NOT FOR PUBLICATION

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY
CAMDEN VICINAGE

CHRISTINE PETRE, Plaintiff, v. ALLIANCE HEALTHCARE MANAGEMENT, LLC, et al., Defendants.	:	Civil No. 20-09002 (RBK/AMD) **OPINION**

KUGLER, United States District Judge:

Presently before the Court is Defendant's Motion to Dismiss (Doc. No. 10) the Complaint for failure to state a claim pursuant to Rule 12(b)(6). For the reasons set forth below, Defendant's Motion is **GRANTED**.

I. BACKGROUND

This is a retaliatory discharge case. A former employee of a skilled nursing home alleges she was discharged for refusing to engage in what she believed to be fraud. Defendants, seeking dismissal of the Complaint, also believe they have spotted something amiss—an erroneous allegation in the complaint which they hope, if tugged on, will unravel the whole case. Both parties are wrong, but Defendants less so because they manage to pick out the deficiency in Plaintiff's complaint.

Before setting forth the relevant facts, we will briefly introduce the Medicare Statute and the Medicare Secondary Payer provision as both are relevant to Plaintiff's theory of the case.

A. Statutory and Regulatory Background

Subchapter XVIII of Chapter 7 of Title 42 of the United States Code is entitled "Health Insurance for Aged and Disabled," and is more commonly known as the Medicare Statute. 42 U.S.C. § 1395 to 1395kkk-1. The Medicare Statute consists of four tranches of benefits: (1) Part A provides inpatient and hospital coverage; (2) Part B provides outpatient and medical coverage; (3) Part C, inserted with the passage of the Balanced Budget Act of 1997, created the Medicare Advantage Program ("MA"); and (4) Part D provides prescription drug coverage. *In re Avandia Mktg., Sales Practices & Prod. Liab. Litig.*, 685 F.3d 353, 357 (3d Cir. 2012). Part A and B, commonly thought of as traditional Medicare, are fee-for-service provisions entitling eligible persons to have the Center for Medicare and Medicaid Services ("CMS") directly pay medical providers for their hospital and outpatient care. *Id.*

Part C, on the other hand, allows Medicare enrollees to obtain their Medicare benefits through private insurers, known as Medicare Advantage Organizations ("MAOs"), instead of receiving direct benefits from the government under Part A and B. *Id.* CMS pays an MAO a fixed amount for each enrollee, per capita. *See* 42 U.S.C. § 1395w-23. The MAO then administers Medicare benefits for those enrollees and assumes the risk associated with insuring them. *In re Avandia Mktg., Sales Practices & Prod. Liab. Litig.*, 685 F.3d at 358. MAOs are therefore responsible for paying covered medical expenses for their enrollees. *Id.* Part C allows MAOs some flexibility as to the design of their MA programs. For instance, the MAO is required to provide the benefits covered under Parts A and B to enrollees, but it may also provide additional benefits to its enrollees. 42 U.S.C. § 1395w-22(a)(1)–(3).

The Medicare Secondary Payer ("MSP") provision, enacted in 1980 to curb skyrocketing health costs and lower Medicare disbursements, is also relevant to Plaintiff's theory of the case. The MSP provision curbs health care costs and preserves Medicare's fiscal integrity by assigning

primary payment responsibility to private insurance plans in situations where private coverage for healthcare costs is available to a Medicare recipient. *Abate v. Wal-Mart Stores E., L.P.*, No. 1:17-CV-288-SPB, 2020 WL 7027481, at *8 (W.D. Pa. Nov. 30, 2020). In other words, the MSP provision is implicated where a beneficiary is covered by both Medicare and private insurance. "These private plans are therefore considered 'primary' under the MSP provision and Medicare acts as a secondary payer responsible only for paying amounts not covered by the primary plan." *Id.* The provision provides in pertinent part that Medicare cannot pay medical expenses where "payment has been made or can reasonably be expected to be made" by a primary plan. *Fanning v. United States*, 346 F.3d 386, 389 (3d Cir. 2003). A "primary plan" is defined, in turn, as a group health plan, large group health plan, a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance. 42 U.S.C. § 1395y(b)(2)(A)(ii).

The cost-shifting provision of the MSP provision works as follows: when a Medicare recipient is covered by both private insurance and Medicare, and such private insurance falls within the definition of a "primary plan," the private insurance is the primary payer for medical expenses and Medicare acts as the secondary payer responsible only for those amounts not covered by the private insurance. Thus, a prerequisite to application of the MSP provision is a private insurance plan that qualifies as a "primary plan."

B. Factual Background

In October of 2019, Plaintiff Christine Petre ("Ms. Petre") was employed as a clinical liaison by Defendant Atlas Healthcare—the owner of several nursing homes located throughout New Jersey. (Doc. No. 1, Compl. at ¶¶ 5, 13). She was primarily responsible for coordinating the care and placement of patients in facilities owned by Defendant, such as Riverfront

Rehabilitation and Health Care Center ("RRHCC"), as well as ensuring that beds were available and that prospective patients had insurance coverage. (*Id.* at ¶¶ 5, 13–14). Throughout her employment, Ms. Petre was directly or indirectly supervised by the Regional Admissions Director—Defendant Estefanny Penafiel ("Defendant Penafiel")—and the co-owners, Defendants Phillip Bak and Sam Goldberger. (*Id.* at ¶ 20).

Beginning in mid-March 2020, the start of the pandemic, Defendants allegedly capitalized on the increase in demand for nursing home beds by expanding a fraudulent scheme to disenroll prospective patients from private health insurance and enroll them in Medicare. (*Id.* at ¶ 17). Defendants allegedly: (1) discriminated against patients that did not have Medicare; (2) misrepresented to prospective patients, social workers, and hospital case managers that beds were not available if the prospective patients did not have Medicare; and (3) directed Ms. Petre to try to "convince prospective patients . . . to disenroll from their then applicable . . . health insurance . . . and to only use Medicare" during their stay at the nursing home. (*Id.* at ¶ 21). Medicare coverage was advantageous to Defendants because they would receive a direct fee for services ranging from $600 to $800 under traditional Medicare but only $200 to $400 under private insurance plans. (*Id.* at ¶ 35(C)). Therefore, Defendants had a financial incentive to maximize the number of patients that were covered by Medicare and would make "any representation possible" even though the representations were often "false or misleading." (*Id.* at ¶ 35(P), (R)(ii)). Defendants also failed to disclose to Medicare that the patients they were disenrolling had primary payer insurance which was allegedly Medicare Advantage. (*Id.* at ¶¶ 35(R)(iii), (C)).

In order to perpetuate this alleged disenrollment scheme, Ms. Petre was instructed by Defendant Penafiel to convince prospective patients to disenroll from private insurance and

enroll in Medicare. (*Id.* at ¶ 29). It was indicated to Ms. Petre that this instruction came from the owners "Sam and Phil." (*Id.*). Even though she expressly stated that she would not try to convince patients to disenroll from private insurance, believed the practice was illegal, and was uncomfortable with it, she was told, "Christine you can't say no." (*Id.*). On one occasion, Defendant Penafiel texted Ms. Petre the following:

> Defendant Penafiel: All your saying is hey we just received the referral for your family member and we're trying to accommodate if we have a bed. We also want to give you the option to disenroll your family member to start Medicare during our stay so the co-pay will be waived from your HMO if you choose to go that route.
>
> Defendant Penafiel: Yes, we could always put the patient back in whatever plan they had when they go back to the community if family wants that
>
> Defendant Penafiel: that's all you have to say and if they say yes then yes if not then we go from there and we deny.

(*Id.* at ¶ 30). At some point, she also informed management that she believed Defendants actions to be "fraudulent" and a form of "fraud." (*Id.* at ¶ 37).

In addition to this allegedly fraudulent disenrollment practice, Defendants' allegedly drained Medicare through a coinsurance scheme. Once a patient switched to Medicare, they became responsible to pay a coinsurance of $176 per day for any day after the first 21 days they were admitted in the nursing home. (*Id.* at ¶ 35(S)). Defendants allegedly told these patients to "disenroll and not to worry about the $176 payment [because] . . . Defendant would just write off the coinsurance not making patients pay." (*Id.* at ¶ 35(S)(i)). In reality, however, Defendants knew that under Medicare regulations, after they wrote three letters seeking payments from the patient, if a payment plan was not made, Defendants would receive 50% of the defaulted coinsurance from Medicare. (*Id.*).

After about six months on the job, Ms. Petre was informed by Defendant Penafiel that ownership was "pissed" at her and recommended she "get on board" with disenrollment. (*Id.* at ¶

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