UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

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

DEFENDANTS' MOTION TO DISMISS
RELATOR'S THIRD AMENDED COMPLAINT

Pursuant to Rules 9(b) and 12(b)(6) of the Federal Rules of Civil Procedure, Defendants (collectively, "Cigna") move to dismiss with prejudice Robert Cutler's third amended complaint (Doc. No. 264). As explained more fully in the accompanying memorandum of law, Cutler's allegations (1) are foreclosed by the False Claims Act's public disclosure bar, (2) are intertwined with and superseded by the Government's complaint-in-intervention, and (3) do not plausibly allege a False Claims Act violation. His third amended complaint should be dismissed in full on each of those independent grounds.

At a minimum, defendants Alegis Care, Home Physicians Management, and Gulf Quest should be dismissed from the case. Cutler does not allege that these defendants were involved in designing the in-home exam program by Cigna that he challenges or that they owned or operated any Medicare Advantage plan that submitted claims for payment to the Government. His allegations as to these defendants therefore do not satisfy Rule 9(b)'s requirements.

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

Date: September 11, 2023

Respectfully submitted,

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I hereby certify that on September 11, 2023, I electronically filed the foregoing document with the Clerk of Court using this Court's CM/ECF system, which will send a Notice of Electronic Filing to the following:

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MEMORANDUM OF LAW IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS RELATOR'S THIRD AMENDED COMPLAINT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes, Rules, and Regulations

Other Authorities

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Paxil® Prescribing Information, NDA 020031/S-071 (July 18, 2014), https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/020031s071,020710s035lbl.pdf 19

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Xanax® Prescribing Information, NDA 018276/S-052 (Dec. 16, 2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/018276s052lbl.pdf 19

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INTRODUCTION

Relator Robert Cutler filed this *qui tam* action during a contractual dispute with Cigna over payment terms for in-home exams that his former company conducted for Cigna's Medicare Advantage ("MA") plan members. From the start, his allegations have parroted others' earlier public allegations about MA plans like Cigna submitting diagnosis codes from in-home exams to the Centers for Medicare & Medicaid Services ("CMS"). Despite successive amendments since Cigna previously moved to dismiss his complaint, Cutler cannot avoid three independent grounds for dismissal: His allegations (1) are impermissibly derivative of public disclosures; (2) are entirely subsumed by and thus do not survive the Government's complaint-in-intervention; and (3) do not state a plausible violation of the False Claims Act ("FCA"). His Third Amended Complaint ("TAC") asserts two theories—that (1) all diagnoses Cigna reported for its members from in-home exams were supposedly "invalid" because they "represented only suspected or possible health conditions," Doc. No. 264 ¶ 101, and (2) all mental health diagnoses were supposedly invalid because the nurse practitioners employed by his company and other vendors to perform the in-home exams lacked state-law authority to make such diagnoses, *id.* ¶¶ 111-112. Both theories fail for all three reasons.

First, Cutler's theories rest on allegations already in the public domain when he filed suit in 2017 and thus are foreclosed by the FCA's public disclosure bar. Before 2017, government reports, CMS guidance, and news articles all alleged that in-home exams are designed to collect diagnoses that trigger higher payments to MA plans, and that they are performed by nurse practitioners who are not equipped to diagnose the serious medical conditions they identify and who do so primarily based on patient self-reporting and medical history, without providing treatment. Nothing Cutler alleges is materially new. The very purpose of the public disclosure bar is to prevent opportunistic lawsuits like this that merely exploit public information.

Second, Cutler abandons the only claim on which the Government declined to intervene, and his remaining claims are superseded by the Government's complaint-in-intervention.

Third, neither of Cutler's theories plausibly alleges any FCA violation. His first theory—that diagnoses from in-home exams reflected "uncertain" or "merely probable" conditions—is contradicted by Cigna's contracts with his former company and other vendors, as well as his own patient examples. Under the contracts Cutler incorporates by reference, the clinicians conducting in-home exams were required to *diagnose* conditions, not merely identify possible diagnoses, and none of his patient examples indicates that any condition was "uncertain," "suspected," or merely "probable." Meanwhile, his second theory—that mental health diagnoses from nurse practitioners were categorically invalid for payment—is refuted by judicially noticeable CMS guidance designating nurse practitioners as an acceptable provider type without limitation. Cutler has not plausibly alleged falsity, scienter, or materiality as to either theory.

At a minimum, defendants Alegis Care ("Alegis"), Home Physicians Management, and Gulf Quest should be dismissed from the case. Cutler does not allege that any of those entities held contracts with CMS to operate Cigna's MA plans or was even involved in designing Cigna's program for in-home exams.

BACKGROUND

Cigna incorporates by reference the detailed background set forth in its memorandum in support of its pending motion to dismiss the Government's complaint-in-intervention. *See* Doc. No. 196 at 13-20. As relevant here, Medicare Advantage organizations ("MAOs") like Cigna manage the care and bear the financial risk for Medicare beneficiaries enrolled in their plans in exchange for a fixed monthly amount per member. *Id.* at 13-14. CMS adjusts plans' payment based on their members' health status using International Classification of Diseases ("ICD") diagnosis codes that MAOs report to CMS for members' health conditions from all covered

medical encounters with providers—a process known as "risk adjustment." *Id.* at 14-15.

This case concerns diagnosis codes submitted from in-home exams conducted as part of Cigna's 360 Program. Between 2013 and 2015, CMS studied diagnosis codes reported by MAOs from in-home exams like Cigna's. *Id.* at 16-17. For years, critics have publicly raised concerns, like those asserted by Cutler and the Government here, that in-home assessments are performed by third-party-employed nurse practitioners who collect diagnostic information based on patient self-reporting and a review of medications, with no treatment and limited diagnostic testing. *Id.* at 17-18. Nevertheless, CMS chose to allow diagnoses from in-home assessments to be submitted for risk adjustment, and maintained that permission in the face of the public criticism, because such assessments "can have significant value as care planning and care coordination tools," and provide access to information that is not otherwise available in a clinical setting. *Id.* (quoting *Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter* ("*Announcement CY 2016*") 145 (Apr. 6, 2015)).[1]

Consistent with CMS's permission, through its 360 Program, Cigna tries to ensure that its members each year receive a comprehensive "360 exam," including a health risk assessment ("HRA"), by the member's primary care provider ("PCP") in the office or, when that is not possible, by another clinician who conducts the exam in the member's home through one of Cigna's vendors. Doc. No. 196 at 18. Under Cigna's contracts with its 360 Program vendors, the

[1] Even on a motion to dismiss, "courts routinely take judicial notice of [agency] guidance documents and documents which are publicly available on the [agency's] website." *Gordon v. Target Corp.*, 2022 WL 836773, at *2 (S.D.N.Y. Mar. 18, 2022). All agency documents cited here are publicly available on the website of the respective agency, as reflected by the URL addresses included in the table of authorities. *Supra* pp. iv-vi. Cigna accordingly requests that the Court take judicial notice of these documents for any proper purpose in deciding its motion to dismiss. Because Cutler's TAC relies on many of the same documents, *e.g.*, Doc. No. 264 ¶¶ 33, 36, those documents may also be considered "part of the pleadings." *Lewis Lumber & Milling, Inc. v. Mereen-Johnson, LLC*, 2018 WL 6181356, at *2 (M.D. Tenn. Nov. 27, 2018).

clinicians must be of a provider type CMS accepts for risk adjustment and must review the member's medical history, complete a physical exam, and document any conditions the member has on a standard 360 form that includes the clinician's signature and credentials. *Id.* at 19.

Cutler filed this *qui tam* action in 2017, during a contentious arbitration between Cigna and Texas Health Management ("THM"), a 360 vendor of which he was general counsel and part owner. *Id.* at 20. Repackaging criticisms of in-home exams leveled against the entire MA industry, his amended complaint alleged (1) that all diagnosis codes from in-home 360 exams were invalid because the exams were a mere "data-gathering exercise," (2) that Cigna pressured clinicians to diagnose conditions they were not equipped to diagnose, and (3) that the codes otherwise lacked support or violated CMS coding rules. *Id.* at 20 (quoting Doc. No. 12 ¶ 56). The Government expressly declined to intervene with respect to Cutler's first theory in 2020, but in 2022 intervened as to his remaining allegations. Doc. Nos. 13, 157, 178. In response to Cigna's motion to dismiss his amended complaint, Cutler sought and was granted leave to file a second and now third amended complaint. Doc. Nos. 236, 255, 260, 263.

Cutler's TAC alleges two FCA theories. First, he alleges that "diagnoses documented during in-home visits … were invalid for risk-adjustment reimbursement because they were necessarily uncertain or merely probabl[e]." Doc. No. 264 ¶ 128; *see id.* ¶¶ 99-104. Second, he alleges that "mental health diagnoses documented during in-home visits" were invalid for risk adjustment because the nurse practitioners who performed the exams "were unqualified" to make such diagnoses "under applicable state laws." *Id.* ¶ 128; *see id.* ¶¶ 105-115.

LEGAL STANDARD

"To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quotation marks omitted). "Moreover, factual allegations that are merely

consistent with the defendant's liability do not satisfy the [plaintiff's] burden, as mere consistency does not establish *plausibility* of entitlement to relief, even if it supports the *possibility* of relief." *AJRN #3 v. Cooper*, 517 F. Supp. 3d 732, 740 (M.D. Tenn. 2021).

ARGUMENT

I. CUTLER'S THIRD AMENDED COMPLAINT SHOULD BE DISMISSED IN FULL

A. Public Disclosures Bar Cutler's Claims

Both of Cutler's theories are foreclosed at the outset by the FCA's public disclosure bar, which requires dismissal when: (1) "before the filing of the *qui tam* complaint, there had been any public disclosures from which fraud might be inferred"; (2) "the allegations in the complaint are 'substantially the same' as those contained in the public disclosures"; and (3) the relator is not an original source of the information. *U.S. ex rel. Rahimi v. Rite Aid Corp.*, 3 F.4th 813, 823, 826 (6th Cir. 2021); 31 U.S.C. § 3730(e)(4)(A). Cutler's two theories rehash publicly disclosed allegations, and thus his is the type of "parasitic lawsuit" that "merely feed[s] off" public disclosures. *U.S. ex rel. Bryant v. Cmty. Health Sys., Inc.*, 24 F.4th 1024, 1030 (6th Cir. 2022). In such circumstances, the public disclosure bar requires dismissal "unless opposed by the Government," 31 U.S.C. § 3730(e)(4)(A), and the Government has indicated that it does not oppose dismissal of Cutler's TAC on this ground.

Cutler's core theory is that the diagnoses generated from Cigna's in-home exams were invalid for risk adjustment purposes because the exams were "non-clinical 'data-gathering' exercise[s]" rather than true "medical exams." Doc. No. 264 ¶¶ 4, 53, 100. Cutler purports to buttress this core theory with allegations that the clinicians conducting the exams were barred from providing medical treatment, *see id.* ¶ 103, and based their diagnoses on "patient-reported information" and "patient self-assessments," *see id.* ¶¶ 5, 54-55, 67, 69, 101, 104. Substantially the same allegations were made in public disclosures long before Cutler filed suit. In 2014, for

example, CMS publicly disclosed its concern that "[i]n general, treatment [was] not a component of [in-home] risk assessments," and that "many home visits are being used primarily for the gathering of diagnoses for payment rather than to provide treatment." *Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter* ("*Advance Notice CY 2015*") 20 (Feb. 21, 2014). In a report to Congress in 2016, the Medicare Payment Advisory Commission ("MedPAC") likewise raised concerns that in-home HRAs are "used solely as a diagnosis-collection vehicle," and that the diagnoses collected during the visits are problematic because they are "based on enrollee self-reporting or cannot be accurately identified with equipment brought into an enrollee's home." MedPAC, *Report to the Congress: Medicare Payment Policy* ("*Report to Congress*") 350 (2016).

Cutler's allegations that Cigna's in-home 360 exams generated "uncertain or merely probable" diagnoses "that required confirmation from the members' PCPs," Doc. No. 264 ¶ 100, similarly parrot media reports from 2014 raising concerns that MA plans were "collect[ing] billions of dollars from *controversial* 'house calls'" during which "doctors and nurses don't offer any treatment" but instead "report their exam findings to the patient's primary care physician." Schulte, Ctr. For Pub. Integrity, *Home Is Where the Money Is for Medicare Advantage Plans* (June 10, 2014) (emphasis added). Indeed, in 2016, MedPAC likewise pointed to "questions" raised by already-filed lawsuits "about the accuracy of diagnoses … collected during in-home HRA visits conducted by independent home visit vendors." *Report to Congress* at 350.

These public disclosures are substantially the same as allegations in the TAC and clearly permit the inference that Cigna relied on in-home vendors to record unsupported diagnoses based on patient self-reporting rather than medical treatment and submitted those diagnoses to CMS for risk-adjustment purposes—i.e., Cutler's theory. "All that is required is that public disclosures put

the government on notice to the possibility of fraud." *Dingle v. Bioport Corp*., 388 F.3d 209, 214 (6th Cir. 2004). At most, Cutler's allegations add "new details to describe essentially the same scheme," which is "not enough to survive the public disclosure bar." *U.S. v. Allstate Ins. Co.*, 620 F. Supp. 3d 674, 688 (E.D. Mich. 2022) (quotation marks omitted).

Cutler's related theory that Cigna "submitted codes for … mental disorders to CMS representing them as having been diagnosed by a qualified provider" even though the providers "lacked the requisite certification," Doc. No. 264 ¶ 111, is likewise foreclosed by the public disclosure bar. The same public sources questioning MAOs' reporting of risk-adjusting diagnoses from in-home exams made clear that the conditions at issue included mental health conditions—including depressive, bipolar, and paranoia disorders. For instance, media reports in 2014 publicly disclosed that major depressive disorder was being diagnosed through in-home assessments, *see* Schulte, *supra*, and MedPAC's report to Congress in 2016 discussed mental health conditions—such as "[m]ajor depressive, bipolar, and paranoid disorders"—being diagnosed during in-home HRAs "often conducted by a nurse practitioner," and reported for risk-adjustment purposes. *Report to Congress* at 347-48.

Nor is Cutler an "original source" under the FCA. Cutler did not supply the Government with information that was "independent of" and "materially add[ed] to the publicly disclosed allegations." 31 U.S.C. § 3730(e)(4)(B). Cutler alleges that the purportedly non-public information that qualifies him as an original source was that Cigna was submitting diagnoses to CMS from in-home exams, and he says this information was disclosed to him during the course of an arbitration with Cigna. Doc. No. 264 ¶¶ 85-95, 124-25. But Cigna's use of in-home exams was readily ascertainable from available public disclosures before then. In 2014, for example, CMS noted that it had "met with vendors and MA organizations" and described what it viewed as standard "industry practices." *Advance Notice CY 2015* at 20. Cigna was easily identifiable from

these disclosures as a significant participant in the MA program. MedPAC's report to Congress in 2016, in fact, named Cigna as one of the ten largest MAOs by enrollment, in the context of a broader discussion of the MA program and industry-wide use of in-home health assessments. *See Report to Congress* at 336. Indeed, starting in 2014, CMS *required* MAOs to identify which diagnoses submitted for risk-adjustment purposes were derived from in-home visits, so that CMS could study the issue. *Announcement CY 2016* at 144. As the Sixth Circuit has recognized, "prior disclosures describ[ing] 'industry-wide abuses and investigations'" can trigger the public disclosure bar for a particular company. *U.S. ex rel. Holloway v. Heartland Hospice, Inc.*, 960 F.3d 836, 844 (6th Cir. 2020) (citations omitted). CMS's study and description of industry-wide practice and MedPAC's explicit identification of Cigna as one of the largest MAOs in this context foreclose any suggestion that Cutler was an original source.

B. Cutler's Theories Are Superseded By The Government's Complaint

Cutler's claims should separately be dismissed because they are superseded by the Government's complaint-in-intervention. "[W]hen the Government decides to intervene in a *qui tam* action, [its] claims become the operative claims insofar as they are duplicative of those of the relator," and the lack of any "material aspect" of Cutler's claims "not covered by" the Government's complaint is grounds for dismissing his claims. *U.S. ex rel. Feldman v. City of New York*, 808 F. Supp. 2d 641, 648-49 (S.D.N.Y. 2011); *see also, e.g.*, *U.S. ex rel. Becker v. Tools & Metals, Inc.*, 2009 WL 855651, at *6 (N.D. Tex. Mar. 31, 2009); *U.S. ex rel. Magee v. Lockheed Martin Corp.*, 2010 WL 972214, at *3 (S.D. Miss. Mar. 12, 2010).

Both of Cutler's theories in the TAC are now inextricably intertwined with and subsumed by the Government's complaint-in-intervention. Cutler's first theory alleges that because the 360 Program was designed as a "non-clinical data-gathering" exercise, the resulting diagnoses were "necessarily uncertain or merely probable," "were not in fact true medical diagnoses," and were

"invalid and unusable as risk adjustment data." Doc. No. 264 ¶¶ 53, 100-101, 128. These allegations are indistinguishable from the Government's allegations that Cigna's "primary purpose" was to "captur[e] … diagnosis codes," and that "[a]t best, the recorded diagnoses could be classified as uncertain, probable, or merely suspected, which rendered them invalid for diagnosis coding purposes under the ICD Guidelines and ineligible for risk adjustment." Doc. No. 178 ¶¶ 4, 13; *see also, e.g.*, *id.* ¶¶ 4-5, 102, 126, 132, 140, 156. Like Cutler, the Government asserts that 360 exams were brief visits intended only to gather suspected medical conditions, targeted high-value patients, involved a review of a patient's medical history and medications, did not rely on proper diagnostic testing, and did not include treatment. *Compare* Doc. No. 264 ¶¶ 50, 55, 63, 67, 69, 122 *with* Doc. No. 178 ¶¶ 5, 108-110, 114, 141.

Cutler's related theory—that nurse practitioners were unqualified to reliably make an "initial diagnosis" of "complex" mental health conditions through in-home exams, *see* Doc. No. 264 ¶¶ 6, 108, 111-112—is likewise subsumed by the Government's allegations that "complex conditions" could not be reliably diagnosed for the first time by nurse practitioners during in-home exams. *See, e.g.*, Doc. No. 178 ¶¶ 132, 140, 151, 169. In addition to the allegations already discussed, the Government's complaint alleges that Cigna trained vendors to diagnose certain "valuable" conditions like "major depression" to maximize risk adjustment scores, *id.* ¶ 127, even though such "complex" conditions "cannot be diagnosed in the home setting without performing necessary testing, imaging, or other diagnostic steps," *id.* ¶ 160. These allegations subsume Cutler's theory that nurse practitioners lacked the qualifications and background "necessary to diagnose these conditions." Doc. No. 264 ¶¶ 112-114.

The TAC thus seeks to pursue only the claims on which the Government has already intervened. Prior to the intervention deadline, the Government expressly declined to intervene in Cutler's earlier theory that Cigna "committed per se [FCA] violations" by submitting diagnoses

from in-home 360 exams that "did not involve the provision of medical treatment." Doc. No. 13 at 1-2. The Government subsequently sought to intervene "on claims … for which it previously made no intervention decision," Doc. No. 157 at 1, and this Court granted intervention on "all of Relator's claims as to which [the Government] did not expressly decline to intervene by the intervention deadline," Doc. No. 169 at 1. Cutler has disavowed any claim that "in-home visits are '*per se* invalid' for risk adjustment purposes unless they involve treatment." Doc. No. 214 at 5. Indeed, in the TAC, he now concedes that CMS has permitted in-home diagnoses for risk adjustment notwithstanding concerns about lack of treatment. Doc. No. 264 ¶ 36. He has thereby abandoned the only non-intervened claim in this case and seeks merely to pursue claims on which the Government intervened. As to those claims, the Government's complaint occupies the field, requiring dismissal of the TAC. *See Feldman*, 808 F. Supp. 2d at 649.

C. Cutler Has Not Adequately Pled A False Claims Act Violation

Even if Cutler's claims were not barred and superseded—which they are—he has not plausibly alleged a viable FCA claim. To proceed as a relator under the FCA, Cutler "must sufficiently allege that: (1) [Cigna] made a false statement … ; (2) with scienter; [and] (3) that was material to the Government's decision to make the payment sought." *U.S. ex rel. Prather v. Brookdale Senior Living Communities, Inc.*, 892 F.3d 822, 830 (6th Cir. 2018) (quotation marks omitted). Cutler fails to adequately plead any of these elements as to either of his FCA theories.

1. Cutler has not plausibly alleged that Cigna knowingly submitted uncertain or merely probable diagnoses

a) Falsity

Cutler's first theory—that Cigna submitted diagnoses that were "necessarily uncertain or merely probabl[e]," Doc. No. 264 ¶ 128—does not sufficiently allege the most basic requirement of an FCA claim: that any claim for payment was false. Under the FCA, a claim for payment may

be factually false if it "misrepresents the amount or quality of goods or services," or legally false if it misrepresents the defendant's "compliance with a statutory, regulatory, or contractual requirement." *U.S. v. SouthEast Eye Specialists, PLLC*, 570 F. Supp. 3d 561, 575 (M.D. Tenn. 2021) (quotation omitted). Cutler does not allege *factual* falsity—i.e., that members did not have the conditions clinicians documented on the 360 forms.[2] Rather, he alleges that even if they did have these conditions, the diagnoses did not comply with CMS requirements and thus were *legally* false. Specifically, he claims that Cigna "misled" vendors to believe that 360 exams were "a mere 'data-gathering' exercise," where clinicians "were not actually diagnosing any diseases," but rather documenting "suspected or probable conditions" as part of a "health risk assessment." Doc. No. 264 ¶¶ 53-55. The resulting diagnoses, he claims, were "invalid and unusable as risk adjustment data." *Id.* ¶ 101. None of the premises for that theory withstands scrutiny.

First, the contracts Cutler relies on squarely contradict his allegations that 360 exams did not involve diagnosing patient health conditions.[3] The contracts say the opposite: A 360 exam "is to review the Member's medical history, complete a physical examination, as well as ***diagnose*** and provide suggested care management." Ex. B at 1 (emphasis added); Ex. C ¶ A-1.1 (emphasis added). Moreover, the contracts required clinicians to document the exam results on a 360 form that contains sections for the clinician to identify "Current Conditions" the member has from lists of common conditions in the Medicare population. Ex. D at 3-7. Each section, in turn, has a box for "Other ***Diagnosis*** (specify)," *id.*, and there is a separate section at the end for the clinician to

[2] Indeed, in response to Cigna's prior motion to dismiss, Cutler stated that "[w]hether a member actually had the condition is beside[] the point" for his theory that diagnoses from in-home 360 exams were invalid for risk-adjustment purposes. Doc. No. 214 at 13 n.7.

[3] Attached as exhibits to this memorandum are Cigna's contracts with THM (Ex. A; Ex. B) and Alegis (Ex. C), the 360 Comprehensive Assessment Form 2016 (Ex. D), and cover pages for 360 forms from Cigna (Ex. E) and Alegis (Ex. F). Because Cutler's complaint refers to and centrally relies on the contracts, Doc. No. 264 ¶¶ 48, 50, 121; 360 form, *id.* ¶¶ 56-59, 68, 83, 117; and cover pages, *id.* ¶¶ 56-57, the Court may consider these exhibits "part of the pleadings … on a motion to dismiss," *Lewis Lumber*, 2018 WL 6181356, at *2.

"list any ***diagnoses***, not already noted under current conditions, which affect patient care, treatment or management," *id.* at 8 (emphases added). That should be the end of Cutler's first theory.

Cutler acknowledges that Cigna "was asking contractors to 'diagnose' diseases," but he alleges THM "was told that … these diagnoses were not in fact true medical diagnoses," and "would be documented for the PCP to consider." Doc. No. 264 ¶ 53. Sixth Circuit precedent is clear that "[w]hen a document contradicts allegations in the complaint, rendering them implausible, 'the exhibit trumps the allegations.'" *Nolan v. Detroit Edison Co.*, 991 F.3d 697, 707 (6th Cir. 2021) (quoting *Williams v. CitiMortgage, Inc.*, 498 F. App'x 532, 536 (6th Cir. 2012)); *see also Song v. Parker*, 2022 WL 509033, at *15 (M.D. Tenn. Feb. 18, 2022). The contracts here specified that diagnosing conditions was a required component of a 360 exam, Ex. B at 1; Ex. C ¶ A-1.1, and they prohibited revision except by "written amendment." Ex. A ¶ 9(h). All of that forecloses Cutler's contrary assertions about the nature of the 360 exams and his reliance on alleged oral representations by Cigna employees to override clear contractual terms.

The "disclaimers" Cutler relies on likewise refute his allegations. Doc. No. 264 ¶¶ 56-57. These statements from cover pages to PCPs for completed 360 forms nowhere suggest that clinicians documented "uncertain" or "merely probable" diagnoses. The Cigna cover page states that the 360 exam is "a comprehensive exam" conducted by trained nurse practitioners and "should be filed into the [patient's] medical record" after the PCP has reviewed it. Ex. E. The Alegis cover letter refers to "the purpose of updating [Cigna's] information regarding the patient and their condition," Ex. F—which, in the context of completed 360 forms, clearly encompasses updating Cigna on its member's diagnoses. Contrary to Cutler's assertion, neither cover page "contain[s] a disclaimer that the 360 Assessment was not a medical exam." Doc. No. 264 ¶ 56. And neither states that the conditions documented on the 360 forms "would not become … medical diagnoses unless and until they were confirmed by the PCP." *Id.* ¶ 55. The PCP is advised to follow up with

any testing or treatment, but none of the notes to the PCP plausibly suggests that the diagnoses on 360 forms were contingent on the PCP's confirmation. *See* Ex. E; Ex. F. The only request to "confirm" anything was that the PCP should verify that they are "the correct PCP" and "the member has a follow-up appointment." Ex. E.

Cutler's own exhibits further contradict his assertion that the clinicians were not making medical diagnoses that would be usable for risk adjustment. The 360 forms attached as Exhibit B to the TAC show that in each case the clinician marked the member's "current conditions" and signed the 360 form with her medical credentials. *E.g.*, Doc. No. 262-1 at 5-10. For each patient, there is also a separate Health Management Report completed and signed by the clinician with ICD codes for the conditions identified during the visit, *e.g.*, *id.* at 12-15, as well as another list of ICD codes reviewed and signed by Sheri Allred, *e.g.*, *id.* at 16-18—THM' s "head coder," Doc. No. 264 ¶ 66. Cutler's allegations require the Court to conclude that all of these forms do not mean what they plainly say, but such "incoherent" allegations are properly rejected at the motion-to-dismiss stage. *Williams*, 498 F. App'x at 536 (quotation marks omitted); *see also Patel v. AR Grp. Tenn., LLC*, 2022 WL 2678733, at *7 (M.D. Tenn. July 11, 2022).[4]

[4] Nor does Exhibit A to the TAC lend support. That correspondence relates to THM's refusal to turn over certain 360 forms to Cigna. Cutler omits two documents from Exhibit A: (1) an email from THM's president, Joe Stroffolino (Ex. G), which was attached to the correspondence, and (2) a draft letter from Cutler (Ex. H) to the Office of the Inspector General of the Department of Health and Human Services ("OIG"), which was attached to Stroffolino's email. Because these are referenced in and integral to understanding Exhibit A, *see* Doc. No. 264-1 at 2, 5, the Court may consider them in fairness to provide "a complete picture in ruling on the current motion to dismiss," *Hartford Fire Ins. Co. v. Harborview Marina & Yacht Club Cmty. Ass'n*, 2016 WL 7178304, at *2 n.3 (D. Md. Dec. 9, 2016) (citing *Magellan Int'l Corp. v. Salzgitter Handel GmbH*, 76 F. Supp. 2d 919, 923 (N.D. Ill. 1999); Fed. R. Evid. 106). In all of these documents, the only issue THM raised with submitting diagnoses to CMS was that some forms were unsigned and THM did not authorize the use of data from the forms it had withheld. *See* 264-1 at 2-5; Ex. G; Ex. H. None of that suggests THM viewed the diagnoses as otherwise unusable for risk adjustment. To the contrary, Cutler's letter to OIG acknowledged that "[h]istorically" Cigna has reported the data to CMS for that purpose, Ex. H, and Stroffolino's email proposed handing over the 360 forms to Cigna in exchange for a settlement payment, precisely so that Cigna could meet "the deadline for submitting risk adjustment data" to CMS, Ex. G.

Nor do the facts Cutler alleges plausibly establish that Cigna violated any of the handful of cited CMS rules and guidance. He alleges, for example, that "in conversations" with THM, two Cigna employees referred to 360 exams as "health risk assessments" or "HRAs," which he asserts "did not involve the diagnosis of any diseases." Doc. No. 264 ¶ 54. But the regulation he cites for that proposition explains that HRAs are "an evaluation tool" that captures, "at a minimum," certain patient risk factors and may be "administered by a health professional" "prior to or as part of" annual wellness visits. 42 C.F.R. § 410.15(a). As the contracts and 360 forms make clear, 360 exams require diagnosis of current conditions—in addition to any standard HRA components. Ex. B at 1; Ex. C ¶ A-1.1; Ex. D at 3-7. CMS has long encouraged MAOs to conduct HRAs as a "best practice" for in-home exams, *Announcement CY 2016* at 146, acknowledging that "HRAs can be a tool for early identification of health risks to improve beneficiaries' health outcomes" and that "MAOs may submit diagnoses documented in HRAs for risk adjustment," Grimm, OIG, *Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns* 20, 38-39 (2020). That forecloses any suggestion that diagnoses from 360 exams were invalid for risk adjustment because they had elements in common with a standard HRA.

Like the Government, Cutler points to various "ICD standards" and CMS guidance. But the facts he alleges do not plausibly establish that Cigna violated those provisions. In particular, Cutler relies on guidance that "uncertain, probable, or suspected diagnoses may not form the basis of legitimate claims for risk-adjustment payments." Doc. No. 264 ¶ 33 (citing CMS, *2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide* ("*2008 Risk Adjustment Guide*") § 7.2.4; CMS, *Medicare Managed Care Manual* (2004)). The guidance at issue, however, directs coders not to code "diagnoses *documented* as 'probable,' 'suspected,' 'questionable,' 'rule out,' or 'working.'" *2008 Risk Adjustment Guide* § 6.4.2

(emphasis added); *accord* CMS, *ICD-10-CM Official Guidelines for Coding and Reporting* § IV.H (2022) ("ICD-10 Guidelines"); CMS, *ICD-9-CM Official Guidelines for Coding and Reporting* § IV.I (2011) ("ICD-9 Guidelines"). As his own patient examples show, none of the diagnoses on the 360 forms was *documented* as "suspected," "uncertain," or merely "probable." *See* Doc. No. 262-1. Nor does Cutler allege otherwise.[5]

b) Scienter

Even had Cutler plausibly alleged that Cigna submitted diagnosis codes for unconfirmed conditions—which he has not—his theory would still require dismissal for failure to satisfy the FCA's "rigorous" scienter requirement. *Universal Health Servs., Inc. v. U.S. ex rel. Escobar*, 579 U.S. 176, 192 (2016). The FCA requires that a defendant act "knowingly," which includes "actual knowledge of the [falsity of the] information," as well as "deliberate ignorance" of or "reckless disregard" for "the truth or falsity of the information." 31 U.S.C. § 3729(a)(1), (b)(1). Cutler must accordingly allege specific facts establishing that Cigna was at least "conscious of a substantial and unjustifiable risk" it was submitting invalid diagnoses. *U.S. ex rel. Schutte v. SuperValu Inc.*, 143 S. Ct. 1391, 1400-01 (2023). He fails to meet this high bar.

Cutler suggests that Cigna knowingly violated (1) guidance prohibiting coding uncertain

[5] Cutler does not address how the facts he alleges implicate any other ICD standard. Like the Government, he alleges that diagnoses "must be based on documented conditions that require or affect patient care, treatment, or management." Doc. No. 264 ¶ 33. His own patient examples, however, document a treatment plan ("Meds," "Monitor," "Diet," "Labs," or "Referral") for each diagnosis. Doc. No. 262-1. That is facially sufficient documentation that a condition affected patient care and was being treated or managed. Cutler argues Cigna was prohibited from reporting "diagnosis codes surmised from prescription medications, medical history, and diagnostic labs." Doc. No. 264 ¶ 33. But the guidance prohibits coding from "alternative data sources," "such as pharmacy records." *2008 Risk Adjustment Guide* § 3.2.4. It does not prohibit a clinician from relying on medications or medical history to establish that a patient has and is being treated for a previously diagnosed condition. Nor does Cutler allege that Cigna coded pharmacy records—he alleges it coded the 360 forms, Doc. No. 264 ¶¶ 55, 58—and under the ICD guidelines, the clinician's "statement that the patient has a particular condition is sufficient" to code and report that diagnosis to CMS regardless of the "clinical criteria used by the provider to establish the diagnosis." ICD-10 Guidelines § I.A.19.

or probable diagnoses; and (2) guidance supposedly prohibiting diagnoses "surmised from" non-exam criteria. Doc. No. 264 ¶ 33. As explained, Cutler has misinterpreted these guidelines. *See supra* pp. 14-15. But even giving credence to his legal interpretations, the contracts he himself relies on refute any allegation that Cigna was aware of the possibility of a false claim. The contracts required clinicians to "diagnose and provide suggested care management" based on "a comprehensive health exam," "clinical history including medications," and "past and current health status." Ex. B at 1; Ex. C ¶ A-1.1. The contracts also required clinicians to maintain all necessary state and federal licenses, to comply with all applicable laws, and to perform the exams "in accordance with good and customary industry practices." Ex. A ¶ 3(a)-(b); Ex. B at 2; Ex. C ¶ A-1.3. In short, the contracts demonstrate that both Cigna and its vendors understood that in-home exams were medical encounters in which medical professionals would diagnose a patient's current medical conditions through a comprehensive exam.

Cutler tries to suggest Cigna had improper motives by alleging that it trained 360 vendors to "diagnose serious health conditions," had a financial interest in reporting diagnoses, and used data analysis to identify at-risk members. Doc. No. 264 ¶¶ 62-84. None of those allegations plausibly establishes that Cigna was aware of a "substantial and unjustifiable risk" any diagnosis was false or invalid. *SuperValu*, 143 S. Ct. at 1400-01. Under the MA payment model, MAOs bear the financial risk for their members' care and are incentivized to ensure that conditions are identified early so that the conditions and costs associated with them can be appropriately managed. MAOs must document the health status of their members every year, or they will not be paid for it—even for chronic conditions reported in prior years. *See 2008 Risk Adjustment Guide* § 6.4.1. And the MA payment model encourages MAOs to identify and document higher-risk conditions so that these conditions can be managed. At most, then, Cutler's allegations show that Cigna had the same incentives every MAO has—incentives the Government created—to

document members' health status and be "paid appropriately" for expected costs. *Id.* § 3.5.1. No plausible inference of fraud can be drawn from those generalized allegations.

Further, even if Cutler's interpretations of the relevant legal requirements were correct, he has not alleged facts demonstrating that Cigna was aware of, and then disregarded, those interpretations. In *SuperValu*, the relators alleged that defendants subjectively "believed" their claims for payment were false, pointing to "notice[s]" the defendants received about the correct meaning of the guidelines and company executives' emails "rais[ing] concerns" about concealing information from regulators. 140 S. Ct. at 1398. In contrast, Cutler has not alleged that Cigna had notice—much less subjectively "believed"—that coding diagnoses from in-home exams was inconsistent with CMS regulations or guidance. To the contrary, CMS's approval of the practice advised Cigna that such risk adjustment data was acceptable. *See supra* p.3.

c) Materiality

Nor do Cutler's allegations satisfy *Escobar*'s "demanding" materiality standard. 579 U.S. at 194. Under *Escobar*, courts consider (1) whether "the Government designates compliance with a particular [legal] requirement as a condition of payment"; (2) whether it "consistently refuses to pay claims in the mine run of cases based on noncompliance" or, conversely, pays claims in full "despite actual knowledge that certain requirements were violated, and has signaled no change in position"; and (3) whether the "noncompliance is minor or insubstantial" or instead goes "to the very essence of the bargain." *Id.* at 193-95 & n.5.

On this issue, Cutler offers only the conclusory assertion that Cigna's "submission of invalid and unsupported ICD codes is material" to CMS's payment because "valid diagnosis codes are key to the integrity of the MA Plan," and "[v]arious contractual and regulatory materials"—specifically, the ICD Guidelines—"require MA[Os] to submit accurate diagnostic data." Doc. No. 264 at 29. This merely parrots the Government's materiality allegations. *See* Doc. No. 178 ¶¶ 91-

101. As Cigna has already explained, the Government has not plausibly alleged that any non-compliance with legal requirements was material to CMS's payment decisions. Doc. No. 196 at 43-47. Cutler himself does not allege that compliance with the guidelines he cites was designated as a condition of payment. And CMS's explicit study of diagnoses from in-home exams—as well as several public sources raising the same allegations he does here—leave no doubt that CMS has known for years that Cigna and other MAOs were reporting diagnoses from in-home exams that did not comply with Cutler's views of the relevant law. *Supra* pp. 3, 6-8. Yet Cutler nowhere alleges that CMS retreated from its longstanding acceptance of and payment for in-home diagnoses.

2. Cutler has not plausibly alleged that Cigna knowingly submitted invalid mental health diagnoses

a) Falsity

Cutler also fails to plausibly allege an FCA claim for his theory that Cigna knowingly submitted invalid mental health diagnoses made by unqualified providers. Again, Cutler does not allege that any mental health diagnoses made during 360 exams were factually false, i.e., that the patients did not in fact have the reported mental health conditions. And the completed 360 forms for his five patient examples show the opposite—that the patient was being treated for existing mental health conditions at the time of the in-home exam:[6]

- The patient examined on February 2, 2016, was diagnosed with paranoid schizophrenia and bipolar disorder, and was taking Risperidone, which treats schizophrenia and bipolar

[6] On a motion to dismiss, courts can take judicial notice of medication labels publicly available on the FDA website, because "the labels are documents not subject to reasonable dispute." *In re Epogen & Aranesp Off-Label Mktg. & Sales Pracs. Litig.*, 590 F. Supp. 2d 1282, 1286 (C.D. Cal. 2008); *see also Ebel v. Eli Lilly & Co.*, 536 F. Supp. 2d 767, 781 (S.D. Tex. 2008) (taking judicial notice that Paxil is a centrally acting drug through publicly available Prescribing Information on FDA website), *aff'd*, 321 F. App'x 350 (5th Cir. 2009).

disorder,[7] and Paxil, which treats major depressive disorder.[8] Doc. No. 262-1 at 20.

- The patient examined on February 23, 2016, was diagnosed with paranoid schizophrenia and major depressive disorder, and was taking Risperidone, which treats schizophrenia, as well as Sertraline (commonly known as Zoloft), which treats major depressive disorder.[9] Doc. No. 262-1 at 3. The clinician indicated that the major depressive disorder was in "partial remission" at the time of the exam. *Id.* at 9.
- The patient examined on February 25, 2016, was diagnosed with paranoid schizophrenia and major depressive disorder, and was taking Invega, which treats schizophrenia;[10] Lorazepam, which treats anxiety disorders;[11] Paxil, which treats major depressive disorder; and Risperidone, which treats schizophrenia. Doc. No. 262-1 at 64. The clinician indicated that the anxiety and depression were "controlled on med[ication]," and that the patient's depressive disorder was in "partial remission." *Id.* at 65, 70.
- The patient examined on March 1, 2016, was diagnosed with paranoid schizophrenia and major depressive disorder, and was taking Alprazolam, which treats anxiety and panic disorders;[12] Bupropion, which treats major depressive disorder;[13] Clozapine, which treats schizophrenia;[14] and Trazodone, which treats major depressive disorder.[15] Doc. No. 262-1 at 35. The patient's medical history also indicated a history of "suicidal ideation." *Id.*

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[7] Risperdal® (Risperidone) Prescribing Information, NDA 020272/S-077, at 1, 3 (Mar. 1, 2016).
[8] Paxil® Prescribing Information, NDA 020031/S-071, at 4-7 (July 18, 2014).
[9] Zoloft® (Sertraline) Prescribing Information, NDA 019839/S-084, at 5-10 (Sept. 12, 2014).
[10] Invega® Prescribing Information, NDA 021999/S-029, at 1, 3 (Apr. 29, 2014).
[11] Ativan® (Lorazepam), Prescribing Information, NDA 017794/S-044, at 2 (Dec. 16, 2016).
[12] Xanax® (Alprazolam), Prescribing Information, NDA 018276/S-052, at 3-5 (Dec. 16, 2016).
[13] Wellbutrin® (Bupropion) Prescribing Information, NDA 18644/S-048, at 1-2 (Dec. 16, 2014).
[14] Clozaril® (Clozapine), Prescribing Information, NDA 019758/S-074, at 1, 4 (Sept. 18, 2015).
[15] Trazodone® Prescribing Information, ANDA 071196/S-062, at 1 (June 2, 2015).

- The patient examined on July 13, 2016, was diagnosed with paranoid schizophrenia and major depressive disorder, and was taking Alprazolam, which treats anxiety and panic disorders, and Trazodone, which treats major depressive disorder. Doc. No. 262-1 at 49.

In short, *all* of Cutler's examples confirm that nurse practitioners were recording mental health conditions *only* where the medications documented on the face of the 360 form clearly support that the patient had already been diagnosed with and was being treated by a prescribing physician for the mental health conditions at issue at the time of the 360 exam. It is therefore unsurprising that Cutler makes no effort to allege that these members did not, in fact, have the conditions the nurse practitioners diagnosed. Thus, he has not alleged any factual falsity.

Instead, Cutler alleges the diagnoses were nevertheless "invalid," or legally false, because the nurse practitioners who conducted in-home exams were not qualified to "initially diagnose" "complex" mental health conditions like major depressive disorder, by "[t]horoughly ruling out other diagnoses." Doc. No. 264 ¶¶ 112-13. But *none* of his patient examples suggests that any new or unconfirmed mental health condition was reported from any in-home exam. The failure to offer a single example illustrating his theory is itself grounds for dismissal. *See U.S. ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 510 (6th Cir. 2007).

More fundamentally, Cutler's legal falsity theory fails because he does not plausibly allege that CMS requires providers to hold any special certifications to diagnose existing mental health conditions. *See* Doc. No. 264 ¶¶ 105-115. To the contrary, CMS has repeatedly acknowledged that nurse practitioners are an acceptable provider type for the purpose of submitting diagnoses for risk adjustment, *see, e.g.*, CMS, *Medical Managed Care Manual* ("*2014 MMCM*") (2014), at ch. 7 tbl.19 (listing nurse practitioners as a clinical specialist capable of diagnosing for risk adjustment), including in the context of in-home health assessments, *see Advance Notice of*

Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter ("*Advance Notice CY 2014*") 22 (Feb. 15, 2013) (noting that health risk assessments are appropriate when "conducted as a face-to-face encounter by a provider that is an acceptable risk adjustment provider type (e.g., a physician *or nurse practitioner*)" (emphasis added)), and CMS has not indicated any limitation on a nurse practitioner's competencies in this regard.[16] Cutler identifies no CMS regulation limiting MAOs' ability to submit a diagnosis from a risk-adjustment-eligible provider type, including a nurse practitioner, for any condition, including mental health conditions. That is fatal to his FCA claim. *See Chesbrough v. VPA, P.C.*, 655 F.3d 461, 468–69 (6th Cir. 2011) (explaining that relators' allegations were deficient where they failed to allege that state-level requirements were recognized in Medicare regulations or were a prerequisite to payment).

Cutler does allege that providers were required to have certain qualifications to diagnose mental health conditions as a matter of state medical practice. But he does not allege that any such state law requirements were incorporated into CMS's risk-adjustment requirements. *See id.*

In any event, none of the state laws Cutler identifies requires nurse practitioners to hold a specialty certification to diagnose mental health conditions, *see* Doc. No. 264 ¶ 105, let alone to do so in those instances where the patient is already receiving treatment for the condition. The only law Cutler does identify, 49 Pa. Code § 21.282a(b), does not prohibit nurse practitioners from

[16] Cutler's patient examples show that the nurse practitioners who conducted the 360 exams also screened patients for depression using the Patient Health Questionnaire ("PHQ")-9. *See* Doc. No. 262-1 at 11, 28, 43, 57, 72. Although Cutler characterizes this as a "basic questionnaire," Doc. No. 264 ¶ 115, CMS itself has described the PHQ-9 as a tool "to screen, diagnose, monitor, and measure the severity of depression." *See* CMS, *Summary of Representative Clinical Depression Screening Tools* 3 (Nov. 30, 2015). And it has determined that depression screening through the PHQ-9 and other tools is "reasonable and necessary for the prevention or early detection of illness or disability." CMS, *National Coverage Analysis (NCA) Decision Memo – Screening for Depression in Adults* (Oct. 14, 2021).

making mental health diagnoses without a certification, as Cutler suggests, but rather requires only that nurse practitioners act "in collaboration with a physician as set forth in a collaborative agreement and within the CRNP's specialty" when "establish[ing] medical diagnoses." 49 Pa. Code § 21.282a(b). That says nothing about mental health diagnoses, and Cutler acknowledges that the nurse practitioners at THM who performed the 360 exams had, in fact, "entered into a collaboration agreement with THM's supervising physician, Dr. Christopher Bloom." Doc. No. 264 ¶ 103.[17]

Cutler alleges that "[s]imilar statutes" in "other states" where 360 exams were performed require nurse practitioners to hold specialty psychiatric certifications, but he cites no other state law. *Id.* ¶¶ 105-106. Cutler has a duty to identify such laws, if any exist. At most, the states he names—Arizona, Georgia, Oklahoma, South Carolina, and Tennessee—mirror Pennsylvania by generally requiring nurse practitioners to practice within their area of specialty or that of their supervising physician. *See* Ariz. Rev. Stat. § 32-1601(23); Ga. Code Ann. § 43-24-25(c); Okla. Stat. tit. 59, § 567.3a; S.C. Code Ann. § 40-33-20(45); Tenn. Code Ann. § 63-7-123. No state law of which Cigna is aware requires a specialty certification for diagnosing existing mental health conditions when patients are already undergoing treatment. Accordingly, Cutler has not plausibly alleged that any state laws were violated here.

b) Scienter

Even if in-home providers had actually diagnosed certain mental conditions outside the scope of their state medical practice *and* those scope-of-practice limits were incorporated into CMS's payment requirements—neither of which Cutler has plausibly alleged—he fails to

[17] Nor does the Texas Board of Nursing position statement that Cutler identifies, Doc. No. 264 ¶ 107, mandate that nurse practitioners hold a particular certification to make mental health diagnoses. By its own terms, that statement "do[es] not have the force of law," but rather is "meant to provide guidance." Texas Board of Nursing, *Board Position Statements* 1 (2023).

adequately plead that Cigna knew any of that. To the contrary, the contracts between Cigna and its vendors obligated the vendors to ensure that all "assessing provider[s]" were appropriately "credentialed, licensed and qualified," to "maintain any and all licenses, permits and other approvals that are required for the performance of" the 360 exams, and to "comply with all applicable laws and regulations in the performance of" the exams. Ex. A ¶ 3(a); Ex. B at 2, 6. Cutler offers no allegations suggesting that Cigna should have questioned rather than relied on vendors' contractual commitments to comply with state licensing and medical practice requirements, or that Cigna was otherwise "conscious" of and disregarded a "substantial risk" that its risk-adjustment submissions may have therefore violated CMS requirements. *SuperValu*, 140 S. Ct. at 1400-02.

c) Materiality

Cutler also fails to establish materiality with respect to his second theory. Even if Cigna had submitted mental health diagnoses that it had reason to know were invalid due to providers' alleged non-compliance with state laws limiting the provider's scope of medical practice—and, again, Cutler has not plausibly alleged any of that—his theory still fails because he has not included any allegations suggesting that CMS would have denied payment for a diagnosis that a provider made in violation of such state laws. To the contrary, CMS has repeatedly reiterated that nurse practitioners are acceptable providers for the purpose of diagnosing conditions for risk adjustment without limitation. *See, e.g.*, *2014 MMCM* ch. 7 tbl.19; *Advance Notice CY 2014* at 22. And it has continuously made risk-adjustment payments to MAOs for mental health diagnoses made in home by nurse practitioners. *See supra* pp. 6-8. That is strong evidence of immateriality. *See Escobar*, 579 U.S. at 193-95 & n.5.

D. The FCA's *Qui Tam* Provisions Are Unconstitutional

Independently, the TAC should be dismissed because the *qui tam* provisions under which

Cutler seeks to litigate in the "name of the Government," 31 U.S.C. § 3730(b)(1), violate Article II of the Constitution by infringing on the Executive Branch's law enforcement authority. The Sixth Circuit has rejected this argument, *see U.S. ex rel. Taxpayers Against Fraud v. Gen. Elec. Co.*, 41 F.3d 1032, 1040-42 (6th Cir. 1994), so Cigna raises its challenge to the *qui tam* mechanism here simply to preserve these "substantial arguments" for further review, *U.S. ex rel. Polansky v. Exec. Health Res., Inc.*, 143 S. Ct. 1720, 1741 (2023) (Thomas, J. dissenting); *see also id.* at 1737 (Kavanaugh & Barrett, JJ., concurring); *Constitutionality of the Qui Tam Provisions of the False Claims Act*, 13 Op. O.L.C. 207, 221-24, 228-32 (1989).

II. AT A MINIMUM, THE NON-MAO DEFENDANTS SHOULD BE DISMISSED

Even if Cutler could otherwise continue his case—and he cannot for the reasons set forth in Part I—Alegis, Home Physicians Management, and Gulf Quest should be dismissed from the case because, by Cutler's own allegations, they are neither MAOs nor involved in the design of the 360 Program that he challenges. Rule 9(b) requires "specific allegations as to each defendant's alleged involvement." *N. Port Firefighters' Pension-Local Option Plan v. Fushi Copperweld, Inc.*, 929 F. Supp. 2d 740, 773 (M.D. Tenn. 2013). Cutler "may not rely upon blanket references to acts … by all of the defendants, for each … is entitled to be apprised of the circumstances surrounding the fraudulent conduct with which [it] individually stands charged." *U.S. ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 342 F.3d 634, 643 (6th Cir. 2003) (quotation marks and citation omitted); *see also D.E.& J Ltd. P'ship v. Conaway*, 284 F. Supp. 2d 719, 730 (E.D. Mich. 2003) (group pleading violates Rule 9(b)'s specificity requirement), *aff'd*, 133 F. App'x 994 (6th Cir. 2005). Cutler's claims as to the three non-MAO defendants do not meet those standards.

Specifically, Cutler alleges that Alegis and Home Physicians Management—which he refers to collectively as "Alegis"—provide home health services, including "the in-home assessments at issue." Doc. No. 264 ¶¶ 17-18. He makes no allegation that either entity is an

MAO or had any role in the design of Cigna's 360 Program. As to Alegis, he alleges only that it was a 360 vendor and used a "disclaimer" for 360 forms similar to other vendors'. *Id.* ¶¶ 48, 57. Far from implicating Alegis in the conduct of MAOs owned by Cigna, Cutler's allegations suggest the opposite—that Alegis was identically situated to other 360 vendors apart from being a Cigna subsidiary, and performed in-home exams at Cigna's direction, unaware of any allegedly invalid risk-adjustment submissions to CMS. *See, e.g.*, *id.* ¶¶ 40, 48-58.

Similarly, as to Gulf Quest, Cutler alleges that it provides management services to a Cigna entity that operates MA plans and that it provided a data-mining tool to rank plan members based on their likelihood to have, or be at highest risk for contracting, "certain high revenue diseases." *Id.* ¶ 63. Cutler fails to adequately plead that, in providing those services to MAOs, Gulf Quest knowingly submitted, or caused to be submitted, any false claim for payment to CMS. *United States ex rel. Hendrickson v. Bank of Am., N.A.*, 343 F. Supp. 3d 610, 635 (N.D. Tex. 2018) ("Relator's vague group pleading approach cripples his ability to establish scienter."), *aff'd*, 779 F. App'x 250 (5th Cir. 2019). Cutler's claims against the three non-MAO defendants—Alegis, Home Physicians Management, and Gulf Quest—should accordingly be dismissed with prejudice.

CONCLUSION

The Court should dismiss Cutler's third amended complaint with prejudice.

Date: September 11, 2023

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 11th day of September, 2023, a copy of the foregoing was filed electronically. Notice of this filing will be sent by operation of the Court's electronic filing system to:

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

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

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

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

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

2. Attached as **Exhibit A** is a true and correct copy of the "Business Services Agreement," entered into on May 2, 2013 between Texas Health Management, LLC, and The Cigna Group's subsidiary HealthSpring Life & Health Insurance Company, Inc. This document is referenced in Relator's third amended complaint. *See, e.g.*, Doc. No. 264 ¶¶ 47-50, 121.

3. Attached as **Exhibit B** is a true and correct copy of the "Amendment To Business Services Agreement By And Between HealthSpring And Texas Health Management," executed on January 26, 2016 between Texas Health Management, LLC, and The Cigna Group's subsidiary HealthSpring Life & Health Insurance Company, Inc. This document is referenced in Relator's third amended complaint. *See, e.g.*, Doc. No. 264 ¶¶ 47-50, 121.

4. Attached as **Exhibit C** is a true and correct copy of the "Amendment To Amended And Restated Clinical Services Agreement," entered into on July 1, 2015, between Alegis Care Services and The Cigna Group's subsidiary HealthSpring Inc. This document is referenced in Relator's third amended complaint. *See, e.g.*, Doc. No. 264 ¶¶ 47-50.

5. Attached as **Exhibit D** is a true and correct copy of the standard 360 Comprehensive Assessment Form 2016. This document is referenced in Relator's third amended complaint. *See, e.g.*, Doc. No. 264 ¶¶ 56-61, 68, 73, 81-83, 87, 90-92, 94-99, 102, 104, 109-111, 115-117, 125.

6. Attached as **Exhibit E** is a true and correct copy of the January 2014 Cigna HealthSpring 360 Comprehensive Physical Exam cover page. This document is referenced in Relator's third amended complaint. *See, e.g.*, Doc. No. 264 ¶¶ 56-58.

7. Attached as **Exhibit F** is a true and correct copy of the Alegis Care cover letter template for transmittal of 360 Forms. This document is referenced in Relator's third amended complaint. *See, e.g.*, Doc. No. 264 ¶¶ 56-58.

8. Attached as **Exhibit G** is a true and correct copy of a December 29, 2017 email from Joe Stroffolino to Dirk Wales and Casey McKeon. This document is referenced and was originally attached to another email included in Exhibit A to Relator's third amended complaint. *See* Doc. No. 264-1 at 2.

9. Attached as **Exhibit H** is a true and correct copy of a draft letter from Robert Cutler to the Office of the Inspector General of the Department of Health and Human Services. This document is referenced in Relator's third amended complaint, *see* Doc. No. 264 ¶ 93, as well as in Exhibit A to Relator's third amended complaint. *see* Doc. No. 264-1 at 5.

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

Date: September 11, 2023

s/ Charles C. Speth
Charles C. Speth

EXHIBIT A

BUSINESS SERVICES AGREEMENT

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

WITNESSETH

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

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

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

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

   (a) **Covered Services.** Shall mean those specifically outlined in Exhibit A.

   (b) **HEALTHSPRING.** Shall mean and include HEALTHSPRING, and all of its affiliated and related companies, individuals and other organizations.

   (c) **VENDOR.** Shall mean and include VENDOR, and all of its affiliated and related companies, individuals and other organizations.

2. **Term and Termination.**

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

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

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

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

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

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

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

(b) Compliance with Laws. VENDOR shall comply with all applicable laws and regulations in the performance of the Covered Services for HEALTHSPRING, including, but not limited to, the provisions of the Health Insurance Portability and Accountability Act of 1966 **("HIPAA")**, as outlined in the Business Associate Agreement executed between the parties.

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

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

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

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

(c) Regulatory. HEALTHSPRING shall be responsible for all insurance and other regulatory compliance in connection with the development and implementation of all approved projects. HEALTHSPR1NG hereby agrees that no products shall be marketed by HEALTHSPRING, without all of the required governmental and other approvals.

5. Fees and Expenses.

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

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

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

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

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

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

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

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

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

9. **Other Provisions.**

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

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

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

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

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

HEALTHSPRING:

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

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

THM:

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

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

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

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

Texas Health Management, LLC

By: _____

Name: MICHAEL E. WALTON

Title: CEO

Date: May 1, 2013

HealthSpring Life & Health Insurance Company, Inc.

By: _____

Name: Jay L. Hurt

Title: Divisional President

Date: May 1, 2013

EXHIBIT A

COVERED SERVICES

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

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

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

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

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

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

EXHIBIT B

FEE SCHEDULE

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

Service	Reimbursement per Member
360	$250
HMR	$50
Finger Stick or Blood Draw	$50

EXHIBIT B

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

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

RECITALS

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

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

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

AGREEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTN: Ryan Host

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

The following scenarios are provided for illustrative purposes only:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THM

Signature

Joe Straffalino

Print Name

Managing Director

Title

1-25-16

Date of Execution

CIGNA-HEALTHSPRING

Signature

Peter R. Gardner

Print Name

COO - Texas

Title

1/26/16

Date of Execution

April 1, 2015

Effective Date

EXHIBIT C

AMENDMENT TO
AMENDED AND RESTATED CLINICAL SERVICES AGREEMENT

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

RECITALS

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

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

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

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

1. Amendments to Agreement.

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

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

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

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

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

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

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

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

By: _____
Shawn Morris, Chief Operating Officer

COMPANIES:

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

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

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

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

EXHIBIT A

ALEGIS CARE SERVICES & COMPENSATION

Exhibit A-1
360 Assessments

Services

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

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

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

- Spirometry
- Glaucoma Testing
- Influenza Immunization
- Pneumonia Immunization

Compensation

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

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

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

Exhibit A-5
Chronic Care Program Services

Services

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

Compensation

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

Exhibit A-2
Chronic Care Management Services

Services

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

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

Compensation

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

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

EXHIBIT D

360 Comprehensive Assessment 2016

[PLACE BARCODE HERE]

Member First Name | **Last Name** | **Member ID** | **Rendering Provider** | **Member's PCP**

DOB (MM/DD/YYYY) | **DOS** (MM/DD/YYYY) | **NPI**

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

Reason for Exam: _____

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

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

☐ CVA with no residual effect

☐ History of Cancer (specify):

Surgical History: ☐ Reviewed and No Surgeries

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

☐ No Current Medications

☐ Medications Reviewed

Allergies: ☐ No known drug allergies

Family History: ☐ Reviewed and No Relevant History

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

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

Habits:

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

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

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

Social History:

Marital Status:
☐ Single ☐ Divorced
☐ Married ☐ Widowed

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

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

Social/Financial concerns:
☐ Yes
☐ No

Illicit Drug Use:
☐ Yes
☐ No

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

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

Difficulty with bathing or grooming?
☐ Yes
☐ No

Difficulty with eating or meal preparation?
☐ Yes
☐ No

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

Hearing:
☐ Normal
☐ Hearing issues / hearing aid

Speech:
☐ Normal
☐ Impaired

Member Name: DOB : / / DOS : / /

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

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

TOTAL number of boxes marked: _____

☐ Fall Risk (4 or more reported)

Depression Screening (18+ y/o)

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

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

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

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

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

☐ PHQ 9 form ☐ Standard Screening Tool ☐ Clinical Interview

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

Urinary Incontinence Screening

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

If Yes, please distribute education material

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

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

0 1 2 3 4 5 6 7 8 9 10

*Pain Screening ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

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

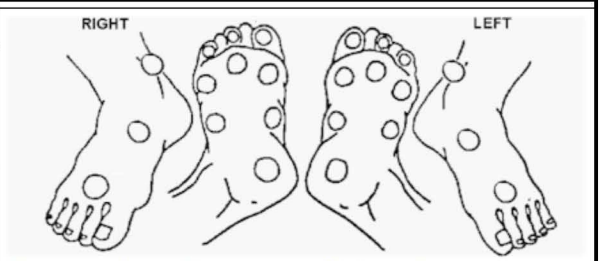
Foot Exam (Complete for diabetic patients)

1. Ask the patient:

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

2. Look at both feet:

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



Key: + = Sensation — = No Sensation

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

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

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

Member Name: DOB : / / DOS : / /

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

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

Current Conditions: **Treatment Plan:**

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

Member Name: DOB : / / DOS : / /

Diabetes Mellitus: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ DM: ☐ Type 1 ☐ Type 2 ☐ Insulin Dependent	☐	☐	☐	☐	☐
☐ DM w/ Secondary Kidney Complications: ☐ Chronic Kidney Disease ☐ Nephropathy	☐	☐	☐	☐	☐
☐ DM w/ Secondary Neurological Complications: ☐ Mononeuropathy ☐ Peripheral Neuropathy ☐ Gastroparesis ☐ Other:	☐	☐	☐	☐	☐
☐ DM w/ Secondary Ophthalmic Complications: ☐ Retinopathy: ☐ Proliferative ☐ Non-proliferative ☐ w/ Macular Edema ☐ Mild ☐ Moderate ☐ Severe ☐ Cataract ☐ Glaucoma	☐	☐	☐	☐	☐
☐ DM w/ Secondary Circulatory Complications: ☐ Peripheral Angiopathy/PVD ☐ w/ Gangrene ☐ w/o Gangrene	☐	☐	☐	☐	☐
☐ DM w/ Secondary Skin Complications: ☐ Non-Pressure Chronic Ulcer ☐ Location(specify):	☐	☐	☐	☐	☐
☐ DM w/ Other Secondary Complications: ☐ Hypoglycemia ☐ Hyperglycemia	☐	☐	☐	☐	☐
☐ Other Secondary Diagnosis (specify):	☐	☐	☐	☐	☐
Respiratory: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ Chronic Bronchitis: ☐ Obstructive ☐ Simple ☐ Mucopurulent ☐ Mixed	☐	☐	☐	☐	☐
☐ COPD: ☐ w/ Acute Lower Resp. Infection ☐ w/ Oxygen Dependence	☐	☐	☐	☐	☐
☐ Emphysema: ☐ Unilateral ☐ Panlobular ☐ Centrilobular ☐ Other:	☐	☐	☐	☐	☐
☐ Asthma: ☐ Chronic Obstructive ☐ Intermittent ☐ Persistent ☐ Mild ☐ Moderate ☐ Severe	☐	☐	☐	☐	☐
☐ Bronchiectasis: ☐ w/ Exacerbation ☐ w/ Acute Lower Respiratory Infection	☐	☐	☐	☐	☐
☐ Obstructive Sleep Apnea	☐	☐	☐	☐	☐
☐ Sarcoidosis ☐ Asbestosis	☐	☐	☐	☐	☐
☐ Pulmonary Fibrosis	☐	☐	☐	☐	☐
☐ Tracheostomy	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐
Musculoskeletal: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ *Rheumatoid Arthritis - DMARD Prescribed: ☐ Yes ☐ No	☐	☐	☐	☐	☐
☐ Lupus	☐	☐	☐	☐	☐
☐ Psoriatic Arthritis	☐	☐	☐	☐	☐
☐ Osteoarthritis Location(s): Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Osteopenia Location(s): Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Osteoporosis Location(s): Side: ☐ Right ☐ Left Kind: ☐ Senile ☐ Postmenopausal ☐ Unspecified Has the patient had a fracture in the past 12 months? ☐ Yes ☐ No If a fracture occured, where was it: ☐ Right ☐ Left Last Bone Density: * Biophosphonate Prescribed ☐ Yes ☐ No Start Date of Bisphosphonate:	☐	☐	☐	☐	☐
☐ S/P Amputation Location: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐
Skin/Subcutaneous: ☐ **Reviewed and No Active Disease**	Meds	Monitor	Diet	Labs	Referral
☐ Ulcer: ☐ Pressure ☐ Stg 1 ☐ Stg 2 ☐ Stg 3 ☐ Stg 4 ☐ Unstageable	☐	☐	☐	☐	☐
☐ Chronic ☐ Location (specify): ☐ Right ☐ Left ☐ Both	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify):	☐	☐	☐	☐	☐

Member Name: DOB : / / DOS : / /

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

→ → → → → Active Neoplasms/Blood Disorders continues on NEXT PAGE → → → → →

Member Name: DOB : / / DOS : / /

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

Member Name: DOB : / / DOS : / /

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

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

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

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

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

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

Long Term Medication Monitoring (Annual) ☐ Reviewed

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

Serum Drug Concentration Date: _____

Patients diagnosed with COPD:

Spirometry: Date: _____

Beta Agonist/AntiCholinergic Prescribed: ☐ Yes ☐ No

***Patients diagnosed with Diabetes:**

*HbA1C <9: Date: _____ Result: _____

*Microalbuminuria: Date: _____ Result: _____

* Retinal Eye Exam: Date: _____ Result: _____

* Name of Eye Care Provider: _____

Patients diagnosed with CAD:

Antiplatelet Therapy Prescribed: ☐ Yes ☐ No

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

Statin prescribed: ☐ Yes ☐ No

if No: specify: _____ ☐ Statin Intolerant

Patients diagnosed with CHF:

ACE or ARB Prescribed: ☐ Yes ☐ No

Beta Blocker Prescribed: ☐ Yes ☐ No

LVF Assessment: Date: _____ Result: _____

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

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

PLAN: _____

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

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

BEHAVIORAL HEALTH REFERRAL: ☐ Yes ☐ No Indication: _____

CASE MANAGEMENT REFERRAL: ☐ Yes ☐ No

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

If yes, please specify: _____

I discussed the following with my patient:

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

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

OTHER/COMMENTS: _____

Patient Email (OPTIONAL)

EXAMINER NAME: _____ EXAMINER SIGNATURE: _____

☐ MD ☐ DO ☐ NP ☐ PA DATE: _____

SUPERVISING PHYSICIAN NAME: _____ (if applicable)

☐ MD ☐ DO

SUPERVISING PHYSICIAN SIGNATURE : _____ (if applicable)

DATE: _____

EXHIBIT E

360 Comprehensive Physical Exam

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

The comprehensive exam includes:

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

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

** Upon Receipt **

(Office Staff)

Please confirm the following:

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

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

January 2014

EXHIBIT F

ALEGIS CARE | 1340 S. Damen Avenue, Suite 400, Chicago, IL 60608
Toll Free : (877)663-4333 Fax : (312)738-1609

DATE

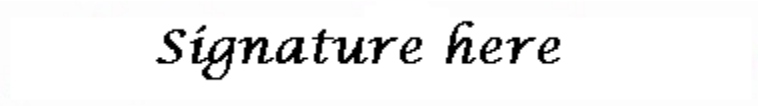
NAME
ADDRESS
CITY, STATE ZIP

Alegis Care recently visited a patient under your care at the request of the patient's insurance provider. This visit was solely for the purpose of updating the insurance provider's information regarding the patient and their condition. Attached are the visit notes from the Alegis Care provider.

Please note that there have been no tests ordered or performed on this patient. Any testing needed based on these notes is up to your discretion as the insurers Primary Care Provider.

Should you have any questions, please contact insurers or my offices at any time.

Best regards,



Dr. Example
Chief Medical Officer
Alegis Care

EXHIBIT G

Message

From: Joe Stroffolino [jstroffolino@hcsimplified.com]
Sent: 12/29/2017 4:39:57 PM
To: Wales, Dirk [/O=HEALTH NET MANAGEMENT, INC/OU=Houston/cn=Recipients/cn=DWales]; McKeon, Casey [/O=HEALTH NET MANAGEMENT, INC/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=Casey.mckeon]
Subject: Texas Health Management
Attachments: Letter to OIG re 2016 HRAs[1].pdf

Dr. Wales / Mr. McKeon,

As I am sure you are aware, the contract between Texas Health Management and HealthSpring ended in January 2017. HealthSpring was a valued business partner and it is unfortunate that the relationship ended on a sour note.

But I am writing now to appeal to your business senses in the hope of quickly and amicably resolving the arbitration and saving what I believe could amount to over $30 million in revenue for HealthSpring.

You probably know that the deadline for submitting risk adjustment data for the 2017 payment year ends on January 31, 2018. If the data is not submitted to CMS by this date then any risk adjustment to the capitated rate for the plan will be lost.

THM and HealthSpring are locked up in arbitration and have been for some time now. Currently, THM is holding approximately 15,000 forms for 360 exams that were performed in 2016. I do not know how much revenue can be obtained from these forms, but I would think that a 0.2 increase in the risk scores would result in a reimbursement in the $30 million range.

I believe (but cannot say for sure) that HealthSpring is resisting settlement because it has been reporting data to CMS from 10,153 forms which were submitted to HealthSpring prior to October 14, 2016. But the forms in HealthSpring's possession are incomplete because they lack electronic signatures and the credentials of the NPs, and THM never authorized the data to be used.

I do not know if Dr. Fessenden has made you aware of this situation, but it is important to understand that we cannot allow HealthSpring to profit improperly from THM's work product. As a result, we have prepared a letter to send to the Office of the Inspector General to inform them that the data from these forms is unusable for risk adjustment purposes. A copy of this letter is attached.

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.

Dr. Fessenden's group is aware of these issues yet to our knowledge he has not been responding to our request to discuss settlement through outside counsel. I want HealthSpring to obtain this revenue, but for reasons I cannot understand we are having problems settling this matter. We have already made 3 settlement offers, and all of them have been rejected by HealthSpring without any real explanation.

We hope that you can assist us in achieving an end result that benefits both parties. If you would like to discuss this matter further, feel free to contact me. Or your legal counsel can reach out to Robert Cutler, General Council for THM. Mr. Cutler's email address is rcutler@hcsimplified.com and his phone number is 347-449-0448.

Best,

Joe Stroffolino
Managing Director
HealthCare Simplified Holdings LLC
1701 Legacy Drive, Suite 2000
Frisco, TX 75034
Direct: 214-799-5700
jstroffolino@hcsimplified.com

EXHIBIT H

U.S. Department of Health and Human Services
Office of Inspector General
P.O. Box 23489
Washington, DC 20026

RE: HealthSpring Life & Health Insurance Company, Inc. ("HealthSpring")

Dear Sir or Madam,

Texas Health Management LLC ("THM") performs annual health risk assessments ("HRAs") for Medicare Advantage plans, including HealthSpring's Medicare Advantage plans in Texas, Arkansas and Arizona. These HRAs are documented in a health assessment form known as a "360 Comprehensive Assessment" ("360 Form"). Historically HealthSpring has reported data from the 360 Forms to CMS to calculate risk adjustments to its monthly capitated rate.

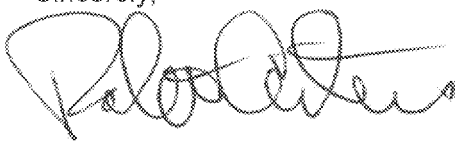
In 2016 nurse practitioners employed by THM performed 14,833 exams in Texas. 10,153 of the exams performed between January 1, 2016 and October 14, 2016 were documented in 360 Forms which did not comply with CMS requirements (the "Re-submit Forms"). The Re-submit Forms had been submitted to HealthSpring for review but at the time of submission they did not bear appropriate electronic signatures. They also were non-compliant in that the ICD codes reflected in the forms were not generated or certified by the examining nurse practitioners.

On October 14, 2016 THM was asked to arrange for the Re-submit Forms to be electronically signed by the examining nurse practitioners and then re-submitted to HealthSpring for review. However, in January 2017 and before any electronically signed Re-submit Forms had been submitted to HealthSpring, a dispute arose regarding payment for the work reflected in the Re-submit Forms. As a result of this and other matters, THM did not provide any compliant Re-submit Forms to HealthSpring, nor has it authorized HealthSpring to use any of the health data in the Re-submit Forms.

Notwithstanding the fact that the Re-Submit forms in HealthSpring's possession do not satisfy CMS requirements, we have reason to believe that HealthSpring has already submitted the health data in them to CMS for risk adjustment purposes. The purpose of this letter is to inform you that the health data reported by HealthSpring to CMS from the nurse practitioners who performed the exams documented by the Re-submit Forms cannot be used to support any risk adjustment calculations for the 2017 payment year because the forms do not constitute valid medical records. A list of these nurse practitioners is attached to this letter as **Exhibit A**. We can also produce a full list of the patient names and dates of service by email upon request.

If you need additional information regarding this matter, do not hesitate to contact me at (347) 449-0448 or by email at rcutler@hcsimplified.com.

Sincerely,



Robert A. Cutler, Esq.*
General Counsel

*Admitted to practice law in the State of New York

EXHIBIT A

SEE ATTACHMENT

Name	NPI	Credentials
[redacted]	[redacted]	AGNP-C
Angelina Silvas	[redacted]	NP-C
[redacted]	[redacted]	APRN-C
[redacted]	[redacted]	WHNP AGPCNP-BC
Brenda Holbert	[redacted]	FNP-BC, AOCNP
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	FNP-C
[redacted]	[redacted]	FNP
[redacted]	[redacted]	FNP-C
[redacted]	[redacted]	FNP-C
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	FNP-BC, MSN
[redacted]	[redacted]	NP-C
[redacted]	[redacted]	AGPCNP-BC
[redacted]	[redacted]	FNP-C
[redacted]	[redacted]	FNP, RN
[redacted]	[redacted]	APRN
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	FNP-C
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	ANP
[redacted]	[redacted]	FNP-C
[redacted]	[redacted]	FNP-C
[redacted]	[redacted]	MSN, AGPCNP-C
[redacted]	[redacted]	AGPCNP-BC
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	MSN, FNP-BC
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	MD
[redacted]	[redacted]	DNP, FNP-C
[redacted]	[redacted]	RN, ANP, GNP
[redacted]	[redacted]	NP-C
[redacted]	[redacted]	FNP-C
[redacted]	[redacted]	FNP-BC
[redacted]	[redacted]	ANP-BC
[redacted]	[redacted]	FNP-C
[redacted]	[redacted]	FNP
[redacted]	[redacted]	APRN
[redacted]	[redacted]	AGACNP-BC