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-HealthSprin g." Relator alleges, as follows:

I. PRELIMINARY STATEMENT

1. This case is about Cigna-HealthSpring's fraud on Medica re 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 toimproperly 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)(l) 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; s*ee 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 affectedpatient 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 of31 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, includ ing 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,

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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 19th day of June 2023.

/s/ Tara L. Swafford
Tara L. Swafford