UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. ANICETO BALITON, Defendant.	No. CR 17CR00430 I N F O R M A T I O N [18 U.S.C. § 371: Conspiracy to Pay and Receive Illegal Remunerations for Health Care Referrals]

The Acting United States Attorney charges:

[18 U.S.C. § 371]

A. INTRODUCTORY ALLEGATIONS

At all times relevant to this Information:

1. Bliss Health Care Inc., doing business as Bliss Hospice Care ("Bliss"), was a hospice located at 1755 South Grand Avenue, Glendora, California 91740, within the Central District of California.

2. Defendant ANICETO BALITON ("BALITON") was an owner and operator of Bliss.

3. Co-conspirators 1 ("CC-1"), 2 ("CC-2"), and 3 ("CC-3") (collectively, the "owner co-conspirators") were also owners and operators of Bliss.

4. Co-conspirator 4 ("CC-4"), Marketer 1 ("M-1"), and Marketer 2 ("M-2"), were "marketers" who recruited beneficiaries for Bliss in exchange for illegal kickbacks.

The Medicare Program

5. Medicare was a federal health care benefit program, affecting commerce, that provided benefits to individuals who were 65 years and older or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services. Medicare was a "Federal health care program" within the meaning of that term as used in Title 42, United States Code, Section 1320a-7b(b) (the "anti-kickback statute"), and a "health care benefit program" as defined by Title 18, United States Code, Section 24(b).

6. Individuals who qualified for Medicare benefits were referred to as Medicare "beneficiaries." Each beneficiary was given a unique health insurance claim number ("HICN").

7. Health care providers that provided medical services that were reimbursed by Medicare were referred to as Medicare "providers." To participate in Medicare, providers, including hospices, were required to submit applications in which the providers agreed to comply with all Medicare-related laws and regulations, including the anti-kickback statute (42 U.S.C. § 1320a-7b(b)), which proscribes the offering, payment,

solicitation, or receipt of any remuneration in exchange for a patient referral or referral of other business for which payment may be made by any federal health care program. If Medicare approved a provider's application, Medicare assigned the provider a Medicare "provider number," which was used for the processing and payment of claims.

8. A health care provider with a Medicare provider number could submit claims to Medicare to obtain reimbursement for services rendered to Medicare beneficiaries.

9. Most providers submitted their claims electronically pursuant to an agreement they executed with Medicare in which the providers agreed that: (a) they were responsible for all claims submitted to Medicare by themselves, their employees, and their agents; (b) they would submit claims only on behalf of those Medicare beneficiaries who had given their written authorization to do so; and (c) they would submit claims that were accurate, complete, and truthful.

10. Medicare coverage for hospice services was limited to situations in which: (1) the beneficiary's attending physician and the hospice medical director certified in writing that the beneficiary was terminally ill and had six months or less to live if the beneficiary's illness ran its normal course, and (2) the beneficiary signed a statement choosing hospice care instead of other Medicare benefits. Once a beneficiary chose hospice care, Medicare would not cover treatment intended to cure the beneficiary's terminal illness. The beneficiary had to sign and date an election form documenting this choice. The election

form had to include an acknowledgement that the beneficiary had been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment, and an acknowledgement that the beneficiary understood that certain Medicare services were waived by the election.

11. CMS contracted with private insurance companies to enroll, process, and pay Medicare claims. National Government Services ("NGS") was the contractor that processed and paid Medicare claims for home health services in Southern California during the relevant time period.

12. To bill Medicare for hospice services, a provider was required to submit a claim form (Form UB-04) to NGS. When a Form UB-04 was submitted, usually in electronic form, the provider was required to certify:

a. that the contents of the form were true, correct, and complete;

b. that the form was prepared in compliance with the laws and regulations governing Medicare; and

c. that the services being billed were medically necessary.

13. A Medicare claim for payment was required to set forth, among other things, the following: the beneficiary's name and unique Medicare identification number; the type of services provided to the beneficiary; the date that the services were provided; and the name and National Provider Identifier ("NPI") of the attending physician who established the plan of care.

B. OBJECTS OF THE CONSPIRACY

14. Beginning no later than in or about June 2011, and continuing through in or about July 2015, in Los Angeles County, within the Central District of California, and elsewhere, defendant BALITON, together with CC-1, CC-2, CC-3, CC-4, and others known and unknown to the Acting United States Attorney, knowingly combined, conspired, and agreed to commit the following offenses against the United States:

a. Knowingly and willfully soliciting and receiving remuneration in return for referring an individual to a person for the furnishing and arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, in violation of Title 42, United States Code, Section 1320a-7b(b)(1)(A); and

b. Knowingly and willfully offering to pay and paying any remuneration to any person to induce such person to refer an individual to a person for the furnishing and arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, in violation of Title 42, United States Code, Section 1320a-7b(b)(2)(A).

C. THE MANNER AND MEANS OF THE CONSPIRACY

15. The objects of the conspiracy were carried out, and to be carried out, in substance, as follows:

a. Defendant BALITON and the owner co-conspirators developed relationships with people known as "marketers." These "marketers," including CC-4, M-1, and M-2, and others known and

unknown to the Acting United States Attorney, traveled throughout Southern California for Bliss to recruit Medicare beneficiaries to receive hospice services, which services Bliss would then bill to Medicare.

b. In exchange for Medicare referrals, defendant BALITON and the owner co-conspirators would pay referring marketers, including CC-4, M-1, and M-2, cash or check kickbacks for each Medicare beneficiary referred to Bliss.

c. For each Medicare beneficiary that marketers, including CC-4, M-1 and M-2, referred to Bliss, defendant BALITON and the owner co-conspirators paid a cash or check kickback of approximately $500-1000.

d. Defendant BALITON, along with the owner co-conspirators, devised and agreed upon a scheme to generate cash for illegal kickbacks by disguising such monies as payroll expenses. Defendant BALITON and the owner co-conspirators agreed to artificially increase the salaries of defendant BALITON and other Bliss employees. After receiving their inflated paychecks, defendant BALITON and the other employees would pay back the extra money in cash, and defendant BALITON and the owner co-conspirators would use that cash to pay kickbacks.

e. From in or about June 2011 to in or about July 2015, defendant BALITON and the owner co-conspirators caused Bliss to bill Medicare, and as a result caused Medicare to pay Bliss at least approximately $2,406,637 for services to patients referred to Bliss as the result of kickback payments that

defendant BALITON, together with CC-1, CC-2, and CC-3, made to CC-4, M-1, and M-2.

D. OVERT ACTS

16. On or about the following dates, in furtherance of the conspiracy, and to accomplish its objects, defendant BALITON, together with co-conspirators CC-1, CC-2, CC-3, CC-4, and other co-conspirators known and unknown to the Acting United States Attorney, aiding and abetting one another, committed and willfully caused others to commit the following overt acts, among others, within the Central District of California and elsewhere:

Overt Act No. 1: On or about February 4, 2013, defendant BALITON caused an individual to pay M-1 approximately $6,050, drawn on check number 1033 from defendant BALITON's bank account at Wells Fargo Bank, as a kickback for the referral of Medicare beneficiaries.

Overt Act No. 2: On or about February 4, 2013, defendant BALITON caused an individual to pay a marketer approximately $2,100, as a kickback for the referral of three Medicare beneficiaries at the rate of $700 per beneficiary. This check was payment for the referral of, among others, Medicare beneficiary J.G.

Overt Act No. 3: On or about February 13, 2013, defendant BALITON caused Bliss to submit a claim to Medicare in the amount of approximately $10,688.79 for hospice services purportedly provided to Medicare beneficiary J.G., knowing that the referral of J.G. was obtained from a referring marketer on the basis of

an illegal kickback that defendant BALITON paid to that marketer.

Overt Act No. 4: On or about February 28, 2013, defendant BALITON caused Bliss to pay an individual approximately $2,221.82, drawn on check number 1346 from Bliss's Bank of America bank account ending in -9937, for the purpose of having that individual return the money to defendant BALITON so that defendant BALITON could generate cash to pay for illegal kickbacks.

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CLAIRE YAN
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U.S. Department of Justice

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

AMENDED

CRIMINAL MINUTES - CHANGE OF PLEA

Case No.: CR 17-430-PSG Date: 8/14/17

Present: The Honorable PHILIP S. GUTIERREZ, ☑ District Judge / ☐ Magistrate Judge

WENDY HERNANDEZ	MAREA WOOLRICH	NONE	CLAIRE YAN
Deputy Clerk	*Court Reporter*	*Interpreter*	*Assistant U.S. Attorney*

USA v. DEFENDANT(S) PRESENT	ATTORNEYS PRESENT FOR DEFENDANTS
ANICETO BALITON	DAVID KALOYANIDES
☐ Custody ☑ Bond ☐ O/R	☐ Appointed ☑ Retained
☐ Custody ☐ Bond ☐ O/R	☐ Appointed ☐ Retained
☐ Custody ☐ Bond ☐ O/R	☐ Appointed ☐ Retained
☐ Custody ☐ Bond ☐ O/R	☐ Appointed ☐ Retained
☐ Custody ☐ Bond ☐ O/R	☐ Appointed ☐ Retained

PROCEEDINGS: CHANGE OF PLEA

☑ Defendant moves to change plea to the Information.
☑ Defendant now enters a new and different plea of Guilty to Count(s) ONE of the Information.

☑ The Court questions the defendant regarding plea of Guilty and finds it knowledgeable and voluntary and orders the plea accepted and entered
☑ The Court refers the defendant to the Probation Office for investigation and report and continues the matter to Monday, 01/29/18 at 10am for sentencing.
☐ The Court vacates the court and/or jury trial date.
☐ The pretrial conference set for _____ is off calendar as to defendant _____.
☑ Court orders:
Based on the government's agreement, the nature of the charges, and the fact that the defendant has made all appearances, the Court finds it appropriate to allow the defendant to remain on bond.

☑ Other: Today's transcripts are ORDERED sealed until further order of the Court.

_____ : 33

Initials of Deputy Clerk WH

cc: Probation Office