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

UNITED STATES OF AMERICA and THE STATE OF TENNESSEE *ex rel.* LISA PENCE, LISA ADKINS, ROBIN DILLON TEAGUE, AMY CARNELL, RACHEL CAROL ANDERSON, and STEVEN TROY MATHIS,	)	
Plaintiffs,	)	CASE NO.: 3:13-cv-00672 (Lead) 3:20-cv-00168 (Member) JUDGE TRAUGER
v.	)	
CURO HEALTH SERVICES HOLDINGS, INC., CURO HEALTH SERVICES, LLC (f/k/a CURO HEALTH SERVICES, INC.), TNMO HEALTHCARE, LLC (d/b/a AVALON HOSPICE), and REGENCY HEALTHCARE GROUP, LLC,	)	**JURY DEMAND**
Defendants.	)	

CONSOLIDATED COMPLAINT IN INTERVENTION

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INTRODUCTION

1. The United States of America and the State of Tennessee bring this case against Curo Health Services Holdings, Inc. and certain of its subsidiaries and their predecessors (collectively, "Defendants") to recover losses sustained to the Medicare and Medicaid Programs for hospice services provided to beneficiaries in Tennessee who were not terminally ill with a life expectancy of six months or less. Defendants operate a national for-profit hospice chain. The vast majority of Defendants' revenues are generated by Medicare and Medicaid payments for claims that Defendants submit or cause to be submitted for hospice services they provide to individuals who Defendants have represented to be terminally ill, and thus, eligible to receive Medicare or Medicaid benefits.

2. Defendants pressured staff at their local Tennessee hospice agencies to maximize admissions and census through aggressive financial targets and incentives, while simultaneously discouraging the discharge of patients who were no longer eligible. Defendants also failed to ensure that physicians who provided legally required and material certifications and recertifications of patients' terminal illnesses received or adequately considered complete and accurate information regarding patients' conditions. Indeed, Defendants failed to adequately train their clinical staff members to identify and assess terminal illnesses, even though certifying physicians relied on staff at Defendants' hospice agencies and their documentation to convey clinical information relevant to the physicians' eligibility assessments. Furthermore, Defendants imposed strict documentation requirements regarding specific information or words that must be included – or must be excluded – from patient medical records.

3. Defendants were aware that these pressures, incentives, and documentation requirements and restrictions caused managers at certain agencies to engage in improper practices

to maximize financial performance without regard for whether patients were eligible for the hospice benefit. Defendants knew or should have known that certain agency managers circumvented clinicians who did not believe a patient was hospice-eligible, falsified relevant documentation such as physician narratives, and forged physician certifications. Defendants were also aware that managers at certain agencies required staff members to provide documentation that misrepresented patients' conditions by exaggerating the extent of patients' illnesses or by omitting information that reflected clinical plateau, stability, or improvement, such that the medical records upon which physicians relied to assess patients' eligibility misrepresented the patients' condition.

4. When confronted with internal complaints regarding patient ineligibility, Defendants continued to submit claims to Medicare for hospice services provided to patients who were determined to be ineligible by their own clinical and compliance personnel. Furthermore, even after Defendants were made aware through internal complaints and audits that they had billed for hospice services provided to Medicare or TennCare beneficiaries in Tennessee who were not hospice-eligible, they did not return Medicare or TennCare payments they had received. And, when internal investigations confirmed certain specifically-identified patients were ineligible to receive Medicare or TennCare hospice benefits, Defendants were on notice that Avalon received potential overpayments from Medicare or TennCare for beneficiaries beyond those identified by internal complainants, yet they failed to undertake due diligence to ensure that Avalon had not received overpayments associated with other patients or claims were not ineligible.

5. Thus, by knowingly submitting false claims or causing the submission of false claims, and knowingly concealing or knowingly and improperly avoiding Avalon's obligations to repay overpayments, for hospice services provided to Medicare and TennCare beneficiaries in Tennessee who were not terminally ill from at least January 1, 2010 through February 20, 2020,

Defendants are liable under the False Claims Act, 31 U.S.C. § 3729, *et seq*. (the "FCA"), the Tennessee Medicaid False Claims Act, Tenn. Code Ann. §§ 71-5-182 to -185 (the "TMFCA"), and common law theories of payment by mistake and unjust enrichment.

JURISDICTION AND VENUE

6. This Court has jurisdiction over this action pursuant to 31 U.S.C. §§ 3730(a) and 3732, 28 U.S.C. §§ 1331, 1345 and 1367(a), and Tenn. Code Ann. § 71-5-183(a).

7. This Court has personal jurisdiction over the Defendants pursuant to 31 U.S.C. § 3732(a). Jurisdiction is proper over the Defendants because the Defendants maintain offices in and have transacted business within this Court's jurisdiction, and some of the acts in violation of 31 U.S.C. § 3729 occurred within this district.

8. Venue is proper in this district under 28 U.S.C. § 1391(b)-(c), and 31 U.S.C. § 3732(a) because the Defendants maintain offices in and transact business in this district and because a substantial portion of the events or omissions giving rise to the claims alleged herein occurred in this district.

PARTIES

9. The United States brings this action on behalf of the United States Department of Health and Human Services ("HHS"). This includes the Centers for Medicare & Medicaid Services ("CMS"), which administers the Medicare and Medicaid programs for HHS.

10. The State of Tennessee brings this action through the Tennessee Attorney General on behalf of TennCare, the State of Tennessee's managed Medicaid agency. The Attorney General has standing to bring this action pursuant to Tenn. Code Ann. § 71-5-183(a).

11. At all times relevant to this Complaint, Defendant TNMO Healthcare, LLC (d/b/a Avalon Hospice) ("Avalon") was a Delaware limited liability company that operates hospices

(known as agencies) in at least 27 different geographic areas in Tennessee. At all times relevant to this Complaint, two Medicare Provider Numbers were issued to Avalon, which were used to submit claims for services provided by Avalon hospice agencies throughout Tennessee through the parent agencies in Nashville (NPI 1407807688) and Chattanooga (NPI 1003867458).

12. Defendant Regency Healthcare Group, LLC ("Regency")[1] is a Delaware limited liability company. Prior to November 2011, Regency provided hospice services throughout the Southeast through various wholly-owned subsidiaries, including Avalon. Regency controlled the operations of its subsidiaries through setting policies, procedures, incentive plans, and financial targets, and hiring managers for its different hospice agencies. Regency also provided centralized management staff, such as regional clinical, operations, and business development managers, as well as compliance personnel.

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[1] For statute of limitations purposes, the United States' Complaint in Intervention, including its claims against Regency Health Group, LLC, relates back to a previously-filed *qui tam* complaint, which mistakenly named Regency Health Care Centers, Inc. as a defendant. (*See United States ex rel. Pence et al. v. Curo Health Services LLC d/b/a Avalon Hospice et al.* (DE 1)). Under the FCA, for statute of limitations purposes, a complaint in intervention by the United States' "shall relate back to the filing date of the complaint of the person who originally brought the action, to the extent that the claim of the [United States] arises out of the conduct, transactions, or occurrences set forth, or *attempted to be set* forth, in the prior complaint of that person." 31 U.S.C. § 3731(c) (emphasis added). Allegations included in the *Pence qui tam* complaint make clear that Relators attempted to name Regency Healthcare Group, LLC as a defendant, including by referencing Curo Health Services Holdings, Inc.'s November 2011 acquisition of Regency. Furthermore, while FCA *qui tam* complaints are filed under seal such that defendants do not initially receive notice through service of the complaint, Defendants received notice of the relevant allegations when the United States provide a redacted version of the *qui tam* complaint in November 1, 2018. Therefore, Regency knew that a sealed *qui tam* complaint had been brought against it but for a mistake concerning the proper party's identity and will not be prejudiced in defending on the merits. *Cf. also* Fed. R. Civ. P. 15(c)(1)(C)(i)-(ii) ("An amendment to a pleading relates back to the date of the original pleading when: . . . the amendment changes the party or the naming of the party against whom a claim is asserted, if [it asserts a claim . . . that arose out of the conduct, transaction, or occurrence set out – or attempted to be set out – in the original pleading] and if . . . the party to be brought in by amendment: (i) received such notice of the action that it will not be prejudiced in defending on the merits; and (ii) knew or should have known that the action would have been brought against it, but for mistake concerning the proper party's identity.").

13. Curo Health Services Holdings, Inc. ("Curo Holdings" or "the Company") is a Delaware corporation that was formed in 2010. Defendant Curo Holdings is a for-profit hospice chain that was created when private equity firm GTRC partnered with Larry Graham and Alice Ann Schwartz, two former executives of a different home health and hospice provider.

14. Curo Holdings operated more than a hundred agencies in states across the country, including in Tennessee, during the relevant time period. Since at least 2015, approximately ninety-five percent of Curo Holdings' revenue was generated by Medicare, and upon information and belief, Medicare continues to provide the vast majority of Curo Holdings' revenue stream. Since it was founded, Curo Holdings has expanded through acquiring other hospice providers, including its November 2011 acquisition of Regency, and by opening new agencies.

15. Curo Holdings centralized the key support functions of its hospice operations, including information technology, accounting, financial reporting, human resources, payroll, training and education, billing and reimbursement, legal, compliance, and regulatory. In particular, Curo Holdings implemented its corporate compliance program for its local agencies, including those in Tennessee.

16. For example, all employees, officers, and directors of Curo Holdings and its agencies must provide an attestation to comply with the Curo Holdings' Code of Conduct and Ethics. And, as part of its quality and compliance program, Curo Holdings developed and implemented auditing programs, including clinical audits focused on diagnoses or length of stay. Curo Holdings utilized its centralized data capability and technology to require all of its agencies, including those in Tennessee, to use its clinical and compliance protocols. Furthermore, Curo Holdings has dedicated a team of compliance nurses to design clinical protocols to embed in all patient visit documentation written by agency staff.

17. Curo Holdings has also centralized control over billing processes through its billing and electronic medical record ("EMR") system, Homecare Homebase ("HCHB"). Curo Holdings uses this system to submit claims to Medicare and other payers (such as TennCare), monitor the Medicare cap, and continuously check the eligibility of every Medicare patient.

18. Curo Holdings is organized by region, with a Curo Holdings management team that oversees the clinical, operational, financial, and sales functions within their respective regions. The regional management teams typically include a Regional or Area Vice President or Manager of Operations and a Vice President of Business Development, and may also include other regional managers, such as a Vice President of Clinical Operations. These regional managers report directly to Curo's senior corporate executives.

19. Each of Curo's agencies is led by a Director of Operations ("DOO") who directly reports to an Area Vice President or Manager of Operations and is ultimately responsible for all of the clinical, operational, financial, compliance, and sales functions at their respective agencies. While DOOs may be associated with different corporate subsidiaries based on their geographic location (such as Avalon in Tennessee), the Company hires these DOOs, sets their compensation, manages their benefits, and prescribes the policies and expectations DOOs are responsible for implementing and achieving. Curo Holdings agencies are staffed by administrative or office personnel (such as patient care coordinators or medical records clerks), nurses, social workers, volunteer coordinators, chaplains, and/or bereavement coordinators.

20. The Company, through its subsidiaries such as Avalon, enters independent contractor agreements with one or more medical directors or associate medical directors for each agency who provide consultation on patient care plans. These medical directors assist agencies on a part-time basis and typically do not see patients. Rather, their roles are generally limited to

attending interdisciplinary group ("IDG") meetings and writing prescriptions or other orders based on clinical information and requests from agency staff. Medical directors are also responsible for providing regulatory-mandated written certifications of terminal illness ("COTIs"), which certify that a patient's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course.

21. Curo Holdings implements these centralized support functions at its various agencies through a complex corporate structure that incorporates legacy entities it has acquired over time and new agencies.

22. Defendant Curo Health Services, LLC (f/k/a Curo Health Services, Inc.) ("Curo Health Services") is a Delaware limited liability company and wholly-owned subsidiary of Curo Holdings. Curo Holdings and Curo Health Services (collectively, "Curo") are both headquartered at 655 Brawley School Road, Mooresville, NC 28117, and during the relevant time period, both entities shared the same officers, including Chief Executive Officer (Larry Graham), Chief Operating Officer (Alice Ann Schwartz), Chief Compliance Officer (Douglas Abell), and Chief Financial Officer (Ron Marino).

23. Defendant Curo Health Services owns various other subsidiaries, including Defendant Regency. In turn, each of these intermediate entities is a corporate parent to a collection of subsidiaries, the vast majority of which are wholly-owned as well, including Avalon.

24. Curo Holdings implements Curo's centralized business functions through Curo Health Services. For example, during the relevant time period, Curo Health Services was generally responsible for coordinating human resources functions (such as issuing employment offers) and setting incentive plans for agency staff and Curo regional executives. And, Curo executed its

compliance function through Curo Health Services personnel, including a vice president of compliance and later clinical compliance monitors.

25. Furthermore, Curo Holdings continues to operate some of these centralized functions using the moniker Curo Health Services, Inc., which was a Delaware corporation formed in 2010, but was subsequently converted into Curo Health Services, LLC. For example, many executives and personnel in Curo's corporate office operations department continue to frequently use the name Curo Health Services, Inc. Curo's office operations department administers many aspects of HCHB, such as processing claims submission, tracking of performance metrics, and identifying outstanding required documentation (such as COTIs). And, at certain times during the relevant time period, incentive plans were issued under the name of Curo Health Services, Inc., even after the entity ceased to exist after its merger with Curo Health Services, LLC.

LEGAL BACKGROUND

I. The False Claims Act

26. The FCA provides for the award of treble damages and civil penalties for, *inter alia*, knowingly presenting or causing to be presented false or fraudulent claims for payment to the United States. 31 U.S.C. §§ 3729(a)(1), amended by 31 U.S.C. § 3729(a)(1)(A).

27. The FCA also imposes liability for knowingly making, using, or causing or be made or used, a false record or statement material to an obligation to pay or transmit money or property to the United States, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the United States. *See* 31 U.S.C. § 3729(a)(1)(G) (2009). The Affordable Care Act ("ACA"), enacted on March 23, 2010, specified that an "obligation" to pay money under the FCA can arise from "the retention of any

overpayment," which are Medicare or Medicaid funds to which a provider is not entitled. 31 U.S.C. §§ 3729(b)(3); 42 U.S.C. § 1320a-7k(d)(4).

28. The ACA also required providers who receive or retain funds from Medicare or Medicaid to report and return overpayments within 60 days after the date on which the overpayment was identified. 42 U.S.C. § 1320a-7k(d)(2). Furthermore, the ACA specifies that any overpayment retained by a person after the deadline for reporting and returning the overpayment is an "obligation" as defined by 31 U.S.C. § 3729(b)(3) for purposes of FCA liability. 42 U.S.C. § 1320a-7k(d)(3). The requirements of this rule are meant to ensure compliance with applicable statutes, promote the furnishing of high quality care, and to protect the Medicare Trust Funds against fraud and improper payments.

29. For purposes of the FCA, 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), amended by 31 U.S.C. § 3729(b)(1).

30. The standard of proof under the FCA is a preponderance of the evidence. 31 U.S.C. § 3731(d).

II. The Tennessee Medicaid False Claims Act

31. The TMFCA provides in pertinent part that a person who:

> (a)(1)(A) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval under the medicaid program;
>
> (a)(1)(B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim under the medicaid program; . . .

> (a)(1)(D) 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 state, or knowingly conceals, or knowingly and improperly, avoids, or decreases an obligation to pay or transmit money or property to the state, relative to the medicaid program; . . .
>
> is liable to the state for a civil penalty of not less than five thousand dollars ($5,000) and not more than twenty-five thousand dollars ($25,000), adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, compiled in 28 U.S.C. § 2461 note; Public Law 101-410, plus three (3) times the amount of damages which the state sustains because of the act of that person . . .

Tenn. Code Ann. § 71-5-182.

32. On June 11, 2011, TennCare issued Policy PI 11-001 to implement the requirements of Section 6402 of the Affordable Care Act with respect to "Reporting and Returning Overpayments." The policy reiterated the ACA's requirement for providers who receive or retain funds from Medicare or Medicaid to report and return overpayments within 60 days after the date on which the overpayment was identified. Furthermore, the policy emphasizes that overpayments that are not returned within 60 days from the date the overpayment was identified can trigger liability under the False Claims Act.

33. Effective April 23, 2012, the TMFCA was revised by Tennessee's General Assembly to mirror the federal FCA and impose liability not only for knowingly making, using, or causing or be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state, but also for knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the state, relative to the Medicaid program. *See* Tenn. Code Ann. § 71-5-182(a)(1)(D).

34. For purposes of the TMFCA, the terms "knowing" and "knowingly" mean that a person, with respect to information —

(1) Has actual knowledge of the information;
(2) Acts in deliberate ignorance of the truth or falsity of the information; or
(3) Acts in reckless disregard of the truth or falsity of the information; and no proof of specific intent to defraud is required.

Tenn. Code Ann. § 71-5-182(b)

35. The standard of proof under the TMFCA is a preponderance of the evidence. Tenn. Code Ann. § 71-5-183.

III. The Medicare Program

36. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.,* establishes the Health Insurance for the Aged and Disabled Program, commonly referred to as the Medicare Program (the "Medicare Program" or "Medicare").

37. The Medicare Program is comprised of four parts. Part A of the Medicare Program is a federally funded health care program, entitlement to which is based on age, disability, or affliction with end-stage renal disease. 42 U.S.C. §§ 426, 426-1. The benefits covered by Part A of the Medicare Program include hospice care under 42 U.S.C. § 1395x(dd).

38. Medicare is administered by CMS, which is part of HHS. At all times relevant to this complaint, CMS contracted with private contractors referred to as Medicare Administrative Contractors ("MACs"), to act as agents in reviewing and paying claims submitted by health care providers. 42 U.S.C. § 1395h; 42 C.F.R. §§ 421.3, 421.100.

39. Medicare payments are typically made directly to health care providers such as Avalon rather than to beneficiaries. This occurs when the Medicare beneficiary assigns his or her right to payment to the provider. In that case, the provider submits its bill directly to Medicare for payment.

40. Hospice providers are reimbursed based upon their submission of an electronic claim form called an "837I," the standard format used by institutional providers to transmit health care claims electronically, or a hard-copy claim form called a "CMS-1450," also known as the UB-04. For purposes of this complaint, both the electronic claim form and the hard-copy claim form will be referred to as the "CMS-1450."

41. When a hospice provider submits a Medicare hospice claim, it represents that it is entitled to payment for the claim.

42. On the CMS-1450, the hospice provider must state, among other things, the beneficiary's name, the beneficiary's diagnosis, the beginning and ending dates of the period covered by the bill, and that the bill type is "hospice." *See* Medicare Claims Processing Manual, Chap. 11, Processing Hospice Claims. By listing a diagnosis on the CMS-1450, the hospice provider implicitly represents that the beneficiary's diagnosis is a terminal one.

43. By submitting the CMS-1450, the provider certifies that the billing information on the claim is true, accurate, and complete; that the provider did not knowingly or recklessly disregard or misrepresent or conceal material facts; that physician's certifications and re-certifications are on file; and that records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

44. All healthcare providers must comply with applicable statutes, regulations, and guidelines in order to be reimbursed by Medicare Part A. A provider has a duty to familiarize itself with the statutes, regulations, and guidelines regarding coverage for the Medicare services it provides. *Heckler v. Cmty. Health Servs. of Crawford Cty., Inc.,* 467 U.S. 51, 64 (1984).

45. Because it is not feasible for the Medicare program, or its contractors, to review every patient's medical records for the millions of claims for payment it receives from hospice providers every year, the Medicare program relies upon the hospice providers to comply with the Medicare requirements and trusts the providers to submit truthful and accurate claims. The Medicare program, through its contractors, also seeks to recoup payments made for improperly paid claims when such payments are identified. This includes payments made to providers for claims submitted on behalf of beneficiaries ineligible for the hospice benefit because they were not properly certified as "terminally ill."

IV. The TennCare Program

46. The Medicaid Program provides funding for medical and health-related services for certain individuals and families with low incomes and limited financial resources. 42 U.S.C. § 1396, *et seq*. Those eligible for Medicaid include pregnant women, children, and persons who are aged, blind, or suffer from other disabilities and who cannot afford the cost of health care. 42 U.S.C. § 1396d. The Medicaid program is a joint federal–state health care program. 42 U.S.C. § 1396b. If a state elects to participate in the program, the costs of Medicaid are shared between the state and the federal government. 42 U.S.C. § 1396a(a)(2). In order to receive federal funding, a participating state must comply with requirements imposed by the Social Security Act and regulations promulgated thereunder.

47. Tennessee participates in the Medicaid program pursuant to Tenn. Code Ann. §§ 71-5-101 to 71-5-199. The federal government, through CMS, provides approximately sixty-five percent of the funds used by the Tennessee Medicaid program to provide medical assistance to persons enrolled in the Medicaid program.

48. In return for receipt of federal subsidies, Tennessee is required to administer its Medicaid program in conformity with a state plan and federally approved waiver that satisfies the requirements of the Act and accompanying regulations. 42 U.S.C. §§ 1396–1396w; Tenn. Code Ann. § 71-5-102. In Tennessee, the Department of Finance & Administration administers the state Medicaid program through TennCare. Tenn. Code Ann. § 71-5-104. TennCare operates as a special demonstration project authorized by the Secretary of HHS under the waiver authority conferred by 42 U.S.C. § 1315. The Tennessee Department of Finance & Administration supervises TennCare's administration of medical assistance for eligible recipients. Tenn. Code Ann. § 71-5-105-107. The Department of Finance & Administration is authorized to promulgate rules and regulations to carry out the purposes of TennCare. Tenn. Code Ann. §§ 71-5-124 to –134.

49. TennCare contracts with private managed care contractors ("MCCs") through contracts, known as Contractor Risk Agreements ("CRAs"), which must follow the requirements of 42 U.S.C. § 1395mm, along with any related federal rules and regulations. Tenn. Code Ann. § 71-5-128. The MCCs contract directly with providers to provide health care services to eligible TennCare beneficiaries. Providers who have entered into such a contract with an MCC are known as Participating Providers. Tenn. Comp. R. & Regs. § 1200-13-13-.01(89). Pursuant to the CRAs, TennCare distributes the combined state and federal Medicaid funding to the MCCs, which then pay Participating Providers for treatment of TennCare beneficiaries. TennCare-eligible persons seeking medical assistance enroll in an MCC to receive health care services from a Participating Provider.

50. Defendant Avalon was a Participating Provider contracted with relevant MCCs throughout the relevant time period.

51. The hospice benefit under TennCare is almost identical to that provided to Medicare beneficiaries under Medicare Part A. Tenn. Comp. Rules & Regs. 1200-13-13-.04(1)(b)10.

V. Conditions of Payment for Medicare and TennCare Hospice Benefits

52. Hospice provides palliative, rather than curative, care to patients. Palliative care is aimed at relieving pain, symptoms, or stress of terminal illness. *See* 42 C.F.R. § 418.3. It includes a comprehensive set of medical, social, psychological, emotional, and spiritual services provided to a terminally ill individual. *See id.* Medicare beneficiaries who elect hospice care agree to forego curative treatment for the terminal condition for which hospice care was elected. 42 C.F.R. § 418.24(d); *see also* 48 Fed. Reg. 56,008, 56,010 (Dec. 16, 1983). In other words, a patient who receives the Medicare hospice benefit no longer receives care that could lead to a cure of the patient's illnesses.

53. Medicare only pays for hospice care provided to "terminally ill" individuals that is "reasonable and necessary for the palliation or management of terminal illness." 42 U.S.C. § 1395y(a)(1)(C).

54. Terminally ill individuals are defined as those with a medical prognosis of a life expectancy of six months or less, if the illness runs its normal course. *Id.* § 1395x(dd)(3)(A); 42 C.F.R. § 418.3.

55. Pursuant to 42 C.F.R. § 418.20, to be eligible to elect hospice care under Medicare, an individual must be: (a) entitled to Part A of Medicare; and (b) certified as terminally ill in accordance with 42 C.F.R. § 418.22.

56. At all times relevant to this case, each written certification required: (1) a statement that the individual's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course; (2) specific clinical findings and other documentation

supporting a life expectancy of six months or less; (3) the signature(s) of the physician(s); and (4) the physician's brief narrative explanation of the clinical findings that support the individual's life expectancy of six months or less. 42 C.F.R. § 418.22; Medicare Benefit Policy Manual, Chapter 9, § 20.1.

57. Thus, as part of the certification requirements, the hospice must not only ensure that it has a certification on file signed by a physician but also must ensure that the medical record that the hospice maintains for the individual contains clinical information and other documentation that support the conclusion that the individual is "terminally ill." *See* 42 U.S.C. § 1395f(a)(7); 42 C.F.R. § 418.22.

58. Hospice is available to individuals for two initial 90-day periods and then an unlimited number of 60-day periods, provided the individual's terminal condition is properly certified generally at the beginning of each period. 42 U.S.C. § 1395d(a)(4); *see also* 42 C.F.R. § 418.21, 418.22.

59. TennCare follows the same hospice benefit period used by Medicare, including an initial 90-day period; a subsequent 90-day period; and an unlimited number of 60-day periods. Tenn. Comp. Rules & Regs. 1200-13-13-.04(1)(b)10.

60. The initial 90-day period must be certified by (a) the Medical Director of the hospice or a physician-member of the hospice IDG and (b) the individual's attending physician, if the individual has an attending physician. For subsequent periods, the hospice provider must obtain the COTI from either the medical director of the hospice or a physician who is a member of the hospice's IDG. *See* 42 U.S.C. § 1395f(a)(7)(A); 42 C.F.R. § 418.22(c).

61. Since January 1, 2011, before the 180th-day recertification and each subsequent recertification, a hospice physician or nurse practitioner must perform a face-to-face encounter

with the patient to gather clinical findings to determine continued eligibility for hospice care. *See* 42 U.S.C. § 1395f(a)(7)(D); 42 C.F.R. § 418.22(c).

62. The hospice IDG should consist of, at a minimum, a physician, a registered nurse, a social worker, and a pastor or other counselor. *See* 42 C.F.R. § 418.56. The IDG is responsible for developing and implementing an individualized plan of hospice care for each patient. *Id.*

63. TennCare follows the same certification procedures and election procedures, as well as statements of election, revocation, and change of hospices as used by Medicare. TennCare Policy Manual, Policy No. BEN 07-001 (Rev. 7).

64. For individuals enrolled in the TennCare program who are not eligible for Medicare, the hospice benefit and requirements for coverage under TennCare are identical to the benefits and requirements for coverage under Medicare. TennCare Policy Manual, Policy No. BEN 07-001 (Rev. 7).

65. Hospice care is paid at a per diem rate based on the number of days and level of care provided during the election period. Medicare Benefit Policy Manual, Chapter 9, § 40; *see also* 42 C.F.R. § 418.302.

66. Hospice providers must maintain a clinical record for each hospice patient that contains "correct clinical information." 42 C.F.R. § 418.104. All entries in the clinical record must be "legible, clear, complete, and appropriately authenticated and dated . . . ." *Id.* § 418.104(b).

67. While physicians certainly are expected to prescribe only necessary services, to ensure the integrity of the Medicare hospice program, payment for hospice services requires supporting medical information. For this reason, clinical information in the patient's medical record supporting a life expectancy of six months or less is a condition of payment for hospice

care separate and independent of a signed physician certification. 42 C.F.R. § 418.22; 42 C.F.R. § 418.200; *see also* 79 Fed. Reg. 50,452, 50,470 (Aug. 22, 2014); 78 Fed. Reg. 48,234-01, 48,245 (Aug. 7, 2013); 74 Fed. Reg. 39,384-01, 39,398 (Aug. 6, 2009); 70 Fed. Reg. 70,532, 70,534-35 (Nov. 22, 2005). Conditioning payment for hospice services on clinical information demonstrating that the patient is terminally ill constitutes an important safeguard to ensure that CMS only pays for hospice benefits for those patients who need them.

68. These important Medicare requirements for coverage of hospice care and submission of hospice claims are communicated to hospice providers in the Medicare statute and its implementing regulations; the Medicare Benefit Policy Manual, Chapter 9; the Medicare Claims Processing Manual, Chapter 11; the Federal Register; and in other published guidance.

69. Upon enrollment as a Medicare provider, a provider agrees "to abide by the Medicare laws, regulations and program instructions [applicable to it]" and acknowledges that "payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions . . . ." CMS-855A, § 15.

VI. Determining Life Expectancy Requires a Physician to Knowledgeably Apply Clinical Research and Guidelines to Complete and Correct Medical Facts

70. CMS has instructed hospice providers to use various clinical tools to assist in determining whether a Medicare beneficiary, based on his or her current clinical status and the anticipated progression of his or her illness, has a prognosis of six months or less. *See* 78 Fed. Reg. 48234, 48247 (Aug. 7, 2013); 79 Fed. Reg. 26538, 26556 (May 8, 2014). *See* 79 Fed. Reg. 26538, 26556 (May 8, 2014); 78 Fed. Reg. 48234, 48247 (Aug. 7, 2013). Multiple available resources provide guidance on clinical indicators of a life expectancy of six months or less, including clinical and functional assessment tools and information, such as Hospice Local Coverage Determinations ("LCDs"). MACs develop LCDs by "considering medical literature, the

advice of local medical societies and medical consultants, public comments, and comments from the provider community." Medicare Program Integrity Manual, Chapter 13, § 13.1.3.

71. During the relevant time period, Cahaba Government Benefit Administrator, LLC ("Cahaba") and Palmetto GBA, LLC ("Palmetto") were the MACs responsible for processing claims submitted by Avalon for payment by the Medicare program. Cahaba and Palmetto have issued LCDs that set forth clinical indicators for determining whether individuals with certain diagnoses have life expectancies of six months or less.

72. Defendants used LCDs to determine whether a Medicare beneficiary was eligible for hospice services.

73. Some diagnoses, like certain cancers, have an inherent prognosis of a life expectancy of six months or less.

74. Other diagnoses, like Alzheimer's disease, dementia, and debility, do not automatically support that a patient has a life expectancy of six months or less, as patients with such diagnoses may have a life expectancy of years before signs and symptoms of advanced disease are present.

75. For example, individuals live for, on average, eight to ten years after diagnosis with Alzheimer's disease. Some live 20 years or more. *See* Mayo Clinic, Alzheimer's Stages: How the Disease Progresses, available at http://www.mayoclinic.org/diseases-conditions/alzheimers-disease/in-depth/alzheimers-stages/ART-20048448?pg=2. LCDs and other clinical publications help identify which Alzheimer's patients are clinically likely to have a life expectancy of six months or less. *See, e.g.*, Palmetto GBA's Local Coverage Determination for Hospice Alzheimer's Disease & Related Disorders (L31539); National Institutes on Aging, Alzheimer's disease and end of life issues, August 1, 2003 (updated December 8, 2011), available at

http://www.nia.nih.gov/print/alzheimers/features/alzheimers-disease-and-end-life-issues; Tsai S, Arnold R., Fast Facts and Concepts #150, *Prognostication in Dementia*, February 2006 (updated April 2009), available at http://www.mypcnow.org/blank-txv87.

76. Similar guidance exists to help identify patients with other diagnoses who are anticipated to have life expectancies of six months or less.

77. In 2013, CMS issued guidance that debility and adult failure to thrive should no longer be used as principal hospice diagnoses because these diagnoses "are incongruous to the comprehensive nature of the hospice assessment, the specific, individualized hospice plan of . . . care, and the hospice services provided." 78 Fed. Reg. 27823, 27832 (May 10, 2013).

78. CMS also has instructed hospice providers that an individual should be considered for discharge from the Medicare hospice benefit if he or she improves or stabilizes sufficiently over time while on hospice, such that he or she no longer has a life expectancy of six months or less. *See* 75 Fed. Reg. 70372, 70448 (Nov. 17, 2010).

VII. Hospice Certification's Effect on TennCare Nursing Facility Benefit

79. Hospice patients may reside in a private home or Nursing Facility ("NF"). When a patient resides in a NF, TennCare, unlike Medicare, covers long-term care in NFs for certain eligible beneficiaries as part of TennCare's Long Term Services and Support ("LTSS") program. Tenn. Comp. R. & Regs 1200-13-01-.01(2)(a).

80. All applicants for and residents in Medicaid-certified NFs must complete the Pre-Admission Screening and Resident Review ("PASRR") process in order to qualify for Medicaid-reimbursed nursing facility care unless they qualify for an exemption from the PASRR process. Tenn. Comp. R. & Regs. 1200-13-01-.10(2)(i)-(l), (3); 1200-13-01.23(2)(d).

81. The PASRR process includes a Pre-Admission Evaluation ("PAE") for each patient,

which is used in determining the Level of Care ("LOC") or "medical eligibility" for each patient.

82. Eligibility for the NF level of services in the TennCare Medicaid LTSS program is limited to individuals whose medical needs, as determined by the PAE, are the greatest. These individuals are classified as "CHOICES Group 1," indicating that they are eligible for TennCare to cover their NF care. Tenn. Comp. R. & Regs. 1200-13-01-.10(4)(c).

83. An individual with a terminal illness is not required to complete a PAE or otherwise show medical eligibility through the PAE process. Tenn. Comp. R. & Reg. 1200-13-01-.10(2)(c)(7)

84. A hospice certification that a patient is terminally ill thus also acts to medically qualify an individual for TennCare payments for room and board in a NF without the individual needing a separate medical evaluation.

85. For a TennCare enrollee who chooses to receive hospice services in a NF, the room and board expenses for the NF become a part of the TennCare payment to the hospice provider.

86. For TennCare patients living in a NF who are receiving hospice services, the TennCare program pays the hospice ninety-five percent of the NF's per diem rate established by TennCare for the enrollee's room and board. The hospice must then reimburse the NF for this portion of the NF's per diem for the enrollee's room and board.

87. Many individuals in Tennessee are eligible for both Medicare and TennCare Medicaid ("dual-eligible"). When a dual-eligible individual living in a NF receives hospice care, Medicare makes the full payment for hospice services, and the TennCare program pays for the individual's room and board in the NF.

DEFENDANTS' FRAUD ON MEDICARE AND TENNCARE

I. Regency and Curo Knowingly Caused Avalon to Present False Claims and Knowingly Concealed or Knowingly and Improperly Avoided Avalon's Obligations to Repay Overpayments for Ineligible Hospice Patients.

A. Regency and Curo pressured Avalon staff to maximize census through aggressive targets, financial incentives, and restrictions on discharging patients.

88. Regency and Curo tightly controlled the finances of their Tennessee agencies and set aggressive targets for the number of hospice patient admissions (referred to as "admissions targets") and the number of patients to remain on hospice care at any one time (referred to as "census targets").

89. Regency and Curo pressured Avalon staff to meet these high admissions and census targets by tracking financial goals on a monthly, quarterly, and annual basis. For example, Regency required each agency to submit detailed reports showing statistics for census, net revenue, gross profit, admissions versus budget, admissions for each Hospice Care Coordinator ("HCC" or "marketer") employed in that agency, and the conversion rate of referrals into admissions. Moreover, Regency had regular monthly conference calls with DOOs to discuss the reports.

90. Curo similarly kept a "scorecard" called a Monthly Operations Overview for each agency that tracked average daily census ("ADC"), referrals, admissions, conversation rate, as well as revenue and profit. When an agency failed to achieve targeted metrics, such as ADC, DOOs were required to submit a written 30-day action plan to Curo regional managers.

91. Curo also held regular operations conference calls with its locations and scheduled agency site visits from Curo regional management in which the performance of each agency was discussed.

92. HCCs were responsible for generating referrals and admissions at each Avalon agency by promoting Avalon's services to nursing facilities and doctors' offices. HCCs provided

education to these referral sources on the benefits of Avalon's hospice services, including financial benefits to nursing facilities and patients, and the process for initiating hospice care. HCCs at certain Avalon agencies also marketed hospice services and benefits, including coverage for medications, directly to patients at nursing and residential facilities.

93. Curo frequently scrutinized decisions not to admit referred patients (*i.e.*, "Not Taken Under Care" or "NTUC" cases). For example, Curo required Avalon agencies with a conversion rate below the targets to give an explanation as to each patient that was referred for hospice services and not admitted. Some Curo regional managers went even farther and required certain DOOs to notify them of all patients that were not admitted.

94. Moreover, throughout the relevant time period, Regency and then Curo implemented financial incentives for HCCs, DOOs, and senior executives that were based upon the number of referrals, admissions, and/or patient census. If employees failed to meet these performance metrics, they were placed on performance improvement plans or terminated.

95. For example, from at least January 2010 through November 4, 2010, Regency incentivized HCCs to maximize admissions by basing financial incentive plans on the number of referrals the marketers obtained each month.

96. Each HCC was required to meet a monthly minimum number of referrals. Once the HCC obtained this goal, the HCC was paid a bonus for each referral, and the bonus amount increased as the HCC's total referrals increased.

97. For example, the November 2010 Regency HCC Incentive Plan required that HCCs attain twelve referrals per month. Under "Goal Level 1," if the HCC attained 12-18 referrals for the month, the HCC received a $40 bonus for all of the referrals. Under "Goal Level 2," if the HCC attained 19-24 referrals, the HCC received an additional $80 bonus for these referrals. Under

"Goal Level 3," if the HCC attained more than 25 referrals, the HCC received an additional $120 bonus for each of these referrals. Furthermore, Regency provided increasing "Incremental Bonuses" each time an HCC obtained an additional 6 referrals beginning at 18, including the 18th referral ($200 incremental bonus), the 24th referral ($400), the 30th referral ($600), and the 36th referral ($800).

98. By early March 2011, Regency maintained the same tiered incentive plan for HCCs, but based the targets on the number of admissions, rather than referrals.

99. Curo maintained this HCC incentive structure after it acquired Regency in November 2011. In some years, the incentive plan specified that "[a]missions performed by HCCs are not eligible to be counted towards the admission incentive," though, upon information and belief, this qualification was not consistently enforced.

100. Moreover, Regency incentivized DOOs by basing salary or bonuses on census. For example, in 2009, Regency hired an Avalon Nashville DOO using a compensation structure including "salary resets" (*i.e.*, raises) when census reached different levels.

101. The Avalon Nashville DOO was also offered a "monetization event bonus" in which she would receive a bonus of twenty percent of base salary if the Nashville provider census exceeded 250 patients within 90 days before a 100% cash sale of the company.

102. Similarly, in May 2011, the Regency Board of Directors authorized a management incentive plan for corporate executives, such as Directors of Business Operations, that provided an ADC Performance Bonus, through which executives could receive a bonus of 17.5% of their base salary if they achieved a certain ADC during the relevant period.

103. Curo continued similar monthly incentives for its management based upon hospice admissions or ADC. For example, in early 2012, Curo based DOO monthly incentives on various metrics that initially included only growth (ADC) (33%) and expense management (67%).

104. Shortly thereafter, the DOO incentive plan was revised to include ADC (30%), admissions (30%), target distributed unbilled amounts (20%), and expense management (20%).

105. While Curo revised the methodology it used to calculate DOO bonuses over time, throughout the relevant time period, ADC and/or admissions remained a primary factor that affected the payout amount a DOO received.

106. When agencies were close to missing their budgets, regional managers would, at times, implement additional incentive boosts based on meeting the budgeted goal. For example, in February 2012, James Cocke (Vice President Operations for the region including Tennessee) announced a $500 "additional incentive" for HCCs, Nurse Liaisons, and DOOs if their office met or exceeded their admission budget for the month.

107. In addition, both Regency and Curo pressured Avalon staff to maximize admissions by ranking HCCs on a monthly basis based on referrals or admissions, and regularly discussing these rankings in group emails and conference calls.

108. Based upon these rankings, Regency and Curo awarded additional bonuses to HCCs who had the most referrals or admissions, such as through a weekly "King of the Mountain" competition Regency implemented in November 2011.

109. Other times, Regency and Curo would promote seasonal competition among offices. For example, in March 2012, James Cocke (Vice President Operations for the region including Tennessee) sent numerous emails cajoling Avalon agencies through a "March Madness" competition based on the percentage of the agencies' budgeted admission. As a result, Avalon

Tullahoma achieved a 231% admission budget score (*i.e.*, it admitted more than two times its target goal) for that month.

110. When an agency failed to meet admissions or census numbers, HCCs and DOOs were placed on performance improvement plans.

111. Furthermore, both Regency and Curo threatened employees with negative consequences in the event of flat or declining census numbers. For example, both Regency and Curo regional business development managers told HCCs that failure to maintain a minimum number of hospice admissions would result in termination. Moreover, DOOs threatened and implemented hiring freezes or staff terminations in the event of flat or declining census numbers.

112. Regency and Curo also pressured Avalon staff to meet census targets by closely monitoring live discharge rates and developed policies specifically designed to reduce the number of live discharges. For example, Regency and Curo tracked live discharge rates by regions and by agencies within a region on a monthly basis and pressured employees to reduce their live discharge rates.

113. Moreover, Regency and Curo required that that their regional managers be notified of any live discharge. Furthermore, since at least 2016, any live discharge due to ineligibility (*i.e.*, the patient's condition has clinically stabilized, plateaued, or improved such that the patient's life expectancy exceeded six months) could proceed only after the Avalon agency received approval from the Area Manager of Operations.

114. In addition, Curo required DOOs to complete a Root Cause Analysis of every live discharge and explain the reason for the live discharge and what could have been done to prevent the live discharge from occurring.

115. The result of Regency's and Curo's policies was that Avalon staff found it difficult to discharge patients who were no longer eligible for hospice.

B. Regency and Curo failed to ensure Avalon's certifying physicians received complete and accurate clinical information from Avalon staff necessary to determine hospice eligibility.

116. Avalon hospice physicians who signed COTIs rarely saw patients in-person. Thus, Avalon nurses and other staff members were key players in the admission and retention process for patients. For example, nurses were responsible for seeing the patients, assessing whether the patients should be admitted, documenting the patients' conditions in the medical records, and orally communicating relevant clinical information to the hospice physicians for them to rely on in determining whether to certify and recertify the patients as terminally ill.

117. Rather than hiring nurses who were experienced in hospice or in assessing the life expectancy of patients, however, Regency and Curo often hired clinical staff with little or no prior hospice experience.

118. Moreover, Regency and Curo failed to train Avalon staff adequately to identify terminally ill patients. Many Avalon staff members felt that they were not adequately trained to assess a patient's life expectancy.

119. When Avalon staff members requested additional training from their DOOs, they were denied. For example, one nurse practitioner who was responsible for completing face-to-face evaluations found hospice assessments for Alzheimer's patients particularly difficult. When he asked for additional training, he was not provided any. He also did not know how to document his assessments when he believed that a patient was ineligible.

120. Similarly, Regency and Curo did not provide adequate training to Avalon office staff members who were responsible for processing and tracking medical records, including face-to-face documentation, physician narratives, certifications, and recertifications.

121. Regency and Curo provided extensive trainings and instructions, however, focusing on how to present information in the medical record to ensure that Medicare and other payors would not deny claims. For example, Regency and Curo expected Avalon nurses to rely on documentation prompts or "cheat sheets" when describing patients' condition in their medical records.

122. Furthermore, Curo identified "bad words" or unhelpful words that it told Avalon personnel should never be documented, such as "stable," "no change," "feels good," or "looks good."

123. Curo also distributed a guide for physician narratives that "specifically discouraged" certain unhelpful items because the information could be "harmful in mak[ing] the case that a patient has a terminal prognosis." This reference guide specified that clinical staff should not document that a patient's life expectancy was greater than six months or that discharge was being considered because this information was "not helpful." Instead, the guide instructs that clinical staff document only that eligibility is still being evaluated.

C. Curo reinforced strict documentation requirements and restrictions through extensive auditing programs that disregarded indications that patients were ineligible.

124. Curo reinforced its documentation expectations and restrictions through extensive auditing programs that frequently revealed that patients' medical records did not support their eligibility.

125. Curo frequently required that Avalon agencies supplement their documentation to ensure that eligibility was supported in the medical record so that claims for the services would be paid by Medicare or other payers. Furthermore, Curo tracked agency performance on these documentation audits and outstanding requests for documentation addendums. The Curo compliance personnel who were responsible for these auditing programs, however, expressly avoided recommending discharge for patients who were no longer eligible.

126. In December 2014, Curo initiated its first clinical quality initiative, which was designed to improve the quality of physician narratives within the COTIs ("Physician Narrative Reviews"). However, this program was not designed to ensure patient eligibility, but to guarantee that the narratives included sufficient clinical information to ensure that Medicare and other payors would pay Avalon's claims.

127. In launching the program, Curo's Vice President of Informatics explained that a physician composed narrative was a prerequisite for CMS, through its fiscal intermediaries, to provide payment for hospice care. She further instructed that the initiative was focused on documentation quality improvement, and emphasized that the reviews were not concerned with ensuring eligibility. In an email announcing the initiative, she wrote:

> ***We want everyone to remember that this is not an issue of eligibility, but of documentation quality improvement***. These audits are not meant to be punitive. They are an opportunity to take an objective look at the information that is documented to certify the terminal illness and to move the quality of that documentation forward. As you look at the narratives for patients who have been on service more than 180 days, it is important that the narrative illustrates the continued decline that is demonstrating a life expectancy of 6 months or less.

(emphasis added).

128. Upon the launch of Physician Narrative Reviews in December 2014, Curo identified dozens of physician narratives dating back to at least September 2014 from Avalon

agencies that did not support a prognosis of six months or less. Curo required DOOs to obtain an addendum for all these physician narratives.

129. The Vice President of Informatics emailed each DOO with a list of patients for whom a physician narrative addendum was required and an action plan that required the medical director to document additional information explaining why the patient had a prognosis of six months or less.

130. Furthermore, each physician narrative addendum was subject to approval by a Curo auditor. Notably, these action plans failed to account for instances in which a patient's prognosis of six months or less simply could not be further supported or otherwise account for live discharges.

131. Curo clinical compliance monitors continued to review all physician narratives and Curo required addendums for any narratives that were deemed deficient, including those that were insufficient to support a prognosis of six months or less to live.

132. Through these Physician Narrative Reviews, Curo's centralized compliance staff learned that many Avalon patient medical records did not provide sufficient documentation to support the patients' continued eligibility. Indeed, the standard issues flagged included: the physician narrative indicated the patient was no longer terminal; the primary diagnosis is not considered a terminal diagnosis; the prognosis in the physician narrative was not consistent with a life expectancy of six months or less; the narrative did not include clinical factors supporting that the patient's prognosis was six months or less; and the narrative failed to reflect disease progression or decline.

133. The clinical compliance monitors also identified multiple instances in which physician narratives appeared to be copied-pasted or written by someone other than the physician.

And, the clinical compliance monitors frequently provided additional comments indicating that the patient appeared custodial, rather than terminal.

134. Despite these questions regarding the terminal status of the patients, Curo compliance personnel conveyed the results of the Physician Narrative Reviews to DOOs with a message repeating Curo's mantra: "We want everyone to remember that this is not an issue of eligibility, but of documentation quality improvement."

135. Curo tracked performance of Avalon agencies on Physician Narrative Reviews by quantifying the "pass rate" for COTIs. To increase the COTI pass rate, at least some Avalon agencies required that the DOO or Patient Care Coordinator ("PCC") be responsible for "guiding" IDG meetings to ensure that certifying physicians' narratives included appropriate clinical information.

136. Regency and Curo also conducted audits on patients with a long length of stay ("LLOS audits"). For example, in approximately 2016, clinical compliance monitors for Curo began to conduct audits routinely of medical records for patients with LLOS because they presented nonpayment or eligibility risk. The auditors' final notes included an eligibility summary and a section that outlined reasons that the patient met eligibility criteria. These final audit results were often included directly in patient medical records.

137. The clinical compliance monitors separately maintained, however, notes reflecting "areas of concern" that tracked various issues with the medical records, including with respect to red flags suggesting the patient was no longer eligible. Many of these notes indicated that the patient would be watched closely due to an apparent lack of decline. Other notes specifically indicated that the patient failed to meet criteria, had clinically plateaued, had chronic or custodial conditions, or included specific inconsistencies in relevant clinical information.

138. When Regency and Curo determined through audits that its medical records did not support a patient's eligibility, it did nothing to ensure that claims for the relevant services were not submitted. For example, in certain instances when Curo held claims following concerns about the eligibility of particular patients, it ultimately submitted claims for services provided to these patients after confirming the patients were ineligible. Thus, Regency and Curo disregarded their own audits that raised concerns regarding patient ineligibility and submitted claims for services nonetheless.

D. Regency and Curo knew that their business practices led certain DOOs to prioritize the admission and retention of patients without regard for eligibility.

139. In response to Regency's and Curo's pressures and incentives, and subject to strict documentation requirements, restrictions, and scrutiny of language in patient medical records, certain DOOs resorted to business practices that enabled their agencies to admit and retain ineligible patients to maximize census. For example, certain DOOs:

- instructed marketers to inform referring physicians and patients that Avalon could admit patients and later discharge the patient if the patient improved;
- permitted an HCC who was an RN, but who also received bonuses based on admissions, to conduct admission assessments of referred patients;
- circumvented patients' primary attending doctors when the doctors did not believe the patients' prognosis was six months or less by convincing a different physician to refer the patients;
- circumvented Avalon nurses or hospice physicians who did not believe certain patients were eligible by finding another nurse or physician who would recommend the patient's admission or continued retention;
- required Avalon staff to exaggerate patients' diagnoses and clinical information to reflect decline or omit any clinical information that reflected patients' clinical stability or improvement; and
- instructed a physician that it was not necessary for them to provide clinical information or signatures in the EMR, such as physician narratives and COTIs, but then used the physician's log-in credentials to complete this documentation without his authorization.

140. Regency and Curo were aware of these practices by certain DOOs through internal complaints from Avalon staff at different agencies. Following these internal complaints, Regency and Curo continued to submit claims without undertaking adequate due diligence to ensure the appropriateness of claims for potentially ineligible patients.

141. Moreover, when Regency and Curo corroborated these complaints, they did not conduct adequate due diligence to determine the scope of ineligible patients or affected claims.

142. Furthermore, even when Regency and Curo identified ineligible patients, they simply discharged the patients without determining whether they needed to repay claims Avalon had already received for these ineligible patients.

E. Defendants knew that COTI requirements were material to payment from Medicare and TennCare, including the need for sufficient clinical information in patient medical records to support a terminal prognosis.

143. For each claim Avalon submitted to Medicare and TennCare for payment, Defendants knew that Avalon was required to maintain COTIs on file.

144. Federal regulations required that COTIs include the presence of clinical information and other documentation in the medical record that support the patient's status as "terminally ill." *See* 42 U.S.C. § 1395f(a)(7); 42 C.FC. § 418.22.

145. The COTIs and supporting documents that Avalon was required to maintain on file were material to the federal and state governments' decisions to pay Avalon's hospice claims.

146. The presence of COTIs, which include a representation that clinical information in the patient's medical record supported a life expectancy of six months or less, is so central to the hospice benefit that it is expressly designated as a condition of payment for hospice care. 42 U.S.C. § 1395f(a)(7); 42 C.F.R. §§ 418.20, 48.200; *see also* 79 Fed. Reg. 50,452, 50,470 (Aug. 22, 2014);

78 Fed. Reg. 48,234-01, 48,245 (Aug. 7, 2013); 74 Fed. Reg. 39,384-01, 39,398 (Aug. 6, 2009); 70 Fed. Reg. 70,532, 70,534-35 (Nov. 22, 2005).

147. Statutes and regulations emphasize that a patient is eligible for the hospice benefit, and thus payment will be made for hospice services to that patient, only when the patient is certified as being "terminally ill," which includes the requirement that clinical information and other documentation in the patient's medical record supports the patient's terminal status. *See, e.g.*, 42 U.S.C. § 1395f(a)(7); 42 C.F.R. §§ 418.20, 418.22, 48.200; *see also* 79 Fed. Reg. 50,452, 50,470 (Aug. 22, 2014); 78 Fed. Reg. 48,234-01, 48,245 (Aug. 7, 2013); 74 Fed. Reg. 39,384-01, 39,398 (Aug. 6, 2009); 70 Fed. Reg. 70,532, 70,534-35 (Nov. 22, 2005). CMS has reiterated the documentation requirements in guidance documents, such as the Medicare Benefit Policy Manual and other publicly available guidance documents. *See* Medicare Benefit Policy Manual, Chap. 9, § 20. Thus, the COTI requirement, including that documentation supports the patient's terminal status, goes to the very core of the hospice benefit.

148. Accordingly, a reasonable person would know that the federal and state governments would not pay hospice claims submitted to Medicare or TennCare if they knew that the beneficiary for whom the claim was submitted did not have a prognosis of being "terminally ill" (*i.e.*, did not have a life expectancy of six months or less) or knew that the clinical information and other documentation in the beneficiary's medical record did not support that the beneficiary was terminally ill.

149. In addition, Defendants had actual knowledge of the importance the federal and state governments attached to the physician certification requirements for hospice claims.

150. Upon enrollment as a Medicare provider, Avalon agreed "to abide by the Medicare laws, regulations and program instructions [applicable to it]" and acknowledged that "payment of

a claim by Medicare is conditioned upon the claims and the underlying transaction complying with such laws, regulations, and program instructions." CMS-855-A, § 15.

151. Furthermore, feedback and training provided by outside auditors hired by Defendants, and Defendants' own internal trainings, made clear that Medicare or its contractors would deny payment for claims submitted on behalf of patients whose eligibility for hospice was questionable or whose clinical records did not contain sufficient documentation to support eligibility.

152. And, Defendants own clinical compliance monitors conducted audits to determine whether certain patients presented an eligibility or nonpayment risk.

153. Finally, as a high-ranking Curo officer explained, Curo developed and implemented the Physician Narrative Review initiative precisely because it knew that the physician narrative statement, which CMS required to be "based on a review of the medical record or examination of the patient," is "a prerequisite for CMS, through its fiscal intermediaries [such as MACs], to provide payment for hospice care."

II. Avalon Submitted False Claims and Retained Overpayments for Ineligible Patients.

A. Defendants' Fraudulent Conduct at Avalon Jackson

1. Regency and Curo incentivized and pressured Avalon Jackson staff to admit and retain patients without ensuring and supporting their eligibility.

154. Avalon knowingly submitted false claims, and Regency and Curo caused the submission of these claims, for hospice care for Medicare patients who were on service at its Jackson, Tennessee, agency from at least June 2010 until January 2015. Defendants also

knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments they identified for services that Avalon had provided to ineligible hospice patients.[2]

155. Beginning in approximately 2010, former Avalon Jackson DOO Barbara Gordon required Avalon Jackson employees to engage in marketing and documentation practices and took steps to circumvent clinicians' concerns about hospice eligibility that led to the admission and retention of ineligible patients.

156. Furthermore, when certifying attending physicians or Avalon hospice physicians would question a patient's eligibility, Gordon ensured the patient was admitted or retained by obtaining a certification from a different physician, including an Avalon Jackson medical director who she knew from prior experience would not adequately assess the patient ("Avalon Jackson Medical Director 1").

157. Regency and Curo knew or should have known that Avalon was admitting and retaining ineligible patients at its Jackson agency, and submitting claims to Medicare for services provided to these patients, through numerous internal complaints, audits, and investigations that were reported to regional and national managers and executives.

158. Even after Gordon resigned, Curo knew or should have known that Avalon Jackson continued to retain patients based on numerous internal audits that concluded documentation for certain patients did not support eligibility.

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[2] Regency caused the submission of false claims by Avalon, and knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments, prior to its November 2011 acquisition by Curo; after the acquisition, Curo caused the submission of false claims by Avalon, and knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments.

159. Regency hired Barbara Gordon as a PCC at Avalon Jackson in November 2009. She was eventually promoted to DOO and served in that role before and after Curo acquired Regency.

160. As a PCC and DOO, Gordon was initially subject to Regency's, and then Curo's, code of conduct and ethics, employee handbook, and policies.

161. On March 12, 2012, Gordon executed a Separation Agreement with Avalon, which a Curo Regional Vice President of Operations signed.

162. Gordon required HCCs to use a script that she wrote when meeting with representatives from long-term care, retirement, or independent living facilities that were potential referral sources. While this script was titled "LCD Rollout," it did not include any guidance with respect to discussing LCDs or hospice eligibility clinical indicators. Rather, the script acknowledged that, when asked if a facility had any patients that would be appropriate for hospice, the facility representative would "inevitably" respond that they did not. The script further instructed HCCs to focus on the ways in which Avalon could be a partner with the facility to help it maintain a full census, decrease the workload and frustration of its staff, and increase reimbursement for the facility's skilled care.

163. Gordon instructed HCCs to inform physicians and patients that Avalon could admit patients and later discharge the patient if the patient improved. For example, Gordon directed HCCs to explain to patients that hospice care might make the patients feel well enough to end hospice care eventually. Gordon also instructed HCCs to tell patients that Avalon could pay for medicine or other items.

164. At least one former Avalon Jackson HCC aggressively promoted Avalon in this manner to residents of the New Southern Apartments, a low-income independent living facility that Avalon Jackson employees referred to as a "conquest account."

165. As Avalon Jackson focused these marketing efforts on residents of the New Southern Apartments, from approximately November 2011 through March 2012, Avalon Jackson admitted residents who were not eligible for hospice services.

166. Furthermore, Gordon pressured nursing staff, who were responsible for assessing patients prior to admission, to maximize admissions by telling them that Avalon Jackson could only hire additional nurses if it increased its census. Gordon made these promises for staffing reinforcements while also requiring Avalon Jackson nurses to work substantial amounts of overtime without additional pay.

167. Gordon also circumvented the clinical opinions of Avalon Jackson nurses who determined certain patients were not hospice-eligible after conducting an initial assessment. Specifically, when a nurse determined that a referred patient was not eligible for hospice after conducting an assessment, Gordon sent other nurses to assess the patient until a nurse indicated the patient was qualified.

168. Gordon also required staff to exaggerate patients' diagnoses and conditions in the medical records to make them appear to be hospice appropriate. She instructed nurses to "find the diagnosis" for a patient that would support admitting or retaining a patient.

169. Furthermore, if nurses could not find a diagnosis under which the patient would be eligible for hospice, Gordon instructed staff to "read between the lines," including when a patient had been on service but no longer met eligibility criteria for his or her admission diagnosis.

170. Gordon also provided instructions to nurses about how to make a patient appear to be eligible for hospice based on the documentation in the patient's record, by exaggerating the patient's condition or by manipulating certain clinical information on a patient.

171. In addition, Gordon told nurses to omit positive information about the patient's condition, such as activities the patient did, like walking or cleaning. For example, based on these instructions, when one former Avalon Jackson nurse took a patient's heart rate, it was high because the patient had been scrubbing the bathroom floor; the nurse documented a high heart rate, but omitted the reason for the elevated pulse in order to satisfy Gordon's expectations for documentation.

172. Gordon also circumvented the clinical determinations of physicians who did not believe a patient was eligible for hospice. When a referring physician or medical director did not believe a patient was appropriate for hospice, Gordon approached another physician to refer or certify the patient's hospice eligibility. For example, when an HIV specialist stated that an HIV patient was not eligible for hospice, Gordon instructed a staff member to attempt to get a family practitioner to refer the patient.

173. Other times, Gordon obtained the attending physician certification from an Avalon Jackson medical director, including Avalon Jackson Medical Director 1, when the patient's prior attending physician would not certify the patient's hospice eligibility.

174. Similarly, when one Avalon medical director did not believe a patient continued to be eligible prior to a required recertification, Gordon presented the patient at the next IDG to a different medical director. In particular, when a medical director questioned certain patients' eligibility, Gordon moved the patients to an IDG roster for Avalon Jackson Medical Director 1 to

review and certify the patient as eligible because this medical director was willing to sign any documents provided to him by the Avalon Jackson staff.

175. Two former medical directors resigned at least in part because they received pushback from Gordon in connection with discussions regarding patient eligibility.

176. Finally, Gordon engaged in various fraudulent documentation practices to ensure that medical records included sufficient information to ensure reimbursement of the claims submitted for Avalon Jackson's hospice services and to avoid negative internal or external audit findings.

177. For example, under both Regency's and Curo's ownership, managers at Avalon agencies received notice prior to a corporate compliance audit.

178. And, on more than one occasion, Gordon required that staff work after their usual hours to "clean-up" documentation before Avalon Jackson underwent an audit or survey. In particular, Gordon forged, falsified, or backdated signatures and clinical information in patients' hard copy medical records, or instructed or encouraged staff to do so, including physician signatures on referral forms, COTIs, recommendations for continued hospice care, and IDG plan of care updates.

179. Avalon continued to submit false claims and retain overpayments for hospice services provided through its Jackson agency under the management of DOOs even after Barbara Gordon resigned. For example, throughout 2012, Curo assigned a series of DOOs from other Avalon agencies, including Avalon Tullahoma DOO 1, to provide temporary support at Avalon Jackson. During this time period, these interim Avalon Jackson DOOs assisted Curo regional and billing personnel in addressing certain billing issues to submit claims associated with patients who were admitted under Gordon's leadership and subsequently determined to be ineligible.

180. Curo eventually found a permanent DOO to replace Gordon in October 2012, though this DOO was terminated in July 2013 for missing patient visits and falsifying documentation of missed patient visits.

181. Furthermore, after Curo implemented Physician Narrative Reviews and LLOS audits, Avalon Jackson continued to submit claims for certain patients even after Curo compliance personnel raised various issues with documentation supporting COTIs.

2. Avalon and Regency knew or should have known that Avalon submitted false claims and retained overpayments for ineligible patients of Avalon Jackson.

182. Avalon and Regency knew or should have known that Avalon Jackson admitted and retained ineligible patients and suffered from persistent compliance issues, including with respect to physician narrative and certifications, under Gordon's leadership.

183. In May 2010, a member of the Regency compliance department, conducted an audit at Avalon Jackson that identified multiple compliance issues. For example, the audit revealed that Gordon had not required that physician narratives be completed for every patient recertification.

184. In response to these findings, Gordon apologized to Marti Miller, the Vice President of Clinical Operations for Tennessee, and the Avalon Nashville DOO[3] ("Avalon Nashville DOO 1") for the poor audit and stated it was the result of high turnover and inadequate time for nurses to complete training.

185. In her annual performance evaluation dated September 24, 2010, Miller concluded that Gordon "Falls Below Requirements" with respect to Compliance. Miller explained, "[Gordon] continues to strive to get compliance scores up. Currently Q2 [and] Q3 continue to have ≥ 30% error rate." Nevertheless, Miller recommended Gordon for a merit increase.

[3] Avalon Jackson was a satellite agency to Avalon Nashville and submitted claims through the NPI registered with Avalon Nashville. Thus, the Avalon Nashville DOO had oversight of the Avalon Jackson agency.

186. By April 2011, Miller was aware of concerns about the appropriateness of patients at Avalon Jackson. Miller wrote to Gordon explaining, "[t]he stated situation on the Ops call, regarding IDT off site and [an Avalon Jackson medical director] being so busy, resulted in expressed concerns to make sure that all patients are appropriate." Consequently, Miller requested that Gordon evaluate Avalon Jackson's length of stay to ensure that "all patients continued to maintain appropriateness." Furthermore, Miller instructed that Gordon's comments be directed only to Miller and Avalon Nashville DOO 1.

187. Miller and Avalon Nashville DOO 1 continued to have concerns about the appropriateness of patients at Avalon Jackson. In October 2011, they requested that a Regional Vice President of Business Development inform the Avalon Jackson Medical Directors that Miller and Avalon Nashville DOO 1 were onsite regularly to conduct ongoing audits regarding patient appropriateness. Miller and Avalon Nashville DOO 1 also asked this Regional Vice President of Business Development to request that these Avalon Jackson Medical Directors give their attention to this issue.

188. Several days later Miller and Avalon Nashville DOO 1 discussed concerns regarding Gordon in response to her request to increase the compensation for one of Avalon Jackson's medical directors. Miller expressed frustration that the only reason Avalon Jackson needed to have three medical directors was due to Gordon's "renegade behavior" and "unwillingness to do as told."

3. Avalon and Curo knew or should have known that Avalon submitted false claims and retained overpayments for ineligible patients of Avalon Jackson.

189. Regional managers continued to be aware of patient eligibility issues associated with Avalon Jackson after Curo acquired Regency in November 2011. Furthermore, by January

2012, Curo national executives were aware of issues at Avalon Jackson, including with respect to patient ineligibility.

190. In January 2012, a Curo Regional Director of Office Operations visited the Avalon Jackson location for several weeks to implement a new EMR system. While the Regional Director of Office Operations was on site, Avalon Jackson staff reported numerous compliance concerns to him regarding Gordon, including that patients were not eligible for hospice services.

191. On January 24, 2012, the Regional Director of Office Operations sent an email to the Curo National Director of Office Operations relaying the concerns that had been reported to him by Avalon Jackson staff. Specifically, he wrote that DOO Gordon was "signing patient's [sic] onto hospice who do not qualify" and that she "[t]hreat[ened] [employees with] losing their jobs when voicing valid concerns or questions." He also reported that Gordon required employees to state falsely on their timesheets that they received lunch breaks and instructed employees not to report hours that she had required them to work.

192. On February 3, 2012, Gordon and Avalon Nashville DOO 1 formally reprimanded a former Avalon Jackson nurse for raising her concerns to the Regional Director of Office Operations. Specifically, her corrective action report stated that she violated company policy by "verbalizing company concerns/issues to [an EMR] trainer rather than following Curo company reporting policies" and "making false malicious statements about supervisor's leadership then failure to adhere to proper chain of command."

193. Furthermore, in late January or early February 2012, the same former nurse reported various concerns she had regarding Gordon to Regional Vice President of Operations James Cocke. In response, Cocke explained that it would be necessary for something detrimental

to happen to a patient before Gordon would face any consequences because Avalon Jackson's financial performance was so strong.

194. In February and March 2012, multiple Avalon Jackson employees again raised concerns to Curo regional and national executives regarding Gordon, including that she admitted patients who did not qualify for hospice and that she forged documentation. During a February 2012 exit interview with a member of Curo's Human Resources department, another former Avalon Jackson nurse reported that Gordon forced Avalon Jackson staff to admit ineligible patients so that she could increase census. She further explained that when she and another nurse assessed a patient and determined that the patient did not qualify for hospice, the patient was admitted after Gordon sent a third nurse to assess the patient.

195. In addition, on February 21, 2012, the Curo compliance hotline received a report regarding falsification of documentation, admission of ineligible patients, and unfair employment practices.

196. In response to these concerns, a Curo Compliance Auditor and the Vice President of Compliance, conducted an on-site investigation at Avalon Jackson. A chart audit of approximately seventeen patients revealed that at least six patients were not hospice-appropriate, and the Compliance Auditor and the Vice President of Compliance raised questions with respect to several other patients for whom eligibility was questionable or who revoked hospice shortly after admission in order to obtain home health or aggressive surgeries.

197. The compliance personnel reported these results to Miller among other regional and national executives.

198. Shortly after the compliance investigation began, Gordon resigned from her position as Avalon Jackson DOO on approximately March 9, 2012.

199. In response to the findings by the Curo compliance personnel, Miller took over the investigation of issues at Avalon Jackson, including by re-auditing the records of the six patients that the Compliance Auditor and the Vice President of Compliance had determined were not hospice appropriate.

200. Miller overruled the findings of Curo's compliance staff with respect to at least some of these patients. Eventually, Curo released billing holds that had been placed on claims associated with these patients, and Avalon continued to submit claims for these patients.

201. Furthermore, Avalon Jackson discharged several patients whose medical records did not support eligibility. Curo released billing holds on these patients, however, such that Avalon submitted claims for these patients for services provided after eligibility concerns had been identified.

202. Through March and April 2012, Miller continued to investigate various concerns reported by Avalon Jackson staff, and she audited additional patient records. For example, Miller audited records for at least another four patients in response to allegations raised by an Avalon Jackson HCC that patients had not received nursing visits.

203. Miller also conducted an eligibility audit of records for certain patients who were residents of the New Southern Apartments, a low-income independent living facility, in response to concerns regarding certain marketing practices targeted towards New Southern residents.

204. Miller concluded that medical records for several New Southern residents did not support eligibility and observed she was not comfortable with the "trend" she observed regarding these patients during her eligibility review.

205. In addition, Avalon Jackson staff members had reported to Miller that an HCC had inappropriately marketed Avalon's services to low-income residents at New Southern Apartments

by telling them that hospice would pay for their medications and that enrolling in hospice did not mean that they were dying.

206. In response to these concerns, Miller audited records for at least seven patients who were residents of New Southern. For five of these patients, Miller concluded that the documentation did not support eligibility or found that the patient's condition appeared to be chronic, rather than terminal.

207. Based on the Avalon Jackson investigation and audits, as well as significant concerns relating to patient ineligibility and flaws in the physician narrative and certification processes at Avalon Jackson that were raised repeatedly under Gordon's leadership, Curo was on notice that Avalon Jackson had been submitting claims for a number of identified Medicare and Medicaid beneficiaries who were not eligible and not properly certified as terminally ill.

208. Further, Curo failed to audit the records of other patients that had been admitted under Gordon's leadership beyond those current or recent hospice beneficiaries specifically identified by employees as problematic to determine the scope of Avalon Jackson patients who were not eligible and not properly certified as terminally ill.

209. Even after Gordon's termination, Avalon and Curo knew or should have known through Curo's own internal Physician Narrative Reviews and audits that Avalon continued to submit claims for certain Avalon Jackson patients who were not eligible and not properly certified as terminally ill.

4. Avalon Jackson Example False Claims and Overpayments

Patient No. 1

210. Defendants knowingly submitted or caused to be submitted false or fraudulent claims to Medicare, and knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments received from Medicare, for hospice services provided to

Patient No. 1 from at least October 2011 through March 2015. These claims were false or fraudulent because, as shown by Avalon Jackson's own medical records for Patient No. 1, the patient was not terminally ill.

211. Patient No. 1 was admitted by Avalon Jackson on June 29, 2010 with a principal diagnosis of end stage heart failure (*i.e.*, congestive heart failure ("CHF")).

212. Throughout Patient No. 1's stay, certain medical records, including physician narratives, for Patient No. 1 indicate the patient was stable, fail to mention any decline, or state that the patient was not declining. Furthermore, the medical records include multiple inconsistencies with respect to Patient No. 1's overall clinical status.

213. DOO Gordon instructed a former Avalon Jackson nurse to document that Patient No. 1 had shortness of breath due to Gordon's concern about supporting the CHF diagnosis, but the nurse did not observe that the patient had any unusual shortness of breath. Gordon also instructed nurses to exaggerate the extent of the patient's illness, including by telling them to deduct five pounds from the patient's weight for "dry weight."

214. Eventually Avalon Jackson changed Patient No. 1's diagnosis to end-stage dementia disease when it became clear that the patient's CHF did not qualify the patient for hospice for eligibility because the patient's disease was not end-stage.

215. On October 6, 2011, while Patient No. 1 had a diagnosis of CHF, one Avalon Jackson medical director ordered that Avalon Jackson immediately reduce home health aide visits and to initiate discharge planning that day with a discharge date effective on October 20, 2011.

216. On October 14, 2011, a former Avalon nurse educated the patient and caregiver about the discharge process. The former nurse also spoke with the patient's daughter regarding discharge planning.

217. Patient No. 1 remained on service, however, and on October 27, 2011, a different Avalon Jackson medical director issued an order to change the patient's terminal diagnosis to end stage dementia and discontinue discharge planning.

218. In February and March 2012, Curo compliance personnel reviewed Patient No. 1's medical records and concluded that the documentation did not support the patient's "terminality."

219. After Miller re-audited Patient No. 1's medical records, the patient's plan of care was discussed at the IDG meeting. While Miller's notes indicate that a medical director made a home visit during the week of March 26 to confirm the patient's eligibility, the patient's medical record does not have any evidence of this visit. The patient's terminal diagnosis, however, was once again "clarif[ied]" to change it back to CHF, and Patient No. 1 remained on service with Avalon Jackson for nearly three more years.

220. Over the next several years, Curo regional managers and compliance personnel audited Patient No. 1's medical record multiple times to assess the patient's eligibility. These audits also concluded that the documentation in the medical record did not support eligibility or the patient's current diagnosis. These audits also repeatedly identified inaccurate clinical information.

221. For example, in June 2013, the then-Avalon Jackson DOO informed Miller that Patient No. 1 was still appropriate for hospice services. In response, Miller raised various questions relating to Patient No. 1's lack of decline:

> [A] review [by a Regional Director of Clinical Operations] indicates no decline for the past few re-certs. The PPS has remained at 30% with no decline. Also the staff is indicating 'slow decline' this statement should not be used in hospice documentation. Slow decline really doesn't mean anything of value when defending eligibility. The patient's MAC has actually increased.

Later that day, Miller emailed the DOO, the Regional Director of Clinical Operations who performed the audit, and Regional Director of Operations James Cocke to explain that Miller had asked the Regional Director of Clinical Operations who performed the audit to "take a close look" at Patient No. 1 and another patient. She explained, "It is of great important that these patient's [sic] eligibility meets all criteria." Cocke replied to request that he be kept in the loop.

222. On January 16, 2014, the physician narrative stated that Patient No. 1 is "not declining" and instructs to "watch closely for decline."

223. Several months later, in June 2014, a Curo clinical compliance monitor audited Patient No. 1's records and informed the then-Avalon Jackson DOO of various issues with documentation associated with the most recent benefit period. The clinical compliance monitor noted Patient No. 1's 670-day length of stay[4] before observing:

> CTI for current BP states "worsening MS" was unable to see previous diagnosis or documentation of MS. Documentation of complete conversations of patient's old school and her ability to communicate contradict [Functional Assessment Staging Tool] FAST score 7C- 7D. This patient's MAC has increased and tends to vary (is it influenced by edema?)

224. Avalon Jackson kept the patient on hospice service, however, and continued to bill Medicare for hospice services for another fourteen months. Patient No. 1 was discharged alive on March 24, 2015, because the patient was stable. Patient No. 1 died on January 2, 2018.

225. Defendants knowingly submitted or caused the submission of at least the following false or fraudulent claims to Medicare, and knowingly concealed or knowingly and improperly

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[4] In reality, however, Patient No. 1's LOS was over 1,400 days as of June 2014 based on the patient's original June 29, 2010 admission date. The original admission date was superseded in Curo's EMR (HCHB) with an admission date in August 3, 2012 after the patient was "discharged in HCHB" for certain days in August 2012 to account for missed face-to-face visits.

avoided Avalon's obligations to repay overpayments, for services provided to Patient No. 1 when the patient was not eligible for the hospice benefit:

Example Patient No. 1				
Claim	**Service From**	**Service To**	**Claim Date**	**Claim Amount**
21130804093505TNR	10/14/2011	10/31/2011	11/04/2011	$3,034.51[5]
21135002847705TNR	11/01/2011	11/30/2011	12/16/2011	$3,959.02
21207601520707TNR	12/01/2011	12/31/2011	03/16/2012	$4,090.99
21207601518307TNR	01/01/2012	01/31/2012	03/16/2012	$4,090.99
21215803784807TNR	02/01/2012	02/29/2012	06/06/2012	$3,827.06
21213001265207TNR	03/01/2012	03/31/2012	10/15/2012	$4,090.99
21215802835307TNR	04/01/2012	04/30/2012	10/15/2012	$3,959.02
21218501510207TNR	05/01/2012	05/31/2012	10/15/2012	$4,090.99
21218501508307TNR	06/01/2012	06/30/2012	10/16/2012	$3,959.02
21229100953707TNR	07/01/2012	07/06/2012	10/17/2012	$791.80
21229600770007TNR	08/03/2012	08/31/2012	11/08/2012	$3,827.06
21229600770107TNR	09/01/2012	09/30/2012	11/08/2012	$3,959.02
21230604496707TNR	10/01/2012	10/31/2012	11/09/2012	$4,103.22
21233801381807TNR	11/01/2012	11/30/2012	12/03/2012	$3,970.86
21301401075807TNR	12/01/2012	12/31/2012	01/14/2013	$4,103.22
21304500448107TNR	01/01/2013	01/31/2013	02/14/2013	$4,103.22
21306401643807TNR	02/01/2013	02/28/2013	03/05/2013	$3,706.14

[5] Patient No. 1 was ineligible during at least the dates of service that are indicated, and this amount represents the portion of the billed and reimbursed claim that is associated with those dates of service.

21310502889107TNR	03/01/2013	03/29/2013	04/15/2013	$3,838.50
21312300212807TNR	03/30/2013	03/31/2013	05/03/2013	$264.72
21312300212907TNR	04/01/2013	04/30/2013	05/03/2013	$3,891.44
21315800931107TNR	05/01/2013	05/31/2013	06/07/2013	$4,021.16
21319000612207TNR	06/01/2013	06/30/2013	07/09/2013	$3,891.44
21323503369807TNR	07/01/2013	07/31/2013	08/23/2013	$4,021.16
21326602704207TNR	08/01/2013	08/31/2013	09/23/2013	$4,021.16
21331800638304TNR	09/01/2013	09/30/2013	11/14/2013	$3,891.44
21404900370408TNR	10/01/2013	10/31/2013	02/18/2014	$4,089.57
21404900370508TNR	11/01/2013	11/30/2013	02/18/2014	$3,957.65
21404900370608TNR	12/01/2013	12/31/2013	02/18/2014	$4,089.57
21403400939904TNR	01/01/2014	01/31/2014	02/03/2014	$4,089.57
21406200299504TNR	02/01/2014	02/28/2014	03/03/2014	$3,693.81
21409101362404TNR	03/01/2014	03/31/2014	04/01/2014	$4,089.57
21412500479804TNR	04/01/2014	04/30/2014	05/05/2014	$3,957.65
21415301200104TNR	05/01/2014	05/31/2014	06/02/2014	$4,089.57
21418200619704TNR	06/01/2014	06/30/2014	07/01/2014	$3,957.65
21421300689104TNR	07/01/2014	07/31/2014	08/01/2014	$4,089.57
21424501608404TNR	08/01/2014	08/31/2014	09/02/2014	$4,089.57
21427401130104TNR	09/01/2014	09/30/2014	10/01/2014	$3,957.65
21430702447004TNR	10/01/2014	10/31/2014	11/03/2014	$4,175.54
21433500584804TNR	11/01/2014	11/30/2014	12/01/2014	$4,040.85
21500500780204TNR	12/01/2014	12/31/2014	01/05/2015	$4,175.54
21503301200504TNR	01/01/2015	01/31/2015	02/02/2015	$4,175.54

21506101701704TNR	02/01/2015	02/28/2015	03/02/2015	$3,771.46
21506400961104TNR	03/01/2015	03/04/2015	03/05/2015	$538.78
Total				$160,537.26

226. Despite multiple instances in which Avalon clinical staff (under both Regency and Curo ownership) or Curo compliance personnel determined Patient No. 1 was not eligible or questioned the patient's eligibility, Defendants never repaid any of the Medicare payments received for Patient No. 1.

227. Furthermore, Avalon and Curo did not undertake adequate due diligence of Patient No. 1's medical records and certifications to determine: (1) whether Patient 1 had been hospice-eligible before Avalon Jackson staff raised concerns regarding this patient's eligibility to Curo compliance personnel in March 2012; and (2) if not, whether they had an obligation to return overpayments Avalon had received from Medicare for services rendered prior to March 2012.

228. Therefore, Defendants knowingly concealed or knowingly and improperly avoided Avalon's obligation to repay overpayments related to some or all of the claims it submitted for Patient No. 1.

229. Furthermore, after each instance in which a member of Avalon's clinical staff or Curo's compliance personnel determined Patient No. 1 was not eligible or questioned the patient's eligibility, Avalon continued to submit claims for Patient No. 1.

230. Therefore, Avalon knowingly submitted false claims for Patient No. 1, and Regency and Curo knowingly caused the submission of these claims.

Patient No. 2

231. Avalon and Curo knowingly submitted or caused to be submitted false or fraudulent claims to Medicare, or knowingly concealed or knowingly and improperly avoided Avalon's

obligations to repay overpayments received from Medicare, for hospice care for Patient No. 2 for services provided to this patient from January 24, 2012 to April 4, 2012. These claims were false or fraudulent because, as shown by Avalon Jackson's own medical records, Patient No. 2 was not terminally ill.

232. Medicare Patient No. 2 was a New Southern Apartment resident that Avalon Jackson admitted with a diagnosis of coronary artery disease on January 24, 2012.

233. Prior to admission, a former Avalon Jackson RN assessed Patient No. 2 and found that the patient was mobile without difficulty, was not short of breath, was able to walk four blocks to his physician's office, and did not use oxygen. The nurse informed Gordon that the patient was not eligible for hospice, and Gordon instructed the nurse to admit Patient No. 2 anyway.

234. When the nurse told Gordon that she would not admit Patient No. 2, Gordon instructed another nurse to evaluate the patient. The second nurse also did not believe that the patient qualified for hospice. Gordon then instructed a third nurse to evaluate the patient, and the patient was admitted.

235. Patient No. 2's cardiologist had recently determined that Patient No. 2's heart disease was moderate. Nevertheless, Avalon Jackson admitted Patient No. 2 based the admission on a COTI signed by Avalon Jackson Medical Director 1 as both the attending physician and the hospice physician.

236. During the course of Patient No. 2's stay, Gordon instructed Avalon Jackson nurses to exaggerate the patient's condition, such as by prohibiting them from documenting the patient's normal resting heart rate.

237. In February or March 2012, Curo compliance personnel determined that documentation in Patient No. 2's medical record did not support a diagnosis of end stage coronary

disease or "terminality."

238. After Miller subsequently re-audited Patient No. 2's record, she instructed one of Avalon Jackson's medical directors to conduct an eligibility visit for this patient. The medical director visited the patient on March 26, 2012 and recommended discharging the patient. He further noted that he did "not feel that [the patient] is a candidate for hospice under his primary diagnosis."

239. Patient No. 2 revoked hospice services on April 4, 2012, to seek aggressive surgery. Patient No. 2 did not die until more than 3.5 years later, on November 26, 2015.

240. In mid-April 2012, Curo regional managers and billing personnel discussed how to resolve billing issues associated with this patient. On April 19, 2012, Avalon Tullahoma DOO 1 (a DOO from the Avalon Tullahoma agency who provided management coverage for Avalon Jackson after Gordon's resignation) explained Avalon staff had changed Patient No. 2's diagnosis had been changed such that "all billings concerns are completed" with the exception that the one COTI order for this patient needed to be signed.

241. However, the sole document in the patient's medical record that appears to be a physician narrative accompanying a COTI, which is titled "PHYSICIAN VERBAL ORDER," contains the notation that "THIS ORDER HAS BEEN VOIDED."

242. When Miller audited Patient No. 2's medical record, Avalon had not yet submitted any claims for this patient. Thus, while Avalon and Curo initially held the submission of claims for this patient, they submitted these held claims for payment *after* they had determined that the patient was ineligible and received a recommendation to discharge the patient. Furthermore, Avalon and Curo released to the holds on these claims and billed Medicare *despite* the concerns relating to the marketing practices that led to the admission of this patient and Miller's conclusion

that documentation in Patient No. 2's chart did not support eligibility. Finally, Avalon and Curo either: submitted claims for this patient despite the fact that the only physician narrative supporting the claims was void; or failed to return overpayments for claims it had received after the physician narrative was voided.

243. Avalon and Curo knowing submitted or caused the submission of the following false or fraudulent claims, or knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments, for services provided to Patient No. 2 when the patient was not eligible for the hospice benefit:

Example Patient No. 2				
Claim	**Service From**	**Service To**	**Claim Date**	**Claim Amount**
21215803785107TNR	01/24/2012	01/31/2012	06/06/2012	$1,100.24
21215803785207TNR	02/01/2012	02/29/2012	06/06/2012	$3,988.36
21215803785307TNR	03/01/2012	03/31/2012	06/06/2012	$4,263.42
21215802831707TNR	04/01/2012	04/04/2012	06/06/2012	$550.12
Total				**$9,902.14**

Patient No. 3

244. Avalon and Curo knowingly submitted or caused to be submitted false or fraudulent claims to Medicare, and knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments received from Medicare, for hospice care for Patient No. 3 for services provided to this patient from November 18, 2011 to May 9, 2012. These claims were

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false or fraudulent because, as Avalon Jackson's own medical records for Patient No. 3 show, the patient was not eligible to receive hospice services.

245. Medicare Patient No. 3 was a resident of the New Southern Apartments that Avalon Jackson admitted with a diagnosis of nonischemic cardiomyopathy on November 18, 2011.

246. In March 2012, Miller reviewed the medical record for Patient No. 3 in response to concerns regarding marketing practices used to obtain new admissions from the New Southern Apartments. Miller concluded that the patient's documentation did not support eligibility.

247. On March 26, 2012, an Avalon Jackson medical director visited the patient to conduct an eligibility review, and he recommended discharging the patient.

248. In mid-April 2012, Curo regional managers and billing personnel held discussions regarding when to move Patient No. 3 to "indigent status," which would avoid the submission of additional claims to Medicare for any additional services provided to this patient.

249. On April 19, 2012, Avalon Tullahoma DOO 1 (who was providing coverage at Avalon Jackson after Gordon's resignation) stated that the issue regarding Patient No. 3's indigent status would be resolved that day. Avalon Jackson, however, continued to submit claims to Medicare including for services provided through May 9, 2012.

250. Patient No. 3 was discharged on approximately May 12, 2012. Patient No. 3 died nearly three years later on February 19, 2015.

251. When Miller reviewed this patient's record in March 2012, Avalon had already received three Medicare reimbursements for this patient. While Avalon and Curo initially held claims for this patient, they submitted these held claims for payment *after* they had determined that the patient was ineligible and discharged the patient.

252. Furthermore, these claims covered hospice services provided to Patient No. 3 for approximately 1.5 months after the medical director had recommended discharging the patient and several weeks after Curo had purportedly made a determination to switch the patient to indigent status, which would have avoided the submission of additional claims to Medicare.

253. Despite the concerns related to the marketing practices that lead to the admission of this patient and Miller's conclusion that documentation in Patient No. 3's chart did not support eligibility, Avalon and Curo failed repay Medicare any of the amounts received (either pre-audit or post-audit) for services provided to Patient No. 3.

254. Avalon and Curo knowingly submitted or caused the submission of the following false or fraudulent claims to Medicare, or knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments received from Medicare, for services provided to Patient No. 3 when the patient was not eligible for the hospice benefit:

Patient No. 3				
Claim	**Service From**	**Service To**	**Claim Date**	**Claim Amount**
21135002821905TNR	11/18/2011	11/30/2011	12/16/2011	$1,787.88
21207902062407TNR	12/01/2011	12/31/2011	03/19/2012	$4,263.42
21207902080107TNR	01/01/2012	01/31/2012	03/19/2012	$4,263.42
21204801945407TNR	02/01/2012	02/17/2012	06/05/2012	$2,338.00
21215802848007TNR	02/18/2012	02/29/2012	06/06/2012	$1,650.35
21215802834607TNR	03/01/2012	03/31/2012	06/06/2012	$4,263.42
21215802835007TNR	04/01/2012	04/30/2012	06/06/2012	$4,125.89

21215802840307TNR	05/01/2012	05/09/2012	06/06/2012	$1,237.77
Total				**$23,930.15**

255. Despite Curo's determination that Patient No. 3 was not eligible in March 2012, Avalon and Curo never returned any of the payments Avalon received for Patient No. 3.

256. Furthermore, Avalon and Curo did not undertake adequate due diligence of Patient No. 3's medical records and certifications to determine: (1) whether Patient No. 3 had been hospice-eligible before Avalon Jackson staff raised concerns regarding this patient's eligibility to Curo in March 2012; and (2) if Patient No. 3 was not eligible, whether Avalon and Curo had an obligation to return overpayments Avalon had received from Medicare.

257. Therefore, Avalon and Curo knowingly concealed or knowingly and improperly avoided Avalon's obligation to repay three overpayments for services provided to Patient No. 3 from November 18, 2011 through January 31, 2012, which totaled $10,314.72.

258. Furthermore, Avalon submitted claims for services provided after Curo had determined that Patient No. 3 was not eligible. Therefore, Avalon knowingly submitted false five claims for Patient No. 3, which totaled $13,615.43, and Curo knowingly caused the submission of these claims.

B. Defendants' Fraudulent Conduct at Avalon Tullahoma

1. Curo incentivized and pressured Avalon Tullahoma staff to admit and retain patients without ensuring and supporting their eligibility.

259. Like all Avalon marketers, Curo's incentive plans awarded Avalon Tullahoma HCCs financial incentives based on the total numbers of admissions that resulted from their referrals.

260. Avalon Tullahoma HCCs relied on aggressive marketing tactics to obtain referrals and admissions to ensure that the agency met certain incentive levels and achieved census goals.

For example, certain Avalon Tullahoma marketers promised patients that Avalon would provide supplies or services, such as utility payments, funeral expenses, or meals donated by third parties that were not provided or guaranteed by Avalon. Avalon Tullahoma used these sales tactics when attempting to obtain referrals for low-income patients. Avalon DOOs, including Avalon DOO Tullahoma DOO 1, were aware of and condoned these practices because other staff members reported patient complaints when Avalon failed to provide these services.

261. From approximately 2011 through 2015, however, Avalon authorized the top-performing marketer, Avalon Tullahoma HCC 1, to perform admission assessments even though her eligibility for bonuses depended on generating a certain number of admissions.

262. Avalon Tullahoma DOO 1 relied on assessments by Avalon Tullahoma HCC 1 to make initial eligibility determinations prior to patients' admissions, and medical directors relied on these assessments in determining whether to certify patients as eligible for hospice.

263. Upon information and belief, at times Avalon Tullahoma HCC 1 sought to attain certain bonus levels by pressuring at least one medical director to send her referrals based on his work outside of Avalon. This medical director generally referred patients to Avalon when they became terminal so that he could continue to be involved in their care, such that there would typically not be a need to press him to refer additional patients if the patients were truly eligible.

264. Avalon and Curo were aware that many patients Avalon Tullahoma HCC 1 referred were not eligible for hospice. During weekly staff meetings, nurses complained that certain patients who were admitted from referrals generated by Avalon Tullahoma HCC 1 were not qualified for hospice.

265. Avalon and Curo undermined the physician certification process by ensuring that its medical directors did not receive clinical information relevant to assessing patients' clinical

condition and life expectancy. The Avalon Tullahoma medical directors who provided most certifications and recertifications did not personally see patients. And, Avalon Tullahoma medical directors frequently did not review patients' medical records at all.

266. Avalon Tullahoma also hired medical directors who held multiple different jobs and were known by Avalon staff to be very busy. From approximately 2011 through 2013, Avalon Tullahoma DOOs and staff often modified their normal IDG practices to fit the physicians' schedules. For example, one medical director was permitted to attend IDG meetings remotely. Avalon also sometimes requested that one associate medical director, who worked with fourteen nursing homes and six different hospice agencies across Middle Tennessee, sign certifications even when he did not attend IDG meetings or access patients' medical records.

267. This medical director attended only a handful of Avalon Tullahoma IDG meetings in 2012, and he did not access the EMR system outside of those meetings. Nevertheless, he signed certifications and recertifications based on his knowledge of the patient or information provided to him by staff. And, he occasionally signed stacks of documents Avalon staff brought him without reviewing each document.

268. Given the limited access to patient medical records that the Avalon Tullahoma medical directors had, they relied heavily on the Avalon staff to convey clinical information relevant to assessing patients' life expectancy. Nevertheless, rather than hiring nurses and other clinical staff at Avalon Tullahoma who were experienced in hospice or in assessing the life expectancy of patients, Avalon and Curo often hired nurses with little or no prior hospice experience.

269. And, Avalon and Curo also failed to adequately train its Avalon Tullahoma staff to identify terminally ill patients or the clinical progression of illnesses.

270. Even when Avalon Tullahoma medical directors had access to and reviewed patients' medical record at IDG team meetings, however, the medical records failed to include complete and accurate information relevant to the physicians' prognostication analysis because Avalon and Curo carefully controlled the language staff members included – and omitted – from their notes.

271. While clinical training on identification of terminally ill patients and assessment of life expectancy was limited, Avalon Tullahoma DOOs and Curo compliance and operations managers provided extensive instructions and placed significant emphasis on the "right words" or clinical information that nurses and other staff members needed to use in describing the clinical status of its hospice patients to ensure Medicare would pay for the services.

272. Avalon and Curo also ensured that the medical record did not include information that reflected a patient's lack of decline, stability, clinical plateau, or improvement. Thus, Avalon and Curo failed to ensure that its nurses documented accurate and complete information about the patients' medical conditions in the medical records.

273. For example, Avalon Tullahoma DOO 1 required nurses to document Functional Assessment Staging ("FAST") scores of at least 7A for any patients with an Alzheimer's diagnosis, even if the nurse did not believe that the patient's condition reflected a 7A FAST score.[6]

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[6] The FAST Scale is a clinical tool designed to assess the progressive limitations associated with Alzheimer's disease. It has seven different stages that reflect disease progression as the score increases, with Stage 6 and Stage 7 each have sub-stages ranging from 6A to 6E and 7A to 7F. For Alzheimer's patients, a FAST score greater or equal to 7A, along with significant comorbid and secondary conditions, are clinical indicators supporting a terminal prognosis based on an Alzheimer's diagnosis.

274. Similarly, when providing feedback following an internal audit that identified fluctuations in a patient's documented FAST scores, one Curo Regional Compliance Director instructed Avalon Tullahoma DOO 1 that a patient's "FAST can decline but not go in reverse."

275. Furthermore, Curo and Avalon ensured that patients' medical records did not include any indication of clinical plateau or improvement.

276. For example, in August 2016, Avalon Tullahoma DOO 3 requested approval to discharge a patient from a Curo Area Vice President of Operations because the patient was not declining and was, in fact, improving. In response, the Area Vice President of Operations observed that the medical record did not support the information that Avalon Tullahoma DOO 3 had relayed regarding the patient because it did not reflect any prior discussion of eligibility in IDG meetings with the physician, and included no reference to the patient's improvement, lack of decline, or discharge plans. Avalon Tullahoma DOO 3 explained, "I wanted to be sure that there was not decline noted in the chart before I encouraged staff to actually doc[ument] discharge or the discussion of d/c [discharge] . . . [I]f you all would like us to begin using terms that denote improvement and or no decline in our doc[umentation] prior to the discussion of D/c we can do that."

277. In the same email, Avalon Tullahoma DOO 3 further explained that if the Area Vice President of Operations approved the discharge, *then* Avalon Tullahoma staff would discuss the need for discharge with the medical director and initiate discharge planning. Thus, Avalon Tullahoma provided relevant clinical information regarding the patient's improvement to the medical director and documented the improvement only after Curo regional managers authorized the patient's discharge.

278. Furthermore, Avalon Tullahoma medical directors' access to clinical information relevant to prognostication was also often limited due to flaws in the process for completing and documenting face-to-face visits, which are required to be completed by a nurse practitioner or physician to gather clinical findings for the hospice physician to determine continued eligibility for hospice care.

279. When Avalon Tullahoma was unable to timely obtain required documentation, staff members falsified clinical visit notes, forged physician or nurse practitioner signatures, or backdated the required documentation.

280. Avalon Tullahoma DOOs and other staff members maintained electronic copies of physicians' signatures in order to forge documents.

281. The IDG meeting did not provide a safeguard to ensure the Avalon Tullahoma medical directors received relevant clinical information from the face-to-face visit prior to evaluating whether to recertify patients. For example, before approximately August 2015, the nurse practitioner or physician who performed the face-to-face visits rarely (if ever) attended IDG meetings.

282. Further, one long-time nurse practitioner who conducted face-to-face visits did not participate in IDG meetings and never spoke with the certifying physicians regarding his assessments throughout the entire time he performed the visits.

283. Through internal audits, Avalon and Curo knew or should have known that Avalon Tullahoma medical directors did not review patients' medical records and did not otherwise receive relevant clinical information. For example, in October 2013, a regional compliance director notified Avalon Tullahoma DOO 1, Regional Director of Operations James Cocke, and Regional Director of Clinical Operations Marti Miller regarding concerns about discrepancies

between certain face-to-face documentation, which was completed by the associate medical director, and certification narratives, which were completed by the medical director. She explained that there were eleven benefit periods in which the face-to-face documentation addressed a primary diagnosis of Alzheimer's without any mention of end stage cardiovascular disease, which was the patient's primary diagnosis. In response, Cocke replied that he did not understand how this occurred for such a long time and asked whether the Avalon Tullahoma hospice physicians were reviewing information provided in the medical records.

284. Finally, the physician certification process did not adequately ensure patient eligibility at Avalon Tullahoma because, on many occasions, Avalon Tullahoma DOOs or staff members used the medical directors' credentials for the EMR without authorization to sign certifications or recertifications. For example, one former Avalon Tullahoma medical director never used Avalon's EMR system outside of the IDG meeting and never used an Avalon tablet or laptop. He also did not authorize any Avalon staff members to use his EMR log-in credentials to sign documentation. Finally, this former medical director never attended IDG meetings late at night. Nevertheless, there were multiple instances in which certifications were signed under this medical director's EMR credentials, including certifications for five different patients that were signed between 8:30 p.m. and 9:30 p.m. on April 10, 2012.

285. Another former Avalon Tullahoma associate medical director attended only a handful of IDG meeting several times in 2012, never used the EMR outside of these meeting, and never gave any Avalon staff members authorization to use his EMR log-in credentials. Yet, there were numerous times in which certifications were signed under this associate medical director's EMR credentials at times outside an IDG meeting, including certifications for six different patients that were signed on October 8, 2015.

2. Avalon and Curo knew or should have known that Avalon submitted false claims and retained overpayments for ineligible patients on service at Avalon Tullahoma.

286. Multiple staff members raised concerns regarding patient eligibility to Avalon Tullahoma DOO 1. For example, nurses complained during staff meetings that the patients Avalon Tullahoma HCC 1 enrolled did not qualify for hospice.

287. Curo regional managers eventually investigated various misconduct that was occurring at Avalon Tullahoma. In April 2014, Curo regional managers terminated Avalon Tullahoma DOO 1 for a policy violation. At the same time, Curo managers terminated a medical records clerk. While the medical records clerk was officially terminated for "poor performance," upon information and belief, her termination was related to falsified and forged medical records.

288. One former social worker reported concerns regarding patient eligibility to both Avalon Tullahoma DOO 1 and Avalon Tullahoma DOO 2, who was subsequently promoted to Area Director of Operations. When the social worker raised concerns to Avalon Tullahoma DOO 1 about inappropriate marketing practices that resulted in the admission of ineligible patients from long-term care facilities, she asked him whether he wanted to keep his job.

289. The social worker also subsequently informed Avalon Tullahoma DOO 2 of concerns about several patients who were admitted but did not qualify for hospice.

290. Other employees also raised concerns regarding patient eligibility to Avalon Tullahoma DOO 2. In the summer of 2015, a former nurse asked Avalon Tullahoma DOO 2 how she should document a FAST score when the patient was previously scored as a 7A, but the nurse did not think the patient met criteria for that score. The nurse also told Avalon Tullahoma DOO 2 that she was seeing certain patients less frequently because the patients were stable. Avalon

Tullahoma DOO 2 instructed the nurse to step-up the documentation to make the patients' records reflect that they were hospice appropriate.

291. During a subsequent IDG meeting the nurse expressed concern to the medical director and Avalon Tullahoma DOO 2 regarding the patient's Alzheimer's diagnosis because she did not believe the patient met the criteria for a FAST 7A score. A nurse practitioner then evaluated the patient and changed the patient's primary diagnosis to chronic obstructive pulmonary disease ("COPD").

292. Shortly thereafter, an audit raised questions regarding inconsistencies between the clinical information in the record and the patient's diagnosis. Avalon Tullahoma DOO 2 then terminated the nurse for "falsifying documentation in order to keep patients on hospice service." In response to the corrective action notice issued to the nurse, the nurse wrote that she was doing as she was directed by her previous supervisor and reported that other employees were doing the same.

293. Unlike her supervisors (Avalon Tullahoma DOOs) who received bonuses for meeting census goals, as a nurse, the nurse did not have any incentive to falsify documentation to support eligibility.

294. Upon information and belief, Avalon and Curo did not undertake any further due diligence to determine the scope of purportedly falsified documentation for this patient or other patients seen by the nurse. The specific patient about whom she raised concerns stayed on service for another approximately 2.5 years, and Avalon and Curo never issued a repayment for services provided to this patient.

295. Finally, Avalon and Curo knew from internal audits and reviews that their medical records did not support that their patients were eligible for the hospice benefit. For example, a

series of quarterly audits conducted by a Curo compliance director in 2013 identified multiple patients for whom the medical records did not support decline or showed "chronicity," significant variations in relevant clinical information (including with respect to diagnoses and FAST scores), and instances in which the face-to-face notes were missing or the visit purportedly supporting a recertification was performed after the recertification.

296. With respect to one inconsistency between the patient's diagnosis and information contained in the physician certification, the compliance staff member noted "these discrepancies can lead to denial." In some instances, when the compliance director found that a patient's medical record did not support eligibility, the same issues were present in subsequent audits and the compliance director's recommendations had not been followed.

297. Nevertheless, in October 2013, the compliance director wrote Avalon Tullahoma DOO 1 to ensure that she understood that "these audits are to assist in establishing and documenting the eligibility, the decline and continued eligibility of the patients[.] [W]e **NEVER** recommend discharge [because] that is the decision of the IDG and ultimately the medical director." (emphasis in original).

298. With the institution of Physician Narrative Reviews and consistent long length of stay reviews by Curo clinical compliance monitors, Curo was aware that the medical records for multiple Avalon Tullahoma patients did not support the patients' eligibility for extended periods of time across multiple benefit periods.

299. For example, over a period of approximately fourteen months, Curo clinical compliance monitors reviewed the medical record of one Avalon Tullahoma patient at least seven times. Each audit found that the medical records for this patient, who was admitted in early 2018 with a CHF diagnosis, reflected minimal decline or did not meet LCD criteria.

300. Furthermore, an audit in November 2018 found that at least one face-to-face visit note indicated that the patient had reached clinical plateau and recommended discharge. Nevertheless, the patient remained on service and Avalon and Curo continued to submit claims on a monthly basis for this patient through at least March 2020.

3. Avalon Tullahoma Example False Claims and Overpayments

Patient No. 4

301. Avalon and Curo knowingly submitted or caused to be submitted false or fraudulent claims to TennCare and Medicare, and knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments received from TennCare and Medicare, for hospice care for Patient No. 4 for services provided to this patient from at least November 2013 through January 2019. These claims were false or fraudulent because, as shown by Avalon Tullahoma's own medical records, Patient No. 4 was not eligible to receive hospice services.

302. Avalon Tullahoma HCC 1 obtained admission paperwork for TennCare beneficiary Patient No. 4 on October 17, 2013. Patient No. 4 was admitted by Avalon Tullahoma on October 18, 2013 with a terminal diagnosis of end stage Alcoholic Cirrhosis of the Liver with Ascites, and the patient remained on service with Avalon Tullahoma continuously for more than five years. Approximately three weeks after Patient No. 4 was initially admitted, he revoked the hospice election on November 6, 2013 to obtain a paracentesis, which is aggressive treatment that is not covered by the hospice benefit. Patient No. 4 was readmitted under the same diagnosis the following day.

303. Throughout the time that Patient No. 4 was on service at Avalon Tullahoma, the medical records do not support a diagnosis of end-stage liver failure or any other terminal diagnosis. For example, upon admission and at multiple points during Patient No. 4's stay, the

patient's lab results failed to meet clinical indicators for end-stage liver disease, such as those set forth in the relevant LCD. End-stage liver disease LCDs explained that a patient will be considered in the terminal stage of liver disease when the patient's laboratory results "show both a *and* b" : (a) "Prothrombin time prolonged more than 5 second over control, or International Normalized Ratio (INR) > 1.5;" and (b) "Serum albumin <2.5 gm/dl." Low levels of serum albumin, which is type of protein made by the liver, indicate poor liver function.

304. Avalon Tullahoma DOO 1 signed the verbal certification for Patient No. 4 on November 7, 2013. On November 14, 2013, an Avalon Tullahoma medical director signed a physician narrative statement that stated only: "Pt with terminal liver disease, serum albumin < 2.5, Ascites, Hospice Appropriate." The only albumin levels reflected in Patient No. 4's medical record, however, were 3.1 and 3.2.

305. Furthermore, Patient No. 4 remained stable for significant portions of the time the patient was on service at Avalon Tullahoma. From approximately November 7, 2013 until October 2, 2014, Patient No. 4 remained ineligible for hospice because, as shown by the patient's medical record, the patient did not have a life expectancy of six months or less due to his clinical stability.

306. For example, the patient's Palliative Performance Score (PPS), which is an assessment of a patient's functional performance and progression towards end of life, remained stable at 50%. Similarly, the patient's abdominal girth, which may be used to gauge progression of fluid buildup in the abdominal cavity (*i.e.*, ascites), remained relatively stable with an overall reduction during this period. Furthermore, laboratory blood tests from April 2014 again confirmed that Patient No. 4 did not meet the laboratory criteria for end-stage liver disease, as his albumin level was measured at 2.9.

307. Patient No. 4 exhibited clinical stability for nearly a year, after which the patient began to demonstrate clinical decline in October 2014.

308. By late November 2015, however, Patient No. 4's condition had once again stabilized, and he remained clinically stable until being discharged live more than three years later because the patient's condition was chronic not terminal. Throughout this time period, Patient No. 4's medical record does not reflect clinical documentation of decline. For example, with few exceptions, during this entire period Patient No. 4's PPS level remained consistently at 40% or 50%. In several instances, the physician recertification document reported a PPS of 30%, although documentation of nursing or face-to-face visits during this period continued to reflect a PPS of 40%. Patient No. 4's abdominal girth and MAC measurements remained relatively stable throughout the entire time period, and any fluctuations in these measurements typically reflected the patient's non-compliance with medication therapy prescribed for edema and ascites. At times, nursing documentation indicated Patient No. 4 was completely dependent for activities of daily living ("ADLs"), though notes during the same time period indicate the patient is able to dress and go out to eat with family.

309. Despite Patient No. 4's clinical stability from late November 2015 through January 2019, Avalon Tullahoma continued to submit claims for hospice services submitted to TennCare and later to Medicare.

310. Throughout this time period, Curo clinical compliance monitors were aware that Patient No. 4's medical records did not support the patient's eligibility, but Curo permitted Avalon to submit claims to TennCare and Medicare nonetheless.

311. For example, Curo clinical compliance monitors began reviewing medical records for Patient No. 4 in February 2016, and reviewed this patient's medical record at least nine times over the next nearly four years before the patient was discharged due to ineligibility.

312. These audits and reviews identified multiple instances in which clinical information indicated Patient No. 4 did not meet objective eligibility criteria, as well as inconsistencies in the documentation and insufficient documentation to confirm terminal status.

313. Specifically, a February 2016 Physician Narrative Review noted that the documentation supporting the COTI must contain sufficient information to confirm the terminal illness. The clinical compliance monitor noted Patient No. 4's high length of stay and asked for evidence showing the patient's terminal progression rather than his custodial state.

314. By May 2016, Curo clinical compliance monitors began to routinely audit Patient No. 4's medical record. The first audit of Patient No. 4 occurred on May 24, 2016, but the clinical compliance monitor did not record her findings. She noted, however, that she recommended to the Avalon Tullahoma DOO that she obtain updated labs for serum albumin. The clinical compliance monitor documented in her notes that the Avalon Tullahoma DOO had explained, "I believe the fluctuations in staff documentation are due to turnover in [nurses] for those patients . . . . The current [nurse] is new to hospice and is also learning. Hopefully we will see more consistency without the use of PRN [as needed] staff."

315. The clinical compliance monitor audited Patient No. 4 again in July 2016 and found that the patient "overall had had little decline over time." She suggested "a close watch for documented decline."

316. In December 2016, another Physician Narrative Review once again found that Patient No. 4's medical records did not confirm the patient's terminal status.

317. In January 2017, when Patient No. 4 became Medicare-eligible, Avalon discharged the patient and readmitted the patient under a "first certification" period. Upon this readmission, Avalon changed Patient No. 4's primary diagnosis to acute alcoholic hepatitis, despite the fact that the patient had been living with cirrhosis since his initial certification period in October 2012.

318. In May 2018, the clinical compliance monitor found that the documentation did not reflect decline over the prior year. Specifically, she noted that there was no change in Patient No. 4's PPS, skin tone, fatigue, and food intake. Furthermore, she noted that the physician narrative dated May 9, 2018 appeared to be copy-and-pasted from nurses notes a week earlier.

319. On May 22, 2018, the clinical compliance monitor communicated with the Avalon Tullahoma DOO regarding her audit of Patient No. 4. In particular, she pointed out that the albumin level should be less than 2.5 (as established by the relevant LCD), but that Patient No. 4's albumin level was 2.9. Thus, Curo's own clinical compliance monitor was aware that Patient No. 4 filed to meet eligibility criteria for end-stage liver disease.

320. Finally, on December 28, 2018, a physician narrative supporting a recertification noted that it "appears patient [is] more chronic than terminal and will discuss at IDG."

321. At a January 2, 2019, IDG meeting Avalon Tullahoma staff decided to discharge the patient because he "appears more chronic than terminal."

322. Thus, Patient No. 4 was finally discharged from Avalon Tullahoma on January 8, 2019 – more than five years after his admission. Patient No. 4 had the second longest length of stay of any patient Avalon admitted at any of its Tennessee facilities during the relevant time period.

323. Avalon and Curo knowingly submitted or caused the submission of the following false or fraudulent claims, and knowingly concealed or knowingly and improperly avoided

Avalon's obligations to repay overpayments received from TennCare and Medicare, for services provided to Patient No. 4 when the patient was not eligible for the hospice benefit:

Example Patient No. 4				
Claim	**Service From**	**Service To**	**Claim Date**	**Claim Amount**
TennCare				
2413357000735	11/07/2013	11/30/2013	12/21/2013	$3,230.64
2414034004999	12/01/2013	12/31/2013	02/01/2014	$4,172.91
2414062008453	01/01/2014	01/01/2014[7]	03/01/2014	$4,172.91
2414083003398	02/01/2014	02/01/2014	03/23/2014	$3,769.08
2414118002310	03/01/2014	03/31/2014	04/26/2014	$4,172.91
2414139026200	04/01/2014	04/30/2014	05/17/2014	$4,038.30
2414202001469	05/01/2014	05/31/2014	07/19/2014	$4,172.92
2414202001467	06/01/2014	06/01/2014	07/19/2014	$4,038.30
2414223010552	07/01/2014	07/31/2014	08/09/2014	$4,172.91
2414273002367	08/01/2014	08/31/2014	09/27/2014	$4,172.91
2414300002822	09/01/2014	09/01/2014	10/25/2014	$4,038.30
2414328002390	10/01/2014	10/02/2014	11/22/2014	$274.88[8]
2416074081975	11/27/2015	11/30/2015	03/12/2016	$558.56[9]

[7] In several instances, the service dates associated with TennCare claims refer only to the first day of the month, but the units and amounts billed confirm the claim covers services provided for the entirety of the month.

[8] Patient No. 4 was ineligible during at least the dates of service that are indicated, and this amount represents the portion of the billed and reimbursed claim that is associated with those dates of service.

[9] Patient No. 4 was ineligible during at least the dates of service that are indicated, and this amount represents the portion of the billed and reimbursed claim that is associated with those dates of service.

2416074082003	12/01/2015	12/01/2015	03/12/2016	$4,328.84
2416074081954	01/01/2016	01/01/2016	03/12/2016	$3,931.42
2416123016706	02/01/2016	02/01/2016	04/30/2016	$3,677.78
2416109005295	03/01/2016	03/01/2016	04/17/2016	$4,328.84
2416137000795	04/01/2016	04/01/2016	05/14/2016	$3,804.60
2416165027938	05/01/2016	05/31/2016	06/11/2016	$3,931.42
2416200063429	06/01/2016	06/30/2016	07/16/2016	$3,804.60
2416228045800	07/01/2016	07/01/2016	08/13/2016	$3,931.42
2416270008086	08/01/2016	08/31/2016	09/24/2016	$3,931.42
2416305010634	09/01/2016	09/01/2016	10/29/2016	$3,804.60
2416328011875	10/01/2016	10/31/2016	11/19/2016	$4,011.40
2417017002001	11/01/2016	11/30/2016	01/14/2017	$3,882.00
2417058011425	12/1/2016	12/1/2016	02/25/2017	$5,101.98
Total				**$97,455.85**
Medicare				
21815100561504TNR	01/20/2017	01/31/2017	05/31/2018	$1,932.92
21815100607504TNR	02/01/2017	02/28/2017	05/31/2018	$4,510.15
21815100611804TNR	03/01/2017	03/31/2017	05/31/2018	$4,614.65
21712900413204TNR	04/01/2017	04/30/2017	05/09/2017	$3,799.42
21715900847304TNR	05/01/2017	05/31/2017	06/08/2017	$3,926.07
21718500651504TNR	06/01/2017	06/30/2017	07/04/2017	$3,799.42
21721601075804TNR	07/01/2017	07/31/2017	08/04/2017	$3,926.07
21724700805004TNR	08/01/2017	08/31/2017	09/04/2017	$3,926.07
21728301143804TNR	09/01/2017	09/30/2017	10/10/2017	$3,799.42

21731002499204TNR	10/01/2017	10/31/2017	11/06/2017	$3,967.75
21733802048604TNR	11/01/2017	11/30/2017	12/04/2017	$3,839.76
21800401138704TNR	12/01/2017	12/31/2017	01/04/2018	$3,967.75
21803600326704TNR	01/01/2018	01/31/2018	02/05/2018	$3,967.75
21806400474904TNR	02/01/2018	02/28/2018	03/05/2018	$3,583.77
21809401121904TNR	03/01/2018	03/31/2018	04/04/2018	$3,967.75
21812401424404TNR	04/01/2018	04/30/2018	05/04/2018	$3,839.76
21815501042004TNR	05/01/2018	05/31/2018	06/04/2018	$3,967.75
21818500490504TNR	06/01/2018	06/30/2018	07/04/2018	$3,839.76
21821801220304TNR	07/01/2018	07/31/2018	08/06/2018	$3,967.75
21906301011904TNR	08/01/2018	08/31/2018	03/04/2019	$3,967.75
21827800557504TNR	09/01/2018	09/30/2018	10/05/2018	$3,839.76
21830900363504TNR	10/01/2018	10/31/2018	11/05/2018	$4,041.09
21833801983704TNR	11/01/2018	11/30/2018	12/04/2018	$3,910.73
21900700823204TNR	12/01/2018	12/31/2018	01/07/2019	$4,041.09
21901100138804TNR	01/01/2019	01/08/2019	01/11/2019	$1,042.86
Total				**$93,987.02**

324. Despite multiple instances in which Curo compliance personnel determined Patient No. 4's medical records did not support the patient's eligibility or questioned the patient's eligibility based on the patient's medical records, Avalon and Curo never returned any of the payments it received for Patient No. 4.

325. Furthermore, Avalon and Curo did not undertake adequate due diligence of Patient No. 4's medical records and certifications to determine whether: (1) Patient No. 4 had been hospice-eligible before Curo compliance personnel determined that the patient's medical record

did not support eligibility; and (2), if not, whether they had an obligation to return overpayments Avalon received from TennCare and Medicare for services rendered during prior periods when the patient's medical records did not support eligibility. Therefore, Avalon and Curo knowingly concealed or knowingly and improperly avoided Avalon's obligation to repay overpayments related to some or all of the claims it submitted for Patient No. 4.

326. Furthermore, after each instance in which a member of Avalon's clinical staff or Curo's compliance personnel determined Patient No. 4 was not eligible or questioned the patient's eligibility, Avalon continued to submit claims for Patient No. 4. Therefore, Avalon knowingly submitted false claims for Patient No. 4, and Curo knowingly caused the submission of these claims.

C. Defendants' Fraudulent Conduct at Avalon Athens

1. Curo incentivized and pressured staff at Avalon Athens to admit and retain patients without ensuring and supporting their eligibility.

327. Like all other Avalon locations, the Avalon Athens DOO 1 received bonuses based on admissions and ADC. In addition, Avalon Athens DOO 1 believed that her job would be in jeopardy if the census numbers at Avalon Athens tanked.

328. Furthermore, Curo's live discharge process made it difficult for Avalon Athens to discharge patients due to ineligibility. For example, a Curo Area Vice President of Operations had to approve all live discharges for Avalon Athens.

329. Consequently, at times Avalon Athens DOO 1 prevented discharges that were recommended by Avalon medical directors and staff. When a medical director indicated that a patient should be discharged, the former PCC discussed the recommended discharge with Avalon Athens DOO 1, who did not herself attend the IDG meetings. Instead of initiating the discharge,

Avalon Athens DOO 1 responded that she would have to terminate staff if Avalon discharged patients.

330. At the same time, Avalon Athens was subject to Curo's increasing expectations and scrutiny of COTI documentation to ensure Medicare would not deny claims. When a patient had stabilized and was no longer eligible, however, Curo's pressure to maintain census, including by avoiding live discharges, was in tension with pressure to ensure that documentation continued to support eligibility.

331. In 2015, as Curo was implementing and enforcing its Physician Narrative Review procedures, Avalon Athens DOO 1 and a former PCC attempted to modify the agency's COTI processes to ensure that the physician narratives satisfied the guidance issued by Curo's corporate office. They struggled, however, to develop a process that was not too onerous on the physicians or nurses.

332. Fearing that she would lose her job in the face of the pressure to ensure the corporate office would not reject COTIs, Avalon Athens DOO 1 removed medical directors from the physician narrative and certification process entirely.

333. Before September 2015, at least one of the Avalon Athens medical directors ("Avalon Athens Medical Director 1") personally entered his narratives into the EMR system during IDG meetings, rather than using a scribe, and signed COTIs. Around September 2015, Avalon Athens DOO 1 instructed the former PCC to stop having the medical directors complete

physician certifications at IDG meetings due to unspecified issues with HCHB that the corporate office had purportedly identified.

334. Following these instructions from Avalon Athens DOO 1, the former PCC told the medical directors not to sign the COTIs at the IDG meetings for at least six months.

335. Avalon Athens DOO 1 also instructed the former PCC to complete the physician narratives.

336. Based on these instructions, Avalon Athens Medical Director 1 – who had not previously worked in hospice – also stopped completing the physician narratives. On several occasions, Avalon Athens Medical Director 1 asked Avalon Athens DOO 1 or the former PCC about the issue with the EMR system, but was told the problem persisted and that he should not worry about it. Further, when he asked how Avalon was able to bill Medicare without a COTI, he did not receive an answer.

337. In April 2016, the former PCC informed Avalon Athens Medical Director 1 that Avalon Athens DOO 1 had used his credentials to sign many COTIs that had been left blank at prior IDG meetings.

338. During the IDG meetings, the IDG team had openly discussed that certain patients no longer met criteria for hospice care and a number of these patients were among those for whom Avalon Athens DOO 1 electronically forged COTIs.

339. The former PCC gave Avalon Athens Medical Director 1 copies of thirty-one physician narrative addendums to COTIs and informed him these documents had been completed by Avalon Athens DOO 1 using his EMR credentials. When Avalon Athens Medical Director 1 reviewed the thirty-one COTI addendums, he observed they were completed on dates when IDGs had not occurred, even though he only accessed Curo's EMR during IDG meetings. Furthermore,

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many of these documents included language and terminology that Avalon Athens Medical Director 1 did not typically use. A number of the addendums appeared to be copy-and-pasted from other portions of the medical record, and some did not contain clinical information that was consistent with the patients' diagnoses. And, at least one of these physician narratives pertained to a patient for whom Avalon Athens Medical Director 1 and the former PCC recommended discharged, but Avalon Athens DOO 1 initially prevented the discharge.

340. Curo's own EMR system and IDG logs confirm Avalon Athens Medical Director 1's signature was electronically forged on these addendums and other COTIs. Specifically, these records confirm that physician narrative addendums and COTIs were signed at dates and times outside the IDG meetings. For example, on Monday, January 4, 2016, there was no IDG held, yet six COTIs were signed under Avalon Athens Medical Director 1's EMR credentials between approximately 9:00 p.m. and 10:00 p.m.

2. Avalon and Curo knew or should have known that Avalon submitted false claims and retained overpayments for ineligible patients on service at Avalon Athens.

341. Avalon Athens Medical Director 1 reported his concerns regarding the fraudulent COTIs to Curo's Chief Compliance Officer and provided copies of the forged physician narrative addendums. In response to Avalon Athens Medical Director 1's concerns, Curo conducted an internal investigation.

342. Avalon Athens Medical Director 1 also reported his concerns to HHS-OIG regarding the forged addendums. In addition, he reported concerns that Avalon had submitted claims for hospice services provided to ineligible patients.

343. On December 30, 2016, AdvanceMed, a CMS program integrity contractor, suspended payments for the Avalon NPI number connected with Avalon Athens' submitted claims.

344. According to its response to the payment suspension, Curo's internal investigation found that the improper use of Avalon Athens Medical Director 1's EMR credentials was limited to instances in which the former PCC used his credentials to help him login to the EMR prior to IDG meetings. This conclusion failed to account for relevant IDG logs and EMR records, however, which showed that his credentials were used outside of IDG meetings.

345. Based on its internal investigation, Curo further concluded there were no issues with respect to patient ineligibility. It nevertheless discharged several patients as a result of the investigation and related audits. And, during the first half of 2016, Curo wrote off Avalon's claims for services provided to multiple patients due to patient ineligibility.

346. Upon information and belief, Avalon and Curo failed to undertake adequate due diligence to determine the scope of the patient ineligibility issues it identified in early 2016, including whether claims associated with other patients or from prior time periods were affected.

347. Thus, based upon the information from its internal investigation, as well as audits conducted by Curo's clinical compliance monitors, Avalon and Curo knew or should have known that Avalon submitted false claims and retained overpayments for ineligible patients at its Athens agency.

3. Avalon Athens Example False Claims and Overpayments

<u>Patient No. 5</u>

348. Avalon and Curo knowingly submitted or caused to be submitted false or fraudulent claims to Medicare, and knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments received from Medicare, for certain services provided to Patient No. 5 during this patient's nearly six-year stay, which spanned from September 2011 through August 2017. These claims were false or fraudulent because, as shown by Avalon Athens' own medical records, Patient No. 5 was not eligible to receive hospice services.

349. Patient No. 5 was admitted to Avalon Athens on September 16, 2011. Patient No. 5 remained on hospice continuously with Avalon for almost six years, even though Curo's internal audits repeatedly observed that the patient's medical records did not reflect decline and indicated the patient was chronic or custodial (*i.e.*, not terminal).

350. Curo's clinical compliance department initially identified concerns regarding Patient No. 5 through its first Physician Narrative Review in December 2014. After emphasizing to Avalon Athens DOO 1 that the review was not an "issue of eligibility, but of documentation quality improvement," Curo's clinical compliance department found that the prior physician narrative was insufficient to establish Patient No. 5's disease progression.

351. By February 16, 2016, Curo's Regional Director of Clinical Operations for Tennessee was monitoring the eligibility of Patient No. 5 after a mock survey, which evaluated certain aspects of Avalon Athens' operations, had found that the patient's medical record did not reflect decline. Specifically, the mock survey conducted in January 2016 found that the documentation did not indicate eligibility on multiple occasions. The Regional Director of Clinical Operations discussed this patient with Avalon Athens DOO 1.

352. The following benefit period began several days later on February 22, 2016. Avalon Athens DOO 1 had previously recorded a verbal certification order from this benefit period on February 11, 2016. On March 17, 2016, a physician narrative addendum supporting the certification was signed using Avalon Athens Medical Director 1's EMR credentials. Avalon

Athens Medical Director 1 did not prepare or sign this addendum, however, and it was signed without his consent or knowledge.

353. This addendum was provided to Avalon Athens Medical Director 1 by the former PCC in April 2016.

354. The medical record for Patient No. 5 does not, however, include any record of this addendum, but rather presents it as the original physician narrative supporting the February 2016 COTI.

355. As part of the May 2016 Physician Narrative Review, Curo's clinical compliance monitors determined that Patient No. 5's most recent physician narrative was deficient and required Avalon Athens DOO 1 to submit an addendum. Specifically, a Curo clinical compliance monitor questioned what decline the patient had exhibited over the prior four- to six-months and found that the COTI documentation did not contain sufficient information to confirm the patient's terminal status.

356. Curo's clinical compliance department began conducting regular audits of Patient No. 5 in June 2016. The initial audit included three benefit periods, dating from December 24, 2016 through June 20, 2016. In noting areas of concern, the clinical compliance monitor found that the patient's condition had changed very little in the past year and recommended that Avalon Athens staff watch the patient closely. Curo then supplemented Patient No. 5's medical record with a "Clinical Eligibility Summary" that included portions of the monitor's findings that suggested the patient met hospice criteria, but specifically omitted the section of the audit that reflected the monitor's concerns regarding the patient's lack of decline for the past year.

357. In August 2016, the Curo clinical compliance monitor audited Patient No. 5's medical records and again found that the patient's condition had not changed over the last several

months. Curo again supplemented the patient's medical record with a "Clinical Eligibility Summary" that referenced only the auditor's notes that suggested Patient No. 5 met hospice criteria without including her concerns regarding the patient's lack of decline.

358. Once again, on October 17, 2016, the Curo clinical compliance monitor found that Patient No. 5 had not changed since her prior audit. At this time, Patient No. 5 had a FAST score of 7D, which reflected improvement from the prior benefit period. Furthermore, the monitor noted that the patient had not had an infection since April 2015, ate all meals, did not have secondary conditions in over a year, and did not have any active comorbidities. Furthermore, the monitor noted that the patient's MAC measurements had been consistent over the prior four benefit periods, with one exception that appeared to be inconsistent with prior and subsequent measurements.

359. Consequently, the compliance monitor emailed the Avalon Athens DOO with instructions to obtain a History & Physician ("H&P") exam that would document measurable decline and the need for continued hospice care.

360. A nurse practitioner subsequently visited Patient No. 5 and scored the patient as FAST 7E, despite acknowledging that the patient's condition was "currently stable."

361. Curo then supplemented Patient No. 5's medical record with a "Clinical Eligibility Summary" that referenced only the auditor's notes that suggested the patient met hospice criteria, including a reference to the lower MAC score that the monitor had acknowledged appeared to be inconsistent with other measurements. Once again, Curo specifically omitted the monitor's concerns regarding the patient's lack of decline.

362. In November 2016, as part of a Physician Narrative Review, a Curo clinical compliance monitor noted that the patient had been on service for five years and concluded that

the patient "easily appears custodial/chronic care." Nevertheless, the monitor instructed the Avalon Athens DOO to submit the outstanding physician narrative addendum for this patient.

363. Eventually Avalon discharged Patient No. 5 in August 2017. The discharge occurred only after the patient had been on service for almost six years, and after Curo's clinical compliance monitor had tracked, since June 2016, a lack of decline that dated back at least to June 2015.

364. Avalon and Curo have not made any repayments to Medicare or Medicaid associated with this patient.

365. Avalon and Curo knowing submitted or caused the submission of following false or fraudulent claims to Medicare, and knowingly concealed or knowingly and improperly avoided Avalon's obligations to repay overpayments received from Medicare, for services provided to Patient No. 5 during substantial portions of the patient's stay when the patient was not eligible for the hospice benefit, including at least:

Patient No. 5				
Claim	**Service From**	**Service To**	**Claim Date**	**Claim Amount**
21607701164104TNR	02/22/2016	02/29/2016	03/17/2016	$992.95[10]
21609501522004TNR	03/01/2016	03/31/2016	04/04/2016	$3,847.69
21612600243604TNR	04/01/2016	04/30/2016	05/05/2016	$3,723.57
21615500798404TNR	05/01/2016	05/31/2016	06/03/2016	$3,847.69
21618901528404TNR	06/01/2016	06/30/2016	07/07/2016	$3,723.57
21621801944204TNR	07/01/2016	07/31/2016	08/05/2016	$3,847.69

[10] Patient No. 5 was ineligible during at least the dates of service that are indicated, and this amount represents the portion of the billed and reimbursed claim that is associated with those dates of service.

21624900548704TNR	08/01/2016	08/31/2016	09/05/2016	$3,847.69
21627801980504TNR	09/01/2016	09/30/2016	10/04/2016	$3,723.57
21630902133204TNR	10/01/2016	10/31/2016	11/04/2016	$3,926.07
21634000958604TNR	11/01/2016	11/30/2016	12/05/2016	$3,799.42
21700902559004TNR	12/01/2016	12/27/2016	01/09/2017	$3,546.13[11]
Total				**$38,826.04**

366. Despite multiple instances in which Curo compliance personnel determined Patient No. 5's medical record did not reflect decline or show that the patient was terminal, Avalon and Curo never returned any of the payments it received for Patient No. 5.

367. Therefore, Avalon and Curo knowingly concealed or knowingly and improperly avoided Avalon's obligation to repay overpayments related to claims submitted for Patient No. 5.

368. Furthermore, in multiple instances in which a member of Curo's clinical compliance department determined that Patient No. 5's medical records did not support eligibility or questioned the patient's eligibility, Avalon continued to submit claims for Patient No. 5.

369. Therefore, Avalon knowingly submitted false claims for Patient No. 5, and Curo knowingly caused the submission of these claims.

D. Defendants' Fraudulent Conduct at Other Avalon Agencies in Tennessee

370. Upon information and belief, Avalon and Curo submitted, or caused to be submitted, false claims to Medicare and TennCare, and knowingly concealed or knowingly and improperly avoided Avalon's obligation to repay overpayments Avalon received from Medicare or TennCare, for ineligible patients admitted on service at other Avalon agencies in Tennessee.

[11] Patient No. 5 was ineligible during at least the dates of service that are indicated, and this amount represents the portion of the billed and reimbursed claim that is associated with those dates of service.

371. Curo and Avalon were aware of concerns that certain patients on service at other Avalon agencies were not eligible. For example, when one former employee began the role of DOO for Avalon Chattanooga in the spring of 2016, she found that there were numerous patients who should have been discharged.

372. Upon information and belief, after these patients were discharged, Avalon and Curo did not undertake adequate due diligence with respect to these patients' medical records and certifications to determine whether they had been hospice-eligible throughout their stay, and, if not, whether they had an obligation to return overpayments Avalon had received from Medicare or TennCare.

373. In addition, when this former employee started as Avalon Chattanooga DOO, she discovered that there were "a ton" of physician narratives that had not been completed for some time. Consequently, she "work[ed] on them" even though she was not a physician and would not have been present at any IDG meetings when the information necessary for these narratives were purportedly discussed.

374. Furthermore, in approximately late 2018 or early 2019, at least two former Avalon nurses repeatedly raised concerns regarding ineligible patients to Avalon and Curo managers, including the Avalon Johnson City DOO, medical director, and the lead nurse, as well as the Curo Area Vice President of Operations, about patients who were not eligible for hospice. When these nurses informed the DOO that certain referred patients were ineligible, the DOO responded that "corporate" was requiring that the patients be admitted.

375. Similarly, in early 2020, Avalon Nashville terminated a former nurse after she repeatedly informed the current Nashville DOO that referrals or patients were not eligible for hospice, including numerous patients who were residents at Hillcrest Healthcare Center, a skilled

nursing facility in Ashland City. For example, one Hillcrest patient who the nurse did not think was hospice appropriate informed the nurse that Hillcrest had told her the only way she could continue to stay at the facility was to elect hospice. When this former nurse did not believe a referred patient was eligible, the Nashville DOO sent a different nurse to evaluate the patient.

FIRST CAUSE OF ACTION
(False Claims Act, 31 U.S.C. § 3729(a)(1)(A))

376. The United States re-alleges and incorporates by reference the preceding paragraphs of this Complaint as if fully set forth herein.

377. By virtue of the acts described above, between January 2010 and February 2020, Defendants Regency Healthcare Group LLC, Curo Health Services Holdings, Inc., Curo Health Services, LLC, and TNMO Healthcare, LLC knowingly presented or caused to be presented to the United States false or fraudulent Medicare claims for payment or approval, in violation of the False Claim Act, 31 U.S.C. § 3729(a)(1)(A); that is, Defendants knowingly presented, or caused to be presented, to the United States claims for payment for hospice services provided to patients who were not eligible for Medicare hospice benefits during all or part of the time the patients were on hospice service.

378. By reason of the foregoing, the United States suffered actual damages in an amounted to be determined at trial; and therefore is entitled to treble damages under the False Claims Act, plus civil penalties of: (a) not less than $5,500 and up to a maximum penalty of $11,000 for each false claim presented or caused to be presented prior to November 2, 2015; and (b) not less than $11,665 and up to a maximum penalty of $23,331 for each false claim presented or caused to be presented after November 2, 2015.

SECOND CAUSE OF ACTION
(False Claims Act, 31 U.S.C. § 3729(a)(1)(G))

379. The United States re-alleges and incorporates by reference the preceding paragraphs of this Complaint as if fully set forth herein.

380. By virtue of the acts described above, Defendants Regency Healthcare Group LLC, Curo Health Services Holdings, Inc., Curo Health Services, LLC, and TNMO Healthcare, LLC knowingly made or used a false record or statement material to an obligation to pay or transmit money to the United States, or knowingly concealed, or knowingly and improperly avoided or decreased an obligation to pay or transmit money to the United States, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1)(G), for overpayments it identified after March 23, 2010.

381. By reason of the foregoing, the United States suffered actual damages in an amounted to be determined at trial; and therefore is entitled to treble damages under the False Claims Act, plus civil penalties of: (a) not less than $5,500 and up to a maximum penalty of $11,000 for each overpayment identified prior to November 2, 2015; and (b) not less than $11,665 and up to a maximum penalty of $23,331 for each overpayment identified after November 2, 2015.

THIRD CAUSE OF ACTION
(Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(A))

382. The State of Tennessee re-alleges and incorporates by reference the preceding paragraphs of this Complaint as if fully set forth herein.

383. By virtue of the acts described above, between January 2010 and February 2020, Defendants Regency Healthcare Group LLC, Curo Health Services Holdings, Inc., Curo Health Services, LLC, and TNMO Healthcare, LLC knowingly presented or caused to be presented false or fraudulent claims for payment or approval under the Tennessee Medicaid program, in violation of the Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(A) that is, Defendants knowingly presented, or caused to be presented, claims for payment under the

Tennessee Medicaid program for hospice services provided to patients who were not eligible for Medicaid hospice benefits during all or part of the time the patients were on hospice service.

384. By reason of the foregoing, the State of Tennessee suffered actual damages in an amounted to be determined at trial; and therefore is entitled to treble damages under the Tennessee Medicaid False Claims Act, plus civil penalties of: (a) not less than $5,000 and up to a maximum penalty of $25,000 for each false claim presented or caused to be presented. Tenn. Code Ann. § 71-5-182(a)(1).

FOURTH CAUSE OF ACTION
(Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(D)

385. The State of Tennessee re-alleges and incorporates by reference the preceding paragraphs of this Complaint as if fully set forth herein.

386. By virtue of the acts described above, Defendants Regency Healthcare Group LLC, Curo Health Services Holdings, Inc., Curo Health Services, LLC, and TNMO Healthcare, LLC knowingly made or used a false record or statement material to an obligation to pay or transmit money to the State of Tennessee relative to the Medicaid program, or knowingly concealed, or knowingly and improperly avoided or decreased an obligation to pay or transmit money to the State of Tennessee, relative to the Medicaid program, in violation of the Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(D), for overpayments it identified after April 23, 2012.

387. By reason of the foregoing, the State of Tennessee suffered actual damages in an amounted to be determined at trial; and therefore is entitled to treble damages under the Tennessee Medicaid False Claims Act, plus civil penalties of: (a) not less than $5,000 and up to a maximum penalty of $25,000 for each overpayment identified. Tenn. Code Ann. § 71-5-182(a)(1).

FIFTH CAUSE OF ACTION
(Payment Under Mistake of Fact)

388. The United States and the State of Tennessee re-allege and incorporate by reference the preceding paragraphs of this Complaint as if fully set forth herein.

389. The United States and Tennessee paid Defendants, either directly or indirectly, for claims submitted by Defendant TNMO Healthcare, LLC for hospice services that were provided to Medicare and TennCare beneficiaries who were not eligible for the hospice benefit, based on misrepresentations of material facts regarding the eligibility of the beneficiaries, and under the mistaken belief that Defendants were entitled to receive payment for such claims.

390. As a consequence of the conduct and the acts set forth above, Defendants were paid by mistake by the United States and the State of Tennessee in an amount to be determined at trial which, under the circumstances, inequity and good conscience, should be returned to the United States and the State of Tennessee.

SIXTH CAUSE OF ACTION
(Unjust Enrichment)

391. The United States and the State of Tennessee re-allege and incorporate by reference the preceding paragraphs of this Complaint as if fully set forth herein.

392. By retaining monies and profits received from payments for hospice services Defendants provided to Medicare and TennCare beneficiaries who were not eligible for the hospice benefit, Defendants retained money that was property of Medicare and TennCare, to which they were not entitled.

393. By virtue of the conduct and the acts described above, Defendants were unjustly enriched at the expense of the United States and the State of Tennessee in an amount to be determined at trial, which, under the circumstances, in equity and good conscience, should be returned to the United States and the State of Tennessee.

PRAYER FOR RELIEF

WHEREFORE, the United States and the State of Tennessee respectfully pray for judgment in their favor as follows:

1) As to the First and Second Causes of Action (False Claims Act), against Defendants Regency Healthcare Group LLC, Curo Health Services Holdings, Inc., Curo Health Services, LLC, and TNMO Healthcare, LLC for: (i) statutory damages in an amount to be established at trial, trebled as required by law, and such penalties as required by law; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate to be determined at trial.

2) As to the Third and Fourth Causes of Action (Tennessee Medicaid False Claims Act) against Defendants Regency Healthcare Group LLC, Curo Health Services Holdings, Inc., Curo Health Services, LLC, and TNMO Healthcare, LLC for: (i) statutory damages in an amount to be established at trial, trebled as required by law, and such penalties as required by law; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate to be determined at trial.

3) As to the Fifth Cause of Action (Payment Under Mistake of Fact), for: (i) an amount equal to the money paid by the United States through the Medicare Program, and by the State of Tennessee through the TennCare Program, to Defendant TNMO Healthcare and illegally retained by Defendants, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate to be determined at trial.

4) As to the Sixth Cause of Action (Unjust Enrichment), for: (i) an amount equal to the money paid by the United States through the Medicare Program, and by the State of Tennessee through the TennCare Program, to Defendant TNMO Healthcare, or the

amount by which Defendants were unjustly enriched, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate to be determined at trial.

5) All other relief as may be required or authorized by law and in the interests of justice.

JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, and Local Rule 7.03(b), the United States and the State of Tennessee hereby demand a jury trial on all claims alleged herein.

Dated: June 1, 2021

Respectfully submitted,

For the United States:

MARY JANE STEWART
ACTING UNITED STATES ATTORNEY
MIDDLE DISTRICT OF TENNESSEE

By: s/Kaitlin E. Hazard

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