UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

UNITED STATES OF AMERICA, EX REL. ROBERT A. CUTLER,	)	
Plaintiff,	)	
v.	)	**Civil Action No. 3:21-cv-00748**
	)	**JUDGE RICHARDSON**
CIGNA CORPORATION, CIGNA HOLDINGS INC., CONNECTICUT GENERAL CORP., HEALTHSPRING, INC., NEW QUEST LLC, HEALTHSPRING LIFE & HEALTH INSURANCE COMPANY INC., GULF QUEST LP., PHYSICIANS MANAGEMENT LLC and ALEGISCARE SERVICES, LLC.	)	**MAGISTRATE JUDGE FRENSLEY**
	)	**JURY TRIAL DEMANDED**
Defendants.	)	

THIRD 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 concerns Cigna-HealthSpring's fraud on Medicare Part C, commonly known as the Medicare Advantage (MA), through its submission of unsupported, inaccurate, and otherwise invalid claims for payment.

2. From at least 2012 until 2017, and likely continuing thereafter, Cigna-HealthSpring violated the False Claims Act (FCA) through a widespread scheme to improperly increase revenues by submitting data to the Centers for Medicare & Medicaid Services (CMS) concerning its MA Plan members which it knew to be false.

3. Cigna-HealthSpring intentionally implemented a program that used registered nurses (RNs) and nurse practitioners (NPs) as a means to diagnose and document chronic diseases without any clinical support and without proper credentials.

4. Through the program, Cigna-HealthSpring hired third party contractors to perform in-home health assessments for MA Plan members, which it knowingly misrepresented to these contractors as a non-clinical "data-gathering" exercise. Despite the fact that these health assessments were not medical exams and the contractors did not perform them as such, Cigna-HealthSpring nevertheless used the information from them as medical data which it submitted to CMS for risk adjustment purposes.

5. These submissions were false not only because the diagnoses were obtained as a result of defrauding providers, but also because they were based on subjective, patient-reported information and represented only suspected or possible health conditions. Cigna-HealthSpring was fully aware that the diagnoses were invalid but submitted the data anyway.

6. In addition, none of the NPs who "diagnosed" mental health conditions held the proper credentials to render such diagnoses. The laws in every state where Cigna-HealthSpring performed health assessments required NPs to be board-certified in psychiatry/mental health in order to diagnose psychiatric conditions. None of the NPs in fact held this certification. Cigna-HealthSpring knew this to be the case but submitted mental health diagnoses to CMS as risk adjustment data anyway.

7. By submitting false claims data to CMS that Cigna-HealthSpring knew was invalid for risk adjustment purposes, Cigna-HealthSpring received billions in dollars in overpayments from the federal government for the 2012 through 2017 service years.

8. Cigna-HealthSpring's knowing violation of Medicare 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

9. 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).

10. 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. Cigna Corporation offers MA Plans in 17 states and the District of Columbia under its Cigna-HealthSpring brand.

11. 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.

12. 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.

13. 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."

14. 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.

15. 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.

16. 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.

17. 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.

18. 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. Defendant Home Physicians Management, LLC and Defendant Alegis Care Services, LLC are collectively referred to as "Alegis."

19. 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.

20. 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

21. 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).

22. 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.

23. 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.

24. 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

25. 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.

26. 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.

27. 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.

28. 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).").

29. 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

30. 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").

31. 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 68,000 ICD diagnosis are grouped into roughly 80 HCCs. Each HCC is assigned a numerical value that impacts risk scores and per-beneficiary payments.

32. 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.

33. 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.

34. 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).

35. 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).

36. 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

37. As described in further detail below, Cigna-HealthSpring 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, codes which it knew were invalid for submissions.

38. In 2012, following Cigna's January 31, 2012 merger with HealthSpring, Inc. Cigna-HealthSpring introduced its in-home health assessment program which it dubbed the "360 Program."

39. The 360 Program was promoted as a means to resolve "gaps in care." These gaps existed because many elderly patients enrolled in the MA Plans did not regularly see a primary care physician (PCP), and consequently the MA Plans knew little or nothing about their health status. The program would close these gaps by using health providers to visit the members in their homes. During these visits health providers would perform a health assessment on the member known as a "360" or "360 Assessment" (360 Assessment).

40. While Cigna-HealthSpring portrayed this program as a tool that could be used to better understand the health needs among its member population, in reality this was not the true purpose of the program. Cigna-HealthSpring's organization was not even set up in a way that would allow it to make any practice use of any information gleaned from a 360 Assessment.

41. Cigna-HealthSpring randomly assigned its members to PCPs without informing the PCPs which members had been assigned to them. Therefore, unless a member had previously seen the PCP before undergoing a 360 Assessment, the PCP did not know who his/her patients were or if they had a 360 Assessment performed.

42. The only way a PCP would ever find out that a patient underwent a 360 Assessment would

be if he or she received a fax from Cigna-HealthSpring with a copy of the health assessment. However, if the PCP did not recognize the name of the patient listed on these faxes they were simply shredded and thrown into the trash. Cigna-HealthSpring did not send these faxes regularly, and the faxes were notoriously unreliable. If a fax were delivered at all, it would arrive months (and as long as a year) after the 360 Assessment was performed.

43. The true purpose of the 360 Program was not to gain knowledge of the members' health status but rather to maximize the profits of the MA Plan by diagnosing as many diseases as possible in as little time as possible. The program was the brainchild of Dr. Dirk Wales, a physician who was also a healthcare entrepreneur, who implemented the program for Cigna-HealthSpring in 2012. Following the program's initial success, Cigna-HealthSpring developed an infrastructure around the program and hired health professionals (especially doctors with business backgrounds) to perform management roles within the plan, including Dr. Michael Fessenden and Dr. Julian Harris.

44. In 2013 Dr. Fessenden was appointed as the Senior Medical Director of the Chronic Care Quality Initiative (CCQI), a group created within Cigna-HealthSpring's Medicare Data Operations unit that administered the 360 Program. Dr. Fessenden was a physician who also held an M.B.A. He previously operated a successful business which was acquired by Cigna-HealthSpring in 2012. Dr. Fessenden managed a core team who included, among other people, Shelley Stevens, Peter Gardner, Whitney Horak, Chaun Tatum-Williams and Glynn Creech. Mr. Creech was the head of coding operations and either directly submitted or oversaw the submission of false codes that are the subject of this Complaint, including the false codes for the 2016 service year which were submitted in connection with the arbitration described in further detail below.

45. Dr. Julian Harris was the President and founder of Care Allies, Inc., a company that developed the 360 business model from 2015 onward. Care Allies managed physician groups within the MA Plans. Just as CMS paid Cigna-HealthSpring a capitated rate to manage the care costs of the MA Plans' member population, Cigna-HealthSpring paid its physician groups capitated rates to manage the cost of caring for specific patients within their practices. In return for agreeing to be paid on a capitated rate structure (which required the practices to forego the traditional fee-for-services payment

arrangement), Care Allies guaranteed that these practices would be profitable and actively assisted them in minimizing costs.

46. Care Allies worked in conjunction with CCQI to use the 360 Program to generate revenue for the MA Plans as well as to protect the profitability of physician practices. The program accomplished these goals in 2 ways: (1) by ensuring that risk scores would be retained from year to year by re-diagnosing health conditions and (2) identifying new diagnoses that could be tied to patient's existing signs or symptoms and thereby allow for further increases in risk scores.

47. The 360 program operated through several inter-related steps that included: (a) engaging third-party contractors employing non-physician health providers to perform 360 Assessments; (b) targeting plan members likely to yield the greatest return on investment and have the contractors conduct 360 Assessments on these individuals; (c) training health providers to identify high revenue diseases through general and selective training and (d) using financial incentives and re-training to award or punish contractors who met or failed to meet the dual objectives of the plan as noted in the preceding paragraph.

A. Cigna HealthSpring misled contractors into believing that the 360 Assessments were health risk assessments.

48. Cigna-HealthSpring used six contractors nationwide to complete the 360 Assessments, the four largest being THM, Alegis, a Cigna-HealthSpring affiliate, ComplexCare Solutions, Inc. and BDPM, Inc. Between 2012 and 2017, THM and Alegis alone accounted for more than half of all 360 visits performed for Cigna-HealthSpring's MA Plans.

49. All the contractors were initially told by officers of Cigna-HealthSpring, including Joseph Cramer and Dr. Michael Fessenden, that they were being hired to conduct in-home health screenings of plan members, and that these services would entail interviewing the member regarding his or her current and former health conditions, a review of current medications and an assessment of any potential health risks based on observable signs and symptoms.

50. However, upon entering into a binding contract with Cigna-HealthSpring, the contractor would be informed that the services would need to include diagnosing or re-diagnosing health conditions

based on the information reported to the provider during the health assessment, including a wide range of serious illnesses and chronic diseases. Cigna-HealthSpring wanted its contractors to do this without access to the patient's health history and without the aid of diagnostic equipment.

51. THM's president Joseph Stroffolino felt uncomfortable with the 360 Assessment from the beginning. He was a party to several calls with Mr. Cramer and later Dr. Fessenden between 2012 and 2017 in which he expressed concern that the company's nurses were performing the 360 Assessment "blind" and could not diagnose, nor would they be willing to diagnose, any conditions that could not be substantiated on the basis of observations alone.

52. THM was also concerned because its nurses did not hold specialty certifications that would allow them to diagnose a number of complex diseases, including psychiatric and mental health conditions. In every state where 360 Assessments were performed, state law required NPs diagnosing mental disorders to be board certified in psychiatry. None of the NPs employed by THM or any other contractors held this certification and Cigna-HealthSpring knew to be the case as they reported to Cigna-HealthSpring at least once annually all of the credentials and certifications that each of their NPs held.

53. Joseph Cramer and Dr. Fessenden managed to quell Mr. Stroffolino's concerns by portraying the 360 Assessment as a mere "data-gathering" exercise. Mr. Stroffolino was told that even though Cigna-HealthSpring was asking contractors to "diagnose" diseases, these diagnoses were not in fact true medical diagnoses. They were potential health conditions that would be documented for the PCPs to consider.

54. These statements were further reinforced by Mr. Cramer and Dr. Fessenden in conversations in which they referred to the 360 Assessments as "HRAs" or "health risk assessments," which were terms used for annual face-to-face preventative health consultations in which a health professional would evaluate the patient's health risks using a patient's self-assessment of his or her health status and which did not involve the diagnosis of any diseases. *See* 42 C.F.R. § 410.15(a). An AWV in fact can be performed by wide range of health professionals, including physicians, physician assistants, nurse practitioners, health educators, registered dietitians and nutritionists.

55. Based on these representations, Mr. Stroffolino and executives employed by the other contractors, including Mark Blackburn (of ComplexCare Solutions) and John Shermyn (of BDPM, Inc.), believed that their nurses could perform the services that Cigna-HealthSpring wanted because the 360 Assessments were not medical exams, and the RNs and NPs were not actually diagnosing any diseases. The "diagnoses" they were making were simply suspected or probable conditions that RNs and NPs were able to glean from self-reported data collected and other sources of information the RNs and NPs examine, and they would not become a medical diagnoses unless and until they were confirmed by the PCP.

56. Documents exchanged among Cigna-HealthSpring, the contractors and providers clearly show that all parties understood that the 360 Assessments were not medical exams. Significantly, all contractors reported their findings from each 360 Assessment to Cigna-HealthSpring using a health assessment form (360 Form) that contained a disclaimer that the 360 Assessment was not a medical exam.

57. THM's disclaimer was prominently displayed on the cover page of the form it prepared and indicated that the plan member's PCP needed to review the information contained in the form 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" (emphasis in the original). Other providers used similar disclaimers on their 360 Forms. Even Cigna-HealthSpring's own affiliate Alegis used a disclaimer. It stated that "The visit was solely for the purpose of updating the insurance provider's information regarding the patient and their condition."

58. But even though Cigna-HealthSpring knew that the 360 Assessments were not regarded or conducted as medical exams, it used the data from the 360 Forms as if they were medical exams. It submitted ICD codes based on the 360 Forms and relied on the 360 Form as a supporting medical record. Cigna-HealthSpring in fact altered the 360 Forms in order to suit this purpose. As the 360 Forms were received by Cigna-HealthSpring from the contractors, the cover pages from the Forms containing the disclaimers were removed. This was done purposely so that if CMS were to ever audit Cigna-

HealthSpring's medical records, the disclaimers would not appear to the auditors.

59. Cigna-HealthSpring also made it appear as if the diagnoses reflected in the 360 Forms had been reviewed and approved by the PCP and were currently being treated. It did this by transmitting copies of the 360 Forms back to the PCPs, and, if possible, within the same service year that the 360 Assessments were performed.

60. In some years, however, this could not be achieved. For example, in 2015 Cigna performed more than 115,000 360 Assessments. This volume was so great that the fax machines could not process the entire volume in the 2015 calendar year, even with assistance from contractors such as THM. This resulted in a massive backlog of 360 Forms that carried over well into the 2016 service year. In an email dated March 3, 2016, Dr. Fessenden advised an employee that:

> We need to distribute the 360s back to the providers. CMS could always take the approach of requesting the PCP's chart and only allowing those documents to be used for risk adjustment determination. Also, not providing the document back to the PCP could allow someone (CMS, a PCP, a health plan employee) to accuse the health plan of using a vendor to up code inappropriately. The provider receiving the exam back is part of the "checks and balance" system.

61. In truth, few doctors who received these faxes ever reviewed the 360 Forms, and even if they did, Cigna never confirmed the accuracy the diagnoses with them. As noted above, most doctors did not even know that members who had a 360 performed were their patients. Consequently, when the 360 faxes came in, these doctors did not recognize the patients' names and typically the 360 Forms would be shredded and thrown into the trash.

B. Cigna-HealthSpring purposely targeted members to undergo 360 Assessments

62. For the 360 Program to achieve its goals, Cigna-HealthSpring had to ensure that its providers were visiting members who could yield significant returns. It therefore turned to Care Allies and Gulfquest, which were both Cigna-HealthSpring affiliates, to assist in these efforts, using data analytics software.

63. Analysts working within CareAllies and Gulf Quest, employed a data-mining tool

known as Predilytics to search plan members' medical histories to find the members who were most likely to have, or to be at the highest risk for contracting, certain high revenue diseases. It would then rank plan 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.

64. Cigna-HealthSpring would then list the names of these patients in order of priority on "target lists" which it distributed out to its contractors. Upon receiving these lists, the contractors would attempt to schedule a visit for the purpose of conducting a 360 Assessment. If a visit was scheduled, Cigna-HealthSpring would provide the contractor a document that it called the "health management report" (Historical HMR).

65. 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 reported to CMS by Cigna-HealthSpring in the prior year. Cigna-HealthSpring intended theses documents to serve as a "cheat-sheet" list of conditions and diagnoses it expected 360 contractors to re-capture during the in-home visit. The list of diagnoses did not indicate the date they were originally 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.

66. NPs and RNs were instructed to rely heavily on this cheat sheet especially if the member had been previously diagnosed with a disease which Cigna-HealthSpring considered "incurable." In one instance in 2016, an NP at THM was reprimanded for not re-diagnosing diabetes for several patients, even though the patients had conveyed the provider that their diabetic condition had been resolved. Ms. Sheri Allred, the head Coder at THM, 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.

67. The 360 Assessment itself was an evaluation that consisted of 2 parts: a patient interview to conduct the self-assessment and basic health screening. The entire evaluation would be completed in 30-45 minutes.

68. During the visit, NPs and RNs completed a check-the-box 360 Form, which was based on a template the Cigna-HealthSpring provided. The form listed various body systems and disease states. Cigna-HealthSpring instructed NPs to document any diagnoses on the 360 Form by checking boxes or recording additional notes.

69. All of the disease and conditions which were diagnosed during a 360 Assessment were based either (1) the Historical HMR, (2) the patient's self-assessment (i.e., subjectively reported information), (3) basic observable signs and symptoms and/or (4) current medications to the extent found within the home. It is on the basis of this information alone that NPs and RNs managed to diagnose all of the serious chronic diseases which Cigna-HealthSpring reported to CMS, including a wide range of psychiatric, neurological disorders and behavioral disorders.

70. Some diseases were even diagnosed on medication in the plan members' medicine cabinets alone or on 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.

C. Cigna-HealthSpring trained contractors to find and diagnose serious health conditions.

71. Cigna-HealthSpring also imposed training requirements to ensure that high revenue conditions were being identified and diagnosed during the 360 Assessments.

72. Dr. Fessenden and a nurse practitioner trainer named Jason Jean were tasked with leading seminars and distributing training materials that would condition nurse practitioner to look for specific diseases. Shelly Stevens, a nurse practitioner who was in charge of operations within the 360 Program, also provided input on training in consultation with CareAllies and Gulfquest employees, including Whitney Horak and Peter Gardner, who tracked the prevalence of various diseases in specific markets.

73. Cigna-HealthSpring highlighted for providers 12 classes of "often underdiagnosed" diseases that it believed the providers should be able to find. During these sessions (which were typically by webinar), attendees were taught to "paint a picture" of a 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.

74. Cigna-Health Spring also encouraged NPs and RNs to diagnose additional mental disorders that overlapped with each other. CCQI regularly distributed newsletters to in-home 360 contractors which contained detailed "clinical focus" sections on groups of clinically related diagnoses that can be diagnosed together. Of particular interest were the mental disorders.

75. Any 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.

D. Cigna-HealthSpring engaged in significant efforts re-train providers who failed to satisfactorily find diagnoses.

76. Cigna-HealthSpring assessed the performance of its Contractors on a weekly basis and implemented disease-specific trainings that were targeted to address contractors who were failing to meet performance expectations. To identify contractors in need of individualized training, Cigna-HealthSpring analyzed each contractor's performance in capturing various high revenue HCCs, then produced various reports to the contractors setting forth their performance across several metrics and comparing its contractors to one another, to competitors and to Cigna-Health's "gold standard."

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.

78. Cigna-HealthSpring rewarded contractors with the highest retention rates and risk score increases with additional compensation. Some contractors such as BDPM (formerly Best Practice Disease Management, Inc.) were paid substantial bonuses for achieving its retention rate goal, which included incentive compensation in the form of a profit share of the monies Cigna-HealthSpring received from CMS. Cigna-HealthSpring would also reward contractors by giving them additional business by allowing them to perform 360 Assessments in new territories.

79. 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, CCQI manager 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."

80. Cigna-HealthSpring kept senior executives informed of its contractors' progress. Numerous reports were distributed by Dr. Fessenden, Dr. Wales and Casey McKeon to senior Cigna-HealthSpring executives, including reports that tracked and evaluated contractors' performance in capturing "often underdiagnosed" generic diagnoses. 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.

81. As part of the contractor evaluations, Cigna-HealthSpring 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. As part of its qualitative evaluation of NPs and RNs, Cigna-HealthSpring 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 other neurological, behavior and psychiatric conditions, during in-home 360 visits .

VI. THE DISCOVERY OF CIGNA-HEALTHSPRING'S FRAUD AND FALSE CODE SUBMISSIONS.

85. Cigna's fraudulent activities went undetected for more than 5 years. In 2017, however, events unfolded that would bring the fraud to the attention of Relator and THM.

86. In December 2016 a major contract dispute had developed in which Cigna-HealthSpring attempted to renegotiate the terms of its existing contract with THM, including the pricing for the services

that THM performed under the contract.

87. At that time, THM had prepared approximately 15,800 360 Forms for the 2016 service year (the 2016 Forms) which it was planning to submit to Cigna-HealthSpring, 10,153 360 Forms (the Correct Forms) of which Cigna-HealthSpring had been provided to Cigna-HealthSpring but required corrected electronic signatures.

88. To compel THM to accept the new contract terms, in January 2017 Cigna-HealthSpring ceased paying THM altogether under the existing contract, thereby forcing THM to either accept the deal or be driven out of business. THM refused to accept the deal and filed a demand for emergency arbitration. From the outset of the proceedings, the parties signed a protective protecting confidential documents exchanged between the parties during the proceedings.

89. With no income coming into the business, within weeks THM defaulted on its credit line. It demanded that Cigna immediately honor the terms of the contract, but Cigna refused. Unable to obtain a decision in the arbitration prior to expending all its remaining resources, in February 2017 THM therefore had no option but to lay off its entire workforce and its business folded. However, the owners and principals of the business continued to pursue the arbitration.

90. In the Arbitration, Cigna-HealthSpring submitted an Answer that demanded possession of the 2016 Forms. In the Answer and subsequent affidavits which were filed both in state and federal court in related proceedings, Cigna-HealthSpring consistently asserted that it intended to submit ICD codes to CMS for all of the diagnoses identified in the 2016 Forms.

91. During the discovery phase of the Arbitration that occurred between July and September 2017, HealthSpring disclosed tens of thousands of documents to Relator including records of code submissions to CMS, documents detailing risk score increases resulting from 360 Assessments that were performed and communications among employees of Cigna-HealthSpring boasting of financial returns to

Cigna-HealthSpring. It was at this time that Relator (and THM) first learned that the 360 Forms that THM had been providing since 2012 had been used by Cigna-HealthSpring to directly submit claims to CMS.

92. Relator relayed his concern to the Tribunal and also informed Cigna-HealthSpring counsel at the Arbitration that Cigna-HealthSpring had made false representations to CMS. Relator demanded that Cigna-HealthSpring cease using data from the 360 Forms for its submissions to CMS but Cigna-HealthSpring refused.

93. Relator also advised Cigna-HealthSpring that THM intended to notify the Office of Inspector General (OIG) of Cigna-HealthSpring's prior false submissions

94. In early December 2017, Cigna-HealthSpring made an application to the arbitration Tribunal for an order directing that THM turn over the 2016 Forms immediately. It advised the Tribunal that it stood to lose millions of dollars in profits because it would be unable to submit ICD codes using the 360 Forms to CMS by the end of the 2016 calendar year.

95. In a subsequent email exchanges among Cigna-HealthSpring's counsel, Mr. Jason Leckerman, Relator, and the Tribunal members, it came to light that Cigna-HealthSpring was not in danger of losing profits because it had already submitted to CMS ICD codes from the Corrected Forms between January and October 2016. A copy of this email is attached as **Exhibit A**. In the email, Cigna-HealthSpring's attorney, Mr. Jason Leckerman, states that:

> we want to be crystal clear: HealthSpring did submit information contained in the forms with signature concerns in 2016….To the extent that had not been clear to the Panel, we are making certain it is now. (Indeed, to be frank, I had not before focused on the precise issue of whether some information had already been submitted to CMS.)

96. Despite this admission, the Tribunal nevertheless ordered THM to turn over the 2016 Forms. THM refused to follow the Tribunal's order, as doing so would result in THM assisting Cigna-HealthSpring in the commission of a fraud on the Government. THM also had an obligation to its former NP employees to defend their credibility as health professionals.

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97. Undeterred, Cigna-HealthSpring sought to confirm the Arbitration award and applied for temporary restraining order in a Texas court to compel THM to turn over the forms. This order was subsequently granted.

98. Eventually THM turned over the forms and on or about May 4, 2018, Cigna proceeded to submit codes from the remaining 5,800 360 Forms for 2016 service year to CMS.

VII. THE FALSE CLAIMS

A. DIAGNOSES DOCUMENTED BY NPs DURING IN-HOME 360 ASSESSMENTS ARE INELIGIBLE FOR SUBMISSION TO CMS BECAUSE THEY WERE NECESSARILY UNCERTAIN OR MERELY PROBABLE.

99. Cigna-HealthSpring knowingly violated the False Claims Act by submitting hundreds of thousands of codes from 360 Forms between 2012 to 2017 which reflected unconfirmed health conditions which were not intended to be used for code submissions.

100. As indicated above, contractors were led to believe that they were performing non-clinical data gathering activities and providing the MA Plan with suspected or probable diagnoses that required confirmation form the members' PCPs. None of the PCPs actually confirmed any of the conditions.

101. The 360 Assessments were not intended to be medical exams nor were they conducted like medical exams. Contractors "diagnosed" without applying their skills, expertise or professional training. They were rendered based almost entirely on subjective, patient-reported information and represented only suspected or possible health conditions. Therefore, the diagnoses were invalid and unusable as risk adjustment data. Cigna-HealthSpring was fully aware that the diagnoses invalid but used them for risk adjustment purposes anyway.

102. Between 2012 and 2017 Cigna-HealthSpring submitted ICD codes using diagnosis obtained from nearly half a million 360 Forms which were prepared as a result of 360 Assessments conducted in the manner described in the preceding paragraph.

103. Moreover, the scope of the NPs' authority was also restricted under each of the collaboration agreements which the NPs entered into with their respective supervising physicians. These agreements did not empower the NPs to diagnose or treat any diseases. In the case of THM, each NP entered into a collaboration agreement with THM's supervising physician, Dr. Christopher Bloom, which limited the NP's scope of authority to performing "health risk assessments," which as noted above THM understood to mean preventative health consultations.

104. Representative examples of chronic diseases that were diagnosed or re-diagnosed either entirely based on subjective, patient-reported information, or based on some combination of patient-reported information, observations and/or medication found in the patient home, are included among the forms attached hereto as Exhibit B. As noted above, Cigna-HealthSpring's counsel admitted to Relator that codes from all of these Forms were submitted to CMS between January and October 2016.

VIII. MENTAL HEALTH CONDITIONS DOCUMENTED BY NPs DURING IN-HOME 360 ASSESSMENTS ARE INELIGIBLE FOR SUBMISSION TO CMS BECAUSE THE NPs LACK THE PROPER CERTIFICATION TO DIAGNOSE THESE CONDITIONS.

105. All states in which 360 Assessments were conducted require an NP to hold a psychiatric mental health certification ("PMH") in order to diagnose psychological disorders.

106. For example, PA Code 21.282a(b) provides that a nurse practitioner may only establish a medical diagnosis if acting within the scope of his or her specialty. Similar statutes exist in Tennessee, Georgia, South Carolina, Arizona, Oklahoma and other states where the 360 Assessments were performed.

107. In Texas, the Board of Nursing issued a position statement that explicitly states that mental health diagnoses can only be used by an NP in the role of a Clinical Nurse Specialist in Psychiatric/Mental Health Nursing or as a Psychiatric/Mental Health Nurse Practitioner. *See* TX BON Position Statement 15.12. The position statement further states that when a psychiatric patient conditions are identified that are outside the NP's scope of practice, the NP must provide a referral.

108. Between 2012 and 2017, Cigna-HealthSpring's contractors performed hundreds of thousands of 360 Assessments in which a NP lacking the psychiatric certification diagnosed at least one mental disorder, which included, schizophrenia, bipolar disorder, major depression, dementia, obsessive

compulsive disorder, autism, mental retardation, Alzheimer's Disease, Parkinson's Disease, borderline personality disorder and/or post-traumatic stress disorder.

109. Representative examples of these 360 Assessments are reflected in the forms attached to this Complaint as Exhibit B. These forms reveal the following:

i. On February 2, 2016, Brenda Holbert, a NP who lacked a PMH certification diagnosed a male patient in Texas with bipolar disorder (current episode mixed, moderate) and paranoid schizophrenia;

ii. On February 23, 2016, Brenda Holbert, a NP who lacked a PMH certification diagnosed a female patient in Texas with paranoid schizophrenia, major depressive disorder;

iii. On February 25, 2016, Brenda Holbert, NP who lacked a PMH certification diagnosed a female patient in Texas with paranoid schizophrenia, and major depressive disorder;

iv. On March 1, 2016, Angelina Silvas, a NP who lacked a PMH certification diagnosed a female patient in Texas with paranoid schizophrenia, major depressive disorder;

v. On July 13, 2016, Brenda Holbert, a NP who lacked a PMH certification diagnosed a male patient in Texas with bipolar disorder and major depressive disorder;

110. These Forms were among the group of 10,153 Corrected Forms which were delivered to Cigna-HealthSpring in 2016. As noted above, Cigna-HealthSpring's counsel admitted to Relator that codes from all of these Forms were submitted to CMS between January and October 2016.

111. Cigna was fully aware that these NPs lacked the requisite certifications because all of the certifications that the NPs held are listed on the 360 Form. Despite this knowledge, Cigna-HealthSpring submitted codes for these mental disorders to CMS, representing them as having been diagnosed by a qualified provider. But the providers were not qualified because they lacked the aforementioned certification.

112. Lack of certification aside, NPs did not possess the background necessary to diagnose these conditions. These diseases and health conditions are 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" <u>may</u> 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).

113. 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…)."

114. 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.

115. 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.

IX. CIGNA DERIVED SUBSTANTIAL FINANCIAL BENEFITS FROM ITS FRAUDULENT SUBMISSIONS.

116. Contractors were responsible for performing the 360 assessment, completing 360 forms for each member visited, and then submitting the forms to Cigna-HealthSpring. At that point, Cigna-HealthSpring used its own internal coders to review the NPs' descriptions in the completed 360 forms and generate ICD codes from those descriptions.

117. Cigna-HealthSpring then submitted risk-adjustment data, including diagnosis codes gathered during in-home 360 visits as reflected on the 360 Forms, 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. 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.

118. 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.

119. 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.

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

120. 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*.

121. 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."

122. 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 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.

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

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.

123. 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.

XII. ORIGINAL SOURCE

124. Relator is the "original source" of the information that forms the basis of this Complaint under 31 U.S.C. § 3730(e)(4).

125. 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 pursuant to a protective order which was signed during the course of the Arbitration. Until the Arbitration took place, neither Relator, nor any of the employees of THM, knew that Cigna-HealthSpring was submitting ICD Codes to CMS directly from the 360 Forms.

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)

126. Relator realleges and incorporates by reference the allegations made in Paragraphs 1 through 126 of this Complaint.

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

128. 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 (i) submitting diagnoses documented during in-home visits that were invalid for risk-adjustment reimbursement because they were necessarily uncertain or merely probably and (ii) submitting mental health diagnoses documented during in-home visits which the documenting health providers were unqualified to make under applicable state laws.

129. 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).

130. 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).

131. 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).

132. 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.

133. 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:

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

ii. 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;

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

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

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

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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 via email, U.S. Mail, or the Court's Electronic Filing System on:

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on this 28th day of July 2023 /s/ Tara L. Swafford
Tara L. Swafford

EXHIBIT A

Robert Cutler

From: Leckerman, Jason <LeckermanJ@ballardspahr.com>
Sent: Wednesday, January 3, 2018 6:56 PM
To: Appel, Al M. (aappel@stroock.com); 'Gerald Harris'; Andrew F. McBride, III
Cc: LisaRomeo@adr.org; Robert Cutler; Wilson, Brittany
Subject: Texas Health Management LLC V. HealthSpring Life & Health Insurance Company, Inc. - Case 01-17-0000-6403
Attachments: 12.29.17 Email.pdf

Dear Members of the Panel:

We do not feel it necessary to address each of Mr. Cutler's statements, which we have already addressed and refuted. We, however, feel compelled to note one point about the 5,800 forms that HealthSpring has not yet received (which are subject to the Panel's Order with which THM refuses to comply). That point is simple: HealthSpring cannot submit data from forms it has never received. To the extent that Mr. Cutler hypothesizes that HealthSpring somehow can submit data it has not received, he is again wrong.

In addition, we have attached Mr. Stroffolino's email to respond to Mr. Cutler's latest accusation of a misrepresentation.

Respectfully,

Jason A. Leckerman

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From: Robert Cutler [mailto:rcutler@hcsimplified.com]
Sent: Wednesday, January 03, 2018 3:45 PM
To: Leckerman, Jason (Phila); Appel, Al M. (aappel@stroock.com); 'Gerald Harris'; Andrew F. McBride, III
Cc: LisaRomeo@adr.org; Wilson, Brittany (Phila)
Subject: RE: Texas Health Management LLC V. HealthSpring Life & Health Insurance Company, Inc. - Case 01-17-0000-6403

Dear Panel Members,

Based on Mr. Leckerman's email below it is undisputed that Respondent has submitted codes to CMS for at least 10,135 forms and has been paid on these submissions. This undermines the very purpose of Order No. 6, which is to conserve the value of the forms. If Respondent has already been paid on the forms then there is no value to conserve by compelling THM to turn them over prior to a decision on the merits.

Mr. Leckerman's email fails to address two important questions: (1) how many forms have been used for code submissions and (2) how much has been paid to Respondent from these submissions. This information is needed to assess Respondent's potential damages and Respondent ought to provide it.

The email also fails to address the issue of whether codes were submitted for the 5,800/4,700 undelivered forms. As we indicated, even though Respondent has never seen these forms, it possesses the historical health data of the patients. If a patient was diagnosed in a prior year with a chronic disease that can be reported year after year, then Respondent could have submitted the codes under the assumption that these same conditions were re-diagnosed during the 360 exam in 2016. Respondent should identify to the Panel how many of these 5,800/4,700 undelivered forms have been used for code submissions and the amount of any reimbursements.

Finally, I would like to point out that Mr. Stroffolino did reach out to Mr. Wales and Mr. McKeon via email, but there is nothing improper about this communication. Mr. Stroffolino is allowed to have contact with the decision-makers at HealthSpring. Mr. Stroffolino was attempting to open a dialog with these executives to ensure that information was not being lost in transmission and to raise some business considerations which are implicated by the case. Mr. Stroffolino did not make any demands or threats of any kind. Mr. Leckerman is lifting language from the email out of context to misrepresent its contents.

Best Regards,

Robert Cutler

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Affiliated Companies:

From: Leckerman, Jason [mailto:LeckermanJ@ballardspahr.com]
Sent: Wednesday, January 03, 2018 12:05 PM
To: Appel, Al M. (aappel@stroock.com) <aappel@stroock.com>; 'Gerald Harris' <gharris317@hotmail.com>; Andrew F. McBride, III <amcbrideiii@mdmc-law.com>
Cc: LisaRomeo@adr.org; Robert Cutler <rcutler@hcsimplified.com>; Wilson, Brittany <WilsonBM@ballardspahr.com>
Subject: RE: Texas Health Management LLC V. HealthSpring Life & Health Insurance Company, Inc. - Case 01-17-0000-6403

Dear Members of the Panel:

Nothing THM has said raises any doubt about the propriety of the Panel's Order and in fact the email only serves to reinforce it. We have reviewed the testimony, which is consistent with the representations in our papers. Mr. Cutler is attempting to deflect from his refusal to comply with the Panel's Order. Moreover, his behavior shows that he can't credibly direct blame to his client for that refusal, as he did on the recent call with the Panel.

As an initial matter, the Panel should understand the background of this exchange. THM has written to the federal government, recklessly accusing HealthSpring of wrongdoing without basis. In fact, THM attempts to use its own failure to comply with the Panel's December 14 Order against HealthSpring as the basis for its accusations. THM is trying to leverage its refusal to turn over the forms as ordered to some yet unrevealed end. As you can see from Mr. Cutler's response to my initial email, he has no legal support for the claims in the letter. Our position on THM's letter is below and speaks for itself.

We also have learned that on December 29, 2017, Joe Stroffolino, no doubt in concert with Mr. Cutler, independently emailed Dr. Dirk Wales, the Chief Medical Officer of HealthSpring, copying Casey McKeon, to whom Dr. Fessenden reports, seeking to extract some unspecified payment from HealthSpring in exchange for the forms (notably, Mr. Cutler did not notify counsel for HealthSpring of this communication). According to Mr. Stroffolino's email to Dr. Wales, "THM is holding approximately 15,000 forms for 360 exams that were performed in 2016." Notably, THM seems to have abandoned any pretense of relying on the Contract for payment or allowing the Panel to decide these issues on the merits, resorting instead to demands of payment in exchange for no longer keeping HealthSpring's forms, and the personal health information of members contained in those forms, hostage.

Focusing on the forms that require signature correction, we want to be clear with the Panel, as Mr. Cutler has accused Dr. Fessenden of false testimony and that I, in turn, have "facilitated a misrepresentation." That accusation is wrong and not supported by Mr. Cutler's email. Again, we have reviewed the testimony cited by Mr. Cutler and also have looked at our papers, and there is nothing that requires correction. But we want to be crystal clear: HealthSpring did submit information contained in the forms with signature concerns in 2016, believing the data to be accurate and that supporting signatures would be quickly forthcoming from THM. To the extent that had not been clear to the Panel, we are making certain it is now. (Indeed, to be frank, I had not before focused on the precise issue of whether some information had already been submitted to CMS.) Whether some of the information has been submitted to CMS is not, however, the issue. The issue, as HealthSpring has explained, is that HealthSpring needs -- and is entitled to receive -- the corrected signatures. Indeed, Mr. Cutler contends in his letter to the federal government that any reliance on the uncorrected forms is unlawful. And it was established at the hearing that the forms with uncorrected signatures may not comply with CMS guidance and, therefore, could result in rejection of that information by CMS. Indeed, if CMS rejects the information associated with those forms in short order, as a result of THM's letter, and HealthSpring cannot resubmit all such information with corrected signatures by the January 31, 2018 deadline, then HealthSpring will likely have no further opportunity to resubmit the information. Also, as Mr. Cutler points out, it was explained by HealthSpring that the forms are necessary for auditing purposes.

There also remain thousands of forms that THM has in its possession that have not been turned over in any form to HealthSpring (that is, with or without signature concerns). As Mr. Stroffolino writes in his December 29 email to HealthSpring: "I also do not know if you have been made aware that approximately 5,800 forms we are holding have not been previously reviewed by HealthSpring's coders and the data has not been entered into OSCR. It will take time to complete this process, and only one month remains before the deadline. Again, I do not know how much revenue is involved, but I would estimate it would be in the $12 million range." HealthSpring cannot confirm Mr. Stroffolino's revenue estimate, which has no basis in fact. But Mr. Stroffolino's email recognizes, what Mr. Cutler refuses to recognize -- namely that HealthSpring does not have this information and that the value of the forms will evaporate in short order.

As we have stated, without getting those 5,800 forms, we do not know how many unique diagnoses they contain, and the value of those forms will disappear if the information is not extracted and provided to CMS by the January 31 deadline. If THM had complied with the Panel's December 14, 2017 Order, HealthSpring would have been able to extract information from the forms and submitted them by the deadline. Instead, the approximately $1.8 million that HealthSpring paid THM to perform this service-that is, to complete the nearly 5,800 exams-will yield no value whatsoever.

Should the Panel wish to address this issue further, we are available at the Panel's convenience.

Respectfully,

Jason A. Leckerman

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From: Robert Cutler [mailto:rcutler@hcsimplified.com]
Sent: Tuesday, January 02, 2018 4:55 PM
To: Appel, Al M. (aappel@stroock.com); 'Gerald Harris'; Andrew F. McBride, III
Cc: Leckerman, Jason (Phila); LisaRomeo@adr.org; Wilson, Brittany (Phila)
Subject: Texas Health Management LLC V. HealthSpring Life & Health Insurance Company, Inc. - Case 01-17-0000-6403

Dear Panel Members,

Respondent previously represented to the Panel that it urgently needs the forms so that it can submit the data in them to CMS by the 1/31/18 deadline and receive payment from CMS. It turns out that this false. THM has learned that Respondent has in fact already submitted codes to CMS for at least 10,153 forms and has been paid on these submissions.

Respondent admitted this when it became aware that THM was sending a letter to the Office of the Inspector General regarding payments for prior code submissions (see email chain below and attachment). In the letter THM advised OIG that Respondent should not have received any payment adjustments based on data submitted from the 10,153 forms that lacked electronic signatures. This should not be a controversial point since Respondent claimed that it had never submitted any codes for these forms. But Respondent objected to the letter, arguing that its prior submissions for the 10,153 forms were proper. In doing so Respondent conceded that it had indeed previously submitted codes for these forms to CMS.

THM also has indirect evidence that Respondent already submitted the codes, including, among other things, a comment from Respondent's in-house counsel during the hearing that the undelivered forms have value as backup for auditing purposes (Tr. 1768:1-7). Backup only matters if the codes in the forms have already been submitted to CMS.

We also suspect (but cannot say for sure) that the 1/31/18 deadline has limited relevance for the remaining 4,700 forms even though Respondent has never seen these forms. Respondent possesses the historical health records for these patients and, because they know that the forms had been completed and know the dates of service from the invoices, could have submitted codes for the diagnoses which re-occur year after year. This is a point that was alluded to during Dr. Fessenden's testimony (Tr. 1765:2-7) It is also supported by the fact that Respondent refused to state in the proposed bond that the forms "could have substantial monetary value."