19 CV 11153

JUDGE CARTER

U.S. EX REL. [SEALED] V. [SEALED]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

JUDGE CARTER

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,
ex rel. [redacted]

Plaintiff-Relator,

v.

MATRIX MEDICAL NETWORK, a/k/a CCHN GROUP HOLDINGS, INC. a/k/a COMMUNITY CARE HEALTH NETWORK, LLC, f/k/a COMMUNITY CARE HEALTH NETWORK, INC., PROVIDENCE SERVICE CORPORATION, FRAZIER HEALTHCARE PARTNERS, and MERCURY PARENT, LLC

Defendants.

19 CV 11153

Civil Action No. _____

FILED IN CAMERA AND UNDER SEAL

Jury Trial Requested

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COMPLAINT

This is a False Claims Act *qui tam* action by Relator to recover treble damages and civil penalties arising from the actions of Matrix Medical Network, also known as CCHN Group Holdings, Inc., also known as Community Care Health Network, LLC, formerly known as Community Care Health Network, Inc., and its related entities, including Providence Service Corporation, Frazier Healthcare Partners, and Mercury Parent, LLC, and any of its successors or predecessors (collectively "Matrix" or "Defendants").

As will be shown, this case is about abuse of patient trust and exploitation of the Medicare Advantage program for financial gain.

I. STATEMENT OF THE CASE

1. Roughly 60 million Americans who are age 65 and over or disabled receive healthcare benefits through the Medicare program.

2. Matrix's fraudulent conduct stems from its participation in a particular Medicare program called the Medicare Advantage program. Around 20 million Medicare beneficiaries participate in this program.

3. A Medicare Advantage plan is a private health insurance plan approved by Medicare and administered by a health care insurer called a Medicare Advantage Organization. A Medicare patient may opt to get all of their health care benefits through a single Medicare Advantage plan instead of traditional Medicare.

These private insurance Medicare plans usually have an HMO or PPO network of doctors.

4. Matrix plays a specific role in the Medicare Advantage program as an intermediary (also called a "first tier entity" in Medicare parlance). Matrix assesses the health needs of patients and makes diagnoses of patient illnesses. These health assessments and diagnoses are provided to the patient's insurer, and health care providers. In turn, health care providers rely upon Matrix's diagnoses to provide courses of treatment and care to patients. The insurers rely upon them to determine Medicare payments owed to the insurers, which then reimburse Matrix for its services.

5. The Medicare Advantage program is projected to pay $250 billion dollars to its participants for services in 2019, accounting for 33 percent of total Medicare spending.

6. Getting the right diagnosis is a key aspect of health care, as it provides an explanation of a patient's health problem and informs subsequent health care decisions.

7. Diagnostic errors—whether deliberate or inadvertent—can lead to negative health outcomes, psychological distress, and financial costs. If misdiagnosis occurs, inappropriate or unnecessary treatment may be given to a patient, or appropriate and potentially lifesaving treatment may be withheld or

delayed.

8. The data bears this out. Each year an estimated 1 in 20 adults experiences missed, delayed, or incorrect diagnoses. Of the estimated 12 million Americans impacted, 4 million are believed to suffer serious harm. Diagnostic errors contribute to about 10 percent of patient deaths. Among a clinician's list of responsibilities, perhaps none is more consequential than the act of diagnosis. The initial determination of a patient's condition sets in motion a series of steps that may include life-altering tests, referrals, and treatments. A correct diagnosis starts a patient on the path toward all that modern medicine has to offer.

9. The health and safety of hundreds of thousands of patients are significantly dependent upon Matrix's health assessments and diagnoses being comprehensive, accurate and truthful.

10. Under the Medicare Advantage program, Matrix is responsible to perform a comprehensive patient assessment that involved meeting in-person with the patient, reviewing the patient's medical records and medical history, performing diagnostic tests such as echocardiograms and diabetes tests, if necessary, determining the patient's diagnosis and which Medicare-approved diagnoses codes (also known as ICD codes) are appropriate for the patient, and completing a written assessment to be used by the patient's health care provider.

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11. Understanding the purpose and use of "ICD codes" is important to understanding the fraudulent scheme Relator alleges. ICD codes inform the provider of the health status of the patient and inform other participants in the Medicare program of how to bill Medicare. Medicare also relies upon ICD codes for reimbursement.

12. Each disease, injury, infection, and symptom has its own ICD code. ICD codes are very specific to the patient's illness, and assignment of an ICD code by a health care provider requires carefulness. For a flavor, "Type 1 diabetes mellitus without complications" is ICD code "E10.9." "Unspecified systolic (congestive) heart failure" is ICD code "I50.20."

13. It is critically important to patient care and treatment and for Medicare reimbursement that health care providers report accurate ICD codes for patients. "Clear and accurate diagnosis and procedure code reporting provides valuable information about patient care. It provides important information for accurate reimbursement such as key Medicare payment and medical necessity determination. Clinical codes must be capable of accurately describing diagnoses, illnesses and medical procedures—especially to improve the quality of health care and design a more equitable reimbursement model."

14. Matrix employs a variety of health care professionals to perform its health assessments and diagnostic tests such as physicians, nurse practitioners,

physician assistants, nurses and other clinical staff. It provides these services in the patient's home and through traveling mobile health clinics—vans, buses, and recreational vehicles.

15. As Matrix is well aware, the Medicare Advantage Organization relies upon the diagnostic codes provided by Matrix to figure out the amount of the claim to submit to the Medicare Advantage Program. The Medicare reimbursement amount is calculated using a complex formula that is risk-adjusted based upon these Matrix-assigned diagnostic codes. The "sicker" the patient, the higher "risk" they are to the insurer and the higher the reimbursement paid by the Medicare program to the insurer.

16. Further, due to the financial trickle-down structure of the Medicare Advantage program, the more money Medicare pays to the insurers, the more money the insurers pay to Matrix for its diagnostic and health assessment services. Unfortunately, Matrix has perversely viewed this arrangement as an incentive to use diagnostic codes to make patients appear sicker than they actually are. In this way, Matrix has fraudulently exploited the Medicare program at the risk to patient health and safety.

17. Matrix has carried out its fraudulent scheme like this.

18. Matrix treated the Medicare program like a money grab. It talked incessantly about "return on investment" and dehumanized patients, calling them

"opportunities."

19. Matrix did not provide meaningful patient interactions or health assessments. It pushed patients through its system as quickly as humanly possible. Its mobile health clinics were tantamount to a "drive by." It pressured clinical staff to increase the number of clinical assessments. Patients were merely numbers to reach quotas and generate bonuses.

20. Matrix also exploited the fact that Medicare would pay more for sicker patients. It created bogus diagnoses of heart disease or diabetes for real patients. Instead of making accurate patient diagnoses, it deliberately chose money-making diagnoses.

21. Matrix papered the medical records of patients to avoid detection of its fraud. It knowingly created false medical records to support the false diagnoses so that finding the fraud through audits would be unlikely. Sometimes it knowingly papered the patient medical records with faulty or unreliable tests results to hide the false diagnoses from the Medicare program. It made sure the patient medical records would appear legitimate if Medicare came knocking at its door.

22. Worse yet, the fraud was directed by leadership at the company. Management used software tools to automate its fraud. And, its compliance program has not prevented the fraud.

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23. In short, Matrix did whatever it took to exploit the Medicare program—all to line its pocket with more money—and gave no consideration to how its greed affected patients.

24. Current and former Matrix employees corroborate these allegations, as these examples show:

- "The main purpose of Matrix is to capture as many Medicare dollars as possible for the insurance company via the nurse practitioner history, physical and exam" (Matrix former nurse practitioner who worked at Matrix for 5 years)
- "Poor benefit to Medicare Advantage members borderline scam. [ ] This company takes advantage of people who think they should have this in home comprehensive health assessment or they will lose their health insurance" (Matrix current employee nurse practitioner)
- "Unethical borderline criminal—pressuring elderly people to accept nurse practitioners to gain access to homes to do a health assessment in order to assign high risk factors to individuals in order to have Medicare in turn over charge the Federal Government. Many times I spoke with elderly people who had the assessment from Matrix's nurse practitioners in the previous year that stated that the NP [nurse practitioner] made up diseases and conditions that they did not have.

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This is fraudulent and if proven to be the case a formal investigation should be launched by the government to shut this business down." (Matrix former employee in Florida)

- "This company is the devil and you will surely regret working here. This job is cut[-]throat and Medicare really needs to look into them because they are truly getting over on the system" (Matrix former nurse practitioner)
- "extreme push to see as many patients as possible. [ ] Hire more NPs [nurse practitioners] because we are getting burned out. There is no way we can continue the high volumes with the long miles (can't document when we are driving)" (Matrix current nurse practitioner)
- "Bonus structure is based on a punitive system of degrading production numbers" (Matrix current physician assistant)
- "Medicare Advantage Bilking Scheme—will speed up collapse of Medicare" (Matrix former health care provider)
- "Data collection agency—Your role is to collect data on the elderly. Matrix feeds this data back to grandma and grandpa's insurance company. As a result, premiums may be 'adjusted.' You will not be actively providing care. You will be passively collecting

information. The purpose of all this is to make the bottom line of big insurance a little bigger. It isn't health care; it's risk adjustment." (Matrix former employee)

25. Matrix has violated the False Claims Act by knowingly submitting or causing the submission of thousands of false claims and using false statements in support of fraudulent claims under the Medicare Advantage program.

26. Enforcing violations of the False Claims Act involving the Medicare Advantage program has been a priority for the United States Department of Justice. "Federal healthcare programs rely on the accuracy of information submitted by healthcare providers to ensure that managed care plans receive the appropriate compensation," said Assistant Attorney General Joseph H. Hunt of the Department of Justice's Civil Division. "We will pursue those who undermine the integrity of the Medicare program and the data it relies upon." https://www.justice.gov/opa/pr/medicare-advantage-provider-pay-270-million-settle-false-claims-act-liabilities (Medicare Advantage Provider to Pay $270 Million to Settle False Claims Act Liabilities).

27. Through its deliberate practices, Matrix knowingly cheated the Medicare Advantage program by causing it to make higher payments than it otherwise would have made. It disregarded entirely its responsibilities under the Medicare program and threatened patient health and safety. Its conduct represents

a gross abuse of trust. Matrix's fraudulent practices cut across all federally-insured patients, including Medicare and Medicaid patients.

II. LEGAL FRAMEWORK

A. Parties

28. Relator, a high-level corporate executive insider, alleges the facts set forth in this Complaint based upon first-hand knowledge, relevant documents and information, and on information and belief.

29. [redacted]

30. Relator has standing to bring this action under 31 U.S.C. § 3730(b)(1). Relator is the original source of these allegations under 31 U.S.C. § 3730(e)(4)(B). Prior to becoming aware of any known public disclosure under subsection (e)(4)(A) of 31 U.S.C. § 3730, Relator voluntarily disclosed to the Government the information on which the allegations or transactions in this claim are based; and Relator has knowledge that is independent of and materially adds to any publicly disclosed allegations or transactions that may exist and has voluntarily provided the information to the Government before filing an action. Relator is either entitled to between 15-25 percent of proceeds resulting from this action or any settlement of the claims raised or identified in this Complaint, under 31 U.S.C. §

3730(d)(1), or between 25-30 percent of the proceeds, under 31 U.S.C. § 3730(d)(2).

31. Defendant Matrix Medical Network also known as CCHN Group Holdings, Inc, also known as Community Care Health Network, LLC and formerly known as Community Care Health Network, Inc. provides patient health assessments and diagnostic testing under the Medicare Advantage program.

32. According to Securities and Exchange Commission ("SEC") filings, it operates its business in all 50 states with 1,700 nurse practitioners to provide services primarily to patients of Medicare Advantage organizations. It is headquartered in Scottsdale, Arizona with regional offices in Waltham, Massachusetts; and Largo and Winter Springs, Florida.

33. Matrix has a significant presence in New York, including the Southern District of New York. A co-founder and Chief Medical Affairs Officer at Matrix for the past nearly 19 years is in the New York City area. Internal company documents from 2017 show more than 20 clinicians were conducting home assessments in New York with over 150 more clinicians being hired with the expectation that Matrix was ramping up its efforts in New York at that particular time.

34. Under the Medicare Advantage program, Matrix Medical Network is known as a "first tier entity." A first tier entity is a party that enters into a written

arrangement with a Medicare Advantage organization to provide health care services for Medicare-eligible individuals under the Medicare Advantage program. 42 C.F.R. § 422.2.

35. Matrix Medical Network provides this "company overview" on its website. "Matrix provides high-touch, specialized care in-home or via mobile health clinics to help health plans [Medicare Advantage organizations] and other at-risk entities improve quality management, revenue integrity, member satisfaction and overall quality of care. Our services range from comprehensive health assessments, post-acute transitions, lab tests and sophisticated diagnostics to ongoing management of complex chronic conditions. Our programs are tailored for populations ranging from infants to seniors. We provide the widest array of services and a streamlined and integrated experience for health plans and other healthcare payors to help ensure higher quality outcomes at lower overall costs."

36. In February 2018, Matrix Medical Network acquired another entity called "HealthFair." Before Matrix Medical Network became the owner and operator, it had contracted with HealthFair to provide its assessment and diagnostic services through HealthFair's mobile health clinics (on wheels). Near the time of acquisition, it announced that this would allow Matrix Medical Network to "expand[] its service offerings to include mobile health assessments, advanced diagnostic testing and additional care optimization services."

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37. Defendant Providence Service Corporation (PSC) acquired Matrix Medical Network in October 23, 2014. PSC was incorporated in Delaware in 1996 and is headquartered in Stamford, Connecticut.

38. This was publicly announced at the time of its acquisition of Matrix Medical Network: "The Providence Service Corporation (Nasdaq: PRSC), a leader in the management and provision of human social services, innovative global employment services and non-emergency transportation through a variety of government-sponsored programs, announced today that it has completed the acquisition of CCHN Group Holdings, Inc. ("Matrix Medical Network" or "Matrix"), a Scottsdale, Arizona provider of in-home health assessment and care management services and a portfolio company of Welsh, Carson, Anderson & Stowe XI, L.P. ("Welsh Carson"), effective October 23, 2014. The companies had announced the signing of an acquisition agreement on September 18, 2014."

39. The Providence Service Corporation told investors at the time of acquisition that it was making "a strategic investment in a national network of highly-skilled nurse practitioners, capable of operating in the challenging home and community setting."

40. Providence Service Corporation markets itself as "the nation's largest manager of non-emergency medical transportation programs for state programs and managed care organizations," offering a range of services including call center

management, network credentialing, vendor payment management and non-emergency medical transport management. Providence is "one of the largest for-profit providers of home and community based behavioral health services" and buys, invests, and manages health care entities like Matrix, almost all of which furnish services to government-insured patients.

41. Defendant Frazier Healthcare Partners ("Frazier") is a private equity and venture capital firm that markets itself as investing in profitable, lower middle-market healthcare companies. Frazier is headquartered in Seattle, Washington.

42. In October 2016, Frazier purchased a 53 percent interest in Matrix Medical Network while Providence Service Corporation retained a 47 percent interest.

43. As a result of the acquisition, Defendant Mercury Parent, LLC, through which Frazier Healthcare Partners holds its equity interest in Matrix Medical Network, was formed.

B. Jurisdiction and Venue

44. This Court has subject matter jurisdiction over the claims asserted in this Complaint, pursuant to the False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, and 28 U.S.C. § 1331.

45. This Court has supplemental jurisdiction over Relator's Arizona Employment Protection Act claim, pursuant to 28 U.S.C. § 1367(a).

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46. Venue is proper in this judicial district pursuant to 31 U.S.C. § 3732(a) because one or more defendants may be found, resides, and/or transacts business in this District, or because an act, proscribed by 31 U.S.C. § 3729, occurred in this District. These allegations are nationwide, as set forth in detail throughout this Complaint. Venue is also proper in this judicial district for Relator's retaliation claims, pursuant to 28 U.S.C. § 1391(b), because Defendant Matrix Medical Network resides in this District, pursuant to 28 U.S.C. § 1391(d), and is subject to the Court's personal jurisdiction, as detailed above.

C. Time Period

47. On information and belief, fraudulent conduct alleged in this Complaint has been occurring since 2014 and is continuing.

D. The False Claims Act

48. The False Claims Act provides, in part: Liability for Certain Acts. — (1) In general.—[ ] any person who— (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; [ ] (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property

to the Government, [ ] is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 [1]), plus 3 times the amount of damages which the Government sustains because of the act of that person. 31 U.S.C. § 3729(a)(1)(A), (B), (G).

49. Under the False Claims Act, scienter must be demonstrated: Definitions—For purposes of this section— (1) the terms "knowing" and "knowingly"— (A) mean that a person, with respect to information— (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud. 31 U.S.C. § 3729(b)(1)-(2).

50. Under section (b)(2) the term "claim*"* — (A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that— (i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government— (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such

contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; [ ]. 31 U.S.C. § 3729(b)(1)-(2).

51. Under the False Claims Act, materiality is defined as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4); *Universal Health Services, Inc. v. United States ex rel. Escobar, et al*. 136 S. Ct. 1989 (2016).

E. Retaliation Provisions

52. The False Claims Act provides relief for retaliatory actions against an employee because of lawful acts done by the employee in furtherance of a False Claims Act action or other efforts to stop one or more violations of the False Claims Act. 31 U.S.C. § 3730(h).

53. The Arizona Employee Protection Act, A.R.S. § 23-1501, prohibits the termination of an employee for refusing to commit an act or omission that would violate an Arizona statute or for disclosing that the employer has violated an Arizona statute.

III. MEDICARE ADVANTAGE PROGRAM

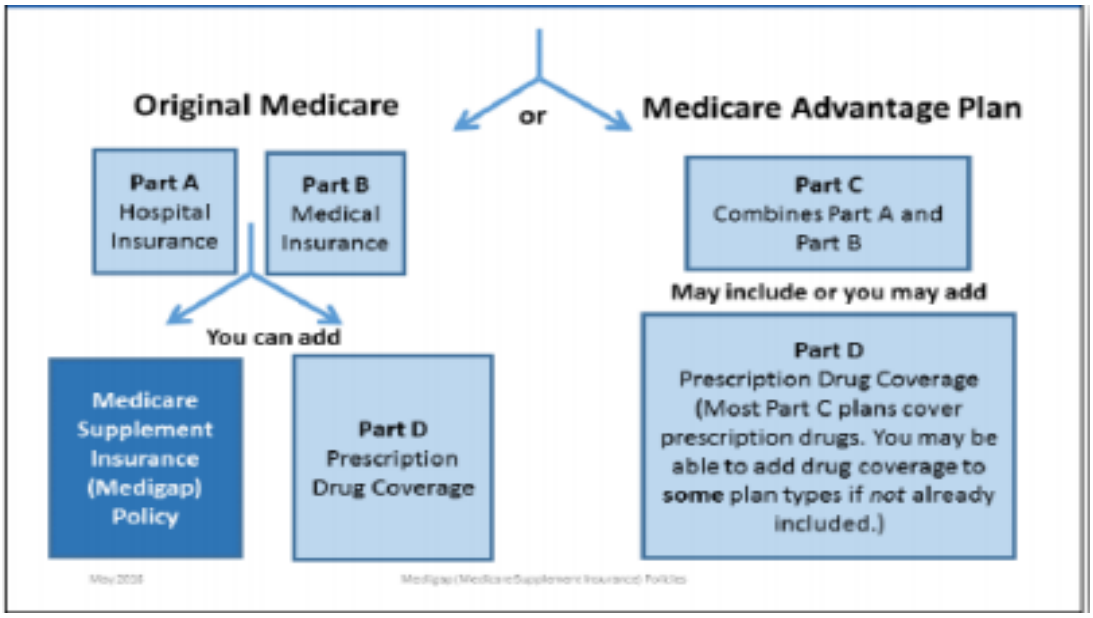
A. Roles and Obligations of Program Participants

54. Medicare is a federally-operated health insurance program administered by the Centers for Medicare and Medicaid Services ("CMS") benefitting individuals 65 and older and the disabled. 42 U.S.C. § 1395c, *et seq*.

55. There are four parts to the Medicare program: Part A covers inpatient care (hospital insurance), Part B covers outpatient care (medical insurance), Part C is the Medicare Advantage program at issue in this case, and Part D is prescription drug coverage. A patient-beneficiary who is eligible for Medicare may choose to be covered under what is commonly referred to as "traditional" Medicare, which is Medicare Parts A and B, in which CMS reimburses healthcare providers for services rendered through the direct submissions of claims. This is known as a fee-for-service payment system.

56. Under the Medicare Advantage program, Medicare beneficiaries may opt out of "traditional" Medicare and instead may enroll as a Medicare beneficiary in a private insurance plan known as a Medicare Advantage Plan ("MA Plan") managed by a private insurance company ("MA Organization"). 42 U.S.C. §§ 1395w-21 to 1395w-28.

57. This simple diagram (below) for Medicare patients illustrates their options.



58. Much like any other private health insurance plan, MA Plans come in a variety of forms. Many MA Plans are structured like a Health Maintenance Organization ("HMO"), in which an MA Organization organizes a network of healthcare providers that a patient may go to for healthcare services with the central point of contact being the patient's primary care physician. Others are structured like a Preferred Provider Organization ("PPO") that offers a network of healthcare providers that patients can use for medical care and where patients may see specialists without a referral.

59. Under the Medicare Advantage program, there are "first tier, downstream, and related entities." 42 C.F.R. §§ 422.504(l)(3), 422.2 & 422.500. A first tier entity like Matrix refers to a "party that enters into a written agreement, acceptable to CMS, with an MA organization . . . to provide . . . healthcare services for a Medicare eligible individual under the MA program." 42 C.F.R. § 422.2.

60. A first tier entity agrees to comply with all applicable Medicare laws, regulations, and CMS instructions, performs its services in accordance with the MA Organization's contractual obligations to the Medicare program, and takes measures to prevent fraud, waste and abuse. 42 C.F.R. §§ 422.504(i)(3)(iii), (i)(4)(v) and 422.503(b)(4)(vi)(C)(1).

61. Furthermore, and importantly, if a first tier entity generates data relating to an MA Organization's claims for payments from the MA Program, as Matrix does, the entity (as well as the MA Organization) must certify the accuracy and truthfulness of that data. 42 C.F.R. § 422.504(l)(3).

B. How Medicare Pays Participants under the Program

62. The Medicare Program reimburses MA Plans differently than it does with traditional Medicare. Medicare pays MA Organizations a capitated or fixed amount for each patient according to a formula. This fixed amount covers Medicare Part A (hospital insurance) and Part B (medical insurance) benefits for the patient.

63. The capitated rate is set by a complex formula but to understand the fraud alleged in this Complaint, it is necessary to get into some detail.

64. The MA Organization submits a bid to Medicare containing data and information that is compared to an administratively set benchmark. 42 U.S.C. §§ 1395w-23(a)(1)(B) and 42 C.F.R. § 422.304.

65. Recognizing that the cost of care will vary for each patient, the Medicare program adjusts the fixed amount for each patient enrolled in a Medicare Advantage plan based on a methodology that takes into account various factors, including the patient's (1) demographic factors such as age and gender, and (2) health status based diagnosis codes. 42 U.S.C. § 1395w-23(a)(1)(C). In this case, those diagnosis codes are determined and reported by Matrix to the MA Organization.

66. This adjustment based upon individual patient factors (as noted) is referred to as a risk adjustment, and each patient is assigned a risk score based on this risk adjustment, referred to as the risk-adjustment factor or "RAF score." The RAF score acts as a multiplier that is applied to the MA Organization's bid for covering Medicare Part A (hospital insurance) and B (medical insurance) services to determine the appropriate capitated payment. 42 U.S.C. § 1395w-23(a)(1)(G) and 42 C.F.R. § 422.308(e). This risk adjustment or "RAF" score can result in higher capitated rates for sicker patients and lower capitated rates for healthier patients.

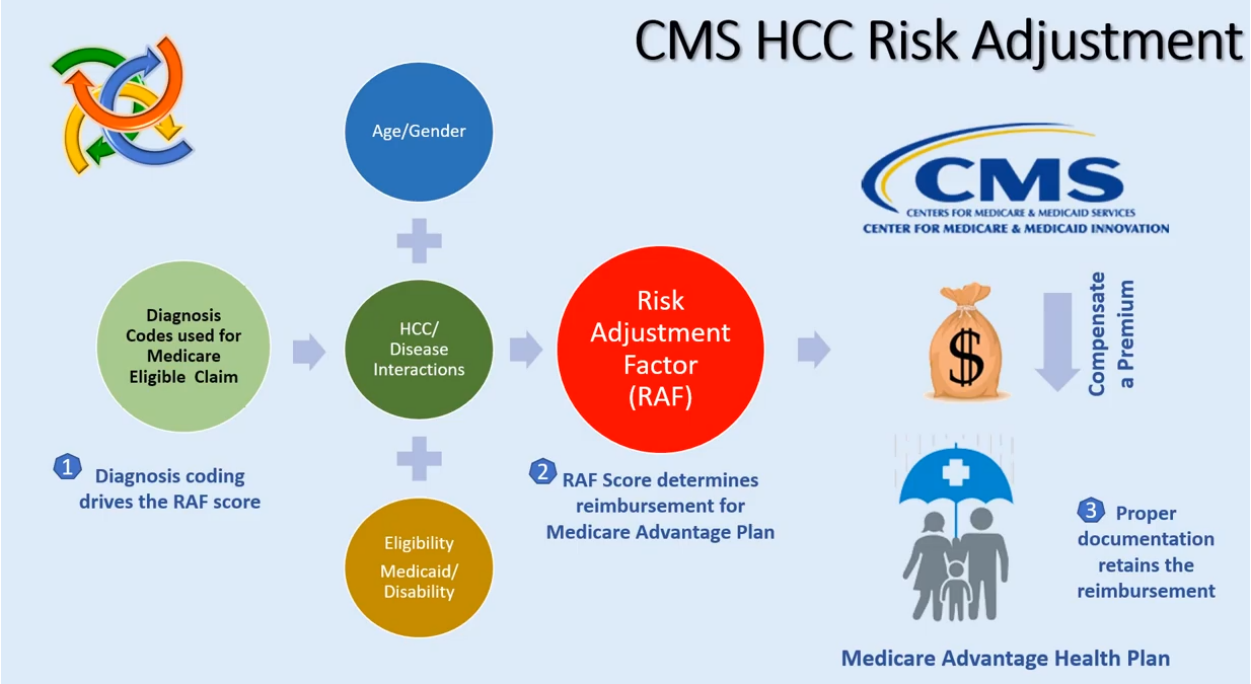
67. More specifically, the Medicare program employs a risk-adjustment model, called the Hierarchical Conditions Category ("HCC") model, which includes both demographic factors (such as age and gender) and medical conditions of a patient to determine the RAF scores for patients in MA Plans. 42

C.F.R. § 422.2.

68. Put more plainly, HCC refers to a system of medical coding used by MA Organizations to determine patients' future medical needs for the next year. Only life-altering medical conditions are recorded. HCC coding seeks to identify Medicare members who have severe or chronic health issues such as peripheral artery disease, peripheral vascular disease and diabetes.

69. The diagnosis codes mapped into HCCs are referred to as "risk-adjusting diagnosis codes." Not all diagnosis codes result in an adjustment in the RAF score and thus not all diagnosis codes affect payment under the Medicare program. Related groups of diagnoses are ranked on the basis of disease severity and the cost associated with their treatment.

70. This simple diagram below describes what goes into the Medicare program's risk-adjusted "HCC" model.



71. The International Statistical Classification of Diseases and Related Health Problems ("ICD") sets forth the standards accepted by the Medicare program and the healthcare industry for the identification of diagnosis codes for health conditions by providers. 45 C.F.R. § 162.1002(a)(1)(i), (b)(1), (c)(2)(i) and 42 C.F.R. § 422.310(d)(1); CMS, Medicare Managed Care Manual, Chapter 7, Exhibit 30 (Rev. 57, Aug. 13, 2004).

72. ICD codes are alphanumeric (letter and number) codes used by healthcare providers (like Matrix), insurance companies and public health agencies to represent diagnoses; every disease, injury, infection and symptom has its own code. The applicable standards for these ICD diagnosis codes are set forth in the International Classification of Diseases, Ninth Revision, Clinical Modification ("ICD-9") through October 1, 2015, and thereafter the International Classification

of Diseases, Tenth Revision, Clinical Modification ("ICD-10").

73. In fact, ICD codes are a determinative factor in the calculation of risk-adjustment payments based on a patient's health status. As alleged in this case, it is Matrix's determination and reporting of fraudulent ICD diagnostic codes that lie at the heart of the fraud. And, it is these same Matrix-reported ICD diagnostic codes that are relied upon by the Medicare program for payment.

74. The HCC model relies on ICD diagnosis codes that are expected to be documented in the patient's medical record at the time of a face-to-face (in-person) encounter between health care provider and patient. In addition, ICD codes should be based on documented conditions that require or affect patient care, treatment or management. CMS, Medicare Managed Care Manual, Chapter 7, § 111.8 (Rev. 57, Aug. 13, 2004); CMS, 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide (2008).

75. The HCC model is prospective, meaning it relies on risk-adjusting diagnosis codes from dates of service by a provider in one year (the "date of service year") to determine payments in the following year (the "payment year"). Each patient's RAF score is calculated anew for the following year. The higher a patient's RAF score, the higher the Medicare payments to the MA Organization. The MA Organization then distributes a contractually-determined percentage of these payments to providers such as Matrix. Thus, ICD codes that map to HCC

codes submitted by Matrix materially impact the amount of the payments made by the Medicare program to an MA Organization, and therefore, to Matrix.

76. Generally, after a face-to-face encounter between a physician and patient, the provider (Matrix, in this case) is obligated to (1) document the encounter in the patient's electronic medical record, (2) assign the diagnosis reflecting the patient's medical conditions and use the capabilities of the electronic medical record to assign the appropriate ICD diagnosis codes, and (3) add those diagnosis codes into Matrix's electronic records system. The diagnosis codes are transmitted electronically (by Matrix, in this case) to the MA Organizations after a patient encounter.

77. In turn, the MA Organizations electronically submit these codes to the Medicare program. The Medicare program maps each patient's ICD diagnosis codes to HCCs (*i.e.*, the risk-adjusting diagnosis codes), and then calculates each patient's RAF score to apply to the payment calculation and determine the reimbursement that Medicare will pay.

78. There are thousands of ICD-10-CM codes that map to one or more of the 79 HCC codes included in the CMS-HCC Risk Adjustment Model. A code can map to more than one HCC as ICD-10-CM contains combination codes (i.e., one code can represent two diagnoses or a diagnosis with a complication).

79. MA Organizations and providers such as Matrix are well aware from

Medicare regulations and written guidance that the Medicare program relies on the risk-adjusting diagnosis codes (ICD codes) they submit to determine and make accurate capitation payments for each patient under the Medicare Advantage program. "Accurate risk-adjusted payments rely on the diagnosis coding derived from the [patient-]member's medical record." 42 C.F.R. § 422.504(l)(3).

80. Often, MA Organizations contract with healthcare providers, including intermediaries like Matrix that offer health assessments and diagnostic testing of patients, which then form the basis for Medicare's capitated rate payments. Pursuant to these agreements, the provider submits diagnostic (ICD) codes to its MA Organizations. The MA Organizations, in turn, submit these diagnosis codes to the Medicare Program through what is known as the Risk-Adjustment Processing System ("RAPS") and through the Encounter Data System ("EDS").

81. Every month, the Medicare program pays the MA Organizations the capitation amount as established by the bid and adjusted using its risk-adjustment methodology for each patient.

82. MA Organizations pay providers through a variety of arrangements; however, many large provider groups enter into a capitated or "gainsharing" arrangement that aligns their financial interests.

83. Put another way, the more money Medicare pays the MA

Organizations, the more money the MA Organization pays the intermediary or first tier entity. Under a capitated arrangement, the MA Organization enters into a contract to pay a portion of the capitation payment from the Medicare program to its first tier entities, less a percentage fee for administration as determined by its contracts.

84. MA Organizations also pay some providers on a fee-for-service basis for each service, such as an office visit provided to a patient. Frequently, providers also enter into "gainsharing" agreements with the MA Organizations where they receive incentive payments based in whole or in part on total revenues that MA Organizations receive from the Medicare program for the patients cared for by these gainsharing providers.

85. If abused, as alleged in this Complaint, such agreements with the MA Organizations can lead providers to fraudulently increase the number and severity of risk-adjusting diagnoses (ICD codes) they report to MA organizations. For example, fraudulently using ICD codes for major illnesses like peripheral artery disease, peripheral vascular disease, and diabetes would create "high value HCCs" and help to inflate RAF scores, which in turn would lead Medicare to pay higher capitated payments per patient.

86. In other words, the health care provider could try to make patients appear "sicker" than they really are and pose a "higher cost risk" than they really

do—exactly as alleged in this case.

87. The more risk-adjustment payments obtained by the MA Organizations for the patients assessed by Matrix, the more money MA Organizations pay to Matrix pursuant to the capitation and gainsharing agreements. The result is fraud and a greater return on investment for an intermediary like Matrix.

IV. MATRIX'S FRAUDULENT SCHEME

A. Its Role and Obligations Under Medicare Advantage

88. Matrix participates in the Medicare Advantage program as an intermediary or a "first tier entity." As a first tier entity, Matrix performs health assessments and diagnostic tests of patients.

89. Matrix contracts with over 30 Medicare Advantage (health insurance) Organizations, allowing Matrix to participate in their networks and to gain access to their patients. Matrix provides its services to hundreds of thousands of Medicare beneficiaries throughout the United States.

90. By participating in the Medicare Advantage Program, Matrix assumed certain duties and obligations to the United States and taxpayers. These duties and obligations were required by federal regulations and reinforced and memorialized in contractual documents.

91. As a first tier entity on behalf of MA Organizations, which submit

claims to Medicare on behalf of patients, Matrix must:

- perform its services in a manner that complies with the MA Organization's contractual obligations to the Medicare program, 42 C.F.R. § 422.504(i)(3)(iii);
- agree to "comply with all applicable Medicare laws, regulations, and CMS instructions," 42 C.F.R. § 422.504(i)(4)(v);
- receive effective compliance training and education relating to preventing fraud, waste, and abuse, 42 C.F.R. § 422.503(b)(4)(vi)(C)(1); and,
- certify the accuracy and truthfulness of the data it generates relating to claims for payment submitted by its MA Organizations, 42 C.F.R. § 422.504(l)(3).

92. As a significant part of its role in the Medicare Advantage program, Matrix submits diagnostic (ICD) codes for the patients it has evaluated to its MA Organizations and certifies that the diagnoses codes are complete, accurate and truthful. The MA Organizations submit these ICD codes electronically to the Medicare Program through data and claims processing systems called RAPS and EDS.

93. MA Organizations that contract with Matrix rely upon the truthfulness, completeness and accuracy of these ICD codes, which are used as part of a Medicare risk-adjustment model (the HCC model) to determine a risk-adjusted

score (RAF score) for each patient. The RAF score is then applied to the payment calculation and determines the amounts that Medicare will pay MA Organizations, which then pay providers like Matrix.

94. Matrix was paid for its services under the Medicare Advantage program through a percentage of the risk-adjusted payments that the MA Organizations received from the Medicare Program.

95. Under the Medicare regulations, Matrix is required to certify that the diagnosis codes (ICD codes) that it submitted or caused to be submitted to Medicare were "accurate, complete and truthful" and supported by written documentation in the patient's medical record. 42 C.FR. §§ 422.504(l)(3), 422.310(d); *United Healthcare Ins. Co. v. Azar*, 330 F. Supp. 3d 173, 189 (D.D.C. 2018) (Medicare requires that "a certification of the 'accuracy' and 'truthfulness' of risk adjustment data [requires] that any reported diagnosis [ ] be substantiated by underlying records," *citing* 42 C.F.R. § 422.310(d), (e), and 42 C.F.R. § 422.504(l)(2)); *United States ex rel. Swoben v. United Healthcare Ins. Co., et al*., 848 F.3d 1161, 1175-1176 (9th Cir. 2016) ("CMS requires medical diagnosis codes [ICD codes] to be supported by a medical record," when they are submitted for payment under Medicare Advantage.).

96. These same regulatory requirements were reinforced under the contracts that Matrix executed with its MA Organizations to provide services to

patients whereby Matrix agreed to the following:

> ***6.3 Federal Funds. Provider acknowledges that payments Provider receives from Plan to provide Covered Services to Covered Individuals are, in whole or part, from Federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving Federal Funds . . . .***
> ***
> ***7.4 Accuracy of Risk Adjustment Data. Provider further agrees to certify the accuracy, completeness, and truthfulness of Provider generated Risk Adjustment Data that Plan is obligated to submit to CMS.*** Within thirty (30) days after the beginning of every Fiscal Year or as required by CMS while the Medicare Advantage Participation Attachment is in effect, Provider agrees to give Plan a certification in writing, in a format that Plan specifies, that certifies to the accuracy, completeness, and truthfulness of Provider's Risk Adjustment Data submitted to Plan during the specified period.
> ***
> ***9.1 Compliance: Medicare Laws/Regulations. Provider agrees to comply, and to require any of his/her/its subcontractors to comply with all applicable Medicare laws, regulations, and CMS instructions.*** Further, Provider agrees that any Covered Services provided by the Provider or his/her/its subcontractors to or on behalf of the Plan's Covered Individuals will be consistent with and will comply with Plan's Medicare Advantage contractual obligations.

(emphasis added).

97. Matrix even publicly acknowledged its obligations to comply with "CMS regulations pertaining to Medicare as well as CMS releases applicable to the operation of MA Plans such as reimbursement rates, risk adjustment

methodologies, adjustments to quality management measurements and other relevant factors."

B. The Driver of the Matrix Business Model was "Return on Investment" (ROI) Not Patient Care

98. Under the Medicare Advantage program, Matrix was an intermediary between patients and their insurers—the MA Organizations. In Matrix's marketing materials to MA Organizations, it promised to cut and control costs while providing quality care: Matrix "provides ongoing care based on need, to supplement regular provider care, while also taking control of the overall treatment plan. We do this to help reduce costs of medical care, close gaps in care and improve quality of life."

99. In reality, Matrix caused increased costs to the MA Organizations that were borne by the Medicare program. These costs would not have otherwise been incurred by the Medicare program in the absence of the alleged fraud. Further, the costs were incurred at significant risk to patient care.

100. The real driver of the Matrix business model was return on investment ("ROI") for the MA Organization and Matrix. Guaranteeing an increase in ROI allowed Matrix to retain and attract new MA Organizations, or so it thought.

101. The MA Organizations paid Matrix a percentage of the risk-adjusted payments that they received from the Medicare program. As a result, from at least as early as 2014, Matrix targeted Medicare and other government-insured patients.

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102. Matrix always had its eye on the ball. Shortly after Providence acquired Matrix in 2014, it told investors and MA Organizations that the acquisition would allow "multiple growth opportunities," with government-insured patients by increasing the "volume" of patient assessments under the Medicare Advantage program:

> [w]e believe Matrix is well positioned to increase CHA [Comprehensive Health Assessment] volumes within its existing MA customer base and to add new MA customers. Matrix's offerings are extensible across adjacent markets (Medicaid, dual eligible, and commercial), which, like the Medicare market, have a need to better assess, stratify, and mitigate risk.

103. Once Frazier acquired a majority interest in Matrix in October 2016, the heat was turned up to make Matrix even more attractive to MA Organizations. Frazier executives thought the best way to do that was to increase ROI even further.

104. Frazier was run by private equity investors and venture capitalists and not health care professionals. Their end game was to maximize the return on investment for the MA Organizations to induce an acquisition of Matrix.

105. The plan was to generate artificially high and profitable patient RAF scores and ROI results to persuade one of its MA Organizations to purchase Matrix and take its business model in-house.

106. In addition to the financial incentives to Frazier posed by an

acquisition, Matrix's most senior executives also hoped to personally benefit from a sale of the company to an MA Organization.

107. The Frazier financiers wanted to get in and out of Matrix and move on to their next venture. As a result, they wanted to make Matrix high-value and were not focused on improving quality of care. Frazier stopped at nothing to accomplish its financial goals.

108. Once the Frazier executives were on the scene, they played an aggressive role in the day-to-day operations and direction of Matrix. Frazier executives had their hands in all Matrix business operations.

109. For starters, Frazier Operating Partner and Chief Strategy Officer at Matrix and Matrix Executive Chairman of the Board took over offices at Matrix headquarters in Phoenix. They regularly joined meetings and participated in routine business calls. At times they listened-in to phone calls, often without the knowledge of Matrix executives who were participating in the call ("ghosting calls"). Frazier representatives also showed up at Matrix's monthly board meetings.

110. Further, once Matrix acquired HealthFair in February 2018 and brought the mobile health clinic business in-house, that became another vehicle to increase the marketability of Matrix.

111. Frazier executives were well aware of the serious compliance issues

addressed in this Complaint related to the mobile health services at the time it brought these services in-house. Yet, Matrix continued with "business as usual" because the HealthFair mobile services helped it work toward its goal of increasing ROI.

112. Frazier and Matrix executives embarked on a "100-day plan" to integrate the business operations of Matrix and HealthFair. As part of that plan, a log of integration problems was updated weekly and shared with Frazier representatives for trouble-shooting. So, Frazier was well aware that it was acquiring and continuing the fraudulent practices of the mobile health services side of the business.

113. Frazier has continued to play an active role in the Matrix core business activities and also has direct knowledge of, and responsibility for, the violations alleged in the Complaint.

114. To improve ROI, Matrix listed these as "action items":

- "EDC NextGen [EHR software] Implementation recommended diagnosis and pre-population"
- "Gain better understanding of ROI drivers and implement improvements"
- "Increase high ROI [patient-]member outreach from XXX to 96%"
- "Improve provider HCC capture rate to XXX"

115. Notably, patient care is not identified as an "action item" or priority.

116. In its list of 2017 business objectives, Matrix again identified priorities for its business and clinical staff as:

- "Truly understand the drivers of ROI in order to optimize the ROI for every client"
- "Move from Retrospective ROI to more of Real-Time ROI to empower Matrix & Client" [MA Organization]
- "Maximize ROI for every client [MA Organization] by understanding all drivers"

117. Again, patient care is not even an afterthought let alone a priority.

118. A particularly troubling part of this business plan was the fact that even the Chief Medical Officer was expected to focus on ROI:

> Create and lead the execution of a strategic plan to optimize ROI performance for our clients within the CHA business, through multi-dimensional improvements to training, operations, and assessment design by end of Q3. Execute upon that plan, establishing clear line of sight to Client ROI (Q4); operations and assessment design by Q3 and results in achieving Client ROI targets."

(parentheticals omitted)

119. Guaranteeing ROI through inflated numbers of health assessments, diagnostic exams, and false positives for high value HCCs was integral to this business plan and continued to drive the business model.

120. Matrix knew that the patient RAF scores would yield higher Medicare payments for older, sicker patients and lower Medicare payments for younger, healthier patients. 42 U.S.C. § 1395w-23(a)(1)(C)(i).

121. Matrix described how high value HCCs would increase RAF scores and maximize reimbursement from the government-insured programs.

122. It confidently told MA Organizations that it could increase Medicare reimbursement by an average of $1,800 per patient and at least $70 million annually. According to Matrix, these figures would be based upon its ability to turn historical and suspect diagnoses into high value diagnoses through tens of thousands of "new HCCs found," meaning that it promised to diagnose patients with very serious illnesses.

123. A "historical diagnosis" is typically the patient's actual or real diagnosis, as shown by the MA Organization's medical records for the patient. In Matrix-speak, a "suspect diagnosis" is the diagnosis that Matrix would like to also "tag" the patient with. These are more serious diseases such as certain forms of heart disease and diabetes that result in a higher RAF score for the patient and

more money for Matrix. As will be shown, Matrix worked hard to turn these more serious "suspect diagnoses" into reportable and higher-value diagnoses codes.

124. Matrix enticed MA Organizations to contract with it for diagnostic health services for government-insured patients by "uncovering and showing [them] value that they might not realize" through strategic plans "generated with the help of Account Management and Clinical" services. (As shown in this Complaint, "account management" included having non-clinical staff and EHR software programs harmfully interfere with clinical decision-making).

125. Matrix persuaded at least one MA Organization that it could guarantee a 5:1 return—for every $100 spent, the MA Organization would get $500 back from the Medicare program: "Acceptance and Net Yield on the MA population is the highest in Matrix BOB [book of business]. [ ] This [government-insured] population is in need and welcomes the Matrix NP [nurse practitioner]. . . . Year over year, Matrix has delivered strong and significant ROI on the MA [Medicare Advantage] CHA [comprehensive health assessment] program (>5:1)."

126. The benefit to Matrix from all of this was two-fold: (1) artificially inflating RAF scores and maintaining lucrative contacts with its MA Organizations and (2) generating greater revenue for Matrix services, particularly increased peripheral artery disease screenings and diabetes visits.

127. For 2017, Matrix identified its top 3 priorities as:

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> BIA [Business Impact Analysis] Analytics: Leverage data analysis ***in order to identify opportunities to create and demonstrate value for our clients [MA Organizations]***
>
> Client ROI: ***Truly understand the drivers of ROI in order to optimize the ROI for every client [MA Organization];*** Move from Retrospective ROI to more of Real-Time ROI to empower Matrix & Client
> CM Analytics: Monitor product performance for Client [MA Organization] from medical cost savings and internal operational performance.

(emphasis added).

128. Matrix even hired an analyst to help ensure a guaranteed amount of ROI. The analyst worked with the Matrix sales department under the direction of the COO "to paint a picture of strong RAF [scores] lift in 2017 HF [HealthFair mobile clinic] visits."

129. In short, Matrix aggressively marketed to MA Organizations to lure them to enter agreements that allowed Matrix a competitive advantage in the marketplace. Matrix knew and intended that falsifying patient diagnoses to reflect high value HCCs would increase Medicare's payments to the MA Organizations and lead to a greater ROI for the MA Organizations and Matrix.

C. Nuts and Bolts—How the Fraud Scheme Worked

130. Matrix performed health assessments and diagnostic tests for patients at home (private and nursing) and in mobile health clinics on wheels—that was the crux of their business aimed at Medicare Advantage patients.

131. Matrix largely used contractors to perform its assessment and testing services rather than turn them into employees. (Throughout the Complaint, we refer to these agents as Matrix "staff" or "physicians" or "medical or clinical staff" or "health care provider" or "nurse practitioner" without regard to whether they are Matrix contractors or employees, as defined under the IRS Code.)

132. Matrix used HealthFair to provide these same services in its mobile health clinics both before and after Matrix acquired HealthFair in February 2018.

133. Matrix was paid between $350 - $450 for each health assessment it completed ($350 for a home assessment and $450 for an assessment at a facility).

134. On top of the payment it received for a patient health assessment, Matrix was paid an additional $125 if it tested the patient for peripheral artery disease and $750 if a visit resulted in a diabetes intervention.

135. Publicly, Matrix described its health assessment process through these activities:

- through a phone-calling campaign, solicit Medicare Advantage patients and schedule a home or mobile visit
- obtain the patient's medical data from the MA Organization
- assign a Matrix nurse practitioner or other health care provider to assess the patient

- conduct a face-to-face home or mobile visit with a Matrix health care provider to discuss the patient's medical history and perform diagnostic tests to arrive at a current diagnosis for the patient
- consult with a physician to confirm results of the diagnostic testing, if deemed necessary by the nurse practitioner.

136. To investors, Matrix portrayed an image of quality patient care:

> Matrix's CHAs [comprehensive health assessments] are conducted at the member's home or residential facility. Unlike a typical 8 to 15-minute office visit with a physician or physician's assistant, which is often singularly focused on a specific symptom or condition, Matrix NPs [nurse practitioners] ***spend up to 60 minutes*** with each member and any of the member's family members or caregivers he or she chooses. The CHA is ***comprehensive*** and is comprised of a number of distinct components. In addition to checking vital signs and performing a physical examination, Matrix NPs review the member's health history and medical prescriptions, conduct a depression screening, evaluate the immediate residential setting for any physical safety issues, review recommended screening tests, and conduct a series of geriatric screens for fall risks, nutrition, and cognitive function. As the evaluation is intended to provide a complete clinical assessment, Matrix NPs are also trained to ***record all diagnoses of medical conditions***.
>
> ***The data collected during the CHA is captured electronically in real-time*** in a portable tablet that each NP brings to the member's residence. The CHA process is also *specifically designed to engage and coordinate* ***with the member's care network to facilitate follow-up care and treatment***. Following each CHA, educational and clinical information is shared with the member,

> provider and MA plan to identify and close gaps in care. The CHA measures MA plan liability and assists in determining risk adjusted payments made by Medicare to the MA plan. In addition to identifying opportunities to ***improve and optimize care***, Matrix's service offering can ***deliver immediate impact on care outcomes.***

(emphasis added)

137. Yet, these promises were knowingly false. Matrix clinical staff rarely spent "60 minutes" with patients. Matrix comprehensive health assessments were not "comprehensive" or designed to accurately diagnose patient health conditions.

138. While Matrix captured some data "in real time," it also falsified patient data back at corporate offices to create a paper record for the false diagnoses. Rather than accurately "record all diagnoses of medical conditions," Matrix coders and clinical staff looked for ways to record false diagnoses that made the patients look sicker (and riskier) than they were.

139. Further, "follow-up care and treatment" was practically non-existent and certainly not designed to "improve and optimize [patient] care."

140. Matrix had written policies and procedures galore—all of which it deliberately disregarded. One quality improvement standard stated: "[t]he Matrix QI [quality improvement] review and audit process supports clinical performance to ensure quality documentation of assessments on our clients' members [MA Organization patients], as part of the home and facility assessment programs. The QI [quality improvement] review process reinforces overall documentation

completeness, support for diagnoses and accuracy of coded diagnoses." Another policy regarding coding and auditing of health assessments addressed "ensur[ing] accurate, complete and consistent coding practices are applied at all times to create high quality health care data."

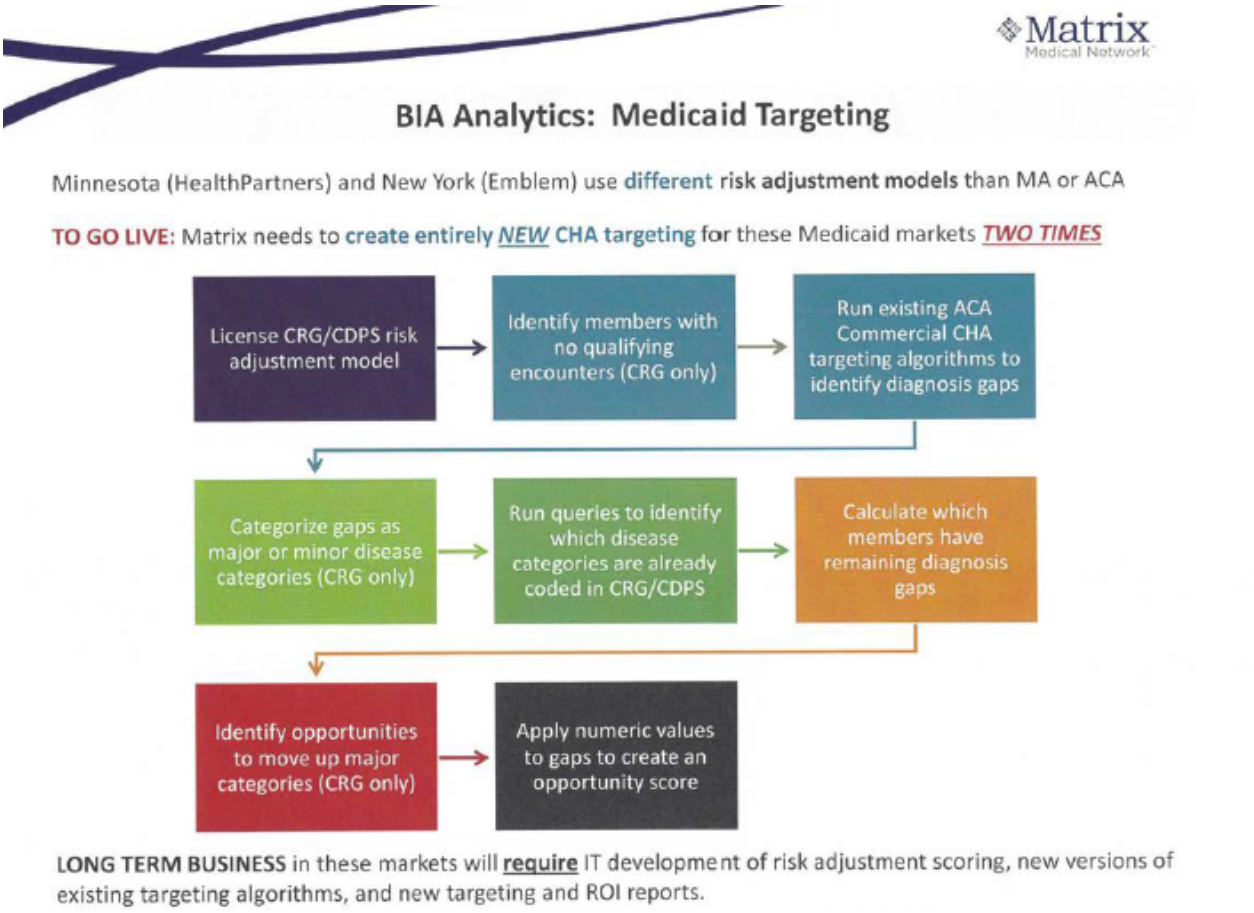
141. Choosing not to follow these written policies, Matrix deliberately undermined patient care and cheated the Medicare program.

1. Matrix Knowingly Reported False Diagnoses to Make Patients Appear Sicker Than They Were

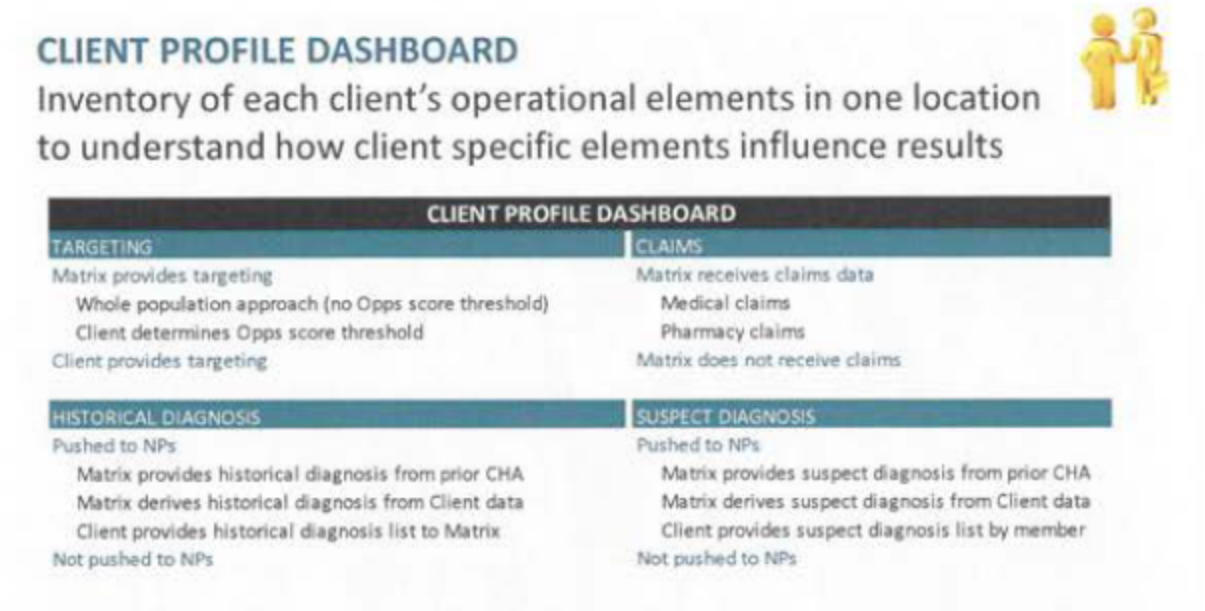
142. Recall that the Medicare program uses a risk-adjustment model, called the Hierarchical Conditions Category ("HCC") model, which takes into account both demographic factors (such as age and gender) and medical conditions of a patient to determine the RAF (risk-adjusted factor) for patients ("patient RAF scores") in MA Plans. The medical conditions shown by diagnosis (ICD) codes—as determined and reported by Matrix in this case—are mapped to one or more HCCs, which are categories of clinically-related medical diagnoses. 42 C.F.R. § 422.2.

143. Matrix routinely created false diagnoses that would be used in the HCC model to inflate the values of patient RAF score and make them appear "sicker" and a higher risk for the insurers. Internally, Matrix referred to this practice as creating "high value HCCs."

144. By its own words, the Matrix strategy ("opportunities to move up major categories [increases numbers of ICD codes with serious diagnoses]") was to fraudulently use diagnostic codes ("diagnostic gaps") to make patients appear sicker than they actually were ("apply numeric values to gaps to create an opportunity score.")



145. To set in motion its aggressive strategy, in Matrix lingo, it directed its clinical staff to "capture historical and suspect diagnoses" from (medical and pharmacy) claims data.



146. Translated, this Matrix strategy described in internal documents like the one above played out like this:

- Use existing diagnoses found in the patient medical records maintained by the MA Organizations ("clients") as a starting point ("capture historical diagnosis")
- Perform tests on all patients ("whole population approach")
- Identify potential high value diagnoses based on these tests, patient symptoms or medications taken (identify "suspect diagnoses")
- Re-diagnose patients with high value illnesses with no proper assessment or physician oversight to make them appear sicker (and riskier) than they actually were.

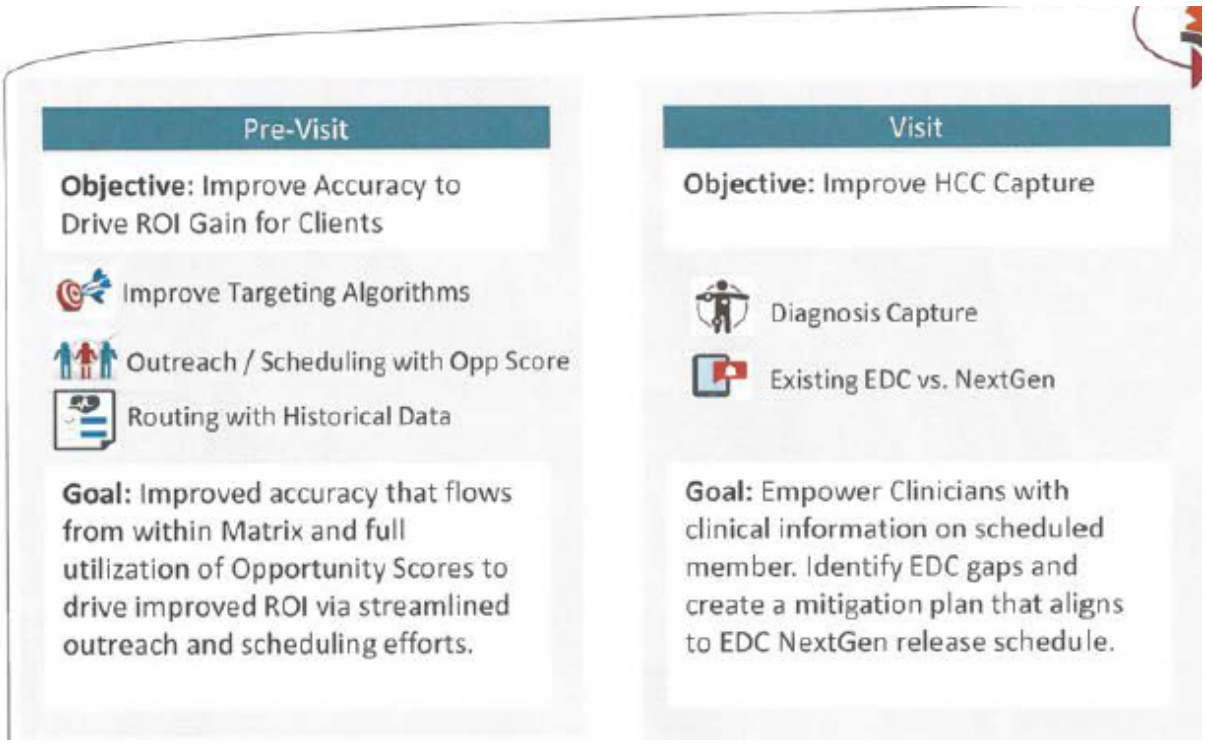
147. As examples of the above:

- If a patient was taking a heart-related medication but had no documented history of heart disease, consider heart disease a "suspect diagnosis" and check the "ICD-10 code I73.9" box for peripheral artery disease ("PAD")
- If a patient had a chronic cough but no history of disease, consider COPD a "suspect diagnosis" and check the "ICD-9 code J44.9" box for COPD
- If a patient was obese but no history of diabetes, consider diabetes ("DM") a "suspect diagnosis" and check the "ICD-10-CM Code E11" box for Type 2 diabetes mellitus.

148. Matrix knew that patients with more serious diagnoses like peripheral artery disease ("PAD") and diabetes mellitus ("DM") posed higher risks to the insurers and would produce a higher RAF score. To overlook the opportunity to inflate diagnoses for these patients would result in "missed opportunities" for a higher return on investment.

149. According to Matrix, diagnosing patients with peripheral artery disease (PAD) or diabetes mellitus (DM) was a "value-add service on completed CHAs [comprehensive health assessments]" to MA Organizations. To justify its falsification of more serious diagnoses codes than warranted for patients, Matrix directed its staff to perform costly—and often unnecessary—diagnostic tests to avoid "missed value-add service opportunities to drive sales."

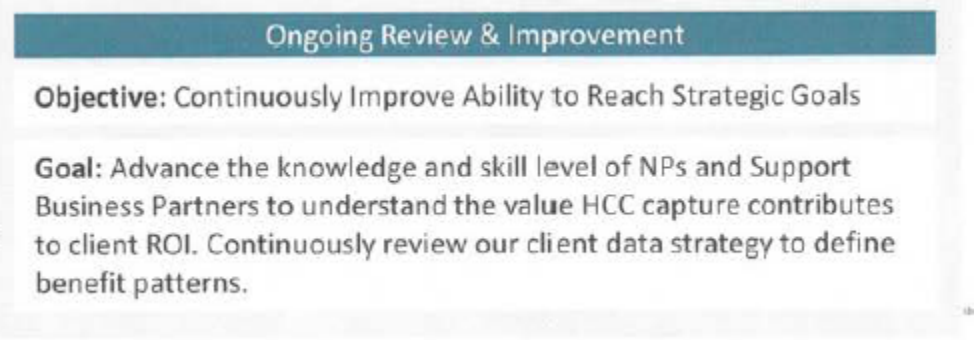
150. Matrix believed that increasing its return on investment ("ROI") required it to "improve HCC capture" to increase patient RAF scores. As its first steps before meeting with a patient ("pre-visit"), Matrix created an algorithm to target patients ("improve targeting algorithm") whose existing medical records ("routing with historical data") would pose an opportunity to drive a return on investment (i.e., patients with "opportunity scores to drive improved ROI)."



151. The visit with the patient itself is described as no more than a way to increase "HCC capture" by arming the clinical staff with data before the face-to-face visit ("routing with historical data") with no talk of meaningful patient interaction, assessment or diagnosing ("empower clinicians with clinical information on scheduled member"). Instead, clinical staff were pressed to change patient diagnoses based only on "suspect diagnoses" ("diagnosis capture") to increase patient RAF scores. Remarkably, patients are labeled inhumanely as "opportunities," and valued based upon their ability to generate "HCC capture" or "ROI" for Matrix.

152. The nurse practitioner was seen as no more than an automaton in the Matrix scheme. Their role was to "understand the value HCC capture contributes

to client ROI" and to "continuously review [Matrix] client data strategy to define benefit patterns."

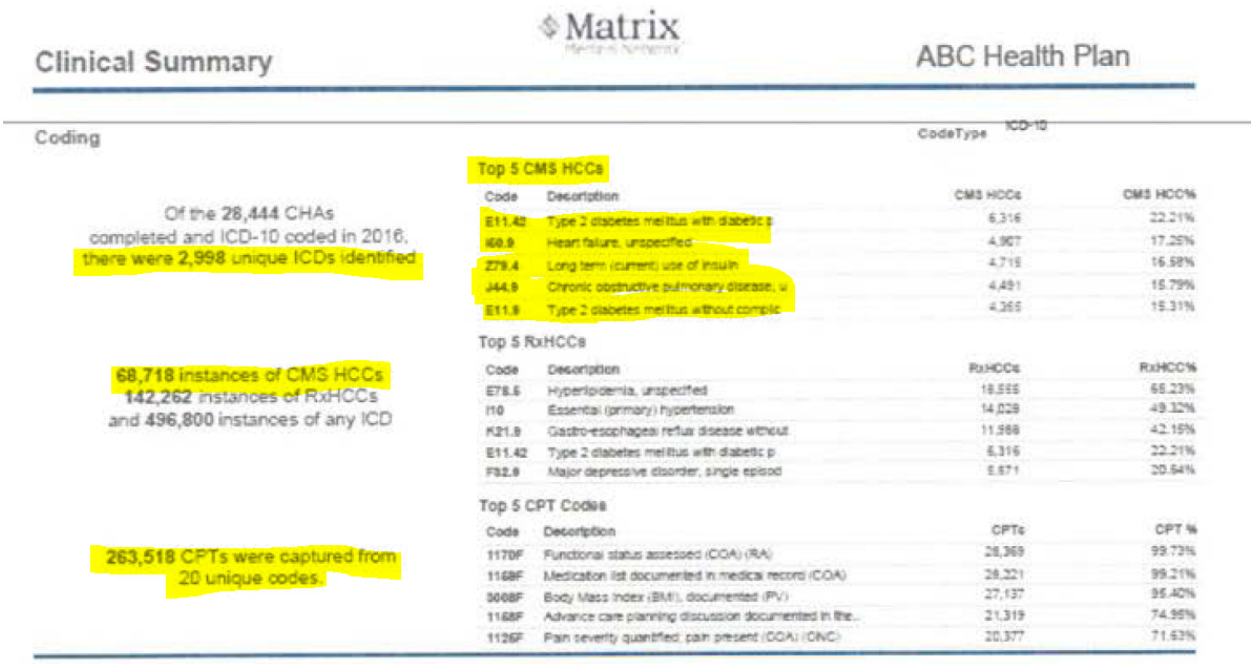


153. Matrix staff were expected to mine patient medical records before in-person (face-to-face) health assessments looking for "suspect diagnoses."

154. Once the Matrix clinician saw the patient, different staff at Matrix corporate offices who had not visited with the patient reviewed the notes from the patient visit to search for additional high value HCCs to add to the patient's medical record.

155. To ensure that it was meeting its objectives, the marketing and sales staff played an unusual and prominent role in clinical decisions and health assessments to ensure Matrix clinical staff were creating high value HCCs.

156. Matrix was aggressive in marketing its ability to "capture [new] diagnoses" to fraudulently inflate patient RAF scores through the HCC model:



(highlighting added)

157. Matrix marketed to its MA Organizations the "HCC capture" they could enjoy based purely on numbers and not the actual disease states of patients.

158. One of Matrix's MA Organizations has an almost 2:1 return on "HCC capture" measured purely on the increasing number of health assessments performed by Matrix. Further, the insurer's high "HCC capture" scores are largely the same for its patients in both the western and eastern regions.

159. Every diagnosis (ICD) code submitted to the Medicare program must be based on an in-person (face-to-face) visit with the patient and that visit must be documented in the medical record. *United States ex rel. Silingo v. Well Point*, Inc., 904 F.3d 667, 623-624 (9th Cir. 2018).

160. However, Matrix created and reported to its MA Organizations and the Medicare program made-up diagnoses for patients without face-to-face visits.

161. One of Matrix's many "MA Organizations" contracted with Matrix to perform a special "diagnoses verification project." In performing the review, the rule of thumb directed by Matrix senior management was to follow the "happy path" in contrast with the "unsupported path." Patients whose historical diagnoses were systematically "confirmed" by Matrix were said to be on the "happy path."

162. Pursuing the "happy path" preserved contractual relationships with MA Organizations and ensured a return on investment.

a. False Diagnoses of Heart Disease and Diabetes Made Patients More Valuable to Matrix

163. Matrix knowingly, systematically and fraudulently diagnosed patients as having serious diseases such as peripheral artery disease ("PAD"), peripheral vascular disease ("PVD"), heart failure, and "diabetes with complications," which led to higher RAF scores for its patients.

164. To drive high value diagnoses, Matrix drafted "cheat sheets" for its coding and clinical staff for "high value" ICD codes, including peripheral vascular disease, peripheral artery disease and diabetes. Its cheat sheet was accompanied by a "tip sheet" that encouraged a "check box" approach for diagnoses.

165. For example, the tip sheet allowed Matrix staff to code a patient as having a first-time diagnosis of peripheral vascular disease ("PVD") if only two

boxes on the cheat sheet of PVD symptoms could be checked. Not surprisingly, certain symptoms can often be signs of varying conditions or diseases. If a patient reported to the Matrix clinician that she had "cool lower extremities" and "thin shiny skin"—two symptoms of peripheral vascular disease as well as other potential causes—Matrix reported to Medicare that the patient had peripheral vascular disease, ignoring the patient's medical history and test results to the contrary. Obviously, observations or reports of cold feet and thin shiny skin do not alone lead to a diagnosis of peripheral vascular disease.

166. Under Matrix's process, "documenting" a serious diagnosis using ICD Codes called for as little as eyeballing a patient to see if they had "shiny skin" or reported "cool lower extremities" (their feet were cold), or by looking at medications they had taken (statins), or even a patient's own self-diagnosis.

167. Matrix's "tip sheet" also allowed medication taken (as reported by the patient) to support a diagnosis of peripheral vascular disease or peripheral artery disease without any corroborating clinical tests or other medical documentation from the patient's medical provider.

168. For instance, the "tip sheet" instructs "if patient provides any of the following history, **this alone is sufficient support**": (1) "follows vascular specialist for diagnosis," (2) "reports finding of peripheral 'blockage' on previous testing, document monitoring/treatment," or (3) "vascular changes due to trauma,

radiation and vasculitis may support peripheral vascular disease or peripheral artery disease but do not support atherosclerosis." (emphasis added)

169. To avoid any reluctance by its clinical staff to diagnose peripheral vascular disease or peripheral artery disease, the "tip sheet" instructs that, if the patient believes they have peripheral vascular disease or peripheral artery disease that is managed without medication, "[t]his is adequate but weak support for diagnosis – if possible strength[en] with PE findings, how it was diagnosed, risk factors, treatment such as lifestyle modifications, and document support clearly."

170. Matrix was also known to troll for indigent patients and patients in rural areas who often did not have routine access to a health care provider and even less access to specialists. Allowing patients who often did not have routine access to a health care provider and even less access to specialists to make self-diagnoses of serious diseases is especially troubling. This population was notably unprotected from Matrix's practices because these patients usually had no primary care physicians who were looking out for them.

171. Yet, Matrix routinely diagnosed patients with peripheral artery disease based upon a single characteristic or a single test, and without a proper assessment of whether the patient actually suffered from the disease. The patient's primary care physician was often in the dark because Matrix's efforts to share these diagnoses with the patient's provider were haphazard at best.

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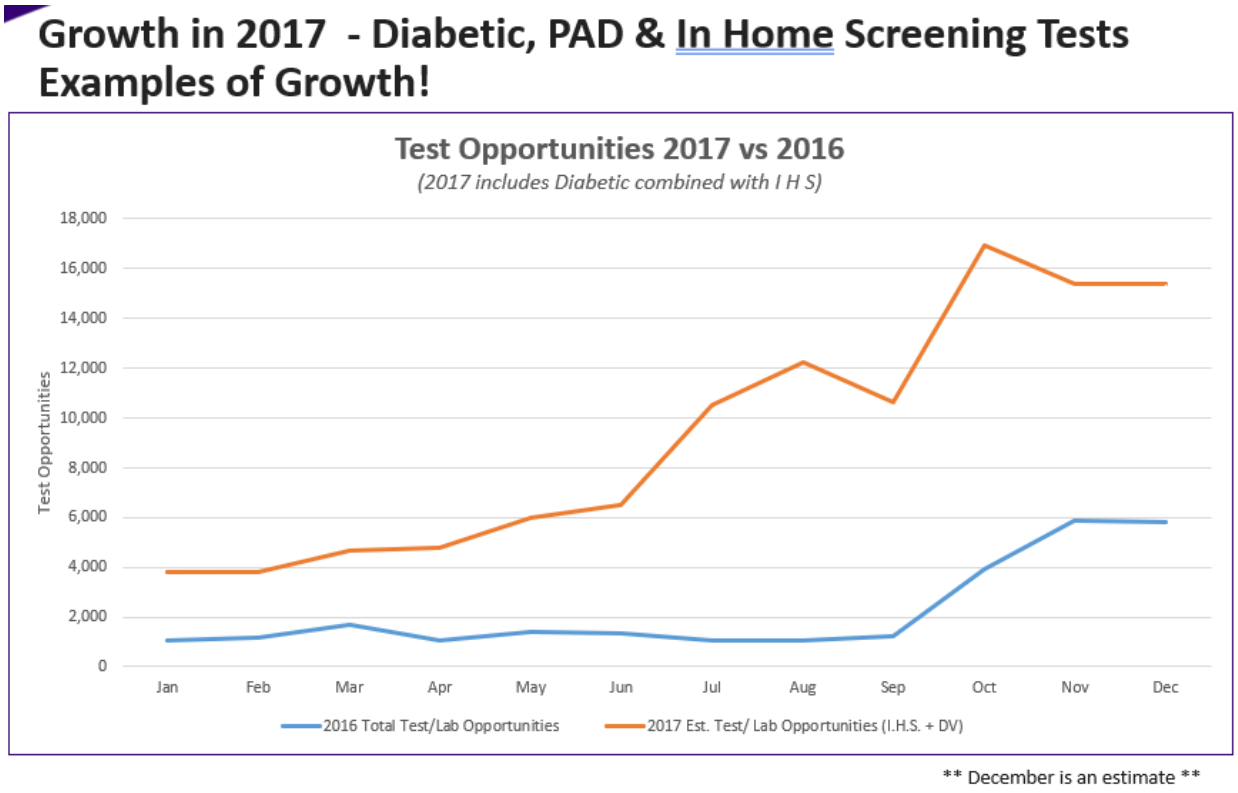
172. MA Organizations provided Matrix lists of patients who may have been eligible for peripheral artery disease tests based on historical diagnoses and services rendered.

173. Matrix, however, decided to test all patients for peripheral artery disease, having learned that a diagnosis of peripheral artery disease, in particular, maximized the potential to inflate high value HCCs.

174. Further, Matrix was paid between $350 - $450 for each health assessment and an additional $125 for each patient tested for peripheral artery disease.

175. Matrix also set goals to increase the numbers of patients who were administered tests to diagnose peripheral artery disease and diabetes without any evidence that its patient population needed those tests: “achieve 15K of diabetes visits” or “achieve $2.2M of add on services (labs, PADs, etc.).”

176. Not surprisingly, the result was an explosion in testing that led to greater numbers of high value HCCs, higher patient RAF scores, and increased reimbursement and ROI from the Medicare program.



177. Testing for peripheral artery disease and diabetes doubled between 2016 and 2017 without any indication that the patient population tested was sicker or more likely to have peripheral artery disease or diabetes. The increased testing simply allowed Matrix to inflate its numbers of patients with falsified diagnoses.

178. Matrix senior executives continually fueled this fire by urging diagnoses that would lead to high value HCCs.

179. In an email blast to Matrix staff in April 2017, the Chief Operating Officer touted "results" defined as numbers of patients "touched," "visited" or "dialed" by phone and the numbers of tests with "positive results" for serious diseases such as peripheral arterial disease ("PAD"), kidney disease and diabetes

("MAU" and "A1C" testing).

Matrix results are generating a lot of attention in the market. These results will enable us to continue to grow and provide services to over 600,000 members in 2017. Below are some record breaking highlights from the first quarter:

- In the first quarter, Matrix touched 144,000 members. This is a new quarterly record.
- In March, Matrix visited 52,000 members. This is a new monthly record.
- In March, Matrix visited 3,500+ members in facilities. This is a new monthly record.

The above is extremely impressive. Even more impressive is the awareness created by our committed Providers and the time spent with members; positively impacting the lives of the Member, Members' families and friends.

- 456 MAU tests completed with 142 positive results (31%).
- 784 A1C tests completed with 92 positives results (12%).
- 771 FIT tests completed with 66 positive results (8.5%).
- 489 Peripheral Arterial Disease (PAD) tests completed with 232 positive results (47%).
- Referred 11,500+ members to Case Management.
- Contacted PCP 4,600+ times.
- Dialed 911 almost 200 times.

180. The numbers of "positive test results" for these diseases are unusually high for an average Medicare population and Matrix executives were well aware that those numbers were not consistent with authoritative data.

181. For example, Matrix's own marketing pamphlet identifies public data showing that an estimated 20 percent of Medicare patients (at most) are likely to suffer from peripheral artery disease. Yet, internally, Matrix COO is touting a "record breaking" 47 percent for Matrix patients—more than double the maximum population of likely PAD sufferers.

182. Equally eye-popping, the internal email blast shows that Matrix staff contacted the primary care physicians for its patients less than one percent of the time—on behalf of only 4,600 patients out of 600,000 patients.

183. In short, Matrix senior executives ensured that Matrix staff's time was almost exclusively spent on finding ways to inflate the numbers of patients labeled with serious heart diseases and diabetes with almost no time or commitment to actual patient care and services.

b. Faulty and Unreliable Diagnostic Tests Supported the False Diagnoses

184. Worse than over-testing patients at the expense of the Medicare program, Matrix also knowingly misinterpreted or misused test results by relying on faulty tests to falsely diagnose patients with serious and chronic illnesses that resulted in high value HCCs.

185. For example, the gold standard test in the industry for peripheral vascular disease and peripheral artery disease is an angiogram or blood test.

186. However, less invasive measures are also available, such as the Ankle-Brachial Index ("ABI"), which is a noninvasive vascular test in which blood pressure cuffs and a hand-held ultrasound device (called a Doppler waveform or transducer) are used to obtain information about arterial blood flow by a measurement of the blood pressure in the lower leg compared to the blood pressure in the arm. Similarly, non-invasive but not as "tried and true" by industry standards is the test used by Matrix called a QuantaFlo, which is a nerve conduction test to measure blood volume changes through use of a toe attachment.

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187. At some locations, Matrix had specialized equipment for testing furnished by the company QuantaFlo. Guidance accompanying this equipment provided that to obtain accurate results to determine nerve conduction, clinicians should use toe warmers:

> Conducting the [PAD QuantaFlo testing] Test foot temperature, note in CHA. Place foot warmers on toes, this should be done for All members. . . . ***Test toes FIRST***, immediately after warming (within 2 minutes)

(emphasis added).

188. Knowing that use of toe warmers was more likely to rule out the presence of peripheral vascular disease or peripheral artery disease for many patients, Matrix management decided to not encourage or require toe warmers for testing. This increased the chances that test results would lead to false positives due to patients' cold feet—which they did. The Matrix individual in charge of supplies routinely stated that toe warmers were not being used or ordered by its clinicians for use with the QuantaFlo tests. When raised as concerning, given their importance to accurate test results, the Senior Vice President of Clinical Services responded: "I really don't care that the providers are not ordering or using toe warmers."

189. Matrix also used forms for QuantaFlo testing that it pre-populated with characteristics showing the existence of peripheral vascular disease or peripheral artery disease (i.e., requiring Matrix staff to "uncheck" boxes), leading

to increasing numbers of false positives for more serious diseases: "NOTE – this will stay populated for your next member, be sure to change or delete the information from the previous member to accurately reflect the member currently being tested." While not directly stating that the boxes should remain checked, Matrix management was well aware that the pre-populated forms were leading to false positives.

190. Matrix also had other tricks up its sleeve to encourage false positive test results for these heart diseases. It stopped its staff from relying on a preventative measure to lessen or eliminate false positive results from the QuantaFlo test.

191. According to the test equipment manufacturer, a built-in warning appears if a test result was too poor to be indicative of a valid finding and a "waveform" would be generated: "A warning box may appear if the test result cannot be used, indicating it was a poor test. Redo the test. Other warnings may indicate the ambient lighting is too high. Either darken the room or cover the testing area to decrease the lighting and retest." This warning system was designed to help avoid relying on tests that reflected false positives when diagnosing a patient.

192. Without medical justification and over the objection of the Corporate Vice President of Quality and Operations, Matrix deactivated this warning function

only to reactivate it on occasions when its own providers complained to management that the QuantaFlo was producing false diagnoses of peripheral artery disease and peripheral vascular disease.

193. Even while knowing that the QuantaFlo test was generating false positive test results for peripheral vascular disease (PVD) and peripheral artery disease (PAD), the Matrix "tip sheet" instructed: "if testing positive, no other support needed for diagnosis."

194. As a final deterrent to obtaining accurate test results for PAD and PVD diagnoses, Matrix instructed its clinical staff that even "[i]f test results are negative [Matrix] provider may [still] elect to make a clinical diagnosis, [if] support and diagnosis must be clearly documented."

195. Another test Matrix misused to fraudulently diagnose patients with high value risk-adjusted ICD codes was the echocardiogram ("ECHO").

196. Matrix knowingly applied erroneous standards in interpreting ECHOS. In fact, several MA Organizations called out Matrix on this practice.

197. A timeline and other documents were provided to Matrix Chief Operating Officer on May 25, 2018. They showed the COO the extent to which one of its MA Organizations and Matrix staff were flagging for executive management that these echocardiograms were leading to false diagnoses of diastolic heart failure:

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- "Matrix Mobile's outdated "ECHO BASIC" diagnostic tool objected to by major client [MA Organization]" because the MA organization suspected that Matrix was knowingly using the wrong clinical criteria to generate false positives
- "Email forwarded to [a Matrix physician] who replied stating he agreed with 'virtually everything' [the MA Organization] presented"
- "Meeting with [the MA Organization] ECHO concerns addressed by [a different Matrix physician]"
- "[A]nother follow-up meeting with [Matrix Nurse Practitioner and Director, Clinical Design] in order to determine how this will be documented within the current Matrix Mobile EMR limitations (much of the criteria is not simple drop down selection within the HRA [health record account])"
- **"[E]mail again regarding the current ECHO Basic use as reference knowing this is concern for over diagnosis Diastolic HF"**

(emphasis in original).

198. The final bullet in this timeline shown to the Matrix Chief Operating Officer makes clear that the COO knew that Matrix's interpretations of echocardiograms resulted in false diagnoses of patients with heart failure – a known high value ICD code.

199. Yet, Matrix persisted in using faulty and unreliable echocardiograms to support serious diagnoses, leading to inflated high value HCCs.

200. In July 2018, another of its MA Organizations wrote to Matrix with similar concerns:

> We've had a meeting with our medical directory[sic] here at [MA Organization] and reviewed the clinical protocols HealthFair provided and at this time we do not feel comfortable with HealthFair preforming [sic] Echo's on our members. We've received feedback from our cardio groups that their [sic] have a low comfort level with these tests being performed by vendors. In addition, our internal staff is looking into writing further clinical policy's surrounding these tests. Can you please relay the message that we would not like either of the HealthFair buses to perform these tests moving forward?

201. Matrix COO and Senior Vice President of Clinical Services were again informed after a "chart review" that patient cardiac conditions continued to be "over-code[d]" due to improperly administered echocardiograms.

202. Matrix physicians, including a cardiothoracic surgeon, repeatedly complained to management that the Matrix echocardiograms were an unreliable source to use to diagnose patients with heart disease.

203. To address these mounting concerns, one Matrix Chief Medical Officer made a proposal in July 2018 to Matrix COO and Senior Vice President of Clinical Services. He suggested allowing Matrix staff to check a box for diastolic heart disease on the "cheat sheet" based solely on the echocardiogram only if the

result was significant (an ejection fraction 'ef' of less than 55%): "[b]y proceeding this way, we will not be over diagnosing DHF [diastolic heart failure], and it will make it easier for the NPs [nurse practitioners] and coders."

204. However, rather than adopt the doctor's proposal to limit reliance upon known faulty echocardiograms, the Senior Vice President of Clinical Services decided that Matrix would rely even *more* upon the faulty tests to diagnose heart disease. She added 4 additional "check box" categories for diastolic heart failure based solely on echocardiogram results: "[w]e realize that this list has a few more items than you initially provided (these items are in **bold print**); however, we wanted to be sure to include a culmination of potential diagnoses that could be reflected on an echo report."

205. Even more troubling, Matrix directed its staff to falsify diagnoses for heart disease even when the echocardiogram results were negative.

206. For example, one Matrix patient had a normal echocardiogram result of 55 percent, which indicates no presence of heart disease. (A normal ejection fraction ("ef") is 55 percent or more, which means that 55 percent of the total blood in the left ventricle is pumped out with each heartbeat). Along with a normal test result, the Matrix physician diagnosed the patient with hypertension, not heart failure, and used the ICD code for hypertension.

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207. Yet, the Matrix Clinical Documentation and Quality Review Department ("CDQI") called this a "missed diagnosis" and directed the physician to "pick [ICD code] hypertensive heart disease WITH HF [heart failure]. Delete the Essent[ial] HTN [hypertension] dx. Update notes section to reflect dx." Responding with disbelief, Matrix Southeast Region Clinical Manager objected: "This is a request from today to update an ECHO. This [is] absolutely contrary to what we have been advised to do based upon the latest update. The EF is 55%. Please advise?"

208. As shown by these examples in 2018, Matrix knowingly and fraudulently submitted ICD codes for heart disease on behalf of patients, even though Matrix staff warned management that they were based on false echocardiograms results:

- "ECHO findings [for Medicare Patient 1] are not enough support for "***Hypertensive heart disease with Heart failure" as the diagnosis, remove diagnosis***, "Hypertension" is the appropriate diagnosis for this patient. Update note and diagnosis. Let me know when complete so the chart can be sent to coding for completion before signing." (emphasis added)
- "ECHO findings [for Medicare Patient 2] indicate "_Hypertensive heart disease WITHOUT Heart failure_" as the diagnosis, **remove HF diagnosis**. Update note and diagnosis. Let me know when complete so the chart can be

sent to coding for completion before signing." (emphasis added)

- "ECHO findings [for Medicare Patient 3] are not enough support for "***Hypertensive heart disease without Heart failure" as the diagnosis, remove diagnosis***, "Hypertension" is the appropriate diagnosis for this patient. Update note and diagnosis. Let me know when complete so the chart can be sent to coding for completion before signing." (emphasis added)
- "ECHO findings [for Medicare Patient 4] are not enough support for "***Hypertensive heart disease without Heart failure" as the diagnosis, remove diagnosis***, "Hypertension" is the appropriate diagnosis for this patient. Update note and diagnosis. Let me know when complete so the chart can be sent to coding for completion before signing." (emphasis added)
- "Provider documentation [for Medicare Patient 5] correct – systolic HF. ***Appears there is a coding error – coder assigned dx of combined HF – provider only indicated systolic in their notes. Echo only consistent with systolic***."

209. In July 2018, Matrix non-clinical staff refused to correct these diagnoses and fraudulently submitted them to the MA Organization, which submitted them to the Medicare program, which paid the false claims:

> I have no authority to change a chart that has been closed. Secondly, where are the guidelines. I cannot amend a chart without any rationale as I am following the

guidelines we have. What criteria are you using, thanks?

210. Around this time, the Corporate Vice President of Quality and Operations informed the COO and the Senior Vice President for Human Resources that she refused to "code" patient diagnoses resulting from echocardiograms that were conducted during Matrix mobile health clinic appointments, contrary to the directive of the Senior Vice President of Clinical Services.

211. Despite the added involvement of the Senior Vice President for Human Resources on this issue, the fraudulent use of echocardiograms persisted.

212. On July 23, 2018, Matrix Nurse Practitioner and Clinical Documentation and Quality Improvement Manager made a written presentation to the Senior Vice President of Clinical Services and the COO in which she echoed the same concerns as the Vice President of Quality and Operations relating to Matrix's knowingly fraudulent use of echocardiograms.

213. Once again, rather than address these troubling issues raised by numerous insiders and outsiders to the company, the Senior Vice President of Clinical Services discounted these concerns during the meeting, and the COO chose to remain silent on the subject.

214. Once the Corporate Vice President of Quality and Operations stopped relying upon echocardiograms to diagnose patients, Matrix for a time was not able to submit ICD codes or invoices to its MA Organizations for payment of services.

This placed Matrix outside of the performance guidelines set by the MA Organization for the timely submission of patient medical records. As a result, the Senior Vice President of Clinical Services took over the role of submitting false patient diagnoses based on the echocardiograms with the approval of the COO.

215. A meeting took place on October 9, 2018, among the COO, the Corporate Vice President of Quality and Operations, the Senior Vice President of Clinical Services, the clinical manager of Matrix mobile health services, and the Director of Quality Operations. Topics of discussion at the meeting included (a) complaints relating to Matrix's continuing fraudulent use of echocardiograms, including the failure to implement functional clinical guidelines to govern their use, and (b) Matrix's practice of diagnosing and attributing ICD codes to patients without meeting in-person (face-to-face) with the patients.

216. Yet again, the concerns raised by the Corporate Vice President of Quality and Operations were unwelcomed and no changes to current practices were implemented.

217. Matrix also knowingly used unreliable blood tests to "code" patients as having diabetes to inflate their RAF scores.

218. Often, Matrix administered blood tests to determine whether certain "hemoglobin A1-C levels" present in a patient's blood were indicative of diabetes, but such tests were of "exceedingly poor quality" and unreliable to support a

diabetes diagnosis, as Matrix staff documented in the patient medical record.

219. However, instead of responding to these concerns of poor test quality, Matrix management often directed staff to remove the notes that reflected inconclusive test results, as shown by this example:

> please remove the A1C remarks from this patients' chart? Also please keep in mind that the remarks section for each test goes back to the client and PCP. Remarks such as the below should only be internal . . . .

220. The Director of Medical Records forwarded this same communication to the Corporate Vice President of Quality and Operations, the Senior Vice President of Clinical Services, and clinical manager of Matrix mobile health services asking: "I know you all have a weekly meeting with [Matrix contracted physicians] and I was wondering if you would be able to remind them that the remarks section gets generated on the PCP report. Notes such as the below, should be communicated internally."

221. Separately, concerns were also raised about patient diabetes diagnoses when the retinal scans did not confirm diabetes: "[c]onflicting information regarding diabetes diagnosis between Retina Scan and CHA [comprehensive health assessment]."

222. Further, because of Matrix's myopic focus on numbers and dollars, patient medical records were unreliable and misleading because they did not provide an accurate picture of the patient's real medical condition.

223. In short, Matrix knowingly used, relied upon and created false, faulty and unreliable test results to fraudulently apply diagnoses codes to patients indicating that they had serious heart diseases or diabetes when they did not. These fraudulent diagnoses were used to support high value HCCs. These high value HCCs were used, in turn, to support false claims that Matrix caused to be submitted to the Medicare program.

2. Matrix Pressured its Clinical Staff with Unrealistic "Metrics"

224. Matrix placed pressure on its clinical staff through the use of metrics. Clinical staff were not rewarded for the quality of patient care and, in fact, quality patient care was disincentivized.

225. Matrix's system of remuneration emphasized quantitative metrics, causing staff to increase productivity to the point of jeopardizing patient care and safety.

226. Frazier executives pressured Matrix clinical staff to dramatically increase the volume of health assessments by certain percentages and baselines. This focus on metrics to increase return on investment can be seen in internal company documents, including this one from January 2017:

- 44% More CHAs [Comprehensive Health Assessments]/Day in October than January!
- CHA per day run nearly 3K at peak in October
- The percent of total CHAs/Day more than triples from May to December

227. To reach these numbers and satisfy its MA Organizations, Matrix pressured staff to (a) increase the numbers of patient assessments it completed and (b) particularly increase the numbers of high value HCCs.

228. For starters, Matrix compensated its staff only for their initial health assessment of a patient. If the health assessment had to be supplemented or amended, as was often the case, such work was unpaid.

229. As a result, Matrix pushed its staff to inflate patient RAF scores upfront and avoid uncompensated work on the back-end. If staff maximized high value HCCs at the get-go, they would have no need to re-visit that patient record before submitting it to the MA Organization on behalf of the patient. The well-known Matrix mantra was "minimum touches, maximum diagnoses."

230. If Matrix was able to obtain one of its clinical staff's "sign off" of a patient record that appeared to support the high value ICD code without requiring follow-up work, this speedy completion of the chart was known as a "fly by."

231. A "fly by" was the holy grail at Matrix. A "fly by" meant that the patient medical record did not need additional work by Matrix staff, which would have been uncompensated.

232. Although less desirable, Matrix also pressured its nurse clinicians to create documentation after the face-to-face visit to support fraudulent diagnoses where necessary.

233. Physicians were also pressured to perform assessments so hurriedly that they often had little to no time to complete and sign the patient record:

> [Nurse Practitioner, Clinical Documentation and Quality Improvement Manager] sends assessments to provider for signature
>
> Provider who sees member on the mobile unit must complete documentation of the assessment (to include documentation of results from tests performed on mobile unit) and sign assessment before it goes to CDQI [clinical documentation and quality improvement department] and coding.

234. That also left patient records vulnerable to fraudulent "doctoring" to support high value HCCs that was rampant.

235. Matrix itself was paid based on the *numbers* of patients assessed and the *numbers* of diagnostic tests performed, which Matrix took as an incentive to pressure its staff.

236. One MA Organization paid Matrix a bonus payment for each assessment completed above a particular target yield: "With the completion of the 1,852 billable assessments and the > 33% yield by 6/30/2016, Matrix invoiced [the MA Organization] the $25.00/assessment bonus or $46,300.00." If Matrix exceeded the target, the MA Organization paid Matrix bonuses.

237. Matrix medical staff were paid to churn patients through the system as quickly as humanly possible. Staff were financially rewarded for "coding accuracy" and "exceeding targets"—"buzz words" for using ICD codes that make

patients look sicker than they are and churning out larger numbers of patient assessments.

238. By design, Matrix non-medical staff such as coders and billers, and medical technicians who did not visit with the patient, completed the patient medical record back at corporate headquarters under pressure by Matrix to use high-value diagnosis codes, which Matrix then used to cause the submission of false Medicare claims and generate greater Medicare reimbursement.

239. Indeed, Matrix treated the health assessments like a "hit and run." They were not used to benefit patients. They were no more than a means to an end. Matrix staff often left parts of the health assessments incomplete because of the pressure to complete as many health assessments as possible:

> I am attaching a spreadsheet with members names and the significant steps in the process that need to be completed in 90 days. ***You will see that first step medication review in the field has not [been] done for many members.***

(emphasis added)

240. Little to no consideration was given to the patient once Matrix submitted the ICD codes to its MA Organizations to use in calculating Medicare payments. Treatment plans amounted to templated language auto-populated into patient records. There was little to no follow-up with a patient's primary care provider. There was little to no follow-up on referrals to specialists or additional

services. There were little to no prescriptions written for patients or follow-up on patient medication management.

241. Matrix monitored staff health assessment completion rates and penalized staff for failing to meet its ambitious metrics.

242. At one point, Matrix executives even formed a peripheral artery disease "Provider Task Force" to track the number of peripheral artery disease tests completed by its clinical staff. Its eagerness to continually increase numbers caused it to meet on a daily basis to kick-start its efforts and to eventually meet every week. The task force also dehumanized patients by calling them "opportunities":

# of NPs	# of Months NP falls into	Sum of Opportunities	Sum of Not Completed	Opportunities per NP	Not Completed per NP	Not Compl. %	CM %
2	5	740	673	370	337	90.9%	9.1%
11	4	3,416	2,380	311	216	69.7%	30.3%
23	3	4,879	3,660	212	159	75.0%	25.0%

(highlighting supplied)

243. If a Matrix health care provider had a completion rate of less than 50 percent, the Matrix COO sometimes called the provider and demanded an explanation.

244. Matrix created scorecards to track the numbers of patients enrolled and the numbers of visits with patients.

245. Matrix pressured its clinical staff to conclude that test results for diagnoses that led to high value HCCs were positive. Training of clinical staff at Matrix was focused on how to code for serious and chronic diseases such as peripheral artery disease, peripheral vascular disease, and diabetes—all designed to teach staff how to increase Matrix's return on investment despite potential harmful consequences to patients.

246. Matrix's COO required each internal department to submit several times each month an updated report known as the "IOI report" ("IOIs") or the "metrics report." All metrics reports were available on a shared drive to allow its executives to review them.

247. Each report detailed metrics to help Matrix reach its numbers goals and maximize ways to generate return on investment for its MA Organizations and Matrix.

248. These metrics reports provided raw data showing how Matrix was faring with its goal to increase the numbers of completed health assessments and high value HCCs and RAF patient scores. The reports also allowed it to continually evaluate whether and how it needed to "rejigger" its electronic health records ("EHR") software to reach these goals.

249. Metrics Reports since 2016 show that Matrix executives knew that over 90 percent of ICD diagnosis codes for its patients were based on

"suggestions" made automatically by its electronic software and not based on in-person (face-to-face) visits with a Matrix clinician. They also reveal that Matrix (ICD) coders were submitting on average at least 11 health assessments per hour when industry standard is close to one-half that amount (no more than 6 assessments coded per hour).

250. Matrix pushed its clinical staff to code as many patients as possible with peripheral artery disease ("PAD"). As shown by every metrics report since at least 2016, Matrix was aware that the figures published by the CDC show no more than 20 percent of individuals older than age 60 are likely to have PAD with the range according to the CDC being 12 to 20 percent at the high end. ("Approximately 8.5 million people in the United States have PAD, including 12-20% of individuals older than age 60.")

251. One Matrix metrics report on January 5, 2017 shows:

- **PAD Testing Update**

PAD Testing Update: 311 tests completed in 2016				
Client	Start Date	Total Tests Completed	# with (+) PAD diagnosis	% of PAD diagnosis/total completed (Goal: 20%)
[redacted]	6/28/2016	220	71	32.3%
[redacted]	7/25/2016	91	59	64.8%

252. Strikingly, Matrix diagnosed peripheral artery disease (PAD) in almost 65 percent of all patients of one of its MA Organization.

253. Another Matrix metrics report on March 16, 2017 shows:

- PAD Testing Update: 2017 YTD

PAD Testing Update: 140 tests completed in 2017				
Client	Start Date	Total Tests Completed	# with (+) PAD diagnosis	% of PAD diagnosis/total completed (Goal: 20%)
[redacted]	6/28/2016	140	54	39%

254. In both examples above, Matrix scored well in excess of 20 percent of its patients as having PAD—more than two to three times the estimates of the CDC. Those are implausible figures.

255. Matrix also pressured clinical staff to test as many patients as possible for PAD and diabetes mellitus. As noted earlier, on top of the payment it received for a patient health assessment, Matrix was paid an additional $125 if it tested the patient for PAD and $750 if the visit resulted in a diabetes intervention.

256. Matrix employed high pressure tactics, sometimes making personal phone calls to physicians who resisted falsely diagnosing patients with serious diseases which they did not have.

257. Further, where Matrix physicians pushed back on making fraudulent diagnoses, Matrix continued to pressure them:

> Hi All, with the rollout of PAD [peripheral artery disease] testing we have been seeing a large number of queries for missed PPAD dx based on quantaflo testing. ***There has also been provider pushback especially when member is asymptomatic or has no PE findings. . . Ultimately we cannot make the provider add the***

> ***diagnosis but we can support and educate the provider on why they should consider the diagnosis***.

(emphasis added)

258. Matrix Senior Vice President for Clinical Services insisted that it was their "licensed responsibility" to make diagnoses and threatened to take them off Matrix's list of contractor-physicians.

259. For example, Matrix wanted physicians to diagnosis patients whose Matrix-administered tests showed positive for peripheral artery disease in instances where the patient displayed no physical signs of the disease. When the threats failed, Matrix requested another of its physicians to make the diagnosis—one who had not met in-person with the patient.

260. Matrix even used internal audits intended to protect against the fraudulent practices alleged in this Complaint to find additional "missed opportunities" to inflate patient RAF scores.

261. In one such audit, on November 15, 2017, the Senior Vice President of Clinical Services notified her staff that the Clinical Services Director "and her team will review the assessments for potential HCC missed opportunities and if something is identified, they will notify the [nurse practitioner in Clinical Documentation and Quality Improvement] of their findings and request that a rework be sent back to the provider for further consideration of amending the record."

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262. Despite all this downward pressure, Matrix falsely reassured one of its MA Organizations that its clinical staff were neither incentivized nor penalized based on "HCC capture," even though Matrix went to great lengths to pressure staff to "capture" historical and suspect diagnoses:

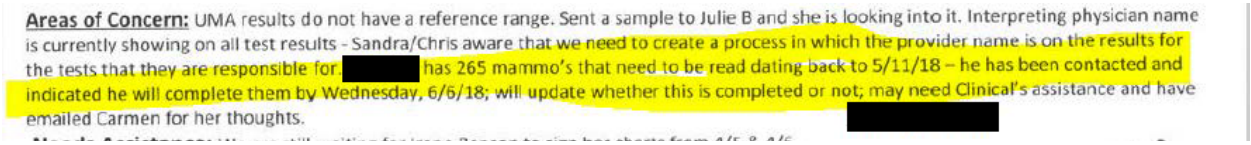
- "Empower NP with clinical info for decision making"
- "Minimize rework as much as possible (i.e., impact to the Provider)
- "Remove penalties for NP for capturing"
- "No NP [nurse practitioner] incentives/payment/NP performance tied to HCC capture"
- "No compensation from the client"
- "Tracking of HCC capture internally used for empowerment/minimize rework/client reporting"

263. Matrix also discouraged its staff to avoid spending time on assessments for patients whose diagnoses would not increase their RAF scores or return on investment.

264. For example, Matrix knowingly failed to properly administer mammograms or follow-up with patients who had concerning mammogram results because the results of mammograms (whether positive or negative for cancer) had no effect on ROI. As a result, Matrix providers were often poorly trained to interpret the results of mammograms, failing to recognize positive results and false negative results that required follow-up. As Matrix intended, its staff was not encouraged to focus on this aspect of patient care.

265. At other times, mammograms were either not timely completed or

follow-up was not conducted with the patient. One physician was so overwhelmed with mammograms that if test results appeared suspicious, he simply indicated that another mammogram should be conducted but no record was sent to the patient or the MA Organization, leaving the patient unaware of the suspicious results.


Areas of Concern: UMA results do not have a reference range. Sent a sample to Julie B and she is looking into it. Interpreting physician name is currently showing on all test results - Sandra/Chris aware that we need to create a process in which the provider name is on the results for the tests that they are responsible for. [redacted] has 265 mammo's that need to be read dating back to 5/11/18 – he has been contacted and indicated he will complete them by Wednesday, 6/6/18; will update whether this is completed or not; may need Clinical's assistance and have emailed Carmen for her thoughts. [redacted]

(highlighting supplied)

266. Further, Matrix pressured its clinical staff to create a paper trail to justify fraudulent diagnoses (ICD) codes. In a May 22, 2018 email, the Senior Vice President of Clinical Services warned clinical staff that their progress on this metric would be monitored:

> We will work with our QI [quality improvement] team to ensure that all our providers are accurately documenting disease processes that can be supported via medications, clinical findings, review of systems, positive test results, etc. We will need to schedule a follow up meeting in the subsequent weeks to identify our progress in this area.

267. A few days later on May 25, 2018, the Vice President of Quality and Operations confirmed to the Chief Operating Officer that this metric was being watched closely and enforced: "MAPS [mapping each patient's diagnosis codes to HCCs, the risk-adjusting diagnosis codes)] criteria required for support of diagnoses. Read receipts confirmed all staff in Matrix's Clinical Documentation and Quality Improvement department were aware of this update effective

immediately. This now should be fully implemented and followed."

268. In short, because of Matrix's myopic focus only on numbers and dollars, patient medical records were deliberately doctored to support any fraudulent diagnoses should the company be audited. Despite the importance of accurate diagnosing and medical records to patient care and treatment, Matrix did not intend that they provide a truthful picture of the patient's real medical condition.

3. Matrix Calculatingly Used EHR Software to Replace Clinical Judgment

269. Matrix viewed automation as the key to meeting its ROI goals. It systematized its process through its electronic health records ("EHR") software.

270. Internal company documents described its business strategy this way: to provide "high value to clients" (its MA Organizations) by pre-populating health assessment forms and using computer-aided (ICD) coding to "ensure that clients are able to submit claims with valid ICD codes in [a] timely manner resulting in high return on investment (ROI)."

271. Matrix was able to achieve these high coding completion rates because of the algorithm of its EHR software that it used to effectuate its fraudulent scheme.

272. In 2016, Matrix sought ways to use EHR software to more efficiently standardize patient coding of high value HCCs that would lead to higher RAF

scores for patients and higher yield for its MA Organizations.

273. Matrix executive management began the rollout of its new computer-aided coding EHR software in a town hall presentation to all staff in February 2016. Describing the software as "intuitive" and "less repetition in questions," it offered these features:

- Diagnoses can be selected along the way through the assessment. Questions regarding support and specificity for diagnoses are integrated into the diagnosis process.
- At the end of the CHA [comprehensive health assessment], providers confirm all diagnoses that were documented throughout the assessment. No longer a list of 180+ diagnoses to browse through and select.

274. Matrix health care providers were incentivized to "sign off" on computer-coded ICDs. They were compensated only for the numbers of health assessments they completed. If they asked questions, made comments to the patient record, or denied the Matrix "auto-diagnosis," they received no payment for the length of time spent doing these important follow-up responsibilities.

275. For all intents and purposes, clinical expertise and evaluation were removed from the process and diagnosing patients was left to the computer.

276. After 2016, Matrix designed another in-house software tool to help it meet its ROI goals called the Comprehensive Health Assessment Tool ("CHA Tool" or "CHAT"). Developed to minimize burden to health care providers and maximize time they spent with patients, Matrix designed the tool to instead push

more patients through the system and spend less time focusing on their care.

277. With CHAT, beginning at the end of 2017, Matrix was able to have diagnoses "pre-populated" in patient medical records before any Matrix health care provider met with the patient. This tool enabled Matrix to both download a patient's historical data provided by the MA Organization and "suggest" new diagnoses for the patient based on factors such as medications taken by the patient:

> Suggested Diagnoses will now pre-populate into CHAT based on information collected from prior year CHA's and information from claims data supplied from the health plan. Suggested diagnoses also appear related to associated diagnoses listed on the medication screen (review the Suggested Diagnosis – Medication Related tip sheet to see how to manage those diagnoses).

278. It is this latter function of the software program that Matrix used to fraudulently manipulate patient diagnoses: "historical and suspected diagnosis will appear or pre-populate to the suggested diagnosis screen." Matrix clinical staff needed only to click a button to create a diagnosis for the patient (click an ICD code), including choosing a diagnosis from a pre-populated menu of "suspect diagnoses" based on a patient's medication. Matrix used this tool to "capture suspect diagnoses."

279. Using one patient as an example, Matrix boasted how its EHR software "suggested" 10 different diagnoses for the patient, many of which were high value HCCs.

280. Another "default feature" example that Matrix embedded into its EHR software was the notation "no exercise" meaning that the patient reported they were not engaging in physical activity. One factor in a list of indicia for peripheral vascular disease and peripheral artery disease is inactivity. Pre-populating patient medical records with a "no exercise" notation led to false positives for serious disease thereby leading to increased RAF scores for its patients.

281. Matrix also designed and used another electronic tool that it called "BOOT"—shorthand for "back-office operational tool." With this tool, Matrix created "macro auto-fills" to eliminate the number of typing keystrokes its staff had to use to keep the diagnoses moving through its system. BOOT helped Matrix avoid any potential "missed opportunities" to diagnose patients with serious diseases such as heart disease. The way it worked was this.

282. If the software program recognized a "missed opportunity" before the Matrix coder submitted the patient medical record to the MA Organization for payment, it "kicked back" the record to the Matrix provider. The provider would be given another opportunity to choose or "click" pre-drafted language to allow the coder to justify a more serious diagnosis. This practice increased the numbers of "high value diagnoses" reported to the MA Organizations.

283. Matrix employed electronic tools in other ways, as well, to manipulate patient records to maximize patient RAF scores. For example, it programmed its

QuantaFlo test for peripheral artery disease so that the medical data for the prior patient tested with the equipment appeared on the screen for the next patient tested. That required the Matrix clinician performing the test to affirmatively change or delete information for the patient being examined. Often, this meant that clinical history supporting a peripheral vascular disease or peripheral artery disease diagnosis from an earlier test on a different patient would carry over from patient to patient.

284. Matrix also rigged its EHR software to allow its staff to change patient diagnoses after the health care provider signed the patient's medical record:

- Allow assessments *to be left unlocked after provider signature* and make the completion of ICDs being entered into HIP [software program that incorporated lab findings into the medical record] be what locks the assessment
- ACES will electronically transfer ICD codes to HIP for provider report (this process is new and still being vetted)
- "allow[] Matrix Coders to code directly into ACES"
- Assessment goes to billing

(emphasis added)

285. This, too, led to increased numbers of false positives for serious "high value HCCs."

286. Matrix primarily implemented these EHR software updates to persuade the MA Organizations that contracting with Matrix would be a profitable endeavor to maximize their ROI. In one marketing presentation, Matrix touted diagnoses that would maximize "HCC capture": (1) "type 2 diabetes with complication," (2) "heart failure, unspecified," (3) "long term use of insulin," (4) "chronic obstructive pulmonary disease," and (5) "type 2 diabetes without complication."

287. In short, Matrix deliberately used its EHR software to falsify diagnoses and inflate claims that it knew its MA Organizations would submit to Medicare.

4. Senior Executives at Matrix Knew About and Directed the Fraud

288. Executive-level meetings were held to discuss these fraudulent software uses in 2017 and 2018. In attendance at those meetings were the COO, the Corporate Vice President of Quality and Operations and the Senior Vice President of Clinical Services.

289. At these meetings, the Corporate Vice President of Quality and Operations argued that falsifying patient medical records and fraudulently inflating patient RAF scores violated federal regulations and was wrong. Yet, there was always push-back from the designer of these strategies—the Senior Vice President of Clinical Services. The COO took no position at the meetings on whether these

practices were fraudulent, unethical or wrong. Nevertheless, the COO took over the role of implementing the use of the CHA Tool for coding patients records. Rather than address the serious concerns repeatedly raised by the Corporate Vice President of Quality and Operations, the COO adopted the proposed and fraudulent coding practices of the Senior Vice President of Clinical Services.

290. Further, plenty of internal audits and reviews showed that deliberate Matrix coding practices were leading to fraudulent diagnoses for patients. These audits and reviews were routinely shared with Matrix executives.

291. A January 2018 internal audit of 253 patient health assessments revealed that 133 of them were "unbillable" due to reliance on the system Matrix executives designed to fraudulently code patient diagnoses (by mining medical records for "keywords" to suggest diagnoses) with no actual support in the patient's medical record.

292. Another internal review revealed that the ICD codes reported to the MA Organizations did not jive with the patient assessments: "Coders review[ed] the 50 assessments for a second time to make sure coding is still valid and no documentation has changed during the provider signature process."

293. However, rather than use internal audits for their intended purposes—to determine and improve coding accuracy, policies and procedures and efficient and effective patient care—Matrix management used audits as an

instrument of fraud.

294. After one internal audit turned up "suspect diagnoses," a Matrix non-clinician contractor requested that more than a dozen patients be retested for colon cancer to determine if any of the negative test results could be changed to positive results:

> we have identified 18 of Matrix's patients that we believe it is prudent to retest for FIT [fecal immunochemical test for colon cancer]. Each of these individuals tested negative, and we want to confirm the negative, ***or as the case may be, identify a positive***. Before we reach out to these individuals, I'd like to speak with you about the process to communicate with this group.

(emphasis added).

295. Pressure to meet goals and metrics was top-down. Matrix executives pressured corporate staff to use high pressure tactics—repeated phone calls and emails—to compel the initial clinician who met with the patient face-to-face to "sign off" on high value diagnoses.

296. Further, Matrix executives stressed the importance of being able to "unlock" a patient medical record to change a diagnosis code even after the clinician had signed it.

> The biggest one is the ability to unlock charts once they are signed. That is functionality that we NEED regardless of coding system used, and the coding team is much more dependent on this than I realized in March.

297. Management encouraged staff at every level of the company,

including non-clinical staff, to access patient medical records and change diagnoses (ICD) codes after the initial clinician signed the record. As a result, the health assessment process was not verifiable and lacked accountability and integrity. Management was well aware of this fact.

298. The Corporate Vice President of Quality and Operations repeatedly raised concerns in written communications and meetings with executive management that Matrix's coding practices led to fraudulent diagnoses being reported to MA Organizations and the Medicare program. In early 2017, the Vice President warned that Matrix needs to:

- Improve HF [heart failure] coding to reduce external audit comments
- Implement a Matrix internal audit program over HF [heart failure].

299. Further, on April 10, 2018, the Corporate Vice President of Quality and Operations sent a written communication to the Senior Vice President of Clinical Services and the Director of Training and Development that flagged three coding practices of Health Fair, its mobile health clinic, to "align [the practices] with current clinical guidelines." She further remarked that while these needed "immediate attention" there were problems beyond these three.

300. Matrix Clinical Educator—also a physician—received a copy of the Corporate Vice President's communication and agreed, stating that she also "couldn't find enough evidence to support [the] coding." The Clinical Educator

expressed her serious concerns with Matrix's fast and loose coding practices that falsely reflected significant disease states in patients, warning that "[c]ontinuing to do so may be viewed as upcoding, and this places our business at risk.":

> CKD – In the document that was highlighted in [the Corporate Vice President of Quality and Operation]'s email, ***the coder indicated that if the provider didn't know the stage of CKD, they should diagnose Diabetic Nephropathy instead. This is clearly incorrect***. Nephropathy, by definition, requires evidence of protein in the urine, and nephropathy can occur quite late in the CKD trajectory. I'm attaching an article on the Albuminuria that shows that only 16% of people with CKD Stage 3 have albuminuria (those 16% could be accurately coded as diabetic nephropathy). ***That means providers would be incorrect the majority of the time if they selected diabetic nephropathy instead of CKD, stage unknown. To make an assumption that diabetic nephropathy is present, without evidence of albuminuria, is risky***. If the member has been told they have kidney disease, the provider really would be better off diagnosing CKD stage unknown, rather than diabetic nephropathy.
> ***
>
> However, I'm attaching the Atrial Fibrillation Guidelines for the Management of Patients. The Guidelines do not indicate that persons with Atrial Fibrillation are automatically in a secondary hypercoagulable state. In fact, the terms Hypercoagulable and thrombophilia do not appear anywhere in the guidelines at all. . . . The Guidelines do mention that fewer than 6% of persons with atrial fib have a[] stroke. Clinicians have used the CHADVasc predictive scores to make a decision as to whether they should treat the patient with an antiplatelet or an anticoagulant. ***CHADVaSC is not an indicator of hypercoagulability. It is a risk score, and offers a sense of the degree of risk for a stroke.***

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> Finally, in reviewing articles about Hypercoagulable states, (see third article attached) most current articles refer to hereditary and acquired hypercoagulability. Look at the list of diagnoses that are considered to have Acquired Hypercoagulable states (which might be considered the Secondary Hypercoagulability group). Atrial fibrillation is not among this list. . . . ***I couldn't find enough evidence to support Health Fair's coding of secondary hypercoagulable state for members with atrial fib, especially not based on the CHADsVAS score. Continuing to do so may be viewed as upcoding, and this places our business at risk.***

(emphasis added).

301. These same concerns were elevated to executive management by lower level clinical and coding staff. "High value HCCs" were not supported by the written health assessment or the diagnostic tests administered by clinical staff. Internal audits reflected these same problems in at least one-quarter to one-third of patient health assessments.

302. However, executives at Matrix continually ignored red flags raised by staff because these practices were by design, and they were increasing Matrix's return on investment.

303. The findings that false diagnoses were not supported by patient medical records were regularly highlighted in meetings with executives:

- "Diabetic Retinal Scan not attached to diabetic visits"
- "PAD (peripheral artery disease test results) PDFs are missing from

some of assessments"

304. Matrix executives were well aware of the effect of their aggressive and fraudulent diagnosis coding practices. Even the Vice President of Marketing was involved in directing clinical staff to submit fraudulent diagnoses.

305. In one presentation during an information technology ("IT") Steering Committee meeting a month after acquiring its mobile health services contractor (HealthFair) in February 2018, virtually all of the allegations in the Complaint were raised and continued to be left unresolved:

- "Single, coded artifact for billers to bill from in Kareo [Matrix electronic billing software]" (knowledge that Matrix was knowingly submitting false claims based on "suspected diagnosis" ("single, coded artifact") rather than actual medical support)
- "Revise coding/NP [nurse practitioner] sign-off and addendum process" (knowledge that patient medical records did not support the ICD code)
- "Allow Provider to diagnose but not select ICD-10 codes" – (knowledge that Matrix coders were overriding decisions of Matrix clinicians)
- "Ability to unlock the charts once they are signed" (knowledge that anyone at Matrix could change a diagnoses code or other important

health information in a patient medical record after the visiting clinician signed the record, rendering the health assessment process not verifiable and lacking in accountability and integrity)

- "Sync values for biometric test between HRA [health risk assessment] and HIP [electronic health records software]" (knowledge that –basic clinical facts such as weight did not match between assessment and diagnostic test records, rendering the patient medical records lacking in integrity]
- "Allow provider to indicate tests without linking and ICD-10 code" – (encouraging Matrix coders to override decisions of Matrix clinicians)
- "Standardize HRA [health risk] Assessment Questions" (emphasizing the number of health assessments completed rather than the quality of the health assessments)
- "Evaluate ability to eliminate billers 'cheat sheets with codes' and configure in Kareo by client [MA Organization]" (allowing coders to rely on "cheat sheets" to choose ICD code for Medicare billing without regard to decisions of clinical staff)

306. Yet, these same issues have persisted.

307. As complaints from Matrix clinical staff relating to the fraudulent creation of "high value HCCs" grew louder in April 2018, Matrix executives

looked for ways around the problem rather than fix it. Despite the arm-waving, Matrix executives continued to try to make good on their promises to the MA Organizations to increase their return on investment:

> For a hypothetical scenario where a suggested diagnosis came from a prior CHA [comprehensive health assessment] and is considered chronic, like diabetes or COPD or the like, if the practitioner rejects the diagnosis and chooses either resolved or no support, what will be the QI [quality improvement] process? The concern is that it will be difficult to explain to our clients [MA Organizations] if we do not re-diagnose the condition when we have in the past.

308. Even the MA Organizations warned Matrix executives that patient diagnoses appeared fraudulent. On a conference call in March 2, 2018, representatives from one of the third largest health insurers in the nation told Matrix executives, including the COO, the Corporate Vice President of Quality and Operations and the Senior Vice President of Clinical Services, that it was uncomfortable with Matrix's overzealous efforts to "rediagnose" patients. Noting that Matrix's "rediagnosis level" was higher than any Medicare provider on its list of providers, the MA Organization directed Matrix to immediately stop its coding practices. The insurer soon ended its contract with Matrix.

309. One month later, in April of 2018, another MA Organization asked Matrix to explain its questionable process for obtaining signatures of clinicians on attestation forms.

310. Fearing that outsiders to the company were becoming aware that Matrix was falsifying patient diagnoses, in May 2018, the Senior VP for Clinical Services temporarily directed that staff should "stop their current process of amending field providers records" (i.e., stop changing the diagnoses of the clinical staff who performed the face-to-face visits).

311. On more than one occasion at executive meetings where the allegations in this Complaint were discussed, the Matrix COO silenced the discussions saying, "none of us look good in orange."

D. Materiality—Matrix Knew that Truthful Reporting of Accurate Patient Diagnoses Was Material to the Government's Decision to Pay Claims

312. Matrix knew that truthful reporting of patient diagnoses was material to the Medicare program's decision to pay claims. Matrix also knew that truthful records and statements in support of claims for diagnostic and testing services were material to the Medicare and Medicaid programs' decision to pay claims. (The allegations in this Complaint apply equally to the Medicare and Medicaid programs).

313. Some of the factors in evaluating materiality under the False Claims Act include (a) statutory, regulatory and contractual language, (b) whether the violations go to the heart of the benefit of the bargain, (c) whether the violations were serious and material and not merely technical or minor infractions of rules,

(d) the Government's actions relative to similar violations, (e) whether any reasonable person would attach importance to Defendants' choice of actions, and Defendants' knowledge relative to these factors. All of these factors demonstrate materiality in this case and have been addressed throughout this Complaint.

314. Matrix knowingly submitted or caused to be submitted thousands of false or fraudulent claims and used false records and statements in support of false or fraudulent claims under the Medicare Advantage program. More specifically, Matrix knowingly submitted false diagnostic codes to MA Organizations knowing that those false diagnostic codes would be used to calculate Medicare payments. Matrix also knowingly submitted or caused to be submitted false records, statements and claims for patient assessments and diagnostic tests.

315. Matrix knew that the false diagnostic codes and the false records and statements in support of false claims for patient assessments and diagnostic tests were material to the Government's decision to pay claims under the Medicare Advantage program.

316. In 1920, U.S. Supreme Court Justice Oliver Wendell Holmes wrote, "Men must turn square corners when they deal with the Government." *Rock Island, Arkansas & Louisiana R.R. Co. v. United States*, 254 U.S. 141, 143 (1920). Matrix did not turn square corners when it knowingly submitted false claims based on

false representations that it knew were material to the Government's decision to pay claims under the Medicare Advantage program.

317. The Medicare reimbursement system of payment is based on a system of trust. Participants in the Medicare Advantage program are trusted to submit or cause to submit complete, accurate and truthful diagnoses codes (ICD codes) to the MA Organizations, which in turn, submit them to the Medicare program. The Medicare program relies upon these diagnoses codes when paying claims. Participants like Matrix are also trusted to submit truthful statements and records and truthful claims for payment of patient assessment and diagnostic services under the Medicare program.

318. The allegations show that Defendants were well aware of the statutory, regulatory and contractual requirements under the Medicare Advantage program and that Defendants knew that these violations were material to the Government's decision to pay.

319. Defendants also well knew that their alleged conduct went to the very heart of the bargain under the Medicare Advantage program. Medicare expects and requires that claims are paid only for accurate and truthful diagnoses and health care services for patients.

320. Further, "the Medicare Advantage payment system is subject to the False Claims Act." *United States ex rel. Silingo v. Well Point, Inc*., 904 F.3d 667,

673 (9th Cir. 2018). More particularly, it includes the precise conduct addressed in this case: "[W]e hold that when, as alleged here, Medicare Advantage organizations design retrospective reviews of [patients'] medical records deliberately to avoid identifying erroneously submitted diagnosis codes that might otherwise have been identified with reasonable diligence, they can no longer certify, based on best knowledge, information and belief, the accuracy, completeness, and truthfulness of the data submitted to [the Medicare program]." *United States ex rel. Swoben v. United Healthcare Ins. Co., et al*., 848 F.3d 1161, 1175 (9th Cir. 2016).

321. The Medicare Program's requirement for complete, accurate and truthful reporting of patient diagnoses (ICD codes) and diagnostic services goes directly to the "essence of the bargain." It is neither "minor nor insubstantial." Diagnoses directly affect payment and are the very essence of the Medicare payment system; their accuracy is material to the Medicare program's decision to make payments to its MA Organizations. Their inaccuracy can also have serious negative impact on patient health and safety, which makes the conduct alleged in this case particularly troubling.

322. Defendants' violations were serious and material, leading to actual or potential patient harm, and not merely technical or minor infractions of rules. Defendants' violations were made with actual knowledge of the seriousness of

their violations, and not simply a case of a defendant acting with reckless disregard. "None of us looks good in orange." (Quote from Matrix Chief Operating Officer).

323. As addressed, the Medicare program makes payments to Matrix's MA Organizations based on reported diagnoses and the MA Organizations share those payments with Matrix. *United States ex rel. Swoben v. United Healthcare Ins. Co., et al*., 848 F.3d 1161, 1167 (9th Cir. 2016) (explaining that "[t]he risk adjustment methodology relies on [patient] diagnoses').

324. Matrix knew that it was submitting false diagnosis codes to MA Organizations, which then submitted them to the Medicare program for reimbursement of federal dollars.

325. Falsified diagnoses affected the Medicare program's payment to Matrix in a direct and immediate way. The unsupported diagnosis codes are the false claims that Matrix caused to be submitted to Medicare.

326. Matrix also submitted or caused the submissions of false or fraudulent claims for services such as the knowingly unreliable and faulty echocardiograms and other diagnostic tests.

327. The Government has pursued other participants in the Medicare Advantage program for the same or similar conduct as alleged in this Complaint:

- On October 1, 2018, a Medicare Advantage provider paid a $270 million

False Claims Act settlement for allegedly causing MA Organizations to submit incorrect diagnosis codes to the Medicare program and obtaining inflated payments. https://www.justice.gov/opa/pr/medicare-advantage-provider-pay-270-million-settle-false-claims-act-liabilities

- In early April 2019, the United States filed suit against providers alleging that they violated the False Claims Act by knowingly submitting unsupported diagnosis codes. *United States ex rel. Ormsby v. Sutter Health, et al*., Case No. 15-CV-01062-JD (N.D. Cal.)
- On April 12, 2019, a Medicare Advantage health care provider and its affiliates paid a $30 million False Claims Act settlement for allegedly submitting unsupported diagnosis codes, which inflated the risk scores of the beneficiaries and led to the MA Organizations being overpaid for certain patient encounters of beneficiaries under their care. https://www.justice.gov/opa/pr/medicare-advantage-provider-pay-30-million-settle-alleged-overpayment-medicare-advantage
- On August 8, 2019, a Medicare Advantage provider and physician paid $5 million to settle False Claims Act allegations that they reported invalid diagnoses codes to Medicare Advantage plans and thereby caused those plans to receive inflated payments from Medicare.

https://www.justice.gov/opa/pr/medicare-advantage-provider-and-physician-pay-5-million-settle-false-claims-act-allegations

328. These resolutions and litigation demonstrate that Defendants' same or similar conduct alleged in this Complaint was material to the Government's decision to pay claims.

329. In short, there is ample evidence to show that Defendants knew or should have known that their violations had the natural tendency to influence the Government's decision to pay the Medicare claims and that any reasonable person would attach importance to Defendants' choice of action.

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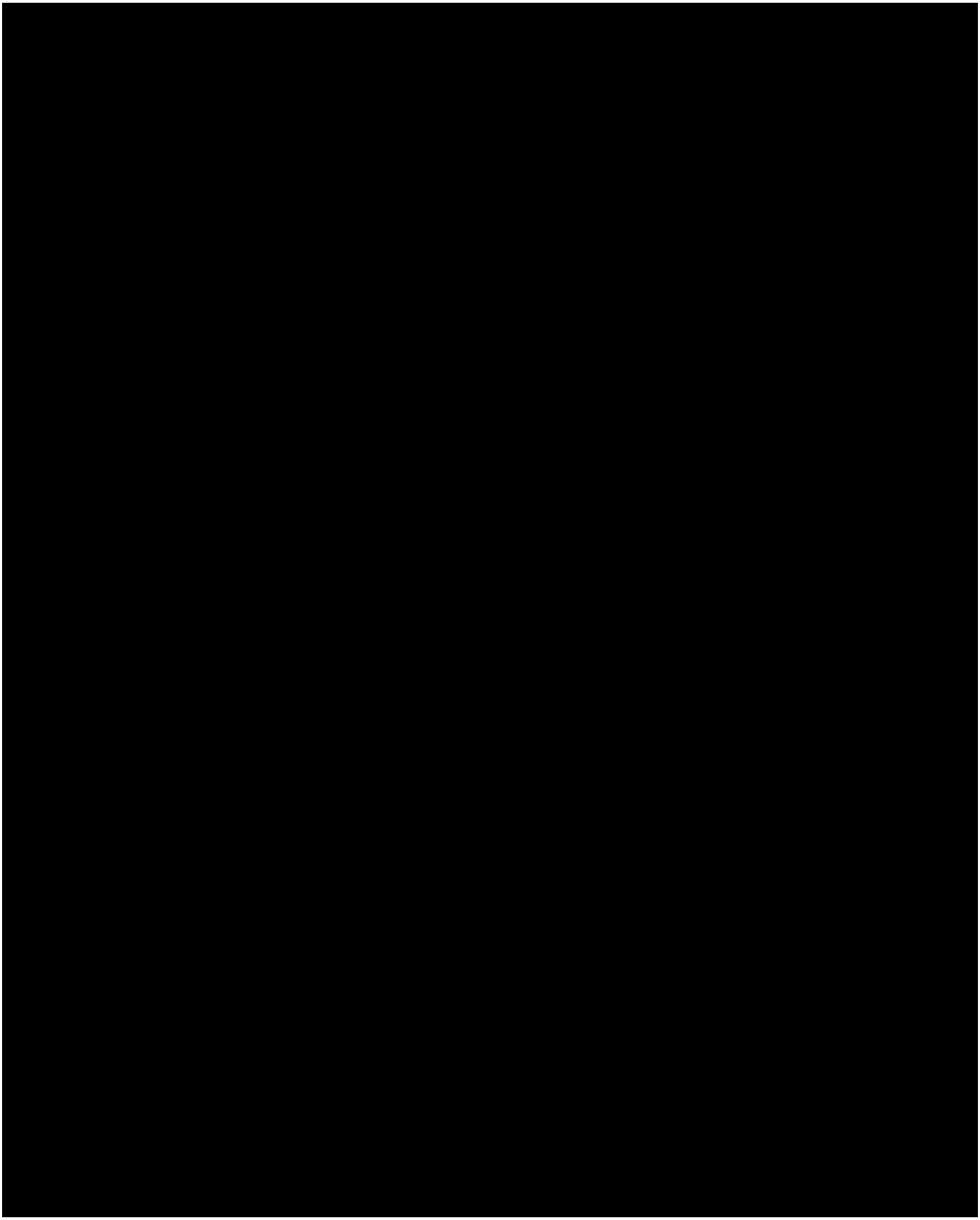

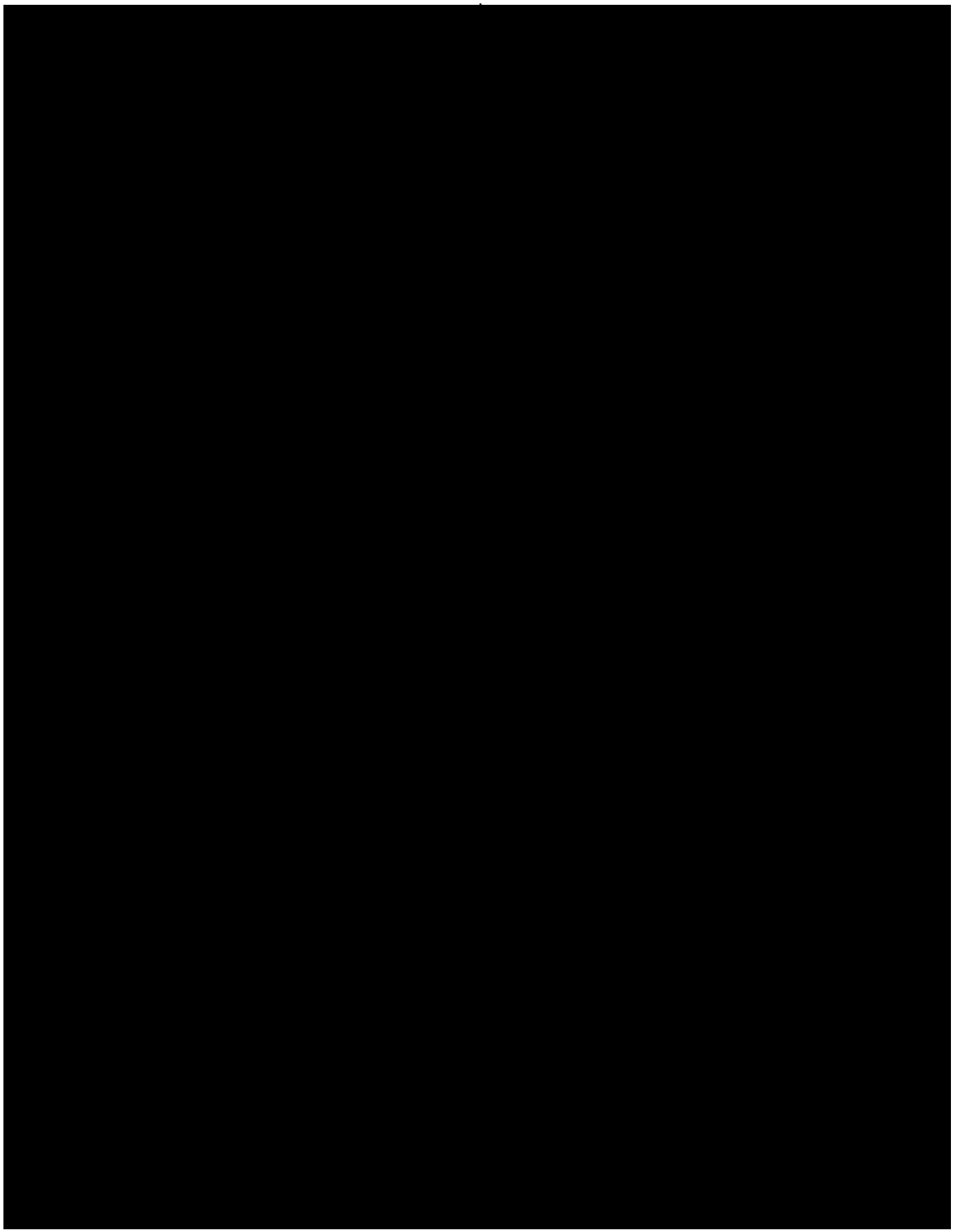

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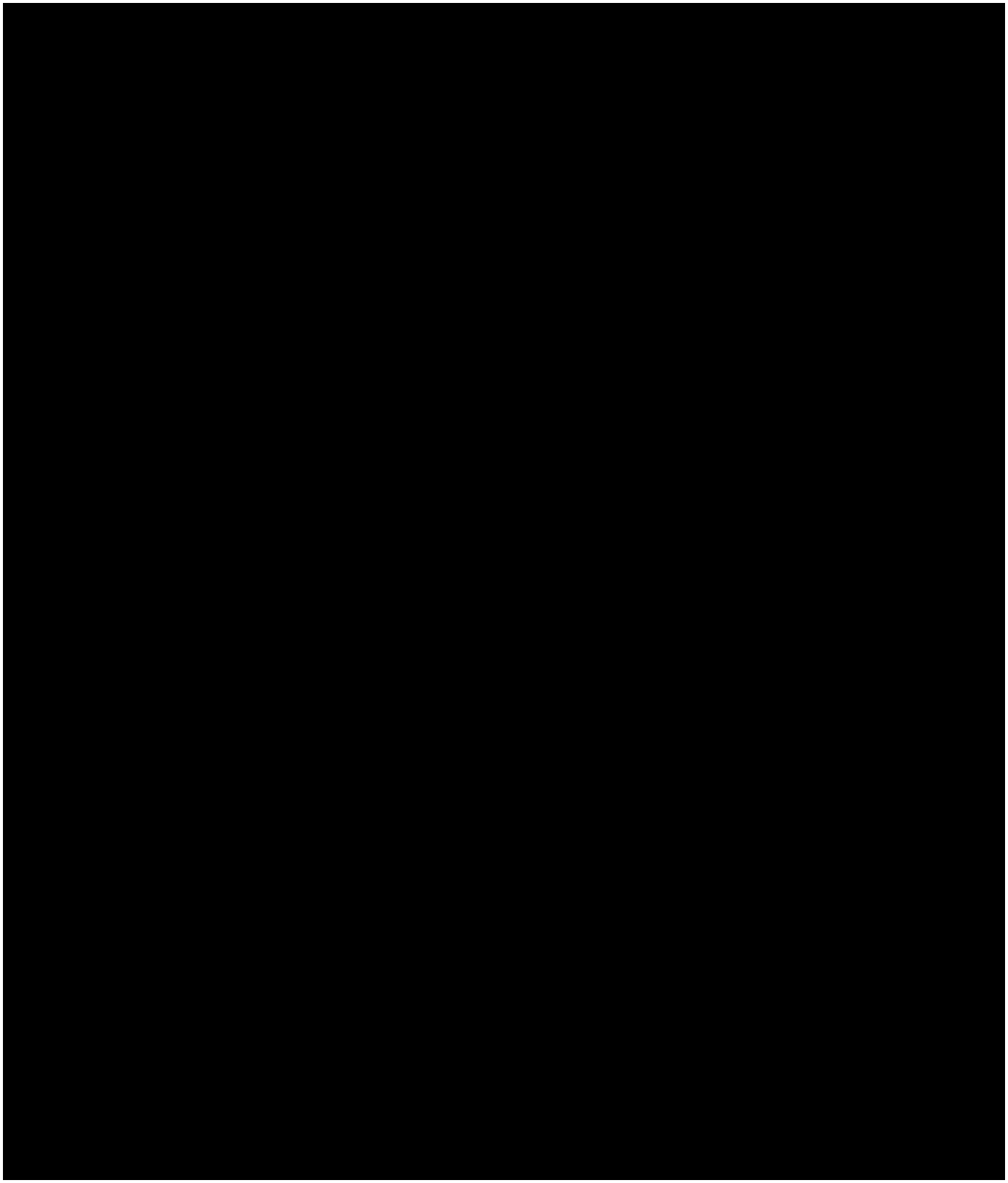

VI. COUNTS

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COUNT I
Federal False Claims Act:
31 U.S.C. § 3729(a)(1)(A)

339. The allegations in the preceding paragraphs are incorporated by reference.

340. Defendants knowingly presented or caused to be presented false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(A).

341. The United States, unaware of the falsity or fraudulent nature of the claims that Defendants caused, paid for claims that otherwise would not have been allowed. Defendants' representations were material to the Government's decision to pay the Medicare and Medicaid claims.

342. Because of these false or fraudulent claims, Defendants are jointly and severally liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act.

343. As a result of Defendants' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT II
Federal False Claims Act:
31 U.S.C. § 3729(a)(1)(B)

344. The allegations in the preceding paragraphs are incorporated by reference.

345. Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729 (a)(1)(B).

346. The United States, unaware of the falsity or fraudulent nature of the records, statements or claims that Defendants made, used or caused to be made or used, paid for unallowed claims. Defendants' representations were material to the Government's decision to pay the Medicare and Medicaid claims.

347. Because of these false or fraudulent claims, Defendants are jointly and severally liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act.

348. As a result of Defendants' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT III
Federal False Claims Act:
31 U.S.C. § 3729(a)(1)(G)

349. The allegations in the preceding paragraphs are incorporated by reference.

350. Defendants knowingly made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government or knowingly concealed or knowingly and improperly

avoided or decreased an obligation to pay or transmit money or property to the Government in violation of 31 U.S.C. § 3729 (a)(1)(G).

351. The United States, unaware of the false or fraudulent nature of the claims, paid for unallowed claims. Defendants' representations were material to the Government's decision to pay the Medicare and Medicaid claims.

352. Because of these false or fraudulent claims, Defendants are jointly and severally liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act.

353. As a result of Defendants' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT IV
Federal False Claims Act:
31 U.S.C. § 3729(a)(1)(C)

354. The allegations in the preceding paragraphs are incorporated by reference.

355. Defendants knowingly conspired to commit a statutory violation under 31 U.S.C. § 3729 (a)(1)(C).

356. The United States, unaware of the false or fraudulent nature of the claims, paid for unallowed claims. Defendants' representations were material to the Government's decision to pay the Medicare and Medicaid claims.

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357. Because of these knowing violations, Defendants are jointly and severally liable to the United States for incurred damages resulting from false or fraudulent claims, trebled, plus civil penalties for each violation of the Act.

358. As a result of Defendants' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT V

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COUNT VI

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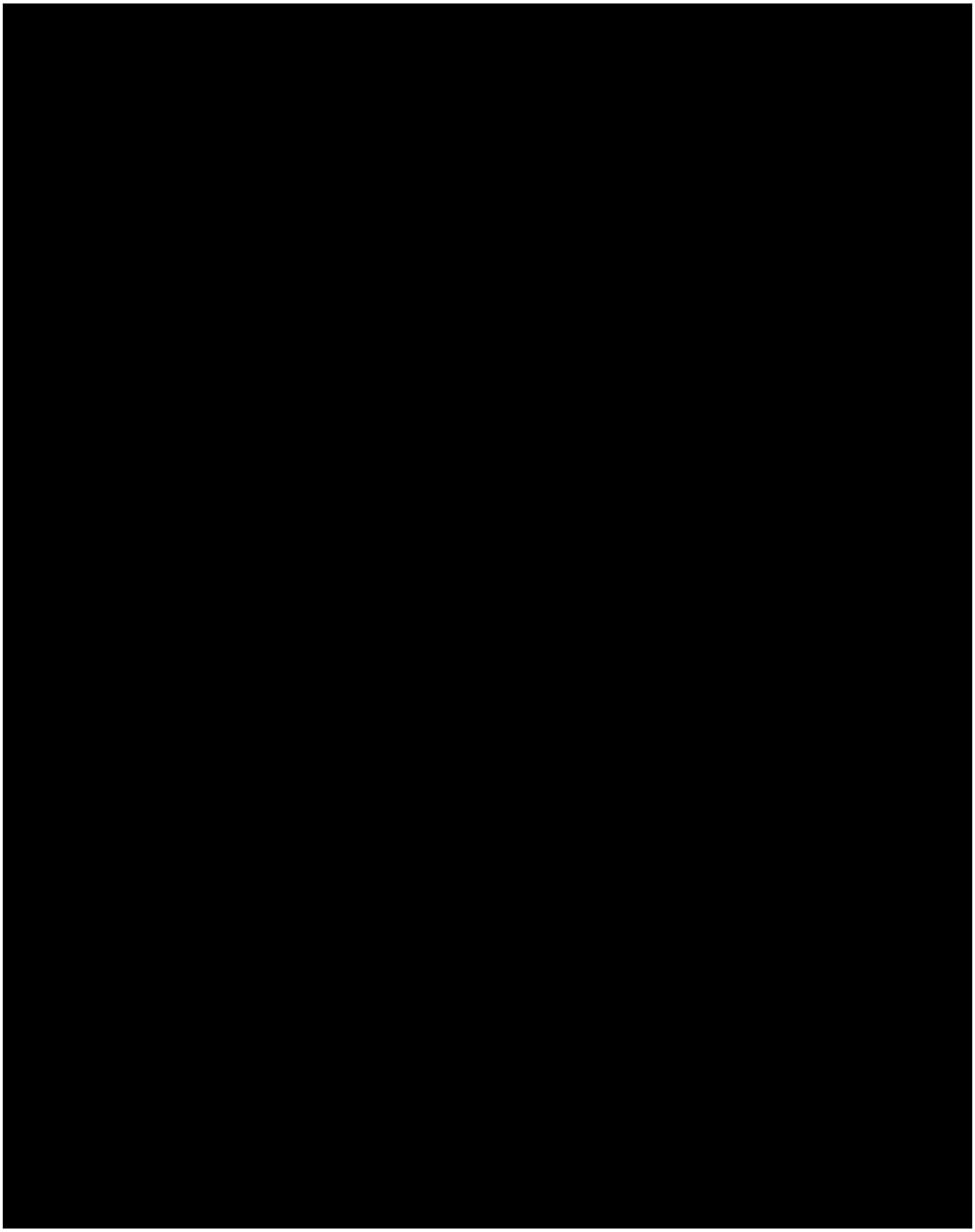

[redacted]

WHEREFORE, Relator, on behalf of Relator and the United States, prays:

(a) That the Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States has sustained because of Defendants' actions, plus a civil penalty of any amount within the applicable statutory ranges, for each violation**;**

(b) That Relator be awarded an amount that the Court decides is reasonable for recovering the proceeds of the action, including but not necessarily limited to the civil penalties and damages, on behalf of the United States, which, pursuant to the False Claims Act, shall be at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim if the Government intervenes and proceeds with the action, and not less than 25 percent nor more than 30 percent of the proceeds of the action or settlement of the claim if the Government does not intervene;

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(c) That Relator receive all relief necessary to make Relator whole for Defendants' violations of 31 U.S.C. § 3730(h);

(d) [redacted]

(e) [redacted]

(f) [redacted]

(g) That Relator receive an award of punitive damages in an amount sufficient to punish Defendant Matrix Medical Network for its willful and malicious conduct and deter future, similar violations;

(h) That judgment be entered against Defendants jointly and severally, in the amounts to be determined at trial; and

(i) That Relator be awarded all costs and expenses incurred, including reasonable attorneys' fees; and

(j) That the Court order such other relief as is appropriate.

Trial by jury is hereby requested.

Dated: December 4, 2019

Respectfully submitted,

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