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

UNITED STATES OF AMERICA *ex rel.* SHERRILL,	)
	) Civil Case No.: 3:22-cv-0981
	)
Plaintiffs,	) JUDGE CRENSHAW
	) MAGISTRATE JUDGE FRENSLEY
v.	)
	) JURY TRIAL DEMANDED
CENTENE CORPORATION,	)
	)
Defendant.	)

UNITED STATES' COMPLAINT-IN-INTERVENTION

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I. PRELIMINARY STATEMENT

Thirty-five million elderly and disabled Americans receive their health care benefits through the Medicare Advantage ("MA") program, also known as Medicare Part C, in which private insurers offer government-approved insurance plans as an alternative to traditional Medicare Parts A and B coverage for hospital and physician services. Under the MA program, the Centers for Medicare and Medicaid Services ("CMS") makes a fixed monthly payment to the private insurers ("Medicare Advantage Organization" or "MAO") for each beneficiary enrolled in their MA plans. Insurers need beneficiaries enrolled in their plans to receive any payment from CMS. To ensure an orderly enrollment process and continuity of benefits, CMS only permits MAOs to enroll beneficiaries in their plans during specific time periods—the annual enrollment period and the open enrollment period—unless the beneficiary qualifies for a Special Enrollment Period (SEP).

From January 2020 through April 2024 (the "Relevant Period"), Defendant Centene Corporation ("Centene"), one of the nation's largest health insurance companies, knowingly and willfully enrolled beneficiaries in its MA plans using a Special Enrollment Period ("SEP") available only to beneficiaries enrolled in a qualified State Pharmaceutical Assistance Program ("SPAP") when Centene knew those beneficiaries were ineligible because they were not enrolled in a qualified SPAP. Indeed, Centene knew that these beneficiaries resided in states that did not even offer qualified SPAPs. But Centene disregarded this fact and pressured its agents to enroll the beneficiaries outside the annual and open enrollment periods using the SPAP SEP even though Centene knew those beneficiaries were not eligible for the SPAP SEP. Further, Centene repeatedly ignored red flags raised by its own compliance team and continued to falsely enroll beneficiaries in its MA plans using the SPAP SEP. Centene did so without competition from other MA plans,

because these enrollments were made outside the annual and open enrollment periods when beneficiaries did not have the same ability to compare different plans offered by various MAOs. Centene also deliberately ignored warnings about the risk posed by its reliance on tele-digital partners ("TDP"), which are third-party field marketing organizations that Centene retained to market and sell its MA plans. Centene knew that these TDPs were improperly using the SPAP SEP, but Centene doubled down on its partnerships with these firms as a key part of its strategy to grow the Medicare Advantage business without competition from other Part C plans.

The United States of America ("United States") suffered millions of dollars in damages when Medicare paid Centene monthly MA payments for beneficiaries whom Centene fraudulently enrolled. The United States brings this Complaint-In-Intervention seeking damages and penalties against Centene under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, and the federal common law theories of unjust enrichment and payment by mistake to guard the Medicare program against fraudulent conduct by one of the nation's largest health insurance companies, and to recover millions of American taxpayer dollars wrongfully obtained by Centene.

II. PARTIES

A. Plaintiff and Relator

1. Plaintiff is the United States. Through the Department of Health and Human Services ("HHS"), and more specifically through CMS, a component agency within HHS, the United States administers the Health Insurance Program for the Aged and Disabled established by Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.* ("Medicare").

2. Relator Donna Sherrill ("Relator") is a resident of Tennessee and a former employee of Centene Corporation. On December 5, 2022, Relator filed this action in this Court

alleging violations of the FCA on behalf of herself and the United States pursuant to the *qui tam* provisions of the FCA, 31 U.S.C. § 3730(b)(1).

3. Relator worked at Centene as a Medicare Benefits Advisor in Nashville, Tennessee from September 2020 to February 2023. In that role, Relator was authorized to market and sell Centene's Medicare Advantage plans under both Centene's Wellcare and Ascension Complete brands to prospective beneficiaries in Tennessee.

B. Defendant Centene

4. Defendant Centene Corporation is a Delaware corporation headquartered just outside St. Louis, Missouri.

5. Centene is a large publicly traded managed care company that markets and sells health insurance products, including MA plans, throughout the United States under various plan names.

6. Centene, through its subsidiaries and affiliates, owns and operates MAOs across the United States. Centene insures around one million MA beneficiaries across 32 states, including Tennessee.

7. Centene, through its MAOs, entered into annual contracts with CMS to offer its MA plans to Medicare beneficiaries. CMS has paid Centene billions of dollars to provide healthcare services and prescription drugs for the beneficiaries enrolled in Centene's MA plans.

III. JURISDICTION AND VENUE

8. On December 5, 2022, Relator Donna Sherrill initiated this action pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b).

9. On September 12, 2025, the United States filed its notice of election to intervene in part (Doc. No. 67) and now files this Complaint-in-Intervention in accordance with 31 U.S.C. § 3730(b)(4)(A) and the Court's August 28, 2026 Order. Doc. No. 108.

10. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1345 and 1367(a) because the United States is the plaintiff. In addition, the Court has subject matter jurisdiction over FCA claims for civil damages and penalties pursuant to 31 U.S.C. § 3732 and 28 U.S.C. §§ 1331, 1345, and 1355, and over the common law claims pursuant to 28 U.S.C. §§ 1331, 1345, and 1367(a).

11. This Court may exercise personal jurisdiction over Centene pursuant to 31 U.S.C. § 3732(a) because Centene transacted business in this District and committed some of the actions described herein, which are proscribed by 31 U.S.C. § 3729, in this District. For example, Centene fraudulently enrolled Medicare beneficiaries into its MA plans in Nashville, Tennessee.

12. Similarly, venue is proper in this jurisdiction under 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b) because Centene transacts business in this District, a substantial part of the events or omissions giving rise to the claims occurred in this District, and/or Centene is subject to the Court's personal jurisdiction under the FCA.

IV. LEGAL FRAMEWORK AND REGULATORY BACKGROUND

A. The False Claims Act

13. The FCA was originally enacted in 1863 to address fraud on the Government during the Civil War, and the FCA reflects Congress's objective to "enhance the Government's ability to recover losses as a result of fraud against the Government." S. Rep. No. 99-345, at 1 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266. The FCA broadly creates liability for "all types of fraud,

without qualification, that might result in financial loss to the Government." *United States v. Neifert-White Co*., 390 U.S. 228, 232 (1968).

14. The FCA provides, in pertinent part, that any person who "(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; [or] (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim" is liable to the United States Government for damages and penalties. 31 U.S.C. § 3729(a)(1).

15. The FCA defines "knowingly" to include "actual knowledge of the information," as well as actions taken in "deliberate ignorance of the truth or falsity of the information" or in "reckless disregard of the truth or falsity of the information." *Id.* § 3729(b)(1)(A). "No proof of specific intent to defraud" is required to establish liability. *Id.* § 3729(b)(1)(B).

16. The FCA defines a "claim" to mean:

> any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that
>
> (i) is presented to an officer, employee, or agent of the United States; or
>
> (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—
>
> (I) provides or has provided any portion of the money or property requested or demanded; or
>
> (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded[.]

Id. § 3729(b)(2).

17. The FCA defines "material" to mean "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." *Id.* § 3729(b)(4).

18. Violations of the FCA carry mandatory per-claim civil penalties, plus three times the amount of damages that the Government sustains as a result of a defendant's actions. *Id.* § 3729(a). Based on statutory adjustments for inflation, for violations occurring after November 2, 2015, and assessed after July 3, 2025, the minimum per-claim penalty is $14,308 and the maximum per-claim penalty is $28,609. 89 Fed. Reg. 9764 (Feb. 12, 2024).

B. Medicare

19. Medicare is a federally funded health insurance program administered by CMS. 42 U.S.C. §§ 1395c *et seq.* To be eligible for Medicare, a person must be over the age of sixty-five, be disabled, or have end-stage renal disease. Individuals who are insured or receive benefits through Medicare are often referred to as "Medicare beneficiaries."

20. The Medicare Program has four "Parts." Parts A and B are commonly known as "traditional" or "original" Medicare. Part A primarily covers inpatient and institutional care, and Part B primarily covers physician, outpatient, and ancillary services and durable medical equipment. Under Medicare Parts A and B, CMS generally reimburses health care providers directly based on payment rates predetermined by the Government.

21. This case involves the Medicare Advantage (MA) program (also known as Medicare Part C), which is an alternative to traditional Medicare.

1. Overview of Medicare Advantage

22. Under the MA program, Medicare beneficiaries can elect to receive their Medicare benefits through privately run insurance plans. *See* 42 U.S.C. §§ 1395w-21–1395w-28; 42 C.F.R.

§ 422.50(a). An individual is eligible to elect an MA plan if she is "entitled to Medicare under Part A and enrolled in Part B" of traditional Medicare. 42 C.F.R. § 422.50(a).

23. Today, more than half of all Medicare beneficiaries are enrolled in MA plans. In 2025, Medicare paid approximately $534 billion to MAOs, representing more than half of the United States' total Medicare payments.

24. MA plans are operated and managed by MAOs that contract with CMS. *E.g.*, 42 C.F.R. §§ 422.2, 422.503(b)(2).

25. Centene's wholly-owned subsidiaries and affiliates operate as MAOs. MAOs may offer one or more MA plans. Centene has offered numerous plans across the United States operating under various names including but not limited to Wellcare, Allwell, Health Net, Fidelis Care, Meridian, Trillium Advantage, and Ascension Complete.

26. Specifically, during the relevant period, Centene operated Medicare Advantage plans in the following states: Alabama, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Washington, and Wisconsin.

27. Under the MA program, when a health care provider furnishes medical services to a Medicare beneficiary, the provider submits information from the patient encounter directly to the MAO that operates the beneficiary's MA plan. The provider then receives payment from the MAO, instead of directly from CMS.

28. To compensate MAOs for providing coverage for beneficiaries on their plans, CMS makes monthly payments to the MAOs in a capitated (i.e., fixed) amount, per beneficiary enrolled

in each MA plan. Unlike under Medicare Parts A and B, these per-member, per-month payments do not depend on the number or type of services provided to a specific beneficiary.

29. The Medicare Advantage program relies on MAOs to provide accurate, complete, and truthful data, including enrollment information, to CMS. As a condition for receiving a monthly payment, the MAO insurer must certify to the accuracy, completeness, and truthfulness of the various data that it has submitted to CMS, including enrollment information. 42 CFR § 422.504(l). Specifically, the insurer must certify that "each enrollee for whom the organization is requesting payment is validly enrolled in an MA plan offered by the organization." *Id.* § 422.504(l)(1). CMS pays a monthly payment for every beneficiary validly enrolled in the insurer's plan. If a beneficiary is *not* validly enrolled, the insurer is *not* entitled to the monthly payment from CMS for that beneficiary.

30. A particular Medicare Advantage plan's provider network, drug coverage, benefits, and premiums may change from year to year. Most Medicare beneficiaries may switch Medicare Advantage plans once each year during the Annual Enrollment Period (sometimes called "AEP"), which runs from October 15 to December 7. *See* 42 U.S.C. § 1395w–21(e)(3)(B)(v); 42 C.F.R. § 422.62(a)(2)(iii).

31. After the Annual Enrollment Period has closed, beneficiaries who may be dissatisfied with their Medicare Advantage plan have at least two options. Medicare beneficiaries may generally disenroll from a Medicare Advantage plan during the Medicare Advantage Open Enrollment Period ("MA OEP") between the window from January 1 and March 31. *See generally id.* § 422.66(b). Beneficiaries may disenroll, for example, because they prefer a different plan's provider network or because they did not fully understand the benefits and premiums of a chosen

plan upon enrollment. Most Medicare Advantage beneficiaries, however, do not switch plans during the Annual Enrollment Period.

32. Beyond disenrollment, dissatisfied beneficiaries may complain to CMS regarding the conduct of MAOs or their affiliates. These complaints are tracked with CMS's "Complaints Tracking Module" (or "CTM"). *See id.* § 422.125. Depending on the urgency of the complaint as determined by CMS, complaints must be resolved by the MAO in two days, seven days, or thirty days. *Id.* § 422.125(b).

33. Complaints may also relate to conduct by brokers who act on behalf of MAOs. Many Medicare beneficiaries seek help from private insurance brokers in considering their health plan options, as there may be multiple available Medicare Advantage plans with distinct provider networks and benefits.

34. CMS requires that MAOs "oversee first tier, downstream, and related entities that represent the MA organization to ensure agents and brokers abide by all applicable State and Federal laws, regulations, and requirements." 42 C.F.R. § 422.2274(c).

35. The rate of complaints that CMS receives relating to a particular Medicare Advantage plan can affect the plan's "Star Rating," a quality rating which can affect payment from CMS. *Id.* § 422.166(e); *see also id.* § 422.162(b) (describing contract ratings by CMS).

36. Outside the AEP and MA OEP, a beneficiary may switch or disenroll from a Medicare Advantage plan if they are eligible for one of the Special Enrollment Periods ("SEP") enumerated in 42 CFR § 422.62(b).

37. A Special Enrollment Period allows Medicare Advantage beneficiaries to make changes to their coverage when certain events happen in their lives. The length of the SEP and the

effective date of the beneficiary's new coverage vary depending on the circumstances that trigger the SEP.

38. For example, beneficiaries may qualify for an SEP if they change where they live, lose their current coverage, or they are affected by an emergency or major disaster. *See* 42 CFR §§ 422.62(b)(1), (2) & (18).

39. A beneficiary's eligibility for an SEP provides an opportunity to make an election but does not necessarily convey their eligibility to enroll in a Medicare Advantage plan. CMS generally holds the MAOs responsible to determine whether the beneficiary is eligible for an SEP.

40. In at least 2020, CMS issued notices of non-compliance to insurance companies for failure to administer an SEP.

41. On April 27, 2021, CMS alerted all MA plans and MA Prescription Drug plans, including those owned and operated by Centene, that it is "the responsibility of the [MA] organization to determine whether the individual is eligible for an SEP."

2. State Pharmaceutical Assistance Program SEP

42. Beneficiaries may also qualify for an SEP if they belong to a qualified State Pharmaceutical Assistance Program ("SPAP"). This particular SEP is available while the beneficiary is enrolled in a qualified SPAP or upon the loss of the beneficiary's eligibility. 42 CFR § 422.62(b)(12).

43. CMS established the SPAP SEP in 2006 to allow beneficiaries who had been automatically enrolled in a Medicare prescription drug coverage ("Part D") plan by their state's SPAP to make one election annually to enroll in a Part D plan of their choice. The current version of the SPAP SEP, formally adopted effective August 2020, is similarly narrow in scope.

44. Not every state has an SPAP, and not every SPAP is a *qualified* SPAP. A qualified SPAP is defined as a state program that meets the requirements of 42 CFR § 423.464(e)(1), which expressly excludes State Medicaid programs and any program that is funded by the federal government. 42 CFR § 423.454.

45. CMS maintains and publishes a list of all qualified SPAPs on CMS' website. At times relevant to this Complaint, the following states did *not* have a qualified SPAP: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Utah, Washington, West Virginia, and Wyoming.

46. Starting in July 2021, CMS began to require MAOs to track and report all Medicare Advantage SEP enrollments. Each type of SEP was assigned an "SEP Reason Code Number" with a description of that SEP's eligibility requirements. Designated as SEP Reason Code Number 38, the SPAP SEP was described as available for "[i]ndividuals who belong to a qualified SPAP or who lose SPAP eligibility."

3. Contractual and Claim Requirements for MAOs

47. To participate in Medicare Advantage, MAOs must execute a written agreement with CMS on an annual basis for each Medicare Advantage plan they operate. Centene executed such agreements or renewals annually for all of the Medicare Advantage plans that it has operated in the United States.

48. CMS regulations list provisions that contracts between MAOs and CMS "must contain." 42 C.F.R. § 422.504.

49. Notably, these provisions include an agreement to comply with "Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including . . . the False Claims Act (31 U.S.C. §§ 3729 et seq.)." *Id*. § 422.504(h).

50. Further, "[a]s a condition for receiving a monthly payment," the MAO must certify to the accuracy, completeness, and truthfulness of the data submitted to CMS, including data relating to enrollment. Specifically:

> the [MAO] agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of relevant data that CMS requests. Such data include specified enrollment information, encounter data, and other information that CMS may specify.

Id. § 422.504(l).

51. Additionally, the MAO "must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an MA plan offered by the organization and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief) is accurate, complete, and truthful." *Id.* § 422.504(*l*)(1).

52. Compliance with these provisions is material to the performance of the contracts between MAOs and CMS to operate Medicare Advantage plans. *Id*. § 422.504(a).

53. Medicare Advantage organizations must also "adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements." *Id*. § 422.503(b)(4)(vi).

54. The accuracy and validity of the enrollment data reported by the MAOs has always been material to CMS' payments, because MAOs are paid only for the beneficiaries who are validly enrolled in their MA plans. Indeed, the United States has sought to enforce the requirement

for accurate, complete and truthful enrollment data by actively pursuing legal actions against MAOs for violating that requirement.

55. For example, in May 2025, the United States filed a complaint against three national health insurance companies and three brokers alleging unlawful kickbacks and discrimination against disabled Americans. *See* United States' Complaint in Partial Intervention, *United States ex rel. Shea v. eHealth, et al.*, No. 21-cv-11777 (D. Mass. May 1, 2025). In that case, the United States alleges FCA liability against the defendants for submitting claims containing false certifications regarding "accurate, complete, and truthful" enrollment information as required by 42 C.F.R. § 422.504(l).

V. CENTENE'S FRAUDULENT ENROLLMENT SCHEME

56. From January 2020 through April 2024, Centene improperly enrolled thousands of beneficiaries using the SPAP SEP when Centene knew that those beneficiaries were ineligible for that SEP because their states did not even offer a qualified SPAP.

57. Centene knew that the majority of the states in which it operated did not have SPAPs, but Centene disregarded that fact to drive up its enrollment numbers and grow its MA business.

A. Centene Knew the SPAP SEP Requirements and Ignored Red Flags Raised by Its Own Compliance Team about the Invalid SPAP SEP Enrollments

Florida Example

58. In May 2020, Centene received a complaint from a beneficiary in Florida alleging that she was enrolled into Centene's Wellcare plan (Contract H5199) without her consent. Centene's Compliance Investigations Unit ("CIU") investigated the complaint and found that the "[sales] agent enrolled the beneficiary using an invalid Special Election Period (SEP)." The CIU noted that the agent "selected the following SEP on the beneficiary's enrollment application, 'I

belong to a pharmacy assistance program provided by my State'" even though the beneficiary "did not advise the agent that she was in a State Pharmaceutical Assistance Program (SPAP)." The CIU further noted that the "State of Florida does not have a SPAP" and concluded that the "beneficiary did not have a valid SEP to enroll into the plan."

59. Centene had submitted this beneficiary's enrollment application on April 24, 2020, for a May 1, 2020 effective coverage date. Because the application was submitted outside the MA OEP, which ended on March 31, 2020, Centene needed a valid SEP to complete the enrollment.

60. The beneficiary was not eligible to use the SPAP SEP, because Florida did not and does not have a qualified SPAP. Nevertheless, Centene submitted this beneficiary's enrollment application using the SPAP SEP, which was invalid, inaccurate, and false.

61. Wellcare, which is Centene's largest and primary Medicare brand and wholly-owned subsidiary, is headquartered in Tampa, Florida. Centene acquired Wellcare on January 23, 2020.

62. Despite the CIU's determination that Centene improperly enrolled this beneficiary using the SPAP SEP because Florida did not have an SPAP, Centene did not report the invalid enrollment to CMS, reprimand or educate its agent, or take any other remedial action to address how its agent enrolled a beneficiary using the SPAP SEP when the beneficiary's state did not have an SPAP.

Louisiana Example

63. In June 2020, Centene received a complaint from a beneficiary in Louisiana alleging that he was enrolled into a Wellcare plan (Contract H2491) without his consent. Centene's CIU investigated the complaint and found that the beneficiary was enrolled without his consent. Additionally, the CIU noted that the enrollment application "indicated election code reason 'I

belong to a pharmacy assistance program provided by my state.' However, there was no discussion regarding a State Pharmaceutical Assistance Program (SPAP) during the conversation with the member."

64. Centene submitted this beneficiary's enrollment application on May 8, 2020, for a June 1, 2020 effective coverage date. Because the application was submitted outside the MA OEP, which ended on March 31, 2020, Centene needed a valid SEP to complete the enrollment.

65. The beneficiary was not eligible to use the SPAP SEP, because Louisiana did not and does not have an SPAP. Nevertheless, Centene submitted this beneficiary's enrollment application using the SPAP SEP certifying that the beneficiary "belong[ed] to a pharmacy assistance program provided by [his] state," which was invalid, inaccurate, and false.

66. Despite the CIU's determination that Centene improperly enrolled this beneficiary using the SPAP SEP because Louisiana did not have an SPAP, Centene merely provided verbal coaching to the agent. Again, Centene did not address how its agent enrolled a beneficiary using the SPAP SEP when the beneficiary's state did not have an SPAP and did not take steps to prevent future non-compliance with CMS' SPAP SEP program requirements.

Tennessee Example

67. In March 2021, Centene received a complaint from a beneficiary in Tennessee alleging that he was misled by a Wellcare agent about the plan's coverage when he enrolled in his Wellcare plan (Contract H1416) in June 2020. Centene's CIU investigated the complaint and found that the beneficiary was enrolled using an "invalid SEP." Specifically, the CIU noted that the application stated the beneficiary "belong[ed] to a pharmac[eutical] assistance program provided by [his] State" even though the "State of Tennessee does not have an SPAP."

68. Centene submitted this beneficiary's enrollment application on June 22, 2020, for a July 1, 2020 effective coverage date. Because the application was submitted outside the MA OEP, which ended on March 31, 2020, Centene needed a valid SEP to complete the enrollment.

69. The beneficiary was not eligible to use the SPAP SEP because Tennessee did not and does not have a qualified SPAP. Nevertheless, Centene submitted this beneficiary's enrollment application using the SPAP SEP, which was invalid, inaccurate, and false.

70. Despite the CIU's determination that Centene improperly enrolled this beneficiary using the SPAP SEP because Tennessee did not have an SPAP, Centene merely provided verbal coaching to the agent. Again, Centene did not address how its system allowed the agent to enroll a beneficiary using the SPAP SEP when the beneficiary's state did not have an SPAP and did not take steps to prevent future non-compliance with CMS' SPAP SEP program requirements.

California Example

71. In May 2021, Centene received a complaint from a beneficiary in California alleging that they were enrolled into a Wellcare plan (Contract H5087) without consent. Centene's CIU investigated the complaint and found that the "agent enrolled the member with an invalid SEP." Specifically, the CIU determined that the agent "recommended SPAP [SEP] at the time of enrollment since the member just moved from Montana to California."

72. Centene submitted this beneficiary's enrollment application on April 21, 2021 for a May 1, 2020 effective coverage date. Because the application was submitted outside the MA OEP, which ended on March 31, 2020, Centene needed a valid SEP to complete the enrollment.

73. The beneficiary was not eligible to use the SPAP SEP, because neither California nor Montana had an SPAP.

74. Centene gave a written warning to this agent. But, again, Centene did not take any systemic action to prevent additional false SPAP SEP enrollments, such as notifying its sales agents to stop enrolling any beneficiaries using the SPAP SEP in states that did not have an SPAP. And Centene did not inform CMS about the invalid enrollment.

Other States

75. Centene's CIU also knew of similar fraudulent enrollments into its MA plans using the SPAP SEP in other states that did not have qualified SPAPs during the period from January 2020 through April 2024, but Centene likewise failed to take action to prevent future non-compliance with CMS' SPAP SEP program requirements until late April 2024.

B. Centene's Leadership Knew about SPAP SEP Violations and Ignored Them in Favor of Growth and Profit

76. As alleged above, Centene knew as early as 2020 that it was enrolling beneficiaries using the SPAP SEP in states that did not have an SPAP. Centene also knew that many of the invalid SPAP SEP enrollments were made by its tele-digital partners ("TDP").

77. In 2020, Centene engaged McKinsey & Company ("McKinsey"), a leading strategy and management consulting firm, to evaluate Centene's CTM (beneficiary complaints tracked by CMS) mitigation efforts, which included examining breakdown of CTMs by source.

78. As alleged above, CTMs negatively impact the MA plan's "Star Rating," a quality rating which can affect payment from CMS. Centene engaged McKinsey to assess and improve its MA segment's star ratings. During a "Centene Forward Stars Executive Steering Committee" meeting on May 3, 2021, McKinsey presented on ways to "help maximize RY23 Stars and revenue impact and start planning for RY24." In that meeting, McKinsey informed Centene's senior leadership that "complaints about the plan and member disenrollment are trending toward 3 stars,

driven by members from tele-digital sales channel." McKinsey identified Centene's TDPs as the "biggest driver of complaints but also growth."

79. Instead of cutting ties with the TDPs, Centene doubled down on its reliance on TDPs to generate sales and grow its MA business. For example, on September 14, 2021, Centene's senior leadership had a meeting to discuss Centene's strategy for the 2021 annual enrollment period, which runs from October 15th to December 7th every year. The meeting attendees included Richard C. Fisher, Centene's Senior Vice President and Medicare CEO; Shawn Holt, Centene's Chief Sales Officer; and Larry Cassar, Centene's Chief Agency Sales Officer. Despite McKinsey's warnings about the risk posed by TDPs, Centene's strategy for the 2021 AEP included plans to "expand strategic teledigital partnerships to drive incremental leads/enrollments – includes call volume being routed to partners as well as co-op dollars we are funding."

80. As predicted by McKinsey's warnings, Centene continued to have problems with enrollments made by its TDPs. And Centene's internal audits reflected the ongoing enrollment problems with its TDPs.

81. For example, in a June 2022 presentation titled "Tele-digital Partner Call Audit Results," Centene's own Medicare Compliance Monitoring and Oversight Team highlighted that over 17 percent of enrollments audited in May 2022 used an "invalid or unsubstantiated SEP" including "Qualified/Lose SPAP." Centene's internal compliance team further flagged that this issue was an "[u]nremediated corrective actions [Previously Reported]."

82. Additionally, Centene's compliance team noted that a TDP's "enrollment with Qualified/Lose SPAP SEP was referred to CIU for further investigation." Yet, as alleged above, Centene's CIU knew about the SPAP SEP violations as early as 2020 and had not taken any systemic action to prevent additional false SPAP SEP enrollments.

83. Furthermore, Centene knew that member attestation was not enough and that it had to validate the member's attestation regarding their SEP eligibility, including the SPAP SEP. For example, as highlighted in the June 2022 presentation, Centene's compliance team had notified Centene's "Enrollment team regarding SEP validation" and that "[m]ost enrollment rejections due to invalid SEP's, but many enrollments effectuated based on Agent/Member attestation."

84. In the June 2022 presentation, Centene's compliance team also emphasized that a TDP "consistently uses invalid/unsubstantiated SEP's on their audits" and that the TDP's sales call script includes "SEP discovery/validation" but that it does not "hold agents accountable on their audit scorecard." Centene's compliance team further noted that it has "not observed agents performing due diligence to find a true and compliant SEP" and that "[t]he SEP is requirement on the enrollment."

85. The audience for the June 2022 presentation was Centene's senior leadership responsible for all of Centene's Medicare Advantage plans across the nation, including its five regional presidents and senior executives overseeing various aspects of Centene's Medicare Advantage operations.

C. Centene Knowingly Disregarded the SPAP SEP Requirements and Pressured Sales Agents to Use the SPAP SEP in States without SPAPs

86. Despite numerous warnings from beneficiary complaints and external and internal audits, Centene continued to disregard the SPAP SEP requirements and pressured its sales team to use the SPAP SEP without verifying the beneficiaries' eligibility.

87. For example, during a sales team meeting on May 17, 2022, Roy Smith, Manager for Centene's Ascension Complete sales team in Tennessee, specifically instructed his sales agents, including Relator Donna Sherrill, to "use the SPAP election if you need to find a SEP for enrollment." These sales agents were Centene employees.

88. Similarly, during a sales team meeting on May 27, 2022, Smith again instructed his sales agents "if needed, to use the SPAP election," so they can do "a better job tracking toward our monthly goals" during the lock-in period. And again on June 3, 2022, Smith advised his sales agents that there will be "plenty of opportunities to enroll people after December 8th because many seniors will be home, and you can still enroll for January 1st effective with SPAP or other SEPs."

89. On August 19, 2022, Smith declared to his sales agents that "we don't have an SPAP in Tennessee…but that's not going to stop us from using that election." And in response to a question by the Relator about whether a "GoodRx" or similar pharmacy discount cards qualified as an SPAP, Smith answered: "there are people who think that it is […] I'm fine with it. And CMS has never challenged on it." Smith knew that Tennessee did not have an SPAP. Instead of properly advising his agents that they cannot use the SPAP SEP in Tennessee, he encouraged them to continue falsely enrolling beneficiaries with impunity.

90. Further, Centene's sales managers specifically instructed Centene's sales agents and third-party brokers to use the SPAP SEP whenever they needed to complete or "save a sale," i.e., revive a previously denied enrollment application. These managers did so even though they actually knew that these beneficiaries were not eligible for the SPAP SEP.

91. For instance, on May 6, 2022, Charles Woelfert, Regional Sales Director for Centene's Ascension Complete plans, emailed the sales managers for the states under his supervision—Alabama, Florida, Illinois, Indiana, Kansas, Michigan, Tennessee, and Texas—urging them to resubmit previously denied or delayed applications using the SPAP SEP: "Please assign the telesales out to W2 agents to do SEP pharmacy assistance on to get them re-enrolled."

92. Woelfert had learned by at least February 2021 that "not every state has the SPAP program" and he shared his findings with the other Centene's Ascension Complete managers,

including Wes Hyland, Vice President of Centene's Ascension Complete plans, in an email: "This [SPAP] SEP seems easier to use than the SEP for LIS but . . . I found that not every state has the SPAP program." Woelfert further highlighted that "[you] simply submit the applications with this [SPAP] SEP and they go through."

93. LIS SEP refers to the Low-Income Subsidy Special Enrollment Period, also known as Extra Help, which allows people with limited income to change their Medicare prescription drug coverage outside the normal enrollment windows.

94. Similarly, on June 20, 2022, Smith emailed Liz Lewis, a Centene sales agent, to rewrite a previously denied application using the SPAP SEP: "Can you see if you can write this app using the SPAP election?" Smith did not provide any information about whether the beneficiary actually belonged to a qualified SPAP or recently lost his eligibility from one.

95. In an email on June 27, 2022, Bob Herbst, Regional Sales Director for Centene's Ascension Complete plans, advised a state sales director in Texas under his supervision to use the SPAP SEP for denied applications. Reflecting Centene's utter disregard for SPAP SEP eligibility requirements, Herbst stated: "The easiest solution would be the SPAP SEP. The bad news is the agent will have to re-write them all."

96. Centene's sales managers repeatedly treated the SPAP SEP as a panacea for all enrollments that have been denied or otherwise delayed even though they knew that not all states have a qualified SPAP required. For example, in an email titled "Awesome Leads" on July 27, 2022, Herbst forwards a batch of denied applications to a state sales manager under his supervision with the following blanket instructions: "These were all NOT enrolled due to various reasons. Give them a call and go enroll them using SPAP!!"

97. Throughout the scheme, Centene's employees and agents completed the vast majority of the MA beneficiary enrollment applications and submitted them online; the beneficiaries did not themselves submit the application and on information and belief were not asked if they belonged to a qualified SPAP by the Centene employee(s) or agent(s). Thus, in the vast majority of instances, the beneficiaries never attested to belonging to an SPAP SEP.

98. Centene's sales managers kept track of SPAP SEP enrollments and often rewarded the sales agents for using the SPAP SEP. For example, in a May 12, 2022 email, Herbst, Regional Sales Director for Centene's Ascension Complete plans, complimented Liz Lewis, a sales agent under his supervision for using the SPAP SEP to enroll a beneficiary: "Well done Liz! The leader in SPAP apps!!"

99. Similarly, in a June 7, 2022 email, sales agents Ruth Meachum and Liz Lewis discussed the prize for winning the "SPAP contest": "Bob [Herbst] wanted to know who won so he can mail the $50 Visa gift card."

D. Centene's Fraudulent SPAP SEP Enrollments Were Part of Centene's Strategy to Grow the Medicare Advantage Business and Increase Profits

100. Centene's core business model revolves around administering government-sponsored health care programs with a focus on low-income populations. The vast majority of Centene's customers live below 250% of the federal poverty line.

101. Centene is the largest Medicaid managed care organization in the nation. It manages state benefits for over 12 million Medicaid recipients.

102. Centene is also the nation's leading standalone Medicare Part D provider with nearly 10 million Part D beneficiaries across all 50 states.

103. Centene's MA business reflects its focus on low-income populations, with dual-eligible (Medicare and Medicaid) beneficiaries making up over 40% of Centene's MA beneficiaries.

104. Centene's competitive advantage is its expertise with the low-income, vulnerable, complex populations. Leveraging that expertise with its dominance in the standalone PDP market, Centene identified certain populations as targets for growth, including the SPAP enrollees.

105. Centene's fraudulent scheme to enroll beneficiaries outside of the MA AEP or MA OEP using the SPAP SEP allowed Centene to market its MA plans without competition from other MAOs and without the counter-messaging and fact-checking of marketing claims that marketplace competition affords.

106. For example, Centene used marketing materials that contained misleading and/or inaccurate information about its dental benefits. Centene's marketing materials, including a six-foot tall banner displayed at physicians' offices and hospitals, stated that there is "no $$ limit on dental benefits, including dentures, implants and other services." These marketing materials were misleading because Centene's MA plans had various restrictions that effectively limited the benefits. For instance, while Centene's Ascension Complete plans from 2020 through 2023 did not have dollar limits on dental benefits, they had limits on the number of certain dental procedures.

107. Centene knew that certain dental benefits would be particularly appealing to its target low-income beneficiaries. Centene also knew that many beneficiaries enrolled in Centene's MA plans because of the advertised dental benefits. For example, on April 22, 2020, Wes Hyland, Vice President of Sales for Centene's Ascension Complete plans, emailed Centene's marketing executive advocating for highlighting dental benefits: "In past experience, dental/vision/etc always

tend to make the phone ring . . . would love to see if there's any way to sneak some of that in for 2021."

108. Centene knew that these dental marketing materials were misleading because it received numerous complaints from not only the beneficiaries who were misled but also its own sales agents and managers. For example, in sworn testimony, Herbst confirmed that numerous agents and brokers complained about "how they were told that Centene's Ascension Complete plans were unlimited dental benefits, when in fact they were not." But Centene continued highlighting these benefits in its marketing materials—even after learning that the descriptions of those benefits were misleading and/or inaccurate.

109. When Centene made misleading and/or inaccurate marketing claims during the MA AEP or MA OEP, other MAOs and brokers competing for the same beneficiaries were touting their own array of benefits and could explain the limitations on Centene's dental benefits. However, the beneficiaries whom Centene improperly enrolled under the SPAP SEP were deprived of the benefits of competing marketing messages and the ability to comparison shop for other MA plans that may have had benefits that were better suited to their individual needs.

110. Furthermore, Centene's growth strategy for its MA plans included a "Cross Sell" campaign, which focused on converting Centene's Part D beneficiaries to its Medicare Advantage plans. In as early as 2019, Centene sought to "expand [its] top-line revenue generation by targeting Members that are more susceptible to Cross Sell in Mature and Niche Programs." Centene identified "SPAP" as a "niche program."

111. According to a January 2021 Centene presentation titled "Cross Sell January 2021 Summary," Centene's cross-sell enrollments increased from 34,284 in 2019 to 73,224 in 2020,

which resulted in over $942 million in revenue and $46 million in profits. In 2020, Centene's Cross Sell campaign created $3.2 billion in "life time revenue" and $286 million in "life time net profit."

112. As alleged above, many qualified SPAPs coordinate benefits with the enrollee's Part D plan. As the Part D sponsor for nearly 10 million beneficiaries in all 50 states, it is essential for Centene to know which states have SPAPs, how many of those are qualified SPAPs, and the type and level of assistance offered by those SPAPs.

113. Centene's failure to comply with its contractual and regulatory obligations was not due to ignorance or mistake. Centene—which operates a sophisticated, centralized Medicare business that controls all aspects of sales, marketing, and enrollment for all of Centene's MA plans—was aware of CMS program requirements for MAOs. Centene understood the requirements of SPAP SEP, which states had qualified SPAPs, and its obligations as an MAO to submit valid enrollment applications.

114. Yet Centene continued to falsely enroll beneficiaries using the SPAP SEP in states that did not have a qualified SPAP because Centene was more concerned about growing its struggling MA business. Indeed, Centene had numerous opportunities to systemically address the SPAP SEP violations. Centene was alerted as early as May 2020 by its own compliance team about the invalid SPAP SEP enrollments. In 2021, Centene was advised by McKinsey regarding the risk of relying on tele-digital partners and doubled down on its partnership with these firms in favor of growth. And in 2022, Centene's own compliance team again flagged ongoing issues with invalid or unsubstantiated SEP enrollments, including the SPAP SEP. But Centene did not take any corrective action until April 24, 2024—over 18 months after the United States put Centene on notice about the allegations here through issuance of a Civil Investigative Demand to Centene.

115. From January 2020 through April 2024, Centene fraudulently enrolled over 13,000 beneficiaries using the SPAP SEP in states that did not have a qualified SPAP at relevant times, and Centene received millions of dollars in monthly payments from CMS for those beneficiaries to which Centene was not entitled since those beneficiaries were not validly enrolled in Centene's MA plans.

VI. CENTENE MADE MATERIAL FALSE CLAIMS

A. Centene Made, or Caused to be Made, Material False Claims Because Centene Violated CMS Requirements for Enrollments Under SPAP SEP

116. In the Relevant Period, Centene knowingly made or presented, or caused to be made or presented, claims for payment to the United States that resulted from invalid enrollments in violation of CMS requirements.

117. In the Relevant Period, Centene also knowingly made or presented, or caused to be made or presented, claims for payments to the United States that falsely represented compliance with material statutory, regulatory, and contractual requirements.

1. Centene's Contracts with CMS Required Centene to Agree to Comply with Statutory, Regulatory, and Contractual Requirements.

118. From January 2020 through April 2024, Centene through its subsidiaries and affiliates entered into contracts with CMS to provide healthcare to Medicare Advantage beneficiaries.

119. In each of those contracts, Centene expressly certified that it would "comply with . . . Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 [U.S.C.] §§3729 et. seq.), and the anti-kickback statute (§ 1128B(b) of the Act)."

120. For each of those contracts, compliance with the contractual and regulatory provisions requiring compliance with these laws and regulations was expressly "material to the performance of the MA contract." *Id*. § 422.504(a).

121. When Centene renewed those contracts for subsequent years in the Relevant Period, Centene again expressly agreed to comply with all applicable federal laws and regulations. For example, on August 31, 2021, Centene through its subsidiary Sunshine State Health Plan, Inc., entered into Contract H1032 with CMS to provide Medicare Advantage plans through December 31, 2022. Centene's Senior Vice President and Medicare CEO Richard Fisher signed the contract on Centene's behalf. On September 7, 2022, Contract H1032 was renewed through December 31, 2023. Centene's Medicare Advantage CFO Garrett Leaf signed the contract on Centene's behalf.

2. Centene Certified in Its Claims for Payment that the Information Centene Provided Was Accurate and Truthful

122. To receive payment from CMS, Centene had to and did submit enrollment information for every beneficiary enrolled in one of its Medicare Advantage plans and, subsequently, monthly enrollment and payment data to CMS as well as a "Certification of Monthly [or Quarterly] Enrollment and Payment Data." Centene submitted enrollment and payment data, as well as the required certifications, to CMS during the Relevant Period.

123. In submitting these data and associated certifications, Centene stated the following, as required by its contracts and regulation: "The Organization hereby requests payment under the contract, and in doing so, makes the following certifications concerning CMS payments to the Organization. The Organization acknowledges that the information described below directly affects the calculation of CMS payments to the Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal

prosecution . . . Based on best knowledge, information, and belief, all information submitted to CMS and/or its contractors is accurate, complete, and truthful."

124. For example, Mr. Fisher signed the certifications on behalf of Centene in 2021, and in 2022, Mr. Leaf signed on behalf of Centene.

125. Centene's enrollment of a beneficiary was the initiation of a demand for CMS's monthly capitated payments to Centene for that beneficiary. Thus, each enrollment by Centene constituted presentment of a claim.

126. Centene's transmittal to CMS of "accurate, complete, and truthful" data concerning "validly enrolled" beneficiaries also was a demand for, and a necessary precursor to, CMS' payment of the capitated rates for beneficiaries enrolled in Centene's plans. *See* 31 U.S.C. § 3729(b)(2) (defining "claim" under the FCA).

127. Every time Centene submitted beneficiary data and attestations concerning enrollments made using the SPAP SEP for beneficiaries that it knew were not enrolled a qualified SPAP because they lived in a state that did not even offer a qualified SPAP, Centene falsely represented compliance with material statutory, regulatory, and contractual requirements. These false representations were material to the United States' payment decision.

VII. REPRESENTATIVE EXAMPLES OF CENTENE'S FALSE CLAIMS TO THE GOVERNMENT

128. From January 2020 through April 2024, Centene carried out its fraudulent enrollment scheme in the following states: Alabama, Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Nebraska, New Hampshire, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, and Washington.

129. Each of the following exemplar beneficiaries were falsely enrolled by Centene using the SPAP SEP as described above. For each of these beneficiaries, Centene submitted claims for payment to CMS in the form of false enrollment applications certifying that the beneficiaries qualified for the SPAP SEP. Centene also submitted false beneficiary data certifying that these beneficiaries were "validly enrolled."

a. In May 2022, under its contract H2853, Centene submitted a claim with beneficiary data to CMS, including data related to Beneficiary 1. Beneficiary 1 resided in Tennessee, which did not have a qualified SPAP. Centene received payment pursuant to this claim. In total, Medicare paid $9,578.09 for the months for which Beneficiary 1 was enrolled in Centene's MA plan, to which Centene was not entitled.

b. In June 2022, under its contract H1032, Centene submitted a claim with /beneficiary data to CMS, including data related to Beneficiary 2. Beneficiary 2 resided in Florida, which did not have a qualified SPAP. Centene received payment pursuant to this claim. In total, Medicare paid $18,328.73 for the months for which Beneficiary 2 was enrolled in Centene's MA plan, to which Centene was not entitled.

c. In July 2022, under its contract H5087, Centene submitted a claim with beneficiary data to CMS, including data related to Beneficiary 5. Beneficiary 5 resided in California, which did not have a qualified SPAP. Centene received payment pursuant to this claim. In total, Medicare paid $12,296.55 for the months for which Beneficiary 5 was enrolled in Centene's MA plan, to which Centene was not entitled.

d. In April 2023, under its contract H9730, Centene submitted a claim with beneficiary data to CMS, including data related to Beneficiary 8. Beneficiary 8 resided in Kentucky, which did not have a qualified SPAP. Centene received payment pursuant to this claim. In total, Medicare paid $64,870.85 for the months for which Beneficiary 8 was enrolled in Centene's MA plan, to which Centene was not entitled.

e. In May 2023, under its contract H5475, Centene submitted a claim with beneficiary data to CMS, including data related to Beneficiary 10. Beneficiary 10 resided in Michigan, which did not have a qualified SPAP. Centene received payment pursuant to this claim. In total, Medicare paid $30,307.15 for the months for which Beneficiary 10 was enrolled in Centene's MA plan, to which Centene was not entitled.

The following table summarizes these and other exemplar false claims in the Relevant Period.

Beneficiary	Parent Org.	Contract Name	Contract Number	State	Application Date; Effective Cov. Blown	Qualified SPAP (Y/N)	CMS Payments to Centene
1	Centene Corp.	Centene Venture Company Tennessee	H2853	TN	5/20/2022; 6/1/2022	N	$9,578.09
2	Centene Corp.	Sunshine State Health Plan, Inc.	H1032	FL	6/9/2022; 7/1/2022	N	$18,328.73
3	Centene Corp.	Harmony Health Plan, Inc.	H1416	TN	8/16/2022; 9/1/2022	N	$14,832.19
4	Centene Corp.	Centene Venture Company Tennessee	H8121	TN	7/30/2022; 8/3/2022	N	$2,280.32
5	Centene Corp.	Wellcare of California	H5087	CA	7/13/2022; 8/1/2022	N	$12,296.55
6	Centene Corp.	Wellcare Health Insurance of Arizona, Inc.	H5199	FL	9/13/2022; 10/1/2022	N	$36,387.70
7	Centene Corp.	Meridian Health Plan of Michigan	H5475	MI	8/12/2022; 9/1/2022	N	$34,863.90
8	Centene Corp.	Wellcare Health Insurance Company of Kentucky	H9730	KY	4/3/2023; 5/1/2023	N	$64,870.85
9	Centene Corp.	Wellcare Health Insurance Company of Kentucky	H9730	KY	5/5/2023; 6/1/2023	N	$22,601.39
10	Centene Corp.	Buckeye Community Health Plan, Inc.	H5475	MI	5/24/2023; 8/31/2023	N	$30,307.15
11	Centene Corp.	Buckeye Community Health Plan, Inc.	H0908	OH	6/29/2022; 7/1/2022	N	$25,917.65
12	Centene Corp.	Buckeye Community Health Plan, Inc.	H0908	OH	8/4/2022; 9/1/2022	N	$15,044.53

130. In each of the above and thousands of other instances, Centene's fraud had a direct and foreseeable impact on CMS. Specifically, Centene's fraud caused CMS to make monthly MA payments to Centene to which Centene was not entitled.

131. As Centene knew, each of those Part C attestations was false. Specifically, Centene knew that invalid enrollments like the examples enumerated in paragraph 129 above were included in its monthly attestation as a condition of payment for those beneficiaries.

VIII. CAUSES OF ACTION

COUNT I

Violations of the False Claims Act:
Presentation, or Causing Presentation, of False or Fraudulent Claims for Payment
(31 U.S.C. § 3729(a)(1)(A))

132. The United States realleges and incorporates by reference all paragraphs of this complaint set out above as if fully set forth in this paragraph.

133. By virtue of the acts described above, Centene knowingly presented or caused to be presented materially false or fraudulent claims for payment or approval to the United States, in violation of 31 U.S.C. § 3729(a)(1)(A). That is, Centene knowingly made or presented, or caused to be made or presented, to the United States claims for payments that falsely represented compliance with material statutory, regulatory, or contractual requirements.

134. Compliance with applicable statutes, regulations, and terms of Centene's contracts with the United States was a requirement of Centene's eligibility to receive payment from the United States.

135. Centene's agreement to comply with "Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. §§ 3729 et seq.) was a requirement of

Centene's contracts with CMS and a condition of its eligibility to receive payment from the United States.

136. Centene's representations of compliance with applicable statutory, regulatory, and contractual requirements were knowingly and materially false.

137. Centene's promise or certification that the data it sent to the United States were "accurate, complete, and truthful" and concerned "validly enrolled" beneficiaries was a requirement of Centene's contracts with CMS and a condition of its eligibility to receive payment from the United States.

138. Centene's promises and certifications were knowingly and materially false when Centene was violating applicable statutory, regulatory, and contractual requirements.

139. Because Centene's representations of compliance with applicable statutory, regulatory, and contractual requirements and its promises or certifications that the data it sent to the United States were "accurate, complete, and truthful" and concerned "validly enrolled" beneficiaries were knowingly false, Centene's claims to the United States were false.

140. The United States, unaware of the falsity of the claims made or caused to be made by Centene, paid claims that it would not have paid had it known of Centene's illegal conduct.

141. Payment of the false and fraudulent claims was a reasonable and foreseeable consequence of Centene's conduct.

142. By reason of the foregoing and because of Centene's wrongful conduct, the United States has suffered actual damages in an amount to be determined at trial, and therefore is entitled under the False Claims Act to recover treble damages plus a civil monetary penalty for each false or fraudulent claim.

COUNT II

Violations of the False Claims Act:
False Records or Statements Material to False or Fraudulent Claims
(31 U.S.C. § 3729(a)(1)(B))

143. The United States realleges and incorporates by reference all paragraphs of this complaint set out above as if fully set forth in this paragraph.

144. By virtue of the acts described above, Centene knowingly made, used, or caused to be made or used false records and statements material to false records or statements—for example, false claims, false statements in claims to federal health care programs, and false statements about compliance with the requirements for valid enrollments of Medicare Advantage beneficiaries using the State Pharmaceutical Assistance Program Special Enrollment Period. These false records or statements were material to false or fraudulent claims that were submitted to the United States, and which the United States paid and approved, in violation of 31 U.S.C. § 3729(a)(1)(B).

145. Compliance with applicable statutes, regulations, and terms of Centene's contracts with the United States was a requirement of Centene's eligibility to receive payment from the United States.

146. Centene's representations of compliance with applicable statutory, regulatory, and contractual requirements were knowingly and materially false.

147. Centene's promise or certification that the data it sent to the United States were "accurate, complete, and truthful" and concerned "validly enrolled" beneficiaries was a requirement of Centene's contracts with CMS and a condition of its eligibility to receive payment from the United States.

148. Centene's promises or certifications that the data it sent the United States was "accurate, complete, and truthful" and concerned "validly enrolled" beneficiaries and the promises

or certifications found in Attachment A to its contracts with CMS ("Attestation of Enrollment") were requirements of Centene's contracts with CMS and a condition of its eligibility to receive payment from the United States.

149. Centene's promises and certifications were knowingly and materially false when Centene was violating applicable statutory, regulatory, and contractual requirements.

150. The United States, unaware of the falsity of the claims made or caused to be made by Centene, paid claims that it would not have paid had it known of Centene's illegal conduct.

151. Payment of the false and fraudulent claims was a reasonable and foreseeable consequence of Centene's conduct.

152. By reason of the foregoing and because of Centene's wrongful conduct, the United States has suffered actual damages in an amount to be determined at trial, and therefore is entitled under the False Claims Act to recover treble damages plus a civil monetary penalty for each false or fraudulent claim.

COUNT III

Unjust Enrichment
(Federal Common Law)

153. The United States realleges and incorporates by reference all paragraphs of this complaint set out above as if fully set forth in this paragraph.

154. The United States is entitled, under federal common law, to the recovery of monies by which Centene has been unjustly enriched due to its actions as described in this complaint.

155. Through the conduct and acts described above, Centene was unjustly enriched at the expense of the United States in an amount to be determined, which, under the circumstances, in equity and good conscience, and as dictated by the needs of justice and fairness, should be returned to the United States or would be unconscionable for Centene to retain.

156. Through the conduct and acts described above, Centene has received payments from the United States to which it was not entitled, which unjustly enriched Centene, and for which it must make restitution. Centene received such payments based on the submission of false claims and based on causing the submission of false claims. In equity and good conscience, such money belongs to the United States and to the Medicare program and should not be retained by Centene.

157. That is, by obtaining monies as a result of its violations of Federal law, Centene was unjustly enriched, and it is liable to account and pay such amounts, which are to be determined at trial, to the United States.

COUNT IV

Payment by Mistake
(Federal Common Law)

158. The United States realleges and incorporates by reference all paragraphs of this complaint set out above as if fully set forth in this paragraph.

159. The United States is entitled, under federal common law, to the recovery of monies paid to Centene as a result of a mistaken understanding.

160. Through the conduct and acts described above, Centene was mistakenly paid at the expense of the United States in an amount to be determined, which, under the circumstances, in equity and good conscience, and as dictated by the needs of justice and fairness, should be returned to the United States or would be unconscionable for Centene to retain.

161. Through the conduct and acts described above, Centene has received payments from the United States to which it was not entitled and for which it must make restitution. Centene received such payments under the mistaken and erroneous belief that the beneficiaries for whom Centene received monthly Medicare Advantage payments were validly enrolled. In equity and

good conscience, such money belongs to the United States and to the Medicare program and should not be retained by Centene.

162. That is, had the United States known the truth, it would not have paid such monies. Centene is thus liable to account and pay such amounts, which are to be determined at trial, to the United States.

IX. PRAYER FOR RELIEF

Wherefore, the United States respectfully requests judgment be entered in its favor and against Defendant as follows:

(a) On the First and Second Claims for relief (violations of the FCA, 31 U.S.C. § 3729(a)(1)(A) and 31 U.S.C. § 3729(a)(1)(B)), judgment against Centene for treble the Government's damages, in an amount to be determined at trial, plus a civil penalty in the maximum applicable amount for each violation of the FCA.

(b) On the Third and Fourth Claims for relief (federal common law claims for unjust enrichment and payment by mistake), judgment against Centene for damages to the extent allowed by law.

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

X. JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure and Local Rule 7.03(b), the United States requests a trial by jury.

Respectfully submitted,

For the United States:

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