UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

UNITED STATES OF AMERICA *ex rel*. ROBERT A. CUTLER, Plaintiff, v. CIGNA CORP. *et al.*, Defendants.	Civil Action No. 3:21-cv-00748 District Judge Eli J. Richardson Magistrate Judge Jeffrey S. Frensley JURY DEMAND

DEFENDANTS' MOTION TO DISMISS THE UNITED STATES' COMPLAINT-IN-INTERVENTION PURSUANT TO RULE 12(b)(6)

Pursuant to Federal Rule of Civil Procedure 12(b)(6), Defendants (collectively, "Cigna") move to dismiss with prejudice the Government's complaint-in-intervention (Doc. No. 178) for failure to state a claim upon which relief can be granted. As explained more fully in the accompanying memorandum of law, the Government's complaint-in-intervention should be dismissed in full because the Government fails to state a claim under the False Claims Act or any other theory of relief. With respect to the False Claims Act, the Government has not plausibly alleged that Cigna submitted claims for payment that were either factually or legally false. The Government has not plausibly alleged that Cigna knowingly submitted any such claims, nor that any legally false claims were material to the Government's payment decision.

The Government's common-law claims for unjust enrichment and payment by mistake likewise fail. Those claims rest on an underlying fraud that the Government has not plausibly alleged, and such quasi-contract claims are unavailable where, as here, the Government does not allege that the parties' contract was invalid.

WHEREFORE, for the reasons set forth in the accompanying memorandum of law, the Court should grant Cigna's motion to dismiss the Government's complaint-in-intervention with prejudice.

December 16, 2022

Respectfully submitted,

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MEMORANDUM OF LAW IN SUPPORT OF DEFENDANTS' MOTIONS TO DISMISS THE UNITED STATES' COMPLAINT-IN-INTERVENTION AND RELATOR'S AMENDED COMPLAINT PURSUANT TO RULE 12(b)(6)

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INTRODUCTION

Under contracts with the Centers for Medicare & Medicaid Services ("CMS"), Cigna offers Medicare Advantage ("MA") plans that provide health care benefits to Medicare-eligible individuals. As part of those plans, Cigna has a health exam program to try to ensure that its members see a provider at least once annually and have any health risks identified and addressed. In certain situations where it is difficult or impossible for the member's primary care provider ("PCP") to conduct this exam in the doctor's office, Cigna contracts with third-party vendors who send licensed clinicians to conduct these medical exams in the convenience and privacy of the member's home. This is an industry-wide practice that CMS has known about—and expressly permitted—for years. Now, in conflict with CMS guidance that "[t]he provider's statement that the patient has a particular condition is sufficient" for reporting the diagnosis to CMS, *ICD-10-CM Official Guidelines for Coding and Reporting* § I.A.19 (2022), the Government alleges that Cigna violated the FCA by not substituting its own clinical judgment for that of the clinicians who conducted these face-to-face exams. The Government's novel theories for extending FCA liability to these circumstances rest on implausible factual assumptions and insupportable readings of MA program rules.

The Government's theory of factual falsity asks the Court to draw the inference that there was a scheme to submit diagnoses for non-existent conditions to CMS based largely on the allegation that licensed clinicians were diagnosing certain conditions that could not be reliably diagnosed in the home because they require "extensive diagnostic testing or imaging" that the Government claims the clinicians "did not have." Doc. No. 178 ¶ 5. But the obvious alternative explanation is that these were not first-time diagnoses made without diagnostic equipment. Rather, based on patient self-reporting and review of patients' medical histories and medications, the clinicians—exercising their professional medical skill and judgment—were making entirely

proper diagnoses of conditions like diabetes and congestive heart failure that were already being treated or managed at the time of the in-home exam. As between that straightforward explanation and the suggestion that thousands of clinicians deliberately violated standards of medical practice to make tens of thousands of medically invalid diagnoses, a vast fraudulent scheme is "not a plausible conclusion." *Ashcroft v. Iqbal*, 556 U.S. 662, 682 (2009).

The Government's other theory of falsity—that Cigna violated a legal duty to second-guess the provider's clinical judgment that a patient has a particular condition—is wrong as a matter of law. The regulatory sources the Government cites focus on MA plans' responsibilities with respect to *coding* accuracy (i.e., correctly reporting the diagnosis the provider made)—not clinical accuracy, which remains within the purview of the clinician who saw the patient. The alleged facts do not establish a violation of any legal requirements, properly understood, and construing them as the Government asks would upend plans' reliance on providers' medical skill and judgment and require plans to overrule providers' clinical assessments of their patients.

Under *Universal Health Services, Inc. v. U.S. ex rel. Escobar*, 579 U.S. 176, 192 (2016), the Government's theory is also independently foreclosed by "strict enforcement" of the FCA's "rigorous" materiality requirement. In 2013, CMS considered the same facts asserted here—that MA plans often arrange for members to have in-home health assessments by clinicians who are not the member's PCP, do not treat the member during the visit, and have limited diagnostic tools—and it chose to *allow* plans to continue using these assessments to report diagnoses. Since then, CMS has maintained that permission despite concerns by other agencies, *qui tam* relators, and the media that some conditions cannot be diagnosed in the home setting. And CMS has reaffirmed that "in-home assessments can have significant value as care planning and care coordination tools," recommending best practices for those assessments to help "lead to improved enrollee health outcomes." *Announcement of Calendar Year (CY) 2016 Medicare*

Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter ("*Announcement CY 2016*") 145-46 (Apr. 6, 2015).

That history should have stopped this lawsuit before it started. But in 2017, Robert Cutler (then general counsel and part owner of a vendor engaged in a contentious arbitration against Cigna) filed this *qui tam* action, repackaging criticisms of in-home health assessments already in the public domain about the entire MA industry. The FCA bars such opportunistic pleading by relators. In any event, the Government's intervention as to a subset of his claims leaves only Cutler's broadest theory—that all diagnoses made during home visits were *per se* invalid. That theory is foreclosed as a matter of law by CMS's policy permitting such diagnoses to be reported as well as by the FCA's public disclosure bar.

Both the Government's complaint-in-intervention and Cutler's amended complaint suffer from multiple fatal defects and should be dismissed in full.

BACKGROUND

A. Payment Under The Medicare Advantage Program

Established by Part C of the Medicare Act, Medicare Advantage is a public-private program that allows eligible individuals to receive government-subsidized health benefits through private insurance plans. *See* 42 U.S.C. § 1395w-21 *et seq*. "Congress's goal in creating the [MA] program was to harness the power of private sector competition to … create a more efficient and less expensive Medicare system." *In re Avandia Mktg., Sales Pracs. & Prod. Liab. Litig.*, 685 F.3d 353, 363 (3d Cir. 2012). In original Medicare, CMS pays providers directly per service. In contrast, MA organizations ("MAOs") like Cigna contract with CMS to manage the care and bear the financial risk for the beneficiaries who enroll in their plans in exchange for a fixed monthly amount per member. This "prospective, lump-sum payment approach has the potential to curb costly and unnecessary overtreatment that the fee-for-service approach tends to

encourage, and it favors preventative care and other health-protective measures, enabling cost efficiencies that can elude a fee-for-service system." *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 873 (D.C. Cir. 2021).

By statute, CMS must adjust the per-member payment to MA plans to account for their members' demographic characteristics and health status—a process known as "risk adjustment." *See* 42 U.S.C. § 1395w-23(a)(1). "[T]he goal of risk adjustment" is "to pay [MA] plans accurately" relative to the average Medicare beneficiary, 152 Cong. Rec. S438-02 (daily ed. Feb. 1, 2006) (statement of Sen. Grassley), "that is, less for healthier enrollees and more for less healthy enrollees," Medicare Program; Establishment of the Medicare Advantage Program, 70 Fed. Reg. 4588, 4657 (Jan. 28, 2005). Risk adjustment thus ensures that plans with higher-risk populations are not disadvantaged in competing with other MA plans and original Medicare. And by eliminating financial incentives favoring healthier enrollees, it ensures that MA plans are broadly available to all Medicare beneficiaries.

To perform that payment analysis, CMS calculates relative factors for demographic and disease categories that predict higher than average future health care expenditures. *See* CMS, *Medicare Managed Care Manual*, ch. 7, § 70.1 (2020).[1] Based on those factors, CMS assigns risk scores to each Medicare beneficiary and adjusts the plan's monthly payment amount by

[1] Even on a motion to dismiss, "courts routinely take judicial notice of [agency] guidance documents and documents which are publicly available on the [agency's] website." *Gordon v. Target Corp.*, 2022 WL 836773, at *2 (S.D.N.Y. Mar. 18, 2022); *see, e.g.*, *Sierra Club v. EPA*, 964 F.3d 882, 893 n.9 (10th Cir. 2020); *U.S. ex rel. Streck v. Allergan, Inc.*, 746 F. App'x 101, 108 (3d Cir. 2018); *U.S. ex rel. Gray v. UnitedHealthcare Ins. Co.*, 2018 WL 2933674, at *5 n.3 (N.D. Ill. June 12, 2018). All agency documents cited here are publicly available on the website of the respective agency, as reflected by the URL addresses included in the table of authorities. *Supra* pp. viii-ix. Cigna accordingly requests that the Court take judicial notice of these documents for any proper purpose in deciding its motions to dismiss. Because the Government's complaint relies extensively on many of the same documents, *e.g.*, Doc. No. 178 ¶¶ 67, 77, 79-80, 85, 106, 166, those documents may also be considered "part of the pleadings." *Lewis Lumber & Milling, Inc. v. Mereen-Johnson, LLC*, 2018 WL 6181356, at *2 (M.D. Tenn. Nov. 27, 2018); *see also Bassett v. NCAA*, 528 F.3d 426, 430 (6th Cir. 2008).

multiplying the base amount per member by a combined factor that reflects the overall health of the plan's population as compared to the average Medicare population. *Id*.

To facilitate the development and application of this payment model, MAOs must submit risk-adjustment data from all covered medical encounters with providers, reporting their members' health conditions using diagnosis codes from the International Classification of Disease ("ICD"). *See* 42 C.F.R. § 422.310; 45 C.F.R. §§ 162.1000, 162.1002.[2] An officer or employee of the MAO must also certify annually that the risk-adjustment data it submits to CMS is "accurate, complete, and truthful" to that officer or employee's "best knowledge, information, and belief." 42 C.F.R. § 422.504(*l*).

B. CMS's Longstanding Approval Of In-Home Health Assessments

Health risk assessments ("HRAs") are a required component of annual wellness visits covered by original Medicare. *See* 42 C.F.R. § 410.15. MAOs must make a "best effort to conduct an HRA annually" for their plan members in order to "ensure that the plan and its provider network have the information required for effective and continuous patient care and quality review." *Medicare Managed Care Manual*, ch. 4, § 110.6. Indeed, CMS has long "strongly encourage[d] the use of such tools for wellness and prevention efforts." *Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter* ("*Advance Notice CY 2014*") 22 (Feb. 15, 2013). And as long as the HRA is "conducted as a face-to-face encounter by a provider that is an acceptable risk adjustment provider type (e.g., a physician or nurse practitioner)," CMS has accepted the data for risk-adjustment purposes. *Id*.

[2] During the relevant period, CMS adopted a new version of the ICD. Health conditions were reported before October 2015 using the ninth edition, including *ICD-9-CM Official Guidelines for Coding and Reporting* (2011) ("ICD-9 Guidelines"), and after October 2015 using the tenth edition, including *ICD-10-CM Official Guidelines for Coding and Reporting* ("ICD-10 Guidelines") (collectively, "ICD Guidelines"). *See* 45 C.F.R. § 162.1002; Doc. No. 178 ¶ 58.

In 2013, CMS considered excluding diagnoses from HRAs conducted in an MA plan enrollee's home unless confirmed by a subsequent doctor's office visit, citing the very concerns at issue in this case. CMS stated that although "these assessments can contribute to improved care by promoting wellness and prevention," it was "concerned that [they] could be used as a vehicle for collecting risk adjustment diagnoses without follow-up care or treatment being provided." *Id.* CMS, however, continued to allow MAOs to report those diagnoses, stating that it would "propose and finalize a policy" on this issue for payment year 2015. *Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter* 35 (Apr. 1, 2013).

In 2014, CMS again considered the issue more broadly with respect to diagnoses from any home visit, not just in-home HRAs. After meeting with vendors and MAOs "to learn more about industry practices," CMS reported that "generally" MAOs hire vendors to conduct HRAs and other risk assessments in members' homes through health care professionals who are not the member's PCP. *Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter* ("*Advance Notice CY 2015*") 20 (Feb. 21, 2014). It further reported that "[t]he assessments usually involve collecting diagnostic information, reviewing medications, assessing functional status, and identifying opportunities for case management," and that the information is "usually forwarded" to the plan and the PCP, "with suggestions for follow-up visits where appropriate." *Id*. Finally, CMS reported that although clinicians could perform limited "lab tests pertinent to" certain quality measures such as diabetes or chronic kidney disease screenings, "[i]n general, treatment [was] not a component of these risk assessments." *Id*.

CMS pointed out that "[i]f medication management is improved and hospitalizations are avoided" through home visits, then "beneficiaries receive better quality of care and MA

organizations face reduced costs of care." *Id*. But CMS noted "little evidence" that "the care subsequently provided to beneficiaries is substantially changed or improved as a result of the assessments." *Id*. Starting in 2014, CMS thus required MAOs to "flag" diagnoses from home visits upon submission into CMS's risk adjustment processing system, so that CMS could study the issue further. *Announcement CY 2016* at 144. Upon further study, CMS then chose in 2015 to *allow* MAOs to continue submitting diagnoses from in-home health assessments. It explained that in-home assessments "can have significant value as care planning and care coordination tools," because "[i]n the home setting, the provider has access to more information than is available in a clinical setting" about risks due to the member's living situation, and such information can "support care planning and care coordination" and "lead to improved enrollee health outcomes." *Id*. at 145-46. CMS accordingly issued guidance on recommended "best practices" to promote those clinical goals. *Id*.

CMS has adhered to this position even in the face of objections like those raised by Cutler and the Government here. In 2016, for example, the Medicare Payment Advisory Commission ("MedPAC")—an agency that advises Congress on issues affecting Medicare, *see* 42 U.S.C. § 1395b-6—recommended that Congress direct CMS to revise the risk-adjustment model to exclude diagnoses from HRAs. *See* MedPAC, *Report to the Congress, Medicare Payment Policy* 352 (Mar. 2016). MedPAC cited CMS's own concerns from 2013 and 2014 that in-home HRAs are performed by third-party vendors and may be "used solely as a diagnosis-collection vehicle," with no clinical follow-up. *Id.* at 350. And MedPAC raised concerns that "diagnoses identified only through HRAs … are often based on enrollee self-reporting or cannot be accurately identified with equipment brought into an enrollee's home." *Id*.

More recently, in 2020, CMS rejected a suggestion by the Office of the Inspector General of the Department of Health and Human Services ("OIG") that CMS should reconsider its

decision to accept diagnoses reported solely from in-home HRAs for risk-adjustment purposes. *See* Grimm, OIG, *Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns* 38-40 (Sept. 2020). In response to OIG, CMS again reiterated that "HRAs are a tool for early identification of health risks to improve beneficiaries' health outcomes" and that "MAOs may submit diagnoses documented in HRAs for risk adjustment." *Id.* at 38-39.

C. In-Home Health Assessments Under Cigna's 360 Program

Through its 360 Program, Cigna tries to ensure that its MA members receive at least once annually a comprehensive "360 exam" that includes an HRA and physical exam. While most 360 exams are performed by the member's PCP in the doctor's office, Cigna contracts with vendors to have licensed clinicians perform the 360 exam in the member's home as needed. For example, the Medicare population includes individuals who are homebound or may not see their PCP in a given year for various reasons, including limited mobility or lack of transportation. The option of an in-home exam helps ensure access to annual HRAs and physicals for all members.

During the relevant period, Cigna contracted with Texas Health Management ("THM"), Alegis Care Services ("Alegis"), and Examination Management Services, Inc. ("EMSI"), among others, to conduct 360 exams in members' homes.[3] These exams, called "360 Comprehensive Assessments," were performed in exchange for a fixed fee, with similar fees for additional health screenings and immunizations administered at the time of the 360 exam. Ex. A at 5. A "360

[3] Attached as exhibits to this memorandum are the contracts between Cigna and Alegis (Ex. A), THM (Ex. B), and EMSI (Ex. C), respectively, and the 360 Comprehensive Assessment Form 2016 (Ex. D). The Government's complaint refers to and relies extensively on these contracts *see, e.g.*, Doc. No. 178 ¶¶ 4, 111, 113-14, 141, 155, as well as the standard 360 form, *see, e.g.*, *id.* ¶¶ 115-18, 140-41, 144-48, 169, which it alleges "was similar in most respects throughout the Relevant Period," *id*. ¶116. The Court may thus consider the attached exhibits "part of the pleadings … on a motion to dismiss." *Lewis Lumber*, 2018 WL 6181356, at *2; *see also Bassett*, 528 F.3d at 430.

Comprehensive Assessment" requires "the face-to-face creation of a comprehensive health assessment" "to review the Member's medical history[,] complete a physical examination, as well as diagnose and suggest care management." Ex. C at 1. Clinicians who conduct 360 exams must have up-to-date state medical licenses and be of a provider type that CMS accepts "for purposes of risk adjustment." *Id*. at 1, 3-4, 13-14, 16. And they must conduct the exam "in a manner that complies with applicable federal, state and local laws and regulations, including those promulgated by … CMS and any state licensing boards as well as any applicable ethical standards." *Id*. at 16.

Under the contracts, clinicians were required to document the encounter on a standard 360 form approved by Cigna. *Id*. at 1. A "completed" 360 form must include, "at a minimum," "clinical support" for all reported diagnoses, a "treatment plan," and the clinician's signature and credentials. Ex. A at 3. The standard 360 form, in turn, contains sections for the clinician to fill out any diagnosis for various "Current Conditions" that are common in the Medicare population, as well as a section for "any diagnoses, not already noted under current conditions, which affect patient care, treatment or management." Ex. D at 3-7. In each of those sections, the clinician must select a "Treatment Plan" for any diagnosis from options for "Meds," "Monitor," "Diet," "Labs," and "Referral." *Id*. Before conducting any 360 exam, clinicians must receive training on how to complete the form to ensure that it is "accurate, compliant and complete." *Id*. at 14. And vendors must ensure that their clinicians have all "necessary equipment and tools" to perform the 360 exam, "including but not limited to" a monofilament test, bone density machine, and spirometer to test for neuropathy, osteoporosis, and lung disease, respectively. *Id*. at 16.

In addition to a "comprehensive health exam," the contracts contemplate that clinicians will recommend "preventive health screenings" and provide "health education" or "anticipatory guidance." *Id.* at 1. But because in-home 360 exams, like in-home HRAs, are intended to

inform—not replace or interfere with—ongoing care management by the member's PCP, the clinician performing an in-home 360 exam could not provide non-emergency medical care and was instead directed to communicate any recommendations regarding treatment or medication to the member's PCP and the plan. *Id*. at 3.

D. Procedural History

1. Cutler's *qui tam* complaint

In January 2017, THM filed an arbitration action against Cigna contesting payment terms for 360 exams. *Texas Health Mgmt. LLC v. HealthSpring Life & Health Ins. Co., Inc.*, 380 F. Supp. 3d 580, 583 (E.D. Tex. 2019). The arbitration—ultimately won by Cigna—was contentious. *See, e.g.*, *id*. at 585. And in the midst of it, in October 2017, THM's general counsel and part owner Robert Cutler filed this *qui tam* action under seal. In June 2019, Cutler filed an amended complaint. *See* Doc. No. 12.

Parroting criticisms of in-home HRAs that had been leveled against the entire MA industry, Cutler's complaint asserts three broad sets of supposed FCA violations. First, Cutler alleges that "[a]ll diagnosis codes derived from in-home 360 assessments" were "ineligible for submission to CMS" and "false" under the FCA because, he alleges, these assessments were designed to be a "data-gathering exercise rather than a legitimate medical encounter." *Id*. ¶ 56.

Second, Cutler claims that Cigna pressured vendors "to record on 360 forms" complex health conditions that he alleges the vendors' clinicians "lacked or were denied the tools and the means necessary to diagnose." *Id*. ¶ 57. And he alleges that it was "impossible" for "generalist" clinicians like nurse practitioners to diagnose "most risk-adjusting conditions" in the context of a 360 exam conducted in the member's home. *Id*. ¶ 59.

Finally, Cutler alleges that the diagnoses from in-home exams that Cigna reported to CMS lacked support in the medical record and were based on patient self-reports, prior history,

or medication use, purportedly in contravention of CMS coding rules. *Id*. ¶¶ 85-89.

2. The Government's complaint-in-intervention

In January 2022, after investigating Cutler's allegations for more than four years and expressly declining to intervene on Cutler's first theory, the Government moved to partially intervene. Doc. No. 157 at 1. On October 14, 2022, the Government filed its complaint-in-intervention. Doc. No. 178.

The Government alleges that Cigna submitted "false and invalid diagnoses of certain serious and chronic medical conditions that were based solely on forms completed during visits to patients' homes conducted by vendors." *Id*. ¶ 1. It alleges that these conditions—which include "chronic kidney disease, congestive heart failure, rheumatoid arthritis, and diabetes with renal complications," *id*. ¶ 7—could not be reliably diagnosed in the home because they require "extensive diagnostic testing or imaging" that the Government says clinicians "did not have," *id*. ¶ 5. The Government does not assert, however, FCA claims against any provider or otherwise assert that any provider acted in bad faith.

Instead, the Government questions Cigna's motives for arranging for in-home exams as part of the 360 program, alleging that "one of its goals" was to generate revenue by identifying diagnoses not previously submitted by another provider. *Id*. ¶ 105-06. The Government further alleges that Cigna pressured vendors that had low rates of high-value diagnoses compared to "expected disease prevalence" in the population, sent monthly performance reports, and put "underperforming" vendors on "quality improvement plan[s]," all for the purpose of eliminating vendors that did not meet Cigna's expectations. *Id.* ¶¶ 132-38.

Finally, the Government alleges that by reporting diagnoses from in-home 360 exams for the conditions at issue, Cigna knowingly violated the ICD Guidelines, which the Government claims require treatment Cigna prohibited clinicians from providing during the exams. *Id*.

¶¶ 154-55. And it alleges that Cigna's failure to take steps to prevent the submission of diagnoses from in-home 360 exams that were not clinically reliable rendered senior executives' annual attestations—that Cigna's data was accurate—false. *Id*. ¶¶ 159-65.

STANDARD OF REVIEW

"To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quotation marks omitted). "Moreover, factual allegations that are merely *consistent* with the defendant's liability do not satisfy the [plaintiff's] burden, as mere consistency does not establish *plausibility* of entitlement to relief, even if it supports the *possibility* of relief." *ARJN #3 v. Cooper*, 517 F. Supp. 3d 732, 740 (M.D. Tenn. 2021). FCA claims must also satisfy the heightened pleading standard of Rule 9(b), which requires a party to "state with particularity the circumstances constituting fraud," Fed. R. Civ. P. 9(b), and to allege, "at a minimum, … the time, place, and content of the alleged misrepresentation …; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud." *U.S. ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 342 F.3d 634, 643 (6th Cir. 2003) (quotation marks omitted).

ARGUMENT

I. THE GOVERNMENT'S COMPLAINT-IN-INTERVENTION SHOULD BE DISMISSED IN FULL FOR FAILURE TO STATE A CLAIM

To plead a claim under the False Claims Act, "the plaintiff must sufficiently allege that: (1) the defendant made a false statement …; (2) with scienter; [and] (3) that was material to the Government's decision to make the payment sought." *U.S. ex rel. Prather v. Brookdale Senior Living Communities, Inc.*, 892 F.3d 822, 830 (6th Cir. 2018) (quotation marks omitted). "In most cases, the false claim is alleged to be 'factually false' because it misstates or misrepresents

the amount or quality of goods or services. A claim can also be 'legally false,' however, … 'when the claimant lies about its compliance with a statutory, regulatory, or contractual requirement.'" *U.S. v. SouthEast Eye Specialists, PLLC*, 570 F. Supp. 3d 561, 575 (M.D. Tenn. 2021) (quoting *U.S. ex rel. Greenfield v. Medco Health Sols., Inc.*, 880 F.3d 89, 94 (3d Cir. 2018)). The Government's complaint fails to state a claim under either FCA theory.

A. The Government Has Not Plausibly Alleged That Cigna Knowingly Submitted *Factually* False Claims For Payment

1. The Government has not plausibly alleged factual falsity

The Government's principal allegations of factual falsity—that the members did not have the reported conditions—are that the clinicians hired by Cigna's 360 vendors "generally lacked the equipment necessary to diagnose serious, complex conditions in the home setting," Doc. No. 178 ¶ 114, and the conditions were not reported by any other provider who treated the member during the same year, *id.* ¶ 149. The Government's focus on diagnoses reported solely from an in-home 360 exam in a given year appears intended to suggest that clinicians were improperly diagnosing these complex conditions for the first time without required diagnostic testing. Those allegations singly or together do not establish a plausible inference that licensed clinicians documented conditions that patients did not have, especially where, as in this case, there are no allegations that any clinician acted in bad faith or otherwise recorded a condition the clinician did not sincerely believe the member had.

Here, as the Government itself alleges, "vendors were paid a fixed amount for each home visit," *id*. ¶ 107; *see* Ex. A at 5, rather than an amount per diagnosis, so they did not stand to financially benefit from documenting non-existent conditions. Nor does the Government allege that Cigna asked vendors to fabricate diagnoses. And the contracts the Government relies on in its complaint say the opposite: Cigna required vendors to ensure that clinicians had, and acted in

accordance with, appropriate medical licensure from the state. *See* Ex. C at 16. The Government's allegations that Cigna tracked performance based on code capture and disease prevalence (*see* Doc. No. 178 ¶¶ 132-39) are consistent with legitimate clinical and financial concerns that the 360 exams be conducted in a thorough manner and reflect expected morbidity. None of this creates a plausible inference of falsity. At best, the Government's allegations permit the inference of the "mere possibility of misconduct," which is insufficient to establish any entitlement to relief. *Iqbal*, 556 U.S. at 679; *see U.S. ex rel. Harper v. Muskingum Watershed Conservancy Dist.*, 842 F.3d 430, 438 (6th Cir. 2016) (dismissal was appropriate where plaintiff's claim could "succeed only if the court [made] inference upon inferences to provide the facts missing" (quotation marks omitted)).

The paucity of the Government's allegations here stands in stark contrast to the "factual falsity" theories in *U.S. ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667 (9th Cir. 2018), *U.S. ex rel. Osinek v. Permanente Med. Grp., Inc.*, 2022 WL 16925963 (N.D. Cal. Nov. 14, 2022), and *U.S. ex rel. Ramsey-Ledesma v. Censeo Health, L.L.C.*, 2016 WL 5661644 (N.D. Tex. Sept. 30, 2016). In *Silingo*, the relator—a former compliance officer of a vendor that performed in-home HRAs—filed a *qui tam* action alleging that her employer had tampered with more than half of its assessment forms by using software that violated CMS's signature requirements and allowed edits to the forms to be made after the visit in order to "exaggerate" diagnoses; that the company "systematically fabricated" diagnoses by having examiners and coders recycle prior diagnoses and medical histories; and that the vendor in fact forged records for assessments that never took place. *Silingo*, 904 F.3d at 674-75. The Government alleges nothing of that sort in this case.

In *Osinek*, the Government likewise alleged far more. There, the Government specifically alleged that Kaiser prompted doctors to add non-existent conditions to charts months after the encounters, citing examples where the findings on the original chart directly conflicted

with the new diagnosis. *See* 2022 WL 16925963, at *7. For example, an obesity-related breathing disorder was added for a patient who was 5'9" and weighed 108 pounds. *Id*. Based on those very different facts, the district court determined that the Government had plausibly alleged that the diagnoses were false, but also held that there was "not enough to make out a plausible case" that they "were emblematic of a wider pattern." *Id*. at *8. Indeed, the court determined that the only plausibly alleged scheme was related to "cachexia," a condition Kaiser allegedly pressured doctors in one market into adding "'over *120 times* more'" than in other markets through algorithm-driven queries to the doctors—even though Kaiser's own audits showed a 90 percent error rate for the added diagnoses. *Id*. No such scheme is plausibly alleged in this case.

In *Ramsey-Ledesma*, the district court declined to dismiss a *qui tam* complaint involving similar theories. But in that case, the district court relied on the relator's "personal observations" of alleged intentional fraud by a vendor. 2016 WL 5661644, at *6. The Government has made no such allegation against any vendor here. More importantly, as the district court explained, the relator there alleged that the diagnoses were false precisely because they "were not based on any diagnosis by a doctor, but instead were created by non-physician coders drawing medical conclusions from the completed assessment forms." *Id*. at *7. In other words, the alleged falsity was "not merely diagnosing high-risk conditions in the absence of laboratory tests that other doctors, in the exercise of their professional judgment, may deem necessary for a diagnosis, but rather that they did so without any physician involvement at all." *Id*. Again, the Government has not alleged "the absence of *any* professional medical diagnosis" here. *Id*. To the contrary, it claims that there was simply no support *beyond* the clinician's diagnosis. *See* Doc. No. 178 ¶ 147.

Nor does the Government point to anything on the form *contradicting* the diagnosis recorded by the medical professional. The only allegation that could be construed as even

remotely involving a contraindication is a passing reference to a specific clinician's diagnosis of congestive heart failure despite an annotation from the physical exam that the patient's heart was "regular and normal" and "cardiac [was] reviewed and unremarkable." *Id.* ¶ 148 (quotation marks omitted). But even in that single example, the obvious alternative explanation is that the patient was already being treated for congestive heart failure at the time of the 360 exam and the condition was being controlled by medication. The inference of bad faith or incompetence is far less plausible than this innocent inference, even from the Government's sole example.[4]

While the Government identifies one instance in which a Cigna coding and performance manager raised a concern about a clinician diagnosing chronic kidney disease "for the first time in the home setting," Doc. No. 178 ¶ 165, there is no suggestion that clinicians were being pressured by Cigna to do so, that there was a pattern of incompetence or malfeasance by vendors' clinicians, or that any internal or external audits showed high error rates with respect to diagnoses reported solely from in-home 360 exams, so as to raise broader concerns. The Government's own allegations regarding this example indicate the opposite—that Cigna asked the vendor to "make sure" its clinicians were "*not* diagnosing [chronic kidney disease] for the first time in the home setting," *id*. (emphasis added).

[4] The Government alleges that the lack of a report by another provider in the same year "casts further doubt on the truth … of these diagnoses." *Id*. ¶ 149. Yet after raising "concerns" about that very fact pattern, CMS expressly chose to allow MAOs to submit diagnoses that are reported only from an in-home exam in a given year. *See supra* pp. 6-7; *Announcement CY 2016* at 144-45. CMS has also directed MAOs to "submit each required diagnosis at least once during a risk adjustment period," explaining that even if a condition is "managed by ongoing medication" or "may not impact every minor healthcare episode," these conditions should be assessed at some point in the year as part of a review of the member's "general health status." CMS, *2008 Risk Adjustment Data Technical Assistance Participant Guide* § 6.4.1. Together, this guidance makes clear that a diagnosis reported from an in-home exam is no less valid and may be critical in ensuring that a plan has complete data about the health status of its members each year. The inference the Government asks the Court to draw—that a diagnosis reported solely from an in-home exam is false—squarely conflicts with that guidance.

To infer based on the allegations in the complaint that in-home 360 exams somehow regularly yielded false diagnoses would require a series of increasingly far-fetched assumptions, including that thousands of health care professionals would deliberately make up false diagnoses at the risk of losing their medical licenses, just to ensure that their employers would retain Cigna's business. Indeed, the obvious alternative explanation, which the Government "does not rule out," *Integra Med Analytics LLC v. Providence Health & Servs.*, 854 F. App'x 840, 844-45 (9th Cir. 2021) (Boggs, J.), is that members were *not* being regularly diagnosed with a complex condition for the first time during the home visit, but rather the clinician was properly diagnosing an ongoing condition based on patient self-reporting, review of medications, and physical examination findings. That a diagnosis reported in one encounter is not reported from other encounters in the same year is consistent with both CMS's risk-adjustment requirements and obvious, non-fraudulent explanations, including that the condition did not require care other than medication during the year. Even if the member was seen by other providers, they may not have reported the diagnosis to Cigna for reasons that, again, do not involve fraud, including that the diagnosis was simply not submitted on the provider's claim; the provider was out of network or a Veteran's Affairs facility and thus did not submit a claim to Cigna; or the provider completed the encounter and submitted a claim to a different MA plan or original Medicare before or after the member was enrolled with Cigna. The Government's complaint does nothing to rule out these obvious reasons why a member may be reported to have a diagnosis from an in-home 360 exam for a condition for which the member is either taking medication or under another provider's care, without any report of the same diagnosis from another encounter with another provider.

"As between [those] 'obvious alternative explanation[s]'" for the facts alleged, on the one hand, and the inexplicable pattern of false diagnoses being reported by thousands of medical professionals, fraud is "not a plausible conclusion." *Iqbal*, 556 U.S. at 682. In *Integra*, the Ninth

Circuit in fact reversed a district court's denial of a motion to dismiss a *qui tam* FCA complaint on similar grounds. 854 F. App'x 840. The relator there alleged that Providence Health & Services and its affiliated hospitals coded certain conditions "at a higher rate than most other comparable institutions"; that "this increased rate was not the result of chance or variations in patient populations"; and that Providence and a consultant it hired "incentivized doctors to use language conducive to coding higher-paying secondary diagnoses through their documentation tips and queries." *Id.* at 844. In rejecting the sufficiency of those allegations, the court concluded that it "need not—and cannot—accept" the implication "that doctors recorded unsupported medical conditions" when that fact was "consistent with a plausible alternative (and legal) explanation" that the provider's clinical documentation initiatives were "ahead of … [the] industry." *Id.* at 844-45. The grounds for dismissal of any theory of factual falsity are much stronger here, where the Government does not even allege that Cigna's in-home 360 exams yielded diagnosis coding at rates that were anomalous relative to the average morbidity of the local population.

The allegations regarding the design of the 360 forms likewise offer no plausible basis to infer factual falsity. The Government does not allege that a diagnosis was lacking for any patient. It alleges only that the diagnosis itself was "[o]ften, the only 'support' in the 360 form." Doc. No. 178 ¶ 147; *see id.* ¶ 169a-e ("the information recorded in the 360 form for this visit does not support or substantiate the diagnosis"). But the diagnosis itself is the medical professional's "statement that the patient has a particular condition," which CMS deems "sufficient" to code and report the condition. ICD-10 Guidelines § I.A.19.

2. The Government has not plausibly alleged scienter

Even had the Government plausibly alleged that clinicians conducting in-home 360 exams were documenting non-existent conditions—which it has not—such a theory still would

have to be dismissed because the Government fails to adequately plead scienter as to any factually false submissions. The FCA imposes liability only where the defendant acts "knowingly," which the statute defines to cover "actual knowledge of the information," as well as "deliberate ignorance" or "reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(a)(1), (b)(1). The Government's allegations do not establish reckless disregard of the truth or falsity of any diagnoses, much less actual knowledge of false diagnoses.

The Government points to Cigna's guidance to clinicians regarding conditions like rheumatoid arthritis to claim that Cigna knew that diagnosing these conditions required specialized tests that it also knew its vendors did not have and could not order. *See* Doc. No. 178 ¶ 142-46. Those allegations rest on a doubly flawed premise. First, the Government perversely assumes that Cigna knew its vendors lacked equipment from the list of equipment it required them to have. But the contracts the Government cites define "Provider Equipment" to mean "the necessary equipment and tools to perform" 360 exams. Ex. C at 16. The "twelve-item list" of "equipment" (Doc. No. 178 ¶ 114) was obviously a floor, not a ceiling, as evidenced by the parties' use of the words "including but not limited to" before that list. Ex. C at 16; *see Curtis v. Cenlar FSB*, 654 F. App'x 17, 19 (2d Cir. 2016) ("[T]he phrase 'including, but not limited to' obviously signals that the list … is illustrative, not exhaustive."). The only reasonable inference from that contractual language is that vendors were required to supplement that list as necessary—not (as the Government claims) that Cigna knew clinicians did not have necessary equipment in any given in-home encounter.

Second, the Government does not plausibly allege that Cigna had reason to believe that thousands of clinicians were violating standards of medical practice during in-home exams when the contract itself required them to comply with those standards. Ex. C at 16. It is not reckless

for Cigna to rely on the contractual commitments of its vendors and the professional obligations of trained and licensed clinicians.

The Government alleges that "Cigna's coders acted with reckless disregard for the truth or falsity of these diagnoses when assigning ICD codes to them despite the lack of supporting clinical information on the forms." Doc. No. 178 ¶ 147. But that claim is flatly inconsistent with guidance on which the Government relies. Under the ICD-10 Guidelines (discussed more below, *infra* pp. 24-28) "[t]he provider's statement that the patient has a particular condition is *sufficient*." ICD-10 Guidelines § I.A.19 (emphasis added). The Government concedes that the 360 forms had the diagnosis marked for each of the conditions that Cigna reported to CMS. Doc. No. 178 ¶ 147. The ICD-10 Guidelines do not require supporting clinical information. In fact, they require no documentation of clinical reasoning because diagnosis coding is "not based on clinical criteria used by the provider to establish the diagnosis." ICD-10 Guidelines § I.A.19. That should be the end of the inquiry. Moreover, as already explained, the Government does not allege that any clinical finding on the 360 form conflicts with the diagnosis the clinician documented. *See supra* pp. 15-16. Thus, the inference the Government is asking this Court to draw—that coders who are not typically clinicians themselves knew that members did not have the conditions the clinicians said the members had—is not reasonable.

The Government alleges that Cigna had access to claims data showing that the diagnoses were not reported by other providers in the same year. Doc. No. 178 ¶ 150. But the Government does not plausibly allege that Cigna knew any in-home diagnosis was "new" based on that data alone, as the Government does not allege Cigna's data from network providers reflected all diagnoses in the underlying medical records or from members' prior health plans, other payers, or out-of-network providers such as Veterans Affairs facilities that do not bill Cigna.

Finally, the Government suggests that Cigna acted recklessly in designing a single form for both in-office and in-home 360 exams, quoting emails from members of its compliance staff who raised general concerns about "'the quality of new diagnoses' from 360 home visits" and floated the possibility that if Cigna were not limiting the conditions that could be identified, it should filter out "conditions that 'should never be diagnosed in the home'" before submitting the diagnoses to CMS. Doc. No. 178 ¶¶ 162-63. But the Government does not allege that anyone at Cigna had identified either a list of conditions for which "new" diagnoses from in-home 360 exams should be filtered or determined circumstances sufficient to identify such diagnoses as truly "new." Moreover, both quotations from Cigna staff members date from "late 2011 or 2012," *id*.—that is, before CMS studied the issue, required MAOs to include a source flag showing any submissions from in-home exams, and chose expressly to allow such submissions, without limit on the categories of conditions that could be reported. Taken together, all that these allegations suggest are possible steps Cigna could have taken to potentially avoid clinical errors by providers; they do not explain why MA plans should second-guess their providers' clinical assessment of patients without any evidence of fraud or incompetence. Even if there *were* resulting errors in the diagnoses—which the Government has not plausibly alleged—that would establish, "at most," that Cigna "was negligent, which is not sufficient to attach liability under the FCA." *U.S. ex rel. Johnson v. Kaner Med. Grp., P.A.*, 641 F. App'x 391, 394-95 (5th Cir. 2016).

In any event, the Government ultimately fails to plead any reason Cigna could not rely on its vendors' contractual obligations and their licensed clinicians' standards of medical practice. The Government attempts to fill the logical gaps in its theory by pointing to the financial interest Cigna had in reporting diagnosis codes for members from in-home exams, *see* Doc. No. 178 ¶¶ 125-130, and it alleges that Cigna used data analysis to identify members most likely to have

unreported chronic conditions so that a home visit would result in a "significant boost" in payments, *id*. ¶ 108. But under the MA payment model, plans bear the financial risk for the care needed by their members and thus have every incentive to ensure that conditions are identified early so that they can be appropriately managed and addressed. And plans must document a member's diagnoses every year, or they will not be paid properly for that member's health status the next year; even for chronic conditions reported in prior years that do not go away, a plan will not be paid for the higher expected costs of caring for that member if the provider treating that condition fails to document the condition for whatever reason. CMS, *2008 Risk Adjustment Data Technical Assistance Participant Guide* § 6.4.1. At most, therefore, these allegations reveal that Cigna had a motive to be paid appropriately for the expected costs of providing health care coverage for its members in light of the structure of the MA payment model, a motive shared by every MAO with respect to every patient and every encounter. No inference of improper intention can plausibly be drawn.[5]

B. The Government Has Not Plausibly Alleged That Cigna Knowingly Submitted *Legally* False Claims For Payment

Lacking any plausible claim that clinicians routinely documented conditions members did not have, the Government's complaint relies alternatively on a theory that Cigna's claims for payment were "legally false," because Cigna supposedly misrepresented its compliance with

[5] Even on a motion to dismiss, the court may consider regulations beyond those cherry-picked by the Government. And the star ratings that CMS uses to measure MAOs' performance under their contracts create significant financial incentives to ensure that members' chronic condition are properly "[m]anaged." 42 C.F.R. § 422.166(b)(1)(ii); *see U.S. v. Aetna Inc.*, 240 F. Supp. 3d 1, 13 (D.D.C. 2017) (explaining star ratings' competitive effects). CMS's quality measures during the relevant period included the percent of plan members diagnosed with rheumatoid arthritis taking an anti-rheumatic drug and the percent of members with diabetes receiving annual retinal exams and kidney and blood screenings. *See, e.g.*, CMS, *Medicare 2019 Part C & D Star Ratings Technical Notes* 37-42. Were financial motives relevant, the Government's theory would make no sense because it relies on MAOs' incentives to report conditions but ignores the incentives to ensure treatment and the substantial financial hit and competitive disadvantage an MAO risks if it fails to do so. *Aetna*, 240 F. Supp. 3d at 13.

either the ICD Guidelines or CMS's data-attestation requirement. To state a claim based on that theory, the Government must allege facts sufficient to show that Cigna "knowingly violated a requirement" it knew was "material to the Government's payment decision." *Universal Health Servs., Inc. v. U.S. ex rel. Escobar*, 579 U.S. 176, 181 (2016).

That theory fails at each step. First, the Government does not plausibly allege that Cigna violated any legal requirement. Indeed, the Government misconstrues the relevant legal requirements. Second, the Government cannot establish that any violation was knowing or reckless because Cigna's interpretation of the legal requirements was at least "objectively reasonable," and there was no authoritative guidance to the contrary. *U.S. ex rel. Purcell v. MWI Corp.*, 807 F.3d 281, 288 (D.C. Cir. 2015). Finally, the Government has not adequately pled that Cigna knew any violation was material to the Government's payment decision. To the contrary, CMS's decision to allow MAOs to continue reporting diagnoses from in-home assessments despite "actual knowledge" of the facts alleged here is "very strong evidence" that any violation of these requirements was *not* material. *Escobar*, 579 U.S. at 195.

1. The alleged facts do not violate any legal requirement

The Government's core allegation of falsity in this case is that clinicians hired by Cigna's vendors to conduct 360 exams in members' homes documented "diagnoses of certain serious and chronic medical conditions" without performing "the testing, imaging, or other diagnostic steps necessary to reliably diagnose these conditions." Doc. No. 178 ¶ 1. But the Government identifies no legal requirement that these tests be performed before an MAO can report such a diagnosis to CMS. Instead, the Government alleges that—independent of whether the member had the condition—reporting conditions that are clinically unreliable in this way violates (1) the ICD Guidelines and (2) the annual attestation that MAOs submit to certify the accuracy of their

data. Neither the ICD Guidelines nor the data-attestation requirement, properly construed, is at all implicated by the alleged facts of this case.

a) ICD Guidelines

Failing to identify an actual statute or regulation setting forth any diagnostic requirements for conditions reported to CMS, the Government attempts to shoehorn such requirements into the ICD Guidelines. But its interpretations stretch each of the provisions it cites well past the breaking point.

The Government alleges that Cigna violated the ICD Guidelines' prohibition on "coding questionable diagnoses" because, it asserts, the clinicians' failure to perform "the testing, imaging, or other diagnostic clinical steps necessary to establish those diagnoses" rendered the conditions that Cigna reported to CMS "merely suspected or probable." Doc. No. 178 ¶ 156 (citing ICD-10 Guidelines § IV.H; ICD-9 Guidelines § IV.I). But the text of the provision contradicts the Government's gloss. It states: "Do not *code* diagnoses *documented* as 'probable', 'suspected,' 'questionable,' 'rule out,' 'compatible with,' 'consistent with,' or 'working diagnosis' or other similar terms indicating uncertainty." ICD-10 Guidelines § IV.H (emphasis added). It thus relates only to properly interpreting the provider's notes from the encounter. It has nothing to do with a provider's use of particular tests to establish the diagnosis.

Indeed, the ICD-10 Guidelines elsewhere provide in no uncertain terms:

> The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is *not* based on clinical criteria used by the provider to establish the diagnosis.

Id. § I.A.19 (emphasis added). And that makes sense because the ICD Guidelines focus on diagnosis *coding and reporting*; they are not intended as a substitute for the provider's clinical judgment that a condition is present.

The Government's reliance on § IV.H is therefore misplaced. That provision would be relevant only if the Government had alleged an ambiguity in the documentation due to the provider's use of words like "probable" or "suspected" before the diagnosis. But the Government's own allegations concede that the clinician checked the box for the diagnosis, thereby leaving no similar ambiguity. *See* Doc. No. 178 ¶¶ 147, 158.

The Government alleges that, in any event, the ICD Guidelines impose a separate requirement of "complete documentation in the medical record." *Id*. ¶ 157 (quoting ICD-10 Guidelines at 1). And it alleges that Cigna's coders violated that requirement by assigning codes in instances where there was "little more than a checked box to indicate a condition was purportedly assessed." *Id*. ¶ 158. But the only elaboration on this supposed requirement in the complaint is that "the documentation should describe the patient's condition, using terminology which includes specific diagnoses, as well as symptoms, problems, or reasons for the encounter." *Id*. ¶ 83 (quoting ICD-10 Guidelines at 112). The Government identifies no provision requiring clinical tests or findings to be documented before a diagnosis can be coded and reported. And any such requirement would conflict with § I.A.19's unequivocal statements that coding is based on the provider's diagnosis, not on clinical tests used to establish it.

Finally, the Government claims that Cigna's submission of codes from in-home 360 exams violated a purported requirement of the ICD Guidelines that "[t]he diagnoses … affect patient care treatment, or management during the home visit." Doc. No. 178 ¶ 13. And the Government alleges that "[t]he ICD Guidelines do not permit reporting a code to 'confirm' a previously made diagnosis" unless the condition "affect[ed] patient care, treatment, and management *during the visit*." *Id*. ¶¶ 79-80, 154-55 (emphasis added). That interpretation rewrites the provision of the ICD Guidelines the Government cites, seeking to impose coding

requirements that are fundamentally at odds with the provision's text, surrounding provisions, CMS guidance, and case law interpreting the provision.

Titled "Code all documented conditions that coexist," the provision here reads in full:

> Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

ICD-10 Guidelines § IV.J; ICD-9 Guidelines § IV.K.[6] The plain text refutes the Government's assertions that this provision requires treatment "during the home visit" (Doc. No. 178 ¶¶ 13, 154). The phrase "at the time of the encounter" appears only in the first clause of the sentence and applies only to the fact that the condition coexisted at that time. The fact that the condition may "affect patient care, management or treatment" is not limited to the encounter and requires only that the coder exercise judgment that the "documented condition" does "affect patient care," whether or not treatment was administered and documented at the visit. This is consistent with CMS's guidance, which permits coding conditions documented during in-home HRAs while acknowledging that "[i]n general, treatment is not a component of these risk assessments." *Advance Notice CY 2015* at 20.

The Government also relies on the preceding section of the ICD Guidelines, which states that "[c]hronic diseases treated on an ongoing basis may be coded and reported as many times as the patient *received treatment and care* for the condition(s)." Doc. No. 178 ¶¶ 80, 154 (quoting ICD-10 Guidelines § IV.I; ICD-9 Guidelines § IV.J). That provision, on its face, is not restrictive. It encourages coding a chronic condition for multiple encounters because it may be

[6] The comma between "patient care" and "treatment or management" was added to the ICD-10 Guidelines in 2022. Although it does not appear in earlier releases of the ICD-10 Guidelines quoted by the Government, *see, e.g.*, Doc. No. 178 ¶¶ 80, 154-55, the added comma appears merely to correct a grammatical oversight.

treated in multiple encounters. It does not say that chronic conditions may never be coded from other encounters in which the condition was specifically assessed but not necessarily treated. And surrounding provisions make clear that all existing conditions the provider assessed during the encounter should be coded, not just the potentially much smaller subset involving medical intervention during the visit. The very next provision after ICD-10 Guidelines §§ IV.I and J, for example, which covers "[p]atients receiving diagnostic services only," requires the coder to "code any confirmed or definitive diagnosis(es) documented"; it makes no mention of care or treatment as additional prerequisites. *Id*. § IV.K. Likewise, the specific provision governing health screenings like HRAs and annual wellness visits states that a condition "discovered during the screening … may be assigned as an additional diagnosis." *Id*. § I.C.21.c.5; *see id*. § IV.Q (cross-referencing § I.C.21). All of that is consistent with the general rule that "[t]he provider's statement that the patient has a particular condition is *sufficient*." *Id*. § I.A.19 (emphasis added).

CMS guidance also confirms that common-sense reading. As CMS has explained to MAOs, "[c]o-existing conditions" that should be coded under this provision "include chronic, ongoing conditions" like "diabetes" and "congestive heart failure" that are "generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly." CMS, *2008 Risk Adjustment Data Technical Assistance Participant Guide* § 6.4.1. Likewise, such conditions include "ongoing conditions" like "rheumatoid arthritis," even though they "may not impact every minor healthcare episode." *Id*. CMS's expectation is that MA members will "have their general health status evaluated" at least once annually, and that all of these conditions "would be part of a general overview of the patient's health," so that the "diagnoses would be documented and reportable at that time." *Id*.

At least one district court has already adopted this interpretation, rejecting arguments similar to the Government's that a condition cannot be coded and reported to CMS unless "the

patient received treatment for that condition in the preceding year." *U.S. ex. rel. Rasmussen v. Essence Grp. Holdings Corp.*, 2020 WL 4381771, at *6 (W.D. Mo. Apr. 29, 2020). The relator in that case argued that the ICD Guidelines require "documentation in the patient's medical record that … *the diagnosis was treated or affected treatment*." Doc. No. 88 at 13, No. 6:17-cv-3273 (W.D. Mo. Feb. 21, 2020). In support, he quoted the same language the Government has relied on here. *See id*. at 14-15 ("*require or affect patient care, treatment or management*"). But the court construed that provision to mean only "that conditions should not be coded if they 'no longer exist,'" not that "treatment" is required. 2020 WL 4381771, at *7. Under the ICD Guidelines, the court explained, the "provider's diagnostic statement that the condition exists" is dispositive. *Id*. (citing ICD-10 Guidelines § I.A.19). And the court characterized relator's position as "inconsistent with how [the MA program] works," because MAOs are paid prospectively based on health status; "[i]f a patient has a medical condition, there is the possibility that treatment will be needed in the ensuing year—even if no treatment was needed in the *prior* year." *Id*. at *6 n.10 (emphasis added). The court said it would therefore "expect a clearer regulation" "if a medical condition cannot be coded unless it has been treated within the past year." *Id*.

In sum, the Government has not plausibly alleged any violation of the ICD Guidelines, properly construed. Its allegations that clinicians did not do required testing, did not document clinical support, and did not treat the patient, do not state a claim for any legal falsity premised on non-compliance with coding requirements. To the contrary, the ICD Guidelines direct coders to do exactly what the Government alleges Cigna's coders did here: code the conditions that the clinician assessed and documented on the 360 form.

b) Data-attestation requirement

The Government alleges that the submission of diagnoses from in-home 360 exams also violated Cigna's obligation to "certify (based on best knowledge, information, and belief) that the [risk-adjustment] data it submits under § 422.310 are accurate, complete, and truthful." 42 C.F.R. § 422.504(*l*)(2). It alleges that Cigna had access to data showing that no other provider reported the same diagnosis in the same year or, "in some instances," for a year or two years after the visit, and it alleges that Cigna knew that vendors' clinicians "had not performed or ordered testing and other diagnostic steps necessary to reliably make such diagnoses" and that the 360 forms "did not support" those diagnoses. Doc. No. 178 ¶¶ 150-151. The Government claims that Cigna's annual data attestations were false as a result. *See, e.g.*, *id.* ¶ 140.

CMS has interpreted the data-attestation requirement, however, *not* to reach the type of allegations regarding clinical decision-making the Government relies on here. To the contrary, as CMS explained in first promulgating this requirement, an MAO's annual attestation of its risk-adjustment data is "restricted … to confirmation of the completeness of the data and the accuracy of *coding*." 65 Fed. Reg. 40170, 40251 (emphasis added). CMS recognized that a broad attestation could otherwise be a "legal trap," and it limited the requirement to two things MAOs "are, or should be, in the position to know." *Id*. In this context, CMS has thus construed "accuracy" to mean *coding* accuracy, which requires only that "[t]he diagnosis must be coded according to" the ICD Guidelines. *Medicare Managed Care Manual*, ch. 7, § 40. Nothing in the rulemaking purports to require MAOs to second-guess the clinical judgment of licensed medical professionals. And the ICD Guidelines say the opposite—that coding depends only on "the provider's diagnostic statement," not on the "clinical criteria used by the provider to establish the diagnosis." ICD-10 Guidelines § I.A.19.

Nor can the data-attestation requirement be construed to prohibit MAOs from submitting diagnoses from in-home exams just because other providers have not reported the same diagnoses from other encounters. The ICD Guidelines, which CMS has adopted for purposes of coding accuracy, focus on proper coding based on the medical record. They do not require MAOs to adjudicate among providers or ignore diagnoses from one encounter on the ground that they were not substantiated by other encounters. As discussed, CMS chose to permit MAOs to report diagnoses for which the sole source is an in-home exam after expressly considering excluding such diagnoses and requiring evidence of treatment. *See supra* pp. 6-7.

Properly understood, the attestation requirement therefore does no more than reiterate CMS's expectation that MAOs will make "best efforts" to ensure that their risk-adjustment data is complete and that the diagnoses reported to CMS are accurately coded. 65 Fed. Reg. at 40251, 40312. For the reasons already discussed, the Government has not plausibly alleged that any of its patient examples violated the ICD Guidelines. *See supra* pp. 24-28. Nor has it plausibly alleged that Cigna failed to undertake "best efforts" to ensure compliant coding.[7]

2. The Government cannot establish scienter

The Government's legal-falsity theories must be dismissed independently because the Government has not plausibly alleged that any violation of the above requirements was reckless, much less knowing. "Disputes as to the interpretation of regulations do not implicate False Claims Act liability." *U.S. ex rel. Swafford v. Borgess Med. Ctr.*, 24 F. App'x 491, 2001 WL

[7] The Government cites CMS's requirement that MAOs implement an effective compliance program. *See* Doc. No. 178 ¶¶ 87-90 (citing See 42 C.F.R. § 422.503(a)). But the complaint contains no particularized allegations that Cigna violated that requirement. As the Government explains, that requires procedures for monitoring and promptly responding to compliance issues. *Id*. But the Government nowhere alleges that Cigna did not satisfy those requirements, that it was aware of an alleged deficiency in its compliance program, or that the deficiency was material to CMS's payment decision—each of which is required to state a plausible claim for any theory premised on Cigna having violated this regulation.

1609913, at *1 (6th Cir. 2001) (per curiam) (citing *Hagood v. Sonoma Cnty. Water Agency*, 81 F.3d 1465, 1477 (9th Cir. 1996)). In adjudicating claims of legal falsity, other circuits and district courts have applied the scienter framework set forth in *Safeco Insurance Co. of America v. Burr*, 551 U.S. 47 (2007), which addressed "willful" violations of the Fair Credit Reporting Act. *U.S. ex rel. Schutte v. Supervalu Inc.*, 9 F.4th 455, 465 (7th Cir. 2021) (collecting cases). As the Seventh Circuit has explained, *Safeco* interpreted "willfully" to encompass the same common-law mental states—"knowingly" and "reckless disregard"—that Congress used in the FCA. *Id.* Courts have therefore applied this "objective scienter" framework to FCA claims of legal falsity, where the plaintiff must establish that any violation of a statutory, regulatory, or contractual requirement was "knowing" or "reckless." *Id.*[8]

Under that framework, a defendant is not liable under the FCA for non-compliance with legal requirements "as long as its interpretation of the relevant [law] was objectively reasonable and no authoritative guidance warned the defendant away from that interpretation." *U.S. ex rel. Proctor v. Safeway, Inc.*, 30 F.4th 649, 652-53 (7th Cir. 2022). All of that is true here and compels dismissal of the Government's complaint.

First, although Cigna believes its readings of the ICD Guidelines and data-attestation regulation are correct for the reasons above, those reasons show, at a minimum, that the legal obligations the Government now seeks to enforce under the FCA were ambiguous and Cigna's interpretations were objectively reasonable. *Supra* pp. 24-30. With respect to the ICD Guidelines, § I.A.19 explicitly states that the provider's diagnostic statement is "sufficient," and

[8] The Sixth Circuit has not yet addressed this issue. In *Schutte*, the Seventh Circuit noted, at the time correctly, that "[e]very other circuit court" to have addressed the issue agreed that "*Safeco*'s scienter standard" applies to the FCA. 9 F.4th at 465. Since *Schutte*, an equally divided Fourth Circuit, sitting en banc, affirmed a district court's judgment applying *Safeco* to FCA claims. *See U.S. ex rel. Sheldon v. Allergan Sales, LLC*, 49 F.4th 873, 874 (4th Cir. 2022). A petition for certiorari in *Schutte* is currently pending before the Supreme Court. *See* Pet., *Schutte*, No. 21-1326 (U.S. Apr. 1, 2022).

that coding is not based on clinical criteria. The clause the Government relies on ("require or affect patient care, treatment or management") requires only that coexisting conditions should be coded if they were assessed by the provider as current conditions. And that reading was adopted by at least one district court confronted with a similar argument in *Rasmussen*. Cigna's reading thus has the same indicia of objective reasonableness identified in *Safeco* itself—"a foundation in the … text" and "a sufficiently convincing justification to have persuaded" at least one district court "to adopt it." 551 U.S. at 69-70. Likewise, Cigna's interpretation of the data-attestation requirement in 42 C.F.R. § 422.504(*l*)(2) is rooted in CMS's own statement in the rulemaking that accuracy is limited to *coding*. *See* 65 Fed. Reg. at 40251.

Second, there was no authoritative guidance warning Cigna away from its readings of the ICD Guidelines or the data-attestation requirement. Authoritative guidance generally requires "binding precedent from the court of appeals or appropriate guidance from the relevant agency." *Proctor*, 30 F.4th at 659. Moreover, any authoritative guidance "must have a high level of specificity to control an issue." *Schutte*, 9 F.4th at 471. Unlike "interpretive" issues about the objective reasonableness of Cigna's reading of these requirements—which are purely "legal questions"—the existence of authoritative guidance warning Cigna away from its interpretations presents a "factual question." *Purcell*, 807 F.3d at 288-89. But the Government does not allege *any* facts from which it would be reasonable to infer that MAOs were ever warned that they must second-guess providers' clinical assessments of their patients rather than accurately code and report to CMS the results of those assessments. The documents the Government cites—CMS's annual advance notices and announcements of MA policies, *see* Doc. No. 178 ¶ 166—state that CMS specifically considered requiring evidence of treatment for diagnoses from in-home exams but then chose *not* to require that. *See supra* pp. 6-7.

As the Supreme Court has instructed, "strict enforcement" of the FCA's "rigorous" scienter requirement is necessary to avoid "concerns about fair notice and open-ended liability." *Escobar*, 579 U.S. at 192. Those concerns are particularly acute where, as in Medicare, parties are "subject to thousands of complex statutory and regulatory provisions." *Id*.; *see U.S. ex rel. Hobbs v. MedQuest Associates, Inc.*, 711 F.3d 708, 715 (6th Cir. 2013). In *Purcell*, the D.C. Circuit explained that where "falsity turns on a disputed interpretive question," it is difficult for the Government to prove "even the loosest standard" of reckless disregard under the FCA. 807 F.3d at 288. And courts have not hesitated to dismiss such claims for failure to plead scienter. *See, e.g.*, *Olhausen v. Arriva Med., LLC*, 2022 WL 1203023, at *2 (11th Cir. Apr. 22, 2022) (per curiam); *Streck*, 746 F. App'x at 110; *U.S. ex rel. Hixson v. Health Management System, Inc*., 613 F.3d 1186, 1189-90 (8th Cir. 2010); *U.S. ex rel. Sheldon v. Forest Labs., LLC*, 499 F. Supp. 3d 184, 213 (D. Md. 2020); *U.S. ex rel. Krawitt v. Infosys Techs. Ltd., Inc.*, 372 F. Supp. 3d 1078, 1089-90 (N.D. Cal. 2019). This Court should do the same.[9]

3. The Government has not adequately pled materiality

Even had the Government plausibly alleged that Cigna knowingly violated the ICD Guidelines or the data-attestation requirement, it has not plausibly alleged that any violation was material to CMS's payment decision. The Supreme Court in *Escobar* made clear that "[t]he materiality standard is demanding" because the FCA "is not 'an all-purpose antifraud statute' … or a vehicle for punishing garden-variety breaches of contract or regulatory violations." 579 U.S. at 194; *see U.S. ex rel. Sheoran v. Wal-Mart Stores E., LP*, 858 F. App'x 876, 879 (6th Cir. 2021). The FCA defines "material" to mean "having a natural tendency to influence, or be

[9] Nor can the Government argue that subjective intent remains relevant under *Safeco*. Absent authoritative guidance foreclosing an objectively reasonable interpretation that would support the defendant's conduct, the defendant cannot have "actual knowledge" or act "in deliberate ignorance" or "reckless disregard" of any violation of the law. 31 U.S.C. § 3729(b)(1)(A).

capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4). Under *Escobar*, courts consider (1) whether "the Government designates compliance with a particular [legal] requirement as a condition of payment"; (2) whether it "consistently refuses to pay claims in the mine run of cases based on noncompliance" or, conversely, pays claims in full "despite actual knowledge that certain requirements were violated, and has signaled no change in position"; and (3) whether the "noncompliance is minor or insubstantial" or instead goes "to the very essence of the bargain." 579 U.S. at 193-95 & n.5. The Government has not pled facts sufficient in this case to establish that the balance of these factors plausibly establish materiality as to either of the legal requirements here.

First, the Government does not allege that compliance with the ICD Guidelines in general—much less the particular provision at issue—was expressly designated as a condition of payment. And although 42 C.F.R. § 422.504(*l*) designates the submission of an annual data attestation as a condition of payment, that designation is "relevant to but not dispositive of the materiality inquiry." *Escobar*, 579 U.S. at 190.

Second, the complaint and the CMS advance notices and announcements the Government incorporates by reference (Doc. No. 178 ¶ 166) leave no doubt that CMS knew most MAOs were reporting diagnoses from in-home exams that did not comply with the putative requirements the Government now seeks to enforce—years later—under the FCA. Yet the Government nowhere alleges that CMS has done anything other than continue to pay these MAOs in full for those diagnoses for the better part of a decade.

The Government acknowledges that Cigna itself met with CMS in 2013 about the company's 360 Program, but alleges that Cigna "omitted important details" about the revenue the program generated and vendors' lack of treatment or diagnostic testing during in-home exams. *Id.* ¶ 168. Even if that is true, CMS identified all of those purported details in its public

statements in 2013 and 2014. As discussed, *supra* pp. 6-7, CMS described concerns that health assessments were merely "a vehicle for collecting risk adjustment diagnoses without follow-up care or treatment," *Advance Notice CY 2014* at 22; it described "industry practices" as "generally" including in-home HRAs by vendor-hired clinicians who are not the member's PCP, *Advance Notice CY 2015*, at 20; and it pointed out that apart from certain labs for quality measures—the same tests vendors could perform for Cigna here, *see* Ex. A at 4; Ex. C at 2—"treatment is not a component of these risk assessments," *Advance Notice CY 2015* at 20; *see also Advance Notice CY 2014* at 22. Since 2014, moreover, CMS has known precisely which diagnoses—including the "serious, complex conditions" at issue, *see* Doc. No. 178 ¶ 102—were being reported from in-home exams. *See supra* p. 7.

Despite actual knowledge of the potential lack of treatment and limited diagnostic testing, CMS chose to allow MAOs to continue submitting these diagnoses from in-home exams for risk-adjustment purposes. *Supra* p. 7; *Announcement CY 2016* at 144-146. Under *Escobar*, that is "very strong evidence" that any putative testing and treatment requirements were not material to CMS's payment decision. 579 U.S. at 195. And CMS "has signaled no change in position." *Id*. In 2020, in fact, CMS specifically rejected OIG's request that CMS reconsider its decision to "allow MAOs to use HRAs … as a source of diagnoses." Grimm, *supra*, at 7. That too is "strong evidence" that the alleged requirements were not material. *Escobar*, 579 U.S. at 195.

Finally, the Government does not plausibly allege that any noncompliance with treatment and testing requirements went to "the essence of the bargain" between CMS and Cigna. *Prather*, 892 F.3d at 834. It points to no CMS guidance or actions notifying MAOs that payment under the contract was premised on the use of certain diagnostic tests, the provision of treatment, or reports by other treating physicians confirming the diagnosis. And that makes sense because, unlike original Medicare, the MA payment model pays MAOs not for the costs they incurred in

treating members but for the costs they are likely to incur in the future based on their members' health in the prior year relative to the average Medicare population. *Supra* pp. 3-4.

Lacking any allegations directly on point, the complaint relies primarily on audits and FCA enforcement targeting the accuracy of MAOs' risk-adjustment data in general. But it points to no audit or action alleging that MAOs must ensure the use of diagnostic testing, the provision of treatment, or confirmation from other encounters before reporting diagnoses from in-home exams. Allegations concerning enforcement against other parties, involving other practices, cannot establish materiality because "the Government's conduct in those cases is not relevant to what it deems material in this action." *U.S. ex rel. Foreman v. AECOM*, 2020 WL 4719096, at *4 (S.D.N.Y. Aug. 13, 2020). In any event, post-hoc enforcement is inherently less probative of materiality; otherwise, the Government could always "manufacture materiality" simply "by alleging it had an option not to pay after the fact." *U.S. v. Strock*, 982 F.3d 51, 63 (2d Cir. 2020).

In short, the Government has not adequately pled materiality under the factors set forth in *Escobar*. CMS knew all the same facts with respect to industry-wide practices that Cigna is alleged to have engaged in here. Its adoption of a policy affirming the permissibility of those practices in the face of concerns about these very facts, *a fortiori*, demonstrates that they are not material. *See Escobar*, 579 U.S. at 195. While the annual data attestations are formally designated as a condition of payment, none of the Government's allegations plausibly shows that Cigna "knew or had reason to know that [CMS] attache[d] importance to the specific matter[s]" in this case, *id.* at 193, or that those issues went to "the very essence of the bargain," *Sheoran*, 858 F. App'x at 879 (affirming dismissal under *Escobar* for failure to plead materiality, among

other things). The Court should accordingly dismiss the Government's legal-falsity theories for lack of materiality.[10]

C. The Government Cannot Proceed On Its Common-Law Claims

The Government's claims for unjust enrichment and payment by mistake (Doc. No. 178 ¶¶ 184-89) rest on the same flawed factual footing and thus must be dismissed for all the reasons above. *Supra* pp. 12-37. These claims are based on allegations that Cigna submitted false claims and was therefore "not entitled" to the payments it received. *Id.* ¶ 185. Such claims "necessarily fail" where the Government has not adequately pled the alleged fraud underlying them. *U.S. ex rel. Alt v. Anesthesia Servs. Assocs., PLLC*, 2019 WL 7372511, at *10 (M.D. Tenn. Dec. 31, 2019). In any event, unjust enrichment and payment by mistake are quasi-contract claims. Here, where the Government alleges that "Cigna entered into annual contracts with CMS to offer its MA plans to Medicare beneficiaries," Doc. No. 178 ¶ 23, "quasi-contractual theories of recovery are unavailable," *Haley v. Bank of Am., N.A.*, 2019 WL 13159817, at *10-11 (E.D. Tenn. July 10, 2019); *see also U.S. ex rel. Morsell v. Symantec Corp.*, 130 F. Supp. 3d 106, 129 (D.D.C. 2015) (quasi-contract claims pled in the alternative "must be supported by, at the very least, an allegation that there is no valid contract").

[10] In other cases involving MAOs' practices of reviewing medical charts to identify additional diagnoses for submission to CMS, courts have dismissed claims premised on the data-attestation requirement for lack of materiality. *See U.S. ex rel. Poehling v. UnitedHealth Grp., Inc.*, 2018 WL 1363487, at *10 (C.D. Cal. Feb. 12, 2018); *U.S. ex rel. Swoben v. Scan Health Plan*, 2017 WL 4564722, at *6 (C.D. Cal. Oct. 5, 2017). *But see U.S. v. Anthem Inc.*, 2022 WL 4815978, at *5 (S.D.N.Y. Sept. 30, 2022). Although those cases involved a different practice from the one at issue here, *Poehling* and *Swoben* make clear that in relying on MAOs' required attestation, the Government must do more than allege that the attestation was "intertwined" with the diagnoses on which payment was based; it must plausibly allege that the attestation "specifically" was material. *Poehling*, 2018 WL 1363487, at *10. The Government has failed to do that here. The district court in *Anthem* went the other way and found materiality adequately pled, but the court did not acknowledge—much less distinguish—*Swoben* and *Poehling* on this issue.

II. THE COURT SHOULD DISMISS ANY REMAINING CLAIMS BY CUTLER

Because the Government has intervened in this FCA action, its complaint-in-intervention supersedes Cutler's amended complaint and "becomes the operative complaint as to all claims in which the government has intervened." *U.S. v. SavaSeniorCare, LLC*, 2016 WL 5395949, at *15 (M.D. Tenn. Sept. 27, 2016). Cutler's amended complaint "continues to be the operative" pleading only for "non-intervened claims." *Id.*; *see* Boese & Baruch, *Civil False Claims and Qui Tam Actions* § 4.04[B] (2022). The Government expressly declined to intervene with respect to Cutler's first and broadest set of allegations that Cigna "committed *per se* [FCA] violations" by submitting diagnoses from in-home 360 exams that "did not involve the provision of medical treatment." Doc. No. 13 at 1-2. The Government sought and was granted intervention on "all" other "claims as to which it did not expressly decline to intervene." Doc. No. 169 at 1.

Cutler's only remaining claim thus rests on alleged *per se* FCA violations. But any such claim must be dismissed both because CMS's and others' public disclosures regarding in-home exams bar that claim, and because it fails as a matter of law in light of CMS's longstanding policy of permitting MAOs to submit diagnoses from home visits without requiring the provision of treatment. No amendment could cure those dispositive legal grounds. Cutler's remaining claim should accordingly be dismissed from the case with prejudice.

A. Public Disclosures Bar Cutler's Non-Intervened Claim

Cutler's sole non-intervened claim is foreclosed by a straightforward application of the FCA's public disclosure bar, which attempts "to discourage opportunistic plaintiffs from bringing parasitic lawsuits" that "merely feed off" publicly available information. *U.S. ex rel. Bryant v. Cmty. Health Sys., Inc.*, 24 F.4th 1024, 1030 (6th Cir. 2022). That bar requires dismissal of a *qui tam* action, "unless opposed by the Government, if substantially the same allegations … were publicly disclosed" and the relator is not "an original source of the

information." 31 U.S.C. § 3730(e)(4)(A). Here, the Government has not opposed dismissal of Cutler's non-intervened claim on this ground.[11]

The public disclosure bar applies where (1) "before the filing of the *qui tam* complaint, there had been any public disclosures from which fraud might be inferred"; (2) "the allegations in the complaint are 'substantially the same' as those contained in the public disclosures"; and (3) the *qui tam* plaintiff is not an original source of the information. *U.S. ex rel. Rahimi v. Rite Aid Corp.*, 3 F.4th 813, 823, 826 (6th Cir. 2021). Each of these three prongs is met here because publicly available information about in-home assessments disclosed the same conduct Cutler alleges, and nothing he alleges materially adds to that publicly disclosed information.

CMS's advance notices and announcements regarding MA rates and policies, MedPAC's report to Congress in 2016, other *qui tam* complaints, and media reports all described the same alleged aspects of MAOs' in-home exams that form the basis for Cutler's broad claim that Cigna committed *per se* FCA violations. These documents qualify as covered public disclosure sources under the FCA because they are "[f]ederal report[s]," other "civil" filings "in which the Government or its agent is a party," or "media" disclosures. 31 U.S.C. § 3730(e)(4)(A). The Sixth Circuit has construed the "sources of public disclosure in § 3730(e)(4)(A)" to have a "broad sweep." *U.S. ex rel. Maur v. Hage-Korban*, 981 F.3d 516, 522-23 (6th Cir. 2020) (alteration omitted). Each of the sources here fall comfortably within that broad scope. *See, e.g.*, *U.S. ex rel. Advocs. for Basic Legal Equal., Inc. v. U.S. Bank, N.A.*, 816 F.3d 428, 431 (6th Cir. 2016); *Walburn v. Lockheed Martin Corp.*, 431 F.3d 966, 974 (6th Cir. 2005); *Rahimi*, 3 F.4th at 823-24.

[11] On December 8, in response to a request for its position on this aspect of Cigna's motion to dismiss, the Government indicated that it does not intend to oppose the public-disclosure bar's application to Cutler's claims that differ from the Government's based on the description in Cigna's September 2020 pre-motion letter (*see* Doc. No. 56 at 2), but the Government reserved its right to oppose or otherwise address the argument in response to the as-filed motion.

Those disclosures made information publicly available regarding substantially the same conduct that Cutler alleges here. Cutler's non-intervened claim—which consists of his first and broadest set of allegations in this case—asserts that in-home assessments were designed to be a "data gathering exercise rather than a legitimate medical encounter," where the provider was "prohibited" by Cigna from "providing medical care." Doc. No. 12 ¶ 47; *see also id.* Count I, ¶ iii. In 2013 and 2014, CMS repeatedly described the same concern using similar language, years before Cutler filed this action. *Supra* pp. 6-7. In 2013, for example, CMS described concerns that HRAs "could be used as a vehicle for collecting risk adjustment diagnoses without follow-up care or treatment." *Advance Notice CY 2014* at 22. In 2014, in deciding to allow such diagnoses to be submitted for the following payment year, CMS again stated that it "remain[ed] concerned that many home visits are being used primarily for the gathering of diagnoses for payment rather than to provide treatment." *Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter* 27 (Apr. 7, 2014). And CMS specifically pointed out that "[i]n general, treatment [was] not a component of these risk assessments." *Advance Notice CY 2015* at 20.

Other public disclosures included substantially the same information before Cutler filed this action. For example, media reports voiced similar concerns about MA plans "collect[ing] billions of dollars from controversial 'house calls'" during which "doctors and nurses don't offer any treatment." Schulte, Ctr. for Pub. Integrity, *Home Is Where the Money Is for Medicare Advantage Plans* (June 10, 2014). MedPAC's report to Congress in 2016 likewise noted CMS's concerns that in-home HRAs are "used solely as a diagnosis-collection vehicle," *Report to Congress* 350. It flagged concerns about the diagnoses reported only from in-home HRAs insofar as they are "based on enrollee self-reporting or cannot be accurately identified with equipment brought into an enrollee's home." *Id*. And it pointed to "questions" raised by *qui tam*

lawsuits "about the accuracy of diagnoses and related documentation collected during in-home HRA visits conducted by independent home visit vendors." *Id.*[12]

Cigna was directly identifiable from these public disclosures. As the Sixth Circuit has recognized, "prior disclosures describ[ing] 'industry-wide abuses and investigations'" can trigger the public disclosure bar for a particular company. *U.S. ex rel. Holloway v. Heartland Hospice, Inc.*, 960 F.3d 836, 844 (6th Cir. 2020) (citing *U.S. ex rel. Gear v. Emergency Med. Assocs. of Ill., Inc.*, 436 F.3d 726, 729 (7th Cir. 2006)). CMS's advance notices and announcements described in-home assessments as a general industry practice; they never indicated that only some MAOs conduct such assessments. *See, e.g.*, *Gear*, 436 F.3d at 729 (barring relator's *qui tam* suit against one hospital filed after critical elements exposing uniform practice among all 125 teaching hospitals had been publicly disclosed); *In re Nat. Gas Royalties*, 562 F.3d 1032, 1042 (10th Cir. 2009) (similar). Moreover, as a significant participant in the MA program, Cigna was directly identifiable from these public disclosures about widespread industry practices, and indeed was specifically named in MedPAC's report as among the top 10 MAOs by share of enrollment. *Report to Congress* at 336; *see U.S. ex rel. Nowak v. Medtronic, Inc.*, 806 F. Supp. 2d 310, 329 (D. Mass. 2011) (company's role as "significant biliary-stent manufacturer" supported application of public disclosure based on industry-wide allegations).[13]

[12] Although the allegations in *Ramsey-Ledesma* went well beyond those here, *see supra* p. 15, the relator in that case also alleged, as Cutler does here, that MAOs engaged a home-exam vendor "for the sole purpose of generating high-risk diagnoses that the MAOs could submit to CMS to increase their capitation payments"; the vendor's clinicians "failed to conduct the laboratory or other diagnostic tests required to make … serious 'diagnoses'"; and the clinicians instead based their diagnoses partly on patient medical "history," "medication list[s]," the patient's "own oral report," and "a cursory examination." Doc. No. 66 ¶¶ 4, 6, No. 3:14-cv-118 (N.D. Tex. Nov. 11, 2015); *see also infra* pp. 42-43 (discussing *Gray*, 2018 WL 2933674).

[13] *See also, e.g., U.S. v. CSL Behring, L.L.C.*, 855 F.3d 935, 944 (8th Cir. 2017) (public disclosure bar triggered if public information either explicitly identifies defendant as a participant or provides enough information about the participant such that the defendant is identifiable); *U.S. ex rel. Findley v. FPC-Boron Employees' Club*, 105 F.3d 675, 686 (D.C. Cir.

Nor is Cutler an "original source" exempt from the public disclosure bar because his allegations did not supply the Government with information that was "independent of" or "materially add[ed] to the publicly disclosed allegations." 31 U.S.C. § 3730(e)(4)(B). None of his allegations would have been likely to change the Government's "decision-making" or was at all "significant" or "essential" to identifying Cigna's practices beyond the information available in the public record before he filed his *qui tam* complaint. *U.S. ex rel. Maur v. Hage-Korban*, 981 F.3d 516, 527 (6th Cir. 2020) (quoting *U.S. ex rel. Advocs. for Basic Legal Equal., Inc. v. U.S. Bank, N.A.*, 816 F.3d 428, 431 (6th Cir. 2016)). To the contrary, his non-intervened claim rests on broad allegations that Cigna conducted in-home 360 exams merely to gather diagnoses rather than provide treatment—allegations entirely derivative of CMS's publicly stated concerns long before this lawsuit. Cutler thus cannot overcome the public disclosure bar.

B. Cutler's Non-Intervened Claim Is Foreclosed As A Matter Of Law

As discussed, Cutler's non-intervened claim rests on his first and broadest set of allegations that diagnoses of chronic conditions reported from in-home exams are *per se* invalid for risk-adjustment purposes because the exams are a mere "data-gathering" effort, *see, e.g.*, Doc. No. 12 ¶¶ 4, 47–48, 50, 55-57, and lack a "treatment" purpose, *see id.* ¶¶ 45, 53, 97; *see also id.*, Count I, ¶ iii. The Government's express declination as to that theory (Doc. No. 13 at 1-2) is unsurprising because it is plainly foreclosed as a matter of law.

Indeed, another district court dismissed a virtually identical claim under Rule 12(b)(6) on these grounds. *See Gray*, 2018 WL 2933674, at *7. In *Gray*, the plaintiff's claim, like Cutler's,

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1997) (GAO hearing publicly disclosing the practice of federal employees' clubs retaining vending machine profits barred *qui tam* suit against a particular club because there was enough information in the public domain for the Government to identify specific groups involved); *Feingold v. Associated Ins. Cos., Inc.*, 2001 WL 1155250, at *7 (N.D. Ill. Sept. 28, 2001) ("[T]he allegations need not *specifically name* Defendants if they are directly identifiable from the publicly disclosed documents").

"assume[d] that the in-home examinations were improper, and that as a result of [the] improper submission and certification of the data obtained from those exams, the government mistakenly overpaid" the MA plan in violation of the FCA. *Id.* at *5. Specifically, the relator alleged that the home health program was a "fraudulent scheme intended to increase the capitated payments made to [the MAO] each month," *id.* at *3. Relying on CMS's statement that "it will not exclude, for payment purposes, diagnoses obtained through in-home examinations," the district court held the relator's theory was premised on a "fundamental flaw" that there is anything unlawful about submissions that the agency permits. *Id*. A relator cannot file an FCA action, the court added, "simply because he finds fault with CMS's decision to consider risk adjustment data received from in-home examinations." *Id.* at *6.

This Court should dismiss Cutler's first theory on the same grounds. As the court explained in *Gray*, CMS has long allowed diagnoses from in-home exams to be submitted for risk-adjustment purposes, so they cannot be *per se* invalid. That is equally dispositive here. In public announcements, CMS has reaffirmed the "significant value" of in-home exams and has expressly and repeatedly *permitted* the use of diagnoses from these exams for risk adjustment after considering excluding them. *See supra* pp. 5-8.

Indeed, CMS regulations *require* MAOs to submit risk adjustment data from in-home exams, because those exams are an "item [or] service provided to a Medicare enrollee." *See* 42 C.F.R. § 422.310(b). An MAO's "risk adjustment data must account" for all such items and services. *Id.* § 422.310(c). And as discussed, the ICD Guidelines are clear that all conditions assessed as current conditions during a patient encounter should be coded and reported for that encounter. *See supra* pp. 25-27.

Given CMS's decision to allow MAOs to continue reporting diagnoses from in-home assessments, Cutler's first theory is foreclosed as a matter of law. *See, e.g.*, *Bailey v. City of Ann*

Arbor, 860 F.3d 382, 387 (6th Cir. 2017) (dismissing action where pleadings "contradict[ed] verifiable facts central to [plaintiff's] claims … mak[ing] his allegations implausible.").

C. Cutler Cannot Proceed On Any Of His Other Claims

As discussed, the Government's intervention with respect to Cutler's other claims means that the Government's complaint-in-intervention is the operative pleading as to those claims. As a result, apart from the allegations as to which the Government expressly declined to intervene, Cutler's allegations have been superseded and are no longer part of this case. *SavaSeniorCare,* 2016 WL 5395949, at *15; *see U.S. ex rel. Banton v. UT Med. Grp., Inc.*, 2010 WL 11493931, at *1 n.1 (W.D. Tenn. Mar. 8, 2010).

Were the Court to determine, however, that Cutler's other claims are not superseded by the Government's complaint for any reason, all of the same arguments for dismissing the Government's complaint-in-intervention apply with equal force to Cutler's complaint. *See supra* pp. 12-37. Cutler, for example, repeatedly alleges that Cigna submitted codes from in-home exams that violated CMS coding rules. *Id*. ¶¶ 85, 87, 88-89. But, like the Government, he does not identify a single coding rule that prohibits a licensed and trained clinician from assessing that a member already has and is being treated for a condition based on patient self-reporting, physical examination findings, and the medications the member is taking.

In addition, any non-intervened claims by Cutler would be subject to the public disclosure bar. *See supra* pp. 38-42. And in any event, he has not adequately pled his other theories with the particularity required by Rule 9(b). Cutler repeatedly alleges that Cigna submitted "invalid" diagnoses from in-home exams for conditions that could not have been diagnosed in the home. *See* Doc. No. 12 ¶¶ 4, 5, 35, 47; 58-68. But he does not identify a single such diagnosis for any patient, much less enough examples to support the broad scheme he

alleges. He does not, for example, point to any medical records of patients who were claimed to have any of the complex conditions he lists. *Id*. ¶¶ 63-66.

Even were his amended complaint not otherwise superseded, Cutler thus fails to specify the "who, what, when, where, and how of the alleged fraud" required by Rule 9(b). *Sanderson v. HCA-The Healthcare Co.*, 447 F.3d 873, 877 (6th Cir. 2006) (quotation marks omitted). These omissions are fatal. As the Sixth Circuit has explained, "where a relator alleges a complex and far-reaching fraudulent scheme," "he must also identify a representative false claim that was actually submitted to the government." *Chesbrough v. VPA, P.C.*, 655 F.3d 461, 470 (6th Cir. 2011). Failing to do so is grounds for dismissal. *See, e.g.*, *U.S. ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 510 (6th Cir. 2007). Although the Sixth Circuit has left open the "possibility" that Rule 9(b)'s requirements may be relaxed where a relator is unable to produce an exemplar claim, *Chesbrough*, 655 F.3d at 472, that does not apply here because, as general counsel and part owner of a 360 vendor, *see* Doc. No. 12 ¶ 92, Cutler was in a position to specify any false diagnoses for particular patients that he believes Cigna reported. His failure to do so after amending once as a matter of right suggests that he has already "pled all the facts that he knows" and that further amendment would therefore be futile. *Yuhasz v. Brush Wellman, Inc.*, 341 F.3d 559, 569 (6th Cir. 2003).

CONCLUSION

For all of these reasons, the Court should dismiss the Government's complaint-in-intervention and Cutler's amended complaint.

December 16, 2022

Respectfully submitted,

s/ David W. Ogden
David W. Ogden (*pro hac vice*)
Howard M. Shapiro (*pro hac vice*)
Charles C. Speth (*pro hac vice*)
Kevin M. Lamb (*pro hac vice*)
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Counsel for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on the 16th day of December, 2022, a copy of the foregoing was filed electronically. Notice of this filing will be sent by operation of the Court's electronic filing system to:

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Law Office of Robert A. Cutler
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Westport, CT 06880
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s/ David W. Ogden
David W. Ogden

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

UNITED STATES OF AMERICA *ex rel*. ROBERT A. CUTLER, Plaintiff, v. CIGNA CORP. *et al.*, Defendants.	Civil Action No. 3:21-cv-00748 District Judge Eli J. Richardson Magistrate Judge Jeffrey S. Frensley JURY DEMAND

DECLARATION OF CHARLES C. SPETH
IN SUPPORT OF DEFENDANTS' MOTIONS TO DISMISS

I, Charles C. Speth, hereby declare as follows:

1. I am a partner at the law firm Wilmer Cutler Pickering Hale and Dorr LLP and represent Defendants in the above-captioned case in which I have been admitted *pro hac vice* to appear and practice before this Court.

2. Attached as **Exhibit A** is a true and correct copy of the "Amendment To Amended And Restated Clinical Services Agreement," entered into on July 1, 2015, between Alegis Care Services and Cigna Corp. subsidiary HealthSpring Inc. It was produced to the Government on February 21, 2019.

3. Attached as **Exhibit B** is a true and correct copy of the "Amendment To Business Services Agreement By And Between HealthSpring And Texas Health Management," executed on January 26, 2016, between Texas Health Management, LLC, and Cigna Corp. subsidiary HealthSpring Life & Health Insurance Company, Inc. It was produced to the Government on October 5, 2018.

4. Attached as **Exhibit C** is a true and correct copy of the "Vender Services Agreement By And Between EMSI And Bravo Health," executed on May 4, 2012, between Examination Management Services, Inc., and Cigna Corp. subsidiaries HealthSpring Bravo Health Pennsylvania, Inc. and Bravo Health Mid-Atlantic. It was produced to the Government on October 5, 2018.

5. Attached as **Exhibit D** is a true and correct copy of the standard 360 Comprehensive Assessment Form 2016. It was produced to the Government on December 19, 2018.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: December 16, 2022

Charles C. Speth

Exhibit A

AMENDMENT TO
AMENDED AND RESTATED CLINICAL SERVICES AGREEMENT

THIS AMENDMENT TO AMENDED AND RESTATED CLINICAL SERVICES AGREEMENT (the "Amendment"), entered into July 1, 2015, is by and among HealthSpring, Inc., a Delaware corporation ("Cigna-HealthSpring") on behalf of itself, its Affiliates and subsidiaries, and each of the Companies set forth on the signature page hereto.

RECITALS

WHEREAS, Cigna-HealthSpring and the Companies have previously entered into that certain Amended and Restated Clinical Services Agreement (the "Agreement") dated June 22, 2014 (the "Agreement Date");

WHEREAS, due to administrative oversight, the exhibits for Alegis Care Services and Compensation for (i) 360 Assessments and (ii) Chronic Care Program Services (collectively, the "Exhibits") were not included in the Agreement, and the parties desire to add the Exhibits to memorialize and ratify the understanding of the parties as of the Agreement Date with respect thereto; and

WHEREAS, the parties desire to amend the Chronic Care Management Services exhibit.

NOW, THEREFORE, in consideration of the foregoing, and of the representations, warranties, covenants and agreements contained herein, and intending to be legally bound hereby, the parties hereto agree as follows:

1. Amendments to Agreement.

   A. Inclusion of Exhibits A-1 and A-5. The Agreement is hereby amended to include Exhibit A-1 360 (Assessments) and Exhibit A-5 (Chronic Care Program Services), in the forms attached hereto, with such amendment to be effective as of the Agreement Date.

   B. Amendment to Exhibit A-2. Exhibit A-2 (Chronic Care Management Services) is hereby deleted in its entirety and replaced with Exhibit A-2 (Chronic Care Management Services) attached hereto.

2. Defined Terms. Capitalized terms not defined herein shall have the meaning ascribed thereto in the Agreement.

3. Ratification. The Agreement is hereby modified to reflect the changes specified in this Amendment. Except as specifically amended and/or supplemented by this Amendment, all other terms and conditions of the Agreement shall remain in full force and effect.

4. Governing Law. This Amendment shall be governed by and interpreted and enforced in accordance with the laws of the State of Tennessee, regardless of any choice of law provisions of any jurisdiction to the contrary.

5. Counterparts. This Amendment may be executed in any number of counterparts, all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, each party has caused this Amendment to Amended and Restated Clinical Services Agreement to be executed and delivered by its duly authorized officer or legal representative as of the date first referenced above.

HEALTHSPRING, INC. ON BEHALF OF ITSELF AND ITS SUBSIDIARIES AND AFFILIATES

By: _____
Shawn Morris, Chief Operating Officer

COMPANIES:

HS CLINICAL SERVICES, P.C.
BRAVO HEALTH ADVANCED CARE CENTER, P.C. (PA)
BRAVO HEALTH ADVANCED CARE CENTER, P.C. (MD)
HOME PHYSICIANS 2011, PC
HOME PHYSICIANS CHESAPEAKE, PC
HPME PHYSICIANS, PC
HOME PHYSICIANS BALTIMORE, PC
ALEGIS CARE-NEW JERSEY, PC
ALEGIS CARE-PENNSYLVANIA, PC
ALEGIS CARE-MICHIGAN, PC
DIRK WALES MD, P.C.

By: _____
Dirk Wales, M.D., President

ALEGIS CARE-WISCONSIN, SC
ALEGISCARE-UTAH, PC
ALEGIS CARE – KANSAS, P.A.
ALEGISC ARE – OHIO, Professional Corporation

By: _____
Michael Fessenden, M.D., President

EXHIBIT A

ALEGIS CARE SERVICES & COMPENSATION

Exhibit A-1
360 Assessments

Services

1. Company shall perform 360 Comprehensive Assessments for pre-selected Members identified by Cigna-HealthSpring who are to be targeted for 360 Comprehensive Assessments. Cigna-HealthSpring and Company shall mutually agree upon the method used to schedule Members for 360 Comprehensive Assessments.
   - "360 Comprehensive Assessment" means the face-to-face creation of a comprehensive health assessment performed on a Member using Cigna-HealthSpring's 360 Comprehensive Assessment form or such other form as reviewed and approved in writing by Cigna-HealthSpring by authorized personnel. The 360 Comprehensive Assessment is to review the Member's medical history, complete a physical examination, as well as diagnose and provide suggested care management. Specifically, the 360 Comprehensive Assessment may include: (1) a comprehensive health exam; (2) an assessment of clinical history including medications; (3) an assessment of risk factors, past and current health status; (4) family history; (5) an assessment of activities of daily living; (6) an assessment of life-planning activities, advance directives; (7) a review of systems; (8) recommendations for applicable preventive health screenings; and (9) health education/anticipatory guidance.
2. Company shall return the Completed 360 Comprehensive Assessment form to Cigna-HealthSpring as directed for review for completeness and compliance with Cigna-HealthSpring's guidelines or as mutually agreed. Company shall be responsible for coordination, collection and follow-up of required Member assessment documentation. A Completed 360 Comprehensive Assessment is a document that, at a minimum:
   - Is completed in blue/black pen or Cigna-HealthSpring approved electronic format;
   - Includes clear marks in all appropriate checked boxes;
   - Is completed during a face to face examination with a Member;
   - Includes actual signature/initials;
   - Includes provider's written, printed name or stamp on designated pages;
   - Includes relevant provider's credentials;
   - Includes clinical support documentation for all diagnoses reported;
   - Has legible hand-writing;
   - Includes completion of treatment plan; and
   - Includes only valid diagnoses coding.
3. Company will ensure that each Authorized Medical Professional will have successfully completed, if applicable, any training program(s) provided or required by Company and/or Cigna-HealthSpring. Each Authorized Medical Professional shall be applicably licensed in the state where such Authorized Medical Professional is performing the 360 Comprehensive Assessments.

4. Company shall not be obligated to provide any Services in a setting where the provision of the Services would pose risk of bodily harm to the Authorized Medical Professional. Company will promptly report such unsafe condition to Cigna-HealthSpring. However, Company will provide or arrange for such Services if a means mutually agreeable to Cigna-HealthSpring and Company can be found to alleviate such unsafe condition.
5. Neither Company nor an Authorized Medical Professional shall provide any prescriptions or recommendations for medical care to Members in connection with the 360 Comprehensive Assessments unless approved by Cigna-HealthSpring.
6. Company shall perform immediate quality assurance ("QA") on every 360 Comprehensive Assessment prior to delivering the 360 Comprehensive Assessments to Cigna-HealthSpring. A description of Company's QA program is required with a sample of associated reporting, as mutually agreed, with stated frequency that will be shared with Cigna-HealthSpring. Company's QA process will, at a minimum, be in accordance with the following:
    - Completed 360 Comprehensive Assessment must be legible and readable;
    - Member name identified on each page of the 360 Comprehensive Assessment form;
    - Correct date of service and Member date of birth must be stated on each page of the 360 Comprehensive Assessment – the dates must all be the same date;
    - All pages of the 360 Comprehensive Assessment form are present as well as any other additional information that may be required;
    - Authorized Medical Professional's full, legible name and ID number on the first page of the 360 Comprehensive Assessment; his/her initials are on all subsequent pages, and his/her full signature and credentials on the signatory page;
    - If the Authorized Medical Professional makes any corrections to the 360 Comprehensive Assessment, the Authorized Medical Professional must draw a line through the area to be corrected, correct the entry and initial next to the correction for the correction to be considered acceptable by CMS

    If any 360 Comprehensive Assessment fails Cigna-HealthSpring's QA process or there are completeness or quality concerns about the 360 Comprehensive Assessments, Cigna-HealthSpring will contact Company. Any 360 Comprehensive Assessments not meeting Cigna-HealthSpring's QA requirements must be corrected and resubmitted to Cigna-HealthSpring (at no additional cost) within 10 business days of notification by Cigna-HealthSpring. Cigna-HealthSpring at any time may audit processes, practices or deliverables.
7. In addition, the parties shall mutually agree upon the manner of delivery of the 360 Comprehensive Assessment documentation, i.e., mail, secure fax, SFTP, etc.
8. Additional services: Company will perform any of the following for each Member at the time of the 360 Comprehensive Assessment if requested by Cigna-HealthSpring:
    - Diabetic Retinal Eye Examination
    - Hemoglobin A1c Screening Test
    - Cholesterol (LDL-C) screening
    - Nephropathy Screening (urine microalbumin)
    - IFIT Colorectal Cancer Screening
    - Bone Density

- Spirometry
- Glaucoma Testing
- Influenza Immunization
- Pneumonia Immunization

Compensation

Company shall be compensated at a rate of $275 per Completed 360 Assessment.

If applicable, upon receipt of proper documentation that these additional services were provided, Company shall be compensated at the rates below, on a per unit basis:

- Diabetic Retinal Eye Examination: $165
- Hemoglobin A1c Screening Test: $50.00
- Cholesterol (LDL-C) screening: $50.00
- Nephropathy Screening (urine microalbumin): $25.00
- IFIT Colorectal Cancer Screening: $25.00
- Bone Density: $100.00
- Spirometry: $80.00
- Glaucoma Testing: $100.00
- Influenza Immunization: $23.00
- Pneumonia Immunization: $115.00

Exhibit A-5
Chronic Care Program Services

Services

1. Home based primary care services will be provided to qualified Members, identified by Cigna-HealthSpring, who have chronic high risk conditions or interim complex care needs.
   - CCP patients will be seen by the Company's provider in their homes at least once monthly subject to conditions or circumstances outside of Company's control including but not limited to patient refusal, inpatient hospitalization, and force majeure.
   - Patients discharged from the hospital shall be seen within two (2) business days by the CCP provider.
   - Provider Group agrees to provide 24/7/365 call coverage through the CCP team.
2. Designated patient schedulers will work directly with the patient/family to schedule home visit appointments.
3. Health risk assessments will be conducted on each patient to improve identification and documentation of conditions and patient needs.
4. Comprehensive geriatric evaluations will be performed on patients age 65 and older, including screening for functional impairment, cognitive impairment, nutritional deficits, and falls.
5. Preventive health services and screening services such as HEDIS measures shall be conducted on each patient as appropriate. These services include: lab testing, biometric screening, radiology services, bone density screening, etc.
6. Medication reconciliation and management services will be provided to all members.
7. National clinical guidelines and industry best-practices will be utilized to develop management plans. For patients with frequent disease exacerbations an early identification and management action plan will be established. "Rescue medications" may be ordered for patients with frequent disease exacerbations, as appropriate.
8. Short and long term goals of care will be identified with the patient and family along with treatment plans to achieve those goals.
9. Education on disease processes and conditions will be provided to the patient and family. Support materials are left in the home.
10. Advance directives and end of life care is thoroughly discussed and end of life goals are identified. Patients will be encouraged to complete durable power of attorney for health care and/or living will documents, to the extent appropriate given their circumstances.
11. Family and caregiver support will be offered.
12. Upon request by Cigna HealthSpring, Company or its designee will participate in Plan case management rounds and patient's interdisciplinary care team meetings related to patients under Company's care as needed.

Compensation

For services noted herein the parties agree that Company shall be compensated at a rate of $285 per case per month for each member that is enrolled as of the 21st day of the month in chronic care management with Company. Company agrees that payments will be retroactively applied to concur with CMS eligibility files. Company will invoice Cigna-HealthSpring on a monthly basis for services set forth herein utilizing appropriate CPT codes for the services rendered.

Exhibit A-2
Chronic Care Management Services

Services

1. Home based primary care services will be provided to qualified Members, identified by Cigna-HealthSpring, who have chronic high risk conditions.
   - CCM patients will be seen by the Company's physician in their homes at least once monthly subject to conditions or circumstances outside of Company's control including but not limited to patient refusal, inpatient hospitalization and force majeure.
   - Patients discharged from the hospital shall be seen within two (2) business days by the CCM nurse practitioner and/or their primary CCM physician.
   - Provider Group agrees to provide 24/7/365 call coverage through the CCM physician team.
2. Continuous care coordination shall be provided by the CCM RN case managers to the extent approved by Cigna-HealthSpring.
3. Designated patient schedulers will work directly with the patient/family to schedule home visit appointments.
4. Health risk assessments will be conducted on each patient to improve identification and documentation of conditions and patient needs.
5. Comprehensive geriatric evaluations will be performed on patients age 65 and older, including screening for functional impairment, cognitive impairment, nutritional deficits, and falls.
6. Preventive health services and screening services such as HEDIS measures shall be conducted on each patient as appropriate. These services include: lab testing, biometric screening, radiology services, bone density screening, etc.
7. Medication reconciliation and management services will be provided to all members.
8. National clinical guidelines and industry best-practices will be utilized to develop management plans. For patients with frequent disease exacerbations an early identification and management action plan will be established. "Rescue medications" may be ordered for patients with frequent disease exacerbations, as appropriate.
9. Short and long term goals of care will be identified with the patient and family along with treatment plans to achieve those goals.
10. Education on disease processes and conditions will be provided to the patient and family. Support materials are left in the home.
11. Advance directives and end of life care is thoroughly discussed and end of life goals are identified. Patients will be encouraged to complete durable power of attorney for health care and/or living will documents, to the extent appropriate given their circumstances.
12. Family and caregiver support will be offered. Social worker services may be available in select markets.

13. Upon request by Cigna-HealthSpring, Company or its designee will participate in Plan case management rounds and patient's interdisciplinary care team meetings related to patients under Company's care as needed.

Compensation

For services noted herein the parties agree that Company shall be compensated at a rate of $475 per case per month for each member that is enrolled as of the 21st day of the month in chronic care management with Company. Company agrees that payments will be retroactively applied to concur with CMS eligibility files.

Company will invoice Cigna-HealthSpring on a monthly basis for services set forth herein.

Exhibit B

AMENDMENT
TO BUSINESS SERVICES AGREEMENT
BY AND BETWEEN
HEALTHSPRING
AND
TEXAS HEALTH MANAGEMENT

This amendment (the "Amendment") shall amend the **Business Services Agreement** (the "Agreement") executed by and between **Texas Health Management, LLC** ("THM") and **HealthSpring Life & Health Insurance Company, Inc.** ("Cigna-HealthSpring"). Unless otherwise indicated herein, all defined terms included herein shall have the same meanings attributed to such terms in the Agreement and references to section numbers are to sections of the Agreement. This Agreement is hereby amended as of the date set forth below.

RECITALS

WHEREAS, Cigna-HealthSpring and THM entered into the Agreement on May 1, 2013;

WHEREAS, THM and Cigna-HealthSpring wish to revise the Agreement to adjust compensation rates; and

NOW THEREFORE, and in consideration of the mutual covenants and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged and stipulated for all purposes, the parties agree to amend the Agreement as described herein.

AGREEMENT

1. Revise the Agreement by adding the following definitions.
    a. ***360 Comprehensive Assessment*** means the face-to-face creation of a comprehensive health assessment, using Cigna-HealthSpring's 360 Comprehensive Assessment form or such other form as reviewed and approved in writing by Cigna-HealthSpring's CMO, by a CMS authorized and Cigna-HealthSpring approved provider (M.D., D.O., N.P., or P.A.) performed on a Cigna-HealthSpring Member. The assessment is to review the Member's medical history; complete a physical examination, as well as diagnose and provide suggested care management. Specifically, the assessment may include, but is not limited to: (1) a comprehensive health exam; (2) an assessment of clinical history including medications; (3) an assessment of risk factors, past and current health status; (4) family history; (5) an assessment of activities of daily living; (6) an assessment of life-planning activities, advance directives; (7) a review of systems; (8) recommendations for applicable preventive health screenings; and (9) health education/anticipatory guidance.

b. **Ineligible Person(s)** means any individual or entity who (1) is excluded, debarred, or otherwise ineligible to participate in the Federal health care programs (e.g., Medicare, Medicaid, etc.) or in Federal procurement or non-procurement programs; (2) has been convicted of a criminal offense related to the provision of health care items or services, but has not yet been excluded, debarred or otherwise declared ineligible; or (3) has been convicted of a criminal offense related to the provision of health care items or services, and has not been reinstated after a period of exclusion.

c. **Assessing Provider** means those employees of Vendor or an organization or individual which has contracted with Vendor and, approved in writing in advance by Cigna-HealthSpring, who are licensed physicians, physician's assistants, nurse practitioners and/or other credentialed, licensed and qualified providers as set forth under the rules and regulations of the United States Department of Health and Human Services ("DHHS"), Centers for Medicare & Medicaid Services ("CMS") and any other applicable federal or state regulations; and satisfies any other credentialing requirements required under this Agreement.

2. Revise the Agreement by adding new Section 3(d) "Services. Vendor shall perform the Services as set forth in this Agreement and in the attached exhibits, which are incorporated fully herein by reference. In connection with its performance of the Services, Vendor shall supply all personnel, equipment and other instrumentalities required to perform the Services, unless otherwise set forth in the Agreement. In addition, all Services performed by Vendor shall be performed in a good and workmanlike manner, in accordance with good and customary industry practices using competent and appropriately experienced personnel and will comport to Vendor's advertising and representations of its services.

   i. Vendor shall not be obligated to provide any Services in a setting where the provision of the Services would pose risk of bodily harm to the Assessing Providers. Vendor will promptly report such unsafe condition to Cigna-HealthSpring. However, Vendor shall provide or arrange for such Services if a means mutually agreeable to Cigna-HealthSpring and Vendor can be found to alleviate such unsafe condition. Moreover, neither Vendor nor its Assessing Providers shall provide any prescriptions or recommendations for medical care to Members; however, Vendor may provide such recommendations to the Member's personal treating physician and Cigna-HealthSpring.

   ii. Assessing Providers shall complete for each Member, Cigna-HealthSpring's 360 Comprehensive Assessment form and any additional Covered Services, which may include, but is not limited to lab work (i.e. LDL, HgA1c) and spirometry. The completed 360 Comprehensive Assessment form will be returned to Vendor for review for completeness and compliance with Cigna-HealthSpring guidelines and any requirements set forth in the Agreement, including being dated, being signed by the Assessing Provider with credentials and having the Member's name, Member's date of birth and date of service on each page. The completed

360 Comprehensive Assessment form shall be returned to Cigna-HealthSpring in accordance with the Agreement. Vendor shall be responsible for coordination, collection, and follow-up of required Member assessment documentation.

iii. Vendor shall be available to consult with Cigna-HealthSpring at all reasonable times during the term of this Agreeemnt regarding the Services. In addition, after termination of the Agreement, Vendor shall be available to consult with Cigna-HealthSpring as circumstances may reasonably require provided Cigna-HealthSpring agrees to pay Vendor the existing consulting rates and actual expenses.

iv. Vendor shall provide sufficient education and training which has been approved by Cigna-HealthSpring to all of its employees (whether full or part-time), temporary employees, call-center and scheduling personnel, Assessing Providers, professional medical coders (if applicable), and any other approved subcontractors performing work for Cigna-HealthSpring regarding their obligations under this Agreement, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), American Recovery and Reinvestment Act of 2009 ("ARRA"), any applicable requirements established under a government-funded program, including but not limited to Medicare and any requirements established by Cigna-HealthSpring.

3. Revise the Agreement by adding new Section 3(e) "Excluded Personnel. Neither Vendor nor its employees or approved subcontractors are now, or have ever been, excluded from participation in any federally funded health care program, including Medicare and Medicaid or are otherwise an Ineligible Person. Vendor shall promptly notify Cigna-HealthSpring of any threatened, proposed, or actual exclusion from any federally funded health care program. If Vendor becomes an Ineligible Person during the Term hereof, or if, at any time Vendor is in breach of this Section, this Agreement shall, as of the effective date of such exclusion or breach, automatically terminate."

4. Revise the Agreement by adding new Section 3(f) "Removal of Personnel. Vendor shall remove any employee, Assessing Provider, professional medical coder (if applicable), or subcontractor from providing Services upon Cigna-HealthSpring's reasonable request."

5. Revise the Agreement by adding new Section 3(g) "Insurance Provisions. Vendor shall maintain, and require any of its approved subcontractors to maintain, such policies of general liability, professional liability (malpractice), and errors and omissions insurance as shall be reasonably necessary to insure against any claim or claims for damages arising by reason of any activities performed in connection with this Agreement. Unless otherwise required by Cigna-HealthSpring, the amounts and extent of such insurance coverage shall not be less than $1,000,000 per occurrence and $3,000,000 as an annual aggregate amount, or as otherwise required by applicable state law or regulations or as agreed to by Cigna-HealthSpring. In the event that an Assessing Provider self-insures, the Assessing Provider must provide proof of excess liability coverage in the aggregate

minimum amount of $10,000,000. Vendor shall make commercially reasonable efforts to obtain from insurers an agreement in each such policy and certificate that the policies will not be invalidated as they affect the interest of Cigna-HealthSpring by reason of any breach or violation of warranties, representations, declarations or conditions contained in the policies. Vendor shall provide Cigna-HealthSpring with at least 30 days written notice of any cancellation, reduction or other material change in the above-referenced coverages. Vendor shall provide memorandum copies of such insurance coverage or evidence of such self-insurance to Cigna-HealthSpring upon request and Vendor shall be responsible for providing copies to Cigna-HealthSpring on behalf of Assessing Providers. Vendor agrees to notify Cigna-HealthSpring within 72-hours after the discovery of any and all incidents, occurrences, claims, or Member-related causes of action involving the Services which are the subject of this Agreement. Vendor will provide all insurance coverage from an insurance company reasonably satisfactory to Cigna-HealthSpring with an AM Best rating of at least A-1."

6. Revise the Agreement by deleting the compensation for 360 Exams and adding the following language for Vendor's and Cigna-HealthSpring's obligations related to completed 360 Exams to Exhibit B, which are completed during Member home visits in any given calendar year:

For 360 Exams and visits completed in 2015 in Texas, Cigna-HealthSpring shall reimburse Vendor at the following rates:

Completed 360 Exams 1-10,000 - $345 per completed exam and visit
Completed 360 Exams over 10,000 - $295 per completed exam and visit

For 360 Exams completed in 2016 and beyond in Texas, the following shall apply:

Based upon annual historical 360 Exam and visit completion rates of Cigna-HealthSpring Members in Texas of approximately 16,000 360 Exams and visits, Cigna-HealthSpring agrees to reimburse Vendor by the fifteenth (15th) calendar day of each month at a rate of Three Hundred Ninety-Three Thousand, Two Hundred Thirty-Five dollars ($393,235.00) per month for the 360 Exams completed in Texas, which equates to an Effective Rate of Two Hundred Ninety-Five dollars ($295) per 360 Exam at an average rate of 1,333 exams per month. The Effective Rate shall apply to current and future Cigna-HealthSpring affiliates, parent companies, successors in interest, and subsidiaries that become parties to this agreement. Vendor agrees to invoice Cigna-HealthSpring by the fifth (5th) day of each month for all completed 360 Exams and visits in the previous month and mail said invoice to:

Cigna-HealthSpring
2900 N. Loop West Suite 1300
Houston, TX 77092

ATTN: Ryan Host

During January of each calendar year, Cigna-HealthSpring shall perform a true-up process to evaluate the number of 360 Exams completed by Vendor during the previous year. During the true-up process, if the number of 360 Exams completed by Vendor during the previous calendar year exceeds the previous year's sum of the expected average of 360 Exams completed (12*1333 = 15996), then Cigna-HealthSpring shall adjust the January reimbursement by an additional $295 per completed 360 Exam above the $393,235.00 monthly payment. If the number of 360 Exams completed by Vendor during the previous calendar year is below the previous year's sum of the expected average of 360 Exams completed (an "overpayment"), then Cigna-HealthSpring shall withhold the overpayment from the January reimbursement at a rate of $295 per 360 Exam. If the overpayment exceeds the $393,250.00 monthly payment, Vendor agrees to pay back the remainder of the overpayment by check within thirty (30) calendar days to Cigna-HealthSpring from the date that Cigna-HealthSpring notifies Vendor, in addition to the withholding of the January reimbursement. For any overpayment notice sent to Vendor by Cigna-HealthSpring, notice shall be deemed effective after the second business day such notice was sent. For the avoidance of doubt, the parties acknowledge and agree that the flat rate reimbursement only applies to current and future parties of this agreement as previously stated and the true-up procedure described in this paragraph shall apply only with respect to the 360 Exams completed in Texas, and that any 360 Exams completed in other markets, including, without limitation, Arizona, shall be invoiced or handled by claims submission and reimbursed separately in accordance with the payment procedures that are applicable in such markets based on the actual number of visits completed (i.e. the amount reimbursed to Vendor per month in such markets shall be in addition to the flat rate reimbursement paid monthly to Vendor under this paragraph).

The following scenarios are provided for illustrative purposes only:

a) In January 2016, Cigna-HealthSpring conducts the true-up process after receiving the January invoice for 360 Exams and visits completed in the 2015 calendar year and calculates the following information based upon Vendor's invoices and other information available:

	Expected 360s completed for previous calendar year	Actual 360s completed for previous calendar year
January-December	15,996	17,000

Instead of paying Vendor $393,235.00, Cigna-HealthSpring shall pay Vendor (17,000-15,996) x $295 = **$689,415.00** in January 2016 to account for the additional 1,004 completed 360 Exams in 2015.

b) In January 2016, Cigna-HealthSpring conducts the true-up process after receiving the January invoice for 360 Exams and visits completed in calendar year 2015 and calculates the following information based upon Vendor's invoices and other information available:

	Expected 360s completed for previous calendar year	Actual 360s completed for previous calendar year
January-December	15,996	15,000

In this scenario, the difference between the expected and actual 360s completed for calendar year 2015 is 996 (15996 – 15000). Instead of the standard $393,235.00 payment, Cigna-HealthSpring shall only pay Vendor $393,235.00 – (996 x $295) = **$99,415.00** to account for the overpayment of $293,820.

7. Revise Agreement by adding new Section 5(b) "Member Non-Liability. Vendor agrees that in no event, including, but not limited to, non-payment by Cigna-HealthSpring, or Cigna-HealthSpring's insolvency or breach of this Agreement, shall Vendor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the Members for Services provided to such Members pursuant to this Agreement. Vendor further agrees that this provision shall survive the termination of this Agreement and shall be construed to be for the benefit of the Members, and this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Vendor and Cigna-HealthSpring, insofar as any such contrary agreement relates to liability for payment for Services provided under the terms and conditions of this Agreement."

8. Revise Agreement by adding new Section 5(c) "Payment of Assessing Providers. Vendor shall be solely responsible for all compensation to its Assessing Providers, professional medical coders (if applicable), personnel, subcontractors, etc. for Services provided to Cigna-HealthSpring under this Agreement."

9. Revise the Agreement by adding new Section 7(d) "Maintenance and Access to Records. Vendor shall maintain such records as reasonably necessary to comply with applicable federal, state or local government laws, rules, and regulations or as required by this Agreement. Cigna-HealthSpring shall upon prior request have access during normal business hours to the books, records and papers of Vendor relating to the Services provided under this Agreement. Cigna-HealthSpring and/or any health oversight agency that is reviewing Cigna-HealthSpring's activities, including but not limited to DHHS, the Comptroller General, or their designee, may audit or evaluate through inspection or other means the operations and records of Vendor as it pertains in any way to the Services provided. Such audit or evaluation shall be conducted with due regard for not unnecessarily interfering with Vendor's other business and responsibilities. Cigna-HealthSpring may conduct such audit as needed to evaluate whether Vendor's activities are being conducted in accordance with this Agreement, Cigna-HealthSpring's policies

and procedures, or any local, state or federal laws and regulations, Vendor's obligations and the expectations of Cigna-HealthSpring. Such audit shall be at the expense of Cigna-HealthSpring. However, in the event that an audit reveals that billing for the Services has been in excess of proper billing by more than 10%, the audit shall be at the expense of Vendor. Vendor further agrees that this provision shall survive the termination of this Agreement. Vendor shall take all reasonable steps to ensure that all 360 Comprehensive Assessment forms and any other Member information (whether electronic or paper format) are protected from loss, destruction or unauthorized use or disclosure and that such records shall be returned to Cigna-HealthSpring upon request or termination of the Agreement, except that copies may be retained to the extent required by applicable document retention laws. The provision of this paragraph shall survive termination of this Agreement."

10. Revise Section 2 by adding new Section 2(e) "Post-termination Obligations. The following shall apply upon the termination or expiration of the Agreement. Each party shall make commercially reasonable efforts to fully cooperate with the other in all matters relating to the winding up of pending work and the orderly transfer of any pending work to the other party or its designees. If not already permanently removed or deleted from any computer, network, or otherwise securely disposed of, to the extent feasible, Vendor shall return to Cigna-HealthSpring all copies of all information associated with or provided by, Cigna-HealthSpring in Vendor's possession or under its control, including but not limited to, all Cigna Health-Spring Confidential Information, except that copies may be retained to the extent required by applicable document retention laws. Such information shall be delivered to Cigna-HealthSpring within 15 business days of termination, and confirmation shall be provided at that time that compliance with this obligation has occurred. Unless otherwise agreed to by the parties, or unless such retention of information is required by federal or state law or regulation, Vendor shall not retain any copies of the Cigna-HealthSpring Confidential Information, as applicable, and shall make no further use of such materials. In addition, Vendor shall comply with the provision for the return or destruction of protected health information as set forth in HIPAA Agreement. Upon expiration or termination of the Agreement, Vendor shall return to Cigna-HealthSpring within 10 days all 360 Comprehensive Assessments, whether or not completed."

11. Revise Section 2(b) to change the written notice period referenced therein by replacing the words "ninety (90) days" with the words "six (6) months."

12. Revise Section 2(d) to read as follows: "Transition Work. If this Agreement expires or is terminated by either party for any reason, all work in progress as of such date of expiration or termination shall continue to completion and HEALTHSPRING shall pay Vendor for any such Covered Services completed promptly following the completion of such Covered Services. In addition, if this Agreement is terminated for no cause under Section 2(b), then, within 30 days after notice of such termination, HEALTHSPRING shall provide Vendor with a list of plan member names for which HEALTHSPRING requests Covered Services to be performed from the date the list is so provided until the

date that this Agreement terminates (the "Termination Period"). Such list shall contain no less than the Minimum Member Volume (as defined below). During the Termination Period, Vendor shall perform Covered Services with respect to such Members and HEALTHSPRING shall pay Vendor for any such Covered Services completed promptly following the completion of such Covered Services. The Minimum Member Volume shall mean thetotal volume of plan member names provided by HEALTHSPRING to Vendor during the 12-month period proceeding the date on which notice is provided under Section 2(b), divided by 2. The terms of this Section 2(d) shall survive any termination or expiration of this Agreement."

13. All Other Terms of Agreement to Remain Unchanged. Except as specified herein, all other terms and conditions of the Areement shall remain in full force and effect as if fully set forth herein.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment to the Agreement as of April 1, 2015 listed below.

THM

Signature

Joe Straffolino

Print Name

Managing Director

Title

1-25-16

Date of Execution

CIGNA-HEALTHSPRING

Signature

Peter R. Gardner

Print Name

COO - Texas

Title

1/26/16

Date of Execution

April 1, 2015

Effective Date

Exhibit C

VENDOR SERVICES AGREEMENT
BY AND BETWEEN
EMSI AND
BRAVO HEALTH

The *Vendor Services Agreement* ("VSA") is effective as of April _____, 2012 ("Effective Date"), by and between Examination Management Services, Inc., ("Vendor"), and HealthSpring Bravo Health Pennsylvania, Inc. and Bravo Health Mid-Atlantic, Inc. (collectively referred to as "Bravo Health") (sometimes collectively referred to as "parties").

Section 1: DEFINITIONS

1.1 DEFINITIONS. Each of the capitalized terms (and the plural thereof, when appropriate) in this VSA shall have the meaning set forth herein, except where the context makes it clear that such meaning is not intended.

a. *"Affiliate"* means, as to the entity in question, any person or entity that directly or indirectly controls, is controlled by, or is under common control with, the entity in question, either now or in the future; and the term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity.

b. "*Assessing Provider*" means those employees of Vendor or an organization or individual which has contracted with Vendor and, who are licensed physicians, physician's assistants, nurse practitioners and/or other credentialed, licensed and qualified providers as set forth under the rules and regulations of the United States Department of Health and Human Services ("DHHS"), Centers for Medicare & Medicaid Services ("CMS") and any other applicable federal or state regulations; and satisfies any other credentialing requirements required under this VSA. Bravo Health retains the right to reasonably disapprove the use of any Assessing Provider upon written notice to Vendor.

c. "*Non-Assessing Provider*" means those employees of Vendor or an organization or individual which has contracted with Vendor, who are not an Assessing Provider but otherwise meet the qualifications set forth in this VSA and any applicable SOW to perform Educational Interventions and/or HEDIS Exams. Services by these Non-Assessing Providers will be completed by Vendor's para-medical examiner network of Vendor's Insurance Services Division, which hereby constitutes an approved network of employees and independent contractors by Bravo Health. Nevertheless, Bravo Health retains the right to reasonably disapprove the use of any Non-Assessing Provider upon written notice to Vendor.

d. "*BPHP/360 Comprehensive Assessment*" means the face-to-face creation of a comprehensive health assessment, using Bravo Health's BPHP/360 Comprehensive Assessment form previously provided to Vendor or such other form as reviewed and approved in writing by Vendor and Bravo Health's CMO, by a CMS authorized and Bravo Health approved provider (M.D., D.O., N.P., or P.A.) performed on a Bravo Health Member. The assessment is to review the Member's medical history; complete a physical examination, as well as diagnose and suggest care management. Specifically, the assessment excludes treatment, but may include: (1) a comprehensive health exam; (2) an assessment of clinical history including medications; (3) an assessment of risk factors, past and current health status; (4) family history; (5) an assessment of activities of daily living; (6) an assessment of life-planning activities, advance directives; (7) a review of systems; (8) recommendations for applicable preventive health screenings; and (9) health education/anticipatory guidance.

e. "*Educational Interventions*" means (1) with respect to colorectal screening the delivery of the Insure Kit to Member, explaining test and the importance of detecting colorectal cancer, aiding Member in filling out any required forms; answering any related questions, and leaving behind any educational materials; (B) with respect to exercise, assessing the level of education in which the Member currently engages, providing Member education on level of exercise Member needs to engage in, identifying exercises Member can perform to bridge the gap—which may include referral to Silver Sneakers benefit, and leaving behind any educational materials; (C) with respect to fall prevention, assessing Member's ability to safely perform everyday actions, offering ways of preventing falls, and leaving behind educational materials; (D) with respect to incontinence, assessing Member's history of urinary incontinence, offering several ways of mitigating current incontinence problem, and leaving behind educational materials; and (E) with respect to diabetic education, discussing importance of regular testing (LDL-C, HBa1C, microalbumin) and having these levels remain in control, discussing importance of taking insulin to control diabetes, and discussing exercise and diet as a way of combating diabetes,

f. "*Ineligible Person(s)*" means any individual or

entity who (1) is excluded, debarred, or otherwise ineligible to participate in the Federal health care programs (*e.g.*, Medicare, Medicaid, etc.) or in Federal procurement or non-procurement programs; (2) has been convicted of a criminal offense related to the provision of health care items or services, but has not yet been excluded, debarred or otherwise declared ineligible; or (3) has been convicted of a criminal offense related to the provision of health care items or services, and has not been reinstated after a period of exclusion.

g. "***Member***" and/or "***Membership***" means those individuals enrolled in Bravo Health's Medicare Advantage health benefit programs and who are being targeted for a BPHP/360 Comprehensive Assessment, HEDIS Exam, and/or Educational Interventions.

h. "***Preventative (HEDIS") Exams***" or "***HEDIS Exams***" means any or all of the following: (1) **Cholesterol (LDL-C) Screenings** - (i) ***Cholesterol Management for Patients With Cardiovascular Conditions:*** an LDL-C test performed during the measurement year, as identified by claim/encounter or automated laboratory data. Use any code in Table CMC-D, and (ii) ***Comprehensive Diabetes Care:*** the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an LDL-C test performed during the measurement year, as identified by claim/ encounter or automated laboratory data. Use any code listed in Table CDC-H; (2) **Blood Draw (HbA1c) Testing**-the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an HbA1c test performed during the measurement year, as identified by claim/ encounter or automated laboratory data; (3) **Nephropathy Screening**-a nephropathy screening test ***or*** evidence of nephropathy, as documented through administrative data and a nephropathy screening test during the measurement year; (4) **Body Mass Index ("BMI") Assessment**-Members 18–74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year; (5) **Blood Pressure**-the most recent BP level (taken during the measurement year), as documented through administrative data or medical record review; and (6) **Bone Density Screening**-women 67 years of age and older who suffered a fracture and who had either a bone mineral density test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

i. "***Services***" means the services to be performed by Vendor under this VSA and any applicable SOW, including but not limited to completion of the BPHP/360 Comprehensive Assessments, HEDIS Exam, and/or Educational Interventions.

j. "***Statement of Work***" or "***SOW***" means the Statement(s) of Work at Attachment B which sets forth in detail the additional Services being performed pursuant to this VSA.

Section 2: TERM AND SCOPE OF SERVICES

2.1 TERM. The VSA shall commence on the Effective Date and shall continue in full force and effect for 1 year ("Initial Term"). The VSA shall automatically renew thereafter for successive 1 year periods (each, a "Renewal Term", and together with the Initial Term, "Term") unless earlier terminated as provided herein. Termination shall not absolve any party from performance of its obligations under this VSA or applicable SOW which arose or accrued during the term of this VSA.

2.2 SERVICES. Vendor shall perform the Services as set forth in this VSA and in the applicable SOWs attached as Attachment B and which are incorporated herein by reference. Each SOW shall set forth, among other things, the commencement date, termination date, specific services to be performed and compensation. In connection with the its performance of the Services, Vendor shall supply all personnel, equipment and other instrumentalities required to perform the Services, unless otherwise set forth in the SOW. In addition, all Services performed by Vendor shall be performed in a good and workmanlike manner, in accordance with good and customary industry practices using competent and appropriately experienced personnel and will comport to the terms of this VSA and applicable SOWs.

2.3 VENDOR PERSONNEL

a. ***Excluded Personnel.*** Neither Vendor nor its employees or approved subcontractors are now, or, to Vendor's knowledge after good faith investigation, have ever been, excluded from participation in any federally funded health care program, including Medicare and Medicaid or are otherwise an Ineligible Person. Vendor shall promptly notify Bravo Health of Vendor becoming aware of any threatened, proposed, or actual exclusion of Vendor or any of its employees or approved subcontractors from any federally funded health care program. If Vendor becomes an Ineligible Person during the Term hereof, or if, at any time, it is determined that Vendor is in breach of this Section, this VSA shall, as of the effective date of such exclusion or breach, automatically terminate.

b. ***Removal of Personnel.*** Vendor shall remove any employee, Assessing/Non-Assessing Provider or subcontractor from providing Services upon Bravo Health's reasonable request.

c. ***Responsible Party***. Vendor shall designate an individual to serve as the responsible party for each SOW and who and who shall be responsible for and authorized to: (1) make decisions regarding the Services; (2) give any necessary approvals; (3) submit any reports relating to the Services and any other information relating to the Services or work to be performed; and (4) provide personnel with information and support for performance of the Services.

2.4 **ADDITIONAL OBLIGATIONS.** Subject to the terms and conditions of this VSA, and in addition to any obligations set forth in the SOW(s), Vendor agrees to the following:

a. ***Provision or Arrangement of Services.***

(1) Vendor will coordinate Services with its Assessing/Non-Assessing Providers which are consistent with any applicable guidelines or instructions agreed to between the parties. Vendor will ensure that prior to completing any BPHP/360 Comprehensive Assessment, HEDIS Exam, and/or Educational Interventions each Assessing/Non-Assessing Provider will have successfully completed, if applicable, any training program(s) provided by Vendor and/or agreed to between the parties.

(2) Vendor shall not be obligated to provide any Services in a setting where the provision of the Services would pose risk of bodily harm to the Assessing/Non-Assessing Providers. Vendor will promptly report such unsafe condition to Bravo Health. However, Vendor shall provide or arrange for such Services if a means mutually agreeable to Bravo Health and Vendor can be found to alleviate such unsafe condition. Moreover, neither Vendor nor its Assessing/Non-Assessing Providers shall provide any prescriptions or recommendations for medical care to Members; however, Vendor may provide such recommendations to the Member's personal treating physician and Bravo Health.

(3) Assessing/Non-Assessing Providers shall complete for each targeted Member, Bravo Health's BPHP/360 Comprehensive Assessment form and any additional reasonably requested services, which may include but is no limited to HEDIS Exams and educational interventions. The completed BPHP/360 Comprehensive Assessment form, HEDIS Exam, and/or Educational Interventions will be returned to Vendor for review for compliance with any requirements set forth in the applicable SOW, including being dated, being signed by the Assessing Provider with credentials and having the Member's name, Member's date of birth and date of service on each page, but only to the extent blank spaces are provided on each page calling for such information. The completed BPHP/360 Comprehensive Assessment, HEDIS Exam, and/or Educational Interventions form shall be returned to Bravo Health in accordance with the SOW but in no event will the submission deadline be less than 7 business days from completion of the BPHP/360 Comprehensive Assessment, HEDIS Exam, and/or Educational Interventions unless otherwise stated in the applicable SOW. Vendor shall be responsible for coordination, collection, and follow-up of required Member assessment documentation to the extent and as required by an applicable SOW.

(4) Vendor shall be available to consult with Bravo Health at all reasonable times during the term of this VSA regarding the Services. In addition, after termination of the VSA, Vendor shall be available to consult with Bravo Health as circumstances may reasonably require provided Bravo Health agrees to pay Vendor the existing consulting rates and actual expenses.

(5) Vendor shall provide sufficient education and training which has been reviewed by Bravo Health to all of its employees (whether full or part-time), temporary employees, call-center and scheduling personnel, Assessing/Non-Assessing Providers and any other approved subcontractors performing work for Bravo Health regarding their obligations, as applicable, under this VSA, SOW, the *Health Insurance Portability and Accountability Act of 1996* ("HIPAA"), *American Recovery and Reinvestment Act of 2009* ("ARRA"), any applicable requirements established under a government-funded program, including but not limited to Medicare and any requirements established by Bravo Health.

b. ***Licensing, Certification and Qualification.***

(1) Vendor shall comply with the Assessing/Non-Assessing Provider Qualification Policy set forth in Attachment A, which is incorporated herein by reference. In addition, Vendor shall require all Assessing/Non-Assessing Providers providing Services, as applicable, to be applicably licensed, qualified and/or certified in the state where the Assessing/Non-Assessing Provider is providing the Services. Vendor shall provide Bravo Health, upon request, a copy of any applicable license, certification and/or qualifications of any Assessing/Non-Assessing Provider performing Services. In addition, Vendor shall require all Assessing/Non-Assessing Providers to comply with any new reasonable licensing, certification and/or qualification requirements of Bravo Health within thirty (30) days, or within such other time frame as agreed upon by the parties, from when they are provided or made available to Vendor and all applicable laws, rules and regulations, unless

otherwise required to by state or federal law. Vendor shall immediately notify Bravo Health upon becoming aware of any Assessing Provider who subsequently fails to meet any licensing, certification and/or qualification requirement or becomes an Ineligible Person and such person shall be prohibited from performing any Services.

(2) Vendor shall make available to Bravo Health its licensing, certification and qualification policies and procedures as well as any documentation needed to support the licensing, certification and/or qualification of any assessment personnel.

c. ***Maintenance and Access to Records.***

(1) Vendor shall maintain such records as reasonably necessary to comply with applicable federal, state or local government laws, rules, and regulations or as required by this VSA or any applicable SOW as well as any other requirements under this VSA. Bravo Health shall upon prior reasonable request have access during normal business hours to the books, records and papers of Vendor relating to the Services provided under this VSA. Bravo Health and/or any health oversight agency that is reviewing Bravo Health's activities, including but not limited to DHHS, the Comptroller General, or their designee, may audit or evaluate through inspection or other means the operations and records of Vendor as it pertains in any way to the Services provided. Such audit or evaluation shall be conducted with due regard for not unnecessarily interfering with Vendor's other business and responsibilities. Bravo Health may conduct such audit as needed to evaluate whether Vendor's activities are being conducted in accordance with this VSA, applicable SOWs, or any local, state or federal laws and regulations, and Vendor's obligations. Such audit shall be at the expense of Bravo Health. However, in the event that an audit reveals that billing for the Services has been in excess of proper billing by more than 10%, the audit shall be at the reasonable expense of Vendor. Vendor further agrees that this provision shall survive the termination of this VSA

(2) Vendor shall take all reasonable steps to ensure that all BPHP/360 Comprehensive Assessment forms, HEDIS Exam, and/or Educational Interventions and any other Member information (whether electronic or paper format) are protected from loss, destruction or unauthorized use or disclosure and that such records shall be returned to Bravo Health upon request or termination of the VSA, except that Vendor shall be entitled to retain an archival copy. The provision of this paragraph shall survive termination of this VSA and any SOW.

2.5 **MEMBER NON-LIABILITY.** Vendor agrees that in no event, including, but not limited to, non-payment by Bravo Health, or Bravo Health's insolvency or breach of this VSA, shall Vendor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the Members for Services provided to such Members pursuant to this VSA. Vendor further agrees that this provision shall survive the termination of this VSA and shall be construed to be for the benefit of the Members, and this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Vendor and Bravo Health, insofar as any such contrary agreement relates to liability for payment for Services provided under the terms and conditions of this VSA.

2.6 **INSURANCE PROVISIONS.** Vendor shall maintain, for itself and its subcontractors, professional liability (malpractice) and errors and omissions insurance, and general liability insurance coverage for Vendor, as shall be reasonably necessary to insure against any claim or claims for damages arising by reason of any activities performed in connection with this VSA including the performance of Services under any SOW. Unless otherwise required by Bravo Health, the amounts and extent of such insurance coverage shall not be less than $1,000,000 per occurrence and $3,000,000 as an annual aggregate amount, or as otherwise required by applicable state law or regulations or as agreed to by Bravo Health. In the event that an Assessing Provider self-insures, the Assessing Provider must provide proof of excess liability coverage in the aggregate minimum amount of $10,000,000. Vendor shall provide Bravo Health with at least 30 days written notice of any cancellation, reduction or other material change in the above-referenced coverages. Vendor shall provide evidence of such self-insurance to Bravo Health upon request and Vendor shall be responsible for providing copies to Bravo Health on behalf of Assessing Providers. Vendor agrees to notify Bravo Health within 72-hours after the discovery of any and all incidents, occurrences, claims, or Member-related causes of action involving the Services which are the subject of this VSA. Vendor will provide all insurance coverage from an insurance company reasonably satisfactory to Bravo Health with an AM Best rating of at least A-.

Section 3: BRAVO HEALTH OBLIGATIONS

3.1 **INFORMATION.** Bravo Health will provide Vendor with the necessary information to allow Vendor to perform the Services and will reasonably cooperate with Vendor with reference to the Services.

3.2 **MODIFICATIONS OR CHANGES TO SERVICES.** Bravo Health shall notify Vendor in writing of any changes that it wishes to make to the Services to be performed under a SOW. If Bravo Health wishes to

have Vendor perform additional services, and if Vendor agrees, Vendor shall provide Bravo Health with a cost estimate and schedule impact for performing the modifications and/or additional services. Upon Bravo Health's written acceptance of the changes in the scope of the SOW, payment for and schedule of work, Vendor shall proceed to perform the work as agreed to by the parties.

3.3 **RESPONSIBLE PARTY.** Bravo Health shall designate an individual to serve as the responsible party for each SOW and who shall be responsible for and authorized to: (a) make decisions regarding the Services; (b) give any necessary approvals; (c) submit any reports relating to the Services and any other information relating to the Services or work to be performed; and (d) provide personnel with information and support for performance of the Services.

Section 4: COMPENSATION AND PAYMENT TERMS

4.1 **PAYMENT.** For Services provided under this VSA, Bravo Health shall pay Vendor in accordance with the applicable SOW. Vendor shall submit a detailed invoice and/or where applicable, an appropriate claims-based on 5010837 format or the then current submission format, for the Service. Bravo Health will pay Vendor for any undisputed claims within 30 days *following its receipt of the invoices submitted by* Vendor. Bravo Health will only dispute claims within such 30 day period and in good faith.

4.2 **PAYMENT OF ASSESSING/NON-ASSESSING PROVIDERS.** Vendor shall be solely responsible for all compensation to its Assessing/Non-Assessing Providers personnel, subcontractors, etc. for Services provided to Bravo Health under this VSA.

Section 5: CONFIDENTIALITY

PROTECTION OF CONFIDENTIAL INFORMATION.

a. Vendor shall maintain in strict secrecy and confidence all information and records related to the Services performed under this VSA, including but not limited to information related to any Bravo Health Members or HealthSpring, Inc. ("HS-Confidential Information"), as defined below, and shall not disclose, directly or indirectly, any HS-Confidential Information to any individual or entity or use, directly or indirectly, any HS-Confidential Information for any purpose, unless Vendor has received the prior written consent of Bravo Health; provided, however, that Vendor may (1) disclose and use HS-Confidential Information as necessary in connection with the performance of the Services and (2) disclose HS-Confidential Information pursuant to a subpoena or other legal process, provided that Vendor has provided to Bravo Health reasonable written notice under the circumstances that Vendor intends to so disclose HS-Confidential Information, together with the nature and substance of HS-Confidential Information intended to be so disclosed to provide Bravo Health and/or HealthSpring, Inc., if reasonably possible under the circumstances, the opportunity to object to such disclosure. All HS-Confidential Information shall be and remain the property of Bravo Health and/or HealthSpring, Inc. Vendor shall take all commercially reasonable steps to prevent the unauthorized use and disclosure of HS-Confidential Information, including but not limited to compliance with the HIPAA Agreement (as set forth in Section 7) entered into by the parties.

b. "HS Confidential Information" means collectively: (1) all trade secrets or confidential or proprietary information of Bravo Health, HealthSpring, Inc. or their Affiliates, including but not limited to, reports, work product, forms, assessment forms, Member lists, and analyses prepared by Bravo Health or HealthSpring, Inc. in connection with the Services; and (2) all information relating to Bravo Health, HealthSpring, Inc. or their Affiliates obtained by Vendor in the performance of the Services. Unless clearly designated otherwise, all information to which Vendor has access during the term of this VSA which relates to or comes from Bravo Health, HealthSpring, Inc. or their Affiliates shall be considered to be HS-Confidential Information. As between HealthSpring and the Vendor, Bravo Health and HealthSpring, Inc. shall be the sole and exclusive owner of all HS-Confidential Information.

c. In the event that Vendor has access to any Member protected health information or comes into contact with same, Vendor agrees to treat all such information in accordance with applicable federal and state laws and regulations including, but not limited to, regulations promulgated under HIPAA.

d. All Vendor employees (whether full or part-time), temporary employees, call-center and scheduling personnel, Assessing/Non-Assessing Providers and any other subcontractors performing work for Bravo Health shall execute a confidentiality and non-disclosure agreement acceptable to Bravo Health agreeing to maintain as confidential and not disclose any proprietary or confidential information of Bravo Health or HealthSpring, Inc., as required of Vendor herein (which acceptance will not be unreasonably withheld, delayed, conditioned, denied

or revoked).

5.2 **WORK FOR HIRE AND OWNERSHIP OF INTELLECTUAL PROPERTY.** Vendor acknowledges and agrees that any and all of Vendor's, or Vendor's employees' Assessing/Non-Assessing Providers' and/or subcontractors' right, title and interest in and to any and all work product generated in connection with the performance of the Services, including any ideas, inventions, original works of authorship, discoveries, developments, concepts, know-how, improvements or trade secrets, whether solely or jointly conceived or developed or reduced to practice, or caused to be conceived or developed or reduced to practice, in whatever physical or electronic medium, which relates to any and all Services performed under the VSA, whether or not patentable or registerable under copyright or similar laws (collectively "Work Product") belongs solely to Bravo Health and HealthSpring, Inc. Such ownership shall inure to the benefit of Bravo Health and HealthSpring, Inc. from the date of the conception, creation or fixation of the Work Product in a tangible medium of expression, as applicable. The parties agree that all copyright aspects of the Work Product shall be considered a "work-made-for-hire" within the meaning of the Copyright Act of 1976, as amended. If and to the extent the Work Product, or any part thereof, is found by a court of competent jurisdiction not to be a "work-for-hire" within the meaning of the Copyright Act of 1976, as amended, Vendor expressly assigns to Bravo Health and HealthSpring, Inc., all exclusive right, title and interest in and to the copyright, patent, trademark, trade secret and all other proprietary rights in and to the Work Product without further consideration, free from any claim, lien for balance due or rights or retention thereto on part of Vendor. Vendor agrees to execute all documents that, in Bravo Health's and/or HealthSpring, Inc.'s sole judgment and discretion, may be required to perfect such assignment. Vendor further agrees that all patent, trade secret or trademark in any formulas, processes, computer programs, ideas, inventions, techniques, or names, and any derivative works created there from that are developed by Vendor under this VSA shall be the sole and exclusive property of Bravo Health and/or HealthSpring as of the date of creation or conception.

5.3 **EXCLUSIONS.** Except with respect to protected health information (as set forth in Section 7, below), the obligations of Bravo Health and Vendor specified in this Section 5 regarding the protection of HS-Confidential Information shall not apply, and neither party shall have further obligations, with respect to any specific information to the extent they can demonstrate, by clear and convincing evidence, that such specific information: (a) is generally known to the public at the time of disclosure by the disclosing party, or becomes generally known through no wrongful act on the part of the receiving party's part; or (b) is in the possession of the receiving party's possession at the time of disclosure by the disclosing party other than as a result of the receiving party's breach of any legal obligation; or (c) becomes known to the receiving party through disclosure by sources other than the disclosing party having the legal right to disclose such confidential information; or (d) is independently developed by the receiving party without reference to or reliance upon the information supplied by the disclosing party; or (e) is required to be disclosed to comply with applicable state or federal laws, rules or regulations, provided that the applicable party provides prior written notice of such disclosure to the other and takes reasonable and lawful actions to avoid and/or minimize the extent of such disclosure.

5.4 **RETURN OF INFORMATION.** Upon expiration or termination of the VSA or any applicable SOW, to the extent feasible, Vendor shall return or destroy all HS-Confidential Information within 15 business days of such receiving a written request, if such information has not already been returned or destroyed. To the extent that HS-Confidential Information cannot be returned or destroyed, the terms and provisions of this Section 5 and the HIPAA Agreement (as defined in Section 7 below) shall survive termination. Vendor shall not retain any copies of the HS-Confidential Information or make any further use of such materials.

Section 6: TERMINATION

6.1 **TERMINATION WITHOUT CAUSE.** This VSA and/or any SOW may be terminated without cause by either party hereto upon 90 days' advance written notice. Such termination will have no effect upon the rights and obligations resulting from any transactions occurring prior to the effective date of the termination.

6.2 **TERMINATION WITH CAUSE.**

a. This VSA may be terminated immediately upon written notice to Vendor in the event that there is (1) imminent harm to Member health; (2) any action by a state medical board, other medical board, licensing board, or other governmental agency that has the potential to impair Vendor's or Assessing/Non-Assessing Provider's ability to perform the Services; (3) a case of fraud or malfeasance; or (4) in the event Vendor or any of Vendor's employees, Assessing/Non-Assessing Providers or contractors, is excluded from participation in the Medicare program or any administrative or regulatory proceedings is initiated that could lead to the exclusion of Vendor or any of Vendor's employees, Assessing/Non-Assessing

Providers or contractors from the Medicare program (42 C.F.R. § 422.752(a)(8)).

b. In the event that either Vendor or Bravo Health fails to cure a material breach of this VSA and/or SOW within 30 days of receipt of written notice to cure from the other, the non-defaulting party may terminate this VSA and/or SOW, effective as of the expiration of said 30 day period. If the breach is cured within such 30 day period, or if the breach is one which cannot reasonably be corrected within 30 days, and the defaulting party makes substantial and diligent progress toward correction during such 30 day period, there shall be an additional 30 day period to cure the material breach and this VSA and/or SOW shall remain in full force and effect. If the material breach is not cured within the applicable cure period following receipt of the written notice, this VSA and/or SOW will automatically terminate effective as of the date in the written notice of termination, but no earlier than the end of the applicable cure period.

c. This Agreement may be terminated immediately upon written notice in the event Vendor or Bravo Health loses licensure or other governmental authorization necessary to perform its obligations under this VSA.

d. Either party may terminate this VSA and/or SOW immediately by providing written notice to the other party upon (1) the filing by or against a party in a court of competent jurisdiction of a petition for bankruptcy, reorganization, dissolution, liquidation, or receivership; or (2) the inability of a party to pay its debts as they mature as evidenced by an order from a regulatory agency or court of competent jurisdiction or an assignment of assets by a party for the benefit of its creditors; (3) an adverse action by any licensing or accreditation agency against either party that materially affects the performance of the VSA; (4) a party fails to maintain insurance as required hereunder pursuant to this VSA; (5) a party has, without the written prior consent of the other party, used, released or disclosed proprietary or confidential information to a third party for purposes prohibited by this VSA; (6) the parties are unable to amend this VSA as provided for herein to comply with any applicable law or regulation; or (7) a change in the law or regulation that, in the opinion of a party's legal counsel, makes such party's operations or performance of its obligations under the VSA unlawful or subject to significant regulatory scrutiny that has a significant risk of a material adverse impact on a party.

e. In addition to the foregoing, Bravo Health may terminate this VSA effective immediately upon written notice to Vendor, if Vendor (1) fails to comply with the Assessing/Non-Assessing Provider Qualifications Policy set forth at Attachment A, which remains uncured after 10 days from Vendor receiving written notice of such from Bravo Health; (2) fails to meet any applicable milestone in a SOW, unless otherwise agreed to in writing by Bravo Health, which remains uncured after 15 days; (3) fails to comply with any material provision of the SOW, which remains uncured after 30 days from Vendor receiving written notice of such from Bravo Health; or (4) as otherwise provided for in this VSA.

6.3 **TERMINATION BY MUTUAL CONSENT.** The parties may terminate this VSA at any time upon mutual written consent.

6.4 **POST-TERMINATION OBLIGATIONS.** The following shall apply upon the termination or expiration of the VSA. Each party shall reasonably cooperate under the circumstances with the other in all matters relating to the winding up of pending work and the orderly transfer of any pending work to the other party or its designees.

a. If not already permanently removed or deleted from any computer, network, or otherwise securely disposed of, to the extent feasible, Vendor shall return to Bravo Health all copies of all information associated with or provided by, Bravo Health or HealthSpring, Inc. in Vendor's possession or under its control, including but not limited to, all HS-Confidential Information. Such information shall be delivered to Bravo Health within 15 business days of termination, and confirmation shall be provided at that time that compliance with this obligation has occurred. Unless otherwise agree to by the parties, or unless such retention of information is required by federal or state law or regulation, and if feasible, Vendor shall not retain any copies of the HS-Confidential Information, as applicable, and shall make no further use of such materials. In addition, Vendor shall comply with the provision for the return or destruction of protected health information as set forth in HIPAA Agreement.

b. ***Return of BPHP/360 Comprehensive Assessments, HEDIS Exams, and/or Educational Interventions.*** Upon expiration or termination of the VSA or any applicable SOW, Vendor shall return to Bravo Health within 10 days all BPHP/360 Comprehensive Assessments, HEDIS Exam, and/or Educational Interventions whether or not completed.

6.5 **EFFECT OF TERMINATION.** In the event of termination of the VSA or any applicable SOW, Vendor shall be entitled to compensation for Services rendered through the date of termination and any authorized expenses incurred in the performance of the Services. Furthermore, except as required by law, neither party may disclose the reasons for any

termination hereunder without the prior written consent of the other party, except that disclosure is permitted to a party's auditors and legal advisor.

Section 7: HIPAA COMPLIANCE

7.1 **BUSINESS ASSOCIATE AGREEMENT**. In order to comply with HIPAA, in addition to any other obligation set forth in this VSA, the parties shall act in accordance with the *Business Associate Agreement* executed by the parties and which is attached hereto as Attachment C and is incorporated herein by reference ("*HIPAA Agreement*").

7.2 **PROTECTED HEALTH INFORMATION.** Vendor agrees to safeguard the privacy and confidentiality of Bravo Health Members, Member information and to comply with all applicable state and federal privacy and confidentiality requirements, including the privacy and security regulations promulgated under HIPAA, ARRA and applicable requirements established under a government-funded program, including but not limited to Medicare, and any reasonable requirements established by Bravo Health or HealthSpring, Inc. Moreover, Vendor and Bravo Health agree that all Member individually identifiable health-related information ("Protected Health Information" ["PHI"] and/or "Electronic Protected Health Information" ["ePHI"]) shall be used and disclosed only as permitted by HIPAA, ARRA and any other applicable state and federal laws. Vendor and Bravo Health shall also adopt and maintain procedures consistent with applicable law to safeguard the security and confidentiality of PHI and ePHI. Except as required to carry out the parties' obligations under this VSA or to fulfill another legal duty, Vendor shall not disclose, sell or otherwise transfer or provide any PHI, ePHI, or other HS-Confidential Information on any individually identifiable Member basis to any third party. In no event shall Vendor sell any *PHI, ePHI* or other *HS-Confidential* Information of either party, whether or not such information is individually identifying. Vendor shall ensure that its Assessing/Non-Assessing Providers have agreed to adhere to all applicable HIPAA regulations.

Section 8: SECURITY REQUIREMENTS

Vendor shall comply with the Security Requirements set forth in Attachment D, which are incorporated herein by reference.

Section 9: MISCELLANEOUS

9.1 **ENTIRE AGREEMENT.** The VSA, including all SOWs, *contains the entire agreement between the* parties. All prior negotiations and all agreements, either oral or written, between the parties are merged into the VSA and there are no understandings or agreements other than those incorporated herein. The VSA supersedes any and all other previous agreements. Any modification of the VSA shall be effective only if it is in writing and signed by the parties.

9.2 **ASSIGNMENT/SUBCONTRACTORS.** Vendor may not assign this VSA or any SOW nor any rights thereunder without the prior written approval of Bravo Health, which approval shall not be unreasonably withheld. Vendor is prohibited from using subcontractors in the performance of the Services unless otherwise approved herein or otherwise in writing by Bravo Health. Any attempted assignment made by Vendor in contravention of this VSA shall be null and void for all purposes. In the event of successors or assigns which are permitted under this VSA, this VSA shall be binding upon and inure to the benefit of the parties and their respective successors and assigns.

9.3 **DISPUTE RESOLUTION.** Any controversy, dispute or claim arising out of or relating to this VSA or the breach thereof, including any question regarding its interpretation, existence, validity or termination, that cannot be resolved informally, shall be resolved by arbitration in accordance with this Section, provided however that a legal proceeding brought by a third party against Bravo Health, Vendor or an Affiliate ("Defendant"), any cross-claim or third party claim by such Defendant against Bravo Health, Vendor or an Affiliate, shall not be subject to arbitration. In the event arbitration becomes necessary, *such arbitration shall be initiated by either* party making a written demand for arbitration on the other party. The arbitration shall be conducted Harris County, Texas, in accordance with the Commercial Arbitration Rules of the American Arbitration Association, as they are in effect when the arbitration is conducted, and by an arbitrator knowledgeable in the health care industry. The parties agree to be bound by the decision of the arbitrator. The parties further agree that the costs, fees and expenses of arbitration will be borne by the non-prevailing party. Notwithstanding this agreement to arbitrate, the parties may seek interim and/or permanent injunctive relief *pursuant to this Agreement* in Harris County, Texas in any court of competent jurisdiction. With respect to disputes arising during the life of this VSA, this Section shall survive the termination or expiration of this VSA.

9.4 **NAMES, MARKS & ADVERTISING RESTRICTIONS.** Neither party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing, or similar publicly disseminated material without first submitting such material to the other party and obtaining the other

party's express written approval of the material and consent to such use. In addition, Vendor agrees not to use Bravo Health's, HealthSpring, Inc.'s, its subsidiaries' or affiliates' name, trademarks symbols, service marks, copyrights, logos or owned or registered designs in any way, including in promotional materials, absent the prior written consent of Bravo Health or HealthSpring, Inc.

9.5 **NOTICES**. Any notice required to be given pursuant to the terms and provisions of this VSA shall be delivered by hand, sent by certified mail, return receipt requested, postage prepaid, or by a nationally recognized overnight mail service addressed as follows:

To Bravo Health at:

3601 O'Donnell St.
Baltimore, MD 21224
Attn: Chief Operating Officer

With copy to General Counsel:
HealthSpring, Inc.
2900 North Loop West, Suite 1300
Houston, TX 77092

To Vendor at:

EMSI
3050 Regent Blvd.,
Suite 400
Irving, TX 75063
Attn: Vice President of Healthcare Services

Notices shall become effective upon receipt. Each party may change the address by written notice in accordance with this paragraph upon at least 10-days prior written notice to the other party.

9.6 **REGULATION; SEVERABILITY.** Bravo Health is subject to the requirements of various state and federal laws. Bravo Health shall be responsible for promptly notifying Vendor in writing of such requirements and the parties shall negotiate in good faith to attempt to amend this VSA to ensure that any provision required to be in this VSA by any of state or federal law, rule or regulation shall bind Vendor and Bravo Health. In the event the parties are not able to reach agreement, Bravo Health may immediately terminate this VSA. If any provision of this VSA is rendered invalid or unenforceable by any local, state, or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this VSA shall remain in full force and effect. Bravo Health shall secure and maintain in effect any and all necessary licenses issued by the applicable government agency required for the performance of Bravo Health's duties under this VSA. Bravo Health shall inform Vendor of any material change with respect to any license or failure to comply with any regulatory filing or requirement of any state or federal laws as may affect the adherence to or performance of obligations under this VSA.

9.7 **FORCE MAJEURE.** No party shall be responsible, or suffer any liability, charge, deduction, or other reduction in compensation, for any delay or failure in performance of any part of this VSA to the extent such delay is demonstrably caused by events or circumstances beyond the applicable party's reasonable control. Such causes shall include, but not be limited to, flood, riot, insurrection, fire, earthquake, acts of terrorism or war, communication line failure, power line failure, changes in applicable law or regulation, explosion, acts of God, or any force or cause beyond the reasonable control of the party claiming the protection of this paragraph. Without relieving either party of its obligations and/or liabilities hereunder, the affected party shall immediately report to the other party any delay whatsoever and its cause. The affected party shall continue to keep the other party reasonably informed and take all reasonable action to minimize the delay.

9.8 **NOTICE OF UNAVOIDABLE DELAY OR ADVERSE CIRCUMSTANCE.**

a. If the delivery of Services under this VSA or any applicable SOW should be unavoidably delayed, Vendor shall immediately notify Bravo Health's Vendor Services Account Manager as set forth in the applicable SOW, with a copy to Bravo Health's Legal Department, in writing and Bravo Health shall extend the time for completion of the Services for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during Vendor's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of Vendor, Vendor's subcontractors, or their agents, and was substantial and in fact caused Vendor to miss delivery dates, and could not reasonably have been guarded against by contractual or legal means. Delays caused by Bravo Health will be sufficient justification for delay of services, and Vendor shall be allowed a day-for-day extension.

b. Vendor shall notify Bravo Health as soon as Vendor has, or reasonably should have, knowledge that an event has occurred which will delay deliveries. Within 5 working days, Vendor shall confirm such notice in writing, furnishing as much detail as is available.

c. Vendor agrees to supply, as soon as such data is available, any reasonable proofs that are required by

Bravo Health to make a decision on any request for extension. Bravo Health shall examine the request and any documents supplied by Vendor and shall promptly and reasonably determine if Vendor is entitled to an extension and the duration of such extension. Bravo Health shall notify Vendor of this decision in writing. It is expressly understood and agreed that neither Vendor nor Bravo Health may be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

d. Each party shall notify the other upon becoming aware of any action, event or occurrence, which could reasonably be expected to prevent or delay the performance of the Services or performance of obligations under this VSA.

9.9 **GOVERNING LAW.** The VSA shall be governed by, as applicable, federal law and/or the laws of where the services are to be provided, regardless of any conflicts of laws or rules that would require the application of the laws of another jurisdiction.

9.10 **WAIVER.** Any waiver of any term, covenant or condition of the VSA by any party shall not be effective unless set forth in writing and signed by the party granting such waiver, and in no event shall any such waiver be deemed to be a waiver of any other term, covenant or condition of this VSA or any subsequent waiver of the same term, covenant or condition.

9.11 **OMISSIONS.** In the event that either party hereto discovers any material omission in the provisions of this VSA or any Statement of Work which such party believes is essential to the successful performance of this VSA or any SOW, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this VSA or the statement of work.

9.12 **CONFLICT.** In the event there is any conflict between the defined terms or HIPAA requirements stated in the VSA and HIPAA, or the parties' obligations under HIPAA, HIPAA shall be controlling. Furthermore, any ambiguity in the VSA shall be resolved in favor of a meaning that permits Vendor to comply with HIPAA.

9.13 **INDEMNIFICATION.** Both parties shall indemnify and hold the other party harmless from any and all costs, expenses, liabilities, losses, damages, injunctions, suits, actions, fines, penalties, claims and demands, including legal costs and reasonable attorney's fees, made by or on behalf of any party, person or governmental authority, and arising out of or resulting from a party's breach of its obligations under this VSA or the negligent performance of Services under any SOW. The party seeking indemnification ("Indemnitee") shall promptly, and in no case more than 15 days after receipt of written notice to it of any claim as to which it asserts a right to indemnification, notify the other party ("Indemnitor") of such claim. Indemnitee shall set forth in such notice the section of this VSA under which the indemnification is claimed, factual support and information regarding the claim, and the amount of such claim. The failure of Indemnitee to give such notice under this Section shall not relieve Indemnitor from any liability that it may have pursuant to this VSA except to the extent the failure to give such notice within such time is materially prejudicial to the Indemnitor's ability to defend itself and/or the Indemnitee.

9.14 **DISASTER RECOVERY & BUSINESS CONTINUATION PLAN.** Vendor shall maintain a Disaster Recovery/Business Continuation ("Disaster Plan") that sets forth a strategy to reasonably respond to an event that impacts Vendor's ability to timely perform its obligations hereunder or under any SOW, including a system breakdown and natural or man-made disaster. The Disaster Plan will include application and system recovery and/or manual procedures as well as operating procedures to enable continued provision of Services within 48 hours of a disaster or system failure. Vendor will maintain or contract for a computing environment which includes required hardware, software, network, power and other related equipment or software necessary to execute the Disaster Plan. Vendor will test its Disaster Plan in accordance with the requirements of the HIPAA Security Rule, but at least annually and in the event of a major change in the company environment, and provide Bravo Health or HealthSpring, Inc. with results. Bravo Health or HealthSpring, Inc. or its designee may audit Vendor's Disaster Plan to monitor performance hereunder.

9.15 **COMPLIANCE WITH LAWS.** This VSA is intended to comply in all material respects with the terms of all applicable federal, state, and local laws and regulations, either presently in existence or enacted, made or enforced hereafter. Each party agrees to comply with all applicable federal, state and local laws and regulations in the performance of its obligations hereunder. If any law or regulation is enacted, modified or subject to judicial interpretation so that this VSA (or any provision hereof) would be found not to comply with such law or regulation, and such non-compliance cannot be remedied, the parties

shall negotiate in good faith to amend this VSA to comply with the law or regulation. If the parties are unable to so amend this VSA within 30 days of either party's good faith notice to the other of the need for amendment, then notice of termination may be given in accordance with this VSA.

9.16 **NON-DISPARAGEMENT.** During the term of this VSA and any applicable SOW, Vendor agrees to refrain from making disparaging comments, remarks, or allegations about Bravo Health or HealthSpring, Inc., including but not limited to, its services, products, personnel and management. For purposes of this VSA, a "disparaging" statement, comment, or remark means (a) a defamatory statement at common law; (b) a false statement of fact which represents or communicates either (1) that the Bravo Health's or HealthSpring, Inc.'s goods, services or qualifications are inferior in quality, and which is made for the purpose of discouraging any third party from utilizing the goods or services of Bravo Health or HealthSpring, Inc.; (2) that Bravo Health or HealthSpring Inc. is not a viable and going concern; or (3) a false statement that the other party's product or service pricing is too high as compared to any products or services offered by others.

9.17 **STATUS AS INDEPENDENT ENTITIES.** The relationship between Bravo Health and Vendor shall be that of independent contractors. None of the provisions of this VSA are intended to create or shall be deemed or construed to create any relationship between Vendor and Bravo Health other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this VSA. Neither Vendor nor Bravo Health, nor any of their respective agents, employees, or representatives shall be construed to be the agent, employee or representative of the other. This VSA shall not create any rights in any third party, who has not entered into this VSA nor shall this VSA entitle any such third party to enforce any rights or obligations that may be possessed by such third party. This VSA shall not create, and shall not be construed as creating, any partnership, joint venture, or agency relationship or employer-employee relationship, or any other relationship except that of independent contractors. Nothing contained in this VSA shall cause either Bravo Health or Vendor to be liable or responsible for any debt, liability or obligation of the other party or any third party unless such liability or responsibility is expressly assumed by the party sought to be charged therewith.

9.18 **HEADINGS.** The section headings used in the VSA are intended for convenience only and shall not be deemed to affect in any manner the meaning or intent of the VSA or any provision hereof.

9.19 **SURVIVAL.** In addition to any other provisions of this VSA which expressly provide that they are to survive the termination of this agreement, the following provisions of the VSA in their entirety shall also survive expiration or termination of the VSA: Section 4, *Compensation and Payment Terms*; Section 5, *Confidentiality*; Paragraph 6.4, *Post-Termination Obligations*; Paragraph 6.5, *Effect of Termination*; Section 7, *HIPAA Compliance*; paragraph 9.4, *Names, Marks & Advertising Restrictions*; paragraph 9.5, *Notices*; paragraph 9.6, *Regulations*; *Severability*; paragraph 9.9, *Governing Law*; paragraph 9.10, *Waiver*; paragraph 9.12, *Conflict*; paragraph 9.16, *Non-Disparagement*; paragraph 9.13, Indemnification; paragraph 9.19, *Survival*; and HIPAA Agreement.

IN WITNESS WHEREOF, the parties hereto have executed the VSA as of the Effective Date.

EMSI

By: _____
Signature

Robert P. Brook, its
Print Name

Executive Vice President
Title

Date of Execution: 5.2.2012

BRAVO HEALTH

By: _____
Signature

_____, its
Print Name

_____, its
Title

Date of Execution: 5/4/12

ATTACHMENT A

ASSESSING/NON-ASSESSING PROVIDER QUALIFICATION POLICY

Pursuant to paragraph 2.4(b) *Licensing, Certification and Qualification* of the VSA, Vendor agrees to comply with the following Assessing/Non-Assessing Provider Qualification Policy.

A-1. INTRODUCTION. Bravo Health maintains the following Assessing/Non-Assessing Provider Qualification Policy defining the required credentials for qualified Assessing/Non-Assessing Providers performing the Services. This policy is designed to be consistent with regulatory and accrediting guidelines.

A-2. OBJECTIVES. The goal of this policy is to ensure that comprehensive medical assessments are completed by qualified, licensed personnel consistent with CMS provider requirements and with the National Committee for Quality Assurance ("NCQA") provider credentials requirements. This goal is achieved by: (a) qualified professionals conducting member comprehensive medical assessments; (b) establishing a process of monitoring on-site visit occurrences; (c) advocating the use of appropriate resources; and (d) ensuring protected health information ("PHI") as defined by the *Health Insurance Portability and Accountability Act of 1996* is available only on a need-to-know basis and that all records related to the member and comprehensive medical assessments are kept confidential.

A-3. SCOPE. Utilizing the BPHP/360 Comprehensive Assessment Form previously provided to Vendor (and which may be unilaterally modified by Bravo Health upon 30-days notice to Vendor), Assessing Providers will conduct face-to-face comprehensive medical assessments of the health plan member's health status only. Vendor and/or Assessing Providers shall not provide any treatment or medication therapy to the member. In addition, Assessing Provider may also provide the HEDIS Exam and/or Educational Interventions.

A-4. QUALIFICATION PROCESS.

a. ***Licenses, Certifications and/or Qualifications.*** To the extent applicable, Vendor shall confirm before any services are performed and continually monitor that all Assessing/Non-Assessing Providers performing BPHP/360 Comprehensive Assessments, HEDIS Exams and Educational Interventions are in compliance with all requirements of this VSA and, as applicable, with NCQA credentialing standards and CMS provider requirements.

(1) Selection of Assessing Providers. All Assessing Providers shall be selected and credentialed through a process in accordance with this VSA and in compliance with applicable DHHS Medicare Advantage laws and regulations and National Committee on Quality Assurance ("NCQA") standards. In addition, all Assessing Providers shall be of an allowed provider type and specialty as indicated by CMS for purposes of risk adjustment and have submitted to CMS form 855B-*Medicare Enrollment Application* and have documentation evidencing acceptance or approval of the application by CMS.

(2) Selection of Non-Assessing Providers. All Non-Assessing Providers shall be selected and credentialed through a process in accordance with this VSA and in compliance with applicable Vendor and Bravo Health qualifications. In addition, the following are additional requirements for a Non-Assessing Provider performing any of the following:

(i) **Blood drawing:** Phlebotomist, professional trained and qualified to draw blood;

(ii) **Nephropathy:** professionally trained on how to properly deliver training subject matter to members in a succinct, understandable and professional manner;

(iii) **Body Mass Index ("BMI"):** professionally trained on proper gathering and BMI calculation;

(iv) **Blood Pressure:** professionally trained on proper use of blood pressure equipment and reading and recording of results;

(v) **Insure Kit/Colorectal Screening:** professionally trained on the proper use of the lab kit; and

(vi) **Bone Density:** professionally trained on the proper use, calibration, and trouble shooting of a bone density machine, and able to read and accurately record results.

(3) Current Valid State License To Practice, In Good Standing. An applicable state licensing agency (e.g. Board of Medical Examiners, Board of Nurse Examiners) must be contacted by Vendor to confirm the Assessing Provider's, and if applicable, Non-Assessing Provider's, active licensure status in the state where the BPHP/360 Comprehensive Assessments, HEDIS Exam and/or Educational Interventions are being performed. If website verification is used, the website must be from the appropriate state licensing agency. A copy of the website verification page or other confirmation of verification of active license must be maintained by Vendor.

(4) Medicare Sanctions. Queries against the National Practitioner Data Bank ("NPDB") must be checked by Vendor for each Assessing/Non-Assessing Provider for Medicare/Medicaid sanctions. In addition, Vendor must also check the Assessing/Non-Assessing Provider against the state and federal Office of Inspector General for Medicare/Medicaid sanctions, and the Excluded Parties List System. Assessing/Non-Assessing Provider self-query is not acceptable. A copy of each of the respective verification pages must be maintained.

(5) Professional Liability Claims. A minimum of a 5 year history of malpractice claim settlements (obtainable from the NPDB) must be reviewed by Vendor for each Assessing Provider. This 5-year time frame may include residency or fellowship years. Coverage limits must meet applicable state requirements and must clearly identify the coverage time frame. If the Assessing Provider has federal tort coverage, the amount of coverage does not need to be provided.

(6) Attestation Regarding The Completeness And Accuracy Of Information Provided. When supplying information about the Assessing/Non-Assessing Provider's credentials, each Assessing/Non-Assessing Provider must complete an attestation addressing each of the following: (i) reason for inability to perform the essential functions associated with the license; (ii) lack of present illegal drug use; (iii) history of loss of license and felony conviction; (iv) history of loss or limitation of privileges or disciplinary actions; and (v) the correctness and completeness of information supplied.

(7) Attestation Must Be Signed. The attestation must be signed and dated by the individual Assessing/Non-Assessing Provider. A signature stamp is not acceptable.

b. ***Non-discrimination***. Vendor shall not discriminate in the selection of an Assessing/Non-Assessing Provider to conduct any of the Services based on race, color, national origin, religion, age, disability, sex, or sexual orientation in accordance with federal, state, and accreditation standards.

A-5. TRAINING.

a. All Assessing/Non-Assessing Providers are required to be appropriately trained before being permitted to perform a BPHP/360 Comprehensive Assessment. HEDIS Exam and/or Educational Interventions and retrained annually or attend such other training as may be agreed to between the parties; however, if clinical standards and/or requirements change Bravo Health may review and disapprove any of Vendor's new additional training and testing. Vendor shall utilize and make available to Assessing/Non-Assessing Providers, if applicable, Bravo Health or HealthSpring, Inc. provided training modules.

(1) In addition to any other training required by this VSA or any applicable SOW, all Assessing/Non-Assessing Providers shall have the following training from Vendor:

(i) trained so that in the event of an emergency during the course of the BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Interventions to contact 911;

(ii) trained on specifics of performing BPHP/360 Comprehensive Assessments using Bravo Health's proprietary BPHP/360 Comprehensive Assessment form and, if applicable, Bravo Health or HealthSpring, Inc. training modules;

(iii) HEDIS Exam and/or Educational Interventions;

(iv) trained to perform the BPHP/360 Comprehensive Assessments to such a level as to provide the most reasonably accurate, compliant and complete BPHP/360 Comprehensive Assessment possible; and

(v) trained to contact Bravo Health if the Assessing/Non-Assessing Provider has identified

an urgent situation or has concerns about a member's health or well-being.

b. Vendor will commit to providing at minimum on a weekly basis, a consolidated active and inactive Assessing/Non-Assessing Provider log which should include at minimum the following details about the Assessing/Non-Assessing Provider: name; demographics; credentials; start and/or end date; state licensure ID; NPI #; and, if applicable, validation that he/she has completed and passed all training with a score of 80% or above.

A-6. POLICY EVALUATION.

a. ***Qualification Policy.*** Bravo Health's Assessing/Non-Assessing Provider Credentialing Policy is reviewed at lease bi-annually and modified as necessary. Any changes to Bravo Health's Provider Credentialing Policy will be provided to Vendor.

(1) Face-To Face Encounters. Face-to-face member comprehensive medical assessments are monitored by numerous methods including the following: (i) the member, their family member, or their caregiver may be asked to sign an attestation confirming that the Assessing Provider actually conducted the comprehensive medical assessments; (ii) an outbound call may be placed to the member to confirm that a face-to-face comprehensive medical assessments occurred and to assess the member's satisfaction with that encounter; (iii) the volume, timing and geographic location of visits may be monitored; and (iv) the concordance between the potential care needs identified during the comprehensive medical assessments and the submitted claims for care provided is monitored.

A-7. OVERSIGHT. Vendor shall have in place a credentials review process to ensure that before any work is performed for Bravo Health that all Assessing/Non-Assessing Providers credentials have been checked and confirmed to be in good standing and shall perform on-going monitoring of the Assessing Providers, and a recheck every two years the Non-Assessing, Provider's standing and credentials. In addition, a full review must be conducted by Vendor at least every 3 years. Bravo Health or HealthSpring, Inc. may review at any time Vendor's credentialing processes to ensure it meets Bravo Health's expectations and are consistent with contractual and accreditation requirements. Vendor must notify Bravo Health within 5 business days of becoming aware of any adverse change in Assessing/Non-Assessing Provider status or credentials, or, in the case of Non-Assessing Providers, just cease using such individuals to perform any services for Bravo Health.

A-8. COLLABORATING AGREEMENTS. To the extent required by the applicable law for the state in which the BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Interventions is being performed, Vendor will obtain and ensure that any required collaborating agreements are in place prior to an Assessing Provider starting the project. Vendor will provide Bravo Health, upon request, with the name, address and contact information for the collaborating physician as well as a copy of the collaborating agreement.

A-9. CONFIDENTIALITY. All Assessing/Non-Assessing Providers shall execute a confidentiality and non-disclosure agreement, prepared by Vendor and which is acceptable to Bravo Health, before the Assessing/Non-Assessing Provider is allowed to perform any services under this SOW. A copy of the executed confidentiality and non-disclosure agreement shall be provided to Bravo Health upon request. In addition, neither Vendor nor any Assessing/Non-Assessing Provider shall use any Bravo Health or HealthSpring, Inc. forms, including but not limited to the proprietary BPHP/360 Comprehensive Assessment forms, outside the scope of the services set forth in this SOW, whether for itself/herself or for any third parties. Moreover, neither Vendor nor any Assessing/Non-Assessing Provider shall disclose, directly or indirectly, any member PHI or any Bravo Health or HealthSpring, Inc. reports or forms, including but not limited to the proprietary BPHP/360 Comprehensive Assessment forms, to any third parties or contractors, except contractors in Vendor's network of service providers who are performing BPHP/360 Comprehensive Assessments in connection with this SOW.

A-10. DOCUMENTATION. Vendor shall provide Bravo Health, upon request, any Assessing/Non-Assessing Providers credentialing, licensing, training, confidentiality documentation, verification, relevant collaborative agreements and/or other documentation related to or required

by this Attachment within 5 business days of such request.

A-11. CONDUCT, BEHAVIOR AND DRESS. In performing the BPHP/360 Comprehensive Assessments, the Assessing/Non-Assessing Provider must adhere to the following conduct, behavior and dress requirements. The Assessing/Non-Assessing Provider shall:

a. wear a picture ID listing their name, credentials, the Bravo Health logo and Vendor name approved by Bravo Health on the outside of their clothing at all times during the BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Interventions;

b. be polite, professional, clean, appropriately attired and neat in appearance and, if requested by Bravo Health, wear a white "lab jacket"; and

c. act in a manner that complies with applicable federal, state and local laws and regulations, including those promulgated by the DHHS, CMS and any state licensing boards as well as any applicable ethical standards.

A-12. SCHEDULED TIME. Assessing/Non-Assessing Providers shall arrive on time for the scheduled BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Interventions. If the Assessing/Non-Assessing Provider will be more than 10-minutes late for a scheduled BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Interventions the Assessing/Non-Assessing Provider shall confirm via telephone with the member that he/she is still available to participate in the BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Interventions. If the member is no longer available, Vendor shall within 1-business day attempt to re-schedule the appointment

A-13. PROVIDER EQUIPMENT. Vendor must ensure that each Assessing/Non-Assessing Provider is provided, as applicable, with the necessary equipment and tools to perform the Services and knows how to properly use the equipment/tools in order to complete, as applicable an Acceptable BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Interventions perform the Services, including but not limited to:

a. Vendor issued company picture ID, listing credentials;

b. white lab jacket;

c. stethoscope - ADC Proscope model 670 or Dual Head Stethoscope equivalent;

d. ophthalmoscope - ADC Standard Ophthalmoscope Pocket Set 5112 or an ophthalmoscope equivalent (requires AA batteriES);

e. MONOFILAMENT (5.07/10gram);

f. tongue blade;

g. urine dipstick kit for protein and glucose testing;

h. tuning fork (128Hz) for vibratory sense testing;

i. blood pressure cuff (Adult size) – ADC Prosphyg 775 Series or equivalent sphygmomanometer;

j. Bone Density Machine (Dexa Scan); and

k. Spirometer.

A-14. DISCIPLINE POLICY. Vendor shall recruit, hire and retain Assessing/Non-Assessing Providers who, at minimum, meet CMS and state and federal regulatory requirements and standards. Failure to comply with these requirements may result in the following action:

a. In the event that Bravo Health determines Vendor has approved an Assessing/Non-Assessing Provider that does not met the credentialing and/or training requirements set forth in this VSA, Bravo Health shall provide in writing a letter to Vendor to immediately discontinue using the unapproved Assessing/Non-Assessing Provider on any Bravo Health projects. In addition, Bravo Health will not compensate Vendor (or will be credit any amounts paid) for any BPHP/360 Comprehensive Assessments, HEDIS Exam and/or Educational Interventions performed by the non-complying Assessing/Non-Assessing Provider.

b. In the event that Bravo Health identifies clinical inconsistencies, behaviors, and/or documentation of concern related to a BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Intervention, Bravo Health shall notify Vendor and provide a reasonable written corrective action plan to be followed by Vendor which may include, but is not limited to immediate discontinuance of the use of the

Assessing/Non-Assessing Provider and/or termination of this VSA. Continued failure of the Assessing/Non-Assessing Provider to correct the identified issues will result in the Assessing/Non-Assessing Provider being prohibited from performing any further BPHP/360 Comprehensive Assessments, HEDIS Exams and/or Educational Interventions on any Bravo Health projects. In addition, Bravo Health will not compensate Vendor (or will be credited any amounts paid) for any BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Intervention performed by the non-complying Assessing/Non-Assessing Provider.

END OF ATTACHMENT A

ATTACHMENT B

STATEMENT(S) OF WORK

Pursuant to the VSA, the following are the applicable SOWs comprising the Services to be performed by Vendor. In addition, the following is applicable to all Statements of Work:

B-1. QUALITY ASSURANCE ("QA") FOR BPHP/360

a. ***Vendor QA.*** Vendor shall perform immediate QA on every BPHP/360 Comprehensive Assessment prior to delivering the BPHP/360 Comprehensive Assessments to Bravo Health. A description of Vendor's QA program is required with a sample of associated reporting with stated frequency that will be shared with Bravo Health. Vendor's QA process will, at a minimum, be in accordance with the following to the extent blank spaces are provided calling for such information:

(1) Completed BPHP/360 Comprehensive Assessment must be legible and readable;

(2) Member name identified on each page of the BPHP/360 Comprehensive Assessment form;

(3) Correct date of service and member date of birth (360 only) must be stated on each page of the BPHP/360 Comprehensive Assessment—the dates must all be the same date;

(4) All pages of the BPHP/360 Comprehensive Assessment form are present as well as any other additional information that may be required by the form;

(5) Assessing Provider's full, legible name and ID number on the first page of the BPHP/360 Comprehensive Assessments; his/her initials are on all subsequent pages; and his/her full signature and credentials on the signatory page;

(6) If the Assessing Provider makes any corrections to the BPHP/360 Comprehensive Assessment, the Assessing Provider must draw a line through the area to be corrected, correct the entry, date, and initial next to the correction for the correction to be considered acceptable by CMS.

(7) The correct ICD-9-CM codes and supporting documentation has to be noted; an ICD-9-CM can be assigned on the basis of the evaluation and clinical findings.

(8) Vendor understands that CMS requirements are subject to modification based on current CMS directives.

b. ***QA Failure.*** If any BPHP/360 Comprehensive Assessments fail Bravo Health's QA process or there are completeness or quality concerns about the BPHP/360 Comprehensive Assessments, Bravo Health will contact Vendor. Any BPHP/360 Comprehensive Assessments not meeting the requirements of this VSA must attempt to be corrected and resubmitted to Bravo Health (at no additional cost) within 5-business days of notification by Bravo Health.

c. ***Bravo Health QA Audit.*** Bravo Health at any time may audit processes, practices or deliverables related to any SOW.

B-2. QUALITY ASSURANCE ("QA") HEDIS EXAMS AND EDUCATIONAL INTERVENTIONS

a. ***Vendor QA.*** Vendor shall perform prompt QA on every HEDIS Exam and/or Educational Intervention. Comprehensive Assessments to Bravo Health. A description of Vendor's QA program is required with a sample of associated reporting with stated frequency that will be shared with Bravo Health.

b. ***QA Failure.*** If any HEDIS Exam and/or Educational Intervention fails Bravo Health's QA process or there are completeness or quality concerns about the HEDIS Exam and/or Educational Intervention, Bravo Health will contact Vendor. Any HEDIS Exam and/or Educational Intervention not meeting this VSA's requirements must be corrected and resubmitted to Bravo Health (at no additional cost) within 5-business days of notification by Bravo Health.

c. ***Bravo Health QA Audit.*** Bravo Health at any time may audit processes, practices or deliverables related to any SOW.

B-3. DELIVERABLES AND MILESTONES

a. ***Delivery & Milestone Expectations.*** Vendor shall employ best reasonable efforts to completely and accurately perform, QA, and

deliver to Bravo Health the total number of BPHP/360 Comprehensive Assessments as well as any HEDIS Exams and/or Educational Interventions data to be performed in the SOW and in accordance with the applicable milestones. If, however, the milestones have not been established as of the effective date of this SOW, the milestones will be agreed to by the parties within 5 business days of the SOW's effective date or within such time as agreed upon by the parties. The expectations, milestones and deliverables set forth in an SOW will be modified as required to reflect any increase or decrease in the number of BPHP/360 Comprehensive Assessments, HEDIS Exam and/or Educational Interventions to be completed.

b. ***Weekly delivery.*** Vendor shall deliver the completed BPHP/360 Comprehensive Assessments and HEDIS Exam and/or Educational Intervention data on a weekly basis to Bravo Health. In addition, the following is required:

(1) Vendor shall deliver all accurately completed and QA-reviewed BPHP/360 Comprehensive Assessments directly to Bravo Health's SFTP site within 5-business days of the BPHP/360 Comprehensive Assessment being performed by the Assessing Provider, provided that the SFTP site is reasonably available to Vendor. Method of delivery will be agreed upon by the parties. Vendor shall notify Bravo Health within 3-business days after Member's scheduled appointment date if they are unable to meet this delivery deadline for any BPHP/360 Comprehensive Assessment performed.

c. ***Missed Deliverables and/or Milestones.*** Vendor understands and acknowledges that its failure to meet any milestone due to other than Force Majeure events may be considered a material breach of the SOW and the VSA and, notwithstanding anything contained in the VSA to the contrary (other than with respect to Force Majeure events), may result in the immediate termination of the SOW. In the event Vendor fails to meet a milestone and/or deliverable, Bravo Health shall notify Vendor and Vendor shall use reasonable efforts to submit to Bravo Health a corrective action plan with 2-business days of such notification. The corrective action plan shall, at a minimum, address in specific detail how Vendor will meet the missed milestones and/or deliverables as well as meet all future milestones and deliverables. If, in Bravo Health's sole reasonable discretion, Vendor falls below the milestone set forth in an SOW due to other than a Force Majeure event and fails to cure the same within 15 days, Bravo Health may equitably reduce the number of BPHP/360 Comprehensive Assessments, HEDIS Exam and/or Educational Interventions to be completed under the SOW or terminate the SOW.

B-4. MEMBER COMMUNICATIONS. Bravo Health shall retain complete control and approval of all Member communications. Any call scripts, member communication scripts, letters, postcards and any other Member-facing communications or materials must be approved in advance by Bravo Health prior to their use, which approval shall not be unreasonably withheld, conditioned, delayed or denied. In addition, any letterhead or postcards utilized shall be branded as "Bravo Health" and must first be approved by Bravo Health. With respect to the call scripts, Bravo Health shall provide Vendor with a FAQ sheet to be approved by Vendor, which approval shall not be unreasonably withheld, delayed or denied, and then utilized by Vendor's scheduling personnel.

B-5. MEMBER COMPLAINT AND ISSUE REPORTING. Vendor shall utilize Bravo Health's established policies and procedures, or such policies and procedures as mutually agreed upon by the parties, to address Member complaints and issues that arise throughout the course of any SOW. Vendor shall notify Bravo Health of all Member complaints and/or issues no later than one (1) business day from the time that Vendor becomes aware of them and shall provide Bravo Health with as much detail as possible. At any time Bravo Health is notified of a Member complaint/issue, Bravo Health shall notify Vendor and Vendor will, within 1-business day or within the time frame agreed upon by the parties, provide Bravo Health with a written report of the incident. The following information should be provided in the Member report: Member name; Assessing/Non-Assessing Provider's name; assessment date and time; Assessing/Non-Assessing Provider's credentials and Assessing/Non-Assessing Provider ID; and a detailed description of the complaint/issue. Bravo Health will review all Member issues and determine what action, if any, should be taken by Vendor. Actions may include, but are not limited to, Vendor sending an approved letter directly to

Member apologizing for having to reschedule more than one time due to a provider cancellation or removal of the Assessing/Non-Assessing Provider from this project. Bravo Health may provide Vendor with a standard template for all communications with Bravo Health Members. At all times written communication to Bravo Health Members must receive prior approval by Bravo Health. The parties shall work together in a timely manner to assure the timely resolution of any Member issue. All Member issues will attempt to be addressed immediately with no more than 1% of valid Member issues throughout each unique SOW project, excepting those issues caused by Force Majeure events. Bravo Health may perform random surveys to assess and appraise Vendor's work performance. If negative results are received, Vendor must take prompt action to attempt to correct the issue. Repeated complaints or issues from Members regarding Vendor or its Assessing/Non-Assessing Providers may result in the termination of an SOW or this VSA.

B-6. ROLES AND RESPONSIBILITIES

a. ***Bravo Health Responsible Party.*** The Bravo Health Responsible Party is charged with ensuring that all criteria of the project are being met. All communications are to be directed to this person unless otherwise directed.

b. ***Vendor Responsible Party.*** The Vendor Responsible Party shall be the point of contact for Bravo Health regarding any issues relating to the delivery of the services under an SOW. The Vendor Responsible Party shall monitor quality and control key areas of the project including, but not limited to, project planning, change management, issue resolution and budget management. In addition, the Vendor Responsible Party shall perform the following:

(1) Participation in Bravo Health scheduled conference call meetings;

(2) Educating and leading the Vendor's project team through the SOW process;

(3) Monitoring the timely completion of milestones, tasks and the preparation of deliverables including project progress;

(4) Managing risk and escalating issues to the Bravo Health in a timely manner;

(5) Planning assignments and coordinating the daily activities of all Vendor resources;

(6) Monitoring Vendor staff and Assessing/Non-Assessing Provider progress by measuring success against project objectives;

(7) Controlling budget and resource assignments in conjunction with the Bravo Health;

(8) Providing a QA mechanism for all Vendor activities and deliverables;

(9) Developing, maintaining and managing Bravo Health project property and materials; and

(10) Ensuring that only Acceptable BPHP/360 Comprehensive Assessments are delivered to Bravo Health.

B-7. ADDITIONAL COMPENSATION AND INVOICING REQUIREMENTS

a. ***Assessment Fee.*** With respect to the BPHP/360 Comprehensive Assessment Vendor understands that if the BPHP/360 Comprehensive Assessment is not an Acceptable BPHP/360 Comprehensive Assessment, Vendor will not be compensated for the BPHP/360 Comprehensive Assessment. An "Acceptable BPHP/360 Comprehensive Assessment" is a BPHP/360 Comprehensive Assessment that is completely and accurately performed in all material respects; Vendor QA'd in accordance with the VSA; delivered and received by Bravo Health; satisfies the terms and conditions of this VSA in all material respects. The Assessment Fee for the BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Intervention is inclusive of all costs and expenses, including but not limited to: travel-related expenses; supplies; copy expenses; costs and expenses incurred via agreement between Vendor and any Assessing/Non-Assessing Providers or other Bravo Health-approved subcontractors; and all required tools needed to complete the BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Intervention. Vendor shall not receive an Assessment Fee for any Services performed by any Assessing/Non-Assessing Provider who does not meet the requirements set forth in A-4 above.

b. ***Member No-Show Fee.*** There will be no fee(s) charged when a Member does not show up for a properly scheduled appointment or refuses the BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Intervention at the time of the visit.

c. ***Invoicing***

(1) With respect to any applicable invoice, Vendor shall provide to Bravo Health, as part of its monthly billing process, an itemized invoice, by SOW, that identifies each completed BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Intervention delivered to Bravo Health, Member name, assessment completion date, service delivery date, state where Member resides, Assessing/Non-Assessing Provider's ID and any additional documentation necessary to support any additional services reasonably requested. Bravo Health shall notify Vendor within 10-business days of receipt of Vendor's invoice if it disputes any portion of the invoice or if any completed BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Interventions identified in the invoice was not received. If no such notification is provided, the invoice shall be deemed acceptable for purposes of billing. Vendor shall have 5-business days after notification of missing BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Intervention information to \ deliver the missing assessment/information or, as applicable, respond to any questions Bravo Health has regarding Vendor's invoice(s). If a BPHP/360 Comprehensive Assessment, HEDIS Exam and/or Educational Interventions in question is not delivered within the requisite time frame, Vendor shall resubmit the invoice to Bravo Health for billing purposes.

(2) In addition, any BPHP/360 Comprehensive Assessments that are not Acceptable BPHP/360 Comprehensive Assessments and listed on an invoice shall be credited unless such record has been replaced within 5-business days from notification from Bravo Health that the BPHP/360 Comprehensive Assessment is not acceptable. Vendor must provide invoices to Bravo Health no later than 10-business days after the end of each month of each applicable SOW. The invoice shall also should include at a minimum, any agreed upon (and which was approved by Bravo Health in writing) reimbursable expenses. At the end of an SOW, Vendor will work with Bravo Health to reconcile any pending, disputed or questionable BPHP/360 Comprehensive Assessments. Bravo Health will provide a proposed final reconciliation within 30 days after receipt of final invoicing from Vendor. This process shall insure that Vendor will provide final invoicing to Bravo Health within 14-business days after the project end date set forth in the applicable SOW.

END OF ATTACHMENT B

ATTACHMENT C

BUSINESS ASSOCIATE AGREEMENT

In order to comply with the *Health Insurance Portability and Accountability Act of 1996*, ("HIPAA") and the *Health Information Technology for Economic and Clinical Health Act of 2009* ("HITECH"), the parties shall comply with the Business Associate Agreement entered into by the parties on or about April _____, 2011 and which is incorporated herein by reference.

END OF ATTACHMENT C

ATTACHMENT D

SECURITY REQUIREMENTS

The following security requirements shall be in addition to, and shall not replace or eliminate, any requirements imposed upon Vendor under the confidentiality or nondisclosure obligations or under any other confidentiality agreement(s) or HIPAA Agreement(s) binding upon Vendor.

D.1 GENERAL REQUIREMENTS. Without limiting any obligation imposed upon Vendor in the HIPAA Agreement, Vendor shall implement and maintain appropriate safeguards and controls and exercise due diligence to protect Bravo Health and HealthSpring, Inc.'s confidential information, including but not limited to Contracted Health Plan's PHI against unauthorized access, use, and/or disclosure. At a minimum, Vendor shall comply with all security and privacy requirements required under HIPAA and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"). Except as otherwise specifically required by Bravo Health or HealthSpring, Inc., the degree of such protection and nature of such safeguards shall be determined by Vendor taking into account all of the following factors (as they from time to time are updated, modified or revised) and, in the event of any conflict or inconsistency, protecting Bravo Health's or HealthSpring, Inc.'s confidential information in accordance with the highest applicable requirement: (a) federal and state legal and regulatory requirements; (b) information technology and healthcare industry best practices; (c) sensitivity of the data; (d) relative level and severity of risk of harm should the integrity, availability, confidentiality, or security of the data be compromised, as determined by Vendor as part of a risk analysis which shall have been performed as part of an overall risk management program; and (e) Bravo Health or HealthSpring, Inc.'s data security requirements, as set forth in this VSA, any SOW and in the HIPAA Agreement.

D.2 DATA TRANSMISSION. Vendor shall implement encryption, in accordance with standards set forth herein and as mutually agreed upon between HealthSpring and Vendor, for all transmission of Bravo Health or HealthSpring, Inc.'s confidential information via public networks (e.g., the Internet). Vendor shall use industry standard encryption algorithms and key lengths when sending Bravo Health or HealthSpring, Inc.'s information via public networks. Such transmissions include, but are not limited to: (a) sessions between web browsers and web servers; (b) email containing Bravo Health or HealthSpring, Inc.'s confidential information; and (c) transfer of files via the Internet (e.g., FTP).

D.3 DATA STORAGE. Vendor shall implement encryption, in accordance with standards set forth herein and as mutually agreed upon between Bravo Health and Vendor, for all storage of Bravo Health or HealthSpring, Inc.'s confidential information on any portable media or portable storage devices including but not limited to: (a) backup data tapes; (b) laptop computers; (c) handheld computers; (d) portable hard disks or hard disk type devices; (e) USB-based "flash", "thumb", or other portable storage devices; and (e) other storage devices not permanently located in Vendor-managed physical spaces.

D.4 ACCESS CONTROL. Vendor shall implement appropriate access control mechanisms designed to prevent all access to Bravo Health or HealthSpring, Inc.'s confidential information and/or Bravo Health or HealthSpring, Inc. resources, except by (a) authorized users and (b) Vendor personnel who have a "need to access" to perform a particular function in support of Bravo Health processing. The access and privileges granted shall be limited to the minimum necessary to perform the assigned functions. In addition, Vendor shall implement processes to ensure that access to Electronic Protected Health Information ("ePHI") is revoked in a timely manner with respect to Vendor's terminated employees and independent contractors. Moreover, Vendor shall maintain and use appropriate mechanisms and processes for detecting, recording, analyzing, and resolving unauthorized attempts to access Bravo Health or HealthSpring, Inc. information or Bravo Health or HealthSpring, Inc. resources. Bravo Health shall be notified in writing of all actual instances of deliberate unauthorized attempts to access

Bravo Health or HealthSpring, Inc.'s confidential information or Bravo Health or HealthSpring, Inc. resources.

D.5 IDENTIFICATION AND AUTHENTICATION. All intended access to any Bravo Health or HealthSpring, Inc.'s confidential information or any Bravo Health or HealthSpring, Inc. resources shall be identified and authenticated. "*Identification*" refers to processes which establish the identity of the person or entity requesting access to Bravo Health or HealthSpring, Inc.'s confidential information and/or Bravo Health or HealthSpring, Inc. resources, and the term "*Authentication*" refers to processes which validate the purported identity of the requestor. For access to Bravo Health or HealthSpring, Inc.'s confidential information or Bravo Health or HealthSpring, Inc. resources, Vendor shall maintain procedures that require Authentication by the use of an individual, unique user ID and an individual password or other appropriate Authentication technique. In addition, Vendor shall implement procedures designed to ensure the protection, integrity, and soundness of passwords.

D.6 ACCOUNT ADMINISTRATION. Vendor shall implement appropriate formal processes for requesting, approving, and administering accounts and access privileges for Bravo Health or HealthSpring, Inc. resources and Bravo Health or HealthSpring, Inc.'s confidential information. These processes shall be required for both Bravo Health-related accounts and Vendor's internal accounts for Bravo Health resources. These processes shall include procedures for granting and revoking emergency access to Bravo Health or HealthSpring, Inc. resources and Bravo Health or HealthSpring, Inc.'s and confidential information. Furthermore, all access by Vendor's employees or contractors for access to systems which are controlled or administered by Bravo Health shall be subject to advance approval by Bravo Health, which approval shall not be unreasonably withheld, conditioned, delayed or denied.

D.7 PHYSICAL SECURITY. Vendor shall implement appropriate physical security controls (including facility and environmental controls) designed to prevent unauthorized physical access to Bravo Health or HealthSpring, Inc. resources and areas in which Bravo Health or HealthSpring, Inc.'s confidential information is stored or processed. Where appropriate, this shall include controls to physically protect protection system. Vendor also shall protect media containing Bravo Health or HealthSpring, Inc.'s confidential information (e.g., paper, tapes, removable media, etc.) against unauthorized physical access. This protection shall be maintained before, during and or destruction, as applicable, of any Bravo Health or HealthSpring, Inc.'s confidential information. Vendor shall adopt and implement a written facility security plan which documents such controls and the policies and procedures through which such controls will be maintained. Vendor shall maintain appropriate records of maintenance performed on Bravo Health or HealthSpring, Inc., resources by Vendor as well as appropriate records of maintenance performed on the physical control mechanisms which are used by Vendor to secure Bravo Health or HealthSpring, Inc. resources.

D.8 PERSONNEL SECURITY. Vendor shall require all of its employees, contractors and agents who have, or may be expected to have, access to Bravo Health's or HealthSpring, Inc.'s confidential information to comply with the provisions of the HIPAA Agreement and any confidentiality agreement(s) binding upon Vendor. Vendor shall also ensure that its employees and contractors remain aware of industry standard security practices, and of its and their responsibilities for protecting Bravo Health's or HealthSpring, Inc.'s confidential information. This shall include, but not be limited to: (a) protection against malicious software (such as viruses); (b) appropriate password protection and password management practices; and (c) appropriate use of workstations and computer system accounts. In addition, Vendor shall adopt and implement a sanction policy which addresses the manner in which violations of Vendor's internal security requirements or security requirements which are imposed on Vendor by law, regulation, or contract shall be handled.

D.9 INFRASTRUCTURE PROTECTION. Vendor shall implement industry standard procedures designed to protect Vendor's processing infrastructure and Bravo Health or HealthSpring, Inc. resources. At a minimum, Vendor shall employ the following standards:

a. formal security programs (policies, standards, processes, etc.);

b. processes for becoming aware of, and implementing, security patches and fixes;

c. router, filters, firewalls, and other mechanisms to restrict access to Vendor's information processing infrastructure and Bravo Health or HealthSpring, Inc. resources (all local site networks which may be accessed via the Internet [whether or not such sites transmit information]) shall be protected against attack and penetration through the use of firewalls);

d. other mechanisms to restrict access to Vendor's information processing infrastructure and Bravo Health or HealthSpring, Inc. resources (all local site networks which may be accessed via the Internet [whether or not such sites transmit information]) shall be protected against attack and penetration through the use of firewalls); and

e. processes to prevent, detect, and eradicate malicious code (e.g., viruses, etc.) and to notify Bravo Health of instances of malicious code detected on Bravo Health or HealthSpring, Inc. resources or affecting Bravo Health's or HealthSpring, Inc.'s confidential information.

D.10 SECURITY MANAGEMENT. Vendor shall adopt and implement written security management policies and procedures designed to prevent, detect, contain, and correct violations of measures which have been taken to protect the confidentiality, integrity, availability, or security of Bravo Health's or HealthSpring, Inc.'s confidential information. Without limiting the generality of the foregoing, such policies and procedures shall (a) assign specific data security responsibilities and accountabilities to specific individual(s) and (b) include a formal risk management program which includes periodic risk assessments.

D.11 INCIDENT RESPONSE. Vendor shall adopt and implement formal processes to detect, identify, report, respond to, and resolve Security Incidents in a timely manner. Vendor shall notify Bravo Health in writing of any Security Incident(s) which result in, or which Vendor reasonably believes may result in, unauthorized access to, modification of, or disclosure of Bravo Health's or HealthSpring, Inc.'s confidential information.

D.12 SECURITY EVALUATIONS. Vendor shall perform periodic evaluations of its processes and systems to ensure continued compliance with obligations imposed by law, regulation or contract with respect to the confidentiality, integrity, availability, and security of Bravo Health's or HealthSpring, Inc.'s confidential information. Vendor shall document the results of these evaluations and the nature of any remediation activities which are taken in response to such evaluations.

D.13 PROTECTION OF STORAGE MEDIA. Vendor shall ensure that storage media containing Bravo Health's or HealthSpring, Inc.'s confidential information is properly sanitized of all Bravo Health's or HealthSpring, Inc.'s confidential information is destroyed prior to disposal or re-use for non-Bravo Health processing. In addition, all media on which Bravo Health's or HealthSpring, Inc.'s confidential information is stored shall be protected against unauthorized access or modification. Moreover, Vendor shall implement reasonable and appropriate processes and mechanisms to maintain accountability and tracking of the receipt, removal, and transfer of storage media used for Bravo Health processing or on which Bravo Health's or HealthSpring, Inc.'s confidential information has been stored.

D.14 DATA INTEGRITY. Vendor shall adopt and implement processes designed to prevent unauthorized or inappropriate modification of Bravo Health's or HealthSpring, Inc.'s confidential information, for both data in transit and data at rest.

D.15 OTHER PROVISIONS APPLICABLE TO ePHI. Vendor Agrees that it shall:

a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Bravo Health or HealthSpring, Inc. as required by 45 CFR, Part 164, Subpart "C";

b. Ensure that any agent, including a subcontractor, to whom Vendor provides ePHI agrees to implement reasonable and appropriate safeguards to protect such ePHI provided, however, that Vendor shall not assign, delegate, or subcontract any obligation of Vendor owed to Bravo Health or HealthSpring, Inc. in violation of the HIPAA Agreement; and

c. Report to Bravo Health any Security Incident of which Vendor becomes aware.

D.16 AMENDMENTS. This Attachment D may be modified by a written agreement executed by Vendor and Bravo Health. Notwithstanding the foregoing, Bravo Health and Vendor may amend this section by providing 30 days advance

written notice of such amendment if either party reasonably determines that such proposed amendment is necessary for Bravo Health to comply with the Standards for Privacy of Individually Identifiable Health Information or the Security Standards for the Protection of ePHI (both of which are set forth at 45 CFR Parts 160 and 164) or any other federal, state or local law, regulation, ordinance, or requirement relating to the confidentiality, integrity, availability, or security of individually identifiable medical or personal information.

D.17 EFFECT OF THESE SECURITY REQUIREMENTS. These Security Requirements are not intended to, nor shall be construed to, reduce or diminish any of Vendor's obligations under the HIPAA Agreement or under any requirements imposed upon Vendor by applicable laws or regulations.

END OF ATTACHMENT D

END OF AGREEMENT

Exhibit D

360 Comprehensive Assessment 2016

[PLACE BARCODE HERE]

Member First Name | **DOB** (MM/DD/YYYY) / /

Last Name | **DOS** (MM/DD/YYYY) / /

Member ID | **NPI**

Rendering Provider

Member's PCP

Location ☐ Private Residence ☐ PCP Practice ☐ Facility | **Source** ☐ Patient ☐ Other (name & relationship): _____

Reason for Exam: _____

***Please note: All HEDIS Stars metrics are asterisked for your convenience**

Past Medical History (list only resolved conditions): ☐ Reviewed and No Past Medical History

☐ CVA with no residual effect

☐ History of Cancer (specify):

Surgical History: ☐ Reviewed and No Surgeries

Medications: (List all medications including OTCs with dosage and frequency or attach printed, signed and dated list and check here: ☐)

☐ No Current Medications

☐ Medications Reviewed

Allergies: ☐ No known drug allergies

Family History: ☐ Reviewed and No Relevant History

	Father	Mother	Children	Siblings	Grandparents
HTN	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐

	Father	Mother	Children	Siblings	Grandparents
High Lipids	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

Habits:

Tobacco Use: ☐ Yes ☐ No
☐ E-Cigarettes ☐ Current Smoker, PPD ____
☐ Current Chew/Dip Use ☐ Previous Smoker, Year quit ____

Alcohol Use:
☐ Yes, Drinks per day ____
☐ No

Alcohol usage a concern for you or others?
☐ Yes ☐ No

Social History:

Marital Status:
☐ Single ☐ Divorced
☐ Married ☐ Widowed

Lives:
☐ Alone ☐ Institutional
☐ Spouse ☐ Family
☐ Other: _____

High Risk for Sexually Acquired Diseases including HIV:
☐ Yes ☐ No

Social/Financial concerns:
☐ Yes
☐ No

Illicit Drug Use:
☐ Yes
☐ No

Current Physical Activity as compared to last year:
☐ More
☐ Less ☐ Same

Ambulatory Status:
☐ Independent
☐ Wheelchair ☐ Walker
☐ Bedbound ☐ Cane

Difficulty with bathing or grooming?
☐ Yes
☐ No

Difficulty with eating or meal preparation?
☐ Yes
☐ No

Vision:
☐ Normal
☐ Require glasses / contacts for routine vision

Hearing:
☐ Normal
☐ Hearing issues / hearing aid

Speech:
☐ Normal
☐ Impaired

Member Name: DOB : / / DOS : / /

***Fall Risk Screening:** (mark all that apply)

- ☐ Unable to perform exam b/c of _____
- ☐ Diagnoses (3 or more existing)
- ☐ Prior History of falls within 3 months
- ☐ Incontinence
- ☐ Visual Impairment
- ☐ Impaired functional mobility
- ☐ Environmental Hazard
- ☐ Polypharmacy
- ☐ Pain affecting level of function
- ☐ Cognitive Impairment

TOTAL number of boxes marked: _____

☐ Fall Risk (4 or more reported)

Depression Screening (18+ y/o)

☐ Screening not performed because the patient is unable to communicate / answer.

Have you felt depressed or down-and-out over the past 2 months? ☐ Yes ☐ No

Have you had a loss of interest in things that normally bring you pleasure? ☐ Yes ☐ No

Have you felt fatigued or had a loss of energy recently? ☐ Yes ☐ No

If two or more "Yes" then complete and document results from either a:

☐ PHQ 9 form ☐ Standard Screening Tool ☐ Clinical Interview

Attach Standard Screening Tool or Clinical Interview to assessment if completed.

Urinary Incontinence Screening

During the last 3 months - have you leaked urine (even a small amount)? ☐ Yes ☐ No

If Yes, please distribute education material

Review of Systems	Negative	Positive/Findings
General	☐	
HEENT	☐	
Cardiac	☐	
Respiratory	☐	
GI	☐	
Musculoskeletal	☐	
Neurological	☐	
Skin	☐	
Psychiatric	☐	
Endocrine	☐	
Hematological	☐	
GU	☐	

***Please assess the overall pain presence in the patient's day to day life:** (all patients should have pain addressed, if no pain, then N/A should be marked)

	0	1	2	3	4	5	6	7	8	9	10
*Pain Screening	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Plan: ☐ Meds ☐ PT ☐ Other ☐ Education ☐ Pain doctor ☐ N/A

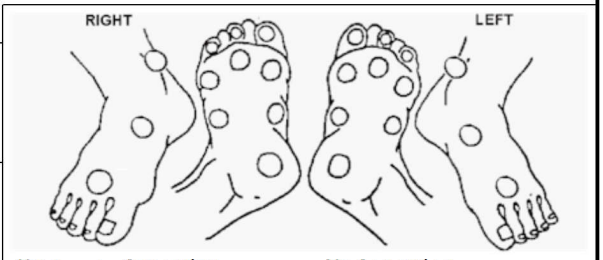
Foot Exam (Complete for diabetic patients)

1. Ask the patient:

- ☐ Burning, tingling, numbness in feet
- ☐ Pain or cramping in calf area during exercise
- ☐ Previous foot ulcer
- ☐ None of these

2. Look at both feet:

- ☐ Infection
- ☐ Ulceration
- ☐ Calluses or corns
- ☐ Skin breaks
- ☐ Nail disorders
- ☐ Foot deformity
- ☐ None of these



Key: + = Sensation — = No Sensation

3. Check for foot pulse:	Left			Right		
Dorsalis pedis	☐ Normal	☐ Weak	☐ Absent	☐ Normal	☐ Weak	☐ Absent
Posterior Tibial	☐ Normal	☐ Weak	☐ Absent	☐ Normal	☐ Weak	☐ Absent
4. Test for neuropathy:	Left Monofilament	☐ Normal	☐ Abnormal	Right Monofilament	☐ Normal	☐ Abnormal

5. Complications due to diabetes: (check all that apply) ☐ None of these

☐ Peripheral neuropathy ☐ Peripheral vascular disease ☐ Ulcer ☐ Gangrene ☐ Amputation: date, side & level: _____

Member Name: DOB : / / DOS : / /

Vitals: *Ht (in): *Wt (lbs): *BMI: Temp (F°): BP: / HR: RR: Gender: ☐ Male ☐ Female

Physical Exam	Normal	Abnormal/Findings
General	☐	
HEENT	☐	
Neck	☐	
Heart	☐	
Lungs	☐	
Breast	☐	☐ Deferred
Abdomen	☐	
Extremities	☐	
GU	☐	☐ Deferred
Musculoskeletal	☐	
Neurological	☐	
Skin	☐	
Psychiatric	☐	
Lymphatic	☐	
Hematologic	☐	☐ Deferred

Current Conditions: **Treatment Plan:**

Cardiovascular: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ History of MI Specify Date:	☐	☐	☐	☐	☐
☐ Angina Pectoris	☐	☐	☐	☐	☐
☐ CAD ☐ CAD w/Angina Pectoris	☐	☐	☐	☐	☐
☐ Cardiomyopathy: ☐ Primary ☐ Secondary ☐ Ischemic	☐	☐	☐	☐	☐
☐ Congestive Heart Failure: ☐ Diastolic ☐ Systolic ☐ Combined Systolic/Diastolic	☐	☐	☐	☐	☐
☐ *Hyperlipidemia	☐	☐	☐	☐	☐
☐ Carotid artery stenosis Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Atrial Fibrillation ☐ Chronic ☐ Paroxysmal ☐ Persistent	☐	☐	☐	☐	☐
☐ Sick Sinus Syndrome: ☐ w/Pacemaker ☐ w/o Pacemaker	☐	☐	☐	☐	☐
☐ Tachycardia Type(specify):	☐	☐	☐	☐	☐
☐ *Hypertension: Date of Diagnosis: _____	☐	☐	☐	☐	☐
☐ Hypertensive Heart Disease with Heart Failure ☐ Hypertensive Heart Disease without Failure	☐	☐	☐	☐	☐
☐ Hypertensive CKD	☐	☐	☐	☐	☐
☐ Hypertensive Heart and CKD ☐ w/Heart Failure ☐ w/o Heart Failure	☐	☐	☐	☐	☐
☐ Peripheral Artery Disease	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐
Nutritional/Metabolic/Endocrine: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ Protein Calorie Malnutrition (BMI<19) If positive: ☐ Mild ☐ Moderate	☐	☐	☐	☐	☐
☐ Obesity (BMI 30-39.9) ☐ Morbid Obesity (BMI >=40)	☐	☐	☐	☐	☐
☐ Hypothyroidism ☐ Acquired (post surgical)	☐	☐	☐	☐	☐
☐ Hyperthyroidism	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐

Member Name: DOB : / / DOS : / /

Diabetes Mellitus: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ DM: ☐ Type 1 ☐ Type 2 ☐ Insulin Dependent	☐	☐	☐	☐	☐
☐ DM w/ Secondary Kidney Complications: ☐ Chronic Kidney Disease ☐ Nephropathy	☐	☐	☐	☐	☐
☐ DM w/ Secondary Neurological Complications: ☐ Mononeuropathy ☐ Peripheral Neuropathy ☐ Gastroparesis ☐ Other:	☐	☐	☐	☐	☐
☐ DM w/ Secondary Ophthalmic Complications: ☐ Retinopathy: ☐ Proliferative ☐ Non-proliferative ☐ w/ Macular Edema ☐ Mild ☐ Moderate ☐ Severe ☐ Cataract ☐ Glaucoma	☐	☐	☐	☐	☐
☐ DM w/ Secondary Circulatory Complications: ☐ Peripheral Angiopathy/PVD ☐ w/ Gangrene ☐ w/o Gangrene	☐	☐	☐	☐	☐
☐ DM w/ Secondary Skin Complications: ☐ Non-Pressure Chronic Ulcer ☐ Location(specify):	☐	☐	☐	☐	☐
☐ DM w/ Other Secondary Complications: ☐ Hypoglycemia ☐ Hyperglycemia	☐	☐	☐	☐	☐
☐ Other Secondary Diagnosis (specify):	☐	☐	☐	☐	☐

Respiratory: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ Chronic Bronchitis: ☐ Obstructive ☐ Simple ☐ Mucopurulent ☐ Mixed	☐	☐	☐	☐	☐
☐ COPD: ☐ w/ Acute Lower Resp. Infection ☐ w/ Oxygen Dependence	☐	☐	☐	☐	☐
☐ Emphysema: ☐ Unilateral ☐ Panlobular ☐ Centrilobular ☐ Other:	☐	☐	☐	☐	☐
☐ Asthma: ☐ Chronic Obstructive ☐ Intermittent ☐ Persistent ☐ Mild ☐ Moderate ☐ Severe	☐	☐	☐	☐	☐
☐ Bronchiectasis: ☐ w/ Exacerbation ☐ w/ Acute Lower Respiratory Infection	☐	☐	☐	☐	☐
☐ Obstructive Sleep Apnea	☐	☐	☐	☐	☐
☐ Sarcoidosis ☐ Asbestosis	☐	☐	☐	☐	☐
☐ Pulmonary Fibrosis	☐	☐	☐	☐	☐
☐ Tracheostomy	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐

Musculoskeletal: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ *Rheumatoid Arthritis - DMARD Prescribed: ☐ Yes ☐ No	☐	☐	☐	☐	☐
☐ Lupus	☐	☐	☐	☐	☐
☐ Psoriatic Arthritis	☐	☐	☐	☐	☐
☐ Osteoarthritis Location(s): Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Osteopenia Location(s): Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Osteoporosis Location(s): Side: ☐ Right ☐ Left Kind: ☐ Senile ☐ Postmenopausal ☐ Unspecified Has the patient had a fracture in the past 12 months? ☐ Yes ☐ No If a fracture occured, where was it: ☐ Right ☐ Left Last Bone Density: * Biophosphonate Prescribed ☐ Yes ☐ No Start Date of Bisphosphonate:	☐	☐	☐	☐	☐
☐ S/P Amputation Location: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐

Skin/Subcutaneous: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ Ulcer: ☐ Pressure ☐ Stg 1 ☐ Stg 2 ☐ Stg 3 ☐ Stg 4 ☐ Unstageable	☐	☐	☐	☐	☐
☐ Chronic ☐ Location (specify): ☐ Right ☐ Left ☐ Both	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐

Member Name: DOB : / / DOS : / /

Renal/Urinary: GFR must be completed on **ALL** patients regardless of current renal disease	Meds	Monitor	Diet	Labs	Referral
Urine Microalbumin Result: _____ Date: _____ eGFR: _____ (Provided GFRs need to be consistent for more than a 3 month period)					
☐ Chronic Kidney Disease (CKD) ☐ CKD unspecified	☐	☐	☐	☐	☐
☐ Stage 1 (GFR >90) ☐ Stage 2 (GFR 60-89) ☐ Stage 3 (GFR 30-59)	☐	☐	☐	☐	☐
☐ Stage 4 (GFR 15-29) ☐ Stage 5 (GFR < 15)	☐	☐	☐	☐	☐
☐ ESRD Dialysis: ☐ Yes ☐ No	☐	☐	☐	☐	☐
☐ AV Fistula: ☐ Graft ☐ Catheter	☐	☐	☐	☐	☐
Renal/Urinary: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ Urinary Incontinence (check one): ☐ Unspecified ☐ Stress ☐ Urge	☐	☐	☐	☐	☐
☐ BPH ☐ w/ LUTS (specify): ☐ w/o LUTS	☐	☐	☐	☐	☐
☐ Cystostomy	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐
Gastrointestinal: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ Pancreatitis: ☐ Acute ☐ Chronic	☐	☐	☐	☐	☐
☐ Cirrhosis liver: ☐ Alcoholic ☐ Non-Alcoholic	☐	☐	☐	☐	☐
☐ End stage liver disease	☐	☐	☐	☐	☐
☐ Colostomy ☐ Ileostomy	☐	☐	☐	☐	☐
☐ GERD	☐	☐	☐	☐	☐
☐ Crohn's Disease location(s):	☐	☐	☐	☐	☐
☐ Ulcerative Colitis	☐	☐	☐	☐	☐
☐ IBS ☐ w/ Diarrhea ☐ w/o Diarrhea	☐	☐	☐	☐	☐
☐ J Tube ☐ G Tube	☐	☐	☐	☐	☐
☐ Chronic Hepatitis: Type:	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐
Eye: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ Cataract ☐ Senile Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Glaucoma Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Macular Degeneration ☐ Exudative ☐ Nonexudative	☐	☐	☐	☐	☐
☐ Legal Blindness ☐ Other Diagnosis _____	☐	☐	☐	☐	☐
Active Neoplasm/Blood Disorders and Current Treatment: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ **Colon Cancer** ☐ Colectomy Date: ☐ Chemo ☐ Radiation	☐	☐	☐	☐	☐
Metastatic and if so, to what site(s)?	☐	☐	☐	☐	☐
☐ **Breast Cancer** Site (☐ Right ☐ Left) Date: Treatment: ☐ Mastectomy ☐ Chemo ☐ Radiation ☐ Hormonal therapy	☐	☐	☐	☐	☐
☐ If Ductal Carcinoma in situ ☐ Right ☐ Left	☐	☐	☐	☐	☐
Metastatic and if so, to what site(s)?	☐	☐	☐	☐	☐
☐ **Prostate Cancer** ☐ Prostatectomy ☐ Hormonal therapy ☐ Chemo ☐ Radiation	☐	☐	☐	☐	☐
Metastatic and if so, to what site(s)?	☐	☐	☐	☐	☐
☐ **Lung Cancer** ☐ Rgt ☐ Lft ☐ Upper Lobe ☐ Lower Lobe ☐ Other:	☐	☐	☐	☐	☐
Treatment: ☐ Lobectomy ☐ Pnemonectomy ☐ Chemo ☐ Radiation	☐	☐	☐	☐	☐
Metastatic and if so, to what site(s)?	☐	☐	☐	☐	☐
☐ **Skin Cancer** (type and site):	☐	☐	☐	☐	☐
☐ Melanoma in Situ (site):	☐	☐	☐	☐	☐
☐ Other Malignancies (specify):	☐	☐	☐	☐	☐

Member Name: DOB : / / DOS : / /

☐ Myelodysplastic Disease						
☐ Multiple Myeloma ☐ Current ☐ In Remission ☐ Relapse						
☐ Drug-induced Neutropenia (specify drug):						
☐ Anemia: ☐ Due to CKD ☐ Drug-induced (specify drug):						
☐ Due to Chemotherapy ☐ B-12 ☐ Iron ☐ General						
☐ Sickle Cell ☐ Other:						
☐ HIV+ ☐ AIDS						
☐ Other Diagnosis (specify):						
Neurological: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ CVA w/ Sequlae:					
Specify late effect: ☐ Cognitive ☐ Speech/Language ☐ Aphasia					
☐ Dysphagia ☐ Other:					
☐ Monoplegia ☐ Dominant ☐ Non-dominant ☐ Left ☐ Right ☐ Upper Limb ☐ Lower Limb					
☐ Hemiplegia/Hemiparesis ☐ Dominant ☐ Non-dominant ☐ Left ☐ Right					
☐ Weakness ☐ Dominant ☐ Non-dominant ☐ Left ☐ Right					
☐ History of Trauma					
☐ Hemiplegia/Hemiparesis ☐ Dominant ☐ Non-dominant ☐ Left ☐ Right					
☐ Monoplegia ☐ Dominant ☐ Non-dominant ☐ Left ☐ Right ☐ Upper Limb ☐ Lower Limb					
☐ Quadriplegia					
☐ Multiple Sclerosis					
☐ Myasthenia gravis					
☐ ALS					
☐ Polyneuropathy from other than diabetes					
☐ Parkinsons Disease: ☐ w/ Dementia ☐ w/ Behavioral Disturbances					
☐ Seizures ☐ Seizure Disorder (Epilepsy)					
☐ Other Diagnosis (specify):					
Psychiatric: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ Dementia: ☐ Unspecified ☐ Vascular					
☐ Senile ☐ w/ Delusions ☐ w/ Depression					
☐ Alzheimers: ☐ Early Onset ☐ Late Onset					
☐ w/ Dementia ☐ w/ Dementia and Behavioral Disturbance					
☐ Depressive Disorder ☐ Mild ☐ Major If major: ☐ Mild ☐ Moderate ☐ Severe					
If major: ☐ Single Episode ☐ Recurrent ▶ ☐ Full Remission ☐ Partial Remission					
If severe: ☐ w/ Psychotic Symptoms ☐ w/o Psychotic Symptoms					
☐ Anxiety					
☐ Bipolar ☐ Current ☐ In Remission (☐ Full ☐ Partial)					
☐ w/ Psychotic features ☐ w/o Psychotic features					
Current kind: ☐ Depressed ☐ Manic ☐ Mixed					
Current severity: ☐ Mild ☐ Moderate ☐ Severe					
☐ Schizophrenia ☐ Paranoid ☐ Simple ☐ Undifferentiated					
☐ Disorganized ☐ Other (specify):					
☐ Alcohol Use ☐ Alcohol Abuse ☐ Alcohol Dependence ☐ In Remission					
☐ Substance Use ☐ Sbst. Abuse ☐ Dependence ☐ In Remission **Specify:**					
☐ Other Diagnosis (specify):					

Member Name: DOB : / / DOS : / /

Preventive Medicine: (Please Use "D" if patient declines, N/A, "S" for scheduled, or "A" for advised)

Osteoporosis Screening (67-85 y/o): Date_____ *Mammogram (52-74 y/o, every 27 mo.): Date _____

*Colorectal Cancer Screening (50-75 y/o) FOBT: Date _____ (Annually) Sigmoidoscopy: Date_____ (Every 5 years) Colonoscopy: Date_____ (Every 10 years)

*Influenza Vaccine (65+ y/o): Date _____ Pneumococcal Vaccine (65+ y/o): Date Given: _____

Advanced care planning: Date _____ Given Vaccine: ☐ Pneumouax ☐ Prevnar

RESULT: ☐ Information given/Discussion ☐ Medical Power Of Attorney ☐ Living Will ☐ Advanced Directive Planning

Long Term Medication Monitoring (Annual) ☐ Reviewed

Anticonvulsants (Phenobarbital, Carbamazapine, Phenytoin, Valproic acid): _____

Serum Drug Concentration Date: _____

Patients diagnosed with COPD:

Spirometry: Date: _____

Beta Agonist/AntiCholinergic Prescribed: ☐ Yes ☐ No

***Patients diagnosed with Diabetes:**

*HbA1C <9: Date: _____ Result: _____

*Microalbuminuria: Date: _____ Result: _____

* Retinal Eye Exam: Date: _____ Result: _____

* Name of Eye Care Provider: _____

Patients diagnosed with CAD:

Antiplatelet Therapy Prescribed: ☐ Yes ☐ No

Beta Blocker prescribed (history of MI): ☐ Yes ☐ No

Statin prescribed: ☐ Yes ☐ No

if No: specify: _____ ☐ Statin Intolerant

Patients diagnosed with CHF:

ACE or ARB Prescribed: ☐ Yes ☐ No

Beta Blocker Prescribed: ☐ Yes ☐ No

LVF Assessment: Date: _____ Result: _____

Please list any diagnoses, not already noted under current conditions, which affect patient care, treatment or management.

DIAGNOSES	SELECT TREATMENT PLAN						
	Meds	Monitor	Diet	Labs	Referral	Other	Describe
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	

PLAN: _____

COORDINATION OF CARE (Please list any providers/specialists involved in the patient's care and any supplier of equipment): ☐ None

HMR reviewed and updated on today's visit? ☐ Yes ☐ No

BEHAVIORAL HEALTH REFERRAL: ☐ Yes ☐ No Indication: _____

CASE MANAGEMENT REFERRAL: ☐ Yes ☐ No

☐ Care Coordination ☐ Social Concerns ☐ Patient Education ☐ Other (specify): _____

If yes, please specify: _____

I discussed the following with my patient:

☐ *Tobacco cessation and education ☐ *Fall risk prevention ☐ Diet Modification ☐ High Risk Medications ☐ 90 Day Rx Fill

☐ *Urinary incontinence ☐ *Physical Activity ☐ Other (specify): _____

OTHER/COMMENTS: _____

Patient Email (OPTIONAL)

EXAMINER NAME: _____ EXAMINER SIGNATURE: _____

☐ MD ☐ DO ☐ NP ☐ PA DATE: _____

SUPERVISING PHYSICIAN NAME: _____ (if applicable)

☐ MD ☐ DO

SUPERVISING PHYSICIAN SIGNATURE : _____ (if applicable)

DATE: _____