

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT DEPARTMENT
OF THE TRIAL COURT
CIVIL ACTION NO.

COMMONWEALTH OF MASSACHUSETTS,

Plaintiff,

v.

UNITEDHEALTHCARE INSURANCE
COMPANY d/b/a UNITEDHEALTHCARE
COMMUNITY PLANS OF
MASSACHUSETTS,

Defendant.

COMPLAINT

The Commonwealth of Massachusetts, by and through its Attorney General, Andrea Joy Campbell, brings this enforcement action pursuant to the Massachusetts False Claims Act, G.L. c. 12, §§ 5A et seq. (the “MFCA”) and common law, to recover damages and civil penalties arising from false and/or fraudulent statements, records, and claims made and/or caused to be made by the Defendant, UnitedHealthcare Insurance Company d/b/a UnitedHealthcare Community Plans of Massachusetts (“United”), to MassHealth, the Commonwealth’s Medicaid program.

INTRODUCTION

1. From at least January 1, 2015 through December 31, 2025 (the “relevant time period”), United contracted with MassHealth to be a Senior Care Organization (“SCO Plan Provider”) to develop and administer a voluntary healthcare program for seniors aged 65 and

older (the “United SCO Plan”).¹ As a SCO Plan Provider, United is paid a per member, per month capitated rate for each senior enrolled in the United SCO Plan. These capitated rates are determined based on United’s own assessments of the member’s health conditions, with higher rates paid for members that United has represented have more serious health conditions.

2. United submits its assessments of the member’s health conditions to MassHealth. Based on those assessments, the members are assigned a level of care, Level 1, 2, or 3. MassHealth then pays United its capitated rate based on the assigned level, with Level 1 resulting in the lowest reimbursement amount and Level 3 resulting in the highest amount.

3. Throughout the relevant time period, United systematically defrauded MassHealth in three principal ways.

4. First, throughout the relevant time period, United has submitted assessments of members in the United SCO Plan that led to their classification as Level 2, which is reserved for members with behavioral health or substance use disorders. United classified members by identifying, in its submissions to MassHealth, that members had diagnoses like depression or anxiety, even though those members lacked any corresponding diagnosis or treatment associated with behavioral health or substantive use disorders. United’s own employees, in testimony and records obtained pursuant to civil investigative demand (“CID”), have confirmed that it would be improper to classify a member as having these conditions without an actual behavioral health or substance use disorder diagnosis and a corresponding treatment for that condition. But United classified these members as having behavioral health or substance use disorders anyway. As a

¹ A different United affiliate, UnitedHealthcare of New England, Inc., and the Commonwealth’s Executive Office of Health and Human Services (“EOHHS”) entered into a new contract governing the United SCO Plan, which became operationally effective on January 1, 2026. If the conduct alleged below is found to have continued through the performance of this new contract, the Commonwealth will seek leave to amend the Complaint accordingly.

result, United received higher capitated payments from MassHealth for these members than it should have.

5. Second, from at least January 1, 2014 and continuing at least through part of 2020, United improperly assessed many members in the United SCO Plan with health conditions ostensibly satisfying Level 3, reserved for members with the most serious health conditions, even though those members did not qualify for Level 3 services. Beginning in 2018 and continuing into 2019, United became aware through a series of internal reviews that many of its members at Level 3 had been improperly classified. United submitted revised assessments that resulted in many of these members being downgraded to Level 1, the lowest reimbursement level paid by MassHealth and reserved for members with the least serious health conditions, or to Level 2, even though those members' health conditions did not appear to change between the time they were downgraded from Level 3. United never disclosed to MassHealth that it had been improperly paid at higher rates for these members prior to their being downgraded, nor has it repaid MassHealth for any of the improperly inflated capitated payments United received while the members were incorrectly classified at Level 3.

6. Third, throughout the relevant time period, United submitted assessments to MassHealth for members in the United SCO Plan that represented that those members qualified for Level 3 because the members either needed daily skilled nursing services or needed skilled nursing services three times per week with two impairments with activities of daily living ("ADLs"). Despite these representations, most of those members did not receive any skilled nursing services in the week prior to United's assessment, nor did those members need the services United asserted they did. As a result, United received higher capitated payments from MassHealth for these members than it should have.

7. United's fraud on the MassHealth program was knowing and intentional.

Throughout the relevant time period, United SCO Plan managers were repeatedly told by United nurses that member evaluations often included clinical assessments that were copied and pasted from prior evaluations of other patients, included inaccurate diagnoses based on comparisons to the patient's medical records or contemporaneous patient assessments, and did not reflect comprehensive, accurate, and clinically appropriate reviews of members' capabilities and health conditions.

8. Moreover, United relentlessly pursued a growth-at-all-costs strategy that failed to allocate resources to ensure that it accurately reported members' conditions to MassHealth. United chronically understaffed the nurses who were responsible for assessing members as part of the United SCO Plan and created an incentive structure in which United's overworked nurses would not have to complete as many member assessments if they represented that the members had more serious health conditions, even if those members did not. United also built a team to conduct quality control of member assessments before submitting those assessments to MassHealth, then abandoned that quality control process for half of member assessments when it developed a backlog that resulted in United making less money.

9. Indeed, Bernadette Di Re, CEO of the United SCO Plan from 2011 through 2020, attributed pressure from United's corporate management to increase membership in the Plan, reduce costs, "cut staff," "[g]et more numbers," and "[g]et more money from the state" as the reason she resigned as CEO of the United SCO Plan and left United entirely.

10. These misrepresented assessments have resulted in United receiving and retaining more than \$100 million in fraudulent payments from MassHealth. These strategies were employed at the direction of senior United personnel and with full knowledge that the assigned

levels of its enrollees were inflated. This action is to recover those monies improperly paid by MassHealth to United.

JURISDICTION AND VENUE

11. The Attorney General is authorized to bring this action pursuant to G.L. c. 12, §§ 5, 5C and G.L. c. 118E, § 44.

12. This Court has jurisdiction over the persons and subject matter of this action pursuant to G.L. c. 12, § 5C, G.L. c. 118E, § 44, and G.L. c. 223A, §§ 2-3. All claims in this action arise from United's transaction of business in the Commonwealth.

13. Venue is proper in Suffolk County pursuant to G.L. c. 12, § 5C, G.L. c. 118E, § 45, and G.L. c. 223, § 5.

PARTIES

14. 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.

15. Defendant UnitedHealthcare Insurance Company is a Connecticut corporation licensed to operate as an insurance company in Massachusetts with a principal place of business at 185 Asylum Street, Hartford, Connecticut. By operation of G.L. c. 175, §§ 151, 154, the Commonwealth's Division of Insurance is the authorized agent for service of process on UnitedHealthcare Insurance Company. Defendant UnitedHealthcare Insurance Company does business in the Commonwealth as UnitedHealthcare Community Plans of Massachusetts. UnitedHealthcare Insurance Company is a wholly owned subsidiary of UHIC Holdings, Inc. UHIC Holdings, Inc. is a wholly owned subsidiary of United Healthcare Services, Inc. United

Healthcare Services, Inc. is a foreign corporation registered to do business in the Commonwealth. The ultimate parent company of these entities is UnitedHealth Group, Inc. which is a publicly held company traded on the New York Stock Exchange.

STATUTORY AND REGULATORY FRAMEWORK

Medicaid

16. Medicaid is a joint state and federal assistance program, which pays medical expenses for certain individuals, including children, seniors, and people with disabilities. It was created in 1965 as part of Title XIX of the Social Security Act. See 130 C.M.R. § 450.101.

17. The federal Medicaid statute sets forth the minimum requirements for state Medicaid programs to qualify for federal funding. See 42 U.S.C. §§ 1396a et seq. The federal 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. at § 1396d(b). The remainder of the Medicaid budget is funded by each state.

18. Originally, payment for all Medicaid services was made on a fee-for-service basis, meaning that providers were paid directly by Medicaid for each service delivered. Over the last few decades, states, including the Commonwealth, have increasingly turned to managed care entities ("MCEs") to administer Medicaid services to members.

19. MCEs are typically private insurance companies that are responsible for delivering and paying for the members' health care services. MassHealth pays for the services provided to MassHealth members enrolled in an MCE on a capitated basis from Medicaid funds MassHealth receives from the United States and the Commonwealth. Each MCE selects its own group of providers and contracts with those providers to form its network. These networks typically include doctors, specialists, hospitals, labs, and other health care facilities.

20. Some MCEs focus on delivering services for a specific category of members, including behavioral health members or members over a certain age. The United SCO Plan is a Senior Care Options plan, which is also a type of MCE.

Senior Care Options Plans

21. Medicaid pays for items and services pursuant to plans developed by the states and approved by the Department of Health and Human Services through the Centers for Medicare & Medicaid Services (“CMS”). Section 1115 of the Social Security Act gives CMS authority to approve experimental, pilot, or demonstration projects that are found by it to be likely to assist in promoting the objectives of the Medicaid program.

22. The program authorizing senior care options plans (“SCO Plans”) was launched by MassHealth in 2004 as a Section 1115(a) Medicaid demonstration program.

23. SCO Plans are a “comprehensive network of medical, healthcare and social service providers that integrates all components of care, either directly or through subcontracts.” G.L. c. 118E, § 9D(a). This includes primary care and specialty physician visits, regular preventative services, laboratory work, emergency care, inpatient hospitalization, mental health and substance abuse treatment services, and transportation for medical care.

24. Enrollment by qualifying MassHealth members in a SCO Plan is voluntary. See G.L. c. 118E, § 9D(c).

25. To enroll in a SCO Plan, a MassHealth member must meet all of the following criteria: (1) be 65 years of age or older; (2) live in a designated service area of a SCO; (3) not be diagnosed as having end-stage renal disease; (4) not be subject to a six-month deductible period under 130 C.M.R. § 520.028; (5) not be a resident of an intermediate care facility for individuals

with intellectual disabilities; and (6) not be an inpatient in a chronic or rehabilitation hospital. See 130 C.M.R. § 508.008(A).

26. Eligible MassHealth members may participate in a SCO Plan by selecting from a specific group of SCO Plan Providers that have been qualified by and contracted with MassHealth. See 130 C.M.R. § 508.008(B). For the year beginning in 2026, there were six SCO Plan Providers from which an eligible MassHealth member might choose: Commonwealth Care Alliance Senior Care Options, Fallon NaviCare, Mass General Brigham SCO, Senior Whole Health SCO, Tufts Health Plan Senior Care Options, and United. See <https://www.mass.gov/info-details/2026-senior-care-options-plans>.

27. SCO Plans are responsible for providing members with the full continuum of MassHealth covered services through their network of contracted providers. See 130 C.M.R. § 508.008(C).

28. Once accepted into the SCO Plan, the SCO Plan member selects a primary care physician from within the network established by the specific SCO Plan Provider that they have chosen. The selected primary care physician then works together with a team of other network providers, such as specialists, registered nurses, and geriatric support services coordinators, to create an individualized care plan which is supposed to be specific to fit the needs of each member enrolled in the SCO Plan.

29. While some members receiving services under a SCO Plan may reside in a nursing home, SCO Plans also cover long-term services and supports to allow program participants to continue to live at home, the home of a relative, or another community-based setting. Those services may include adult day care, personal care assistance, personal emergency response systems, respite care, and homemaker services. As of 2021, according to Slide 20 of

one of United’s internal presentations, attached as **Exhibit 1**, over 90% of the United SCO Plan members lived in the community, as opposed to institutional settings. As of October 2024, community residents comprised over 95% of the United SCO Plan membership.

Leveling, Rate Cells, and Capitation Payments to SCO Plan Providers

30. MassHealth pays SCO Plan Providers a capitated rate, i.e., a set dollar payment per member per month to cover a specified set of services and administrative costs for the member without regard to the actual number of services provided. See G.L. c. 118E, § 9D(a).

31. The amount of the monthly capitation payments made by MassHealth to SCO Plan Providers is determined according to “rate cells,” also known as “rate levels.”

32. Because individuals that qualify for enrollment in the SCO Plan have differing health circumstances, there is a wide variance in their utilization of health care services and, correspondingly, the total cost of services they receive. Those with serious illnesses or multiple chronic conditions require more care, which in turn leads to higher medical costs than their healthier counterparts.

33. Members enrolled in a SCO Plan who reside in community settings and are not institutionalized, i.e., not residing in hospitals or nursing facilities, are assigned one of three levels of care: “Community Other,” “Behavioral Health,” and “Nursing Home Certifiable.” Those rate levels are defined in contracts between MassHealth and SCO Plan Providers.

34. Level 3, or Nursing Home Certifiable, is the highest level of care and is defined to include members who require one skilled service, which can include nursing or therapy services, daily, or one skilled nursing service at least three times per week and have at least two impairments in ADLs.

35. Level 2, or Behavioral Health, is defined to include members who do not meet the Level 3 criteria but have a diagnosis for a behavioral health or substance use disorder.

36. Level 1, or Community Other, is the lowest level of care and is defined to include members who do not meet the Level 3 criteria and do not have a diagnosis for a behavioral or substance use disorder.

37. In addition to the three rate levels, MassHealth capitation rates for community-based members vary by the region of Massachusetts where the member lives. There are three applicable regions: Eastern Massachusetts, Western Massachusetts, and Cape Cod.

38. SCO Plan Providers are responsible for conducting and documenting their own clinical assessments of members to determine the appropriate level of care. For members to be classified in either Level 2 or Level 3, registered nurses are responsible for performing these clinical assessments in-person utilizing a mandated standard assessment tool, the Minimum Data Set – Home Care 2.0 (“MDS-HC”).

39. The MDS-HC form, a sample of which is attached as **Exhibit 2**, includes sixteen sections with detailed questions requiring an extensive examination of the member’s clinical condition and daily functions. For an initial assessment, the MDS-HC assessment requires a nurse to travel to a member’s residence to conduct the assessment, such that the nurse can see the member perform a series of tasks (including ADLs) in their home environment.

40. The MDS-HC form also requires the assessing nurse to list any disease diagnoses affecting the member’s condition at Section J and to quantify the number and types of care-related services received by the member in the previous seven days at Section P.

41. Upon completion of the MDS-HC assessment, the SCO Plan Provider submits the MDS-HC assessment to MassHealth. MassHealth has an electronic system that relies on the

inputs provided on the MDS-HC assessment to determine the member's rate level. If the member requires assistance with two or more activities of daily living and has a skilled need three or more times per week, or if the member requires daily skilled services, then the member is assigned Level 3. If the member does not satisfy the Level 3 criteria but has a diagnosis fitting within specified categories of behavioral health- or substance use disorder-related diagnoses, then the member is assigned Level 2. All other members are assigned Level 1. If the SCO Plan Provider does not submit an MDS-HC assessment to MassHealth, the member is assigned Level 1 by default.

42. SCO Plan Providers are required by MassHealth to perform an initial assessment of each member within thirty days of enrollment and then, depending on the member's rate level, follow-up evaluations based on a set schedule thereafter. Members requiring complex care are re-assessed every three months, and other members are re-assessed every six months.

43. SCO Plan Providers also submit a "Request for Services" form to MassHealth when they submit the MDS-HC assessment, a sample of which is attached as **Exhibit 3**.

44. MassHealth relies on the accuracy of the MDS-HC assessments and does not have the resources to conduct its own health assessment of each member in a SCO Plan. Thus, it is critical that the SCO Plan Provider be truthful and accurate when reporting SCO Plan members' MDS-HC assessments to MassHealth.

45. The capitated rates vary widely based on the level assigned to the SCO Plan member. For example, for a SCO Plan member residing in Eastern Massachusetts, for January 1, 2025 through December 31, 2025, MassHealth paid \$1,305.57 per month for a Level 1 SCO Plan member, \$1,831.14 per month for a Level 2 SCO Plan member, and over \$4,265.49 per month for a Level 3 SCO Plan Member. If MassHealth had known that a member was assigned an

improper level based on an untruthful or inaccurate assessment, MassHealth would not have made the capitated payment at that rate to the SCO Plan Provider.

LEGAL AND STATUTORY FRAMEWORK

Massachusetts False Claims Act

46. The MFCA establishes liability for any person² who: (1) knowingly presents or causes to be presented, a false or fraudulent claim for payment; (2) knowingly makes, uses or causes to be made or used a false record or statement material to a false and fraudulent claim; (9) knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money to the Commonwealth; or (10) is a beneficiary of an inadvertent submission of a false claim to the Commonwealth, or is a beneficiary of an overpayment from the Commonwealth, and who subsequently discovers the falsity of the claim or receipt of overpayment and fails to disclose the false claim or receipt of overpayment to the Commonwealth. See G.L. c. 12, § 5B.

47. Any person who violates the MFCA is liable for “a civil penalty of not less than \$5,500 and not more than \$11,000 per violation, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus three times the amount of damages, including consequential damages, the Commonwealth or a political subdivision thereof sustains because of such violation.” Id.

48. For purposes of the MFCA, the terms “knowing” and “knowingly” mean that a person possesses actual knowledge of relevant information, acts with deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information; and no proof of specific intent to defraud is required. Id. at § 5A.

² For purposes of the MFCA, a “person” is defined as a natural person, corporation, partnership, association, trust or other business or legal entity. See G.L. c. 12, § 5A.

49. If a person enters into a contract with MassHealth and fails to “familiarize themselves with the legal requirements, standards and procedures of the Medicaid program,” the knowledge requirement is met. 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)).

50. The MFCA defines “claim” as “a request or demand, whether pursuant to a contract or otherwise, for money or property, whether or not the commonwealth or a political subdivision thereof has title to the money or property, that: (1) is presented to an officer, employee, agent or other representative of the commonwealth or a political subdivision thereof; or (2) 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.” Id. at § 5A.

FACTUAL ALLEGATIONS

Contracts with MassHealth

51. United first became a SCO Plan Provider in 2004 and entered into a contract with MassHealth governing its obligations as a SCO Plan Provider. United has entered into additional contracts with MassHealth since that time.

52. As of December 2025, the United SCO Plan was governed by a Third Amended and Restated Contract, executed by United and MassHealth on September 18, 2023, which was

extended through December 31, 2025 pursuant to an amendment executed between United and MassHealth.

53. Under the terms of United's contracts with MassHealth, United must comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of the contracts.

54. These contracts also require United to have delivered and coordinated all components of MassHealth-covered services to members enrolled in the United SCO Plan in accordance with and subject to the provisions of their contract and all applicable federal and state laws, regulations, rules, billing instructions, and bulletins, as amended.

55. Its contracts with MassHealth also require United to conduct comprehensive assessments for SCO members "residing in the community with complex care needs" by utilizing the assessment tool designated by MassHealth, the MDS-HC assessment.

56. United is also required to maintain, for each member participating in the United SCO Plan, a "Centralized Enrollee Record" or "CER," containing, among other information, records of all covered services provided to the member pursuant to the SCO Plan and all data from the periodic assessments.

57. In addition, United is required to maintain a quality management program, which includes quality assessment and performance improvement, for services furnished to the SCO members. The United SCO Plan CEO or CFO is required to certify on an annual basis that United "is in compliance with this Contract as it relates to program integrity requirements and has not been made aware of any instances of Fraud and Abuse other than those that have been reported by [United] in writing" to MassHealth.

United’s Payments from MassHealth

58. From January 1, 2014 through December 31, 2025, United was paid more than \$5 billion³ by MassHealth in capitated payments for its SCO Plan. Of that amount, over \$3.8 billion is attributable to SCO Plan members residing in community, or non-institutional, settings.

59. Of United’s SCO Plan members who reside in the community, the table below shows the amount paid for each rate cell level, as well as the percentage of days its members spent in each rate cell level, divided by year.

Calendar Year	SCO Community Level 1 (Community Well)		SCO Community Level 2 (Behavioral Health/Substance Use Disorder)		SCO Community Level 3 (Nursing Home Certifiable)	
	Capitated Amount Paid	Percentage of Member Days in Level 1	Capitated Amount Paid	Percentage of Member Days in Level 2	Capitated Amount Paid	Percentage of Member Days in Level 3
2014	\$13,747,007	56.21%	\$2,950,411	5.64%	\$160,193,962	38.15%
2015	\$13,234,746	49.17%	\$3,395,839	5.84%	\$216,222,276	44.99%
2016	\$14,442,534	46.69%	\$3,957,697	5.81%	\$263,034,573	47.51%
2017	\$17,395,067	47.83%	\$5,747,328	7.24%	\$262,339,224	44.93%
2018	\$32,354,163	46.65%	\$9,854,091	9.32%	\$263,035,317	44.04%
2019	\$44,896,076	47.71%	\$14,339,589	10.46%	\$245,791,995	41.83%
2020	\$65,057,645	49.73%	\$22,012,556	12.86%	\$210,556,963	37.41%
2021	\$81,338,513	51.77%	\$23,358,269	12.22%	\$229,166,635	36.01%
2022	\$91,611,987	53.72%	\$23,127,804	11.22%	\$246,129,811	35.07%
2023	\$76,146,333	57.52%	\$20,349,361	8.54%	\$269,464,254	33.94%
2024	\$89,225,276	57.37%	\$23,935,715	7.98%	\$288,313,483	34.65%
2025	\$134,335,721	59.40%	\$19,210,487	7.07%	\$306,793,237	33.54%
Grand Total	\$673,785,067	52.46%	\$172,239,146	8.93%	\$2,961,041,730	38.60%

60. Di Re, the former CEO of the United SCO Plan, confirmed that Level 3 members offered the highest profit margin for United, at least as of February 2020.

³ The data set forth in this Complaint reflecting payments made to United, leveling assessments, and member populations reflects the best information available to the Commonwealth. Data and related calculations are subject to further validation and, if necessary, refinement based on additional data acquired from other sources.

United's Corporate Structure and SCO Operations

61. United's corporate parent is UnitedHealth Group, Inc., a publicly traded company. United's operations are part of the UnitedHealthcare Community & State segment of UnitedHealth Group, Inc., which operates plans in over thirty states and reported revenue of over \$94 billion as of December 31, 2025.

62. The United SCO Plan has grown consistently during the relevant time period. As of February 2015, according to United's internal documents, the United SCO Plan enrolled approximately 14,000 members. See Exhibit 4 at 10. As of the first quarter of 2021, the United SCO Plan had 21,498 members. See Exhibit 1 at 16. In December 2025, MassHealth made payments for 25,443 members enrolled in the United SCO Plan. Throughout this period, United has maintained the largest market share in Massachusetts out of all SCO Plan Providers. See Exhibit 5 at 123045.

63. Internally in company documents, United SCO Plan executives have characterized the plan as “[h]istorically . . . a strong financially performing program” with profits of 4% to 8%. See id. at 123059.

United's Assessment Process for SCO Plan Members

64. Once a member has been enrolled in United's SCO Plan, United is required by its contracts with MassHealth to perform a comprehensive assessment of the member's clinical and functional status to determine the member's appropriate rate cell level, to create an individual plan of care in conjunction with the member's primary care providers, and to complete a functional assessment, which evaluates the member's needs for additional support or services, such as whether the member requires meals to be delivered at home.

65. The functional assessment is the mechanism by which United documents a member's functional impairments and substantiates the needs for services and support.

66. To prepare a submission for MassHealth that will determine the member's rate cell level, upon enrollment in the United SCO Plan, United staff begin by conducting preliminary interviews of members, focusing on what services and supports the members receive currently. See Exhibit 4 at 18. For those members presently receiving little or no services and without significant medical conditions (and who are likely to be classified at Level 1), United will perform an initial assessment through a Geriatric Services and Support Coordinator, typically a social worker. If the initial assessment by the social worker does not identify any significant medical issues, diagnoses, or impairments, United may submit an MDS-HC assessment to MassHealth reflecting those conditions or may simply forego the submission of an assessment, which, by default, results in the member being assigned to Level 1.

67. If United identifies significant medical issues or impairments for the member during the initial enrollment interview or the initial assessment by the Geriatric Services and Support Coordinator, United will perform a more detailed assessment. For those members, United assesses the member utilizing the MDS-HC form.

68. The MDS-HC assessments are performed for United by registered nurse case managers ("Field Nurses"). The Field Nurses are managed by Clinical Services Managers. According to the CID testimony of Sandra Wolfgang, Associate Director of Medical Clinical Operations for United's SCO Plan, early in the United SCO Plan, Clinical Services Managers supervised eight or nine Field Nurses, but as the United SCO Plan member population has increased, Clinical Services Managers now supervise upwards of twenty Field Nurses each.

69. Field Nurses are required to complete the MDS-HC assessment in a face-to-face meeting⁴ in the member's home. The MDS-HC assessment relies on structured interviews, clinical assessment protocols, and observations of the member in their physical environment. These MDS-HC assessment interview questions include evaluations of the member's cognitive abilities, hearing, communication, vision, mood and behavioral health, social functioning, formal and informal support services, and detailed assessments of the member's activities of daily living and instrumental activities of daily living, as well as medical history, current diagnoses and treatments, and chronic illnesses.

70. According to United's estimates, it takes a Field Nurse approximately eight hours to conduct each initial assessment of a SCO member to make a Level 2 or 3 classification.

71. Along with the MDS-HC assessment, United also completes a "Request for Services" form during its initial submission to MassHealth. United instructed its Field Nurses to summarize the member's condition in this form by including a request for a specific rate cell level assignment with a summary of the conditions ostensibly satisfying that leveling recommendation. See **Exhibit 6** at 22-28. United described this form as "critical" and material to MassHealth's review and acceptance of an MDS-HC assessment. See **Exhibit 7** at 30.

72. According to United's training materials for Field Nurses, "[I]ack of proper or insufficient documentation of clinical need [on the MDS-HC] will . . . generate [an] inappropriate category. Accuracy is important." See *id.* at 6.

73. In addition to performing these regular MDS-HC and functional assessments, Field Nurses were responsible for coordination of care for the members. These tasks include monitoring members' plans of care, working with primary care physicians, home health aides,

⁴ Due to the COVID-19 pandemic, MassHealth permitted assessments to be conducted telephonically or by video on a temporary basis from March 18, 2020 through November 3, 2021.

and other service providers, ordering durable medical equipment, and requesting additional services as appropriate.

74. Field Nurses record the results of each member's MDS-HC assessment in United's data system, and, at least from January 1, 2015 through February 2020, that MDS-HC data would be reviewed by a separate team of nurses at United before submission to MassHealth. This review team was referred to internally at United as the MDS Team (the "MDS Team" and/or "MDS Nurse(s)"). Currently, the United SCO Plan employs eight nurses on the MDS Team.

75. MDS Team members were initially responsible for comparing the diagnoses listed in the MDS-HC assessment to the member's medical records and plan of care. The MDS Team would also review the MDS-HC data for logical consistency with the member's other assessments and care-related documents, including the functional assessments, health risk assessments, individual plan of care, and any requests for services like personal care attendants or nursing visits. United viewed the function of the MDS Team review as "ensur[ing] the [MDS-HC] submission is appropriate." See Exhibit 7 at 5. Di Re, CEO of the United SCO Plan from 2011 to 2020, described the MDS Nurses as quality control for United's MDS-HC submissions, responsible for checking the work performed by Field Nurses..

76. United communicated similar messages regarding the role and function of the MDS Team to external audiences in job postings as well. United described the MDS Team's role on LinkedIn as "assist[ing] the [Field Nurse] with ensuring that the documentation entered by the field RN team meets State guidelines" and "facilitat[ing] accurate determination of the MDS-HC that accurately reflects the patient's care needs and captures all resources utilized to ensure accurate representation of the member's clinical and functional needs." See Exhibit 8.

United likewise described the role to entail “documentation review of the member’s information contained within the health plan’s centralized medical record.” See id.

77. For example, in the course of its review, the MDS Team may flag an MDS-HC assessment that includes a diagnosis for depression but without any corresponding records of treatment for depression or other indication that the member suffers from depression in the member’s medical records. Another example would be a member reported having a complete inability to perform one or more activities of daily living, for example dressing and undressing, but who has been receiving personal care support services for only three or four days a week.

78. According to United’s internal documents, before United reduced the role of its MDS Team as described below, discrepancies identified by the MDS Team were initially to be reported to the Field Nurse or, in some instances, the Field Nurse’s immediate supervisor, i.e., the Clinical Services Manager, as an “MDS Rework” or “MDS Rejection.” See Exhibit 9. The Field Nurse would then resolve those discrepancies by either updating the MDS-HC assessment or otherwise addressing the issue flagged by the MDS Team. See Exhibit 6 at 83.

79. In its training materials for Field Nurses, United described the role of the MDS Team as “gatekeepers,” who are responsible for double-checking MDS-HC assessments and resolving any potential discrepancies. See Exhibit 7 at 55.

80. After the MDS Team finishes its review, the MDS-HC assessment is transmitted by United to MassHealth via an online portal. In limited instances, MassHealth will reject the MDS-HC assessment due to, for example, member ineligibility or data inconsistencies that are readily apparent from the MDS-HC assessment, typically returning a system-generated error stating “Member not found based SSN/DOB and/or Name.” Otherwise, the MDS-HC assessment is not reviewed by MassHealth manually; rather, it is processed by MassHealth’s

electronic system, and the inputs provided by United result in MassHealth's electronic system automatically identifying the member's rate level. MassHealth then calculates United's monthly capitation payments by including those members in the corresponding rate levels as determined by the MDS-HC process. As a result, if United inaccurately reports the members' diagnoses and need for services on the MDS-HC assessment, MassHealth will pay United an inaccurate capitated rate.

81. United nurses understood what information would result in the assignment of certain levels, often referencing "auto approval" of specific levels based on the particular information included in the MDS-HC assessments. See, e.g., Exhibit 10 at 255782. MDS Nurse Michelle Gour, who testified pursuant to a CID, stated that she understood that MassHealth's leveling is determined by United's inputs on the assessments.

82. United continues to receive the monthly capitation payment for that member unless and until the member disenrolled from the United SCO Plan, passes away, or is re-leveled based on a subsequent MDS-HC assessment United submits to MassHealth.

83. United is required by its contracts with MassHealth to perform ongoing assessments of members on a periodic basis. Level 1 and Level 2 members are assessed on semi-annual basis, and Level 3 members are assessed on a quarterly basis. See Exhibit 4 at 19, 21.

United Knowingly and Recklessly Disregarded Known, Persistent Inaccuracies in Leveling Assessments and Prevented Identification of Additional Errors

Chronic Understaffing and Overburdening of Field Nurses

84. United SCO Plan Field Nurses are required to complete a substantial number of tasks for each assigned member. As of January 2015, Steven Bucchianeri, the then-Vice President of Health Services and Clinical Operations at the United SCO Plan, who reported

directly to Di Re, described the duties of a United SCO Field Nurse. Bucchianeri stated that Field Nurses must conduct onboarding and leveling of new members each month, which takes approximately eight hours and includes completion of assessments, creation of plans of care, and communication with primary care service providers. Bucchianeri also stated that, in addition to onboarding new members, Field Nurses are responsible for coordinating care for an average of eighty-five members, which can include completion of ongoing assessments and reassessment if the member requires a higher level of care and maintenance of plans of care.

85. In February 2015, Bucchianeri advised Di Re and Donna Carris, the then-Chief Financial Officer of the United SCO Plan, that there were too few Field Nurses in the United SCO Plan to perform these duties. See **Exhibit 11** at 152220. Because of the staffing deficiencies, Bucchianeri sent a draft proposal to Di Re and Carris requesting the creation of a new team of seven Field Nurses, whose sole responsibility would be to onboard new SCO Plan members. See *id.* at 152221. Bucchianeri’s staffing proposal was made, in part, because pursuant to United’s contracts with MassHealth, United was required to perform an initial assessment of each new SCO Plan member within 30 days of the member’s joining, plus conduct reassessments and also maintain plans of care. With the current number of Field Nurses, United could not meet those contractual requirements. See *id.* Bucchianeri advised Carris that “[a] renewed emphasis has been placed on **compliance for all of these measures** as a result of the recent state-requested attestations.” See *id.* at 152220 (emphasis added).

86. A subsequent draft of the proposal includes comments from Bucchianeri confirming that nursing staff at the United SCO Plan already were operating at full capacity to accomplish contractually required assessments and maintain compliance, and staffing needs could not be addressed through load balancing or workflow improvements.

87. Later in 2015, Di Re reported to MassHealth that United was in the process of hiring additional nursing staff to address compliance with its obligations to perform assessments and maintain plans of care for United SCO Plan members. See Exhibit 12.

88. Despite Di Re's representations to MassHealth, United's staffing issues persisted. According to internal staffing requisition forms from April 2016 prepared by then-Clinical Service Manager Kathleen Walsh, United noted the possibility of "[s]taff burnout and turnover," as well as noncompliance with contractual obligations to complete initial and ongoing assessments of members in the United SCO Plan. See Exhibit 13.

89. United's understaffing of Field Nurses persisted through August 2017, when Bucchianeri submitted an "Investment Request Form" and a staffing proposal to United management. These documents set forth a detailed proposal requesting funds to hire thirty-eight additional staff, including twenty-one Field Nurses. See Exhibit 14. In this request, Bucchianeri highlighted that the United SCO Plan "continues to struggle with compliance and accurate alignment of care level" for United SCO Plan members, citing the inability to maintain adequate staffing levels as the primary contributing factor. Id. at 89763. In a section of the Investment Request Form entitled "Alternate/Risks to Investment," Bucchianeri stated that, as of August 2017, "[a]pproximately 400 [SCO] members have either missing or expired MDS-HC assessments....[t]he [SCO Plan] has not been able to achieve 90% or greater compliance with Initial and Ongoing assessment completion, as required by the state contract...." Id.

90. The Attorney General's Office has interviewed several former Field Nurses working for the United SCO Plan throughout the relevant period, many of whom described serious issues with understaffing. One former Field Nurse informed the Attorney General's Office that she submitted requests to the United SCO Plan management to alleviate workload

and these requests were denied. She also reported that United instead pressured middle management to meet monthly quotas for completion of assessments, including MDS-HC assessments. Another former Field Nurse stated that her Field Nurse team would lose nurses on a regular basis, resulting in them being constantly behind and under pressure to catch up to quotas set by United.

91. Multiple witnesses recounted that it was necessary to work substantial overtime hours to keep up with their regular expected workload. A former Clinical Services Manager said that multiple Field Nurses under her supervision regularly worked seventy-to eighty-hour weeks.

92. Because of United's chronic understaffing, Field Nurses found other means of reducing their workload, including leveling members higher to prevent additional patients from being added to their roster and by copying and pasting patient notes into their MDS-HC assessments.

93. Multiple former employees interviewed by the Attorney General's Office reported that Field Nurses were incentivized to include data in the MDS-HC assessments that would result in higher levels for members. That is because a Field Nurse's case load at the United SCO Plan is directly proportional to the levels of his/her assigned members. As Wolfgang testified, for workload purposes, two Level 2 members are equivalent to one Level 3 member. Indeed, several Field Nurses reported that they increased the diagnoses on the MDS-HC assessment, which would result in higher rating levels for members assigned to them, so that they were not given additional patients to monitor.

94. Multiple witnesses independently reported to the Attorney General's Office that Field Nurses, as a group, discussed how their collective desire to keep their patients at Level 3 contributed to over-leveling at United.

95. On several occasions, United was also informed that Field Nurses would copy and paste assessments for members from prior assessments or from other members. An MDS Team member who contacted the Attorney General's Office reported that she witnessed the repetition of assessment language across multiple member's assessments performed by the same Field Nurse and other Field Nurses working with that nurse. She also reported that Field Nurses would copy and paste assessments from prior years without alteration.

96. A former Field Nurse told the Attorney General's Office that the United SCO Plan management went so far as to explicitly forbid the practice of cutting and pasting in or around 2018 or 2019.

97. Even after United forbade the practice of cutting and pasting, it continued, as United's SCO Plan management knew. Wolfgang testified that Field Nurses would copy language from one patient's assessment to another patient's assessment. Wolfgang further testified that, in the summer or fall of 2020, she brought the cutting and pasting issue to the United SCO Plan's senior management, including Senior Health Services Director Joanne Sullivan, Director of Clinical Operations Jessica Alvarez Montano, and then-Vice President of Medical Clinical Operations Jumelie Miller. Chat messages between Wolfgang and Gour on September 3, 2020 discuss instances of several Field Nurses copying and pasting assessment information. Gour expressed frustration reviewing MDS-HC assessments from two Field Nurses in particular: "I swear..every single note is exactly the same. How do I know what is really true??" **Exhibit 15** at 216295.

98. On January 27, 2021, Gour chatted with Brenda Gonzalez, another nurse and member of the United SCO Plan's MDS Team, stating: "So sick of my team. lol So the nurse that left after being confronted about copying and pasting.. her member's [sic] are all being

reassessed and some [are] no longer NHC [i.e., Level 3]...or much fewer service needs” See **Exhibit 16** at 217488.

99. According to an MDS Team member who was interviewed by the Attorney General’s Office, a May 2023 assessment that resulted in a Level 3 rating included a Request for Services form that was “nearly identical” to those attached to the member’s two prior annual MDS-HC assessments. That form included purported diagnoses of osteoarthritis and glaucoma that were not being treated, according to the member’s medical records. This issue was communicated to managers of the Field Nurse and the MDS Team.

100. In addition to being overworked, some of the Field Nurses at United’s SCO Plan were undertrained. Two former Field Nurses reported that proper training would require at least a year, if not more. Due to frequent turnover, Field Nurses often failed to ever be properly trained before resigning from United, as one former Field Nurse reported that new Field Nurse hires frequently would leave after six months or less due to burnout.

101. Because the Field Nurses were overworked, they were unable to complete key quality control steps. For example, in an August 2021 chat exchange, a Field Nurse recounted that, to address a “huge backlog” of Level 2 MDS-HC assessments awaiting confirmation of diagnoses from the members’ providers, Field Nurses were told that no verification of the diagnoses was to be conducted. See **Exhibit 17** at 238770.

Enabling Upcoding

102. The Attorney General’s Office spoke with multiple former nurses who had performed and reviewed assessments for the United SCO Plan, and several independently reported that they were encouraged to submit member assessments directed towards higher rate cell levels.

103. One former United SCO Plan nurse told the Attorney General's Office that the United SCO Plan trained its nurses, including her, to assess each member by always focusing on members' worst day and asking about the worst days when assessing the member. This training by the United SCO Plan directly contradicts the explicit instructions for all MDS-HC assessments, which require nurses to primarily base scores on the member's last three days. This former nurse stated that her Clinical Services Manager attended these training sessions and did not correct the individual conducting the training or ever instruct her to do otherwise.

104. This same former nurse stated that she was trained to conduct assessments with the goal of satisfying the requirements for a Level 3 rating category. She explained that United's trainers told her that she did not need to consider whether a member's physician had officially diagnosed a condition before she included it in the member's MDS-HC assessment. She further reported that nurses felt pressured to exaggerate diagnoses, for example to diagnose occasional headaches as migraines.

105. A former Field Nurse reported that United management also encouraged her to increase member levels but that, when she sought to reduce a member's level, her MDS-HC assessments were scrutinized and called into question. She also reported that she was challenged by United management when she did not include a behavioral health diagnosis in an MDS-HC assessment after searching for and finding no documentation in the member's clinical record of that diagnosis.

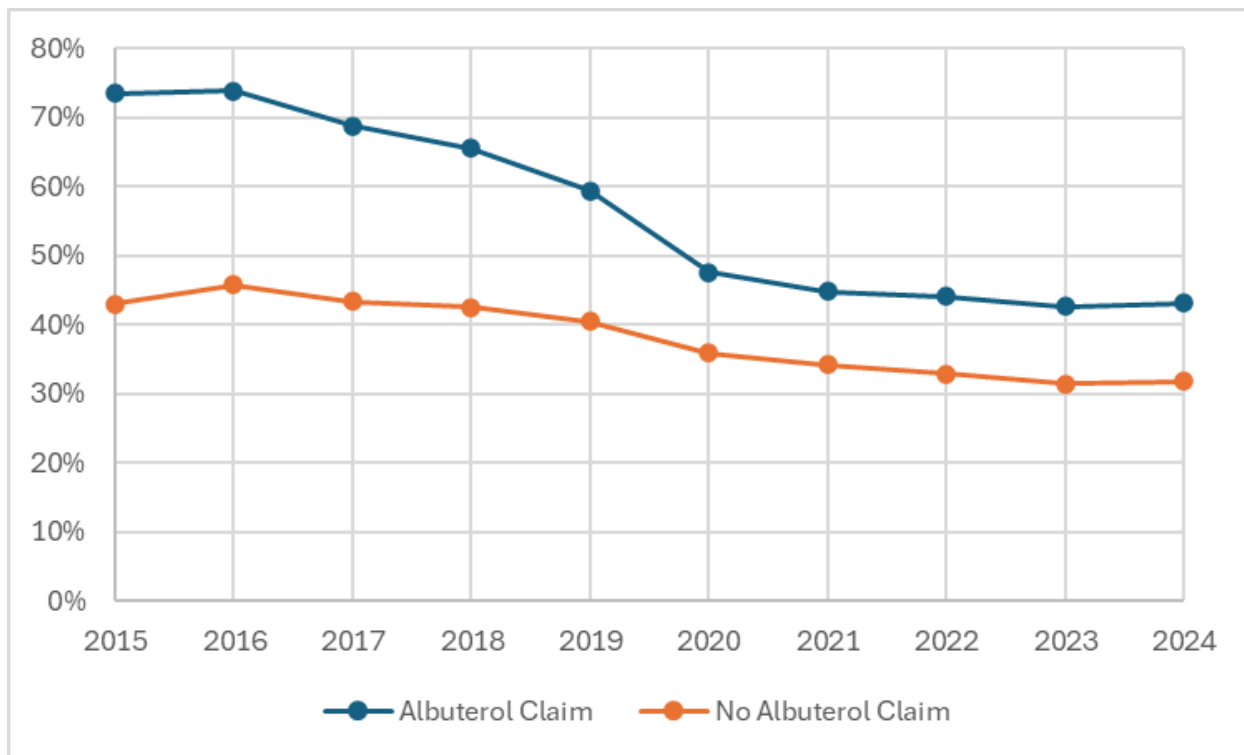
106. Another Field Nurse who contacted the Attorney General's Office likewise stated that she observed Field Nurses changing levels based on cost considerations for United, and that Field Nurses were encouraged to record deficiencies in activities of daily living to bump members' levels higher.

107. Another Field Nurse informed the Attorney General’s Office that, contrary to all of the formal guidance provided by MassHealth and even United’s internal trainings, she was instructed to code all members over the age of seventy-nine at Level 3, regardless of their ability to care for themselves. This Field Nurse added that she was regularly pushed by managers to justify an increase in a member’s level. She was aware of the reimbursement differences between these levels and noted that she “was not going to commit fraud to make [United] money.”

108. Two former Field Nurses informed the Attorney General’s Office that they were instructed by United that, even though inhalers are not an independent basis for meeting Level 3, members using an inhaler should automatically be leveled at Level 3. One Field Nurse reported receiving the instruction from United SCO Plan management and understood that it was the operating guidance from 2014 to 2017. Another, who also was a manager for a time, stated that any kind of inhaler, even emergency inhalers, counted for purposes of this instruction.

109. Similarly, a former case manager at United’s SCO Plan told the Attorney General’s Office that United management told her that, if a member had a need for an inhaler, including albuterol, that member should always be coded at Level 3, no matter what other health conditions the member had.

110. The Attorney General’s Office has conducted an analysis of members within United’s SCO Plan who were classified as Level 3 and identified that members with albuterol claims in their claims data were consistently categorized at Level 3 at a higher rate than other members, especially in 2015, 2016, and 2017:



111. Another Field Nurse at United resigned in part due to what she considered to be inappropriate pressure from her manager to alter assessment information. On March 12, 2021, this Field Nurse stated in her resignation letter that she “was frequently asked to change documentation from my supervisor on assessments that was inaccurate to reduce company costs.” See Exhibit 18.

MassHealth Audits Identifying Upcoding

112. MassHealth’s Office of Long-Term Services and Supports performed an audit of United’s SCO member records in 2018 and sent the findings to United’s CEO, Di Re, on July 30, 2018. As part of that audit, MassHealth found that, out of a thirty-member sample, sixteen MDS-HC assessments resulting in Level 3 assignments were not supported by the member’s other documentation, namely the member’s plan of care. See Exhibit 19. United’s internal communications discussing the audit results noted that one assessment appeared to include copy-

and-pasted data. See Exhibit 20.⁵ MassHealth requested that United submit a corrective action plan to achieve compliance with the findings identified.

113. United submitted a corrective action plan to MassHealth on February 7, 2019. See Exhibit 21. In its corrective action plan, United agreed to re-level one member to Level 1 and disenrolled, then re-enrolled another member, who was also re-leveled to Level 1. United then committed to conducting new MDS-HC assessments of the other fourteen members within 30 days of submission of the corrective action plan. See id. at 88706.

114. MassHealth conducted another audit of United's SCO Plan on February 8, 2019, where it requested documentation associated with three members to validate the placement of those members in Level 3. MassHealth submitted its findings to the United SCO Plan's CEO, Di Re, on March 8, 2019. See Exhibit 22.⁶ MassHealth found that

[E]ach of the [m]embers was eligible for placement in [Level 3] only because he or she required a skilled service (here, physical therapy) three days per week and daily assistance with [ADLs] . . . In other words, if the [m]ember did not need or receive physical therapy three days per week and daily assistance with [ADLs], he or she was ineligible for placement in [Level 3]. Yet, for each [m]ember, the documentation submitted by United demonstrated that a physician did not order, and the [m]ember did not receive, physical therapy three times per week, notwithstanding the contrary representation in Section P of the MDS-HC form. Likewise, for each [m]ember, the documentation submitted by United contained no evidence that the [m]ember required assistance with [ADLs], notwithstanding the contrary representation in Section H2 of the form MDS-HC. Because each [m]ember's need for thrice-weekly physical therapy and daily assistance with ADLs formed the basis of each [m]ember's placement in [Level 3] . . . MassHealth has determined that United inappropriately placed each of those [m]embers in [Level 3].

Id.

⁵ This spreadsheet has been excerpted to remove personally identifying information of SCO members and for readability.

⁶ Member names and identifying information have been redacted.

115. MassHealth offered United the opportunity to dispute the findings in its February 2019 audit by submitting documentation to support the members' placement in Level 3. MassHealth noted that, if United failed to do so, MassHealth would re-level those members to Level 1 and that MassHealth "reserves the right to pursue any overpayments made by MassHealth as a result of the misplacement of a [m]ember in [Level 3]." Id.

116. United responded to MassHealth's 2019 audit findings on April 5, 2019. See Exhibit 23.⁷ In its communication, United informed MassHealth that it was re-leveling the three members at issue and would be requesting Level 1 for two of those members and Level 2 for one of those members.

117. In each instance, MassHealth's audit findings were based on SCO program requirements that were consistent back to 2014. Di Re stated that she was not aware of any changes in directions from MassHealth with respect to MDS-HCs and leveling during her time as CEO of the United SCO Plan apart from a 2016 guidance bulletin. Di Re also testified that the United SCO Plan did not make any drastic changes to its operations and management as a result of these audit findings.

Internal Identification of Upcoding

118. In 2018, United conducted an internal chart review that identified incongruencies between a member's health risk assessment and the member's plan of care, specifically where conditions were listed on the health risk assessment that were not reflected in the plan of care. For example, the chart review reported that the members' health risk assessments included reports of "dizziness" and "breathing problems" that were not otherwise present in the members' medical care plan. See Exhibit 24 at 12.

⁷ Member names and identifying information have been redacted.

119. A nurse working as a member of the United SCO Plan's MDS Team told the Attorney General's Office about multiple instances of purported conditions being added to a member's MDS-HC assessment without any corresponding diagnosis, treatment, or other justification in the member's medical record. Specifically, this employee reported that depression, diagnoses, dizziness, shortness of breath, glaucoma, chronic heart failure, and atrial fibrillation were frequently added as conditions for the member in the MDS-HC assessment to justify the member's supposed deficiencies or other necessary services, even if the member did not have those conditions.

120. This MDS Team nurse identified multiple MDS-HC assessments where no corresponding diagnosis supported the data included on the MDS-HC assessment. For example, one MDS-HC assessment prepared in May 2023 included a diagnosis of tuberculosis with no corresponding reference in the member's primary care records.

121. This MDS Team nurse also recalled an MDS-HC assessment prepared in April 2023 by a Field Nurse requesting a Level 2 rating purportedly based on a new diagnosis of depression and prescriptions from the member's primary care physician for anxiety and depression. However, the records from the member's visit with his primary care physician, only one month before, failed to reference any depression diagnosis or other behavioral health issue. The same Field Nurse submitted another MDS-HC assessment a month later again requesting a Level 2 rating for another member, citing diagnoses of depression and anxiety that were not present in the member's primary care physician record.

122. Several MDS-HC assessments from May 2023 included reports of members' inability to bathe and/or dress independently, notwithstanding that the limitation only concerned the member's lower body, which could be assisted, if not resolved, with durable medical

equipment. These MDS-HC assessments were approved based on managers' recommendations, despite one reported deficiency being described internally as weak at best.

123. The false and inaccurate information being put in MDS-HC assessments was reported to United SCO Plan management as a matter of course, as both Wolfgang and Gour testified. For example, MDS Team members described a meeting with United SCO Plan management, including Jack Webb, the-then Associate Director of Medical Clinical Operations, on April 26, 2023, where they reported instances of Field Nurses submitting inaccurate MDS-HC assessments without supporting medical records. See **Exhibit 25** at 206135-36.

124. United's management was told repeatedly by Field Nurses that they felt pressured to alter documentation or increase levels based on encouragement to management. No fewer than three Field Nurses made internal reports to United's compliance team, later relayed to SCO Plan management, including Sullivan and a Clinical Services Manager, warning that they felt pressured to adjust assessments based on financial, rather than medical, considerations.

Cutting its Internal Audits and Reviews

125. United's MDS Team was designed to improve the accuracy of its MDS-HC assessments, but by April 2019, United had a backlog of over 1,100 MDS-HC assessments that needed to be submitted, in addition to new requests for MDS-HC assessments that were arriving daily. See **Exhibit 26**. United thus decided to reevaluate the workload of the MDS Team.

126. On August 9, 2019, United SCO Plan senior leadership, including Wendy Sanchez, then-Health and Human Services Manager, Montano, and Sullivan conducted an "MDS Team Huddle" with a group of MDS Team Members after consultation with senior leadership the previous day. In that MDS Team Huddle meeting, United instructed the MDS Team to submit backlogged MDS-HC assessments without auditing to catch up. At the same time,

Sanchez directed United's MDS Team to undertake an accelerated review of other MDS-HC assessments queued for review, assigning each nurse seventeen assessments to review each day. See **Exhibit 27**. Just four months prior, United had estimated internally that each MDS Team nurse could perform only five to six accurate reviews each day. See **Exhibit 26**.

127. Even though Sanchez, Montano, and Sullivan advised the MDS Team that the direction to stop auditing MDS-HC assessments would only last for the month of August 2019, that directive ultimately became the operating procedure for the United SCO Plan.

128. Because many MDS-HC assessments were being submitted to MassHealth without further review, the accuracy of United's MDS-HC assessments submitted to MassHealth plummeted. In a chain of written email communications ending in January 2020, Montano wrote to Kevin Bolling, a United economics consultant, and noted that the "rate of . . . rejections [by MassHealth] related to clinical documentation discrepancies has increased by 50% since May 2019." See **Exhibit 28** at 39619. In that same email chain, Montano also cited a need to retrain staff to decrease the rate of rejection regarding MDS-HC assessments submitted by United to MassHealth. See *id.*

129. Notwithstanding the chronic reports of inaccurate MDS-HC assessments and understaffing, United did not increase the size of its MDS Team. Instead, United did the opposite and cut down on its quality control process. Di Re testified that the only issues she ever encountered with the MDS Nurses were stresses caused by low staffing and high volume of work.

130. On or about January 29, 2021, Wolfgang sent an "info blast" to MDS Team Nurses dictating a new workflow for MDS review to be effective on February 1, 2021. See **Exhibit 29** at 205458. The instructions made clear that, from February 1, 2021 forward, the

MDS Team would no longer verify member’s diagnoses, medication, and eligibility for assistive services, categorizing these items as “EXCLUDED from the review.” See id. The info blast also advised the MDS Team that they were only allowed to review each MDS-HC assessment for clinical rate category accuracy by only utilizing the MDS-HC assessment and the functional assessment, and not the member’s clinical records. See id.

131. After the receipt of the January 29, 2021 info blast, two MDS Team Nurses, Gour and Karen Burgio, chatted with each other about the new requirements, writing:

Gour: ... SO IF [THE MEMBER DOESN'T] MEET ELIGIBILITY FOR PCA.. [SIC] WE PUT IT THROUGH ANYWAY?

Burgio: so I dont [sic] have to look at the actual diagnosis in the ccp [coordinated care plan] or in the med [records] so long as the [MDS-HC] matches the functional [assessment]

Gour: yep[.] this makes my eye twitch. lol

Burgio: lol.. ok so our work was cut in 3/4 basically[.] no looking at dates, diagnosis, medications, no icue [Integrated Clinical User Experience],⁸ no nadda[.] got i[t]

See Exhibit 30 at 207611-12.

132. On May 19, 2022, United SCO Plan senior management, including Sullivan and Webb, held a meeting with the MDS Team to discuss the changes to the auditing process. During this meeting, members of the MDS Team again raised concerns about the sufficiency and accuracy of information contained in MDS-HC assessments that were being submitted to MassHealth. In response, United senior management, including Sullivan and Webb, advised the MDS Team not to “reject” assessments but rather to submit MDS-HC assessments to MassHealth as received from the Field Nurses and relay corrections to the Field Nurses after the submission.

⁸ The Integrated Clinical User Experience was created by United as a platform to house the medical and behavioral health services information into one central delivery system.

133. In June 2022, Wolfgang sent out a written document titled “MDS Communicated Guidance – Role modification: Moving from Audit to Reviews,” explicitly instructing MDS Team members to “move from an auditing process for the MDS . . . to a review process allowing for a portion of the [MDS-HC] assessments to be processed as a transcription only.” See Exhibit 31 at 76659.

134. Wolfgang testified that, in June 2022, United dictated that the MDS-HC assessments conducted by approximately one-half of the Field Nurses would no longer be subject to any kind of audit or review. For the Field Nurses no longer subject to review, the MDS Team was instructed to transcribe the MDS-HC assessments “as is,” and that the MDS Team members “will not be verifying information in the MA [functional assessment], Medical Records, Care Plan or any information in [United’s Centralized Enrollee Record]” See id. at 76660.

135. As to the remainder of the MDS-HC assessments, the MDS Team was instructed to limit their review and audit of MDS-HC data strictly to the corresponding functional assessment, meaning that the MDS-HC assessments would be verified only against the functional assessment created by the same Field Nurse, and without reference to any supporting medical records or claims data. See id. Even then, the only criterion to evaluate the MDS-HC assessment was whether the “MDS coding meets [the] rate category requested.” [Id] Otherwise, the MDS Team “will not ask [the Field Nurse] to make corrections.” Id. at 76659.

136. After June 1, 2022, MDS Team members continued to raise concerns with United SCO Plan management regarding the change in MDS-HC review from auditing to transcription.

137. The following year, during an April 26, 2023 meeting attended by the MDS Team and United management, including Sullivan and Webb, MDS Team members identified the

likelihood of incorrect, or even fraudulent, MDS-HC submissions, citing particular examples of erroneous assessments flagged by the MDS Team. See Exhibit 25 at 206135-37.

138. In response, United's management declined to alter the new MDS-HC submission process or otherwise increase its scrutiny of the data submitted to MassHealth, instead putting sole responsibility for accurate submissions on the Field Nurses conducting the assessments, who, because of United's staffing decisions, were overworked and incentivized to upcode. Indeed, following the April 26, 2023 meeting with Sullivan and Webb, members of the MDS Team discussed among themselves the need for certain Field Nurses to be placed on corrective action plans due to subpar work, talked about the fact that that MDS-HCs are submitted without medical records, and considered requesting explicit assurances that MDS Team members acting as "data entry workers" to submit MDS-HC assessments would not be held accountable for rating levels that United is not "qualified to receive reimbursement for." See id. at 206135.

139. After the April 26, 2023 meeting, a United MDS Team member, Brenda Gonzalez, summarized her feelings by stating: "I just think we cant [sic] be MDS Nurses and say we just submit." See id. at 206137. Another MDS Team member, Melissa DeLuca, stated "It appears that they [United] want us to be data entry workers" and suggested reporting further up the chain to United management, because "[a]s employees we are all held to the standard if we suspect something is not right in regards [sic] to billing." See id. at 206137-38.

140. United's instructions to the MDS Team in January 2023, which was charged with quality control of submissions to MassHealth with respect to evaluating Level 2 diagnoses were unequivocal: "If the MDS includes the appropriate information you will submit."

United's Improper Classification of Level 2 Members

141. By choosing profits over quality control and by incentivizing Field Nurses to code higher diagnoses than members had, United submitted MDS-HC assessments to MassHealth that resulted in members being classified as Level 2 even when they did not meet the criteria for Level 2, resulting in MassHealth making higher capitated payments to United than it should have.

142. For a member to be assigned to Level 2, the MDS-HC assessment must record both a diagnosis of behavioral health or substance use disorder and a treatment corresponding to that diagnosis.

143. According to United's Field Nurse training materials, the MDS-HC assessment must recite and describe the treatments or services necessary to address a cognitive impairment diagnosis, typically a prescribed medication or therapy. See Exhibit 7 at 16-17, 19. If the patient does not have a prescription to address a behavioral health or substance use disorder, the MDS-HC assessment must explain what treatments the member is receiving to justify the Level 2 assignment. See id. at 14, 19.

144. According to United's internal documents, Field Nurses are not permitted to make diagnoses themselves. Instead, any applicable behavioral health diagnosis must originate from the member's primary care team. See Exhibit 32 at 184417. Similarly, a member's self-reported recitation of his/her medical conditions is not sufficient to establish a diagnosis and must be confirmed with the member's primary care team.

145. Field Nurses were repeatedly instructed that, to ensure that a member was assigned to Level 2, both the requirements for a verified diagnosis and a treatment plan

administered by a primary care physician or other behavioral health therapist must be present.

See **Exhibit 33**.

146. Despite the fact that United SCO Plan senior management instructed United SCO Plan employees that both a verified diagnosis and a treatment plan are necessary for a member to be assigned to Level 2, a member of the MDS Team told the Attorney General's Office that there were specific instances where a member's MDS-HC assessment included depression diagnoses, thereby purporting to satisfy the Level 2 requirement, but where there were no corresponding diagnoses or records of treatment for the member in the primary care team records.

147. This MDS Team Nurse also reported that, beginning around 2020 and gradually over time, United SCO Plan management changed their instructions to remove guardrails that would have ensured that Level 2 members had been coded accurately. Specifically, MDS Team Nurses were instructed that, if MDS-HC assessments included a behavioral health diagnosis, even absent a treatment plan or prescription, the MDS Team Nurse should not question the member's assignment to Level 2.

148. In January 2023, United made explicit that the MDS Team need not confirm whether a person whose MDS-HC assessment would result in a Level 2 classification actually had behavioral health diagnoses and treatments. United advised the MDS Team that "if [Field Nurses] submit the MDS asking for X rating category and they included it in the [request for services] summary and checked it off on the MDS, you can assume [the Field Nurses] verified it thru medical records or claims." United SCO Plan management further instructed the MDS Team to ensure only that there was an applicable behavioral health diagnosis in the MDS-HC assessment and recited in the requested level but otherwise not to undertake any additional review to verify that this diagnosis was supported by the member's medical records.

149. Similarly, a former Field Nurse told the Attorney General's Office that the goal at United was to make every member Level 2 as often as possible. She described a situation in which she was able to confirm a behavioral health diagnosis from a primary care physician's receptionist, but not the primary care physician. Her manager instructed that this member should be submitted to be Level 2, over the former Field Nurse's objections.

150. Another former Field Nurse recalled performing a periodic assessment for a Level 2 member and requesting clinical documentation from the member's doctors for the MDS-HC assessment. The Field Nurse found that there was no documentation of diagnosis, treatment, or medications that would support Level 2 assignment for the member. The Field Nurse thus submitted an updated MDS-HC assessment to relevel them. Following this releveling, the Field Nurse was called to a meeting where she was questioned why the member had been leveled down.

151. A former case manager told the Attorney General's Office that she always checked diagnoses and treatments to make sure a member qualified for Level 2, but she was aware that other Field Nurses at United did not. When filling in for certain Field Nurses, she would double-check whether their patients at Level 2 actually qualified because of diagnoses and treatment; she found that those patients would often not meet Level 2 criteria.

152. The Attorney General's Office undertook an analysis of members in the United SCO Plan assigned to Level 2 and compared them to treatments received by members. United relied upon specific diagnoses to satisfy Level 2 requirements, which included diagnoses such as Alzheimer, dementia, and schizophrenia, as well as various categories of depression. See Exhibit 34 at 14. According to the analysis conducted by the Attorney General's Office, for the United SCO Plan population rated Level 2 from 2016 through 2022, 18.29% had no medical

claims reflecting any treatment for any of United’s specified diagnoses in the year preceding or following MassHealth’s Level 2 capitated payment to United, resulting in approximately \$18,592,798 in payments to United for members without relevant treatment. If those members had been classified as Level 1, United instead would have been paid approximately \$13,119,737. United has not repaid MassHealth for this difference.

153. The Attorney General’s Office also conducted this analysis with respect to all mental health- and substance use disorder-related diagnosis codes, not just the ones United relied on internally to satisfy Level 2 requirements, as the scope of mental health diagnosis expanded over time from Alzheimer’s and dementia to encompass other behavioral health conditions and substance use disorder diagnoses.⁹ Of the members for whom United received a Level 2 capitated payment from MassHealth from January 2014 to December 2024, 8.94% had no associated claims with any behavioral or developmental health or substance use disorder diagnosis code in the year preceding or following the Level 2 capitated payment. Thus, on average, nearly 10% of the United SCO Plan members rated as Level 2 in any given month do not have any corresponding mental health or substance use disorder claims for treatment in the surrounding two years. MassHealth made approximately \$13,075,643 in payments to United SCO Plan for these member months. If those members had been classified as Level 1, United instead would have been paid approximately \$8,337,922. United has not repaid MassHealth for the difference.

154. The Attorney General’s Office also compared the MDS-HC assessments for Level 2 members in the United SCO Plan from 2014 through 2024 with claims data for services

⁹ The nomenclature for the Level 2 category correspondingly changed over time from “Alzheimer’s Disease/Dementia or Chronic Mental Illness” (AD/CMI) to “Community Behavioral Health” (CBH). Level 2 has also been referred to as “Behavioral Health/Substance Use Disorder” (BH/SUD).

received by each of those members. The Attorney General's Office undertook to determine whether that claims data included the behavioral health and/or substance use disorder diagnosis listed by United on the MDS-HC assessment it submitted to MassHealth. Of the MDS-HC assessments from which United received a Level 2 capitated payment from MassHealth from January 2014 to December 2024, 29.55% had no associated claims with any behavioral or developmental health or substance use disorder diagnosis code that matched what United submitted on the MDS-HC assessment to MassHealth to justify the Level 2 capitated payment in the year preceding or following the date of the MDS-HC assessment. In other words, no actual medical claims supporting the diagnosis codes United put on its MDS-HC assessments to justify its Level 2 payments from MassHealth were present for nearly 30% of its Level 2 assessments during the time period relevant to this analysis. United was paid approximately \$47,223,898 by MassHealth for these months in which the mental health diagnosis listed on the MDS-HC was not supported by medical claims. If United had been paid at the Level 1 rate for these members, it would have received approximately \$30,500,509 instead. United has not repaid MassHealth for any capitated payments it should not have received for these members.

155. For example, member S.W. was assigned Level 2 based on MDS-HC assessments prepared by United from 2021. From 2021 through 2025, United submitted an MDS-HC assessments that sought continued assignment at Level 2 due to the diagnosis of a singular depressive episode in 2018, notwithstanding confirmation in S.W.'s medical records that she discontinued medication due to improved symptoms. S.W. had no other behavioral health-associated claims in that period.

156. S.W. has been classified as Level 2 since enrollment in United's SCO Plan in August 2020. From August 2020 through December 2025, United has received \$54,657 in

corresponding capitation payments for S.W. If S.W. had been appropriately classified at Level 1 starting in 2020, United would have been paid approximately \$36,933 for S.W.'s services.

United has not repaid MassHealth for the difference.

157. Member A.A. originally enrolled with United in September 2011 and was moved from Level 3 to Level 2 in January 2017. According to ten MDS-HC assessments conducted between December 2014 and December 2023, United said that A.A. had a diagnosis of depression. From September 2013 through October 2015, A.A. was prescribed Fluoxetine, an antidepressant medication, although the MDS-HC assessment conducted in November 2017 indicated that A.A. did not utilize any psychiatric medication. A.A. has had no medical claims paid by United for treatment of depression, and the MDS-HC assessments conducted in January 2020, January 2021, January 2022, December 2022, and December 2023 state that A.A. managed their symptoms by socializing with friends and family and attending church.

158. A.A. was classified as Level 2 from January 2017 through February 2025, and United received \$66,498 in corresponding capitation payments. If A.A. had been appropriately classified at Level 1 starting in January 2017, United would have been paid approximately \$43,000. United has not repaid MassHealth for the difference.

United's Failure to Return Overpayments from Improperly Classified Level 3 Members

159. United's decision to choose profits over quality control and to incentivize overworked Field Nurses to code members higher on MDS-HC assessments also resulted in members being classified as Level 3 when they did not meet those criteria, resulting in MassHealth making higher capitated payments to United than it should have. United became aware of this problem, submitted updated MDS-HC assessments that resulted in reclassifications

of the members to Level 1, and never returned any of the money it had improperly received from MassHealth from when those members had been improperly coded at Level 3.

160. On March 16, 2021, the Attorney General’s Office interviewed a Field Nurse who reached out to the Attorney General’s Office to express concerns with the United SCO Plan. The Field Nurse reported that, upon being hired by United in mid-2017, her supervisor directed her and other Field Nurses to ensure that members would be categorized at Level 3. Similar to other Field Nurses who have spoken with the Attorney General’s Office, this Field Nurse also reported that she was given training on how to be more lenient with the functional assessment tool, such that this tool would be consistent with the data submitted on the MDS-HC assessment. She characterized her training as instructions on “how to make members a certain level.”

161. When members are classified at Level 3 (even if improperly so), however, the members generally qualify for a variety of support services, such as personal care attendant services and adult day health center services, often referred to as home- and community-based services (“HCBS”). In 2017 and 2018, United determined that the expenses for these support services for United SCO Plan members were too high.

162. In April 2019, United SCO Plan management highlighted costs associated with home and community-based services for members as an “affordability” issue requiring remediation. See Exhibit 26 at 93407. United began developing plans to reduce services provided to members. Kathleen Cooney, a then-Associate Director of Medical and Clinical Operations, wrote that there were “areas of opportunity” to decrease costs currently borne by the United SCO Plan by reducing personal care attendant and companion services. Id.

163. Around the same time, United’s parent exerted additional pressure on the United SCO Plan to increase its revenue. During a May 2019 meeting with officers of the United SCO

Plan and employees from the United parent’s corporate functions, Heather Cianfrocco, the then-CEO of UnitedHealth Group Inc.’s Community and State business segment (which includes the United SCO Plan and other state plans), publicly “lambasted” Di Re for the performance of the United SCO Plan. Specifically, Di Re was criticized for the United SCO Plan not meeting financial targets set by United’s parent corporation. Di Re recalled that there were likely several reasons why the United SCO Plan was not meeting its parent’s revenue targets, and the cost of home and community-based services and the requests for staffing resources would have been included. Di Re testified that Cianfrocco demanded that Di Re call Daniel Tsai, the then-Secretary of EOHHS, to ask for more money from MassHealth.

164. United senior management, including United SCO Plan then-CEO Di Re and other officers from the United SCO Plan, described these support services as the “primary contributor to affordability issues” during an August 2019 presentation to executives from United’s national parent operations. See **Exhibit 35** at 4. The presentation further stated that “remediation of the underlying causes of HCBS trend” is the “key to long term sustainability” for the United SCO Plan. *Id.*

165. As a result, United undertook a “renewed and rigorous focus on medical affordability and . . . utilization management” for member support services. See **Exhibit 5** at 123059.

166. To address these cost concerns, management of the United SCO Plan ultimately decided to redevelop United’s functional assessment tool for MassHealth members. Under this new initiative, MassHealth members in the United SCO Plan were evaluated with a Massachusetts-specific tool, as opposed to the previous functional assessment tool that was used for similar programs administered by United across multiple states. The revised, Massachusetts-

specific functional assessment tool employed more stringent standards to authorize the provision of supports and services to United SCO Plan members. Sullivan described the new functional assessment tool as “just being more realistic and just trying to . . . get folks to understand that we need to be documenting appropriately what members need and not just putting numbers down . . . We have people on 50 and 60 hours’ worth of things.” Di Re testified that United’s reason for implementing these changes was “overprescribing services [for members] unnecessarily in some cases.”

167. The deployment of the new functional assessment tool was announced internally on July 9, 2019, with an effective date of July 15, 2019, to the United SCO Plan Field Nurses. See Exhibit 36. Field Nurses then began performing new functional assessments of United SCO Plan members according to the usual schedule for assessments of members. Management of the United SCO Plan prepared and distributed talking points for Field Nurses to accompany the roll-out of the new functional assessment tool. The talking points addressed the possibility that a member, assessed using the new tool, would ultimately have their services reduced. United also noted that, if the member’s services were reduced pursuant to this functional assessment, United may also be required to update its MDS-HC assessment for that member, which could lead to a reduction in their rate cell level. See id. at 100847-48.

168. In its internal training materials, United stressed the importance of explaining in narrative fashion why members should be assigned certain rate cells based on their health conditions. United highlighted transitions between levels as a circumstance when this rationale is particularly important in a job aid saved in the “MDS Corner,” a collection of reference materials specifically for Field Nurses and the MDS Team: “A member who has been at NHC level for seven years, and we are now asking for a Community Well level, will require a clear

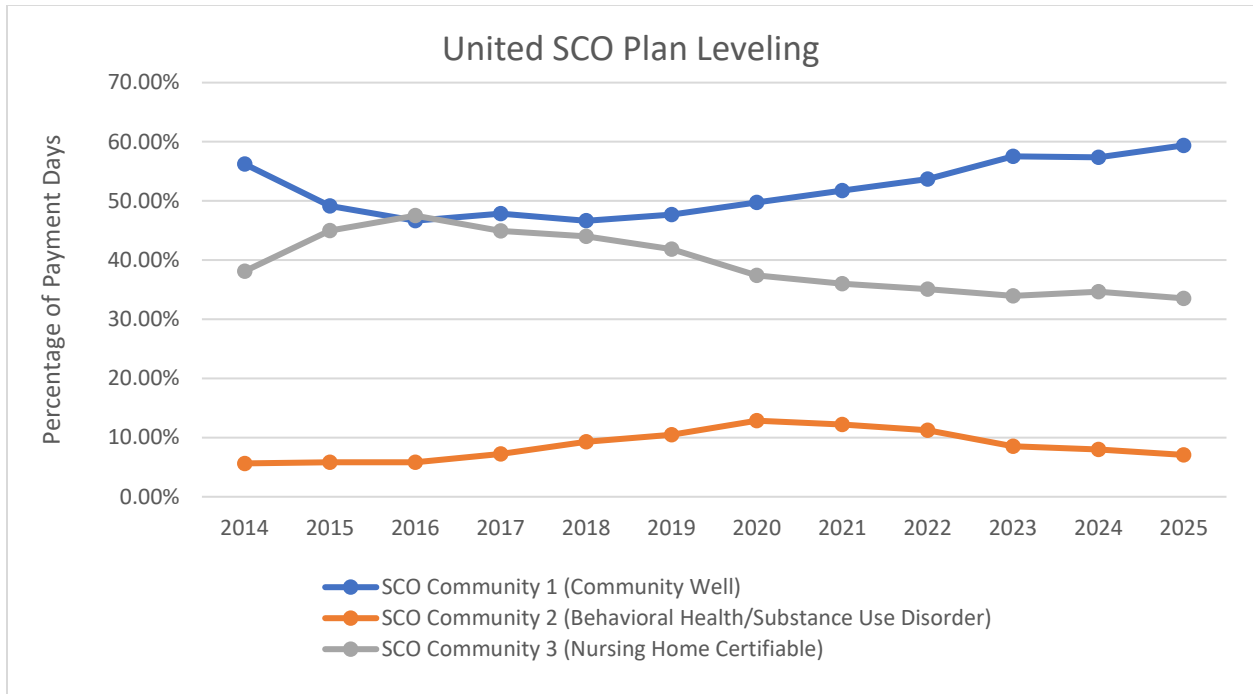
detailed reason for a member’s significant improvement.” See **Exhibit 37**. One former Field Nurse even reported that Dr. Cheryl Ellis, the chief medical officer of the United SCO Plan, suggested specific language for Field Nurses to include in assessments, particularly in circumstances where the member had no improvement in health or abilities, but United nonetheless reduced their services. See **Exhibit 38** at 23828.

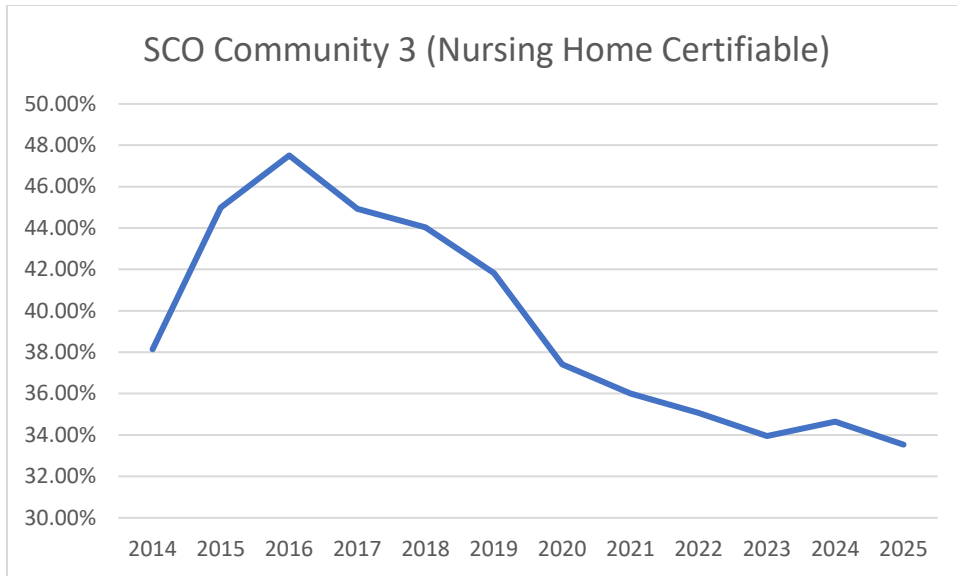
169. United had previously instructed its Field Nurses to use the functional assessment as a support tool for the subsequent MDS-HC assessment, emphasizing that the functional assessment must be consistent with the MDS-HC assessment. See, e.g., **Exhibit 33; Exhibit 37**. Indeed, United described the MDS-HC assessment in training materials as “all based on the [functional assessment]” and that after the functional assessment, “you should already know what level you will be requesting.” **Exhibit 34** at 4.

170. As the new functional assessment tool was utilized by United’s Field Nurses, unsurprisingly, the number of members appealing United’s reductions of their services increased considerably. United management sought additional assistance from other employees outside of the United SCO Plan to address the rapid increase in member disputes. On October 29, 2019, Di Re emailed Dr. Jack D’Angelo, another medical director at United, asking if he had availability to assist Dr. Ellis to “keep up with a significant increase in cases resulting from our re-assessments using [the] new [functional assessment].” See **Exhibit 39** at 53635. Dr. Ellis described this as “obviously a very busy time” for her in light of the increased volume of appeals to review, which required the United SCO Plan to seek additional outside help from Dr. D’Angelo.

171. The claims data for United SCO Plan members supports United employee statements that United systematically reduced the number of members who were classified as

Level 3 over time. As Di Re confirmed, members with higher rating levels should receive qualitatively or quantitatively more services than members assigned to lower levels. As the below figures demonstrate, the Level 3 population in the United SCO Plan dropped once United’s initiative to reduce services was underway.





172. The reduction in United’s Level 3 population also coincides with United’s back-and-forth communications with MassHealth surrounding its two audits of United’s SCO Plan, described above, which suggests that MassHealth’s audits may have also contributed to some of United’s re-leveling of its members.

173. Many of the members who United re-leveled out of Level 3 were not re-leveled because they were healthier; they were re-leveled despite no apparent change in condition because they had been improperly leveled in the first place.

174. Following the interview with the Field Nurse, the Attorney General’s Office issued a civil investigative demand to United and requested, among other things, assessments for a sample of sixty members who had been categorized as Level 3 for a period of time, but who were re-classified to Level 1 after September 2019.

175. Of the sixty sets of assessments reviewed, twenty-five of the members reduced from Level 3 had consistent, repeated assessments that reflected no apparent change in overall health condition, but then suddenly developed improved health conditions after United re-examined its Level 3 member population.

176. For example, member I.T. was initially assessed at Level 3 by United in September 2016. While I.T. reported complete independence, the United case manager recommended that she receive supervision for safety and submitted an MDS-HC assessment that resulted in I.T. being leveled at Level 3.

177. I.T. declined needing services on assessments in March 2017, October 2018, February 2019, and November 2019, including, in November 2019, after recovering from a surgery. Nevertheless, United submitted MDS-HC assessments throughout this time period that resulted in I.T. being placed in Level 3.

178. In July 2020, I.T. was re-leveled to Level 1 by United's MDS-HC assessment that stated that I.T. had experienced "improvement," even though no change in condition or services was evident from I.T.'s medical documentation.

179. From September 2016 through June 2020, I.T. was classified as Level 3 based on United's MDS-HC assessments. United received \$125,277 in corresponding capitation payments during that period. By contrast, following the June 2020 assessment, I.T. was rated Level 1. United should have received approximately \$13,300 in corresponding capitation payments for I.T. if I.T. had been classified as Level 1 from September 2016 through July 2020. United has not repaid MassHealth for the difference.

180. Another member, E.R., was assessed by United in February 2016. According to the MDS-HC assessment, E.R. required assistance with four activities of daily living: bathing, grooming, dressing, and ambulation. The MDS-HC also listed diagnoses of depression, Type 2 diabetes, and hypertension. Based on this MDS-HC assessment, E.R. was classified as Level 3.

181. E.R.'s assessments reported consistent difficulty with bathing, dressing, and ambulation through 2019, including additional MDS-HC assessments in May 2017 and April

2018. The May 2017 MDS-HC assessment also cited a need for daily skilled nursing for medication management and pain management.

182. In August 2019, however, United's assessment of E.R. completely changed. The August 2019 MDS-HC assessment reflected that E.R. had no difficulty performing any activities of daily living, nor that E.R. had symptoms of any mood disorders. There is no indication in E.R.'s record attributing the change in condition to any treatment.

183. From March 2016 through August 2019, E.R. was classified as Level 3 based on United's MDS-HC assessments. United received \$89,275 in corresponding capitation payments during that period. By contrast, during the subsequent four years and three months after the August 2019 assessment, E.R. was rated Level 1. United should have received approximately \$6,600 in corresponding capitation payments for E.R. if E.R. had been classified as Level 1 from March 2016 through August 2019. United has not repaid MassHealth for the difference.

184. Another member, M.J., was assessed by United in October 2015. The MDS-HC assessment reported that M.J. needed daily assistance with bathing, grooming, and dressing, and required daily skilled nursing to manage Type 2 diabetes, hypertension, and arthritis. M.J. was assigned Level 3 based on United's MDS-HC assessment.

185. United continued to recommend that M.J. be assigned to Level 3 consistently over the next three years, including assessments in December 2016 and June 2018 reporting the same ADL assistance requirements and diagnoses. Excluding a lapse due to overdue assessments from April 2018 through June 2018, M.J. remained at Level 3 until October 2019, when she was again re-leveled due to a lapsed assessment.

186. In December 2019, United conducted another MDS-HC assessment and reported wholly different results. United reported that M.J. demonstrated complete independence with all

ADLs, whereas United's last MDS-HC assessment reported deficiencies with six ADLs. United also reported that M.J.'s "health has improved," citing decreased pain because of current pain medication. The pain medication in question appears to be Tylenol, which United recorded M.J. as taking as needed since 2015.

187. From December 2014 through September 2019, United rated M.J. as Level 3 (excepting lapses due to expired assessments) and received approximately \$144,675 in capitation payments. By contrast, in the subsequent six years, M.J. was rated Level 1, based on United's newfound representations to MassHealth. United should have received approximately \$11,250 in capitation payments for M.J. if M.J. had been classified as Level 1 from December 2014 through September 2019. United has never repaid MassHealth for the difference.

188. The Attorney General's Office has evaluated the number of members whose MDS-HC assessments were reduced from Level 3 from the second quarter of 2019 through the first quarter of 2020. The Attorney General's Office has determined that 5.38% of members in the United SCO Plan who received a Level 3 payment during this time period were reduced from Level 3 to Level 2, and that 4.91% of Level 3 members were reduced from Level 3 to Level 1 during this period. From January 2014 through March 2020, United was paid more than \$97 million in capitated payments at the Level 3 rate for those members prior to their re-leveling. United has not repaid MassHealth for the difference between the capitated payments it received and what it was entitled to, based on the members' actual health status.

189. Prior to its switch to the new functional assessment and the MassHealth audit results, both of which appear to have spurred United to reduce its Level 3 population, United had made a larger profit on those members whose levels were reduced during this time period compared to other members.

190. The Attorney General's Office reviewed the capitated payments MassHealth made to United from January 1, 2014, through March 31, 2019. Among the months for which United was reimbursed at Level 3 during this time period, the average capitated payment for members whose level was not reduced was \$2,933.68 and the average amount United spent on services for those members was \$2,259.95, meaning United was netting over \$700 per member per month.

191. By contrast, the average capitated payment for members whose level was reduced was \$2,877.46, but the average amount United spent on services for those members was \$1,348.09, meaning United was netting roughly \$1,500 per member per month.

192. Throughout this time, United never informed MassHealth that it had received higher capitated payments for these members than their conditions warranted and that it would be engaged in a widespread re-leveling of members as a result. In fact, Di Re testified that she had no memory of ever communicating to MassHealth that United had assessed SCO Plan members in a way that would require the down-leveling of a significant number of members, or that United had down-leveled a significant number of members at all.

**United's Submission of False MDS-HC Assessments for Level 3 Members
Who Are Not Receiving Skilled Services**

193. United's decision to choose profits over quality control and to incentivize overworked Field Nurses to code members higher on MDS-HC assessments also resulted in members being classified as Level 3 when they did not meet those criteria, specifically because those members were not receiving a skilled service, such as skilled nursing, at least three times per week.

194. United knew that, for a member to be classified as Level 3, the member had to need skilled services like nursing daily or had to need skilled services three times per week and

require assistance with at least two ADLs. This requirement was reflected in the contracts United signed with MassHealth throughout the relevant time period and was reiterated in Appendix Q to United's contract with MassHealth, which was adopted in March 2015. In that Appendix, MassHealth specifically noted that "Failure to document the specific daily skilled need under 130 CMR 456.409(A) (path 1); or failure to document the specific three needed services under 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C) (path 2), may result in MassHealth reallocating the member to the [Level 1] rating category AND recouping the difference between the [Level 1] payment level and the [Level 3] payment level, retroactive to the date of the MDS-HC submission."

195. United's internal documents similarly reflect that United was aware that its members would not be eligible for placement in Level 3 if those members did not receive skilled services daily (or at least three times per week).

196. In addition to requesting details about a member's existing diagnoses, treatments, and abilities to perform ADLs based on the in-person assessment, the MDS-HC also requires United to report utilization of specific services within the prior seven days. See **Exhibit 2** at Section P (titled "Service Utilization (in Last 7 Days)"). The form includes line items to catalog the number of days, hours, and minutes corresponding to the formal care services received by the member according to specific categories, including home health aides, physical therapy, and visiting nurses.

197. Notwithstanding that the MDS-HC form instructed United to report the frequency and quantity of services received by the member in the previous week, United repeatedly trained its staff to always record that the member had received seven days of formal care from visiting

nurses in the prior week if United was seeking a Level 3 rating regardless of whether those services were actually performed.

198. United's instructions to its Field Nurses to enter this data were straightforward and unequivocal:

Visiting Nurses - **For NHC members**, always 7 days/7 hours
- **For ADCMI/CW members**, time will be 0, 0, 0 unless member is receiving VNA services

See **Exhibit 6** at 71. In fact, United's instructed its Field Nurses to enter accurate information for every other formal care service in this section.

199. Cheat sheets prepared by United SCO Plan clinical staff included the same instruction: "**Visiting Nurses**- if requesting NHC status, must be at least 7 days, 3 hours and 30 minutes." See, e.g., **Exhibit 40** at 43591.

200. United's training materials for its clinical staff similarly and inaccurately described the requirements to meet Level 3 as "members who live in the community and who require supervision or assistance with at least 2 ADLs for 3 or more days per week. These members **might also need** skilled nursing services in the home to administer medications or they may also receive physical therapy." See **Exhibit 34** at 11 (emphasis added). United's apparent insistence that the requirement for Level 3 members to need skilled services was optional is furthered by its instruction to clinical staff that "Minimum of 2 ADL impairments at supervision or greater can be an indicator for [Level 3] due to chronic condition(s) causing the impairments." Id. at 26.

201. United clinical staff acknowledged that this representation did not reflect actual services performed. An MDS Nurse, Cintia Casillo, recounted difficulties she was having with MDS-HCs from a certain group of Field Nurses in a chat with Wolfgang. These Field Nurses were apparently reporting visiting nurse utilization accurately, causing Casillo to comment:

“somethin[g] is happening that [the Field Nurses] think skill[ed] nursing is only reported for ones w/ ‘real’ VNA.” See **Exhibit 41** at 256090.

202. United knew that recording seven days of skilled nursing in the MDS-HC would necessarily result in auto-approval of the members at Level 3. As MDS Nurses Karen Burgio and Michelle Gour discussed in a chat, listing seven days of skilled nursing will translate to a Level 3 categorization even with no corresponding ADL deficiencies. See **Exhibit 42** at 204298-99.

203. Furthermore, as noted above, United was audited for this very issue by MassHealth in February 2019, where MassHealth concluded that three of United’s members in Level 3 had not been ordered to receive, nor had they received, the skilled services listed on United’s MDS-HC assessment. United attempted to rectify the issue with these three members with MassHealth as a result of that audit, agreeing to submit revised MDS-HC assessments that would result in lower levels for those members. See **Exhibit 23**.

204. Former Field Nurses interviewed by the Attorney General’s Office confirmed that United instructed them to write seven days of skilled services for all members who they wanted to place in Level 3, regardless of whether the member had recently received or even needed the services. One former Field Nurse stated that United instructed case managers to always list seven days of skilled nursing and home health aide services for Level 3 members in Section P, regardless of actual services provided. She later came to believe this practice was misleading and potentially fraudulent, and contrasted this with her later employer, another SCO provider, which instructed her to place actual services received in Section P.

205. A former United case manager similarly told the Attorney General’s Office that she was instructed to put seven days of skilled nursing services on MDS-HC forms for all members who had a need for assistance with two ADLs (even if durable medical equipment

made those members independent). She stated that she did not even arrange for seven days' worth of skilled nursing services for some of these patients; she explained that United told her to only offer two days for many of these patients, even if they needed more, which she believed caused harm to patients. She also stated that United instructed her to report that family members were performing services and assisting with ADLs, even though they were not doing that most of the time. She now works for a different SCO Plan, where she has not been instructed to put seven days of skilled nursing services on MDS-HC forms anytime a patient has two ADL needs.

206. Another former United case manager similarly reported being told to always enter seven days of skilled nursing for Level 3 members regardless of whether they received them. She also reported that United SCO Plan employees were always instructed to enter this amount regardless of whether or not a family member was assisting the patient or if the patient refused services.

207. Despite knowing about this requirement, United has systemically failed to comply with it. The Attorney General's Office conducted an analysis of United's MDS-HC assessments submitted to MassHealth for its Level 3 population with dates of assessment between January 1, 2014, to December 30, 2024. Of the 88,696 MDS-HC assessments resulting in a capitation rate of Level 3 United submitted during this time period, 88,052, or 99.3% of those members, were listed as receiving visiting nursing services seven days per week. Despite this assertion, according to claims data submitted by nursing agencies, 89.47% of those assessments listing seven days of skilled nursing had not received a single nursing visit in the week preceding the MDS-HC assessment, which is the relevant time period for the assessment.

208. Out of this population of MDS-HC assessments, for 49,828 assessments seven days of visiting nursing was the only form of skilled care that was reported to be utilized. Among

this subgroup, 92.03% of assessments had no claims for visiting nurses submitted by providers in the week prior to the assessment, reflecting that those patients did not need seven days of skilled nursing per week. As a result, United was paid at least \$1.4 billion for members that were not eligible for Level 3. If United was instead reimbursed at the Level 1 rate for these members, United would have been paid approximately \$235 million instead. United has not repaid MassHealth for the difference between the capitated payments it received and what it was entitled to, based on the members' actual health status.

209. That United's Level 3 members did not need, and were not actually receiving, skilled nursing services has been confirmed by the members themselves.

210. The Attorney General's Office spoke with member J.C. who has been enrolled in the United SCO Plan since 2014. From February 2019 through August 2024, United assessed J.C. a total of six times. Each time United assessed J.C. at Level 3 except for one assessment in July 2022, when United reduced her to Level 2. United increased J.C. to Level 3 for the following assessment in August 2023. In each Level 3 assessment, United reported that J.C. received seven days a week of visiting nursing, homemaking services, or both.

211. Contrary to United's reporting in the MDS-HC assessments, J.C. reported that she had never been visited by a nurse through United except for brief check-ins once or twice per year, and moreover that she only had daily homemaking services for approximately one year, which she elected to discontinue.

212. From May 2020 through August 2025, United was paid approximately \$131,883 by MassHealth in capitation payments at the Level 3 rate for J.C. for months related to MDS-HC assessments where visiting nursing was the only documented skilled service, and no nursing visits occurred in the week prior. Had these payments been at the Level 2 rate instead, United

would have been paid approximately \$50,300 instead. United has not reimbursed MassHealth for the difference.

213. The Attorney General's Office also spoke with member F.K., who has been enrolled in the United SCO Plan since 2019. Beginning in August 2020, United assessed F.K. five times, each time at Level 3. Each of those five assessments likewise reported that F.K. was receiving home health aides, visiting nurses, and homemaking services seven days per week.

214. F.K. reported that, apart from check-ins from United case manager nurses, she has not received any formal services from United at all. Claims data reflects that F.K. received personal care attendant services, not skilled services, and over the five years of Level 3 assessments, F.K. received skilled nursing services on eight days.

215. From October 2020 through September 2025, United was paid approximately \$96,211 by MassHealth in capitation payments at the Level 3 rate for F.K. for months related to MDS-HC assessments where visiting nursing was the only documented skilled service, and no nursing visits occurred in the week prior. Had these payments been at the Level 2 rate instead, United would have been paid approximately \$31,700. United has not reimbursed MassHealth for the difference.

216. The Attorney General's Office also spoke with the daughter of member L.P. L.P. has been enrolled in the United SCO Plan since 2017. United has performed three assessments of L.P. during that time, and each assessment requested assignment of L.P. to Level 3. Each assessment also reported that L.P. received visiting nursing services seven days per week. A December 2024 assessment also reported that L.P. received daily home health aide and homemaking services.

217. L.P.'s daughter stated that she coordinates L.P.'s care, and the only nursing visits L.P. receives are annual check-ins from United nurses. L.P.'s daughter also stated that she serves as L.P.'s personal care attendant, and, while she believes she is authorized to seek compensation from United for this work, she has not yet done so.

218. From September 2017 through December 2025, United was paid approximately \$113,407 by MassHealth in capitation payments at the Level 3 rate for L.P. for months related to MDS-HC assessments where visiting nursing was the only documented skilled service, and no nursing visits occurred in the week prior. Had these payments been at the Level 1 rate instead, United would have been paid approximately \$24,087. United has not reimbursed MassHealth for the difference.

Tolling of the Statute of Limitations

219. The Commonwealth first became aware of these allegations during its interview with a former Field Nurse of United on March 16, 2021.

220. In addition, United entered into a series of agreements with the Commonwealth tolling any applicable statutes of limitation, beginning June 2, 2022 and continuing through May 5, 2023, then beginning again on December 5, 2024 and continuing through May 27, 2026.

CAUSES OF ACTION

Count One

Presentment of False Claims, G.L. c. 12, § 5B(a)(1)

221. The Commonwealth incorporates by reference the allegations set forth in paragraphs 1 to 220 above as if fully set forth herein.

222. During the relevant time period, United violated G.L. c. 12, § 5B(a)(1) by knowingly presenting, or causing to be presented, false or fraudulent claims for payment or

approval to MassHealth, resulting in United receiving inflated capitated payments from MassHealth to which they were not entitled.

223. Specifically, United presented or caused to be presented false or fraudulent claims for payment or approval in the form of MDS-HC assessments that inflated members' health conditions to receive higher capitated payments from MassHealth.

224. United's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

225. If MassHealth had known that United had presented or caused to be presented false claims based on these false MDS-HC assessments, MassHealth would not have made the capitated payments and/or taken other appropriate action to ensure that United did not receive capitated payments to which it was not entitled, including by recouping payments through administrative processes or making payment adjustments.

226. By virtue of United's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

Count Two

Use of False Records or Statements, G.L. c. 12, § 5B(a)(2)

227. The Commonwealth incorporates by reference the allegations set forth in paragraphs 1 to 226 above as if fully set forth herein.

228. During the relevant time period, United violated G.L. c. 12, § 5B(a)(2) by knowingly making, using, and causing to be made or used, false records or statements material to false or fraudulent claims resulting in it receiving inflated capitated payments from MassHealth to which it was not entitled.

229. Specifically, United made, used, or caused to be made or used, false MDS-HC assessments that inflated members' health conditions to receive higher capitated payments from MassHealth.

230. United's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

231. If MassHealth had known that United had made, used, or caused to be made or used, false MDS-HC assessments, MassHealth would not have made the capitated payments and/or taken other appropriate action to ensure that United did not receive capitated payments to which it was not entitled, including by recouping payments through administrative processes or making payment adjustments.

232. By virtue of United's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

Count Three

Avoidance of Obligation to Transmit Funds to the Commonwealth, G.L. c. 12, § 5B(a)(9)

233. The Commonwealth incorporates by reference the allegations set forth in paragraphs 1 to 232 above as if fully set forth herein.

234. During the relevant time period, United knowingly made, used, or caused to be made or used a false record or statement material to an obligation to pay or transmit money to the Commonwealth and/or knowingly concealed or knowingly and improperly avoided or decreased its obligation to pay or transmit money to the Commonwealth, resulting in United retaining inflated capitated payments from MassHealth to which it was not entitled.

235. Specifically, United knowingly concealed or knowingly and improperly avoided or decreased its obligation to pay or transmit money to the Commonwealth by failing to notify or repay MassHealth for members whose health conditions had been inflated on MDS-HC assessments and for whom United received higher capitated payments from MassHealth than it should have.

236. United's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

237. By virtue of United's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

Count Four

Beneficiary of Overpayments, G.L. c. 12, § 5B(a)(10)

238. The Commonwealth incorporates by reference the allegations set forth in paragraphs 1 to 237 above as if fully set forth herein.

239. During the relevant time period, United was the beneficiary of overpayments from the Commonwealth, subsequently discovered the falsity of its receipt of overpayments, and failed to disclose the receipt of the overpayments from the Commonwealth.

240. Specifically, United was the beneficiary of overpayments, subsequently discovered the falsity of its receipt of overpayments, and failed to disclose the receipt of overpayments by failing to repay MassHealth for members whose health conditions had been inflated on MDS-HC assessments and for whom United received higher capitated payments from MassHealth than it should have.

241. United's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

242. By virtue of United's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

Count Five

Common Law - Unjust Enrichment

243. The Commonwealth incorporates by reference the allegations set forth in paragraphs 1 to 242 above as if fully set forth herein.

244. During the relevant time period, United submitted or caused to be submitted MDS-HC assessments for United's SCO members that inflated members' health conditions to receive higher capitated payments from MassHealth. United also failed to notify or repay MassHealth for members whose health conditions had been inflated on MDS-HC assessments and for whom United received higher capitated payments from MassHealth than it should have.

245. Based on this unlawful conduct, United received overpayments from MassHealth.

246. If United had not misrepresented its SCO Plan members' health conditions, MassHealth would not have paid these capitation payments. By retaining capitation payments improperly received from MassHealth, United has retained funds that are the property of the Commonwealth and to which United is not entitled.

247. It is unfair and inequitable for United to retain revenue from MassHealth for capitation payments that it obtained in violation of MassHealth regulations.

248. By virtue of United's conduct, United has been unjustly enriched and is liable to account and pay such amounts to the Commonwealth.

Count Six

Common Law - Breach of Contract

249. The Commonwealth incorporates by reference set forth in paragraphs 1 through 248 above as if fully set forth herein.

250. United entered into valid contracts with MassHealth for which adequate consideration was exchanged. United breached its contracts with MassHealth during the relevant time period by submitting MDS-HC assessments for United's SCO members that inflated members' health conditions to receive higher capitated payments from MassHealth.

251. Each false MDS-HC assessment that United submitted to MassHealth constitutes a breach of United's contracts with MassHealth.

252. As a result of United's breach of its contracts with MassHealth, the Commonwealth has been damaged.

JURY DEMAND

The Commonwealth demands a 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, Two, Three, and Four – for the amount of the Commonwealth's damages, 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. Count Five – for the amount of the Commonwealth's damages, as is proved at trial, interest, and costs; and
- c. Count Six – for the amount of the Commonwealth's damages, as is proved at trial, and interest at the statutory rate of 12% pursuant to Mass. Gen. Laws c. 231, § 6C, from the date of each breach of contract, together with such other relief as may be just and proper.

Respectfully submitted,

COMMONWEALTH OF MASSACHUSETTS

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