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

UNITED STATES OF AMERICA, Plaintiff-Intervenor, v. COMMUNITY CARE HEALTH NETWORK LLC, d/b/a MATRIX MEDICAL NETWORK, Defendant.	**Case No. 19 Civ. 11153 (ALC)** **JURY TRIAL DEMANDED**

COMPLAINT-IN-INTERVENTION OF THE UNITED STATES OF AMERICA

The United States of America (the "Government"), by and through its attorney, Jay Clayton, United States Attorney for the Southern District of New York, brings this Complaint-In-Intervention seeking damages and penalties against Defendant Community Care Health Network LLC, d/b/a Matrix Medical Network ("Matrix"), under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, and alleges as follows:

PRELIMINARY STATEMENT

1. Under the Medicare Part C program (also known as Medicare Advantage), Medicare Advantage Organizations ("MAOs") administer managed care plans and are responsible for covering the cost of services rendered by healthcare providers to Medicare beneficiaries enrolled in the plans. The MAOs in turn receive monthly capitated payments from the Centers for Medicare and Medicaid Services ("CMS") for providing such coverage. CMS adjusts these payments for demographic and health status "risk" factors that affect beneficiaries' expected healthcare expenditures. To make these adjustments, CMS relies on "risk adjustment" data, including medical diagnosis codes, submitted by the MAOs. This payment model is designed to pay MAOs more to provide healthcare for sicker enrollees (expected to incur higher healthcare costs) and less for healthier enrollees (expected to incur lower costs). MAOs are required under their contracts with CMS and pursuant to applicable federal regulations to certify the "accuracy, completeness, and truthfulness" of the diagnosis data submitted to CMS.

2. Matrix contracts with MAOs to conduct health assessments of Medicare Advantage plan members in their homes. Based on these in-home assessments, Matrix provides diagnosis codes to the MAOs for ultimate submission to CMS as part of the MAOs' risk adjustment data. CMS relies on this risk adjustment data, including the medical diagnosis codes, to determine the capitated payments paid to the MAOs for each beneficiary. As a "first tier

entity" that contracts with MAOs, Matrix is required to certify the accuracy and truthfulness of the data it generates relating to claims for payment submitted by MAOs.

3. During the period from 2014 to 2019 (the "Relevant Period"), Matrix knowingly caused MAOs to submit false and invalid diagnoses of the following chronic medical conditions to CMS for risk adjustment purposes: proliferative diabetic retinopathy, drug-induced polyneuropathy, rheumatoid polyneuropathy, atrial fibrillation, rheumatoid arthritis, chronic obstructive pulmonary disease, and simple chronic bronchitis (the "Invalid Diagnoses"). Matrix reported the Invalid Diagnoses to MAOs based on its in-home assessments even though: (a) there was not sufficient information to support the diagnoses; (b) the diagnoses did not conform with the guidelines for coding and reporting diagnoses as required by CMS; and (c) the conditions were frequently not diagnosed by any other healthcare provider who saw the beneficiary during the year in which the home visit occurred or in the preceding two years or subsequent two years. As a result of the reporting of these Invalid Diagnoses, the MAOs obtained inflated risk adjustment payments from CMS to which they were not entitled.

4. Matrix marketed its services to MAOs in part by representing that the in-home assessments would allow MAOs to capture diagnoses for use in the risk adjustment process that had not been reported by the beneficiaries' other providers. In marketing and other materials provided to MAOs, Matrix advertised its ability to find and document diagnoses that were not otherwise reported by a patient's primary care physicians and would therefore increase a patient's risk adjustment score and the MAOs' payments.

5. During the Relevant Period, Matrix's business model focused on reporting diagnoses that could lead to higher risk adjustment payments, as opposed to prioritizing accurate and reliable diagnoses and patient care. The purpose of the home visits was not to treat patients'

medical conditions; indeed, Matrix did not provide medical treatment or prescribe medications as part of the home visits.

6. Matrix's in-home assessments were typically conducted by nurse practitioners. Based on the visit, the nurse practitioner completed an electronic, check-the-box form concerning the individual's reported medical history and the results of a basic physical assessment. After the visits, Matrix's coding teams reviewed the assessment forms and diagnoses listed and identified the applicable diagnosis codes to be sent to the MAOs for ultimate submission to CMS as part of their risk adjustment data.

7. Matrix reported diagnoses for certain chronic medical conditions that are typically diagnosed based on diagnostic testing or imaging that was not available in the home setting. When they went to patients' homes, Matrix nurse practitioners generally had only basic medical equipment like a scale and blood pressure cuff, and, with limited exceptions like a finger prick test for blood sugar, generally did not conduct blood or urine tests. Instead, when completing the assessments, the nurse practitioners relied largely on the patients' own self-assessments, their medications, and their responses to various basic screening questions. The nurse practitioners did not have access to the patients' full medical history and typically did not obtain or review relevant records from the patients' primary care physicians in advance of the visit.

8. After the visits, Matrix's "Quality Improvement" staff reviewed the diagnoses entered to assess whether the nurse practitioner had any "missed" diagnoses, which they then urged the nurse practitioner to add. At times, Matrix even added diagnoses without the nurse practitioner's signoff.

9. The Invalid Diagnoses generated by the Matrix home visits did not conform with the International Classification of Diseases ("ICD") Official Guidelines for Coding and Reporting (the "ICD Guidelines"), as required by applicable federal regulations. The diagnoses

did not affect patient care, treatment, or management during the home visit, as required under the ICD Guidelines, and thus were ineligible for risk adjustment. The patients did not receive treatment or care for the condition during the assessment. Indeed, with respect to the Invalid Diagnoses, patients frequently did not receive treatment or care for the condition at any point during the year of the assessment or during years preceding and following the assessment. In addition, the Invalid Diagnoses were not supported by the minimal information recorded on the Matrix assessment forms, in violation of the ICD Guidelines' medical record documentation requirement. The forms on their face did not contain sufficient information to support the Invalid Diagnoses. At best, the recorded diagnoses could be classified as uncertain, probable, or merely suspected, which rendered them invalid for diagnosis coding purposes under the ICD Guidelines and ineligible for risk adjustment.

10. Through the operation of its home assessment program, Matrix reported codes for thousands of Invalid Diagnoses to MAOs, which in turn submitted those codes to CMS. Based on these unlawful false claims, the MAOs improperly received millions of dollars in risk adjustment payments from CMS, in violation of the FCA. If CMS had known that the MAOs had submitted false diagnosis codes based on these Invalid Diagnoses, CMS would not have made risk adjustment payments based on those specific diagnosis codes or would have taken other appropriate actions to ensure that the MAOs did not retain risk adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or enforcement actions.

JURISDICTION AND VENUE

11. This Court has jurisdiction over the claims under the FCA pursuant to 31 U.S.C. §§ 3730(a) and 28 U.S.C. §§ 1331 and 1345.

12. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b) because Matrix transacts business in this District and because a substantial part of the events giving rise to the claims herein occurred within this District. For example, during the Relevant Period, Matrix conducted home health assessments in New York.

13. This Court may exercise personal jurisdiction over Matrix pursuant to 31 U.S.C. § 3732(a), which provides for nationwide services of process.

THE PARTIES

14. Plaintiff is the United States of America. Through its Department of Health and Human Services ("HHS"), and more specifically through CMS, a component agency within HHS, the Government administers the Medicare Program, including, as relevant here, the Medicare Advantage Program and the Part C risk adjustment payment system.

15. Relator Nancy Cahill previously worked for Matrix. In 2019, Relator filed a *qui tam* complaint under the False Claims Act in this district.

16. Defendant Community Care Health Network, LLC, d/b/a Matrix Medical Network, is headquartered at 424 Church Street, Suite 2600, Nashville, Tennessee 37219. Matrix operates across the United States and, during the Relevant Period, contracted with over thirty MAOs to conduct health assessments of Medicare Part C plan members in their homes.

THE FALSE CLAIMS ACT

17. The False Claims Act was originally enacted in 1863 to address fraud on the Government in the midst of the Civil War, and it reflects Congress's objective to "enhance the Government's ability to recover losses as a result of fraud against the Government." *See* S. Rep. No. 99-345, at 1 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266.

18. As relevant here, the FCA establishes treble damages liability to the Government where an individual or entity:

i. "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval[;]" or

ii. "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim[.]"

31 U.S.C. §§ 3729(a)(1)(A) & (a)(1)(B).

19. "Knowingly," within the meaning of the FCA, is defined to include a defendant acting in reckless disregard or deliberate indifference of the truth or falsity of information, as well as actual knowledge of such falsity by the defendant. *See id*. § 3729(b)(1). Further, "no proof of specific intent to defraud" is required to establish liability under the FCA. *Id*.

20. For purposes of section 3729(a)(1)(B), the FCA defines "material" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." *Id*. § 3729(b)(4).

21. Finally, in addition to treble damages, the FCA also provides for assessment of a civil penalty for each violation or each false claim. *See* 31 U.S.C. § 3729(a)(1).

THE MEDICARE ADVANTAGE PROGRAM AND ITS RISK ADJUSTMENT PAYMENT SYSTEM

A. Medicare Advantage and the Role of MAOs

22. Medicare is a federally operated health insurance program administered by CMS benefiting individuals 65 and older and the disabled. *See* 42 U.S.C. § 1395c *et seq*.

23. Parts A and B of the Medicare Program are commonly known as "traditional" Medicare. Part A covers inpatient and institutional care, while Part B covers physician, hospital, outpatient, and ancillary services and durable medical equipment. Under Medicare Parts A and B, CMS reimburses healthcare providers (for example, hospitals and physicians' offices) directly using a fee-for-service system. Specifically, healthcare providers submit claims to CMS for medical services that they have rendered. CMS, in turn, pays the providers directly for each service based on payment rates it establishes.

24. Under Medicare Part C, which is at issue in this case, Medicare beneficiaries can elect to receive Part A and Part B benefits through a Medicare Advantage plan ("MA plan" or "Part C plan"). *See* 42 U.S.C. §§ 1395w-21 to 1395w-28. The MA plans are operated and managed by MAOs that contract with CMS. *See* 42 C.F.R. §§ 422.2, 422.503(b)(2).

25. Under Medicare Part C, beneficiaries receive healthcare services from providers, such as hospitals and doctors, who contract with and are paid by the MAOs. More specifically, when a healthcare provider furnishes medical services to a Medicare beneficiary enrolled in an MA plan, the provider submits claims and encounter data to the MAO that operates the MA plan to receive payment from the MAO. This data includes, but is not limited to, the date of the encounter, the services rendered, and the diagnosis codes corresponding to the medical conditions that were assessed, managed or treated during the encounter.

26. Congress expressly delegated authority to CMS to issue rules to implement and regulate Medicare Part C. *See* 42 U.S.C. § 1395w-26(b). Pursuant to that delegation, CMS has promulgated regulations that, *inter alia*, define the MAOs' obligations and responsibilities. *See generally* 42 C.F.R. Part 422. As discussed more fully below, *see infra* ¶¶ 48-52, CMS's Part C regulations require MAOs to submit annual attestations concerning the accuracy and truthfulness of the diagnosis data they submit to CMS to receive payments.

27. In addition to issuing regulations, CMS also has defined the MAOs' obligations contractually. For example, to participate in Medicare Part C, MAOs must execute a written agreement, or a renewal of the written agreement, with CMS on an annual basis for each of the MA plans they operate. The MAOs for which Matrix conducted home health assessments executed such agreements or renewals annually for the MA plans they operated during the Relevant Period.

28. By executing these contracts, MAOs agree to comply with CMS's requirements relating to the submission of diagnosis data. Specifically, the contracts require the MAOs to operate MA plans "in compliance with the requirements of [] applicable Federal statutes, regulations, and policies," including the "Medicare Managed Care Manual," and "implement a compliance plan in accordance with [42 C.F.R.] § 422.503(b)(4)(vi)." As discussed further below, federal regulations and policies include requirements relating to the submission of diagnosis data.

29. CMS regulations also explicitly impose obligations on first tier entities like Matrix. The regulations provide, *inter alia*, that "[a]ll contracts or written arrangements between MA organizations and first tier, downstream, and related entities must contain . . . [a] provision requiring that any services or other activity performed by a first tier, downstream, and related entity in accordance with a contract are consistent and comply with the MA organization's contractual obligations." 42 C.F.R. § 422.504(i)(3)(iii). Additionally, all such contracts or written agreements "must specify" that the entity "comply with all applicable Medicare laws, regulations, and CMS instructions." *Id.* § 422.504(i)(4)(v). Finally, in addition to the MAOs' own annual attestations, if data submitted by an MAO for risk adjustment purposes is generated by a first tier entity, the entity must "certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data." *Id.* § 422.504(l)(3).

B. Medicare Part C's Risk Adjustment Payment System and the Role of ICD and HCC Codes in CMS's Calculation of Risk Adjustment Payments

30. Under the Medicare Advantage Program, CMS makes monthly capitated payments to MAOs for each beneficiary enrolled in each of the MAOs' MA plans. These per-member per-month capitated payments are pre-determined and fixed before the beginning of each payment year as part of a bidding and contract negotiation process specified by statute.

These payments ("PMPM payments") do not depend on the amount or types of services actually provided to the beneficiary during the payment year.

31. Under the Medicare Advantage Program, CMS adjusts these PMPM payments for each beneficiary. These adjustments reflect the predicted cost of insuring each beneficiary, which is referred to as the predicted risk. The predicted risk reflects the beneficiary's age, sex, and other demographic factors and his or her health status. 42 U.S.C. § 1395w-23(a)(1)(C). CMS uses its risk adjustment payment system to adjust the capitated amounts based on the expected risk of insuring each beneficiary.

32. More specifically, for each beneficiary enrolled in a Part C plan, CMS calculates a risk score—also known as the risk adjustment factor or "RAF"—which acts as a multiplier for purposes of determining the PMPM payment for that beneficiary. *See* 42 C.F.R. § 422.308(e).[1] Beneficiaries who have severe and chronic medical conditions have higher risk scores. Thus, CMS pays MAOs more for beneficiaries with such medical conditions and less for beneficiaries without those conditions.

33. Since 2004, CMS has employed a Hierarchical Condition Category ("HCC") model to calculate the risk score for Medicare beneficiaries enrolled in MA plans. The HCC model takes into account both the demographic factors and health status of Medicare beneficiaries. *See* 42 C.F.R. § 422.2.

34. HCCs refer to disease groupings that include diagnosis codes that predict average healthcare spending. *See id*. Between 2004 and 2013, there were 70 HCCs in CMS's Part C risk

[1] To determine the base monthly payment amount for Medicare beneficiaries enrolled in a specific Part C plan, CMS uses a bidding process in which each Part C plan, through its MAO, submits a bid amount. That bid is then compared to an administratively set benchmark set by CMS. *See* 42 C.F.R. Part 422, subparts F and G.

adjustment model. Starting in 2014, when CMS revised its model, the number of HCCs increased to 79.

35. Each HCC correlates with the marginal predicted cost of medical care for a set of medical conditions included in a category. Higher relative values (also sometimes referred to as relative factors, or coefficients) are assigned to HCCs that include diagnoses with greater disease severity and treatment costs.

36. A particular Medicare beneficiary may have conditions that are included in none of the HCCs or may have conditions that are included in multiple HCCs. This will affect the PMPM payment calculated by CMS for that beneficiary.

37. To determine which HCCs, if any, apply to a particular Medicare beneficiary, the HCC model relies on the diagnoses—more specifically the diagnosis codes—assigned to the beneficiary. The MAOs submit these diagnosis codes to CMS. They obtain the codes from various sources, including, but not limited to, the claims and encounter data submitted to them by healthcare providers that treat plan members.

38. ICD diagnosis codes are alphanumeric codes used by healthcare providers, insurance companies, and public health agencies to represent medical conditions. Every disease, injury, infection, and symptom has its own code. The applicable ICD diagnosis codes are set forth in the International Classification of Diseases, Ninth Edition, Clinical Modification ("ICD-9") through October 1, 2015, and thereafter in the International Classification of Diseases, Tenth Revision, Clinical Modification ("ICD-10") ("ICD Guidelines").[2] *See* 45 C.F.R. § 162.1002 (listing dates for use of medical data code sets). HHS regulations require that the data MAOs submit conforms to the ICD, including the ICD Guidelines. *See* 42 C.F.R. § 422.310(d)(1)

[2] A more recent version of the ICD Guidelines, ICD-11, went into effect in 2022, after the Relevant Period.

(requiring MAOs to submit data that conforms to relevant national standards); 45 C.F.R. § 162.1002 (adopting the ICD as a national standard).

39. Finally, the HCC model is prospective, meaning that it relies on risk adjusting diagnosis codes from dates of service by a provider in one year (the "DOS year" or "date of service year") to determine payments in the following year (the "payment year"). In other words, CMS calculates the risk score for each Medicare Part C beneficiary anew for each payment year based on the ICD codes from medical encounters that occurred in the immediately preceding year. The higher a Part C beneficiary's risk score, the higher the PMPM payments made by CMS to the MAO.

C. The Risk Adjustment Payment Process and Diagnosis Data Reporting Systems

40. In most cases, the ICD diagnosis codes reported to CMS for risk adjustment purposes originate from healthcare providers who treat Part C beneficiaries. In this scenario, the risk adjustment data is typically generated and reported in five steps.

- First, based on a face-to-face encounter between a healthcare provider and a Part C beneficiary, the provider documents the encounter in the beneficiary's medical record, including the beneficiary's illnesses or medical conditions.
- Second, the provider—or, most often, a coder working for the provider—assigns the diagnosis codes reflecting the beneficiary's medical conditions documented by the provider in the beneficiary's medical record for that encounter.
- Third, the MAO receives claims data from the provider, which includes the diagnosis codes assigned by the provider or coder. Healthcare providers can transmit diagnosis codes to an MAO when they submit claims for payment for

treating the beneficiary, in encounter records reporting the services rendered, or by alternative means.

- Fourth, the MAO submits the diagnosis codes to CMS using CMS's risk adjustment data submission systems.
- Finally, CMS relies on the submitted codes to map the beneficiary's diagnosis codes to HCCs and to determine each beneficiary's risk score or RAF, and uses that score to calculate the risk adjusted PMPM payment for that beneficiary.

41. CMS's HCC model relies upon MAOs and their contracted providers, including first-tier entities like Matrix, to correctly document and submit ICD diagnosis codes for their patients pursuant to the ICD Guidelines. When an MAO reports to CMS a relevant diagnosis for a covered patient, that reported diagnosis can directly increase the amount that CMS pays the MAO for providing coverage. A higher risk score translates into higher payments by CMS to the MAO. Thus, the risk adjustment diagnosis codes that correspond to HCCs directly impact how much money CMS pays an MAO. The HCC model does not predict any costs associated with a patient simply having a condition or having been diagnosed with a condition in the past. Rather, as explained above, the HCC model predicts expected costs based upon particular ICD diagnoses coded in conformance with the ICD Guidelines during the service year directly preceding the payment year.

42. CMS, through its regulations and guidance, has made clear that it relies on the risk adjusting diagnosis codes to determine and make accurate payments for each patient enrolled in an MA plan. "Accurate risk-adjusted payments rely on the diagnosis coding derived from a member's medical record." CMS, *2013 National Technical Assistance Risk Adjustment 101 Participant Guide* (2013); *see also* 42 C.F.R. § 422.504(*l*).

43. During the Relevant Period, CMS utilized two electronic systems for collecting risk adjustment diagnosis data—the Risk Adjustment Processing System ("RAPS") and the Encounter Data Processing System ("EDPS"). Up to 2014, CMS calculated risk adjustment payments based solely on the RAPS-submitted diagnosis data. Starting in 2015, CMS calculated risk adjustment payments using a combination of RAPS and EDPS-submitted diagnosis data.

44. The data that MAOs submit through the RAPS system have several components. For example, the component known as AAA identifies the submitter, while the component known as BBB identifies the MAO. As relevant here, the CCC component contains the Medicare identification number for a particular beneficiary as well as up to ten diagnostic clusters for that beneficiary. Each cluster, in turn, contains the date on which the medical treatment occurred, the type of provider, a diagnosis code from the medical encounter, and a "Delete Indicator," which allows MAOs to correct or withdraw a false cluster by advising CMS to delete the inaccurate diagnosis code in that cluster. Each diagnostic cluster includes a distinct diagnosis that can increase a beneficiary's risk score.[3]

45. Each diagnosis cluster submitted by an MAO is a claim for payment for purposes of the FCA because the reported diagnosis code in the cluster factors directly into CMS's risk adjustment calculations and impacts the resulting payments made by CMS to the MAO for each beneficiary enrolled in the MA plan.

46. During the Relevant Period, CMS determined the PMPM payments made to MAOs in three phases. First, CMS made an initial calculation based on the diagnosis data reported by the MAO for the 12-month period ending in the June before a given payment year

[3] In the EDPS system, MAOs similarly submit data with a number of components, known as "loops." ICD diagnosis codes are among the data that MAOs are required to submit to CMS using EDPS.

(*e.g.*, diagnosis data from July 2013 through June 2014 for payment year 2015). *See* 42 C.F.R. § 422.310(g) (requiring MAOs to submit such diagnosis data by September of the year preceding the payment year). This initial calculation determined the interim monthly payments that CMS made to the MAO in the first six months of the payment year. Second, CMS recalculated the risk scores for beneficiaries enrolled in the MAO's plans based on diagnosis data for medical encounters during the year immediately preceding the payment year (*e.g.*, diagnosis data from January through December 2014 for payment year 2015). Based on that recalculation, CMS would make retroactive adjustments to payments made during the first half of the payment year and also update the interim PMPM payments for the second half of the payment year. Third, after the payment year ended but before MAOs were required to submit their risk adjustment attestations, CMS provided a further opportunity for the MAOs to submit additional diagnosis data or correct the diagnosis data already submitted by deleting diagnoses (also referred to as making deletions or retractions). Based on the additional submissions or corrections, CMS recalculated the risk scores again "to determine if adjustments to payments [were] necessary." 42 C.F.R. § 422.310(g)(2). CMS would then make any necessary adjustments as part of the annual reconciliation process to ensure that the final payments to the MAO were accurate.

47. In addition, since at least 2003, MAOs and entities that submit risk adjustment data on their behalf have been required to execute Electronic Data Interchange ("EDI") agreements prior to submitting risk adjustment data. These EDI agreements are contracts pursuant to which the MAOs attest to the accuracy of the data submitted. *See, e.g.*, 2003 Regional Risk Adjustment Training for Medicare+Choice Organizations Participant Guide, § 6.1; 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations Participant Guide, § 4.1; 2005 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide § 4.1; 2006 Risk Adjustment Data Basic Training for Medicare Advantage

Organizations Participant Guide § 4.1; 2007 Risk Adjustment Data Training for Medicare Advantage Organizations Participant Guide § 4.1; 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide § 4.1; Risk Adjustment 101 Participant Guide § 2.1 (2013). *See* also Medicare Managed Care Manual, Chapter 7, § 111.6.1 (Rev. 57, 08-13-04); *id*. § 120.2.1 (Rev. 114, 06-07-13). By executing these EDI agreements, the MAOs agree that (i) they will be responsible for all risk adjustment data submitted to CMS by themselves, their employees, and their agents; (ii) they will submit risk adjustment data that is accurate, complete, and truthful based on best knowledge, information, and belief; (iii) they will research and correct risk adjustment data discrepancies; and (iv) CMS has the right to audit and confirm the risk adjustment data, including diagnoses, submitted by the MAO, and the right of access to the beneficiaries' medical records to conduct such audits. In turn, the MAOs must require any first tier entities like Matrix to agree that CMS has the right to audit and confirm the risk adjustment data and that "any services or other activity performed by a first tier, downstream, and related entity in accordance with a contract are consistent and comply with the MA organization's contractual obligations." 42 C.F.R. § 422.504(i)(3)(iii).

D. MAOs' and First Tier Entities' Attestation Obligations

48. Given the material impact of diagnoses in calculating payments, CMS requires MAOs and first tier entities like Matrix to ensure—and attest—that the diagnosis codes submitted for risk adjustment payments are accurate, complete, and truthful.

49. Medicare Advantage regulations require MAOs to submit annual attestations to CMS about the validity of the diagnosis data they submit for the relevant payment year. *See* 42 C.F.R. § 422.504(l). The regulations further specify that the MAOs' submission of their annual attestations is a condition of payment. *Id*. The MAOs' obligation to submit these annual attestations is also included in their contracts with CMS. A copy of the attestation is attached to

each contract, and the contracts specify that, "[a]s a condition of receiving a monthly payment under" the contract, the MAO must "request payment … on the forms attached" to the contract. The attached forms include "Attachment B," which requires the MAO to certify the "accuracy, completeness, and truthfulness" of the diagnosis data submitted to CMS. The contracts also specify that CMS can terminate the MAO's participation in the Medicare Advantage Program if CMS determines that the MAO has submitted false data or failed to provide CMS with valid risk adjustment data. 42 C.F.R. § 422.510.

50. The regulations in turn specify that if data submitted by an MAO for risk adjustment purposes is generated by a first tier entity, the MAO must require the entity to "certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data." 42 C.F.R. § 422.504(l)(3).

51. Since 2000, CMS has made clear that the purpose of the annual attestation requirement is to place the responsibility on MAOs, and other entities that generate risk adjustment data, to make "good faith efforts to certify the accuracy" of the diagnosis data the MAOs submit. *See* 65 Fed. Reg. 40,170, 40,268 (June 29, 2000); *see also* MMC Manual Chap. 7, § 111.7 (2004) ("CMS expects [MAOs] to design and implement effective systems to monitor the accuracy, completeness, and truthfulness of risk adjustment data and to exercise due diligence in reviewing the information provided to CMS.").

52. During the Relevant Period, MAOs that submitted diagnosis codes reported by Matrix signed and submitted annual attestations to CMS. The MAOs submitted those annual attestations after the final submission deadline for reporting the diagnosis data for each payment year.

E. Standards and Requirements Governing Diagnosis Reporting and Risk Adjustment Payments

53. In addition to the attestations described in the previous section, CMS imposes numerous obligations with respect to the diagnosis codes submitted to obtain risk adjustment payments.

54. Diagnosis codes submitted for risk adjustment purposes must conform with the ICD, including the ICD Guidelines. *See, e.g.*, 42 C.F.R. § 422.310(d)(1) ("MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards."); 45 C.F.R. § 162.1002(a)(1)(i), (b)(1), (c)(2)(i) (establishing the ICD, including the ICD Guidelines, as the national standard for diagnosis coding); 42 C.F.R. § 422.504(h)(2) (requiring MAOs to comply with HIPAA simplification rules at 45 C.F.R. part 162, which includes the adoption of the ICD and ICD Guidelines as the national standard); *see also* CMS, *Medicare Managed Care Manual*, Chapter 7 § 40 (Rev. 118, Sept. 19, 2014) ("The diagnosis must be coded according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting*."); CMS, *Medicare Managed Care Manual*, Chapter 7 § 40 (Rev. 114, June 7, 2013); CMS, *Medicare Managed Care Manual*, Chapter 7, (Rev. 57, Aug. 13, 2004); ICD Guidelines, Preamble ("These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. . . . Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under [HIPAA].").

55. The ICD Guidelines impose numerous requirements and limitations on what diagnoses may be coded for a particular medical encounter. The Guidelines provide different standards for permissible coding of diagnoses depending on whether an encounter is an outpatient visit or a non-outpatient visit (*i.e.*, hospitalization). *Compare* ICD Guidelines §§ II, III

(non-outpatient guidelines), *with* § IV (outpatient guidelines). This Complaint concerns outpatient visits, which are covered by Section IV of the ICD Guidelines.

56. To begin, the ICD Guidelines provide that if a patient does not have a medical condition at the time of an encounter, it may not be coded. Moreover, the ICD Guidelines provide that uncertain conditions—those characterized as probable, suspected, questionable, working diagnoses, or the like—may not be coded. *See* ICD-10 Guidelines § IV.H; ICD-9 Guidelines § IV.I. In addition, prior conditions (those that no longer exist) may be coded only with special ICD "history codes" if the prior condition has an impact on current care or influences treatment. *See* ICD-10 Guidelines § IV.J; ICD-9 Guidelines § IV.K.

57. Significantly, for an outpatient medical encounter, the ICD Guidelines only permit the coding of documented conditions that both exist at the time of the encounter *and* "require or affect patient care treatment or management." ICD-10 Guidelines § IV.J; ICD-9 Guidelines § IV.K. In other words, it is not enough that a condition merely exists; the condition must have specifically mattered to patient care, treatment or management during the encounter with the patient. Furthermore, the ICD Guidelines state that "[c]hronic diseases treated on an ongoing basis may be coded and reported as many times as the patient *receives treatment and care* for the condition(s)." ICD-10 Guidelines § IV.I (emphasis added); ICD-9 Guidelines § IV.J.

58. Even if a patient was previously diagnosed with a chronic condition, an MAO may not submit the diagnosis for payment for the current payment year unless the patient had an encounter with a healthcare provider during the preceding date of service year and the chronic condition required or affected patient care, treatment, or management during that encounter.

59. In addition, diagnosis codes submitted for risk adjustment purposes are valid only if they are documented in the medical record as a result of a face-to-face encounter between the patient and a healthcare provider. *See, e.g.*, CMS, *Medicare Managed Care Manual*, Chapter 7

§ 40 (Rev. 118, Sept. 19, 2014) ("All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit."); CMS, *Medicare Managed Manual*, Chapter 7 § 111.3 (Rev. 57, Aug. 13, 2004) ("Physician risk adjustment data is defined as diagnoses that are noted as a result of a face-to-face visit by a patient to a physician (as defined above) for medical services.").

60. As relevant here, the ICD Guidelines consistently provided that "accurate coding cannot be achieved" in the absence of "complete documentation in the medical record." *See*, *e.g.*, ICD-10 Guidelines at 1. Pursuant to this requirement, a diagnosis code is accurate and valid for risk adjustment payment purposes only if it is documented in and supported by the medical record for a particular face-to-face encounter between a patient and a healthcare provider. *See* ICD-10 Guidelines at 111 ("For accurate reporting of ICD-10[] diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter.").

61. CMS has repeatedly provided training and instructions to MAOs and first tier entities like Matrix on how to implement the medical record documentation requirement. For example, CMS emphasized that MAOs were responsible for submitting "risk adjustment data that are substantiated by the physician or provider's full medical record," *see* MMC Manual Chap. 7, § 111.8 (Aug. 2004), and must ensure that "[a]ll diagnosis codes submitted [are] documented in the medical record," *see* MMC Manual Chap. 7, § 40 (June 2013).

62. CMS offered trainings to participants in the Medicare Advantage program on how to implement this regulatory requirement starting as early as 2003. *See* 2003 Regional Risk Adjustment Training for Medicare+Choice Organizations Participant Guide § 4.1 (MAOs "must submit risk adjustment data that are substantiated by the patient's medical record"). To emphasize the importance of this requirement, CMS continued to provide training on this

regulatory requirement from 2004 until at least 2014. *See* 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations Participant Guide, §§ 5.1, 5.5, 6.1.3; 2005 Risk Adjustment Data Basic Training Participant Guide for Medicare Advantage Organizations §§ 4.1, 5, 5.1, 5.5, 8.7.3, 9.1, 9.2; 2006 Risk Adjustment Data Basic Training for MA Organizations Participant Guide §§ 5.1, 5.4, 5.5, 7.7.3, 8.1, 8.2; 2007 Risk Adjustment Data Training for Medicare Advantage Organizations Participant Guide §§ 6.1, 6.4, 7.1, 7.2, 8.7.3; 2008 Risk Adjustment Data Technical Assistance Participant Guide for Medicare Advantage Organizations §§ 5.6, 6, 6.1, 6.4, 6.5, 7.1, 7.2; 2012 Regional Technical Assistance Participant Guide § 2.2; Risk Adjustment 101 Participant Guide §§ 3.2.4; 4.3 (2013); Risk Adjustment Webinar at p. 48 (July 1, 2014).[4]

F. The "Materiality" of Accurate and Truthful Diagnosis Data

63. The accuracy and validity of the diagnosis data reported by MAOs has always been "material" to CMS's payment decisions because the data directly impacts the amounts paid to the MA plan for each beneficiary. Indeed, since the early 2000s, CMS has conducted audits of diagnosis codes submitted by MAOs, known as Risk Adjustment Data Validation ("RADV") audits. The HHS Office of the Inspector General conducts similar audits of the validity of the diagnosis data submitted by MAOs for payment.

64. In 2001, CMS alerted MAOs that they were "required to submit medical records for validating encounter data" and that "[m]edical record reviews of a sample of hospital encounters may be audited to ensure the accuracy of diagnostic information." *See* MMC Manual, Chapter 7, § 110.3 (October 2001). In 2004, CMS updated its public guidance to MAOs by explaining that "[a] sample of risk adjustment data used for making payments may be validated

[4] These trainings are available at https://www.hhs.gov/guidance/ and https://www.csscoperations.com/.

against hospital inpatient, hospital outpatient, and physician medical records to ensure the accuracy of medical information. Risk adjustment data will be validated to the extent that the diagnostic information justifies appropriate payment under the risk adjustment model." *See* MMC Manual, Chapter 7, § 111.8 (August 13, 2004).

65. To facilitate its audit of risk adjustment diagnosis data, CMS promulgated a regulation to require MAOs as well as healthcare providers who render care to Part C beneficiaries to supply the underlying medical records to CMS for use in RADV audits of risk adjustment diagnosis code submissions. *See* 42 C.F.R. § 422.310(e). For each audit, CMS selects a sample of enrollees in an MAO's MA plans and reviews the medical records for those enrollees to determine if the diagnosis codes submitted by the MAOs are supported by those records.

66. CMS regulations and contracts with MAOs also make clear that the requirement that risk adjustment data be accurate and valid is a condition of payment. *See* 42 C.F.R. § 422.504(*l*).

67. In addition to the materiality of the diagnosis codes to CMS's payment decisions, the annual risk adjustment attestations are also material to payment. As previously alleged, their submission to CMS is a condition of payment.

68. Furthermore, because the accuracy and validity of diagnosis data submissions directly impacts the integrity of the risk adjustment payment system, the Government also has sought to enforce the requirement for data accuracy by actively pursuing legal remedies against MAOs that have knowingly submitted inaccurate and untruthful diagnosis data to CMS as well as healthcare providers that knowingly caused MAOs to submit inaccurate and untruthful diagnosis data to CMS. For example:

- In August 2012, the Government reached a $3.82 million settlement with SCAN Health Plan, a Long Beach, California-based managed care company, based on

allegations that SCAN had used outside vendors to review medical charts of SCAN's Part C beneficiaries to identify new diagnosis codes for SCAN to submit to CMS, but had failed to disclose to CMS that chart review results also indicated that some of the previously-submitted diagnosis codes might need to be deleted, which enabled SCAN to improperly obtain higher risk adjustment payments from CMS.

- In May 2017, the Government obtained a $32.5 million settlement from Freedom Health, Inc., a Tampa-based MAO, to resolve allegations brought in a *qui tam* action that Freedom Health had submitted unsupported diagnosis codes to CMS on behalf of two MA Plans and thereby obtained inflated risk adjustment payments. In addition to paying the Government to settle these allegations, Freedom Health also agreed to be subject to a Corporate Integrity Agreement that included procedures for "determin[ing] whether Freedom properly submitted risk adjustment eligible diagnoses to CMS in accordance with CMS's rules and criteria under the Medicare Advantage Program." *See* Corporate Integrity Agreement, App. C at 1.
- In October 2018, the Government obtained a $270 million settlement from DaVita Medical Holdings LLC, a healthcare provider. This settlement was based in part on allegations that DaVita had given improper coding guidance to its employees so that they would report inaccurate diagnosis codes to MAOs to boost the payments received by DaVita from these MAOs. The settlement also addressed claims that DaVita had hired coding companies to perform retrospective chart reviews to identify new diagnosis codes to report to MAOs for submission to CMS, but that DaVita did not take corrective action with respect to previously-submitted codes that were not be substantiated by these chart reviews.

- In August 2019, the Government entered into a settlement with Beaver Medical Group, L.P., a California-based physician group, to resolve allegations that, to increase its payments from MAOs pursuant to revenue-sharing arrangements, Beaver had knowingly submitted diagnoses that were not supported by the medical records, and thereby caused CMS to calculate risk adjustment payments based on inaccurate diagnosis data.
- In August 2021, the Government entered into a $90 million settlement with Sutter Health, a California-based health care services provider, and certain affiliates, based on allegations that Sutter Health had knowingly submitted unsupported diagnosis codes for certain patient encounters for beneficiaries under its care, which caused inflated payments to be made to certain MAOs as well as to Sutter Health.
- In September 2023, the Government entered into two settlement agreements with The Cigna Group, which owns and operates MAOs that offer MA plans, to resolve claims that it had submitted and failed to withdraw inaccurate and untruthful diagnosis codes for its Medicare Advantage Plan enrollees in order to increase its payments from Medicare. Cigna was required to pay $172 million under those settlements. In one of the settled cases, the Government alleged that Cigna reported diagnosis codes to CMS that were based solely on forms completed by vendors retained and paid by Cigna to conduct in-home assessments of plan members and that those diagnosis codes were not supported by the information documented on the forms.
- And in January 2026, the Government entered into a $556 million settlement with affiliates of Kaiser Permanente, an integrated healthcare consortium. The settlement resolved allegations that the Kaiser affiliates submitted invalid diagnosis codes for MA plan members as a result of a scheme to pressure physicians to alter medical

records after patient visits to add diagnoses that the physicians had not considered or addressed at those visits, in violation of CMS rules.

MATRIX CAUSED MAOS TO SUBMIT FALSE AND INVALID DIAGNOSIS CODES FOR CHRONIC MEDICAL CONDITIONS THAT WERE BASED ONLY ON MATRIX'S IN-HOME ASSESSMENTS

69. During the Relevant Period, Matrix caused MAOs to submit false and invalid diagnoses of the following chronic medical conditions for risk adjustment purposes: proliferative diabetic retinopathy, drug-induced polyneuropathy, rheumatoid polyneuropathy, atrial fibrillation, rheumatoid arthritis, chronic obstructive pulmonary disease, and simple chronic bronchitis (defined above as the "Invalid Diagnoses"). Matrix focused on reporting diagnoses that could lead to higher capitated payments for its client MAOs, instead of ensuring that all of its diagnoses were appropriate and well-supported. The clinical information gathered during the in-home assessments often did not support the Invalid Diagnoses. In addition, the diagnoses were frequently not made by other healthcare providers who treated the patient and did not conform with the ICD Guidelines.

A. Matrix's Home Visit Program

70. During the Relevant Period, Matrix contracted with over thirty MAOs to perform in-home health assessments of Medicare Part C beneficiaries around the country. The MAOs paid Matrix a fee, generally in the range of $350 to $450, for each assessment. Matrix's nurse practitioners typically performed the assessments.

71. As discussed above, patients needed to have a "face-to-face encounter" with a healthcare provider for a diagnosis code to be reported for risk adjustment purposes. The in-home visits served as such an encounter and often led to MAOs reporting diagnosis codes that had not been previously submitted by a patient's primary care physician or another doctor.

72. The MAOs typically provided Matrix with lists of plan members to target. Matrix was then responsible for scheduling and conducting the home assessments.

73. The Matrix nurse practitioners who performed the assessments did not have access to the patient's full medical history and usually did not obtain and review the medical records maintained by the patient's primary care physician prior to the visit.

74. During the assessment, the nurse practitioners performed a basic physical examination, checked the patient's vital signs, and, in some cases, conducted limited diagnostic testing. They typically only brought basic medical equipment like a scale and blood pressure cuff to the home, and, with limited exceptions like a finger prick test for blood sugar, generally did not conduct blood or urine tests.

75. The nurse practitioners did not provide medical care or treatment during the home visits, and did not write prescriptions for any of the diagnosed conditions. Nor did they refer the patients to specialists for follow-up care, other than generalized suggestions that the patient follow up with their doctors. While Matrix assessment forms included suggested management or follow up sections, these were limited to generic steps or advice, such as "[c]ontinue present medication & follow up with PCP for ongoing monitoring," "[d]iscussed importance of taking medications as prescribed," or "[g]ave member approved educational materials to review."

76. Instead of providing actual treatment or care, the nurse practitioner's primary task during the home visit was to complete an electronic assessment form to identify diagnoses. The form included a health history which was obtained orally from the patient, any findings from the physical exam, the patient's vital signs, and the results of any of the limited diagnostic testing that might have been performed. The nurse practitioners based their diagnoses largely on the patients' own self-assessments, the medication they were taking, and their responses to various

basic screening questions. They did not order additional testing (such as blood tests, laboratory work, or imaging) to confirm any new diagnoses.

B. Matrix's In-Home Assessment Program Focused on Increasing the Medicare Part C Payments Received by MAOs

77. Matrix's home visit program was designed in large part to identify additional diagnosis codes that could be reported to CMS to increase patient risk scores, and therefore the capitated payments that the MAOs received from CMS for their plan members.

78. Indeed, Matrix advertised its services to MAOs by representing that the assessments would allow the MAOs to capture diagnoses for use in the risk adjustment process that were not reported by the plan member's other healthcare providers. In marketing materials sent to MAOs, Matrix advertised its ability to secure HCC "Lift," meaning to make diagnoses that resulted in higher HCC disease scores and, thus, higher risk adjustment payments.

79. Matrix also advertised and calculated the "increase in RAF score" from Matrix's assessments and estimated the amount by which the diagnoses Matrix identified increased the risk adjustment payments received by the MAOs. In one presentation from 2017, for example, Matrix calculated an average RAF increase of 0.164 from the in-home assessments it performed on an MAO's plan members, leading to an average per member per year impact of $1,574.

80. Additionally, Matrix's contracts with some MAOs required it to report on the MAO's "ROI," or return on investment. An MAO's "ROI" represented a comparison between the cost of the assessments and the estimated increase in Medicate Part C payments the MAO received as a result of reporting the additional diagnoses. The reported ROIs were substantial; in 2019, for example, a Matrix proposal to one MAO advertised that the overall ROI from Matrix's assessments was more than 4:1.

81. Matrix also took steps to increase the likelihood that the in-home assessments would generate certain lucrative diagnoses that could inflate reimbursement rates for the MAOs.

82. For instance, in advance of the assessments, Matrix analyzed claims data and other historical medical information to identify potential diagnoses that it then pre-populated on the electronic assessment form. The nurse practitioner was also required to record a diagnosis for each medication listed on the form, which would auto-populate as "suggested" diagnoses that would automatically appear on the final version of the assessment form unless the nurse practitioner affirmatively deleted them.

83. After the nurse practitioner completed the assessment form, Matrix's "Quality Improvement" staff reviewed the form to assess whether there were any "missed" diagnoses. If "missed' diagnoses were identified, nurses were asked to "rework" the assessments to add the diagnoses that were supposedly missing. At times, Matrix even added diagnoses without the nurse practitioner's approval after the nurse had left Matrix. Matrix also deducted points from providers' performance evaluations based on purported missed diagnoses, and these performance evaluations in turn affected the nurse practitioner's compensation.

84. Nurse practitioners frequently added diagnoses as a result of this review process. At times, however, the nurse practitioners resisted requests to add diagnoses and expressed significant discomfort with being asked to do so. For example, one nurse practitioner who refused to add a diagnosis stated, "I am not trying to be difficult about this, just trying to protect my license and my livelihood." In another instance a nurse practitioner stated that they were "pressured" to conduct a test "regardless of [their] clinical judgment" and were "not going to put [their] name on a diagnosis [they] personally can't back up," while another stated, "I have resigned and I am not diagnosing [the supposedly missed condition]." Despite nurse practitioners raising these concerns, Matrix continued to urge providers to add diagnoses to their assessments.

C. Many In-Home Assessments Resulted in Invalid Diagnoses

85. Matrix reported Invalid Diagnoses that were not supported by clinical findings or the information documented by the nurse practitioner in the assessment form. In many cases, based on the content of the forms, there was no sound basis to conclude that the plan member had the medical conditions recorded. Yet Matrix reported the Invalid Diagnoses to the MAOs, which in turn submitted the applicable diagnosis codes to CMS and certified that the data was accurate and truthful. Matrix acted with reckless disregard for the truth or falsity of these diagnoses when reporting them to MAOs despite the lack of supporting clinical information.

86. The Matrix nurses conducting the in-home assessment could not and did not perform tests, imaging, or other steps necessary to diagnose certain conditions because they lacked the equipment to do so in the home, and did not order tests or make referrals to confirm potential diagnoses.

87. In many cases, even a cursory review of the forms would have made clear that there was no sound clinical basis for recording the Invalid Diagnosis. In fact, in some cases, the forms show clinical exam findings that contradict the supposed diagnosis. For example, Matrix diagnosed one patient in Florida with chronic obstructive pulmonary disease—a progressive lung disease that restricts airflow—despite the absence of any reported wheezing or cough and without performing a pulmonary function test. Likewise, Matrix diagnosed patients with atrial fibrillation—an irregular and often rapid heart rhythm—without electrocardiogram testing and where the patient's physical examination revealed a normal pulse.

88. Furthermore, the fact that no other healthcare provider who treated or cared for the plan member during the year of the assessment—and in many cases during the years before and after the home visit—reported that the plan member suffered from the Invalid Diagnosis casts further doubt on the truth, reliability and accuracy of these diagnoses.

89. Matrix knew that it was reporting diagnosis codes corresponding to HCCs that were not otherwise reported for the plan member in that year. Indeed, identifying such diagnosis codes was a primary purpose of the home assessments. And Matrix calculated the returns on investment it reported to MAOs by evaluating the financial impact of diagnoses that had not otherwise been reported for the member in a particular year.

90. Matrix acted with reckless disregard as to the truth of the diagnosis data it provided to MAOs for risk adjustment submission. Matrix knew that it was regularly reporting Invalid Diagnoses, including because the assessment forms on their face did not support the Invalid Diagnoses and because the same diagnoses had not been reported by any other healthcare provider during the service year. Further, as a "first tier entity," Matrix was required to and did certify the accuracy and truthfulness of the data it generated relating to claims for payment submitted by the MAOs. Matrix's certifications were false with respect to the Invalid Diagnoses.

D. The Invalid Diagnoses Did Not Conform with the ICD Guidelines and Thus Were Improperly Submitted for Risk Adjustment Purposes

91. The Invalid Diagnoses did not conform with the ICD Guidelines as required under applicable CMS regulations and MAOs' Part C contracts. Matrix caused false claims for payment to be submitted by knowingly submitting diagnosis codes for MAO plan members that were inconsistent with the ICD Guidelines and thus ineligible for risk adjustment.

92. *First,* the ICD Guidelines permit coding for conditions diagnosed during outpatient visits only when the condition exists at the visit *and* it "require[s] or affect[s] patient care treatment or management." ICD-10 Guidelines § IV.J; ICD-9 Guidelines § IV.K. For chronic diseases specifically, the ICD Guidelines state that "[c]hronic diseases treated on an ongoing basis may be coded and reported as many times as the patient received treatment and care for the condition(s)." ICD-10 Guidelines § IV.I; ICD-9 Guidelines § IV.J. The ICD Guidelines do not permit reporting a code to "confirm" a previously made diagnosis for a

chronic condition if the diagnosis does not affect patient care, treatment, and management during the visit.

93. During the Relevant Period, Matrix regularly reported Invalid Diagnoses that did not meet these requirements. Specifically, as discussed above, the nurse practitioners who conducted its home assessments did not provide medical care or treatment. They did not prescribe medication for the condition or even refer the patient to a specialist. And the plan member often received no care or treatment for the condition at any time during the entire service year. Thus, the Invalid Diagnoses did not, contrary to the ICD Guidelines, "require or affect patient care treatment or management" during any medical encounter during the relevant date of service year. ICD-10 Guidelines § IV.J; ICD-9 Guidelines § IV.K.

94. *Second*, the ICD Guidelines also prohibit coding questionable diagnoses (for example, those that are merely suspected or probable) during outpatient visits. *See* ICD-10 Guidelines § IV.H; ICD-9 Guidelines § IV.I. Nonetheless, as discussed above, Matrix regularly recorded Invalid Diagnoses during home visits for complex conditions without performing the testing, imaging, or other diagnostic clinical steps necessary to establish those diagnoses. Submitting codes for diagnoses that were merely suspected, or which appeared previously in a patient's history but were not properly diagnosed at the time of the home assessment, violated the ICD Guidelines.

95. *Third*, the ICD Guidelines require that all diagnosis codes assigned to patients be supported by the information set forth in their medical records. The Guidelines specify that "accurate coding cannot be achieved" in the absence of "complete documentation in the medical record." *See supra* ¶ 60.

96. However, as discussed above, the Invalid Diagnoses do not satisfy this medical record documentation requirement. The information on the health assessment form itself did not support assigning a diagnosis code and submitting it to CMS for payment.

MATRIX'S PRACTICE OF REPORTING INVALID DIAGNOSES RESULTED IN THE SUBMISSION OF FALSE CLAIMS

97. Matrix reported diagnosis codes for thousands of Invalid Diagnoses to MAOs which then submitted the codes to CMS for risk adjustment payment purposes. As a result, MAOs received improperly inflated capitation payments for many plan members to which they were not entitled. Examples include:

a. Patient A[5]: An MAO with which Matrix contracted submitted a false claim and received money from CMS based on a diagnosis made during a Matrix home assessment of Patient A that was false and invalid and did not conform with the ICD Guidelines. Based solely on an assessment conducted by a Matrix nurse practitioner on June 25, 2018, in Pennsylvania, the MAO submitted a diagnosis code for chronic obstructive pulmonary disease (which mapped to HCC 111) for Patient A and received an additional risk adjustment payment of $2,758.92 for payment year 2019 based on that submission. Matrix knew that the nurse practitioner who recorded this diagnosis did not possess the clinical information necessary to reliably make this diagnosis. The information recorded in Matrix's assessment form for this visit does not support or substantiate this diagnosis. Further, no other provider reported this diagnosis (or any other diagnosis that mapped to HCC 111) for Patient A during 2018.

[5] In order to protect the confidentiality of patients' personal health information, this complaint does not include the names of specific patients or their insurers.

b. Patient B: An MAO with which Matrix contracted submitted a false claim and received money from CMS based on a diagnosis made during a Matrix home assessment of Patient B that was false and invalid and did not conform with the ICD Guidelines. Based solely on an assessment conducted by a Matrix nurse practitioner on November 8, 2018, in Pennsylvania, the MAO submitted a diagnosis code for rheumatoid arthritis (which mapped to HCC 40) for Patient B and received an additional risk adjustment payment of $1,113.12 for payment year 2019 based on that submission. Matrix knew that the nurse practitioner who recorded this diagnosis did not possess the clinical information necessary to reliably make this diagnosis. The information recorded in Matrix's assessment form for this visit does not support or substantiate this diagnosis. Further, no other provider reported this diagnosis (or any other diagnosis that mapped to HCC 40) for Patient B during 2018.

c. Patient C: An MAO with which Matrix contracted submitted a false claim and received money from CMS based on a diagnosis made during a Matrix home assessment of Patient C that was false and invalid and did not conform with the ICD Guidelines. Based solely on an assessment conducted by a Matrix nurse practitioner on November 26, 2018, in Arizona, the MAO submitted a diagnosis code for atrial fibrillation (which mapped to HCC 96) for Patient C and received an additional risk adjustment payment of $2,353.32 for payment year 2019 based on that submission. Matrix knew that the provider who recorded this diagnosis did not possess the clinical information necessary to reliably make this diagnosis. The information recorded in Matrix's assessment form for this visit does not support or substantiate this diagnosis. Further, no

other provider reported this diagnosis (or any other diagnosis that mapped to HCC 96) for Patient C during 2018.

d. Patient D: An MAO with which Matrix contracted submitted a false claim and received money from CMS based on a diagnosis made during a Matrix home assessment of Patient D that was false and invalid and did not conform with the ICD Guidelines. Based solely on an assessment conducted by a Matrix nurse practitioner on May 20, 2016, in New Jersey, the MAO submitted a diagnosis code for proliferative diabetic retinopathy (which mapped to HCC 122) for Patient D and received an additional risk adjustment payment of $2,004.10 for payment year 2017 based on that submission. Matrix knew that the provider who recorded this diagnosis did not possess the clinical information necessary to reliably make this diagnosis. The information recorded in Matrix's assessment form for this visit does not support or substantiate this diagnosis. Further, no other provider reported this diagnosis (or any other diagnosis that mapped to HCC 122) for Patient D during 2016.

98. In these and thousands of other instances, Matrix's misconduct had a direct and foreseeable impact on CMS. Specifically, Matrix's misconduct not only enabled MAOs with whom Matrix contracted to obtain and retain improperly inflated risk adjustment payments from CMS, it also adversely affected the integrity and accuracy of CMS's risk adjustment payment system. If CMS had known that the MAOs had submitted false diagnosis codes based on these Invalid Diagnoses, CMS would not have made risk adjustment payments based on those specific diagnosis codes or would have taken other appropriate actions to ensure that the MAOs did not retain risk adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or enforcement actions.

99. Further, for each payment year in the Relevant Period, the MAOs submitted Part C annual attestations for their Medicare Advantage plans, which certified to CMS that the risk adjustment diagnosis data the MAOs had submitted for those Medicare Advantage plans was "accurate, complete, and truthful" based on the MAOs' "best knowledge, information, and belief."

100. The MAOs' attestations were based in part on Matrix's certifications to the MAOs that the diagnosis data it submitted to them was accurate, complete, and truthful.

101. Each of those Part C attestations was false. Specifically, Matrix knew that invalid diagnoses like the examples enumerated in paragraph 97 above were present in the diagnosis data it reported to MAOs and were likely to be included in their risk adjustment submissions.

102. Matrix also knew that the MAOs' submission of the false annual attestations to CMS had a direct and foreseeable impact on CMS. Specifically, as Matrix knew, CMS's procedures require MAOs to submit Part C annual attestations before CMS will proceed with the final reconciliation phase of the risk adjustment payment process. Thus, the false attestations submitted by the MAOs caused CMS to move forward with final reconciliation for the Medicare Advantage plans and disburse inflated final reconciliation payments to the MAOs during the Relevant Period.

FIRST CLAIM
Violation of the FCA: Presentation of False or Fraudulent Claims for Payment 31 U.S.C. § 3729(a)(1)(A)

103. The Government incorporates by reference paragraphs 1 through 102 above as if fully set forth in this paragraph.

104. Matrix violated 31 U.S.C. § 3729(a)(1)(A) by knowingly (with actual knowledge or deliberate ignorance or reckless disregard of the truth) causing the MAOs with which Matrix

contracted to present false or fraudulent claims for payment or approval to CMS resulting in the receipt of Medicare payments from CMS to which the MAOs were not entitled.

105. Specifically, Matrix knowingly (with actual knowledge or deliberate ignorance or reckless disregard of the truth) caused false claims for risk adjustment payments to be made by reporting to MAOs, for submission to CMS, false, inaccurate, improper, and invalid diagnosis codes for Medicare Part C patients.

106. If CMS had known that the MAOs had presented false claims based on these false, inaccurate, improper, and invalid diagnosis codes, CMS would have refused to make risk adjustment payments based on the false, inaccurate, improper, and invalid coding and/or taken other appropriate actions to ensure that the MAOs did not receive or retain risk adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or obtaining repayments in enforcement actions.

107. By reason of the false claims that Matrix knowingly caused to be presented, the United States has been damaged in a substantial amount to be determined at trial, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

SECOND CLAIM
Violation of the FCA: Making and Using False Records or Statements
31 U.S.C. § 3729(a)(1)(B)

108. The Government incorporates by reference paragraphs 1 through 107 above as if fully set forth in this paragraph.

109. Defendants violated 31 U.S.C. § 3729(a)(1)(B) by knowingly (with actual knowledge or deliberate ignorance or reckless disregard of the truth) making, using, and causing to be made or used, false records and statements material to false or fraudulent claims, resulting in the MAOs for which Matrix performed in-home assessments receiving Medicare payments from CMS to which they were not entitled.

110. Specifically, Matrix knowingly (with actual knowledge or deliberate ignorance or reckless disregard of the truth) made, used, or caused to be made or used, false records and statements—in the form of, for example, false risk adjustment submissions and false attestations as to the accuracy of diagnosis codes by Matrix and the MAOs for which Matrix performed in-home assessments—that were material to the payment of false claims for risk adjustment payments for Medicare Part C patients.

111. If CMS had known that Matrix and the MAOs had made or used false records or statements material to these false claims, CMS would have refused to make risk adjustment payments based on the inaccurate, improper, and invalid coding and/or taken other appropriate actions to ensure that the MAOs did not receive or retain risk adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or obtaining repayments in enforcement actions.

112. By reason of these false records or statements, the Government has been damaged in a substantial amount to be determined at trial and is entitled to recover treble damages plus a civil monetary penalty for each false record or statement.

PRAYER FOR RELIEF

WHEREFORE, the United States respectfully requests that judgment be entered in its favor against Matrix as follows:

(a) A judgment against Matrix for treble the Government's damages, in an amount to be determined at trial, plus a civil penalty in the maximum applicable amount for each violation of the FCA by Matrix.

(b) Costs and such further relief as the Court may deem appropriate.

Dated: New York, New York
May 26, 2026

Respectfully submitted,

JAY CLAYTON
United States Attorney for the
Southern District of New York

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA *ex rel.* NANCY CAHILL, Plaintiff-Relator, v. MATRIX MEDICAL NETWORK, *et al.*, Defendants.	19 Civ. 11153 (ALC)
UNITED STATES OF AMERICA, Plaintiff-Intervenor, v. COMMUNITY CARE HEALTH NETWORK LLC, d/b/a MATRIX MEDICAL NETWORK, Defendant.	

ORDER

WHEREAS, by notice dated May 26, 2026 and pursuant to the False Claims Act, 31 U.S.C. §§ 3730(b)(2) and (4), the United States of America (the "Government") partially intervened in the above-captioned *qui tam* action with respect to certain allegations and False Claims Act claims asserted against defendant Community Care Health Network LLC, d/b/a Matrix Medical Network ("Matrix").

IT IS HEREBY ORDERED that:

1. The seal shall be lifted as to this Order and any matter occurring in this action on or subsequent to the date of this Order.

2. All documents submitted in this action before the date of this Order shall remain under seal and shall not be made public, except to the extent the seal was partially lifted pursuant to the Court's prior Order dated February 10, 2025, and except as provided for in Paragraph 3 below.

3. The seal shall be lifted as to the Government's Notice of Election to Partially Intervene; the Government's Complaint-In-Intervention; the Stipulation and Order of Settlement and Dismissal entered into by the United States, Matrix and Relator; the Stipulation and Order of Settlement and Release Between the United States and Relator; and Relator's complaint.

Dated: New York, New York
June 2, 2026

SO ORDERED:

HONORABLE ANDREW L. CARTER
UNITED STATES DISTRICT JUDGE