinic to UnitedHealthcare. The claim was billed under L.S., LPCMH, NPI XXXXXX3568. By submitting a claim under CPT Code 90853, Connections certified that a licensed provider or a

master's level clinician otherwise eligible under the supervisory protocol was the rendering provider. In reality, the rendering provider, L.J., met neither of those requirements.

g. On November 7, 2017, Patient D.R. received mental health treatment billed under CPT Code 90837 at the Millsboro Clinic to UnitedHealthcare. The claim was billed under L.M., LPCMH, NPI XXXXXX7624. By submitting a claim under CPT Code 90837, Connections certified that a licensed provider or a master's level clinician otherwise eligible under the supervisory protocol was the rendering provider. In reality, the rendering provider, K.D., met neither of those conditions.

h. On December 8, 2017, Patient A.C. received mental health treatment billed under CPT Code 90834 at the Dover Clinic to Highmark Health Options. The claim was billed under F.E., LPCMH, NPI XXXXXX2574. By submitting a claim under CPT Code 90834, Connections certified that a licensed provider was the rendering provider. In reality, D.D., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

i. On January 2, 2018, Patient A.M. received mental health treatment billed under CPT Code 90834 at the Newark Clinic to AmeriHealth Caritas Delaware. The claim was billed under M.S., LCSW, NPI XXXXXX2259. By submitting a claim under CPT Code 90834, Connections certified that a licensed provider was the rendering provider. In reality, C.E., an unlicensed

provider, identified by Connections as an "Other Counselor," was the rendering provider.

j. On January 2, 2018, Patient T.S. received mental health treatment billed under CPT Code 90853 at the Smyrna Clinic to AmeriHealth Caritas. The claim was billed under R.T., LCSW, NPI XXXXXX6375. By submitting a claim under CPT Code 90853, Connections certified that a licensed provider was the rendering provider. In reality, F.G., an unlicensed provider, identified by Connections as a "CADC," was the rendering provider.

k. On January 22, 2018, Patient W.M. received mental health treatment billed under CPT Code 90834 at the Dover Clinic to Medicaid FFS. The claim was billed under M.S., LCSW, NPI XXXXXX5909. By submitting a claim under CPT Code 90834, Connections certified that a licensed provider was the rendering provider. In reality, D.D., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

l. On January 26, 2018, Patient D.P. received mental health treatment billed under CPT Code 90837 at the Harrington Clinic to AmeriHealth Caritas. The claim was billed under M.S., LCSW, NPI XXXXXX5909. By submitting a claim under CPT Code 90837, Connections certified that a licensed provider was the rendering provider. In reality, S.H., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

m. On January 29, 2018, Patient S.R. received mental health treatment billed under CPT Code 90834 at the Millsboro Clinic to AmeriHealth Caritas. The claim was billed under K.C., LCSW, NPI XXXXXX2486. By submitting a

claim under CPT Code 90834, Connections certified that a licensed provider was the rendering provider. In reality, N.J., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

n. On April 6, 2018, Patient E.R. received mental health treatment billed under CPT Code 90834 at the Millsboro Clinic to AmeriHealth Caritas. The claim was billed under L.M., LPCMH, NPI XXXXXX7624. By submitting a claim under CPT Code 90834, Connections certified that a licensed provider was the rendering provider. In reality, D.C., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

o. On April 10, 2018, Patient T.N. received mental health treatment billed under CPT Code 90837 at the Seaford Clinic to AmeriHealth Caritas. The claim was billed under L.B., LCSW, NPI XXXXXX7189. By submitting a claim under CPT Code 90837, Connections certified that a licensed provider was the rendering provider. In reality, A.D., an unlicensed provider, identified by Connections as a "CADC, Other Counselor," was the rendering provider.

p. On May 17, 2018, Patient A.F. received mental health treatment billed under CPT Code 90834 at the Smyrna Clinic to Highmark Health Options. The claim was billed under J.M., LCSW, NPI XXXXXX3811. By submitting a claim under CPT Code 90834, Connections certified that a licensed provider was the rendering provider. In reality, L.C., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

q. On June 26, 2018, Patient C.M. received mental health treatment billed under CPT Code 90832 at the Wilmington Clinic to AmeriHealth Caritas. The

claim was billed under L.T., LCSW, NPI XXXXXX6088. By submitting a claim under CPT Code 90832, Connections certified that a licensed provider was the rendering provider. In reality, A.C., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

r. On August 29, 2018, Patient T.E. received mental health treatment billed under CPT Code 90837 at the Wilmington Clinic to Highmark Health Options. The claim was billed under L.T., LCSW, NPI XXXXXX6088. By submitting a claim under CPT Code 90837, Connections certified that a licensed provider was the rendering provider. In reality, A.C., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

s. On November 30, 2018, Patient T.P. received mental health treatment billed under CPT Code 90834 at the Newark Clinic to Highmark Health Options. The claim was billed under E.C., LCSW, NPI XXXXXX7123. By submitting a claim under CPT Code 90834, Connections certified that a licensed provider was the rendering provider. In reality, P.W., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

t. On January 2, 2019, Patient B.M. received mental health treatment billed under CPT Code 90853 at the Newark Clinic to Medicaid FFS. The claim was billed under M.S., LCSW, NPI XXXXXX2259. By submitting a claim under CPT Code 90853, Connections certified that a licensed provider was the

rendering provider. In reality, D.P., an unlicensed provider, identified by Connections as a "CADC," was the rendering provider.

u. On January 9, 2019, Patient M.C. received mental health treatment billed under CPT Code 90791 at the Dover Clinic to AmeriHealth Caritas. The claim was billed under L.C., LCSW, NPI XXXXXX8187. By submitting a claim under CPT Code 90791, Connections certified that a licensed provider was the rendering provider. In reality, D.D., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

v. On August 19, 2019, Patient B.V. received mental health treatment billed under CPT Code 90791 at the Harrington Clinic to Highmark Health Options. The claim was billed under J.M., LCSW, NPI XXXXXX3811. By submitting a claim under CPT Code 90791, Connections certified that a licensed provider was the rendering provider. In reality, P.M., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

w. On September 5, 2019, Patient L.D. received mental health treatment billed under CPT Code 90837 at the Seaford Clinic to Highmark Health Options. The claim was billed under L.C., LCSW, NPI XXXXXX8187. By submitting a claim under CPT Code 90837, Connections certified that a licensed provider was the rendering provider. In reality, M.L., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

x. On October 8, 2019, Patient T.H. received mental health treatment billed under CPT Code 90853 at the Millsboro Clinic to Highmark Health Options. The claim was billed under G.C., LPCMH, NPI XXXXXX5460. By submitting a claim under CPT Code 90853, Connections certified that a licensed provider was the rendering provider. In reality, A.F., an unlicensed provider, identified by Connections as a "CADC," was the rendering provider.

y. On October 31, 2019, Patient J.W. received mental health treatment billed under CPT Code 90853 at the Seaford Clinic to AmeriHealth Caritas. The claim was billed under C.K., LCSW, NPI XXXXXX5806. By submitting a claim under CPT Code 90853, Connections certified that a licensed provider was the rendering provider. In reality, M.H., an unlicensed provider, identified by Connections as an "Other Counselor," was the rendering provider.

103. Every time a Connections provider used the Mental Health CPT Codes when submitting a claim for reimbursement to FFS, Highmark Health Options, and AmeriHealth Caritas when an unlicensed professional rendered the mental health service being billed for, the Connections provider did so with actual knowledge that Connections was not entitled to the higher rate of reimbursement under the Mental Health CPT Codes or with deliberate ignorance or reckless disregard of the truth or falsity of the claim for reimbursement.

104. Every time a Connections provider used the Mental Health CPT Codes when submitting a claim for reimbursement to UnitedHealthcare when the professional who rendered the mental health service being billed for was not eligible for reimbursement from UnitedHealthcare based on their professional qualifications, the Connections provider did so

with actual knowledge that Connections was not entitled to reimbursement for the service billed for or with deliberate ignorance or reckless disregard of the truth or falsity of the claim for reimbursement.

105. Connections' submission of false or inaccurate claims was material to Medicaid's reimbursement determination because it directly affected the amount of reimbursement: absent Connections' false claims, Connections was not eligible to be reimbursed by Medicaid at all for some of those services, or at the rate reimbursed for others.

106. Connections' submission of false or inaccurate claims was material to Medicaid's reimbursement determination because the government has a vested interest in ensuring that only properly licensed or credentialed providers are rendering mental health treatment or, at least, ensuring that Medicaid does not overpay when unlicensed individuals are rendering such treatment.

107. Connections and its providers knew that the qualification of the rendering provider was a material fact to Medicaid's determination whether to reimburse for mental health treatment. For example, UnitedHealthcare had a supervisory protocol addendum that specifically addressed these services. Moreover, FFS, Highmark Health Options, and AmeriHealth Caritas follow the Medicaid policy which also specifically addresses these services.

108. Connections knew that if it submitted claims for payment for services billed under the Mental Health CPT Codes that were performed by unlicensed providers, UnitedHealthcare would not reimburse such claims.

109. Connections knew that if it billed FFS, Highmark Health Options, and AmeriHealth Caritas using the appropriate H codes to reflect the licensure and credentials of the person who actually rendered the service, it was only eligible for the lower H Code

reimbursement rate. Instead, Connections used the Mental Health CPT Codes, which resulted in higher reimbursement rates that Connections was not entitled to receive.

110. If Medicaid or any of the MCOs had known that Connections was falsely or fraudulently representing that a service was performed by a licensed professional when it was not, UnitedHealthcare would not have paid the claim, and FFS, Highmark Health Options, and AmeriHealth Caritas would have paid the claim at the lower H Code rate.

111. Medicaid claims records from January 2015 through October 2019 demonstrate that Medicaid paid Connections more than $4,356,910.90 as a direct result of Connections submitting false claims to Medicaid representing that a licensed professional rendered a patient service billed under the Mental Health CPT Codes when, in fact, an unlicensed professional rendered the patient service instead. The $4,356,910.90 overpayment accounts for Medicaid's total overpayment through UnitedHealthcare for Connections' submission of non-eligible claims for services performed by unlicensed clinicians who did not meet the supervisory protocol addendum, and the partial overpayment through FFS, Highmark Health Options, and AmeriHealth Caritas for Connections' submission of claims for services performed by unlicensed clinicians that should have been submitted for reimbursement at a lower rate by using the H Codes.

CLAIMS FOR RELIEF

COUNT ONE

112. This is a claim under the False Claims Act, 31 U.S.C. § 3729(a)(1)(A).

113. The United States realleges and incorporates by reference each and every allegation contained in paragraphs 1 through 111 of this complaint.

114. Defendant knowingly (as defined by 31 U.S.C. § 3729(b)) presented or caused to be presented false or fraudulent claims for payment or approval by the United States in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1)(A). That is, Defendant knowingly submitted and/or caused to be submitted claims seeking reimbursement for services provided by a specific person at a specific rate when that person did not perform the services. Each such submission "constitute[d] a false or fraudulent claim for purposes" of the False Claims Act. 42 U.S.C. § 1320a-7b(g).

115. By reason of the foregoing, the United States suffered actual damages in an amount to be determined at trial, and is therefore entitled under the False Claims Act to treble damages plus a civil penalty for each false or fraudulent claim, as provided by 31 U.S.C. § 3729(a).

COUNT TWO

116. This is a claim under the False Claims Act, 31 U.S.C. § 3729(a)(1)(B).

117. The United States realleges and incorporates by reference each and every allegation contained in paragraphs 1 through 111 of this complaint.

118. Defendant knowingly (as defined by 31 U.S.C. § 3729(b)) made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1)(B). That is, Defendant made and/or caused to be made numerous false records and statements, including false statements in claim forms submitted to Medicare and Medicaid, by falsely certifying, *inter alia*, that (i) the claims complied with all applicable laws regulations, and program instructions for payment, and (ii) the services Defendant billed to Medicare and Medicaid were provided by the provider listed on the claim form or by a provider authorized to bill "incident to" the provider listed on the claim form.

119. By reason of the foregoing, the United States suffered actual damages in an amount to be determined at trial, and is therefore entitled under the False Claims Act to treble damages plus a civil penalty for each false or fraudulent claim, as provided by 31 U.S.C. § 3729(a).

COUNT THREE

120. This is a claim at common law for unjust enrichment.

121. The United States realleges and incorporates by reference each and every allegation contained in paragraphs 1 through 111 of this complaint.

122. As a consequence of the conduct and acts set forth above, Defendant was unjustly enriched at the expense of the United States through the false claims submitted to Medicare and Medicaid during the relevant period.

123. The United States suffered actual damages as a result of Defendant's conduct. Defendant is therefore liable to the United States for actual damages, interest and the costs associated with the investigation, prosecution and collection of the debt in this matter.

COUNT FOUR

124. This is a claim at common law for payment by mistake.

125. The United States realleges and incorporates by reference each and every allegation contained in paragraphs 1 through 111 of this complaint.

126. As a consequence of the conduct and acts set forth above, Defendant caused the United States to make payments by mistake for claims submitted to Medicare and Medicaid during the relevant time period and, as a result, the United States has suffered actual damages.

WHEREFORE, plaintiff United States of America respectfully requests that judgment be entered in its favor and against Defendant as follows:

1. As to Counts One and Two (False Claims Act) for (i) statutory damages in an amount to be established at trial, trebled as required by law, and such penalties as are required by law; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief this Court deems appropriate, to be determined at trial.
2. As to Count Three (Unjust Enrichment), for (i) an amount equal to the amount the Defendant was unjustly enriched, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief this Court deems appropriate, to be determined at trial.
3. As to Count Four (Payment by Mistake), for (i) an amount equal to the money paid by the United States, and illegally retained by the Defendants, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief this Court deems appropriate, to be determined at trial.

JURY DEMAND

The United States requests a trial by jury with respect to all issues so triable.

Respectfully submitted,

DAVID C. WEISS
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