

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION**

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

**RELATOR ROBERT A. CUTLER’S RESPONSE IN OPPOSITION TO DEFENDANTS’
MOTION TO DISMISS RELATOR’S AMENDED COMPLAINT PURSUANT TO
RULE 12(b)(6)**

Relator Robert A. Cutler, by and through counsel, submits this Response in Opposition to Defendants’ Motion to Dismiss Relator’s Amended Complaint Pursuant to Rule 12(b)(6). As discussed below, Relator’s Amended Complaint is properly pled, and Defendants’ motion should be denied. In the alternative, Relator has attached a proposed Second Amended Complaint that he seeks leave to file pursuant to Fed. R. Civ. P. 15 should the Court determine that additional details are necessary. Furthermore, Relator adopts and incorporates by reference the arguments made in United States of America’s Memorandum of Law in Opposition to Defendants’ Motion to Dismiss, to the extent relevant to the arguments made by Defendants regarding Relator’s claims.

INTRODUCTION

Despite a longstanding history of healthcare violations, penalties and fines, Defendants claim that their in-home 360 program is tip-top compliant, even going so far as to suggest that

CMS supports its operation. (Def. Memo. at 7.) They paint a fantastical portrait of a program which relied on the independent clinical judgment of third-party health providers operating under arm's length service contracts. (*see id.* at 1-2, 9.) Defendants embellish their narrative with exhibits that include a 360 form and service contracts with the providers themselves. On this basis, Defendants allege they had no reason to “second-guess” the clinical judgment of their providers. (*Id.* at 2, 21, 32.) Thus, if any codes were falsely reported, so claim Defendants, the providers, not Defendants, are to blame. (*Id.* at 19-20.)¹

But this image of the 360 program is a complete fabrication. Defendants ignore the facts alleged in Relator's Amended Complaint (the “Complaint”). Among them is the crucial detail that Defendants engineered the program for the purpose of defrauding CMS and played an active part in obtaining codes that Defendants knew were in fact false. Defendants' fantasy world is based on nothing more than the exhibits attached to their supporting memorandum. And these exhibits are not even complete.

The 360 form is missing the pages at the end of the document known as a “health management report” (“HMR”).² The HMR was used to track diagnostic codes that nurse practitioners (“NPs”) needed to replicate from year to year. (Doc. 12, Amend. Compl. (“Compl.”) at ¶ 43.) As described in paragraph 43 of the Complaint, before each visit, NPs received a “cheat sheet” of all the diagnostic codes submitted to CMS in previous years. When the NP would visit the member, he or she would use this cheat sheet as a reference to find diseases. After diseases were “diagnosed” during the 360, the NP would convert the diseases into ICD codes and list them

¹ An almost identical argument was asserted by the defendants in *U.S. v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1173-74 (9th Cir. 2016)(noting that “defendants' attempts to portray themselves as the passive victims of their providers' errors wholly misstates [the] legal theory, which focuses on the defendants' own conduct in allegedly conceiving, directing and conducting retrospective reviews designed to identify only favorable reporting errors”).

² *See* 360 form attached as Exhibit A(redacted). *See Clark v. United States*, No. 13-490C, 2014 WL 128614, at 1-2 (Fed. Cl. Jan. 6, 2014)(acknowledging the rule of completeness from Federal Rules of Evidence Rule 106 applies to Fed. R. Civ. P. 12(b)(6) pleadings.)

in the HMR. Defendants' coders would then take the codes from the HMR, submit them to CMS and then use the HMR to update the list of historical health conditions for that member. (*Id.* at ¶¶ 43, 46, 68 and 88). This list of conditions, as updated (the "Historical HMR"), would then serve as a "cheat sheet" for the following year, and the cycle would repeat itself.

The 360 form is not the only exhibit missing pages. Defendants also failed to provide a complete version of the Business Services Agreement with Texas Health Management LLC ("THM"). Contrary to the image Defendants are trying to portray, this agreement provides that Defendants "shall be responsible for all insurance and other regulatory compliance." It also shows that in addition to paying THM to perform the 360s, Defendants were paying the company a separate fee specifically to prepare an HMR for each member visited by an NP.³

The exhibits clearly do not support Defendants' outlandish portrait of the 360 program. The 360s were not performed by independent, well-trained "clinicians [] exercising their professional skill and judgment" (Def. Memo. at 1), as Defendants assert. Defendants' own employees even represented to the Court that the decisions regarding the "protocols and procedures for performing the 360 exams" were made by Defendants from their office in Nashville (Docs. 73, 85, 87, 88), not by the nurse practitioners performing 360s in the members' homes.

The allegations in the Complaint show that Defendants were dictating the NPs' performance of the 360 in order to ensure that high revenue diagnostic conditions would be found, and in doing so Defendants knew they were violating CMS rules. To create the appearance of propriety, they ensured that copies of the 360s were sent back to the primary care providers in the service year which the 360s were performed. This gave the false impression that the doctor had actually been treating the member during the year for the "diagnosed" condition. (Compl at ¶ 3,

³ See Business Services Agreement, attached as Exhibit B, pg. HS00000015.

31.) This well-orchestrated fraud would have never come to light but for the arbitration that occurred in 2017 which Defendants reference in their supporting memorandum (Def. Memo. at 10). Tens of thousands of documents were disclosed to Relator revealing that the 360 program, although couched in terms of closing gaps in care, was really just a money-making scheme.

LEGAL STANDARD

In considering a motion to dismiss under Rule 12(b)(6), the Court must construe the complaint in the light most favorable to a relator, accept his or her allegations as true, and draw reasonable inferences in his or her favor. *U.S. v. Southeast Eye Specialists, PLLC*, 570 F. Supp. 3d 561, 574 (M.D. Tenn. 2021). A complaint should not be dismissed under Rule 12(b)(6) unless it appears beyond doubt that the non-moving party can prove no set of facts in support of his or her claim which would entitle him or her to relief. *U.S. ex. rel. Pogue v. American Healthcorp, Inc.*, 977 F. Supp. 1329, 1331 (M.D. Tenn. 1997). Whether a complaint states a plausible claim for relief is ultimately a context-specific task that requires the Court to draw on its judicial experience and common sense. *Verble v. Morgan Stanley Smith Barney, LLC*, 148 F. Supp. 3d 644, 649 (E.D. Tenn. 2015)

Claims brought under the False Claims Act must be pled with particularity under Fed. R. Civ. P. 9(b). The purpose of this rule is to provide fair notice so that the Defendant may prepare an informed pleading responsive to the specific allegations of fraud. *U.S. v. Smith & Nephew, Inc.*, 749 F. Supp. 2d 773, 782 (W.D. Tenn. 2010). However, the rule is more leniently applied in those situations where the alleged fraud did not occur at a discrete time and place and instead the transactions involved are complex or cover a long period of time. *See Id.*

LAW AND ARGUMENT

Relator's basic argument could not be more straightforward. Defendants committed fraud

under the False Claims Act by submitting ICD codes for diagnoses that (1) were not conditions that required or affected patient care, treatment, or management during the relevant service year; (2) could not have been treated or assessed during 360 visits; and/or (3) lacked medical record support or otherwise violated CMS coding rules. (Comp. at ¶ 47.) But Defendants do not bother to address this argument at all. Instead, they miscast Relator’s argument as an attack on accepted industry practices. They portray Relator’s argument as claiming that in-home exams are “per se invalid,” that “data gathering” cannot be used as a basis for code submissions and that codes can only be submitted for payment if they involved treatment.

A. Relator is not arguing that in-home visits are *per se* invalid for risk adjustment purposes.

Defendants claim that Relator asserts that in-home visits are “*per se* invalid” for risk adjustment purposes unless they involve treatment. (Def. Memo., at 38.) This is false. Nowhere in the Complaint does Relator allege such a legal theory. It is evident that Defendants lifted this language from the notice filed by the Government partially declining to intervene (Doc.13)⁴ and falsely attribute it to the Relator (Def. Memo. at 38)(noting that “Cutler’s first and broadest set of allegations [is] that Cigna ‘committed ‘per se [FCA] by submitting diagnoses from in-home 360 exams”). Defendants are attacking a legal theory that they themselves conjured up.

B. Relator does not allege that claims can only be submitted for payment if they involve treatment, nor is he saying “data gathering” cannot be used as a basis for code submissions.

Defendants mischaracterize the Complaint as asserting that diagnoses are only useable for code submission if they involve treatment. (Def. Memo. at 40-41.) There is no such assertion in

⁴ Specifically, the Government declined relator’s claims “insofar as” he is asserting that diagnosis codes submitted for risk-adjustment purposes constituted *per se* violations of the False Claims Act. Relator presumes that the reason the Government filed this notice was to clarify that it would not intervene to challenge widely accepted practices within the industry to the extent that his Complaint could be understood as asserting such position.

the Complaint. Rather, the Complaint asserts that the submitted ICD codes were invalid because they did not represent actual conditions that required or affected patient care, treatment or management during the relevant service year (Compl. ¶ 3, 47), which is the standard that applies for diagnosis to be useable for risk adjustment purposes. *See* 42 C.F.R. § 162.1002(c) (adopting the ICD as the standard medical data code set); *ICD-10-CM Official Guidelines for Coding and Reporting*, U.S. Department of Health and Human Services, at 104, (2014). This standard was not satisfied because the NPs were severely limited in what they could do to the point where the 360 was not an actual face to face encounter. *See* 42 C.F.R. § 422.26(a).

Defendants fail to distinguish (1) the act of *limiting* a provider's ability to diagnose and treat diseases from (2) engaging a medical professional for the *limited purpose* of diagnosing diseases and not for treating them. If a qualified healthcare provider independently diagnoses a condition, then the diagnosis can be used solely for purposes of payment and not treatment. Relator does not dispute this. (*See* Compl. at ¶ 34.) However, what a Medicare Advantage organization ("MAO") cannot do is restrict a NP's professional judgment, including the ability to advise a plan enrollee as to "health status, medical care, or treatment options." *CMS Manual System, Pub. 100-16 Medicare Managed Care, Transmittal Chapter. 6 § 40*, (Mar. 27, 2007). If the MAO does so, it can be sanctioned, and the visit will not be a true face-to-face encounter. *See* 42 C.F.R. § 422.26(d); *U.S. v. AseraCare, Inc.*, 938 F. 3d 1278, 1297 (11th Cir. 2019).

Based on the allegations in the Complaint, this is precisely what Defendants were doing. They engaged providers for the limited purpose of gathering data about the member but then directed the providers to diagnose chronic diseases using only the criteria Defendants wanted them to use, such as medications in the home or specific signs and symptoms. (Compl. ¶ 2, 69, 68, 71, 72.) They were restricted in their abilities to conduct testing, they did not have access to the

member's medical charts, and they could not make specialist referrals or prescribe medications. (*Id.* at ¶ 74.) They could not assess whether the information Defendants were requiring them to use to diagnose a disease was adequate to support the diagnosis they were making. The “diagnoses” were therefore invalid and unusable for risk adjustment purposes.

C. Relator's claims are not superseded by the Government's claims because the Government did not intervene in all of Relator's claims.

Defendants also incorrectly argue that Relator is barred from pursuing his claims because the Government sought and was granted intervention on all other claims as to which it did not expressly decline to intervene. (Def. Memo. at 38.) While the Government was indeed granted this right, it did not actually intervene in all of Relator's claims in its Complaint-in-Intervention. Specifically, the Government only intervened as to claims that (a) were based only on the home visits conducted by NPs; (b) required specific testing or imaging to be reliably diagnosed, which was not performed; (c) were not supported by the information documented on the 360 form completed by the NPs; and (d) were not reported by any other healthcare provider who saw the plan member during the year in which the home visit occurred, (Doc. 178, Int. Compl. at ¶ 7), which is a narrower subset of Relator's claims. (*See* Compl. at ¶ 58.)

Defendants are in effect arguing that Relator's remaining claims have been dismissed because the Government did not pursue them. But this view is not supported by the language in the FCA. The FCA is clear that a Relator's claims can only be dismissed by the Government if the Government moves to dismiss them, and only then after Relator has had opportunity to be heard. *See* 31 U.S.C § 3730(c)(2)(A); *see U.S. ex rel. White v. Mobile Care EMS & Transport, Inc.*, No. 1:15-cv-555, 2021 WL 6064363, *8 (S.D. Ohio Dec. 25, 2021); *U.S. v. Community Health Network*, No. 1:14-cv-01215-RLY-DLP, *9-*11 (S.D. Ind. Nov. 25, 2020)(copy attached as Exhibit C). To date, the Government has not exercised this right.

D. The public disclosure bar does not apply because the allegations in the Complaint are not based on any public disclosures; and, even if they are, Relator is the original source of the information.

Defendants also incorrectly assert that the public disclosure bar precludes Relator's claims. In assessing the application of the public disclosure bar, the courts apply a 3-factor test: (1) whether there has been any public disclosures from which fraud might be inferred; (2) an analysis of how closely related the allegations in the complaint are to those in the public disclosures and (3) whether the Relator is an original source of the information. *U.S. ex. rel Rahimi v. Rite Aid Corp.*, 3 F.4th 813, 824 (6th Cir. 2021).

Defendants claim that there are public documents which "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." (Def. Memo. at 39.) As an initial matter, this argument lacks merit because, as noted above, Relator is not claiming any *per se* violations. He is not arguing that diagnoses obtained from home visits are invalid unless they "offer treatment." (*Id.* at 40.) He is not alleging claims based on public disclosures of "industry-wide abuses and investigations." (*Id.* at 41.) He is not challenging accepted industry practices (*Id.* at 41.)

The claims he has alleged do not rely on any public disclosures. Defendants do not point to anything which shows that the allegations in the Complaint are "substantially the same as those contained in [a] public disclosure" *Rahimi*, 3 F. 4th at 824. Defendants merely refer to call letters, reports and articles that raise concerns about the propriety of using in-home visits to obtain diagnostic data for payment rather than treatment. (Def. Memo. at 40.) None of these documents describe or caution against a fraudulent scheme whereby MAOs obtain invalid diagnostic codes by commandeering the actions of the NPs performing the in-home visits.

Even if *arguendo* the allegations were based on public disclosures, it would not be enough

to expose the scam Defendants were perpetrating. See *U.S. v. Bristol-Meyer Squibb Co.*, 874 F.3d 905, 918-19 (2017); *United States v. Savanseniorcare, LLC*, No. 3:18-cv-01202, 2021 WL 1663579, *5 (M.D. Tenn. Apr. 28, 2021). This is because, as conceded by Defendants, obtaining diagnostic codes from the performance of an in-home exam is not prohibited by CMS. (Def. Memo. at 2, 7-8.) Nothing would put the government “on notice” of Defendants’ scheme (*Id.* at ¶ 74); see *U.S. ex rel. Maur v. Hage-Korban*, 981 F.3d 526, 522-23 (6th Cir. 2020)

Even if *arguendo* public disclosures were enough to disclose the fraud in this case, Relator still qualifies as the original source because he possesses direct and independent knowledge of the information on which the allegations are based. Indeed, much of the evidence was obtained during a private arbitration. Relator pored through thousands of non-public emails, transcripts, memoranda, excel spreadsheets and other documents to uncover Defendants’ fraudulent conduct, as well as questioned Defendants employees and interviewed witnesses. (See Compl. at ¶ 100);⁵see *U.S. ex rel. Antoon v. Cleveland Clinic Foundation*, 788 F. 3d 605, 617-19 (6th Cir. 2015)(noting that a relator who has direct knowledge of the true state of facts is an original source even though his knowledge of the misrepresentation is not first-hand); *U.S. ex rel. Griffith v. Conn*, 177 F. Supp. 3d 961, 970-71 (E.D. Ky. 2015).

E. The Complaint complies with the pleading with particularity requirements of Fed. R. Civ. P. 9(b).

Defendants also challenge Relator’s claims on the grounds that Relator does not “identify a single [] diagnosis, much less enough examples to support the broad scheme he alleges.” (Def. Memo., at p. 44-45.) This is false, and Defendants know it to be false.

First, the Court should take judicial notice of the representative examples provided in the

⁵ Defendants fail to point to anything that supports their conclusory statement that Relator did not “supply the Government with information that was ‘independent of’ or ‘materially add[ed] to the publicly disclosed allegations.’” (Def Memo. at 44.)

Government's Complaint-in-Intervention. While those examples pertain only to intervened claims, they would apply equally to the allegations in Relator's Complaint because the intervened claims are a narrow subset of Relator's claims. *See Chesbrough v. VPA, PC*, 655 F. 3d 461, 470 (6th Cir. 2011)(noting that "the government had intervened in the Chesbrough's action, it could presumably have identified actual claims submitted by VPA").

But more importantly, given the voluminous amount of evidence and the detailed description of the 360 program that Relator has pled in his Complaint, a representative example is not necessary. So long as a relator identifies the time, place, and content of the alleged instances of fraud, the requirements of Rule 9(b) will be satisfied. Relator has done so here. He provided the time periods involved, the nature of the fraud and the individuals who participated. (Compl. at ¶¶ 36, 51-52, 69- 72, 75, 77, 80, 82, 89); *see U.S. v. Ford Motor Company*, 532 F. 3d 496, 504 (6th Cir. 2008) Indeed, it was Relator's company itself that was actually performing 360s and the purpose of the 360 was, after all, to obtain diagnostic codes for submission to the Government. *See U.S. ex. Prather v. Brookdale Senior Living*, 838 F.3d 750, 755 (6th Cir. 2016). However, should the Court determine that more specific documentation is required, Relator would ask for leave to amend the complaint to provide more specific examples of the Defendant's fraud, as ample documentary evidence exists. An attached proposed Second Amended Complaint is provided as Exhibit D. Particularly, Paragraphs 102-105 of the proposed Second Amended Complaint contain the additional allegations. Because the referenced Exhibits A – C to the Second Amended Complaint contain private health information, these exhibits will be filed with the Court at a later date once a protective order is in place.

F. Relator has pled all the elements of a FCA claim.

Section 3729(a)(1)(A) of the FCA prohibits "knowingly present[ing], or caus[ing] to be presented, a false or fraudulent claim for payment or approval." A claim under § 3729(a)(1)(A) "requires proof that the alleged false or fraudulent claim was 'presented' to the government." *U.S. ex rel. Marlar v. BWXT Y-12, LLC*, 525 F.3d 439, 445 (6th Cir. 2008). The FCA also prohibits one from knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(B). At the pleading stage, one need only plead the scheme and identify a representative false claim that was actually submitted to the Government. *McFeeters v. Northwest Hospital*, No. 3-13-0467, 2015 WL 328212, at *3-*4, (M.D. Tenn. Jan. 23, 2015).

1. Relator has alleged the same scheme as the Government, but his claims are different.

Relator and the Government allege the same basic scheme: that Defendants through the in-home 360 program obtained invalid diagnostic codes which they then submitted to the Government for payment. Relator and the Government also allege that the codes were unusable because the diagnoses were unsupported. However, they each assert different reasons why support was lacking, and therefore the scope of their respective claims is different.

The Government asserts that the diagnoses were unsupported because they (a) were based only on the home visits conducted by the providers; (b) required specific testing or imaging to be reliably diagnosed, which was not performed; (c) were not supported by the information documented on the 360 form completed by the providers; and (d) were not reported by any other healthcare provider who saw the plan member during the year in which the home visit occurred.

(Int. Compl. at ¶ 7.)⁶ Relator, on the other hand, asserts that the diagnoses were unsupported because they (1) were not conditions that required or affected patient care, treatment, or management during the relevant service year; (2) could not have been treated or assessed during 360 visits; and/or (3) lacked medical record support or otherwise violated CMS coding rules. (Comp. at ¶ 47.)

2. The claims submitted by Defendants were false because the underlying diagnoses were invalid and therefore unusable for risk adjustment purposes.

Falsity can be established either by an express false certification, or through the implied certification theory which holds a defendant liable for violating the continuing duty to comply with the regulations on which payment is conditioned. *US ex rel. Wall v. Circle Const., LLC*, 697 F.3d 345, 356 (6th Cir. 2012). Here, Defendants' submissions were false because they certified to CMS the accuracy, completeness, and truthfulness of the diagnostic codes, when in fact the diagnoses were invalid and could not be used for risk adjustment purposes. 42 C.F.R. § 422.504(l).

The ICD codes were unusable for the following reasons. Under CMS rules, MAOs are instructed to document all conditions that “affect patient care, treatment or management.” *See* 42 C.F.R. § 162.1002(c) (adopting the ICD as the standard medical data code set); *ICD-10-CM Official Guidelines for Coding and Reporting*, U.S. Department of Health and Human Services, at 104, (2014). CMS guidance prohibits MAOs from interfering with a medical professional's activities. *CMS Manual System, Pub. 100-16 Medicare Managed Care, Transmittal Chapter. 6 § 40*, (Mar. 27, 2007). Defendants did not comply with these requirements. NPs were instructed to diagnose chronic and behavioral diseases based on criteria established by Defendants, such as

⁶ The Government specifically mentions rheumatoid arthritis, congestive heart failure, chronic kidney disease, and diabetes with renal complications as conditions that cannot be diagnosed in a home setting without conducting extensive testing, imaging, or other diagnostic steps. (Int. Compl. at ¶ 102.) Relator is pursuing all such claims to the extent not being pursued by the Government. (*See* Compl. at ¶ 58.)

finding generic signs and symptoms or medications within the home. (Compl. ¶¶ 48-55.)⁷ NPs could not conduct any testing, they did not have access to the member’s medical charts, and they could not make specialist referrals or prescribe medications. (*Id.* at ¶ 74.) The diagnoses were therefore not true medical diagnoses and were invalid for risk adjustment purposes.

Second, the ICD codes were unusable because the diagnoses were obtained by NPs who were unqualified to diagnose or treat the conditions they were identifying. (*Id.* at ¶¶ 60-66, 74.) Certain mental and behavioral conditions in particular cannot be diagnosed or treated by generalist NPs without specialty certifications which the NPs did not hold. (*Id.* at ¶¶ 64-65.) Because the NPs were not qualified, the visits did not qualify as true face-to-face encounters and, therefore, the diagnoses were invalid.

Third, the ICD codes were unusable because they were not supported by a true medical record. NPs’ diagnoses were recorded on a 360 Form which was a self-assessment form, not a true medical record. Data was recorded on the basis of self-assessment data and a “check-the-box” evaluation of diseases. (*Id.* at ¶¶ 86-87.) It is unclear from the form on what basis the diagnoses were rendered - that is whether by a self-assessment data or clinical findings. Providers also advised Defendants that they could not use the form as a medical record and that it was for the health plan’s internal records only. (*Id.* at ¶ 54.)

3. Defendants’ submissions were knowingly made because the 360 program was deliberately designed to capture and document inaccurate, unsupported or unreliable conditions.

Liability under the False Claims Act will not attach unless a violation is made knowingly. *See U.S. ex rel. Prather v. Brookdale*, 892 F.3d 822, 837 (6th Cir. 2018). Here, Relator has pled

⁷ Whether a member actually had the condition is besides the point. CMS requires that the conditions be re-diagnosed each service year, or else the plan must assume that the member has the same health as a Member within that same demographic.

that Defendants knowingly made false submissions. Defendants acted intentionally and were active participants in the fraud. In “purposeful violation of CMS,” they designed the 360 program to capture diagnoses that were “uncertain, probable, or merely suspected.” (Compl. ¶ 86.) Defendants had an obligation to ensure the accuracy of the data they were submitting from 360 visits but blatantly disregarded this obligation. *See United Healthcare*, 848 F at 1169; *U.S. v. Care Alternatives*, 952 F. 4d 89, 97 (3d Cir. 2020); *U.S. ex rel. Silingo v. WellPoint, Inc.*, 907 F. 3d 667, 673 (9th Cir. 2018).

4. Furnishing accurate codes was material to the Government’s decision to pay Defendants.

A False Claims Act violation must be “material,” meaning “having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” *Universal Health Services, Inc. v. U.S. ex rel. Escobar*, 136 S. Ct. 1989, 2002-03 (2016). The materiality requirement looks to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation. *Id.*

Relator has sufficiently pled materiality. (Compl. at ¶ 32-33). The accuracy of codes derived from medical records is of critical importance in determining plan participants’ risk scores and the payments made to MAOs. It has been noted in a number of cases, that they are “the only factors that CMS uses to determine a beneficiary’s health status and thus calculate how much CMS will pay for that beneficiary.” *U.S. ex rel. Zafirov v. Florida Medical Associates LLC*, Case No. 8:19-cv-1236-KKM-SPF, 2022 WL 4134611, *6 (M.D. Fla. Sept. 12, 2022); *U.S. ex rel. Omsby*, 444 F. Supp. 3d 1010, 1086 (N.D. Cal. 2020). The data is also used for a variety of other important purposes. *See* 42 C.F.R. § 422.310(f)(1).

Moreover, Defendants in this case were obtaining false codes by violating a CMS rule prohibiting an MAO from interfering with the providers’ ability to engage with the member. This

was sanctionable conduct that can deprive an MAO of the right to collect any payments. 42 C.F.R. § 422.26(a). Had CMS been aware of Defendants' activities it would have been strongly influenced not to make any payments at all. *See* 42 C.F.R. § 422.750(a).

CONCLUSION

Defendants ignore the allegations in the Complaint and paint a false portrait of the 360 program, one that is not even supported by the exhibits attached to their supporting memorandum. The 360 program was in reality a scam designed to pocket billions of dollars from the U.S. Government. There is no basis to dismiss Relator's claims; and, accordingly, the Defendants' Motion to Dismiss should be denied. Should the Court determine, however, that more particularity is needed as to the allegations, Relator requests leave to amend and has attached a proposed Second Amended Complaint.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served via email, U.S. Mail, or the Court's Electronic Filing System on:

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on this 15nd day of February 2023.

/s/ Tara L. Swafford
Tara L. Swafford

Exhibit A



360 Comprehensive Physical Exam

The 360 Exam is a comprehensive exam designed to focus on preventative health care for our HealthSpring members. The exam is conducted by Bravo Health trained Nurse Practitioners (NPs) in the member's home.

The comprehensive exam includes:

- Review of Systems
- Medication review
- Fall risk screening
- Depression screening
- Foot exam

The home visit is not a substitute for PCP treatment and DOES NOT replace the annual physical or HMR completed by the PCP. The member is encouraged to see his/her PCP for all labs and recommended treatment following a 360 exam and the Nurse Practitioners may assist the member in scheduling follow-up visits with the PCP.

**** Upon Receipt ****
(Office Staff)

Please confirm the following:

1. Confirm you are the correct PCP
2. Verify the member has a follow-up appointment with PCP

Once reviewed, the exam should be filed into the medical record. If the PCP/Office Staff have any questions regarding the 360 Comprehensive Exam, please feel free to call Bravo Health at 832-553-3300 ext. 3094.

January 2014

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

Unable to perform exam b/c of [REDACTED]

Diagnoses (3 or more coexisting)

Prior history of falls within 3 months

Incontinence

Visual impairment

Impaired functional mobility

Environmental hazards

Polypharmacy

Pain affecting level of function

Cognitive impairment

AL number of boxes marked: [REDACTED]

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? [REDACTED]

Have you had a loss of interest in things that normally bring you pleasure? [REDACTED]

Have you felt fatigued or had a loss of energy recently? [REDACTED]

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)? [REDACTED]

If Yes, please distribute education material

Review of systems	Negative	Positive/Findings
General	[REDACTED]	[REDACTED]
HEENT	[REDACTED]	[REDACTED]
Cardiac	[REDACTED]	[REDACTED]
Respiratory	[REDACTED]	[REDACTED]
GI	[REDACTED]	[REDACTED]
GU	[REDACTED]	[REDACTED]
Musculoskeletal	[REDACTED]	[REDACTED]
Neurological	[REDACTED]	[REDACTED]
Skin	[REDACTED]	[REDACTED]
Psychiatric	[REDACTED]	[REDACTED]
Endocrine	[REDACTED]	[REDACTED]
Hematological	[REDACTED]	[REDACTED]

***Please assess the overall pain presence in the patient's day here:**

0 1 2 3 4 5 6 7 8 9 10 *Plan [REDACTED] Meds [REDACTED] PT [REDACTED] Other [REDACTED]

*Pain screening [REDACTED] Education [REDACTED] Pain doctor [REDACTED] N/A [REDACTED]

Foot exam (Complete for diabetic patients)

1. Ask the patient:

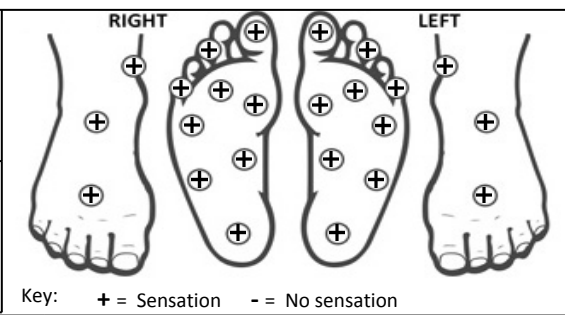
Burning, tingling or numbness in feet Previous foot ulcer

Pain or cramping in calf area during exercise None of these

2. Look at both feet:

Infection Calluses or corns Nail disorders None of these

Ulceration Skin breaks Foot deformity



3. Check for foot	Left			Right		
Dorsalis pedis	[REDACTED] Normal	[REDACTED] Weak	[REDACTED] Absent	[REDACTED] Normal	[REDACTED] Weak	[REDACTED] Absent
Posterior Tibial	[REDACTED] Normal	[REDACTED] Weak	[REDACTED] Absent	[REDACTED] Normal	[REDACTED] Weak	[REDACTED] Absent
4. Test for neuropathy	Left Monofilament	[REDACTED] Normal	[REDACTED] Abnormal	Right Monofilament	[REDACTED] Normal	[REDACTED] Abnormal

5. Presence of diabetes complications: (check all that apply)

Peripheral neuropathy Peripheral vascular disease Ulcer Gangrene None of these

Amputation (date, side & level): _____

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

Physical exam	Normal	Abnormal/Findings
General		[REDACTED]
HEENT		[REDACTED]
Neck		[REDACTED]
Heart		[REDACTED]
Lungs		[REDACTED]
Breast		[REDACTED]
Abdomen		[REDACTED]
Extremities		[REDACTED]
GU		[REDACTED]
Musculoskeletal		[REDACTED]
Neurological		[REDACTED]
Skin		[REDACTED]
Psychiatric		[REDACTED]
Lymphatic		[REDACTED]
Hematologic		[REDACTED]

Current Conditions:

Cardiovascular: <input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
History of MI Specify Date: _____	[REDACTED]				
Angina Pectoris					
CAD <input type="checkbox"/> CAD w/ Angina Pectoris					
Cardiomyopathy <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Ischemic					
Congestive Heart Failure: <input type="checkbox"/> Diastolic <input type="checkbox"/> Systolic <input type="checkbox"/> Combined Systolic/Diastolic					
Hyperlipidemia					
Carotid artery stenosis Side: <input type="checkbox"/> Right <input type="checkbox"/> Left					
Atrial Fibrillation <input type="checkbox"/> Chronic <input type="checkbox"/> Paroxysmal <input type="checkbox"/> Persistent					
Sick Sinus Syndrome <input type="checkbox"/> w/ Pacemaker <input type="checkbox"/> w/o Pacemaker					
Tachycardia Type (specify): [REDACTED]					
Hypertension Date of diagnosis: _____					
Hypertensive Heart Disease with Heart Failure <input type="checkbox"/> Hypertensive Heart Disease without Failure					
Hypertensive Renal Disease					
Hypertensive Heart and Renal Disease <input type="checkbox"/> w/ Heart failure <input type="checkbox"/> w/o Heart failure					
Peripheral Artery Disease					
Other Diagnosis (specify): [REDACTED]					

Nutritional/Metabolic/Endocrine: <input checked="" type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Protein Calorie Malnutrition(BMI<19). If positive: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate	[REDACTED]				
<input type="checkbox"/> Obesity (BMI 30-39.9) <input type="checkbox"/> Morbid Obesity (BMI>=40)					
<input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Aquired (post surgical)					
<input type="checkbox"/> Hyperthyroidism					
<input type="checkbox"/> Other Diagnosis (specify): _____					

Diabetes Mellitus: Reviewed and no active disease

	Meds	Monitor	Diet	Labs	Referral
DM: <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Insulin Dependent					
<input type="checkbox"/> DM w/ Secondary Kidney Complications: <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Nephropathy					
<input type="checkbox"/> DM w/ Secondary Neurological Complications: <input type="checkbox"/> Mononeuropathy <input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Gastroparesis <input type="checkbox"/> Other: _____					
<input type="checkbox"/> DM w/ Secondary Ophthalmic Complications: <input type="checkbox"/> Retinopathy: <input type="checkbox"/> Proliferative <input type="checkbox"/> Nonproliferative <input type="checkbox"/> w/ Macular Edema <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Cataract <input type="checkbox"/> Glaucoma					
<input type="checkbox"/> DM w/ Secondary Circulatory Complications: <input type="checkbox"/> Peripheral Angiopathy/PVD <input type="checkbox"/> w/ Gangrene <input type="checkbox"/> w/o Gangrene					
<input type="checkbox"/> DM w/ Secondary Skin Complications: <input type="checkbox"/> Non-Pressure Chronic Ulcer Location (specify): _____					
<input type="checkbox"/> DM w/ Other Secondary Complications <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperglycemia					
Other Secondary Diagnosis (specify): [REDACTED]					

Respiratory: Reviewed and no active disease

	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Chronic Bronchitis: <input type="checkbox"/> Obstructive <input type="checkbox"/> Simple <input type="checkbox"/> Mucopurulent <input type="checkbox"/> Mixed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> COPD: <input type="checkbox"/> w/ acute lower respiratory infection <input type="checkbox"/> w/ oxygen dependence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Emphysema <input type="checkbox"/> Unilateral <input type="checkbox"/> Panlobular <input type="checkbox"/> Centrilobular <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Obstructive <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bronchiectasis: <input type="checkbox"/> w/ Exacerbation <input type="checkbox"/> w/o acute lower respiratory infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pulmonary Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Diagnosis (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal: Reviewed and no active disease

	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> *Rheumatoid Arthritis-DMARD Prescribed <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteoarthritis Location(s): _____ Side: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteopenia Location(s): _____ Side: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteoporosis Location(s): _____ Side: <input type="checkbox"/> Right <input type="checkbox"/> Left Kind: <input type="checkbox"/> Senile <input type="checkbox"/> Post menopausal <input type="checkbox"/> Unspecified					
Has the patient had a fracture in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If a fracture occurred, where was it: _____ <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last Bone Density: _____					
*Bisphosphonate Prescribed <input type="checkbox"/> Yes <input type="checkbox"/> No					
Start date of bisphosphonate: _____					
<input type="checkbox"/> S/P Amputation Date: _____ Traumatic <input type="checkbox"/> Yes, Location: _____ <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Diagnosis (specify): [REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Skin/Subcutaneous: Reviewed and no active disease

	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Ulcer: <input type="checkbox"/> Pressure <input type="checkbox"/> Stg I <input type="checkbox"/> Stg II <input type="checkbox"/> Stg III <input type="checkbox"/> Stg IV <input type="checkbox"/> Unstageable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic <input type="checkbox"/> Location (specify): _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Diagnosis (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Member Name: [REDACTED]		DOB: [REDACTED]		DOS: [REDACTED]				
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		
<input type="checkbox"/> Chronic Kidney Disease(CKD)	<input type="checkbox"/> CKD Unspecified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stage I (GFR>90)	<input type="checkbox"/> Stage II (GFR60-89)	<input type="checkbox"/> Stage III (GFR30-59)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stage IV (GFR15-29)	<input type="checkbox"/> Stage V (GFR<15)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ESRD	Dialysis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AV Fistula:	<input type="checkbox"/> Graft	<input type="checkbox"/> Catheter		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal/Urinary: <input type="checkbox"/> Reviewed and no active disease				Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Urinary Incontinence (check one):		<input type="checkbox"/> Unspecified	<input type="checkbox"/> Stress	<input type="checkbox"/> Urge	[REDACTED]			
<input type="checkbox"/> BPH	<input type="checkbox"/> w/LUTS (specify): _____	<input type="checkbox"/> w/o LUTS		[REDACTED]				
<input type="checkbox"/> Cystostomy		[REDACTED]						
Other Diagnosis (specify): _____		[REDACTED]						
Gastrointestinal: <input type="checkbox"/> Reviewed and no active disease				Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Pancreatitis:	<input type="checkbox"/> Acute	<input type="checkbox"/> Chronic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cirrhosis liver:	<input type="checkbox"/> Alcoholic	<input type="checkbox"/> Non-Alcoholic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> End stage liver disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Colostomy	<input type="checkbox"/> Ileostomy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> GERD		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crohn's Disease location(s): _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ulcerative Colitis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IBS	<input type="checkbox"/> w/ diarrhea	<input type="checkbox"/> w/o diarrhea		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> J Tube	<input type="checkbox"/> G Tube		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic Hepatitis: Type: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Diagnosis (specify): _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye: <input type="checkbox"/> Reviewed and no active disease				Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Cataract	<input type="checkbox"/> Senile	Side: <input type="checkbox"/> Right <input type="checkbox"/> Left		[REDACTED]				
<input type="checkbox"/> Glaucoma	Side: <input type="checkbox"/> Right <input type="checkbox"/> Left		[REDACTED]					
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Exudative	<input type="checkbox"/> Nonexudative		[REDACTED]				
<input type="checkbox"/> Legal Blindness		[REDACTED]						
Other Diagnosis (specify): _____		[REDACTED]						

Member Name: [REDACTED]	DOB: [REDACTED]	DOS: [REDACTED]			
Active Neoplasms/Blood Disorders: [REDACTED] Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Colon Cancer <input type="checkbox"/> Colectomy Date: _____ <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metastatic and if so, to what site(s)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breast Cancer Site (<input type="checkbox"/> Right <input type="checkbox"/> Left) Date: _____ Treatment: <input type="checkbox"/> Mastectomy <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Hormonal therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> If Ductal Carcinoma in situ <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metastatic and if so, to what site(s)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Prostatectomy <input type="checkbox"/> Hormonal therapy <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metastatic and if so, to what site(s)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lung Cancer <input type="checkbox"/> Rgt <input type="checkbox"/> Lft <input type="checkbox"/> Upper Lobe <input type="checkbox"/> Lower Lobe <input type="checkbox"/> Other: _____ Treatment <input type="checkbox"/> Lobectomy <input type="checkbox"/> Pneumonectomy <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metastatic and if so, to what site(s)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Skin Cancer (type and site)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Melanoma in Situ (site): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Malignancies (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Myelodysplastic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Current <input type="checkbox"/> In Remission <input type="checkbox"/> Relapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Drug-induced Neutropenia (specify drug): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anemia: <input type="checkbox"/> Due to CKD <input type="checkbox"/> Drug-induced (specify drug): _____ <input type="checkbox"/> Due to Chemotherapy <input type="checkbox"/> B-12 <input type="checkbox"/> Iron <input type="checkbox"/> General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sickle Cell <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HIV+ <input type="checkbox"/> AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Diagnosis (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Neurological: <input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
[REDACTED] CVA w/ Sequelae	[REDACTED]				
Specify late effect: [REDACTED] Cognitive [REDACTED] Speech/Language [REDACTED] Aphasia [REDACTED] Dysphagia [REDACTED] Other: _____					
<input type="checkbox"/> Monoplegia <input type="checkbox"/> Dominant <input type="checkbox"/> Non-Dominant <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Upper Limb <input type="checkbox"/> Lower Limb					
<input type="checkbox"/> Hemiplegia/Hemiparesis <input type="checkbox"/> Dominant <input type="checkbox"/> Non-Dominant <input type="checkbox"/> Right <input type="checkbox"/> Left					
<input type="checkbox"/> Weakness <input type="checkbox"/> Dominant <input type="checkbox"/> Non-Dominant <input type="checkbox"/> Right <input type="checkbox"/> Left					
<input type="checkbox"/> History of Trauma					
<input type="checkbox"/> Hemiplegia/Hemiparesis <input type="checkbox"/> Dominant <input type="checkbox"/> Non-Dominant <input type="checkbox"/> Right <input type="checkbox"/> Left					
<input type="checkbox"/> Monoplegia <input type="checkbox"/> Dominant <input type="checkbox"/> Non-Dominant <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Upper Limb <input type="checkbox"/> Lower Limb					
<input type="checkbox"/> Quadriplegia					
<input type="checkbox"/> Multiple Sclerosis					
<input type="checkbox"/> Myasthenia gravis					
<input type="checkbox"/> ALS					
<input type="checkbox"/> Polyneuropathy from other than diabetes					
<input type="checkbox"/> Parkinson's Disease: <input type="checkbox"/> w/ Dementia <input type="checkbox"/> w/ behavioral disturbances					
<input type="checkbox"/> Seizures <input type="checkbox"/> Seizure Disorder (Epilepsy)					
<input type="checkbox"/> Other Diagnosis (specify): _____					

Psychiatric:	<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Dementia	<input type="checkbox"/> Unspecified <input type="checkbox"/> Vascular	[REDACTED]				
	<input type="checkbox"/> Senile <input type="checkbox"/> w/ Delusions <input type="checkbox"/> w/ Depression					
<input type="checkbox"/> Alzheimer's:	<input type="checkbox"/> w/ Early Onset <input type="checkbox"/> w/ Late Onset					
	<input type="checkbox"/> w/ Dementia <input type="checkbox"/> w/ Dementia and Behavioral Disturbances					
<input type="checkbox"/> Depressive Disorder	<input type="checkbox"/> Mild <input type="checkbox"/> Major if major: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe					
	if major: <input type="checkbox"/> Single Episode <input type="checkbox"/> Recurrent <input type="checkbox"/> Full Remission <input type="checkbox"/> Partial Remission					
	if severe: <input type="checkbox"/> w/ psychotic symptoms <input type="checkbox"/> w/out psychotic symptoms					
<input type="checkbox"/> Anxiety						
<input type="checkbox"/> Bipolar	Current [REDACTED] in Remission [REDACTED] Full [REDACTED] Partial)					
	w/ psychotic symptoms <input type="checkbox"/> w/out psychotic symptoms					
Current kind	Depressed [REDACTED] anic [REDACTED] Mixed					
Current severity	Mild [REDACTED] oderate [REDACTED] Severe					
<input type="checkbox"/> Schizophrenia	Paranoid [REDACTED] imple [REDACTED] Undifferentiated					
	Disorganized [REDACTED] ther (specify): _____					
<input type="checkbox"/> Alcohol Use	Alcohol Abuse [REDACTED] Alcohol Dependence <input type="checkbox"/> In Remission					
<input type="checkbox"/> Substance Use	<input type="checkbox"/> Sbst Abuse <input type="checkbox"/> Dependence <input type="checkbox"/> In Remission specify: _____					
<input type="checkbox"/> Other diagnosis (specify):	_____					

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

Osteoporosis Screening (67-85 y/o)	Date [REDACTED]	*Breast Cancer Screening (52-74 y/o, every 27 mo):	Date [REDACTED]
*Colorectal Cancer Screening (50-75 y/o):	Date [REDACTED]	Sigmoidoscopy (Every 5 years):	Date [REDACTED]
*Influenza Vaccine (65+ y/o):	Date [REDACTED]	Colonoscopy (Every 10 years):	Date [REDACTED]
Advance care planning:	Date [REDACTED]	Pneumococcal Vaccine (65+ y/o):	Date [REDACTED]

Given Vaccine: Pneumouax Prevnar

RESULT: [REDACTED] Information given/Discussion [REDACTED] Medical Power of Attorney [REDACTED] Living Will [REDACTED] Advanced Directive Planning

Member Name [REDACTED] DOB: [REDACTED] DOS: [REDACTED]

Long Term Medication Monitoring (Annual) Reviewed
 Anticonvulsants (Phenobarbital, Carbamazepine, Phenytoin, Valproic acid):

 Serum Drug Concentration: Date [REDACTED]

***Patients diagnosed with Diabetes:**
 *HbA1C <9: Date [REDACTED] result [REDACTED]
 *Microalbuminuria: Date [REDACTED] result [REDACTED]
 *Retinal Eye Exam: Date [REDACTED] result [REDACTED]
 *Name of Eye Care Provider [REDACTED]

Patients diagnosed with COPD:
 Spirometry: Date [REDACTED]
 Beta Agonist/Anticholinergic Prescribed: Yes No

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:
 LVF Assesment: Date [REDACTED] Result [REDACTED]
 ACE or ARB Prescribed: Yes No

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

DIAGNOSES	SELECT TREATMENT PLAN						
	Meds	Monitor	Diet	Labs	Referral	Other	Describe
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PLAN _____



HMR reviewed and updated on today's visit? Yes No
BEHAVIORAL HEALTH REFERRAL: Yes No Indication: [REDACTED]

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 _____

OTHER/COMMENTS:
 [REDACTED]

2017 HEALTH MANAGEMENT REPORT (HMR)

Patient: [REDACTED]

Patient DOB: [REDACTED]

A) List all Current/Active Conditions for this Date of Service.

B) MUST provide a brief treatment plan for all active conditions you manage and/or name and specialty of referred to provider (i.e. Rx, PT, monitoring, etc.).

Code	Description	Required: Treatment Plan for condition managed by provider OR identify referred-to physician and specialty					
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):
[REDACTED]	[REDACTED]	Rx	Monitor	Diet	Other:	[REDACTED]	I Referral (name/specialty):

Electronically Signed By: [REDACTED]

Date of service: [REDACTED]

Printed physician name [REDACTED]

Please Print Legibly

Important - Must Ensure:

- 1 Patient's Name and DOB have been entered at the top of this form and are legible.
- 2 Review of HMR is reference in Progress Note for DOS.
- 3 All pages signed/dated by PHYSICIAN.
- 4 Original HMR placed in patient's chart.

2017 HEALTH MANAGEMENT REPORT (HMR)

Patient: [REDACTED]

Patient DOB: [REDACTED]

A) List all Current/Active Conditions for this Date of Service.

B) MUST provide a brief treatment plan for all active conditions you manage and/or name and specialty of referred to provider (i.e. Rx, PT, monitoring, etc.).

[REDACTED]	Rx	Monitor <input type="checkbox"/> Diet <input type="checkbox"/> Other:	Referral (name/specialty):
[REDACTED]	Rx	Monitor <input type="checkbox"/> Diet <input type="checkbox"/> Other:	Referral (name/specialty):
[REDACTED]	Rx	Monitor <input type="checkbox"/> Diet <input type="checkbox"/> Other:	Referral (name/specialty):
[REDACTED]	Rx	Monitor <input type="checkbox"/> Diet <input type="checkbox"/> Other:	Referral (name/specialty):
[REDACTED]	Rx	Monitor <input type="checkbox"/> Diet <input type="checkbox"/> Other:	Referral (name/specialty):
[REDACTED]	Rx	Monitor <input type="checkbox"/> Diet <input type="checkbox"/> Other:	Referral (name/specialty):
[REDACTED]	Rx	Monitor <input type="checkbox"/> Diet <input type="checkbox"/> Other:	Referral (name/specialty):
[REDACTED]	Rx	Monitor <input type="checkbox"/> Diet <input type="checkbox"/> Other:	Referral (name/specialty):

Electronically Signed By:

[REDACTED]

Date of service:

[REDACTED]

Printed physician name:

[REDACTED]

Please Print Legibly

Important - Must Ensure:

- 1 Patient's Name and DOB have been entered at the top of this form and are legible.
- 2 Review of HMR is reference in Progress Note for DOS.
- 3 All pages signed/dated by PHYSICIAN.
- 4 Original HMR placed in patient's chart.

Member Name:

[Redacted]

DOB:

[Redacted]

Member ID:

[Redacted]

DOS	Code	Description	Source	Error	Notes(Include Explanation for "other "Source)
[Redacted]					

[Redacted]

Reviewer signature

Date

Member Name:

[REDACTED]

DOB:

[REDACTED]

Member ID:

[REDACTED]

Page #: 2

[REDACTED]

[REDACTED]

Reviewer signature

Date

Exhibit B

BUSINESS SERVICES AGREEMENT

THIS BUSINESS SERVICES AGREEMENT, is made to be effective as of the 1st day of May , 2013 (hereinafter referred to as the "Effective Date"), by and between, Texas Health Management, LLC, a Delaware corporation ("VENDOR" or "THM"), and HealthSpring Life & Health Insurance Company, Inc., a Texas insurance company ("HEALTHSPRING").

WITNESSETH

WHEREAS, HEALTHSPRING wishes to engage VENDOR to perform certain business services for HEALTHSPRING; and

WHEREAS, the purpose of this written Agreement is to set forth the rights and obligations of HEALTHSPRING and VENDOR, with respect to the services to be rendered to HEALTHSPRING by VENDOR.

NOW, THEREFORE, in consideration of the above premises and of the mutual promises, which are set forth in this Agreement, HEALTHSPRING and VENDOR, intending to be legally bound, hereby agree as follows:

1.

Definitions. In addition to the other definitions, which are set forth in this Agreement, the following words, shall be defined as set forth in this Section 1. All words not defined in this Section 1, or in any other provision of this Agreement, shall be interpreted by reference to their ordinary and customary meaning.

- (a) **Covered Services.** Shall mean those specifically outlined in Exhibit A.
- (b) **HEALTHSPRING.** Shall mean and include HEALTHSPRING, and all of its affiliated and related companies, individuals and other organizations.
- (c) **VENDOR.** Shall mean and include VENDOR, and all of its affiliated and related companies, individuals and other organizations.

2. **Term and Termination.**

(a) **Term.** The initial term of this Agreement shall be for one (1) year commencing on the Effective Date, and shall automatically renew unless the Agreement is terminated in accordance with the provisions herein.

(b) **No Cause Termination.** This Agreement may be terminated, in its entirety or with respect to an individual Covered Service provided under the Agreement, by either party for any reason at any time, provided that the party wishing to terminate provides the other party hereto, with a written notice of such termination ninety (90) days prior to the date on which termination is to take effect.

(c) **Termination for Cause.** This Agreement may be terminated by either party if the other party commits a material breach of a material provision of this

Agreement, provided, that the party wishing to terminate this Agreement provides the other party hereto, with a written notice setting forth a detailed description of the alleged material breach, and the other party fails to remedy such breach within thirty (30) days after receiving such notice.

(d) Work in Progress. If this Agreement is terminated by either party all work in progress shall continue to completion, and HEALTHSPRING hereby agrees to pay VENDOR for the Covered Services, in accordance with the terms and conditions of this Agreement.

3. VENDOR Obligations. In performing the Covered Services under this Agreement, VENDOR hereby agrees to comply with all of the following requirements.

(a) Maintenance of Licenses. VENDOR shall maintain any and all licenses, permits and other approvals that are required for the performance of the Covered Services, as applicable.

(b) Compliance with Laws. VENDOR shall comply with all applicable laws and regulations in the performance of the Covered Services for HEALTHSPRING, including, but not limited to, the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as outlined in the Business Associate Agreement executed between the parties.

(c) Status of Contractor. It is expressly acknowledged that the VENDOR is an "independent contractors," and nothing in this Agreement is intended and nothing shall be construed to create an employer/employee, partnership, joint venture or other type of relationship, or to allow either to exercise control or direction over the manner or method by which the other performs the services that are the subject matter of this Agreement; provided always that the Covered Services to be provided hereunder shall be furnished in a manner consistent with the standards governing such services and the provisions of this Agreement.

4. HEALTHSPRING Obligations. During the Term of this Agreement, HEALTHSPRING shall provide the support and other resources required in order to facilitate the performance of the Covered Services by VENDOR. HEALTHSPRING hereby agrees to comply with all of the following requirements.

(a) Compliance with Laws. HEALTHSPRING shall comply with all applicable laws and regulations in the performance of its obligations under this Agreement.

(b) Approvals. If this Agreement requires the consent, approval and/or other acknowledgement by HEALTHSPRING before an action may be taken, HEALTHSPRING hereby agrees that its approval will be on a timely basis.

(c) Regulatory. HEALTHSPRING shall be responsible for all insurance and other regulatory compliance in connection with the development and implementation of all approved projects. HEALTHSPRING hereby agrees that no products shall be marketed by HEALTHSPRING, without all of the required governmental and other approvals.

5. Fees and Expenses.

(a) **Reimbursement.** During the Term of this Agreement, HEALTHSPRING shall reimburse VENDOR for Covered Services in accordance with Exhibit B attached hereto, within 95 days of claims receipt.

6. **Billing, Advances, Etc.** HEALTHSPRING and VENDOR hereby agree that all fees, expense reimbursements and other payments required by this Agreement shall be paid by HEALTHSPRING to VENDOR in a timely manner, and shall be billed in accordance with Exhibit B.

7. **Confidentiality.** In the course of carrying out of the terms and conditions of this Agreement, the parties may have access to confidential information concerning the other party and its affiliates ("Confidential Information"). Therefore, each party hereto agrees to the following:

(a) Each party is only authorized to view or use the other party's Confidential Information to the extent necessary to assess a potential business process or opportunity, and/or to carry out the terms and conditions of this Agreement;

(b) Neither party may remove the other party's Confidential Information from the other party's premises, without prior permission; and

(c) Each party may only disclose the other party's Confidential Information to its employees and its independent contractors who have a need for the information to perform their tasks; provided however, the owner of the Confidential Information agrees in writing to such disclosure in advance and the employee or independent contractor receiving such Confidential Information agrees to be bound to the terms of disclosure as set forth herein.

The term "Confidential Information" shall not include information, which is (i) publicly known, (ii) rightfully received from a third party, (iii) independently developed without using information obtained from the other party, so long as such independent development can be clearly documented and verified, or (iv) which is required to be disclosed pursuant to a requirement of a governmental agency or law, so long as the disclosing party provides the other party with written notice of such requirement, prior to any such disclosure, if possible.

Each party understands and acknowledges that any unauthorized use or disclosure of Confidential Information may subject them to liability to the other party, and/or to others, and hereby agrees to indemnify the other party, as set forth in Section 10 of this Agreement.

8. **Mutual Indemnification.** Each party to this Agreement on behalf of itself and its respective affiliates, related companies, successors and assigns hereby agrees to indemnify, hold harmless and defend the other party hereto, and such other party's affiliates, related companies, officers, directors, and employees from and against, any and all fines, penalties, losses, liabilities, claims, actions, proceedings (whether legal or administrative), damages, injuries, demands, costs, expenses, attorneys' fees and other liabilities incurred by the protected parties, and which arise from the indemnifying party's performance, non-performance and/or breach of this Agreement.

9. Other Provisions.

(a) Miscellaneous. This Agreement (i) shall bind and inure to the benefit of the parties hereto and their respective agents, other legal representatives, successors and to the extent this Agreement is assignable, assigns; (ii) may be executed in one or more counterparts (including signed faxes), each of which shall be deemed to be an original copy of this Agreement, and all of which when taken together, shall be deemed to constitute one and the same instrument; (iii) shall be construed under Tennessee law; (iv) may not be assigned, waived and/or otherwise modified in any manner whatsoever, without the written approval of all of the parties; and (v) contains the entire agreement between VENDOR and HEALTHSPRING with respect to the subject matter hereof, and supersedes any and all prior or contemporaneous understandings and agreements between the parties with respect to the subject matter hereof.

(b) Additions. After the Effective Date of this Agreement, the parties may add to the list of Covered Services to be performed by VENDOR by letter, faxes, formal Amendment to this Agreement, or by any other written document, provided that a representative of both parties signs such written document.

(f) Disputes. Notwithstanding anything herein to the contrary, any disputes arising out of this Agreement which cannot be settled through negotiation and communication between the parties, shall be referred to and resolved in accordance with the Commercial Rules of the American Arbitration Association. Each party shall be responsible for its own costs and fees in connection with the arbitration proceedings.

(h) Modification and Severability. This Agreement can only be modified by a written amendment duly signed by both HEALTHSPRING and VENDOR. If any provision of this Agreement is held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining portions of that provision, and all of the other provisions of this Agreement, shall not in any way be affected or be impaired thereby.

(j) Notices and Correspondence. All notices pursuant to this Agreement shall be in writing via certified mail or courier to the addresses set forth below:

HEALTHSPRING:

HealthSpring Life & Health Insurance Company, Inc.
Attn: Jessica Columbus
2900 N. Loop West, Suite 1300
Houston, TX 77092

with a copy to:

HealthSpring Life & Health Insurance Company, Inc.
Attn: Teresa Jordan, Associate Chief Counsel
2900 N. Loop West, Suite 1300
Houston, TX 77092

THM:

Texas Health Management, LLC
Attn: Michael Walton
2500 Legacy Drive Suite 206
Frisco, TX 75034


Any other general correspondence, including invoices and account information, shall be sent to the addresses set forth above via regular mail.

(k) Survival. The definitions contained in this Agreement and the following provisions of this Agreement, shall survive the non-renewal and/or termination of this Agreement for any reason: 7 and 8.

IN WITNESS WHEREOF, the undersigned authorized representatives of VENDOR and HEALTHSPRING respectfully, have set forth their signatures below, intending for their respective organizations to be legally bound thereby, as of the Effective Date of this Agreement.

Texas Health Management, LLC

HealthSpring Life & Health
Insurance Company, Inc.

By: 

By: 

Name: MICHAEL E. WALTON

Name: Jay L. Hurt

Title: CEO

Title: Divisional President

Date: May 1, 2013

Date: May 1, 2013

EXHIBIT A

COVERED SERVICES

This Exhibit A is part of and subject to, the Business Services Agreement between VENDOR and HEALTHSPRING.

1. The Covered Services provided under the Agreement are the following:

Texas Health Management (THM) will complete 360's or 360's plus lab work and Health Management Reports (HMR's) for selected members via in-home visits with members.

Nurse practitioners will complete the forms by questioning and observing the patients to find any swelling, lesions, or other indicators of health concerns.

In addition to the blood draw/finger stick, THM's staff will also educate patients on other tests needed as appropriate such as a diabetic retinopathy, mammogram, glaucoma screening, etc.

2. The Covered Services outlined in this Exhibit A may be modified by amendment agreed to by both parties.

EXHIBIT B

FEE SCHEDULE

Vendor shall be reimbursed at the following rates dependent upon services provided:

<u>Service</u>	<u>Reimbursement per Member</u>
360	\$250
HMR	\$50
Finger Stick or Blood Draw	\$50

Exhibit C

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

UNITED STATES OF AMERICA and)	
STATE OF INDIANA ex rel. Thomas P.)	
Fischer,)	
)	
)	
Plaintiffs,)	
)	
v.)	No. 1:14-cv-01215-RLY-DLP
)	
COMMUNITY HEALTH NETWORK, INC.,)	
<i>et al.</i> ,)	
)	
Defendants.)	

ORDER

This matter comes before the Court on Plaintiff-Relator's Motion for Leave to File Second Amended Complaint, Dkt. [108]. On March 17, 2020, Defendant Community Health Network, Inc.¹ filed a response in opposition. (Dkt. 115). On March 24, 2020, the United States of America and the State of Indiana filed Statements of Interest. (Dkts. 120, 121). On March 31, 2020, Plaintiff-Relator filed a reply in support of the Motion for Leave to Amend. (Dkt. 47). On April 14, 2020, with this Court's permission, Community Health Network filed a sur-reply in opposition to Plaintiff-Relator's request for leave. (Dkt. 129). The Motion is now fully briefed and ripe for decision. For the reasons discussed below, Plaintiff-Relator's Motion is **GRANTED**.

¹ Community Health Network, Inc. is the only Defendant that has been served with a Complaint and entered counsel appearances in this matter.

I. BACKGROUND

In October 2015, Community Health Network, Inc. ("CHN") recruited Plaintiff-Relator Thomas P. Fischer ("Relator") from his private practice to serve as CHN's Chief Financial Officer. (Dkt. 1 at 6). CHN is a non-profit health system located in Indianapolis, Indiana which includes hospitals, surgery centers, urgent care centers, and patient facilities. (Id. at 7). CHN employs over 350 physicians through subsidiaries and affiliates, primarily through its subsidiary Community Physician Network ("CPN"). (Id.).

In December 2012, CHN promoted Relator to serve as its Chief Operating Officer and Chief Financial Officer. (Id. at 6-7). In this dual role, Relator became aware of significant, unexpected monetary losses at CPN. (Id. at 45). As a result, he began asking CPN management for explanations regarding the losses and expressed concern that he believed the losses were directly tied to CHN paying physicians "commercially unreasonable rates." (Id. at 46). Starting in July 2013, Relator began requesting financial information regarding Visionary Enterprises, Inc. ("VEI")² surgery centers and continued expressing concern about excessive physician compensation to a number of individuals, including CHN senior management. (Id. at 47). On November 27, 2013, CHN terminated Relator from his positions. (Id. at 48).

On July 21, 2014, Relator, on behalf of the United States of America (the

² VEI is a for-profit subsidiary of CHN which acquires and manages ambulatory surgical centers on behalf of CHN. (Dkt. 1 at 8). Ownership in many of the surgical centers is shared with CPN physicians. (Id).

"Government") and the State of Indiana (the "State"), initiated this *qui tam* lawsuit pursuant to the False Claims Act ("FCA")³ against Defendants Community Health Network, Inc., Community Health Network Foundation Inc., Community Physicians of Indiana, Inc., VEI, Community Surgery Center-North, Community Surgery Center-South, Community Surgery Center-East, Community Surgery Center-Hamilton, Community Surgery Center-Kokomo, Community Surgery Center-Northwest, Hancock Surgery Center, Community Endoscopy Center, and Community Digestive Center (collectively, the "Community Defendants"). (Id. at 2). The original Complaint consists of two main parts.

First, Relator alleged that the Community Defendants knowingly defrauded the Government and State by engaging in a fraudulent scheme to pay physicians improper and excessive compensation to ensure that they referred patients, including Medicare and Medicaid patients, to CHN. (Id. at 4, 31-39). This fraudulent scheme, Relator alleged, violates the Stark Law,⁴ the Anti-Kickback Statute,⁵ and the FCA. (Id. at 25). Specifically, Relator asserted that Defendants paid kickbacks and illegal remunerations to induce physicians to refer patients to CHN, (Id. at 25), solicited and received kickbacks from Indianapolis nursing home

³ The FCA prohibits, among other acts, presenting to the government "a false or fraudulent claim for payment or approval." *U.S. v. UCB, Inc.*, 970 F.3d 835, 840-41 (7th Cir. 2020) (citing 31 U.S.C. § 3729(a)(1)(A)). The Indiana FCA prohibits the same conduct. Ind. Code § 5-11-5.7-2.

⁴ The Stark Law is a wide-ranging federal statute that prohibits a physician who has a "financial relationship" (including compensation and ownership interests) with an entity from referring patients to the entity for "designated health services" covered by Medicare unless an exception is available. 42 U.S.C. § 1395nn.

⁵ The Medicare and Medicaid Fraud and Abuse Statute, or the Anti-Kickback Statute, prohibits knowingly and willfully making any false statement or representation of a material fact in any application for any benefit or payment under a federal health care program. 42 U.S.C. § 1320a-7b.

facilities in exchange for patient referrals, (Id. at 25-26), ensured the profitability of ambulatory surgical centers in which its physicians had ownership interests, (Id. at 29, 39), and provided lucrative medical directorships to referring physicians. (Id. at 43). Relator alleged that all claims submitted to Medicare, Medicaid, or a government funded healthcare program for services rendered pursuant to a referral from a physician who was paid an illegal remuneration are false claims that violate the FCA and Indiana FCA. (Id. at 4, 25-26).

Second, Relator alleged that CHN retaliated against him in violation of the applicable FCA and Indiana FCA anti-retaliation provisions. Relator alleged that he was discharged in retaliation for expressing concern to CHN leadership that operating losses and budget variances were a direct result of illegal activities related to physician compensation, referral patterns, and business practices. (Id. at 7, 46, 49). Relator's original complaint alleged eight counts for: (1) FCA violations; (2) Indiana FCA violations; (3) retaliation under the FCA; (4) retaliation under the Indiana FCA; (5) breach of contract; (6) breach of oral contract; (7) promissory estoppel; and (8) quantum meruit. (Id. at 51-58).

As required by the FCA statutory provisions, Relator filed the original Complaint under seal. *See* 31 U.S.C. § 3730(b)(2). The original Complaint remained under seal while the Government and State investigated Relator's allegations to determine the appropriateness of intervention. On October 15, 2015, Relator filed a First Amended Complaint under seal. (Dkt. 32).

Relator's allegations in the original Complaint and the First Amended Complaint are nearly identical, except that Relator provided greater factual detail regarding nursing home kickbacks in exchange for patient referrals, (*see* Dkt. 32 at 50-51), and added a ninth count for blacklisting asserting that CHN knowingly provided false information to Relator's prospective employers after his termination. (*See* Dkt. 32 at 59-60, 63-64, 68-69).

On August 7, 2019, the Government filed a Notice of Election to Intervene in Part and Decline to Intervene in Part. (Dkt. 86). The Government opted to intervene "in that part of the action which alleged that [D]efendant Community Health Network, Inc. violated the FCA by submitting claims to Medicare that were referred by physicians with whom [it] had employment relationships that violated the Stark Law." (Dkt. 86 at 1). The Government declined to intervene with respect to the remaining allegations and requested that this Court unseal the Complaint. (*Id.*) In its Notice, the Government did not explicitly indicate whether its decision to intervene was based on the original Complaint or the First Amended Complaint, but a subsequently filed Statement by the Government refers to the First Amended Complaint as the operative Complaint in this matter.⁶ The Court agrees.

On December 23, 2019, this Court granted the Government's request to unseal the Complaint and ordered that it serve its own complaint on Defendant CHN within 120 days. (Dkt. 93 at 1). This Court further ordered that the seal be

⁶ On March 24, 2020, the Government filed a Statement of Interest Regarding Relator's Standing to Pursue Non-Intervened Claims. (Dkt. 120). The Government requested that this Court unseal Relator's First Amended Complaint, as it is the operative Complaint in this matter. (*Id.* at 9). The Court unsealed the First Amended Complaint on November 24, 2020. (Dkt. 132).

lifted on all matters occurring in the action after the date of the order. (Id. at 2).

That same date, December 23, 2019, this Court granted the State's Notice of Election to Decline Intervention. (Dkt. 94).⁷ On January 6, 2020, the Government filed its Complaint in Intervention. (Dkt. 96).

The Government's Complaint in Intervention focuses on false claims arising from the performance of health services by physicians with compensation arrangements with CHN that exceeded fair market value or considered the volume or value of their referrals to CHN, thereby violating the Stark Law. (Id. at 3). These physicians allegedly referred patients to CHN for health services, and, in turn, CHN submitted these false claims to Medicare knowing that they were not eligible for payment, in violation of the FCA. (Id. at 3-4).

On March 3, 2020, Relator filed the present Motion for Leave to File Second Amended Complaint. (Dkt. 108). Initially, Relator asserted that an amendment to its First Amended Complaint was necessary to address issues raised by the Government in its Complaint in Intervention and add new claims and Defendants based on evidence developed over the course of the Government's four-year investigation. (Id. at 2). On March 17, 2020, CHN filed a response in opposition, arguing that the Court should deny the Relator's request for leave to amend the complaint. (Dkt. 115). On March 24, 2020, the Government and the State each filed a Statement of Interest. (Dkts. 120, 121). On March 31, 2020, Relator filed a reply, in which he does not argue that the amendment adds claims, but asserts that the

⁷ The State filed its Notice of Election to Decline Intervention on December 5, 2019. (Dkt. 92).

amendment adds a new Defendant, renames Defendants, and adds evidence and details to the fraudulent scheme outlined in the First Amended Complaint. (Dkt. 124 at 2). On April 14, 2020, with this Court's permission, CHN filed a sur-reply in opposition to Relator's request for leave to amend. (Dkt. 129).

CHN opposes Relator's Motion for Leave to Amend for two main reasons: (1) the proposed amendments are futile; and (2) the Relator unduly delayed in filing the proposed second amended complaint. (Dkt. 115 at 2-3).

II. LEGAL STANDARD

After the opportunity to amend the pleadings as a matter of course has passed, a party may amend a complaint only with the consent of the opposing party or leave of the court. Fed. R. Civ. P. 15(a). Leave to amend should be "freely given when justice so requires" absent considerations such as "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, and futility of amendment." Fed. R. Civ. P. 15(a)(2); *Foman v. Davis*, 371 U.S. 178, 182 (1962).

An amendment is futile if the amended pleading would not survive a motion to dismiss. *McCoy v. Iberdrola Renewables, Inc.*, 760 F.3d 674, 685 (7th Cir. 2014). To survive a motion to dismiss, the amended complaint must "contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Id.* at 685 (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). Before denying a motion to amend, however, it should be "clear" that the proposed amended

complaint "is deficient" and would not survive such a motion. *Johnson v. Dossey*, 515 F.3d 778, 780 (7th Cir. 2008); see *Runnion ex rel. Runnion v. Girl Scouts of Greater Chi. & Nw. Ind.*, 786 F.3d 510, 519-20 (7th Cir. 2015) ("Unless it is certain from the face of the complaint that any amendment would be futile or otherwise unwarranted, the district court should grant leave to amend.") (quoting *Barry Aviation Inc. v. Land O'Lakes Mun. Airport Comm'n*, 377 F.3d 682, 687 (7th Cir. 2004)).

For undue delay, courts look to the similarity of the factual basis for the claims in the original complaint to the new claims raised in the amended complaint, the moving party's explanation for waiting to raise the new claims, whether the moving party is attempting to introduce a new theory of the case, and whether granting the motion to amend will require new or duplicated discovery efforts. See *Marshall v. Town of Merrillville*, 262 F. Supp. 3d 733, 738 (N.D. Ind. 2017); see also *Bethany Pharmacal Co.*, 241 F.3d at 861 (7th Cir. 2001). Typically, "delay by itself is normally an insufficient reason to deny a motion for leave to amend" and "must be coupled with some other reason." *Dubicz v. Commonwealth Edison Co.*, 377 F.3d 787, 793 (7th Cir. 2004) (citations omitted).

The party seeking to amend has the burden of showing that undue prejudice will not result to the non-moving party. *McDaniel v. Loyola Univ. Med. Ctr.*, 317 F.R.D. 72, 77 (N.D. Ill. 2016). "Ultimately, 'the decision to grant or deny a motion to file an amended pleading is a matter purely within the sound discretion of the district court.'" *Brunt v. Serv. Emps. Int'l Union*, 284 F.3d 715, 720 (7th Cir. 2002).

III. DISCUSSION

A. Futility of the Proposed Second Amended Complaint

CHN argues that Relator's request to amend should be denied on futility grounds. (Dkt. 115 at 2). Specifically, CHN asserts that Relator's proposed second amended complaint should be denied as futile because: (1) the Government's Complaint in Intervention supersedes Relator's pleadings and is considered the operative complaint in this matter; (2) the FCA claims are barred by the applicable statute of limitations; and (3) the claims are foreclosed by the FCA's "original source" requirement. (Id).

i. Intervention in Part

First, CHN argues that the claims in Relator's proposed second amended complaint are futile because the Government has intervened in this matter. (Dkt. 115 at 13). As such, the Government's Complaint in Intervention "supersedes the Relator's pleadings" and serves as the operative complaint. (Id. at 16). Accordingly, Relator has no right to conduct this action and any pleading filed by him has no legal effect. (Id. at 19-20).⁸ In reply, Relator contends that because the Government elected to intervene in part and the State of Indiana declined to intervene at all, Relator has standing to litigate non-intervened claims. (Dkt. 124 at 16).

⁸ CHN points out that the Relator's "disregard for the Government's commanding role in *qui tam* actions is highlighted by his public filing of the proposed second amended complaint in violation of the FCA's sealing requirement." (Dkt. 115 at 3). The Court notes that a violation of the FCA seal provision does not mandate dismissal of a relator's complaint, *see State Farm Fire & Cas. Co. v. U.S ex rel. Rigsby*, 137 S. Ct. 436, 442 (2016), and declines to deny leave to amend on this basis.

The FCA allows private persons, or relators, to prosecute *qui tam* actions "against alleged fraudsters on behalf of the United States government." *U.S. ex rel. Berkowitz v. Automation Aids, Inc.*, 896 F.3d 834, 840 (7th Cir. 2018) (citing *U.S. ex rel. Watson v. King-Vassel*, 728 F.3d 707, 711 (7th Cir. 2013); 31 U.S.C. § 3730. As such, 31 U.S.C. § 3730(b)(1) requires that a *qui tam* action under the FCA must be filed "in the name of the Government." 31 U.S.C. § 3730(b)(1). "Before 1986, if the government intervened in the action, the relator's participation was at an end." *U.S. v. UCB, Inc.*, 970 F.3d 835, 841 (7th Cir. 2020). "In 1986, however, Congress amended the FCA to allow for the relator's continued participation even after the government intervenes." *Id.* Thus, as it stands, "§ 3730(b)(4)(B) gives the relator 'the right to conduct the action' – without qualification – when the government has declined to intervene." *Id.* at 845. "If the Government proceeds with the action," it assumes "primary responsibility" for prosecuting it. 31 U.S.C. § 3730(c). Relator still retains "the right to continue as a party to the action." *Id.*

Here, CHN argues that the word "action" in 31 U.S.C. § 3730(c) refers to the entire *qui tam* lawsuit. (Dkt. 115 at 14). Thus, even when the Government intervenes in part, Relator cannot pursue any claims, including non-intervened claims. (*Id.* at 17). In support, CHN relies on one sole case from outside this Circuit, *U.S. ex rel. Brooks v. Stevens-Henager Coll., Inc.*, 359 F. Supp. 3d 1088, 1095 (D. Utah 2019), which held that relators are not permitted to litigate non-intervened claims. The Court disagrees.

The Court finds in this case that the Relator is permitted to litigate non-intervened claims notwithstanding the Government's partial intervention and the State's non-intervention. *See Carnithan v. Cmty. Health Sys., Inc.*, No. 11-CV-312-NJR-DGW, 2015 WL 9258595, at *1 (S.D. Ill. Dec. 18, 2015); *see also U.S. ex rel. Trombetta v. EMSCO Billing Servs., Inc.*, No. 96 C 226, 2002 WL 34543515, at *1 (N.D. Ill. Dec. 5, 2002). This interpretation aligns with the FCA mandate vesting the government with the primary responsibility for prosecuting the action but allowing relator to continue as a party and not directing relator to abandon individual claims simply because the government intervenes in part. *See* 31 U.S.C. § 3730 ([i]f the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action); Ind. Code § 5-11-5.7-4(e) (if attorney general or inspector elects not to proceed with the action . . . the person who initially filed the complaint may proceed with the action).

"Courts regularly allow relators to pursue their separate claims after the government's intervention." *U.S. ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1075 (N.D. Cal. 2020) (citing *U.S. ex rel. Ketroser v. Mayo Found.*, 729 F.3d 825, 826 (8th Cir. 2013) (relator filed an FCA case, government intervened in part and settled intervened claim, and relator filed an amended complaint asserting additional claims against defendant); *U.S. ex rel. Fallon v. Accudyne Corp.*, 97 F.3d 937, 938 (7th Cir. 1996) ("Attorney General took over the prosecution of Count I . . . but left Count II in the hands of the relators.")).

Moreover, CHN's argument, that permitting the Relator to litigate his FCA allegations "while the Government simultaneously prosecutes its own FCA action" is prejudicial to CHN, is similarly overruled. (Dkt. 115 at 21). CHN is aware of the various claims being alleged, regardless of which party litigates those claims. *See Carnithan*, 2015 WL 9258595, at *3. No initial pretrial conference has occurred, discovery has not yet commenced, and this case is in its infancy; thus, even if the Court were to conclude that prejudice may occur (which it does not), that prejudice is mitigated by the early stage of the lawsuit and ability to rectify any logistical issues. The Court declines to deny leave to amend on this basis.

ii. Statute of Limitations

Next, CHN argues that the new allegations contained in Relator's proposed second amended complaint are time barred by the FCA's six-year statute of limitations. (Dkt. 115 at 11). Specifically, because Relator filed his original Complaint on July 21, 2014 and filed his proposed second amended complaint on March 3, 2020, any new FCA claims within the second amended complaint fall outside the six-year statute of limitations. (Id. at 10-11). Further, CHN argues that it "appears that Relator's new FCA claims are being brought more than three years after the Government learned of, or was in a position to learn of, the claims as a result of its investigation." (Id).

In response, Relator contends that the FCA provides a ten-year statute of limitations. (Dkt. 124 at 11). Thus, because the second amended complaint alleges ongoing FCA violations beginning in 2009, the applicable statute of limitations does

not bar the claims. (Id. at 11-12). Even if the statute of limitations barred some or all claims, Relator argues, a response to a motion to amend is not the proper avenue to address an affirmative defense. (Id. at 12).

The FCA statute of limitations provides:

...

(b) A civil action under section 3730 may not be brought –

(1) more than 6 years after the date on which the violation of section 3729 is committed, or

(2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed,

whichever occurs last.

...

31 U.S.C. § 3731. Under Federal Rule of Civil Procedure 8(c)(1), a statute of limitations argument is an affirmative defense, not an attack against the sufficiency of the pleadings. *U.S. ex rel. McGee v. IBM Corp.*, 81 F. Supp. 3d 643, 656 (N.D. Ill. 2015); Fed. R. Civ. P. 8(c)(1).

Here, Relator filed the original Complaint on July 21, 2014 – approximately five years after CHN's allegedly fraudulent scheme began, (Dkt. 1), and filed a First Amended Complaint, which included nearly identical allegations, on October 15, 2015. (Dkt. 32). Relator's proposed second amended complaint asserts that beginning in 2009, CHN "began a systematic, corporate-wide campaign to increase the number of both its employed and affiliated physicians and physician practice

groups to increase market share in the Indianapolis region" by "steer[ing] high-margin business to surgery centers owned (or partially owned) by its employed physicians" and sending referrals to nursing home providers in exchange for money. (Dkt. 108-1 at 21-22). The proposed second amended complaint does not add new claims, but provides additional factual detail to the central allegations involving improper compensation paid to physicians that were detailed in the original Complaint and First Amended Complaint. The second amended complaint also clarifies the business names of certain Defendants, for example, by amending "Community Surgery Center North" to "North Campus Surgery Center, LLC d/b/a Community Surgery Center North." (Dkt. 108-1 at 1). Finally, the proposed second amended complaint adds North Campus Office Associates, L.P. as a Defendant. (Id).

A motion to amend is an "ill-suited vehicle for determining statute of limitations and relation back issues." *Miller v. Panther II Transportation, Inc.*, No. 1:17-cv-04149-JMS-TAB, 2018 WL 3328135, at *7 (S.D. Ind. July 6, 2018); *cf. U.S. ex rel. McGee*, 81 F. Supp. 3d at 656 (declining to decide that FCA claims were barred by the statute of limitations on motion to dismiss). The proposed second amended complaint does not assert new claims, and, when accepted as true, Relator's factual allegations provide the Court with sufficient information to plausibly determine that the lawsuit falls within the applicable ten-year statute of limitations. It is not plain from the face of Relator's proposed second amended complaint that this litigation is time-barred, and the Court declines to conclude as

such. *See Runnion*, 786 F.3d at 519-20. Instead, CHN will have an opportunity to assert the statute of limitations as an affirmative defense should it choose to do so.

iii. Original Source

Next, CHN argues that Relator's new claims are barred by the FCA's "original source" requirement. (Dkt. 115 at 11). CHN argues that because the new allegations in Relator's proposed second amended complaint are based on information developed after Relator left CHN, the new claims in the proposed second amended complaint are futile because Relator is not the original source of the information. (Dkt. 115 at 12).

In reply, Relator argues that the FCA does not have an "original source" rule. (Dkt. 124 at 13). Instead, the FCA has a "public disclosure" rule which "includes a savings provision if the relator is an "original source." (Id). As such, Relator contends, because no public disclosure was made in this matter, the original source inquiry is inapplicable. (Dkt. 124 at 13-14).

CHN filed a sur-reply, arguing that Relator cannot be an "original source" for allegations that are "grounded in information discovered after he left his employment. (Dkt. 129 at 6). Moreover, CHN argues, a public disclosure occurred in this case when the Government informed CHN of its active investigation into CHN's physician compensation, patient referrals, and related business practices. (Id. at 8).

CHN's argument is a jurisdictional challenge to Relator's proposed second amended complaint. The FCA generally bars *qui tam* actions that are based on

information already in the public domain. *U.S. ex rel. Ziebell v. Fox Valley Workforce Dev. Bd., Inc.*, 806 F.3d 946, 951 (7th Cir. 2015) (language of FCA "clearly withdraws jurisdiction over *qui tam* actions that are based on publicly disclosed information unless the relator is an "original source" of the information"); see *Rockwell Int'l Corp. v. U.S.*, 549 U.S. 457, 468 (2007); *Glaser v. Wound Care Consultants, Inc.*, 570 F.3d 907, 912 (7th Cir. 2009). "The point of the jurisdictional bar is to 'deter parasitic *qui tam* actions.'" *U.S. ex rel. Gear v. Emergency Med. Assocs. of Ill., Inc.*, 436 F.3d 726, 728 (7th Cir. 2006). Once information is public, "only the Attorney General and a relator who is an 'original source' of the information may represent the United States." *Id.* (quoting *U.S. ex rel. Fallon*, 97 F.3d at 941).

In order to determine whether a *qui tam* claim falls within the public-disclosure bar, the Court must assess three questions: (1) whether the relator's allegations have been publicly disclosed; (2) if so, whether the lawsuit is "based upon" those publicly disclosed allegations; and (3) if it is, whether the relator was the original source of the information. *Glaser*, 570 F.3d at 913. But a relator can still proceed if he brought to bear some "genuinely new" and "material" information beyond what was public. *Cause of Action v. Chi. Transit Auth.*, 815 F.3d 267, 281 (7th Cir. 2016); *U.S. ex rel. Goldberg v. Rush Univ. Med. Ctr.*, 680 F.3d 933, 936 (7th Cir. 2012).

[F]utility, in the context of Rule 15, refers to the inability to state a claim, not the inability of the plaintiff to prevail on the merits." *Gorss Motels, Inc. v.*

Brigadoon Fitness Inc., No. 1:16-cv-330-HAB, 2020 WL 2570046, at *3 (N.D. Ind. May 21, 2020). Taking the Relator's allegations as true, the Court is not certain that the proposed second amended complaint, on its face, alleges facts demonstrating that a public disclosure occurred or that Relator is not the original source of the information. Relator has stated a claim at this stage of the proceedings; whether Relator can support that claim is a question better left to the discovery process. Accordingly, the Court, applying the liberal standard for amending pleadings early in a lawsuit, finds that Relator's proposed second amended complaint is sufficient to survive CHN's jurisdictional public disclosure challenge.⁹

B. Undue Delay

Finally, CHN argues that Relator's request for leave should be denied for undue delay. (Dkt. 115 at 8). Specifically, CHN asserts that because Relator waited six years before requesting leave to amend, the Court should deny the request for leave. (Id).

In reply, Relator argues that the six-year delay in this case is attributable to the procedural requirements of the FCA and Indiana's FCA, not Relator's actions. (Dkt. 124 at 2). Further, because Relator requested leave before the April 21, 2020 deadline to serve the complaint; there is no scheduling order; discovery has not begun; no responsive pleading filed; and no trial date has been set, therefore no undue delay has occurred. (Id. at 2, 9). The Court agrees.

⁹ CHN attempts to bring allegations regarding "claims smuggling," (See Dkt. 115 at 12), but does not flesh out that argument. As such, the Court shall not evaluate that argument here.

Here, on August 7, 2019 and upon completion of its investigation, the Government filed an Election to Intervene in Part, (Dkt. 86), and on December 5, 2019, the State filed a Notice of Election to Decline Intervention. (Dkt. 92). On December 23, 2019, this Court granted the Government's Notice of Election. (Dkt. 93). Approximately two weeks later, on January 6, 2020, the Government promptly filed its Complaint in Intervention. (Dkt. 96). Two months later, on March 3, 2020, Relator filed the instant Motion for Leave to Amend. (Dkt. 108).

Leave to amend should be "freely given," absent considerations such as undue delay. *Foman*, 371 U.S. at 182. This is not the case of a party seeking leave to amend well into litigation of the lawsuit, *Sanders v. Venture Stores, Inc.*, 56 F.3d 771, 773-74 (7th Cir. 1995), or one in which Relator "failed to act with diligence." *Campania Mgmt. Co. v. Rooks, Pitts & Poust*, 290 F.3d 843, 849 (7th Cir. 2002). Instead, any delay in this case is attributable to that which is permitted by the FCA, which requires that Relator's Complaint remain sealed until the completion of government investigation into the claims. Thus, because the delay between the filing of the original Complaint (and First Amended Complaint) and the present Motion for Leave to Amend is attributable to government investigation permitted by the language of the FCA, the Court declines to deny Relator's request based on undue delay.

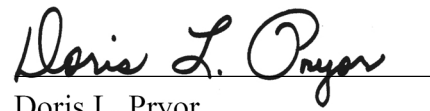
IV. CONCLUSION

For the reasons discussed above, the Court **GRANTS** Plaintiff-Relator's

Motion for Leave to File Second Amended Complaint, Dkt. [108]. Plaintiff-Relator is permitted to file the Second Amended Complaint within ten (10) days from the date of this Order. Plaintiff-Relator shall serve the Defendants the Second Amended Complaint within fourteen (14) days of filing the Second Amended Complaint.

So ORDERED.

Date: 11/25/2020

A handwritten signature in black ink, reading "Doris L. Pryor", written over a horizontal line.

Doris L. Pryor
United States Magistrate Judge
Southern District of Indiana

Distribution: All ECF-registered counsel of record via email.

Exhibit D

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION**

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

SECOND AMENDED COMPLAINT

Robert A. Cutler brings this *qui tam* action as Relator under the False Claims Act, 31 U.S.C. §§ 3729-3733 on behalf of the United States of America against Cigna Corporation; Cigna Holdings, Inc.; Connecticut General Corp.; HealthSpring Inc.; New Quest, LLC HealthSpring Life & Health Insurance Company, Inc.; Gulf Quest, LP; Home Physicians Management, LLC; and Alegis Care Services, LLC. These entities are collectively referred to throughout this Complaint as "Defendants" or "Cigna-HealthSpring." Relator alleges, as follows:

I. PRELIMINARY STATEMENT

1. This case is about Cigna-HealthSpring's fraud on Medicare Part C, commonly known as the Medicare Advantage (MA) Plan, through its submission of unsupported, inaccurate, and otherwise invalid claims for payment.
2. From at least 2012 until at least 2017, and likely continuing thereafter, Cigna-HealthSpring knowingly violated the False Claims Act (FCA) through a widespread scheme to improperly increase its revenue by submitting false information to the Centers for Medicare &

Medicaid Services (CMS) related to the health status of beneficiaries enrolled in its MA health plans.

3. MA rules require Cigna-HealthSpring to ensure that each diagnosis it submits to CMS is supported in the beneficiary's medical record as derived from a face-to-face encounter with a qualified provider in the relevant service year. CMS rules also require that diagnoses submitted as part of the MA Plan's payment scheme were cared for, treated, managed, assessed, or impacted the beneficiary's care during the encounter in which the diagnosis was recorded.

4. Cigna-HealthSpring was aware of the requirements for participation in MA and of relevant rules governing submission of claims for risk-adjustment reimbursement. Cigna-HealthSpring nonetheless knowingly violated those rules and requirements by designing and implementing a program in which contracted registered nurses and nurse practitioners conducted a "data-gathering" health assessment in plan members' homes and—based primarily on subjective, patient-reported information—documented suspected, possible, and otherwise unsupported, invalid health conditions that Cigna-HealthSpring then submitted to CMS as false claims for payment.

5. By submitting false claims for payment to CMS based on diagnosis information Cigna-HealthSpring knew was invalid for risk adjustment, Cigna-HealthSpring received billions in overpayments from the federal government.

6. Cigna-HealthSpring's knowing violation of Medicare rules and requirements and deliberate submission of false claims is material to the government within the meaning of the False Claims Act. Medicare pays Cigna-HealthSpring for assuming the risk of insuring its plan member population and calculates its payments in large part based on information Cigna-HealthSpring supplies about plan member health status. Cigna-HealthSpring's obligation to

submit accurate health status information in its claims to CMS is at the very heart of Cigna-HealthSpring's bargain with the government.

II. PARTIES

7. Relator is a United States citizen residing in the State of Connecticut and a former officer of Texas Health Management LLC (THM), a Texas limited liability company (now defunct). THM was a service provider for Cigna-HealthSpring between 2012 and 2017. Relator's knowledge of the matters giving rise to this action stem from his position as an officer and beneficial owner of equity in THM. He is suing on behalf of the United States pursuant to 31 U.S.C. § 3730(b).

8. Defendant Cigna Corporation is a Delaware corporation with its principal place of business located at 900 Cottage Grove Rd., Bloomfield, Connecticut 06002. Cigna Corporation through its subsidiaries is one of the largest health services organizations in the United States. Based on its 2018 Annual Report filed with the U.S. Securities and Exchange Commission, in 2018, Cigna Corporation earned approximately \$48.65 billion in total revenue and had approximately \$153.23 billion in assets at year end. Cigna Corporation offers MA Plans in 17 states and the District of Columbia under its Cigna-HealthSpring brand.

9. Defendant Cigna Holdings, Inc. is a Delaware corporation and wholly-owned subsidiary of Cigna Corporation with its principal place of business located at 900 Cottage Grove Rd., Bloomfield, Connecticut 06002. On information and belief, Cigna Holdings, Inc. is a

holding company that, through its direct and indirect wholly-owned subsidiaries, owns and controls all Cigna Corporation assets in the United States.

10. Defendant Connecticut General Corporation (CGC) is a Connecticut corporation and wholly-owned subsidiary of Cigna Corporation with its principal place of business located at

900 Cottage Grove Rd., Bloomfield, Connecticut 06002. On information and belief, CGC is a holding company of numerous direct and indirect wholly-owned subsidiaries that engage in a range of insurance and insurance-related businesses within the United States.

11. Defendant HealthSpring Inc. is a Delaware corporation and wholly-owned subsidiary of CGC with its principal place of business located at 9009 Carothers Pkwy, Building B , Suite 501, Franklin, Tennessee 37067. On information and belief, HealthSpring Inc. is the parent company of all the entities that collectively comprise the business known as “HealthSpring” or “Cigna-HealthSpring.”

12. The Cigna-HealthSpring business has been a part of the CGC ownership structure since 2012 when Cigna Corporation acquired HealthSpring Inc. for \$3.8 billion.

13. Defendant New Quest, LLC is a Texas corporation and wholly-owned subsidiary of HealthSpring Inc. with its principal place of business located at 44 Vantage Way, Suite 300, Nashville, Tennessee 37242. On information and belief, New Quest, LLC is the owner and manager of several direct and indirect wholly-owned subsidiaries that operate MA Plans and health maintenance organizations within the United States and engage in other insurance-related businesses. The MA Plans operated by New Quest LLC’s subsidiaries provide health insurance to more than 300,000 Medicare beneficiaries nationwide.

14. Defendant HealthSpring Life & Health Insurance Company, Inc. (HLHI) is a Texas corporation and wholly-owned subsidiary of New Quest, LLC with its principal place of business located at 2900 North Loop W, Suite 1300, Houston, Texas 77092. HLHI is one of the entities involved in operating MA Plans under the Cigna-HealthSpring brand.

15. Defendant Home Physicians Management, LLC is a Delaware corporation and wholly-owned subsidiary of New Quest, LLC with its principal place of business at 1340 South

Damen Avenue, Suite 210, Chicago, Illinois 60608. Home Physicians Management, LLC operates under the name Alegis or Alegis Care as a multi-specialty medical health services company that provides home healthcare services to the elderly and disabled.

16. Defendant Alegis Care Services, LLC is an Illinois limited liability company and wholly-owned subsidiary of New Quest with its principal place of business located at 1340 South Damen Avenue, Suite 210, Chicago, Illinois 60608. Alegis Care Services, LLC provides healthcare services to Medicare beneficiaries enrolled in MA Plans, such as chronic care management services and health assessments, including the in-home assessments at issue here. We refer to Defendant Home Physicians Management, LLC and Defendant Alegis Care Services, LLC collectively as “Alegis.”

17. Defendant Gulf Quest, LP is a Texas limited partnership and subsidiary of New Quest with its principal place of business located at 2900 North Loop W, Suite 1300, Houston, Texas 77092. On information and belief, Gulf Quest provides management services to HLHI.

18. The United States, on whose behalf Relator brings this action, is the real party in interest with respect to the claims asserted herein. The United States, through CMS, has ongoing contracts with Defendants through which Cigna-HealthSpring acts as an MA Organization and participates in the Medicare program.

III. JURISDICTION AND VENUE

19. Pursuant to 28 U.S.C. § 1331, this District Court has original jurisdiction over the subject matter of this civil action because it arises under the laws of the United States, in particular the FCA, 31 U.S.C. § 3729 *et seq.* Additionally, the FCA specifically confers jurisdiction upon the United States District Court, 31 U.S.C. § 3730(b).

20. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. §

3732(a) because that section authorizes nationwide service of process and because Defendants have at least minimum contacts with the United States, and can be found in, reside, or transact or have transacted business in the Middle District of Tennessee.

21. Venue exists in the United States District Court for the Middle District of Tennessee pursuant to 31 U.S.C §§ 3732(a) and 3730(b)(1) because all of the Defendants have at least minimum contacts with the United States, and one or more of the Defendants can be found in, reside, or transact or have transacted business in the Middle District of Tennessee.

22. There have been no public disclosures of the allegations or transactions contained herein that bar jurisdiction under 31 U.S.C § 3730(e).

IV. LEGAL AND REGULATORY BACKGROUND

A. THE MEDICARE PROGRAM

23. Medicare is a federally-funded health insurance program for the elderly and disabled administered by CMS, an agency within the United States Department of Health and Human Services (HHS). Initially created in Title XVIII of the Social Security Act of 1965, Medicare now has four Parts: Parts A through D.

24. Medicare Parts A and B are collectively referred to as “traditional” or “fee-for-service” Medicare. Part A of the Medicare statute covers medical services furnished by hospitals—and other institutional care providers—such as inpatient hospital care, skilled nursing facility care, home health agency care, and hospice care. Medicare Part B provides supplemental coverage of medical items and services not covered under Part A, including outpatient physician services performed in both hospital and nonhospital settings; radiology services; and clinical diagnostic laboratory tests.

25. Under Part A, Medicare reimburses hospitals for inpatient services based on

prospectively determined rates applied to each patient upon discharge. Reimbursement under Medicare Part B—for both physician-provided medical services and other covered services—depends only on the services (or durable goods) provided and is generally made in accordance with fee schedules that limit the amount providers may charge.

26. Medicare Part C generally covers the same benefits as those covered under Parts A and B but does so under a managed care model administered through private health insurers (MA Organizations) that contract with CMS. MA Organizations that offer MA Plans essentially agree to assume the risk of insuring Medicare beneficiaries for their healthcare needs. Rather than pay providers directly based on the medical services provided, Medicare Part C pays MA Organizations a monthly capitated rate for each covered beneficiary, and tasks the MA Plan with paying providers for services rendered to plan members. MA insurers are generally paid more for providing benefits to beneficiaries with higher-risk scores—generally older and sicker people— and less for beneficiaries with lower-risk scores, who tend to be younger and healthier. 42 C.F.R. §§ 422.308(c) and 422.310; *see also* 70 Fed. Reg. 4588, 4657 (intending to pay MA Organizations “appropriately for their plan enrollees (that is, less for healthier enrollees and more for less healthy enrollees).”).

27. Under Medicare Part D, CMS makes payments to Part D plans and Medicare Advantage Part D plans for prescription drug benefits.

B. THE RISK-ADJUSTMENT MODEL AND PAYMENT INTEGRITY

28. CMS, through a risk-adjustment model, ensures MA Organizations are compensated commensurate with the risk the Organizations have undertaken. To determine the capitated rate it pays an MA Organization for each enrolled beneficiary, CMS takes into account each beneficiary’s demographics and health status, which together result in each beneficiary’s unique risk score. To calculate a beneficiary’s risk score, CMS relies on information from the MA Organization in whose plan that beneficiary is enrolled. The Part C payment model is

prospective: it relies on diagnoses assigned to a given beneficiary in one year (the “date of service” or “DOS” year) to determine that beneficiary’s risk score for the following year (the “payment year” or “PY”).

29. MA Organizations must report beneficiaries’ health status in International Classification of Diseases (ICD) codes that describe the relevant health conditions. CMS organizes the ICD codes into separate groups of clinically related health conditions known as Hierarchical Condition Categories (HCCs) that have similar cost implications. Over 3,000 ICD diagnosis codes are grouped into roughly 80 HCCs. Each HCC is assigned a numerical value that impacts risk scores and per-beneficiary payments.

30. CMS payments to Part D plans are also risk-adjusted based in part on health status. Part D employs a health-based risk-adjustment model known as the Rx Hierarchical Condition Categories (RxHCC) model. Like HCCs, RxHCCs are also groups of clinically-related medical diagnoses that are ranked by disease severity and the anticipated cost associated with the pharmaceutical drugs used to treat them.

31. Regulations require MA Organizations to submit risk-adjustment data to CMS in accordance with CMS instructions. 42 CFR § 422.310(b). To be eligible for submission to CMS, diagnoses must be derived from a face-to-face encounter with a qualified provider type that occurred during the relevant service year. Diagnoses must be coded according to ICD standards and must be based on documented conditions that require or affect patient care, treatment, or management. Medicare Managed Care Manual, Chapter 7 (August 13, 2004) (“2004 MMCM”) (stating that diagnosis codes submitted for risk adjustment payments should be for documented conditions that “require or affect patient care treatment or management”); *see also* 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide

(“2008 RA Participation Guide”) at §§ 3.1.3, 6.4.1, 7-13, 7-14, 7-17. Accordingly, uncertain, probable, or suspected diagnoses may not form the basis of legitimate claims for risk-adjustment payments. 2004 MMCM; 2008 RA Participation Guide at § 7.2.4 (stating that risk-adjustment claims and payments cannot be based on questionable diagnoses). Diagnosis codes surmised from prescription medications, medical history, and diagnostic labs are likewise unacceptable. *Id.* at §§ 3.2.4, 4.3, 7.2.4.

32. CMS has specifically notified MA Organizations that it relies on the data they submit to make appropriate and accurate payments under the MA Plan: “[a]ccurate risk-adjusted payments rely on the diagnosis coding derived from the member’s medical record.” (*See, e.g.,* CMS 2013 National Technical Assistance Risk Adjustment 101 Participant Guide at p.13.) Because CMS relies on the data supplied by MA Organizations like Cigna-HealthSpring for its calculation of beneficiary risk scores and associated payments to MA Organizations, CMS requires MA Organizations—by contract and under applicable rules—to ensure the validity of the diagnoses they submit. An MA Organization “maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS” and cannot delegate its ultimate responsibility for its obligations to the Medicare Program. 42 C.F.R. § 422.504(i). Further underscoring the importance of accurate data, CMS requires that all contracts or agreements between MA Organizations and third-parties providing relevant services “must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions.” 42 C.F.R. § 422.504(i)(4)(v).

33. As a condition of receiving risk-adjustment payments, MA Organizations must submit an annual Risk Adjustment Attestation to CMS that certifies the validity of the Organization’s risk-adjustment data, including diagnoses. 42 C.F.R. § 422.504(l).

34. CMS has not expressly prohibited MA Organizations from deriving diagnoses from visits performed in plan members' homes; however, the diagnosis codes gathered in those visits are only valid to the extent they meet CMS requirements for risk-adjustment eligibility. Notably, CMS has conveyed concerns about in-home visits designed solely to capture codes, in which patients are not actually treated and for which the plan does not take steps to ensure adequate follow-up. *See* Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter at 27 (April 7, 2014) (recognizing risk that home visits may “be[] used primarily for the gathering of diagnoses for payment rather than to provide treatment and/or follow-up care to beneficiaries” and instituting requirement that plans identify diagnoses stemming from home visits); Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter at 144-146 (April 6, 2015) (reiterating concerns and intent that providers “actually receive and use the information collected in these assessments and that the care subsequently provided [be] substantially changed or improved as a result of the assessments.”).

V. CIGNA-HEALTHSPRING'S FRAUDULENT CONDUCT

35. As described below, Cigna-HealthSpring has knowingly defrauded the United States through an intentional and systematic pattern and practice of submitting to CMS invalid diagnosis codes derived from in-home health assessments.

36. In 2012, following Cigna's January 31, 2012 merger with HealthSpring, Inc. (including subsidiary Bravo Health), Cigna-HealthSpring introduced its “360 Program.” The program was conceptually and structurally similar to existing HealthSpring programs dating back to at least 2010, which were ostensibly designed for primary care providers (PCPs) to

conduct annual health assessments for Part C beneficiaries enrolled in the company's insurance plans. In practice, many of these annual assessments were completed not by PCPs, but by third-party contracted providers who conducted the short screening visits in plan members' homes.

37. Cigna-HealthSpring's 360 assessment was designed as an "enhanced" version of an annual wellness visit (AWV). An AWV is a Medicare benefit that entitles each beneficiary to an annual face-to-face preventative health consultation in which a qualified provider evaluates the patient primarily based on the patient's anecdotal self-assessment of his or her health status. Such annual screening visits can be an important tool in closing "gaps in care," facilitating care coordination, and improving plan members' quality of care. But care coordination and improved quality were not the purposes of Cigna-HealthSpring's 360 Program. Instead, Cigna-HealthSpring designed the program so that, in practice, the 360 assessment was a mere data-gathering exercise used to improperly record lucrative diagnoses to fraudulently raise risk scores and increase payments from CMS.

38. Cigna-HealthSpring's program consisted of several interrelated steps and efforts carried out by various teams: carefully targeting plan members likely to yield the greatest return on investment; incentivizing PCP participation in the program; contracting with third-parties to perform the 360 visits in plan member's homes; and encouraging both PCPs and contractors to "capture" and record lucrative diagnoses that Cigna-HealthSpring would then submit to CMS.

39. As a first step in implementing its 360 Program, Cigna-HealthSpring prioritized plan members that its analytics predicted would likely yield the highest risk-score increases and thus the greatest return on Cigna's investment in the 360 Program. To achieve this goal, analysts working within Cigna-HealthSpring affiliates, including Gulf Quest, employed a data-mining tool known as Predilytics to search plan members' medical histories and then organize members

into different priority categories: “critical,” “high,” “moderate,” “low,” and “very low.” Cigna-HealthSpring assigned the highest priorities to plan members with chronic diseases and those who had not received a 360 assessment within the relevant service year.

40. After targeting and prioritizing plan members, Cigna-HealthSpring sought to recruit PCPs to perform the 360 assessments in priority order. To incentivize PCPs to perform 360 assessments, Cigna-HealthSpring offered bonuses. At one time, Cigna-HealthSpring offered a \$150 bonus per completed exam for PCPs who performed a certain volume of 360s each year. Cigna-HealthSpring also offered those PCPs choosing to participate in the program \$1,000 each time they attended one of Cigna-HealthSpring's 360 training seminars, which were aimed at teaching PCPs to find high revenue diagnoses.

41. Despite Cigna-HealthSpring's various efforts to recruit and incentivize PCPs to complete 360 assessments, many PCPs declined to perform the assessments for their patients. Determined to complete as many 360 assessments as possible, Cigna-HealthSpring turned to third-party contractors to conduct and document the 360 assessments in these plan members' homes. For the most part, and as Cigna-HealthSpring endorsed, contractors hired nurse practitioners (NPs) to complete and document in-home 360 assessments. Some contractors also hired registered nurses (RNs) to complete the visits.

42. Cigna-HealthSpring's use of contractors to perform in-home 360 visits is in keeping with HealthSpring's pre-acquisition practice, particularly the practices of Bravo Health. Following the acquisition, Cigna-HealthSpring used six contractors nationwide to complete 360 assessments, including THM and Alegis, a Cigna-HealthSpring affiliate. Between 2012 and 2017, THM and Alegis accounted for more than half of all 360 visits performed for Cigna-HealthSpring's MA Plan.

43. When a PCP declined to perform a 360 assessment, Cigna-HealthSpring added the plan member's name and contact information to a "target list." Cigna-HealthSpring then divided the "target list" by geographic market and distributed the appropriate list to the contractor that operates in that market. Beginning in 2012, Cigna-HealthSpring included a document it called the "health management report" ("Historical HMR"). The Historical HMR included two .txt files: one file was a list of the beneficiary's medications and the date on which they were last reviewed; the second file was a list of diagnoses previously reported to CMS by Cigna-HealthSpring. Cigna-HealthSpring intended the document to serve as a "cheat-sheet" list of conditions and diagnoses it expected 360 contractors to capture during the in-home visit. The list of diagnoses did not indicate the date they were reported or any other information concerning their status. In 2012, Cigna-HealthSpring provided vendors Historical HMRs for only a small portion of target-list beneficiaries. The percentage increased over time and reached close to 100% by 2016.

44. Once in receipt of the target list, contractors generally reached out to targeted plan members to schedule the in-home 360 visits. After scheduling an appointment, the contractor sent an NP or RN to the beneficiary's home to conduct the visit, which Cigna-HealthSpring made clear to contractors was for "data gathering." These visits typically lasted approximately 30 minutes to one hour.

45. During the visit, NPs and RNs were expected to complete a check-the-box 360 form listing various body systems and disease states. Cigna-HealthSpring instructed NPs to document diagnoses on the 360 form by checking boxes or recording additional notes, and expected NPs to record 20 or more diagnoses per visit. To complete the form, NPs and RNs relied primarily on the patient's self-assessment, i.e., subjectively reported information, as well

as current medications to the extent available and, during certain time periods and for certain plan members, limited laboratory findings. Cigna did not permit NPs or RNs conducting home visits to provide any medical care to beneficiaries, including treatment, medication management, or referrals to specialists.

46. Cigna-HealthSpring submitted diagnosis data gathered on 360 forms to CMS. Depending on the service year, Cigna-HealthSpring submitted this information to CMS in the form of either Risk Adjustment Processing System (RAPS) files or Encounter Data Processing System (EDPS) files.

A. DIAGNOSES DOCUMENTED BY NPs DURING IN-HOME 360 ASSESSMENTS ARE INELIGIBLE FOR SUBMISSION TO CMS

47. Cigna-HealthSpring knowingly designed its 360 Program as a data-gathering exercise rather than a legitimate medical encounter and required NPs and RNs to perform 360 visits according to Cigna-HealthSpring's specific instructions. Cigna-HealthSpring prohibited NPs and RNs from providing medical care during 360 visits and designed the visits to deprive NPs and RNs of the time and tools necessary to treat the very conditions it expected NPs and RNs to capture. As a result, diagnoses documented during these visits are invalid for risk-adjustment reimbursement because the reported diagnoses: (1) did not represent conditions that required or affected patient care, treatment, or management during the relevant service year; (2) could not have been treated or assessed during 360 visits; or (3) lacked medical record support or otherwise violated CMS coding rules.

i. Cigna-HealthSpring Prohibited NPs and RNs from Providing Patient Care

48. Cigna-HealthSpring knew that under relevant Medicare rules, diagnoses documented during its in-home 360 visits could not themselves form the basis of legitimate risk-

adjustment claims to CMS. For this reason, Cigna-HealthSpring told contractors that NPs and RNs were to perform a “data-gathering” function to inform Cigna-HealthSpring and assist beneficiaries’ PCPs in overall care coordination. In fact, Cigna-HealthSpring explicitly prohibited NPs and RNs from treating or otherwise providing non-emergency care to beneficiaries during in-home 360 visits. For example, Cigna-HealthSpring prohibited contractors from allowing NPs or RNs to write prescriptions, counsel beneficiaries to adjust or discontinue medication, order most diagnostic tests, or refer beneficiaries to specialists.

49. Cigna-HealthSpring’s prohibition on providing medical care during in-home visits was express in its agreements with contractors, including its agreements with THM. For example, in one of its agreements with THM, Cigna-HealthSpring mandated that “neither Vendor [THM] nor its Assessing Providers shall provide any prescriptions or recommendations for medical care to Members”

50. Based on contract language, explicit Cigna-HealthSpring directives, and ongoing communications and patterns of practice, contractors generally understood that Cigna-HealthSpring confined contractors’ role in completing in-home 360 visits to data-gathering, and that NPs and RNs conducting the visits were not to provide medical care except in rare emergency situations. In instances in which Cigna-HealthSpring believed NPs or RNs had gone beyond their data-gathering function, Cigna-HealthSpring reiterated its prohibition on care in communications to contractors such as THM.

51. This strict limitation is reflected in numerous communications between Cigna-HealthSpring and THM, as well as within Cigna-HealthSpring, including, for instance, the following:

- In a November 11, 2015 email from Sheri Allred, THM’s former Medical Coding

Operations Manager, Allred told a THM-contracted NP: “There should be NO recommendations or instructions given to the patients on anything. The NP is strictly gathering data, NOT diagnosing or recommending. The words ‘recommend or instructed’ should not even be listed on the 360 form. These directive[s] are from HS [HealthSpring].”

- In a June 3, 2016 email, THM Medical Director Dr. Christopher Bloom instructed a THM NP: “While it seems like a small matter, telling patients to start or stop any medication is the biggest no no we have seeing patients. It . . . could even cause THM to lose its contract with Cigna!”
- In a June 2, 2016 email, Sheri Allred cautioned a THM-contracted NP: “NP’s are never supposed to recommend a pt. to DC [discontinue] a medication. That is considered practicing medicine and HS will not allow that.”
- In a July 27, 2016 email from Dr. Shannon Morris, THM’s Director of Nurse Practitioner Services, to THM CEO Joe Stroffolino, Morris wrote: “All NPs are instructed/directed to collect health related data . . . to evaluate the health status and health risk of the individual member without making recommendations for their care.”
- In an October 2016 email, Cigna-HealthSpring’s 360 Program Clinical Operations Manager Shelly Stevens reported: “THM understands and has expressed to all of their providers that they should not be making referrals to any specialists, etc. . . .”

52. In the event Cigna-HealthSpring or its PCPs perceived an NP’s or RN’s conduct as violating Cigna-HealthSpring’s prohibition against providing medical care, Cigna-HealthSpring was quick to contact contractors and reiterate its 360 Program rules. Cigna-HealthSpring generally became aware that an NP or RN had potentially gone beyond data-

gathering through PCP complaints. For example, in an October 19, 2016 email including Cigna Coding Director Lechaunda Tatum-Williams and Network Operations Administrator Leslie Anders, Anders reported that a PCP found an NP's suggestion that a plan member see an endocrinologist "quite aggravating because the vendor 360 nurse should not be making recommendations for specialist referrals to patients."

53. To fulfill their contractual mandate from Cigna-HealthSpring, contractors integrated Cigna-HealthSpring's prohibition on providing medical care during in-home visits into internal policies. For example, in THM's Collaborative Practice Agreement, NPs agreed their "scope of practice is limited to collecting pertinent health information (subjective data) and a focused physical examination (objective data)" and that "[p]rescriptive authority . . . will not be utilized" in the course of completing in-home 360 visits. As a result, NPs and others conducting in-home 360 visits were fully aware that they were not permitted to provide care or recommend treatment of any kind, except in emergencies.

54. Cigna-HealthSpring contractors understood and made clear to Cigna-HealthSpring that the diagnoses captured on 360 forms were not eligible for submission to CMS as the basis of claims for increased risk-adjustment payments. For example, THM expressed to executives at Cigna-HealthSpring both verbally and in writing that any health conditions and related codes recorded on 360 forms were to be used only as information for plan members' PCPs to review, and that the diagnoses were not confirmed. Contractors also provided disclaimers on the cover pages of their submissions to Cigna-HealthSpring. For example, THM included a cover page with each form that instructed that plan member's PCP to review the information contained therein before incorporating it into the member's medical record. The cover page clearly stated that "[t]he home visit is not a substitute for PCP treatment and DOES

NOT replace the annual physical or HMR completed by the PCP.” The cover page to Alegis’s form included a similar caution: “The visit was solely for the purpose of updating the insurance provider’s information regarding the patient and their condition.”

55. Cigna-HealthSpring’s and its contractors’ knowledge that in-home 360 visits were solely for data-gathering purposes is evident in Cigna-HealthSpring’s imposition of aggressive targets for both the volume of in-home visits and the number of codes captured per visit and per year. In some instances, NPs were expected to see an average of 35 beneficiaries per week, a volume inconsistent with both the assignment of reliable initial diagnoses and the provision of medical care. Additionally, Cigna-HealthSpring expected NPs and RNs to generate upwards of 20 or more diagnoses per plan member per in-home 360 visit. This expectation is inconsistent with treating or managing the underlying conditions, particularly given the limited time allotted to each visit based on Cigna-HealthSpring’s volume expectations. Indeed, even setting aside Cigna-HealthSpring’s clear prohibition on the provision of medical care, 360 visits were, by Cigna-HealthSpring’s design, so cursory that it defies common sense to claim that most of the risk-adjusting conditions captured on 360 forms were properly diagnosed, treated, monitored, or otherwise assessed as required by CMS.

56. Given that Cigna knowingly and specifically designed its in-home 360 Program as a rushed data-gathering exercise rather than a legitimate medical encounter, none of the 360 assessments could on their own serve as a basis for claims to CMS for increased risk-adjustment payments. All diagnosis codes derived from in-home 360 assessments violate CMS rules, are ineligible for submission to CMS, are invalid as the basis of increased risk-adjustment payments and are false within the meaning of the False Claims Act.

ii. Cigna Pushed NPs and RNs to Capture Health Conditions NPs and RNs were not Equipped to Diagnose or Treat in In-Home 360 Exams

57. Even if Cigna-HealthSpring permitted contractors' NPs and RNs to go beyond their prescribed data-gathering function and provide non-emergency medical care, Cigna-HealthSpring designed the 360 Program such that NPs and RNs conducting in-home 360 visits lacked or were denied the tools and the means necessary to diagnose, confirm, or treat the very conditions Cigna-HealthSpring expected and pressured in-home 360 contractors to record on 360 forms.

a. NPs and RNs Lacked Relevant Experience and were Denied the Diagnostic Tools and Patient Information Necessary/Critical to Diagnose and Treat these Conditions

58. In addition to Cigna-HealthSpring's blanket prohibition on the provision of medical care during in-home 360 visits, NPs and RNs performing in-home 360 visits were particularly ill-suited to diagnose or confirm most risk-adjusting conditions because NPs and RNs: (1) were generalists who lacked the training or experience to diagnose these conditions; (2) lacked or were denied the diagnostic tools and specialized equipment necessary to diagnose the conditions; and (3) were denied access to full medical records, ongoing patient contact, and crucial opportunities to coordinate care.

59. It is impossible or impracticable for generalist family NPs and RNs to diagnose and treat most risk-adjusting conditions in the context of the in-home 360 visits Cigna-HealthSpring designed. Cigna-HealthSpring personnel in charge of the 360 Program knew this. Nonetheless, Cigna-HealthSpring expected NPs to "capture" complex conditions including, among others, mental health conditions such as schizophrenia, major depressive disorder, and drug and alcohol dependence; cancers, such as breast cancer, prostate cancer, and lung cancer; heart conditions; lung conditions, such as chronic obstructive pulmonary disease; neurological disorders; autoimmune diseases; and Alzheimer's disease and other dementias.

60. These types of conditions are difficult to detect, often requiring a specialist's

expertise, multiple visits with providers, and various diagnostic tools unavailable to NPs conducting 360 visits in beneficiary homes, including the ability to order laboratory and pathology work and the opportunity to review and interpret it, and access to imaging technology including x-ray, MRI, and CT scan equipment. Many conditions share symptoms with other disorders and diseases, and reaching a definitive diagnosis involves not only observing various symptoms, but also ruling out other conditions with overlapping or similar manifestations.

61. Behavioral and mental health conditions are particularly complex, both in terms of initial diagnosis and ongoing treatment. As just one example, to initially diagnose major depressive disorder, a provider first refers to the *Diagnostic and Statistical Manual of Mental Disorders* (currently in its Fifth Edition and commonly cited as “the DSM-5”), which provides a list of symptoms that, if found to “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” may represent a major depressive episode so long as the convergence of symptoms is “not attributable to the physiological effects of a substance or another medical condition.” Under DSM-5 diagnostic protocols, after a clinician identifies a major depressive episode, he or she must then determine whether (1) “the occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum disorders;” and (2) “there has never been a manic episode or hypomanic episode.” American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition 161 (2013).

62. Thoroughly ruling out other diagnoses is complex and requires both expertise and diagnostics, such as lab values: the DSM-5 counsels that “[t]he evaluation of symptoms of a major depressive episode is especially difficult when they occur in an individual who also has a

general medical condition (e.g. cancer, stroke, myocardial infarction, diabetes...). Some of the criterion signs and symptoms of a major depressive episode are identical to those of general medical conditions (e.g., weight loss with untreated diabetes; fatigue with cancer...).”

63. A definitive diagnosis of major depressive disorder is only appropriate when made in accordance with DSM-5 criteria and confirmed through appropriate lab work such as CBC, thyroid-stimulating hormone, vitamin B12, and folate levels to rule out physical disorders that can cause depression. Treatment for depression depends on many factors but generally entails medication and psychotherapy, either in isolation or combination.

64. During 360 visits, NPs and RNs recorded major depressive disorder on plan members’ 360 forms after walking members through a basic screening questionnaire generally used to elicit some depressive symptoms. The questionnaire is insufficient alone for diagnosing major depressive disorder, and neither NPs nor RNs took necessary additional steps to reach a definitive and appropriate diagnosis. NPs and RNs likewise failed to provide ongoing care for major depressive disorder during in-home 360 visits—generalist NPs and RNs lacked the specialized training and expertise necessary to provide psychotherapy, and Cigna-HealthSpring prohibited in-home 360 providers from prescribing, adjusting, or discontinuing beneficiary medications.

65. With rare exception, there are no behavioral health conditions that a generalist NP or RN can reliably diagnose during a 360 visit, particularly for the first time, and Cigna-HealthSpring’s limitations on the provision of medical care during 360 visits made “recaptured” diagnoses, including depression diagnoses, invalid for risk-adjustment purposes.

66. As with behavioral health conditions, neither NPs nor RNs could reliably diagnose or provide care for most cancers in a 360 visit. To initially diagnose most cancers, for

example, a provider—generally an oncologist—relies on a combination of imaging (MRI, ultrasound, etc.), extensive laboratory work, biopsy results, a full patient health history, and more. Treatment for the various types of cancers depends on many factors, but may involve excision surgery, chemotherapy, radiation therapy, immunotherapy, and/or other intensive medical care. By design, an in-home 360 visit could neither produce a reliable initial cancer diagnosis, nor entail any medical care for a beneficiary’s previously diagnosed, existing cancer.

67. As another example, NPs and RNs conducting in-home 360 visits could neither initially diagnose nor provide the requisite care for heart conditions during 360 visits. To diagnose most heart conditions, a provider relies on testing unavailable to in-home 360 providers, including extensive bloodwork, electrocardiogram testing, and sometimes angiogram, as well as coordination with a cardiologist. Treatment for acute, emergency heart conditions requires intensive care in a hospital setting, generally under a specialist’s care, until the condition stabilizes. Treatment might include, for example, advanced cardiac life support, catheterization, or cardiopulmonary resuscitation.

68. Moreover, many conditions were also inappropriate to code from 360 visits because NPs and RNs lacked vital context, including a preexisting relationship with beneficiaries, access to full prior medical history, and necessary opportunities for care coordination. Cigna-HealthSpring expected NPs to diagnose various complex health conditions even though NPs and RNs had limited information available to them in the home. NPs and RNs were generally armed with only the cursory Historical HMR (medication history and diagnosis history) during the 360 assessment. Additionally, neither NPs nor RNs could coordinate care by referring beneficiaries to the specialists equipped to properly treat complex conditions.

b. Cigna Nonetheless Pushed Contractors to Inappropriately Capture Diagnoses During In-Home 360 Visits

69. Despite the way Cigna-HealthSpring designed the 360 Program—including the limitations it imposed on NPs and RNs conducting in-home 360 visits—it expected NPs and RNs to capture lucrative, complex diagnoses on the 360 form. Cigna-HealthSpring identified particular diagnoses it wanted NPs and RNs to capture during in-home visits, then, through general and targeted trainings and materials, directed and otherwise influenced contractors and their providers to record these diagnoses on 360 forms. Cigna-HealthSpring’s close control of NP and RN training and education was explicit in its agreements with 360 contractors. For example, in its contract with THM, Cigna-HealthSpring required that THM “shall provide sufficient education and *training which has been approved by Cigna-HealthSpring* to all of its employees . . .” (emphasis added).

70. Cigna-HealthSpring identified at least 12 classes of generic chronic diagnoses it believed were “often underdiagnosed” across its plan-member population and invested significant resources in attempting to capture those diagnoses via in-home 360 visits. In one effort, Cigna-HealthSpring’s Chronic Care Quality Initiative (CCQI) team regularly distributed newsletters to in-home 360 contractors. These newsletters contained detailed “clinical focus” sections on groups of clinically related diagnoses, as well as on particular conditions, including conditions uniquely ill-suited to diagnosis and treatment in 360 visits such as schizophrenia, major depressive disorder, bipolar disorder, and cancer, among others. The newsletters also contained schedules for general trainings related to conditions and condition groups that roll up into high-value HCCs.

71. Cigna-HealthSpring also separately distributed training calendars to 360 vendors to share with their contracted NPs and RNs. These training courses covered documenting and coding certain conditions and were designed to encourage NPs and RNs to record high-value

diagnoses. For example, a May 2015 Cigna-HealthSpring disease-specific training calendar distributed to THM included sessions on depression, CVAs [stroke], diabetes, chronic kidney disease, cancer, chronic obstructive pulmonary disease, congestive heart failure, hypertension, substance abuse and dependency, and other risk-adjusting diagnoses that are virtually impossible to diagnose in the context of an in-home 360 visit.

72. In trainings and educational seminars led by Dr. Fessenden, Cigna's Senior Medical Director for CCQI, attendees were taught to "paint a picture" of the disease, disorder, or condition on the 360 forms by including notes that could link any signs or symptoms from the 360 assessment to prior health conditions in the Historical HMR. At one seminar, Dr. Fessenden advised attendees, including THM personnel, that they could diagnose rheumatoid arthritis if they simply noted in their 360 forms (1) pain in the wrists, proximal interphalangeal joints and metacarpophalangeal joints with morning stiffness lasting more than 1 hour and (2) systemic symptoms of fatigue and weight loss. These symptoms are common to numerous illnesses.

73. Cigna-HealthSpring similarly pushed 360 contractors to either recapture or diagnose other conditions, often for the first time, through its general trainings. For example, Cigna-HealthSpring expected and encouraged NPs and RNs to record cancers, including prostate, breast, and lung cancers, on 360 forms, even though, by design, these providers could neither have diagnosed nor provided care for cancer during an in-home 360 visit.

74. Cigna-Health Spring also encouraged NPs and RNs to "diagnose" behavioral and mental health conditions for the first time during 360 visits. In an attempt to make the 360 forms appear to reflect legitimate medical encounters capable of producing diagnosis codes eligible for submission to CMS, Cigna-HealthSpring instructed contractors to have their NPs check a "psych referral" box on a plan member's form for all newly diagnosed insomnia, anxiety, depression,

alcohol and drug abuse, or other mental and behavioral health conditions. Despite appearances, Cigna-HealthSpring explicitly prohibited NPs and RNs from in fact making any psychiatric referrals.

75. Cigna-HealthSpring generally provided its trainings and educational seminars by webinar. Follow-up directives, clarifications, and specific instructions related to condition capture were largely communicated through telephone conversations between Cigna personnel, including Dr. Fessenden and Shelley Stevens, and high-level employees at 360 contractors, including at THM Dr. Bloom and Sheri Allred, who communicated Cigna-HealthSpring's directives to NPs and RNs. For example, throughout the life of its contracts with Cigna-HealthSpring, THM staff, including Dr. Bloom, conferred by telephone with Dr. Fessenden regarding, *inter alia*, Cigna-HealthSpring's instructions for capturing major depressive disorder during 360 visits, Cigna-HealthSpring's requirements for "linking" diabetes diagnoses to comorbid conditions, and Cigna-HealthSpring's views on the chronic, lifelong nature of certain diagnoses.

76. In addition to general training that applied to all contractors, Cigna-HealthSpring also assessed each contractor's performance and implemented disease-specific trainings that were targeted to address each contractor's perceived short-comings. To identify contractors in need of individualized training, Cigna-HealthSpring used analytics to track contractors' performance in capturing diagnosis codes, then produced various reports setting forth contractors' performance across several metrics and comparing its contractors to one another and to competitors.

77. In one such evaluation, Cigna-HealthSpring measured contractor performance based on "chronic retention rates," or the number of a beneficiary's chronic health conditions

that NPs and RNs recaptured during the 360 visit as a percentage of the conditions reported for that beneficiary in the previous year. Cigna-HealthSpring set a “goal” of retaining 85% of all previously identified chronic conditions across all assigned beneficiaries. Cigna-HealthSpring also tracked and evaluated contractors’ performance in capturing “often underdiagnosed” generic diagnoses, regardless of whether beneficiaries were previously assigned those diagnoses. It then compared contractors’ results against other vendors’ performance. In its reporting, Cigna-HealthSpring color-coded conditions based on the percentage the contractor had “underdiagnosed” as compared to a competitor, with red reflecting the most significant “undercoding” compared to the baseline, and yellow reflecting a lower discrepancy.

78. As part of its reporting, Cigna-HealthSpring closely monitored 360 contractors’ impact on its plan members’ risk scores. This analysis was based in part on 360-derived claims that Cigna-HealthSpring submitted to CMS, and on corresponding risk-score increases and decreases CMS calculated based on Cigna-HealthSpring’s claims and communicated back to Cigna-HealthSpring.

79. Cigna-HealthSpring rewarded contractors with the highest retention rates and risk-score increases with additional business volume.

80. For contractors with low retention rates or poor risk-score increases, Cigna-HealthSpring imposed targeted trainings in which Cigna-HealthSpring employees provided instruction on initially coding or recapturing the specific high-value chronic conditions the contractor had failed to capture at a rate acceptable to Cigna-HealthSpring. For example, in a September 22, 2016, email, Cigna’s Chronic Care Quality Initiative Manager and Editor Jason Jean sent Network Operations Vice President Whitney Horak a meeting report detailing THM’s diagnostic “strength areas” and “areas to improve” as well as recommendations for an

“[e]ducational focus on diabetes, vascular, congestive heart failure, and chronic obstructive pulmonary disease, fibrotic lung disorders, and coagulation defects.”

81. Cigna-HealthSpring also evaluated individual NP performance on both a quantitative and qualitative basis and exercised near-absolute control over the manner in which NPs and RNs conducted in-home visits and completed 360 forms. Cigna-HealthSpring’s direction and supervision of contractors’ NPs and RNs is enshrined in its contracts, which carve out Cigna-HealthSpring’s right to direct 360 vendors to terminate individual NPs and RNs.

82. As part of its quantitative analysis of individual NPs, Cigna-HealthSpring checked 360 forms for the number of conditions NPs recorded against the average number of diagnoses—between 20 and 30 per beneficiary per visit—typically captured. Cigna-HealthSpring designated forms with fewer than the average number of diagnoses as “scant,” and viewed “scanty charting” as a “red flag” that triggered a closer review. For NPs who captured fewer diagnoses than Cigna-HealthSpring required, Cigna-HealthSpring compelled 360 contractors to supply performance improvement plans. For example, in August 2014, Dr. Fessenden communicated Cigna-HealthSpring’s displeasure with THM’s performance reports and requested that THM “supply a performance improvement plan (PIP) for all providers who have completed at least 100 exams and have more than a 3% difference from the competitor for CHF and COPD.” Fessenden also laid out Cigna-HealthSpring’s requirements for the plan: “In the performance improvement plan, we want to know how you are going to educate the provider and when the education will be complete.” Finally, Fessenden warned THM that “[w]e will be requesting education on other specific diseases in the future based on the disease prevalence results.”

83. Cigna-HealthSpring also evaluated NPs and RNs on a qualitative basis and

communicated with 360 contractors regarding perceived coding and completion errors on particular 360 forms. For example, Cigna-HealthSpring directed THM to instruct its NPs to follow certain condition-specific protocols while completing 360 forms. The protocols were highly detailed: whether to check or avoid certain binary boxes on the form, where to record certain information while completing the forms (e.g., in the form's "medications" section or under "review of systems"), which of the form's pre-filled "treatment" options to select for a particular condition, and in which instances communications with the plan member's PCP were expressly prohibited.

84. As a result of Cigna-HealthSpring's training and pressure, contractors in fact captured the targeted high-yield diagnosis codes, including particularly suspect diagnoses such as major depressive disorder and various cancers, during in-home 360 visits.

iii. Cigna-HealthSpring Knowingly and Intentionally Pushed Contractors to Code Conditions that Lacked Medical-Record Support or Otherwise Violated CMS Coding Rules

85. In addition to pressuring its contractors to capture lucrative diagnosis codes, Cigna-HealthSpring established specific coding protocols that it knew or should have known violated ICD and CMS coding rules. Cigna-HealthSpring pushed its contractors to code conditions that were invalid and violated CMS eligibility rules because they were (1) necessarily uncertain or merely probable given the 360 Program's design and the structure of the 360 form; and (2) gathered from ineligible sources including prescription medication lists, prior medical history, and diagnostic labs.

86. Cigna-HealthSpring, in purposeful violation of CMS rules, designed its 360 form to force NPs to capture diagnoses that were uncertain, probable, or merely suspected. The 360 form reflects in a single document two sources of patient health information collected during 360 assessments: (1) patient-reported subjective information, and (2) clinical indicators observable

during 360 visits. Importantly, the 360 form did not—by design—indicate the source of the information the NPs recorded. In other words, the 360 form did not require the NP or RN to state whether the health information he or she documented derived from patient-reported subjective information or from observable clinical indicators.

87. Cigna-HealthSpring designed the form to record all health information indiscriminately. The 360 form contains only two check-the-box options to document a beneficiary's health conditions: (1) diagnose the disease or (2) indicate that there is “no active disease.” This structure forced NPs and RNs to either initially diagnose or otherwise confirm a condition or rule it out entirely. NPs and RNs, who understood the visits to be for data-gathering purposes, would generally document a diagnosis based on any hint or suggestion—even anecdotal—of a health condition, because the only other option was to rule out the possibility of the health condition altogether.

88. Cigna-HealthSpring also knowingly violated CMS coding rules by pushing NPs and RNs to diagnose conditions based solely on plan members' past medical history, particularly for diseases Cigna-HealthSpring determined were not “curable.” For example, in May 16, 2016 emails between Sheri Allred and a THM-contracted NP, Ms. Allred questioned why the NP listed diabetes as a past medical illness, but not a current one, for several plan members seen in in-home 360 visits. The NP explained that the three relevant charts pertained to members who had temporary diabetes (i.e., “a reaction to exogenous steroids”) or had their diabetes resolved after gastric bypass surgery, and that all members had normal laboratory results, and none were medicated for diabetes. Ms. Allred instructed the NP that there is a “directive” from Cigna-HealthSpring and Dr. Fessenden to diagnose diabetes as a current illness if it appears in the member's past medical history (the Historical HMR) because Cigna-HealthSpring considers

diabetes “not . . . curable.” Cigna-HealthSpring instituted this directive despite knowing that diagnosis codes based on conditions that have resolved or that do not require or impact patient care are not appropriate for risk-adjustment reimbursement.

89. Cigna-HealthSpring further violated CMS coding rules by instructing contractors’ NPs to diagnose or otherwise capture health conditions based on plan members’ medicine cabinets or weak “links” between certain medications or symptoms and other risk-adjusting diseases. For example, Cigna-HealthSpring encouraged contractors to record atrial fibrillation, deep vein thrombosis, and pulmonary embolus based on the presence of certain classes of anti-coagulation medications on members’ medication lists or in their homes. Similarly, plan members on Metformin were assumed to be diabetic, even though the medication has broader applications, and even though CMS prohibits MA Organizations from capturing conditions based solely on a beneficiary’s prescribed medications.

B. CIGNA-HEALTHSPRING SUBMITTED TO CMS THE INELIGIBLE DIAGNOSES CAPTURED IN IN-HOME 360 VISITS AS FALSE CLAIMS FOR PAYMENT

90. Cigna-HealthSpring submitted risk-adjustment data, including diagnosis codes gathered during in-home 360 visits, to CMS through CMS’s Risk Adjustment Processing System (RAPS), and later through CMS’s Encounter Data Processing System (EDPS). Each submission of a RAPS or EDPS file is a claim for payment. As explained above, given the 360 Program’s design, the majority of risk-adjusting diagnoses captured via in-home 360 visits are invalid for risk-adjustment purposes. When Cigna-HealthSpring bundled those invalid diagnoses into RAPS and EDPS files and submitted those files to CMS, Cigna-HealthSpring submitted false claims within the meaning of the FCA.

91. Cigna-HealthSpring directly submitted to CMS the invalid diagnoses its

contractors captured via in-home 360 visits. Contractors were generally responsible for performing the 360 assessment, completing 360 forms for each beneficiary visited, and then submitting the forms to Cigna-HealthSpring. At that point, Cigna-HealthSpring employed internal coders to review the NPs' descriptions in the completed 360 forms and generate ICD codes from those descriptions.

92. Contractors did not submit diagnosis codes derived from in-home 360 visits to CMS. Some contractors, including THM, did perform their own preliminary ICD coding in-house. Like the diagnoses recorded on 360 forms during in-home visits, these diagnosis codes did not represent confirmed risk-adjustment codes—only preliminary codes meant to serve as useful data for PCPs, in keeping with the 360 Program's ostensible "data-gathering" purpose. After THM assigned ICD codes based on information in its 360 forms, it prepared a report that listed the codes. This report and the 360 form were then combined into a single electronic document that contractors provided to Cigna-HealthSpring and, in some instances, shared with the beneficiary's PCP. Without confirming that the beneficiary had the diagnoses or received the requisite care for the conditions, Cigna-HealthSpring represented the ICD codes as confirmed medical diagnoses and submitted the codes to CMS as claims for increased risk-adjustment payments.

93. Cigna-HealthSpring derived financial benefit from its scheme to submit unsupported and otherwise invalid ICD codes to CMS for payment. Relying on the accuracy of the risk-adjustment data Cigna-HealthSpring submitted to it, the United States, through CMS, paid these false claims by issuing increased risk-adjustment payments tied to beneficiaries who underwent in-home 360 visits. In each instance, the false claims Cigna-HealthSpring submitted to CMS resulted in higher beneficiary risk scores and thus increased risk-adjustment payments to

Cigna-HealthSpring.

94. As a result of the fraudulent scheme described herein, Relator expects that Defendants submitted hundreds of thousands of false claims from its six contractors during the relevant period. Although the exact amount will be proven at trial, the United States has paid billions of dollars in improper, inflated payments to Defendants under the MA Plan as a result of this scheme.

C. CIGNA-HEALTHSPRING'S CONDUCT WAS KNOWING WITHIN THE MEANING OF THE FALSE CLAIMS ACT

95. For purposes of the FCA, a person “knows” a claim is false if that person: “(i) has actual knowledge of [the falsity of] the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information.” 31 U.S.C. § 3729(b)(1). The FCA does not require proof that the defendants specifically intended to commit fraud. *Id.*

96. Cigna-HealthSpring knew it submitted diagnosis codes that were invalid for risk-adjustment purposes and false within the meaning of the False Claims Act because the codes did not comport with CMS requirements. Cigna-HealthSpring was aware of the legal, regulatory, and Medicare Program requirements for submitting claims. For instance, Cigna-HealthSpring's agreements with its 360 contractors evince its knowledge of the relevant CMS rules and requirements, as well as its ultimate responsibility for compliance. For example, in a contract with THM, Cigna-HealthSpring agreed to “comply with all applicable laws and regulations in the performance of its obligations under this Agreement” and to “be responsible for all insurance and other regulatory compliance in connection with the development and implementation of approved projects.”

97. Nonetheless, as alleged throughout this Complaint, Cigna-HealthSpring designed

its 360 Program to generate diagnoses in the absence of medical treatment, care, or management. In addition to designing the program, Cigna-HealthSpring closely oversaw its vendors, directed their efforts, and dictated their practices. As alleged in detail above, Cigna-HealthSpring issued specific clinical and coding guidance to 360 vendors, provided related trainings, set targets for visit volume and diagnosis recapture, dictated the manner in which NPs conducted and documented in-home 360 visits, and used recapture rates and other qualitative and quantitative analyses to assess 360 contractor and individual NP performance. Cigna-HealthSpring's actions were intended to yield maximum profit from beneficiaries who derived little to no benefit from the visits.

D. CIGNA-HEALTHSPRING'S SUBMISSION OF INVALID, UNSUPPORTED ICD CODES IS MATERIAL TO THE GOVERNMENT

98. Cigna-HealthSpring's submission of invalid and unsupported ICD codes is material to the government because valid diagnosis codes are key to the integrity of the MA Plan. Various contractual and regulatory materials require MA Organizations to submit accurate diagnostic data, i.e., diagnosis codes recorded in compliance with ICD coding guidelines and derived from qualifying encounters in which the reported conditions were diagnosed, treated, assessed, monitored, or otherwise considered in the provision of patient care. Diagnosis data is central to CMS's calculation of the amount of money it pays to MA Organizations, including Cigna-HealthSpring. The requirements thus go to the very essence of the bargain between CMS and Cigna-HealthSpring.

99. CMS would not have paid the claims had it known that Cigna-HealthSpring submitted diagnosis codes for conditions that were not diagnosed, treated, assessed, monitored, or otherwise considered in the course of qualified encounter.

VI. PUBLIC DISCLOSURE/ORIGINAL SOURCE

100. To the extent that the facts alleged in this Complaint have been previously disclosed to the public or the government in any fashion, Relator is an “original source” of the information as defined in 31 U.S.C. § 3730(e)(4).

101. The information upon which Relator’s claims are based was not publicly known prior to the filing of this action. This information was disclosed to Relator during the course of an arbitration involving THM and Cigna-HealthSpring that took place in New York City in 2017 (the “Arbitration”).

102. The Arbitration concerned possession of over 1500 360 forms relating to the 2016 service year that THM refused to turn over to Cigna-HealthSpring due to non-payment of services. Several examples of these forms are attached as **Exhibit A** to this Complaint. Cigna-HealthSpring sought to obtain these forms so that it could extract the ICD codes from the “health maintenance report” attached to each 360 form and submit these codes to CMS for risk adjustment purposes.

103. On December 14, 2017, the arbitration panel issued an interim award ordering THM to turn over the 360 forms it was holding to Cigna-HealthSpring in order to allow Cigna-HealthSpring to timely submit the ICD codes. The forms were subsequently delivered to Cigna-HealthSpring and the codes were extracted and submitted to CMS for risk adjustment purposes on or about May 4, 2018. Because none of the codes submitted from these forms were valid diagnoses, all of the submissions were fraudulent.

VII. REPRESENTATIVE EXAMPLE OF A FALSE CLAIM

104. Over 2,000 pages of testimony and tens of thousands of documents were obtained by Relator during the Arbitration, including a list more than 2,452 pages in length containing all of the diagnostic codes submitted to CMS for the 2015 service year for certain

members enrolled in the plans in East Texas. A copy of this list is attached as **Exhibit B**.

105. By comparing this list against the 360 forms that were completed for these same members in the East Texas in 2016, one can find specific submissions that were made to CMS in 2015 that were false. For example, the list reflects code submissions of systolic congestive heart failure, chronic kidney disease and hypertensive heart disease with heart failure for a particular member in 2015, but that same member had a 360 performed by THM in 2016 that showed he did not have any of these conditions at all. In fact, he did not even have a history of these conditions, and his heart rate was completely normal. Excerpts of the relevant pages from the list and the 360 Form are attached as **Exhibit C**.

COUNT I

Substantive Violations of the Federal False Claims Act 31 U.S.C. §§ 3729(a)(1)(A)–(C), (a)(1)(G), and 3732(b) (As to All Defendants)

106. Relator realleges and incorporates by reference the allegations made in Paragraphs 1 through 100 of this Complaint.

107. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §§ 3729–3733, as amended.

108. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly presented, or caused to be presented to the United States false and fraudulent claims, and knowingly failed to disclose material facts, to obtain payment or approval from the United States and its contractors, grantees, and other recipients of its funds in violation of 31 U.S.C. § 3729(a)(1)(A). They did so by submitting diagnoses documented during in-home visits that were invalid for risk-adjustment reimbursement because the reported diagnoses: (1) did not represent conditions that required or affected patient care, treatment, or management during the relevant service year; (2) could not have been treated or

assessed during the in-home visits; or (3) lacked medical-record support or otherwise violated CMS coding rules.

109. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements, which also omitted material facts, to induce the United States to approve and pay false and fraudulent claims in violation of 31 U.S.C. § 3729(a)(1)(B).

110. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used, false records or statements material to an obligation to pay or transmit money or property to the government, or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the government, in violation of 31 U.S.C. § 3729(a)(1)(G).

111. Through the acts described above, Defendants, their agents, employees, and co-conspirators conspired with one another to violate 31 U.S.C. §§ 3729(a)(1)(A)–(C) and (G).

112. The United States, unaware of the falsity of the claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

113. By reason of the payment made by the United States, as a result of Defendants' fraud, the United States has suffered damages in an amount to be determined at trial.

RELIEF REQUESTED

WHEREFORE, Relator requests judgment be entered against Defendants, ordering that as to all counts for the violations of the Federal False Claims Act, Defendants:

114. Cease and desist from violating the False Claims Act, 31 U.S.C. § 3729 *et.*

seq.;

115. Pay an amount equal to three times the amount of damages the United States has sustained because of Defendants ' actions, plus a civil penalty against Defendants of not less than \$11,463 and not more than \$22,927 for each violation of 31 U.S.C. § 3729;

116. Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d);

117. Relator be awarded all costs of this action, including attorneys' fees, expenses, and costs pursuant to 31 U.S.C. § 3730(d); and

118. That the United States and Relator be granted all such other relief as the Court deems just and proper.

DEMAND FOR JURY

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands a trial by jury .

Respectfully Submitted,

/s/ Tara L. Swafford
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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served
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on this 15nd day of February 2023.

/s/ Tara L. Swafford
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