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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO (Eastern Division)

UNITED STATES OF AMERICA, **Plaintiff, *ex rel.*** **[UNDER SEAL]** **Relators,** **v.** **[UNDER SEAL]** **Defendants.**	Case No 2:23-CV-3345 **FILED UNDER SEAL** **PURSUANT TO 31 U.S.C. § 3730(B)(2)** **COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. §§ 3729, *ET SEQ.*** **JURY TRIAL DEMANDED** JUDGE MARBLEY MAGISTRATE JUDGE VASCURA

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO (Eastern Division)

UNITED STATES OF AMERICA, **Plaintiff, *ex rel.*** **JASON MEDVED &** **ANTHONY DONNADIO** **Relators,** **v.** **SOUTHERNCARE, INC. D/B/A SOUTHERNCARE** **&** **GENTIVA HEALTH SERVICES** **&** **KINDRED HEALTHCARE, INC.** **&** **HUMANA, INC.** **Defendants.**	Case No. _____ **FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(B)(2)** **COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. §§ 3729, *ET SEQ.*** **JURY TRIAL DEMANDED**

INTRODUCTION

1. *Qui tam* relators Jason Medved ("Medved" or "Relator") and Anthony Donnadio ("Donnadio" or "Relator"), by their attorneys, individually, and on behalf of the United States of America file this Complaint against Defendants SouthernCare, Inc. d/b/a SouthernCare Hospice

Services ("SCHS"), Gentiva Health Services ("Gentiva"), Kindred HealthCare, Inc. ("Kindred"), and Humana, Inc. ("Humana"), to recover damages, penalties, and attorneys' fees for violations of the federal False Claims Act, 31 U.S.C. §§ 3729 *et seq.* ("FCA" or "False Claims Act"). SCHS, Gentiva, Kindred, and Humana, Inc. are collectively referred to as "Gentiva/SCHS" or "SCHS" (except as otherwise specifically noted) or Defendants.

2. Defendants violate the False Claims Act by admitting plainly ineligible patients for hospice care and subsequently billing federally funded insurance for that care. Defendants SCHS also require excessive patient visits to increase its total reimbursement from CMS. With this conduct, the Defendants knowingly caused false claims for payments to be submitted to the government.

JURISDICTION AND VENUE

3. This Court has subject matter jurisdiction over this action under 28 U.S.C. § 1331, and 31 U.S.C. § 3732(a)-(b). This is an action arising under the laws of the United States, specifically the FCA.

4. The Court has personal jurisdiction over the claims brought because SCHS and Gentiva do business in the Southern District of Ohio and have hospice facilities in the Southern District of Ohio.

5. Venue is proper in this Court pursuant to 31 U.S.C. § 3732(a), 28 U.S.C. §§ 1391 and 1395(a) because the nature of the misconduct arose from claims submitted from SCHS's and Gentiva's hospice facilities located in the Southern District of Ohio.

6. Venue in this judicial district and division is proper pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the events or omissions giving rise to the claims herein occurred in this judicial district and this division.

7. This action is not based on a "public disclosure." This action is based on information that is within the direct and independent knowledge of the Relators. Relators have provided said information to the Government prior to filing this action.

8. Relators are the "original source" within the meaning of 31 U.S.C. § 3730(e)(4)(B) and have direct and independent knowledge of the allegations set forth in this Complaint.

9. Pursuant to 31 U.S.C. § 3730(b)(2), prior to filing this action, Relators have provided the Government with a copy of this Complaint and a written disclosure of substantially all material, evidence, and information in their possession.

THE PARTIES

I. Relator Jason Medved

10. Jason Medved ("Relator" or "Medved") resides and works in Ohio.

11. Medved has worked as a Registered Nurse in the healthcare field beginning in 2014, following his graduation from Mercy College of Nursing in Ohio.

12. Medved began working for SouthernCare Hospice in January 2017 as an RN (Registered Nurse) case manager, providing home hospice care services to patients.

13. Medved's duties include managing patient care, communicating with family members, ordering supplies, filling patient medications, and participating in biweekly interdisciplinary meetings to discuss patient progress.

14. Medved manages between 12 to 18 SCHS hospice patients at a time. Medved reports to Casey Cline, a Gentiva/SCHS director of operations, and Anthony Zorella, a Gentiva/SCHS patient care manager.

15. Around 2018, Medved raised his initial concerns that patients were being improperly admitted to hospice care to Erica Stacey, who in 2018 was the Director of Operations for SouthernCare Hospice. Stacey instructed Medved to find something wrong with the patients to justify keeping the patient in hospice care. Stacey was promoted later that year to become Regional Director of Clinical Operations for Ohio for Gentiva/Kindred at Home Hospice. In 2023, Stacy became Gentiva Hospice Regional Vice President of Clinical Operations – Southwest.

II. Relator Anthony Donnadio

16. Anthony Donnadio ("Relator" or "Donnadio") resides and works for Defendant in Ohio.

17. Donnadio has worked in the healthcare field as a Registered Nurse since 2015, when he graduated from Mercy College of Nursing in Ohio.

18. Donnadio began working for SouthernCare Hospice in 2016 as an RN case manager in Ohio.

19. Donnadio's duties include coordinating patient care, assessing medical conditions, collaborating with hospice physicians to provide comfort for patients in hospice care, and supervising other healthcare professionals.

20. Donnadio manages up to 20 patients at a time.

21. Donnadio reports to Casey Cline, Gentiva/SCHS director of operations, and Anthony Zorella, Gentiva/SCHS patient care manager.

22. Donnadio participated in patient assessments to determine whether patients were eligible for admission to hospice care under the criteria set by insurers, particularly those patients whose care is paid for by Medicare, Tricare, Medicaid, or other federal insurers. But SCHS created an admittance nurse position in 2021 and delegated the majority of new patient assessments to the person in this position. Brianna Mathews was the admittance nurse for Donnadio's patients. Occasionally, Donnadio conducts patient assessments to determine if a patient qualifies for hospice care, but a majority are completed by Matthews.

23. Each of Defendants' hospice branches with a patient census of approximately 100 patients has an admittance nurse position.

24. Mathews quit her position as admittance nurse effective September 1, 2023.

Relators believe Mathews quit her position as admittance nurse due to the pressure she experienced from management to admit each patient she assessed, even though not all qualified for hospice admission under applicable law.[1]

III. Defendant SouthernCare, Inc. d/b/a SouthernCare Hospice Services

25. SouthernCare, Inc. is a for-profit corporation doing business in Ohio and other states. SouthernCare, Inc. was formerly owned by Curo Health Services ("Curo"), a hospice provider, beginning in 2014. Humana Inc. and private equity firms TPG Capital and Welsh, Carson, Anderson & Stowe acquired Curo and its wholly-owned subsidiary SouthernCare in July 2018 for $1.4 billion.

26. SouthernCare, Inc. currently operates under the Gentiva name and by the trade name SouthernCare Hospice Services ("SCHS") under the ownership of Defendant Gentiva.

[1] *See* paragraphs 99 to 101 for text messages between Mathews and Relators where Mathews described feeling pressured to admit patients despite their eligibility.

27. Defendants, doing business as SCHS, provide hospice services through six Ohio locations, including a Wintersville, Ohio (Jefferson County) location in this District and this division.

28. A typical large Gentiva/SCHS facility, like that where Relators work, employs ten RNs, two LPNs, ten medical aides, two chaplains, two social workers, and business staff. It maintains a patient census of approximately 130-150 patients at a time. Other Ohio locations have patient censuses that vary between about 60 to about 150.

29. Defendants are all responsible for the violations of law alleged by SCHS, Gentiva, and their parent companies under "piercing the corporate veil" principles. Under Ohio law, the elements for piercing exist here:

> (1) control over the corporation by those to be held liable was so complete that the corporation has no separate mind, will, or existence of its own,
>
> (2) control over the corporation by those to be held liable was exercised in such a manner as to commit fraud or an illegal act against the person seeking to disregard the corporate entity, and
>
> (3) injury or unjust loss resulting from such control and wrong, focusing on the extent of the parent company's control of the subsidiary and whether the parent company misused the control so as to commit specific egregious acts that caused injury.

Defendants' ownership and control over their subsidiaries shows no independent decision-making, implementation of a wide ranging plan to exploit the Medicare hospice program for their own benefit and to the detriment of patients, and use of subsidiary corporations to commit wrongdoing and fraud in violation of the False Claims Act, yet avoid legal responsibility.

IV. Defendant Gentiva Certified Healthcare Corp. also known as Gentiva Health Services, CenterWell Certified Healthcare Corp., and Centerwell Home Health

30. Gentiva Certified Healthcare Corp. is a national health provider specializing in home care, palliative care, and hospice care, now doing business as Gentiva Health Services.

31. Gentiva began business in 1992 or earlier and operates in 36 states, with over 430 locations nationwide. Gentiva now has, in addition to its Ohio SCHS facilities, eight additional hospice facilities in Ohio, including four located in this District, and two located in this Division, including those in Mount Vernon, Ohio and Columbus, Ohio.

32. Gentiva Health Services has operated variously as part of Gentiva Certified Healthcare Corp., CenterWell Certified Healthcare Corp., Centerwell Home Health, Curo Health Services, Kindred Healthcare, Inc., and Humana, Inc.'s Kindred at Home Hospice division. Defendant Kindred acquired Gentiva in 2015.

33. Gentiva Health Services as it now exists was created with Humana Inc. hospice and home care assets, combining various of Humana's home health and hospice care assets. In 2022 Gentiva was the largest hospice provider in the United States, with over 25,000 caregivers and nearly 30,000 employees providing hospice, palliative, and personal care services to more than 20,000 patients. In 2022 it operated over 360 hospice sites, several palliative care sites, and 50 personal care sites across the country and has since acquired more hospice locations, including a substantial number in Ohio.

34. Effective in August 2022, a private investment firm, Clayton, Dubilier & Rice, acquired majority ownership interest in Gentiva, with Humana Inc. owning 40%.

V. Defendant Kindred Healthcare, Inc. (formerly Vencor, Inc. and related companies)

35. Kindred Healthcare, Inc. is a national health provider specializing in long-term acute care hospitals, inpatient rehabilitation hospitals, and behavioral healthcare. Kindred was created in 2001, as a result of the bankruptcy of Vencor, Inc. and related companies, which

operated long term care and other health care facilities and was the target of multiple False Claims Act suits and other federal prosecutions.

36. In October 2014, Kindred Healthcare, Inc. and Gentiva Health Services, a provider of home health care, hospice and related services in the United States, announced a merger agreement under which Kindred would acquire all outstanding shares of Gentiva common stock for $19.50 per share in a combination of cash and stock. The deal was officially signed into agreement effective January 31, 2015, with Gentiva becoming a wholly owned subsidiary of Kindred.

37. By August 2015, Gentiva Certified Healthcare Corp. was operating under the assumed name of Kindred at Home. Kindred continued to own Gentiva until July 2018.

VI. Humana, Inc.

38. In July 2018, Humana, Inc. and private equity firms TPG Capital and Welsh, Carson, Anderson & Stowe acquired Kindred Healthcare, Inc.'s Kindred at Home's operations, with Humana owning 40% interest and having the option to acquire the entire Kindred at Home operation in the future. Shortly thereafter the same group acquired Curo Health Services, Inc., a hospice company, owned by a Boston private equity firm, with over 200 locations nationwide.

39. Humana's hospice holdings were enlarged by its 2018 acquisition of Kindred Healthcare, Inc. (including Gentiva and SCHS) and Curo Health Services. Humana and private equity firms TPG Capital and Welsh, Carson, Anderson & Stowe combined Curo Health Services, Inc. with Kindred at Home in 2018, resulting in Kindred at Home becoming the largest hospice provider in the United States. Defendant Gentiva was also previously part of Kindred at Home Hospice Division, as the former Kindred Healthcare hospice operations under Humana, Inc. ownership were known.

40. Humana, Inc. and the co-owners of Kindred at Home hospice services offered their services to patients under the name of Kindred at Home, Hospice Division and as Gentiva Health Services, as well as using legacy names of other hospice entities that they acquired, including SouthernCare Hospice Services (SCHS).

41. In August 2021, Humana exercised its option to acquire full ownership of Kindred at Home. A year later, Humana Inc. completed its $2.8 billion sale of a portion of Kindred at Home's hospice and personal care segments, including the Gentiva operations, divesting a 60% stake to the private equity firm Clayton, Dubilier & Rice. Humana retained a 40% ownership share of the Kindred at Home/Gentiva business. The resulting business, no longer a division of Humana, Inc., was to be known as Gentiva Health Services and included SCHS.

OVERVIEW OF APPLICABLE LAWS AND REGULATIONS

I. The False Claims Act 31 U.S.C. §§ 3729 *et seq.*

42. During all times relevant to the facts of this case, the federal False Claims Act provided in pertinent part that:

> [A]ny person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval, is liable to the United States Government for a civil penalty of not less than $5,500.00 and not more than $10,000.00, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note; Public Law 104-410)[2], plus three times the amount of damages which the Government sustains because of the act of that person.
>
> *See* 31 U.S.C. § 3729(a)(1)(A).

[2] Civil penalties increased to a minimum of $11,665 and a maximum of $23,331 per false claim for claims assessed after June 19, 2020. Adjustments to penalties for violations occurring after November 2, 2015, 85 Fed. Reg. 37005, 37006 (June 19, 2020).

Additionally,

> [A]ny person who knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;, is liable to the United States Government for a civil penalty of not less than $5,500.00 and not more than $10,000.00, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note; Public Law 104-410)[3],plus three times the amount of damages which the Government sustains because of the act of that person.
>
> *See* 31 U.S.C. § 3729(a)(1)(B).
>
> * * * *
>
> (b) . . . For purposes of this section (1) the terms "knowing" and "knowingly" (A) mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud; (2) the term "claim" (A) means any request or demand, whether under contract or otherwise, for money or property and whether or not the United States has title to the money or property, that (i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; . . . (3) the term "obligation" means an established duty, whether or not fixed, arising from an expressed or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and (4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

See 31 U.S.C. § 3729 (2009).

II. Medicaid

50. In 1965, Congress enacted Title XIX of the Social Security Act under 42 U.S.C. §§ 1396, *et seq.* ("The Medicaid Program" or "Medicaid"). Under the program, the Federal

[3] *Id.*

Government provides matching funds to states to enable states to provide medical assistance to residents who meet certain eligibility requirements. The objective is to help states provide medical assistance to residents whose incomes and resources are insufficient to meet the costs of necessary medical services.

51. Medicaid serves as the nation's primary source of health insurance coverage for low-income populations, providing coverage to over sixty-five million people. All states, the District of Columbia, and the United State territories have Medicaid programs.

52. The United States, through the Center for Medicare and Medicaid Services ("CMS") monitors the state-run Medicaid programs.

53. Federal law prohibits providers from making "any false statement or representation of a material fact in any application for any… payment under a federal healthcare program." *See* 42 U.S.C. § 1320a-7b(a)(1).

54. Federal regulations require each state to designate a single state agency to administer and be responsible for the state's Medicaid program.

55. Ohio's Department of Medicaid administers its Medicaid program. Other states have similar offices.

56. To be paid under Ohio Medicaid and in other states, all services must meet Medicaid's requirements.

57. Enrolled providers of medical services to Medicaid recipients, including Defendants, are eligible for and have collected reimbursement for covered services submitted for payment under the provisions of Title XIX of the 1965 Amendments to the Federal Social Security Act.

58. As a condition of participating in the Medicaid program, enrolled providers agree

to abide by the rules, regulations, policies, and procedures governing reimbursement.

III. Medicare

59. In 1965, Congress enacted Title XVIII of the Social Security Act under 42 U.S.C. §§ 1395, *et seq.* ("The Medicare Program" or "Medicare"), authorizing the Federal Government to pay for the cost of certain medical services for persons aged 65 and older through a federally subsidized health insurance program.

60. The United States, through the Department of Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS"), administers and manages the Medicare Program. There are three parts to the Medicare Program. Medicare Program Part A is the relevant part to this case, and it covers inpatient hospitals' care, skilled nursing facilities, hospice, lab tests, surgery, and home health care.

61. To be eligible to receive Medicare hospice care benefits, there must be an individualized written plan of care established for the patient. 42 C.F.R. § 418.56(b)-(c).

62. Another requirement towards receiving Medicare funding of hospice services is maintaining accurate clinical records with the patient's treatment history and necessity of hospice care. 42 C.F.R. § 418.104.

a. Eligibility Requirements for Hospice Care

63. Section 42 C.F.R. § 418.20 states the criteria for patients to be eligible for hospice care under Medicare. To be eligible for hospice care, a patient must be entitled to Part A of Medicare and certified as being terminally ill in accordance with 42 C.F.R. § 418.22.

64. To be entitled to Part A of Medicare, a person must be 65 or older and meet the citizenship and residency requirements, get disability benefits from Social Security or the

Railroad Retirement Board for at least 25 months, get disability because the person has Lou Gehrig's disease (ALS), or have end-stage renal disease and meet certain criteria.

65. To comply with 42 C.F.R. § 418.22, hospice centers must obtain written certification from a licensed physician that the patient is terminally ill for the periods the patient selects to receive hospice care.

66. Patients can elect to receive hospice care during one or more of the following periods: an initial 90-day period, a subsequent 90-day period, or an unlimited number of subsequent 60-day periods. 42 C.F.R. § 418.21(a)(1)-(3).

67. The periods are available in the order listed and can be selected separately and at different times. 42 C.F.R. § 418.21(b).

68. Certification of a patient's terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. 42 C.F.R. § 418.22(b).

69. The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. 42 C.F.R. § 418.22(b)(1).

70. Clinical information and other documentation that support the medical prognosis must accompany the hospice services eligibility certification and must be filed in the patient's medical record with the written certification as set forth in 42 C.F.R. § 418.22(d)(2). Initially, the clinical information may be provided verbally; but it must be documented in the medical record and included as part of the hospice's eligibility assessment. 42 C.F.R. § 418.22(d)(2).

71. The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms. 42 C.F.R. § 418.22(b)(3).

72. If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature. 42 C.F.R. § 418.22(b)(3)(i).

73. If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum. 42 C.F.R. § 418.22(b)(3)(ii).

74. The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his/her examination of the patient. 42 C.F.R. § 418.22(b)(3)(iii).

75. The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. 42 C.F.R. § 418.22(b)(3)(iv).

76. The narrative associated with the 3rd benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less. 42 C.F.R. § 418.22(b)(3)(v).

77. The physician or nurse practitioner who performs the face-to-face encounter with the patient described in 42 C.F.R.§ 418.22(a)(4) must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner or a non-certifying hospice physician shall state that the clinical findings of that visit

were provided to the certifying physician for use in determining continued eligibility for hospice care. 42 C.F.R.§ 418.22 (b)(4).

78. All certifications and recertifications must be signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies. 42 C.F.R.§ 418.22(b)(5).

79. During a Public Health Emergency, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter may occur via a telecommunications technology and is considered an administrative expense. 42 C.F.R.§ 418.22(a)(4)(ii).

b. Admission to Hospice Care

80. The hospice center can only admit a patient on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician if the patient has an attending physician. 42 C.F.R. § 418.25(a).

81. When the physician decides to certify that the patient is terminally ill, the hospice medical director must at least consider the diagnosis of the terminal condition of the patient, whether the patient has other health conditions (regardless of whether the other conditions are related to the terminal condition), and current clinically relevant information supporting all diagnoses. 42 C.F.R. § 418.25(a)(b)(1)-(3).

c. Requirements for Coverage

82. For hospice services to be covered, they must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions. 42 C.F.R. § 418.200. Certification that the individual is terminally ill must be completed as set forth in section 42 C.F.R. § 418.22.

83. The individual must elect hospice care in accordance with 42 C.F.R. § 418.24. Election of hospice care can be harmful to patients because they lose access to curative care. The Medicare hospice program limits patients to palliative care. 42 C.F.R. § 418.14(b)(2). For end-stage rental patients, for example, cessation of kidney dialysis will likely lead to death within a few weeks as dialysis is considered curative. Likewise, hospice care for cancer patients means that drugs that prolong life or cure cancer, will no longer be paid for by Medicare. For patients who are not truly terminally ill and are not likely to die within 6 months, the lack of curative medicines and care while in hospice can cause needless pain, suffering, psychological injury, and mental and physical distress. Thus, improper hospice admission has a real impact upon patient quality of life and future prognosis. A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in 42 C.F.R. § 418.56. The services provided must be consistent with the plan of care. 42 C.F.R. § 418.56(e).

d. Hospice Admission Requirements using the FAST Scale for Dementia Disease Progression

84. The Functional Assessment Staging Tool ("FAST") is a scale commonly used by health care providers to determine the disease progression of a dementia patient[4] and is mandated in many jurisdictions.

85. The FAST scale has 7 stages of disease severity. A patient in stage 1 is aging normally and no symptoms are present.[5]

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[4] Beth Rush, *The Dementia Fast Scale (Functional Assessment Staging Tool)*, DEMENTIA MAP (Mar. 3, 2023), https://www.dementiamap.com/fast-scale-functional-assessment-staging-tool/.
[5] *Id.*

86. A patient in stage 7 has severe dementia and cannot function properly. The patient has loss of speech, locomotion, and consciousness. There are six substages within stage 7 (a through f), each substage represents an increase in severity of the patient's dementia.[6]

87. To be eligible for hospice care, a patient needs to score a 7a or higher on the FAST scale and have a comorbid disease.[7] A comorbid disease is any coexisting health condition.[8]

FACTUAL ALLEGATIONS

I. *While Patients Were Admitted Inappropriately for Many Years, Improper Admissions Increased Substantially under the Direction of Humana, Inc. and Gentiva Health Services*

88. About 5 years ago, Medved initially raised concerns that his patients were inappropriately admitted to hospice care to Erica Stacey, the SCHS director of operations. In response, Stacey told Medved that he needed to find something wrong with all patients he assessed so the patient could remain in hospice care. Stacey was later promoted to a corporate position.

89. Before Gentiva's 2021 reconfiguration as Humana's umbrella operation over all its hospice entities, most, but not all, SCHS patients were admitted to hospice care in accord with Medicare and other legal requirements. Relators' experience is that knowingly inappropriate patient admissions were happening prior to 2018, but both observed a significant increase in

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[6] *Id.*

[7] *Hospice Alzheimer's Disease & Related Disorders*, Centers for Medicare & Medicaid Services, (lasted visited September 25, 2023), https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34567.

[8] Daniel Yetman, *Comorbidity: Causes and health Implications*, HEALTHLINE, (Apr. 4, 2022), https://www.healthline.com/health/comorbidity#takeaway.

inappropriate patient admissions with changes in ownership, but especially after the Humana, Inc. 2021 reorganization under the Gentiva name.

90. If Medved or Donnadio determined a patient did not meet criteria to qualify for federally funded hospice care, they would not admit the patient. Gentiva's practice was to override their nursing judgment and send a second nurse to ensure the patient was admitted despite Relators' assessment of the patient.

91. Prior to the transition to Gentiva, RN staff at SCHS, including Relators, conducted their own patient assessments to determine if patients were appropriate for hospice care.

92. Relators attend an interdisciplinary group meeting that occurs on a biweekly basis. During these meetings, all branch staff and directors review each patient to ensure the patient is receiving necessary services.

93. In early 2021, shortly after Gentiva took control of their hospice services, the tone of these meetings changed, and Relators frequently identified several patients not appropriately enrolled because the patients did not have severe or qualifying health conditions.

94. For example, one patient discussed during this group meeting and ultimately admitted to hospice care was obese, but the patient did not have any severe health conditions such as heart irregularities, difficulty breathing while resting, or any terminal conditions. Medved raised his concerns that this patient was inappropriately admitted to hospice care, but the issues he raised were brushed off and not seriously considered.

95. In January 2023, Medved had an in-person conversation with his supervisor Zorella, and expressed his concern that patients were being inappropriately admitted to hospice care. In response, Zorella told Medved that he has weekly corporate calls where Laura Wright,

Gentiva's Senior Area Vice President and other corporate employees instructed him to admit all patients regardless of eligibility.

96. Gentiva/SCHS created an admittance nurse position in 2021 and delegated many new patient assessments to be performed by the admittance nurse. Brianna Mathews was the sole admittance nurse for the branch where Relators worked. The other RNs, including the Relators, rarely assess patient eligibility. The other RNs and Relators assess patient eligibility only if the admittance nurse is not in the office.

97. A physician or nurse practitioner can complete a face-to-face encounter with the patient. At SCHS/Gentiva, Mathews, a registered nurse, conducted these assessments, although she did not hold the requisite nurse practitioner degree and licensure. *See* 42 C.F.R. §§ 418.22(a)(4), (b)(4).

98. At Relators' facility the admissions nurse enrolled nearly 100% of patients she assessed. Relators understood that the admissions nurse was instructed to admit unqualified patients by her supervisor, former Gentiva/SCHS Branch Manager Andrew Hospodor.

99. On May 8, 2023, Mathews texted Medved that "[SCHS's] mindset about numbers and what not makes me ill… they have been crazy about everything . . . Just constantly pushing the numbers . . . admitted ASAP no matter what . . . ."

100. On May 8, 2023, Mathew texted Donnadio that "[SCHS] just care about getting [people] on no matter what . . . doesn't matter what's going on with them . . . doesn't matter about our other [patients] just get that number up for the day."

101. Later on May 8, 2023, Mathews texted Donnadio that "[SCHS] want everyone admitted no matter what, the doctors are wrong the diagnoses are wrong, everything is a mess."

102. During the interdisciplinary group meeting on August 3, 2023, Relators told SCHS/Gentiva management that Patient 1 is not appropriate for hospice care. Their supervisor, Zorella, replied that he and other local management, Casey Cline, have no say when it comes to which patient is admitted or discharged and that Vice President Laura Wright tells them they are to admit everyone who seeks hospice admission and they will reevaluate the patients' eligibility after the first recertification period. Patients are rarely found ineligible during the first recertification period or discharged from hospice care.

103. Relators' branch is the parent branch for Gentiva/SCHS operations in Ohio. The Relators believe the pressure to admit patients regardless of eligibility is Defendants' unified corporate practice, policy and procedure, as indicated by Vice President Wright's directives to admit all hospice applicants and, thus, similar inappropriate admissions are occurring at all Gentiva locations.

II. *Gentiva/SCHS admits patients who are plainly ineligible for hospice care and subsequently bills CMS for that care.*

104. A patient is qualified for hospice care if his or her attending physician (if he or she has one) and the hospice physician certifies them as terminally ill, with a medical prognosis of 6 months or less to live if the disease runs its normal course.

105. The primary admitting physician at Relators' location is Dr. Bruce Willner. Dr. Willner is the medical director of the hospices located in Ohio, but he primarily works at Relators' branch.

106. Dr. Willner does not assess patients in person or consult with the patient's primary care physician (if applicable), but nonetheless he certifies false terminal illness

diagnoses for patients so they qualify for hospice care without fulfilling the basic requirements for a face-to-face patient encounter and consultation with the patient's own physician.

107. Many Gentiva patients are enrolled into hospice care despite the fact their primary care physicians never referred them or never ordered hospice care.

108. Gentiva/SCHS's in-house physician and medical director, Dr. Willner, is listed as the referring Primary Care Provider (PCP) on Defendants' hospice enrollment forms.

109. Patients enrolled in Gentiva/SCHS hospice become upset because their medical conditions are listed as terminal during the admission process, yet their primary care physicians had informed them they were not terminally ill.

110. Relators have witnessed numerous examples of patients who were inappropriately admitted to hospice care by Gentiva/SCHS.

111. Patient 1 was assessed on February 11, 2023. Gentiva/SCHS diagnosed her with Chronic Obstructive Pulmonary Disease ("COPD") and designated her as terminally ill. COPD is not a terminal disease, and it alone does not qualify a patient for hospice care. Patient 1 asked Medved what was her terminal illness because neither she, nor her primary care physician, were aware she was diagnosed with a terminal illness. She later revoked hospice case to seek aggressive treatment for her condition. The Gentiva/SCHS on-call nurse sent an email stating this patient does not need hospice.[9]

112. Patient 2 was inappropriately diagnosed with Alzheimer's disease and admitted to hospice care on December 11, 2020. Patient 2's case manager described her as alert and pleasantly confused. Donnadio has personally provided care for this patient. Patient 2 only

[9] Patient 1 was initially discussed *supra* at paragraph 102.

speaks Spanish and his location does not have any Spanish-speaking staff. This patient ambulates independently and primarily cares for herself. Patient 2's health has not worsened and she was inappropriately diagnosed with Alzheimer's disease. Patient 2 should not have been admitted to hospice care and she should be discharged since her condition has not declined. After more than two years, Patient 2 is still in hospice care.

113. On July 7, 2021, Patient 3 was originally admitted into Gentiva/SCHS's hospice care with a diagnosis of end stage cirrhosis of the liver. Patient 3 does not have cirrhosis of the liver and revoked hospice care in January 2022. Patient 3 was readmitted on January 29, 2022 and revoked again from hospice care on July 14, 2022. Patient 3 was readmitted on or around July 30, 2022 and is presently in hospice care. Patient 3 remained improperly on hospice services for at least two years. In August 2023, Relator Medved met with Zorella and Dr. Willner. They discussed a couple of patients, including Patient 3. Dr. Willner asked Zorella why Patient 3 was still on service for hospice care. Zorella shrugged his shoulders and grinned. Zorella then stated, "It's not up to me or Stacey, it's up to Laura Wright."

114. On August 24, 2022, Patient 4 was admitted to hospice due to a diagnosis of end stage COPD. Patient 4 does not have COPD and does not show the symptoms of having such diagnosis. For example, a patient with end stage COPD would have disabling dyspnea and would need to use oxygen. According to Dr. Mumtaz Hussain, Patient 4 does not need to use oxygen if she does not want to use it. If Patient 4 did have end stage COPD, oxygen would not be optional for her, she would need it to live. Patient 4 is still in hospice care.

115. Patient 5 was admitted into hospice care on February 15, 2023, for chronic kidney disease. During an interdisciplinary group meeting, Donnadio told Dr. Willner Patient 5 does not have any symptoms of chronic kidney disease. Dr. Willner spoke to Patient 5's daughter and

asked her if Patient 5 ever experienced confusion. Patient 5's daughter said Patient 5 occasionally experiences confusion. Dr. Willner then changed Patient 5's diagnosis from chronic kidney disease to Alzheimer's disease so she would be admitted for hospice care. Patient 5 only experiences mild confusion and does not meet the minimum requirements for an Alzheimer's diagnosis. Patient 5 is still in hospice care.

116. On or around April 20, 2023, Patient 6 was admitted for terminal liver failure and treated with opioids. Donnadio told Dr. Willner that Patient 6 did not show any symptoms for a terminal illness. For example, the patient's vitals were normal. Dr. Willner reviewed Patient 6's medical record and found that Patient 6 did not have any significant medical history or terminal illness, but has a history of drug seeking behavior. The following day, Patient 6 was discussed at an interdisciplinary group meeting where it was determined Patient 6 would be discharged since he was inappropriate for hospice care. Patient 6 remained in hospice care. Patient 6 was discharged on May 5, 2023. Zorella sent an email stating Patient 6 was discharged for "plateau of condition." According to Donnadio, when patients are discharged because of plateau of condition, Gentiva/SCHS does not have to repay Medicare/Medicaid. When patients are discharged because of an improper admission (i.e., the patient did not qualify for admission), Gentiva/SCHS must reimburse Medicare/Medicaid.

117. Patient 7 was admitted to hospice care on May 8, 2023. Patient 7 asked Medved why she was in hospice care. Patient 7 spoke to her Primary Care Provider, Dr. Arthur Duran, and he advised she did not need hospice care. Patient 7 revoked from hospice care on May 12, 2023, four days after being admitted.

118. Patient 8 was also incorrectly diagnosed with chronic kidney disease and admitted to hospice care on May 16, 2023. During an interdisciplinary group meeting, Dr. Willner

reviewed Patient 8's previous hospital stay and said that he needed to change the diagnosis since the patient did not have chronic kidney disease. Dr. Willner changed the patient diagnosis to Alzheimer's disease. Patient 8 scored below a 7 on the FAST scale and did not qualify for hospice care. Patient 8 revoked from hospice care on July 2, 2023.

119. Patient 9 was originally admitted due to heart disease on June 9, 2023. According to Relators, Patient 9 does not have signs of heart disease. For instance, Patient 9 does not use oxygen, there is no trace edema, no complaints of dyspnea (shortness of breath). If Patient 9 had heart disease, he would have disabling dyspnea and would be expected to have weight gain from edema. Patient 9 has lost weight. SCHS changed his diagnosis in June 2023 to Alzheimer's disease. Patient 9's care manager describes Patient 9 as alert and oriented with confusion at times. Patient 9 is still in hospice care.

120. When Patient 10 was initially admitted to hospice care on July 28, 2023, he was designated as terminally ill due to kidney disease. A nurse, Vanessa Colburn, spoke to Patient 10 and his wife, who informed her that he did not have kidney disease. Colburn informed Medved that the patient did not have kidney disease. Medved advised Dr. Willner that Patient 10 did not have kidney disease. Dr. Willner reviewed Patient 10's medical history and confirmed that Patient 10 did not have kidney disease. Three days later, during an interdisciplinary group meeting, Medved brought this patient up and reminded Dr. Willner that Patient 10 did not have kidney disease. Dr. Willner denied that he said Patient 10 did not have kidney disease. Dr. Willner denied this even though Medved was on the phone with Dr. Willner when Dr. Willner reviewed Patient 10's medical record. Zorella said the kidney disease billing code was used to admit Patient 10 because it warrants charging Medicare more with that diagnosis. Then Dr. Willner said, "[Patient 10] is in his late 70's, most his age have some type of kidney issues." A

diagnosis for any kidney condition was not supported by Patient 10's medical records. Patient 10 is still in hospice care.

III. *Patients with Alzheimer's Disease who were inappropriately admitted to hospice care.*

121. For patients with Alzheimer's Disease, the patient needs to score 7 or higher on the FAST scale and have a comorbid disease to qualify for hospice care. According to Relators, a patient who scores a 7 or higher on the FAST scale is non-verbal and experiences severe confusion.

122. Relators witnessed first-hand numerous examples of patients with Alzheimer's disease who were admitted to hospice care inappropriately because their disease had not progressed sufficiently to qualify them for federally-funded hospice care.

123. Patient 11 was admitted to hospice care on December 5, 2020. Patient 11 scored a 6e on the FAST scale. SCHS inappropriately admitted her to hospice care. Patient 11 is deaf, but she was admitted to hospice care due to Alzheimer's disease. Patient 11 is able to communicate using a dry erase board and by lip reading. Since Patient 11 is still able to communicate, her Alzheimer's disease is not severe enough for her to qualify for hospice care. Patient 11 is still in hospice care.

124. Patient 12 was admitted to hospice care on January 7, 2021. Patient 12 scored a 6d on the FAST scale. SCHS inappropriately admitted her to hospice care. Patient 12 was alert, well oriented, and had intermediary confusion. Patient 12's Alzheimer's disease was not severe enough to qualify for hospice care. Patient 12 is still in hospice care.

125. Patient 13 was admitted to hospice care on April 12, 2021. Patient 13 scored a 6d[10] on the FAST scale and was admitted to hospice care. Patient 13 needed a score of 7 to qualify. Patient 13 was at Gentiva/SCSS for two years. Patient 13 was re-evaluated and scored a 6e, which means she still did not qualify for hospice care. Patient 13 passed away on May 5, 2023.

126. Patient 14 scored a 6e[11] on the FAST scale. While Relator Medved was on vacation, Dr. Willner and then Patient Case Manager Casey Cline changed Patient 14's FAST score to a 7c.[12] SCHS admitted Patient 14 to hospice care on July 27, 2021. Relator asked Dr. Willner and Cline about the change, but they ignored him. Patient 14 is still in hospice care.

127. Patient 15 was admitted to hospice care on April 23, 2022. Patient 15 scored a 6d on the FAST scale. SCHS inappropriately admitted her to hospice care. Patient 16 is still on hospice care.

128. Patient 16 was admitted to hospice care on May 16, 2022. Patient 16 scored a 6d on the FAST scale. SCHS inappropriately admitted him to hospice care. According to Relators' observations, Patient 16 had very mild confusion during admission. So, Patient 16's disease was not severe enough to qualify for hospice care. Patient 16 passed away on July 15, 2023.

129. Patient 17 was admitted to hospice care June 6, 2022. Patient 17 scored a 6e on the FAST scale. SCHS inappropriately admitted him to hospice care. Patient 17 passed away on May 14, 2023.

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[10] Scoring a 6d indicates that the patient has urinary incontinence.
[11] 6e indicates the patient experiences fecal incontinence.
[12] 7c would indicate that the patient is not able to walk.

130. On January 17, 2023, Patient 18 scored a 6d on the FAST score and Gentiva/SCHS admitted her to hospice care. Patient 18 needed to have scored a 7 on the FAST scale to qualify. Patient 18 is still in hospice care.

131. On January 27, 2023, Patient 19 was admitted into hospice care with a FAST score of 7d. If this assessment were correct, Patient 19 would be bedbound and she would not able to do anything for herself. According to Relators, Patient 19 is not bedbound and she is able to do things for herself. A second nurse, Angela Taylor, checked Patient 19's chart and questioned why Patient 19 was admitted to hospice care. Dr. Willner even questioned why Patient 19 is still in hospice care. Nonetheless, Patient 19 is still in hospice care.

132. Patient 20 was admitted to hospice care on February 7, 2023. Patient 20 scored a 6d on the FAST scale. SCHS inappropriately admitted her to hospice care. Patient 20 is still in hospice care.

133. On April 29, 2023, Patient 21 was admitted into hospice care. Patient 21 scored a 6e on the FAST scale. SCHS inappropriately admitted him to hospice care. Patient 21's wife requested that the hospice signs not be visible so the patient would not know he was in hospice care. Patient 21 passed away on July 8, 2023.

134. Patient 22 was admitted to hospice care on May 30, 2023. Patient 22 scored a 6e on the FAST scale. SCHS inappropriately admitted him to hospice care. Patient 22 passed away on August 23, 2023.

135. Patient 23 was admitted to hospice care on June 3, 2023. Patient 23 scored a 6e on the FAST scale. SCHS inappropriately admitted her to hospice care. Patient 23 is still in hospice care.

136. Patient 24 was admitted to hospice care on June 6, 2023. Patient 24 scored a 6e on the FAST scale. SCHS inappropriately admitted him to hospice care. According to Relators, Patient 24 does not show signs of Alzheimer's disease: she is very alert and oriented, able to have normal conversations, and remembers how she used to play the cello. Relators believe Patient 24 was incorrectly diagnosed with Alzheimer's disease. Patient 24 is still in hospice care.

137. On June 30, 2023, Patient 25 was admitted for Alzheimer's disease and dementia. Donnadio discussed Patient 25 with a nurse from the skilled nursing facility where the patient resides. She documented that Patient 25 is able to talk normally and that he is not confused. Patient 25 was admitted to hospice care without the patient's knowledge or consent. Patient 25's daughter signed him into hospice care even though the patient does not speak to his daughter. The nurses were instructed to hide the fact that Patient 25 is in hospice care from Patient 25. Patient 25 found hospice care business cards in his room and was upset because he was admitted to hospice care without his knowledge. Jennifer Zamarelli, Admissions Coordinator for SCHS, sent an email stating Patient 25's daughter "called office requesting that NO Hospice paperwork be left in pts room. [Patient 25] found a business card and is "fit to be tied."" Patient 25 was admitted for Alzheimer's disease, but Patient 25's disease is not severe enough to qualify him for hospice care. For a patient with Alzheimer's disease to qualify for hospice care, the criteria is for the patient to only be able to say five words or less. Patient 25 is able to speak coherently in full sentences and was able to identify the business cards and express his anger towards it. Patient 25 is still in hospice care.

138. Patient 26 scored was admitted with a 7a on the FAST scale. The admission note documents that Patient 26 provided her own health history. If Patient 26's Alzheimer's disease was severe enough to be scored as a 7a and qualify her for hospice care, she would not be able to

confirm her health history. Jason Lasher, Patient 26's case manager, documented Patient 26 as having a 6e on the FAST scale. On August 9, 2023, Patient 26 was reviewed during an interdisciplinary meeting. Nurse Preceptor Angela Taylor[13] told Gentiva/SCHS staff members that the FAST score can only be changed if the patient's condition has worsened, which was not the case for Patient 26. Taylor did not discuss Patient 26's eligibility, but Taylor further stated that if Medicare caught this discrepancy, it would be investigated. In response, Gentiva/SCHS's directors said they would tell staff members to document in a way that was consistent with the diagnosis Gentiva/SCHS used for admitting the patient.

IV. *SCHS does not appropriately discharge patients.*

139. Relators have identified patients who should be discharged, but Gentiva/SCHS keeps them in hospice care.

140. Patient 9 should also be discharged from hospice care since his condition has not worsened.[14]

141. Patient 27 was admitted to hospice care on June 12, 2020. Patient 27 has been in Gentiva/SCHS hospice care for three years. Patient 27's condition has not changed since she was admitted three years ago, so she should be discharged. But Dr. Willner continues to certify her as hospice-eligible and keeps her in hospice care. Her family admitted that when Dr. Willner conducts routine face-to-face visits with Patient 27, Dr. Willner pressures the family to give him only bad information about her health so she can remain as a patient. Patient 27 was admitted for chronic respiratory disease. Her oxygen use and vital signs have remained the same since she

[13] Angela Taylor is a nurse preceptor for the Ohio hospice locations and trains nurse managers. She travels to the different Gentiva locations and reviews patients' charts. Taylor has also asked about multiple patients, stating that in her review she found them not qualified for hospice care.
[14] Patient 9 is initially discussed *supra* at paragraph 119.

was admitted to hospice care. According to Relators, when a patient's condition is unchanged (referred to as a "plateau"), the patient should be discharged. Patient 27's condition has remained the same for the last three years and she has not been discharged. Patient 27 is still in hospice care.

142. Patient 28 was inappropriately admitted to Gentiva/SCHS hospice care for arthritis on September 2, 2021. According to Relators, this diagnosis alone does not qualify a patient for hospice care. During Gentiva/SCHS's biweekly group meetings, Donnadio informed the Gentiva/SCHS medical directors and patient care managers (including Dr. Willner and Zorella) that Patient 28 should be discharged. The medical directors told Donnadio that they would look into it, but they have never responded substantively to Donnadio about this issue. The state preceptor, Taylor, reviewed Patient 28's chart and agreed with Donnadio that the patient should be discharged. Patient 28 is still in hospice care.

143. Patient 29 was admitted to hospice care for heart disease on November 7, 2021. Patient 29 was appropriately admitted. At the time of admission, she was unable to care for herself, did not take her medications, and was not eating enough or drinking enough liquids. Her condition has since improved. Even Dr. Willner has stated during multiple meetings that Patient 29 should no longer be in hospice care, but SCHS has not discharged her. In August 2023, Relator Medved met with Zorella and Dr. Willner. They discussed a couple of patients including Patient 29. Dr. Willner asked Zorella why Patient 29 was still in hospice care. Zorella shrugged his shoulders and grinned. Zorella then stated "It's not up to me." Zorella has repeatedly said that he has no say in which patient gets admitted, that he is following Vice President Laura Wright's instructions.

144. Patient 30 was admitted to hospice care in March 2023. On July 19, 2023, Patient 30 called SCHS's office and said she wanted to be discharged from the nursing home to go back to her home, which was against medical advice. Patients are not able to be in hospice care at the same time the patient is being evaluated by different disciplines to determine what the care plan for the patient should be. Cline and Medved exchanged text messages regarding Patient 30. Medved asked Cline, "Hey, should I put in a narrative note in about [Patient 30 and her son] were told to sign out of [nursing home] [against medical advice] by someone here?" Cline said that Patient 30 was able to sign herself out. A social worker from SCHS told Patient 30 she could go home and they could provide her with the supplies she needed to go home. SCHS complied with Patient 30's request to go home so it did not have to remove Patient 30 from hospice care. At that time, Patient 30's Medicaid application was still being processed. Because the patient signed out against medical advice, no long term care facility would admit Patient 30 unless she personally paid a significant amount of money for her care, in advance of admission. Patient 30 passed away on August 14, 2023, still in hospice care.

145. Relators have identified instances where Gentiva/SCHS falsified a discharge date to avoid paying for patients to be hospitalized.

146. Gentiva/SCHS instructs its nurses to advise patients not to pursue aggressive treatment for their medical conditions and not to go to the hospital.

147. In January 2023, Donnadio exchanged text messages with Cline regarding the discharge date for Patient 31. Patient 31 was admitted to hospice care on November 22, 2021. Patient 31 had a clot in her leg that needed to be removed. Patient 31 was in a lot of pain, so Donnadio advised Patient 31 to go to the hospital. On January 26, 2023, Patient 31 went to the hospital and underwent a procedure for her leg.

148. Patient 31 was in the hospital for a couple of days. When Patient 31 discharged from hospice care, Cline instructed Donnadio to put the date Patient 31 was admitted to the hospital as her discharge date. Cline stated, "Ok she is discharged from us as of the 26th when she went to the hospital. Can you please get a revocation paper signed for the date please."

149. If Gentiva/SCHS had correctly dated Patient 31's discharge from hospice care, Gentiva/SCHS would have been responsible for covering her inpatient hospital services. Since Gentiva/SCHS listed Patient 31's discharge date as her hospital admission date, January 26, 2023, it was not responsible for paying for Patient 31's inpatient hospital services.

V. *Gentiva/SCHS requires excessive patient visits to increase its total reimbursement from CMS.*

150. Gentiva/SCHS has mandated that all RN staff conduct a certain number of total visits per week for each patient.

151. The Gentiva/SCHS mandates require RNs to conduct patient visits in excess of what is necessary under their treatment plans.

152. Gentiva/SCHS is reimbursed $5,000 per patient per month, but also receives $200 per patient visit.

153. Gentiva/SCHS requires excessive patient visits to increase its reimbursement from CMS and other federal payors.

154. On January 26, 2023, Former Director of Operation Andrew Hospodor sent an email directing staff to fulfill corporate frequency requirements for nursing visits. The directive required skilled nursing, aides, and chaplains to perform a minimum of 24 visits weekly. Social workers were to complete a minimum of 21 weekly visits. Hospodor stated that the number of visits is a "companywide" focus and is being "monitored on a national level." He goes on to say:

> If you have a patient who is 1 x/wk (with documented orders reflecting patient choice and verified by your PCM) that you will have to increase a different patient on your caseload to reflect that deficit. Meaning, if Jones is only wanting 1 day a week, and Bob is on 2 days per week, you will have to increase Bob to 3 days per week to make up that difference.

155. On February 17, 2023, Zorella sent out an email reminding staff members of the frequency requirements for nursing visits. He further stated, "any patient who is currently on a 1x/week frequency, please reach out to the primary caregiver or patient to discuss increasing visits to 2x/week." He also stated: "If you have a patient who is 1x/week there should be another patient who is 3x/week to compensate."

156. Relators witnessed many numerous instances of patients' charts documenting unnecessary patient visits.

157. Patient 19 has unnecessary nursing visits documented in her chart.[15]

158. Medved exchanged text messages with June Burns, a former Gentiva/SCHS Patient Care Manager who was fired in 2022, regarding the increase in nursing visits to meet the company's policy. He texted Burns on March 15, 2022. Burns stated, "Kara put in bunch orders increasing visits per [Hospodor] . . . [Hospodor] coming down hard on me because power's coming down hard on him."

COUNT I
Violation of the False Claims Act
31 U.S.C. § 3729(a)(1)(A)

159. Relators incorporate all the allegations set forth in the foregoing paragraphs as though fully alleged herein.

[15] Patient 19 was initially discussed *supra* in paragraph 137.

160. The False Claims Act imposes liability on any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval. See 31 U.S.C. § 3729(a)(1)(A).

161. Defendants knowingly presented or caused to be presented to the government false claims when it bills federal and state Medicare and Medicaid programs for hospice care and additional nursing visits.

162. The submission of false claims is material to the government's decision to reimburse the Defendants.

163. But for Defendants' submission of false claims, the government would not have approved and paid the claims.

164. The United States of America has been damaged by the aforementioned misrepresentation.

165. By virtue of these false claims, Defendant is liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act.

COUNT II
Violation of the False Claims Act
31 U.S.C. § 3729(a)(1)(B)

166. Relators incorporate all the allegations set forth in the foregoing paragraphs as though fully alleged herein.

167. The False Claims Act imposes liability on any person who knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim. See 31 U.S.C. § 3729(a)(1)(B).

168. Defendants knowingly caused to be made or made a false record or statement material to a false or fraudulent claim when it falsely certifies patients as terminally ill to enroll the patients into hospice care.

169. The false records were material to the government's decision to reimburse the Defendant.

170. But for Defendants' creation of claims, the government would not have approved and paid the claim.

171. The United States of America has been damaged by the aforementioned misrepresentation.

172. By virtue of these false claims, Defendant is liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act.

PRAYER FOR RELIEF

WHEREFORE, Relators, acting on behalf of themselves and the United States of America, demands and prays that judgment be entered against Defendants for violations of the federal False Claims Acts as follows:

(a) In favor of the United States against Defendants for treble the amount of damages to the federal government from the submission of false claims, plus the maximum civil penalties for each violation of the Federal False Claims Act;

(b) In favor of Relators for the maximum amount pursuant to 31 U.S.C. § 3730(d) False Claims Act provision to include reasonable expenses, attorney's fees, and costs incurred by Relators;

(c) That a trial by jury be held on all issues;

(d) That, in the event the United States Government elects to intervene in and proceed with this action, Relators be awarded between 15% and 25% of the proceeds of the action or of any settlement in accord with 31 U.S.C. § 3730(d)(1);

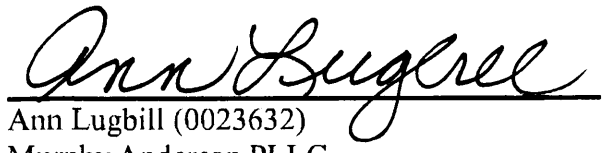
(e) That, in the event that the United States Government does not proceed with this action, Relators be awarded between 25% and 30% of the proceeds of the action or of any settlement in accord with 31 U.S.C. § 3730(d)(2);

(f) That, pursuant to 31 U.S.C. § 3730(c)(5), Relators be awarded a share of any alternate remedy that the United States Government elects to pursue;

(g) That permanent injunctive relief be granted to prevent any recurrence of the False Claims Act conduct described above for which redress is sought in this Complaint;

(q) That the United States Government and Relator receive all other relief, both in law and equity, to which they may reasonably be entitled.

Respectfully Submitted,



Ann Lugbill (0023632)
Murphy Anderson PLLC
2406 Auburn Avenue
Cincinnati, Ohio 45219
Phone: 513.784.1280
Fax: 877.784.1449

Ann Lugbill
Arlus J. Stephens
Trial Attorneys for Relators
Mark Hanna
Murphy Anderson PLLC
1401 K St. N.W., Suite 300
Washington, D.C. 20005[16]
Phone: 202.223.2620
Fax: 202.223.8651
alugbill@murphypllc.com
astephens@murphypllc.com
mhanna@murphypllc.com

R. Scott Oswald (to be admitted *pro hac vice*)
Lydia A. Pappas (to be admitted *pro hac vice*)
The Employment Law Group, P.C.
1717 K Street, N.W., Suite 1110
Washington, D.C. 20006
Telephone: 202.261.2822
soswald@employmentlawgroup.com
lpappas@employmentlawgroup.com

Attorneys for *Qui Tam* Relators

JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relators Medved and Donnadio hereby demand a jury trial on all claims that may be tried to a jury.

Respectfully Submitted,

Ann Lugbill (0023632)
Arlus J. Stephens

[16] Please direct all communications to attorneys' Washington D.C. locations.

CERTIFICATE OF SERVICE

The Disclosure to the United States was served upon the U.S. Attorney for the S.D. Ohio, Attention Andrew J. Malek, on September 29, 2023 by certified U.S. Mail at the address below. The Complaint, together with the Disclosure, was served upon the United States Attorney for the Southern District of Ohio and the United States Attorney General as set forth below.

/s/Ann Lugbill
Ann Lugbill, Attorney

Complaint and Disclosure By U.S. Mail (certified) on or before October 12, 2023:

United States Attorney for the S.D. Ohio
Attn: Andrew Malek
U.S. Attorney's Office
303 Marconi Boulevard, Suite 200
Columbus, OH 43215

Complaint and Disclosure By United States Mail (certified) on or before October 12, 2023:

United States Attorney General
Attn: The Honorable Merrick Garland
Office of the Attorney General, Civil Division
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530-0001

Complaint and Disclosure By United States Mail (certified) on or before October 12, 2023, Courtesy Copy:

United States Attorney General
Office of the Attorney General, Civil Division
Attn: Jamie Yavelberg, Director
Commercial Litigation Branch
175 N Street, NE
Washington, D.C. 20002