COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT DEPARTMENT
CIVIL ACTION NO. 21-2642 F

COMMONWEALTH OF MASSACHUSETTS,

Plaintiff,

v.

PRESTIGE HEALTH CARE SERVICES, INC.; ISDORY LYAMUYA; AND AUGUSTUS KORMAH

Defendants.

COMPLAINT

INTRODUCTION

1. The Commonwealth of Massachusetts, by and through its Attorney General, Maura Healey, brings this civil action against Prestige Health Care Services, Inc. ("Prestige"), Isdory Lyamuya, and Augustus Kormah (together, the "Defendants") for restitution, civil penalties, and costs. The Commonwealth alleges that the Defendants—through Prestige, a Massachusetts Medicaid program ("MassHealth") provider—knowingly and willfully presented or caused to be presented fraudulent claims for payment to MassHealth for services that did not comply with home health agency regulations.

2. Medicaid is a joint state-federal program that provides health care benefits to certain eligible individuals, including low-income children, seniors, and people with disabilities. State governments create, manage, and fund their own Medicaid programs and the federal government reimburses a portion of costs if those programs meet minimum requirements set forth in federal Medicaid statutes. 42 U.S.C. §§ 1396a, *et seq*. The federal reimbursement portion of each state's Medicaid budget, known as the Federal Medical Assistance Percentage, is based on the state's per capita income compared to the national average. *Id.* § 1396d(b). MassHealth is the Medicaid program in Massachusetts.

3. Prestige contracted with the Executive Office of Health and Human Services ("EOHHS"), the state agency that administers MassHealth, to provide medical services to MassHealth program members. Prestige's contract and MassHealth's regulations, required Prestige to comply with MassHealth regulations when billing MassHealth for medical services provided to MassHealth members.

4. From at least as early as February 18, 2017 to at least July 29, 2019, Prestige submitted claims to MassHealth that violated MassHealth regulations for home health care services. On numerous occasions, Prestige failed to ensure that the MassHealth member's physician had authorized and signed a plan of care ("POC") certifying that home health care services were medically necessary, a material regulatory requirement. Through these acts, Prestige violated the Massachusetts False Claims Act, G. L. c. 12, § 5B, *et seq.*; the Massachusetts Medicaid False Claims Act, G. L. c. 118E, §§ 40, 44; statutes and MassHealth regulations regarding overpayments, G. L. c. 118E §§ 36(5), 44; 130 C.M.R. §§ 450.237, 450.260(A), 450.260(I); and the common law. The Commonwealth has suffered significant damages as a result of Prestige's actions.

5. Defendant Isdory Lyamuya owned, operated, and served as an officer, manager and Chief Executive Officer of Prestige during the relevant period herein. Defendant Augustus Kormah operated and served as the Chief Operating Officer of Prestige during the relevant period herein. Both knew or acted in deliberate ignorance and/or with reckless disregard of the fact that Prestige was submitting claims to MassHealth that violated MassHealth regulations. Both thus were ultimately responsible for submitting or causing to be submitted Prestige's false claims to MassHealth from at least as early as February 18, 2017 to at least as late as July 29, 2019. As such, Isdory Lyamuya and Augustus Kormah violated the Massachusetts False Claims

Act, G. L. c. 12, § 5B, *et seq.*; and the Massachusetts Medicaid False Claims Act, G. L. c. 118E, §§ 40, 44. Defendant Isdory Lyamuya additionally violated statutes and MassHealth regulations regarding overpayments, G. L. c. 118E §§ 36(5), 44; 130 C.M.R. §§ 450.237, 450.260(A), 450.260(I), and the common law. The Commonwealth has suffered significant damages as a result of their actions.

JURISDICTION AND VENUE

6. The Attorney General has authority to bring this action under G. L. c. 12, §§ 5, 5C, and 10, and G. L. c. 118E, § 44. The Court has jurisdiction over this action pursuant to G. L. c. 12, § 5C; G. L. c. 118E, § 44; and G. L. c. 223A, §§ 2 and 3.

7. Venue is proper in Suffolk County under G. L. c. 223, § 5; G. L. c. 12 § 5C; and G. L. c. 118E, § 45, because EOHHS is located in Boston, Massachusetts, in Suffolk County, and § 45 provides that any action brought under G. L. c. 118E may be brought in Suffolk County.

THE PARTIES

8. Plaintiff the Commonwealth of Massachusetts is a sovereign state and body politic duly organized by law and is represented by the Attorney General of the Commonwealth, who brings this action in the public interest and on behalf of the Commonwealth, its citizens, and taxpayers.

9. Defendant Prestige is a for-profit foreign corporation, incorporated in Washington D.C., operating a home health care agency that does business in Massachusetts. Its Washington D.C. business address is 7410 Georgia Avenue NW, Suite 3, Washington DC, 20012. Its registered office and principal place of business in Massachusetts is 340 Main Street, Suite 977, Worcester, MA 01608.

10. Defendant Isdory Lyamuya is an individual who resides at 6016 Summerhill Road, Temple Hills, MD 20748.

11. Defendant Augustus Kormah is an individual who resides at 1 Brookside Avenue, Worcester, MA 01602.

STATEMENT OF FACTS

I. MassHealth only pays for Home Health Services that are Authorized by a Physician and Timely Documented in a Plan of Care.

12. Home health care services are skilled and supportive services provided to MassHealth members in their homes to meet skilled health care needs and to assist with associated activities of daily living. The services are designed to allow members to reside and receive care in their homes when they might otherwise require the services of an acute care or residential facility.

13. In general, MassHealth pays for three kinds of home health care services: nursing, therapy (physical, occupational, and speech/language), and home health aide services, which can only be provided if the member also requires nursing or therapy services. Home health agencies providing services to MassHealth members are governed, in part, by MassHealth regulations at 130 C.M.R. §§ 403, *et seq.* and 130 C.M.R. 450, *et seq.*

14. MassHealth initially approved Prestige as a home health agency provider on April 4, 2014. Prestige's provider contract with MassHealth was fully executed by both parties on December 31, 2014. Prestige's provider contract requires Prestige to "comply with all federal and state laws, regulations, and rules applicable to [Prestige's] participation in MassHealth." As a MassHealth provider, Prestige was required to "familiarize [itself] with the legal requirements, standards and procedures of the Medicaid program." *See Commonwealth v. Mylan Labs.*, 608 F. Supp. 2d 127, 154 (D. Mass. 2008) (citing *Heckler v. Community Health Servs.*, 467 U.S. 51, 63-65 (1984)).

a. Plan of Care Requirements

15. MassHealth only pays for health care services that are medically necessary. *See* 130 C.M.R. § 450.204. For a provider to appropriately bill MassHealth for any home health care services, the individual MassHealth member's physician must have reviewed and signed a POC certifying that home health care services are medically necessary. *See* 130 C.M.R. §§ 403.408; 403.420(A).[1] MassHealth will only pay for home health services if "the member's physician certifies the medical necessity for such services and establishes an individual plan of care in accordance [with requirements specified at 130 C.M.R. 403.420]." 130 C.M.R. 403.409(A). The requirement that a POC be authorized and signed by a physician is thus a material condition of MassHealth's payment to the provider for services rendered.

16. The POC must specify the type and frequency of the services to be provided to the member and the type of professional who must provide them. 130 C.M.R. § 403.420(B). The POC must also contain: "(1) all pertinent diagnoses, including the member's mental status; (2) the types of services, supplies, and equipment ordered; (3) the frequency of the visits to be made; (4) the prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments; (5) any safety measures to prevent injury; (6) any teaching activities to be conducted by the nurse or therapist, to teach the member, family member, or caregiver how to manage the member's treatment regimen . . . ; (7) the discharge plans; and (8) any additional items the home health agency or physician chooses to include." *Id.*

17. After the initial certification, the member's physician must sign and recertify the written POC every 60 days thereafter (the "certification period") for the services to continue to

[1] The substance of the cited regulatory requirements remained consistent throughout the relevant period. EOHHS promulgated regulations under 130 C.M.R. 403, *et seq.* effective August 12, 2016 and July 14, 2017. Citations to 130 C.M.R. 403, *et seq.* are to regulations promulgated July 14, 2017, which are presently in effect.

be appropriately billable to MassHealth. *See* 130 C.M.R. §§ 403.402; 403.420(A)(1); 403.420(C).

18. The physician must sign the POC "before the home health agency submits its claim for those services to the MassHealth agency for payment," unless the physician authorizes the services via verbal orders to the home health agency. *See* 130 C.M.R. § 403.420(B). Verbal orders must be documented in the clinical record before the services are provided and, in the event of a verbal order, the agency must obtain the physician signature on the POC within 45 days after submitting a claim for the service. *See* 130 C.M.R. § 403.420(D). In either event, MassHealth regulations require a physician-authorized and signed POC, which, among other things, is supposed to demonstrate medical necessity.

b. Recordkeeping Requirements

19. MassHealth regulations include general recordkeeping requirements as well as recordkeeping requirements specifically related to POCs.

20. MassHealth will not pay a provider for services if the "provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. All providers must keep such records, including medical records, as are necessary to disclose fully the extent and medical necessity of services provided to, or prescribed for, members and must provide to the MassHealth agency and the Attorney General's Medicaid Fraud Control Unit . . . on request such information and any other information about payments claimed by the provider for providing services . . . ." 130 C.M.R. § 450.205(A). These records must be kept for "at least six years after the date of medical services for which claims are made or the date services were prescribed . . . ." 130 C.M.R. § 450.205(G).

21. Additionally, MassHealth home health regulations explicitly require that the provider maintain up-to-date medical records, including plans of care. *See* 130 C.M.R.

403.419(C)(3)(b); 130 C.M.R. 403.402. Home health regulations specify that MassHealth may disallow payment if the medical records do not provide sufficient documentation of the services provided. *See* 130 C.M.R. 403.419(C)(3).

22. Accordingly, at all times relevant herein, MassHealth regulations required home health agencies to obtain and maintain physician-authorized POC for any home health services billed to MassHealth. *See* 130 C.M.R. § 403.419(C)(3)(b); 130 C.M.R. § 403.420.

II. Claims Submission and Billing

23. Prestige submitted claims directly to MassHealth as well as to MassHealth managed care entities ("MCEs") which administered the services of certain MassHealth members. MCEs contract with MassHealth to receive monthly capitation payments from the Medicaid program in exchange for coordinating and paying providers for services provided to the patient. In addition to contracting directly with MassHealth, Prestige entered into contractual agreements with MCEs to provide services to their members.

24. Massachusetts regulations do not distinguish among MassHealth beneficiaries who receive benefits directly from MassHealth and MassHealth beneficiaries who receive benefits via MCEs. All of these MassHealth beneficiaries are MassHealth members under 130 C.M.R. § 450.101, and their benefits are paid for using funds that have been provided by the United States and the Commonwealth through MassHealth.

25. All claims submitted by providers on behalf of any MassHealth beneficiary, regardless of whether that beneficiary receives care directly from MassHealth or through an MCE, must comply with MassHealth regulations, including those set forth in 130 C.M.R. §§ 403.000 *et seq.* and §§ 450.000 *et seq.*

26. Every provider that submits claims to MassHealth certifies when submitting a claim for payment that "the information submitted in, with, or in support of the claim is true,

accurate, and complete." 130 C.M.R. § 450.223(2)(e). Therefore, providers impliedly certify that they are complying with applicable regulations when submitting claims for payment.

27. Similarly, pursuant to Prestige's provider agreements with MassHealth and the various MCEs, providers must comply with all federal and state laws and regulations, including the Massachusetts False Claims Act. An MCE cannot change MassHealth's conditions of payment for MassHealth providers. MCE contracts do not alter the expectations of MassHealth regarding regulatory compliance.

28. Under the Massachusetts False Claims Act, a "claim" is "made to a contractor, subcontractor, grantee or other person, if the money or property is to be spent or used on behalf of or to advance a program or interest of the commonwealth or political subdivision thereof and if the commonwealth or any political subdivision thereof: (i) provides or has provided any portion of the money or property which is requested or demanded; or (ii) will reimburse directly or indirectly such contractor, subcontractor, grantee or other person for any portion of the money or property which is requested or demanded." G. L. c. 12, § 5A.

29. A request for payment made by a provider to an MCE on behalf of a MassHealth member is a "claim" for the purposes of G. L. c. 12, § 5B. Presenting a false or fraudulent request or demand for payment to an MCE for services provided to a MassHealth member is therefore a "false claim" for the purposes of G. L. c. 12, § 5B.

30. The Massachusetts Medicaid False Claims Act applies to "any false statement or representation of a material fact in any application for any benefit or payment under [chapter 118E]." G. L. c. 118E § 40(1). MassHealth may deliver services under chapter 118E through contracts with managed care entities. *See* G. L. c. 118E §§ 7, 12. A false statement or

representation of a material fact to an MCE is therefore a "false statement or representation" for the purposes of G. L. c. 118E § 40.

31. Claims submitted to MassHealth and MCEs are submitted in batches and either approved or denied based on applicable system edits. A system edit may automatically deny a claim if a required field is not filled out—for example, the name of the member who received the services. Additionally, claims or providers may be flagged for further review for high utilization of certain Current Procedural Terminology ("CPT") codes or other anomalies. Usually, though, claims are batched for submission and are then approved or denied by a computer algorithm that allows or denies such claims based on the system edits that have been programmed into the system.

32. In short, MassHealth providers bill largely on the honor system. If MassHealth or the Massachusetts Attorney General's Office later learn that claims should not have been paid—whether due to fraud or for any other reason—they must recoup funds which have already been paid to the provider.

33. The Massachusetts Attorney General's Office has access to claims data submitted by Prestige through the Medicaid Management Information System ("MMIS"). This database allows investigators to export and review reports of claims information based on the billing and servicing provider ID.

34. From the period of February 18, 2017 to July 29, 2019, MMIS data reflects that Prestige was paid $9,695,475.39 directly by MassHealth and $1,002,788.29 by MCEs for home health care services provided to MassHealth members.

III. The Defendants Knowingly Submitted and Caused to be Submitted False Claims to MassHealth for Services that were not Properly Authorized by a Physician.

35. Isdory Lyamuya incorporated Prestige in Washington, D.C. on April 28, 2011 and registered as a foreign corporation in Massachusetts on September 20, 2011. Lyamuya is the owner of Prestige. Since April 14, 2017, Lyamuya has been the sole officer, director, and CEO of Prestige.

36. Lyamuya, as CEO on Prestige's behalf, signed Prestige's MassHealth Provider agreement. Prestige became a MassHealth provider on April 4, 2014. As part of the provider agreement, Prestige agreed to comply with all state and federal statutes, rules, and regulations applicable to Prestige's participation in MassHealth.

37. Throughout the relevant time period, Lyamuya was involved in day-to-day management of Prestige and had the authority to make staffing decisions, set company policy, and oversee billing and admission decisions. Lyamuya worked in Prestige's main office several days per week and had final authority over decisions affecting the company.

38. Augustus Kormah became Chief Operating Officer of Prestige as early as February 18, 2017, having previously worked for the company in marketing. Kormah, along with Lyamuya, ran day-to-day operations of the company and oversaw the entire office. Kormah attended regular staff meetings and oversaw the staffing and procedures of the billing and plan of care processes.

a. In 2017, External Auditors Determined Prestige was Regularly Billing MassHealth without Required Physician Authorization Documented in a Plan of Care.

39. In 2017, Prestige hired a consultant specializing in home health company audits to assist Prestige in preparing for an accreditation renewal. Over the course of several months, the consultant reviewed the clinical records for 48 patients, including 34 MassHealth patients, to ensure compliance with relevant regulations, including whether the patient's plan of care was

properly authorized and signed by a physician.[2] The results of the audit were sent directly to Lyamuya.

40. On February 17, 2017, the consultant emailed Lyamuya the results of an audit of 20 patient records. A copy of this email and its attachments are included with this Complaint as Exhibit 1-A. The audit found that 12 of the 20 records lacked evidence of a timely, signed POC by a physician, including 7 of 15 MassHealth patients for whom Prestige had billed for home health services. Prestige and Lyamuya never notified MassHealth of an overpayment for these claims nor repaid the overpaid funds to MassHealth.

41. On March 9, 2017, the consultant emailed Lyamuya and two Prestige employees the results of an audit of 10 patient records. A copy of this email and its attachments are included with this Complaint as Exhibit 1-B. The audit found that 6 of the 9 records that required a POC lacked evidence of a timely, signed POC by a physician, including 4 of 7 MassHealth patients for whom Prestige had billed for home health services. Prestige and Lyamuya never notified MassHealth of an overpayment for these claims nor repaid the overpaid funds to MassHealth.

42. On April 7, 2017, the consultant emailed Lyamuya and three Prestige employees the results of an audit of 10 patient records. A copy of this email and its attachments are included with this Complaint as Exhibit 1-C. The audit found that 10 of the 10 records lacked the evidence of a timely, signed POC by a physician, including 9 of 9 MassHealth patients for whom Prestige had billed for home health services. Prestige and Lyamuya never notified MassHealth of an overpayment for these claims nor repaid the overpaid funds to MassHealth.

43. On May 22, 2017, the consultant emailed Lyamuya and three Prestige employees the results of an audit of 10 patient records. A copy of this email and its attachments are included

[2] The audit related to 50 patients covered by multiple insurers. While most insurers require POCs, the insurance provider for two patients did not.

with this Complaint as Exhibit 1-D. The audit found that 9 of the 9 records that required a POC lacked evidence of a timely, signed POC by a physician, including 3 of 3 MassHealth patients for whom Prestige had billed for home health services. Prestige never notified MassHealth of an overpayment for these claims nor repaid the overpaid funds to MassHealth.

44. In total, the audit determined that 20 of 34 MassHealth patients[3] for whom Prestige had billed for services lacked a timely, signed POC in the medical record.

b. Between 2017 and 2019, Prestige Frequently Failed to Obtain Required POCs

45. Following the 2017 audits, Prestige's management failed to correct the known issues with obtaining and maintaining proper physician authorization documented in a POC. Prestige routinely began patient care without a signed POC or verbal order. Employees repeatedly raised concerns with Lyamuya and Kormah regarding the many patients for whom a physician had not authorized care. Lyamuya and Kormah acknowledged that the company had a large number of patients without a POC and recognized that the POC issues were problematic for the company.

46. Prestige obtained clients through doctor's referrals and through their team of marketers who found clients at adult day care facilities and through personal and familial relationships. At the start of care, nurses employed by Prestige visited the potential clients and drafted POCs describing the services Prestige would provide. Prestige then submitted these POCs to the patient's physician to get approval for the services. According to statements by the employee responsible for billing MassHealth, Prestige frequently began providing services before obtaining approval from the physician.

[3] Four of these MassHealth patients received benefits administered by MCEs.

47. In some instances, physicians did not authorize the services listed in the POC. While some did not return the POC at all, others returned the POC with notations such as "services not needed." These types of responses from physicians began to occur more frequently through 2018. The receptionist responsible for receiving the POCs told investigators from the Commonwealth that, if the company received such a rejection, they often shredded the document. Despite the denial, Prestige would often try to get approval for the patient by having a different nurse conduct an evaluation. They would then re-submit the revised POC.

48. Prestige also submitted POCs that were more than a month old and sometimes much older. Some physicians rejected the POCs because they were outside of the sixty-day treatment period specified in the POC.

49. Prestige's medical record system, Axxess, allowed for reports to be run to identify which patients had signed POCs and which did not. In 2018, the director of nursing ran an administrative report that found there were over 600 POCs that had not been authorized that year. These 600 POCs represented more than approximately 300 patients.

50. The director of nursing emailed the report to Lyamuya and Kormah. Kormah responded to the email saying that he would take care of it. The director of nursing told investigators from the Commonwealth that she continued to bring up the report and the issue with POCs at regularly held staff meetings attended by Lyamuya and Kormah until she left the company in November 2018.

51. In late 2018 or early 2019, the company receptionist ran a separate report that found over 200 unsigned POCs. She sent this report to Lyamuya and Kormah.

c. Lyamuya and Kormah were Aware of the Quantity of Unauthorized POCs and were Aware that MassHealth would not pay for Services without an Authorized POC

52. Multiple employees, including the director of nursing, administrator, receptionist, and biller, told investigators from the Commonwealth that they raised concerns to Lyamuya and Kormah about POCs that lacked physician authorization.

53. Prestige also held weekly meetings at which the POCs without physician authorization were discussed. The attendees of these meetings included the director of nursing, administrator, biller, and scheduler. Kormah regularly attended these meetings and Lyamuya attended approximately half. According to Prestige's former administrator, if Lyamuya did not attend the meeting, Kormah would brief him on what was discussed. Lyamuya additionally had access to written meeting notes.

54. In these weekly meetings, employees discussed the number of POCs that remained unauthorized by a physician. They reviewed a report that showed how many POCs were unauthorized and how long they had been out for physician approval. The group discussed how to follow up with the physician including whether employees should personally drive to the physician's offices. In some cases, Kormah did drive to physician's offices in an attempt to obtain approval for the services, yet sometimes even this was unsuccessful.

55. In addition to the weekly meetings, between late 2017 and early 2019, Lyamuya called at least five special meetings to discuss POCs lacking authorization. At these meetings, he directed employees to bring the POCs directly to doctor's offices to obtain approval.

56. Around January 2018, prior to a review by outside surveyors, Lyamuya was aware of the large number of POCs lacking physician authorization. He told employees to identify the specific unauthorized POCs and that he, Kormah, and a marketing employee would bring them to physician's offices directly to be signed.

57. In March or April 2018, Lyamuya instructed a billing employee to report to him whenever a physician's office refused to sign a POC and informed the billing employee that he would determine how to respond.

58. Other employees informed investigators from the Commonwealth that Lyamuya would get upset about the unauthorized POCs. Lyamuya acknowledged to employees in the weekly meetings that Prestige was not supposed to bill MassHealth if the patient lacked a physician-authorized POC.

d. Lyamuya and Kormah allowed Prestige to continue billing MassHealth for Home Health Services without Physician-Authorized POCs

59. In 2018, Prestige hired an outside contractor to work as its administrator. The administrator was to update Prestige's policies and procedures and educate staff to ensure the company was in compliance with relevant regulations. The administrator informed investigators from the Commonwealth that she reported to Kormah and often communicated with Lyamuya.

60. The administrator stated that she regularly informed Lyamuya and Kormah about issues with the company. She explained to them the corrective steps necessary to come into compliance, but management never took her advice and never changed the way the company operated.

61. The administrator identified that the company lacked physician-authorized POCs and identified that the company had issues with its process for obtaining and maintaining POCs. According to her, Prestige lacked a process to ensure that the POC had been signed and authorized by a physician before billing MassHealth.

62. The administrator raised her concerns in multiple emails sent to Lyamuya and Kormah. She also spoke to Lyamuya about her concerns on at least three occasions.

Additionally, whenever the administrator identified an issue with a client's POC, she raised the issue with Kormah.

63. The administrator developed a written process for the company that would obtain and track POCs, including a tracking sheet to determine whether the POC had been signed. The administrator sent this process to Lyamuya, however it was never implemented.

64. According to the employee responsible for billing MassHealth, she generated bills for MassHealth in the Axxess medical records system. Bills were based on patient reports for home health services and nursing notes for nursing services. The Axxess software then checked for correct diagnosis codes and, if required, prior authorizations. The biller then submitted the claim to MassHealth via Axxess using ZirMed, a claims management system.

65. The billing system was not set up to require a physician-authorized POC before billing MassHealth and no one in the billing process was responsible for ensuring that a POC had been authorized and returned to Prestige. Prestige's Axxess computer software had a system to track POCs, but Prestige did not regularly use it. Additionally, Prestige had no system for noting verbal orders in patient records.

66. The employee responsible for billing MassHealth informed investigators that she did not look at POCs to confirm whether they had been signed before billing. According to another billing employee, half the POCs she saw were unsigned.

67. The employee responsible for billing MassHealth notified Lyamuya upon her start that she had minimal experience in billing. That employee had previously worked for Prestige conducting prior authorizations and started working in billing after the previous biller quit. When she started billing, she began to handle intakes as well, in addition to performing her prior responsibilities handling prior authorizations.

68. Eventually, the employee raised concerns about billing to Kormah and Lyamuya. She told them she was not comfortable billing MassHealth when she did not have enough information. The day after she raised this concern with Lyamuya, she was terminated.

e. In 2019, MassHealth Determined Prestige Failed to Maintain POCs according to MassHealth Regulations and Terminated the Company as a Provider.

69. On July 11, 2019, MassHealth conducted an on-site audit of Prestige after the agency became aware of multiple complaints that the company was failing to pay employees and was about to file for bankruptcy.[4] MassHealth conducted the audit to, *inter alia*, determine whether Prestige was in compliance with MassHealth regulations.

70. MassHealth auditors selected 30 patient records for review. A table created by the auditors detailing their findings is included here as Exhibit 2. Member ID numbers have been redacted and member names have been replaced with member initials to protect anonymity. Auditors identified violations of program requirements in 23 of the 30 patient records. The audit found significant issues with POCs, finding that, for 21 of those 23 patients, at least one 60-day certification period in the patient's medical record lacked a compliant POC authorizing or reauthorizing home health services. For 3 patients, the auditors found no POC in the file at all.

71. For example, according to the audit findings, member "C.H." (Row 1 of Exhibit 2), had "[n]o Plans of Care provided in their entire medical record." However, between October 1, 2018 and July 11, 2019, Prestige submitted to MassHealth claims for service codes G0156- Services of Home Health Aide in the home health setting, per 15 minutes; G0299- Services of a Registered Nurse in home health setting, per visit; G0300- Services of a Licensed Practical Nurse in home health setting, per visit; and T1502- Administration of oral, intramuscular, and/or

[4] Prestige petitioned for bankruptcy on May 22, 2019. As part of the proceedings, day to day management of the company was transferred to a bankruptcy trustee, which handled the transfer of members to other providers. Prestige's bankruptcy proceedings were dismissed upon the trustee's motion on July 24, 2019.

subcutaneous medication by health care agency/professional, per visit. MassHealth paid Prestige $46,244.15 for these claims.

72. As another example, the audit found that for member "E.V." (Row 8 of Exhibit 2), a "Plan of care [was] provided but unsigned; [and the medical records was] missing old Plans of Care (up to May 6th) . . . ." Despite the lack of a physician-authorized POC in the medical record, between January 11, 2018 and May 2, 2019, Prestige submitted to MassHealth claims for service codes G0299- Services of a Registered Nurse in home health setting, per visit and G0300- Services of a Licensed Practical Nurse in home health setting, per visit. MassHealth paid Prestige $8,607.70 for these claims. A redacted version of the unsigned POC is included as Exhibit 3.

73. For member "M.C." (Row 13 of Exhibit 2), the auditors found "[n]o Plans of Care provided." Despite the lack of any physician-approved POC in the medical record, between May 24, 2018 and June 30, 2019, Prestige submitted to MassHealth claims for service codes G0156- Services of Home Health Aide in the home health setting, per 15 minutes; G0299- Services of a Registered Nurse in home health setting, per visit; G0300- Services of a Licensed Practical Nurse in home health setting, per visit; and T1502- Administration of oral, intramuscular, and/or subcutaneous medication by health care agency/professional, per visit. MassHealth paid Prestige $38,338.62 for these claims.

74. Based on the results of the audit, MassHealth determined there was a "credible allegation of fraud" and withheld further payment to Prestige as of July 26, 2019. Shortly thereafter, MassHealth terminated Prestige as a provider on July 29, 2019.

CAUSES OF ACTION

Count One - Defendant Prestige
False Claims in Violation of Massachusetts False Claims Act, G. L. c. 12, § 5B(a)(1)

75. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

76. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Prestige submitted false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician.

77. Because compliance with these regulations is material to MassHealth's payment decision, if MassHealth had known that Defendant Prestige billed for home health services without the required physician-authorized POC, MassHealth would not have paid these claims.

78. Defendant Prestige either knowingly presented or caused to be presented false or fraudulent claims for payment, acted with deliberate ignorance of the truth or falsity of the information being submitted, or acted in reckless disregard of the truth or falsity of the information being submitted to MassHealth.

79. These claims were false inasmuch as they were for services not eligible for reimbursement because Defendant Prestige misrepresented compliance with applicable state laws and regulations that are conditions of payment. These misrepresentations were material as that term is defined in the Massachusetts False Claims Act and interpreted by the courts.

80. By virtue of Defendant Prestige's submission of false claims to MassHealth, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus civil monetary penalties.

Count Two - Defendant Prestige
Reverse False Claims in Violation of Massachusetts False Claims Act, G. L. c. 12, § 5B(a)(10)

81. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

82. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Prestige submitted false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician.

83. As a result of Defendant Prestige's material misrepresentations of compliance, Defendant Prestige received money to which it was not entitled, and which it has retained.

84. Defendant Prestige became aware of payment it inappropriately received for home health services. Defendant Prestige knew or should have known that it had failed to comply with MassHealth regulations concerning billing for home health services without the required physician-authorized POC, and that Defendant Prestige was in receipt of money that should not have been paid. These sums of money therefore constitute overpayments. Defendant Prestige has never disclosed to MassHealth, or repaid to MassHealth, any overpayments as a result of billing these claims.

85. Defendant Prestige is therefore a beneficiary of overpayments from the Commonwealth, having subsequently discovered the receipt of overpayments. Defendant Prestige has failed to disclose to the Commonwealth the false claims and/or receipt of overpayments, in violation of G. L. c. 12, § 5B(a)(10).

86. By virtue of the knowing and improper retention of overpayments, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus civil monetary penalties.

Count Three - Defendant Prestige
False Claims in Violation of Massachusetts Medicaid False Claims Act, G. L. c. 118E, §§ 40(1), 44

87. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

88. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Prestige, either knowingly and willfully or with willful blindness, made or caused to be made false statements or representations of material facts in its submissions to MassHealth for payment of home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained timely POCs authorized by the MassHealth member's physician. If MassHealth had known that the member's physician had not authorized a POC, MassHealth would not have paid these claims.

89. These claims were false since they were for services that were not eligible for reimbursement because Defendant Prestige misrepresented compliance with applicable state laws and regulations that are conditions of payment. These misrepresentations were material as that term is interpreted by the courts.

90. By virtue of the false claims that Prestige submitted, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus the costs of investigation and litigation, in accordance with G. L. c. 118E, § 44.

Count Four - Defendant Prestige
Reverse False Claims in Violation of Massachusetts Medicaid False Claims Act, G. L. c. 118E, §§ 40(3), 44

91. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

92. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Prestige submitted false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician. As a result of Defendant Prestige's noncompliance, Prestige received money to which it was not entitled, and which it has retained.

93. Defendant Prestige became aware of payments it inappropriately received for home health services. Prestige knew or should have known that it had failed to comply with MassHealth regulations concerning billing for home health services without the required physician-authorized POC, and that Defendant Prestige was in receipt of money that should not have been paid. These sums of money therefore constitute overpayments. Defendant Prestige has never disclosed to MassHealth, or repaid to MassHealth, any overpayments as a result of billing these claims.

94. Defendant Prestige concealed or failed to disclose to the Commonwealth the false claims and/or receipt of overpayments in order to retain those overpayments.

95. By virtue of the knowing and improper retention of overpayments, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus the costs of investigation and litigation.

Count Five - Defendant Prestige
Recovery of Overpayment, G. L. c. 118E §§ 36(5), 44

96. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

97. By July 29, 2019 at the latest, Defendant Prestige knew or should have known it had failed to comply with MassHealth regulations concerning POCs, in violation of 130 C.M.R. § 403.419, 130 C.M.R. 403.420, and 130 C.M.R. § 450.00, *et seq.* Defendant Prestige submitted claims for services that did not comply with these regulations. MassHealth paid those claims.

98. By virtue of Defendant Prestige's submission of claims to MassHealth while in violation of 130 C.M.R. § 403.419, 130 C.M.R. 403.420, and 130 C.M.R. § 450.00, *et seq.*, MassHealth made overpayments to Defendant Prestige.

99. Defendant Prestige is liable to repay the Commonwealth for the amount received from these overpayments because it accepted responsibility for all overpayments as a condition of its participation as a MassHealth provider. *See* G. L. c. 118E § 36(5). The Attorney General is authorized to bring a civil action for violations of G.L. c. 118E. *See* G.L. c. 118E, § 44.

Count Six - Defendant Prestige
Unjust Enrichment

100. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

101. From at least as early as February 18, 2017 to at least July 29, 2019, Prestige submitted false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician.

102. Based on its unlawful billing, Defendant Prestige received overpayments from MassHealth.

103. If Defendant Prestige had not impliedly misrepresented compliance with applicable state laws and regulations, MassHealth would not have paid these claims. By retaining monies improperly received from MassHealth, Defendant Prestige has retained funds that are the property of the Commonwealth of Massachusetts and to which Defendant Prestige is not entitled.

104. It is unfair and inequitable for Defendant Prestige to retain revenue from MassHealth for payments that it obtained in violation of MassHealth regulations and its MassHealth provider contract.

105. As consequence of the actions set forth above, Defendant Prestige has been unjustly enriched and is liable to account and pay such amounts to the Commonwealth.

Count Seven - Defendant Prestige
Breach of Contract

106. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

107. Defendant Prestige entered into a valid contract with MassHealth, for which adequate consideration was exchanged. Defendant Prestige breached its MassHealth provider contract from at least as early as February 18, 2017 to at least July 29, 2019, by submitting or causing to be submitted false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician.

108. Each claim Defendant Prestige submitted or caused to be submitted that was not in compliance with MassHealth rules and regulations constitutes a breach of Defendant Prestige's provider contract.

109. By failing to comply with all applicable state and federal laws, regulations, and rules applicable to the MassHealth program, Defendant Prestige materially breached its MassHealth provider contract.

110. As a result of Defendant Prestige's breach of its provider contract, the Commonwealth has been damaged.

Count Eight - Defendant Isdory Lyamuya
False Claims in Violation of Massachusetts False Claims Act, G. L. c. 12, § 5B(a)(1)

111. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

112. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Isdory Lyamuya caused Defendant Prestige to submit false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician.

113. Because compliance with these regulations is material to MassHealth's payment decision, if MassHealth had known that Defendant Prestige billed for home health services without the required physician-authorized POC, MassHealth would not have paid these claims.

114. By virtue of his management and ownership of Defendant Prestige, Defendant Isdory Lyamuya, in his role at Defendant Prestige as outlined above, knowingly caused to be presented false or fraudulent claims for payment, acted with deliberate ignorance of the truth or falsity of the information being submitted, or acted in reckless disregard of the truth or falsity of the information being submitted to MassHealth.

115. These claims were false inasmuch as they were for services not eligible for reimbursement because Defendant Prestige misrepresented compliance with applicable state

laws and regulations that are conditions of payment. These misrepresentations were material as that term is defined in the Massachusetts False Claims Act and interpreted by the courts.

116. By virtue of the false or fraudulent claims that Defendant Isdory Lyamuya knowingly caused to be submitted, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus civil monetary penalties.

Count Nine - Defendant Isdory Lyamuya
Reverse False Claims in Violation of Massachusetts False Claims Act, G. L. c. 12, § 5B(a)(10)

117. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

118. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Isdory Lyamuya caused Defendant Prestige to submit false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician.

119. As a result of Defendant Isdory Lyamuya's material misrepresentations of compliance, he has received money to which he was not entitled, and which he has retained.

120. Defendant Isdory Lyamuya became aware of payments Defendant Prestige inappropriately received for home health services. Defendant Isdory Lyamuya knew or should have known that Defendant Prestige had failed to comply with MassHealth regulations concerning billing for home health services without the required physician-authorized POC, and that Defendant Prestige was in receipt of money that should not have been paid. As sole beneficial owner of Prestige, Defendant Isdory Lyamuya has retained these funds. These sums of

money therefore constitute overpayments. Defendant Isdory Lyamuya has never disclosed to MassHealth, or repaid to MassHealth, any overpayments as a result of billing these claims.

121. As sole owner of Defendant Prestige, Defendant Isdory Lyamuya is therefore a beneficiary of overpayments from the Commonwealth, having subsequently discovered the receipt of overpayments. Defendant Isdory Lyamuya has failed to disclose to the Commonwealth the false claims and/or receipt of overpayments, in violation of G. L. c. 12, § 5B(a)(10).

122. By virtue of the knowing and improper retention of overpayments, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus civil monetary penalties.

Count Ten - Defendant Isdory Lyamuya
False Claims in Violation of Massachusetts Medicaid False Claims Act, G. L. c. 118E, §§ 40(1), 44

123. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

124. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Isdory Lyamuya, in his role at Prestige as outlined above, either knowingly and willfully or with willful blindness, caused to be made false statements or representations of material facts to MassHealth for payment of home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician. If MassHealth had known that the member's physician had not authorized a POC, MassHealth would not have paid these claims.

125. These claims were false since they were for services that were not eligible for reimbursement, as Defendant Isdory Lyamuya, through his ownership and management, caused Defendant Prestige to misrepresent compliance with applicable state laws and regulations that

are conditions of payment. These misrepresentations were material as that term is interpreted by the courts.

126. By virtue of the false claims that Defendant Isdory Lyamuya caused to be submitted, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus the costs of investigation and litigation, in accordance with G. L. c. 118E, § 44.

Count Eleven - Defendant Isdory Lyamuya
Reverse False Claims in Violation of Massachusetts Medicaid False Claims Act, G. L. c. 118E, §§ 40(3), 44

127. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

128. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Isdory Lyamuya caused Defendant Prestige to submit false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician.

129. As a result of Defendant Isdory Lyamuya's material misrepresentations of compliance, he has received money to which he was not entitled, and which he has retained.

130. Defendant Isdory Lyamuya became aware of payments Defendant Prestige inappropriately received for home health services. Defendant Isdory Lyamuya knew or should have known that Defendant Prestige had failed to comply with MassHealth regulations concerning billing for home health services without the required physician-authorized POC, and that Defendant Prestige was in receipt of money that should not have been paid. These sums of money therefore constitute overpayments. Defendant Isdory Lyamuya has never disclosed to MassHealth, or repaid to MassHealth, any overpayments as a result of billing these claims.

131. As sole beneficial owner of Defendant Prestige, Defendant Isdory Lyamuya has retained these funds and is therefore a beneficiary of overpayments from the Commonwealth, having subsequently discovered the receipt of overpayments. Defendant Isdory Lyamuya has failed to disclose to the Commonwealth the false claims and/or receipt of overpayments.

132. By virtue of the knowing and improper retention of overpayments, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus civil monetary penalties.

Count Twelve - Defendant Isdory Lyamuya
Recovery of Overpayment, G. L. c. 118E §§ 36(5), 44

133. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

134. By July 29, 2019 at the latest, Defendant Prestige knew or should have known it had failed to comply with MassHealth regulations concerning POCs, in violation of 130 C.M.R. § 403.419, 130 C.M.R. 403.420, and 130 C.M.R. § 450.00, *et seq.* Defendant Prestige submitted claims for services that did not comply with these regulations. MassHealth paid those claims.

135. By virtue of Defendant Prestige's submission of claims to MassHealth while in violation of 130 C.M.R. § 403.419, 130 C.M.R. 403.420, and 130 C.M.R. § 450.00, *et seq.*, MassHealth made overpayments to Defendant Prestige.

136. Defendant Prestige accepted responsibility for all overpayments as a condition of its participation as a MassHealth provider. *See* G.L. c. 118E § 36(5). The Attorney General is authorized to bring a civil action for violations of G.L. c. 118E. *See* G.L. c. 118E, § 44.

137. As owner of Defendant Prestige, Defendant Isdory Lyamuya is liable to repay the Commonwealth for the amount Defendant Prestige received from these overpayments. *See* G.L. c. 118E, § 36.

Count Thirteen - Defendant Isdory Lyamuya
Unjust Enrichment

138. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

139. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Isdory Lyamuya knowingly caused Defendant Prestige to submit false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician.

140. Based on Defendant Prestige's unlawful billing, Defendant Isdory Lyamuya received overpayments from MassHealth.

141. If Defendant Isdory Lyamuya had not caused Defendant Prestige to impliedly misrepresent compliance with applicable state laws and regulations, MassHealth would not have paid these claims. By retaining monies improperly received from MassHealth, Defendant Isdory Lyamuya, as the sole beneficial owner of Defendant Prestige, has retained funds that are the property of the Commonwealth of Massachusetts and to which he is not entitled.

142. It is unfair and inequitable for Defendant Isdory Lyamuya to retain revenue from MassHealth for payments that he obtained in violation of MassHealth regulations.

143. As consequence of the actions set forth above, Defendant Isdory Lyamuya has been unjustly enriched and is liable to account and pay such amounts to the Commonwealth.

Count Fourteen - Defendant Augustus Kormah
False Claims in Violation of Massachusetts False Claims Act,
G. L. c. 12, § 5B(a)(1)

144. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

145. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Augustus Kormah caused Defendant Prestige to submit false claims for payment to MassHealth for home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician.

146. Because compliance with these regulations is material to MassHealth's payment decision, if MassHealth had known that Defendant Prestige billed for home health services without the required physician-authorized POC, MassHealth would not have paid these claims.

147. Defendant Augustus Kormah, by virtue of his operational responsibility at Defendant Prestige, knowingly caused to be presented false or fraudulent claims for payment, acted with deliberate ignorance of the truth or falsity of the information being submitted, or acted in reckless disregard of the truth or falsity of the information being submitted to MassHealth.

148. These claims were false inasmuch as they were for services not eligible for reimbursement because Defendant Prestige misrepresented compliance with applicable state laws and regulations that are conditions of payment. These misrepresentations were material as that term is defined in the Massachusetts False Claims Act and interpreted by the courts.

149. By virtue of the false or fraudulent claims that Defendant Augustus Kormah knowingly caused to be submitted, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus civil monetary penalties.

Count Fifteen - Defendant Augustus Kormah
False Claims in Violation of Massachusetts Medicaid False Claims Act, G. L. c. 118E, §§ 40(1), 44

150. The Commonwealth incorporates by reference the allegations contained in the preceding paragraphs of this Complaint as if fully alleged herein.

151. From at least as early as February 18, 2017 to at least July 29, 2019, Defendant Augustus Kormah, in his role at Defendant Prestige as outlined above, either knowingly and willfully or with willful blindness, caused to be made false statements or representations of material facts to MassHealth for payment of home health care services that violated MassHealth regulations at 130 C.M.R. §§ 403 *et seq.* because Defendant Prestige had not obtained and maintained POCs timely authorized by the MassHealth member's physician. If MassHealth had known that the member's physician had not authorized a POC, MassHealth would not have paid these claims.

152. These claims were false since they were for services that were not eligible for reimbursement, as Defendant Augustus Kormah, by virtue of his operational responsibility, caused Defendant Prestige to misrepresent compliance with applicable state laws and regulations that are conditions of payment. These misrepresentations were material as that term is interpreted by the courts.

153. By virtue of the false claims that Defendant Augustus Kormah submitted or caused to be submitted, the Commonwealth has suffered actual damages and is entitled to recover treble damages plus the costs of investigation and litigation, in accordance with G. L. c. 118E, § 44.

JURY DEMAND

154. The Commonwealth demands trial by jury in this action of all issues so triable.

PRAYERS FOR RELIEF

WHEREFORE, the Commonwealth demands and prays that after trial on the merits, judgment be entered in its favor as follows:

a. Counts One and Two – for the amount of the Commonwealth's damages, as is proved at trial, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts, and civil penalties as required by G. L. c. 12, § 5B, together with such other relief as may be just and proper;

b. Counts Three and Four – for the amount of the Commonwealth's damages, as is proved at trial, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts, together with such other relief as may be just and proper;

c. Counts Five and Six – for the amount of the Commonwealth's damages, as is proved at trial, together with such other relief as may be just and proper;

d. Count Seven – for the amount of the Commonwealth's damages, as is proved at trial, and interest at the statutory rate of 12 percent per year pursuant to G. L. c. 231, § 6C, from the date of each breach of contract, together with such other relief may be just and proper;

e. Counts Eight and Nine – for the amount of the Commonwealth's damages, as is proved at trial, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts, and civil penalties as required by G. L. c. 12, § 5B, together with such other relief as may be just and proper;

f. Count Ten and Eleven – for the amount of the Commonwealth's damages, as is proved at trial, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts, together with such other relief as may be just and proper;

g. Count Twelve and Thirteen – for the amount of the Commonwealth's damages, as is proved at trial, together with such other relief as may be just and proper;

h. Count Fourteen – for the amount of the Commonwealth's damages, as is proved at trial, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts, and civil penalties as required by G. L. c. 12, § 5B, together with such other relief as may be just and proper;

i. Count Fifteen – for the amount of the Commonwealth's damages, as is proved at trial, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts, together with such other relief as may be just and proper; and

j. All other relief as the Court deems appropriate.

Respectfully Submitted,

COMMONWEALTH OF MASSACHUSETTS

MAURA HEALEY
ATTORNEY GENERAL

By: _____

Scott Grannemann, BBO #699955
Assistant Attorney General
Medicaid Fraud Division
One Ashburton Place
Boston, MA 02108
(617) 727-2200
Scott.Grannemann@mass.gov

DATE: November 16, 2021